Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. fax	re: address and phone number (partial) (1 page)	02/16/1999	P6/b(6)
002. resume	re: George Maglaras (partial) (1 page)	02/16/1999	P6/b(6)
003. note	re: medical information (1 page)	n.d.	P6/b(6)
004. note	re: medical information (1 page)	n.d.	P6/b(6)
005. note	re: medical information (2 pages)	n.d.	P6/b(6)
006. list	List of possible speakers re: medical information, phone numbers, SSN, and DOB (2 pages)	n.d.	P6/b(6)
007. memo	Dee Dee Henzler to Judy Riggs re: SSN and DOB (1 page)	02/16/1999	P6/b(6)
008. note	re: SSN, DOB, and phone number (partial) (1 page)	n.d.	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20468

FOLDER TITLE:
Nursing Home Event

2012-0463-S
rc702

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
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C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

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AMERICAN NURSES ASSOCIATION
GOVERNMENTAL AFFAIRS
600 MARYLAND AVENUE, SW - SUITE 100 WEST
WASHINGTON, DC 20024-2571
202-651-7000
FAX NUMBER 202-554-0189

FAX COVER PAGE

TO: Barbara Woolley, Assistant to the President
Office of Public Liaison

FROM: Jocelyn E. Coffey - 202-651-7083
Government Affairs
AMERICAN NURSES ASSOCIATION

DATE: February 16, 1999

FAX NUMBER 456-6218

PHONE NUMBER 456-2155

TOTAL PAGES WITH COVER 1

New Hampshire Nurse

Barbara,

Below is the name, address, phone and fax numbers for the President of the New Hampshire Nurses Association:

Sally Patton, BSNS, MS, RN
President
P6/(b)(6)
603-650-7758 - work
603-650-6623 - fax
sally.patton@hitchcock.org

[001]

member President of NPracticioners Ass. political

If you have any questions, please don't hesitate to call me at 651-7083.

Thank you!
Jocelyn

Laurie Harding

To: Barb Wooley/Aviva Steinberg
Devora Adler

From: Al Rutherford
Dover Lead

Date: 2/16/99

Re: Panelist Bio

4 Pages Total

Please Deliver ASAP

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GEORGE MAGLARAS

P6/(b)(6)

P6/(b)(6)

(603)742-1458 Work

002

SUMMARY OF QUALIFICATIONS

Experienced in County and Municipal Government, Planning, Community Development, Budget Administration, and Economic and Industrial Development. Twenty (20) years of State, County, and local government involvement.

EXPERIENCE

January 1975 to Present	Proprietor of George's Marina, Dover, New Hampshire
January 1976 to December 1979	Dover Citizens Advisory Committee on Community Development; Chairman 1977 to 1979
January 1976 to December 1980	New Hampshire State Legislator; Strafford County Legislative Delegation Chairman 1978-1980
January 1979 to December 1987	Dover Planning Board; Chairman 1981 to 1987
January 1983 to December 1984	Strafford County Board of Commissioners; Vice Chairman
January 1990 to December 1991	Mayor, City of Dover, New Hampshire
November 1991 to November 1992	New Hampshire State Industrial Development Authority
November 1992 to November 1994	New Hampshire Business Finance Authority Member
January 1987 to Present	Strafford County Board of Commissioners; Chairman
January 1990 to Present	Dover Economic Development Corporation

POLITICAL AND BUSINESS AFFILIATIONS

* 1998 Chairman, New Hampshire Association of Counties Elder Care Reform Committee
* 1999 Chairman, New Hampshire Association of Counties Tobacco Settlement Committee

1997 County Commissioner of the Year, New Hampshire Association of Counties

1992 Co-Chairman New Hampshire Clinton for President Campaign

Vice President and Founder of New Hampshire Democrat Leadership Council (DLC)

Founder of New Hampshire Democratic Forum

Founder Cocheco Valley Humane Society

Former Member National Association of Counties Steering Committee on Land Use, Energy and Environment

Political and Business Affiliations Continued

Member of New Hampshire Association of Counties Executive Committee

Member Strafford Regional Planning Commission

Member Greater Dover Chamber of Commerce

BACKGROUND AND ACCOMPLISHMENTS

Strafford County Board of Commissioners

As Chairman of the Board of Strafford County Commissioners (a governing board comprised of three duly elected officials), Mr. Maglaras' responsibilities include the administration of all County operations, management of a $25 million budget and supervision of over four hundred (400) employees.

During Mr. Maglaras' terms as Commissioner, the following advancements in Strafford County, and the State of New Hampshire, have been achieved:

Strafford County has constructed a new Department of Corrections, which was recognized as one of the top ten correctional facilities in the United States.

A Jail Industries Program was created over thirteen years ago to provide prisoners housed in the House of Corrections the necessary job and learning skills to help integrate them more easily back into the work force upon release.

A $2.5 million renovation project of an abandoned County building (the Alms House) now utilized as a residential facility for chemically dependent persons, and a minimum security area for the House of Corrections with a capacity of fifty-six inmates. The County now houses minimum security inmates for both the Federal Government and the State of New Hampshire.

Riverside Rest Home, the County's intermediate nursing care facility, has been expanded two times over the past six (6) years. The first expansion was in-house and enabled the facility to open a forty-one (41) bed Alzheimer's Disease Unit, the only one of its kind in the County.

The second expansion included an addition to the Rest Home and split the Alzheimer's Unit in order to better serve those residents suffering from behavioral and related disorders. The number of residents the County can care for has increased from 205 to 215, inclusive of the ever-expanding number of County residents with Alzheimer's and Related Disorders.

The County completed a $1.1 million sewer project with the cooperative efforts of a public/public partnership between the County and the City of Dover.

Strafford County initiated a mediation and diversion program for adolescents designed to prevent costly out-of-home placements of troubled youths. This was the first program of this type in the State and serves as a model to other Counties.

The County performed an energy retrofit on the Justice and Administration Building in 1996/1997 to determine how to better conserve energy. This two-part endeavor included replacement of the current lighting system with more energy efficient lighting and also replacement of the electric heating/air conditioning system with a more efficient gas system. The Building is currently twenty-six (26) years old and

Background and Accomplishments Continued

the original system was beginning to fail; in order to meet the needs of the tenants and offices in the building before a complete failure occurred, the County utilized additional revenues and bonds to complete this project.

In 1998, Mr. Maglaras was appointed by the New Hampshire Association of Counties to serve as Chairman of a three (3) member Committee established to work with State officials in formulating, presenting, and lobbying for the passage of an Elder Care Reform Legislation. The purpose of this legislation, which was became law on January 1, 1999, is to provide senior citizens with "choices" regarding health care options in a home/community setting and to reduce the reliance on institutional care. This legislation will assist the State of New Hampshire and New Hampshire's ten (10) Counties in caring for the increasing elderly population, while offering more home and community based choices, with the same Medicaid dollars.

In 1999, the New Hampshire Association of Counties appointed Mr. Maglaras to serve as Chairman of a three (3) member Committee established to work with State officials in establishing a "fair share" reimbursement formula for the New Hampshire Counties as part of the State of New Hampshire's Tobacco Settlement.

Chairman of the New Hampshire Counties Commissioners' Council, charged with the responsibilities of managing the agenda and support for the thirty (30) County Commissioners on issues important to New Hampshire's Counties. Some of these issues include Elder Care, Medicaid funding, and Youth Related issues.

Services within the County have expanded tremendously over the past few years to meet with growing needs of the residents of the County This has been done with improved efficiency and expansion of non-tax revenues. All of the above projects and endeavors have been accomplished while keeping tax increases for the thirteen Strafford County cities and towns at the rate of inflation, or less, for the past seven (7) years.

City of Dover, Mayor

As Mayor of the City of Dover from 1990 to 1991, Mr. Maglaras set policy on a $32 million municipal/school budget, in cooperation with the City Council. Major steps were taken to prevent dependency on Federal and State government by maintaining services while expanding revenue sources through economic diversification and investment in infrastructure. Mr. Maglaras also revised the role of the Dover Industrial Development Authority (DIDA) by statute to allow DIDA to act as a redevelopment authority using enterprise zones, tax increment financing, as well as expanding its financial capacity to promote economic growth. A Dover Economic Commission was established, the focus of which was to review the city's regional competitiveness, and make specific recommendations resulting in reduction of government regulation, as well as identifying new markets and increasing the City's capacity to attract new businesses by making additional land available for commercial and industrial growth. Enterprise Park was created, a 300 acre multi-purpose research and development park which as been recognized as the first in the State.

Mr. Maglaras also introduced the use of public/private partnerships to municipal government to meet increasing demands, including the administration of a new $32 million secondary waste water facility, developed and implemented a recycling and waste reduction program, labor relations activities, as well as expansion of the infrastructure and rehabilitation of waterfront district.

New Hampshire State Legislator

Mr. Maglaras was elected to the Legislature in 1976, as New Hampshire's youngest State Legislator at the age of 18 and re-elected in 1978, serving until 1980. As a Legislator, several bills were sponsored, including an Election Reform Package and legislation dealing with expanding the energy needs of New Hampshire.

Last non profit
Nh based HMO
all Nh residents
are enrolled in
for profit
merger
Union Leader
Gov ind. general
concern.

Pending when
governor took
off. new
Commissioner
BBA

Interagency Wiring
group.

Last year
process works

CHIP plan

0-1 for MC up to 300% FPL

Medicaid 0-185

Phase 2 for healthy kids

~~300% 0-18~~

185% - 200

0-19

186 - 300%

RW covering Kids

Schools

Daycare

Hospitals

Healthykids

. outreach

1800

Seamless

mail in form

& 2 pg form

eliminated need for face to face

JEANNE SHAHEEN
GOVERNOR

State of New Hampshire
Governor's Office

State House
Concord, N.H. 03301

Tel. (603)271-2121 FAX (603)271-6998

FAX

Date: 2/16/99
Number of pages including cover sheet: 28

To: Devola Adler
Phone:
Fax phone: 202-456-5557
CC:

From: Dawn Chown
Secretary
Governor Shaheen's Office
Phone: (603) 271-2121
Fax phone: (603) 271-6998

REMARKS: ☐ Urgent ☐ For your review ☐ Reply ASAP ☐ Please comment

As of Feb 1, 1999, 583 people are enrolled in the CHIP program.

Post-it Fax Note 7672

To Barbara Wooley

Company

Location

Fax # 202/456-6218 Telephone #

Comments

No. of Pages 5 Today's Date 2/16/98 Time

From Tricia Brooks

Company

Location Dept. Charge

Fax # Telephone #

Original Disposition: ☐ Destroy ☐ Return ☐ Call for pickup

New Hampshire HEALTHY KIDS

BIOGRAPHICAL SKETCH

Tricia Brooks
Executive Director
New Hampshire Healthy Kids Corporation

New Hampshire Healthy Kids Corporation was created by special legislative act in 1993 to provide affordable, comprehensive health coverage to uninsured children. Tricia Brooks was appointed Executive Director in May, 1994, with responsibility for developing the Healthy Kids health care plan and managing day-to-day operations of the nonprofit organization. From a start of 39 members in March, 1995, the program now covers more than 1900 kids statewide. Recently the State of New Hampshire announced its plan to expand children's health insurance in partnership with New Hampshire Healthy Kids. Healthy Kids will take the lead in marketing and outreach efforts and coordinate mail-in enrollment in all the children's health insurance programs.

Prior to launching the Healthy Kids program, Tricia served as second in

Prior to launching the Healthy Kids program, Tricia served as second in command at New Hampshire Public Radio where she was responsible for marketing, development, finance and signal expansion. Tricia holds an MBA from Suffolk University in Boston and is a summa cum laude graduate of Mars Hill College in North Carolina.

Though not from New Hampshire originally, which you will know when Tricia speaks, she is proud to say she lives with 3 natives -- her husband and 2 children -- in Bow, NH.

6 DIXON AVENUE, CONCORD, NH 03301-4944 (603) 228-2925

New Hampshire HEALTHY KIDS

FACTS ABOUT NEW HAMPSHIRE'S CHILDREN'S HEALTH INSURANCE PLAN
Healthy Kids Gold ❤ Healthy Kids Silver

Title XXI
In August 1997, Congress appropriated $24 billion over five years to extend health coverage to low-income uninsured children through Title XXI of the Social Security Act. Title XXI or the State Children's Health Insurance Program (CHIP) gives states the flexibility to expand Medicaid coverage, create a private insurance program or a combination of the two. Federal funding is provided at a higher match than Medicaid to encourage states to extend coverage. (For NH – CHIP is 65% federal / 35% state compared to 50% / 50% for Medicaid.)

A Unique Partnership
In May 1998, New Hampshire submitted its Title XXI proposal to the Health Care Financing Administration (HCFA). New Hampshire's plan represents a new and unique partnership. The Department of Health and Human Services is working with New Hampshire Healthy Kids Corporation to administer the children's health insurance programs and coordinate enrollment and outreach. The 35% required state funding match is provided through a grant from the Healthy New Hampshire Foundation.

New Hampshire's Title XXI – CHIP Plan
In September 1998, New Hampshire received approval of its Title XXI plan. Under New Hampshire CHIP, infants up to the age of one in families with incomes between 186% and 300% FPL (Federal Poverty Level) qualify for Medicaid coverage. Children ages 1 through 18 qualify for Healthy Kids Silver with premiums based on income. The following chart uses a family of four as an example.

		Healthy Kids Gold*	Healthy Kids Silver		
Family of Four		Yearly Income is Below	Yearly Income is Between		
Children Ages 1 – 18*	Family Income	$30,422	$30,434-41,125	$41,126-49,350	$49,351-65,801
	Premium	$0	$20	$40	$80

* Infants under the age of one qualify for Healthy Kids gold in families with incomes up to $49,350.

Healthy Kids Gold
Healthy Kids Gold (formerly called Medicaid) is the most comprehensive of the children's health coverage programs. Children in families at the lowest income levels qualify for coverage at no cost. Because healthcare is so important in the first year of life, infants are eligible at higher incomes. Families can voluntarily enroll in one of two managed care plans, Matthew Thornton Health Plan or TUFTS Health Plans, or opt for the traditional fee-for-service program administered by the Department of Health & Human Services.

Healthy Kids Silver
The Healthy Kids Silver program offers a modified version of the original Healthy Kids plan with premiums based on family size and income. Families will pay $20, $40, or $80 per month per child plus copayments for certain services. Healthy Kids Silver is administered by the New Hampshire Healthy Kids Corporation. Coverage is provided through BlueCross BlueShield of New Hampshire and Northeast Delta Dental.

Expanding Our Reach

Seacoast Healthy Kids

Since September 1995, the Foundation for Seacoast Health has funded a pilot project which has proven the impact of offering sliding scale premiums. Families with incomes between 185% and 300% FPL are offered premiums at a reduced rate. Eligibility is extended to families residing in Portsmouth, Greenland, New Castle, Rye, Newington, and North Hampton.

The results are impressive. A survey conducted in collaboration with Portsmouth area schools in SAU 50 and 52 indicates the number of uninsured children who do not qualify for Medicaid has been cut in half since the inception of Seacoast Healthy Kids. The success of this pilot project has inspired other groups to consider similar initiatives.

HealthLink Healthy Kids

Several years ago Lakes Region General Hospital made an ongoing commitment to address the issue of uninsured families by creating HealthLink, a program that offers sliding fee health services combined with care management. This award winning program has teamed up with Healthy Kids to further its impact on uninsured children.

Cheshire Healthy Kids

As 1997 drew to a close, plans were in the works for a third community to work through Healthy Kids to the benefit of its area children. Cheshire Healthy Kids will be launched in 1998 in collaboration with Cheshire Medical Center and its Council for a Healthier Community.

Health Care Transition Fund Grant Supports Marketing, Outreach and Research

As a premium-based program, Healthy Kids is unique even among children's health care plans with similar missions and target populations. In many ways, we are charting new territory in discovering which marketing methods and messages appeal to uninsured families. A $50,000 grant from the Health Care Transition Fund has enabled Healthy Kids to take a more professional approach toward its marketing and outreach activities. By testing different techniques and evaluating the results, Healthy Kids is able to identify the best ways to reach families. What we are learning is not only essential to meeting our goals, but is proving to be of interest to other programs around the country.

FROM 1997 Healthy Kids Annual Report

Dear Friends

Along every stage of development and growth, Healthy Kids has found enthusiastic partners whose support has been critical to our success. 1997 will be remembered for the new partnerships we forged. It was a year that, despite challenges to the program's affordability, we moved closer to our vision of assuring that every child goes to school healthy and ready to learn.

As enrollment growth slowed due to increased costs, hundreds of physicians, dentists and other health professionals joined with us to help preserve the program's affordability. New partners were found in RiteAid, Shop 'n Save and Wal-Mart, who helped extend our visibility in communities throughout New Hampshire. Their support, along with contributions from other businesses, foundations and individuals, helped us leverage a $100,000 challenge grant from the Lou & Lutza Smith Foundation.

These latest partners join Blue Cross and Blue Shield of New Hampshire, the state's twenty-six hospitals and Northeast Delta Dental, in taking a leadership role to address the problem of uninsured children. At year's end more than 1,800 children — nine percent of New Hampshire's uninsured kids — were enrolled in Healthy Kids.

Our priority in 1998 is to secure long term sustainable funding that will provide for a sliding premium scale based on income. To maximize the impact of Healthy Kids, we must more closely match the cost of participation to a family's ability to pay. The Seacoast Healthy Kids project — which has cut the number of uninsured kids in half — offers evidence of the significant impact a sliding scale would make.

In 1997, Congress took land-mark action in creating the State Children's Health Insurance Program. We are encouraged by the commitment voiced by State officials to take advantage of this new opportunity to address the problem of uninsured children. We hope 1998 will be the year that covering kids becomes a public policy priority.

Rodney E. Tenney
Chair, Board of Directors

Tricia Brooks
Executive Director

the names you have were enrolled in this

see next page

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Karen 9 years
been air
4 part time employees;
priority for her

once a year for the last 3 or 4 years

$400/month 10% of contribution
focused on this year trying to

trying to figure out

Options

impact of not having health insurance

fell down stairs → payments

income low enough for her for Medicaid

pressures of her

25 has a little girl

9 & 11 yrs old girls

not just about option time

search for health care, admin red tape.

PRESIDENT CLINTON HIGHLIGHTS PROPOSALS TO IMPROVE ACCESS TO QUALITY HEALTH CARE AT NEW HAMPSHIRE ROUNDTABLE DISCUSSION
February 18, 1999

Today, President Clinton and Governor Jeanne Shaheen will meet with a panel of New Hampshire residents to discuss the wide range of health care challenges currently facing the nation. The President will emphasize the importance of providing targeted tax credit to defray the costs of long term care services, and will contrast such targeted tax cuts to the Republicans' proposal for an across-the-board tax cut that will squander the budget surplus.

The President will highlight initiatives in his FY 2000 budget that increase access to health care and improve its quality:

- **Addressing growing long-term care needs.** The President's budget includes a historic new initiative to support elderly and disabled Americans with long-term care needs or the family members who care for them. This initiative invests over $6 billion over five years in long-term care, including a $1,000 tax credit to compensate for the cost of long-term care services; a new $625 million National Family Caregiver Program, which will help states provide direct services and support for those caring for elderly family members with long-term care needs; a new proposal to allow states to provide home- and community-based care to people whose income level now qualifies them for nursing-home care under Medicaid; and a national campaign to educate Medicare beneficiaries about long-term care options. The President also will praise New Hampshire's efforts to expand community-based care services for Medicaid enrollees and to provide critical information to elderly and chronically ill adults about their long-term care options.

- **Improving economic opportunities for Americans with disabilities.** More than 70 percent of Americans with disabilities are unemployed, often because they face significant barriers to work, such as the risk of losing health care. The President has proposed a series of bold new initiatives to enable people with disabilities to return to work. This five-year, $3.2 billion initiative includes full funding for the Jeffords-Kennedy-Roth-Moynihan Work Incentives Improvement Act which will enable many workers with disabilities to buy into Medicaid and Medicare; a $1,000 tax credit to help offset the cost of the services and supports that people with disabilities may need to get and keep a job; and a new regulation to increase the amount that people with disabilities can earn and still maintain Social Security benefits. New Hampshire currently provides community-based services through Medicaid to individuals with disabilities, and in recognition of the State's innovation in this area, the Vice President recently gave the State a grant to help remove barriers to employment for people with disabilities.

- **Helping small businesses provide health care coverage for their employees.** The President's budget includes a $44 million investment in targeted tax credits to increase health care coverage by encouraging small businesses to participate in voluntary purchasing coalitions that provide a variety of health care choices at relatively low cost.

This initiative provides a new 10 percent tax credit for small businesses that decide to offer coverage by joining coalitions; encourage private foundations to support coalitions by making their contributions towards these organizations tax-exempt; and offers technical assistance to small business coalitions from the Administrators of the Federal Employees Health Benefit Plan. Governor Shaheen has proposed legislation that creates voluntary small-business purchasing alliances to reduce costs and increase options for small businesses offering health insurance to their employees. She believes that the Administration's proposal will provide needed financing for this effort.

- **Implementing the Children's Health Insurance Program, the largest investment in children's health in a generation.** The Administration is committed to implementing the Children's Health Insurance Program (CHIP) and has developed a national outreach campaign to sign up every child eligible for Medicaid or CHIP coverage. New Hampshire, under Governor Shaheen's leadership, is one of 46 states that already have implemented the CHIP program: the State's program -- Healthy Kids -- provides health insurance to thousands of uninsured New Hampshire children.

- **Protecting patients with a strong, enforceable patients bill of rights.** The President again will call on Congress to pass a strong, federally enforceable patients' bill of rights that includes: guaranteed access to needed specialists; access to emergency room services when and where the need arises; and access to a meaningful external appeals process to resolve disputes with health plans. The President is already doing everything he can to implement these protections by extending them to the 85 million Americans covered by federal health plans. Governor Shaheen has proposed an HMO Accountability Act to provide similar patient protections.

February 17, 1999

HEALTH CARE ROUNDTABLE WITH NEW HAMPSHIRE RESIDENTS

DATE:	February 18, 1999
LOCATION:	Dover Municipal Building
TIME:	11:15am - 12:05pm
FROM:	Bruce Reed

I. PURPOSE

You will discuss with a group of New Hampshire residents the variety of health care challenges currently facing the nation and highlight the initiatives in your FY 2000 budget that address these challenges. You will highlight the long-term care tax credit and contrast targeted tax credits of this kind to the Republicans' proposal for an indiscriminate, across-the-board tax cut.

II. BACKGROUND

You will highlight initiatives in your FY 2000 budget that increase access to health care and improve its quality:

- **Addressing growing long-term care needs.** Your budget includes a historic new initiative to support elderly and disabled Americans with long-term care needs or the family members who care for them. This initiative invests over $6 billion over five years in long-term care, including a $1,000 tax credit to compensate for the cost of long-term care services; a new $625 million National Family Caregiver Program, which will help states provide direct services and support for those caring for elderly family members with long-term care needs; a new proposal to allow states to provide home- and community-based care to people whose income level now qualifies them for nursing-home care under Medicaid; and a national campaign to educate Medicare beneficiaries about long-term care options. You also will praise New Hampshire's efforts to expand community-based care services for Medicaid enrollees and to provide critical information to elderly and chronically ill adults about their long-term care options.

- **Improving economic opportunities for Americans with disabilities.** More than 70 percent of Americans with disabilities are unemployed, often because they face

significant barriers to work, such as the risk of losing health care. You have proposed a series of bold new initiatives to enable people with disabilities to return to work. This five-year, $3.2 billion initiative includes full funding for the Jeffords-Kennedy-Roth-Moynihan Work Incentives Improvement Act which will enable many workers with disabilities to buy into Medicaid and Medicare; a $1,000 tax credit to help offset the cost of the services and supports that people with disabilities may need to get and keep a job; and a new regulation to increase the amount that people with disabilities can earn and still maintain Social Security benefits. New Hampshire currently provides community-based services through Medicaid to individuals with disabilities, and in recognition of the State's innovation in this area, the Vice President recently gave the State a grant to help remove barriers to employment for people with disabilities.

- **Helping small businesses provide health care coverage for their employees.** Your budget includes a $44 million investment in targeted tax credits to increase health care coverage by encouraging small businesses to participate in voluntary purchasing coalitions that provide a variety of health care choices at relatively low cost. This initiative provides a new 10 percent tax credit for small businesses that decide to offer coverage by joining coalitions; encourage private foundations to support coalitions by making their contributions towards these organizations tax-exempt; and offers technical assistance to small business coalitions from the Administrators of the Federal Employees Health Benefit Plan. Governor Shaheen has proposed legislation that creates voluntary small-business purchasing alliances to reduce costs and increase options for small businesses offering health insurance to their employees. She believes that the Administration's proposal will provide needed financing for this effort.

- **Implementing the Children's Health Insurance Program, the largest investment in children's health in a generation.** Your Administration is committed to implementing the Children's Health Insurance Program (CHIP) and has developed a national outreach campaign to sign up every child eligible for Medicaid or CHIP coverage. New Hampshire, under Governor Shaheen's leadership, is one of 46 states that already have implemented the CHIP program: the State's program -- Healthy Kids -- provides health insurance to thousands of uninsured New Hampshire children.

- **Protecting patients with a strong, enforceable patients bill of rights.** You again will call on Congress to pass a strong, federally enforceable patients' bill of rights that includes: guaranteed access to needed specialists; access to emergency room services when and where the need arises; and access to a meaningful external appeals process to resolve disputes with health plans. You are already doing everything you can to implement these protections by extending them to the 85 million Americans covered by federal health plans. Governor Shaheen has proposed an HMO Accountability Act to provide similar patient protections.

III. PARTICIPANTS

Governor Jeanne Shaheen
Beth Dixon, Concord, NH
David Robar, New London, NH
Karen Goddard, Nashua, NH
Christine Monteiro, Nottingham, NH
Stephen Gorin, Canterbury, NH

IV. PRESS PLAN

Open Press.

V. SEQUENCE OF EVENTS

- You will be announced into the auditorium accompanied by Governor Jeanne Shaheen.
- Gov. Shaheen will make welcoming remarks and introduce you.
- You will make remarks.
- Gov. Shaheen will introduce the roundtable participants and begin the discussion.
- Gov. Shaheen will make concluding remarks.
- You will work a ropeline and depart.

VI. REMARKS

To Be Provided by Speechwriting.

DISABILITY INITIATIVE QS AND AS
January 12, 1999

Q. Shouldn't this tax credit be refundable? Doesn't this mean that low-income people are not helped by this initiative?

A. No. First, let's set the facts straight. The vast majority of low-income people with disabilities are already covered by Medicare and Medicaid. This initiative expands these health insurance options and provides states incentives to take them. Thus, most of the funding in this initiative is targeted towards those low-income people in the process of returning to work.

The tax credit helps offsets the higher costs of work (e.g., personal assistants, special transportation) for people with disabilities who pay taxes, irrespecitve of their income or state of residence. It also, unlike Medicaid and Medicare, allows the worker to use the funds for whatever expenses they incur. This could be assistance with dressing in the morning; costs of special transportation; or payments for assistive devices that improve the worker's productivity.

Q: What will the tax credit pay for that Medicaid and Medicare won't cover?

A: Workers with significant disabilities would receive a $1,000 a tax credit in recognition of the formal and informal costs associated with employment. People are considered disabled if they need personal assistance with one or more activities of daily living. The tax credit can be used for anything the recipient wishes to use it for.

<u>What does Medicare cover?</u>

Medicare pays for skilled nursing care for individuals who are homebound. It does not pay for any type of personal assistance. The majority of the expenses individual with disabilities who are insured by Medicare are likely to incur are associated with personal assistance and home health care services. The tax credit can be applied to these expenses.

<u>What does Medicaid cover?</u>

All Medicaid programs provide home health services for people who are eligible for nursing facility services. However, Medicaid has an optional home and community-based services waiver program that allows States to provide case management, homemaker services, home health aid services, personal care services, adult day health, habilitation and respite care, so personal assistance and home health benefits actually differ significantly by State.
Some Medicaid programs have copayments for their home health and community based services programs. In some States, copayments can be more than $1000 per month. The tax credit can be applied to these expenses.

Q. Why are we only doing tax initiatives? Are you rejecting traditional Medicare and Medicaid program expansions? Aren't you catering to Republicans?

A: Each policy in the President's budget was designed to be the most cost-effective approach to solving a particular problem. This tax credit for workers with disabilities is no exception. Workers with disabilities have very different costs -- for rural residents, it may be transportation; for people limited use of their hands, it may be assistive devices. A tax credit offers the flexibility to assist with a wide-ranging and changing set of needs that Medicaid cannot.

Similarly, the informal, unmeasurable costs of family caregiving are best addressed through a tax credit, as proposed in our long-term care initiative. If Medicaid or Medicare expanded to cover respite care, for example, not only would this undermine rather than strengthen informal family caregiving -- it would cost billions more.

In no way does the President's support for these tax credits undermine his commitment to Medicare and Medicaid. This President has an unparalleled record of protecting, strengthening and expanding these programs. For example, the President's aggressive actions to reduce Medicare fraud contributed to record-low spending growth in 1998 -- the same year that he added new preventive benefits, health plan choices, and low-income protections to Medicare.

Q. How many people will benefit from this proposal?

A. There are no exact counts of people who would benefit from these proposals combined. We do know that 200,000 to 300,000 people would likely benefit from the tax credit, and possibly millions from the new options, services and programs in the Work Incentive Improvement Act and the assistive technology initiative.

Q. What are this initiative's prospects of passing?

A. Removing barriers to work for people with disabilities goes beyond partisan politics. We can all agree that something must be done so that people with disabilities can fully participate in today's strong economy. The President has thanked Senators Jeffords, Kennedy, Roth and Moynihan for their leadership. We hope that early passage of this bill can show the American public that this Congress and President can work together to address real problems that are affecting people's lives today.

LONG-TERM CARE INITIATIVE
QS AND AS, January 4, 1998

Q. How is this tax policy different than the $500 credit in the Republican Contract with America?

This proposal is quite different -- and we think much better. First, it would give twice as much assistance ($1,000 credit). Second, many more people would be eligible under this proposal. It would go to people who have long-term care needs or their spouses, not just to relatives who qualify as caregivers. It also would broaden significantly the definition of a "caregiver" by eliminating the "support test," which essentially excludes people with Social Security income. Our proposal also targets the dollars on middle-class families by phasing out the credit at higher income levels. Finally, it is part of a larger, well-rounded initiative that would help caregivers both financially and through real services in the new Family Caregiver Program.

We are glad, however, that Republicans have supported a similar concept, and seem to want to take credit for this proposal. It makes us optimistic that Republicans and Democrats in Congress can work together to pass this initiative and provide meaningful support for family caregivers.

Q. Didn't the President veto a family caregivers' tax credit in 1995?

A. The President vetoed the 1995 Republican budget, which included massive cuts to Medicare, Medicaid, education, and environmental spending. Someplace within that budget was a long-term care tax deduction that was poorly targeted and disproportionately benefited upper income families. For obvious reasons, the President was not willing to sign the whole 1995 Republican budget to gain this poorly constructed long-term care tax proposal.

Background: There were actually two different proposals offered by Republicans in 1995: a **$500 tax credit** that was introduced in early 1995 as a refundable credit for taxpayers housing certain family members (parent, grandparent) needing "custodial care" (2 + ADLs or similar level of disability due to cognitive impairment); and a **tax deduction** of $1,000 for taxpayers housing certain family members (parent, spouse or former spouse) who are "physically or mentally incapable of caring for himself." The latter was in the Balanced Budget Act of 1995 that was vetoed by the President.

Q. Why isn't the tax credit refundable? Doesn't this mean that low-income people are not helped by this initiative?

A. No. Eligibility for the tax credit was carefully designed so it reaches virtually all taxpayers with significant long-term care needs. In addition, many individuals who do not pay taxes will be able to gain some benefit from this credit because their caregiver files tax returns. Finally, other aspects of the initiative announced today will benefit all people with long-term care needs, regardless of tax status. The new Family Caregiver Program targets assistance to low-income families who provide long-term care to their elderly relatives, and the Medicare long-term care information campaign will help all beneficiaries regardless of income.

Q. Why isn't there a greater emphasis placed on private long-term care insurance in your initiative?

A. The Federal employees' insurance initiative and the Medicare education campaign are both designed to give people information and encourage them to purchase high-quality long-term care insurance. However, even according to optimistic industry projections, if every baby boomer who could afford private insurance purchased it, less than one-third of long-term care costs would be paid for by private insurance in 2030. This initiative explicitly recognizes that long-term care will continue to be funded and provided through multiple sources and thus addresses it through a multi-faceted response.

Q. By focusing on family caregivers, are you implying that you are not interested in expanding Medicare and Medicaid long-term care coverage?

A. The President has a strong track record of encouraging innovative long-term care services through Medicaid. Today, 20 percent of Medicaid long-term care spending is devoted to home and community-based long-term care services -- double the percent in 1987. The President has encouraged the shift away from Medicaid's "institutional bias" by approving over 300 waivers for local home and community-based care programs and proposing to repeal the need for such waivers.

Medicare was not designed to cover long-term care, as the Bipartisan Commission on the Future of Medicare has noted. The President looks forward to the recommendations of this Commission on long-term care and other benefits. But given the financing crisis facing Medicare, it seems unlikely that the Commission will vote for a significant expansion of Medicare coverage in this area.

While Medicare and Medicaid cannot be relied on to finance all long-term care, the President will continue to support creative targeted policies, both administrative and legislative, that cost-effectively and appropriately provide for effective long-term care services.

Q. Isn't this a drop in the bucket relative to the size of the long-term care problem?

A. Any initiative that spends $6.2 billion over 5 years has to be considered a significant proposal. It would make a major contribution toward helping over 2 million Americans afford and obtain much-needed long-term care services. No one in this Administration has or will suggest that this initiative on its own will address all of the problems. But it recognizes and provides meaningful support for the caregiving provided to Americans of all ages with chronic illness or disability.

Q. Isn't this policy another attempt to distract from impeachment?

A. Anyone who has followed this President since he has taken office will recognize his ongoing commitment to help meet the needs of American families. This initiative is a classic example of that commitment. The President has been working on it since the Spring of 1998 and, because it is a new initiative that will be included in his upcoming FY2000 budget, wanted to release it early to ensure that it receives the attention and consideration that it deserves.

Q How do you think Republicans will respond to this initiative? Will it pass this year?

A. The President believes that this initiative has great potential to attract strong bipartisan support in this Congress. It addresses a set of real problems through an approach that both Republicans and Democrats can embrace. And he believes that any policy to recognize and relieve the tremendous responsibilities that caregivers shoulder should and will receive favorable consideration by both parties in the upcoming Congress.

OVERVIEW OF NEW HAMPSHIRE'S HEALTH CARE PROGRAMS

SMALL GROUP AND INDIVIDUAL MARKET REFORMS

- In 1994, State Senator Shaheen led efforts to reform the individual and small group health insurance market. The reforms have been used as a model for other states. Unlike many other states, New Hampshire extended the full range of market reforms to the individual market. Components of the reform package include a modified community rating, guaranteed issue on all products, portability and renewability, a prohibition on medical underwriting, and a nine month limitation on exclusions for pre-existing conditions.

- In 1998, the State implemented a risk adjustment and subsidy mechanism to stabilize and improve the individual insurance market. This mechanism is funded by an assessment on all health carriers in all markets.

MANAGED CARE REFORMS

- In 1997, new protections were enacted into law requiring that HMOs provide access to a sufficient number of physicians so that consumers don't have to drive too far or wait too long to see a doctor; requiring that the medical providers in their networks be appropriately trained and qualified; requiring HMOs to provide an internal grievance procedure for disputes with consumers; and requiring HMOs to have a quality assessment and improvement program. This year, additional protections were enacted into law, including direct access to ob-gyn providers and a requirement that HMOs disclose in writing the rationale for a decision to deny care and provide the credentials of the HMO's medical director responsible for the decision.

- This past week, Governor Shaheen announced the HMO Accountability Act, a new initiative to offer consumers enrolled in managed care plans greater protections. Major provisions of the legislation include an external grievance procedure; increased disclosure of critical information including who within a health plan made the decision to deny care, their professional credentials and board status; a ban on financial incentives designed to limit medically necessary care; provisions to ensure accountability of medical directors; and protections for providers who advocate for patients.

CHILDREN'S HEALTH INSURANCE

- In May of 1998, the State began implementation of its CHIP program, which increases Medicaid eligibility for infants aged 0-1 up to 300% of the FLP and creates a separate State program (Healthy Kids) for children (aged 0-19) in families up to 300% of the poverty level. Parents pay a sliding scale premium. As part of New Hampshire's new outreach efforts, the State has changed the name of the Medicaid program to Healthy Kids Gold in order to reduce the potential for welfare stigma; designed a combined enrollment form for both programs; eliminated the requirement for a face to face interview, and has initiated a community outreach program to identify and enroll eligible children.

DISABILITY

- New Hampshire has long been a leader in the area of community based services and supports for persons with disabilities and their families. It pioneered the first statewide family support program for children and adults with developmental disabilities which is now being extended to new populations, i.e. those with chronic illness, mental illness and traumatic brain injury.

- In 1998, the Social Security Adminsitration awarded the state with a grant to help remove barriers to employment for people with disabilities. The grant will support the state to conduct comprehensive statewide planning and policy development, and two local pilot initiatives – in Manchester and Keene.

PURCHASING COALTIONS

- In 1996, the state helped to create The New Hampshire Healthcare Purchasers Roundtable. This public private partnership includes large purchasers of health coverage and represents approximately 300,000 insured lives. The roundtable works on quality improvement and the group has issued several report cards. The Roundtable also provides assistance to purchasers with contracting issues. Currently, the Roundtable is conducting a rate analysis project on increasing health insurance rates.

- Over this past year, Governor Shaheen has worked to establish a Health Insurance Purchasing Alliance for small employers. Her legislative proposal was not adopted by the legislature in the last session. The legislature instead decided to study the issue and have since recommended passage of the proposal. The goal of the purchasing alliance to enable small employers to offer choice of coverage, increase bargaining clout and encourage competition based on quality.

PRESIDENT CLINTON'S INITIATIVE ENCOURAGING SMALL BUSINESSES TO OFFER HEALTH INSURANCE

February 18, 1999

This initiative would encourage small businesses to offer health insurance to their workers by developing and/or joining coalitions for purchasing health insurance. Fewer small businesses offer health insurance because of their higher administrative costs and premiums relative to large businesses. As a result, nearly half of uninsured workers are in firms with fewer than 25 employees. This three-part initiative would: (1) provide a tax credit to small businesses who decide to offer coverage by joining coalitions; (2) encourage private foundations to support coalitions by allowing their contributions towards these organizations to be tax exempt; and (3) offer technical assistance to small business coalitions from the Office of Personnel Management, which runs the Federal Employees Health Benefits Program (FEHBP). This initiative would cost about $44 million over 5 years, and provide thousands of workers and their families the option of affordable health insurance.

INSURANCE AND SMALL BUSINESSES

- **Most of the uninsured work in small businesses.** Workers in small firms are less likely to have access to affordable, job-based health insurance. Although worker in firms with fewer than 25 employees make up about 30 percent of the workforce, they comprise nearly half of the uninsured. Only one-third of firms with fewer than 10 employees and two-thirds of firms with 10 to 24 employees offer coverage, compared to over 95 percent of large firms.

- **Higher premiums and administrative costs.** Small employers state that high premiums and the uncertainty in premium costs are major reasons why they do not offer health insurance. Premiums for the same benefits are higher for small firms than large firms because there are fewer people who can share in the risk of illness and because administrative costs per employee are higher. Insurers' administrative expenses ranged from approximately 5 percent of premiums for the largest employer plans to 30 percent or more of premiums for the smallest employers. As a result of this and other factors, small firms typically offer less generous benefits -- or do not offer coverage at all.

SMALL BUSINESS HEALTH PURCHASING COALITIONS

This initiative would encourage the development of and participation in small business health purchasing coalitions. Coalitions pool employees across firms to gain market power; negotiate with insurers over benefits and premiums; provide comparative information about available health plans; and administer premium payments made by small employers and their participating employees. Despite these advantages, there are few small business health purchasing coalitions today. This in part reflects the lack of up-front funding to develop coalitions (e.g., hiring staff, developing a negotiating strategy, marketing to small businesses). Additionally, coalitions that cannot quickly attract a large enough number of small firms to join them could find themselves without the bargaining power that they need to reduce costs and offer choice.

POLICIES TO ENCOURAGE COALITIONS

- **Tax credit for employers who join coalitions**: A tax credit equal to ten percent of employer contributions to employee health plans, up to $200 for a single policy and $500 for a family policy, would be given to qualifying employers. A qualifying small business would have between 3 and 50 employees and purchase coverage through a qualified coalition. To target the credit to employers who would not otherwise offer coverage, eligible employers could not have had an employee health plan during any part of 1997 or 1998. Employers would need to cover seventy percent of those workers who have wages (including deferred wages) in excess of $10,000 and who are not covered elsewhere by a health plan (typical in the group market). This credit is temporary (up to two years) since the goal is to encourage the one-time action of joining the coalition. The credit would be available for employers taking this option before December 31, 2003.

  A qualified coalition is a certified, non-profit organization that negotiates with health insurers to provide health insurance to the employees of its small business members. Its members would include all interested employers with 50 or fewer employees in its area, without regard to the health status or occupation of their employees. It could collect and distribute health insurance premiums but would not be an insurer (bear risk) itself. Its board would include both employer and employee representatives of small businesses, but could not include service providers, health insurers, insurance agents or brokers, and others who might have a conflict of interest. Where feasible, the coalition would offer several health plan choices and at least one open enrollment period per year. These plans would follow state requirements and their premiums could not be rated according to the occupation or existing health status.

- **Financial assistance in creating coalitions.** Currently, funding the start-up expenses of small business health purchasing coalitions would not qualify as a "charitable purpose" Consequently, private foundations are reluctant or, in some cases, prohibited by their own rules from offering grants for this purpose. Under this proposal, any grant or loan made by a private foundation to a qualified small business health purchasing coalition would be treated as a grant (or loan) made for charitable purposes. This special rule would apply only to grants (or loans) made to qualified coalitions for the purpose of funding qualified coalition start-up expenses made during the first two years of their operations. The special foundation rule would apply to grants and loans made prior to December 31, 2003 for start-up expenses incurred prior to December 31, 2005.

- **Technical assistance in creating coalitions.** The Office of Personnel Management (OPM) runs the Federal Employees Health Benefits Program (FEHBP). This program serves as a model for consumer choice of health plans. OPM has considerable experience in working with private plans in coordinating a bidding process, negotiating benefits and premiums, and distributing consumer information. To help small business health purchasing coalitions do the same, it would provided any needed technical assistance to qualified coalitions, sharing its administrative experience.

THE CLINTON ADMINISTRATION'S BOLD NEW INITIATIVE TO IMPROVE ECONOMIC OPPORTUNITIES FOR AMERICANS WITH DISABILITIES

February 18, 1999

The President has proposed an historic new initiative that will remove significant barriers to work for people with disabilities. This four-part initiative, which invests over $3 billion over five years, includes: (1) full funding of the Work Incentives Improvement Act which was recently introduced by Senators Jeffords, Kennedy, Roth and Moynihan; (2) a new $1,000 tax credit to help with work-related costs for people with disabilities; (3) doubling the funding for assistive technologies; and (4) increasing the amount that people can earn while on disability in order to ease the transition to work. People with disabilities will also benefit from the President's $6 billion long-term care initiative that complements the health insurance and work incentive proposals. Together, this is the most important effort to improve opportunities for people with disabilities since the Americans with Disabilities Act was passed.

CRITICAL NEED TO REMOVE BARRIERS TO WORK

Since President Clinton and Vice President Gore took office, the American economy has added 17.8 million new jobs. Unemployment is at a 41-year low of 4.3 percent. However, the unemployment rate among working-age adults with disabilities is nearly 75 percent. About 1.6 million working-age adults have a disability that leads to functional limitations and 14 million working-age adults have less severe but still significant disabilities. People with disabilities can bring tremendous energy and talent to the American workforce, yet some outdated, institutional barriers and fewer opportunities often limit their ability to work.

Under current law, people with disabilities often become ineligible for Medicaid, Medicare, or disability insurance if they work. This means that many people with disabilities are put in the untenable position of choosing between health care coverage and work. In addition, the extraordinary advances in technology and communications are often not accessible to or adapted for people with disabilities. Moreover, working itself is usually more expensive for people with disabilities who need personal assistance getting to and from work; special transportation, or technology that is not paid for by their employers.

INITIATIVE TO IMPROVE ECONOMIC OPPORTUNITIES FOR AMERICANS WITH DISABILITIES

- **Funding the Work Incentives Improvement Act in the President's budget.** Health care -- particularly prescription drugs and personal assistance -- is essential for people with disabilities to work. The President included in his FY 2000 budget the Work Incentives Improvement Act. This proposal, which costs $1.2 billion over 5 years, would:

  - <u>Improve access to health care by:</u>
    -- Providing greater incentives and options for states to enable people to return to work to maintain eligibility for Medicaid. This provision: eliminates barriers to the buy-in for people with income above the current limits; allows people who are only able to work because of treatments that are covered to buy into Medicaid; and provides health care grants for states that take these important options;

  - Extending Medicare coverage, for the first time, for people with disabilities who

return to work. While Medicare does not provide as comprehensive a benefit as Medicaid, it assures that all people with disabilities who return to work have access to health care coverage, even if they live in a state that does not take the Medicaid option;

- Creating a new Medicaid buy-in demonstration to help people with a specific physical or mental impairment that, as defined by the state, is reasonably expected to lead to a severe disability without medical assistance. This could help people with muscular dystrophy, Parkinson's Disease, HIV or diabetes who may be able to function and continue to work with appropriate health care, but such health care is currently only available once their conditions have become severe enough to qualify them for SSI or SSDI and thus Medicaid or Medicare.

-- Modernize employment-related services by creating a "ticket" that will increase options and access for SSI or SSDI beneficiaries to go to either a public or a private provider for employment-related services. If the beneficiary goes to work and achieves substantial earnings providers would be paid a portion of the benefits saved through either an outcome or "milestone" payment.

-- Create a Work Incentive Grant program to provide benefits planning and assistance, facilitate access to information about work incentives, and foster coalitions to better integrate services to people with disabilities working or returning to work.

- **Providing an $1,000 tax credit for work-related expenses for people with disabilities.** The daily costs of getting to and from work, and being effective at work, can be high if not prohibitive for people with disabilities. Under this proposal, workers with significant disabilities would receive an annual $1,000 tax credit to help cover the formal and informal costs that are associated with and even prerequisites for employment, such as special transportation and technology needs. Like the Jeffords-Kennedy-Roth-Moynihan Work Incentive Improvement Act, this tax credit, which will help 200,000 to 300,000 Americans, helps assure that people with disabilities have the tools they need to return to work. It also has the advantage of helping people in all states irrespective of whether states take up optional coverage. It costs $700 million over 5 years.

- **Improving access to assistive technology.** Technology is often not adapted for people with disabilities and even when it exists, people with disabilities may not know about it or may not be able to afford it. This new initiative would accelerate the development and adoption of information and communications technologies, which can improve the quality of life for people with disabilities and enhance their ability to participate in the workplace. This initiative: (1) helps make the Federal government a "model user" of assistive technology; (2) supports new and expanded state loan programs to make assistive technology more affordable for Americans with disabilities; and (3) invests in research and development and technology transfer in areas such as "text to speech" for people who are blind, automatic captioning for people who are deaf, and speech recognition and eye tracking for people who can't use a keyboard. It would cost $35 million in FY 2000, more than doubling the government's current investment in deploying assistive technology.

- **Increasing the amount that people can earn while on disability to ease the transition to**

work. A new proposed regulation increases the substantial gainful activity (SGA) level from $500 to 700 per month. Under current rules, people lose eligibility for Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) benefits if they can engage in any substantial gainful activity (SGA) that exceeds $500 per month. Many hesitate to work because they cannot afford to give up critical benefits. Increasing the SGA level would enable the 400,000 beneficiaries who now work to work more, easing their transition to work. This initiative costs $1.2 billion over five years.

TASK FORCE ON EMPLOYMENT OF ADULTS WITH DISABILITIES. Last March, President Clinton signed the executive order establishing the Presidential Task Force on Employment of Adults with Disabilities. Led by Alexis Herman, Secretary of Labor, and Tony Coelho, this Task Force is charged with coordinating an aggressive national policy to bring adults with disabilities into gainful employment. It produced a set of interim recommendations in December, 1998, summarized below along with the Administration's actions to address them:

RECOMMENDATION	ACTION
1. Work to pass the Work Incentive Improvement Act	President includes in budget
2. Work to pass the Patients' Bill of Rights	High Presidential priority
3. Examine tax options to assist with expenses of work	President includes in budget
4. Foster interdisciplinary consortia for employment services	President includes in budget
5. Accelerate development/adoption of assistive technology	President includes in budget
6. Direct Small Business Administration to start outreach	Vice President announced 12/98
7. Remove Federal hiring barriers for people w/ mental illness	Mrs. Gore announced 1/99
8. Develop a model plan for Federal hiring of people w/ disabilities	Vice President announced 12/98

THE PRESIDENT'S HISTORIC LONG-TERM CARE INITIATIVE
February 18, 1999

The President has proposed an historic, seven-part initiative designed to address the broad-based and varied long-term care needs of Americans of all ages. It would not only improve nursing home quality, options for community-based services, and the purchase of long-term care insurance, but would, for the first time, support families who care for their ill relatives. These millions of spouses, children, other relatives and friends are the major providers of long-term care in the U.S. This initiative recognizes this by providing a $1,000 tax credit for people with long-term care needs or their families to offset the costs of care and a new Family Caregivers Program that offers respite services, information, and other assistance as needed. Altogether, this $6 billion initiative lays the groundwork for long-term care policy for the twenty-first century.

MILLIONS OF AMERICANS HAVE LONG-TERM CARE NEEDS

- **More and more Americans have a range of long-term care needs.** Over five million Americans have significant limitations due to illness or disability and thus require long-term care. Approximately, two-thirds are older Americans. Also, millions of adults and a growing number of children have long-term care needs because of health condition from birth or a chronic illness developed later in life.

- **The aging of Americans will only increase the need for quality long-term care options.** The number of Americans age 65 years or older will double by 2030 (from 34.3 to 69.4 million), so that one in five Americans will be elderly. The number of people 85 years or older, nearly half of whom need assistance with everyday activities, will grow even faster (from 4.0 to 8.4 million).

MULTI-FACETED INITIATIVE TO SUPPORT FAMILY CAREGIVERS AND ADDRESS GROWING LONG TERM CARE NEEDS. The Clinton Administration's historic long-term care initiative includes:

- **Supporting families with long-term care needs through a $1,000 tax credit.** This initiative, for the first time, acknowledges and supports millions of Americans with long-term care needs or the family members who care for and house their ill or disabled relatives through a $1,000 tax credit. This new tax credit supports the diverse needs of families by compensating a wide range of formal or informal long-term care for people of all ages with three or more limitations in activities of daily living (ADLs) or a comparable cognitive impairment. This proposal, which supports rather than supplants family caregiving, would provide needed financial support to about 2 million Americans, including 1.2 million older Americans, over 500,000 non-elderly adults, and approximately 250,000 children. It costs $5.5 billion over five years and phases out beginning at $110,000 for couples and $75,000 for unmarried taxpayers.

- **Creating a new National Family Caregiver Support Program.** 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 new nationwide program would support families who care for elderly relatives with chronic illnesses or disabilities by enabling states to create "one-stop-shops" that 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, such as teaching model

approaches for caregivers that are coping with new responsibilities and offering training for complex care needs, such as feeding tubes. This program, which costs $625 million over five years, would assist approximately 250,000 families nationwide.

- **Expanding Medicaid eligibility for people in home- and community-based care settings.** Historically, Medicaid policy and practice has inadvertently discriminated against people with long-term care needs who want to live in the community by making it much easier to expand coverage to nursing homes than community-based services. To eliminate this "institutional bias," this proposal would enable states to expand their programs to cover community-based care as well as nursing home residents with income up to 300 percent of the Social Security Income (SSI) limits, without requiring a complicated and frequently time-consuming Federal waiver. This proposal contributes towards this initiative's goal of giving people with long-term care needs the choice of remaining in their homes and communities. It costs $110 million over five years.

- **Encouraging partnerships between public housing for the elderly and Medicaid.** This proposal would provide $100 million in competitive grant funds to qualified elderly housing facilities (Section 202 facilities) to convert to assisted living facilities, so long as those facilities provide Medicaid home and community-based services. As people living these housing facilities age, their need for long-term care services rises, often leaving them with no choice but to move to a nursing home. This proposal would allow such people to "age in place" by funding the conversion of their homes into assisted living facilities. Only sites that agree to bring Medicaid home and community-based services into their converted assisted living facilities would qualify for grants, to ensure that low-income elderly have access to this option.

- **Nursing home quality initiative.** This proposal will provide $110 million to strengthen Federal oversight of nursing home quality and safety standards by working with States to improve their nursing home inspection systems, crack down on nursing homes that repeatedly violate safety rules, establish a national registry of abusive nursing home workers, and publish nursing home quality ratings on the internet.

- **Having the Federal government serve as a model employer by offering quality private long-term care insurance to Federal employees.** A new proposal would allow 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, which costs $15 million over five years, 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.

- **Launching a national long-term care education campaign**. Nearly 60 percent of Medicare beneficiaries are unaware that Medicare does not cover most long-term care, and many do not know what long-term care services would best meet their needs. This $10 million nationwide campaign would provide all 39 million Medicare beneficiaries with critical information about long-term care options including: what long-term care Medicare does and does not cover; how to find out about Medicaid long-term care coverage; what to look for in a quality private long-term care policy; and how to access information about home-and community-based care services that best fit beneficiaries' needs.

STATEMENT -- BETH DIXON

I am the mother of four children. My youngest child has a disablity and requires a great deal of support to experience a typical life. About six years ago we discovered my father had Alzheimer's disease, and my mother was his primary caregiver. About a year and a half ago, my parents sold their home, and moved in with us. I was sure that we would be able handle whatever we needed to with supports in the community to assist us in caring for my dad at home. After calling many agencies and organizations, I realized there was very little help available to families in this situation. As the disease progressed, and my dad's condition deteriorated, my mother made the very tough decision to place him in a nursing home over an hour away. I had been doing all I could to help her help him, while also taking care of my family. We all wanted my dad to be able to stay at home as long as possible, but eventually my mother felt that she had no option but to put him in a nursing home, she was exhausted, and she was feeling guilty about living with us.

Beth, your experience as a caregiver and your contribution as an advocate are inspirational. Would the services we're talking about today have made a difference in your circumstances, and in people who faced similar caregiving challenges?

STATEMENT -- DAVID ROBAR

Thank you Governor Shaheen, for your past and continued support of people with disabilities. As you can see this is a very personal issue for me and I am proud and pleased to see that you and the President have taken on these very tough issues. As someone who is personally affected by these issues every day, I would like to share my story with you.

In 1990, I sustained a spinal cord injury that changed my life dramatically. After spending 3 months in the hospital and 3 months in rehab, I returned home to adjust to a new life. Despite all these changes, I was determined to finish my degree and with the help of Vocational Rehabilitation, I finished my degree in Business Administration. When I began looking for a job I found myself in a catch 22. Currently, the personal attendant benefits I receive through the Medicaid program are what makes it possible for me to work -- they literally get me out of bed in the morning. If I were to work full time -- which I would like to -- I would make too much to be eligible for Medicaid, and I would lose my personal attendant benefits and my health care coverage. If I were to pay for my personal attendant services out of pocket, it would cost me more than I would make working full time.

Mr. President, your support for the Work Incentives Improvement Act and the other initiatives you have promoted to address the long term care needs of individuals of all ages, is the first critical step towards eliminating barriers to employment for individuals with disabilities, and I want to thank you for your support.

David, we really welcome your support for our long term care and disability initiatives. An economy that has such a low unemployment rate particularly drives home the point that we must take advantage of every American who can make a contribution to the workforce. We must tap every resource. Do you believe that there are many people with disabilities, in New Hampshire and throughout the country, who desperately want to work, but simply cannot afford to working if it means losing their health insurance?

Absolutely, Mr. President. About 15 million working-age adults have significant disabilities which inhibit their ability to work. People with disabilities can bring tremendous energy and talent to the American workforce, yet institutional barriers often limit their ability to work. A National Organization on Disability poll showed that 72% of the people with disabilities want to work. Unlike many Americans, many people with disabilities want to pay taxes -- or a least want the opportunity to pay taxes -but are currently forced to choose between employment and access to critical health care services. The initiatives you have proposed will change that for millions of Americans, and I want to thank you for your leadership once again.

STATEMENT -- KAREN GODDARD

I am a single mom of two girls and have been self employed for eight years. For the past few years, I have been searching for an affordable health insurance package for both myself and my employees. We have never been to find a plan for which we could afford the monthly premiums. Although I've been able to find health insurance for my children, I am often worried about what would happen if I had an accident or got very sick. I know that I am not alone in this situation; many of my friends, most of them with children, are also uninsured. We are often frustrated by the fact that health insurance, even for people for who are healthy, is just so incredibly expensive. As business owners and parents, we would like to find a way to find adequate health insurance that we can afford.

Do you think having someone work through the administrative processes associated with purchasing health care, as well as getting a small break on the price, would make it easier for you to find a health insurance plan that works for you and your employees?

Yes, I do. What appeals to me as a small business owner is the fact that someone else would take care of the adminsitrative aspects of finding a health insurance plan. As a parent, I would appreciate having a range of health insurance options, so that I could choose the best one for me and my family. And, of course, getting a break on the price doesn't hurt -- every little bit helps. Mr. President and Governor Shaheen, I want to tell you both how much I appreciate your efforts to take on these difficult issues that are so important to small business owners like me.

STATEMENT -- CHRISTINE MONTEIRO

I am the mother of four daughters, 25, 22, 16, and 11. For the past 11 years, my husband and I have been running a family business. We have had at least four different insurance plans. The premium starts out affordable, but the deductibles are so high that the plans don't even cover doctor or dentist visits. Also, after one year even the premium is no longer affordable. So for the first six years we had our business we were on and off of health insurance plans, and for the past five years we have had no insurance coverage. Last month, we found out about Healthy Kids through my doctor's office. We were told this would be a way to get health insurance for our daughters at an affordable rate that would only increase with an increase in my income. One of my daughters has been to the doctors three times already this month. Without Healthy Kids I don't know how we would be able to pay for her medical bills. I don't have to worry anymore about taking my girls to the doctor.

One of the greatest challenges we face in administering this new children's health plan is actually locating those who are eligible for this coverage. Your experience illustrates one way (ie: utilizing provider offices) that we can link the program to the population in need, but I was wondering if you can give us some of your own suggestions on where and how best we can locate parents of these children who are eligible for CHIP or Medicaid.

STATEMENT -- STEPHEN GORIN

Good morning, Mr. President. Welcome to New Hampshire. I'd like to briefly address an issue I know you understand well: the need for a Patients Bill of Rights. I've traveled throughout New Hampshire, and spoken on this issue before many audiences, including providers and consumers. Invariably, I've found strong support for the bill of right. The stories I've heard are chilling: families denied access to specialists physicians offered incentives to limit referrals, and consumers denied the right to appeal adverse decisions. Although NH has made some progress in recent years, largely due to the hard work of our governor, a recent study by Families USA found that we still lag behind many states in consumer protections. Governor Shaheen's HMO Accountability Act will remedy some of these problems and we applaud her efforts. However, as you well know, we also need action at the federal level. Due to a loophole in federal law, an estimated 600,000 New Hampshire residents lack a means of holding managed care organizations accountable for injury or damages. The patients bill of rights closes this loophole. We've heard much today about the need to expand access. As an advocate, I certainly understand the need to provide coverage for all our residents. In a sense, however, coverage is only half the picture. Without a patients bill of rights, coverage can be meaningless. Consumers need to know that if they go to an emergency room, their plan will pay for it and if they have cancer, they will have access to an oncologist. They also need to know that they will have the right of independent appeal if they are denied treatment or care. Both consumers and purchasers want value for their product, and only a bill of rights can ensure that they get it.

We also know, Mr. President, that some in Congress have introduced legislation purporting to be a patients bill of rights. Unfortunately, this legislation is more a bill of goods than a bill of rights. We urge you to hold out for legislation that will provide real protection and ensure the accountability of managed care organizations to consumers.

The NH Legislature needs to enact the HMO Accountability Act and Congress needs to enact a patients bill of rights that allows the states to regulate managed care organizations and protect all our citizens.

Steve, I know you've played an active and supportive role in the Governor's work in providing State based patient protections.A lot of critics suggest that these reforms will increase costs and that businesses will no longer be able to sustain the cost of providing health insurance, driving up the numbers of the uninsured. How do you respond to that?

First Mr. President, I believe we can't afford not to pass this legislation. We need to restore the public's confidence in our health care system. But most importantly, the estimates produced by independant analysts completely undermine the false claims by the opponents of this long overdue legislation. Every independant analyst, whether it be CBO, Coopers and Lybrand, or Kaiser Family Foundation, have all concluded that these costs will be minimal -- less than $2.00 a month per enrollee. I think that's a very small price to pay to ensure continued confidence in the health care system -- that you'll have the health care you'll need when you need it.

Draft 02/17/98 5:45pm
Jeff Shesol

PRESIDENT WILLIAM J. CLINTON
REMARKS ON LONG-TERM CARE TAX CREDIT
DOVER, NEW HAMPSHIRE
February 18, 1999

Acknowledgments: Gov. Shaheen; Beth Dixon; Karen Goddard; Shawn Minotti; David Robar; other panelists TK

I want to thank the Governor for her remarks, and I especially want to thank her for all she's doing to improve the quality and availability of health care here in New Hampshire. I think her proposals are good ones. And I think they will go a long way toward helping the people of New Hampshire meet the challenges of health care in the 21st Century.

Today, our panelists will discuss a number of these challenges: from the rights of patients to the concerns of small businesses providing coverage; and from the health care needs of children to those of the elderly and people with disabilities. My administration has been working for six years now to make progress in these areas; and my latest balanced budget renews that commitment. We remain focused on the future. And that is why I want to talk this morning about meeting the greatest challenge of the new century: the aging of America. As the Baby Boom becomes the Senior Boom, long-term care will become a growing need. So it is more important than ever that we help families provide that essential kind of care for their loved ones. In my balanced budget, I have proposed and paid for a long-term care tax credit of $1,000 to help families do exactly that.

I will have more to say about that proposal in a moment. But first, let me put it into a larger picture, and say that a long-term care tax cut is exactly the kind of tax cut we should be making. As you know, we are engaged in a great national debate right now about how to use the budget surplus. Now, we can all agree that America should have tax cuts. But there are two very different ways we can go about it. First, there is the old way -- failed and full of risk -- that some Republicans are trying to resurrect. They are saying: splurge today, save tomorrow. That's not the approach that Vice President Gore and I have proposed. Our approach says invest today, save for tomorrow. Our kind of tax cut is one that doesn't destroy our fiscal discipline, but preserves it. Our kind of tax cut is not indiscriminate, but is, instead, targeted to meet people's real needs for the future. Above all, our kind of tax cut allows us to meet our responsibility to future generations -- and to invest the lion's share of the surplus in saving Social Security and Medicare first.

Even some Republican moderates are coming to see the wisdom in this approach, in targeted tax cuts. I look forward to working with them to make the right choices for future generations -- to make sure we don't squander our historic opportunity to save Social Security and Medicare, and pay down the debt. As I said in my State of the Union Address one month

ago, we can make good on that opportunity -- while providing tax relief like USA Accounts, and while making targeted tax cuts in areas from urban investment to clean energy technology, and from child care to long-term care. That is the way we should use our surplus: We should invest it. Invest it in America's future.

As I have said: In the future, in the 21st Century, America will be an aging nation. And as the ranks of the elderly grow, so do the numbers of vulnerable Americans who cannot fend for themselves. Already, millions of households are caring for elderly relatives and neighbors and people with disabilities. It is the cycle of life. Our parents worked and saved and sacrificed for us in our youth; adult children are working and saving and sacrificing for their parents in old age.

Providing long-term care at home is, more and more often, a common choice, but it is rarely an easy one. We heard about these challenges at the Family Conference the Vice President hosted in Nashville last summer; and he is now helping to lead our efforts by holding a series of forums across the nation. Since long-term care is rarely covered by private insurance or Medicare, out-of-pocket expenses can be high. Moreover, caregivers who hold jobs outside the home -- and that is a vast majority -- may have to take unpaid leave or work fewer hours to fulfill all their responsibilities.

We have taken steps to ease the burdens on these families in a number of ways: by strengthening Medicare, by extending the trust fund, by promoting prevention and cracking down on fraud and abuse. But the aging of America in the 21st Century will demand more of us. The long-term care tax cut I proposed last month would help to meet the needs of individual families, empowering them to do what is best, showing them how very much we value the work they do. And it is only one part of our comprehensive long-term care initiative: I have also proposed a national Caregiver Support Program, as well as new steps to help Medicaid pay for home- and community-based care. Caregiving is a vital and sacred compact among generations -- and one we should recognize and reward as a nation.

There is more we must do to improve health care in America. We should also join together across party lines to pass a strong, enforceable Patients' Bill of Rights -- as well as the landmark legislation proposed by Senators Kennedy, Jeffords, Roth, and Moynihan to allow people with disabilities to keep their health insurance when they go to work. We must keep working to help small businesses insure their employees, since it is the smallest companies that often have the greatest difficulty in providing coverage. And we must keep working until our uninsured kids have the coverage they need and deserve. In 1997, we passed the largest investment in children's health in a generation, helping extend coverage to up to 5 million children; and now, in states across the country, Governors like Jeanne Shaheen are working to implement their programs. In this way, we are all working together to build a stronger and healthier America for the 21st Century.

I know our panelists have some important perspectives to share. I am looking forward to starting that discussion.

POTENTIAL QUESTIONS AND BACKGROUND FOR ROUNDTABLE DISCUSSION

BACKGROUND ON BETH DIXON: *Beth Dixon* is a 49 year old mother of four from Concord, New Hampshire who spent the majority of the last year caring for her father, who suffered from Alzheimers and died in March of 1998. When Ms. Dixon's father was first diagnosed with Alzheimers, both her parents moved in with her. She speaks very well about the emotional strain that caregiving for a relative caused, for both her, her mother, and her children. Ms. Dixon was a "sandwich" caregiver, faced with the responsibility of caring for both a parent and her children. She believes that the new $1000 tax credit, which her parents would have qualified for, and the proposed National Family Caregivers Support Program would have made an incredible difference in the family's quality of life and would have postponed her father's entry into a nursing home.

- **PRESIDENT CLINTON: Question for Beth Dixon:** Beth, your experience as a caregiver and your contribution as an advocate are inspirational. Would the services we're talking about today have made a difference in your circumstances, and in people who faced similar caregiving challenges?

  [The PRESIDENT has the opportunity for a follow-up question.]

BACKGROUND ON DAVID ROBAR: *David Robar* is a 34-year-old native of New Hampshire who sustained a spinal cord injury in 1990 which resulted in permanent quadriplegia. Before his accident, he was a world class ski jumper and a potential candidate for the 1988 Olympic Ski Team. At the time of his injury, he returned to school to study business at New England College, in Henniker, NH. After his accident, Mr. Robar returned to school and obtained his B.A. in 1992. He now works part-time in communications for the Granite State Independent Living Center. Currently, the personal attendant benefits he receives through the Medicaid program are what makes it possible for him to work. If he were to work full time, he would make too much to be eligible for Medicaid and lose his personal attendant benefits -- but if he were to pay for his personal attendant services out of pocket, it would cost him over $40,000 a year, more than he would make working full time. He is frustrated because he feels that he is unable to really use the college education that he worked hard to get, and speaks passionately about his desire to be a fully contributing member of the workforce.

- **PRESIDENT CLINTON: Question for David Robar:** David, we really welcome your support for our long term care and disability initiatives. An economy that has such a low unemployment rate particularly drives home the point that we must take advantage of every American who can make a contribution to the workforce. We must tap every resource. Do you believe that there are many people with disabilities, in New Hampshire and throughout the country, who desperately want to work, but simply cannot afford to run the risk of working without health insurance?

[The PRESIDENT has the opportunity for a follow-up question, possibly on the Patients Bill of Rights.]

BACKGROUND ON KAREN GODDARD: *Karen Goddard*, is a 37 year-old, divorced, single mother of 2 children from Nashua, NH. She is the owner of 2 maternity and children's clothing stores, and has 4 part-time employees. While 3 of her employees are covered under their spouses' health insurance policy, she is currently unable to purchase health insurance for herself or the other employee because of the high cost associated with purchasing individual coverage. Finding a health insurance package that meets their needs is a priority for both Ms. Goddard and her employee, and she is somewhat frustrated by the fact that they have been searching for an affordable insurance option for over four years and have been unable to find one. Ms. Goddard speaks eloquently about the fears and financial difficulties that being uninsured causes, and is enthusiastic about the financial assistance that the small business tax credit would provide, as well as the increased health insurance options that would be associated with participation in a small business purchasing coalition.

- **PRESIDENT CLINTON: Question for Karen Goddard:** Karen, you talked about how you've tried for a long time to find an affordable health insurance option that suits your needs. We're working with Governor Shaheen to make it easier for small business owners to offer health insurance by giving them financial assistance that makes it easier for them to purchase insurance as a group. Do you think having someone work through the administrative processes associated with purchasing health care, as well as getting a small break on the price, would make it easier for you to find a health insurance plan that works for you and your employees?

[GOVERNOR SHAHEEN has the opportunity to ask a follow-up question.]

BACKGROUND ON CHRISTINE MONTEIRO: *Christine Monteiro* is a 41 year old woman with four girls who have been insured intermittently for the past 11 years and completely uninsured for 5 years. When one of her daughters was ill, Mrs. Monteiro took her uninsured child to see the doctor. She recieved treatment and was advised that her daughter might be eligible for the new CHIP program. After almost immediately following up, she was thrilled to discover that her kids were indeed eligible. Since that time, she has learned that one of her daughters has a physical ailment that will require specialty care that her new CHIP insurance covers. This has provided her with immeasurable relief from worry and she is extremely appreciative for this insurance.

- **PRESIDENT CLINTON: Question for Christine Monteiro:** One of the greatest challenges we face in administering this new children's health plan is actually locating those who are eligible for this coverage. Your experience illustrates one way (ie: utilizing provider offices) that we can link the program to the population in need, but I was wondering if you can give us some of your own suggestions on where and how best we can locate parents of these children who are eligible for CHIP or Medicaid.

[GOVERNOR SHAHEEN has the opportunity to ask a follow-up question.]

BACKGROUND ON STEPHEN GORIN: Stephen Gorin is a professor in the Social Work Program at Plymouth State College in New Hampshire and is the Executive Director of the New Hampshire Chapter of the National Association of Social Workers, the State's most visible patient advocacy organization. Dr. Gorin hosts a biweekly radio program on WKXL-AM/FM in Concord, NH.

- **PRESIDENT CLINTON: Question for Stephen Gorin:** Steve, I know you've played an active and supportive role in the Governor's work in providing State based patient protections.A lot of critics suggest that these reforms will increase costs and that businesses will no longer be able to sustain the cost of providing health insurance, driving up the numbers of the uninsured. How do you respond to that?

NH

- Kirk Donovan
- Avira Sternberg
- Mindy Myers
- Doug Sosnik
- Ann Edwards
- Al (in Dover)?
- Barbara
- Patrice
- Julie Goldberg

departing Andrews 940
Peas International 1050
greeters: 1105
Governor
site: Dover Municipal bldg
288 Central Avenue
auditorium
parking on street

audience: can have 200 people
POTUS friends 80–100
Barbara seniors 30

10am arrival time
1030 in seats
event begins @ 1105–10

Al setting up ticket distribution
w George Meglaris Wed btwn
8–5

200 people
open press
Panelists
President
Gov Shaheen
6 people

50 minutes
½ hold for
meet & greet

greeting behind backstage
unveiled out

Gov welcoming remarks
Introduces panelists
President remarks
Panelists discuss

quality
PBQR
& physician for quality

George McGuire
City
Commissioner

Impeas
Helicopter in Merrimack

- Steve Gorenflo VP in NH
  health care advocate
  Healthcare Alliance

THE HENRY J. KAISER FAMILY FOUNDATION

11-12pm

DREW E. ALTMAN, PH.D.
PRESIDENT AND CHIEF EXECUTIVE OFFICER

January 27, 1999

Dear Colleague:

I am pleased to invite you to a policy roundtable on **Options for Expanding Health Insurance Coverage: What Difference Do Different Approaches Make?** The conference will be held in Washington, D.C. on Wednesday, February 17 at the Hotel Washington. Invited participants include congressional staff, state and federal officials, members of the press, and a broad range of policy experts.

Once again, concerns about growing numbers of Americans without health insurance are generating discussion of policy action. But what kind of action and for whom remains a controversial question. The purpose of the roundtable is to address this question, drawing upon research and analysis we have supported through a two-year Project on Incremental Health Reform, directed by Judy Feder of Georgetown University and Sheila Burke of Harvard University. The project, a description of which is attached, solicited a varied range of coverage proposals from policy experts; estimated and compared the impact of those proposals on coverage and costs; and commissioned analyses of a number of issues raised by incremental health reform proposals. The proposals, comparisons and cross-cutting analyses reveal fundamental tensions and choices that must be addressed in pursuing any strategy to expand coverage.

The roundtable will focus on three areas of tension and choice (see attached agenda):

Federal Entitlements vs. State Discretion

- Does enactment of the Children's Health Insurance Program (CHIP) provide a model for political compromise on future coverage legislation?
- Does implementation of CHIP provide a model for balancing federal entitlements and state discretion in practice?

Tax Preferences vs. Direct Subsidies

- Does the way we provide financial support affect who and how many get coverage?
- Do different policy approaches emphasize different policy goals?

2400 SAND HILL ROAD MENLO PARK, CALIFORNIA 94025 650 854-9400 FAX 650 854-4800
WASHINGTON, DC OFFICE: 1450 G STREET, NW, SUITE 250 WASHINGTON, DC 20005 202 347-5270 FAX 202 347-5274

Reaching the Uninsured vs. the Already Insured (Crowd-out)

- How do different approaches affect the likely participation of the uninsured vs. the already insured?
- Are there benefits as well as costs to crowd-out?

Following brief remarks by analysts, we will engage in what we hope will be a lively discussion of each issue, evoking differences in points of view and preferred strategies and their implications for policy action.

We hope you will join us.

Sincerely,

Drew Altman

OPTIONS FOR EXPANDING HEALTH INSURANCE COVERAGE:
WHAT DIFFERENCE DO DIFFERENT APPROACHES MAKE?

A Conference Sponsored by the Kaiser Family Foundation
The Hotel Washington, Washington, D.C.
February 17, 1999
8:45 am - 2:30 pm

The purpose of this roundtable is to engage congressional and administration staff, other federal officials, state policymakers and selected members of the press in a discussion of the trade-offs and controversies associated with alternative approaches to expanding health insurance coverage–all of which are either under consideration (tax preferences vs. direct subsidies, use of the CHIP model for adults) or in the process of implementation (new state programs vs. Medicaid under the Children's Health Insurance Program or CHIP).

A series of topics will be used to guide the discussion. Each topic is developed or further explored in papers commissioned under the Kaiser Commission Project on Incremental Health Insurance. Copies of the papers will be distributed at the conference.

8:45-9:15 am **Continental Breakfast**

9:15-9:30 am **Welcome by Kaiser Family Foundation**

Drew Altman, President and CEO
The Henry J. Kaiser Family Foundation

9:30-10:00 am **Overview of Tradeoffs raised by Expansions**

Judy Feder, Dean of Policy Studies
Georgetown Public Policy Institute
Georgetown University

Sheila Burke, Executive Dean
Kennedy School of Government
Harvard University

10:00-11:00 am **Federal Entitlements vs. State Discretion: Lessons from CHIP**

Chair: Sheila Burke

Speakers: Cindy Mann, Senior Fellow
The Center on Budget and Policy Priorities

Alan Weil, Director, Assessing the New Federalism
The Urban Institute

	Lead comments:	Howard Cohen, Share Holder Greenberg Traurig
		Karen Nelson, Senior Health Advisor Office of the Honorable Henry Waxman
		Trish Riley, Executive Director National Academy for State Health Policy
11:00 am-12:00 pm	**Tax Preferences vs. Direct subsidies: Reaching the Uninsured**	
	Chair:	Judy Feder
	Speakers:	Linda Blumberg, Senior Research Associate The Urban Institute
		Mark Pauly, Professor of Health Care Systems The Wharton School of the University of Pennsylvania
	Lead Comments:	Chris Jennings, Deputy Assistant to the President for Health Policy White House
		Chip Kahn, President, (invited) Health Insurance Association of America
		Jim Mongan, President Massachusetts General Hospital
12:00-1:00 pm	**LUNCH**	
1:00-2:00 pm	**Crowd-out: Causes, Costs and Consequences**	
	Chair:	Diane Rowland, Executive Vice President The Henry J. Kaiser Family Foundation
	Speakers:	John Holahan, Director, Health Policy Center The Urban Institute
		Kevin Piper, Vice President Alpha Center

Lead Comments: Karen Davis, President
The Commonwealth Fund

Kathy Means, Chief Health Analyst
Senate Finance Committee

Bridgett Taylor, Minority Professional Staff Member
Commerce Committee Democratic Staff

2:00-2:30 pm **Wrap-Up**

Sheila Burke and Judy Feder
Drew Altman

Henry J. Kaiser Family Foundation Project on Incremental Health Reform

In November, 1997, the Kaiser Family Foundation initiated a project to examine different strategies for expanding health insurance coverage. The project began by soliciting the development of alternative proposals from experts with diverse points of view: Linda Blumberg, Stuart Butter, Rick Curtis, John Holahan, Pamela Loprest, Mark Merlis, Marilyn Moon, Mark Pauly, Wendell Primus, Tom Rice and Gail Wilensky. Experts were asked to identify a population on whom to target coverage, specify a mechanism for providing that coverage, and lay out both the rationale for and the operational details of their approach.

A varied set of options resulted--many involving alternative approaches to covering children; others, sub-populations of adults (people between jobs, near-elderly, low-income adults). As intended, mechanisms also varied--specifically, in terms of reliance on tax preferences, direct subsidies, or a mix of strategies.

The next step of the analysis was to model the impact of the proposals on costs and coverage. Any estimate of a policy proposal relies on assumptions-- particularly about who will participate (among the uninsured and the already insured) under various policy parameters. This project was unique in applying a common set of assumptions, developed with input from participating policy experts, to such a broad range of proposals. Analysts at the Urban Institute (Sheila Zedlewski and Cori Uccello) undertook the empirical estimates, with assistance from the Actuarial Research Corporation. A committee of policymakers and policy experts advised at various points in the process.

A third piece of the project involved exploration of a variety of issues raised by the choice of a population or policy approach. These issue include an assessment of the issues and evidence on tax based vs. direct subsidy approaches (Sherry Glied), a review of the literature on crowd-out (Lisa Dubay), an examination of incremental expansions and the private health insurance market (Mark Merlis, Nicole Tapay, and Judith Feder), an ethical analysis of incremental reform's policy choices (Ruth Faden and Matt Powers), a political analysis of the Children's Health Insurance Program as a political compromise (Alan Weil), and an estimate of the impact of states' policy choices on coverage and costs under CHIP (John Holahan, Cori Uccello, and Judith Feder).

This policy roundtable discussion will highlight some of the findings from these papers. Experts' proposals, comparative results, and cross-cutting papers will be available at the conference.

GEORGETOWN UNIVERSITY

Georgetown Public Policy Institute

REGISTRATION FORM

OPTIONS FOR EXPANDING HEALTH INSURANCE COVERAGE: WHAT DIFFERENCE DO DIFFERENT APPROACHES MAKE?

A Conference Sponsored by the Kaiser Family Foundation

The Hotel Washington
515 15th Street, N.W.
Washington, D.C. 20004

February 17, 1999
8:45 am - 2:30 pm

I will attend ☐ **I will not be able to attend** ☐

Name: _____

Title: _____

Affiliation: _____

Address: _____

City/State/Zip _____

Telephone: _____

FAX: _____

Please FAX as soon as possible to:
Institute for Health Care Research and Policy at (202) 687-3110
No later than 5:00 PM Friday, February 5, 1999.
If you have any questions, please call (202) 687-0880 or (202) 687-3867

Mailing Address:
Institute for Health Care Research and Policy
2233 Wisconsin Avenue NW Suite 525
Washington DC 20007
202-687- FAX: 202-687-3110

GEORGETOWN UNIVERSITY

Georgetown Public Policy Institute

FACSIMILE COVER SHEET

TO: Chris Jennings

White House

FAX NO.: 456-5557

FROM: Judy Feder

DATE: January 27, 1999

PAGES INCLUDING THIS COVER SHEET: 8

COMMENTS:

Mailing Address:
Institute for Health Care Research and Policy
2233 Wisconsin Avenue NW Suite 525
Washington DC 20007
202-687- FAX: 202-687-3110

8629229

Roselie
Rosemary
Wooley
Wrally 202
8983521

Today ———.

focused specifically
Sp - emp on LTC

Illustrating how tax cuts
designed to target populations
most in need

LTC
disability
~~Kids~~

SMB
kids
> coverage.

M.C.
w/ yr

→ PBOR

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
004. note	re: medical information (1 page)	n.d.	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20468

FOLDER TITLE:
Nursing Home Event

2012-0463-S
rc702

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

NH

- QUALITY
  PBOR

next call @ 4pm tomorrow
5

- COVERAGE
  ~~SB co-op~~
  ~~MC DUPH~~
  ~~CH~~

- LTC INIT

Immunization

- DISABILITY
  ~~4/10~~ 5

- Alan Hirsch 3-6
  ~~DAG~~ in South Carolina ~~4/6~~ next Tuesday

DC next Tuesday
~~ERISA~~ pre-emption Unum vs
AMA; HIU

- 12 (lunch) Michelle McPh
  919 716 6006
  UNC
  6013

Withdrawal/Redaction Marker
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
005. note	re: medical information (2 pages)	n.d.	P6/b(6)

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Domestic Policy Council
Devorah Adler
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
006. list	List of possible speakers re: medical information, phone numbers, SSN, and DOB (2 pages)	n.d.	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20468

FOLDER TITLE:
Nursing Home Event

2012-0463-S
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
007. memo	Dee Dee Henzler to Judy Riggs re: SSN and DOB (1 page)	02/16/1999	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20468

FOLDER TITLE:
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Senate Bill 409

- **Mission of SB 409**
  - Helps elderly and chronically ill adults remain independent by providing them visible and accessible information and assistance about the programs and services that support them in their homes and communities
  - Strengthens consumer choice by offering alternatives for care that were heretofore unavailable to the Medicaid long term care consumer
  - Preserves state, county and federal resources by de-emphasizing costly nursing home care as the only care option available to frail elders
- **Mandates Community-Based Focal Points To Provide Information And Assistance To Seniors And Chronically Ill People**
  - All seniors, chronically ill people, their families and caregivers, and providers may access focal points regardless of economic status
  - Focal points will provide information and assistance to consumers and providers
  - Focal points will provide short term service coordination to overcome barriers caused by fragmented long term care system
  - Focal points will be community based, reflecting local social and medical service systems
  - Collaboration of community-based providers is essential and will be required
  - State will mandate minimum standards that focal points must meet and perform quality assurance reviews
  - SB 409 establishes the Long Term Care Assistance fund to develop the community based infrastructure and to support focal points. Fund is non-lapsing and is endowed with $1-$4 million. No funds may be expended without consulting the oversight committee of Health and Human Services and without the approval of fiscal committee.
- **Provides For Statewide Community Based Long Term Care Assessment And Counseling For All Nursing Home Applicants**
  - All applicants for nursing homes, whether able to pay for their own care or eligible for Medicaid, will receive education about home and community based services
  - Will strengthen consumer choice by educating consumers about care options that can help the consumer stay independent for as long as possible at home or in the least restrictive setting in the community
  - Will delay spend down of private resources since consumers are more likely to choose community based alternatives that are less expensive than nursing home care
  - Discourages nursing home industry from causing private pay people who do not require nursing home level of care to spend down their private resources by imposing a penalty of up to one year of the cost of care if the person spends down and becomes eligible for Medicaid within three years of entry into the nursing home
- **Expands Options for Medicaid Long Term Care Consumers**
  - For first time in New Hampshire history, provides mid-level care alternative to Medicaid nursing home eligible people
  - Defines mid-level care as residential care, supported residential care, congregate housing and assisted living
  - Preserves state, county, and federal resources since mid-level care can be provided at one-half the cost of nursing home care
- **Changes Funding Of Medicaid Nursing Home Level Services**
  - Creates county and state government partnership to equally share the cost of the non-federal share of home-based, mid-level, and nursing home services
  - In past, county government paid more than the state for cost of nursing home care. By equalizing the responsibility to pay for care, state's incentive to emphasize nursing home care is eliminated
  - Supports consumer choice
- **Other Administrative Actions Supporting the Mission Of SB 409**
  - Federal approval obtained to expand the services that can be provided under the Medicaid Home and Community Based Waiver for the Elderly and Chronically Ill
  - Implementation of acuity based rates for nursing home reimbursement
  - Restructuring of DEAS to establish a quality assurance function relative to work performed by providers and evaluation of DEAS policy
  - Adjusted and raised home health rates
  - Contract negotiations underway to implement Senior Prescription Drug Discount Program

Status Report on Implementation of SB 409

- **Major Implementation Efforts Underway, Prioritizing Those Parts Of SB 409 That Support Building The Community Based Infrastructure**
  - Focal points, long term care assessment and counseling, and mid-level care are highest priorities for implementation
- **Focal Points**
  - Department prepared policy paper defining mission and functions of focal points. Policy paper served as framework for discussion in public meetings with NH citizens about what they need and want from focal points
    - Input for framework received from the State Committee on Aging (SCOA), the Department's Long Term Care Advisory Committee, and public meetings throughout the state organized by the Area Committees on Aging (ACOAs)
    - Public meetings well attended by consumers, providers and caregivers
    - Major themes and concerns that public raised: overwhelming support for the concept, concern about adequacy of service structure to support demand for services, concern about duplication of information and assistance function, funding availability for infrastructure
  - Next steps
    - Refine policy paper
    - Begin drafting Request for Proposals. DEAS will seek input from SCOA and the ACOAs
    - Prepare spending plan for Fiscal Committee approval
- **Long Term Care Assessment and Counseling (LTCAC)**
  - Three county pilots have been in operation. Period of operation varies from over one year to several months. Scope of Activity is limited to Medicaid population.
  - DEAS has reviewed the county-based pilot programs to determine how we can build on their experiences to establish a statewide program. Draft report in process.
  - Next Steps
    - Outline statewide model
    - Draft RFP
    - Issues for consideration: types of entities performing LTCAC, collocation of focal points with LTCAC, collocation of HCBC nurse function, collocation of DEAS district office staff.
- **Establishment of Mid-level Care for Medicaid Long Term Care Consumer**
  - Workgroup consisting of DHHS staff (DEAS and licensing), industry representatives, and consumers convened to revise administrative rules relative to residential care facilities.
  - Discussions to assess information systems requirements and changes underway
    - Changes to New Heights eligibility system (financial eligibility)
    - Changes to Medicaid Management Information System (MMIS) to pay for services
- **Funding Of Long Term Care Service System**
  - SB 409 required each county to ratify the changes in county funding of nursing home care, mid-level care, and home care, and related ancillary payments such as hospital, doctor, and prescription drug costs
  - All ten counties have ratified SB 409 funding changes
- **Administrative Actions to Support Older Americans and SB 409 initiatives**
  - Amendment of Medicaid HCBC-ECI waiver approved by HCFA
    - HCFA worked in partnership with DHHS to review and approve waiver in timely manner
    - Existing services: homemaker, home health aide, Personal Emergency Response System, in home day, respite care, adult medical day, private duty nursing.
    - New Services: personal care, adult group day, environmental modifications, assistive technology, specialized medical equipment, home-delivered meals, consolidated long term care services, mid-level care, shared housing, adult foster care, in home mental health counseling.
    - All new services require service definitions, policy development, systems support, staff and provider education, and provider enrollment before they can be implemented.
  - Acuity Based Rates implemented effective 2/1/99
  - Contract negotiations underway to implement Senior Prescription Drug Discount Program
  - Home health rate adjustment and increase implemented effective 2/1/99

STATE OF NEW HAMPSHIRE
OFFICE OF THE GOVERNOR

JEANNE SHAHEEN
GOVERNOR

CHIP

The N.H. Children's Health Insurance Plan

For the first time in New Hampshire's history, affordable health care insurance will be made available to nearly all New Hampshire children through an innovative new health insurance plan - The New Hampshire Children's Health Insurance Plan ("CHIP").

CHIP will expand eligibility for affordable health insurance for children whose families are unable to afford the full cost of private insurance and will replace and restructure the existing Medicaid program for children.

CHIP will offer two benefits packages -- *Healthy Kids Gold* and *Healthy Kids Silver*. Children now eligible for Medicaid will be enrolled in the *Healthy Kids Gold* plan. Other uninsured children under 19 years of age whose family income is too low to afford the full cost of health insurance will be eligible to enroll in *Healthy Kids Silver*.

Made Possible by a New Partnership

CHIP represents an exciting new partnership between the State of New Hampshire, the federal government, the Healthy Kids Corporation and the Healthy New Hampshire Foundation.

After extensive negotiations with the federal government, Governor Jeanne Shaheen received notice of official approval on September 15, 1998 from the U.S. Department of Health and Human Services to obtain federal funding for CHIP and to begin enrolling uninsured children in CHIP in January, 1999.

Families whose children enroll in *Healthy Kids Silver* will contribute to the cost of that insurance based on a sliding fee scale based on family income. The federal government will fund 65 percent of the remaining costs of the *Healthy Kids Silver* program. The Healthy New Hampshire Foundation, a recently formed charitable organization, will fund the other 35 percent of the remaining costs of the *Healthy Kids Silver* program.

Healthy Kids Gold will replace our traditional Medicaid program for children. The State of New Hampshire will continue to be responsible for administering and

funding approximately 50 percent of this program and the federal government will continue to fund the other approximately 50 percent cost of this program.

The Healthy Kids Corporation, established in 1993 by legislation supported by then State Senator Jeanne Shaheen, will administer the *Healthy Kids Silver* program and take the lead in outreach efforts to enroll uninsured children for both programs.

A Shared Responsibility with Families

Families whose children enroll in *Healthy Kids Silver* will contribute to the cost of insurance based on a sliding fee scale based on family income. Families with incomes between 185 percent and 250 percent of the federal poverty level will pay $20 per month per child. Families with incomes between 250 percent and 300 percent of the federal poverty level will pay $40 per month per child. Families in *Healthy Kids Silver* will also pay small co-payments for doctor visits and prescription drugs.

Children now eligible for Medicaid will be enrolled in the *Healthy Kids Gold* plan, and will receive benefits at no cost as is the case now with traditional Medicaid.

Comprehensive Benefits with an Emphasis on Prevention

CHIP is designed to get children the health services they need when they need it. Both *Healthy Kids Gold* and *Healthy Kids Silver* offer comprehensive benefits including inpatient and outpatient hospital services, doctor visits, prescription drugs, mental health services, durable medical equipment, eyeglasses, home health visits, dental services, physical therapy, emergency care and more. *Healthy Kids Gold* benefits are more comprehensive in nature, specifically designed to meet the special needs of very low-income families.

More Efficient and User-Friendly

CHIP will completely replace and restructure the existing Medicaid program for children, making it more efficient and user-friendly. A single two-page application for both CHIP programs will replace the current six-page application for the existing Medicaid program. Applications will be available at schools, public health clinics, hospitals, child care centers as well as the district offices of the Department of Health and Human Services. No longer will families be required to meet face-to-face with employees of the state Department of Health and Human Services in order to apply for their children's health benefits. Once the application is completed and mailed in, families will be notified of their children's benefit plan and required monthly contribution.

A Wise Investment

Approximately 20,000 children in New Hampshire today do not have any health insurance coverage. While the parents of most uninsured children work, the cost of health insurance is so high that many working families simply cannot afford coverage for their children.

Health coverage for children is a smart investment. Studies show that insured children are in better health than those who are uninsured. Preventive health and dental care, early treatment of illness, and management of chronic conditions help to reduce the frequency and duration of illness among children. Children without insurance are more likely to go without regular check-ups, not have all their immunizations and miss more school. Health care for uninsured children frequently takes place in the most costly setting – hospital emergency rooms. Often medical intervention has been put off until the child's condition requires more extensive and expensive treatment. These costs are shifted to other payers and passed on to employers and individuals in the form of higher insurance premiums. Moreover, lack of health insurance is frequently a barrier to participation in school athletic and other extra-curricular activities.

SB 494:

An act establishing the voluntary small employer purchasing alliance

Proposal introduced

What is a Health Insurance Purchasing Alliance (HIPA)?

A HIPA is a private organization through which small businesses join forces to purchase health insurance for their workers. The primary goal of a HIPA is to obtain better value in purchasing health insurance by consolidating purchasing responsibilities and resources for their small business members.

A HIPA can help us achieve the following important health goals:

Reduce costs for health insurance by:

- aggregating purchasing power to negotiate with health plans
- reducing administration costs

Enhance employee choice of plans by:

- encouraging participation of multiple health plans
- allowing employees to choose among health plans available through the HIPA

Foster competition based on value by:

- ensuring consumers receive clear information about plans including plan quality
- requiring plans to offer standardized benefit packages for "apples to apples" comparisons
- reducing the opportunity for health plans to engage in risk selection and cost-shifting from other purchasers
- reducing the incentive for health plans to risk select by risk adjusting rates

Enhance quality by:

- providing consumers with information to compare plans for best value
- negotiating with plans to set specific quality improvement goals

Reduce the overall level of uninsurance by:

- making insurance more affordable
- discouraging risk selection

had study Cnte
recommended psg

What a HIPA does

- ✓ Negotiating and contracting
- ✓ Marketing
- ✓ Enrollment
- ✓ Premium collection and distribution
- ✓ Consumer information ;
- ✓ Data analysis and evaluation
- ✓ Plan performance measurement
- ✓ Quality improvement
- ✓ Consumer ombudsman

What a HIPA doesn't do

- × Bear risk
- × Directly pay individual health care providers
- × Market for just one carrier
- × Provide health care services
- × Function as a health plan (HMO, PPO, etc)

Why organize a HIPA?

Small employers have the most difficulty covering their employees. An alliance will facilitate the purchase of health insurance for small employers.

- Of the 54 million Americans between the ages of 18 and 65 who are employed in businesses with 100 or fewer workers, only 40% obtain health insurance from their employer compared with 83% of employees in firms employing 1,000 or more workers.

A HIPA will increase choice of plans available to its members

- Workers in small firms tend to have little choice of plans.
- In 1996, 80% of the small firms that offered coverage offered only one plan.
- Only 6% offered choice from 3 or more plans.Small employers generally pay more in administrative costs.

A HIPA will increase the efficiency of the health delivery system

- The cost of health insurance as measured by the difference between premiums and benefits paid (the "loading charge") is greater for small firms than for large firms. This is due to the fact that administrative costs involved in insuring a small employer can be very high.
- Although premiums for the average plan are roughly the same for large and small firms, benefits tend to be lower and deductibles higher in small firms. Additionally, employees in small firms pay a larger portion of the health insurance premium than those in large firms. This has led to a striking growth in out of pocket costs for employees in small firms.

SB 162 – AS INTRODUCED

1999 SESSION

99-0601
01/09

SENATE BILL ***162***

AN ACT establishing the voluntary small employer health insurance purchasing alliance.

SPONSORS: Sen. Fraser, Dist 4; Sen. Trombly, Dist 7

COMMITTEE: Insurance

ANALYSIS

This bill establishes the New Hampshire voluntary small employer purchasing alliance to provide, on a voluntary basis, health insurance coverage to member small employers and their employees in New Hampshire.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

SB 162 - AS INTRODUCED

99-0601
01/09

STATE OF NEW HAMPSHIRE

In the Year of Our Lord One Thousand Nine Hundred and Ninety-Nine

AN ACT establishing the voluntary small employer health insurance purchasing alliance.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Chapter; The Voluntary Small Employer Health Insurance Purchasing Alliance Act. Amend RSA by inserting after chapter 420-J the following new chapter:

CHAPTER 420-K

THE VOLUNTARY SMALL EMPLOYER HEALTH INSURANCE PURCHASING ALLIANCE ACT

420-K:1 Purpose. The purpose and intent of this chapter is to:

I. Increase the affordability, efficiency, and fairness of health care coverage for small employers by providing for the establishment of a statewide purchasing alliance through which small employers and their employees may purchase health coverage in the manner of large employer groups.

II. Allow small employers and their employees to obtain better value in purchasing health insurance by consolidating purchasing responsibilities and resources, thereby increasing bargaining power and purchasing expertise and reducing the administrative cost of health plan contracting, enrollment, premium collection and payment for multiple employers.

III. Provide small employers and their employees a meaningful choice of health carriers and health benefit plans through an open and fair process in which qualified carriers compete to provide health coverage to alliance members.

IV. Foster competition based on value by:

(a) Providing consumers with clear information about health carriers and coverages, including performance measurement and consumer satisfaction data;

(b) Requiring carriers to offer standardized coverages for meaningful comparison; and

(c) Reducing the incentive and opportunity for health carriers to engage in risk selection and cost-shifting from other purchasers.

420-K:2 Definitions. In this chapter:

I. "Commissioner" means the insurance commissioner.

II. "Eligible dependent" means "eligible dependents" as defined in RSA 420-G:2, V.

III. "Eligible employee" means "eligible employees" as defined in RSA 420-G:2, VI.

IV. "Employee enrollee" means an eligible employee, self-employed individual or an eligible dependent of an eligible employee who is enrolled in a health benefit plan offered through the alliance by a participating carrier.

V. "Health benefit plan" means "health coverage" as defined in RSA 420-G:2, IX.

VI. "Health carrier" means "health carrier" as defined in RSA 420-G:2, VIII.

VII. "Member small employer" means a small employer who enrolls in the alliance.

VIII. "Participating carrier" means a carrier deemed by the alliance as meeting the requirements of RSA 420-K:6 and in contract with the alliance.

IX. "Purchasing alliance" or "alliance" means the New Hampshire voluntary small employer purchasing alliance, a non-risk bearing, nonprofit corporation that provides, on a voluntary basis, health insurance coverage through multiple unaffiliated participating carriers to member small employers and their employees throughout New Hampshire.

X. "Small employer" means "small employer" as defined in RSA 420-G:2, XVI.

420-K:3 Jurisdiction of the Commissioner.

I. The commissioner shall have the authority to regulate the establishment and conduct of the alliance authorized under this chapter.

II. Nothing in this chapter shall be deemed to be in conflict with or limit the powers granted to the commissioner under the laws of this state.

420-K:4 Alliance Establishment and Oversight.

I. The commissioner shall:

(a) Issue a request for proposals that solicits nonprofit entities established under RSA 292 to submit bids to assume administrative and fiscal responsibility for the operation of the alliance. The commissioner shall assess bidder's qualifications in the areas of administrative capacity, financial responsibility, and demonstrated ability to fulfill the purposes and requirements of this chapter. Within 6 months of issuing the request for proposals, the commissioner shall select from among the qualified bidders and award administrative and financial responsibility for the operation of the alliance to the selected nonprofit entity. If no qualified nonprofit entity submits a bid pursuant to the commissioner's request for proposals, the commissioner may reissue a request for proposals at any time if the commissioner has reason to believe that there is a possibility of a response from a qualified nonprofit entity.

(b) Include in the request for proposals issued pursuant to RSA 420-K:4, I(a), a requirement that applicants submit at least the following information and documents with their response:

(1) A business plan consisting of a detailed, written plan of operations explaining how the applicant intends to fulfill the purposes and requirements of this chapter. Material changes in policy or operations of the business plan are subject to the prior approval of the commissioner on the same basis as the original business plan;

(2) The applicant's nonprofit articles of incorporation, bylaws and other formation and business operation documents. An applicant shall demonstrate to the satisfaction of the commissioner that its corporate governance makes it an appropriate and effective representative of small employers and their eligible employees' interests. An applicant shall demonstrate that it is not

merely a marketing or distribution channel for a single product or the products of a single carrier and that it will organize and facilitate meaningful competition between multiple unaffiliated carriers;

(3) A list of officers and directors of the applicant and the contract administrator, if one is employed, and personal biographical information or firm descriptions for each. The personal biographical information and firm descriptions shall demonstrate that those involved in the operation of the alliance have the expertise, experience, and character to effectively and professionally represent small employers and their eligible employees in a fiduciary capacity;

(4) Evidence of adequate security and prudence in the accounting, deposit, collection, handling, and transfer of moneys. An applicant shall affirmatively demonstrate adequate financial controls to the satisfaction of the commissioner; and

(5) Any other information required by the commissioner and deemed pertinent to the policies and operation of the alliance.

(c) Specify the information and documents that the alliance will be required to submit to the commissioner on a periodic basis to enable the commissioner to perform its oversight function. This shall include at least the following information and documents:

(1) Quarterly financial statements and annual reports designed to ensure that the alliance is fulfilling the purposes and requirements of this chapter, is adequately representing the interests of small employers and their eligible employees, is operating in a sound financial fashion, is not a risk-bearing entity, is utilizing sound financial controls and money management, and is not mismanaging or misappropriating funds either through neglect or malfeasance;

(2) Proposed material changes in the policy or operations of the business plan. Such proposed changes are subject to approval by the commissioner prior to implementation by the alliance; and

(3) Any other information required by the commissioner and deemed pertinent to the policies and operation of the alliance.

(d) Develop standard procedures for the resolution of disputes between the alliance and participating carriers, and between the alliance and member small employers or their eligible employees.

(e) Prepare an annual report on the operations of the alliance for the governor, the presiding officers of the legislature, the commissioner of health and human services, and the commissioner of insurance including program and financial operations and an accounting of outside revenues received and all internal and independent audits.

II. The commissioner may:

(a) Approve all assessments made upon member small employers by the alliance for costs incurred or anticipated in connection with the operation of the alliance.

(b) If review by the commissioner reveals that the entity selected to administer the alliance is not in compliance with the provisions of this chapter or is not acting in the best interests of its enrollees or has failed to comply with a lawful order of the commissioner, relieve that entity of its duties and in the interim may assume, or appoint another entity to assume, the duties of the alliance until a new administrator is appointed.

(c) In the event the alliance becomes insolvent, the commissioner may place the alliance in receivership for the purpose of protecting the interests of alliance enrollees.

(d) Exercise all other powers reasonably necessary to carry out the provisions of this chapter.

420-K:5 Powers and Duties of and Restrictions on the Purchasing Alliance.

I. The entity selected by the commissioner to assume administrative and fiscal responsibility for operation of the alliance shall:

(a) Establish and operate the alliance as a statewide entity offering health benefit plans that are available to all small employers in the state.

(b) Establish administrative and accounting procedures for operating the alliance, for providing services to member small employers and enrollees and for preparing an annual budget.

(c) Develop standard enrollment procedures for enrolling small employers and their eligible employees and dependents.

(d) Establish procedures for annual or rolling open enrollment periods during which:

(1) An enrollee may elect to enroll in any other health benefit plan that is available through the purchasing alliance and that provides health coverage where he or she lives or works; and

(2) Any late enrollees may elect to enroll in any health benefit plan that is available through the purchasing alliance and that provides health coverage where he or she lives or works.

(e) Establish procedures and mechanisms for billing and collection of premiums from member small employers, including any share of the premium paid by employee enrollees.

(f) Establish conditions of participation for small employers which conform to the requirements of this chapter and RSA 420-G and include, but are not limited to, the following.

(1) Assurances that the member small employer is a valid small employer group and is not formed for the purpose of securing health benefits coverage.

(2) Prepayment of premiums or other mechanisms to assure that payment will be made for coverage.

(g) In enrolling member small employers, the alliance shall provide that each eligible employee is permitted to enroll in any health benefit plan offered by any participating carrier so long as the health benefit plan provides coverage where he or she works or lives.

(h) Establish conditions of participation for participating carriers.

(i) Develop model contracts which detail for potential contractors the requirements of the alliance and provide a copy of the contract to interested carriers.

(j) Develop and make available a list of objective criteria that shall be met by participating carriers in order to be eligible to participate in the alliance.

(k) Establish conditions of participation for agents or brokers.

(l) Define a set of standardized health benefit plans which the alliance will contract to purchase from participating carriers. A participating carrier contracting to provide one or more such benefit plans through the alliance shall be deemed to be in compliance with the guaranteed issue and renewability requirements in RSA 420-G:6, III with respect to such benefit plan or plans so long as it actively markets, issues, and renews such plan or plans to all eligible employees of all member small employers of the alliance.

(m) Except as provided herein, contract, through an open and fair competitive process, with at least 3 unaffiliated participating carriers in each regional service area of the state to ensure that enrollees have a choice from among a reasonable number of differing types of competing carriers and health benefit plans. The alliance may contract with less than 3 participating carriers in a given service area if the commissioner determines that it is impracticable or otherwise inconsistent with the interests of enrollees to attempt to contract with 3 or more participating carriers.

(n) Place into its contracts between the alliance and member small employers the following:

(1) For administrative purposes, the alliance shall be the policyholder or contract holder of the health benefit plan on behalf of member small employers, their eligible employees and eligible dependents;

(2) Provide that the participating carrier shall issue a certificate of coverage, or equivalent document, specifying the essential features of the health benefit plan's coverage to each enrolled eligible employee; and

(o) Provide to alliance members clear, standardized information on each participating carrier and the qualified health benefit plans offered by each participating carrier, including information on price, benefits, enrollee costs, quality, patient satisfaction, enrollment, grievance procedures and rights and responsibilities. Furthermore, the alliance shall provide qualified health benefit plan comparison sheets to participating members and their employees with information regarding coverage that may be obtained through the participating carriers.

(p) Transmit enrollment and eligibility information to participating carriers on a timely basis.

(q) Provide that in the event a member small employer terminates coverage purchased through the alliance, the former member small employer shall be ineligible to purchase a health benefit plan through the alliance for a predetermined period of time to be established by the commissioner.

(r) Develop uniform standards for data to be provided by participating carriers. In formulating such standards, the alliance shall strive for consistency with health care data collection activities underway in New Hampshire and nationally. Any data collection requirements promulgated by the commissioner shall be based on a determination of their feasibility and cost-effectiveness, including their consistency with national standards for electronic data interchange, and their necessity for supporting the evaluation of participating carriers and their provider networks with respect to cost containment, quality, control of expensive technology, and customer satisfaction.

(s) Specify in contracts with participating carriers how all premiums shall be transmitted and the frequency of that transmission, along with appropriate language for penalties and grace periods on late payments of premiums.

(t) Request from the commissioner certification that all participating carriers are licensed small group carriers and that the carriers satisfy the financial requirements established under state law.

(u) Maintain a trust account or accounts for deposit of all moneys received and collected for the operation of the alliance. The alliance, its board members, employees and agents shall have a fiduciary duty with respect to all moneys received or owed to it to assure payments of its obligations and a full accounting to its members and the commissioner.

(v) Assure the offering of the same premiums and prices on negotiated health care coverage to all member classes equally, and treat all members within a class equally with regard to membership and administrative fees and benefits of membership.

(w) Review information and recommendations from consumers, employers, participating carriers or health care providers and other sources and, as appropriate, issue periodic reports or recommendations to the commissioner to improve the delivery of health services and the purchasing of health coverage.

(x) Submit to the commissioner, on a periodic basis as determined by the commissioner, quarterly financial statements, annual reports, proposed material changes in the policy or operations of the business plan, and any other information required by the commissioner regarding the policies and operation of the alliance.

II. The entity selected by the commissioner to assume administrative and fiscal responsibility for operation of the alliance may:

(a) Receive, review, and act, as appropriate, on grievances against participating carriers by member small employers or enrollees.

(b) Undertake any activity necessary to administer the alliance, including marketing and publicizing the alliance, and assuring that participating carriers, participating small employers, and enrollees are in compliance with alliance requirements.

(c) Establish contracts with participating carriers to provide health coverage to alliance members. The alliance shall not be required to specify the amounts encumbered for each contract, but may allocate funds to each contract based on projected and actual subscriber enrollments. The alliance may establish performance standards for specific contractual elements and penalties for failure to fulfill contractual obligations.

(d) Establish contracts with small employer members.

(e) Contract with qualified, independent third parties for services necessary to carry out the powers and duties of the alliance.

(f) Enter into all other contracts as are necessary to carry out the powers and duties of the alliance.

(g) Appoint a beneficiary advisory council to evaluate alliance functions and the performance of participating carriers in order to assess the efficacy of the operations for member small employers and enrollees.

(h) Appoint advisory committees, as necessary, to provide technical assistance in the operation of the program and in carrying out the purposes of this chapter.

(i) Assess member small employers a reasonable fee for costs incurred or anticipated in connection with the operation of the alliance.

(j) Require as a condition of membership that all employers include all their eligible employees or a minimum percentage of employees in coverage purchased through the alliance. The alliance may require an employer making membership application to the purchasing alliance that would entail entering fewer than 100 percent of the employer's eligible employees or dependents to demonstrate that the resultant membership will not result in an adverse selection group being brought into the alliance or that the action would otherwise function as a form of risk selection or risk avoidance.

(k) Reject or allow a carrier to reject an employer from membership or drop or allow a carrier to drop a member small employer if the member employer or any of its eligible employees fail to pay premiums or engage in fraud or material misrepresentation in connection with a health benefit plan purchased through the alliance. If a member small employer or enrollee is dropped from coverage, the enrollee shall be entitled to continuation and conversion coverage to the extent provided for under applicable state and federal continuation laws and the state conversion law.

(l) Contract with licensed insurance agents or brokers to market and service coverage made available through the alliance to its members. Compensation for agents and brokers may not vary based on the actual or expected health status or medical utilization of the group to which coverage is sold.

(m) Exclude a carrier or freeze enrollment in a carrier for failure to achieve established quality, access or information reporting standards of the alliance.

(n) Require that member employers and their eligible employees continue to pay administrative fees that are part of the contract with the alliance if a member employer or enrollee cancels prior to completion of a contract period.

(o) Negotiate with participating carriers the premium rates charged for coverage offered through the alliance consistent with RSA 420-K:6.

(p) Request such information from participating carriers as is necessary to carry out the powers and duties of this chapter.

(q) Sue or be sued, including taking action necessary for securing legal remedies on behalf of the alliance, member small employers, or enrollees.

(r) Apply for loans or loan guarantees from the New Hampshire business finance authority under RSA 162-A for the purpose of funding startup costs.

(s) Receive and accept loans, grants, funds, or anything of value from a public or private entity. This shall include:

(1) Employer premiums;

(2) Employer participation fees;

(3) Employer late fees;

(4) Employer reinstatement fees;

(5) Agent and broker fees paid by the employer;

(6) Interest earned on accounts;

(7) Funds paid by the participating carriers for a pooled marketing effort;

(8) Public sector and private sector grants, gifts, loans or donations; or

(9) Other lawful sources.

(t) The alliance may also receive and accept contributions from a legitimate source of property, labor, or any other thing of value. The alliance, however, shall not accept anything of value from a person or entity that has a vested interest in its decisions.

(u) Expend funds to pay:

(1) Participating carriers under their contracts.

(2) Third parties for services provided under contract.

(3) Employer billing adjustments.

(4) Agent and broker fees.

(5) The alliance's administrative expenses.

(6) All other expenditures duly authorized by the board.

(v) Exercise all powers reasonably necessary to carry out the powers and duties granted or imposed under this chapter.

III. The entity selected by the commissioner to assume administrative and fiscal responsibility for operation of the alliance shall not:

(a) Purchase health care services, assume risk for the cost or provision of health care services, or otherwise contract with health care providers for the provision of health care services to enrollees.

(b) Exclude from membership in the alliance a small employer, eligible employee or eligible dependent of an eligible employee who agrees to pay fees for membership and the premium for health coverage through the alliance and who abides by the bylaws and rules of the alliance.

(c) Prohibit the participation of small employers, or differentiate classes of membership, based on industry type, experience, gender, family status, education, health status, income, or other means in conflict with the rating methodology specified in RSA 420-G:4.

(d) Charge a fee not directly related to the operation of the alliance or for non-health coverage related activities.

(e) As a condition of membership, require a small employer, eligible employee, or eligible dependent to subscribe to limited health coverage or non-health coverage related products or services.

(f) Operate the alliance or market the alliance in a county or primary urban statistical area in a way which would cause the alliance to select a risk pool with actuarially projected health care utilization over a 2-year period which is below the projected average for all individuals residing in that county or primary urban statistical area. The measurement and composition of projected utilization by members of the alliance to all individuals shall be done on a county or primary urban statistical area basis and not across all members of the alliance.

(g) Engage in any competitive act or practice that results in the selection of member small employers and enrollees based on any of the risk factors specified in this paragraph or based on small employer size.

(h) Require or take any action inconsistent or in conflict with state laws or regulations.

420-K:6 Requirements for Participating Carriers.

I. In order to qualify as a participating carrier, a carrier must be able to satisfactorily demonstrate all the following operating characteristics to the alliance:

(a) The carrier is licensed and in good standing with the department of insurance.

(b) The ability to administer health coverage, to provide adequate service, and to comply with all contractual requirements of the alliance.

(c) The ability to provide enrollees with reasonable access to covered services.

(d) The ability to provide coverage for enrollees in any regional service area in which the carrier plans to participate through the alliance.

(e) The ability to arrange and pay for the appropriate quality, level, and type of health care services.

(f) The ability to provide standard data required by the alliance, in a manner prescribed by the alliance, including information on plan performance, enrollee satisfaction, provider payment

and incentive structures, and such other standard surveys as may be prescribed by the alliance, and to meet reasonable satisfaction measures as may be established by the alliance.

(g) The ability to meet quality of care standards established by government and industry authorities.

(h) A strong financial condition.

(i) Adequate administrative management.

(j) A procedure to address enrollee grievances and appeals.

(k) The ability to achieve satisfactory enrollment levels within the service area in which the carrier is licensed.

(l) All other criteria established by the alliance.

II. In evaluating which carriers may participate in the alliance, the alliance shall consider, among other factors:

(a) Minimum geographic service area and participation requirements, maximum thresholds for premium rates, and standards for determining whether a carrier operates efficiently.

(b) The ability of a carrier to provide high quality services within a regional service area.

(c) Pricing and the competitiveness of each bid from a carrier.

(d) The effect of contracting with additional carriers on the administrative costs of the alliance and member small employers, the efficiency of the alliance, and the competitiveness of the premiums that will be paid to participating carriers.

III. Participating carriers that contract with or employ health care providers shall have mechanisms to accomplish all of the following, in a manner satisfactory to the alliance, in consultation with the carrier's licensing agency:

(a) Review the quality of care covered.

(b) Review the appropriateness of care covered.

(c) Provide accessible health care services.

IV. Every participating carrier shall:

(a) Meet the standards established by the alliance pursuant to this chapter.

(b) Provide data and information as required by the alliance.

(c) Comply with all laws and regulations regarding underwriting, rating, claims handling, sales, solicitation, licensing, fair marketing, unfair trade practices, the provisions of this chapter, and other applicable state statutes.

(d) Enroll and dis-enroll individuals in the manner specified by the alliance.

(e) Comply with other requirements established by the alliance pursuant to this chapter.

V. Nothing in this chapter shall prohibit participating carriers from contracting with particular health care providers or types, classes, or categories of health care providers, or setting reimbursement methodology.

VI. Notwithstanding anything to the contrary in RSA 420-G:6, in the event the participating carrier elects to terminate its contract with the alliance, the participating carrier shall:

(a) Provide advance notice of its decision to the alliance; and

(b) Provide notice of the decision at least 180 days prior to the nonrenewal of health coverage to the member small employers and employee enrollees. A participating carrier that elects not to renew a health benefit plan with the alliance shall be prohibited from writing new business through the alliance for a period of 3 years from the date of the notice to the alliance or until the alliance, with the concurrence of the commissioner invites the former participating carrier to renew participation, whichever is sooner.

420-K:7 Marketing Health Benefit Plans.

I. The alliance shall establish marketing standards for use by participating carriers.

II. Any marketing, advertisement, or educational material for health coverage sold through the alliance shall be approved by the alliance prior to its use. The alliance shall review all materials submitted to it and the materials shall be deemed approved if not disapproved within 30 days. The alliance may, through its contracts with participating carriers, deem certain classes of materials to be approved.

III. The alliance shall make approved marketing materials available to member small employers in an efficient and standardized manner. These materials shall include, but not be limited to, an accurate summary of benefit plans, rates, cost, and accreditation information relating to the offerings of the participating carrier.

IV. This section shall not be construed to prohibit or to compel the alliance or a participating carrier from using the services of an agent or broker.

V. A participating carrier, agent, broker, contractor, or producer of a participating carrier, or independent insurance agent, broker, contractor, or producer shall not engage, directly or indirectly, in an activity or marketing practice that would encourage member small employers or eligible employees to:

(a) Refrain from enrolling in a health benefit plan offered through the alliance because of their health status or claims experience;

(b) Seek coverage from other participating carriers because of their health status or claims experience; or

(c) Enroll or fail to enroll in the alliance because of their health status or claims experience.

VI. Alliance members shall be encouraged to notify the commissioner of marketing practices or materials that are contrary to the provisions of this section. The commissioner shall monitor compliance with this section and investigate possible violations of the provisions of this section or other related unfair trade practices.

420-K:8 Risk Adjustment Mechanism. In order to reduce the incentive for risk selection and to improve fairness and efficiency, and in the absence of a risk adjustment mechanism established by regulation or order for the entire small group market, the alliance may establish a payment mechanism to adjust payments to participating carriers prospectively or retrospectively based on the amount of risk covered by each participating carrier. To establish such a mechanism, the alliance may appoint an advisory committee composed of individuals that have risk adjustment and actuarial expertise to help establish the risk adjusters.

420-K:9 Conflict of Interest. No officer or board member or director or contract administrator of the entity selected by the commissioner to assume administrative and fiscal responsibility for operation of the alliance or members of their households may be employed by, be a consultant for, be a member of the board of directors of, or be affiliated with, an agent of, or otherwise be a representative of a carrier or other insurer, a health care provider or agent or broker. This provision shall not preclude an officer or board member or director or contract administrator of the entity selected by the oversight board to assume administrative and fiscal responsibility for operation of the alliance from purchasing health coverage through the alliance.

420-K:10 Purchasing Alliance Distinguished From Multiple Employer Welfare Arrangement. The alliance shall not bear risk therefore, pursuant to RSA 415-E:2, II, shall not be subject to the requirements of RSA 415-E.

420-K:11 Minimum Participation Requirements. The provisions of RSA 420-G:9 permitting carriers to impose minimum participation requirements on small employer groups shall not be applicable to the alliance or to member small employers, and health carriers may not impose minimum participation requirements, either on an employer-by-employer basis or as a percentage of all alliance enrollees, as a condition of becoming a participating carrier.

420-K:12 Purchasing Alliance Evaluation. The alliance shall make a report not later than January 1, 2001 to the governor, the commissioner of insurance, and the presiding officers of the legislature which shall include at least the following:

I. The progress achieved in making affordable health care coverage available to employees of member small employers.

II. The progress achieved in assuring choice of health carriers and health care coverage to employees of member small employers.

III. The need, if any, for financial incentives or other mechanisms to increase participation in the alliance.

IV. Other changes in the law or procedure needed to accomplish the goals set out in RSA 420-K:1.

2 Effective Date. This act shall take effect 60 days after its passage.

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
008. note	re: SSN, DOB, and phone number (partial) (1 page)	n.d.	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
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FOLDER TITLE:
Nursing Home Event

2012-0463-S
rc702

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

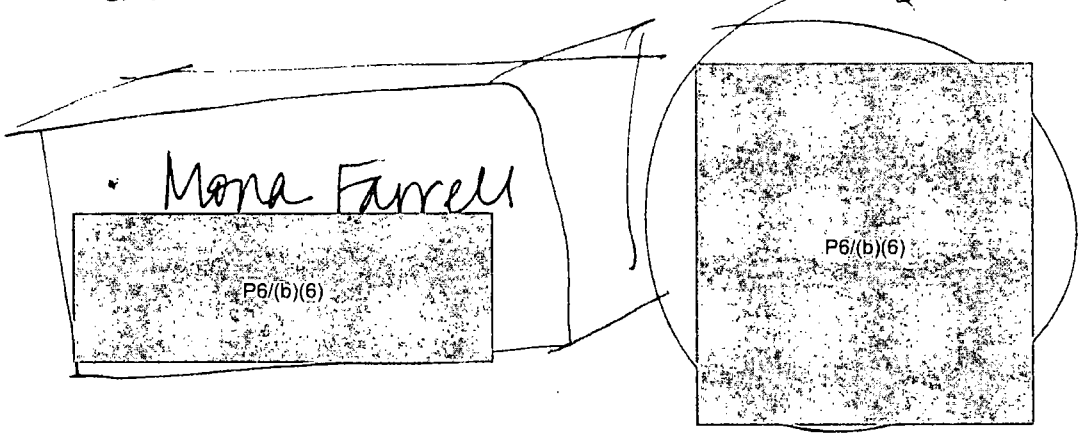
Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

disability person

1st I want to commend you for LTC; not just about elderly, you've recognized in policies, support for all — whatever stage of life — disability comm so supportive of ltc. What I really want to talk to you today about is empowering people w disabilities to work

[008]



The HMO Accountability Act

In recent years, the New Hampshire health insurance market has gone from primarily indemnity coverage to primarily managed care coverage. Of the northern New England states, New Hampshire now has the highest managed care enrollment, with approximately 368,000 persons in managed care plans. This constitutes about 80% of employer sponsored coverage, up from 28% just four years ago.

While most people are satisfied with their HMO, some people – especially those with significant health problems – have had serious difficulty getting the services they need.

The HMO Accountability Act is designed to give consumers the information and tools they need to protect themselves if they receive their health care through an HMO -- without imposing undue regulatory burden on the managed care industry.

Independent Review

At present, HMO members have nowhere to turn if an HMO denies them care other than to the HMO itself. The HMO Accountability Act offers consumers who are dissatisfied with their HMO the opportunity to take their complaint to an independent, external review panel of experts who have no financial interest in the outcome of the treatment decision.

Disclosure of Critical Information

Too often, inappropriate HMO personnel are involved in making key medical decisions that should be left to the patient and physician. The HMO Accountability Act requires HMOs to disclose the credentials of the person within an HMO who made the decision to deny care. The Act also entitles consumers to important information about the financial arrangements between your provider and HMO. If you suspect your provider has denied you care or access to a specialist because of a financial arrangement with the HMO, you are entitled to information about the specific financial arrangement between your HMO and provider.

announced in Shaheen's campaign

Protecting Consumers in Managed Care

Accountability of HMO Medical Directors

Increasingly, our health care system in New Hampshire is run by insurance executives thousands of miles away. The HMO Accountability Act keeps medical decisions close to home by requiring HMO Medical Directors to be registered to practice medicine in New Hampshire. This will enable our Board of Medicine to hold them accountable for treatment decisions.

No Financial Incentives to Deny Care

HMOs can maximize profit by creating financial incentives to delay care, restrict treatment options and limit care. The HMO Accountability Act bans financial arrangements between HMOs and providers that would encourage providers to withhold medically necessary care.

Protections for Providers who Stick Up for Patients

Providers who advocate for their patients often put their jobs on the line. The HMO Accountability Act prohibits HMOs from removing doctors or other providers from their network for advocating on behalf of an HMO member.

Pennies for Protections

A Coopers & Lybrand study conducted for the Kaiser Family Foundation estimated the cost of independent reviews to be minimal – about a dime per patient per month, or $1.20 a year.

We Need Your Help to Pass the HMO Accountability Act!

Your elected officials need to hear from you! Contact your State Representative and State Senator and encourage them to vote for the HMO Accountability Act. If you don't know who represents you in Concord, call 271-2548 to find out.

If you are interested in learning more about the HMO Accountability Act or you want to help make sure it becomes law, please call Governor Shaheen's office at 271-2121.

HMO Accountability Act

Section by Section Analysis

Section 1	**Statement of Purpose**
	The purpose of this Act is to strengthen protections for families who receive their medical care from managed care organizations. The Act provides consumers with the information and tools consumers need to hold managed care organizations accountable for the health care treatment decisions they make. *(page 1, beginning on line 1)*
Sections 2, 3, 4 & 5	**Definition of the Practice of Medicine; Medical Directors Defined and Required**
	Section 2 amends the statutory definition of the *practice of medicine* to include medical necessity decisions made by the medical director of an HMO or another entity conducting utilization review. Section 2 will give the New Hampshire Board of Medicine the ability to hold HMO medical directors accountable for the decisions they make to limit or deny medically necessary care. *(page 1, beginning on line 5)* Sections 3 and 5 require every HMO and organization that makes utilization review decisions to employ a medical director. It also requires the medical director to have final responsibility for the utilization review system, its operations and the decisions resulting from the utilization review system *(page 1, section 3, beginning on line 19 and page 2, section 5, beginning on line 3).* Section 4 defines medical director. *(page 1, beginning on line 23)*
Sections 6, 7, 8, &9	**Information Provided to Consumers**
	These sections require managed care companies to give consumers who are denied a requested medical service or referral more information about the person employed or under contract with the HMO who made the decision to deny or limit services. The HMO will be required to provide the name of the individual making the determination, the person's title and qualifying credentials.

Section 10 | **External Review Process**

This section establishes an external independent review process. It spells out who is eligible for external review, what kinds of cases will be considered on external review and how the process will work. *(page 3, section, beginning on line 5)*

The decision from the external review will be binding on the HMO (*page 4, lines 34-35).*

Eligibility for the external review process
Any person enrolled in a managed care plan who has a grievance and who has completed the first level of internal grievance review provided by the plan itself can request an external review. *(page 3, lines 8-10)*

Beneficiaries enrolled in Medicare, Medicaid or the Children's Health Insurance Program are eligible for a review process determined by federal law and are therefore not eligible for independent external review under the provisions of this act. *(page 5, lines 10-12)*

External review administration
The New Hampshire Insurance Department will administer the external review process (page 3, lines 6-7). In most cases, the Department will contract with an independent review organization to conduct the appeal *(page 3, lines 22-24).*

If the determination in question is one regarding whether or not a service is a covered benefit or whether or not the carrier has provided the beneficiary internal grievance procedures consistent with state law, then the New Hampshire Insurance Department will conduct the review *(page 3, lines 35-37).*

Cases eligible for external review
A beneficiary has the right, with certain conditions, to external independent review of any decision by a health carrier to deny, reduce, or terminate health care services or to deny or reduce coverage or payment for such services or of any allegation that the carrier has failed to provide to the beneficiary internal grievance review procedures that are consistent with statutory requirements. *(page 3, lines 8-14)*

Section 10, cont.

If the carrier's denial, reduction or termination is based on one of the following reasons, the case will be heard by an independent review organization pursuant to a contract with the insurance department:

- the heath care service is a covered benefit but is not medically necessary,
- the selected provider is not one that is available to the beneficiary under the health plan,
- the health care treatment is experimental, investigational or an off-label drug, or
- the health care service involves a condition that is pre-existing. *(page 3, lines 22-34)*

The service in question must be valued at $300 or more or involve the denial of a referral for diagnostic services. *(page 3, lines 14-18)*

The external reviewer

The external review will be conducted by health professionals credentialed in the area of the medical service in question who will apply professional standards generally accepted by the medical community in making their determination. *(page 4, lines 4-6)*

The reviewing entity and persons serving on the review panel must be free of conflict. *(page 4, lines 7-8)*

The external reviewer must provide for the review in a timely manner. *(page 4, line 9)*

The external reviewer will have the authority to provide for continuation of benefits while the review occurs. *(page 4, line 10)*

The external reviewer shall provide for an expedited review process if the health or life of the beneficiary is in jeopardy. *(page 4, lines 11-13)*

The external reviewer shall render a written decision that contains the following information:

- a statement describing the nature of the grievance,
- evidence or documentation used in the decision,
- findings of fact, and
- the clinical and legal rationale for the decision. *(page 4, lines 30-35)*

Section 10, cont.

The external reviewer shall maintain confidentiality of any health care information acquired or provided in the review. Records of independent review are exempt from public disclosure under RSA 91-A. *(pages 4, lines 30-35)*

The beneficiary

The beneficiary needs to request the external review in writing *(page 3, lines 14-18)*

The beneficiary will pay a filing fee of up to $25. The Commissioner of Insurance may waive or reduce the fee if the consumer cannot afford to pay *(page 4, lines 21-24)*. If the consumer prevails in the external review, then the carrier will reimburse the beneficiary for any filing fees paid *(page 4, lines 28-29)*.

The beneficiary shall be notified in a timely fashion about his or her ability to file a request for a independent review. *(page 4, lines 15-16)*

The beneficiary can represent him or herself or chose another representative including a provider, relative or lawyer. *(page 4, lines 17-20)*

The beneficiary can access any relevant records or information in possession of the health carrier. *(page 4, line 17-20)*

The beneficiary can appear in person before the reviewing body, and submit information to the reviewing body. *(page 4, line 19-20)*

The beneficiary shall be protected from retaliation for exercising the right to an independent review. This prohibits a health carrier or provider from dropping a patient because they filed an independent review request. *(page 4, lines 25-26)*

External Review Costs

The health carrier shall pay the administrative cost of the review.

Section 10, cont.	
	Reporting requirements. The Commissioner of Insurance will report annually on the external review process to the governor and legislature. Their report shall contain the following: ❖ the number of independent external review grievances, ❖ the number of decisions resolved wholly or partially in favor of the beneficiary ❖ the number of decisions resolved wholly or partially in favor of the health carrier, and ❖ common themes or issues that may require legislative action. *(page 5, lines 3-6)*
Section 11	**Provider Contract Standards**
	A ban on financial arrangements designed to limit or deny medically necessary care This section prohibits insurers and health care providers from entering into financial arrangements that create incentives to limit or deny medically necessary care. This language is not intended to ban capitated payment arrangements. This language will allow the Insurance Department to promulgate rules and standards for the use of capitated payment arrangements between carriers and providers. *(page 5, lines 16-19)* ***Increased information disclosure*** This section also gives consumers access to information describing the financial arrangements between a managed care company and its providers. The description must be written in a clear and understandable manner and include information on financial arrangements that may limit services, restrict referrals or limit treatment options. (*page 5, lines 20-24)* ***Protections for providers who advocate on behalf of a consumer*** Finally, this section prohibits a health carrier from removing a provider from their network or refusing to renew the contract because a provider advocated on behalf of a covered person for medically necessary care. *(pages 5, lines 25-28)*
Section 13:	**Effective Date**
	The HMO Accountability Act will take effect 60 days after its passage.