

FOIA MARKER

This is not a textual record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

Collection/Record Group: Clinton Presidential Records

Subgroup/Office of Origin: Health Care Task Force

Series/Staff Member: General Files

Subseries:

OA/ID Number: 3582

FolderID:

Folder Title:

Gay Issues

Stack:

S

Row:

53

Section:

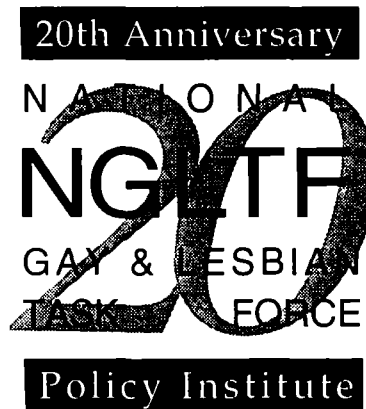
1

Shelf:

10

Position:

2



THE CLINTON HEALTH SECURITY ACT:

**How will Lesbians, Gay Men, and
Bisexuals be affected ?**

**AN ANALYSIS BY THE
NATIONAL GAY AND LESBIAN TASK FORCE**

The National Gay and Lesbian Task Force Policy Institute
Health Policy Project
1734 14th St. NW
Washington, D.C. 20009
(202)332-6483, ext. 3310

Peri Jude Radecic, NGLTF Executive Director
Marj Plumb, Health Policy Director

TABLE OF CONTENTS

	<i>Page</i>
Principles Of Universal Health Care	1
Review	2
Anti-Discrimination	3
Youth	4
Families	5
Red-Lining	6
Non-Profit Community Clinics	7
Women's Health Care	9
National Health Board	10
Regional Alliance Boards	10
Provider Advisory Boards	11
Home And Community-Based Services	12
Medical Provider Training	13
Medically Underserved Populations	13
Summary Of Suggestions	15

NATIONAL GAY & LESBIAN TASK FORCE

PRINCIPLES OF UNIVERSAL HEALTH CARE

The National Gay and Lesbian Task Force reflects the interests of a broad cross-section of the U.S. population. Because lesbian, gay, bisexual and transgender communities are a part of every town, city, county and state in this nation, our constituents cross every demographic category invented by human beings. We truly are everywhere. NGLTF supports the following principles of health care reform as providing the most effective and fair means to ensure the best health care system for all people.

- **Universality:** Health care must be a basic right for all persons residing in the U.S., including immigrants, prisoners, the homeless, the poor and the under/unemployed.
- **Accessibility:** Health care must be broadened to mean not just the provision of medical care but must include outreach and education that will ensure that all people know how to maintain and improve their health and know how to obtain care.
- **Equality:** Benefits should be standard and broad, offering the same quality of care to all. Poorer people should not experience barriers (such as co-payments) which serve to limit access.
- **Diversity:** People should be able to choose culturally and linguistically appropriate care, non-western and non-traditional methods of treatment and community-based providers including gay-identified and gay-sensitive providers.
- **Social Responsibility:** Health is not just an individual's concern but is also the responsibility of the community and of the government. The government must ensure that health care is delivered fairly to all members of our society.

NGLTF will assess all proposals for health care reform by these principles.

NATIONAL GAY & LESBIAN TASK FORCE

REVIEW OF THE HEALTH SECURITY ACT SB 1757/ HR 3600

The Health Security Act as presented to Congress by President Clinton relies on a system known as Managed Competition. Managed Competition is based on the belief that if consumers have a choice of health plans, the health plans will want to offer the best service for the lowest premiums to attract new consumers and retain current consumers. The Health Security Act is intended to ensure consumers the choice between at least one "lower-cost sharing" plan and one "higher-cost sharing" plan. Consumers have a choice of providers within the plan they choose. All plans will have a monthly premium and annual limits on how much each consumer pays out of his/her own pocket. The "lower-cost sharing" plan will include payments of between \$10 and \$25 per visit and at least 20% of the visit charge if you go to a provider out of your plan. The "higher-cost sharing" plan will include a deductible and payments for service of between 20% - 50% of the service charge. A new structure called Health Alliances will represent consumers in negotiating for health insurance rates and service. Sparsely populated states such as Montana might have one alliance, while California and New York might have eight or ten.¹ The Health Alliances will tell consumers what plans are available in their area, what the premiums are for each plan, register consumers for the health plan of their choice and collect the monthly premiums. A new National Health Board will oversee the benefits and costs.

NGLTF is encouraged by several elements of the President's proposal for health care reform:

- o Single payer option for states
- o Employer mandate to provide health insurance
- o Standard comprehensive health benefits package
- o Mental health and substance abuse benefits (although limited)
- o Global cost containment
- o Consumer involvement and a grievance system

¹ Congressional Quarterly, *Health Care's Hour*, Volume 51, P. 27

- o Insurance reform to remove pre-existing conditions exclusions, lifetime caps and experience ratings
- o Subsidies for low-income individuals (although limited)

While we applaud the President's intentions to overhaul the health care system we have several major concerns about this particular plan. There is no evidence that managed competition will control costs without cutting access (rationing service) and affecting quality. Since we do not currently have effective methods of ensuring quality medical care. The enactment of this bill could result in system-wide service rationing without adequate safeguards.

Additionally, the principles of health care reform NGLTF supports - universality, accessibility, equality, diversity and social responsibility - are not met by this bill as successfully as we would desire. This bill will not adequately address the needs of:

- The poor and lower middle class (especially those persons above income limits for federal subsidizes)
- Rural populations (where health plans and medical providers will still be limited)
- People with serious health problems (needing access to services that are limited or not covered)
- Non-legally recognized families (many lesbian and gay families could be forced into separate health plans)
- Immigrants and prisoners (who are not covered by this bill)
- People of color, women, lesbians, gay men and bisexuals (who have had historical access barriers because of racism, sexism and homophobia)

NGLTF offers the following list of specific concerns about the Health Security Act as presented to Congress on November 20, 1993 as Senate Bill S1757 and House Bill HR3600. Suggestions for dealing with the concerns are marked by a ▼.

ANTI-DISCRIMINATION: "While health alliances would be under federal mandates that would bar discrimination, there are no provisions in those mandates including sexual orientation."² The bill

² ACLU, Washington Office. *The American Health Security Act and Civil Rights*. p. 4

specifically states that Health Plans cannot discriminate in the selection of providers of health services based on the "race, national origin, sex, language, age, or disability of the provider"³ but does not include sexual orientation. This is a serious flaw when the discrimination against lesbian, gay and bisexual medical providers is a very real threat. A Survey of San Diego physicians found that 40% would not refer patients to fellow physicians whom they know are gay, lesbian or bisexual.⁴ We believe these attitudes could limit lesbian, gay and bisexual physicians from being accepted into health plans as well.

▼ Anti-discrimination provisions related to providers need to include "sexual orientation" to protect lesbian, gay and bisexual medical providers from discrimination when attempting to join health plans.

Lesbian, gay and bisexual patients have experienced homophobia from medical providers. In the San Diego survey cited above 40% of those surveyed stated they were sometimes or often uncomfortable providing care to Gay or Lesbian patients.⁵ In a survey of third year New York medical students, those surveyed felt that more than one-fourth of their peers and half of their faculty had negative attitudes toward Gay and Lesbian patients.⁶ These surveys reflect the kind of homophobia, and sometimes hostility, that lesbian, gay and bisexual patients confront throughout this country. This bill does not make the healthcare system safe for lesbians, gay men or bisexuals.

▼ Anti-discrimination provisions related to consumers need to include "sexual orientation" to protect lesbian, gay and bisexual patients from discrimination when enrolling in a health plan or seeking services from a medical provider.

YOUTH: NGLTF believes that family coverage, as it is currently written, could limit the ability of youth to access services without parental consent or knowledge; this is a concern specifically for lesbian, gay and bisexual youth seeking STD, HIV, pregnancy- related services, mental health, and substance abuse services. Under this

³ Health Security Act, Section 1402 (c) (2) (A)

⁴ Mathews et al., Physicians' Attitudes Toward Homosexuals. West J Med 144:106, 1986

⁵ Mathews et al., Physicians' Attitudes Toward Homosexuals. West J Med 144:106, 1986

⁶ McGrory, Survey of Third Year New York Medical Students. Psychosom 31:426, 1990

bill's structure, parents would receive information about what health services their children are using because all services used by any family member would need to be recorded and reported for the purpose of determining whether deductibles and the out-of-pocket limit has been met.

▼ Congress needs to ensure full funding of the Public Health Service (Title III) section of this bill that will continue to fund free anonymous services and expand the school based services provision in the bill to include out of school youth.

FAMILIES: Family coverage, as written in the bill, includes only single parents with children or married couples (as determined under applicable State Law) with or without children and therefore does not include gay and lesbian couples or their families.⁷ This definition might limit corporations, universities and state and local governments that wish to extend health insurance to domestic partners (as many already do).⁸ The primary benefit of providing family coverage is to ensure that all members of the family are enrolled in the same health plan.⁹ This is an important benefit and can impact the quality of care members of a family receive.

The current definition of family would also limit the ability of lesbian and gay couples to receive family counseling for mental health or substance abuse services.¹⁰ And, finally, this provision also discriminates financially against non-traditional families. A married couple with one child would have an annual out-of-pocket expense cap of \$3000 aggregate; a non-married couple with one child would pay \$1500 more for out-of-pocket expenses to a combined \$4500 limit (\$1500 aggregate for an individual plan plus \$3000 aggregate for a single parent family plan).

▼ The bill should allow for a broader definition of family to include the people in our lives who actually participate in our healthcare decisions. At the very least, the bill must allow for other definitions of family including domestic partners that would allow corporations, universities and state and local governments the ability to provide benefits for lesbian and gay employees and their families.

⁷ Health Security Act, Section 1011.

⁸ NGLTF, *Domestic Partnership Organizing Manual*, 1992.

⁹ Health Security Act, Section 1323 (e)

¹⁰ Health Security Act, Section 1115 (b) (4)

RED-LINING/DEFACTO DISCRIMINATION: The Health Security Act restricts health plans from attracting or limiting enrollees “on the basis of personal characteristics” but does not specifically list race, sexual orientation or gender.¹¹ This is especially important because health plans will be permitted to limit enrollment “because of the plan’s capacity to deliver services or to maintain financial stability.”¹²

▼ Sexual orientation, gender, race and age language need to be added to every section of the bill where discrimination is discussed.

▼ Strong protections need to be added to forbid geographic red-lining and enrollment limitations that function as discrimination against people with HIV/AIDS, other disabilities and poor people.

The bill outlines a means to “randomly” enroll individuals in health plans that are oversubscribed. This will leave some individuals without coverage or without appropriate coverage.¹³ For instance, if the lower-cost sharing plan is full, low-income individuals could be forced into the higher-cost sharing plan and if the higher-cost sharing plan is full it could leave all individuals with limited choice of medical providers through the lower-cost sharing plan.

▼ Assurances need to be added guaranteeing that all individuals seeking to enroll in either a lower-cost sharing plan or a higher-cost sharing plan are able to do so within a reasonable period of time.

Each State will designate geographic areas that will be called “alliance areas.” Each of these geographic areas will have its own community rating to determine premium rates. People living in areas with high rates of poverty and/or disease rates (San Francisco, New York, Washington, D.C.) could have higher premium rates and fewer health plans willing to operate in that area.

▼ There must be a cap on premiums or a provision added that ties the rates of premiums to within a certain percentage of bordering alliance areas or alliance areas within a state to avoid some areas being charged much higher premiums.

¹¹ Health Security Act, Section 1402 (a) (1)

¹² Health Security Act, Section 1402 (b) (2)

¹³ Health Security Act, Section 1323 (f) (2) (B)

NON-PROFIT COMMUNITY CLINICS AND SERVICES: Non-profit community clinics have the longest history of providing culturally sensitive services to underserved communities in this country. Their expertise and accessibility is essential to the long-range success of national health reform. There are several areas where the bill's language needs to be strengthened to better reflect a national commitment to these institutions.

In the bill there are two methods for determining whether existing community clinics can be categorized as "essential community providers" for the purpose of participation in health reform. Community clinics funded by one or more of eleven federal funding programs are automatically considered an "essential community provider"; or the Secretary of Health will certify non-federally funded providers if the community clinics are functioning in a designated "health professional shortage area" or serving officially designated "medically underserved persons".¹⁴ Many health providers who serve the lesbian, gay, bisexual or other communities (women's clinics, clinics in projects, mental health and substance abuse providers) are not federally funded and are not in "health professional shortage areas." Lesbians, gay men and bisexuals are also not currently designated as "medically underserved populations."

▼ Lesbian/gay and women's community clinics should be automatically certified as essential community providers; and, broader language needs to be added to allow the Secretary of the Department of Health and Human Services to certify other community clinics who do not fit the first two criteria but are providing essential service to underserved communities.

The first criteria for being automatically considered an essential community provider is being funded by one or more of eleven federal funding programs. Therefore, if a community clinic receives Family Planning Title X funds or Ryan White funding for HIV services, it would automatically be part of the new health system. However, the bill does not specifically state that Essential Community Providers must be contracted with by Health Plans for all the services they provide, not just those for which they receive federal funding. This may lead to Health Plans contracting with Ryan White funded community clinics only for the HIV services they provide.

¹⁴ Health Security Act, Section 1581 (a) (1) and (2)

The clinic would not be reimbursed for the primary care it provided to non-HIV+ people.

▼ The bill should specifically state that certified Essential Community Providers must be considered eligible for all the health plan services they provide, not just those that are federally funded.

In the bill, health plans have the option to include essential community providers in their system or simply make payments to those providers for services rendered.¹⁵ Community clinics have been essential providers for underserved communities for over thirty years and should have the ability to decide whether they join health plans operating in their area.

▼ Language needs to be added to the bill to allow each essential community provider the ability to elect participation in health plans.

The bill states that, in the development of participation agreements, health plans must treat essential community providers at least as favorable as other providers participating in the health plan.¹⁶ Because health plans will have a wide latitude in the agreements they make with providers this statement does not ensure fair treatment to the essential community providers.

▼ Language needs to be added to the bill to ensure that health plans contract with essential community providers at least as favorably as the best treatment given any other provider in their health plan.

Essential community providers without a participation agreement by a health plan can decide to be paid by a state established fee schedule or under federal Medicare rates. Either of these options may still be 40-60% below the actual costs of service.

▼ Essential community providers must be assured an accurate rate for the essential services they provide. This could include the use of a Federal Reinsurance Fund to compensate essential community providers for the difference between what the health plan pays and what the true cost of service is. Additional funding

¹⁵ Health Security Act, Section 1431 (c) (1)

¹⁶ Health Security Act, Section 1431 (b)

should be made available to expand and improve community clinics.

The participation of essential community providers in this new health system is only secure for five years; at that time the Secretary of Health must prepare recommendations to the Congress with recommendations concerning whether and to what extent, essential community providers should continue to be included in the health system.¹⁷ This is unacceptable.

▼ Remove the Sunset Requirement that could limit the participation of community clinics in the health plan to five years.

WOMEN'S HEALTH CARE: The bill legislates dangerously restrictive benefits for pap smears and mammograms. Pap smears are provided for females who have reached "childbearing age." Annual pap smears, chlamydia and gonorrhea tests are available for women at risk of "fertility-related infectious illnesses." If a woman is not at risk for a fertility-related infectious illness or has had three consecutive negative smears she can then only get pap smears every three years. Coverage for mammograms does not begin until age 50 and then are only allowed every two years.¹⁸

▼ The American Cancer Society recommendations should be used. ACS states that a baseline mammogram be taken at 40 years of age and every two years afterward until the age of 50 when a mammogram should be done annually. The ACS also recommends that pap smears should begin with sexual activity or at least by 18 years of age, occur annually, and *at the discretion of the patient and her medical provider*, less frequently after three consecutive negative smears.

The use of the terms "childbearing age" and "fertility related infectious illnesses" are heterosexist and inaccurate. Pap smears are needed when a woman becomes sexually active, which may be prior to menstruation. "Fertility related infectious illnesses" refers only to sexually transmitted diseases that could cause infertility in women. There are many gynecological conditions and diseases that are serious to a woman's health, yet do not cause infertility, for which

¹⁷ Health Security Act, Section 1432

¹⁸ Health Security Act, Section 1114

annual pap smears are recommended. We question the overemphasis in this section on fertility concerns.

▼ Throughout the section of the bill describing pap smear benefits the language “for females who have reached childbearing age” should be changed to “for females who are sexually active, menstruating or at least by 18 years of age” and “fertility related infectious illnesses” should be changed to “sexually transmitted diseases”.

NATIONAL HEALTH BOARD: A new National Health Board would regulate standard benefits packages (as approved by Congress) and their costs. The seven board members would be appointed by the President and confirmed by the Senate. The boards’ regulatory powers are not as well established as they should be. The bill grants states unlimited discretion to set quality standards, allowing for tremendous variations in service from state to state and allows each health plan unlimited discretion to establish a list of drugs that they will pay for. This could result in wide variances of care between health plans.

▼ The National Health Board should be given the authority to establish prescription formularies and to regulate - and roll back drug prices.

▼ The National Health Board should be given the authority to set minimum quality and access standards for health plans.

REGIONAL ALLIANCE BOARDS: The bill creates Regional Alliance Boards, possibly over 200 nationwide, which will have a great deal of power and control in the new health care system. The bill states that regional alliances must be governed by a Board of Directors who are appointed, presumably by the state governor. The bill calls for equal representation of employers and consumers on these boards and no conflict of interest (i.e. no health providers)¹⁹ but there is no assurance that the regional alliance boards will be representative of the communities they serve.

▼ The Regional Alliances should be mandated to ensure diversity by race, age, gender, sexual orientation, and socioeconomic status.

¹⁹ Health Security Act, Section 1302 (b)

Health plans have a strong incentive to reduce access to their services to increase their profits. Complicated or lengthy grievance procedures are disincentives for consumers to get the treatments they request but are denied. Differences in treatment protocols between health plans in the same area will be confusing for consumers and will make discrimination harder to determine. In this system, regulation is the only method to ensure fair and equitable treatment for all consumers.

▼ The Regional Alliances should handle all disputes and appeals for denied treatment. Disputes that cannot be resolved by a health plan within a limited time period -- perhaps 15 days or so for non-urgent matters - should be handled by the alliance.

▼ The Regional Alliances should establish treatment protocols, including policies toward experimental treatments, that all health plans operating in the alliance area be required to operate by.

PROVIDER ADVISORY BOARDS: The bill also establishes Provider Advisory Boards to advise the Regional Alliances on provider concerns and leaves the establishment of such boards to the Regional Alliances.²⁰ There is no language ensuring that these board must include participation from medical providers and community clinics experienced in serving underserved communities.

▼ The Provider Advisory Board should be mandated to have designated seats for Essential Community Providers operating within the alliance area.

RELIGIOUS CLAUSE: The bill states that "A health professional or a health facility may not be required to provide an item or service in the comprehensive benefit package if the professional or facility objects to doing so on the basis of a religious belief or moral conviction."²¹ While the purpose of this clause is to allow health professionals the right to not perform abortions, the language is so vague the possibilities for abuses are great.

²⁰ Health Security Act, Section 1303

²¹ Health Security Act, Section 1162

- ▼ The National Health Board should be required to review all requests of the use of this clause by health professionals and facility directors to ensure accurate interpretation.
- ▼ A health facility must be controlled by a religious institution in order to refuse to provide an item or service but only based on religious belief not moral convictions (facilities cannot have moral convictions).
- ▼ Entire health plans cannot refuse to provide an item or service based on religious belief or moral convictions. This provision should be applicable solely to individual providers and facilities.
- ▼ Non-discrimination language must be developed to restrict a provider or facility from raising religious objections to providing services to people based on personal characteristics (such as lesbians, gay men and bisexuals).
- ▼ Clear efforts must be made to ensure that consumers have access to a provider in their plan or area who provide all covered services and that consumers are fully informed about which providers in their area have invoked this section.

HOME AND COMMUNITY-BASED SERVICES: The bill defines a disabled person, for the purposes of benefits, as an individual who "requires hands-on or standby assistance, supervision, or cueing to perform three or more activities of daily living."²² We believe that this is too restrictive and is an example of service rationing to control costs; it is not based on a principled analysis of service needs. Individuals with diseases such as HIV infection and cancer should not have to fight the bureaucracy for home- and community-based services.

- ▼ Home- and community-based services should be available for anyone who is unable to perform one or more activities of daily living.
- ▼ Home and community-based services should be provided to anyone who has received a diagnosis of a terminal illness.

²² Health Security Act, Section 2103 (a) (1) (A)

MEDICAL PROVIDER TRAINING: Lesbians, gay men and bisexuals have historically suffered from the homophobic attitudes of medical providers. Both general/family practice physicians and obstetric/gynecology physicians were rated among the highest in negative attitudes towards lesbian/gay clients in a survey of homophobic attitudes reported in the *Western Journal of Medicine*.²³ A survey of third year New York medical students found that they believed "more than one-fourth of their peers and half of their faculty had negative attitudes toward Gay and Lesbian patients and to AIDS patients."²⁴ Other surveys have found that lesbians fear receiving inferior care if they are open about their sexual orientation.²⁵

▼ Medical schools should be encouraged through financial incentives to include human sexuality and diversity training as part of their basic curriculum for medical students. Health plans (such as Health Maintenance Organizations and Preferred Provider Organizations) and the new Health Alliances should be encouraged, again through financial incentives, to train all their staff annually in human sexuality and diversity.

MEDICALLY UNDERSERVED POPULATIONS: Many surveys have reported a higher degree of medical access problems for lesbians and the consequent concern that this may lead to poorer health status for this population.²⁶ Lesbians also obtain fewer screening exams and use the medical system less often than heterosexual women.²⁷

▼ Lesbians should be designated a Medically Underserved Population under section 330 of the Public Health Service Act. This will encourage health plans to enroll and serve lesbians.

²³ Mathews et al, Physicians' Attitudes Toward Homosexuals. *West J Med* 144:106, 1986

²⁴ McGrory, *Psychosom* 31:426, 1990

²⁵ Stevens & Hall, *J Nursing Scholarship* 20:5, 1988

²⁶ NGLTF, *Lesbian Health Issues and Recommendations*, July 1993

²⁷ O'Hanlan, Katherine A., *Lesbian Health Perspective*, address to the American Medical Women's Association national meeting, San Francisco, CA, November 16, 1992.

Special Thanks To: the following organizations whose framing of health reform issues for their constituencies were useful in the development of this document: AIDS Action Council, American Civil Liberties Union Washington Office, Boston Women's Health Care Coalition, Consumers Union, Health Policy Advisory Center, Human Rights Campaign Fund, National Association of Community Health Clinics, National Black Women's Health Foundation, National Center for Lesbian Rights, Universal Health Care Action Network, Whitman-Walker Clinic Lesbian Services

NATIONAL GAY & LESBIAN TASK FORCE

SUMMARY OF SUGGESTIONS TO IMPROVE THE HEALTH SECURITY ACT FOR LESBIANS, GAY MEN AND BISEXUALS

1. Anti-discrimination provisions related to providers need to include "sexual orientation" to protect lesbian, gay and bisexual medical providers from discrimination when attempting to join health plans.
2. Anti-discrimination provisions related to consumers need to include "sexual orientation" to protect lesbian, gay and bisexual patients from discrimination when enrolling in a health plan or seeking services from a medical provider.
3. Congress needs to ensure full funding of the Public Health Service (Title III) section of this bill that will continue to fund free anonymous services and expand the school based services provision in the bill to include out of school youth.
4. The bill should allow for a broader definition of family to include the people in our lives who actually participate in our healthcare decisions. At the very least, the bill must allow for other definitions of family including domestic partners that would allow corporations, universities and state and local governments the ability to provide benefits for lesbian and gay employees and their families.
5. Sexual orientation, gender, race and age language need to be added to every section of the bill where discrimination is discussed.
6. Strong protections need to be added to forbid geographic red-lining and enrollment limitations that function as discrimination against people with HIV/AIDS, other disabilities and poor people.
7. Assurances need to be added guaranteeing that all individuals seeking to enroll in either a lower-cost sharing plan or a higher-

cost sharing plan are able to do so within a reasonable period of time.

8. There must be a cap on premiums or a provision added that ties the rates of premiums to within a certain percentage of bordering alliance areas or alliance areas within a state to avoid some areas being charged much higher premiums.

9. Lesbian/gay and women's community clinics should be automatically certified as essential community providers; and, broader language needs to be added to allow the Secretary of the Department of Health and Human Services to certify other community clinics who do not fit the first two criteria but are providing essential service to underserved communities.

10. The bill should specifically state that certified Essential Community Providers must be considered eligible for all the health plan services they provide, not just those that are federally funded.

11. Language needs to be added to the bill to allow each essential community provider the ability to elect participation in health plans.

12. Language needs to be added to the bill to ensure that health plans contract with essential community providers at least as favorably as the best treatment given any other provider in their health plan.

13. Essential community providers must be assured an accurate rate for the essential services they provide. This could include the use of a Federal Reinsurance Fund to compensate essential community providers for the difference between what the health plan pays and what the true cost of service is. Additional funding should be made available to expand and improve community clinics.

14. Remove the Sunset Requirement that could limit the participation of community clinics in the health plan to five years.

15. The American Cancer Society recommendations should be used. ACS states that a baseline mammogram be taken at 40 years of age and every two years afterward until the age of 50

when a mammogram should be done annually. The ACS also recommends that pap smears should begin with sexual activity or at least by 18 years of age, occur annually, and *at the discretion of the patient and her medical provider*, less frequently after three consecutive negative smears.

16. Throughout the section of the bill describing pap smear benefits the language "for females who have reached childbearing age" should be changed to "for females who are sexually active, menstruating or at least by 18 years of age" and "fertility related infectious illnesses" should be changed to "sexually transmitted diseases".

17. The National Health Board should be given the authority to establish prescription formularies and to regulate - and roll back drug prices.

18. The National Health Board should be given the authority to set minimum quality and access standards for health plans.

19. The Regional Alliances should be mandated to ensure diversity by race, age, gender, sexual orientation, and socioeconomic status.

20. The Regional Alliances should handle all disputes and appeals for denied treatment. Disputes that cannot be resolved by a health plan within a limited time period -- perhaps 15 days or so for non-urgent matters - should be handled by the alliance.

21. The Regional Alliances should establish treatment protocols, including policies toward experimental treatments, that all health plans operating in the alliance area be required to operate by.

22. The Provider Advisory Board should be mandated to have designated seats for Essential Community Providers operating within the alliance area.

23. The National Health Board should be required to review all requests of the use of this clause by health professionals and facility directors to ensure accurate interpretation.

24. A health facility must be controlled by a religious institution in order to refuse to provide an item or service but only based on

religious belief not moral convictions (facilities cannot have moral convictions).

25. Entire health plans cannot refuse to provide an item or service based on religious belief or moral convictions. This provision should be applicable solely to individual providers and facilities.

26. Non-discrimination language must be developed to restrict a provider or facility from raising religious objections to providing services to people based on personal characteristics (such as lesbians, gay men and bisexuals).

27. Clear efforts must be made to ensure that consumers have access to a provider in their plan or area who provide all covered services and that consumers are fully informed about which providers in their area have invoked this section.

28. Home- and community-based services should be available for anyone who is unable to perform one or more activities of daily living.

29. Home- and community-based services should be provided to anyone who has received a diagnosis of a terminal illness.

30. Medical schools should be encouraged through financial incentives to include human sexuality and diversity training as part of their basic curriculum for medical students. Health plans (such as Health Maintenance Organizations and Preferred Provider Organizations) and the new Health Alliances should be encouraged, again through financial incentives, to train all their staff annually in human sexuality and diversity.

31. Lesbians should be designated a Medically Underserved Population under section 330 of the Public Health Service Act. This will encourage health plans to enroll and serve lesbians.

^bc-hillary - a1717

^ (ATTN: National editors)

^Hillary Clinton Defends President's Policy on Gays (Los Angeles)

^By Douglas P. Shuit= ^ (c) 1993, Los Angeles Times=

LOS ANGELES First lady Hillary Rodham Clinton wrapped up her two-day visit to Los Angeles Tuesday by defending her husband's compromise policy on homosexuals in the military and talking about the need to reform the health care system.

During a 30-minute live interview on a radio talk show, Clinton said her husband's policy on homosexuals in the military eased restrictions barring homosexuals but continued to allow military authorities to investigate and discharge gay men and lesbians for misconduct, including public displays of same-sex affection.

The first lady called the policy on homosexuals ``a step forward.'' When asked whether she would be satisfied with that answer if she were gay, Clinton said ``if I knew anything about how government works, and how difficult change is, I would be ecstatic.''

On still another subject, Clinton called for stronger control of illegal immigration. Calling immigrants ``a great source of strength for this country,' ' she drew a distinction between legal and illegal immigrants and said she would like to see ``our laws (against illegal immigration) enforced or changed so they can be better enforced.''

Clinton, who heads a White House task force on health care reform, also appeared on the national ABC television show ``Home,' ' where she discussed health care reform and family life in the White House.

Since the president's inauguration in January, the first lady has been occupied with drafting a health reform package that will provide a basic medical benefits to the 40 million Americans who now lack health coverage. She said the plan would also try to cap the sharply rising costs of the health care delivery system. Current estimates are individuals, governments, insurers and employers will spend more than \$900 billion on health care in 1993,

a figure that has been growing by about \$100 billion a year.

Clinton told the television audience that the unveiling of the White House plan, which was initially supposed to have been released in May, had been put off until at least September because President Clinton has been concentrating on the federal budget, his deficit-reduction plan and a tax increase package.

``Trying to bring anything else as important as health care into the middle of that just didn't seem possible,' ' she said. ``Everybody wanted to keep their focus on trying to get a reasonable budget that actually would bring down the deficit. So we are all waiting for that to get finished and as soon as it is we are going to come with health care.''

Clinton also talked about motherly differences she had with her daughter, Chelsea, 13, over clothes and pierced ears. ``Sometimes I'm just amazed at what they wear to school,' ' Clinton said.