Chapter 4

SECURITY

"Six months ago, my sister-in-law, Pam, had a disabling stroke. Pam is only 39 years old, and she's a severe diabetic. Six months have passed, her short-term memory has deteriorated, her vision is leaving, and it looks as if my brother will either have to hire someone to come into their home full time to care for her, or put her in a nursing home, which his medical plan does not cover.

My brother's attorney has advised him to divorce Pam so that her medical bills don't pull him into financial ruin. My brother has two young sons that he's caring for and in order to continue to provide for them, he is giving this consideration...

A man who loves his wife must divorce her so that her misfortune (in sickness and in health) does not leave him with the inability to raise their family."

A.P.
Toledo, Ohio

Americans buy health insurance to provide security for themselves and their families. Security, in its full sense, is what health care reform must give us all. We must be secure that no American will face exclusion from coverage because of illness, occupation or age. We must be secure that health benefits will be comprehensive enough to keep us healthy and cover our health care needs throughout life.

Comprehensive Benefits

Under the Health Security Act, all American citizens and legal residents will be guaranteed a comprehensive package of health benefits that can never be taken away. They will receive a Health Security card entitling them to enroll in a health plan. Everyone will have a choice of at least three — and, in most communities, many more — health plans. And no matter which plan people choose, they will receive the comprehensive benefits package.

COVERED BENEFITS

Benefits covered under the nationally guaranteed comprehensive package carry no lifetime limits. The package covers the following health services when they are medically necessary or appropriate:

- Hospital services, including bed and board, routine care, therapeutics, laboratory and diagnostic and radiology services and professional services.
- Emergency services.
- Services of health professionals delivered in professional offices, clinics and other sites.
- Clinical preventive services.
- Mental health and substance-abuse services (for details, see box on mental health and substance abuse).
- Family planning services.
- Pregnancy-related services.
- Hospice care during the last six months of life.

- Home health care, including skilled nursing care, physical, occupational and speech therapy, prescribed social services and home-infusion therapy after an acute illness to prevent institutional care.
- Extended-care services, including inpatient care in a skilled nursing home or rehabilitation center following an acute illness for up to 100 days each year.
- Ambulance services.
- Outpatient laboratory and diagnostic services.
- Outpatient prescription drugs and biologicals, including insulin.
- Outpatient rehabilitation services including physical therapy and speech pathology to restore function or minimize limitations as a result of illness or injury.
- Durable medical equipment, prosthetic and orthotic devices.
- Routine ear and eye examinations every two years.
- Eyeglasses for children under age 18.
- Dental care for children under age 18.

PLANNED EXPANSION OF BENEFITS

Beginning in the year 2001, the nationally guaranteed benefits package will expand to include the following:

- Preventive Dental care for adults.
- Orthodontia if necessary to prevent reconstructive surgery for children.
- Expanded coverage for mental health and substance abuse treatment.

The coverage provided by the comprehensive benefits package equals that provided by America's major employers, such as Fortune 500 companies. It covers a full array of clinical services, from doctors' offices, to clinics, to hospitals, to rehabilitation centers, to laboratories, hospices, home-health agencies and other professional offices.

The comprehensive benefits package provides far more coverage for clinical preventive services than traditional insurance. It waives the usual co-payments and deductibles for a wide range of preventive services that are vital to keeping people healthy. Preventive services covered without co-payments include prenatal, well-baby and well-child checkups, physicals for adults, immunizations and regular screening tests such as mammograms and Pap smears.

The Health Security Act particularly expands preventive services for certain low-income women and children. By fully funding the

PREVENTIVE SERVICES

The Health Security Act offers comprehensive coverage for a specific set of preventive screenings, laboratory tests and periodic checkups. Included in the benefit package, at no cost to the consumer, is coverage for preventive care such as immunizations and specific screening tests.

Some preventive services will be targeted to groups that have a high risk for certain diseases, such as men considered especially vulnerable to cardiac problems and women with a close family history of breast cancer. Children will receive a full range of prevention services, including immunizations, well-baby checkups and developmental screenings at no extra charge.

Special Supplemental Food Program for Women, Infants and Children (WIC), more families will be able to receive nutrition counseling and get nutritious food — part of the overall strategy for keeping people healthy rather than waiting until they get sick.

"We believe reform will enhance both medical security for the nation's 65 million children and peace of mind for their parents. We are especially impressed by the commitment of yourself and the First Lady to ensuring all children have access to appropriate health care, because it is such an important investment in the nation's future"

Lawrence A. McAndrews, President and CEO
National Association of Children's Hospitals
and related institutions.
September 21, 1993

The benefit package also expands traditional coverage of mental health and substance abuse treatment. Insurance companies often tightly limit their coverage of mental health; they adopt that policy partly because they depend on the public mental health system — and the taxpayers who pick up the bills — to serve millions of people who lack coverage for even basic treatment, or who suffer from chronic or serious illness. The Health Security Act eliminates the lifetime limits on mental illness that can devestate family savings; and it provides coverage for regular clinical visits, and offers more flexible care.

For millions of Americans, the comprehensive benefits package will provide a significant expansion of coverage. Those whose current benefits are more generous — a much smaller number — will have every right to continue receiving richer benefits. Nothing in the Health Security Act prevents employers from providing more extensive benefits, with no strings attached.

MENTAL HEALTH AND SUBSTANCE ABUSE

The Health Security Act offers Americans guaranteed coverage for mental illness and substance abuse, ending the agony that families confront when a serious mental illness occurs.

The benefit package gradually expands coverage for mental illness and substance abuse, both for inpatient and outpatient therapy. Out-patient services will include diagnostic office visits for medical management, substance abuse counseling, and relapse prevention. The benefit package also provides coverage for a wide range of new approaches, such as intensive care delivered outside the hospital.

The Health Security Act eliminates lifetime limits on mental health and substance abuse treatments. Initially it contains limits on the number of days of inpatient and outpatient treatment, but it commits to removing those limits by the year 2001.

Types of services covered:

- Inpatient care
- Alternative treatment programs which provide intensive care outside hospitals
- Outpatient therapy with requirements for patients to share part of the cost.
- Brief office visits and medical management for patients who take medication.

Not everything is covered in the benefits package. It would just be too expensive. Examples of services that are not covered include:

- Services that are not medically necessary or appropriate
- A private room in a hospital
- Adult eyeglasses and contact lenses
- Hearing aids
- Cosmetic surgery

Individuals will be free to purchase supplementary insurance, although the comprehensive benefits package leaves little need for additional coverage. Employers are also free to offer additional benefits or absorb co-payments and deductibles.

However people choose to receive health care, the Health Security Act guarantees all Americans something no amount of money can buy in today's insurance market: the knowledge that they will always have comprehensive health benefits that can never be taken away — no matter what happens in their lives or their jobs. If they lose a job or change employers, coverage will continue without interruption. If they move, get married, separate from a spouse, experience a catastrophic illness or confront any other crisis, their health coverage will continue uninterrupted.

Insurance Reform

The Health Security Act outlaws discriminatory insurance practices that prevent millions from obtaining health coverage today. It will return the concept of health insurance to its roots: offering protection to everyone whether they're healthy or sick, young or old. It will put an end to the practice of underwriting — searching for only the healthiest people to insure.

Under the Health Security Act, health plans will be required to:

- Enroll everyone who applies, whether they're healthy or sick, young or old;

- Charge everyone the same price for the same comprehensive benefits — no more charging higher rates to sick people, older people, or people with pre-existing conditions;
- Provide coverage without resorting to "lifetime limits" that cut off coverage when people need it most; and
- Limit deductibles in fee-for-service plans to $200 for an individual and $400 for a family.

By establishing a uniform, comprehensive benefits package, the Health Security Act no longer makes it advantageous for insurance companies to shape benefits and policies that attract the healthy and avoid the sick. Health alliances, in turn, will help organize the private market so that consumers — for the first time — can compare plans and providers and make informed choices. Their mission will be to promote competition among health plans based on quality and price — not on who can screen out sick patients.

Limits on What Consumers and Businesses Pay

The Health Security Act also takes several important steps to protect families and businesses from rising health costs and financial ruin. To provide secure financial protection against the most devastating illnesses and injuries, it prohibits so-called "lifetime limits" and restrictions on the amount of medically necessary or appropriate care. The limits, which are included in six out of every ten insurance policies today, can mean bankruptcy for families in which catastrophic illness strikes. The Act also sets maximum annual out-of-pocket limits; even those who select the most expensive plans can spend no more than $1,500 a year for an individual, or $3,000 for a family. Insurance picks up the full cost of any medical care that exceeds those limits.

The Health Security Act also limits deductibles — the amount people pay each year before insurance kicks in, which can run into the thousands today — to $200 for individual's and $400 for families who choose traditional fee-for-service plans.

Employers will pay a maximum of 7.9 percent of their payroll for health care. Small businesses — those with fewer than 75 employees

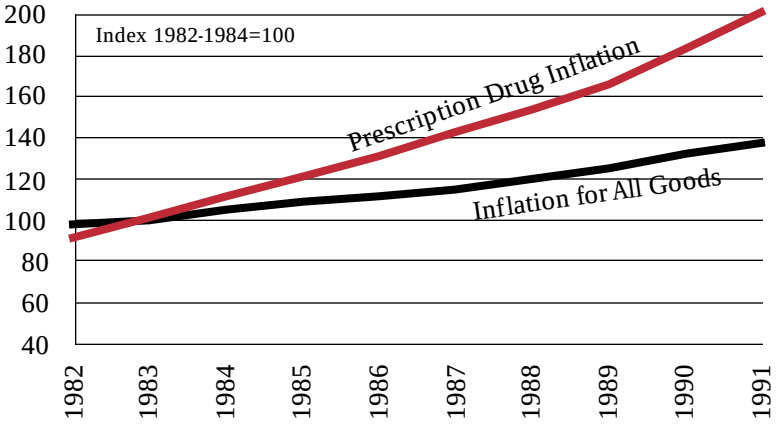
— will receive discounts of between 30 and 80 percent, compared to what the average large business pays. And the self-employed will be able to deduct from their taxes 100 percent of their health care, up from today's 25 percent.

PROTECTING OLDER AMERICANS

The Health Security Act preserves and protects the Medicare program, providing older Americans with the health security they deserve. People covered by Medicare will see little difference in how, where or from whom they receive their health care, but they will receive new prescription drug benefits.

Americans eligible for Medicare will automatically receive the new prescription drug benefit — which will cover drugs and biological products, including insulin, approved by the Food and Drug

Older Americans and Prescription Drugs



- More than 60% of those older than 65 have no insurance for drug costs.[1]
- Prescription drugs are the largest cost of daily living for 45% of all people over 65.[2]
- More than 5 million Americans over age 55 say they have to choose between buying food and paying for medication.[3]

Source: U.S. Department of Labor, Bureau of Labor Statistics

[1] USA Today, 9/25/93
[2] USA Today, 9/25/93
[3] Robert Wood Johnson Foundation

EARLY RETIREES

When Americans over age 55 find that health problems or other events require them to stop working, they often confront the worst possibilities in the current health insurance market: because of age, or medical conditions, individual coverage is difficult to obtain or very expensive. Under health care reform, American workers who retire between the ages of 55 and 64 will never have to worry about losing their health coverage.

Under the Health Security Act, individuals over age 55 who retire before they are eligible for Medicare will pay for their coverage like other people who do not work and will be eligible for discounts based on income.

When reform is fully implemented, at the end of this decade, early retirees will become eligible for greater discounts requiring them to pay only the portion of their insurance premium that they paid as employees, unless they have an annual income higher than $100,000 for an individual, or $125,000 for a couple.

To be eligible for this greater discount, early retirees will have to have worked for ten years, the same standard used for eligibility under the Social Security Act.

The coverage for early retirees in the Health Security Act will provide a major financial benefit to employers who traditionally cover the cost of retirees' health premiums.

Employers who wish to provide coverage for any or all of the retired employee's share of the premium or for cost sharing required by health plans will continue to do so, as they do today.

When they reach age 65, retired workers have the choice of staying in their health plan or enrolling in Medicare, just as they do today.

Administration — when they enroll in the Part B benefit, which covers physician and other outpatient services. Under the drug benefit, there will be a $250 annual deductible for each person. Individuals on Medicare will also pay 20 percent of the cost of each prescription up to a maximum of $1,000 over the course of a year.

Part B premiums will increase about $11 a month to cover 25 percent of the cost of this new benefit. But for seniors who have Medigap policies, which cover services not provided by Medicare, premiums for those policies should decline since they will no longer cover prescription drugs.

As Americans enrolled in health plans through alliances turn sixty-five, they can choose between remaining in their health plan or entering the Medicare system.

Older Americans will also see their long-term care options expand and improve under health care reform. The Health Security Act creates a new home and community-based care program and expands the range of choices for disabled individuals who require long-term care.

Among other things, the Health Security Act will:

- Expand home and community-based services;
- Improve Medicaid coverage for people in nursing homes;
- Improve the quality and reliability of private long-term care insurance and provide tax incentives to encourage people to buy it; and
- Provide tax incentives to help people with disabilities work.

ACCESS TO CARE IN RURAL AND URBAN AREAS

The challenges of guaranteeing health security in rural and inner-city communities are essentially similar: both include unusually high numbers of people without health insurance, making it difficult to attract doctors. Scarce economic resources create barriers to organizing effective networks of care.

Greater incidence of poverty aggravates health problems. Many people in these areas require special services — rides to the doctor,

LONG-TERM CARE

Beginning in 1996, a new home and community-based care program will enable older Americans with severe disabilities to remain in their own homes or with their loved ones, yet still receive the care and assistance they need.

Medicaid nursing home coverage will be enhanced, allowing nursing home residents to keep $70 per month for living expenses. States will have the option to provide even greater financial protection by allowing individuals to retain up to $12,000 in assets, instead of today's $2,000.

The Health Security Act also provides tax incentives to encourage people to buy private long-term care insurance that meets new standards, and tax incentives to help individuals with disabilities to work.

babysitting and translators, just to get access to health care services.

Although urban and rural areas have some of the same problems, the circumstances that cause them are often very different. In rural areas, geography is the main obstacle. With a relatively small population spread over a large area and health care professionals in short supply, patients often have to travel long distances to see a doctor. Doctors are reluctant to practice in rural areas because they have no help or support from peers. Without enough doctors, nurses and health facilities, building networks of care becomes more difficult, as does the task of attracting enough health plans to foster competition.

In inner-city communities, the challenge is almost the opposite: crowded cities with culturally diverse populations. Only a few blocks away from world famous academic health centers, residents of low-income neighborhoods contend with a laundry list of health care problems too few doctors and nurses; little or no access to culturally-

sensitive care; high rates of infant mortality and low-birthweight babies; frequent violence; and serious health epidemics such as AIDS.

To serve both communities, the goals of health care reform are similar: increase the economic base for health care through universal coverage, provide discounts to make care affordable, and create incentives to attract health care providers to the area.

The Health Security Act includes new loan programs and invest-

THE MAYO CLINIC

A Model for Reform

If you went searching for the highest-quality medical care in the world, you might not immediately think to head to rural Minnesota. But there in Rochester, you'd find the Mayo Clinic, a magnet for patients all across America.

The largest managed care practice in the United States, the Mayo Clinic is known worldwide for its effectiveness at diagnosing and treating illness, and for the excellent physicians who work there. And they've proved that you can control costs and provide top-flight care, holding cost increases well below national averages.

The Mayo Clinic has led the way in encouraging the development of networks of doctors in rural areas, and linking rural physicians and regional health centers in order to increase the availability of high-quality care. These kinds of rural networks serve as the cornerstone for the Health Security plan's strategy to make care more available for residents of rural and remote areas.

ments to increase the level of service available in underserved urban and rural areas. Expansion of the National Health Service Corps will send new physicians and other health professionals into underserved rural and inner-city communities, substantially increasing the supply of doctors and nurses. Successful programs, such as community and migrant health centers, will expand to increase the number of places where people can find care.

A new program of federal grants and loans will support doctors and hospitals in rural and inner-city communities form their own networks and compete with other health plans. This program will link federally funded clinics with other community providers bolstering their skills to coordinate care, negotiate with health plans, and form their own health plans.

The Health Security plan — by supporting the creation of new clinics and offices and renovating and converting existing clinics and offices — will ensure more and better places to seek care in these areas. In addition, it will improve the level of care — and reduce isolation — for urban and rural residents. This will be done by linking members of the practice networks with each other and with regional and academic health centers through the development of more sophisticated information systems.

Two new programs will overcome barriers to care for hard-to-reach, isolated, or culturally-diverse populations. One will support school health services for adolescents. Another will support transportation, child-care, translation, outreach and follow-up services for those in need of care but who are not being served by current programs.

Hospitals, clinics, doctors and health professionals who traditionally serve in these areas are also eligible for designation as “essential community providers”, gaining special protections during the implementation of health reform. To help these key providers adapt to the changes in the system after reform, the Health Security Act requires health plans to contract with essential community providers for five years to enable them to continue to serve the residents in these rural and urban communities who depend on them.