

Clinton Administration Description of President's Health Care Reform Plan, ``American Health Security Act of 1993,' ' dated Sept. 7, 1993, obtained by the Bureau of National Affairs Sept. 10, 1993

Analysis by the Association of American Physicians and Surgeons
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Provision of Plan

Analysis, Questions, Comments

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| p.3 | ``Shortages of doctors, clinics, and hospitals form barriers to [high quality] care." | Plan will decrease number of specialists and of facilities offering advanced technology. |
| p.7 | ``Increased investment in research advances medical knowledge." | See lists of research priorities (pp. 137-143), mostly unrelated to basic science, diagnosis, and treatment. ``Technology assessment" will hinder the application of any discoveries that occur. |
| p.9 | ``New criminal penalties for fraud related to health care and for the payment of bribes or gratuities to influence the delivery of health services and coverage" | This means that seeking or providing care outside the system may be punished as a crime. |
| p.11 | ``Wise allocation of resources: The nation should balance prudently what it spends on health care against other important national priorities." | What will be competing with medical care for the sick? Highways? Schools? The National Endowment for the Arts? |
| p.13 | ``Eligible individuals enroll in a health plan through a health alliance." | Who is ineligible in a ``universal-access" system? Only illegal aliens? |
| p.14 | ``The national health security card serves as proof of eligibility." | Doesn't it also serve as a national identification card, similar to that required in a totalitarian society? |
| p.15 | ``It is the obligation of every eligible individual to enroll in a health plan. Anyone who does not meet the established deadline for enrollment automatically is enrolled in a health plan when he or she seeks medical care." | Is the enforcement mechanism the denial of medical care (unless one is ineligible, i.e. an illegal alien)? How does one enroll? Is a premium payment required on the spot? Back premium payments? If you can't pay, will you have to declare bankruptcy and lose your house and your car? |
| p.15 | ``The Secretary of Labor ensures that all employers fulfill the obligation to make contributions or provide coverage through a qualified health plan." | How? By shutting down their business? |
| p.17 | ``Any individual not eligible for the national benefit package may purchase coverage from a private insurance plan to the extent such plans are available." | Is there any chance whatsoever that plans will be available if their only market is undocumented aliens? |
| p.17 | Guaranteed national benefit package: ``including mental health services, substance-abuse treatment, some dental services and clinical preventive services." | Cost estimate? |

- p.19 "Pregnancy-related services" "Hospital services" are defined, but these are not. Is abortion on demand included, even for sex selection in the 9th month? Norplant for teenagers without parental consent? In vitro fertilization?
- p.19 "Health education classes" in things like "stress management" are guaranteed benefits. Cost Estimate?
- p.34 "Consumer out-of-pocket costs for health services in the comprehensive benefit package are limited, to ensure financial protection." Does this mean that catastrophic insurance is outlawed, and that no one is allowed to pay for a service that is unavailable due to expenditure targets, utilization review, or other rationing technique?
- p.42 "Independent" National Health Board. Does independent mean free of political oversight, so that controversial decisions such as the content of the nationally guaranteed benefit program can be imposed without congressional debate? Is such a delegation of powers constitutional?
- p.43 Qualifications for National Health Board: "expertise in relevant subjects" which include law but not medicine or surgery.
- p.46 "The Secretary of HHS has the authority to order the withholding of federal health appropriations" (thereby forcing states to comply).
- p.50 "States may establish one, and only one, regional alliance in each area." Monopolies are required.
- p.51 "Individuals and families who move into the region served by the alliance notify the alliance within 30 days." This means that people can't change their residence freely, as the government is involved in every move. Currently, those who have an individual insurance policy need only send a change-of-address; they don't have to sign up with another entity. We need more portability, not less.
- p.52 "In the event that more consumers apply to enroll in a particular health plan than its capacity allows, alliances develop a process of random selection for use in determining which new applicants may enroll." Do any insurance plans now have to refuse new enrollments due to exceeding their capacity? If not, why does the Administration anticipate having such a problem? Will this provision not result in forcing consumers to sign up with the least desirable plan?
- p.62 At least one fee-for-service plan must be offered, unless the requirement is waived, and such plans may impose "reasonable" requirements, such as utilization review. In other words, such plans are not really required. In any event, they are not really free-choice plans because of utilization review, prior approval requirements, and price controls.
- p.63 "Balance billing" There is an across-the-board ban on balance billing. Such price-control measures always result in shortages, poorer quality, and other disruptions of the marketplace.
- p.64 Enforcement is by the Department of Labor. The mechanism is not clear, but bankruptcy proceedings are evidently anticipated (see p. 237). Also, statistics on your

		employment, which pays your way under this system, will be maintained by the Dept. of Labor. Potentially, your value to society in terms of your labor productivity could be linked to your entitlement to medical care.
p.70	Community rating is required.	This will increase premiums for a large number of low-risk consumers.
p.73	"States also may require all payers...to reimburse essential community providers."	Some providers receive preferential treatment. Among these "providers" are school-based clinics, see pp. 148 and 184-185.
p.74	"Health plans accept every eligible person [without regard to risk]....Health plans may not terminate, restrict, or limit coverage ...for any reason, including nonpayment of premiums.	Why should enrollees pay the premiums then? And what is to keep the plans solvent? (See p. 237.)
p.76	"Health plans in states that allow advance directives and surrogate decision making related to medical treatment are required to provide information about those legal options at the time of enrollment in the plan."	This extends the requirement that now applies to facilities receiving Medicare payment. It could open the door to pressuring persons with high medical expenses to "opt" for euthanasia or premature withdrawal of treatment.
p.76	"A Health plan is authorized to limit the number and type of health care providers who participate in the health plan [and to] require participants to obtain health services other than emergency services from ... providers authorized by the health plan."	Choice of physician can thus be severely restricted. In fact, a patient might have to settle for a "provider" with less training than a physician.
p.77	Plans may also use "single source" suppliers for pharmacy, medical equipment, and other health products and services.	Monopolies and cartels will thus be permitted or encouraged, and competition potentially destroyed.
p.77	"State laws relating to the corporate practice of medicine...do not apply to arrangements between integrated health plans and their participating providers."	A health plan administrator can make clinical decisions on the basis of expenses incurred, and if care is withdrawn for such reasons, patients will not have legal recourse in the form of a malpractice suit.
p.79	Encounter data and quality data must be maintained and reported electronically.	This could impose heavy costs on facilities that do not use electronic data processing or that use a format different from the one the government will require.
p.80	"Once developed, only the model policies may be offered."	Here is the end of innovation in "health care delivery systems" and insurance products.
p.81	"Any health plan that sells duplicate coverage is disqualified from participating in alliances. Any firm or individual who offers such policies is subject to loss of the license to sell insurance."	Consumers will be forced to put all their eggs in one basket.

p.83	Premiums will be adjusted to reflect the level of risk, taking into effect factors such as services to disadvantaged populations.	If you live in a major urban area, you will pay dearly but will not receive more; in fact, health plans may retreat to lower-risk areas.
p.93	"A national health care budget serves as a backstop to that system of incentives and organized market power. The budget ensures that health care costs do not rise faster than other sectors of the economy."	The budget is a method of price controls that puts a lid on expenditures . The plan actually mandates increases in costs . Therefore, services will have to be restricted. The market will be destroyed and replaced by regulated monopolies.
p.94	The premium "target" is determined by a fairly complex method that amounts to capitation.	Capitation rewards providers for denying service and restricting access.
p.98	Budget enforcement: If the weighted-average premium exceeds its target, plans and providers are "assessed."	Physicians will pay collectively out of pocket if patients receive "excessive" care.
p.99	"Controlling health investments through planning"	Is this a revival of the "certificate of need"? Investors will be prevented from spending their money on medical facilities that do not fit the central plan.
p.100	In the current system, "state and federal inspection agencies audit the work being done in hospitals, doctors' offices, and laboratories, and penalize the providers if they fail to follow the rules. Patients play a minor role, lacking reliable information...."	Under the Clinton Plan, there will be still more rules—practice guidelines with the "force of law" for example—and even more draconian penalties. Large volumes of data will have to be provided to health alliances, but patients will have to choose between plans on the basis of a "report card."
p.101	National Quality Management Program	Physicians are not included in list of persons "representative of the population."
p.108	CLIA revised to exempt laboratories performing waived tests and microscopy from all requirements under CLIA, including registration and payment of fees (under review).	This would be a step in the right direction if it survives the review.
p.111	The national health security card "assures access to <i>needed</i> health services."	Does lack of the card prevent access? Does the card prevent access to "unneeded" (but desired) services? Note that "need" will be defined by the National Health Board.
p.112	"The Board establishes national, unique identifier numbers for plans, providers, and patients, selecting an identification number system...."	What contractor wishes to implement this system, how much profit would the contractor make, and what role did it play in drafting the legislation?
p.112	"Health plans implement and maintain core discrete electronic documentation of all clinical encounters"	Same question as above. Also, does this mean that confidential (undocumented) consultations with physicians will be forbidden? Will physicians who do not input data electronically for every patient be forbidden to practice?
p.116	"Certain public health surveillance and data systems will continue to be needed to ... address emerging	Is the role of the CDC to be changed or integrated with the national health system? Will it be subservient to the National

	threats to the public health"	Health Board? What happens to sensitive information, e.g. HIV testing? Will we just have "universal precautions" regarding disclosure?
p.119	All payers, major employers,... and group practices of 20 or more professionals must implement core electronic data transaction set within 6 months.	Same question as for p. 112
p.123	Individuals who are the subject of data collected "have the right to know about and approve the uses to which the data are put."	Do they have the right to disapprove and prevent the uses, or decline to provide the data?
p.123	"The national privacy policy explicitly forbids the linking of health care and other information through the identification number."	Will this prohibition prevent this linkage from happening?
p.126	HHS will control the allocation of residency slots and (p. 129) assure preferential treatment of certain groups of persons.	Physicians will no longer be able to enter any specialty they choose (and are competent to practice). Some groups (e.g. white men, Jews, Asians, etc.) will have opportunities restricted by quotas (or their functional equivalent).
p.130	Priority project: training for school-based health providers.	Is this a code word for contraceptive services for schoolchildren, with or without parental consent?
p.133	"Reduce rates for office consultations to equal office visits."	Physicians will no longer be compensated for acquiring special skills or undertaking more complex tasks.
p.144	"Enforcement functions related to air pollution (including indoor air), exposure to high lead levels,...Identification, containment and provision of appropriate emergency and treatment resources for community-wide health problems including emergency preparedness and control of violence."	Will the new Health Plan subsume the functions of OSHA, EPA, FEMA, and law enforcement agencies, perhaps including BATF? And how did "indoor air" become a "core public health function," there being no evidence that it is a threat? (Also see p. 147.)
p.148	"Comprehensive school health--Furthering development of links between health and education in a nascent program of comprehensive school health program (<i>sic</i>)"	See also p. 71. Will the Health Plan subsume some functions of the Dept. of Education? Does "comprehensive" health include mental health, and how is that defined (right thinking, for example?) Will the schools soon teach health and sex and contraception as well as they teach algebra?
p.169	- 170. Provider networks, "safety zones," provider collaboration, collective bargaining, state action immunity..."This safe harbor does not apply to the implicit or explicit threat of a boycott." McCarran-Ferguson would be repealed.	Though McCarran-Ferguson would be repealed, certain groups would gain other types of immunity from antitrust. Some types of collusion would be protected, some cooperative actions forbidden. Is this not a legal minefield?
p.172	"Fines, penalties, forfeitures , and damages...for fraud or abuse in health care delivery are deposited in a trust fund to supplement federal efforts to combat health care fraud and abuse."	What are the implications of using the penalties to fund the enforcement activities that collect those penalties?

- p.173 "Current federal authority is amended to allow forfeitures of proceeds derived from health care fraud. The forfeiture remedy allows the federal government to use either criminal or civil remedies to seize assets derived from fraudulent or illegal activities."
- What "illegal activities" are subject to forfeiture? What about coding errors? Alleged kickbacks? Alleged unnecessary multiple admissions? Routine waiver of copayments? "Failing to report information or reporting inaccurate information that is required to be submitted to a data bank"? "Failing substantially to provide medically necessary services"? "Engaging in any practice that reasonably could be expected to have the effect of denying or discouraging enrollment..." (such as renting an office on the second floor)? Is there any limit to forfeiture other than the physician's net worth and earning capacity, or any proportionality to the alleged offense? Does the government have to prove the physician guilty, or does the physician have to prove his property innocent?
- p.187 Medicare cost "savings" through such measures as prospective payment for out-patient services; increasing Part B premiums; subjecting all state and local employees to hospital insurance tax—as well as by decreasing services to elderly patients.
- "Savings," in the Clinton lexicon, appears to refer to such items as increasing taxes.
- p.210 Federal Employee Health Benefits Plan abolished
- In addition, all other special health programs will be integrated into the national plan. There is to be no escape! We recommend that this provision be the last to be deleted if the Plan is amended.
- p.217 Rulemaking. "Rapid implementation...is vital. To expedite implementation, the National Health Board, the Department of Labor, and the Dept of HHS are authorized to issue any regulations by the Act on an interim and final basis."
- Does this mean that the Administrative Procedure Act is circumvented, so that public notice and comment are eliminated or restricted?
- p.221 "Individuals who work less than a full year...are also responsible for any unpaid employer share to the extent that they have non-wage income."
- The unemployed are to be taxed also. In other words, the functional equivalent of a payroll tax is to be extended to those who are not on a payroll. It is not clear whether the amount will be based on the non-payroll income they receive or the wages they presumably would have received had they been employed.
- p.222 Premiums. Individual annual premium \$1500, family premium \$2100.
- These premiums are absurdly low for the type of "comprehensive" benefits required. What is the basis for the estimates? They are probably in error; newspapers are giving estimates about twice as high.
- p.225 Enforcing payments: "Alliances may require employee withholding to avoid bad debt." "Employers are required to make premium contributions at least monthly, but may make them more frequently." Electronic submissions may be
- Self-employed persons may have difficulty calculating just what their income is. Will they have to do the equivalent of a Schedule C on form 1040 four times a year instead of just once?

required. Pro-rata payments must be made for part-time workers. Self-employed must make "contributions" at least quarterly, capped at a certain percentage of self-employed income.

p.237 "Federal guidelines require that regional alliances exercise due diligence in collecting unpaid employer and consumer premium contributions, including the imposition of interest charges and late fees for non-payment and other credit and collection procedures. **Premium contributions owed to regional alliances are privileged compared to other corporate or personal obligations in bankruptcy proceedings.** Alliances recover for unpaid premium contributions through a premium assessment paid by employers and consumers."

Are increased bankruptcy rates expected? Is the "premium assessment" just another form of cost-shifting?