

**CBO ESTIMATES THAT THE PATIENTS' BILL OF RIGHTS (S.1890/H.R.3605)
IS AFFORDABLE**

Today, the Congressional Budget Office (CBO) confirmed that the bipartisan Patients' Bill of Rights (S.1890/H.R.3605) will have only minimal effects on premiums. In most cases, the cost to the individual would be only about \$2 per month.

The CBO estimates are only a fraction of the flawed and grossly inflated analyses that insurers and other special interests cite to try to stall this long overdue legislation. In fact, the CBO estimates are conservative; and other independent estimates have predicted substantially lower costs. Today's CBO analysis proves, yet again, that the Patients' Bill of Rights is well worth the cost of assuring Americans the protections they need and deserve.

A few dollars per month to assure Americans the protections they need and deserve. The new CBO estimates translate into about \$7 per month per privately insured person. In most cases, individuals would pay only about \$2 per month, since employers pay most of health insurance premiums. Today, millions of Americans often lack access to much needed care: they cannot see the specialists they need or cannot talk freely with doctors and nurses about all of their medical options. \$2 per month is a small price to pay to assure access to high quality, accessible, and necessary health care.

Increases for basic quality care that health plans should already be providing today. Any premium increase will primarily be the result of health plans providing basic health services that they should already be offering -- such as assuring essential care by specialists or emergency room coverage. It is astonishing that some plans consider that providing basic protections in the Patients' Bill of Rights would be considered new costs. This only demonstrates that plans have been cutting back on access and quality to save costs -- more proof that a Patients' Bill of Rights is needed.

Individuals in health plans that already provide high quality health services should see no increases. Many high quality health plans already provide most of the protections in the Patients' Bill of Rights. People covered by these plans would see much lower -- and possibly no -- increase in costs.

**QUOTES FROM CONSUMERS, DOCTORS, AND NURSES ON WHY THE
REPUBLICAN LEADERSHIP PROPOSAL IS MORE RHETORIC THAN A
PATIENTS' BILL OF RIGHTS**

August 1, 1998

“The Senate Republican Leadership bill fails to meet basic patient protections standards that the public demands.”

“We are concerned that S. 2330 would provide limited patient protections for only 48 million out of 161 million insured persons in this country. At this important crossroads, we cannot afford to leave some patient protections behind.”

American Medical Association

“The few consumer protections claimed for these alternative bills, S.2330 and H.R. 4250 are like the Wizard of Oz: if one looks behind the curtain there is pitifully little substance to be found.”

“For instance, the “so-called ‘independent medical review’ of decisions when the reviewer is allowed only to judge conformity with the plans definition of medical necessity is ‘a hoax.’”

American Nurses Association

“Beneath its rhetoric and mostly symbolic provisions, S.2330 clearly fails to address women’s well-founded concerns about managed care. It is cynical attempt to divert attention from the real issue: what kind of fundamental protections all Americans, and especially women, will really be able to count on in the era of managed care.”

“The Republican Leadership bill has many serious shortcomings. Most of its provisions do not even apply to about 100 million people ... it lets health plan bureaucrats, *not* doctors, have the last word in important treatment decisions ... it does *not* make sure that patients can see the specialists they need when they need to.”

National Partnership for Women and Families

“If this bill is enacted, it could be devastating for the thousands of women who undergo breast cancer treatment every year.”

“They don’t guarantee that breast cancer patients would have some fundamental rights, including: the right to receive accurate information about their health plans; access to the right providers; and involvement in treatment decisions based on good science. In short, these bills don’t provide women with what they need or what they deserve.”

“Continuity of care is another critical aspect not properly addressed in the Republican Patients’ Bill of Rights. Under this bill there isn’t adequate protection for a person whose employer changes to a plan that does not include the individual’s physician in its network. This is especially important for women dealing with complicated breast cancer procedures, chemotherapy treatments and ongoing care.”

National Breast Cancer Coalition

“The House and Senate GOP bills do little or nothing to improve the quality of care for small businesses and their workers. The House GOP bill shortchanges small businesses by excluding them from the grievances and appeals process, while almost none of the patient protections in the Senate bill apply to people with small business.”

American Small Business Alliance

“Unfortunately, the House and Senate Republican bill will not bring peace of mind to anyone seeking emergency care.”

“The Republican managed care bills will: lead to more coverage disputes not less; create confusion instead of clarity for patients and physicians; create new paperwork requirements for emergency room physicians; and establish new loopholes for HMOs to deny coverage for emergency services.”

American College of Emergency Physicians

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

July 24, 1998

STATEMENT BY THE PRESIDENT

The patients' bill of rights should not be designed for the political needs of any party; it should be designed to meet the health needs of all Americans. Unfortunately, the House Republicans passed legislation today that simply does not meet this test. This bill leaves out millions of Americans; it leaves out critical patient protections; and it adds in "poison pill" provisions which undermine the possibility of passing a strong bipartisan patients' bill of rights this year.

The Republican Leadership's legislation does not apply to the individual insurance market and therefore excludes millions of Americans. It does not include many important protections such as ensuring direct access to specialists, so that patients can see the cancer doctors or heart specialists that they need, or ensuring that care will not abruptly change if a patient's provider is unexpectedly dropped or an employer changes health plans. Moreover, the enforcement mechanism in this legislation is insufficient as it gives little recourse to patients who are injured or who die because of a health plan's actions. Finally, this legislation is undermined by provisions that have nothing to do with patients' rights.

Americans want a patients' bill of rights that gives them the protections they need in a rapidly changing health care system. The legislation passed by the House Republicans today falls far short of ensuring Americans the quality care they need and deserve. It is my strongest hope that the Senate will move quickly to have a fair and open debate that can produce a strong, enforceable, and bipartisan patients' bill of rights this year.

**PRESIDENT CLINTON ANNOUNCES NEW INTERNAL APPEALS REGULATION FOR
OVER 120 MILLION AMERICANS AND REITERATES NEED FOR CONGRESS TO MAKE
A STRONG PATIENTS' BILL OF RIGHTS THE LAW OF THE LAND**

August 29, 1998

Today, in his weekly radio address, President Clinton announced a new regulation that requires all private employment-based health plans, covering over 120 million Americans, to implement an internal appeals process that, for the first time, gives enrollees a fair, timely process to address all grievances with their health plans. This new proposed regulation, released by the Department of Labor, is part of the President's ongoing efforts to institute the patients' bill of rights for all health plans under Federal oversight.

In releasing this regulation, the President emphasized that the Administration does not have the statutory authority to ensure other critical protections for patients in private employment-based health plans, such as access to specialists, emergency care protections, and independent external appeals. Only Congress can achieve this result by passing a strong, enforceable patients' bill of rights. The President urged the Senate to take up the patients' bill of rights as its first order of business when they return next week, but explained why he could not sign the Republican Leadership proposals as currently drafted.

ANNOUNCED A NEW INTERNAL APPEALS REGULATION FOR MORE THAN 120 MILLION AMERICANS IN PRIVATE EMPLOYMENT-BASED HEALTH PLANS. While the Republican Leadership has delayed passing a patients' bill of rights, the President has directed Federal agencies to implement these patient protections whenever possible. The Department of Labor is releasing a new proposed regulation that will ensure that patients receive a timely, fair internal review when they have a grievance against their health plan -- and, for the first time, that they receive an expedited review for urgent claims. The proposed regulation:

- Requires plans to provide enrollees with better disclosure regarding their appeal rights;
- Cuts the maximum time health plans have to respond to non-urgent appeals from 90 to 30 days, and requires plans to respond to urgent appeals within 72 hours; and
- Gives enrollees greater access to records relevant to any denial of benefit claims.

HIGHLIGHTED NEED FOR STRONG LEGISLATION AND URGED CONGRESS TO MAKE IT THE FIRST ORDER OF BUSINESS. The Labor Department proposed regulation the President unveiled today does virtually all the Administration can do to require private employment-based plans to comply with the patients' bill of rights. Congress must act to ensure that Americans in private health plans receive most of the other consumer protections outlined in the bill of rights, including access to specialists, emergency care protections, and an external appeals mechanism. The President accordingly urged the Republican Leadership to make the passage of a strong patients' bill of rights its first order of business when Congress returns.

PRESIDENT CLINTON ANNOUNCES HE WOULD VETO REPUBLICAN LEADERSHIP PATIENTS' BILL OF RIGHTS AND THAT FEDERAL HEALTH PLANS CONTINUE TO IMPLEMENT PATIENTS' BILL OF RIGHTS

August 10, 1998

Today, in a speech in Louisville, Kentucky, the President outlined the inadequacies of the Gingrich/Lott patients' bills of rights, showing that they have more loopholes than protections. He announced that if Congress sends him such flawed legislation, he would veto it. While the Republican Leadership stalls on passing a real patients' bill of rights, the President continues to implement patient protections for the 85 million Americans in federal health plans. Today, the Office of Personnel Management is releasing a new regulation to prohibit gag rules, as part of its efforts to meet the President's directive to bring all Federal health plans into compliance with the patients' bill of rights. Today, the President:

ANNOUNCED HE WOULD VETO THE GINGRICH-LOTT PROPOSALS THAT ARE MORE LOOPHOLES THAN PATIENT PROTECTIONS. The President said that these Republican proposals:

Contain Empty Promises. Many of the provisions in the Republican plans are symbolic gestures rather than real patient protections. As the American Nurses Association says: "Republican leaders who promise protection from managed care abuses for patients only deliver slogans for the patients and protections for the managed care industry." For example these bills:

- **Let HMOs, not health professionals, define medical necessity.** The Republican Leadership proposals provide for an external appeals process, but make this process meaningless by allowing HMOs themselves, rather than independent health professionals, to define what services are medically necessary. This loophole will make it very difficult for patients to prevail on an appeal to get the treatment their doctors believe they need.
- **Allow financial incentives to threaten critical patient care.** The Republican legislation purports to protect patients from financial incentives to limit care, but applies this protection in only a very narrow set of circumstances. The bills thus leave most patients, in most health care settings, vulnerable to financial incentives that limit patient care. By pretending remove those incentives, while allowing them to go forward, the Republican Leadership bills mislead patients as to the risks of improper care.

Leave Out Essential Protections For Patients. The Republican Leadership proposals fail to include several critical patient protections. The National Breast Cancer Coalition, raising concerns about the absence of important protections, says that "if these bills are enacted, it could be devastating for the thousands of women who undergo breast cancer treatment every year." The Republican Leadership proposals:

- **Fail to guarantee direct access to specialists.** The Republican Leadership proposals fail to ensure that patients with serious health problems have direct access to the specialists they need. For example, patients with cancer or heart disease may be denied access to the doctors they need to treat their conditions.

- **Fail to protect patients from abrupt health care changes.** The Republican Leadership bills fail to assure continuity of care when an employer changes health plans. This deficiency means that pregnant women or individuals undergoing care for a chronic illness may have their care suddenly altered mid course, potentially causing adverse health consequences.
- **Fail to compensate patients who have suffered harm as a result of a wrongful health plan action.** The proposed per day penalties in the Republican Leadership plans fail to compensate patients who suffer serious harm or even death because of a health plans' wrongful action. For example, if a health plan improperly deny a lifesaving cancer treatment to a child, it will only incur a penalty for the number of days it takes to reverse its decision but will not have to pay the family for all the damages it will suffer as the result of having a child with a now untreatable disease. And because the plan will not have to pay for all the harm it causes, it will have insufficient incentives to change health care practices for the future.

Reverse Course on Some Critical Protections. In some areas, the Republican Leadership bills undermine current patient protections that are law today. The American Medical Association says that these bills "would roll back vital patient protections enacted in the states." Similarly, the Kentucky Chapter of the American College of Physicians says that "the Republican bills basically gutted the 'prudent layperson standard'" that assure real emergency room protections. The Republican bills:

- **Undermine existing medical privacy protections.** The House Republican Leadership bill would preempt some existing medical privacy protections guaranteed by state law, without putting any protections in their place. As a result, the bills would increase the number of individuals who can review and give out health records without a patient's knowledge or consent.
- **Reverse course on emergency room protections.** The Republican Leadership proposals back away from the emergency room protections that Congress implemented for Medicare and Medicaid beneficiaries in the Balanced Budget Act of 1997. The Republican bills include a watered-down provision that does not require health plans to cover patients who go to an emergency room outside their network and does not ensure coverage for any treatment beyond an initial screening. These provisions put patients at risk for the huge costs associated with critical emergency treatment.

Leave Millions of Americans Out in the Cold. The Republican Leadership bills do not apply to all health plans and therefore leave out millions of Americans. As the American Nurses Association says: "we will not agree to leave a large segment of the population unprotected." The bills:

- **Do not cover all health plans.** Both Republican Leadership bills leave millions of Americans unprotected. The Lott proposal, for example, covers only self-insured plans, thus leaving out 100 million Americans, including millions of Americans in small businesses. These Americans are held hostage to the hope that states will provide them with every patient protections that the Republicans in Congress will not.

ANNOUNCED A NEW “ANTI GAG” REGULATION FOR FEDERAL EMPLOYEES. While the Republican Leadership delays passing strong patient protections, the Clinton Administration is implementing the patients’ bill of rights for the 85 million Americans in Federal health plans. The President:

- **Announced release of anti-gag regulation.** Today, the President announced that the Office of Personnel Management (OPM) is releasing a new regulation prohibiting plans participating in the Federal Employees Health Benefits Program (FEHBP) from using gag clauses. This regulation will ensure that health professionals can discuss all medical treatment options with their patients. Earlier this year, OPM notified all participating health plans that they must provide other new patient protections -- including assuring access to specialists, continuity of care, and access to emergency room services -- to their enrollees. FEHBP has 350 participating health plans that serve 9 million federal employees and their families, including over 100,000 people in Kentucky.
- **Built on efforts to extend patients’ bill of rights to all Federal health plans.** In June, the Department of Health and Human Services extended the patients’ bill of rights to the 40 million Americans who receive Medicare. Last month, the Department of Veterans’ Affairs began to put in place a new, rapid appeals process for the 3 million veterans who receive health care. Last week, the Department of Defense issued a directive to all military bases throughout the world, extending patient protections to 8 million servicemen and women and their families at nearly 600 hospitals and clinics around the world.

**PRESIDENT CLINTON ANNOUNCES A NEW REGULATION TO BRING THE
MEDICAID PROGRAM INTO COMPLIANCE WITH THE PATIENTS' BILL OF
RIGHTS AND REITERATES CALL ON CONGRESS TO PASS A STRONG PATIENTS'
RIGHTS BILL THIS YEAR**

September 17, 1998

Today, in a speech before the International Brotherhood of Electrical Workers, President Clinton announced that the Department of Health and Human Services has completed a new regulation to bring the Medicaid program into compliance with the patients' bill of rights. This new proposed regulation -- part of the President's ongoing efforts to institute the patients' bill of rights for all federal health plans -- will provide critical patient protections to millions of Americans served each year by the Medicaid program, including children, people with disabilities, and older Americans. The President also urged Congress to pass a strong patients' bill of rights this year, and criticized the Senate Republican Leadership for failing to bring this important legislation to a vote. Today, the President:

ANNOUNCED A NEW REGULATION TO BRING MEDICAID INTO COMPLIANCE WITH THE PATIENTS' BILL OF RIGHTS. The President announced that the Department of Health and Human Services has completed a new regulation that will give the over 20 million Medicaid beneficiaries in managed care plans the patient protections they need and deserve. This proposed regulation would require managed care plans in all fifty states to provide needed patient protections to Medicaid beneficiaries including:

- Access to the specialists they need;
- Anti-gag rules to ensure that health professionals can discuss all medical treatment options with their patients;
- Access to providers for women's health services;
- Access to emergency room services when and where the need arises;
- Disclosure of clear, up-to-date information about benefits, plan operations, and protections; and
- A timely internal appeals process as well as an independent external appeals to assure patients can address grievances with their health plans.

HIGHLIGHTED THE EXECUTIVE ACTIONS THE ADMINISTRATION HAS TAKEN TO APPLY THE PATIENTS' BILL OF RIGHTS TO TENS OF MILLIONS OF AMERICANS IN FEDERAL HEALTH PLANS. The Medicaid regulation the President announced today is part of his longstanding effort to bring Federal health plans into compliance with the patients' bill of rights. In June, the Department of Health and Human Services extended the patients' bill of rights to Medicare beneficiaries. The Department of Defense, the Department of Veteran Affairs, and the Office of Personnel Management have issued directives extending similar patient protections to servicemen and women, veterans, and federal employees. Taken together, these executive actions are extending protections to tens of millions of Americans.

UNDERScored NEED FOR STRONG LEGISLATION AND URGED THE REPUBLICAN LEADERSHIP TO STOP STALLING AND PASS A BILL THIS YEAR. While the President has acted to ensure that Federal health plans implement the patients' bill of rights, Congress must act to ensure that private health plans give their patients the protections they need and deserve. Just yesterday, the Republican Leadership again refused to allow an up or down vote on the patients' bill of rights. The President urged the Republican Leadership to stop stalling and pass a strong enforceable patients' bill of rights this year.

REITERATED WHY THE ADMINISTRATION CANNOT SUPPORT THE REPUBLICAN LEADERSHIP PATIENTS' BILL OF RIGHTS. The President also reiterated his serious concerns about the shortcomings of the current Republican Leadership bills which:

- **Let HMOs, not informed health professionals, define medical necessity.** The Republican Leadership proposals provide for an external appeals process, but make this process meaningless by allowing the HMOs themselves, rather than informed health professionals, to define what services are medically necessary. This loophole will make it very difficult for patients to prevail on appeals to get the treatment their doctors believe they need.
- **Fail to guarantee direct access to specialists.** The Republican Leadership proposals fail to ensure that patients with serious health problems have direct access to the specialists they need. This means that patients with cancer or heart disease may be denied access to the doctors they need to treat their conditions.
- **Reverse course on emergency room protections.** The Republican Leadership proposals back away from the emergency room protections that Congress implemented in a bipartisan manner for Medicare and Medicaid beneficiaries in the Balanced Budget Act of 1997. The bills include a watered-down provisions that do not ensure coverage for any treatment beyond an initial screening. These provisions put patients at risk for the huge costs associated with critical emergency treatment.
- **Fail to protect patients from abrupt health care changes.** The Republican Leadership bills fail to assure continuity of care when an employer changes health plans. These deficiencies mean that pregnant women or individuals undergoing care for a chronic illness may have their care suddenly altered mid course, potentially causing severe adverse health consequences.
- **Allow financial incentives to threaten critical patient care.** The Republican Leadership proposals fail to prohibit secret financial incentives to providers. This omission would leave patients vulnerable to financial incentives that limit patient care.
- **Undermine existing medical privacy protections.** The House Republican Leadership bill would preempt some existing medical privacy protections guaranteed by state law, without putting protections in their place. As a result, the Republican bill would increase the number of individuals who can review and give out health records without a patient's knowledge or consent.
- **Fail to compensate patients who have suffered harm as a result of a wrongful health plan action.** The proposed per-day penalties in the Republican Leadership plans fail to hold health plans accountable when patients suffer serious harm or even death because of a health plan's wrongful action. For example, if a health plan improperly denies a lifesaving cancer treatment to a child, it will incur a penalty only for the number of days it takes to reverse its decision; the plan will not have to pay the family for all the damages they will suffer as the result of having a child with a now untreatable disease. And because the plan will not have to pay for all the harm it causes, it will have insufficient incentive to change its health care practices in the future.

- **Do not cover all health plans.** Both Republican Leadership bills leave millions of Americans unprotected. The Senate Republican proposal, for example, covers only self-insured plans, thus leaving out more than 100 million Americans, including millions of Americans in small businesses. These Americans are left to hope that states will provide them with the set of patient protections that the Republicans in Congress will not.

THE WHITE HOUSE

WASHINGTON

MOSCOW

September 1, 1998

The Honorable Trent Lott
Majority Leader
United States Senate
Washington, D.C. 20510

Dear Senator Lott:

Thank you for your letter regarding the patients' bill of rights. I am pleased to reiterate my commitment to working with you -- and all Republicans and Democrats in the Congress -- to pass long overdue legislation this year.

Since last November, I have called on the Congress to pass a strong, enforceable, and bipartisan patients' bill of rights. During this time, I signed an Executive Memorandum to ensure that the 85 million Americans in federal health plans receive the patient protections they need, and I have indicated my support for bipartisan legislation that would extend these protections to all Americans. With precious few weeks remaining before the Congress adjourns, we must work together to respond to the nation's call for us to improve the quality of health care Americans are receiving.

As I mentioned in my radio address this past Saturday, ensuring basic patient protections is not and should not be a political issue. I was therefore disappointed by the partisan manner in which the Senate Republican Leadership bill was developed. The lack of consultation with the White House or any Democrats during the drafting of your legislation contributed to its serious shortcomings and the fact it has failed to receive the support of either patients or doctors. The bill leaves millions of Americans without critical patient protections, contains provisions that are more rhetorical than substantive, completely omits patient protections that virtually every expert in the field believes are basic and essential, and includes "poison pill" provisions that have nothing to do with a patients' bill of rights. More specifically, the bill:

- **Does not cover all health plans and leaves more than 100 million Americans completely unprotected.** The provisions in the Senate Republican Leadership bill apply only to self-insured plans. As a consequence, the bill leaves out more than 100 million Americans, including millions of workers in small businesses. This approach contrasts with the bipartisan Kassebaum-Kennedy insurance reform law, which provided a set of basic protections for all Americans.

- **Lets HMOs, not health professionals, define medical necessity.** The external appeals process provision in the Senate Republican Leadership bill makes the appeals process meaningless by allowing the HMOs themselves, rather than informed health professionals, to define what services are medically necessary. This loophole will make it very difficult for patients to prevail on appeals to get the treatment doctors believe they need.
- **Fails to guarantee direct access to specialists.** The Senate Republican Leadership proposal fails to ensure that patients with serious health problems have direct access to the specialists they need. We believe that patients with conditions like cancer or heart disease should not be denied access to the doctors they need to treat their conditions.
- **Fails to protect patients from abrupt changes in care in the middle of treatment.** The Senate Republican Leadership bill fails to assure continuity-of-care protections when an employer changes health plans. This deficiency means that, for example, pregnant women or individuals undergoing care for a chronic illness may have their care suddenly altered mid course, potentially causing serious health consequences.
- **Reverses course on emergency room protections.** The Senate Republican Leadership bill backs away from the emergency room protections that Congress implemented in a bipartisan manner for Medicare and Medicaid beneficiaries in the Balanced Budget Act of 1997. The bill includes a watered-down provision that does not require health plans to cover patients who go to an emergency room outside their network and does not ensure coverage for any treatment beyond an initial screening. These provisions put patients at risk for the huge costs associated with critical emergency treatment.
- **Allows financial incentives to threaten critical patient care.** The Senate Republican Leadership bill fails to prohibit secret financial incentives to providers. This would leave patients vulnerable to financial incentives that limit patient care.
- **Fails to hold health plans accountable when their actions cause patients serious harm.** The proposed per-day penalties in the Senate Republican Leadership bill fail to hold health plans accountable when patients suffer serious harm or even death because of a plan's wrongful action. For example, if a health plan improperly denies a lifesaving cancer treatment to a child, it will incur a penalty only for the number of days it takes to reverse its decision; it will not have to pay the family for all the damages the family will suffer as the result of having a child with a now untreatable disease. And because the plan will not have to pay for all the harm it causes, it will have insufficient incentive to change its health care practices in the future.

- Includes "poison pill" provisions that have nothing to do with a patients' bill of rights. For example, expanding Medical Savings Accounts (MSAs) before studying the current demonstration is premature, at best, and could undermine an already unstable insurance market.

As I have said before, I would veto a bill that does not address these serious flaws. I could not sanction presenting a bill to the American people that is nothing more than an empty promise.

At the same time, as I have repeatedly made clear, I remain fully committed to working with you, as well as the Democratic Leadership, to pass a meaningful patients' bill of rights before the Congress adjourns. We can make progress in this area if, and only if, we work together to provide needed health care protections to ensure Americans have much needed confidence in their health care system.

Producing a patients' bill of rights that can attract bipartisan support and receive my signature will require a full and open debate on the Senate floor. There must be adequate time and a sufficient number of amendments to ensure that the bill gives patients the basic protections they need and deserve. I am confident that you, and Senator Daschle can work out a process that accommodates the scheduling needs of the Senate and allows you to address fully the health care needs of the American public.

Last year, we worked together in a bipartisan manner to pass a balanced budget including historic Medicare reforms and the largest investment in children's health care since the enactment of Medicaid. This year, we have another opportunity to work together to improve health care for millions of Americans.

I urge you to make the patients' bill of rights the first order of business for the Senate. Further delay threatens the ability of the Congress to pass a bill that I can sign into law this year. I stand ready to work with you and Senator Daschle to ensure that patients -- not politics -- are our first priority.

Sincerely,

Bar Clinton

224-2047

SUPERBUG

BACKGROUND ON THE SUPERBUG

(1) An Increasing Public Health Problem. Recent reports have indicated that resistance to anti-biotics is increasingly becoming a public health crisis, causing prolonged illnesses and even death. One example of this emerging disease is Staph (staphylococcus aureas), the most commonly-acquired hospital-based infection that impacts 500,000 hospitalized Americans per year. Contracted through cuts, rashes, or surgical incisions, staph can be lethal if it not treated properly. Due to antibiotic resistance, this infection now only responds to vancomycin, and over the past year, CDC has documented the first cases of resistance to this last resort drug. If Staph becomes completely resistance to vancomycin, it would definitively cause tens of thousands of deaths.

Another disease that is increasingly antibiotic resistant is Streptococcus Pneumoniae, the bacteria causing pneumonia, childhood ear infections, and meningitis. There are more than seven million ear infections in children each year and about 500,000 cases of pneumonia. While there were no reported cases of resistance as recently as 1990, recent studies show that resistance to antibiotics, particularly penicillin, has become quite common. Without appropriate measures, the spread of antimicrobial resistance with this strain will cause millions to suffer more serious prolonged illnesses even resulting from what are now simple ear infections. This is also a dangerous trend as the use of stronger and harsher drugs, especially among children, is detrimental to immune systems and more dangerous.

(2) Economic costs for Patient Care from Infections Disease. Antibiotic resistance is not only bad for public health but is extremely costly to the health care system. The Centers for Disease Control reports that when a patient acquires an infection, treatment costs increase by an average of \$2,100 (1992 dollars). Blood stream infections cause the patient to stay in the hospital an average of 7 additional days and results in an average \$3,517. A 1995 Office of Technology and Assessment Report estimated that the emergence of antimicrobial resistance among six common bacteria in hospitals costs a minimum of \$611 million per year in hospital expenses, stemming from: prolonged hospital stays, extra physician visits when antibiotics are ineffective, extra and more expensive drug treatment costs.**

(3) Lack of Understanding of Antibiotic Resistance. Health experts do not understand the causes of antimicrobial resistance and do not know why some drugs are becoming ineffective or which ones they can expect will have problems in the future. In the past, the public health response to antibiotic resistance, has been to develop more effective, stronger drugs. However, experts now believe that research and progress in pharmaceuticals cannot keep pace with the increasing number of antibiotic resistant strains. Instead, they believe that a public health, prevention-oriented approach is the only way to prevent this from becoming an increasingly problematic health care problem.



THE KAISER-HARVARD PROGRAM ON THE PUBLIC AND HEALTH/SOCIAL POLICY

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**EMBARBOED FOR RELEASE UNTIL:
9:00 am (EDT), Thursday, September 17**

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NEW SURVEY FINDS THE PUBLIC MORE WORRIED ABOUT MANAGED CARE AND MORE SUPPORTIVE OF PATIENT PROTECTION LEGISLATION, BUT CRITICISMS STILL REGISTER

Most Say Congress is Just Playing Politics with Patients' Rights in an Election Year

WASHINGTON, D.C. — A new survey released today shows that Americans are increasingly concerned about managed care and support for consumer protection proposals has grown. However, criticisms by opponents that regulation will drive up costs and cause employers to drop coverage continue to register with the public. In addition, most people believe that politicians have been using the issue to gain political advantage in an election year, rather than making a serious attempt to pass laws to protect consumers.

The Kaiser/Harvard *Survey on Americans' Views on the Consumer Protection Debate* found that since last fall more people are following the managed care debate, and the increased scrutiny has taken a toll on the managed care industry. Compared with previous Kaiser/Harvard surveys, more Americans see managed care plans as doing a "bad job" in serving consumers and worry that their plans are more concerned about profits than about their health care. More people are also reporting that they or someone they know has had problems with their health plans.

In addition, at a time when the public has been wary of "big government" and opponents of managed care regulation have taken to the airwaves, when presented with the arguments for and against regulation, respondents' support for government involvement to protect consumers in managed care plans has risen from 52 percent in September 1997 to 65 percent.

"The President's troubles may have sidetracked legislative action for now, but this issue is likely to return to the legislative agenda because the public's underlying concerns are still there," said Drew Altman, Ph.D., President of the Kaiser Family Foundation.

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Attitudes Towards Health Plans

More Americans now see managed care plans as doing a bad job serving consumers (36 percent, up from 21 percent a year ago) than a good job (30 percent, down from 34 percent). The public also appears to be increasingly worried about how their health plan will treat them, with 33 percent "very" worried that their plan is more interested in saving money than in providing them with the best treatment if they are sick, up from 18 percent just a year ago.

Such worries are most common for those in the most restrictive forms of managed care (43 percent very worried). At the same time, the percentage of those reporting that they or someone they know has had at least one problem with their health plan rose from 48 percent to 57 percent in an eight-month period.

And although managed care issues have been prominent in the news, those who hold unfavorable views continue to report that they base their opinions more on their own experience (37 percent) or the experience of friends and family (35 percent) than on media coverage (18 percent). In fact, 30 percent of Americans report that they or someone they know has had an HMO or other managed care plan deny treatment or payment for something a doctor recommended.

Attitudes Towards Regulation

The number of Americans supporting government regulation of health plans has risen significantly in the past year. When presented with arguments for and against regulation, 65 percent say "government needs to protect consumers from being treated unfairly and not getting the care they need" versus 28 percent who say "additional government regulation is a bad idea and would raise the cost of health insurance." By comparison, 52 percent responded favorably towards government regulation when presented with this tradeoff in September 1997.

Support has also risen for the most controversial and hotly debated consumer protection measure – the right of consumers to sue their health plans – from 64 percent in December 1997 to 73 percent.

However, as with our earlier surveys, support for consumer protection drops substantially when possible consequences are raised:

- Support for comprehensive consumer protection legislation drops from 78 to 40 percent (with 40 percent opposed) when people are told that it could raise the cost of a typical family health insurance policy by \$200 per year (approximately the cost estimated by the Congressional Budget Office for a leading patient protection proposal).
- While an overwhelming majority support specific consumer protection measures, support for these also drop substantially when respondents are presented with criticisms made by opponents that they may get the government too involved in the health care system, raise costs, or cause employers to drop health coverage.

Politics and Patient Rights

When asked how important candidates' stands on specific issues will be in the upcoming election, 47 percent cited education, 42 percent taxes, and 40 percent Social Security as important factors to their vote. Managed care regulation was cited by 34 percent, as was Medicare, ahead of two

other major issues that have been hotly contested by the Congress: tobacco regulation (17 percent) and campaign finance reform (15 percent).

Republicans (77 percent), Democrats (78 percent) and Independents (79 percent) are equally supportive of consumer protection legislation, including controversial measures like allowing consumers to sue health plans. While support for the right to sue plans has increased slightly among Democrats (increasing from 70 percent to 75 percent in eight months), it has increased more significantly among Republicans, rising from 56 percent to 74 percent over the same period.

"Regulation of managed care ranks higher as an issue for the public than others currently being debated by the Congress, such as regulation of tobacco and campaign finance reform," said Robert J. Blendon, Sc.D., Professor of Health Policy and Political Analysis at Harvard University.

The increasingly combative nature of the managed care debate has also registered with the public. Forty-one percent of those surveyed said they have seen, heard or read television, radio and print ads that are being used by candidates and interest groups to influence the debate. The public is cynical, however, about the motives of elected officials, with 66 percent saying that Members of Congress are using the debate over consumer protection to gain political advantage in an election year, and only 25 percent saying that they are serious about consumer protection.

In terms of trust in handling this issue, the public gives neither party a big edge. However, should the Congress fail to pass consumer protection legislation, those surveyed would be more likely to hold Republicans responsible (35 percent) than Democrats (20 percent). Seventeen percent would blame both parties equally.

Consumer Protection Legislation Generally Includes Five Broad Measures

Proposals before Congress to expand the regulation of health plans include a number of consumer protection measures, including:

- Requiring plans to provide more information to enrollees
- Making it easier for people to obtain coverage for an emergency room visit
- Providing easier access to ob-gyns, pediatricians, and other medical specialists
- Allowing consumers to appeal a health plan's decision to an independent reviewer
- Giving consumers with employer-sponsored health coverage expanded rights to sue their health plans

Methodology

This Kaiser Family Foundation/Harvard University Survey of Americans' Views on the Consumer Protection Debate was designed and analyzed by researchers at the Kaiser Family Foundation and Harvard University. The survey was conducted by telephone by Princeton Survey Research Associates with 1,200 adults, 18 years and older, nationwide between August 6 and August 20, 1998. The margin of error is plus or minus 3 percent for the national sample. The margin of sampling error may be higher for some of the sub-sets in this analysis.

Because many people are unsure – or don't know – what kind of health insurance they have, insured respondents under age 65 in this survey (715 respondents) were asked a series of questions about their health plan to establish what kind of coverage they have. They were asked if they were required to do any of the following by their plan: choose doctors from a list and pay more for doctors not on the list; select a primary care doctor or medical group; and/or obtain a referral before seeing a medical specialist or doctor outside the plan. Respondents were listed as being in "heavy" managed care if they reported their plans had all of the characteristics described above. Respondents were listed as being in "light" managed care if they reported their plans had some but not all of the characteristics listed above. And, respondents were listed as having "traditional" insurance if they reported their plans as having none of the characteristics.

Previous Kaiser/Harvard surveys are cited for the purpose of comparison. They are: the Kaiser/Harvard *National Survey of Americans' Views on Consumer Protections in Managed Care* with 1,204 adults (age 18 or older) between December 12-30, 1997 (margin of error plus or minus 3 percent); and the *Kaiser/Harvard 1997 National Survey of Americans' Views on Managed Care* with 1,204 adults nationwide between August 22 and September 23, 1997 (margin of error plus or minus 3 percent). Additional comparisons are made with preliminary data from a new Kaiser/Harvard national survey.

The Kaiser Family Foundation, based in Menlo Park, California, is a non-profit, independent national health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries.

Copies of the questionnaire and top line data for the findings reported in this release are available by calling the Kaiser Family Foundation's publications request line at 1-800-656-4533 (Ask for publication #1438). Also available are the top line data from the Kaiser/Harvard *National Survey of Americans' Views on Consumer Protections in Managed Care* (#1356) and the *Kaiser/Harvard 1997 National Survey of Americans on Managed Care* (#1328).

PAGE: 006/026

Kaiser Family Foundation/Harvard University

TO: 4565557

Survey of Americans' Views on the Consumer Protection Debate

CHART PACK

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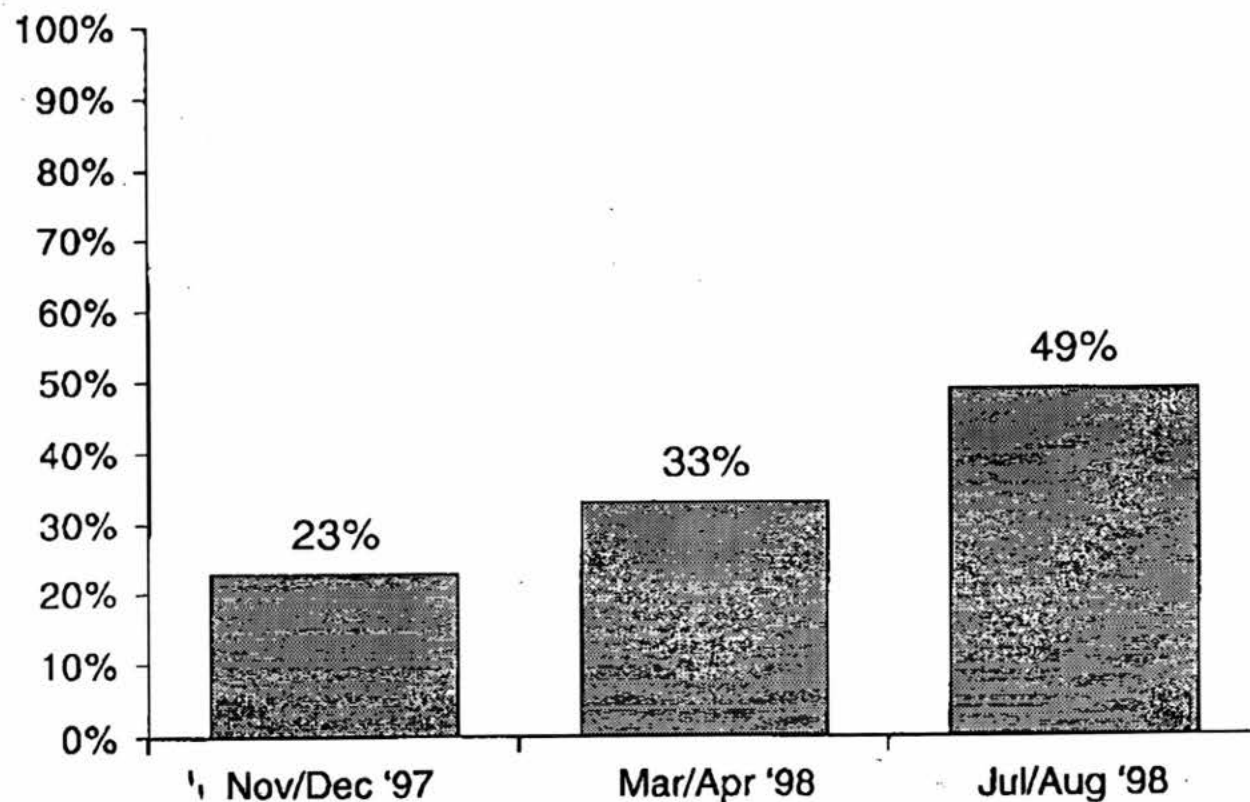
September 17, 1998

I. ATTITUDES TOWARD MANAGED CARE AND REGULATION

CHART 1

FOLLOWING THE ISSUE

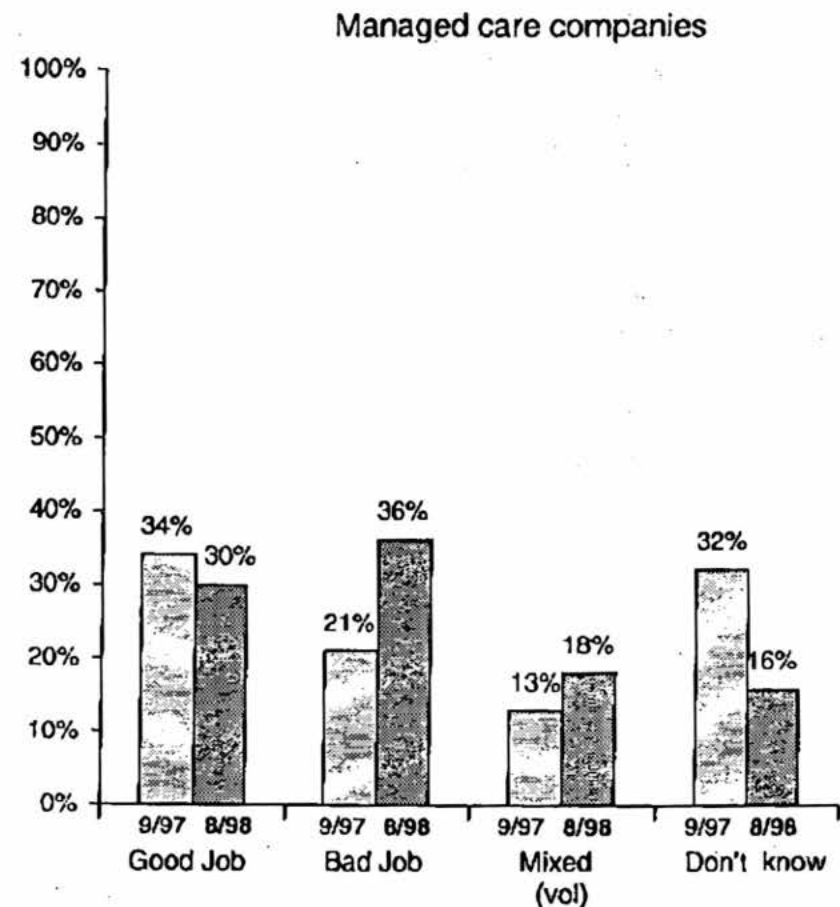
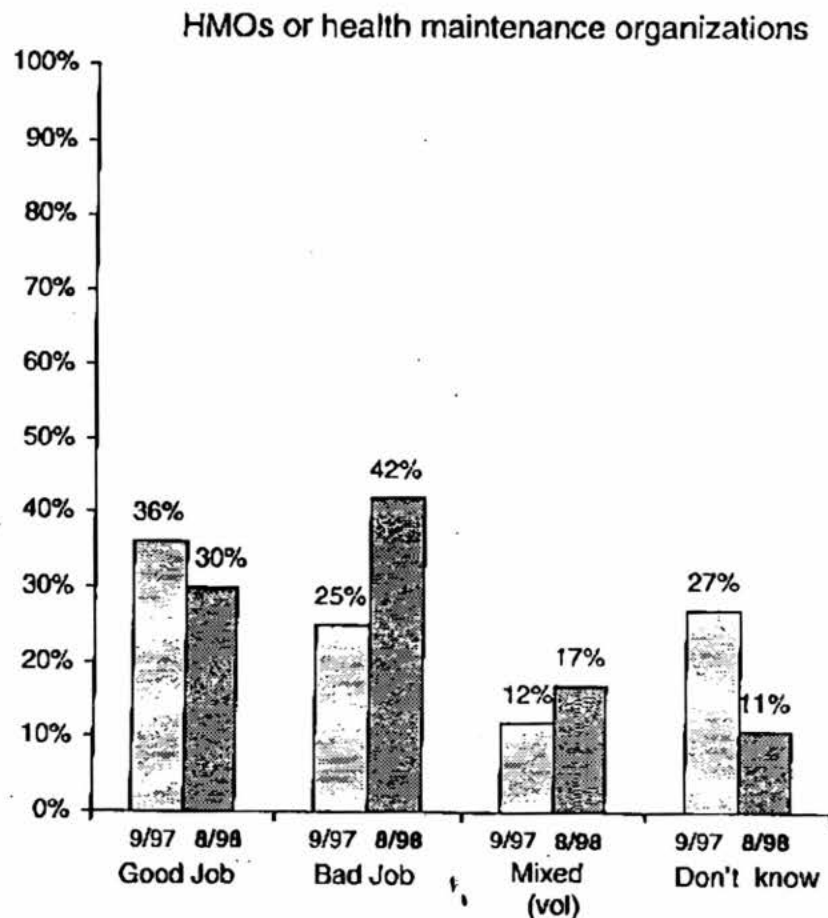
Percent of Americans following very/fairly closely the "debate over consumer protection legislation for people covered by HMOs and other managed care health plans"...



Source: Kaiser/Harvard Health News Index, Nov/Dec'97, March/April '98, Jul/Aug '98.

MORE AMERICANS NOW SAY HMOs AND MANAGED CARE COMPANIES DOING A BAD JOB

Percent of Americans who say what kind of job each is doing serving health care consumers...



Note: VOL means response was volunteered by respondent, not an explicitly offered choice

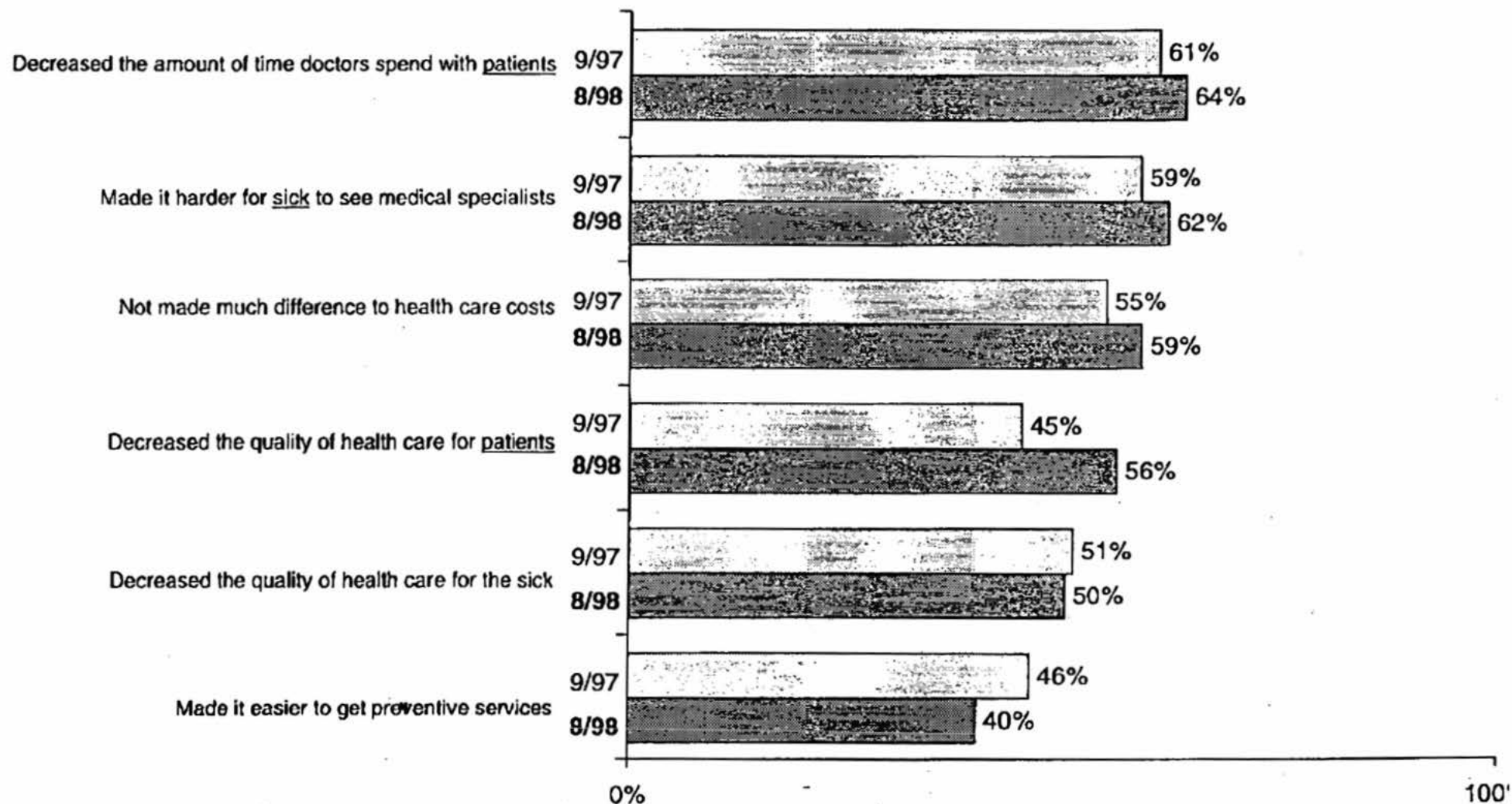
Source: Kaiser/Harvard Survey of Americans' Views on the Consumer Protection Debate, September 1998 (conducted 8/98); Kaiser/Harvard National Survey of Americans' Views on Managed Care, November 1997 (conducted 9/97).

PAGE: 010'026

CHART 3

SPECIFIC CONCERNS ABOUT MANAGED CARE

Percent of Americans who say during the past few years
HMOs and other managed care plans have...



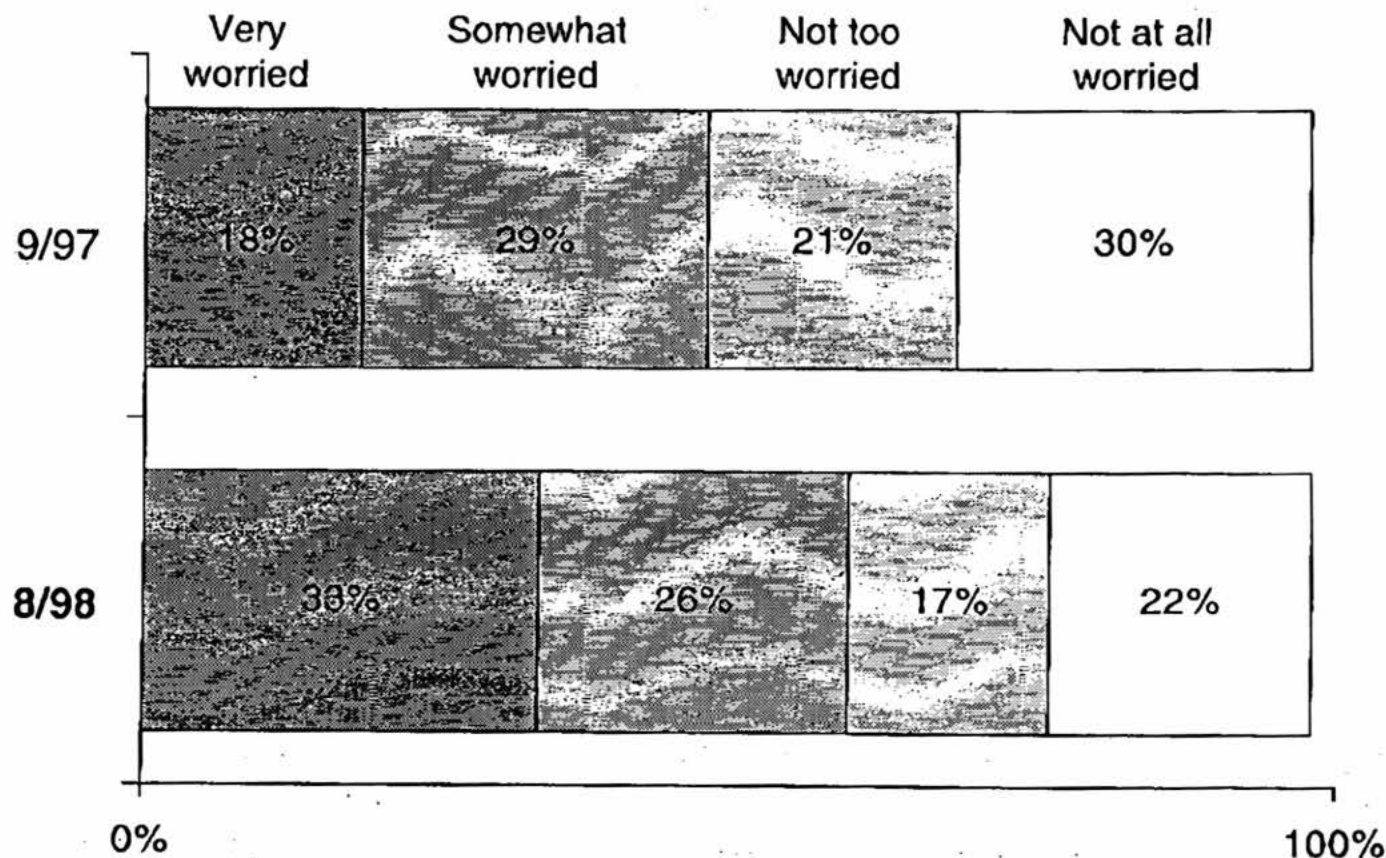
Source: Kaiser/Harvard Survey of Americans' Views on the Consumer Protection Debate, September 1998 (conducted 8/98); Kaiser/Harvard National Survey of Americans' Views on Managed Care, November 1997 (conducted 9/97).

SEP-17-98 06:26 FROM:

CHART 4

AMERICANS MORE WORRIED ABOUT HOW HEALTH PLANS WILL TREAT THEM

Percent of Americans who say they are worried that their health plan would be more concerned about saving money than about what is the best treatment for them if they were sick



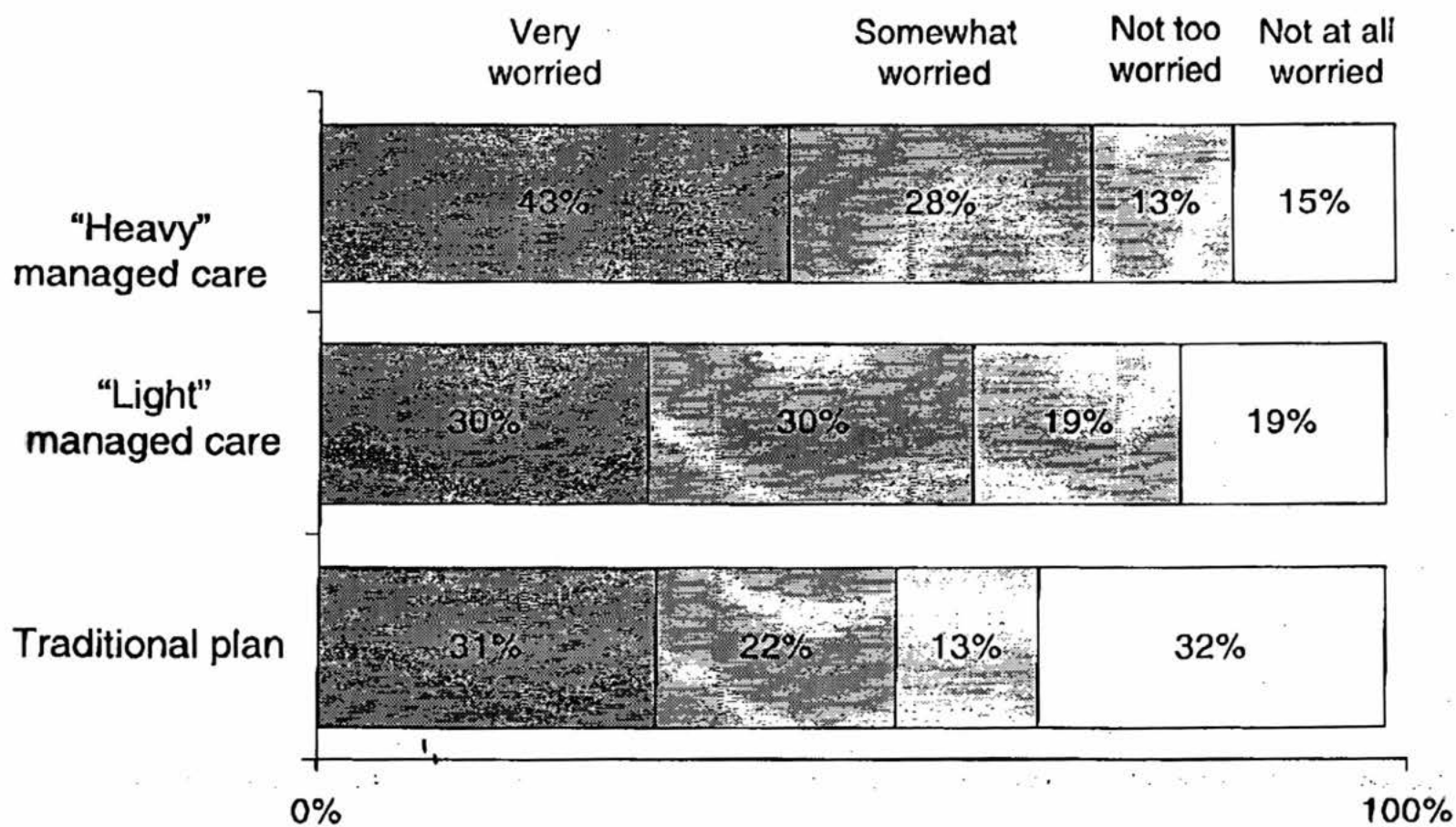
Note: Don't know not shown

Source: Kaiser/Harvard Survey of Americans' Views on the Consumer Protection Debate, September 1998 (conducted 8/98); Kaiser/Harvard National Survey of Americans' Views on Managed Care, November 1997 (conducted 9/97).

CHART 5

PEOPLE IN "HEAVY" MANAGED CARE PLANS MOST WORRIED ABOUT HOW HEALTH PLANS WILL TREAT THEM

Percent of insured Americans under 65 who say they are worried that their health plan would be more concerned about saving money than about what is the best treatment for them if they were sick...

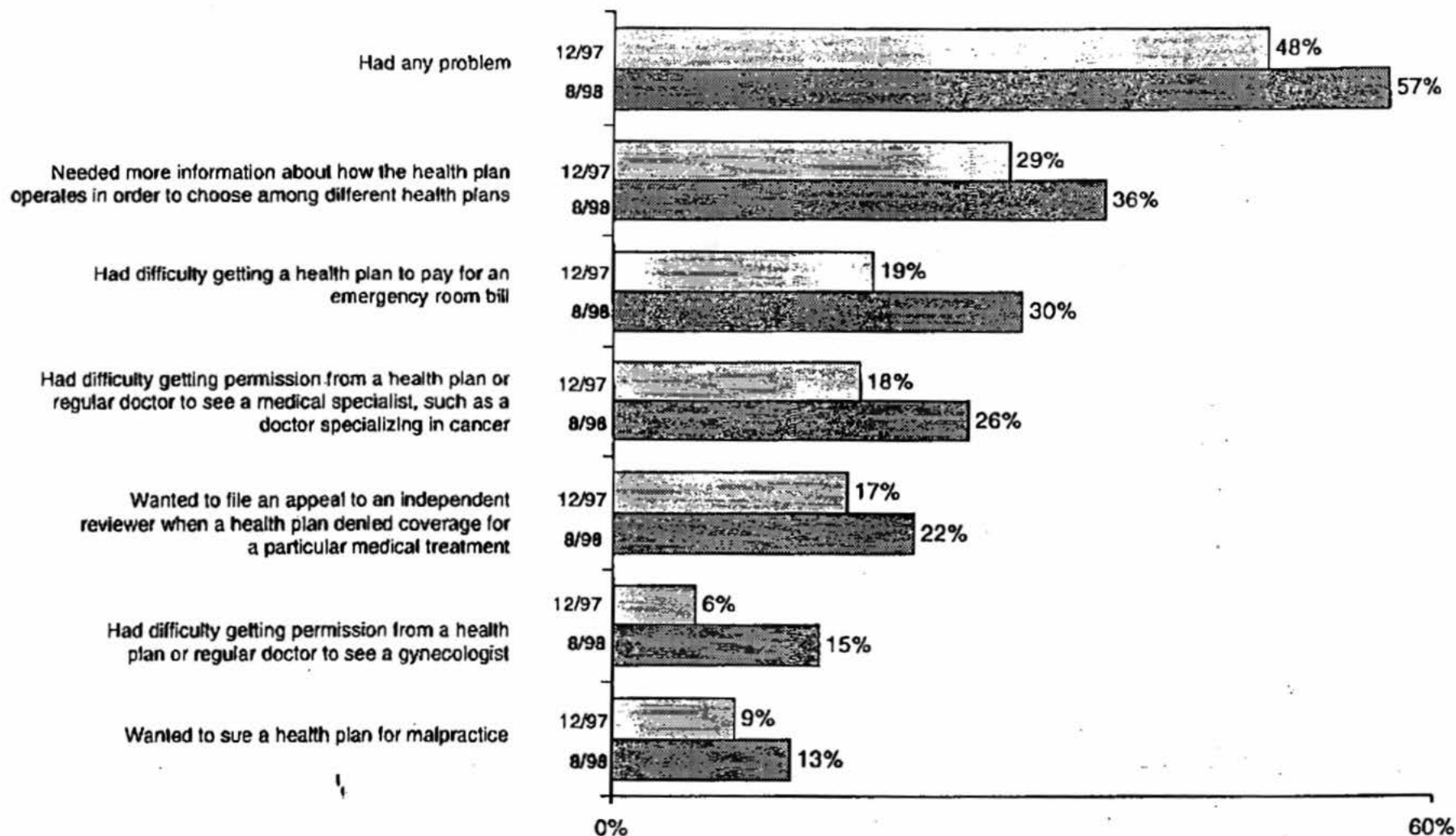


Note: Don't know not shown

Source: Kaiser/Harvard Survey of Americans' Views on the Consumer Protection Debate, September 1998 (conducted 8/98).

MORE PEOPLE REPORTING PROBLEMS WITH HEALTH PLANS

Percent of Americans who say during the past few years they or someone they know has...



Source: Kaiser/Harvard Survey of Americans' Views on the Consumer Protection Debate, September 1998 (conducted 8/98); Kaiser/Harvard National Survey of Americans' Views on Consumer Protections in Managed Care, January 1998 (conducted 12/97).

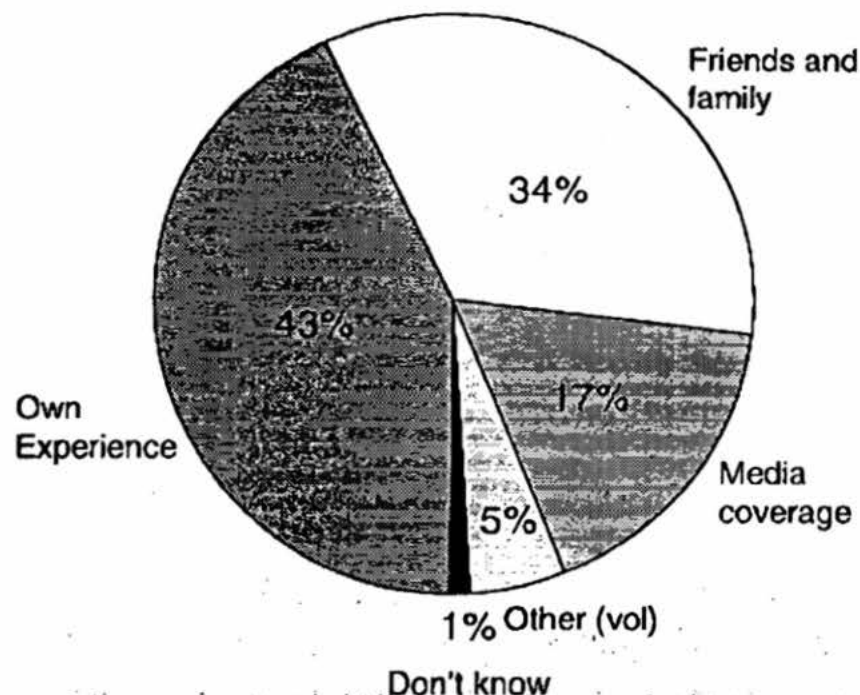
PAGE: 014/026

CHART 7

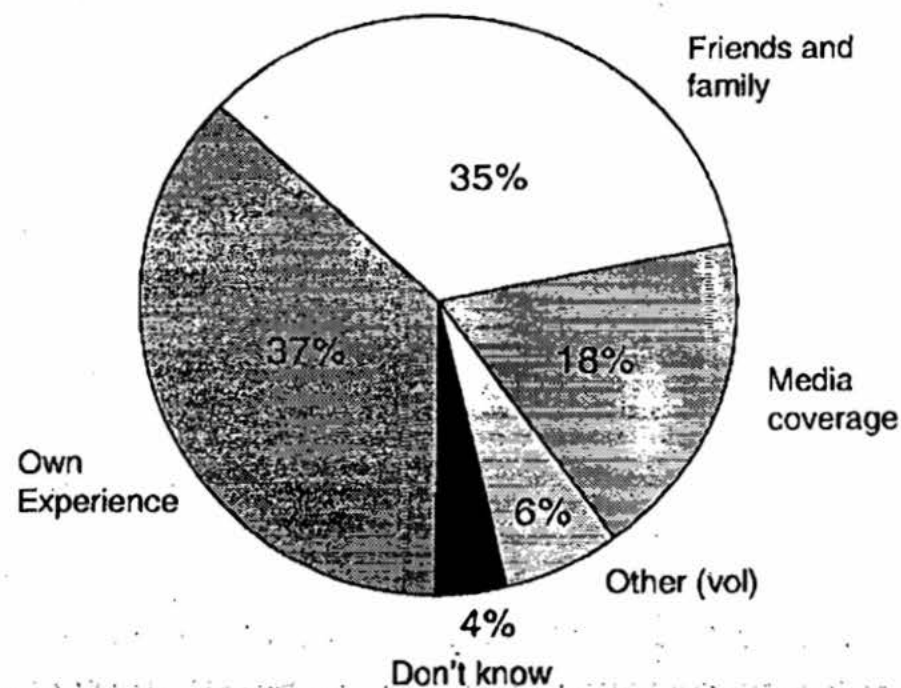
SHAPING PUBLIC VIEWS ON MANAGED CARE

Percent who say their views of HMOs or managed care are most influenced by...

Among those who think HMOs
do a bad job



Among those who think managed
care plans do a bad job



Note: VOL means response was volunteered by respondent, not an explicitly offered choice

Source: Kaiser/Harvard Survey of Americans' Views on the Consumer Protection Debate, September 1998 (conducted 8/98).

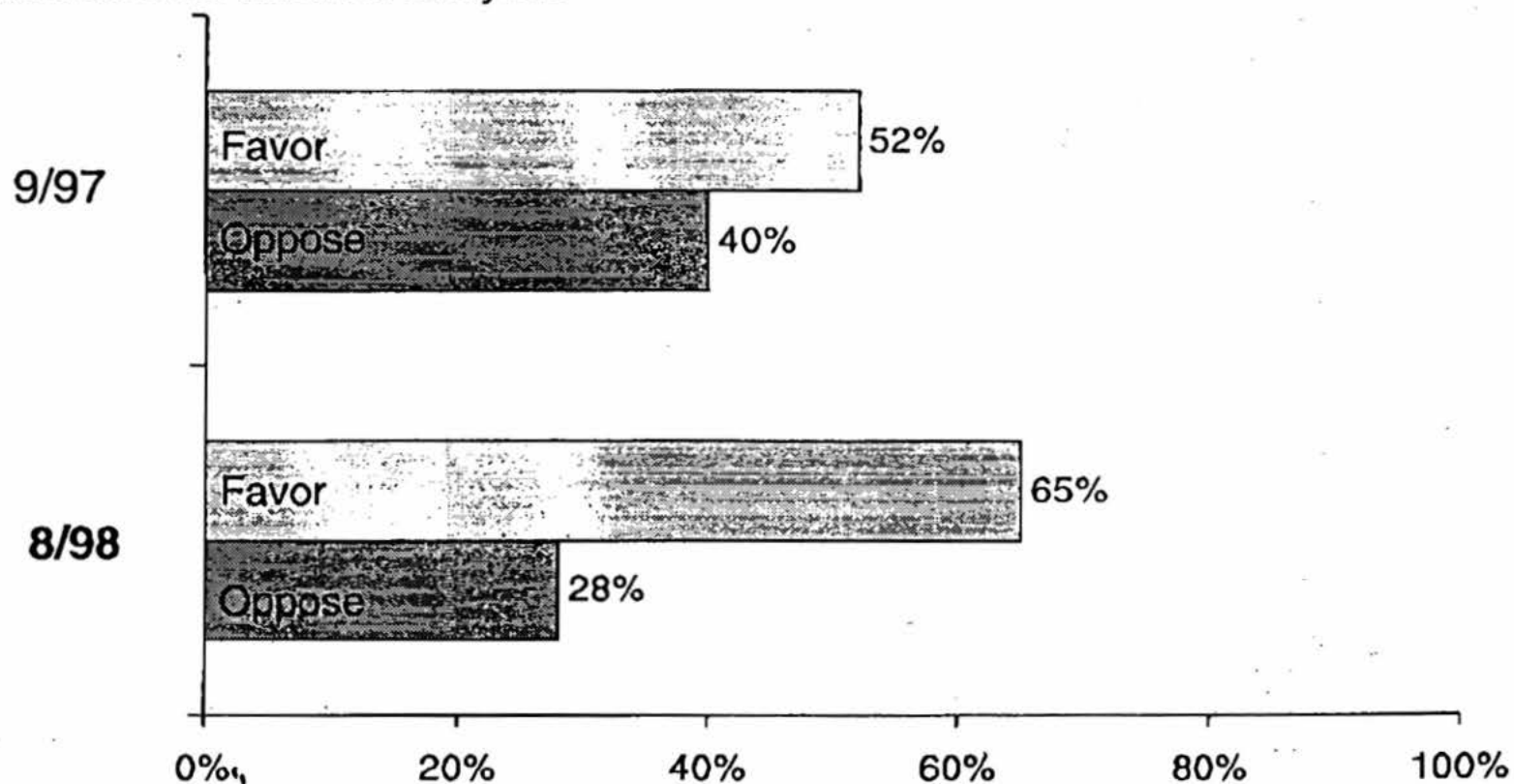
SEP-17-98 06:09 FROM: TO: 4565557

CHART 8

PUBLIC OPINION ON GOVERNMENT SPONSORED CONSUMER PROTECTIONS IN MANAGED CARE

Favor: "The government needs to protect consumers from being treated unfairly and not getting the care they should from HMOs and managed care plans"

Oppose: "Additional government regulation is a bad idea/it isn't worth it and would raise the cost of health insurance too much for everyone"



Note: Don't know not shown

Source: Preliminary data from new Kaiser/Harvard national survey of Americans (conducted 8/98); Kaiser/Harvard National Survey of Americans' Views on Managed Care, November 1997 (conducted 9/97).

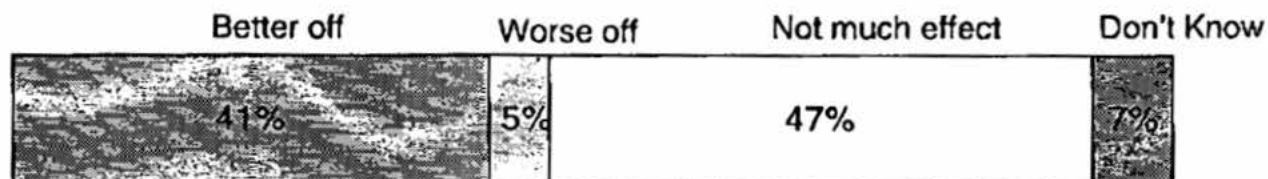
CHART 9

SUPPORT FOR CONSUMER PROTECTIONS, BUT COST MATTERS

Would you favor a law that would provide [a variety of consumer protections] ...?



If the law passed, do you think you and your family would be ...?



Would you still favor this law if it might raise premiums by \$200 a year ...?

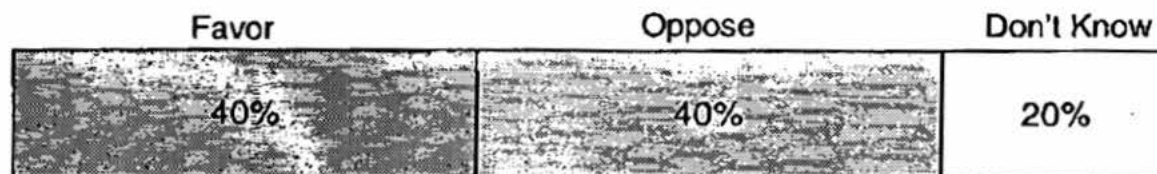
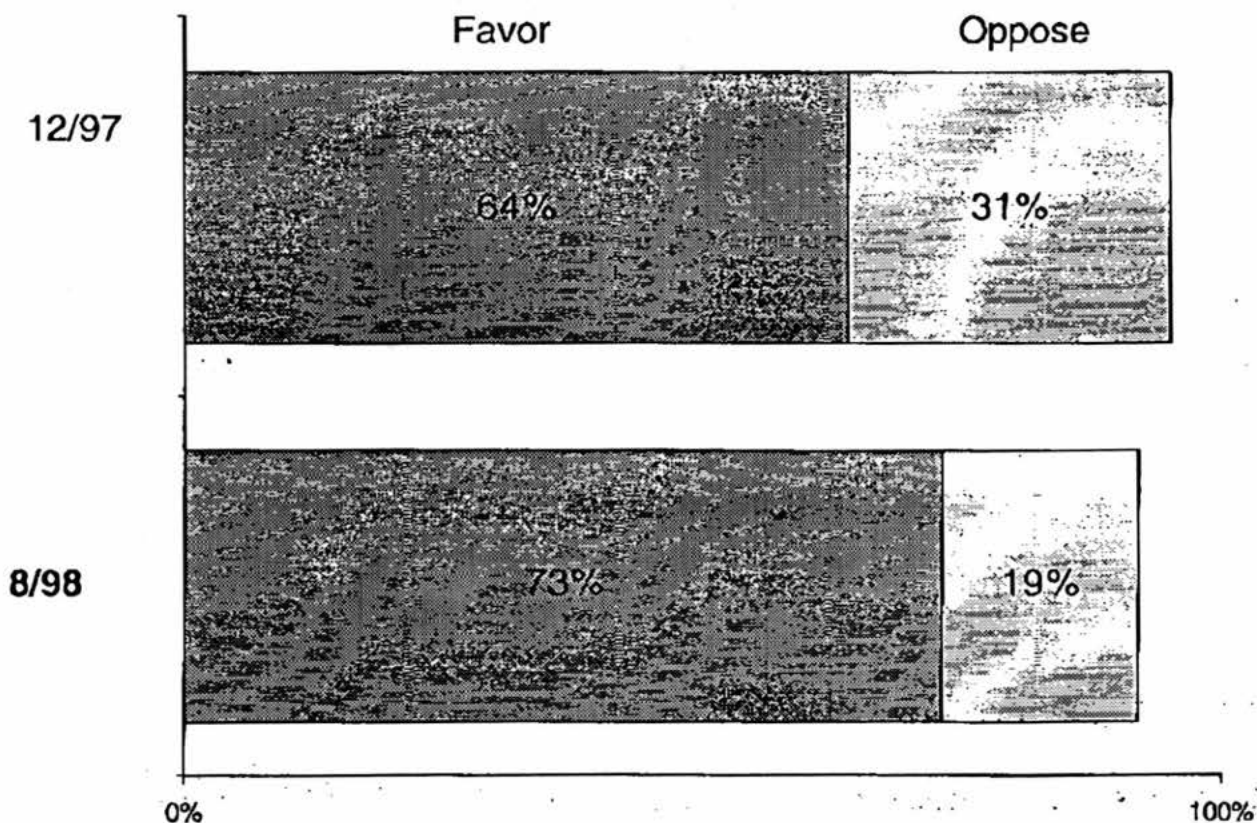


CHART 10

SUPPORT RISES FOR RIGHT TO SUE

Percent of Americans who say they would favor/oppose a law requiring health plans to allow patients to sue a health plan for malpractice, like they can now sue a doctor...



Note: Don't know not shown

Source: Kaiser/Harvard Survey of Americans' Views on the Consumer Protection Debate, September 1998 (conducted 8/98); Kaiser/Harvard National Survey of Americans' Views on Consumer Protections in Managed Care, January 1998 (conducted 12/97).

CHART 11

SUPPORT FOR PROVISIONS FALLS WHEN POTENTIAL CONSEQUENCES TALKED ABOUT

Percent of Americans who favor laws requiring health plans to...

		Basic Question	Cost Increase	Government Too Involved	Employers Drop Coverage
<i>Allow people to appeal to an independent reviewer...</i>	Favor	81	56	51	42
	Oppose	12	33	35	42
<i>Allow people to see a specialist...</i>	Favor	82	58	53	39
	Oppose	13	33	37	45
<i>Pay for an emergency room visit...</i>	Favor	78	60	55	42
	Oppose	15	29	34	41
<i>Allow people to sue health plan directly...</i>	Favor	73	54	49	41
	Oppose	19	35	37	44

Note: Don't know not shown

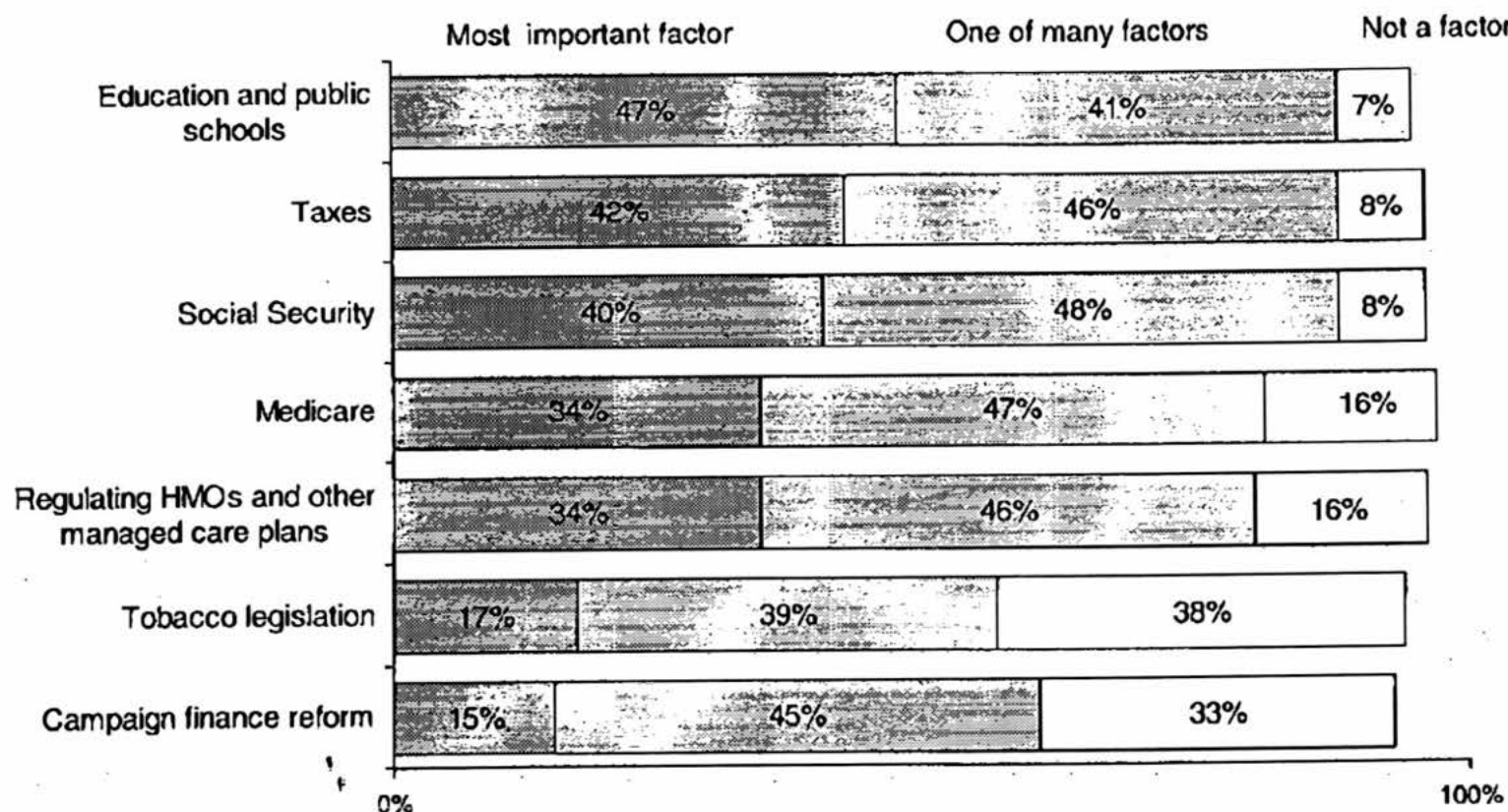
Source: Kaiser/Harvard Survey of Americans' Views on the Consumer Protection Debate, September 1998 (conducted 8/98).

II. POLITICS AND PATIENT RIGHTS

CHART 12

EDUCATION, TAXES, SOCIAL SECURITY TOP ISSUES IN UPCOMING ELECTION: MEDICARE AND REGULATING MANAGED CARE ALSO IMPORTANT

Percent of Americans who say a candidate's position on the following issues is the most important factor in their decision, one of many factors, or not a factor...



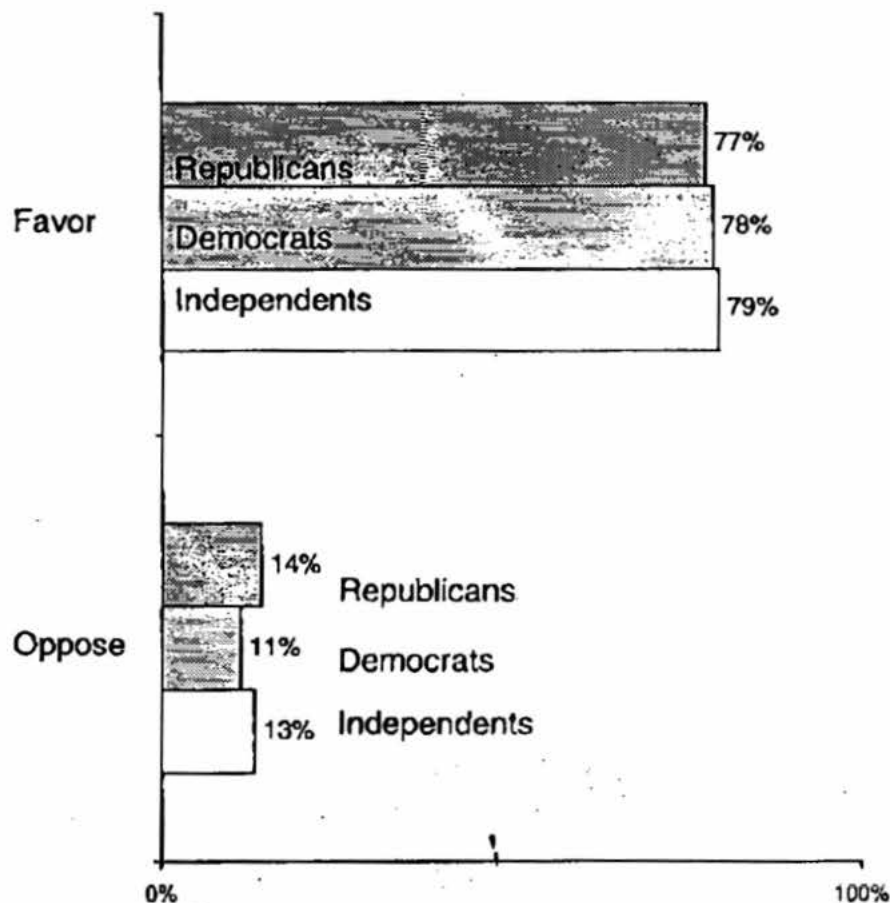
Note: Don't plan/not eligible to vote (vot) and don't know not shown

Source: Kaiser/Harvard Survey of Americans' Views on the Consumer Protection Debate, September 1998 (conducted 8/98).

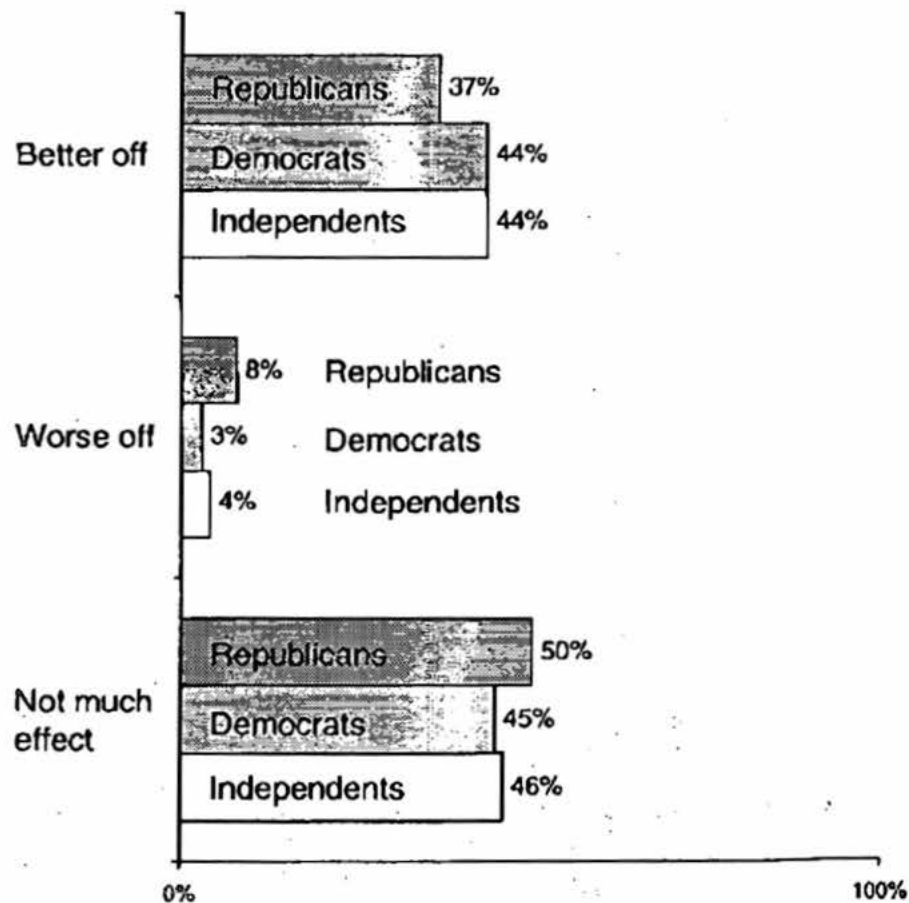
CHART 13

SUPPORT PERSISTS ACROSS PARTY LINES, BUT REPUBLICANS A BIT LESS LIKELY TO SEE PERSONAL BENEFIT FROM CONSUMER PROTECTIONS

Would you favor a law that would provide a variety of consumer protections ...?



If the law passed, do you think you and your family would be ...?



Note: Don't know not shown

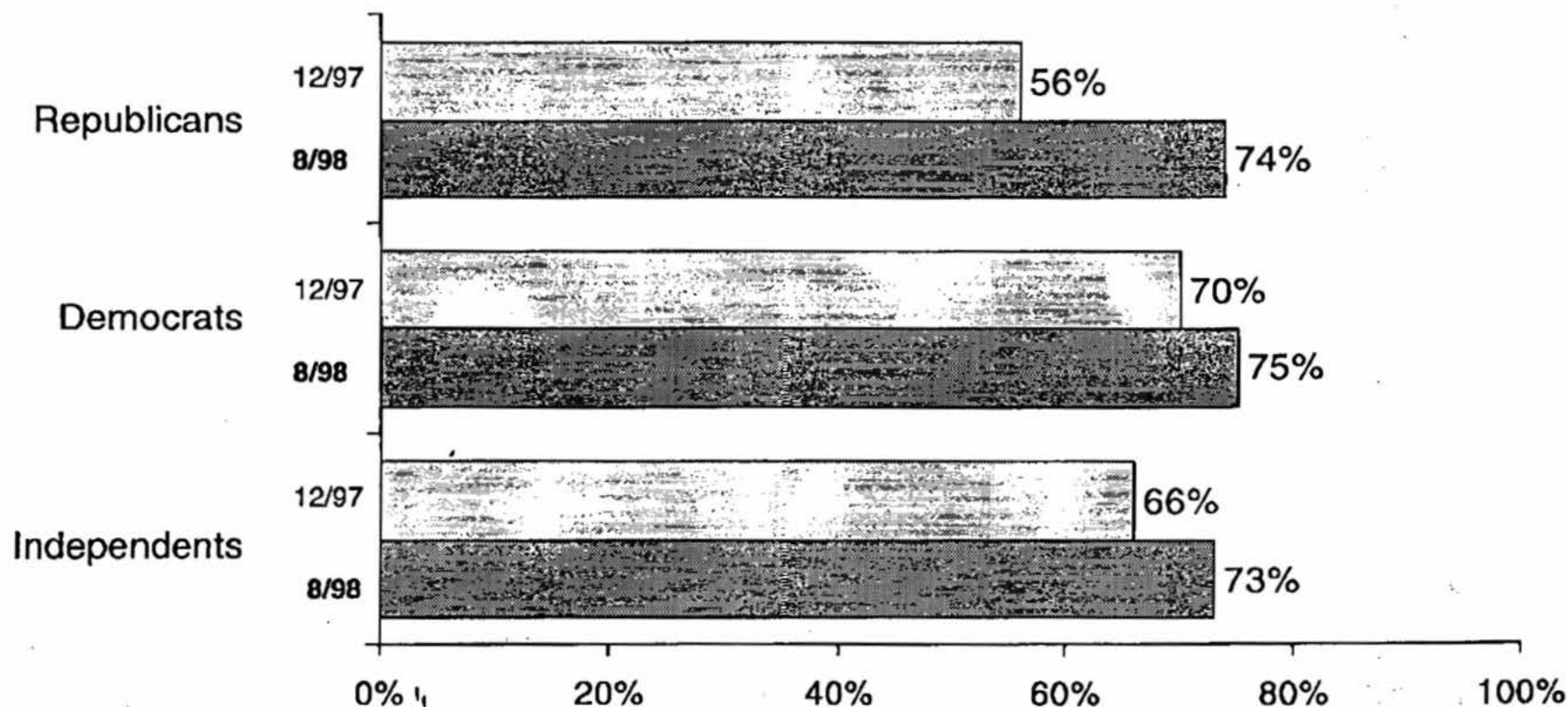
Source: Kaiser/Harvard Survey of Americans' Views on the Consumer Protection Debate, September 1998 (conducted 8/98).

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CHART 14

SUPPORT PERSISTS ACROSS PARTY LINES ON PATIENTS' RIGHT TO SUE A HEALTH PLAN

Percent of Americans, by political party, who say they would favor a law allowing patients to sue a health plan for malpractice, like they can now sue a doctor...



SEP-17-98 06:13 FROM:

Source: Kaiser/Harvard Survey of Americans' Views on the Consumer Protection Debate, September 1998 (conducted 8/98); Kaiser/Harvard National Survey of Americans' Views on Consumer Protections in Managed Care, January 1998 (conducted 12/97).

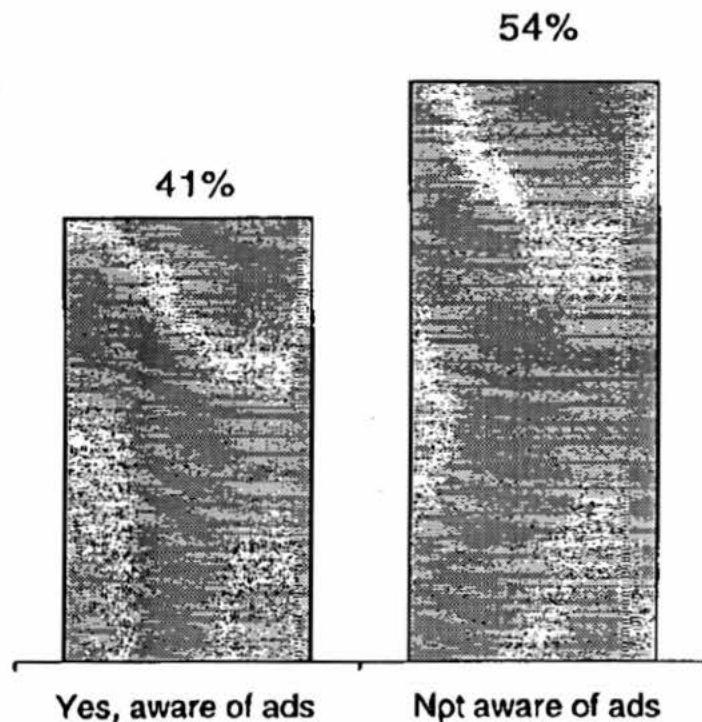
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TO: 4565557

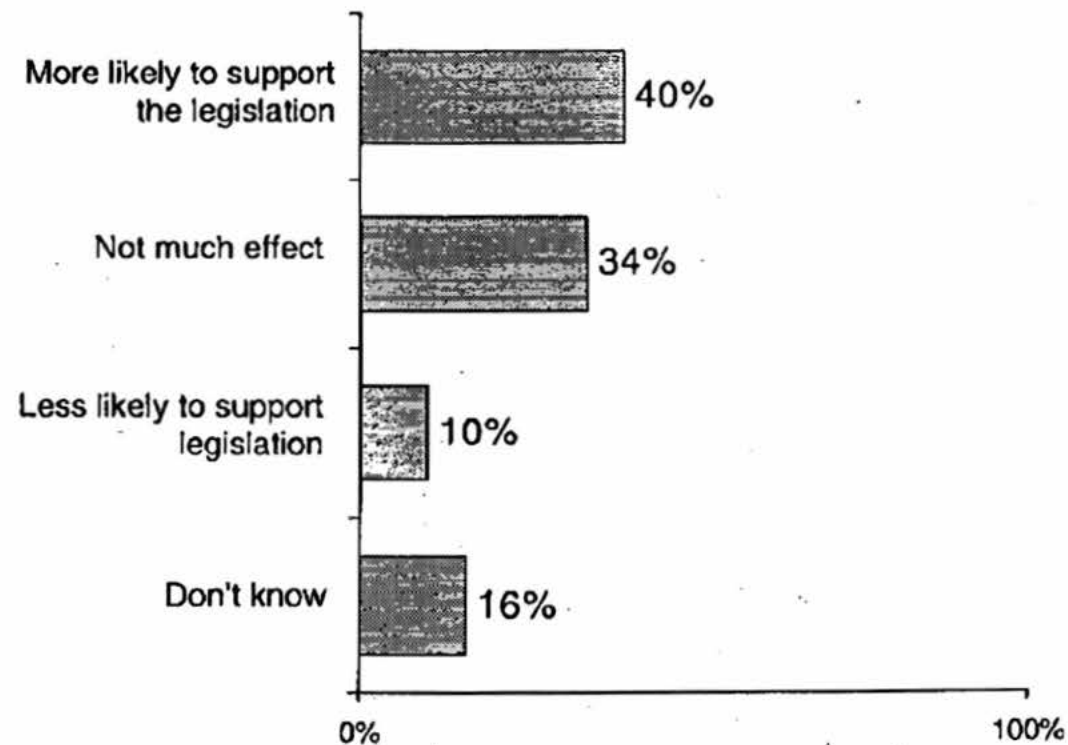
CHART 15

AMERICANS HAVE SEEN MORE ADS ABOUT DEBATE... AND IMPACT FAVORS SUPPORTERS

Percent of Americans who say in the past few months they have seen or heard of tv, radio, or other media ads about the proposed legislation to regulate health plans and protect consumers



Percent of people who were aware of the ads about proposed legislation to regulate health plans who say the ads have made them...



Note: Don't know not shown

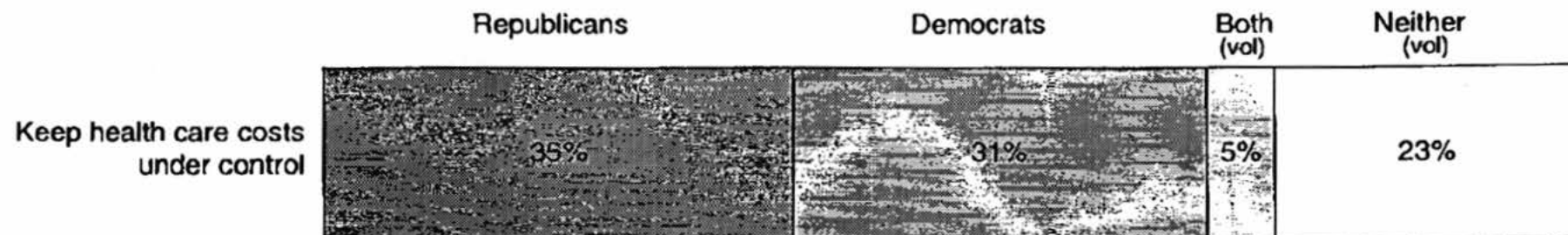
Source: Kaiser/Harvard Survey of Americans' Views on the Consumer Protection Debate, September 1998 (conducted 8/98).

SEP-17-98 06:14 FROM:

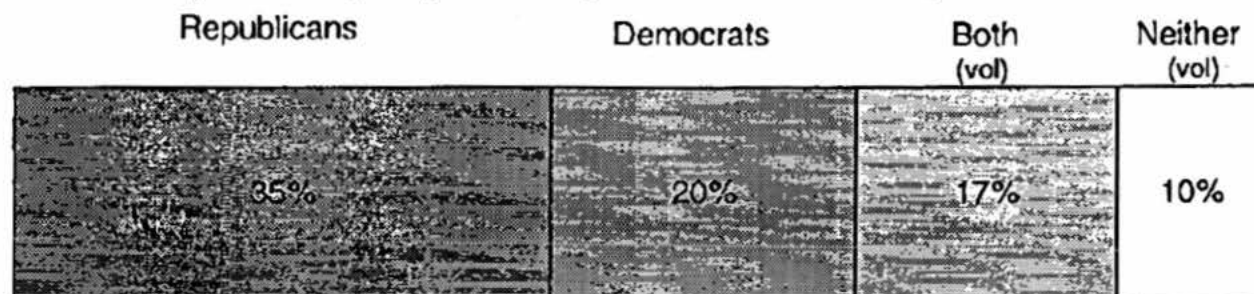
CHART 16

POLITICAL PARTIES AND MANAGED CARE

Percent of Americans who say they trust each political party more to...



If Congress doesn't pass legislation to regulate health plans and protect the rights of consumers, which political party would you hold most responsible?



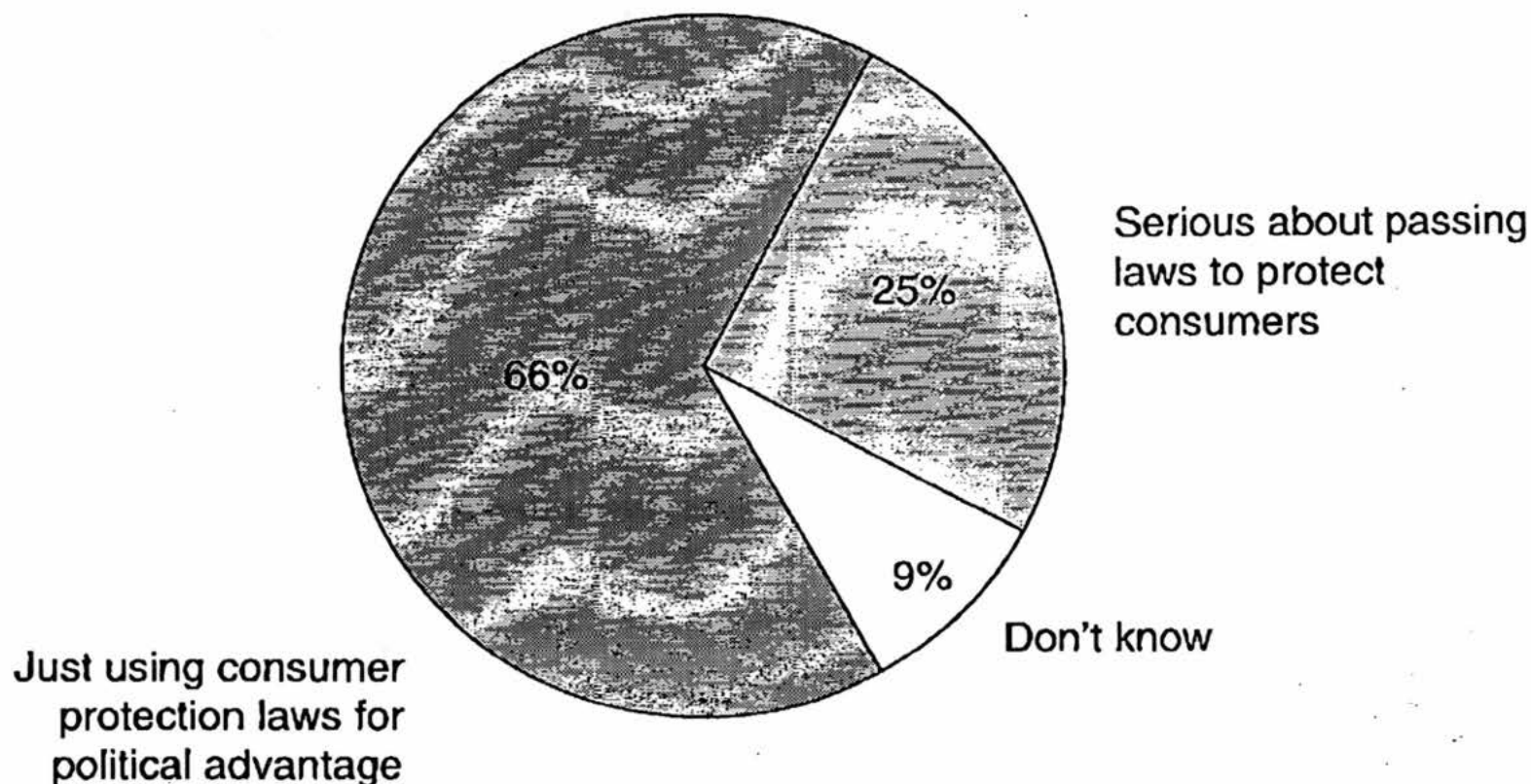
Note: Don't know not shown; VOL means response was volunteered by respondent, not an explicitly offered choice

Source: Kaiser/Harvard Survey of Americans' Views on the Consumer Protection Debate, September 1998 (conducted 8/98).

CHART 17

PUBLIC DOESN'T BELIEVE DEBATE ABOUT PATIENTS' RIGHTS IS FOR REAL

Percent of Americans who say members of Congress are...



Source: Kaiser/Harvard Survey of Americans' Views on the Consumer Protection Debate, September 1998 (conducted 8/98).



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St. Louis Post-Dispatch

June 26, 1998, Friday, FIVE STAR LIFT EDITION

SECTION: NEWS, Pg. A4

LENGTH: 1016 words

HEADLINE: GOP, DEMOCRATS PUSH HEALTH COVERAGE REFORM;
BOTH SIDES MAKE PITCHES FOR LEGISLATION TO CONTROL SOME POLICIES OF HMOS;
NOVEMBER ELECTIONS SPUR ACTION

BYLINE: Tim Poor; Post-Dispatch Washington Bureau

DATELINE: WASHINGTON

BODY:

Health-insurance reform was shoved to the back burner after President Bill Clinton's initiatives failed four years ago, but now it's steaming again on the political stove.

Heated by a growing public anger toward managed-care companies - and coming elections - politicians of both parties made high-profile pitches this week for health care legislation. They say they would rein in health-maintenance organizations and restore a more direct relationship between doctor and patient.

With little time left in this year's session, Congress may not pass sweeping regulations before it adjourns this year. But Democrats and Republicans both hope their proposals will help them win in the November elections.

In November, Clinton asked Congress for legislation guaranteeing patients a "consumer bill of rights." Provisions included the right of patients to seek emergency care, choose their own specialists, appeal coverage decisions to an outside panel, receive information on all treatment options regardless of cost and have their medical information kept confidential.

Congress passed those protections for Medicare patients. But Republican leaders were reluctant to require private health insurers to adopt the same standards. The U.S. Chamber of Commerce, the Health Insurance Association of America and Blue Cross Blue Shield said they would oppose writing the standards into law.

In a memo to aides, Senate Majority leader Trent Lott, R-Miss., called the initiatives "a Trojan horse for implementing the once-defeated Clinton health care plan." Lott urged health-insurance lobbyists to "get off your butts, get off your wallets" to help defeat legislation.

Clinton reiterated his support for legislation in his State of the Union message this year. House Democrats introduced a bill in March.

Their proposal would allow patients to choose doctors outside of those offered by their HMO and would require that patients have access to specialists. The bill would require health insurers to set up internal appeals boards made up of doctors to rule when patients disagreed with managed-care decisions. State

File:
Opposition
Patients'
Rights

ADMINISTRATION PRINCIPLES ON THE PATIENTS' BILL OF RIGHTS

- **The patients' bill of rights has been a longstanding priority for the President.** In 1996, the President called for the establishment of a bipartisan Quality Commission to examine the changing health care system. In March of 1997, he appointed the Commission and instructed them to develop a patients' bill of rights as their first order of business. In November, he endorsed the patients' bill of rights and called on Congress to make it the law of the land. In his State of Union address, he focused the nation on this issue and reiterated his call on Congress to pass this legislation. One month later, he issued an Executive Memorandum directing the Federal health plans overseeing 85 million Americans to implement the patients' bill of rights. Since that time, he has been ensuring that the Federal agencies are implementing these protections and reiterating his call on Congress to pass legislation this year.
- **Any patients' bill of rights should contain a range of federally-enforceable protections.** These include: guaranteed access to needed health care specialists; access to emergency room services when and where the need arises; continuity of care protections to assure patient care will not abruptly change if their provider is dropped; access to a timely internal and independent external appeals process for consumers to resolve their differences with their health plans; a limit on financial incentives to doctors; assuring that doctors and patients can openly discuss treatment options; assuring that women have direct access to an OB-GYN.
- **Any bill of rights should include an enforcement mechanism that ensures recourse for patients who have been maimed or who have died as a result of health plan actions.** A right without a meaningful remedy is simply not a right.

The House Republican Proposal is Designed Address Their Political Problems -- Not Patient Concerns. The fact that Republicans have yet to introduce a bill with less than 37 days left raises serious questions as to whether they are truly committed to passing a bill of rights or selling a bill of political goods to the American public. The Republican proposal falls short in many areas. For example, it does not include:

- **Access to specialists.** We have continually heard about cancer patients who are denied access to an oncologists. Assuring access to needed specialists is an absolutely essential protection.
- **Financial incentives for doctors.** Patients should not be put at risk through unknown destructive financial incentives to limit patient care.
- **Continuity of care protections.** This protection assures some of the most vulnerable patients -- include pregnant women or people with disabilities -- that their care will not change abruptly if their provider is unexpectedly dropped from a health plan.
- **A strong, workable enforcement provision** that is essential to ensure that these protections are real. We strongly believe that a right is simply not a right without a remedy.
- **Poison pill provisions.** The House Republican proposal also includes a number of poison pill provisions that are apparently designed to kill this legislation. Congress explicitly rejected these provisions as late as last year, and they have nothing to do with the patients' bill of rights. These include:
 - Medical malpractice caps that impose arbitrary caps that preempt state laws' enforcement of medical malpractice that even the AMA says should not be in this bill;
 - Multi employer welfare associations that could increase premiums for businesses and employees, undermine the insurance market, and are opposed by consumers, insurers, providers, and governors.
 - Expansion of untested Medical Savings Accounts that help the healthy at the expense of the sick.

The President Remains Committed to Passing a Strong Enforceable Patients' Bill of Rights in This Congress. Notwithstanding his concerns, he will work to pass a strong enforceable patients' bill of rights this year.

Q&As on Patients' Bill of Rights

Q: What is the Administration's response to the patients' bill of rights proposal unveiled by the House Republicans?

A: President Clinton has been calling on this Congress to pass a patients' bill of rights for eight months, so that crucial medical decisions will be made by doctors, not accountants. We welcome the fact that the House Republicans have finally entered this debate by announcing their intention to introduce legislation on this issue. Their long-overdue announcement explicitly affirms the President's longstanding position that Federal legislation is needed.

However, the fact that Republicans have yet to introduce a bill with less than 37 days left raises serious questions as to whether they are truly committed to passing a patients' bill of rights or selling a bill of political goods to the American public.

Moreover, from what we have seen on the Republican proposal, it seems as if they are trying to address their political problems rather than patient concerns. For example, it does not guarantee patients access to the specialists they need, such as heart specialists or oncologists. It does not include limits on financial incentives for doctors to limit patient care, and it does not ensure continuity of care -- so that vulnerable patients will not have their care changed abruptly if their provider is dropped from a health plan. It does not include strong remedies for people who are seriously injured or who die because a health care plan wrongly denied them care.

In addition, the Republican proposal includes poison pill provisions, such as multi employer welfare arrangements (MEWAs), arbitrary caps on medical malpractice awards that supersede state laws, and medical savings accounts. These provisions are apparently designed to stall the progress on a patients' bill of rights.

Without important protections and with added poison pills, the Republicans' patients' bill of rights is nothing more than a bill of goods. However, the President remains committed to working together to pass a strong, bipartisan bill before this Congress adjourns.

Background: Important patient protections that are not included in the Republicans' patients' bill of rights and poison pill provisions, include:

- **Access to specialists.** Again and again we have heard about cancer patients who are denied access to an oncologist. Assuring access to needed specialists is absolutely essential protection.
- **Financial incentives for doctors.** Patients should not be put at risk through unknown destructive financial incentives to limit patient care.



Statement on the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry

by House Majority Leader Dick Armey

November 20, 1997

Today House Majority Leader Dick Armey made the following comment on the recommendations of the President's hand-picked Advisory Commission on Consumer Protection and Quality in the Health Care Industry:

Related Links

[Response to Calls for Increased Health Care Regulation](#)

[Health Care Quality: Bureaucracy or Consumer Choice](#)

[Armey Responds to the President's Initiative](#)

[ClintonCare 1993 Bureaucracy Chart](#)

[Moral Equivalent of War 1993 memo](#)

[The Health Care Section of the Library](#)

"The President's new crusade reminds me of the old adage, if you don't learn from your mistakes you are bound to repeat them. The President refuses to accept that America rejected the substance of ClintonCare in 1993, not just its presentation.

"The President has publicly vowed to keep trying to enact his 1993 health care plan. And this sweeping regulatory regime he has endorsed today is a giant leap toward government-run health care.

"Like a typical Washington commission, the President's advisors responded to families' frustrations with managed care rules and regulations by proposing a deluge of new rules and regulations.

"Competition and choice are the answer to families' frustrations. In today's rapidly evolving health care market, the number of choices available to families has mushroomed. Families shopping for quality and value are voting with their feet, and forcing health plans to become more consumer-friendly. The regulations proposed by the commission would stop that market evolution in its tracks. Families would have fewer choices and insurers would have less incentive to serve families better."

Armey's [1993 memo](#) that led to the defeat of ClintonCare, and his recent [memo revealing the President's strategy to try again](#), are available on the Internet at freedom.house.gov.

"The President's new crusade reminds me of the old adage, if you don't learn from your mistakes you are bound to repeat them."

-- House Majority Leader Dick Armey responds to the president, 11/20/97

Healthcare Quality: First, Do No Harm

May 6, 1998



Related Links

[Armey Responds to the President's Healthcare Initiative](#)

[Healthcare Quality: First, Do No Harm](#)

[On the President's Call for Increased Health Care Regulation](#)

[Socialized Medicine on the Installment Plan](#)

[Reason 10 to Oppose the Clinton Health Bill](#)

Today, House Majority Leader Dick Armey introduced H. Con. Res. 272, expressing the sense of the House on health care quality. Below is Armey's floor statement outlining the resolution and its purpose.

Mr. Speaker,

Today I am introducing a resolution on health-care quality. It expresses the sense of the House that Congress should not pass any legislation that:

- ☐ Makes health insurance unaffordable.
- ☐ Swells the ranks of the uninsured.
- ☐ Diverts scarce health resources to lawyers and bureaucrats.
- ☐ Or imposes political considerations on medical practice, such as so-called body-part mandates.

The resolution is needed to remind us our first duty is to "do no harm," and thus not to pass any so-called "quality" bill that would in fact do serious harm to the quality of patient care. I am thinking of bills like the White House-Democrat Leadership "Patient Bill of Rights Act," a bill that would have the perverse effect of eliminating every kind of managed-care plan except restrictive HMOs, enable nurses and doctors to go on strike, and drive up premiums and drive down coverage by letting trial lawyers sue health plans for malpractice. Worst of all, this liberal dream bill would let HHS bureaucrats define "medical necessity," which is as good as giving them power over life and death. It is an audacious step toward Clintoncare.

I am the first to acknowledge the serious flaws in today's health-care system. While America leads the world in excellent medical drugs, devices, and doctors, and while insurance plans are improving every day thanks to market forces, the fact is we have real problems in our health system.

- ☐ Government policy, both state and federal, makes insurance unaffordable for millions.
- ☐ The tax break for health insurance discriminates against the unemployed and small-business workers.
- ☐ Many employers offer their workers no real choice of plans or doctors.

And of course we have all heard about the bad health plans, the ones that deny services in violation of contract, or that let remote bureaucrats with cook books impose medical decisions over the advice of trained, on-site health professionals. I do not know how many of these accusations are true, but even one is too many if it is true and preventable. So this problem demands our serious attention.

But in trying to improve, we have an obligation not to destroy. We should serve the good of patients and consumers, and not the financial interests of certain industries or trade associations. Above all, we should not assist President Clinton in his openly acknowledged scheme to socialize our health system step by step.

In passing this resolution, the House would be going on record in favor of legislation that promotes rather than degrades quality. It is identical to a resolution by Senator Nickles of Oklahoma that recently passed the Senate by a vote of 98 to zero. Even Senator Kennedy voted for it, reluctantly. I want us to approve the Nickles resolution in the House, so that we may not be outdone in our zeal for good by our distinguished colleagues across the Rotunda.

Thank you, Mr. Speaker.

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Freedom Works: Home Page of the Office of the House Majority Leader

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MEMORANDUM

June 25, 1998

TO: Rahm Emanuel
FR: Chris Jennings
RE: Patient's Bill of Rights Status

This memo responds to your request for an up-to-the-moment status report on the Republican Leadership's Patients' Bill of Rights. It also outlines positioning options for the President's and your consideration vis a vis the bill in general and the enforcement provisions more specifically.

House Republican Bill of Rights and Our Response To It. The reaction to the Republican House Leadership's announcement of their intention (they have provided no details) to introduce a Patients' Bill of Rights has been almost universally negative. The base Democrats, the consumer advocates, and the providers have labeled it a "sham;" the insurers and big business community are criticizing it as overly regulatory. Notwithstanding the positioning nature of these reactions, it is remarkable how far the Republicans apparently have moved toward the President's position.

With the exception of the access to specialist/out-of-network referral, continuity of care, and requirement for financial disclosure provisions, the House Republicans appear to have included virtually every one of the consumer protections recommended by the President's Quality Commission. They have even (reportedly) included a Federal Court-enforced remedies provision that reportedly has a damages cap of between \$100,000 and \$250,000. Less than two months ago, many conservative Democrats and most Republicans would have labeled the current Republican plan as something between excessively regulatory and a Government takeover of the health care system. In fact, just 4 months ago, the President's Quality Commission would not even touch the issue of enforcement. The political ground has obviously shifted dramatically.

Administration Reaction of Republican Proposal. We have taken the position that the Republican proposal both affirms the President's longstanding position that strong, Federal, and enforceable legislation is needed and confirms (through their bill's provisions or lack thereof) that the Republican Leadership is not serious. In short, we say that any bill without all of the Quality Commission's protections and a strong enforcement provision is nothing more than a "bill of goods." We also charge that any bill that piles on "poison pill" provisions (like MEWAs, arbitrary caps for medical malpractice, and MSAs) is designed to kill, rather than enhance, the chances of an acceptable bill emerging. We will find out how or if the Republicans respond to our criticism when they introduce a bill -- which will not happen before until after the July 4th recess.

The Dingell/Ganske/Kennedy Bill and Democratic Positioning. The Democratic Leadership and base Members have been even more critical of the Republican plan than us. Their bill starts with more provisions than were recommended by the Quality Commission and, particularly in the absence of CBO cost estimates for their bill, they are extremely comfortable criticizing the much less comprehensive Republican plan.

The Democratic plan builds on the Quality Commission's recommendations by adding, among other provisions, requirements for ERISA remedies, a medical necessity provision (that prohibits any insurer from denying coverage for any service that a physician deems is medically necessary), mandatory clinical trial coverage, mandatory 48-hour hospital coverage following a mastectomy, mandatory coverage for breast reconstruction following a mastectomy, required access to prescription drugs that are not on a plan's formulary if a doctor deems necessary, and a "whistleblower" provision, which protects health professionals against retribution if they report and document quality problems. Although most of these provisions are generally defensible policy and certainly politically attractive, they do add costs (at least 2 percent higher premiums than the Quality Commission's recommendations.)

Congressional Budget Office (CBO) Estimate. The next big hurdle for the Democrats will be next Wednesday's or Thursday's expected release of the CBO premium estimates of the Dingell/Ganske bill. We anticipate that the premium will be projected to increase by about 4 percent for the average employee, which amounts to about \$6 a month. We are working on a positive roll-out strategy for this estimate, using it to buttress our claim that the benefits of any such legislation are more than worth the modest cost. If all agree in the White House and he is available, we might want to have the Vice President announce the generally good-news estimate during this Congressional recess period.

The Republican (and the insurer and big business) response to the CBO estimate will be swift and critical. They will cite overall health care expenditure increases (that will amount to billions of dollars, although a small fraction of the nation's trillion dollar health expenditures base) and flawed coverage loss projections (probably in the neighborhood of 200,000 to 2 million Americans.) It is important to point out that the likely CBO cost estimate for the Republican bill will be much lower than the Dingell bill -- about one fourth of it (1 percent). If the opponents cost and coverage argument takes hold, it could seriously impede the momentum that the Patient Bill of Rights now enjoys. We are currently in the process of working on a strong, message document, as well as some Qs & As, to prepare for the release of the CBO document.

"Blue Dog" Democrats Could Create Difficulty. Finally, it is important to note that some "blue-dog" House Democrats may seriously consider joining up with the Republicans when and if their bill goes to the floor. They are generally most influenced by the small business lobby and the Republican bill has received its only real support from the NFIB. Similarly, the Senate is populated by numerous Democrats who are and always will be uncomfortable with standing by Senator Kennedy. As a consequence, if the Senate Republicans feel pressured to develop their own Patients' Bill of Rights (and Chafee is now drafting a bill), there may be a number of Democrats who could sign on, particularly if the "poison pill" provisions are dropped and a few more patients' protections are added on.

Enforcement/Liability/Remedies Provision.

Clearly, because of the popularity of HMO regulation, it is probable that a consensus can be achieved on most if not all of the traditionally-desired patient protections. Decisions on what protections make it in will be linked to two variables: CBO cost estimates and perceived political pain associated with opposition to popular provisions. With the possible exception of some of the "poison pill" provisions mentioned earlier, the only seemingly apparent "line-in-the-sand" issue that could define the difference between Republicans and Democrats might be the issue of need for strong remedies for those aggrieved parties that have suffered serious health consequences or death because a health plan wrongly denied care.

To date, the Administration has consistently stated that this legislation must include a strong enforcement provision -- that a "right without a remedy is no right." To provide us with some flexibility and consistent with our directions from senior staff, we have never locked ourselves into a particular approach.

Both the Dingell-Ganske and the Norwood bills include state-court enforced liability provisions. Simply stated, the bills explicitly clarify that the Employee Retirement Income Security Act (ERISA) would no longer pre-empt or supersede state laws that provide for a right of action against a health plan that has denied care to a patient. Without this provision, the only current remedy a patient can obtain through ERISA law is payment for the cost of the benefit he or she should have had. In other words, for the 122 million Americans in ERISA covered plans, patients cannot get any compensation for treatment costs, pain and suffering, or lost wages.

Current Law Example: A doctor orders a cancer screening test for a patient he thinks might have breast cancer, but the plan denies coverage. The patient, as a consequence, does not take the test, but 6 months later comes back with a more noticeable lump. The doctor orders the test and, this time, the HMO pays for it. He finds the patient has a cancer that has spread throughout her body and that it is now untreatable. He and his patient are devastated because they know that, had they had the test results 6 months earlier, they could have successfully treated the cancer. Now the patient must undergo a radical mastectomy and, even with that, her survival odds are very low. She is furious and asks her lawyer to sue the HMO. Her lawyer tells her she can, but it really isn't worth the trouble since the only thing she can get compensated for under the law is the cost of the original cancer screening test. She can collect no damages to pay for the mastectomy, the chemotherapy and any other treatment her doctor may order to save her life. She gets no compensation for the lost wages from the job she must leave and she gets no enumeration for all the pain and suffering she is going through as a consequence of her HMO denying her treatment.

Fears of Business and Labor (Taft-Hartley) Community. The prospect of opening up health plans to law suits at the state level petrifies both the business and the Taft-Hartley plans. (Labor has been quiet to date because it is poor P.R., and would hurt our chances of passing a good bill.) They fear that the trial lawyers will ride jump herd over their plans and that costs will balloon (in terms of lawsuit settlements and/or because their health plans will be so nervous that they will stop making even appropriate denials).

Notwithstanding the fears of the liability of these provisions, however, the preliminary (not for attribution) projections from CBO seem to assume that the existence of a state-based right of action would increase premiums by only about 1 percent, about one-fourth the total premium hike projected for the Dingell-Ganske bill. (This figure will not be released by CBO until after their first analysis has been circulated next Wednesday or Thursday.) CBO believes that most of the suits are now being directed at doctors and that any new suits against managed care plans would generally substitute for -- not add onto -- what is already out there. The business and labor community strongly believe that state-enforced liability would amount to much more than that and have been actively lobbying CBO to increase their estimate. The business community is projecting 10-30 percent premium increases and many will threaten to drop coverage altogether. Regardless of the true number, the opponents will pull out all of the guns to stop this provision from becoming law. They not only fear this provision in this context, but they are petrified it sets a precedence for all private employer benefits (e.g. pensions) now protected by ERISA to become vulnerable to lawsuits from aggrieved employees.



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Statement on the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry

by House Majority Leader Dick Armey
November 20, 1997

Today House Majority Leader Dick Armey made the following comment on the recommendations of the President's hand-picked Advisory Commission on Consumer Protection and Quality in the Health Care Industry:

Related Links

[Response to Calls for Increased Health Care Regulation](#)

[Health Care Quality: Bureaucracy or Consumer Choice](#)

[Armey Responds to the President's Initiative](#)

[ClintonCare 1993 Bureaucracy Chart](#)

[Moral Equivalent of War 1993 memo](#)

[The Health Care Section of the Library](#)

"The President's new crusade reminds me of the old adage, if you don't learn from your mistakes you are bound to repeat them. The President refuses to accept that America rejected the substance of ClintonCare in 1993, not just its presentation.

"The President has publicly vowed to keep trying to enact his 1993 health care plan. And this sweeping regulatory regime he has endorsed today is a giant leap toward government-run health care.

"Like a typical Washington commission, the President's advisors responded to families' frustrations with managed care rules and regulations by proposing a deluge of new rules and regulations.

"Competition and choice are the answer to families' frustrations. In today's rapidly evolving health care market, the number of choices available to families has mushroomed. Families shopping for quality and value are voting with their feet, and forcing health plans to become more consumer-friendly. The regulations proposed by the commission would stop that market evolution in its tracks. Families would have fewer choices and insurers would have less incentive to serve families better."

Armey's 1993 memo that led to the defeat of ClintonCare, and his recent memo revealing the President's strategy to try again, are available on the Internet at freedom.house.gov.

"The President's new crusade reminds me of the old adage, if you don't learn from your mistakes you are bound to repeat them."

-- House Majority Leader Dick Armey responds to the president, 11/20/97

Healthcare Quality: First, Do No Harm

May 6, 1998



Related Links

[Arney Responds to the President's Healthcare Initiative](#)

[Healthcare Quality: First, Do No Harm](#)

[On the President's Call for Increased Health Care Regulation](#)

[Socialized Medicine on the Installment Plan](#)

[Reason 10 to Oppose the Clinton Health Bill](#)

Today, House Majority Leader Dick Arney introduced H. Con. Res. 272, expressing the sense of the House on health care quality. Below is Arney's floor statement outlining the resolution and its purpose.

Mr. Speaker,

Today I am introducing a resolution on health-care quality. It expresses the sense of the House that Congress should not pass any legislation that:

- ☐ Makes health insurance unaffordable.
- ☐ Swells the ranks of the uninsured.
- ☐ Diverts scarce health resources to lawyers and bureaucrats.
- ☐ Or imposes political considerations on medical practice, such as so-called body-part mandates.

The resolution is needed to remind us our first duty is to "do no harm," and thus not to pass any so-called "quality" bill that would in fact do serious harm to the quality of patient care. I am thinking of bills like the White House-Democrat Leadership "Patient Bill of Rights Act," a bill that would have the perverse effect of eliminating every kind of managed-care plan except restrictive HMOs, enable nurses and doctors to go on strike, and drive up premiums and drive down coverage by letting trial lawyers sue health plans for malpractice. Worst of all, this liberal dream bill would let HHS bureaucrats define "medical necessity," which is as good as giving them power over life and death. It is an audacious step toward Clintoncare.

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- ☐ Government policy, both state and federal, makes insurance unaffordable for millions.
- ☐ The tax break for health insurance discriminates against the unemployed and small-business workers.
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And of course we have all heard about the bad health plans, the ones that deny services in violation of contract, or that let remote bureaucrats with cook books impose medical decisions over the advice of trained, on-site health professionals. I do not know how many of these accusations are true, but even one is too many if it is true and preventable. So this problem demands our serious attention.

But in trying to improve, we have an obligation not to destroy. We should serve the good of patients and consumers, and not the financial interests of certain industries or trade associations. Above all, we should not assist President Clinton in his openly acknowledged scheme to socialize our health system step by step.

In passing this resolution, the House would be going on record in favor of legislation that promotes rather than degrades quality. It is identical to a resolution by Senator Nickles of Oklahoma that recently passed the Senate by a vote of 98 to zero. Even Senator Kennedy voted for it, reluctantly. I want us to approve the Nickles resolution in the House, so that we may not be outdone in our zeal for good by our distinguished colleagues across the Rotunda.

Thank you, Mr. Speaker.

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Freedom Works: Home Page of the Office of the House Majority Leader

freedom
works 

After four months of discussion, deliberation and debate, our Working Group on Health Care Quality will today unveil our plan to protect patients without big government.

Our package delivers in three key areas:

- accessibility***, so millions more Americans receive health care coverage;
- affordability***, so people can purchase health care that best fits their needs; and,
- accountability***, so patients are guaranteed to receive the care they need.

Most importantly, we add needed patient protections to ensure health plans keep the promises they made to their patients.

Accessibility:

- **Ensuring Point of Service** will allow patients new avenues to health care coverage where quality and choice are unavailable.

Providing Direct Access for OB/GYN will allow women the opportunity to bypass the health plan's bureaucracy and go directly to their provider.

Providing Direct Access to Pediatricians will guarantee families peace of mind that their child's pediatrician is the primary care physician.

Affordability:

Creating Association Health Plans will provide avenues so small businesses can pool together for their employees to enjoy the kinds of coverage afforded in big businesses.

Creating HealthMarts will increase consumer choice by serving as a cooperative group marketplace where working families may choose from a menu of benefit options.

Creating Community Health Center Networks will promote expansion of health coverage to all patients within their communities.

Expanding Medical Savings Accounts will make it easier for patients to increase access to health care services and have greater control over their health care dollars.

Accountability:

Expediting Internal Review will hold plans accountable by providing patients access to immediate decisions about what is covered for routine and emergency services.

Providing Independent Medical Expertise in External Appeals will provide unprecedented patient protection by guaranteeing that an independent doctor decides if a requested service is medically necessary, if originally turned down by internal review.

Safeguarding Confidential Information will protect personal and sensitive health care data from abuse.

Ensuring Emergency Room/Prudent Layperson Standards will allow all patients to have ready access emergency care when they need it most by prohibiting health plans from arbitrarily refusing to pay for covered emergency benefits.

Disclosing Plan Information will make it easier for patients to learn more about what their health plan coverage includes.

Lifting the "Gag Rule" will allow free and open communications between patients and doctors in order to make fully-informed decisions about the best course of treatment.

Although the Working Group's proposal is revenue neutral, members recommend to the House Ways & Means Committee that appropriate offsets be found in order to accelerate 100% tax deductibility for the self-employed and consider other necessary tax changes to increase accessibility, affordability, and accountability for more uninsured Americans and their families.

You may want to recognize other members (Norwood) to speak.

DEMOCRATIC BILL

Areas Where Different Than Quality Commission

(.5%)

ERISA Remedies. The Democratic bill includes a state remedy provision that allows state cause of action to recover personal damages for personal injury or wrongful death. It includes a provision to ensure that employers are not liable if they are not involved in the decision. The Quality Commission did not recommend a remedies provision.

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Clinical Trials. The Democratic bill requires plans to cover patient care costs associated with clinical trials at NIH and trials with similar peer review process. Quality Commission did not recommend any benefit mandates.

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Mastectomies. The Democratic bill requires health plans to allow women to stay in the hospital 48 hours following a mastectomy and 24 hours following lymph node removal. (Rep. DeLauro is the main sponsor on a freestanding bill with this language). The Quality Commission did not recommend any benefit mandates.

- **Breast Reconstruction.** The Democratic bill requires health plans that cover breast cancer surgery to provide coverage for breast cancer reconstruction following the mastectomy to reestablish symmetry -- including surgery on the non-diseased breast. (Rep. Ecshoo main sponsor of a freestanding bill on this issue). The Quality Commission did not recommend any benefit mandates.

(.5) •

Medical Necessity. The Democratic bill includes a provision that states that a health insurer may not arbitrarily interfere with or alter the decision of the treating physician regarding the manner or setting in which the particular services are delivered if the services are determined to be medically necessary. The Quality Commission did not make such a recommendation.

- **Mandatory Point-of-Service Option.** The Democratic bill requires that plan provide a POS option w/ all of the same services as provided in other plans, although the POS option can have higher premiums and cost sharing. The Quality Commission did not include this option.
- **Whistleblower Protections.** The Democratic bill included compromise legislation that builds on new provisions that the Joint Commission on Accreditation of Healthcare Organizations is already adopting. The Quality Commission did not include this provision.
- **Access to Women's Health Specialists.** The Democratic bill goes further than the Quality Commission in this area that it allows women to choose OB-GYN as primary care provider in addition to allowing direct access to OB-GYNS as a specialist. We supported the provision that the Democrats adopted in the Health Security Act. Many women's groups strongly prefer the provision in the Democratic bill to the Quality Commission's recommendations.
- **Financial Incentives.** The Democratic bill prohibits health plans from using any type of financial incentives for physicians. The Quality Commission only requires health plans to disclose any financial incentives to physicians.



Associated Press

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ation for possible perjury, ob-
ion and witness tampering.

Nasty, Costly Battle Shapes Up Over Changing Managed Care

By LIZETTE ALVAREZ

WASHINGTON, May 30 — Not long after Senator Edward M. Kennedy introduced a bill this spring to overhaul managed care, his staff put out a feeler to the unwitting heroine of the movement, Helen Hunt, the actress who portrayed the exhausted, angst-ridden, H.M.O.-bashing mother of an asthma sufferer in the movie "As Good as It Gets."

Would she be interested in promoting the bill?

Ms. Hunt is mulling it over, but countless others have jumped at the chance, offering Democrats and lobbyists a public relations coup in the explosive battle on Capitol Hill to revamp managed health care: victims and their horror stories.

The powerful insurance and small-business lobbies, meanwhile, are fighting back. Last week, they began running advertisements featuring "fat cat trial lawyers" who are "laughing all the way to the bank" at the prospect of an expanded lawsuit provision in proposed legislation. The radio spots were broadcast in Ohio, Florida and Missouri, where some of the 12 House members on a Republican managed-care study group — and their constituents — would be certain to hear them.

As Congress considers wrestling with managed care in the next two months, lobbyists are busy making sure their viewpoints are heard too. Each side has spent at least \$1 million in advertising and close to \$2 million in campaign contributions, mostly to Republicans. They have hired astute lobbyists and bargained members with faxes and

telephone calls. And they have delivered not-so-subtle reminders of party and corporate loyalties.

"They are lobbying like heck and spending money like crazy," said Representative John D. Dingell of Michigan, the senior Democrat on the Commerce Committee. Mr. Dingell has introduced one of the major pieces of legislation on managed care along with Senator Kennedy, the Massachusetts Democrat, and Senator Tom Daschle of South Dakota, the Democratic leader.

In just a few months, the managed-care conundrum has become one of the issues of the year on Capitol Hill, with Democrats comparing it to the minimum wage in its populist appeal. Originally, only a few quixotic Republicans agreed with Democrats on the issue, but slowly, with the polls showing its resonance, it has spread to the rank and file.

Republican leaders, who for months shied away from the issue despite broad bipartisan support for one of the bills, have relented. Doing something about managed care, say lobbyists and members of Congress, has become practically unavoidable. Now the question is what.

"The Republicans are in a box and the industry is probably not much more popular than tobacco right now," said Charles N. Kahn 3d, the chief operating officer and president-designate of the Health Insurance Association of America, which represents commercial insurers.

Any day now a House study group appointed by Speaker Newt

Continued on Page A23

BIG PAYOUT IS SET BY MERRILL LYNCH IN A COUNTY'S SUIT

\$400 MILLION SETTLEMENT

Orange County, Calif., Say
Firm Helped Cause Losses
That Led to Bankruptcy

By ANDREW POLLACK
with LESLIE WAYNE

LOS ANGELES, June 2 — Merrill Lynch & Company agreed today to pay \$400 million to Orange County, Calif., to settle claims that the leading Wall Street brokerage firm helped push the affluent county into bankruptcy four years ago with reckless investment advice.

The settlement will largely close the book on the biggest municipal bankruptcy in the nation's history, a financial debacle that was unthinkable at the time and resulted in sharply reduced services ranging from public schools to health clinics.

The bankruptcy also shook the foundations of municipal finance around the country and illuminated how treasurers of local governments can deploy enormous sums of taxpayer dollars in exotic investments that can go awry.

The settlement by Merrill is one of the largest in any securities-related litigation and is by far the largest stemming from the 1994 bankruptcy, which set off a storm of lawsuits as the county sought to recover some of the more than \$1.6 billion in losses from investments considered highly risky.

Merrill, which has consistently maintained it did nothing wrong, said it had decided to settle because the costs and distraction of the litigation did not justify the battle. Even though Orange County had sought \$2 billion, the magnitude of the settlement was still considered huge and goes a long way to restoring much of what Orange County lost.

The county still has lawsuits pending against 17 Wall Street securities houses and a variety of other companies. But Merrill was clearly the main target, since it was much more

Clinton Speaks Up on Census, Pushing the Use of Sampling

By JAMES BENNET

DALLAS, June 2 — President Clinton plunged into the debate over

understanding of the needs of our people," Mr. Clinton said, before sitting down in Houston with a group of

Nasty and Costly Battle Looms on Managed Care

Continued From Page A1

Gingrich of Georgia is expected to complete a bill to counter the existing proposals, which many Republicans consider too radical, too regulatory and too likely to stoke frivolous lawsuits. So far, though, the effort has drawn the ire of Mr. Gingrich, a reaction that shows how contentious an issue it is for Republicans, and members are busy retooling the bill.

"In politics, you never know which way the football will bounce," said Representative Harris W. Fawell, an Illinois Republican in the study group who said the public's concerns about managed care would be addressed in the group's bill. "The Democrats have jumped on it, and they seem to think it will be a nice vehicle for retaking Congress."

Supporters of the overhaul effort say they simply want to give patients access to more doctors, the right to appeal a managed care organization's decision to an impartial panel and the freedom to sue the organizations for malpractice.

President Clinton revved up the issue in his State of the Union Message in January when he called for a patient's bill of rights, without offering specifics. Lobbyists, sensing change, got to work.

But it was not until April, when Democrats in Congress introduced their bill, that the political warfare broke out and the "anecdote" faced off against the advertisement.

Democrats got an immediate, significant boost when the American Medical Association decided to endorse the bill, despite traditional reservations about lawsuits. Groups representing nurses, pediatricians, anesthesiologists and many others came on board, and all have been lobbying on behalf of the bill. Labor unions have also made it a priority.

In late April, the effort was bolstered again when a Republican pollster conducted a survey that made some Republicans cringe. It showed that 67 percent of the people surveyed were willing to pay \$17 more a month in premiums to change the system.

About the same time, Senate Democrats started their "victim a day" campaign, which brought one Demo-

A public relations battle over changing managed care is under way.

crat or another to the Senate floor each day to let fly a poignant anecdote about an ordinary American who had been victimized by a managed care company.

One day recently, Senator Barbara Boxer of California told of Harry Christie, whose 9-year-old daughter was found to have a rare kidney tumor and needed the expert skills that only two doctors in America could provide. The insurance company directed them to a general surgeon.

"This is my only child," Ms. Boxer quoted Mr. Christie as saying.

"You're out of luck," came the reply from the company, Ms. Boxer said. The family paid for the surgery themselves.

On Thursday, President Clinton took up the mantle and comforted Regina Powers, a breast cancer patient who recounted her gut-wrenching confrontation with a health maintenance organization when she wanted to see an oncologist and a breast surgeon.

"This is urgent — I mean, how many more stories do we have to hear like Regina's before we actually act?" Mr. Clinton asked at a news conference with Ms. Powers.

Senate Democrats have threatened to attach their bill to other pieces of legislation in June and July, a pressure tactic that is not permitted in the House. But House members supportive of the overhaul efforts have raised the specter of a "discharge petition," the procedural maneuver that revived the moribund campaign finance debate, if Republican leaders fail to act.

Meanwhile, groups on both sides of the issue have contributed generously to Congress. The managed care industry has given more than \$1.5 million in contributions to Federal candidates and parties so far this election season, paying particular attention to Republican leaders, according to the nonpartisan Center for Responsive Politics.

Health specialists who are not doc-



Paul Hos

Leslie A. Pryor and Wes Metheny in Washington yesing industry groups that oppose a bill to overhaul ma

tors have doled out more than \$1.8 million, with 53 percent of it going to Democrats. The American Medical Association has weighed in with more than \$646,000, 71 percent going to Republicans.

The groups opposing the overhaul effort see their biggest challenge as muffling the swell of violins.

"I don't think the debate and discussion is very objective," Mr. Kahn said in frustration. "It's a disease-of-the-month club approach, and then it's also a Chinese menu of solutions, some of which are thought out and others of which the cost implications are not even analyzed or thought through."

To get their message out, lobbyists have run a series of newspaper and radio advertisements since January. They have stuck closely to one theme of warning: Pass this legislation, and expect to see premiums jump, the number of the uninsured to rise and frivolous lawsuits to multiply.

The lobbyists have focused on certain Republican members, first on the 88 who co-sponsored a bill by Representative Charlie Norwood, the Republican dentist from Georgia who spearheaded the first overhaul effort. Six of those members backed

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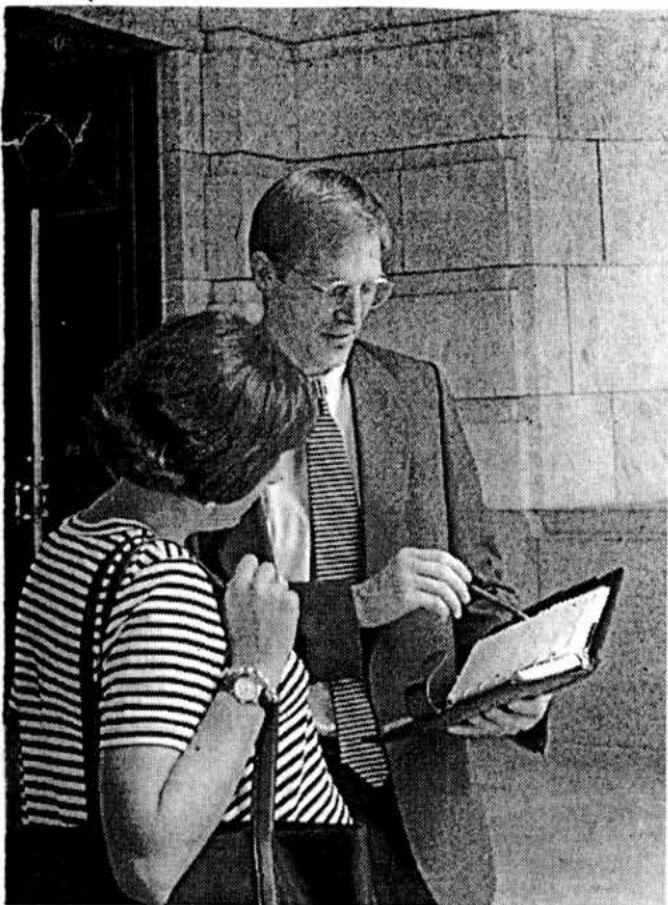
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Now it is the bers, many of who to the views of in and small-busin with a few moder ators, who are th from both sides.

Proponents of run television well, and at leas ganization has s: advertisements i be foundering.

All agree tha political tongue-l tensify, reaching bill actually hits

SUMMERTIME MEMORIES:
THE FRESH AIR FUND



Paul Husefros/The New York Times

Panel Finds Medicare Costs Are Underestimated by U.S.

By ROBERT PEAR

WASHINGTON, June 2 — A bipartisan Federal advisory panel said today that the long-term costs of Medicare were likely to be higher than estimated by the Clinton Administration, because the program was likely to continue growing at a brisk pace.

That conclusion increases the pressure for major changes in the popular health program for the elderly.

The Administration had been assuming that the growth of Medicare spending per beneficiary would slow after 2010, just as the first baby boomers become eligible. But the National Bipartisan Commission on the Future of Medicare, at a two-day meeting that ended today, said it was just as plausible to assume that there would be no slowdown.

Medicare spending grows not only because the number of beneficiaries and their average age are increasing, but also because elderly people are receiving more health care and more costly services. The Administration assumed that the average annual growth in Medicare spending per beneficiary would gradually drop to about 4 percent, the commission said, but experience suggests that it could just as easily remain at around 6 percent.

Those differing assumptions lead to a difference of \$760 billion a year in Medicare spending by 2030, the panel said.

The 17-member commission, created by Congress and headed by Senator John B. Breaux, Democrat of Louisiana, has decided to assess the effects of all its proposals on Medicare spending under both sets of assumptions.

The panel is considering fundamental changes in the structure of Medicare, but has not yet made specific recommendations. The higher estimates of Medicare spending, considered more realistic by many commission members, accentuate the need for changes in the program to keep it solvent for 76 million baby boomers, born from 1946 to 1964.

One panel member, Representative John D. Dingell, Democrat of Michigan, said the estimates of Medicare spending could have a profound effect on the commission's recommendations, which must be submitted to the President and Congress by March 1, 1999.

Another panel member, Bruce C.

Vladeck, former administrator of the Medicare program, said any forecast of Medicare spending beyond 10 years was "an exercise in comparative fantasy."

But most commission members said it was necessary to make such estimates because otherwise the panel would not see the huge effects of the baby boom on Medicare.

Laura D'Andrea Tyson, a commission member and former economic adviser to President Clinton, said history suggested that the Administration's estimates of future Medicare spending were, in fact, optimistic.

The Administration assumes that the growth of Medicare will slow so that costs per beneficiary eventually grow at about the same rate as the nation's economy, measured by the total output of goods and services per person. But Mr. Breaux and other commission members said this assumption was at odds with the history of Medicare because costs have generally increased faster than the gross domestic product.

Stuart H. Altman, a Brandeis University professor appointed to the commission by Mr. Clinton, said, "We are going to see a resumption of health cost increases in this country." If that coincides with the "tidal wave" of baby boomers reaching retirement age, he said, there will be immense pressure to restrict spending or to ration health care.

The advisory panel got a vivid reminder of the politics of Medicare when it convened today at the Library of Congress. In the audience were dozens of members of the Gray Panthers, an advocacy group for the elderly. They held up signs that said, "No more Medicare cuts!" They also demanded that the commission hold public hearings.

In an interview, Mr. Breaux said the commission would hold hearings on July 10 and 13 and seek public comment in other ways.

Commissioners agreed that they must also assess the overall fairness of the Medicare program and the adequacy of its benefits.

Senator John D. Rockefeller 4th, Democrat of West Virginia, a member of the commission, said he hoped that the panel would not become entranced with cost projections. "If this commission is simply about solvency," he said, "I'd like to get that cleared up right now, because I'm not sure I belong on it."

and Wes Metheny in Washington yesterday represent-
ups that oppose a bill to overhaul managed care.

A popular issue brings out the checkbooks.

off. When nine Republicans supported the Democratic proposal, they were snowed under with faxes, letters and telephone calls. Two of the lawmakers dropped their support within 24 hours.

Now it is the study-group members, many of whom are sympathetic to the views of insurance companies and small-business owners, along with a few moderate Republican senators, who are the focus of attention from both sides.

Proponents of an overhaul have run television advertisements as well, and at least one umbrella organization has said it will run radio advertisements if the bill appears to be foundering.

All agree that the lobbying and political tongue-lashings will only intensify, reaching fever pitch once a bill actually hits the floor.

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Washington, DC 20510-7050

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6/3/98

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Nicole Bennett 224.8994

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MESSAGES:

1) Carol Anclinson's testimony

2) article on her testimony

3) Center For Patient Advocacy
 Terre Hall

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Call if you have any questions

of Pages including cover: 2

Neil Kahanovitz, M.D.
President and Founder



CENTER FOR
PATIENT ADVOCACY

Testimony

of

Carol Anderson

Democratic Policy Committee
Hearing on Managed Care Reform

Tuesday, December 16, 1997

Good afternoon Senator Kennedy and Congressman Dingell. Thank you for inviting me to speak today.

My name is Carol Anderson. I am here today as a patient and member of the Center for Patient Advocacy to tell you my personal experiences with managed care and give you a clear understanding of why federal legislation is needed to ensure that patients receive the quality care they need and deserve.

In 1994, I was given a diagnosis of breast cancer and, like millions of other women, was afraid. What would my future be? Would I even have a future? After the initial shock, my main concern was my health. What did I need to do to get rid of this thing inside my body? After many consultations with different doctors and talking to cancer survivors, I had a mastectomy with TRAM (transverse rectus abdominis myocutaneous) flap reconstruction in October 1994. I was hospitalized for seven days and just as I started to battle the cancer, I was also forced to battle my health plan.

Even though my doctor recommended a seven day hospital stay, my health plan originally approved only one day. After both myself and my doctor requested a longer stay, the plan authorized three days. When I appealed for a longer stay, the plan refused to cover it and the hospital was forced to write off the balance.

"Working for Quality Healthcare in America"

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Because of my recovery, time away from work and limited resources, my husband and I decided to enroll me in his HMO. We made this decision only after the plan assured me that I could keep my current doctors and continue to receive the treatment and surgeries that were planned for the near future. However, six weeks later a representative from the plan told me that they would not cover my type of reconstruction, and in no case would they cover any type of reconstruction adjustment after the initial reconstruction.

My doctors and I vigorously fought the health plan and I eventually did receive my reconstruction. But I was lucky. I knew what to do and how to fight HMOs and other managed care plans. You see, this was not the first time I had experienced the problems with managed care. It was just the first time as a patient.

I work in an oncologist's office. My job is to verify insurance coverage and obtain authorizations for surgeries and procedures for patients with cancer. At work, I see the dangers managed care poses to patients *every day*. I see denials for needed care. I see the arbitrary limits plans place on hospital stays and the treatment decisions they make in order to save money, not to provide the most effective care to the patient. And, unfortunately, I see these things day in and day out.

The hardest part of my job is telling patients that they cannot receive a needed treatment because their health plan will not authorize it. And because I work with cancer patients, many of them young children, it is especially difficult for me because these treatments literally can mean the difference between life and death.

There are many, many examples I could give you that show the dangers of managed care. But for the sake of time, I will speak about just one.

I was given the file of a 12-year old boy diagnosed with bone cancer in his lower leg. I contacted his health plan to obtain authorization for a procedure recommended by his oncologist that would save the boy's leg. The plan denied authorization, saying that amputation was the only approved course of treatment. With my help, the family appealed the initial decision. It was denied. We then appealed to the next level. Again, it was denied. We took the appeal to the highest level -- to the medical director at the HMO. But he too denied treatment. The only treatment that would save this child's leg.

Next, I suggested that the child's father speak with his employer, since the employer provided his health insurance. Once his employer became involved, the procedure was finally approved and immediately performed -- *nearly four months after the initial request*. However, it was too late to save the boy's leg. The cancer spread and his leg ultimately was amputated.

Patients like this do not have time to spare when it comes to treatment options. In health care, month after month of delay can equal death.

The experience I was forced to endure and the case I have just told you about are not isolated and rare. They are very real and quite common. To give you a better idea of what I mean, let me tell you more about my job. Each day at work, I am handed a stack of files and a list of phone numbers to call. This may sound like ordinary office work. And for me it is. What is frightening is that I am calling to argue on behalf of patients whose health plans have denied authorization for treatments a doctor has determined to be medically necessary. What is more frightening is that for me this is ordinary! For the patient it is terrifying.

The managed care industry claims that my experiences and those of others are "anecdotes." Frankly, this is offensive. Is the industry prepared to tell me and the thousands of other patients who have been harmed by managed care that we are just stories? That we don't count? We are people, not commodities.

The decisions managed care plans make do not simply have an impact on how their stock is trading in New York. They impact real people and their families and often may mean the difference between life and death. The managed care industry must understand this and they must realize that health care is not a one-size-fits-all proposition.

The reality in managed care is that the decisions affecting a patient's health care are increasingly being made by health plans, **not by patients and their doctors**. I know this because I see it at work every day. And while physicians and other health care professionals continue to be held accountable for their medical decisions that result in harm, managed care plans are not because the Employee Retirement Income Security Act (ERISA) preempts state liability laws as they apply to the self insured health plans which cover more than half of all insured Americans. ERISA, enacted more than 20 years ago, does not recognize the changes that have occurred in the nation's health care system. It does not recognize that, today, the practice of medicine often no longer occurs in the doctor's office, but in the HMO's boardroom.

Under ERISA, managed care plans can make medical decisions with no regard for the potentially deadly consequences to patients. I find it hard to understand how a society that embraces the principle that we should all be held accountable for our actions would permit an industry that makes life and death decisions on a daily basis to escape responsibility.

Managed care plans must be held accountable for their decisions, just like everyone else is. And, if they are, I believe that they will become more interested in providing quality health care and saving lives than simply saving money.

Today, I ask you to view the managed care reform debate from the patient's perspective. Patients need honest, straightforward information to make informed decisions about their health care needs and treatment options. They need access to

OPINION

A Frustrating Story Of Health Benefits Denial



JOHN MACDONALD

This is the time of year that columnists, in the spirit of the holiday season, look for uplifting subjects. But the most compelling story I heard this week was a real downer. So be prepared to be frustrated, maybe even angry.

The story comes from Carol A. Anderson, who works in the Washington office of 11 oncologists, verifying insurance coverage and obtaining authorizations for surgeries and other procedures for cancer patients.

Anderson is also a spokeswoman — and an effective one — for the Center for Patient Advocacy, a non-profit, grass-roots organization founded to represent the interests of patients nationwide.

In the last three years, she has had the special experience of seeing the health care system from both the patient and professional levels. Neither were happy experiences, even though she knew her way around.

Anderson's personal encounter with the health care system came in 1994, when she was diagnosed with breast cancer. "Like millions of other women, I was afraid," she told a forum on Capitol Hill this week.

Although her doctor had recommended a seven-day hospital stay for the surgery she was to have, her health plan initially approved only one day. That's when trouble began. Using knowledge from her job, Anderson and her doctor appealed and got her hospital stay extended to three days. Still, she had to remain the full seven days, and the hospital was forced to cover the balance, Anderson said.

After her mastectomy, she switched to her husband's HMO, but only after being assured she could keep her doctor and receive the reconstructive surgery he had planned. Six weeks later, however, the HMO balked.

"My doctors and I vigorously fought the health plan and I eventually did receive my reconstruction," Anderson related. "But I was lucky. I knew what to do and how to fight HMOs and other managed-care plans. You see, this was not the first time I had experienced the problems with managed care. It was just the first time as a patient."

Anderson went on to tell the forum the story of a 12-year-old boy with bone cancer in his leg. When she called the boy's health plan to get permission for the treatment his doctor had recommended, the plan refused. The only approved course of treatment was amputation, the health plan said.

After three appeals to the health plan, the boy's father went to his employer, who

Anderson said, choking back tears. "The cancer spread and his leg ultimately was amputated."

What makes this more disturbing is that Anderson says that cases such as the 12-year-old's happen all the time. "What is frightening," she said, "is that I am calling to argue on behalf of patients whose health plans have denied authorization for treatments a doctor has determined to be medically necessary. What is more frightening is that for me this is ordinary. For the patient it is terrifying."

Executive Director Terre McFillen Hall emphasized that the Center for Patient Advocacy does not believe all health plans operate like the ones Anderson mentioned.

Indeed, a recent nationwide poll done by Harvard University experts showed that two-thirds of those surveyed gave their health plan a grade of A or B. The bad news is that one-third gave their plan a C or lower.

As Rep. Henry A. Waxman, D-Calif., told the forum, well-run managed-care plans have made significant contributions to good health and to controlling escalating medical costs. But there have been so many incidents like the ones Anderson described that many lawmakers believe federal action is needed.

Anderson agrees. "The managed-care industry claims that my experiences and those of others are anecdotes," she said. "Frankly, this is offensive. Is the industry prepared to tell me and the thousands of other patients who have been harmed by managed care that we are just stories? That we don't count? We are people, not commodities."

File The Quality
Whole

(O)PTIONS FOR EXTERNAL REVIEW OF CLAIMS DENIALS UNDER ERISA-COVERED PLANS

CURRENT LAW

- ERISA requires that every employee benefit plan provide adequate written notice to a participant or beneficiary whose claim is denied, and afford a reasonable opportunity for a full and fair review of the denial by an appropriate named fiduciary.
- The statute does not require any external review of benefit claims other than the participant's right to file a civil action for review by a court. Although the participant may file the action in a state court, the plan may have the action removed to federal court. ERISA preempts any state law remedies that might otherwise be available.
- Regardless of the jurisdiction in which the matter is decided, the court must apply ERISA, not state law, and may only provide "equitable remedies." That is, the court may order that the denied benefit be provided. It may not award damages for any injury caused by the denial.
- In addition, the courts generally grant significant deference to the plan fiduciary's decision, overturning it only if they find that the plan acted arbitrarily. Moreover, courts often do not permit the claimant to introduce evidence that was not presented during the plan's internal decision-making and review procedure.
- Because claims determinations are generally made by persons who are employed by the entity responsible for paying the claim, an internal claims determination process is subject to an inherent conflict of interest.

Teanne

OVERVIEW OF OPTIONS

Shortcomings of External Review Without Improving Remedies

- External review measures, by themselves, do not fully address the imbalance of incentives in the current system. Under ERISA, a plan fiduciary who fails to assure compliance with current statutory and regulatory requirements, or any future external review requirements, is not accountable for that failure.
- There are many examples of claims decisions that are simply wrong. Even if ultimately corrected, some of these wrong decisions will cause injury before they are corrected. The lack of remedies under the current statutory scheme prevents the injured parties from receiving compensation.
- An external review system without remedies would provide no disincentive for plan fiduciaries to arbitrarily deny care with the expectation that many participants will not pursue the matter to the external tribunal.
- The options described below are based on the assumption that a truly independent, expeditious and inexpensive external review process could be established.

OPTION 1 — Provide External Review for All Claims

- Amend ERISA to provide for external review of a denied or delayed claim within a time period appropriate to the claim.
 - *E.g.*, a denial of emergency care could be reviewed within a matter of hours, other types of claims might need to be reviewed within a few days.
 - The external review organization would have appropriate guidelines or could decide on a case by case basis how quickly a request for review should be processed.

Option 1 cont'd

- The reviewer would have access to independent medical and legal expertise.
- The external review organization would decide the claim on principles of contract law, and would issue decisions binding on the plan and the participant.
 - Option: The decision could be subject to an "appellate review" by a court limited to the record and with an arbitrary and capricious standard of review.
 - Option: No further review of the merits of the external review decision (only review of jurisdictional or procedural issues).
- The external review organization could be authorized to:
 - Option: Award costs, attorneys fees and expert witness fees to:
 - Option: Either party
 - Option: Successful participants only
 - Option: Successful p's and to plans for frivolous claims
 - Option: Assess penalties payable to the government (without a showing of bad faith unless damages also available)
 - Option: Award compensatory damages to a participant (perhaps capped for pain and suffering and other non-economic damages)
 - Option: Award capped punitive damages (what showing would be required?)

(If the external reviewer awards any type of damages, then, for Constitutional reasons, the plan would probably have to be given the right to *de novo* review by a court with a jury trial. The jury could be limited to reviewing the damage award, and not be able to overturn the award of the benefit)
- Standard and Scope of External Review
 - The standard of review would be *de novo*,
 - Submission of information that was not before the plan would be allowed.

Option 1 cont'd

- **Exclusivity of External Review Process**
 - Option: The external review forum would be the exclusive forum for claims denials.
 - Option: External review would be optional for the participant
 - Option: Only participants with large or serious claims could waive external review and go directly to court where they could obtain:
 - Option: state law remedies, or
 - Option: expanded ERISA remedies.
- **Cost of the External Review Process**
 - Option: borne by the plan in all cases;
 - Option: borne by the claimant if unsuccessful;
 - Option: borne by the Federal government.

Option 2 — Provide External Review for Small Claims Only

The purpose of an external review procedure for small claims would be to provide an expeditious and inexpensive forum for the great majority of claims. Federal district courts are not well suited for reviewing such matters, and the expense of going to court makes this an infeasible option for dissatisfied claimants who have small claims.

- Amend ERISA to require the external review in Option 1 for small claims only, *i.e.*, claims that meet all the following conditions:
 - (1) below a certain threshold amount (based on the \$ value of the claim, *e.g.*, \$5,000),
 - (2) no injury is alleged, and
 - (3) do not involve imminent threat to life, further serious deterioration of health or intractable pain)
- In some states, the tribunal could be existing forums such as small claims court.
- Private entities could be certified to provide external review, but development of safeguards against inherent bias may be difficult.

Option 2 cont'd

- The tribunal would have the power to order payment of the benefit.
 - Option: The tribunal could award attorneys and expert witness fees to a successful claimant.
 - Option: The tribunal could assess penalties for egregious conduct.
- The external review forum would be the exclusive forum for claims denials that meet its conditions. Claimants could not choose to go directly to court.
- Judicial Review of External Review Decision
 - Option: limited to the external review record and under an arbitrary and capricious standard.
 - Option: limited to jurisdictional and procedural issues.
- Treatment of Claims Not Subject to External Review
 - Claims larger than the threshold amount, claims where an injury is alleged and claims involving imminent threat to life, further serious deterioration of health or intractable pain would be exempt from this process, regardless of the \$ amount — the claimant could go straight to court.
 - In order for this option to make sense, the court's standard or review for such claims would need to be *de novo*, that is without deference to the plan's decision, and to allow the introduction of new evidence.
 - Option: The court would be required to award costs, attorneys fees and expert witness fees to:
 - Option: Either party
 - Option: Successful participants only
 - Option: Successful p's and to plans for frivolous claims
 - Option: The court could assess penalties payable to the government (without a showing of bad faith unless damages also available)
 - Option: The court could award compensatory damages to a participant (perhaps capped for pain and suffering and other non-economic damages)

- Option: The court could capped punitive damages (what showing would be required?)
- Option: Prohibit removal of civil actions to Federal court except for very large claims (e.g., over \$50,000)

Option 3 — Provide External Review for Large Claims Only

The purpose of providing external review for large claims is to have a much smaller, and therefore, less expensive system that would decide only those matters where a great deal is at stake either for the participant or the plan. The purpose of an expeditious external review would be to decrease the likelihood of serious injury resulting from a wrong decision by the plan.

- Amend ERISA to require the external review process described in Option 1 for serious claims only, *i.e.*, claims that meet threshold conditions:
 - imminent threat to life, further serious deterioration of health, or intractable pain,
 - injury resulting from the denial is alleged, or
 - minimum dollar amount(The dollar threshold, which would only apply if the health or injury threshold did not, should be set fairly high, say \$5,000 or more, to avoid overwhelming the external review system.)
- Exclusivity of External Review Process
 - Option: The external review forum would be the exclusive forum for claims denials that meet its conditions.
 - Option: A participant with a claim that is eligible for external review could choose to go directly to court.
- Treatment of Claims Not Subject to External Review
 - Small Claims, and claims not involving imminent threat to life or of serious further deterioration of health or intractable pain would be exempt from the external review process, and claimants

Option 3 cont'd

could go to court to obtain payment of the benefit, but not damages. (Due to the cost of going to court, and the limited remedies available, this would have the practical effect of limiting small claims to internal review)

- Option: Require that courts not give deference to the plan's decision, and allow submission of new evidence.

Note: Under any of the above options, claims that do end up in court, could be decided by either Federal or State courts at the option of the participant — the plan would not be able to remove a claim filed in State court to Federal court.

SARAH'S SUPER SASSY SUMMARY
of Quality/Patients' Bill of Rights

- **SIDE BY SIDE** -- Comparison of Dingell/Norwood/Commission
- **NORWOOD** -- How it differs from Commission
-- Memo to Erskine and business
- **DINGELL/KENNEDY** -- Summary of legislation
- **QUALITY COMMISSION'S BILL OF RIGHTS** -- Summary of the provisions recommended by the President's Quality Commission.
- **SUMMARY OF STUDIES** -- Summary of studies estimating the costs of quality provisions.
- **Q&As** -- Q&As plus Chris's WH press briefing.
- **FEDERAL GOVT. ANNOUNCEMENT** -- Press releases
- **EXECUTIVE ORDERS**
- **VP SUMMARY** -- Summary of agency reports
- **STATE LEGISLATION** -- Amazing summary of what every state has done in the area of consumer protections.
- **POTUS SPEECHES**
- **DEMOCRATIC UNITY EVENTS**

GAO report
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Divider Title: Side-by-Side

PROVISION	QUALITY COMMISSION	NORWOOD	DINGELL
Information Disclosure	<u>Yes.</u> Access to accurate, easily understood information about consumers' health plans, facilities and professionals to assist them in making informed health care decisions.	<u>Yes.</u> Provide patients w/ access to clearly understandable info re health plans, including about plan benefits, mix of network health professionals, in and out of network costs etc.	<u>Yes.</u> At time of initial coverage and upon request make available info such as coverage description, financial obligation, access and change providers, limits on use of providers, grievance procedures, financial incentives, how address non-English, percentage of premiums for benefits.
Access to Specialists	<u>Yes.</u> Consumers with complex or serious medical conditions who require frequent speciality care should have direct access to a qualified specialist of their choice. Authorizations, when required, should be for an adequate # of visits.	<u>Ambiguous.</u> Patients will have direct access to specialists if that care is needed in the judgement of treating health professionals.	<u>Yes.</u> Individuals with condition or disease of sufficient seriousness to require specialist, shall make referral.(direct access?) Do not have to guarantee access to non-participating specialist if they do then at no cost to the individual. If ongoing specialist needs then specialist can coordinate as primary care provider and if appropriate gets ongoing referral.
Giving women access to qualified providers to cover routine women's health services	<u>Yes.</u> Women should be able to choose a qualified provider offered by a plan for the provision of covered care to provide routine and preventative women's services.	<u>No Provision</u>	<u>Yes**</u> Women should be able to designate OB-GYN as a primary care provider. If not, may not require direct authorization for routine OB-GYN services. <i>(Goes beyond the Commission b/c allows to choose as primary care provider.)</i>
Continuity of Care	<u>Yes.</u> Course of treatment for chronic or disabling condition at the time they involuntarily change health plans or when provider is terminated, care see up to 90 days or through pregnancy -- providers have to keep speciality providers up to 90 days.	<u>Yes.</u> In circumstances where changes in health professionals might disrupt care, providers for continuous coverage for a reasonable period of time. <i>(Unlike Commission it does not have specific time periods)</i>	<u>Yes.</u> If provider terminated (for reasons other than quality) remain with provider under same rates for (1) 90 days (2) thru pregnancy; (3) terminal illness (life expectancy of 6 months.)

→ same rates
+
terminal
care for
6 months.
Any out?

Access to Emergency Services	<u>Yes.</u> Emergency room services covered "prudent layperson standard"	<u>Yes.</u> Access to emergency room services w/o prior authorization with "prudent layperson" standard. Similar to Commission.	<u>Yes.</u> Similar to Commission. Without prior authorization, regardless of treating physicians, prudent layperson standard.
Out of Network Referral When Network Inadequate	<u>Yes.</u> If plan has insufficient number or type of providers to provide a covered benefit, plan should ensure that the consumer can obtain the benefit outside the network at no greater cost than if obtained from participating providers. Also should maintain adequate reasonable proximity to providers.	Requires plans to have to have an adequate mix and range of health professionals to ensure access to the services provided by the plans.	<u>Yes.</u> Must have sufficient # of providers to ensure that all services are covered.
Anti-Gag/Conscience Clause	<u>Yes.</u> ensure that provider contracts do not contain any "gag clauses" or other contractual mechanisms to prevent communication.	<u>Yes.</u> Can't prohibit or limit health professionals from engaging in medical communications.	<u>Yes.</u> Forbids anti-gag clauses.
Financial Incentives	<u>Yes.</u> Does not forbid the use of financial incentives but does ensure that they are disclosed.	<u>Yes.**</u> Forbids any provisions -- either direct or indirect -- to reduce medically services.	<u>Yes **</u> Forbids health plans from having any financial incentives.
Whistleblower	<u>No Provision</u>	<u>No Provision.</u>	<u>Under Negotiations.</u>
Confidentiality	<u>Yes</u> Consistent with HHS recommendations w/ exception of law enforcement.	<u>Yes.</u> Requires plans to establish procedures to comply w/ state and Federal privacy laws w/ respect individually identifiable information.	<u>Yes.</u> Not complete but requires health plans to develop a written plan to follow Federal and state privacy laws. (Pending add'l language from the Senate).
Utilization Reviews	??	<u>Yes.</u> Use health professionals to make review determinations (w/ no incentives for those who make determinations to deny) In urgent cases, make a determination w/i 30 minutes and in other cases w/i 24 hours, w/ the right to appeal decisions.	<u>Yes.</u> SB update.

Describe acceptable incentive for me

enforce?



Internal/External Appeals	<u>Yes</u> Includes internal and external appeals process along w/ expedited appeals when necessary.	<u>Yes.</u> ** For prior authorization w/i 24 hours and for other services w/i 30 days.(for internal appeals)	<u>Yes</u>
ERISA Remedies	Commission currently developing options.	<u>Yes.</u> ** Allows state cause of action to recover damages for personal injury or wrongful death against any person that provides insurance or admin services to or for an employee welfare benefit plan.	<u>Yes.</u> ** <i>Need to explore business case out. I want real details on that one</i>
48 Hour Mastectomy Law	<u>No provision</u>	<u>No Provision.</u>	<u>Yes.</u> ** Cannot limit hospital stays to less than 48 hours following mastectomy.
Breast Reconstruction	<u>No provision</u>	<u>No Provision.</u>	<u>Yes</u> ** Health plans that cover breast cancer surgery, must provide coverage for breast cancer reconstruction following the mastectomy to reestablish symmetry -- including surgery on the non-diseased breast.
Clinical Trials	<u>No provision.</u>	<u>No Provision.</u>	<u>** Yes</u> Cannot deny coverage of or impose additional restrictions on covering patient care costs for those who participate in clinical trials. (NIH approved and those w/ similar peer review).
Drug Formularies	<u>No provision</u>	<u>No provision</u>	<u>Yes.</u> ** Have to disclose the chosen formulary and provide exceptions from formulary when non-formulary is indicated.
Mandatory POS Option	<u>No provision.</u>	<u>Yes.</u> ** Requires plans to offer a mandatory point of service option with same reimbursement rates and fair and reasonable premiums.	<u>Yes</u> ** Requires plans to offer a POS option w/ all the same services. Can have higher premiums, cost-sharing etc.

*For what does 2 address * mean?*

→ Limitation on purchases

→ want to know process

reimburse?

Someone needs to explain to me who does external appeals. what is process

Non-Discrimination Provisions.	Cannot discriminated against consistent w/ their policy on race, disability, genetic info, sexual orientation, etc.	Cannot discriminate on the basis race, sex, etc, <i>(Does not appear to go quite as far as Commission or Dingell) in what way?</i>	Cannot discriminated against consistent w/ their policy on race, disability, genetic info, sexual orientation, etc. <i>Similar to the Commission.</i>
Health Quality Advisory Board	Health Quality Council and Forum Under Development	<u>No provision</u>	<u>Yes.</u> Requires HHS to create a advisory board for quality to provide recommendations to continuously monitor and improve health care quality. Annual report to the Congress.
Ombudsman	<u>No provision.</u>	<u>No provision</u>	<u>Yes.</u> ** States shall provide for the creation of an health insurance ombudsman to: assist consumers in choosing health options; provide counseling for those who are dissatisfied. Federal govt must do this in those areas where states do not.
Internal Quality Assurance Program		<u>Yes</u> ** Requires plans to have a quality improvement program that systemically assesses and improves patient outcomes, and supports and emphasizes preventive care.	<u>Yes.</u> ** Requires plans to have internal quality assurance program to systematically review health services, consistency, patient outcomes. Must have procedures for reporting. Collect standardized data.

→ How much?
→ How paid?
Dr?

→ Why will the state w/ external appeal reference?

Provider Provisions	<u>No provision.</u>	<u>Yes. **</u> -- Have to all health plans and professionals to apply to become participating provider each calendar year, -- notification when not selected -- appeal, and -- allow for corrective action plan if not, -- maintain an objective standard for selecting participating health professionals and providers. -- No discrimination on the basis of hospital affiliation, licensing etc. <i>(Could be broadly interpreted.)</i>	<u>Yes. **</u> -- written notification -- non-discrimination based on licensure. -- -- non-discrimination based on race, sex, etc <i>check tax/ HHS.</i>

Want more detail

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Divider Title: Norwood

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Divider Title: Dingell/Ken

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Divider Title: Summary of Rights -
Commission



July 23, 1998
(House)

STATEMENT OF ADMINISTRATION POLICY

(THIS STATEMENT HAS BEEN COORDINATED BY OMB WITH THE CONCERNED AGENCIES.)

H.R. 4250 - Patient Protection Act of 1998 (Rep. Gingrich (R) GA and 57 others)

Nearly two years ago, the President announced he would establish a non-partisan Quality Commission to make recommendations on how best to assure patient protections and quality health care. When he appointed this Commission, he directed that it develop a patients' bill of rights as its first order of business. Since last November, the President has been calling on the Congress to pass a strong, enforceable patients' bill of rights. It was not until last week that the Republican Leadership finally introduced long-overdue legislation on this issue.

The Administration believes that the Republican Leadership's introduction of H.R. 4250 clearly demonstrates that there is broad-based consensus on the need for Federal legislation to ensure that Americans have patient protections. The President is committed to working with the Congress to pass an enforceable patients' bill of rights this year.

Unfortunately, H.R. 4250 is seriously flawed legislation. It covers too few people, it provides too few patient protections, and it contains unnecessary and irrelevant provisions that undermine the chances for a bipartisan agreement on a patients' bill of rights. As such, the Administration strongly opposes H.R. 4250, as currently drafted, and the President's senior advisors would recommend that he veto this bill if it were presented to him by the Congress.

First, H.R. 4250 does not apply to the individual insurance market and therefore millions of Americans would not be assured these patient protections. The President has repeatedly stated that every health plan should have to provide its enrollees with a patients' bill of rights.

Second, this legislation does not provide many critical provisions that are necessary to assure high quality care. The following protections are either absent from this legislation or are insufficient:

Access to specialists. H.R. 4250 does not assure persons with chronic or serious conditions direct access to specialists. Moreover, there is no requirement that a plan cover a specialist that is not in the network if the network does not have sufficient providers to treat the condition. As such, patients would not be assured access to needed specialists to treat, for example, cancer or heart conditions.

Continuity of care protections. H.R. 4250 does not include a requirement that a patient's care will not abruptly change if their provider is unexpectedly dropped from a health plan or if their employer changes health plans. This provision is essential for patients -- such

as pregnant women or the chronically ill -- whose care will be seriously undermined by an abrupt change.

Financial incentives for doctors. This legislation does not contain sufficient provisions that prevent patients from being put at risk through unknown destructive financial incentives to limit patient care.

Emergency room services. The emergency room services provision is insufficient, as it does not prohibit plans from limiting access to an emergency room that is outside the plan's network. Moreover, it does not address coverage of post-stabilization care, which puts patients at risk for huge costs for needed treatment that a doctor believes should take place in the facility in which they were initially admitted.

Gag Rules. H.R. 4250 only prohibits gags on physicians in direct contract with a plan. The majority of doctors, however, contract with plans through medical groups, third party administrators, or other arrangements. Therefore, there are no prohibitions of gag rules for most contracts.

External appeals. We are extremely concerned that the external appeals in H.R. 4250 are only advisory -- not binding. The right to an appeal is meaningless if health plans can disregard these decisions. Moreover, patients would be required to pay a fee to participate in an appeals process, up to \$100. Consumers should be able to address serious grievances without having to pay. In addition, the plan would be allowed to develop its own definition of medical necessity making it extremely difficult for an enrollee to prevail on appeal.

Insufficient enforcement provision. The enforcement mechanism in this legislation is insufficient as it gives little or no recourse to patients who are injured or who die because of a health plan's actions. The proposed \$250 per day penalties are wholly insufficient for patients who suffer serious harm or even death because of a wrongful action by a health plan.

Third, H.R. 4250 contains provisions that have nothing to do with patients' rights and only serve to reduce the likelihood that an acceptable agreement can be reached on this important issue. Recognizing our concerns with these provisions, the Congress agreed as recently as last year to keep them off bipartisan legislation -- specifically, the Balanced Budget Act of 1997. These provisions include:

Caps on medical malpractice awards and limits on malpractice actions. While the Administration has consistently supported medical malpractice reforms, it opposes federally imposed caps on punitive and non-economic damages in medical malpractice cases.

Expansion of Medical Savings Accounts (MSAs). H.R. 4250 would subvert the MSA demonstration project enacted in the Health Insurance Portability and Accountability Act of 1996. Under H.R. 4250, the MSA tax break may accrue only to the healthiest and wealthiest individuals and attract them out of the general health insurance market, potentially raising premiums for all other people. There is no evidence that the claimed cost containment benefit of MSAs outweighs the cost of providing a tax break primarily for healthy and higher-income individuals.

Association Health Plans (AHPs). H.R. 4250 would create a new insurance option for small groups and individuals that would exempt them from many existing State safeguards in such areas as solvency, marketing, underwriting, rating practices, benefits, and consumer protections. Under current law, States regulate the small group and individual markets, thereby helping to make coverage affordable. H.R. 4250 would permit AHPs to discriminate by cherry-picking healthier groups and individuals. Those remaining in the State's insurance pool would face higher premiums, leading to higher levels of uninsurance and undermining the stability of the State insurance pool.

For these reasons, the President agrees with provider organizations, such as the American Medical Association and the American Nurses Association, and virtually every major consumer organization that H.R. 4250 is insufficient and does not provide patients with the protections they need and deserve. While we have serious concerns with H.R. 4250, the President remains committed to passing a strong, enforceable and bipartisan patients' bill of rights this year. The bipartisan substitute legislation offered by Mr. Dingell and Dr. Ganske covers all health plans, contains strong enforceable patient protections, and has no "poison pill" provisions that have nothing to do with these patient protections. As such, the President would sign H.R. 3605 into law. It is the President's hope that Republicans and Democrats can work across party lines to put progress ahead of partisanship and pass legislation that provides Americans with the patients' protections they need and deserve.

Pay-As-You-Go Scoring

H.R. 4250 would affect both direct spending and receipts; therefore, it is subject to the pay-as-you-go requirement of the Omnibus Budget Reconciliation Act of 1990. OMB's preliminary scoring estimate of the bill is under development.

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CONSUMER BILL OF RIGHTS AND RESPONSIBILITIES

The "Consumer Bill of Rights" consists of the following rights and responsibilities:

- (1) **Access to Accurate, Easily Understood Information** about consumers' health plans, facilities and professionals to assist them in making informed health care decisions.
- (2) **Choice of Health Care Providers** that is sufficient to assure access to appropriate high quality care. This right includes assuring consumers with complex or serious medical conditions access to specialists, giving women access to qualified providers to cover routine women's health services, and providing access to continuity of care for consumers who are undergoing a course of treatment for a chronic or disabling condition.
- (3) **Access to Emergency Services** when and where the need arises. This provision requires health plans to cover these services in situations where a "prudent layperson" could reasonably expect that the absence of care could place their health in serious jeopardy;
- (4) **Participation in Treatment Decisions** including requiring providers to disclose any incentives, financial or otherwise -- that might influence their decisions, and prohibit "gag clauses" which restrict health care providers' ability to communicate with and advise patients about medically necessary options;
- (5) **Assurance that Patients are Respected and Not Discriminated Against**, including discrimination in the delivery of health care services consistent with the benefits covered in their policy based on race, gender, ethnicity, mental or physical disability, and sexual orientation;
- (6) **Medical Privacy** which assures that individually identifiable medical information is not disseminated and that also provides consumers the right to review, copy and request amendments to their own medical records;
- (7) **Grievance and Appeals Processes** for consumers to resolve their differences with their health plans and health care providers -- including an internal and external appeals process; and
- (8) **Consumer Responsibilities** which asks consumers to take responsibility by maximizing healthy habits, becoming involved in health care decisions, carrying out agreed-upon treatment plans, reporting fraud, among others.

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 - What benefits, cost sharing,**
 - Knowledge about facilities, doctors**
- (2) **Choice of Health Care Providers** that is sufficient to assure access to appropriate high quality care. This right includes
 - **assuring consumers with complex or serious medical conditions access to specialists,**
 - **giving women access to qualified providers to cover routine women’s health services, and**
 - **Continuity of Care** providing access to continuity of care for consumers who are undergoing a course of treatment for a chronic or disabling condition;
- (3) **Access to Emergency Services** when and where the need arises. This provision requires health plans to cover these services in situations where a “prudent layperson” could reasonably expect that the absence of care could place their health in serious jeopardy;
- (4) **Participation in Treatment Decisions** including requiring providers to disclose any incentives, financial or otherwise -- that might influence their decisions, and prohibit “gag clauses” which restrict health care providers’ ability to communicate with and advise patients about medically necessary options;
 - **Anti-gag Clauses**
 - **Requiring Disclosure for any Financial Incentives that exist for physicians.**
 - **Assuring patients know all treatment options**
 - **Assuring Information Clear, Culturally Competent.**

- (5) **Assurance that Patients are Respected and Not Discriminated Against**, including discrimination in the delivery of health care services consistent with the benefits covered in their policy based on race, gender, ethnicity, mental or physical disability, and sexual orientation;
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Divider Title: Q + A's

Q: Are you planning to endorse the Norwood/D'Amato consumer bill of rights legislation?

A: I applaud Congressman Norwood and Senator D'Amato for their leadership on this issue. We are encouraged that so many Republicans and Democrats understand the need for national legislation. There are a number of bills on the Hill at this time. Some Members have indicated their interest in modifying their legislation before Congress comes back. We look forward to working with all Republicans and Democrats as we move forward throughout this process.

Q: Isn't the Health Care Consumer Bill of Rights that you have called on Congress to pass really just "Clinton Care II"?

A: Inflammatory and inaccurate rhetoric is only being used by defenders of the status quo. These recommendations are aimed provide Americans essential protections to give them confidence in their health care system.

Both Democrats and Republicans recognize the importance of this issue, and nearly 100 Republicans have co-sponsored legislation that focuses in these issues. Moreover, each of the rights proposed by the President's commission has been enacted by a Republican Governor. We should focus on the national interest rather than special interests.

The bill of rights is a sensible, moderate approach to fixing some of the problems that are plaguing consumers, providers, and health plans as we move through this historic transition.

Q: Aren't these rights are going to raise health insurance premiums and cause more people to become uninsured?

A: No. The Quality Commission asked for an independent analysis of the few rights that are thought to be the most expensive and concluded that the cost impact was quite minimal. Also, nearly every state around the country has enacted some type of consumer protections without seeing a rise in health care premiums or a rise in the number of uninsured. Finally, those who are the greatest advocates of this legislation are consumers, advocates and experts who are extremely concerned about the number of uninsured in this country. They do not believe that a consumer bill of rights that guarantees Americans quality care will increase the number of uninsured.

Update of (B)
numbers.

Q: Why do we need a Health Care Consumer Bill of Rights?

A: The nation's health care system is undergoing historic transformations that are affecting the way millions of Americans receive their health care. Some of these changes have been quite beneficial. They have lowered costs and improved preventive benefits.

At the same time, for too many Americans these changes are also causing turmoil and distrust. A recent Kaiser study showed that Americans believe that managed care is making it harder for people to see specialists and to get access to emergency room care. The President asked the Commission to examine these changes and recommend ways to better protect consumers as we move through this transition.

A Health Care Bill of Rights will give Americans newfound confidence in their health care. It will give them much-needed protections -- such as a sense of security that they will have access to emergency services in an expedited fashion; that they will have access to the specialists they need, and that there is a rigorous process in place when they have health care grievances.

Q: Many businesses have said they can come into compliance with the bill of rights voluntarily. Why do you need Federally enforceable legislation?

A: There are some businesses who will come into compliance voluntarily, and we welcome their commitment to do so. However, these rights should be made real for all Americans, and voluntary compliance cannot assure that outcome.

Q: Business and some Congressional leaders are saying that this Patients Bill of Rights represents Clinton Care II?

A: Inflammatory and inaccurate rhetoric is only being used by defenders of the status quo. These recommendations are aimed provide Americans essential protections to give them confidence in their health care system.

Democrats are unified on the need for legislation, and nearly 100 Republicans have co-sponsored legislation that focuses in these issues. Moreover, each of the rights proposed by the President's commission has been enacted by a Republican Governor. We should focus on the national interest rather than special interests.

The Bill of Rights is a sensible, moderate approach to fixing some of the problems that are plaguing consumers, providers, and health plans as we move through this historic transition.

Q: This is a Democratic unity event. Do you intend to work with Republicans on this issue?

A: Absolutely. There are many Republicans that recognize the need for national consumer protections. In fact, nearly 100 Republicans in the House have signed onto the bill co-sponsored by Congressman Norwood. We look forward to working with Republicans and Democrats to make a consumer bill of rights real for all Americans.

Q: What do you think of the Norwood/D'Amato legislation?

A: I applaud Congressman Norwood and Senator D'Amato for their leadership on this issue. We are encouraged that so many Republicans and Democrats understand the need for national legislation. There are a number of bills on the Hill at this time. Some Members have indicated their interest in modifying their legislation before Congress comes back. We look forward to working with all Republicans and Democrats as we move forward throughout this process.

Q: There are bipartisan bills in the Congress that have legally enforceable mechanisms to assure these consumer protections. The Administration has been silent on this issue. How will the administration propose to make these rights real?

A: The Administration believes that consumers should have adequate remedies when they have been harmed by medical or other types of health plan decisions. We have not yet determined the best enforcement tool for addressing this concern, but we are currently evaluating options.

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

February 20, 1998

PRESS BRIEFING BY
DEPUTY ASSISTANT TO THE PRESIDENT FOR HEALTH POLICY
CHRIS JENNINGS

The Briefing Room

1:26 P.M. EST

MR. TOIV: Good afternoon, everybody. For those of you who heard the President's speech today, you heard him mention Chris Jennings as a person who worked very hard on the health care proposal and on just about every one of the President's health care proposals. Chris is here to brief on the President's announcements today and the Vice President's report and answer any questions you have on it. Chris is Deputy Assistant to the President for Health Policy.

MR. JENNINGS: Thank you, Barry. Hello. I'll just give you a quick summary of what's happened today and then I'll open up for any questions.

Back on November 20th of last year, when the President's Advisory Commission on Quality and Consumer Protection reported its recommendations in response to the President's charge to develop a Consumer Bill of Rights, the President, as you know, endorsed that bill of rights and suggested there should be federal standards. But as he did that, he also released an executive memorandum directive to all the departments and agencies that have jurisdiction over federal health care programs, asking them to report back by today -- or yesterday, February 19th, to the extent to which they came into compliance with the Consumer Bill of Rights, and also in so doing to say what other actions they have the authority to take to come into compliance and what other legislative burdens or hurdles for them to come into compliance.

Just yesterday we got the final report; it was released to the Vice President. He had been working on it for quite a while coordinating these departments' reports. He conveyed it in this report that some of you may have seen, that the President and the Vice President -- I'll hold up, The Report to the President from the Vice President. And it's on the consumer protections.

And he conveyed it, and the President received it, and in so doing he released another executive memorandum reviewing all the recommendations and instructing all the various agencies -- and by all agencies, I mean Department of Health and Human Services, which administers Medicare, Medicaid, Indian Health Services; the Department of Labor; the Department of Defense; the Department of Veterans Affairs; and the Office of Personnel Management that administers the FEHBP and 9 million people there -- to come into compliance with the authority that the various departments had said that they had but had not come into compliance.

In fact, as a result of the President's action today, all federal programs -- health care programs -- will come into compliance by no later than the end of next year, consistent with the recommendations of the Consumer Bill of Rights.

The report did say that we are largely in compliance, or we have made great inroads. There are a number of examples where we

MORE

have not, in various fields. In Medicare and Medicaid we do not have the explicit authority or the directive or protections on the disability requirement. The disability requirement is access to -- access to specialist requirement. And we are going to be moving on that by regulation. Donna Shalala has indicated today that she will move as quickly as she can and work very closely with states for the Medicaid program to do that.

In VA, in DOD, there are other areas -- grievance appeals process that they are not in compliance with. In FEHBP they are not in compliance with anti-gag. Today, as a matter of fact, on the Medicaid side, we are releasing a letter -- a directive from the Department of Health and Human Services to make sure that we come in compliance with the access to emergency services protections that are included in the Consumer Bill of Rights. So today's action by the President, again, will ensure that everyone comes in compliance.

I think the other newsworthy note about this in this whole report, pointed out by the Vice President, is since we are largely in compliance today and are moving to come into full compliance, the charge that the Consumer Bill of Rights is going to increase costs significantly really doesn't compute with our own experience in the Medicare-Medicaid programs. As you know, in the last couple of years we have been growing at the lowest growth rates in a number of years, and I think that that gives us great confidence in suggesting that we can provide these protections to all Americans.

First we have to start with the federal health care programs, and now, as you know, the President reissued his challenge to the Congress to pass bipartisan legislation this year to extend those protections, not just to the over 85 million people who are in federal health care programs, but the 225 million Americans who have health insurance.

So I'll conclude with that and open it up for any questions you may have.

Q Does the AMA and hospital association and these others, are they in support of it?

MR. JENNINGS: The AMA has indicated a great deal of support for the consumer protections under the President's advisory board. They are very actively working on the Hill to develop compromise legislation. We've actually worked, interestingly enough, collaboratively on this front. I think that they will actually be a partner as we go forward.

There have been some insurers and some in the business community who have concerns, not so much with the Consumer Bill of Rights advocated by the President's advisory commission, but by some of the issues they think go beyond that that they fear will come from the Hill. And they're a little bit nervous about that legislative process.

But the fact of the matter remains that if we are going to provide these protections to all Americans, we are going to have to require federal legislation to do that and our hope is that we can do that this year.

Q The President said it wasn't going to necessarily be a burden, but what's the price tag --

MR. JENNINGS: Well, we don't have cost-by-cost breakdowns of all these things. But when the Quality Commission released its report the business members on the commission asked for a study by the Lewin Group to give them a sense of how much cost the quality protection provisions that they were most concerned about would cost in terms of increased premiums. And they basically said

between, like, I think 60 cents and \$1.50 per month more for those particular protections related to appeals rights and other related issues.

It really depends on how many protections you're going to be putting on this to determine how much it's going to cost. But, again, these particular provisions don't cost a lot. These are structural reforms that ensure access to protections. Our feeling is -- and there's no evidence to conclude otherwise, that it would increase costs significantly, that's why we think they're so important; not just because they'll improve quality, but they actually will improve the public's confidence in a very rapidly changing health care delivery system which we think is critically important.

And there's one last point I want to point out to you. This is not, in the President's mind, an issue of managed care bashing. This is an issue of increasing the public confidence in a very significantly changing health care delivery system so that they're more comfortable with where we're going into the future, because obviously we need to constrain costs as we have in the last several years and into the future while we balance the needs to protect quality consumer protection.

Q But, Chris, just to follow up, for these particular -- what was announced today, there is no exact estimate -- there is no estimate of what the costs would be for the people -- for what was instituted today.

MR. JENNINGS: In terms of the federal programs, we don't see any federal costs. In terms of, for example, OPM, who administers 350 different health plans across the country, there may be some premium increases to come into compliance. We don't know the exact cost.

If you ask most of these health plans, the major health plans, they'll tell you that they are largely in compliance today, with some exceptions. But I can tell you this, none of them, based on my experience and my discussions with them on the specific recommendations in the Quality Commission, say that those particular provisions are cost prohibitive, in their mind.

I think that they're concerned about other areas, which they call and label provider protections rather than consumer protections. And they're concerned about other related issues related to enforcement mechanisms.

But as to the basic, core, structural recommendations in the President's commission advisory -- excuse me, the President's quality and consumer protections recommendations, we have not seen any evidence to in any way suggest that it's a big cost, by anyone.

Q But this was prompted, wasn't it, by managed care failures? It may not be bashing, but it sure --

MR. JENNINGS: Well, I have to say that where there is wrongdoings in managed care or any other health plan, we have to go after them and go after them very strong and forcefully. And we think that one way to ensure that those abuses don't occur is to ensure those rights are in place. There have been abuses in managed care and in other areas as well that have undermined, or certainly call into question, the level of quality provided to both beneficiaries of the public program and enrollees in private plans. That's why we have to have these basic protections.

Q Well, the private plans then, how many are under compliance? I mean, you said that most of the federal programs are under compliance or moving along that way?

MR. JENNINGS: They're moving.

Q Private plans are already as well, people that aren't insured through federal programs?

MR. JENNINGS: Well, it varies dramatically. In some states, the insured plans have to come into compliance with very similar recommendations. In some -- but in, obviously, most -- most Americans are in self-insured plans that aren't regulated in any way in that regard. Some have voluntarily come into compliance in many of these areas, but probably not entirely.

For example, there is not a lot of evidence to suggest that every plan in this country have an external appeals process. So that they may provide you an internal appeals process that you go to in that internal -- in that plan's appeals process, where they go to their people that you appeal to, and if you're not happy with it you have no place to go.

But what the Quality Commission recommended is not only to have an internal appeals process, but also to have an external third-party review process. And I would suggest that there are many plans in this country that do not have those protections. Many do, and where they do we laud them and praise them, and the President did when he released the report last November.

Q Wouldn't that be expensive to have a third-party appeals process?

MR. JENNINGS: Well, actually, again, GTE and others who do have third party-processes in place, they have found that it has not been that expensive; that rarely is it used; but it increases the confidence of their enrollees in their plans that there is a place to go if they have a concern. And that is the fundamental commitment that the President's commission made when it made its Consumer Bill of Rights recommendation.

Q Can I try once more on cost, so I don't misunderstand. I take it there are at least a million people covered by the understanding that he signed today?

MR. JENNINGS: There's actually probably 88 million people who would come under protections.

Q And this is mandating that these plans meet the bill of rights?

MR. JENNINGS: By no later than the end of next year that all the plans -- whether they be Medicare, Medicaid, Indian Health Services, DOD, DVA, or Federal Employees Health Benefits -- that they meet those criteria.

Q So you're mandating something for 88 million Americans. You don't know whether it's going to cost a lot more, but the one way to make up that cost you cited was premium increases for the 88 million that could be up, what, a dollar a month or so. Is that --

MR. JENNINGS: Where these protections are in place, in private plans and in public plans, there have not been significant cost increases. So we don't have any evidence to suggest that these are significant costs. Where there are any cost increases, generally you'll see them on the premium side. But I'll tell you, most people would suggest that to the extent that a dollar or \$1.50 a month would ensure that they have protections in place, that they know that they have an appeals process, that they know that they have access to the specialists they need when they need it, that they know they have

emergency care services -- I think most people would say that's worth it to the extent it even costs that much.

Q But I just want to confirm that this is being mandated. You don't really know exactly what it costs, but the cost will be borne by the people who pay the premiums.

MR. JENNINGS: Well, we do know -- well, we do know that it doesn't cost that much because we've had the experience of most of the federal health care programs that have these in place today. And I must say again, look at the cost -- a lot of these protections have been put in place in '95, '96, '97 under the President's leadership, and that has occurred at the same time that we've had the lowest increases in cost in Medicare-Medicaid. The baseline growth rates have been very, very significantly reduced during that same period that people suggest that these types of protection will increase costs.

So let's not kid anyone, it could cost some money. But based on our experience, it is not going to cost much, and in terms of the peace of mind and the security it provides to Americans about they know they have those protections, we think it's more than worth that amount. But again, we have no evidence to suggest that this is very significant at all.

Q Do you anticipate then that the 350 carriers that are currently in the program, the federal health plan, will come into compliance and stay --

MR. JENNINGS: We've talked to OPM; they feel that there are a number of areas that they have to move to come into compliance. It includes, in terms of complete compliance, anti-gag rules; they need to have regulations, disclosure that they're committing to -- and the President directed them to release in short order -- disclosure of financial incentives, access to emergency room services. All those provisions we anticipate they'll move very quickly to amend in there what they call their call letters next month, to the extent they possibly can for next year's health plans.

If they don't, then they'll do it in the next year's cycle. But by the end of 1999 they are committing to, through the President's directive to come into complete compliance, complete contractual compliance with those commission's recommendations.

Q Chris, has the White House made a decision about whether or not it can support the Norwood bill and, if not, are you working with Democrats on an alternative bill? What's the status of what you do support on the Hill?

MR. JENNINGS: Well, the Norwood -- first, I think we should say about Mr. Norwood that he has, along I think with the President and the Vice President, have really raised this issue in a way that we think makes it inevitable that there is going to be bipartisan legislation in this Congress. He deserves a great deal of credit in that regard.

We haven't endorsed the legislation because as it was drafted we weren't completely comfortable with it. There were some provisions that tended to be a little bit more oriented to provider protections as opposed to consumer protections. But he has thoughtfully included a great deal of many consumer protections as well. As you may know, he's redrafting some of those provisions to address some of the concerns that have been raised. We haven't seen where that is. But obviously we can't endorse the bill as it currently is constructed.

As for the Democrats' legislation, they are finalizing it. As I understand it, they are hoping to introduce it sometime

within the next couple of weeks. That legislation is something that we're very encouraged by, we have not taken a formal position on because they have not relayed the final legislation to us. But we're encouraged and we look forward to working with them, obviously. We think it's a constructive effort and will lead to a collaboration with Republicans to pass bipartisan legislation this year.

Q What about one of the provisions that Norwood has, the right of patients to sue managed care plans? The White House hasn't formulated a position on that.

MR. JENNINGS: No, the President believes that there should be enforcement mechanisms, and we are evaluating options in that regard. You may know that the Quality Commission, which is due to release its final report at the end of March, is meeting next week and beyond to begin to discuss some of those options. We will want to hear from them how best they think we should enforce these provisions. They have one way -- they have a remedies provision that involves litigation. That certainly is one viable option. But again, as you say, the President hasn't made a final determination and wants to hear from his commission.

Q Thank you.

MR. JENNINGS: Thank you all so much.

END

1:44 P.M. EST