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Clinton Presidential Records Digital Records Marker

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Divider Title: Quality

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Divider Title: Side-by-Sides

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.)

- some rates
 &
 terminal
 care for
 6 months.
 Any cost?

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
embodied?



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

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. Payment claim 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>Much to explore business come 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.

Re what does 2 answers mean?

Limitation on purchases

want to know process

reimburse?

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 for?

→ Why will the states w/ external accreditation reference?

Provider Provisions	<u>No provision.</u>	<u>Yes. **</u> <i>have a process for</i> -- 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 text/ HHS.</i>

Want more detail

NORWOOD BILL
Areas Where Differs From Commission

- **Access to Women's Health Providers.** No special provisions
- **Access to Specialists.** HHS believes this provision is poorly drafted in Norwood -- and unclear what kind of authorization is necessary. *In what way possibly?*
- **ERISA Remedies.** 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.
- **Mandatory POS Option.** The Norwood legislation requires health plans to have a mandatory POS option, that has the same reimbursement rates and fair and reasonable premiums.
- **Provider Protections.** The Norwood legislation contains extensive provider protections, including:
 - Allows all health professionals and providers in a service area to apply to become a participating provider at least one period in each calendar year. Provide reasonable notice about the chosen period.
 - Have to select health professionals and providers based on an objective standards of quality --developed with the suggestion and advice of professional associations, health professionals, and providers and make these selection available to every health professionals and providers.
 - Rights of Providers Who Are Turned Down
 - (1) Notification: Plan has to notify any health professional or provider of any information indicating why they failed to meet the standards of the issuer.
 - (2) Review Gives those who are turned down the opportunity to review the information and discuss all information on which the determination is based.
 - (3) Reapply Allows the health professional or providers to submit supplemental or corrected action plan.
 - (4) Appeal Provides a due process appeal for all determinations that are adverse to the health professional or provider.
- Anti-discrimination Provisions
 - Health professionals may not be discriminated against because of their lack of affiliation with hospital, age, gender, race, or based solely on licensing.

MEMORANDUM

February 4, 1998

TO: Erskine, Gene S.
FR: Chris Jennings
RE: Norwood Legislation

The business community is extremely concerned about the upcoming debate on consumer protections and quality, and in particular, the issue of ERISA preemption. The Norwood legislation, which has the support of over 200 House Members and nearly 100 Republicans, includes a provision which would amend ERISA to make available, for the first time, economic damages, as well as damages for physical pain and suffering and wrongful death under ERISA plans.

The business community strongly object to the bill's enforcement mechanism, which they believes gives the courts broad authority that could lead to excessive litigation. They claim this issue would lead to large increases in health care premiums and cause more people to become uninsured. They are particularly concerned because they believe that with regard to the issue of consumer protections, the issue is not whether it will come up but when.

In addition, there are a number of provisions in the legislation that are designed to protect providers at least as much consumers. For example, the bill comes close to effectively assuring any willing provider protections, which would mean that even the most inefficient, expensive, and poorest quality providers could not be excluded from health plans. These provisions are not only controversial but they could also prove to be quite costly. Cost projections will be used to suggest that more people will become uninsured and could become a powerful countervailing argument for no Federal legislation.

Because of these sensitivities, we have explicitly not endorsed the Norwood legislation. (However, we do believe that the fact that the bill exists -- and has so many cosponsors -- makes it more likely that Congress will act on this issue this year.) We have also not yet taken a position on the best approach to remedies, except to say that we believe that consumers should have the confidence that these consumer protections are Federally-enforceable. The primary outstanding issue is what position we will take with regard to enforcement.

You should also be aware that the business community is much more comfortable with the recommendations passed out by the President's Quality Commission, particularly because it does not take a position on remedies.

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

A: With regard to the issue of ERISA preemption, the Administration has made no decisions about how best to ensure that consumer protections are real for Americans. We do believe that consumers must have the full confidence that they have a place to go if these consumer protections are not made real.

The President has not endorsed the Norwood legislation primarily because it addresses the concerns of providers as much as consumers. We think that this legislation goes too far to undermine managed care. The Administration believes that high quality managed care can offer quality care at often reduced costs. However, we do need to work to increase the public's confidence in managed care. The President has called on the Congress to pass a consumer bill of rights that would provide consumers much-needed confidence in a rapidly changing health care system.

PROVIDER PROTECTIONS IN THE NORWOOD LEGISLATION

- **Application Process.** Allows all health professionals and providers in a service area to apply to become a participating provider at least one period in each calendar year.
- **Requires Health Plans To Develop and Maintain Objective Standards.** *see enclosed standards* Health plans would have to select health professionals and providers based on an objective standards of quality -- developed with the suggestion and advice of professional associations, health professionals, and providers and make this criteria available to every health professionals and providers.
- **Extensive Rights For Providers Who Are Turned Down**
 - (1) Notification: Plan has to notify any health professional or provider of any information indicating why they failed to meet the standards of the issuer.
 - (2) Gives Providers the Option for Thorough Review: Gives health professionals and providers who are turned down from the health plan the opportunity to review the information and discuss all information on which the determination is based.
 - (3) Option to Revise and Continuously Reapply: Allows the health professional or providers to submit supplemental or a corrected action plan. The plan would have to review their modified version as many times as the health provider or professional desired.
 - (4) Unlimited Appeals Process: Provides an unlimited process for unlimited appeals for all determinations that are adverse to the health professional or provider.
- **Taken together these would provisions would have a significant impact on administrative costs and would require health plans to let providers in the network -- both of which could be expensive.**
- **Anti-Discrimination Provisions.** Forbids health plans from discriminating against health providers or professionals solely on the basis of licensure (This is an unclear provision which many opponents interpret to mean that all health providers could participate in the plan -- perhaps even with similar reimbursement rates. However, you should note before criticizing it that it was in the BBA for Medicare.)

PROVISION	QUALITY COMMISSION	NORWOOD
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.
Access to Specialists	<u>Yes.</u> Consumers with complex or serious medical conditions who require frequent specialty 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.
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>
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 specialty 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>
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.
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.
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.

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.
Whistleblower	<u>No Provision</u>	<u>No Provision.</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.
Utilization Reviews	<u>No Provision</u>	<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.
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 one hour and for other services w/I 24 hours. Payment claim w/I 30 days.(for internal appeals)
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.
48 Hour Mastectomy Law	<u>No Provision</u>	<u>No Provision.</u>
Breast Reconstruction	<u>No Provision</u>	<u>No Provision.</u>
Clinical Trials	<u>No Provision.</u>	<u>No Provision.</u>
Drug Formularies	<u>No Provision</u>	<u>No Provision</u>
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.

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)</i>
Health Quality Advisory Board	Health Quality Council and Forum Under Development	<u>No provision</u>
Ombudsman	<u>No provision.</u>	<u>No provision</u>
Internal Quality Assurance Program	<i>under discussion</i>	<u>Yes</u> ** Requires plans to have a quality improvement program that systemically assesses and improves patient outcomes, and supports and emphasizes preventive care.
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 <u>corrective action</u> 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>
-- Notification	<u>No Provision</u>	<u>Notification</u> : Plan has to notify any health professional or provider of any information indicating why they failed to meet the standards of the issuer.
-- Health plan has to review	<u>No Provision</u>	<u>Gives Providers the Option for Thorough Review</u> : Gives health professionals and providers who are turned down from the health plan the opportunity to review the information and discuss all information on which the determination is based.

-- Reapply	<u>No Provision</u>	<u>Option to Revise and Continuously Reapply:</u> Allows the health professional or providers to submit supplemental or a corrected action plan. The plan would have to review their modified version as many times as the health provider or professional desired.
-- Appeals	<u>No Provision</u>	<u>Unlimited Appeals Process:</u> Provides an unlimited process for unlimited appeals for all determinations that are adverse to the health professional or provider.
-- Anti-discrimination	<u>No Provision</u>	Anti-Discrimination Provisions. Forbids health plans from discriminating against health providers or professionals solely on the basis of licensure. (This is an unclear provision which many opponents interpret to mean that all health providers could participate in the plan -- perhaps even with similar reimbursement rates. However, you should note before criticizing it that it was in the BBA for Medicare.)

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48 Hour Mastectomy Law	<u>No Provision</u>	<u>No Provision.</u>
Breast Reconstruction	<u>No Provision</u>	<u>No Provision.</u>
Clinical Trials	<u>No Provision.</u>	<u>No Provision.</u>
Drug Formularies	<u>No Provision</u>	<u>No Provision</u>
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.

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)</i>
Health Quality Advisory Board	Health Quality Council and Forum Under Development	<u>No provision</u>
Ombudsman	<u>No provision.</u>	<u>No provision</u>
Internal Quality Assurance Program	<i>under discussion</i>	<u>Yes</u> ** Requires plans to have a quality improvement program that systemically assesses and improves patient outcomes, and supports and emphasizes preventive care.
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 <u>corrective action</u> 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>
-- Notification	<u>No Provision</u>	<u>Notification:</u> Plan has to notify any health professional or provider of any information indicating why they failed to meet the standards of the issuer.
-- Health plan has to review	<u>No Provision</u>	<u>Gives Providers the Option for Thorough Review:</u> Gives health professionals and providers who are turned down from the health plan the opportunity to review the information and discuss all information on which the determination is based.

-- Reapply	<u>No Provision</u>	<u>Option to Revise and Continuously Reapply:</u> Allows the health professional or providers to submit supplemental or a corrected action plan. The plan would have to review their modified version as many times as the health provider or professional desired.
-- Appeals	<u>No Provision</u>	<u>Unlimited Appeals Process:</u> Provides an unlimited process for unlimited appeals for all determinations that are adverse to the health professional or provider.
-- Anti-discrimination	<u>No Provision</u>	Anti-Discrimination Provisions. Forbids health plans from discriminating against health providers or professionals solely on the basis of licensure. (This is an unclear provision which many opponents interpret to mean that all health providers could participate in the plan -- perhaps even with similar reimbursement rates. However, you should note before criticizing it that it was in the BBA for Medicare.)

Hotels
Thurs Am

- Privacy & ~~at~~ confidentiality

- Norwood

- Dingell

- Ponder

Cardin

- Mr. Hester

Other Member - Dennis 

- 2nd panel → states database
→ collection of data w/ confidentiality

collect data - confidentiality / screening software

Medicare Commission

2

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Clinton Presidential Records Digital Records Marker

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

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

Divider Title: Enforcement

Remedies Statements Made By DOL Officials:

- Improving the availability of meaningful remedies to participants of ERISA-covered benefit plans has been a long-standing priority of this Administration.
 - On June 11, 1993, Secretary Reich wrote a letter to Congress drawing attention to the fact that the courts had abridged the remedies available to pension and health plan participants, and endorsed an expansion of the rights of certain participants and beneficiaries to seek recovery for lost benefits and for new federal civil monetary penalties. In that letter, he complained that "[c]ourt decisions over the last several years have worked to unnecessarily narrow the remedies that an aggrieved pension or health plan participant may seek for violation of rights that ERISA was intended to guarantee."
 - The first issue that former PWBA Assistant Secretary Olena Berg addressed in public testimony when she took her post was the need to improve the remedies available to participants and the Department in enforcing ERISA's pension provisions. At that House Education and Labor Committee hearing on July 27, 1993, Berg clearly stated that "the Administration favors a complete reversal of the Mertens decision so as to provide more comprehensive remedies for the Secretary of Labor and for participants and beneficiaries," and exhorted Congress to pass legislation to expand the remedies available under ERISA.
- In her September 10, 1997 testimony before the President's Health Care Commission former PWBA Assistant Secretary Olena Berg highlighted the limited remedy available under ERISA: "...the remedies available under ERISA cannot be changed by regulation. Remedies under ERISA for abusive delay or denial of claims are limited. The Supreme Court has ruled that ERISA does not allow the participant to get any compensation for wrongful denial or delay of a benefit but the benefit itself and other costs the plan would have incurred."
- Marc Machiz, DOL Associate Solicitor for Plan Benefits Security, testified before the President's Health Care Commission on January 27, 1998. He discussed ERISA preemption and the limited remedies under ERISA, stating, "[i]f a participant or beneficiary suffered four weeks of lost wages and excruciating pain because of a plan's wrongful refusal to preauthorize a procedure that could have mitigated the health problem, under ERISA, all he or she would be entitled to is having the procedure performed." He also stated that, "[w]hile improvements in the procedural protections offered to participants and beneficiaries, if not unduly burdensome to plans, are welcome, they do not adequately address the lack of remedies...they do nothing to make whole those injured by inappropriate claims practices."
- On February 25, 1998 Marc Machiz again testified before the President's Health Care Commission. Mr. Machiz discussed proposed amendments to ERISA's claims review requirements and added that improving remedies available under ERISA is also

state tribunal for resolution. This would not necessarily be state court, but any entity, such as an ALJ or an arbitrator, that the state designates to hear a claim. Damages would be limited to 50,000, and exhaustion would also be required.

TALKING POINTS ON CHAFEE/GRAHAM DRAFT:

- The Chafee-Graham draft proposal gives DOL and HHS the authority to obtain a civil penalty for a pattern or practice of violations of the patient protections contained in the bill. DOL and HHS could pay out of a civil penalty it obtains a payment to participants and beneficiaries to compensate them for injuries they suffered as a result of the violation. This is problematic for three reasons:
 - The government needs a stronger enforcement tool than simply a pattern or practice penalty capped at only \$100,000.
 - A government-obtained civil penalty alone is inadequate. The draft provides no new individual right of action to obtain compensatory damages for a wrongful benefit delay or denial. It does not provide an individual who has been harmed by such conduct to be made whole. This is crucial given the inability of consumers to obtain such compensatory damages under ERISA.
 - The bill would be administratively unworkable. The government would be required to set up a new administrative process to determine what kind of restitution is necessary for each individual participant or beneficiary involved in a violation, and would need to create a trust fund in which to pay out monies to participants and beneficiaries. This would create a new bureaucracy, which we need to avoid.
- We believe that these problems can be addressed by simply adding new language to existing sections 141 and 142 of the draft bill.
 - Our proposal would include giving DOL and HHS the ability not only to obtain a civil penalty for pattern or practice violations, but for individual violations as well. The individual civil penalty would be limited to up to \$10,000 per violation. The maximum civil penalty that the government could obtain for a pattern or practice violation would increase from the draft language. This is necessary to provide an adequate deterrent to plans.
 - Our proposal would also allow individuals to have an individual right of action to obtain compensatory damages. However, the proposal is a moderate approach that would be narrowly tailored and contain limits to control unnecessary litigation.
 - ▶ An individual could sue in federal court for compensatory damages but only when they have an egregious claim involving more than \$50,000. No punitive damages would be available, an individuals would be required to exhaust administrative options.
 - ▶ For claims below \$50,000, an individual could bring a federal claim to a

necessary: "[u]nder ERISA ... working men and women give their labor in exchange for the promise of benefits, but are not compensated for injuries when benefits are wrongly withheld." He concluded by saying, "[t]he Department believes that it cannot assure that the system is fair unless we give workers appropriate access to a disinterested decisionmaker, and meaningful remedies where a plan's delay or denial of care injures a worker or member of his family."

- In her March 24, 1998 testimony before the Senate Labor Committee at a hearing on quality issues, PWBA Deputy Assistant Secretary Meredith Miller clearly articulated the Administration's position that "ERISA's current enforcement mechanisms are insufficient to safeguard participants' health benefit rights. ERISA's relatively weak enforcement mechanisms sometimes fail to hold plans accountable for denying covered benefits and to fairly compensate injured participants... The Administration believes we must carefully consider a range of options for strengthening enforcement to better safeguard participants' rights."
- Former PWBA Assistant Secretary Olena Berg testified at a May 14, 1998, Senate Appropriations Committee hearing on the issue of remedies about the inequities of the current system for ERISA participants. She noted that "[t]oday in America, there are 125 million people who are enrolled in ERISA-covered health plans and,...[] are, therefore, unprotected by adequate remedies." Berg asserted that "this varied treatment depending upon which law governs your particular health benefit plan is unjustifiable" and called on Congress to pass legislation that would improve the remedies available under ERISA. Berg stated that the Administration is "strongly committed to improving consumer protections and the quality of health care in the employment-based system, including improved internal claims review procedures and external review....[and] ensuring that these protections are enforceable."
- At a May 19, 1998 Senate Labor Committee hearing on grievance and appeals procedures, Former PWBA Assistant Secretary Berg reiterated the Administration's concerns about the need for remedies, noting that any solution that addresses participants' concerns about wrongfully delayed or denied ERISA claims must have three essential components, including strengthening internal claims review requirements, requiring independent external review, and additional remedies. Berg further asserted that "[o]nly in combination will fairer internal reviews, external reviews and improved remedies secure consumers' rights to their benefits."

Draft Specs for Chafee-Graham Provisions Relating to Enforcement:

Our proposal would create a two-tiered enforcement system that would allow for enforcement either by the federal government or by individuals.

1. **Federal Agency Enforcement Authority:** DOL and HHS would have the authority to impose civil monetary penalties (CMPs) under the following circumstances:
 - a. Pattern or Practice of Violations or Unreasonable Benefit Delays or Denials: DOL and HHS could impose CMPs for a pattern or practice of violations of the Promoting Responsible Managed Care Act (PRMCA) or HIPAA (Part 7 of ERISA or Title XXVII of PHS Act) provisions, or unreasonable delays or denials of a benefit.
 - CMP Amount: up to \$500,000 per pattern or practice of conduct, with up to quadruple damages if conduct involves unreasonable delay or denial of a benefit.
 - Payable to federal government (either treasury or enforcing agency).
 - b. Individual Violation of PRMCA or HIPAA: DOL and HHS could impose CMPs for an individual violation of PRMCA or HIPAA.
 - CMP Amount: up to \$10,000 per violation.
 - Payable to federal government (either treasury or enforcing agency).
 - Violations of the substantive provisions of HIPAA would be actionable (not a wrongful denial of a benefit).
2. **Individual Right of Action:** An individual could bring an action for a violation of PRMCA or HIPAA, or a wrongful benefit delay or denial that results in injury. The type of action would vary depending on the magnitude of the injury involved:
 - a. "Egregious" Claims: Individuals with whose claim involved more than \$50,000 could bring an action in federal court for compensatory damages and costs.
 - Damages available would include compensatory damages (including actual and consequential losses resulting from the injury), attorney's fees, and expert witness fees. They would not include punitive damages.
 - De Novo standard of review.
 - Threshold amount claimed would include the damages claimed and the value of the delayed or denied benefit.
 - Exhaustion of claims review procedures required, except if exhaustion futile.
 - b. "Smaller" Claims: For individuals with claims valued under the \$50,000 threshold, the individual could bring a federal claim (which would be the same as the one available for "egregious claims") to a state tribunal for a decision and award of damages.
 - Not removable to federal court (unless damages greater than \$50,000)

- State tribunal could be any entity the state designated to hear such claims (e.g., an ALJ, arbitrator, or state insurance commissioner) or leave the claims for decisionmaking by the existing state courts.
- Damages available would include compensatory damages, attorney's fees and expert witness fees up to \$50,000.
- Exhaustion of claims review procedures required, except if exhaustion futile.

OPTIONS 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.

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.

IMPROVING REMEDIES FOR IMPROPER CLAIMS DENIALS UNDER ERISA-COVERED PLANS

CURRENT LAW — Need For Change

- Persons who administer an employee benefit plan are not responsible to participants and beneficiaries for the consequences of wrongfully delaying or denying a claim for benefits.
- Under ERISA, a participant, whose request for medical services has been improperly delayed or denied by the plan administrator, can only recover the benefits that should have been provided, but not damages such as lost wages, additional medical costs, pain and suffering, or wrongful death. A successful participant is not even assured of recovering his or her costs, attorneys fees or expert witness fees.
- In addition, courts generally give deference to the plan's decision. They will not overrule a benefit denial unless the plan's decision was unreasonable (*i.e.*, arbitrary and capricious, or abuse of discretion).
- At the same time, ERISA preempts the state law remedies available to persons not covered by ERISA plans. This is true whether the plan funds its benefits through an insurance policy or directly from the employer's assets.
- These restrictions on available remedies reduce any economic incentive for an administrator to provide fair and expeditious resolution of benefit claims. The person who determines whether to approve claims may be under pressure to deny them because he or she works for the entity responsible for paying the claims.
- Improper delays or denials of claims for benefits can affect the quality of care afforded to participants.
- Persons outside of an ERISA plan (*e.g.*, in the individual insurance market, or in non-ERISA plans) can generally avail themselves of a broad range of remedies.

OPTIONS — We see four potential approaches:

- **A Federal Law Approach:** Amend ERISA to make available economic damages (e.g., cost of care, lost wages) where personal injury or wrongful death occurs in connection with an improper denial or delay in deciding health benefit claims under an ERISA plan. Additional damages, such as for pain and suffering, would be available where the delay or denial was unreasonable.
- **State Law Approach:** Modify ERISA preemption to permit states to apply their existing substantive laws and remedies, or enact new ones, specifically for the improper denial or delay of health benefit claims which result in personal injury or wrongful death. Under this approach, a state could decide whether or not to provide any such substantive law or remedy.
- **State Law Remedies for Insured Plans and a Federal Law Remedy for Self-Funded Plans:** Establish a federal standard for self-funded plans, and permit state insurance laws to apply to plans that are funded through insurance policies. This approach would allow the states to fully enforce their insurance laws, but would not subject self-funded plans (which are usually larger plans) to the diversity of state remedies.
- **Civil Penalty Approach:** Establish a scheme of dollar denominated civil money penalties for improper claims delays or denials. Various options exist under this approach depending on whether the penalty would be imposed by the courts in private actions or assessed by the Secretary, and on whether the penalty would apply to individual cases or only upon a showing of a pattern and practice of improper claims handling.

An element of any of the approaches summarized above could be that employers should be insulated from liability unless they directly engage in making determinations on benefit claims. As part of this element, agreements requiring employers to indemnify HMOs for their liability could be prohibited.

DESCRIPTION OF POTENTIAL APPROACHES

A. A Federal Law Approach — New ERISA Standards

- Amend ERISA to: (1) make available damages for economic losses (e.g., cost of care, lost wages) when an improper denial or delay in deciding health benefit claims under an ERISA plan results in personal injury or wrongful death; and possibly (2) make available additional damages (e.g., pain and suffering) where the delay or denial of the benefit is unreasonable (i.e., arbitrary and capricious, abuse of discretion)
 - Economic damages would be available if the court disagreed with the plan's determination. No deference would be granted to the plan's decision. A finding that the plan acted unreasonably would not be required.
 - Additional damages would be available against the entity that administered the claim if the delay or denial of the claim was objectively unreasonable or arbitrary. It would not require proof of an evil motive.
 - The damages would be available for all types claims regardless of amount as long as there was a personal injury or wrongful death. (Option: Have threshold requirements, e.g., dollar amounts or qualitative.)
 - Scope of Review for Recovery of Benefits
 - Submission to the court of information that was not before the plan would be allowed.
 - Reasonable costs, attorneys fees, and expert witness fees must awarded to the successful claimant.
 - Remedies Options in Addition to Recovery of the Benefit (available under current law):
 - Economic Remedies (for Improper Benefit Denials):
 - Option A: Compensatory Economic Damages (e.g.,

cost of care, lost wages) Resulting From the Personal Injury

- Option B: Compensatory Economic Damages Whether or Not They Result from the Personal Injury (e.g., claimant sells house to pay cost of care)
- Other Types of Remedies (for Unreasonable Benefit Denials) (any combination)
 - Physical Pain and Suffering (with Caps?)
 - Emotional Distress (with Caps?)
 - Punitive Damages with Caps

B. A State Law Approach — Limit ERISA Preemption

- Modify ERISA preemption to permit states to apply their existing substantive laws and remedies, or to enact new substantive laws and remedies, addressing the improper denial or delay of health benefit claims.
- States would be able to impose any standard for awarding damages under this approach. They would also be able to award any type of damages, including damages for emotional distress and punitive damages.
- Option: Impose federal caps on damages that a state court can award in a case involving an ERISA plan.
- Under this approach, a state could decide not to provide any such remedy.

C. A Combination Approach — State Law Remedies for Insured Plans and a Federal Law Remedy for Self-Funded Plans

- Establish the above-described federal standard for self-funded plans, and permit state insurance laws to apply to plans that are funded through insurance policies.

- This approach would allow states to fully enforce their insurance laws, but would not subject self-funded plans (which are usually larger plans) to the diversity of state standards and remedies.
- It may cause confusion for participants by creating two different legal schemes, particularly for participants of self-funded plans that are administered by an insurance company, or for employees of employers who provide both insured and self-funded coverage options.

D. A Civil Penalty Approach

Option 1 — Mandatory Civil Penalty Awarded by Court in Cases Brought by a Participant or Beneficiary to Enforce the Terms of the Plan

- Amend ERISA to require a court to impose a civil money penalty against the plan in an amount of at least \$5,000 and up to, at the court's discretion, \$25,000 (Option: or more) where an improper denial or delay in deciding health benefit claims under an ERISA plan results in personal injury or wrongful death.
- The penalty would be payable to the participant or beneficiary in addition to whatever equitable relief (e.g., provision of the claimed benefit) was ordered by the Court.
- Attorneys fees, expert witness fees and costs would be mandatory for successful claimants.

Option 2 — Add to Option 1 a Civil Penalty in Cases of a Pattern and Practice of Improper Claims Handling

- If the court finds that the benefit denial at issue was part of a pattern and practice of improper claims denials, the court would be required to

impose an additional civil money penalty of at least \$15,000 up to, at the court's discretion, \$150,000.

- The court, in setting the penalty amount in a given case, would be permitted to take into account the penalties that the plan has already paid for the same pattern and practice.
- "Pattern and practice" would mean improperly denying or delaying claims with such frequency as to indicate an intent to materially reduce costs to the plan through the improper denial or delay of claims
- The penalty would be payable to the participant or beneficiary in addition to: (1) whatever equitable relief (e.g., provision of the claimed benefit) ordered by the court and (2) the mandatory penalty.
- Attorneys fees, expert witness fees and costs would be mandatory for successful claimants.

Option 3 — Option 1 and/or Option 2 for Self-Funded Plans and Penalties Set by State Law for Insured Plans

- For plans that are not self-funded (i.e., insured plans, including plans that shift risk to HMOs, etc.) all claims dispute cases would be decided by state courts (not removable to federal court). States could enact their own penalty amounts providing that they were higher than the penalties under the Federal law.

Option 4 — Discretionary Civil Penalty Assessed by the Secretary of Labor in Cases of a Pattern and Practice of Improper Claims Handling.

- If the plan has engaged in a pattern and practice of improper claims denials, the Secretary could assess a large penalty amount (e.g., up to \$10 million, at the Secretary's discretion, or an amount based on the value of claims processed by the violator).
- The penalty would be payable to the government.

- Liability for the penalty would be determined after an administrative hearing with Federal court review in cases where assessment of the penalty is challenged.

Option 5 — Option 1 (with or without Option 3) and Option 4

Option 6 — Option 1, Option 2 (with or without Option 3) and Option 4

IMPROVING REMEDIES FOR IMPROPER CLAIMS DENIALS UNDER ERISA-COVERED PLANS

CURRENT LAW — Need For Change

- Persons who administer an employee benefit plan are not responsible to participants and beneficiaries for the consequences of wrongfully delaying or denying a claim for benefits.
- Under ERISA, a participant, whose request for medical services has been improperly delayed or denied by the plan administrator, can only recover the benefits that should have been provided, but not damages such as lost wages, additional medical costs, pain and suffering, or wrongful death. A successful participant is not even assured of recovering his or her costs, attorneys fees or expert witness fees.
- At the same time, ERISA preempts the state remedies available to persons not covered by ERISA plans. This is true whether the plan funds its benefits through an insurance policy or directly from the employer's assets.
- These restrictions on available remedies reduce any economic incentive for an administrator to provide fair and expeditious resolution of benefit claims. The person who determines whether to approve claims may be under pressure to deny them because he or she works for the entity responsible for paying the claims.
- Improper delays or denials of claims for benefits can affect the quality of care afforded to participants.
- Persons outside of an ERISA plan (e.g., in the individual insurance market, or in non-ERISA plans) can generally avail themselves of a broad range of remedies.

Grievance
Procedures
appeals

pick
up
utiliz

→ movement under
Norwood

Democrats picked
up Norwood

→ puts everyone
into state law
plan.

Federal law approach

→ strengthen current
law.

~~few~~ large administrative
burden.

→ big penalties.

PREFERRED APPROACH — Recognize Need for Better Remedies Without Expressing a Preference for a Particular Approach

- We recognize that current law provides inadequate remedies with respect to the administration of health benefit claims and that this may detrimentally affect the quality of health care. We believe that any new legal structure should make the entity responsible for the unreasonable delay or denial of benefits financially accountable for the injuries caused by such improper administration of claims.
- We see three potential approaches:
 - **A Federal Law Approach:** Amend ERISA to make available economic damages, as well as damages for physical pain and suffering and wrongful death, which result from an unreasonable denial or delay in deciding health benefit claims under an ERISA plan.
 - **State Law Approach:** Modify ERISA preemption to permit states to apply existing, or enact new remedies, specifically for the improper denial or delay of health benefit claims.
 - **State Law Remedies for Insured Plans and a Federal Law Remedy for Self-Insured Plans:** Establish a federal standard for self-insured plans, and permit state insurance laws to apply to plans that are funded through insurance policies. This would overturn the Supreme Court's interpretation of ERISA preemption in the Pilot Life decision. It would allow the states to fully enforce their insurance laws, but would not subject self-insured plans (which are usually larger plans) to the diversity of state remedies.

Testify - w/o position.
could support various
approaches.

→ ~~the~~ employer

sheer

enforceable,
no punitive
no damages,

DESCRIPTION OF POTENTIAL APPROACHES

Option No. 1: A Federal Law Approach — New ERISA Standards

- Amend ERISA to make available economic damages, as well as damages for physical pain and suffering and wrongful death, which result from an unreasonable denial or delay in deciding health benefit claims under an ERISA plan.
 - This would be an objective standard, based on current state insurance law, under which the entity which administers claims would be liable if there was objectively unreasonable conduct which caused a delay or denial of a claim. It would not require proof of an evil motive.
 - It may be necessary to require that the entity which administers claims meet financial responsibility criteria to ensure its ability to pay potential damages and to insulate employers from liability.
 - This cause of action would be available for all claims regardless of amount or type. (Option: Have threshold requirements, e.g., dollar amounts or qualitative)
 - Standard and Scope of Review
 - The standard of review would be *de novo* (i.e., without deference to the plan's decision)
 - Submission of information that was not before the plan would be allowed.
 - Remedies Available
 - Recovery of Benefit
 - Reasonable Costs, Attorneys Fees, Expert Witness Fees for either party
 - Compensatory Economic Damages
 - Physical Pain and Suffering (with caps?)
 - Damages for Wrongful Death (with caps?)
 - Option: Punitive damages with caps

Option No. 2: A State Law Approach — Limit ERISA Preemption

- Modify ERISA preemption to permit states to apply their existing substantive laws and remedies, or to enact new laws, addressing the improper denial or delay of health benefit claims.
 - States would be able to impose any standard for awarding damages under this approach. They would also be able to award any type of damages, including damages for emotional distress and punitive damages.
 - Option: Impose federal caps on damages that a state court can award in a case involving an ERISA plan.
 - This approach would not permit states to mandate benefits.

Option No. 3: A Combination Approach — State Law Remedies for Insured Plans and a Federal Law Remedy for Self-Insured Plans

- Establish the above-described federal standard for self-insured plans, and permit state insurance laws to apply to plans that are funded through insurance policies.
 - This approach would overturn the Supreme Court's interpretation of ERISA preemption in the Pilot Life decision.
 - This approach would allow states to fully enforce their insurance laws, but would not subject self-insured plans (which are usually larger plans) to the diversity of state standards and remedies.
 - It may cause confusion for participants by creating two different legal schemes, particularly for participants of self-insured plans that are administered by an insurance company.

(The above alternative approaches make no reference to any administrative external review process that could be established. If such a process were established, each of the approaches may need to be changed somewhat to accommodate it.)

REASONS WHY A CIVIL PENALTY APPROACH SHOULD NOT BE ADOPTED

- A system of civil penalties for improper claims administration would result in payments to the government, but would not provide any recovery to the injured participant and therefore participants may not have an adequate incentive to file complaints or cooperate in investigations.
- Such a system would only provide an effective deterrent against improper claims handling if it is operated on a large scale. Very large investigative and complaint handling resources would be required in order to sanction the improper handling of any meaningful number of benefit claims.
- Even if sufficient resources were committed to such a system, inevitably, the enforcement agency's handling of some egregious claims denials would subject it to adverse publicity.



The Campaign for
Health Care Accountability

* FAX COVER

DATE:

TO:

Chris Jennings

FROM:

MICHAEL HUDSON

303-604-1392

303-604-2692 (FAX)

COMMENTS:

As mentioned I'll be in DC w/ group
from Tex. Medical Assoc. the week of
Jan 26 - hope to see you then -

MH

NUMBER OF PAGES, WITH COVER:

7



The Campaign for
Health Care Accountability

January 15, 1998

Dear Colleague:

I wanted you to be aware of the exciting managed care reform project on which I am working -- the Campaign for Health Care Accountability.

The enclosed Issue Paper, "*Closing the Managed Care Loophole*," describes the need for federal legislation amending ERISA to insure that states like Texas have the authority to establish legal accountability for health care decisions. Texas was the first state to enact such legislation last year, and that law has been challenged in federal court based on the argument that ERISA preempts any state action in the liability area -- clearly a misinterpretation of ERISA in our view.

Bills pending in Congress have broad, bipartisan support, and the Administration appears to be making managed care accountability a major focus in 1998. On the other side, the insurance industry and business lobby are pushing the Republican Leadership to stonewall on managed care reform. It promises to be an interesting battle this year.

Please let me know if I can provide any further information on the managed care accountability issue and my role in the debate.

Best regards,


Michael Hudson

Enclosure



The Campaign for
Health Care Accountability

Closing the Managed Care Liability *Loophole*: A Question of Simple Fairness

Issue Paper/Media Backgrounder

Summary:

Over the past two decades America's health care system has changed dramatically with more and more citizens enrolling in some form of managed care system like health maintenance organizations (HMOs), preferred provider organizations (PPOs), etc. The Department of Labor estimates that 65% of Americans are enrolled in some form of managed care.

Efforts by managed care organizations to contain costs have injected them into decisions about what health care services are "medically necessary"-- decisions historically made by patients in concert with their health care provider. Often these judgments are made on an economic rather than medical basis and are in direct conflict with physicians and other providers. When these medical determinations lead to patient injury or death, however, the managed care plans claim immunity from any legal accountability because of a federal law, the Employee Retirement Income Security Act of 1973, known as ERISA. They argue that ERISA precludes liability under state law. *Approximately two-thirds of those in managed care programs receive their coverage through plans governed by ERISA.*

→ State legislatures are attempting to deal with abuses by managed care organizations by passing state laws that clarify the accountability of such organizations when they engage in medical treatment decisions. The state of Texas enacted such legislation in 1997 only to have Aetna Insurance Company immediately challenge the law claiming ERISA preempted any state action in this area. This legal challenge is currently working its way through the federal courts. Meanwhile, at least 18 other states are considering similar legislation--all of which will undoubtedly meet legal challenges.

- abuses of managed care

Several bills have been introduced in Congress to amend ERISA to clarify that federal law does not preclude states from establishing this accountability for managed care organizations, and a well publicized political battle is shaping up for 1998. Two narrowly drawn bills by Rep. Charles Norwood and Sen. Richard Durbin would not add any further federal regulation of health care, but rather would follow the current theme of states' rights and devolution by ensuring that the *states retain authority* to establish accountability for medical treatment decisions. Other bills go further in establishing a new federal remedy.

History of ERISA:

In tracing the origin and evolution of ERISA, it is clear that Congress did not intend the 1973 law to preempt state action on medical liability. Twenty-four years ago, today's managed care system could not even have been imagined by lawmakers. In recent hearings before two House subcommittees, Rep. Norwood documented the extensive history of ERISA as it relates to managed care accountability. ERISA was designed principally to provide uniformity and protection for pension plans. The law was later applied to health benefit plans to avoid state mandated benefits on multi-state employers. This allowed a large employer to develop a consistent benefit plan for all employees regardless of geographical location.

Over the years, however, managed care philosophy began to integrate the decisions to pay for care with clearly medical judgements. Such situations empower managed care organizations to decide if care will be provided, not on the basis of whether such care is a covered benefit, but rather if such care is medically necessary. When these decisions lead to harm, the only recourse for the patient under ERISA is "the cost of the benefit denied". This remedy is appropriate when an employee has been denied a pension benefit, but is clearly inadequate when dealing with health benefits. In health care decisions, the cost of the benefit denied may be only the minor cost of a service. It does not include lost wages, pain and suffering, and in many cases even the medical expenses incurred as a result of the denied care. For example, if a woman dies of breast cancer because her managed care plan negligently denied payment for a specialist's consultation and mammogram that could have saved her life, the recovery would be limited to the cost of those health care services -- perhaps \$200.

Court Decisions:

Courts throughout the country are hearing cases in which individuals have been harmed as a result of negligent decisions made by HMOs, utilization review agents and other managed care organizations. These managed care organizations are avoiding accountability for their actions by claiming that they are immune from state legal actions because of ERISA. While decisions in such cases vary among the federal circuits depending on the fact situations, all too often the managed care defendant is non-suited not because it was not responsible for the harm, but rather because of a court's interpretation that under ERISA the managed care organization cannot be held accountable for its actions.

Federal and state court decisions across the country are moving to hold managed care plans accountable. In non-ERISA cases the courts are finding managed care plans accountable under theories of agency, vicarious liability and direct negligence when they make health care treatment decisions. In ERISA cases the courts are finding managed care organizations liable in agency and vicarious liability cases. The problem is that case law is slow to develop, and the courts continue to render inconsistent rulings interpreting ERISA. In the most egregious cases of an outright denial of necessary care, the courts are holding that ERISA preempts unless an agency

theory applies. *Meanwhile, patients are being harmed by negligent managed care decisions and left with no recourse.*

The controlling case in the 5th Circuit, where the Texas case will be decided, *Corcoran vs. U.S. Healthcare, Inc.*, underscored the problem and need for federal legislative action. There the Court said: "...the Corcorans have no remedy, either state or federal, for what may have been a serious mistake...Our system, of course allocates this task [reevaluation of ERISA] to Congress, not the courts..."

When physicians or other health care providers make medical decisions they are held legally accountable for the results of those decisions. Now we have these decisions being made by third parties who are escaping all legal accountability due to interpretations of federal law. This leaves physicians and other health care providers as the sole defendants in lawsuits where the harm to the patient was caused by an immune third party--the managed care organization.

It seems apparent that this problem will not be resolved any time soon through the courts and that a federal legislation solution is required.

Other States:

Texas was the first state to enact legislation holding managed care organizations accountable. Senate Bill 386 was enacted by the Legislature and allowed to become law by Governor George W. Bush in 1997. This law holds managed care organizations accountable in Texas courts when their negligent decisions to delay or deny care result in harm to an individual.

Now at least 18 other states are considering similar legislation, and that number will undoubtedly increase with the opening of state legislatures in January, 1998. Those states include: *Alabama, Georgia, New York, New Jersey, Missouri, Florida, California, Ohio and Colorado.* It is expected that when the other states enact similar bills, they will be immediately challenged in the courts based on the ERISA preemption argument.

Congressional Legislation:

During 1997, numerous bills have been introduced in Congress seeking changes in the managed health care system, including the issue of legal accountability. Rep. Charles Norwood, a conservative Republican dentist from Georgia has introduced the *Patient Access to Responsible Care Act, HR 1514*. The companion bill was introduced in the Senate by Sen. D'Amato of New York. These bills make extensive revisions to ERISA, including the liability provision. Mr. Norwood and Sen. Richard Durbin of Illinois have also introduced single-issue bills dealing only with amending ERISA to clarify the liability issue, S 1136 and HR 2960. Other bills have been introduced by Reps. George Miller, Pete Stark and John Dingell, which call for even more sweeping changes in managed care including, in the Miller-Stark bill, a new federal cause of

These are forcing laws that will be challenged by ERISA.

action for injured patients.

In October, Rep. Norwood's PARCA bill -- with 218 co-sponsors -- was heard by subcommittees from the House Education and Workforce and Commerce committees. Mr. Norwood hopes to have the bill marked-up in committee early in 1998 and to press for floor consideration in the House.

The Senate bills have not been heard in committee, and media reports indicate that Majority Leader Trent Lott wants to delay any action on managed care reform.

The Insurance Industry's Political Campaign Against Reform:

A recent syndicated article in Congressional Quarterly was headlined, "Fight Brewing Over Managed Care," and the Wall Street Journal headline read: "All Sides Get Ready for Push to Regulate HMO's." Each of the national television networks has included major recent stories about managed care abuses, with compelling stories of patients denied care and their lack of equitable remedy.

In response to the groundswell of media and public concern and movement of bills in Congress, the insurance and business industries have begun an aggressive campaign to defeat managed care reform. According to press accounts, Republican leadership in the Senate and House have joined in this strategy calling it a "war." House Majority Leader Dick Armey has circulated a lengthy memo characterizing the managed care reform bills as "Clinton Care 2," and *urging business and insurance forces to gear up and lobby members of Congress against the bills during the holiday recess.*

Impact on Employers and Business:

Not surprisingly, the insurance industry has attempted to project the business community as the most visible opponents to managed care reform, claiming that changes in ERISA will drastically increase insurance costs and cause employers to reduce or even eliminate insurance coverage. This ploy was attempted in Texas during the legislative session as well.

The Texas legislation, however, included a clear and comprehensive exemption of employers from liability--unless the employers themselves were actually making health care treatment decisions. The Norwood single-issue bill, HR 2960, includes this employer exemption, and Sen. Durbin intends to add it to his bill.

Explosion in Litigation:

Another "red herring" advanced by insurers is the claim that allowing states to enact managed care accountability would lead to a further explosion in litigation and increased costs in health insurance--passed on, of course, to business and consumers in increased premiums.

In fact, the lawsuits are already being initiated against doctors, hospitals, nurses and other providers, and this reform would simply allow states to add managed care decision-makers into this proportional liability situation.

In Texas this issue was also hotly debated. Finally, the insurance industry admitted that the new law might add only 3% to overall costs. Milliman and Robertson recently completed an actuarial determination of the cost of the Texas liability legislation to a Texas based HMO and set the cost at 34 cents per member per month. While the Texas statute went into effect in September, 1997, there have been few, if any cases filed under that Act.

While opponents would argue that this ERISA clarification would increase litigation across the country, the important fact not pointed out is that the federal change does nothing more than allow each state to decide how to deal with managed care organizations. States are free to apply to these lawsuits any tort reform measures such as alternative mediation, caps on recoverable damages, or other such protections. This legislation simply allows each state to take responsibility for what has historically been a state role--overseeing the quality of health care services delivered to the citizens of the state.

Public Support for Reform:

Public opinion surveys have indicated very strong public support for managed care accountability. In a survey by the Republican Wirthlin Group, 85% indicated support for holding managed care plans accountable.

The Campaign for Health Care Accountability:

Under the leadership of a broad coalition of consumers and health care providers who worked for passage of the Texas law, a national campaign has been created to advocate for enactment of the federal ERISA amendment. The Campaign is seeking support from health care provider and citizen groups in all the states and nationally. Currently the focus is on working in the states to *encourage co-sponsorship of the Norwood and Durbin bills and counter the misinformation campaign being mounted in opposition to managed care accountability reform.*

For more information about the Campaign, contact Connie Barron or Harold Freeman at (512) 370-1300 or Mike Hudson at (303) 604-1392.

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Divider Title: Compare Bills

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Divider Title: House Vote / SAP

THE PATIENTS' BILL OF RIGHTS: Improved Prospects For Passage In The New Congress?

On July 24, 1998, the Republican-controlled House of Representatives defeated the Democratic *Patients Bill of Rights* legislation by a vote of 217 "nays" to 212 "yeas," with 6 members "Not Voting." The following analysis takes a look at whether the prospects for passage of the bill have improved following the 1998 elections. If re-elected Members cast their votes as they did in 1998, it appears there are *more than* the 218 votes needed to pass the Democratic Patients' Bill of Rights in the new Congress.

The July 24, 1998 "Patients' Bill Of Rights" Vote

Summary: House Vote #336 on HR 4250
On the Dingell (D-MI) Substitute Amendment consisting of the text of HR 3605, the Democratic-sponsored Patients' Bill of Rights legislation.

<u>Defeated:</u>	<u>212 - 217</u>
Democrats:	201 - 0
Republicans:	10 - 217
Independents:	1 - 0

The 1999 "Patients' Bill Of Rights" Vote: More Than A Majority For Passage At 221 Votes

189 Democratic Supporters Returning

189 Democrats who supported the Patients' Bill of Rights on July 24, 1998 will return to Congress in 1999.

+22 Freshman Democratic "Yea" Votes (Running Vote Count: 211)

22 newly elected Democratic Members of Congress, most of whom campaigned on the Patients' Bill of Rights, will take seats in Congress in 1999.

+9 Republican "Yea" Votes Returning (Running Vote Count: 220)

9 of the 10 Republicans who voted with Democrats (see chart below for full list) to pass the Patients Bill of Rights on July 24, 1998 will return to Congress in 1999 -- all except for Jon Fox (R-PA).

+1 Independent "Yea" Vote Returning (Running Vote Count: 221)

Rep. Bernard Sanders (I-VT) will return to Congress in 1999.

The 1999 Patients Bill Of Rights Vote: Other Possible Votes Beyond 221

Summary Of Other Possible Votes:

Narrowly Re-Elected Incumbent Republicans Who Faced Patients' Rights Issue:

5

Richard Baker (LA-6); John Hostettler (IN-8);
Ann Northrup (KY-3); James Rogan (CA-27);
Heather Wilson (NM-1)

Newly Elected Republicans Who Campaigned On Patients' Rights:

3

Don Sherwood (PA-10); Ernie Fletcher (KY-6); Judy Biggert (IL-13)

WILL ONE OR MORE OF THE 5 NARROWLY RE-ELECTED INCUMBENT REPUBLICANS WHO FACED THE PATIENTS' BILL OF RIGHTS ISSUE DURING THEIR CAMPAIGNS SUPPORT THE BILL?

Name	District	Election Result	7/24/98 Vote
Baker, Richard	LA-6	51% - 49%	Nay

1. **Baker: "This Issue Is Moving Up The Ladder Of Importance."** According to the Baton-Rouge Advocate: "*The 'patients' rights' issue was caught in election-year politics and was not resolved this year. A wide gulf remains between Republican and Democratic versions of patient-protection legislation. That same gulf exists between the candidates running in the 6th Congressional District - Republican incumbent U.S. Rep. Richard Baker and Democrat Marjorie McKeithen. One of them will face the issue in the next Congress after winning the Nov. 3 election. 'This issue is moving up the ladder of importance, not going down,' Baker said.*" [Advocate (Baton Rouge, La.), 10/12/98 (emphasis added)]

Name	District	Election Result	7/24/98 Vote
Hostettler, John	IN-8	52% - 47%	Nay

2. **Hostettler: Opponent Ran TV Ads And Made Patients' Rights The "Key Issue":** *"Gail Riecken, the Democrat trying to unseat Rep. John Hostettler in southwestern Indiana's 8th District congressional race, has tried to make HMOs a key issue."* [Associated Press, 10/19/98 (emphasis added)]

According to Roll Call: *"In Indiana, Democratic House candidate Gail Riecken is running an ad similar to [Georgia Senatorial candidate Michael] Coles' [in which he attacked his opponent's record on HMOs] in which a woman asserts that her baby suffered brain damage when a C-section was refused. Riecken's campaign says she has gone from 20 points behind Republican Rep. John Hostettler to 8 points back, but the HMO issue hasn't put her into the lead yet."* [Roll Call, 10/22/98 (emphasis added)]

Name	District	Election Result	7/24/98 Vote
Northup, Anne	KY-3	52% - 48%	Nay

3. **Northrup: Opponent Made HMO Reform "No. 1 Issue."** According to the National Journal: *"Still, Gorman -- who is seeking to unseat first-term GOP Rep. Anne Meagher Northup -- managed to get Gephardt to attend a fund-raising breakfast with about 40 local supporters, many of them labor-union leaders, and a rally at a senior-citizens center to press for reform of health maintenance organizations, which Gorman has played as his No. 1 issue."* [National Journal, 9/5/98]

Name	District	Election Result	7/24/98 Vote
Rogan, James	CA-27	51% - 47%	Nay

4. **Rogan: Said It Was "Essential" To Pass A Patients' Bill Of Rights.** When asked by the Los Angeles Times, "If you go to Washington, what kind of agenda will you pursue?" Rogan responded *"I would want to work to pass an HMO patients' 'bill of rights.' I think it's essential."* [Los Angeles Times, 11/1/98 (emphasis added)]

Name	District	Election Result	7/24/98 Vote
Wilson, Heather	NM-1	46% - 43%	Nay

5. **Wilson: Opponent Made Patients' Rights A Key Issue.** According to CongressDaily, *"In New Mexico, Democratic challenger Phil Maloof sought to use the issue to tie his opponent to House Speaker Gingrich, chiding Rep. Heather Wilson, R-N.M., in one ad for voting 'with Newt Gingrich' and against key patient rights like minimal hospital stays, the right to sue and guaranteed emergency room treatment."* [CongressDaily, 11/2/98]

**WILL ONE OR MORE OF THE 3 NEWLY ELECTED FRESHMAN REPUBLICANS WHO
CAMPAIGNED ON THE PATIENTS' RIGHTS ISSUE VOTE FOR THE BILL?**

1. Rep.-Elect Don Sherwood (PA-10):

A Moderate Who Campaigned On His Support For A Patients' Bill Of Rights.

According to *U.S. News & World Report*, "What the Democrats once viewed as among their brightest opportunities for gaining a congressional seat is now seen as a down-to-the-wire race where the party's best hope is to pull support from independent-minded Republicans who can be persuaded that a GOP vote will hurt education, Social Security, and health care. That's not easy when the Republican candidate, Don Sherwood, talks about his 23 years on the school board in his hometown of Tunkhannock and his support for a patients' bill of rights and for bolstering the Social Security fund. Sherwood is running so centrist that he even voices support for a minimum wage boost..." [*U.S. News & World Report*, 10/12/98 (emphasis added)]

2. Rep.-Elect Ernie Fletcher (KY-6):

A Doctor Who Ran Two TV Ads About Patients With HMO Horror Stories.

According to the *National Journal's* "1998 Political Ads" section of their Cloak Room web page: "...Fletcher is emphasizing his medical career in his efforts to defeat Democrat Ernesto Scorsone for the 6th District seat being vacated by Senate candidate Rep. Scotty Baesler. Two 60-second spots feature patients of Fletcher's, talking about their experiences. The doctor appears in a casual shirt in his living room, arguing that HMOs let them down, and vowing to pursue reform. Jack Smith says Fletcher saved him from blindness by taking on an indifferent HMO, while Kay Cockrell discusses her fight against breast cancer." [*National Journal's* "1998 Political Ads" (Cloak Room Web Page), 9/21/98 (emphasis added)]

3. Rep.-Elect Judy Biggert (IL-13):

Frm. Chair of Chicago Visiting Nurses Assoc. Who Is Concerned That Health Decisions Are Not Being Made By Doctors.

According to the *National Journal's* New Member Profile of Judy Biggert: "A former chairwoman of the Visiting Nurses Association of Chicago, Biggert is likely to make health care reform an important part of her agenda. She says that 'health care decisions are being made by someone who's not a doctor, someone who's concerned about the bottom line.'" [*National Journal's* "New Member Profiles" (Cloakroom Web Page), 11/4/98]

The July 24, 1998 "Patients' Bill Of Rights" Vote -- In Detail --

Overview

Defeated

217 "Nea" votes
212 "Yea" votes
6 "Not Voting"

Democrats who voted "Yea" (201)

Abercrombie (HI), Ackerman (NY), Allen (ME), Andrews (NJ), Baesler (KY), Baldacci (ME), Barcia (MI), Barrett (WI), Becerra (CA), Bentsen (TX), Berman (CA), Berry (AR), Bishop (GA), Blagojevich (IL), Blumenauer (OR), Bonior (MI), Borski (PA), Boswell (IA), Boucher (VA), Boyd (FL), Brady (PA), Brown (CA), Brown (OH), Brown (FL), Capps (CA), Cardin (MD), Carson (IN), Clay (MO), Clayton (NC), Clement (TN), Clyburn (SC), Condit (CA), Conyers (MI), Costello (IL), Coyne (PA), Cramer (AL), Cummings (MD), Danner (MO), Davis (FL), Davis (IL), DeFazio (OR), DeGette (CO), Delahunt (MA), DeLauro (CT), Deutsch (FL), Dicks (WA), Dingell (MI), Dixon (CA), Doggett (TX), Dooley (CA), Doyle (PA), Edwards (TX), Engel (NY), Eshoo (CA), Etheridge (NC), Evans (IL), Farr (CA), Fattah (PA), Fazio (CA), Filner (CA), Frank (MA), Frost (TX), Furse (OR), Gejdenson (CT), Gephardt (MO), Goode (VA), Gordon (TN), Gutierrez (IL), Green (TX), Hall (OH), Hall (TX), Hamilton (IN), Harman (CA), Hastings (FL), Hefner (NC), Hilliard (AL), Hinchey (NY), Holden (PA), Hooley (OR), Hoyer (MD), Jackson-Lee (TX), Jackson (IL), Jefferson (LA), John (LA), Johnson (WI), Johnson, E. B. (TX), Kanjorski (PA), Kaptur (OH), Kennedy (RI), Kennedy (MA), Kennelly (CT), Kildee (MI), Kilpatrick (MI), Kind (WI), Kleczka (WI), Klink (PA), Kucinich (OH), LaFalce (NY), Lampson (TX), Lantos (CA), Lee (CA), Levin (MI), Lewis (GA), Lipinski (IL), Lofgren (CA), Lowey (NY), Luther (MN), Maloney (CT), Maloney (NY), Manton (NY), Martinez (CA), Mascara (PA), Matsui (CA), McCarthy (NY), McCarthy (MO), McDermott (WA), McGovern (MA), McHale (PA), McIntyre (NC), McKinney (GA), McNulty (NY), Meehan (MA), Meek (FL), Meeks (NY), Menendez (NJ), Millender-McDonald (CA), Miller (CA), Minge (MN), Mink (HI), Moakley (MA), Molloy (WV), Moran (VA), Murtha (PA), Nadler (NY), Neal (MA), Oberstar (MN), Obey (WI), Olver (MA), Ortiz (TX), Owens (NY), Pallone (NJ), Pascarella (NJ), Pastor (AZ), Payne (NJ), Pelosi (CA), Peterson (MN), Pickett (VA), Pomeroy (ND), Posner (IL), Price (NC), Rahall (WV), Rangel (NY), Reyes (TX), Rivers (MI), Rodriguez (TX), Roemer (IN), Rothman (NJ), Roybal-Allard (CA), Rush (IL), Sabo (MN), Sanchez (CA), Sandlin (TX), Sawyer (OH), Schumer (NY), Scott (VA), Serrano (NY), Sherman (CA), Sisisky (VA), Skaggs (CO), Skelton (MO), Slaughter (NY), Smith, Adam (WA), Snyder (AR), Spratt (SC), Stabenow (MI), Stark (CA), Stenholm (TX), Stokes (OH), Strickland (OH), Stupak (MI), Tanner (TN), Tauscher (CA),

Taylor (MS), Thompson (MS), Thurman (FL), Tierney (MA), Torres (CA), Towns (NY), Traficant (OH), Turner (TX), Velazquez (NY), Vento (MN), Visclosky (IN), Waters (CA), Watt (NC), Waxman (CA), Wexler (FL), Weygand (RI), Wise (WV), Woolsey (CA), Wynn (MD)

***Republicans who voted
"Yea"***

(10)

Bilbray (CA); Boehlert (NY); Forbes (NY); Fox (PA); Ganske (IA); Horn (CA); LaTourette (OH); Leach (IA); Morella (MD); Roukema (NJ)

Independent who voted "Yea"
(1)

Sanders (VT)

***Republicans who voted
"Nay"***
(217)

Aderholt (AL), Archer (TX), Armey (TX), Bachus (AL), Baker (LA), Ballenger (NC), Barr (GA), Barrett (NE), Bartlett (MD), Barton (TX), Bass (NH), Bateman (VA), Bereuter (NE), Bilirakis (FL), Bliley (VA), Blunt (MO), Boehner (OH), Bonilla (TX), Bono (CA), Brady (TX), Bryant (TN), Bunning (KY), Burr (NC), Burton (IN), Buyer (IN), Callahan (AL), Calvert (CA), Camp (MI), Campbell (CA), Canady (FL), Cannon (UT), Castle (DE), Chabot (OH), Chambliss (GA), Chenoweth (ID), Christensen (NE), Coble (NC), Coburn (OK), Collins (GA), Combest (TX), Cook (UT), Cooksey (LA), Cox (CA), Crane (IL), Crapo (ID), Cubin (WY), Cunningham (CA), Davis (VA), Deal (GA), DeLay (TX), Diaz-Balart (FL), Dickey (AR), Doolittle (CA), Dreier (CA), Duncan (TN), Dunn (WA), Ehlers (MI), Ehrlich (MD), Emerson (MO), English (PA), Ensign (NV), Everett (AL), Ewing (IL), Fawell (IL), Foley (FL), Fossella (NY), Fowler (FL), Franks (NJ), Frelinghuysen (NJ), Gallegly (CA), Gekas (PA), Gibbons (NV), Gilchrest (MD), Gillmor (OH), Gilman (NY), Gingrich (GA), Goodlatte (VA), Goodling (PA), Goss (FL), Graham (SC), Granger (TX), Greenwood (PA), Gutknecht (MN), Hansen (UT), Hastert (IL), Hastings, Richard (WA), Hayworth (AZ), Hefley (CO), Herger (CA), Hill (MT), Hilleary (TN), Hobson (OH), Hoekstra (MI), Hostettler (IN), Houghton (NY), Hulshof (MO), Hunter (CA), Hutchinson (AR), Hyde (IL), Inglis (SC), Istook (OK), Jenkins (TN), Johnson, Sam (TX), Johnson, Nancy (CT), Jones (NC), Kasich (OH), Kelly (NY), Kim (CA), King (NY), Kingston (GA), Klug (WI), Knollenberg (MI), Kolbe (AZ), LaHood (IL), Largent (OK), Latham (IA), Lazio (NY), Lewis (KY), Lewis (CA), Linder (GA), Livingston (LA), LoBiondo (NJ), Lucas (OK), Manzullo (IL), McCollum (FL), McCrery (LA), McDade (PA), McHugh (NY), McInnis (CO), McIntosh (IN), McKeon (CA), Metcalf (WA), Mica (FL), Miller (FL), Moran (KS), Myrick (NC), Nethercutt (WA), Neumann (WI), Ney (OH), Northup (KY), Norwood (GA), Nussle (IA), Oxley (OH), Packard (CA), Pappas (NJ), Parker (MS), Paul (TX), Paxon (NY), Pease (IN), Peterson (PA), Petri (WI), Pickering (MS), Pitts (PA), Pombo (CA), Porter (IL), Portman (OH), Pryce (OH), Quinn (NY), Radanovich (CA), Ramstad (MN), Redmond (NM), Regula (OH), Riggs (CA), Riley (AL), Rogan (CA), Rogers (KY), Rohrabacher (CA),

Ros-Lehtinen (FL), Royce (CA), Ryun (KA), Salmon (AZ), Sanford (SC), Saxton (NJ), Scarborough (FL), Schaefer, Dan (CO), Schaffer, Bob (CO), Sensenbrenner (WI), Sessions (TX), Shadegg (AZ), Shaw (FL), Shays (CT), Shimkus (IL), Shuster (PA), Skeen (NM), Smith (OR), Smith (TX), Smith, Linda (WA), Smith (MI), Smith (NJ), Snowbarger (KA), Solomon (NY), Souder (IN), Spence (SC), Stearns (FL), Stump (AZ), Sununu (NH), Talent (MO), Tauzin (LA), Taylor (NC), Thomas (CA), Thornberry (TX), Thune (SD), Tiahrt (KA), Upton (MI), Walsh (NY), Wamp (TN), Watkins (OK), Watts (OK), Weldon (PA), Weldon (FL), Weller (IL), White (WA), Whitfield (KY), Wicker (MS), Wilson (), Wolf (VA), Young (AK)

Members "Not Voting"
(1 Rep; 5 Dem)

Ford D-TN (announced "for"); Gonzalez D-TX (absent due to illness); Hinojosa D-TX (announced "for"); Markey D-MA (absent due to death in family); Yates D-IL (absent due to illness in family); *Young R-FL*

FINAL VOTE RESULTS FOR ROLL CALL 336(Republicans in roman; Democrats in *italic*; Independents underlined)

H R 4250 YEA-AND-NAY 24-JUL-1998 1:52 PM
AUTHOR(S): Dingell of Michigan Substitute Amendment
QUESTION: On Agreeing to the Amendment

	<u>YEAS</u>	<u>NAYS</u>	<u>PRES</u>	<u>NV</u>
REPUBLICAN	10	217		1
DEMOCRATIC	201			5
INDEPENDENT	1			
TOTALS	212	217		6

--- YEAS 212 ---

<i>Abercrombie</i>	<i>Gordon</i>	<i>Nadler</i>
<i>Ackerman</i>	<i>Green</i>	<i>Neal</i>
<i>Allen</i>	<i>Gutierrez</i>	<i>Oberstar</i>
<i>Andrews</i>	<i>Hall (OH)</i>	<i>Obey</i>
<i>Baesler</i>	<i>Hall (TX)</i>	<i>Olver</i>
<i>Buldacci</i>	<i>Hamilton</i>	<i>Ortiz</i>
<i>Barcia</i>	<i>Harman</i>	<i>Owens</i>
<i>Barrett (WI)</i>	<i>Hastings (FL)</i>	<i>Pallone</i>
<i>Becerra</i>	<i>Hefner</i>	<i>Pascrell</i>
<i>Bentsen</i>	<i>Hilliard</i>	<i>Pastor</i>
<i>Berman</i>	<i>Hinchey</i>	<i>Payne</i>
<i>Berry</i>	<i>Holden</i>	<i>Pelosi</i>
<i>Bilbray</i>	<i>Hooley</i>	<i>Peterson (MN)</i>
<i>Bishop</i>	<i>Horn</i>	<i>Pickett</i>
<i>Blagojevich</i>	<i>Hoyer</i>	<i>Pomeroy</i>
<i>Blumenauer</i>	<i>Jackson (IL)</i>	<i>Poshard</i>
<i>Boehlert</i>	<i>Jackson-Lee (TX)</i>	<i>Price (NC)</i>
<i>Bonior</i>	<i>Jefferson</i>	<i>Rahall</i>
<i>Borski</i>	<i>John</i>	<i>Rangel</i>
<i>Boswell</i>	<i>Johnson (WI)</i>	<i>Reyes</i>
<i>Boucher</i>	<i>Johnson, E. B.</i>	<i>Rivers</i>
<i>Boyd</i>	<i>Kanjorski</i>	<i>Rodriguez</i>
<i>Brady (PA)</i>	<i>Kaptur</i>	<i>Roemer</i>
<i>Brown (CA)</i>	<i>Kennedy (MA)</i>	<i>Rothman</i>

<i>Brown (FL)</i>	<i>Kennedy (RI)</i>	<i>Roukema</i>
<i>Brown (OH)</i>	<i>Kennelly</i>	<i>Roybal-Allard</i>
<i>Capps</i>	<i>Kildee</i>	<i>Rush</i>
<i>Cardin</i>	<i>Kilpatrick</i>	<i>Sabo</i>
<i>Carson</i>	<i>Kind (WI)</i>	<i>Sanchez</i>
<i>Clay</i>	<i>Kleczka</i>	<i><u>Sanders</u></i>
<i>Clayton</i>	<i>Klink</i>	<i>Sandlin</i>
<i>Clement</i>	<i>Kucinich</i>	<i>Sawyer</i>
<i>Clyburn</i>	<i>LaFalce</i>	<i>Schumer</i>
<i>Condit</i>	<i>Lampson</i>	<i>Scott</i>
<i>Conyers</i>	<i>Lantos</i>	<i>Serrano</i>
<i>Costello</i>	<i>LaTourette</i>	<i>Sherman</i>
<i>Coyne</i>	<i>Leach</i>	<i>Sisisky</i>
<i>Cramer</i>	<i>Lee</i>	<i>Skaggs</i>
<i>Cummings</i>	<i>Levin</i>	<i>Skelton</i>
<i>Danner</i>	<i>Lewis (GA)</i>	<i>Slaughter</i>
<i>Davis (FL)</i>	<i>Lipinski</i>	<i>Smith, Adam</i>
<i>Davis (IL)</i>	<i>Lofgren</i>	<i>Snyder</i>
<i>DeFazio</i>	<i>Lowey</i>	<i>Spratt</i>
<i>DeGette</i>	<i>Luther</i>	<i>Stabenow</i>
<i>Delahunt</i>	<i>Maloney (CT)</i>	<i>Stark</i>
<i>DeLauro</i>	<i>Maloney (NY)</i>	<i>Stenholm</i>
<i>Deutsch</i>	<i>Manton</i>	<i>Stokes</i>
<i>Dicks</i>	<i>Martinez</i>	<i>Strickland</i>
<i>Dingell</i>	<i>Mascara</i>	<i>Stupak</i>
<i>Dixon</i>	<i>Matsui</i>	<i>Tanner</i>
<i>Doggett</i>	<i>McCarthy (MO)</i>	<i>Tauscher</i>
<i>Dooley</i>	<i>McCarthy (NY)</i>	<i>Taylor (MS)</i>
<i>Doyle</i>	<i>McDermott</i>	<i>Thompson</i>
<i>Edwards</i>	<i>McGovern</i>	<i>Thurman</i>
<i>Engel</i>	<i>McHale</i>	<i>Tierney</i>
<i>Eshoo</i>	<i>McIntyre</i>	<i>Torres</i>
<i>Etheridge</i>	<i>McKinney</i>	<i>Towns</i>
<i>Evans</i>	<i>McNulty</i>	<i>Traficant</i>
<i>Farr</i>	<i>Meehan</i>	<i>Turner</i>
<i>Fattah</i>	<i>Meek (FL)</i>	<i>Velazquez</i>
<i>Fazio</i>	<i>Meeks (NY)</i>	<i>Vento</i>
<i>Filner</i>	<i>Menendez</i>	<i>Visclosky</i>

Forbes	Millender-McDonald	Waters
Fox	Miller (CA)	Watt (NC)
Frank (MA)	Minge	Waxman
Frost	Mink	Wexler
Furse	Moakley	Weygand
Ganske	Mollohan	Wise
Gejdenson	Moran (VA)	Woolsey
Gephardt	Morella	Wynn
Goode	Murtha	

-- NAYS 217 --

Aderholt	Gillmor	Paul
Archer	Gilman	Paxon
Armey	Gingrich	Pease
Bachus	Goodlatte	Peterson (PA)
Baker	Goodling	Petri
Ballenger	Goss	Pickering
Barr	Graham	Pitts
Barrett (NE)	Granger	Pombo
Bartlett	Greenwood	Porter
Barton	Gutknecht	Portman
Bass	Hansen	Pryce (OH)
Bateman	Hastert	Quinn
Bereuter	Hastings (WA)	Radanovich
Bilirakis	Hayworth	Ramstad
Bliley	Hefley	Redmond
Blunt	Herger	Regula
Boehner	Hill	Riggs
Bonilla	Hilleary	Riley
Bono	Hobson	Rogan
Brady (TX)	Hoekstra	Rogers
Bryant	Hostettler	Rohrabacher
Bunning	Houghton	Ros-Lehtinen
Burr	Hulshof	Royce
Burton	Hunter	Ryun
Buyer	Hutchinson	Salmon
Callahan	Hyde	Sanford
Calvert	Inglis	Saxton

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.

-30-30-30-



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.

* * * * *

Clinton Presidential Records Digital Records Marker

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

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

Divider Title: Loft Letter 8/98

TRENT LOTT
MISSISSIPPI

United States Senate

OFFICE OF THE MAJORITY LEADER

WASHINGTON, DC 20510-7010

August 11, 1998

The President
The White House
Washington, DC 20500

Dear Mr. President,

Yesterday you said you would veto the health care quality bills proposed by House and Senate Republicans. Ever-changing procedural demands by Senators Daschle and Kennedy prevented the Senate from considering health care legislation in July, and are likely to make it difficult for the Senate to pass reforms this fall. Your veto threat only makes our job harder.

Senate Republicans have repeatedly offered to accommodate consideration of this legislation. We have a simple goal – we want to pass health care reform, and we want to do so in a way that allows us to finish our appropriations bills on time.

We ask for two things. First, that you make a public statement that indicates your willingness to work with us, not against us. Second, that you urge Senator Daschle to agree to limit time and amendments for considering health care reform this September.

Without your cooperation, we fear that we may not be able to consider health care quality legislation this fall. We believe the American people want a change in law, not a campaign issue.

Respectfully,



Trent Lott

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

TOM DASCHLE
SOUTH DAKOTA

United States Senate
Office of the Democratic Leader
Washington, DC 20510-7020

August 13, 1998

The President
The White House
Washington, DC 20500

Dear Mr. President:

Those who continue to oppose strong patients' rights legislation received precisely the right message from you Monday, when you reiterated your strong support for patients' rights and stated your intention to veto legislation that provides inadequate protections for patients. I am writing to assure you that Senate Democrats share your resolve to enact strong, enforceable patient protections for all Americans.

In recent weeks, opponents of meaningful HMO reform legislation have gone to great lengths to turn reality on its head and accuse HMO reform proponents of blocking consideration of reform legislation. The Republicans were dragged to the HMO reform debate. They have delayed consideration of this critical legislation for almost a year, and they have contorted the Senate schedule to avoid votes on HMO reform.

On October 22, 1997, a memo from the Health Insurance Association of America, the chief lobbyists against HMO reform, presented the true Republican position on the issue: "The message we are getting from House and Senate leadership is that we are in a war and need to start fighting like we're in a war." Reaching new heights of hypocrisy, Republicans now claim that those of us who have been pushing the reform effort for over a year are responsible for *their* delays.

The Republican leadership's "willingness" to bring HMO reform legislation to the Senate floor is wholly contingent upon their ability to predetermine the outcome. Their strategy is to disallow amendments that would correct the severe deficiencies in their bill, which is clearly not a serious attempt to address the problems facing Americans in managed care plans. As you'll recall, the Majority Leader's initial proposal was to allow himself the option to return Democratic HMO legislation to the Senate calendar -- thereby killing it -- even if the Senate passed it. Now Senator Gramm, a key opponent of real reform, has indicated his intention to object to any consideration of HMO reform beyond the two votes he has personally determined to be appropriate.

As much as the Republican leadership would like to make it so, this debate is not about procedure. It is about patients' rights. Republicans have made clear their absolute resolve to block enactment of the Democratic bill; therefore, Democrats have no choice but to try to improve the Republican bill. Every amendment Democratic senators have proposed to offer represents an attempt to correct a serious problem in the Republican bill.

The enclosed memo outlines the key differences in the two bills and the changes necessary to make the Republican bill acceptable. Those changes include, among others: covering the 113 million Americans excluded from the Senate Republican plan; guaranteeing direct access to necessary specialists; guaranteeing that patients will be provided necessary care in the closest emergency room; guaranteeing that patients may receive the prescription drugs their doctor prescribes; guaranteeing that doctors, not HMO bureaucrats, will determine what treatments are medically necessary; and guaranteeing that HMOs will be held accountable if their decisions lead to serious injury or death.

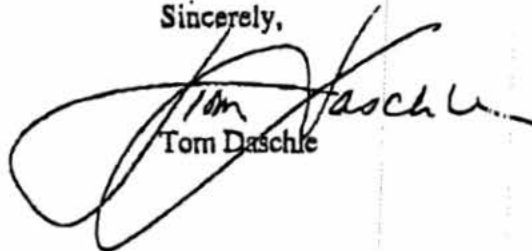
The President
August 13, 1998
Page two

Every Democratic amendment represents an attempt to correct a critical problem in the Republican bill. This issue is not simply about senators' rights to offer them; it is about patients' rights to have them.

If patients' rights are not adequately protected, or if 113 million Americans are excluded from the protections, Congress will have no right to claim that it has passed meaningful HMO reform. My Democratic colleagues and I stand firmly behind your decision to veto such legislation if it reaches your desk. Such a veto would be both justifiable and sustainable, but it is not what we are seeking. I will continue to urge the Majority Leader to begin a full and fair debate on HMO reform legislation as soon as we return from the August recess, and I hope you will do the same.

Thank you for your commitment to this issue of great concern to the American people.

Sincerely,



Tom Daschle

Enclosure

DATE: July 22, 1998
TO: Cosponsors of S.1890, the Patients' Bill of Rights
FROM: Senator Daschle and Senator Kennedy
RE: Update -- Senate Republican leadership bill

On Friday, July 17, the Senate Republican leadership introduced their health care bill, S. 2330. As we expected, in an attempt to confuse supporters of our legislation, the Senate Republican leadership has called their legislation "The Patients' Bill of Rights." A more apt title would be the "The Patient Bill of Wrongs" or "The Insurance Company Bill of Rights." Their legislative language reveals even more gaps and loopholes than we discovered in the outline they released last week, even for such straightforward and non-controversial provisions as emergency care and independent, external appeals.

The Republican bill seeks to give the appearance of reform without the reality. Among other gaps, the Republican bill still leaves medical decisions in the hands of insurance company accountants, does not provide a right to needed specialty care for children or adults, and provides no effective mechanism to hold plans accountable when plan abuse kills or injures patients. Because, as the Republican Leadership acknowledges, their proposal applies primarily to self-funded plans, most protections in the plan do not even apply to HMOs. As a result, almost two-thirds of privately insured Americans are not covered by the Republican plan.

This memo describes what is in the Republican plan, and perhaps more notable, both who and what it leaves out.

Who is covered by the Republican plan

The most striking loophole in the Republican plan is that most of the patient protections in the plan apply only to self-funded employer plans. These plans cover only 48 million of the 161 million people with private insurance. (See attached chart.) It is important to note that the Democratic Patients' Bill of Rights extends equal protections to all 161 million privately insured Americans.

Two patient protections in the Republican bill that apply more broadly are (1) information disclosure requirements; and (2) internal and external appeal requirements. Even these protections appear not to apply to state and local government workers and people who purchase insurance plans on their own, such as self-employed small businessmen and women (38 million people). Both provisions are full of loopholes.

Protections Omitted from the Republican Bill but Included in S.1890

Access to Specialists. The Republican bill does not ensure access to specialty care. If a child with cancer needs access to a pediatric oncologist, there is no requirement she will have access to that specialist.

Physician Decision-making. The Republican bill does nothing to protect patients when an insurance company bureaucrat tells them they must have a medical procedure on an outpatient basis or be discharged from a hospital prematurely. Our Patients' Bill of Rights prevents insurers from arbitrarily interfering with the decisions of the treating physician.

Ability to Hold Plans Accountable When Abusive Practices Kill or Injure Patients. The Republican bill does nothing to provide meaningful remedies when abusive plan practices kill or injure a patient. Under their plan, the only remedy available is the cost of a denied procedure, even if a patient is killed or disabled for life. Our Patients' Bill of Rights allows patients to seek meaningful remedies under state law.

Referrals Outside the Network. If an HMO's network does not include a provider qualified to treat a patient's condition, the Republican bill does not ensure access to an appropriate specialist outside the network.

Standing Referrals and Specialists as Primary Care Physicians. The Republican bill does not allow patients with diseases or disabilities requiring continuing care by a specialist to have standing referrals that would avoid the need to obtain insurance company or primary care doctor permission for each visit, nor do they allow such individuals to designate their specialist as their primary care doctor. Children and adults with such diseases as cancer or severe arthritis will continue to face insurance company red tape every time they need to see their oncologist or rheumatologist.

Restrictions on Prescription Drugs. The Republican bill does not ensure that patients who have drug benefits can get the prescription drug their doctor prescribes and that they need. The Patients' Bill of Rights requires HMOs to make needed prescription drugs available even if they are not on the HMO's approved list (formulary).

Clinical Trials. The Republican bill does not provide access to quality clinical trials for patients with such conditions as advanced breast cancer or Alzheimer's Disease for which there may be no effective conventional treatment.

OB/GYN as Primary Care Doctor. The Republican bill does not allow women to choose their obstetrician/gynecologist as a primary care provider.

Continuity of Care. The Republican bill does not allow a patient undergoing an active course of treatment or in the last trimester of pregnancy to continue with their doctor if their employer changes to an insurance plan that does not include that doctor in its network. Furthermore, it leaves the chronically ill without any protection.

Protection Against Retaliation for Doctors and Nurses. The Republican bill does not protect doctors and nurses from retaliation when they advocate for their patient's needed care.

Limits on Improper Financial Incentives. The Republican bill does not limit HMOs' and insurance companies' use of improper financial incentives to withhold needed care. Doctors can be penalized financially for providing the best possible care for their patients.

Availability of Quality Information to Assist Consumers in Choosing Plans. The Republican bill does not require plans to provide information on quality of care that can help consumers choose among plans and that can be an incentive to plans to improve their performance (consumer satisfaction, immunization rates, etc.).

Network Adequacy. The Republican bill does not require that an HMO's network be adequate to meet its members needs, so HMOs still would be allowed to operate with few doctors and long waiting periods for appointments. They could force patients to drive hours to get needed care, even if there are non-network providers nearby.

Inadequate Protections Included in the Republican Plan

Emergency Medical Care. The Republicans claim to include access to emergency care for the 48 million Americans covered in their plan. But their bill language substantially narrows the standard adopted by Congress for Medicare and Medicaid, so much so that the American College of Emergency Physicians says their approach "will establish new loopholes for the managed care industry to second-guess patients and emergency physicians about the delivery of legitimate emergency services."

Perhaps most egregious, the GOP bill does not guarantee that patients can go to the closest emergency room that may not be in the HMO's network.¹ In addition, their bill only guarantees an emergency medical screening without prior authorization from the HMO.² There is no guarantee that treatment to stabilize a patient would be covered.³ A real prudent layperson definition would require managed care plans to cover all services required to evaluate, and if necessary, stabilize a patient. The bill also appears to allow HMOs to charge significantly more if emergency care is sought without prior authorization or from an out-of-network hospital, creating huge loopholes that will allow continued abuse by the HMO industry.⁴

Finally, the Republican bill does not cover necessary post-stabilization and maintenance care following emergency care. Too often, plans turn off their phones after normal business hours, making it impossible for physicians to obtain authorization 24 hours a day for care immediately following an emergency. The Republican plan does not address necessary maintenance and post-stabilization care after emergency services are provided, leaving providers and patients at significant risk.

External Review of Plan Decisions. The Senate Republicans claim their bill provides for an independent, external review of HMO's decisions to deny care, similar to the provisions in S.1890. They claim their provision will solve everyone's problems with HMOs. But when you look at the fine print, their provision is full of loopholes.

- it fails to cover almost 40 million privately insured Americans who buy insurance on their own or have coverage through state and local governments.⁵
- the process is not independent, as they claim, since plans choose and pay the external review entity, and there is no requirement that the reviewer have no affiliation with the HMO or insurer.⁶
- it won't help anyone whose HMO is denying care that costs less than \$1000. That could include a child's asthma treatment, a mammogram, a biopsy of the breast, a colonoscopy, or physical therapy sessions that are needed to fully recover from an accident. If an HMO says no to these kinds of tests and treatments, the patient is out of luck.⁷

¹ See Section 721 of the Republican plan.

² Section 721 (a) (1)

³ Section 721 (a) (2) only covers the care if the plan agrees that treatment should have been approved by a "prudent emergency medical professional."

⁴ Section 721

⁵ Section 121 (amending Section 503 of ERISA) is the relevant section of the bill. ERISA does not cover non-group or state and local government plans.

⁶ Section 503 (e) (3)

⁷ Section 503 (e) (1) (i)

- many decisions by HMOs to deny access and care are not appealable under the GOP bill. External review is restricted to questions of medical necessity or whether a treatment is experimental or not.⁸ This continues to leave the plan as judge and jury in many important decisions, such as whether the beneficiary has followed the "prudent layperson" standard in seeking emergency care, whether the beneficiary qualifies for continuity of care, and whether the beneficiary can have access to a specialist, because the provider designated by the plan is not qualified to provide a covered service, since these are not appealable decisions under the Republican bill.
- the Republican bill allows HMOs to prevent cases from going to an external review. Under their bill, the HMO, not the external review entity, decides whether specific cases qualify for an appeal.⁹ HMOs also can prevent an external appeal by failing to make a timely decision on an internal appeal. Under the GOP bill, an external appeal is conditioned on completion of an internal appeal.¹⁰ Therefore, HMOs could indefinitely delay the process, even where a case is urgent.

Direct Access to OB/GYN and Pediatricians. Like our Patients' Bill of Rights, the Republican bill allows direct access to obstetrician/gynecologists for routine care only; but as noted above, the Republican plan does not allow a woman to choose an obstetrician/gynecologist as her primary care physician.¹¹ The Republican plan also allows direct access to pediatricians for children, but all plans already allow children to have a pediatrician as a primary caregiver. The Republican plan does not guarantee access to pediatric specialists.¹²

Point-of-Service Plans. Like our Patients' Bill of Rights, the Republican bill requires a point-of-service option if a closed panel HMO is the only plan offered. The requirement for a point of service option does not apply to small employers (employers with 2-50 employees), the very businesses least likely to offer a choice of plans.¹³

Prohibition on Gag Rules. Like our Patients' Bill of Rights, the Republican bill prohibits gag clauses. The Republican provision is meaningless, however, since it does not (1) deal with improper financial incentive arrangements, (2) provide any protections for patient advocacy, or (3) prohibit contract clauses that allow the termination of a physician from the network at the option of the plan without giving any justification for the action.¹⁴

Continuity of Care. Like our Patients' Bill of Rights, the Republican bill requires continued coverage of physician care for patients undergoing a course of treatment if their physician is dropped from the network. Unlike the Patients' Bill of Rights, as noted above, there is no comparable protection in the more common case of the employer changing to a plan that does not include the individual's physician in its network, or for patients who are undergoing treatment but are not pregnant, terminally ill, or institutionalized.¹⁵

8 Section 503 (e) (1)
 9 Section 503 (e) (1)
 10 Section 503 (e) (1) (c)
 11 Section 723
 12 Section 724
 13 Section 722 (c)
 14 Section 726
 15 Section 725

Medical Privacy. Like our Patients' Bill of Rights, the Republican bill provides limited privacy protections for patient records. Republicans have kept comprehensive privacy bills bottled up in committee for three years.

Plan Information. Like our Patients' Bill of Rights, the Republican bill requires HMOs to provide specified information to subscribers but, as noted above, the Republican proposal does not require provision of quality information. Specific exclusions from coverage under the plan are provided only on request -- an invitation to deceptive marketing.¹⁶ The GOP bill also does not get patients information about changes in the benefits an HMO will cover when they need it most -- before an HMO makes the change and limits coverage. Patients still will discover that their HMO can deny care they thought was covered, since there's no requirement to inform enrollees of changes in coverage before they happen.

Prohibition on Use of Genetic Information. The Republican bill prohibits use of "predictive genetic information" to deny coverage or set premiums. Republicans have kept genetic information legislation bottled up in committee for 18 months. An effective prohibition would apply to employers as well as health insurers, another shortcoming of the Republican proposal.

Prohibition on Drive-through Mastectomies and Requirement of Coverage for Reconstructive Surgery after Mastectomy. The Republican provision and our Patients' Bill of Rights appear similar. This and their genetic information provision are the only provisions that the Republicans apply to all privately insured Americans.

Additional Provisions

Perhaps to compensate for the weakness of their patient protection provisions, the Republicans have added a number of unrelated measures to their proposal. The legislation includes several noncontroversial public health authorizations and reauthorizations, including the reauthorization of the Agency for Health Care Policy Research and the authorization or reauthorization of a number of programs for women at the NIH and CDC. In most cases, these reauthorizations are years overdue and should have been enacted long ago through the normal committee process.

Tax provisions

Immediate Phase-in of Full Deductibility for Health Insurance Premiums of the Self-employed. This noncontroversial provision speeds up the scheduled phase-in of full deductibility that was enacted in the Kassebaum-Kennedy bill. The estimated cost is \$7 billion over 10 years, according to Senator Roth.

Expansion of Medical Savings Accounts. The bill would eliminate the 750,000 cap on the number of MSAs that could be sold; lower the minimum deductible to \$1,000 per individual (compared to the current level of \$1,500) and \$2,000 per family (\$3,000 currently); increase the amount that could be contributed each year; allow amounts in the MSA in excess of the annual deductible to be spent on non-health expenses without a tax penalty; and open up the program to large businesses (the current four-year test program restricts MSAs to the self-employed and small businesses).

Because of our strong concerns that MSAs will make health insurance unaffordable for millions of Americans and would work only for the healthy and wealthy, we agreed only to a pilot study of these plans as part of the Kassebaum-Kennedy legislation.

¹⁶ Section 713 (b) (13) (F)

MSAs disproportionately attract the healthy and wealthy. If enough people sign up, MSAs could make conventional health insurance unaffordable. If the number of MSAs sold exceeds the current cap, the consequences for the health care system could be severe. MSAs have proven to be a flop in the marketplace, however.

The Republican plan would make the program a more attractive tax avoidance gimmick, since it would be easy for employers to give pay raises in the form of non-taxable contributions to MSAs -- raises that could be spent for any consumer good without the tax penalty in current law.

The program changes included in the Republican plan will cost an estimated \$4 billion.

Flexible Spending Accounts. The proposal would allow unused amounts in an FSA to be rolled over from one year to the next, up to a maximum of \$500 a year.

REPUBLICAN PLAN EXCLUDES MORE THAN 100 MILLION PEOPLE (2/3 of Privately Insured)

EXCLUDED

People buying
individual
policies

15 million

State and local
government
workers

23 million

People whose
employer pro-
vides coverage
through an
insurance policy
or an HMO

75 million

Total Excluded: 113 million

COVERED

People covered
through a self-
funded
employer plan

48 million

Total Covered: 48 million

Clinton Presidential Records Digital Records Marker

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Divider Title: CBO Estimates

**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.



CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

July 16, 1998

H.R. 3605/S. 1890 Patients' Bill of Rights Act of 1998

As modified by the sponsors

SUMMARY

The Patients' Bill of Rights Act of 1998 would impose new requirements on the structure and operation of group health plans and health insurance issuers and would provide members of health plans and insured individuals with new rights to obtain certain health care services. It would require both internal and external review processes for members to appeal decisions by health plans and insurers. It would also amend the Employee Retirement Income Security Act (ERISA) to allow individuals to sue health plans and insurers for personal injury or wrongful death under state tort laws. These provisions would have a significant effect on the costs of private insurance as well as the federal budget. Because of the extent and complexity of the changes to the health insurance system that could result from such provisions, estimates of their effects are subject to more than the usual amount of uncertainty.

The bill would affect the federal budget in three ways. First, by increasing premiums for employer-sponsored health benefits, it would substitute nontaxable employer-paid premiums for taxable wages and would therefore decrease federal income and payroll tax revenues. The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) estimate that the proposal would reduce federal tax revenues by \$40 million in 1999 and by \$4.6 billion over the 1999-2003 period. Second, the bill would impose additional costs on the Federal Employees' Health Benefits Program, most of whose plans are classed as health insurance issuers. CBO estimates that these costs would amount to \$240 million over the 1999-2003 period, of which \$90 million would be mandatory. Third, it would require additional spending for administration and regulatory activities, subject to appropriation of the necessary amounts. These discretionary costs would total an estimated \$255 million over the next five years.

The bill's requirements on group health plans offered by state, local, and tribal governments would be optional under the Public Health Service Act (PHSA). Consequently, those requirements would not constitute intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA).

The bill would establish several private-sector mandates as defined by UMRA. Provisions imposing new functions and operating practices on private insurers and health plans would create private-sector mandates. Provisions that would indirectly raise plan costs, such as those giving plan members the right to sue plans for personal injury, would not be considered private-sector mandates. After 1999, the estimated costs of the private-sector mandates would greatly exceed the threshold established in UMRA (\$100 million in 1996, adjusted for inflation).

As specified by the sponsors, this estimate is based on the introduced bill, the technical changes contained in Senate amendment 3063 introduced on July 7 (excluding the revenue provisions), and a change in the effective date of section 302(b) to July 1, 1999.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of the bill is shown in Table 1. The costs of this legislation fall within budget function 500 (health) and other functions.

BASIS OF ESTIMATE

The bill would significantly change the relationships between employers, health plans, health insurers, providers, and patients. These changes would be complex and would be imposed on a rapidly evolving health care system. In some areas, limited data on which to base a cost estimate are available. CBO has consulted with a variety of experts, including representatives of managed care plans, health insurers, providers, and private industry; state regulators; practicing and academic health and ERISA lawyers; and health policy researchers. This cost estimate represents CBO's best judgment about the likely effects of the bill.

TABLE 1. ESTIMATED BUDGETARY EFFECT OF THE PATIENTS' BILL OF RIGHTS ACT

	By fiscal year, in millions of dollars									
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
REVENUES										
Income and HI Payroll Taxes	-28	-446	-752	-911	-1,066	-1,177	-1,265	-1,355	-1,450	-1,553
Social Security Payroll Taxes	-12	-197	-332	-402	-470	-519	-558	-597	-640	-685
Total	-40	-643	-1,084	-1,313	-1,535	-1,697	-1,823	-1,952	-2,090	-2,237
DIRECT SPENDING										
FEHBP—Annuitants	0	5	15	30	40	55	65	70	75	80
AUTHORIZATIONS OF APPROPRIATIONS										
FEHBP—Active Workers	0	10	30	45	65	90	100	105	115	120
Federal Administrative Costs	15	55	55	65	65	65	70	70	75	75
Total	15	65	85	110	130	155	170	175	190	195

SOURCES: Congressional Budget Office and Joint Committee on Taxation.

NOTES: HI = Hospital Insurance

FEHBP = Federal Employees Health Benefits Program

CBO estimated the impact of each provision on health plan premiums in the 10 years following enactment (which is assumed to occur by October 1, 1998). This cost impact is expressed as the expected ultimate percentage change in average health insurance premiums—that is, the change when all of the bill's provisions are fully phased in. CBO estimates that premiums for a typical employer-sponsored health plan would rise by 4.0 percent in the absence of any compensating changes on the part of employers. Table 2 shows the estimated effect of each provision on premiums, before employers modify their behavior to offset some of the increase. The effects are expressed as a percentage of total premiums for all nonfederal employer-sponsored plans, including plans that would face no increase in costs.¹

Employers could respond to premium increases in a variety of ways to reduce their impact. They could drop health insurance entirely, reduce the generosity of the benefit package, increase cost-sharing by beneficiaries, or increase the employees's share of the premium.

1. Most of the provisions of the bill were extended to the Federal Employees Health Benefits Program under a Presidential memorandum of February 20, 1998. This estimate includes the costs of the provisions of the bill that cannot be implemented administratively.

TABLE 2. ESTIMATED ULTIMATE EFFECT OF THE PATIENTS' BILL OF RIGHTS ACT ON PREMIUMS FOR EMPLOYER-SPONSORED HEALTH INSURANCE (In percents)

Provision	Increase in Premiums
Section 101—Access to Emergency Care	0.2
Section 102—Offering of Choice of Coverage Options	0.1
Section 103—Choice of Providers	a
Section 104(a)—Obstetrical and Gynecological Care	0.1
Section 104(b)—Specialty Care	a
Section 105—Continuity of Care	0.2
Section 106—Coverage for Clinical Trials	0.4
Section 107—Access to Needed Prescription Drugs	b
Section 108—Adequacy of Provider Network	0.1
Section 109—Nondiscrimination in Delivery of Services	b
Section 111—Internal Quality Assurance Program	0.2
Section 112—Collection of Standardized Data	0.3
Section 113—Process for Selection of Providers	b
Section 114—Drug Utilization Program	b
Section 115—Standards for Utilization Review Activities	b
Section 116—Health Care Quality Advisory Board	0
Section 121—Patient Information	b
Section 122—Protection of Patient Confidentiality	b
Section 123—Health Insurance Ombudsmen	0
Section 131—Establishment of Grievance Process	0.3
Section 132—Internal Appeals of Adverse Determinations	c
Section 133—External Appeals of Adverse Determinations	c
Section 141—Prohibition of Interference	b
Section 142—Prohibition of Improper Incentive Arrangements	b
Section 143—Participation of Health Care Professionals	0.1
Section 144—Protection for Patient Advocacy	d
Section 151—Promoting Good Medical Practice	0.8
Section 152—Standards for Breast Cancer Treatment	b
Section 153—Standards for Reconstructive Breast Surgery	e
Section 302—ERISA Preemption	1.2
Total	4.0

a. Included in estimate of section 103.

b. Less than 0.05 percent.

c. Included in estimate of section 131.

d. Included in estimate of section 143.

e. Included in estimate of section 152.

CBO assumed that employers would deflect about 60 percent of the increase in premiums through these strategies. The remaining increase in premiums would be passed onto workers in the form of lower wages. These lower wages would reduce federal receipts from income and payroll taxes.

Title I of the bill, comprising seven subtitles, would establish standards to protect consumers in managed care plans and other health insurance plans. Title II would apply the standards to group health plans and issuers of individual health insurance coverage as defined in title XXVII of the Public Health Service Act. Title III would apply the standards to group health plans and group health insurance coverage under the Employee Retirement Income Security Act. Title IV would apply the standards to group health plans under the Internal Revenue Code. In this estimate, the costs of the patient-protection standards are assigned to the corresponding sections of title I.

In addition, title III would amend ERISA to allow enrollees in employer-sponsored health insurance plans to sue their plans under state law for damages resulting from personal injury or wrongful death. It would also require the Secretary of Labor to investigate complaints of discrimination or retaliation against health care professionals. The incremental costs of these provisions are shown separately.

Access to Care

Subtitle A would impose requirements on the structure of health plans and the access to services and providers they offer their members. These requirements would affect access to emergency and specialty care, coverage of clinical trials, and adequacy of provider networks.

Section 101—Access to Emergency Care. This section would require plans to pay for emergency care received without prior authorization in any licensed hospital emergency department when the condition is serious enough to meet the "prudent layperson" standard (as applicable to Medicare+Choice plans). Moreover, the plan could charge the patient no more than if the emergency department were in the plan's network. CBO assumes, therefore, that the plan would be responsible for paying the provider's full charge for emergency services rendered. Finally, the plan would be required to pay for post-stabilization care rendered at the nonparticipating institution consistent with yet-to-be-released regulations governing Medicare and Medicaid.

This standard is already in place for fully insured ERISA health plans under the laws of 5 states with about 6 percent of the U.S. population. CBO assumed that roughly half of current denials of payment for emergency room visits would meet the prudent layperson standard and that the costs to health plans of treating patients in nonparticipating emergency departments would be 50 percent higher than they would be in participating hospitals. Once the prudent layperson standard became widely understood, members of plans would increase emergency visits and probably their use of nonparticipating hospital emergency departments. The return to fee-for-service insurance payment to nonparticipating providers would encourage hospitals to raise their charges for emergency departments. CBO estimates that the new prudent layperson standard, the removal of restrictions on nonparticipating providers' payment rates, and the inducement of additional visits to emergency rooms would increase the average premium by 0.2 percent across all private employer-sponsored health plans.

Section 102—Offering of Choice of Coverage Options. This section would require health plan sponsors to offer point-of-service (POS) plans whenever their existing offerings of plans did not offer a choice among provider networks. About 7 percent of employees—most in small firms—currently work in organizations offering employee health plans that limit choice of provider and do not offer an alternative plan. The provision would increase the administrative cost of processing out-of-plan claims and increase the use of services by those who selected the POS option. Because the provision would not impose any requirements on the financial terms of the POS option, employers could offset some of its costs by increasing cost-sharing by beneficiaries. Based on out-of-plan use in currently available preferred provider organization (PPO) and POS plans, CBO estimated that 10 percent of employees in firms newly offering the POS option would select it and that the net costs (benefit payments and administrative expenses) for those individuals would increase by 11 percent. The net effect averaged across all employer-sponsored health plans would be an increase of 0.1 percent in premiums.

Section 103—Choice of Providers. This section would require health plans to allow enrollees to choose among the participating health care providers who are available to accept patients, but it would allow health plans to restrict choice among specialists if the plan clearly informed participants of these limitations. Alone, this section would have negligible effects on health care costs because it would give plans the right to close physician practices to new patients and would also allow plans to write rules into their description of benefits that detailed limitations on access to specialists. However, this provision would be appealable under sections 132 and 133 and could interact with section 108 (requiring an adequate provider network) as it was considered by appeals bodies. For example, if only one physician in a specific subspecialty was available to see patients at the time of referral, patients might argue on the basis of both this section and section 108 that the plan was not

providing a sufficient choice of providers. Because of the interaction of this section with section 108, CBO includes the cost of this section its estimate of section 108.

Section 104(a)—Obstetrical and Gynecological Care. This subsection would grant women specific rights to designate a participating obstetrical and gynecological specialist as their primary care provider and to receive covered preventive women's health and pregnancy services from a participating obstetrical and gynecological specialist.

This provision would require an immediate change in the design and operation of some plans, but it would not affect all types of plans. Fee-for-service and PPO plans do not require referrals to specialists. In addition, fully-insured ERISA plans and self-purchased insurance products are subject to state mandates on access to obstetrical and gynecological specialists; these mandates already exist in states containing almost 70 percent of the population. CBO estimates that only 22 percent of individuals in employer-sponsored plans would be newly affected by section 104(a) to a substantial extent. CBO relied on an estimate of the effect of this provision in California made by Price Waterhouse for the Kaiser Family Foundation which found that such plans could see a 1 percent increase in physician costs or a 0.35 percent increase in overall costs.² Thus, across all employer-sponsored plans, section 104(a) would raise employer-sponsored premiums by about 0.1 percent.

Section 104(b)—Specialty Care. Section 104(b) would require plans to pay for referrals to specialists when such care is justified by the complexity or seriousness of the condition and the plan provides benefits for such treatment. If the referral were made to an out-of-network specialist, the patient could be charged no more than if the provider were participating in the network. The provision also would require a plan to establish a procedure for designating a specialist as the primary care provider when the plan is organized on a gatekeeper model and when the patient has a condition justifying coordination of care by a specialist. The plan would also have to establish a procedure for allowing standing referrals to a specialist when it was appropriate. Disputes arising out of this provision would be appealable under sections 132 and 133.

Although the provision does not explicitly specify that a plan would be required to refer a patient to a nonparticipating specialist, the provision would give appeal agencies the power to decide whether participating specialists had adequate expertise to treat the condition. Thus, this provision would stimulate appeals of plan decisions regarding virtually all aspects of referral management. Consequently, it would reduce the power of health plans in contract negotiations with specialists, especially sub-specialists concentrating on specific diseases or

2. Health Policy Economics Group, Price Waterhouse, LLP, "The Impact of Managed Care Legislation: An Analysis of Five Legislative Proposals from California" (November 1997).

conditions. Patients and referring physicians could argue in the appeals process that certain centers of excellence or sub-specialists were uniquely qualified to treat unusual conditions. As these providers came to recognize the potential loss of plans' power to steer patients to designated specialists, they could become less willing to make fee concessions as a condition of joining the plan's network. These effects would be felt most heavily by the plans that rely heavily on provider discounts to achieve savings.

Plans would also have to establish new policies and procedures for dealing with requests for redesignation of specialists as primary care physicians in certain cases and for standing referrals. The setup and maintenance of such procedures would involve minor additional administrative costs. However, to the extent that patients with chronic conditions were assigned to specialists for primary care, the plan's pricing power with its other primary care providers could be reduced. Like section 103, this subsection would interact with section 108, which requires an adequate provider network. Therefore, CBO includes its cost in the estimate of section 108.

Section 105—Continuity of Care. This section would add about 0.2 percent to the average premium. During a transitional period, it would require employee health plans to pay for care delivered by a nonparticipating provider when the plan terminates its contract with a provider while a patient is receiving a course of care. The transition period would be 90 days, with a longer period allowed for pregnant or terminally ill patients. The termination could result either from dropping a physician from a plan's network or from deleting an insurance product from a plan's offerings. The right to transitional care would require health plans to adopt new systems and procedures for contracting with providers and for handling transitions from one insurance plan to another. These systems would involve a one-time development cost as well as additional ongoing costs.

In the case of terminating a contract with an individual provider, the major cost to a plan would be the cost of notifying enrollees. Health plans generally gain or lose fewer than 10 percent of contracting physicians a year. Notification would involve identifying recent encounters by enrollees with terminated physicians and informing the enrollee of rights to transitional care, if the provider remained willing to accept the terms of the old contract.

In the case of terminating an insurance product, costs would increase not only because enrollees would have to be notified but also because systems and procedures would be required to administer the transition between plans. This system would require insurers to contract with willing out-of-plan providers for a limited period of time and incur costs associated with contract negotiations. The new health plan would be responsible for educating the out-of-plan provider about the plan's policies regarding quality assurance and utilization review. Although these arrangements could increase costs of health insurers, they

would also impose a burden on providers. Therefore, the aggregate cost of the claims exceptions process would be largely attenuated by its infrequent use.

Section 106—Coverage of Clinical Trials. This section would require health plans to pay for routine patient care associated with certain clinical trials sponsored by the National Institutes of Health (NIH), Department of Veterans Affairs (VA), Department of Defense (DoD), or NIH-sponsored cooperative groups. Only trials for life-threatening or serious illnesses for which no standard treatment is effective would qualify. The federal government's or cooperative group's contribution could be limited to in-kind contributions. The health plan would be required to pay for care at a rate no higher than it pays to participating providers, and it could require a patient to be treated by a participating provider, if such a provider was collaborating in the trial.

A high but declining portion of trial-related patient care costs is currently paid by private health plans.³ CBO estimates that health plans currently pay at least 90 percent of these costs. NIH personnel indicated that their supported clinical trials generally cover only the research costs (for example, data collection and statistical analysis) and sometimes the experimental therapy. Medical procedures or services are paid out of the research budget infrequently (for example, when they are performed exclusively to further a research objective and have no diagnostic or therapeutic value to the patient). Private sponsors or in-kind contributions by providers may play some role, but these sources of funding are likely to be small in the aggregate.

NIH-sponsored cooperative groups typically mount studies funded by private entities as well as NIH. For example, cooperative groups sponsored by the National Cancer Institute (NCI) receive funding from NCI to support a research infrastructure and a peer review process as well as for specific NCI-sponsored trials. However, they also conduct studies on behalf of private sponsors. As with NIH-sponsored studies, the private sponsor pays for research costs and often the experimental therapy but typically relies on insurers and health plans to pay for other care provided to participants in the trial.

CBO obtained estimates from NIH, VA, and DoD of the number of individuals who entered their sponsored treatment trials each year. Most of these entrants are under age 65, and most have private insurance. The estimate assumes that virtually all such trials would meet the test of being for serious or life-threatening illness for which no existing therapy is fully effective. The estimate also assumes that the bill would not require health plans to pay for treatments that would not be covered by the plan if they were not experimental.

3. Robert E. Meckanic and Allen Dobson, "The Impact of Managed Care on Clinical Research: A Preliminary Investigation," *Health Affairs*, Fall 1996, vol. 15, no. 3, pp. 72-89.

Because the provision would reduce the cost of clinical trials to governmental and private sponsors, it would be likely to increase the number of patients enrolled in approved trials. At least three responses would occur. First, researchers would expand the size of trials to answer more research questions and to do so with greater precision. Second, more trials would be funded. Third, researchers would seek to test more expensive treatments.

CBO assumed that today each patient in an NIH-sponsored trial has costs of care that are 25 percent higher than the costs of similar patients who do not enter trials. This estimate is based on preliminary unpublished results of several small studies that compare costs of cancer patients in clinical trials with similar patients who are not in trials. Those studies have found smaller incremental costs, but they did not include the relatively infrequent trials involving highly expensive therapies (such as autologous bone marrow transplantation for breast cancer). The cost differential could be expected to grow in the future as new trials involve more expensive therapies.

CBO further assumed that the provision would triple the number of individuals enrolled in clinical trials gradually over the next 10 years. Although this figure may be an underestimate of the long-term effect, constraints on the availability of trained clinical research personnel would limit the rate of increase in the near term. In addition, the power to limit payment may provide large managed care organizations with some bargaining power over the design and cost of trials. The net effect would ultimately be to increase the average premium across all kinds of employer-sponsored health plans by 0.4 percent.

Section 107—Access to Needed Drugs. Section 107(a) would require plans using restrictive drug formularies to have written policies and a process for making exceptions. CBO surveyed the evidence on current pharmaceutical benefits and concluded that virtually all drug formularies already have such processes in place. Therefore, the costs of this provision would be negligible.

Section 107(b) would prohibit a health plan from refusing coverage, as an experimental treatment, for a drug or device that is approved by the Food and Drug Administration (FDA) when it is prescribed for the approved use. This prohibition could create new administrative costs for health plans that currently rely on investigational technology clauses in their benefit contracts to deny payment for new treatments. These clauses allow plans to avoid conducting case-by-case reviews of medical necessity for some new technologies. CBO assumes that plans would gradually adjust to the new requirement by excluding some specific technologies from covered benefits and by using determinations of medical necessity to limit coverage for others. Because the number of new technologies excluded as investigational is small, the additional administrative costs associated with these changes would be less than 0.05 percent of premiums.

Section 108—Adequacy of Provider Network. This section would require plans to establish networks that provide adequate and appropriate levels of availability to needed services. It provides little specific language defining what kinds of networks would be considered adequate or appropriate. CBO assumes that the requirements for consumer choice (section 103) and access to specialists (section 104(b)) would necessitate several participating providers within specialties and subspecialties in order to assure geographic proximity and timely access. Thus, this provision would put pressure on plans to augment their networks of providers. In conjunction with sections 103 and 104, this section would reduce the pricing power of plans when they negotiated contracts with providers. Depending on how it was interpreted by regulation, the requirement for an adequate network could require plans to become price-takers in areas with few physicians in certain key specialties and in small metropolitan areas or rural areas with few physicians in general. This loss of pricing power would increase premiums by an estimated average of 0.1 percent for all employer-sponsored plans.

Section 109—Nondiscrimination in Delivery of Services. This section would prohibit plans from discriminating against health plan members in the delivery of health care services on the basis of race, color, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment. Plans would not be prohibited from limiting health insurance coverage on the basis of pre-existing conditions or from charging higher premiums for such coverage. CBO estimates that this provision would increase premiums by less than 0.05 percent.

Quality Assurance

Subtitle B lays out a program for assessing and monitoring the care delivered and outcomes of care for plan members. It would require plans to set up an internal quality assurance program to oversee the collection of data on services and outcomes and to correct problems of quality; develop a set of standards and procedures for selecting participating providers, including verification of the provider's background; and, for plans with prescription drug benefits, have a quality improvement program that encourages appropriate use of prescription drugs and reduces the incidence of adverse drug interactions. It would also specify requirements for utilization review (UR), including standards of timeliness and involvement of clinical peers (that is, physicians) in the UR process.

Section 111—Internal Quality Assurance Program. This section would require each health plan or health insurer to maintain a separate office responsible for carrying out the provisions of the subtitle. The program would have a unit director and a written plan for quality assurance, with criteria for plan performance and patient outcomes. It also would

Patients' Bill of Rights Amendment Summary of Revenue Offsets

1) Modify foreign tax credit carryback and carryforward rules.

Under current law, foreign tax credits may be carried back to offset tax liability in the previous two years. Unused credits may be carried forward to offset tax liability in the succeeding five years. This proposal, which has been approved previously by the Senate, would reduce the carryback period from two years to one year and extend the carryforward period from five to seven years. The Finance Committee originally approved this change on the grounds that it would reduce some of the complexity associated with carrybacks, while continuing to address the timing differences between US and foreign tax rules. The proposal would be effective for tax years beginning after 12/31/01.

2) Clarify the meaning of "subject to" liabilities under section 357(c).

A taxpayer generally is required to recognize gain on the transfer of an asset between corporations controlled by the same taxpayer to the extent the sum of the liabilities assumed, plus those to which the transferred asset is subject, exceeds the basis in the asset. If a liability is secured by multiple assets, it is unclear under present law whether a transfer of one asset where the transferor remains liable is a transfer "subject to the liability." This proposal would replace the "subject to the liability" standard. Instead, the extent to which a liability is assumed for federal income tax purposes would be determined on the basis of all the facts and circumstances. In general, if non-recourse indebtedness is secured by more than one asset, and any assets securing the indebtedness are transferred subject to the indebtedness without any indemnity agreements, then for all Federal income tax purposes the transferee would be treated as assuming an allocable portion of the liability based on the relative fair market values of the assets securing the liability.

3) Restrict special net operating loss carryback rules for specified liability losses.

Under current law, the portion of a net operating loss that qualifies as a specified liability loss (product liability and liabilities that arise under Federal or State law or any tort of the taxpayer) may be carried back ten years rather than two years, which is the general rule. This proposal would clarify that only a limited class of liabilities would qualify for the special ten-year rule. These would include any amount allowable as a deduction that is attributable to a liability under Federal or State law for reclamation of land, decommissioning of a nuclear power plant, dismantlement of an offshore oil drilling platform, remediation of environmental contamination, or payments under workers' compensation statute.

4) Reinstate Superfund corporate environmental income and excise taxes.

Beginning in 2000, the proposal would reinstate the small tax on the income of larger corporations and excise taxes on petroleum, chemicals and imported substances which expired on January 1, 1996. As before 1996, these revenues would be deposited in the Hazardous Substance Superfund Trust Fund. The corporate income tax is equivalent to 0.12% of the company's modified alternative minimum taxable (AMT) income in excess of \$2 million. For purpose of this tax, modified AMT income is defined as corporate AMT income, determined without regard to the alternative tax net operating loss deduction and the deduction for the corporate environmental income tax.

5) Clarify and expand math error procedures.

Current law provides that if a taxpayer fails to provide a correct taxpayer identification number that is required by statute, the IRS may, when the Social Security number is nonexistent or belongs to an individual with a different name, use the streamlined procedures that are typically reserved for mathematical and clerical errors on tax returns ("math error procedures") in order to expedite the assessment of tax. This proposal would clarify that age discrepancies in verifying eligibility for the child tax credit, the dependent care tax credit, the personal exemption for dependents, the Hope and Lifetime Learning tax credits, and the earned income tax would also be subject to these streamlined procedures. Thus, for purpose of the math error procedures, the term "correct TIN" would be defined as the TIN assigned by the Social Security Administration (SSA) to the individual identified on the return including name, date of birth, and SSN. This would allow the IRS to use the math error procedures to deny eligibility for the particular credit if the taxpayer does not meet the statutory age restrictions for the credit.

6) Impose excise tax on the purchase of structured settlements.

Current law confers favorable tax treatment to structured personal injury settlements on the grounds that recipients of annuities are less likely than recipients of lump sum awards to consume their awards rapidly and require public assistance. This favorable treatment is conditional upon a requirement that the periodic payments may not be accelerated by the injured person. Nevertheless, certain factoring companies have been purchasing these annuities from recipients for heavily discounted lump sums. This proposal would impose a 20% excise tax on the purchase of structured settlements unless such purchase is pursuant to a court order finding that the extraordinary and unanticipated needs of the recipient render such a sale necessary.

7) Modify deposit requirement for FUTA.

Under current law, if an employer's liability for Federal unemployment (FUTA) taxes is over \$100 for any quarter, it must be deposited by the last day of the first month after the end of the quarter. Beginning in 2004, under this proposal, employers having more than \$1,100 in annual FUTA tax liability would be required to pay their taxes by the last day of the month following the month in which the tax liability was generated.

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Divider Title: Consumer Support

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Divider Title: GOP Principals

REPUBLICAN HEALTH CARE PRINCIPLES



Senate Republicans will soon unveil legislation to help provide affordable, quality health care for all Americans. The legislation will adhere to the following principles.

Assistant Majority Leader Don Nickles

Media Contact: Brook Simmons 202/224-6010
Gayle Osterberg 202/224-6011

Republican Health Care Principles

- Republicans will demand that HMOs play by the rules and provide access to patient-centered care. Many consumers fear that their health care plans will not give them access to care when they need it most, that they will be denied the benefits they've paid for and been promised, and that their health plans care more about cost than they do about quality. These are real fears of unacceptable conditions and HMOs must do better.

Republicans believe that all consumers have the right to:

Receive accurate, easy-to-understand information about what their health plans provide, including information about out-of-pocket expenses and information about health care providers;

Receive the benefits they have paid for and been promised;

Hold their health plans accountable through a fair and expeditious appeals process;

Communicate openly with their doctors about their treatment options;

Know that their medical care is based on the best scientific information available, not on political considerations; and

Access to their medical records and the right to know that their medical information will be used only to provide better health care.

- Republicans support expanding health care coverage to more Americans by enhancing its affordability. We will not adopt legislation that will make health insurance more costly or drive businesses — especially small businesses — to drop coverage of their employees. While CBO has not completed its analysis of PARCA or the "Patients Bill of Rights," a 1997 Milliman and Roberts study of PARCA found that the legislation would increase health care premiums by an average of 23 percent. To the average family, that's an annual premium hike of \$1,220, or more than \$100 per month. That study, significantly, did not take into account the additional costs that would be imposed by the liability provisions.

Higher health care costs mean more uninsured people. According to a 1997 study by Lewin, for every 1 percent increase in premiums, 400,000 people lose their health insurance coverage. Congress should not pass legislation that would cause hundreds of thousands and perhaps millions of people to become uninsured.

- **Republicans believe in expanding choice. We will not force every American into an HMO.** Extensive new federal requirements included in the so-called Patients Bill of Rights will force all health plans to resemble HMOs. Ironically, many of the bills which claim to expand choice actually would limit choice. Rather than expanding regulation and forcing a "one-size-fits-all" approach to health care, Congress should focus efforts on reforming the tax rules which limit and in some cases prohibit consumer's choices.
- **Republicans believe that health resources should be used for patient care, not to pay trial lawyers.** Medical malpractice laws have led doctors to practice defensive medicine, making health care more costly without improving patient outcomes. Expanding malpractice liability will exacerbate these problems. Moreover, health plans are likely to micromanage clinical decisions in order to protect themselves against costly lawsuits. Congress should not pass legislation on the assumption that people can sue their way to health care quality.
- **Republicans believe the private sector is more capable of keeping pace with the rapid changes of health care. The government is not the best caretaker of health care quality.** Republicans agree with leading physicians such as Dr. Bob Waller of the Mayo Clinic, who warned that increased federal regulation of health care quality, by freezing in place standards that will quickly become obsolete, will actually diminish the quality of care that patients receive. We also agree with the approach taken by the President's own hand-picked Commission on Quality which did not recommend legislation or regulation. Instead, the President's Commission -- which he has conveniently disavowed -- recommended voluntary implementation of consumer protections.
- **Republicans believe consumers have the right to a health system driven by the best scientific evidence available -- not one hamstrung by political considerations.** Congress should not practice medicine. Over the past several years, Congress has imposed a number of "body part" mandates on health insurance plans. These mandates, though well-intentioned, are often misguided. For example, the *Journal of the American Medical Association* last year published a study which concluded that maternity length-of-stay requirements do not improve health outcomes for mothers or their babies and may do more harm than good. Congress should not magnify and repeat past errors by imposing new body part mandates on health plans.

- **The federal government should focus on a system which will give providers and physicians more time with patients and less time on paperwork.** Bills that impose extensive information disclosure requirements on health plans will force those plans to impose extensive paperwork requirements on providers. Instead of simply filing claims information with insurers — as providers in fee-for-service and PPOs do — doctors will have to supply insurance companies with information about their patients, the care their patients receive, treatment outcomes, and patient satisfaction, among other things. This will require doctors to spend more time filling out forms and less time treating their patients.
- **Republicans will not politicize or simplify an issue as important as health care quality.** Many on the other side are willing to jeopardize insurance coverage for millions of Americans for a political “slam dunk.” Republicans will not exploit the fears of Americans in order to enjoy a political victory. The issues surrounding the quality of our nation’s health care deserve to be debated responsibly and cautiously. We will not pass legislation which increases the number of uninsured, makes health care unaffordable, and diminishes rather than enhance health care quality.

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.

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Divider Title: Senate Strat

SUMMARY OF CHANGES

Manager's Amendment to H.R. 4250

July 23, 1998

Changes to the "gag rule" (Section 1001) -The Republican bill still doesn't get at the problem with gag clauses. They still only address part of the issue.

The managers amendment changed the flawed Republican gag clause provision by clarifying that health plans could not "restrict" the treatment information that health care professional provide their patients.

While a step forward, they retained language in the bill that limits the application of the gag clause restriction to direct contracts between health care providers and health plans.

This limitation leaves out many, if not most, managed care arrangements where individual physicians actually contract with medical groups rather than directly with health plans.

In contrast, the bipartisan Ganske-Dingell bill extends the prohibition on gag clauses to subcontracts -- assuring that health care professionals in all types of managed care will be protected.

Changes to health plan information and disclosure (section 1001 and 1201). The Republican bill still does not give people the information they need to make informed decisions about their health plan. The manager's amendment requires health plans to make available to prospective enrollees health plan information and to plan enrollees information about the number of times that external reviewers recommend modification or reversal of a plan's benefit decisions.

What the amendment fails to do however, is require plans to disclose the number of times that the plan failed to follow the recommendations of an external reviewer. This is vital information for consumers because, under the Republican bill, the external reviews are not binding on the health plan. They are recommendations that the plan is free to disregard. For the consumer to get the benefit of an external review, he or she must go to court and get a judgement that the plan violated its contract. In contrast the bipartisan Ganske-Dingell bill, decisions by external reviewers are binding on the plan and the consumer can get his or her benefits without the need to resort to court.

Change to Emergency Services (Section 1001). The managers amendment changed the flawed Republican emergency care provision by clarifying that health plans could not apply network limitations to enrollees seeking emergency screening services under the prudent layperson standard. While a step forward, they failed to fix several other flaws in their emergency care provisions which severely undermine the protections extended to enrollees. The bill still permits plans to charge people more for seeking emergency services in outside of the plan's network if the enrollee did not get prior authorization for the emergency services. This defeats the whole purpose of the "prudent layperson" definition. The bill does not include "severe pain" as an

emergency -- which means that an individual with severe chest pains risks having to pay for services out of pocket if he or she goes to an emergency room without getting prior authorization.

Change to External appeals (Section 1201) The Republican bill still falls short of providing people with adequate remedies if they are harmed by the plan. The original provision said that civil penalties could be in the amount of up to \$250 a day, up to an amount not to exceed \$100,000. The manager's amendment would permit penalties up to \$500 a day (or \$1,000 a day in the case of bad faith) up to a total of \$250,000. The Republican amendment still falls short in that it says that if the plan fails to follow the opinion of the external appeals you can be awarded \$500 a day, however if the plan willfully decides not to follow the opinion of the external appeals you can be awarded up to \$1,000 still up to the \$250,000 cap. So in other words, if a person is delayed for a week and who becomes seriously injured or incapacitated would only be able to recover \$3,500 under the provision, or if the plan willfully harmed them then they could get \$5,000.

Change to Confidentiality of Medical Records (Section 5001) The Republican's managers amendment still preempts any State law that requires the patient's consent for the release of medical records. The manager's amendment change prohibits health care providers and health plans from selling or bartering protected health information.

Deletion of MSAs in the Federal Employees Health Benefits plan. The Republican manager's amendment no longer contains MSA for federal employees.

The Republican manager's amendment moved the fraud and abuse provision, which requires the GAO to do a study on the department of justice's compliance with the guidelines on the false claims act, to another section of the bill -- Title IV which references DOJ authority.

The effective date for the implementation of health marts is now January 1, 2000.
plans from selling protected health information as part of conducting health care operations.

The Republican manager's amendment adds a new section regarding sense of the house -- it is the sense of the house that people should be empowered to choose their own health care.

The Republican's managers amendment adds a new section which prohibits the Secretary of HHS from implementing regulations on health identifiers until legislation is enacted specifically approving the standard.

Revenue Offsets to pay for Medical Savings Account Provisions: (1) restrict 10-year net operating loss carry back rules for specified liability losses (2) clarify the meaning of "subject to" liabilities under IRC section 357(c)(3) limit the use of non-accrual experience method of accounting to amounts to be received for the performance of qualified professional services (4) information returns relating to the discharge of July 23, 1998 indebtedness by certain entities, (5) clarify and expand the mathematical error procedures, and (6) add vaccines against rotavirus to the list of taxable vaccines.

S. 2330
Outline of Potential Amendments

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SCOPE AND EFFECTIVE DATE

1. Scope. Redraft all consumer protections into the HIPAA structure. This would extend all protections to all private sector health plans.

As drafted: The majority of the consumer protections in this bill apply only to self-funded ERISA plans. The Information Disclosure and Appeals provisions apply only to group health plan (whether self-funded or fully insured). Only the genetic discrimination, the mastectomy length of stay and reconstructive surgery provisions would apply to the entire private health insurance market.

2. Effective Dates. The effective date of all consumer protection provisions should be no later than the plan year beginning on or after July 1, 1999.

As drafted: There are different effective dates for different Titles and subtitles. Most protections do not become effective until the plan year beginning on or after January 1 of the second calendar year following the date of enactment or until final regulations are issued.

EMERGENCY ROOM SERVICES

1. Prohibit in-network requirements. Add a provision prohibiting plans from restricting coverage of emergency medical services to in-network providers. Make all emergency services protections apply regardless of whether the care is rendered in-network.

As drafted: The bill does not prohibit plans from requiring enrollees to go to an emergency room that is in the plan's network. All the emergency services protections apply only if the enrollee goes to an emergency room that is in the plan's network.

2. Prohibit differential cost sharing. Add a provision prohibiting differential cost sharing between in-network and out-of-network emergency services, and between pre-authorized and not pre-authorized emergency services.

As drafted: It is unclear whether the bill bans differential cost sharing for going to an emergency room outside the plan's network (the language is ambiguous), or for getting emergency medical services that are not pre-authorized.

3. Cover post-stabilization care. Add a provision clarifying that coverage of post-stabilization services are to be covered pursuant to the Guidelines to be published by the Secretary of HHS pursuant to the BBA mandate.

As drafted: The bill does not address coverage of post-stabilization care.

EXTERNAL APPEALS

1. Broaden cases eligible for external review. Revise the language describing which cases may go to external review. Eliminate the \$1000 threshold for cases involving medical necessity. It could be appropriate to allow the Secretary to define a "significant monetary" threshold, but only if there is an exception for cases where the life or health of the enrollee is in jeopardy. Allow appeals of violations of the consumer protection in the bill to go to external appeal. Revise the language so that the external appeal entity -- not the plan -- makes the decision whether the external appeals threshold has been met. Add language making clear that decisions to deny a requested service because it is on the plan document's list of exclusions from coverage count as initial coverage determinations (to which the coverage determination deadlines and internal appeals provisions apply).

As drafted: The threshold for most cases to get to external review is a \$1,000 for review of any determination based on medical necessity or medical appropriateness. External appeals are limited to medically necessary or appropriate and experimental or investigational determinations. Other provisions in the bill cannot be appealed (e.g. information disclosure, anti-gag, etc.) The plan determines whether the external appeal threshold has been met. Decisions not to provide a requested service because it is listed as a coverage exclusion appear not to be eligible for internal appeal (nor would the deadlines for coverage determinations apply).

2. Standard of Review. Add a provision requiring that the standard for the external appeal is de novo review.

As drafted: The standard for review is not de novo.

3. Appropriate Deadlines for Review. Add a clear requirement that emergency appeals be decided according to the medical exigencies of the case, but not more than 72 hours. Lengthen the time the enrollee has to ask for an external appeal. Add a deadline for the plan to forward information to the external review entity, and a deadline for the appeal if information is not received. In addition, add a provision to the time frame for initial coverage decisions to require the plan to act as quickly as the medical exigencies of the case require, and add a deadline for concurrent review determinations. Add provisions to prevent plan from using delay tactics to prevent appeals from getting to external review. The provisions should define failure by the plan to meet the deadline for a coverage determination as an "adverse coverage determination" that

can be appealed, and should define failure to meet the internal appeals deadlines as an “adverse coverage determination” that can be appealed. An alternative approach is to add a provision requiring that enrollees be able to proceed to the next appeal level when the plan fails to meet its deadlines.

As drafted: There is a provision that external appeals be decided according to the medical exigencies of the case, but there is no clear 72 hour deadline for emergency cases. The enrollee has only 30 days to file an appeal. The time frame for external review does not begin to run until the review entity has received all necessary information, but there is no deadline for the plan to forward the information. This could mean an indefinite delay, even where the case is urgent. The deadline for initial coverage determinations is a minimum, and does not take into account the medical exigencies of the case. No time frame is given for concurrent determinations (for decisions to certify or deny coverage of an extended stay or additional services). The definition of appealable decisions (“adverse coverage determinations”) does not include cases where the plan exceeds the deadlines for internal coverage or appeals decision. There is no requirement that enrollees be allowed to proceed to internal or external review if the plan does not meet deadlines for coverage determinations and internal appeals. Thus, a plan can prevent a case from going to external review by failing to make a decision on internal appeal.

4. Ensuring independence of the review entity. Add a mechanism for the state to set rules regarding how the external review entity is chosen, or to choose the external review entity (this would allow states that currently have external appeals to maintain their existing systems). [Note: this is not applicable to the bill as currently drafted, but would be if the bill is redrafted into the HIPAA framework.] Revise the list of prohibited conflicts of interest to prohibit use of reviewers who are affiliated with the employer, plan sponsor, or plan fiduciary.

As drafted: The plan selects the external review entity. There is no mechanisms for restricting bias in the choice of entities. The clause listing prohibited conflicts of interest for the reviewer does not include affiliation with the employer, plan sponsor, or plan fiduciary.

5. Add a provision allowing a representative to act for the enrollee. Add language clarifying that the electronic notification of adverse coverage determinations is at the enrollee’s options.

As drafted: A person must be designated as a “legal” representative to appeal on someone’s behalf (e.g., a spouse would not be able to file an appeal for an incompetent spouse). The plan may provide the notice of adverse coverage determinations electronically.

ACCESS TO CARE

1. Continuity of Care. Add a provision providing continuity of care protection for the

chronically ill, and eliminating the 90 cut-off of continuity protections for the terminally ill. Add a provision extending the continuity of care protections to situations in which an employer changes health insurance issuers and the provider is not in the new network.

As drafted: The continuity of care does not apply to persons with chronic illnesses (unless they are institutionalized). The continuity of care limits the transition period to 90 days and does not make an exception for terminally ill patients, even though the definition of terminally ill is an enrollee with six months or less to live. The continuity of care provision only protects the enrollee if the provider is dropped from the plan's network. It does not apply when an employer changes health issuers and the provider is not in the new network.

2. Protecting the Chronically Ill. Add a provision providing direct access to specialists for persons with chronic or serious conditions. Add a provision allowing persons with conditions requiring ongoing care to receive standing referrals or to designate a specialist as a primary care physician.

As drafted: There is no provision to allow persons with chronic or serious conditions direct access to specialists. There is no provision to allow persons with conditions requiring ongoing care to receive standing referrals or to designate a specialist as a primary care physician. Persons with ongoing conditions would be required to return to their primary care physician each time to get the necessary referral.

3. Network Adequacy. Add a requirement that a plan have a network with a sufficient number, distribution and variety of providers who are available and accessible in a timely manner. Add a requirement that a plan cover the services of a specialist who is not in the plan's network if the network lacks the provider capacity to treat the enrollee's condition.

As drafted: There is no requirement that a plan have a network with a sufficient number, distribution and variety of providers who are available and accessible in a timely manner. In addition, there is no requirement that a plan cover the services of a specialist who is not in the plan's network if the network lacks the provider capacity to treat the enrollee's condition.

4. Women's Health. Add provisions requiring plans to allow enrollees to designate Ob/Gyns as primary care physicians.

As drafted: The bill does not require plans to allow Ob/Gyns to be designated as primary care physicians.

INFORMATION TO ENROLLEES

1. Getting Information to Enrollees When they Need It. Add a provision requiring that enrollees be informed of material changes to information about an enrollees rights and benefits (this should include everything in the list of information that is provided automatically, but need not include material changes to information that is provided on request) prior to the effective date of those changes (this can be accomplished by providing clear regulatory authority to the Secretary). The plan's list of specific coverage exclusions should be added to the list of information automatically provided to the enrollee.

As drafted: This bill fails to fix a key existing problem with the ERISA information disclosure provisions -- plans are not required to notify participants and beneficiaries of material changes in benefits and coverage prior to the effective date of those changes. The plan's list of specific coverage exclusions are not automatically provided to the enrollee, they are only available upon request.

2. Protect Provider/Patient Communications. Add language making clear that the anti-gag provision prohibits restrictions on the provider's communications to the patient.

As drafted: The anti-gag clause only applies when a plan prohibits the provider from giving medical advice, it does not ban the plan from *restricting* advice.

3. Add language requiring that information about provider compensation incentive arrangements be provided automatically, and eliminate the requirement that it be provided only by category of payment method. Eliminate the exception for proprietary information.

As drafted: The information provided to the enrollee about provider compensation incentive arrangements that could cause a provider to limit coverage are not available automatically, they are only available upon request. Even then, the consumer gets information only by general category of payment type, not an actual summary of the financial incentive. Finally, the bill includes a loophole large enough to make the disclosure requirement meaningless -- "proprietary" information need not be disclosed. Since this term is not defined, it could include anything.

4. Add provisions that prevent plans from retaliating against health care providers who advocate on behalf of their patients.

5. Add to the Genetic Information and Services language:[Kennedy amendments re penalties, employers, disclosure]

QUALITY

1. Add a Quality Council (or Health Care Quality Advisory Board). The duties of the Council should be: [from Jeffords]

2. Add the requirement that a plan conduct internal quality assurance, and standards for QA (with "deeming" for accredited plans), including collection and reporting of aggregate quality data (using nonidentifiable information).

3. Add standards for utilization review.

As drafted: These important provisions are entirely missing from the bill.

ENFORCEMENT

MEDICAL NECESSITY

POSSIBLE DEMOCRATIC AMENDMENTS

1. Cover the excluded 100 million Americans: apply protections to all Americans (including state and local workers and those purchasing coverage directly in the individual market), not just those in self-insured plans.
2. Access to Providers:
 - a. Access to specialists: (1) guarantee access to specialists when necessary including referrals outside network when the HMO does not have a qualified provider to treat a condition, (2) standing referrals to specialists for individuals with ongoing conditions, and (3) the ability to designate specialists as primary care providers for individuals with serious ongoing conditions that require a specialist to coordinate their care. (Note: These provisions could be offered together or separately). *Boxer has requested this amendment.*
 - b. Adequacy of provider network: guarantee sufficient number, distribution, and variety of providers to ensure promised coverage will be available and accessible in a timely manner; guarantee access to specialists outside network if necessary; choice of doctors within HMO.
 - c. Continuity of care: expand to cover case where employer changes plan.
3. Appeals process: Repair and highlight the deficiencies of the Republican appeals process: (1) assure independence of reviewers; (2) eliminate \$1,000 threshold to get an appeal; (3) expand scope to cover all contract interpretation issues and rights guaranteed to patients by this legislation, not just medical necessity and whether the treatment is experimental; (4) allow patient/doctor to provide information on the case, not just the HMO; (5) eliminate plan's ability to delay decisions by not providing all necessary information; (6) eliminate the HMOs discretion regarding cases that can be appealed. Substitute language of S.1890 for full grievance and appeal section. *Dodd has requested this amendment.*
4. Emergency care: make access emergency care consistent with that available under Medicare and Medicaid (ability to go to closest emergency room, coverage for treatment following emergency screening, post-stabilization care, drop prudent doctor standard, no additional cost sharing out-of-network, etc.)
5. Restoring the Doctor/Patient Relationship:
 - a. Protection of physician decision-making and elimination of inappropriate drive-through procedures. Section 151 of Patients' Bill of Rights. *Senator Feinstein could offer this amendment in conjunction with her hospital length of stay amendment described below.*
 - b. Gag Rule Fix: ensure providers are not punished for patient advocacy, without which prohibitions on gag clauses are ineffective: (1) add "restrict" to protection against gag clauses; (2) no discharge of doctor/nurse from network without reason and procedures; (3) protection against retaliation for patient advocacy; (4) guarantee that doctor can talk about HMOs' utilization techniques and financial incentives with patient.
 - c. No improper financial incentives for providers or utilization workers: (1) no improper financial incentive arrangements with providers; (2) prohibition on contingent compensation arrangements and conflicts of interest for utilization review workers (incentives to make inappropriate decisions (115 (c)(2)(C) in S.1890).
 - d. Prescription drugs: guarantee access to needed prescription drugs off the HMO formulary. Could be folded into restoring the doctor patient relationship.

6. Liability.
7. Quality information: provide quality information to patients (patient satisfaction, immunization rates, etc.).
8. Clinical trials.
9. Point-of-service option. Require the offering of a point-of-service option when an individual only has a choice of closed panel HMOs. In our bill currently, a point-of-service is only required when an individual only has one plan offered and that plan is a closed-panel HMO.
10. Genetic information and services: expand to include employment--or improve whole provision depending on analysis of language.
11. Strike MSA Provision.

Senator Requests

Children's protections: Reed

Confidentiality: Leahy

Assisted living facilities: Mikulski

Report Card on Healthcare Quality: Lieberman

Emergency Medical Care for Veterans: Daschle

Hospital Length of Stay: Feinstein.

Vaccines for Children: Feinstein

Coverage of Reconstructive Surgery: Feinstein

Mental Health: Conrad

Disability Amendment: Harkin

Kids and Managed Care (Medicaid?): Kerrey

Apply bill to Federal Programs: Kerrey

Round Two Amendments

Access to specialists: this version could include only guaranteed access to see a specialist or some other subset of the original amendment.

Patient advocacy protections: this version could include a subset of the original amendment, such as no retaliation when doctors/nurses advocate to get needed care for their patients.

Liability: this version could involve a federal right of action with compensatory damages.



Non-discrimination.

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