COMPARISON OF THE FLAWED REPUBLICAN PATIENTS BILL OF RIGHTS AND THE STRONG BIPARTISAN NORWOOD-DINGELL BILL

PATIENT PROTECTION	REPUBLICAN BILL PASSED BY THE SENATE	BIPARTISAN NORWOOD-DINGELL REAL PATIENTS' BILL OF RIGHTS
Covering All Health Plans	NO – Leaves out over 110 million Americans	YES
Keeping Your Doctor Through Critical Treatments	NO	YES
Provides Strong Emergency Room Protections	NO	YES
Assuring Access to Specialists	NO	YES
Assuring Patients Have an Independent Appeals Process	NO	YES
Holding Health Plans Accountable for Harming Patients	NO	YES

COMPARISON OF CONSUMER PROTECTIONS: PRESIDENT'S ADVISORY COMMISSION, MEDICARE+CHOICE, AND PROPOSED LEGISLATION

PROVISION	**Advisory Commission**	**Medicare+Choice (Interim Final Reg.)**	**House Republican (consumer protection provisions only) (HR448)**	**Senate Republican (consumer protection provisions only) (S300) [and S326, as passed out of HELP]**	**Daschle/Dingell (S6/HR358)**	**Chafee (S374)**	**Ganske (HR719)**	**Norwood (HR216)**
1. Entities Regulated	Recommendations apply to all health care consumers.	All plans participating in the Medicare+Choice program.	All group health plans, and health insurance issuers in the group market only (i.e., where state rules are preempted by ERISA, plus some but not all areas where states could regulate). For POS provisions, only issuers that are HMOs. For Privacy provisions, all plans, providers, schools, etc.	Only where state rules are pre-empted by ERISA: All ERISA plans for Information Disclosure and Appeals, self-insured plans only for all other consumer protection provisions. For Privacy provisions, all plans, providers, schools, etc.	All group health plans, and health insurance issuers in both the group and individual markets (i.e., both where state rules are preempted by ERISA and where states could regulate).	All group health plans, and health insurance issuers in both the group and individual markets (i.e., both where state rules are preempted by ERISA and where states could regulate).	All group health plans, and health insurance issuers in both the group and individual markets (i.e., both where state rules are preempted by ERISA and where states could regulate).	All group health plans, and health insurance issuers in both the group and individual markets (i.e., both where state rules are preempted by ERISA and where states could regulate).

COMPARISON OF CONSUMER PROTECTIONS:
PRESIDENT'S ADVISORY COMMISSION, MEDICARE+CHOICE, AND PROPOSED LEGISLATION

2. Information Disclosure	List of information to be disclosed automatically, additional information to be disclosed on request. Information should be provided at "appropriate times (i.e. decision points)."	List of information to be disclosed automatically, additional information to be disclosed on request. HHS provides information prior to each open season, plans provide information at time of enrollment and updates at least annually.	List of information to be disclosed automatically, additional information to be disclosed on request. Uses existing SPD time frames. Does not fix current ERISA law that allows notice of material reductions in benefits to be provided after the effective date of the changes, except requires advance notice of exclusions from formulary.	List of information to be disclosed automatically, additional information to be disclosed on request. Disclosure is one time only, within a year of enactment. Does not fix current ERISA law that allows notice of material reductions in benefits to be provided after the effective date of the changes.	List of information to be disclosed automatically, additional information to be disclosed on request. Information must be issued at time of enrollment and at least annually thereafter. Gives Secretary authority to require notice of changes be provided to enrollee before the effective date of the changes.	List of information to be disclosed automatically, additional information to be disclosed on request. Information must be issued at time of enrollment and at least annually thereafter. Gives Secretary authority to require notice of changes be provided to enrollee before the effective date of the changes.	List of information to be disclosed automatically, additional information to be disclosed on request. Information must be issued at time of enrollment and at least annually thereafter. Gives Secretary authority to require notice of changes be provided to enrollee before the effective date of the changes.	List of information to be disclosed by plan automatically and on request, additional information to be disclosed by health care professionals and facilities on request. Information must be issued at time of enrollment and at least annually thereafter. Does not fix current ERISA law that allows notice of material reductions in benefits to be provided after the effective date of the changes, except requires advance notice of exclusions from formulary.

COMPARISON OF CONSUMER PROTECTIONS: PRESIDENT'S ADVISORY COMMISSION, MEDICARE+CHOICE, AND PROPOSED LEGISLATION

3. Network Adequacy								
a. Basic standard for network adequacy	Yes	Yes	No	No	Yes	Yes	Yes	Yes
b. Enrollees can go out of network if network not adequate for their particular needs	Yes, at no additional cost beyond that for participating providers.	Does not address situations where network is not adequate, but mandates coverage of out-of-network services in limited specified situations, at no additional cost to enrollee.	No	No	Yes, at no additional cost to enrollees beyond that for participating providers.	Yes, at no additional cost to enrollees beyond that for participating providers.	Yes, at no additional cost to enrollees beyond that for participating providers.	No

4. Direct Access to Specialists								
a. Complex/ serious conditions requiring on-going care	Authorization should be "for an adequate number" of visits. Yes	Treatment plans must provide an adequate number of visits. Yes	No Yes	No Yes	Standing specialist referrals and specialists may serve as primary care physicians. Yes, and plan must	Standing specialist referrals and specialists may serve as primary care physicians. Yes	Standing specialist referrals and specialists may serve as primary care physicians with respect to the condition. Yes	When medically indicated in the judgment of the treating health professional. Yes

COMPARISON OF CONSUMER PROTECTIONS: PRESIDENT'S ADVISORY COMMISSION, MEDICARE+CHOICE, AND PROPOSED LEGISLATION

b. Routine and preventive Ob/Gyn					allow Ob/Gyn to be designated as primary care physician.			
c. Pediatricians	No	No	No. Plan must allow pediatrician to be designated as PCP.	Yes	No. Plan must allow pediatrician to be designated as PCP.	No	No. Plan must allow pediatrician to be designated as PCP.	No. Plan must allow pediatrician to be designated as PCP.
5. Continuity of Care/ Transitional Care	When the provider is dropped from the plan or the employer changes health plans. For people in a course of treatment for a chronic or disabling condition (for 90 days) and pregnant women beyond their first trimester (through postpartum care).	No provision for an enrollee to continue with managed care provider. Enrollee can return to original Medicare (the ability to do this will be limited after 2001 and is further limited by lack of access to MediGap policies).	No	When the provider is dropped from the plan. For inpatients and terminally ill persons (for 90 days), for women past first trimester of pregnancy (through postpartum care).	When the provider is dropped from the plan or the employer changes health plans. For persons in a course of treatment (for 90 days), inpatients (through discharge), women past first trimester of pregnancy (through postpartum care), and terminally ill persons (for remainder of life).	When the provider is dropped from the plan or the employer changes health plans. For persons in a course of treatment (for 90 days), inpatients (through discharge), women past first trimester of pregnancy (through postpartum care), and terminally ill persons (up to 180 days).	When the provider is dropped from the plan or the employer changes health plans. For persons in a course of treatment (for 90 days), inpatients (through discharge), women past first trimester of pregnancy (through postpartum care), and terminally ill persons (for remainder of life).	When the provider is dropped from the plan, the employer changes health plans, or other similar circumstances. For a "reasonable period of time" when such circumstances might disrupt continuity of care for the individual.
6. Mandatory POS Option	No	BBA permits, but does not mandate, a POS option.	Yes, with exception if POS premium will be more than 1% greater than the closed panel premium or if HMO would need new license.	Yes, with exception for small employers	Yes	No	Yes	Yes, with exception for self-funded group health plans.

COMPARISON OF CONSUMER PROTECTIONS: PRESIDENT'S ADVISORY COMMISSION, MEDICARE+CHOICE, AND PROPOSED LEGISLATION

7. Access to Emergency Services								
a. Bans prior authorization requirements	Yes.	Yes	Yes	Yes	Yes	Yes	Yes	Yes
b. Bans in-network requirements	Yes	Yes	Yes	No (may be drafting error)	Yes	Yes	Yes	Yes
c. Prudent layperson standard for coverage of screening and stabilization	Yes	Yes	For screening exam only. Any additional emergency medical services covered under "prudent emergency medical professional" standard (unclear is this includes stabilization care).	Yes	Yes	Yes	Yes	Yes
d. Emergency medical condition includes "Severe Pain"	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
e. Post-stabilization care	Emergency department should contact the plan	ER required to contact organization to obtain	Not addressed	Not addressed	Mandates process consistent with	Mandates process consistent with	Mandates process consistent with	Mandates process consistent with

	or provider to discuss post-stabilization care and promote continuity of care.	authorization for post-stabilization care; if the organization fails to respond or cannot be contacted within 1 hour, authorization is deemed.			Medicare guidelines	Medicare guidelines	Medicare guidelines	Medicare guidelines
8. Limits on Physician Incentives	No	Prohibits specific payments to physicians "as an inducement to reduce or limit medically necessary services." Where physician is at substantial financial risk for services not provided by those physicians, requires stop loss coverage, disclosure, and surveys of enrollees and disenrollees.	No	No	Same as Medicare	Same as Medicare	Same as Medicare	Substantially same as Medicare, but without referencing Medicare and without requiring surveys.
9. Anti-Gag Rule								
a. Communication about condition and treatment	Yes	Yes	Yes, but only applies to direct contract between plan and	Yes	Yes	Yes	Yes	Yes, but only applies to relationship between plan and individual

COMPARISON OF CONSUMER PROTECTIONS: PRESIDENT'S ADVISORY COMMISSION, MEDICARE+CHOICE, AND PROPOSED LEGISLATION

b. Protection for advocating on behalf of patient	Yes	No	provider No	No	Yes	Yes	Yes	health professional. No
10. Non-discrimination	Yes	Yes	No	No	Yes	Yes	No	No
11. Confidentiality of Health Information	Individually identifiable health information cannot be used without the written consent of the enrollee except for research, fraud investigations, and public health reporting. Consumers have the right to review, copy, and request amendments to their medical records.	A M+C organization must establish procedures to safeguard the privacy of any individually identifiable enrollee information.	Nothing in consumer protection provisions. A Separate Privacy Title requires plans to safeguard the privacy of health information, and provide access for individuals to inspect, copy, and amend their health information. The Title overrides many State protections without providing adequate Federal protection.)	Nothing in consumer protection provisions. A separate Privacy Title requires plans to safeguard the privacy of health information, and provide access for individuals to inspect, copy, and amend their health information. [S326 removed this subtitle]	Plan must safeguard the privacy of individually identifiable information, and allow timely access for individuals to their health information.	Plan must safeguard the privacy of individually identifiable information.	Plan must safeguard the privacy of individually identifiable information, and allow timely access for individuals to their health information.	Plan must comply with federal and state laws to protect the confidentiality of individually identifiable information.

COMPARISON OF CONSUMER PROTECTIONS: PRESIDENT'S ADVISORY COMMISSION, MEDICARE+CHOICE, AND PROPOSED LEGISLATION

12. Coverage determinations								
a. Deadline	"Timely"	Yes	Only for decision on physician's request for prior authorization for specialty care. Not for other determinations.	For pre- and concurrent authorization.	For decisions covered by broad definition of UR	For prior authorizations, continued care, and previously provided services.	For decisions covered by broad definition of UR	For benefit payment and prior authorization.
b. Expedited Process and/or tied to medical exigencies of the case	Yes	Yes	No*	Yes (but plan decides), not tied to medical exigencies of case.	Yes	Yes	Yes	No*

13. Internal appeal								
a. Decisions that can be appealed	Denial of coverage, reduction or termination of services, or denial of payment for services.	Denial or discontinuation of benefits, payment, or services.	Adverse benefit payment decisions, advance determinations of coverage, and required determinations of medical necessity	Adverse initial coverage determinations – does not include failure to meet determination deadlines, or disputes regarding items and services specifically listed as excluded in the coverage	Denials or discontinuation of benefits, payment, or services, adverse UR determinations, certain violations of the statute.	Adverse initial coverage determinations and imposition of prohibited manner or setting limitations.	Denials or discontinuation of benefits, payment, or services, adverse UR determinations, certain violations of the statute.	Adverse benefit payment decisions and advance determinations of coverage.

COMPARISON OF CONSUMER PROTECTIONS: PRESIDENT'S ADVISORY COMMISSION, MEDICARE+CHOICE, AND PROPOSED LEGISLATION

b. Deadline	"Timely"	Yes	No*	documents.	Yes	Yes	Yes	No*
c. Expedited process and/or tied to medical exigencies of the case	Yes ("consistent with Medicare")	Yes	No*	Yes Yes	Yes	Yes	Yes	No*

14. External appeal								
a. Decisions that can be appealed	Any decision to deny, reduce or terminate coverage or payment based on determination that treatment is experimental or not medically necessary.	Any determination which is, in whole or in part, adverse to the enrollee.	Adverse re whether care meets plan's definition of medical necessity or experimental, and no ERISA §502 suit has been initiated.	Disputes re whether care meets plan's definition of medical necessity, and experimental treatment where there is significant risk to life or health.	Same as internal appeals, but not including denials for services specifically listed in plan documents as excluded from coverage.	Same as internal appeals, including contractual exclusions.	Same as internal appeals, but not including denials for services specifically listed in plan documents as excluded from coverage. Plan may request appeal.	Same as internal appeals, but not including denials for services specifically excluded as a benefit of the plan.
b. Failure to meet internal review deadline moves dispute to external review	"Timely"	Yes	In theory only, because internal "deadlines" can be indefinite.	No	Yes	Yes. If plan fails to meet deadline, must automatically forward case file to external reviewer. Expedited disputes not	Yes	In theory only, because internal "deadlines" can be indefinite.

COMPARISON OF CONSUMER PROTECTIONS: PRESIDENT'S ADVISORY COMMISSION, MEDICARE+CHOICE, AND PROPOSED LEGISLATION

						resolved wholly in favor of the enrollee must also be automatically forwarded for external review.		
c. Barriers / thresholds	For medical necessity decisions, a "significant threshold" unless the denial jeopardize life or health.	None -- all disputes not resolved wholly in favor of the enrollee are automatically forwarded to the external review entity.	Non-Medicaid/CHIP enrollees may be required to pay a fee (the greater of the lesser of $100 or 10% of the care under dispute or $25). Enrollee has only 30 days to appeal.	For Medical Necessity disputes, the amount involved must exceed a significant financial threshold. Enrollee has only 30 days to appeal.	A "significant threshold" unless the denial jeopardizes the life or health (including development, in the case of a child) of the patient.	A "significant" threshold unless the denial jeopardizes the life or health or ability to regain or maintain maximum function (including development, in the case of a child under 6) of the patient.	$100 unless the denial jeopardizes the life or health of the patient.	Enrollee has only 30 days to appeal.
d. Review entity selection	External review should be "independent" and "fair to all parties"	HCFA chooses entity	Plan chooses intermediary, which chooses reviewing expert.	Plan chooses entity	Selected either by appropriate authority, or by plan under rules developed by appropriate authority to prevent bias.	Selected either by appropriate authority, or by plan under rules developed by appropriate authority to prevent bias.	Selected either by appropriate authority, or by plan under rules developed by appropriate authority to prevent bias.	Plan chooses intermediary, which chooses reviewing expert.
e. Protections against reviewers' bias/ conflict of interest	External review should be "independent" and "fair to all parties"	Review entity chosen by HCFA, not plan.	Reviewers/entity must not be affiliated with any party to the dispute, receive only	Reviewers must not have any affiliation with the case, the enrollee, or the	Certified by appropriate authority as having no conflict of interest and meeting	Certified by appropriate authority as having no conflict of interest and meeting	Certified by appropriate authority as having no conflict of interest and meeting	Reviewers/entity must not be affiliated with any party to the dispute, receive only

COMPARISON OF CONSUMER PROTECTIONS: PRESIDENT'S ADVISORY COMMISSION, MEDICARE+CHOICE, AND PROPOSED LEGISLATION

			reasonable compensation not contingent on decisions, not be subject to retaliation from the plan, be free from conflict of interest as determined by regulation, and in some cases reviewer is blind to identity of plan and enrollee, and vice versa.	provider. Affiliation with plan or employer is not prohibited. Reviewers can receive only reasonable compensation not contingent on decisions.	any other regulatory requirements. If more than one certified entity is available to a plan, rules of the applicable authority assure that the selection process creates no incentives for bias.	any other regulatory requirements. If more than one certified entity is available to a plan, rules of the applicable authority assure that the selection process creates no incentives for bias.	any other regulatory requirements. If more than one certified entity is available to a plan, rules of the applicable authority assure that the selection process creates no incentives for bias.	reasonable compensation not contingent on decisions, not be subject to retaliation from the plan, be free from conflict of interest as determined by regulation, and the reviewer must be blind to the identity of plan and enrollee, and vice versa.
f. Deadline	"Timely"	Yes	No*	No	Yes	No. Review entity establishes time frames similar to internal appeal time frames.	Yes	No*
g. Expedited process and/or tied to medical exigencies of the case	Yes ("consistent with Medicare")	Yes	No*	No	Yes	No. Review entity establishes time frames similar to internal appeal time frames.	Yes	No*
h. Binding v. Advisory	Silent	Binding on plan	Advisory. If offered by plan, enrollee can	Binding on plan	Binding on plan	Binding on plan	Binding on plan	Binding on plan

COMPARISON OF CONSUMER PROTECTIONS: PRESIDENT'S ADVISORY COMMISSION, MEDICARE+CHOICE, AND PROPOSED LEGISLATION

i. *De Novo* standard	"Objective and credible"	Yes	agree to binding ADR in lieu of external appeals process.No, review based on plan's definition of medical necessity and experimental.	No, review based on plan's definition of medical necessity, and must take into consideration plan's guidelines [S326 requires reviewer to make "independent" determinations based on a variety of evidence]	Yes	Yes	Yes, without regard to plan's definition of medical necessity.	No, plan forwards record for review, including terms of the plan, to reviewers.
15. Quality Advisory Board	Commission recommends creation of the Advisory Council for Health Care Quality and the Forum for Health Care Quality Measurement and Reporting.	No	No	No, gives some of the relevant responsibilities to AHCPR.	Creates Health Care Quality Advisory Board.	No	No	No
16. Experimental therapies	No	Medicare excludes coverage for experimental therapies. M+C organizations may cover experimental therapies through supplemental benefits.	No coverage mandate. Plan must disclose whether experimental therapies are excluded from coverage and the definitions it uses.	No coverage mandate. Plan must disclose whether experimental therapies are covered.	No coverage mandate. Plan must disclose how it decides if treatment is experimental.	No coverage mandate. Plan must disclose how it decides if treatment is experimental.	No coverage mandate. Plan must disclose how it decides if treatment is experimental.	No coverage mandate. Plan must disclose whether experimental therapies are excluded from coverage and the definitions it uses.
17. Clinical trial coverage mandate	No	No	No	No	Yes, if enrollee has a serious illness for	Yes, if enrollee has a serious illness for	Yes, if enrollee has a serious illness for	No

Devorah R. Adler
02/01/2000 01:08:39 PM

Record Type: Record

To: Eric P. Liu/OPD/EOP@EOP
cc: Anna Richter/OPD/EOP@EOP
bcc:
Subject: Re: pbor

Here's a summary of what we didn't like about Coburn-Shadegg -- the differences were not limited to enforcement. Hope this is useful -- let me know if you need anything else.

Thanks, Devorah

While the Coburn/Shadegg amendment offers some additional protections, such provisions are far too weak. The legislation is unacceptably flawed in numerous areas, including:

A flawed enforcement provision that severely limits patients ability to hold plans accountable. Under the Coburn/Shadegg amendment, the roadblocks to accessing court based remedies include:

Imposing a health care cost cap that must be exceeded to sue or even appeal a harmful plan decision. Under this provision, a woman who was denied a mammography and subsequently had her cancer spread would not be able to sue the plan let alone appeal the original denial of service.

Requiring patients who have already been harmed to exhaust all levels of appeals before seeking redress. Under this provision, a patient who by any definition has been injured as a result of a plan decision must go through an unnecessarily time consuming appeals process even though the outcome is clear.

Requiring time consuming and burdensome certification in order for a patient injured by a plan decision to file a case. This requirement may be without precedent, and it certainly implements an extraordinary hurdle for enrollees seeking redress.

Newborns would not be provided the same access to emergency care protections as provided to adults. Parents would need to receive prior approval to be sure they can be reimbursed for emergency care services for their children.

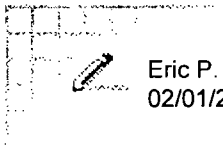
No protections against plans limiting access to necessary medications. This bill allows plans to deny coverage of prescription drugs that are not part of the plan's drug formulary even when prescribed by health care providers and determined to be to

medically necessary.

An external review process that is biased against low-income patients. All patients, even if they are unable to afford it, must pay a $25 filing fee to have their case considered by an external review entity. If the patient cannot pay the filing fee, the appeals entity will not hear their case.

Meaningless information disclosure requirements that leave patients in the dark about their rights. Plans are not required to inform enrollees of their limited new rights. Moreover, plans may meet their information disclosure requirements by providing patients with technical billing and diagnostic codes, which are intended for use by health care professionals, not patients.

Eric P. Liu



Eric P. Liu
02/01/2000 10:56:43 AM

Record Type: Record

To: Devorah R. Adler/OPD/EOP@EOP

cc:
Subject: pbor

Can you remind me how Norwood-Dingell differed from Coburn-Shadegg on the appeals issue?

ERIC—
CJ wanted
to make sure
you saw
this.
Hex—
Pls call
w/ questions.
B

HEALTH
CARE—
PBM

Managed Care Is Still a Good Idea

By Uwe Reinhardt

Is managed care dead? Some say yes, given the United Health Group's decision last week to stop overruling doctors' decisions about treatment. But in truth, managed care is a good idea, and it's here to stay. Only the techniques of managing are being changed.

At its most general level, "managed care" simply means that those who pay for health care have some say over what services they will pay for and at what price. No health-insurance system can work for very long without these prudent measures. True, America's health insurers did function without them for several decades after World War II. Until the early 1990s, most group policies incorporated the philosophy that only the physician and the patient should determine the treatment for a particular illness. It was accepted that the insurer would pay each health-care provider his "usual, customary and reasonable" fees, with few questions asked.

This genteel philosophy rested on the belief that modern medical practice is firmly anchored in science, that the providers of health care would do no less, but also no more, than good medical science dictated, and that the fees charged for health care would remain "reasonable."

Unfortunately, this open-ended social contract produced a track record that gave the lie to these assumptions. Two decades ago, pioneering research by Dartmouth epidemiologist and physician John Wennberg showed that the use of health services and health spending per capita varied widely across regions in the U.S. in ways that could not be explained by health status or clinical science. In the most recent edition of that research, Dr. Wennberg and his associates report that in 1996 Medicare paid a statistically adjusted $7,800 per elderly American in Miami and $7,700 in Baton Rouge, La., vs. just $4,900 in Tallahassee, Fla., $3,923 in Shreveport, La., $3,900 in Portland, Ore., and $3,700 in Minneapolis.

Put on the defensive by such data, the medical profession pointed out that medicine is both art and science and argued that the variations in cost simply reflected differences in preferred practice style. This response begged the question that has been one of the chief drivers behind the managed-care movement: Which of the varied practice styles is the most cost-effective? Managed care was further fueled by research during the 1980s in which clinical experts deemed unnecessary substantial portions of health services actually delivered to patients.

It would be facile to blame physicians for their failure to control costs. After all, the knowledge base of clinical science expands at a pace that exceeds the busy physician's ability to keep up with the best medical practices. Some mechanism must therefore be found to help them do so. Managed care ought to be one such vehicle. It turns out that the preauthorization and concurrent review of medical treatments—the methods American managed-care companies have typically used during the past few years—are not the best means to this end. These intrusive tactics irritate patients, insult physicians and often cost more than they save.

Periodic, statistical profiles of individual physicians' practices promise to be a more productive approach to cost and quality control. It is a common method of cost control in other countries. That method grants the physician clinical autonomy within some range of pre-established norms and intervenes only when physicians deviate substantially from them. In industry, the approach is known as "management by exception." The development and updating of these practice norms is a perpetual search for the best clinical practices. To be effective, that search should be conducted in close cooperation with the practicing physicians to whom the norms apply.

Much as patients and their physicians may dream of the unmanaged, open-ended "golden age" of medicine, a return to that regime is unthinkable. In the last years of that open-ended contract, the premiums employers paid for their employees' health insurance rose between 15% and 25% each year. Had the trend continued, half of the nation's gross domestic product would have gone to health care by 2050.

As recently as October 1993, the Congressional Budget Office forecast that in 2000 the U.S. would spend more than $1.6 trillion on health care (or 18.9% of projected GDP), up from $675 billion (12.2% of GDP) in 1990. In its most recent forecast, the government projects total spending of only $1.3 trillion next year, about $300 billion less than its forecast of six years ago. The bulk of that saving must be credited to the ability of the managed-care industry to exercise some control over both the fees and the use of health services.

Economic theory and empirical research suggest that in the long run, employees pay the cost of fringe benefits in the form of lower take-home pay. It follows logically that the bulk of the health-care cost savings achieved by the managed-care industry must have flown through to the take-home pay of employees, especially in this decade's tight labor markets. Alas, employees seem unaware of this standard economic theory. That's why they stood idly by as the health system chewed up their paychecks during the late 1980s, and why they now show no gratitude for the savings that managed care has funneled back into their pockets. Instead, they subscribe to the folklore that these savings flowed through to their employers' bottom line and into the paychecks of managed-care executives.

American workers have paid a high price for that ignorance, and they may pay it again in the near future, as health-insurance premiums are rising again at near double-digit rates. For American business leaders, one of the most effective methods of health-care cost control would be to level with their employees about who actually pays for health insurance.

Mr. Reinhardt is a professor of political economy at Princeton University.

THE WALL STREET JOURNAL
WEDNESDAY, NOVEMBER 17, 1999

THE WHITE HOUSE

WASHINGTON

HEALTH CARE – PBR

October 6, 1999

TO: Bruce Reed, Gene Sperling, Larry Stein, Joel Johnson, Loretta Ucelli, Eric Liu, Barry Toiv, Chuck Brain, Dan Mendelson, Rich Tarplin, Melissa Skolfield

FROM: Chris Jennings

RE: Today's Joint Committee on Taxation's Estimates on Republican "Access" Proposal

Today, in a letter to Senator Kennedy, the Joint Committee on Taxation (JCT) released an estimate clearly documenting that the Republican "access" package will only provide coverage to less than 1 percent of the 44 million Americans who are now uninsured.

They are projecting that no more than 320,000 Americans who are currently uninsured would be covered as a result of the approximately $50 billion "access" package the Republican leadership is endorsing. As a consequence, not only does the Republican package threaten to further segment healthy from sicker populations and undermine the chances on bipartisan agreement on a strong enforceable Patients' Bill of Rights, it also utilizes tens of billions of dollars of the surplus that should be dedicated to Social Security and Medicare.

We've attached a copy of the SAP on H.R. 2990 as well.

Please call with questions.

Congress of the United States

JOINT COMMITTEE ON TAXATION
1015 LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6453
(202) 225-3621

OCT 06 1999

Honorable Edward M. Kennedy
United States Senate
SR-315
Washington, DC 20510

Dear Senator Kennedy:

This is in response to your letter of October 4, 1999, requesting revenue estimates and other information concerning several of the health care tax provisions in the conference agreement on H.R. 2488 and two of the health care tax provisions in S. 1344.

The conference agreement on H.R. 2488 contains an above-the-line deduction for health insurance expenses and long-term care insurance expenses for which the taxpayer pays at least 50 percent of the premium. The deduction would be phased in at 25 percent for taxable years beginning in 2002 through 2004, 35 percent for taxable years beginning in 2005, 65 percent for taxable years beginning in 2006, and 100 percent for taxable years beginning in 2007 and thereafter. Taxpayers enrolled in Medicare, Medicaid, Champus, VA, the Indian Health Service, the Children's Health Insurance Program, and the Federal Employees Health Benefits Program would be ineligible for the deduction for health insurance expenses.

The conference agreement on H.R. 2488 also contains a provision that would allow long-term care insurance to be offered as part of cafeteria plans, effective for taxable years beginning after December 31, 2001.

For the purpose of preparing revenue estimates for these provisions in H.R. 2488, we have assumed that the provisions will be enacted during calendar year 1999. Estimates of changes in Federal fiscal year budget receipts are shown in the enclosed table.

We estimate that in calendar year 2002 about 9.1 million taxpayers would claim the 25-percent deduction for health insurance expenses. About 100,000 of these 9 million taxpayers would be new purchasers of health insurance. Assuming an average of two persons covered by each policy, about 200,000 persons would be newly insured as a result of the 25-percent deduction for health insurance expenses.

We estimate that in calendar year 2002 about 4.7 million taxpayers would claim the 25-percent deduction for long-term care insurance expenses, and an additional 300,000 taxpayers

Congress of the United States

JOINT COMMITTEE ON TAXATION

Washington, DC 20515–6453

would use cafeteria plans to pay their share of premiums for employer-sponsored long-term care insurance. About 80,000 of these 5 million taxpayers would be new purchasers of long-term care insurance.

S. 1344 contains a provision that would increase the deduction for health insurance expenses of self-employed individuals. Under present law, when certain requirements are satisfied, self-employed individuals are permitted to deduct 60 percent of their expenditures on health insurance and long-term care insurance. The deduction is scheduled to increase to 70 percent of such expenses for taxable years beginning in 2002 and 100 percent in all taxable years beginning thereafter. S. 1344 would increase the rate of deduction to 100 percent of health insurance and long-term care insurance expenses for taxable years beginning after December 31, 1999.

S. 1344 also contains provisions that would eliminate certain restrictions on the availability of medical savings accounts, remove the limitation on the number of taxpayers that are permitted to have medical savings accounts, reduce the minimum annual deductibles for high-deductible health plans to $1,000 for plans providing single coverage and $2,000 for plans providing family coverage, increase the medical savings account contribution limit to 100 percent of the annual deductible for the associated high-deductible health plan, limit the additional tax on distributions not used for qualified medical expenses, and allow network-based manage care plans to be high-deductible plans. These provisions would be effective for taxable years beginning after December 31, 1999.

For the purpose of preparing revenue estimates for these provisions in S. 1344, we have assumed that the provisions will be enacted during calendar year 1999. Estimates of changes in Federal fiscal year budget receipts are shown in the enclosed table.

We estimate that in calendar year 2000, about 3.3 million taxpayers would claim the 100-percent deduction for health insurance expenses of self-employed individuals. About 60,000 of these taxpayers would be new purchasers of health insurance. Assuming an average of two persons covered by each policy, about 120,000 persons would be newly insured as a result of the 100-percent deduction for health insurance expenses.

Congress of the United States

JOINT COMMITTEE ON TAXATION
Washington, DC 20515–6453

Honorable Edward M. Kennedy
United States Senate

Page 3

We do not have an estimate of the number of individuals who would be newly insured as a result of the medical savings account provisions of S. 1344.

I hope this information is helpful to you. If we can be of further assistance, please let me know.

Sincerely,

Lindy L. Paull

Lindy L. Paull

Enclosure: Table #99-3 206

#99-3 208
VERY PRELIMINARY
6-Oct-99

- Senator Kennedy -

ESTIMATED REVENUE EFFECTS OF VARIOUS PROVISIONS RELATING TO HEALTH CARE

Fiscal Years 2000 - 2009

[Millions of Dollars]

Provision	Effective	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2000-04	2000-09
Health Care Provisions in the Conference Agreement for H.R. 2488													
1. Provide an above-the-line deduction for health insurance expenses - 25% in 2002 through 2004, 35% in 2005, 65% in 2006, and 100% thereafter	tyba 12/31/01	—	—	-444	-1,379	-1,477	-1,803	-3,137	-5,876	-8,299	-8,848	-3,300	-31
2. Provide an above-the-line deduction for long-term care insurance expenses - 25% in 2002 through 2004, 35% in 2005, 65% in 2006, and 100% thereafter	tyba 12/31/01	—	—	-48	-328	-364	-417	-677	-1,315	-2,027	-2,148	-741	-7,32
3. Allow long-term care insurance to be offered as part of cafeteria plans; limited to amount of deductible premiums [1]	tyba 12/31/01	—	—	-104	-151	-171	-190	-202	-204	-215	-247	-426	-1,48
Total of Health Care Provisions in the Conference Agreement for H.R. 2488		—	—	-596	-1,858	-2,012	-2,410	-4,016	-7,397	-10,541	-11,241	-4,467	-40,07
Health Care Provisions in S. 1344, as passed by the Senate													
1. Immediate 100% deductibility of health insurance and long-term care insurance premiums for the self-employed	tyba 12/31/99	-245	-1,007	-1,040	-657	—	—	—	—	—	—	-2,949	-2,94
2. Liberalization of conditions for enrolling in MSAs	tyba 12/31/99	-93	-281	-326	-370	-414	-459	-502	-546	-590	-634	-1,483	-4,21
Total of Health Care Provisions in S. 1344, as passed by the Senate		-339	-1,288	-1,366	-1,027	-414	-459	-502	-546	-590	-634	-4,432	-7,16

Joint Committee on Taxation

NOTE: Details may not add to totals due to rounding.

Legend for "Effective" column: tyba = taxable years beginning after

[1] Estimate assumes concurrent enactment of the above-the-line deduction for long-term care insurance (item 2.).

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

October 6, 1999
(House)

STATEMENT OF ADMINISTRATION POLICY

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

H.R. 2990 - Quality Care for the Uninsured Act
(Rep. Talent (R) MO)

The Administration strongly opposes House passage of H.R. 2990, legislation explicitly designed to interfere with the passage of a free-standing Norwood-Dingell Patients' Bill of Rights. This legislation is completely unfunded and would therefore spend the social security surplus. The spending of the surplus would have virtually no impact in expanding coverage to the uninsured. If H.R. 2990 were presented to the President, his senior advisers would recommend that he veto the bill.

Although we look forward to continuing to work with the Congress on a bipartisan basis to increase access to health insurance coverage, H.R. 2990 is not the answer. While H.R. 2990 contains certain provisions that the Administration supports, such as a 100 percent deduction for health insurance premiums for the self-employed, it also includes numerous controversial provisions, such as expanding the availability of Medical Savings Accounts and association health plans, that independent health policy analysts fear would do more to segregate the healthy from the unhealthy than to cover the uninsured. In fact, preliminary analysis indicates that the bill's costs would lead to a coverage expansion of less than one percent of the currently uninsured. These provisions are unrelated to the purposes of the Patients' Bill of Rights, and would further undermine the chances for a bipartisan agreement on meaningful legislation to provide all Americans the health care protections they need and deserve.

In addition, the Administration is seriously concerned that H.R. 2990 fails to include adequate offsets for the bill's significant pay-as-you-go costs. Failure to provide adequate offsets for these costs is likely to force spending of surplus dollars that should go to Social Security and Medicare.

Pay-As-You-Go Scoring

H.R. 2990 would affect receipts; therefore, it is subject to the pay-as-you-go requirement of the Omnibus Budget Reconciliation Act of 1990. OMB's scoring of H.R. 2990 is under development. Preliminary estimates based on scoring of similar provisions indicate that H.R. 2990 would result in paygo costs of more than $50 billion over 10 years.

****

Devorah R. Adler
10/04/99 11:13:25 PM

Record Type: Record

To: Robert J. Pellicci/OMB/EOP@EOP, Sandra Yamin/OMB/EOP@EOP

cc: Anna Richter/OPD/EOP@EOP
Subject: COMMENT ON SAP

Hello --

Attached below are our comments on the SAP -- mostly minor. Our edits are in **BOLD** and they're mostly sentence structure. The one addition is the one on the CPS numbers, which (for obvious reasons having to do with yesterday's headlines) is probably necessary.

However, we have one substantive policy edit that Chris feels strongly about. It is on the sentence below:

In particular, the legislation sponsored by Representatives Coburn and Shadegg would require patients to undergo a separate certification process to affirm that they have been harmed prior to allowing any court proceeding *(a provision that may well be unconstitutional)*.

I know that DOJ wants to strip out the clause in italics. I think that the first thing to note is that we do not say for sure that it is unconstitutional -- we just say that it might be. Also, there have been a number of lawyers that Chris has talked to that say that this provision is, in their estimation, unconstitutional. We have a written analysis from Sarah Rosenbaum at Georgetown to this effect, which I can share with you if you'd like. We feel that we should keep the provision in italics.

Can we talk about this in the morning if there are concerns about this edit?

Thanks a lot.

Devorah

DRAFT -- NOT FOR RELEASE

October 4, 1999
(House)

H.R. 2723 - Bipartisan Consensus Managed Care Improvement Act of 1999

(Reps. Norwood (R) GA and Dingell (D) MI and 132 cosponsors)
and
H.R. 2990 - Quality Care for the Uninsured Act
(Rep. Talent (R) MO)

The President strongly supports the enactment of H.R. 2723, the Bipartisan Consensus Managed Care Improvement Act of 1999. This bipartisan legislation would provide new patient protections to all Americans in all health plans, and hold health plans accountable **if** their actions cause harm to patients.

Since November 1997, when he received the report of his Quality Commission, the President has been calling on the Congress to pass a strong, enforceable, and bipartisan patients' bill of rights. In the absence of congressional action, the President directed the Federal health plans, covering over 85 million Americans, to implement the patient protections recommended by the Commission. More specifically, as a result of the President's administrative actions, Medicare, Medicaid, the Federal Employees Health Benefits Program and its almost 300 private health insurance plans, the Departments of Veterans Affairs, Defense, and Labor are in - or moving into - compliance with the Patients' Bill of Rights to the fullest extent of the law. In addition, just last Saturday, the President announced a proposed rule that will include similar patient protections to the Children's Health Insurance Program

Many States have passed legislation **that** provides important protections to their residents, including requiring new protections for patients in emergency situations, establishing access to independent external appeals processes, and ensuring access to specialists. Over 30 States prohibit health plans from requiring prior authorization before going to an emergency room, over 25 States require plans to provide access to an independent external appeals entity after exhausting internal appeals processes, and over 20 States require health plans to provide referrals to specialists when the physicians participating in the HMO network are not adequate to treat the enrollees' condition. Just last week, the State of California enacted a new law establishing an independent medical review system for patients to dispute claims when their treatment has been delayed, denied, or modified by their health plan. **This new law also provides** enrollees with a fair, unbiased, internal and external appeals process, and allowing patients harmed by health plan decisions to hold the plans accountable in the courts.

While all these actions are important, **the incomplete patchwork of state protections combined with** limits on State jurisdiction and Federal regulatory authority make it impossible to ensure that all Americans in all health plans have the protections they need. States do not have the authority to regulate self-insured plans, leaving almost 50 million people unprotected nationwide. Moreover, Federal law frequently preempts State enforcement even over plans regulated by the States.

The outcome of the debate on H.R. 2723 will determine whether this Congress is serious about responding to the public's need for assistance in navigating the Nation's ever-changing health care delivery system. The President is strongly committed to working with Members of both parties to pass a meaningful Patients' Bill of Rights this year; he is equally committed,

however, to vetoing any legislation that is a Patients' Bill of Rights in name only.

On August 5, 1999, the President commended Representatives Norwood, Dingell, and Ganske for their leadership in introducing a strong, enforceable Patients' Bill of Rights. He endorsed H.R. 2723 because it provides meaningful patient protections, such as the right to emergency care wherever and whenever a medical emergency arises; the right to access the health care specialists that a patient needs; the right to ensure care is not disrupted during treatment; and the right to an unbiased internal appeals process and an independent external appeals process that allows patients to get the care they were promised.

The Administration strongly opposes any amendments to H.R. 2723 that would seek to weaken key provisions of the bill and finds the development of alternative legislation designed solely to undermine the enforcement provisions to be unacceptable. **In particular, the legislation sponsored by** Representatives Coburn and Shadegg would require patients to undergo a separate certification process to affirm that they have been harmed prior to allowing any court proceeding (a provision that may well be unconstitutional). It would provide the illusion of enforcement provisions while actually establishing roadblocks to prevent patients who have been harmed by plan decisions from holding their plans accountable. The President has consistently indicated that a right without a legal remedy is **no** right at all. He **will not support** legislation that provides the public with a false sense of security.

Although we look forward to continuing to work with Congress on a bipartisan basis to build on the steps we have already taken to increase access to health insurance coverage, such actions cannot and should not impede a vote of a free standing Patients Bill of Rights. Therefore, the Administration also strongly opposes House passage of H.R. 2990, legislation the Republican Leadership **may** attach to the final Patients' Bill of Rights bill. Attaching this legislation to the Patients' Bill of Rights is explicitly designed to interfere with the possibility of an up or down vote on final passage of a free-standing Norwood-Dingell Patients' Bill of Rights. Although H.R. 2990 contains certain provisions that the Administration supports , such as a 100 percent deduction for health insurance premiums for the self-employed, it also includes numerous controversial provisions, such as an expansion of the Medical Savings Account Demonstration and multiple employer welfare arrangements, that independent health policy analysts fear would do more to segregate the healthy from the unhealthy than to cover the uninsured. These provisions are unrelated to a Patients' Bill of Rights and would further undermine the chances for a bipartisan agreement and diminish the bill's strong support. **If H.R. 2990 were presented to the President as a free-standing bill, his senior advisers would recommend that he veto the bill.**

Enacting meaningful Patients' Bill of Rights legislation is long overdue. **We strongly urge the House to** pass a "clean" H.R. 2723, which enjoys broad bipartisan support, and give all Americans the health care protections they need and deserve.

Pay-As-You-Go Scoring

H.R. 2990 would affect 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 H.R. 2990 is under development.

* * * * * * * * * *

(Do Not Distribute Outside Executive Office of the President)

This Statement of Administration Policy was developed by the Legislative Reference Division (Pellicci) in consultation with the DPC (Jennings/Adler), HD (Kirchgraber), EIML (Menchik), NSD (White), and VA/Pers (Fairhall/LaPlaca). The Departments of Health and Human Services (per Jane Horvath) and Labor (per Jim Greene) concur in the proposed position. The Departments of the Treasury (per Karen Dorsey) and Veterans Affairs (per Walt Hall) and OPM (per Harry Wolf) have no objection. The Department of Defense did not respond to our request for views.

NOTE: HHS has recommended a "senior advisers" veto threat of H.R. 2990 if the bill were presented to the President as a free-standing bill. The Department of Labor concurs in the HHS recommendation.

The Department of Justice (per Greg Jones) recommends deletion of the parenthetical phrase (a provision that may well be unconstitutional) because it cannot verify its accuracy.

OMB/LA Clearance: _____

The position is consistent with the President's statement on H.R. 2723 on August 5, 1999.

Summary of H.R. 2723

Overview

H.R. 2723 amends the Employee Retirement Income Security Act (ERISA), the Public Health Service Act, and the Internal Revenue Code to provide new patient protections under group health plans and health insurance issuers.

Entities Regulated

The bill applies to all of the following: employer-sponsored group health plans (ERISA plans), both fully insured and self-insured plans; health insurance issuers in the group and individual markets; non- Federal plans (i.e., state and local government plans); and vision and dental limited scope coverage plans.

Patient Protections

Liability - Removes the ERISA preemption of State law to allow a cause of action against

plans for personal injury or wrongful death. The bill would shield the plan from punitive damages if the external review was completed in a timely manner and the plan followed the external reviewer's decision.

Internal Review - Requires physicians to review all denials involving medical judgment. Reviewers must not have made the initial plan decision.

External Review - Allows all denials involving medical judgment to go to external review. A filing fee is required, but an exception is made for indigent persons. Plans must contract with one or more certified external review entities. Each case must be reviewed by a panel of at least three clinical peers. Reviewers are not bound by plan definitions of medical necessity, experimental, or related terms and are required to consider certain specified evidence. The external review determination is binding on the plan or insurance issuer.

Enforcement of External Review - If a plan or issuer fails to follow the external review determination, the patient may receive a civil monetary penalty of $1,000 per day until the benefit is provided. Plans or issuers could be assessed a penalty of up to $500,000 for a pattern or practice of refusal to follow external review determinations or other violations of the external review provisions.

Point of Service - All issuers in the group market must offer a point of service option to each enrollee, unless the enrollee is offered the option through another group health plan or issuer in the group market.

Emergency Services - Requires plans and issuers to cover emergency screening and stabilization services on a "prudent layperson" basis if the plan or issuer provides any benefits for services in an emergency department. It also requires reimbursement for post-stabilization services in accordance with HHS regulations if the plan or issuer covers such services.

Continuity of Care - Provides a transitional treatment period when a provider is dropped from the plan or employer changes plans. Transitional period is up to 90 days for an ongoing special condition, after discharge for surgery or transplantation, through postpartum care for pregnancy, or for the remainder of the patient's life for a terminal illness.

Prescription Drugs - Physicians and pharmacists must participate in formulary development. The nature of the formulary restrictions must be disclosed to enrollees and providers on request. Plans must provide for exceptions from the formulary when medically indicated.

Clinical Trials - Plans must cover routine costs of participation in certain clinical trials if the patient has a life-threatening or serious illness for which no standard treatment is effective and participation in the trial offers meaningful potential for significant clinical benefit.

Information Disclosure - Detailed disclosure requirements include: plan benefits; limitations and exclusions; out-of-network coverage; how to select and obtain referrals to providers; emergency medical care coverage and definitions; prior authorization rules; and grievance and

appeals procedures.

Anti-Gag Rule - Prohibits limitations or restrictions on advice to a participant about their health status, or the medical care or treatment, regardless of whether benefits for that care or treatment are provided in the plan.

Utilization Review (UR) Standards - Requires all plans performing UR to use written clinical review criteria developed with input of practicing providers and based on valid clinical evidence.

Whistle-Blower - Prohibits plans from retaliating against providers who make disclosures to or participate in investigations by public regulatory agencies, private accreditation bodies, or management personnel of the plan.

Competing Measures

In addition to H.R. 2723 (Norwood/Dingell), a revised version of H.R. 2824, introduced by Reps. Coburn (R-OK) and Shadegg (R-AZ), and H.R. 2926, introduced by Rep. Boehner are likely to be offered as wholesale substitutes for H.R. 2723. In addition, the House Leadership is planning a separate vote on H.R. 2990, its tax-and-access bill.

Revised Coburn/Shadegg - Like H.R. 2723, it would cover all 160 million privately insured persons. The most significant differences between the two bills are:

-- Liability. Creates a Federal cause of action under ERISA that allows enrollees to sue for personal injury or wrongful death. Non-economic damages are capped at $500,000. Patients would be allowed to go forward with a lawsuit even if the reviewers ruled that they had not been injured, but if they do, they would face a "loser pays" rule that would hold them responsible for the other side's legal costs. Employers are not subject to liability unless they directly participated on a claim for benefits.

-- Other. Unlike H.R. 2723, Coburn/Shadegg does not provide for coverage of clinical trials or off-formulary drugs when medically necessary. It also does not include any whistleblower protections.

-- Medicare+Choice Competitive Demonstrations. Unlike H.R. 2723, Coburn/Shadegg includes language that would prevent funds from being used to administer the Medicare+Choice Competitive Pricing Demonstration Project. These demonstrations were passed by the Congress as part of the BBA in order to provide valuable information regarding the use of competitive pricing methodologies in Medicare. The information that we could learn from these demonstrations is particularly relevant as we consider the important task of reforming Medicare.

H.R. 2926 (Boehner) - Covers only those persons with employer-sponsored insurance (leaves out over 100 million individuals -- the people who purchase insurance themselves without their employer's help) and is the only House bill that would not allow patients to sue their plans if a

patient is injured when insurance plans deny treatment.

H.R. 2990 (Talent) - Included in the Leadership's tax and access bill are expanded Medical Savings Accounts, HealthMarts, Association Health Plans, a 100 percent deduction for health insurance premiums for self-employed individuals, and tax deductions for long-term care premiums. The bill would also provide for an expanded orphan drug tax credit and a "medical innovation" tax credit. The innovation tax credit would allow a 40 percent credit for qualified medical research costs for human clinical testing of any drug, biologic, or other medical device.

Pay-As-You-Go Scoring

According to HD (Miller), H.R. 2990 would affect receipts; therefore, it is subject to the pay-as-you-go requirement of the Omnibus Budget Reconciliation Act of 1990. OMB's preliminary scoring of the bill is under development. To date, CBO has not scored H.R. 2990.

THE WHITE HOUSE

WASHINGTON

HEALTH
-PBR

October 4, 1999

STATEMENT ON PATIENTS BILL OF RIGHTS LEGISLATION

DATE:	Tuesday, October 5, 1999
LOCATION:	South Portico
BRIEFING TIME:	2:45pm – 3:00pm
MEET & GREET TIME:	3:05pm – 3:10pm
EVENT TIME:	3:10pm – 3:15pm
FROM:	Bruce Reed, Mary Beth Cahill, Chris Jennings

I. PURPOSE

To encourage the Congress to put politics and parliamentary gimmicks aside and pass a strong, enforceable, bipartisan Patients Bill of Rights (the Norwood-Dingell bill) to improve the quality of health care delivered to all Americans in all health plans.

II. BACKGROUND

Today, at a departure statement, you will urge the Congress to hold a fair, up or down vote on the Norwood-Dingell Patients Bill of Rights. You will be joined by Secretary Shalala, Secretary Herman, and representatives of the health care advocacy and provider community, including the American Medical Association and the American Nurses Association.

In your statement, you will highlight the fact that the Norwood-Dingell bill has already received broad-based support from over 300 health care provider and consumer groups. You will reiterate your belief that this strong bipartisan bill should not be undermined by the addition of legislative "poison pills", extraneous provisions, and procedural gimmicks designed to thwart the House's ability to hold an up and down vote on final passage of the Norwood-Dingell Patients' Bill of Rights.

The Republican leadership seek to include a number of "poison pill" provisions, such as an expansion of the Medical Savings Account Demonstration, that independent health policy analysts fear would do more to segregate the healthy from the unhealthy than to cover the uninsured. In addition, you will state that you strongly oppose any amendments that would seek to weaken key provisions of the bill, such as the approach advocated by Congressmen Coburn and Shadegg in their alternative legislation, which would require patients to undergo a separate certification process to affirm that they have been harmed prior to allowing any court proceeding (a provision that may well be unconstitutional).

Finally, you will reiterate that the time has long passed for the Congress to act on a strong Patients Bill of Rights. You will emphasize that enactment of this legislation has real life consequences for patients.

III. PARTICIPANTS

Briefing Participants:
Bruce Reed
Mary Beth Cahill
Larry Stein
Chris Jennings
Paul Glastris

Statement Participants:
YOU
Secretary Donna Shalala
Secretary Alexis Herman
Thomas Reardon, National President, American Medical Association
Beverly Malone, National President, American Nurses Association
Judith Lichtman, President, National Partnership for Women & Families
John Seffrin, CEO, American Cancer Society
Ron Pollack, President, Families USA

IV. PRESS PLAN

Open Press.

V. SEQUENCE OF EVENTS

- **YOU** will greet the statement participants in the Diplomatic Reception Room.
- **YOU** and the statement participants will proceed to the South Portico.
- **YOU** will make brief remarks and depart.

VI. REMARKS

To be provided by speechwriting.

HEALTH CARE —
PBM

Lowell A. Weiss
10/01/99 09:43:36 AM

Record Type: Record

To: Eric P. Liu/OPD/EOP@EOP, Devorah R. Adler/OPD/EOP@EOP

cc:
Subject: need comments back asap -- see bold

Draft 9/30/99 8:15 p.m.
Lowell Weiss

PRESIDENT WILLIAM J. CLINTON
RADIO ADDRESS ON PATIENTS' BILL OF RIGHTS
THE WHITE HOUSE
October 1, 1999

Good morning. Although my voice has been a little hoarse, I want to speak with you this morning about your voice - about how you can make the difference this week to help secure the vital health care protections you have long deserved.

Like many of you, I have been appalled by the tragic stories of men and women fighting for their lives - and at the same time forced to fight insurance companies focused only on the bottom line. I have met the husbands and wives of those who have died when insurance companies overruled a doctor's urgent warnings. I met a former HMO employee who broke down in tears when describing how callous delays wound up costing a 12-year-old cancer patient his leg.

But if we work together, we have the power to put patients first once again. Just this week, Governor Gray Davis signed into law an ambitious health care reform package, giving the 20 million residents of California a strong and enforceable Patients' Bill of Rights. Now it is time to do the same for every American. Because I don't care whether you're from California or Connecticut or anywhere in between; families all across America need greater patient protections at this time of great change.

My Administration has worked very hard to do its part. Through executive action, we have granted all of the patient protections we can give under law to more than 85 million Americans who get their health care through federal plans.

Today, I am pleased to announce that this month we will propose rules to extend patient protections to each and every child covered under the Children's Health Insurance Program. These children are from some of the hardest-pressed working families. That is why I feel so strongly about giving them not only access to health care, but also a guarantee of

quality care.

And yet some in Congress seem intent on moving in the opposite direction. Republican leaders have recently attached language to a budget bill to deprive 120 million employees of the right to an internal appeal of any coverage decision that denies them care they were promised. Blocking this basic right is simply unacceptable. It puts special interests first, and patients last.

But this week, the House of Representatives has a chance to effectively erase this action, as they sit down to vote, at long last, on whether to give all Americans all the protections of the Patients' Bill of Rights. This vote is critical. For all the steps this Administration and many states have taken to extend patient rights, we do not have the authority to protect every family unless Congress acts.

I encourage you to urge your Representatives to vote for the comprehensive, bipartisan Patients' Bill of Rights sponsored by Congressmen Charlie Norwood and John Dingell. This legislation would give every American the right to emergency room care and the right to see a specialist. The right to know that you can't be forced to switch doctors in the middle of a cancer treatment or pregnancy. The right to hold your health plan accountable if it causes you or a loved one great harm. The bill has already been endorsed by more than 300 health care and consumer groups across the country.

I am convinced that the votes are there to pass this Patients' Bill of Rights this week. But we need your help to make it clear to the Republican leaders that we cannot tolerate any attempt to kill this bill with legislative poison pills. Together, let's tell them to give this legislation the straight up-or-down vote it deserves. Let's not allow anything to jeopardize the remarkable bipartisan consensus we have worked so hard to build.

If you make your voice heard, and Republican leaders permit every Member to vote on the strong, bipartisan bill that stands today, this week can bring the most important health protections in years. Partisan posturing and delay will only make matters worse. To me it's the same choice patients face every day: proactive, preventative medicine now - or expensive, last-minute interventions later. The American people are counting on the Congress, and especially the Republican leaders, to make the responsible choice.

DRAFT: PRESIDENT CLINTON ANNOUNCES NEW PATIENT PROTECTIONS ~~COVERING THE~~ CHILDREN'S ~~HEALTH INSURANCE PROGRAM~~ AND URGES CONGRESS TO ~~DO ITS PART AND~~ PASS A STRONG, ENFORCEABLE PATIENTS' BILL OF RIGHTS

October 2, 1999

~~Today,~~ In his weekly radio address, President Clinton will announce that later this month the Department of Health and Human Services ~~will~~ release a proposed regulation extending important patient protections to the Children's Health Insurance Program (CHIP) ~~, including access~~ to ~~emergency services where and when the need arises, ensuring access to specialists,~~ and ~~establishing a strong, fair, and timely appeals process~~. Extending these new rights to the CHIP program means that every Federal health care program – covering over 85 million Americans – is coming into compliance, to the fullest extent of the law, with the Patients' Bill of Rights. The President will also cite the enactment of strong patient protections in California for 20 million people this week as an example that states are also moving aggressively in this area. Finally, he will underscore that ~~Federal and State authority is limited and inadequate and, as such,~~ Congress must act to ensure that all Americans in all plans have the patient protections they need. Today, the President will:

~~ANNOUNCE~~ **NEW, STRONG, PATIENT PROTECTIONS FOR THE CHIP PROGRAM.** Today, President Clinton will announce that later this month, the Department of Health and Human Services will release a proposed regulation extending critical patient protections to every child enrolled in the new CHIP program. This new program, which is expected to cover up to 5 million uninsured children, will be required to ensure that all plans include: access to needed health care specialists; access to emergency room services when and where the need arises; assurances that doctors and patients can openly discuss treatment options; and access to a fair, unbiased, and timely appeals process to address health plan grievances.

COMMEND GOVERNOR DAVIS AND THE STATE OF CALIFORNIA FOR ENACTING A STRONG, ENFORCEABLE, PATIENTS BILL OF RIGHTS. The President will praise the state of California for moving ahead as the Congress stalls and enacting a bipartisan, strong, enforceable, Patients Bill of Rights that extends new protections to over 20 million people. This new law establishes an independent medical review system for patients to dispute claims when treatment has been delayed, denied or modified by their health plan; provides enrollees with a fair, unbiased, internal and external appeals process; and allows patients who have been harmed by health plan decisions to hold their plans accountable through the courts.

OMB + OIRA Have Cleared

STRESS THE CONTINUING NEED FOR STRONG FEDERAL LEGISLATION. ~~The President will remind Americans that~~ despite these strong steps forward for patients' rights, more needs to be done to assure that all Americans in all health plans get the quality care they need and deserve. Tens of millions of Americans across the country will be denied basic protections. This is because state jurisdiction does not cover self insured plans covering millions of Americans and Federal law may preempt state laws in many areas including enforcement and external appeals. Moreover, because few states have passed comprehensive protections, there can be no uniformity of these protections until and unless Federal legislation is enacted.

STATE HIS DISAPPOINTMENT THAT CONGRESS IS MOVING IN THE WRONG DIRECTION. The House Labor Appropriations bill, despite strong opposition by the Administration and Democrats, insisted on including a provision that will prevent the Department of Labor from issuing regulations to provide . This will deprive 120 million employees of the right to a timely and effective internal appeal of any coverage decision that denies them care they were promised.

~~URGE THE~~ CONGRESS TO SUPPORT PATIENTS' RIGHTS RATHER THAN SPECIAL INTERESTS AND PASS A STRONG, ENFORCEABLE PATIENTS BILL OF RIGHTS. Noting that the Norwood-Dingell Patients' Bill of Rights already has a bipartisan majority in the House, the President will urge the Republican leadership to commit to a fair, up-or-down vote on this legislation next week, without loading it up with provisions that water down its strong protections or threaten the bipartisan support it has already achieved. Unlike the partisan Senate passed bill, this legislation covers all Americans in all plans, provides real patient protections (access to specialists, continuity of care protections, emergency room protections), holds plans accountable when they do harm to patients and is strongly supported by the American Medical Association and over 300 health care and consumer organizations. The President will encourage the Congress to act constructively to protect the rights of Americans nationwide.

BUILDS ON STRONG ADMINISTRATION RECORD OF PROTECTING PATIENTS' RIGHTS. President Clinton has a long history of promoting patients' rights, and he has already used his authority to make many of these rights real for the 85 million Americans who get their health care through federal plans ~~, from~~ Medicare and Medicaid, ~~to the~~ Federal Employees Health Benefits Plan (FEHBP), ~~to~~ the Department of Defense and the Veterans Administration. The Administration's record on patients' rights include:

- Appointing a Quality Commission to examine ~~potential quality concerns in~~ the changing health care industry. In 1996, the President created a non-partisan, broad-based Commission on Quality and charged them with developing a patients' bill of rights as their first order of business.

- Challenging Congress to Pass a Patients Bill of Rights. In October of 1997, the President accepted the Commission's recommendation that all health plans should provide strong patient protections and called on the Congress to pass a strong enforceable patients' bill of rights. He also called on the Congress to make passing the patients' bill of rights a top priority in his 1998 and 1999 State of the Union Addresses.

- Extending Critical Patient Protections to All Federal Health Plans. In February of 1998, the President directed the Federal health plans, covering 85 million Americans, to implement the

patients' bill of rights. Over the next year, critical steps were taken to meet this goal. For example, the Office of Personnel Management issued their annual call letter notifying their 285 health plans they needed to implement patient protections to participate in FEHBP; the Health Care Financing Administration issued an Interim Final regulation to implement patient protections for older Americans and people with disabilities covered by Medicare; and the President announced a proposed rule to bring the Medicaid program into compliance.

HMO-Overhaul Opponents Base Case on Voter Apathy

By Shailagh Murray
Staff Reporter of The Wall Street Journal

WASHINGTON — Here is a novel approach to lobbying: Try to convince lawmakers that your issue is no big deal.

That's the risky wager being placed by the managed-care industry, as it faces an uphill battle against tough health maintenance-organization overhaul measures in the House.

The thinking at the American Association of Health Plans goes like this: Despite all the HMO horror stories, the outcries of doctors and the relentless pounding by consumer groups, polls by the industry and outsiders show that most people like their own health-care plans. They also suggest voters don't pick political candidates for their stance on managed-care overhaul. So, lawmakers can safely oppose or stonewall the measures that the House is expected to consider this fall.

"There is not the makings of a revolution out there, when you have 80% to 90% approval ratings," says Mark Merritt, chief strategist for the AAHP, which represents 1,000 health-maintenance organizations and preferred-provider groups. "It's like campaign-finance reform: Everyone likes it, but no one cares."

The HMOs' pitch seemed to work in the Senate, where Republicans passed a narrow overhaul bill this summer. But House members are proving a skeptical bunch, in part because of the intensity of HMO critics. Two tough bills have gained backing from rank-and-file lawmakers from both parties, including conservative Republicans. The GOP reformers have even vowed to buck opponents in the House leadership to produce legislation that includes the managed-care industry's nightmare: a liability clause allowing patients to sue their health plans.

Vote Early in October

To avoid an embarrassing fight with fellow Republicans, House Speaker Dennis Hastert of Illinois, who has remained publicly noncommittal, announced Friday that he will bring both bills to a vote during the week of Oct. 4.

"This is a bedrock conservative principle," says Rep. John Shadegg, an Arizona Republican who co-authored one of the House bills with his physician-colleague, GOP Rep. Tom Coburn of Oklahoma. "I teach my kids about taking responsibility for what they do wrong." Plus, he has his own polls. "Sixty-five percent of Republicans," the congressman notes, "think an HMO should be held negligent when they mess up."

That is strong medicine for Mr. Merritt's team. The AAHP is spending at least $5 million in advertising, polling and grassroots activities, and conducted a public relations blitz in 60 House districts over the summer recess. But when lawmakers returned after Labor Day, they were as determined as ever to pass a tough bill.

What happened? Overhaul supporters don't dispute the AAHP's findings that managed-care overhaul isn't as pressing to voters as other issues. Indeed, in the latest Wall Street Journal/NBC News poll, the public ranked passage of a patients' bill of rights, as managed-care regulation is popularly known, as a lower priority than revamping Medicare, cutting taxes, restricting gun sales and increasing defense spending.

But a recent Journal/NBC poll also found that 56% of voters have a somewhat negative or very negative view of HMOs, up from 50% a year ago. To Rep. Shadegg and other reformers, this indicates a growing frustration among many people about medical care, and a sense that health plans are more concerned about bottom lines than patients.

Experience With Babies

Lawmakers' stands on managed care also can be powerfully influenced by their own experiences. Dr. Coburn has spent years delivering babies; Rep. Charlie Norwood, the Georgia Republican and co-author of the bipartisan bill, is a dentist. Rep. Shadegg talks of his fears for his sister, a breast-cancer survivor. His take on the industry's low-key stance is blunt: "Their argument is cynical, calculating and just wrong."

And then there are the political realities. Conservative GOP Rep. Lindsey Graham of South Carolina, a co-sponsor of both overhaul bills, put it bluntly in a recent news conference: "This is an issue that can hurt us because we're not taking it seriously." Says Rep. Shadegg, "I guarantee you, the members who talk to me are scared."

That is because House members are often elected on populist themes, such as term limits, that may resonate more in their districts than nationally. Even some insurance-industry officials say that if the GOP-led House fails to produce tough patient protections before next year's election, Democrats could have a powerful weapon to help regain the majority.

"What's important is not how the public feels at a given time, but how an issue can be shaped politically," says Charles "Chip" Kahn, president of the Health Insurance Association of America. "I don't argue with the polling data. My question is, what does it all mean?"

Though an ally of Mr. Merritt in opposing the two House bills, Mr. Kahn has his own theory: that the polls mask a widespread public disappointment with where the health-care system is headed.

Even AAHP officials concede that the managed-care industry hasn't helped matters by failing to counter its attackers and their gripping stories. That is why, in addition to the lobbying, in recent weeks AAHP executives have been guests on more than 100 local talk-radio programs.

'Things Go Wrong'

Earlier this month, AAHP President Karen Ignagni spent a half-hour chatting live with the morning host at KVI, a large Seattle AM station. Ms. Ignagni was quick to deliver the industry line, that patients can't "sue their way to better health care." But she spent much of the session lamenting how her industry has become a villain. "Things go wrong," she told the sympathetic host, Kirby Wilbur. "That doesn't mean the whole system is wrong."

The industry still has strong prospects for beating back unwanted regulation. In the House, members of the GOP leadership strongly dislike both pending bills. One outspoken critic is Rep. John Boehner, an Ohio Republican who claims the two measures would expose employers to lawsuits. Rep. Boehner may yet produce a third patient-protection bill that bars such actions, though it wouldn't be likely to pass. Any bill that does ultimately pass in the House, however, is likely to be light years from the Senate legislation.

Meanwhile, even the AAHP's foes are intrigued by the group's gamble that voter passivity will ultimately trump the horror stories. "This is a test of whether money can change the message—and whether polling is really legitimate," says Jamie Court, advocacy director for the Foundation for Taxpayer and Consumer Rights in Santa Monica, Calif.

Mr. Court's organization is one of the harshest critics of HMOs in the country. Its "casualty of the day" faxes, sent to 1,000 Washington decision-makers for five months last year, helped to rally many on Capitol Hill to the overhaul cause. The group's most recent target was Gov. Gray Davis, who was feted by HMO industry leaders in July, as the California legislature debated statewide managed-care changes.

Liability Provision Approved

The Democratic governor began citing his own polls as he urged lawmakers not to go overboard. He might have taken a page from the AAHP briefing book: He argued Californians are generally happy with their health care. But two weeks ago, California lawmakers passed a series of new HMO regulations, including a liability provision that gives patients a right to sue. Gov. Davis is expected to sign them.

For their part, California managed-care lobbyists didn't follow the lead of their national counterparts. Rather than targeting their efforts on killing the liability provision, they won a comprehensive external-review process that must be exhausted before a lawsuit can be filed. (The House bills contain similar provisions.)

"We decided to say we knew there was a problem . . . and to try to find a solution that would actually improve the system and reassure people that they'll get the care they need," says Walter Zelman, president of the California Association of Health Plans, the AAHP's Sacramento equivalent.

THE WALL STREET JOURNAL
MONDAY, SEPTEMBER 20, 199

Congressional Time Crunch Will Play In Decisions Regarding Spending Bills

By David Rogers
Staff Reporter of The Wall Street Journal

WASHINGTON—As Republicans prepare for a year-end confrontation with President Clinton regarding budget priorities and tobacco taxes, they are trying to clear the decks this week of spending bills affecting everything from **Lockheed Martin** Corp.'s F-22 to emergency farm aid.

Under a revised spending plan adopted Friday, Senate Republicans agreed to billions more for defense in anticipation of the House restoring funds for the purchase of F-22 fighters as test planes for the Air Force. Senate Appropriations Committee Chairman Ted Stevens (R., Alaska) wants the full complement of six aircraft under contract with Lockheed. F-22 critics want fewer, but some purchases seem certain and GOP opponents in the House are being undercut by their own leaders, who are anxious to move bills.

Toward that end, the GOP hopes to complete negotiations tomorrow night on an emergency farm-aid bill that has grown to nearly $8 billion. The House is retreating from deep Energy Department cuts opposed by Senate Budget Committee Chairman Pete Domenici (R., N.M.). And hundreds of millions of dollars more will be restored for space-science programs cut by the House less than two weeks ago.

The targets would lift spending above what either chamber has approved. The GOP no longer appears to be clinging to the pretense of staying within prescribed budget caps and instead would allow spending to go about $14.5 billion higher.

That number matches the on-budget surplus projected by the Congressional Budget Office, although there is serious doubt it still exists. CBO's estimates show the surplus has been exhausted, given spending commitments by Congress. But by keeping what amounts to two sets of books, Republicans have clung to the claim that excess spending under $14.5 billion won't require borrowing from the Social Security trust fund.

The collapse of the budget caps and shift of focus to Social Security changes the technical nature of the spending debate. The multiyear caps—first adopted as part of the balanced-budget plan in 1997—govern the level of appropriations, which may be spent out during several years. By comparison, the claims and counterclaims about Social Security focus more narrowly on the direct outlays that result from these bills only in the 12-month period that begins Oct. 1.

To the extent Republicans ignore CBO as Congress's scorekeeper, the GOP becomes that much more dependent on the Office of Management and Budget, which is allied with the president. Yet the two sides also have common interests at times in playing down the costs of their actions.

A case in point is the farm package, which would lift total aid to agriculture to more than $20 billion this calendar year. Republicans are desperate to see the money distributed before Oct. 1 so it won't appear to come from Social Security funds. While that seems unrealistic, it might be to the president's advantage to score the costs as committed in fiscal 1999, so as to minimize any threat to Social Security in fiscal 2000.

The reason why is that Mr. Clinton wants to keep the numbers manageable himself. He will want more spending, for everything from foreign aid to education. But the administration wants to keep the total in add-ons to less than $8 billion so it can pay for the costs and protect Social Security with tobacco taxes.

The chief accomplishment of the GOP plan is to minimize House and Senate differences. The goal is to produce passable bills: between $9 billion to $11 billion is allocated to try to expedite committee action this week on a long-delayed bill funding the departments of Labor, Education, and Health and Human Services. But by pumping so much into defense-about $6 billion over Mr. Clinton's request-the plan doesn't leave enough for other priorities to receive the president's signature.

THE WALL STREET JOURNAL.
MONDAY, SEPTEMBER 20, 199

HEALTH - PBOR

8/23/99

STATEMENT BY THE PRESIDENT

Protecting the health of America's families is not and should never be a partisan issue. Demonstrating this fact, the American Medical Association, the largest organization of physicians in the nation, has just endorsed the bipartisan Patients' Bill of Rights sponsored by Congressman Norwood and Congressman Dingell.

The AMA's action sends a strong message to Congress that it is time to put politics aside and pass a Patients' Bill of Rights that provides meaningful protections for all Americans in all health plans, and holds plans accountable when their actions cause harm to patients. With over 20 House Republicans cosponsoring the Norwood-Dingell bill, it is clear that a bipartisan majority in the House of Representatives is ready to vote for a strong and enforceable Patients' Bill of Rights.

The bipartisan Norwood-Dingell coalition has placed the needs of patients over the desires of special interests. It is long past time for the entire Congress to follow suit.
I reiterate my call to Speaker Hastert to schedule a vote on this important legislation immediately upon return from the Congressional recess in September.

30-30-30

American Medical Association
Physicians dedicated to the health of America

News Release

FOR IMMEDIATE RELEASE August 23, 1999

AMA ENDORSES NORWOOD-DINGELL PATIENTS' RIGHTS BILL
"This bill delivers the strong protections that patients need and voters want"

Washington – The American Medical Association today announced its support for the bipartisan Norwood-Dingell patients' rights bill (H.R. 2723) and called for patients, physicians and the public to mobilize behind the legislation.

"This bill delivers the essential protections patients and voters are demanding," said Thomas R. Reardon, MD, president of the AMA. "Doctors will be allowed to make medical decisions. Health plans will be held accountable for their actions. Patients can appeal if their care is delayed or denied. And the bill's protections will apply to everyone with private health insurance."

The AMA's Board of Trustees voted to endorse the bill during a meeting over the weekend in Chicago. Though the AMA has long-advocated strong patient protections, this is the first time this congressional session that AMA has endorsed a specific patients' rights bill.

"The Norwood-Dingell bill is a win-win for patients and for Congress," Dr. Reardon said.

H.R. 2723 is sponsored by Rep. Charles Norwood (R-GA) and John D. Dingell (D-MI). More than 60 Republican and Democratic members of the House of Representatives are co-sponsors.

"We are pleased that so many members of Congress from both sides of the aisle are determined to enact fair, responsible and meaningful patient protections," Dr. Reardon said. "We will support any and all bills that get the job done the right way."

"The AMA also commends Representatives Tom Coburn of Oklahoma and John Shadegg of Arizona for their efforts to develop meaningful patient protection legislation. We will continue to work with Rep. Coburn, Rep. Shadegg and the House Republican leadership as the Coburn-Shadegg proposal moves toward introduction and formal consideration. We also want to thank Speaker of the House Dennis Hastert for promising a House floor vote on patients' rights legislation in September."

-- more --

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"At the same time I'd like to alert patients and the public that strong forces are at work against them on this issue. The insurance industry has diverted more than $100 million from patient care to pay for an irresponsible propaganda campaign intended to scare patients and intimidate members of Congress.

"We find it difficult to comprehend how the politics of greed can drive insurance executives to work to kill fundamental protections that members of their own families will need when they themselves require health care."

Dr. Reardon called for a stepped-up national drive to mobilize state medical societies, national medical specialty societies, national patient groups and other health organizations around a bipartisan coalition supporting strong patients' rights legislation.

"What Are HMOs So Afraid Of?" is the theme of AMA-designed ads running this week in the hometown newspapers of 28 members of the House of Representatives. The AMA, American Dental Association, American College of Obstetricians and Gynecologists, American Academy of Ophthalmology, and the Patient Access Coalition (a national coalition of 129 patient advocacy and provider groups) are financing the ad campaign.

"We can never match the insurance industry's anti-patient war chest, but we have something better on our side – the will of the public to see that Congress enacts patients' rights legislation and our commitment as physicians to be sure patients receive necessary care," Dr. Reardon said.

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