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~~001a. memo~~	~~Leslie Kramerich to Chris Jennings re: Pegram v. Herdrich Brief (1 page)~~	~~11/17/1999~~	~~P5~~	DMS 4/6/15
~~001b. paper~~	~~re: draft Q&As on Pegram v. Herdrich (3 pages)~~	~~11/17/1999~~	~~P5~~	DMS 4/6/15

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Medicare [Folder 24]

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RESTRICTION CODES

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P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
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b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
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b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

FREQUENTLY ASKED QUESTIONS ABOUT THE INTERNATIONAL PRESCRIPTION DRUG PARITY ACT S. 1191

Introduced in the Senate by Senator Byron L. Dorgan (D-ND), along with Senators Olympia Snowe (R-ME), Paul Wellstone (D-MN), and Tim Johnson (D-SD)

What does the International Prescription Drug Parity Act do?
The bill would allow U.S. consumers access to lower priced prescription drugs by allowing their pharmacists to import prescription drugs into the United States. These are the same drugs available in the United States, manufactured by the same company, frequently made in the same plant, and sold under the same brand name.

This would address the absurd situation where American consumers are paying substantially higher prices for their prescription drugs than are the citizens of Canada, Mexico, and other countries. The International Prescription Drug Parity Act amends the Federal Food, Drug, and Cosmetic Act to allow American pharmacists and distributors to import prescription drugs into the United States *as long as they are approved by the U.S. Food and Drug Administration and manufactured at FDA-inspected facilities*. Pharmacists and distributors will be able to purchase these drugs at lower prices and then pass the huge savings along to American consumers.

Why is this bill needed?
Under federal law, pharmaceutical companies and individual consumers are the only ones allowed to import drugs approved by the U.S. Food and Drug Administration into this country.

Yet, if an American pharmacist or distributor wants to purchase these FDA-approved drugs at the much-lower prices available in other countries and pass the savings along to their customers, they are prohibited by law from doing so. The irony is that many of these drugs are made in our country and shipped to pharmacists and distributors in other countries for sale at lower prices there, but American pharmacists and distributors cannot reimport these drugs made in the United States back into this country. We need to amend current federal law to allow pharmacists and distributors to buy drugs, which are approved for sale in the United States, from other countries to take advantage of the lower prices available there. This is a common-sense thing to do. It is pro-business, pro-consumer and pro-American.

What is the price difference between prescription drugs sold in the United States and other countries?
A number of studies over the past decade, as well as anecdotal evidence, confirms that there is a significant price difference for drugs between the United States and other countries. For instance, a 1999 review by Senator Dorgan's office of a dozen of the most commonly used prescription drugs revealed that North Dakota consumers pay, on average, 205% more than their Canadian counterparts. Similarly, a study by the National Council of Senior Citizens of the top 10 prescription drugs used by older Americans found that in every instance, U.S. citizens were paying *significantly* more for the same drugs than Canadian and Mexican consumers. A U.S.

General Accounting Office study in 1991 studied 121 drugs and found that, on average, they cost 32 percent higher than the same products in Canada.

In fact, the following chart shows that the same drug that costs a senior citizen in the United States $1.00 costs seniors in other countries a fraction of that price:

Country	Price
United States	$1.00
Germany	$0.71
Sweden	$0.68
United Kingdom	$0.65
Canada	$0.64
France	$0.57
Italy	$0.51

Who supports the International Prescription Drug Parity Act?
This bill has been endorsed by Families USA, Public Citizen, the National Community Pharmacists Association, and the North Dakota Pharmaceutical Association.

Who opposes the International Prescription Drug Parity Act?
As one would expect, the bill is opposed by the pharmaceutical manufacturing industry.

What are some of the claims the big drug companies make about this legislation?
One claim that the pharmaceutical companies make is that this legislation could cut into the amount they spend on research. However, only about 20 cents of each prescription drug dollar is spent on research and development – about the same as the manufacturers spend on advertising and marketing – and even less (between 5 and 25 cents) is spent on actual production of the drug.

The fact is that profits exceed research costs at the top ten U.S. drug companies. Pharmaceutical companies' after-tax profits averaged 17 percent from 1994 to 1998, compared with 5 percent for all other industries, according to a December, 1999, report from the non-partisan Congressional Research Service (CRS).

In addition, American taxpayers heavily subsidize pharmaceutical research. For instance, in 1996 alone, the pharmaceutical industry was able to reduce its tax liability by $3.8 billion using a variety of tax credits. As a result, according to the CRS, drugmakers pay significantly less in taxes than other industries: The average effective tax rate for pharmaceutical companies was 16.2 percent from 1993 to 1996, compared to the average effective tax rate of 27.3 percent for all other major industries.

Another popular claim of the pharmaceutical industry is that this bill would import other countries' price controls. The International Prescription Drug Parity Act merely extends the benefits of free trade to buyers of prescription drugs. Drug manufacturers already benefit from free trade by buying the ingredients for their products at the lowest prices on the world market, and in fact, many of the ingredients they use can be imported free of tariffs. This bill would

merely enable American consumers to make the global economy work for them, too.

The truth is that drug companies do not set U.S. prices to cover research costs, they set them to maximize profits. They can set drug prices at extraordinary levels in our country because current law protects them from competition.

Claims vs. Facts
The International Prescription Drug Parity Act
(S. 1191/H.R. 1885)

CLAIM: *The FDA opposes the bill.*

FACT: The FDA has not taken a position on this bill. A National Public Radio story aired in July incorrectly reported that FDA opposes this legislation, and NPR later issued a correction at FDA's request. The legislation's authors consulted closely with the FDA in drafting S.1191/H.R. 1885 and incorporated many of its suggestions into the legislation that was introduced.

Dr. Jane Henney, the current FDA Commissioner, has expressed concern about the current situation whereby individual American consumers are traveling to foreign countries and bringing back prescription drugs – sometimes without even a prescription and without any assurance that the drugs are being properly stored or transported. S. 1191/H.R. 1885 would help to eliminate the need for patients to travel to other countries to get more affordable medications by allowing their pharmacists to do so under more controlled conditions.

CLAIM: *The legislation will reduce pharmaceutical research.*

FACT: Pharmaceutical manufacturers say that this legislation could cut into the amount they spend on research. What they don't mention is their extraordinary profit margins – the industry's 18% average profit margin was recently described by the *Wall Street Journal* as the "envy of the corporate world." Perhaps the manufacturers' claims would be believable if drug companies actually devoted a substantial share of their revenue to research. However, only about 20 cents of each prescription drug dollar is spent on research and development, and even less – between 5 and 25 cents – is spent on actual production of the drug. And the fact is that profits exceed research costs at the top ten U.S. drug companies.

Research and the resulting new miracle drugs cannot help American patients if they cannot afford them. Of course, pharmaceutical manufacturers perform important and life-saving research that should not be jeopardized but nor should Americans subsidize the drug R&D for the entire world.

CLAIM: *Savings realized by pharmacists and wholesalers will not be passed along to consumers.*

FACT: The pharmacy marketplace is highly competitive. Community pharmacies generally have modest gross margins and low profits. In addition, their customers who do not have insurance coverage for prescription drugs are extremely price sensitive and will take their business to mailorder companies or elsewhere if the lower prices are not passed on. As a result, pharmacists will have little choice but to pass the lower costs on to their customers.

CLAIM: *The bill poses health and safety risks because it will allow prescription drugs to be adulterated or become subpotent during foreign handling.*

FACT: Drugs are already frequently imported into this country. However, only

manufacturers are allowed to reimport prescription drugs which were made in the United States. S. 1191/H.R. 1885 applies only to drugs that have been approved by the Food and Drug Administration (FDA) and made at FDA-approved facilities using "good manufacturing practices." In addition, the pharmacists and wholesalers who would be able to import drugs into the U.S. under S.1191/H.R. 1885 would have to meet the same stringent standards for quality shipment and storage already in place for manufacturers.

CLAIM: *The bill imports other countries' price controls.*

FACT: This bill merely extends the benefits of free trade to buyers of prescription drugs. Drug manufacturers already benefit from free trade by buying the ingredients for their products at the lowest prices on the world market, and in fact, many of the ingredients they use can be imported free of tariffs. Our bill would merely enable American consumers to make the global economy work for them, too.

According to the legislation's opponents, prescription drugs are less expensive in other countries because those countries' governments keep prices artificially low, not because U.S. prices are unreasonably high. If pharmaceutical companies really are unable to achieve a profit in those other countries, one would reasonably expect them not to compete in those markets. Obviously, this is not the case.

Even if one is willing to agree that U.S. consumers should subsidize lower prices and pharmaceutical research for the rest of the world, this implies that there is a correlation between the cost of research and prescription drug prices that just does not exist in reality. For example, the cancer drug Taxol is marketed at a wholesale price of nearly 20 times its manufacturing cost, even though the drug was largely developed and tested by the National Institutes of Health, not by the manufacturer, at a cost to American taxpayers of $30 million.

The truth is that drug companies do not set U.S. prices to cover research costs, they set them to maximize profits. They can set drug prices at extraordinary levels in our country because current law protects them from competition.

CLAIM: *The legislation won't do anything to ensure drug coverage for Medicare beneficiaries who could still have difficulty paying for their medicines even if the bill were enacted.*

FACT: True. But the legislation will make such coverage more feasible and affordable. About 19 million elderly Americans have little or no prescription drug coverage, and more than 2 million older Americans pay more than $100 a month for their medication. S. 1191/H.R. 1885 would save these senior citizens an average of 34 percent.

A prescription drug benefit for Medicare beneficiaries would be more affordable for our nation if Americans were charged wholesale prices comparable to those charged for the same drugs in Canada. According to one study, our nation would save more than $16 billion annually if we could buy medications at the Canadian prices – money which could be used to provide help to Americans who are currently without prescription drug coverage.

THE PRESIDENT HAS SEEN
02-19-00

C Jennings
Where would this?
RR

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Jennings
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02-19-00

Insurance Man's Medicare Drug Plan Draws GOP Interest

By Juliet Eilperin
Washington Post Staff Writer

Insurance magnate Patrick J. Rooney, who helped make medical savings accounts a hallmark of conservative health care policy, is marketing a plan to provide prescription drug coverage to Medicare recipients and has received a friendly reception from some key Republicans on Capitol Hill.

Rooney's proposal bears some similarity to the plan advanced by President Clinton to add a drug benefit to the Medicare program. Under Rooney's plan, as with Clinton's; the federal government would pick up half the cost of a senior's prescription drugs, up to a total of $2,500 a year.

But unlike Clinton, Rooney would not require seniors to pay a premium to receive that benefit. Instead, he anticipates, the government would pay for the benefit—which government actuaries estimate could cost up to $160 billion over 10 years—through savings achieved by restructuring the Medicare program.

Several top Republicans emphasized that the program is one of several options they are considering on prescription drugs this year. But it would mark an important shift for the GOP, which traditionally has resisted the idea of providing prescription coverage for all Medicare patients.

Scott Reed, a GOP strategist who now chairs the Republican Leadership Coalition and is promoting the Rooney plan, said the proposal could boost congressional Republicans' standing on what is shaping up as one of the hottest issues on the campaign trail this year.

"It gets the Republican Party off defense on prescription drugs, which has to be a political priority as we move into a national election," Reed said, adding that Democrats currently hold the upper hand in the debate. "They've put us in the corner of defending large prescription drug companies at the expense of granny."

The plan, however, seems likely to draw scrutiny from Democrats, who view Rooney with considerable suspicion given his close ties to the GOP and his past promotion of medical savings accounts, in which individuals are permitted to save money tax-free to pay for health expenses. Critics see such accounts as disproportionately benefiting the wealthy without greatly expanding access to health coverage.

Democrats noted that Rooney's Golden Rule Insurance Co. reaped the rewards of the tax-free medical savings accounts Congress first approved in 1996. "His motives on health care issues have always been questionable," said Laura Nichols, spokeswoman for House Minority Leader Richard A. Gephardt (D-Mo.).

The 73-year-old Indianapolis businessman and his companies have donated more than $1 million to the GOP over the past decade, according to the public interest lobby group Common Cause.

In an interview this week, Rooney said he did not stand to benefit financially from the proposal. "I'd like when I am gone for people to say, 'You know, he did good things,'" he said, adding that he hoped seniors would reward Republicans at the ballot box.

In addition to meeting with aides to the top three House Republicans, Rooney has personally visited with House Ways and Means Committee Chairman Bill Archer (R-Tex.) and seven other GOP lawmakers to sell his plan. Sen. Robert C. Smith (R-N.H.) said Wednesday he is drafting a plan based on the Rooney proposal.

Archer said he is intrigued by Rooney's approach: "This would be for anybody, anybody who is a Medicare recipient. . . . I'm excited because I think it can work."

Administration officials were more cautious, saying they could not comment until they review details of the plan.

Rooney's approach would represent a major departure from how the Medicare program has been structured since it was created in the 1960s. The program has two parts that pay for hospital and doctor bills—but not prescription drug costs—for people 65 and older. There is a $776 annual deductible for hospital costs and a $100 deductible for physician office visits.

Under the Rooney proposal, a prescription drug plan would be added to the program and there would simply be one $675 annual deductible for all health care costs. The plan also envisions the government prohibiting insurance companies that offer so-called Medigap policies—which pick up costs not covered by Medicare—from covering any of the deductibles.

That provision is central to the way the Rooney program works because actuaries estimate that Medigap coverage encourages excessive use of health care services by seniors. Rooney and his associates estimate that, for each elderly patient with Medigap coverage for their deductibles, the government pays an extra $1,400 a year for services that otherwise would not be used.

Golden Rule sells Medigap plans in multiple states, though Rooney said insurers may lose money under his plan because premiums would decline dramatically.

Some health care officials questioned the premise that a prescription drug benefit could be provided without costing the federal government money. Consumer groups also argued that the combined high deductible could deter all but the sickest seniors from enrolling in the program.

"The vast majority of people could not benefit from this," said Ron Pollack, executive director of the group Families USA. "In fact, if they opted into this, they would be worse off than they are today."

Staff writer Amy Goldstein contributed to this report.

The Washington Post
Friday, February 18, 2000

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United States Senate

COMMITTEE ON FINANCE

DANIEL PATRICK MOYNIHAN
Ranking Minority Member

faxed: Mark Miller
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From: liz

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Date: _____ **Time:** _____

Comments: _____

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GREATER NEW YORK HOSPITAL ASSOCIATION
GNYHA
Greater New York Hospital Association
355 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
Kenneth E. Raske, President

January
Twenty-Four
2000

The Honorable Daniel Patrick Moynihan
United States Senate
Washington, D.C. 20510

Dear Senator Moynihan:

Last year I wrote to you to express Greater New York Hospital Association's concerns regarding Senator Breaux's Medicare reform proposal. A copy of that March 11, 1999, letter is attached. On November 9, 1999, Senator Breaux, along with Senators Frist, Kerrey, and Hagel, introduced the "Medicare Preservation and Improvement Act of 1999" (S.1895), which put the Breaux proposal into legislative language. The concerns expressed in the attached letter about the Breaux proposal apply to S.1895 as well. Should the Finance Committee take up S.1895 in the near future, I trust you will keep these serious concerns in mind.

I would like to raise a further concern about S.1895. Under S.1895, many extremely important functions of the U.S. Health Care Financing Administration (HCFA) would be transferred to a new, independent, seven-member Medicare Board. These functions include determining beneficiary eligibility and enrollment; protecting beneficiaries from unscrupulous HMO practices; contracting with Medicare HMOs and insurers; setting Medicare managed care premiums; promulgating Medicare rules and regulations; and reporting to Congress on the progress of the Medicare program.

GNYHA strongly opposes entrusting the Medicare program to an independent Medicare Board that is unaccountable to future Administrations and Congresses. The Medicare program is too important to all Americans to be insulated from the important accountability that comes with our political system. While it is inevitable that people become frustrated with bureaucracies, bureaucracies must at least answer to the will of the people, as expressed through their elected representatives, including the President and members of Congress. The Board that would be created by S.1895 would deny citizens the important opportunity of affecting important changes to the administration of the Medicare program through appeal to elected representatives. Indeed, S.1895 contains provisions that explicitly prohibit future Administrations from having any significant involvement with the Medicare program, including oversight.

Apparently, the proposal to create an independent Medicare Board is born out of irritation with HCFA. While all government agencies can be frustrating to deal with, I would like to state for the record that GNYHA has always found the HCFA staff to be extremely knowledgeable and helpful. The Medicare and Medicaid programs are extremely complex and difficult to administer. The implementation of the Balanced Budget Act of 1997 has been a Herculean task. GNYHA has not always agreed with all of the implementation decisions HCFA has made, as you well know; however, the agency staff members have always been fair minded and, I believe, have acted with the best interests of the Medicare and Medicaid programs in mind. It would be wrong, I believe, to wrest the administration of this important program from an expert staff with years of experience and entrust it to an unproven, unaccountable Board.

As always, I thank you for your consideration. If you have any questions, please feel free to call me. I look forward to working with you on this and other important health care matters in the coming months.

My best.

Sincerely,

Kenneth E. Raske
President

cc: The Honorable Nancy-Ann Min DeParle

Attachment

Pls make copies for:

Chris Peacock
Rich T
Jane H
Gary C
Chris J
Deborah } fax 456-5557
Mark Miller — 395-7840

THX
Bonnie

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

JAN 21 2000

The Honorable Fortney H. (Pete) Stark
United States House of Representatives
Washington, DC 20515-0513

Dear Representative Stark:

Thank you for your letter concerning recent questions about the complexity of Medicare, particularly the number of pages of law and regulations. I, too, was interested to read the press release that accompanied the "Medicare Preservation and Improvement Act of 1999", introduced by Senators Frist and Breaux. The press release quoted the Senators as stating that "We must change a federal program that now requires more than 132,000 pages of regulations, three times larger than the IRS code." I was surprised to read this statement, because I have spent some time looking into this issue myself. I believe that the Senators have been misinformed, and I am glad to have the opportunity to set the record straight.

Soon after I became the Administrator, I read a similar statement made by Robert Waller, M.D., then the Chief of the Mayo Clinic, in a Washington Times op-ed piece. I began investigating the matter, first by questioning Medicare staff and reviewing the regulations myself, and then by talking with Dr. Waller to find out where he had obtained his information. I also appointed a senior medical advisor, Steven Gleason, D.O., who led a Physician Regulatory Issues Team that conducted a review of the Medicare laws, regulations, and carrier manuals to determine the nature of the regulatory burden Medicare imposes on physicians. The Physician Regulatory Issues Team spent considerable time meeting with physicians around the country to discuss these issues. While there are certainly concerns among physicians about the Medicare law and regulations, we found that the volume was considerably lower than the tax laws and regulations.

The statutory language related to HCFA is located in titles XI, XVIII, XIX, and XXI of the Social Security Act, and encompasses 900 pages. HCFA's regulations that implement these statutory requirements are located in the Code of Federal Regulations at 42 C.F.R. Parts 400 to 498, and encompass 1,700 pages. In contrast, I understand that the Internal Revenue Service code, which represents the statutory language under which the IRS operates, encompasses 3,000 pages, and that the implementing regulations, located in volumes 1 through 20 of the Code of Federal Regulations encompass approximately 13,200 pages.

Our Physician Regulatory Issues Team continues to work to communicate with physicians about Medicare's requirements, and to ensure that these requirements are

appropriate. I hope that you and your colleagues will advise us of any suggestions you may have to simplify and clarify Medicare's rules.

I look forward to working with you to strengthen and improve Medicare. With best regards,

Sincerely,

Nancy-Ann Min DeParle
Administrator

Three-quarters believe the state will suffer from a growing gap between the rich and the poor by 2020. Those polled said that while California in the next two decades will be better off in the areas of education, race relations, and job opportunities, most expect the state to see an increase in crime and a degraded environment. Governor Gray Davis (D) maintains strong approval rating, with 51% of Californians saying he has done an excellent or good job. Only 37% say the Legislature has done the same.

Poll finds Californians support the "Limit on Marriage" ballot initiative. The same poll tested Californians on Proposition 22, the "Limit on Marriage" initiative on the March 2000 ballot, which would add a provision to the family code providing that only a marriage between a man and a woman is valid or recognized in California. The majority of those polled (58%) are in favor of the initiative.

	Likely Voters	9/99	Dem	GOP	Other	Central Valley	Bay Area	Los Angeles	S. CA	Latino
Yes	58%	63%	47%	74%	46%	64%	48%	59%	60%	59%
No	38%	34%	48%	22%	50%	32%	46%	35%	37%	38%
DK	4%	3%	5%	4%	4%	4%	6%	6%	3%	3%

IOWA

Vilsack to seek two-term gubernatorial limits. On Wednesday, Governor Vilsack said he will ask the state Legislature to approve a constitutional amendment limiting a governor to two four-year terms. Governor Vilsack said, "If you can't get it done in eight years, then maybe it's time to move on." The previous governor, Terry Branstad (R), served for 16 years. Republican legislative leaders controlling the General Assembly said they are likely to approve such an idea when Governor Vilsack formally presents it to them at the start of the session next month. Governor Vilsack said he would not ask lawmakers to impose term limits on themselves because there is sufficient turnover in the Legislature. Governor Vilsack said the proposed amendment will be part of a 77-point program he presents to lawmakers. The Legislature convenes January 10.

Copied Reed Jennings Podesta

MONTANA

Democratic Senate candidate takes group to Canada to buy prescription drugs. U.S. Senate candidate Brian Schweitzer (D) continues to attract state and national media to his campaign to unseat two-term Senator Conrad Burns (R). On Tuesday, Schweitzer took 35 retired Montana Medicare recipients, all with out-of-pocket pharmaceutical bills of well over $1,000 a year, on a daylong bus trip to buy medicine across the United States border in Canada. (Typically in Canada, having a prescription filled costs one-third to one-half the amount it would cost in the United States.) Schweitzer has made the high cost of drugs to uninsured retirees in the United States the centerpiece of his uphill campaign to unseat Burns. Mr. Schweitzer has promised that, if elected, he will fight to repeal the law that prohibits prescription medicine from being imported into the United States, and he will work for Medicare coverage of drugs. Senator Burns, running for his third term, opposes repealing the law against importing drugs on the grounds that Americans could be subjected to adulterated and inferior medicine and supports the Medicare coverage of prescription drugs in principle. This was the second bus trip to Canada Mr. Schweitzer has organized this year.

cc B Reed
C Jennings
we should consider repeal at least as to Canada

cc B Reed C Jennings we should consider repeal at least as to Canada

DATE: _____

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
ROOM 405H, HUMPHREY BUILDING
200 INDEPENDENCE AVE, SW
WASHINGTON, D.C. 20201

PHONE: (202)690-7450 *FAX: (202)690-8425*

FROM:

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TO: Chris Jennings

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ROOM: _____

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FAX: 456-5557

(INCLUDING COVER): 3

REMARKS:

Lemieux Talking points in response to Rick Foster's letter

From: Liz Fowler <Liz_Fowler@finance-mln.senate.gov>
To: Washington.DC1(BWashington2),HCFA.SMTP_Gateway("je...
Date: 2/23/00 6:36pm
Subject: Fwd: HCFA Political Items

FYI, swift response by Jeff Lemieux on Foster's estimate...

Forward Header
Subject: Fwd: HCFA Political Items
Author: Jeff Lemieux <jlemieux@dlcppi.org> at Internet
Date: 2/23/00 6:11 PM

Couple of notable mistakes in the letter:

1. First paragraph talks of constraints placed on plans' cost-sharing rules." B-F plan places no constraints on cost-sharing rules other than what's in current law.

2. Didn't pulled GME and DSH out of premium system. That will dramatically the question of whether or not the 12% is the right figure.

3. In the fourth paragraph, says "Under the Medicare Com mission's two alternative proposals.." There was only one proposal of the Medicare Commission. (Two baselines, but the baselines were identical until after 2010, so that's not what he means.)

4. Second to last paragraph, says "This result could increase the cost of supplementary coverage substantially, causing high-option plans..." Supplementary coverage is not allowed for high-option plans.

These four miscues, some major, some perhaps with innocent explanations, nevertheless illustrate that this memo was thrown together in great haste. It is a very sloppy effort, to be sure.

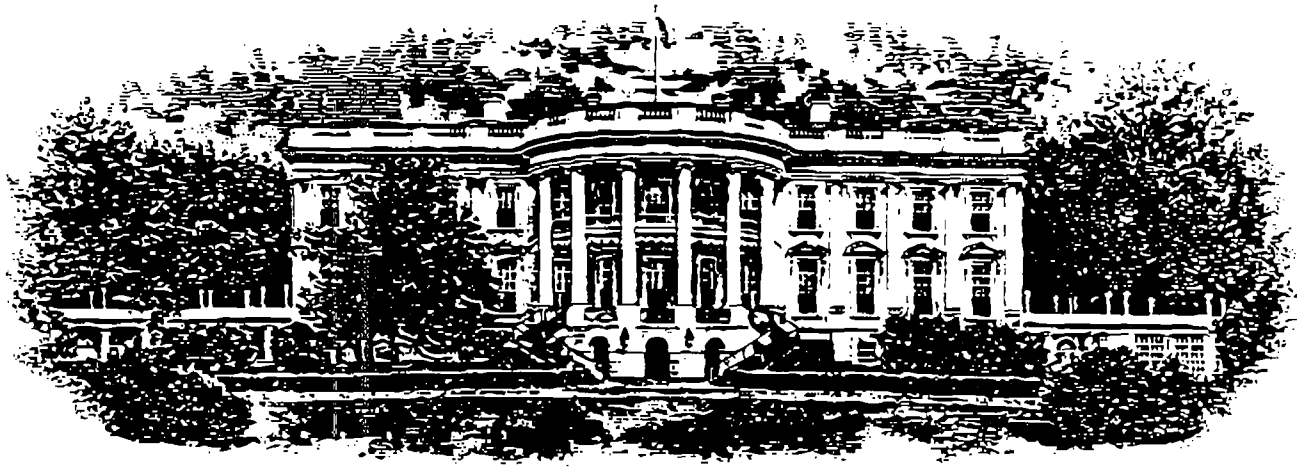
From: Liz Fowler <Liz_Fowler@finance-min.senate.gov>
To: Washington.DC1(BWashington2),HCFA.SMTP_Gateway("je...
Date: 2/23/00 6:37pm
Subject: Fwd: Talking pts.

and another... (don't know who prepared this one)

---------- Forward Header ----------
Subject: Fwd: Talking pts.
Author: Jeff Lemieux <jlemieux@dlcppi.org> at Internet
Date: 2/23/00 6:12 PM

1. Very sloppy HCFA effort, as evidenced by mistakes in the letter.
2 Typical political tactic from HCFA, a bureaucracy desparately trying to protect itself from competition
3. Intent of B-F is to discover, through the new Medicare Board, exactly what the right premium percentage is. Once GME and DSH are factored out, 12% might be right. But in the Medicare Commission, we assumed Home Health transfer would be reflected in Part B premium at time of implementation. If that doesn't happen either because home health spending has fallen or because HCFA will manipulate the calculations that were agreed to in BBA97, then the 12% will have to be lowered as implementation approaches.
4. If private plans were so efficient as to force the FFS premium up so far so fast, the government would save a bundle of money right off the bat. Obviously, that's not the intent. The intent is to save money slowly over the long haul, with FFS improving its value as well. So if B-F worked so well to get huge savings at first, we could afford relief.
5. If HCFA cannot provide cost estimates, then it really could not provide this sort of analysis either. That makes it certain that this is just a political fire drill.

THE WHITE HOUSE
Office of the Press Secretary



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Friday, February 4, 2000

CQ DAILY MONITOR

The Morning News Briefing, Updated Continuously on www.CQ.com/news

GOP: 'Everything' on Managed Care Table

Right to sue health plans a stumbling block when conference begins Feb. 10; Only four dissenting voices heard as Senate confirms Greenspan again

HILL NEWS

Republican conferees on managed care legislation (HR 2990) are scrambling to nail down their negotiating strategy before official bargaining on the measure begins Feb. 10.

"Everything is on the table," Sen. Bill Frist, R-Tenn., said Thursday after House and Senate GOP conferees held an initial get-together. "I don't see any intransigence on anybody's part — or maybe there is some, but nobody's locked down totally."

Republican leaders have vowed to push a final bill through Congress by the spring recess. Democrats suspect the GOP is bent on producing a bill that is heavy on insurance-related tax breaks for employers and individuals and light on enforceable new rights for patients in managed care plans.

But to get a final bill through the House, GOP conference negotiators must satisfy a group of renegade Republicans who sided with Democrats in pressing tough new patient protection provisions through that chamber.

Frist said the first priority for Republican conferees was to try to understand each other's viewpoint. "It's clear that senators don't know what's in the House bill, and they don't know what's in our bill. ... Now, we've got to make a concerted effort to learn what's in the bills."

The House bill is much broader than the Senate-passed version (S 1344), covering all 161 million privately insured Americans. Much of the Senate bill applies only to the 48 million people in health plans exempt from state regulation, although certain provision would apply to all group insurance plans.

The House bill also gives patients in managed care plans significantly wider rights than the Senate measure. Both measures would allow patients to appeal adverse coverage decisions to an independent, external review unit, grant them access to specialists and guarantee coverage for emergency care. But the Senate language is far more restrictive on these points.

Only the House bill would allow patients to go into state courts to sue their health plans for damages if a denial of care results in injuries.

continued on page 2

***CUBAN CLOUT:** Elian Gonzalez saga has become a test case for measuring the power of Cuban-American community. (Story, p. 9)*

TODAY AT A GLANCE

House Floor: Not in session.

Senate Floor: Not in session.

Prescription Drugs: Sen. Bill Frist, R-Tenn., will speak at the National Center for Policy Analysis on a study outlining how a competitive premium Medicare system would finance a prescription drug benefit program.

Economic Indicators: The Labor Department will issue its report on U.S. employment in January; the Commerce Department will issue housing completions for December.

Campaign 2000: The American Enterprise Institute will sponsor a discussion of issues surrounding the presidential elections.

Democratic Meeting: President Clinton will attend a morning session of the Senate Democratic Caucus Issue Conference at the Library of Congress.

GOP Leaders Tell Lobbyists To Draft Drug Options Fast

Feb. 18 target is set for Proposals from drug makers, Insurers, employers and more

THE PULSE OF CONGRESS

House Republican leaders have urged pharmaceutical manufacturers, employer groups and insurance lobbyists to give them options before the Presidents' Day recess for constructing a prescription drug benefit for low-income seniors and those with extra-high drug costs.

At a "listening session" Tuesday in the office of House Majority Whip Tom DeLay, Texas, representatives of 16 industry groups debated the merits and disadvantages of various plans to help seniors buy drugs. Congressional Republicans are being pelted in campaigns across the country by Democrats pushing for a new universal drug option in the federal Medicare program. President Clinton reiterated his call for a Medicare drug benefit during his State of the Union address Jan. 27.

Republicans insist that federally subsidized drug coverage should go only to seniors who now lack it and need it most. And they do not much want it connected to Medicare.

Industry groups are divided among themselves about the best approach. Some, such as the Health

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INSIDE ..... Friday

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THE PULSE OF CONGRESS

continued from page 1

Insurance Association of America (HIAA), want a tax credit coupled with block grants to the states to subsidize prescription drug purchases for low-income seniors. Drug makers argue against a block grant, fearing states might be given the flexibility to impose some form of price controls. Others raised questions about the cost and effectiveness of tax credits.

Included in the discussion were representatives of HIAA; the Healthcare Leadership Council; the National Association of Chain Drug Stores; the National Association of Manufacturers; the Pharmaceutical Research and Manufacturers Association; the Federation of American Health Systems; the U.S. Chamber of Commerce; and various drug manufacturers.

Industry groups were encouraged to get their recommendations in to House leaders by Feb. 18. By that time, Speaker J. Dennis Hastert of Illinois expects to have a working group of members in place to examine the proposals. Members are looking for a targeted approach that could be financed with the projected non-Social Security surplus, which could reach up to $1.9 trillion over a decade.

"There's a healthy interest in doing something if we can find a plan that really does not have the potential to blow the top off the budget," said Rep. Roy Blunt, R-Mo., who represented DeLay in the meeting this week.

House members are not the only ones in Congress seeking input from industry. Senate Finance Committee Chairman William V. Roth Jr., R-Del., and ranking Democrat Daniel Patrick Moynihan, N.Y., asked drug manufacturers and insurers earlier this year to present a joint proposal to address the problem. So far, the requested common solution has not arrived.

— Rebecca Adams

Seattle Still Waiting For Aid To Help Defray WTO Security Costs

Seattle is no longer a city under siege, but the two senators from the state of Washington are reminding their colleagues and the Clinton administration that there was a significant pricetag attached to the meltdown during the World Trade Organization's meeting.

According to state officials, the cost of providing security during the early December meeting topped $12 million. Last year, the Washington lawmakers convinced their colleagues to include $5 million for the State Department to help cover security costs related to the WTO meeting. Washington state lawmakers tried but failed to get language directing the department to release at least half of the money to Seattle to help cover its costs.

But so far, the State Department has declined to turn any money over to Seattle, claiming it does not have the legislative authority to do so.

Republican Slade Gorton and Democrat Patty Murray are both working to get the money released, but there is obvious friction between the two. Murray contends Gorton did not work hard enough last year while she was tussling with the administration over the funding. Pointing to a letter that she sent to appropriators in September urging stronger language regarding the $5 million, Murray said: "Perhaps if other senators had signed the letter when I asked last year we would have been able to provide earmark money for Seattle and avoid part of the problem now facing my state."

Gorton, for his part, sent a letter to Vice President Al Gore this week asking him to help out. "While I have expressed reservations about how the city of Seattle chose to deal with the onslaught of protesters, I believe that the enacted financial assistance is not only required, but overdue," he wrote.

The senators have turned to Judd Gregg, R-N.H., chairman of the CJS Appropriations Subcommittee, who has agreed to discuss the matter with the State Department. And with Gore traveling to Washington this week to woo voters and funders, Gorton has urged local officials and media to question the vice president about the matter.

— Matthew Tully

Quick Insights

• ***Fire When Reagan-Ready***

First the international trade center, then the airport. Now, a missile range? The practice of naming locations after former President Ronald Reagan could go global with HR 3554, which would name the U.S. Army missile range at Kwajalein Atoll in the Marshall Islands after him. The missile range was instrumental in testing Reagan's treasured Strategic Defense Initiative and has more recently been used as a staging area for interceptor missile tests. Never mind that the last test of the interceptor missile failed on Jan. 19.

— Niels C. Sorrells

People ON THE Move

House Armed Services Committee aide **Tommy Glakas** has left Capitol Hill to serve as a senior intelligence officer for the Defense Intelligence Agency, where he will focus on export control issues.

For the last two years, Glakas was the Armed Services panel's Democratic staff director. His successor, **Jim Schweiter**, has returned after a two-year stint with the Pentagon. Schweiter was counsel and later general counsel for the committee from 1988-1998.

Lobbyists and Advocates

★ **David Aaron**, undersecretary of Commerce for international trade, is heading to the private sector as a senior international trade adviser for the law firm of Dorsey & Whitney. He will specialize in trade issues involving the European Union and Asia.

★ **Michael Reilly** joined the Health Industry Manufacturers Association as director of government and public affairs. Reilly will organize "innovation councils," aiming to bring together patients, scientists, researchers, physicians and others in the health care industry to improve patient access to health care technology.

Reilly most recently worked as a Brookings Institute legislative fellow for Rep. Michael Bilirakis, R-Fla.

★ The American Plastics Council promoted **Marty Durbin** to director of federal and international affairs. Durbin has worked in the group's government affairs office since 1994.

Around the Agencies

★ Assistant U.S. Trade Representative **Donald M. Phillips** is taking on a new assignment, handling affairs involving China, Hong Kong, Taiwan and Mongolia. He replaces **Robert B. Cassidy**, who is retiring.

A 20-year veteran trade negotiator for the Office of the U.S. Trade Representative, Phillips had been serving as assistant trade representative for Asia-Pacific and Asia Pacific economic cooperation affairs.

— Eileen Simpson

To tell us of key personnel changes, please call (202) 887-8515, fax (202) 835-1635 or e-mail people@cq.com.

American Association of
HEALTH PLANS

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FAX TRANSMISSION COVER SHEET

DATE: 12/2/99

RECIPIENT: Chris Jennings

COMPANY: Domestic Policy Council

TELEPHONE: 202-456-5560

FAX: 456-5557

RE: CEO memo: Changing Health Plan Practices

SENDER: CJ Pellerin

COMMENTS: Karen wanted me to send this to you as it has been covered in the press by USA Today (Friday 11/26) and Monday 11/29.

Also - hear you want to chat on Tom Reports - We're ready + available!

YOU SHOULD RECEIVE 3 PAGES, INCLUDING THIS COVER SHEET.
IF YOU DO NOT RECEIVE ALL PAGES OF THIS FAX,
PLEASE CALL 202-778-3222.

American Association of
HEALTH PLANS

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INITIALS: DCCR DATE: 08/03/12
2012-0463-S

Memorandum

~~CONFIDENTIAL~~

To: AAHP Member Plan Presidents/CEOs and Board of Directors

From: Karen Ignagni

Date: November 18, 1999

Re: Changing **Health Plan Assumptions & Practices**

The public's response to the announcement by UnitedHealth Group has created an extraordinary opportunity for health plans to change the dynamics confronting managed health care, if we have the foresight to take advantage of it. The last two weeks have demonstrated two things: (1.) That public opinion of our industry is – and always has been - driven more by our own business practices than by public relations; and (2.) That patients want to hear more about the tangible steps that health plans are taking to improve confidence in the system and address patient and physician concerns.

At the same time, it's critical to understand that the public has also imposed upon all health plans an expectation of further leadership and action. In short, it is time for our industry to aggressively confront both these challenges and opportunities, and to do so now.

A New Approach: Changing Business Assumptions & Practices

In this context, we must think beyond the legislative and political fights that have consumed us for the past several years. We're already preparing for next year's round of legislative and political battles, both in Washington and around the nation. But strategically, we need to focus more time and energy on whether our operating rules and business practices meet the fundamental test of public understanding.

Plans already have taken steps to address many of the public's concerns. We have worked hard to clear up confusion surrounding coverage for emergency room visits; we have condemned so-called gag clauses, and we've streamlined appeals processes, to name a few of the initiatives embedded in our *Code of Conduct*. Given the strong interest in health plan policies and practices, now is the time to take the lead in describing these initiatives and to discuss what additional steps we should take.

In addition, we also need to ask ourselves some tough questions: Are our business practices taking into consideration the new environment in which health plans operate? Are there new and better ways to improve patient safety *and* keep costs under control? How can we empower patients to make better and informed decisions and to bring doctors and others together as our *partners* in the mission of keeping health care affordable?

The Next Steps: Reaching Out to Patients & Physicians

In the coming year, AAHP will be accelerating its ongoing research into public attitudes about the health care system. As we have with the *Code of Conduct*, we'll continue our mission of assisting health plans to be more responsive to patient and physician concerns. Just as we need to be bold in examining where change needs to occur within our ranks, we need to be more aggressive in taking our message and our mission to Main Street. We need to do a better job of educating consumers, physicians, the business and employer communities and our own neighbors about the real and lasting improvements health plans have made in the way we provide care for millions of Americans.

Just as important, we need to reach out to physician and patient groups to restart a dialogue about improving the system. Toward that end, I am requesting a meeting with the American Medical Association (AMA) and will keep you posted on developments.

Leading the Way through Genuine Change

This year, our member plans have continued to demonstrate leadership by recommending that health plans adopt independent external review programs and, most recently, our new Patient Assistance and Consumer Trust (PACT) initiative that seeks to further empower patients in their dealings with their health plan. These initiatives demonstrate our ongoing commitment to patients and the fact that we are addressing new areas for improvement as they arise.

We have a strong record of accomplishment. But even more important, I firmly believe that our industry is again on the cutting edge of an exciting new era of change. An era that will demonstrate anew that it has been our innovation -- not short-sighted political approaches -- that have delivered on the promise of the best health care delivery system in the world. As we have in the past, I am confident you will rise to this challenge and lead the way.

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

UnitedHealth Group

November 17, 1999

UnitedHealth Group
9900 Bren Road East Minnetonka MN 55343

Mr. Chris Jennings
Deputy Assistant to the President
for Health Policy Development
The White House
Old Executive Office Building
Room 216
Washington, DC 20502

Dear Mr. Jennings:

I write to share what I believe is a very significant event in the health care marketplace. UnitedHealthcare is announcing publicly today that we are implementing a new and evolutionary approach to improving health care – one that is premised on empowering people with more choice and control of their health care. We call this Care Coordination.

As the Chairman and Chief Executive Officer of UnitedHealth Group, a diversified health and well-being enterprise serving Americans through all stages of life, I have watched our health business evolve over the years. UnitedHealthcare has always been an industry pioneer – developing and offering products with open access and broad provider networks, promoting the notion of everyone having a principle physician appropriate to one's health needs rather than the care system itself; providing coverage for out-of-network services (through point-of-service products); collaborating with physicians on best practices (through our Clinical Profiles program); advancing performance-based accountability through confidential physician report cards; and providing members the assurances that their medical coverage decisions can be reviewed by a third party.

Our collective experience has led us to advance the way we interact with providers and patients around medical coverage decision-making. Like you, we have heard from our constituents that they are tired of the hassles that they experience under their health plan – particularly when they believe that their relationship with their physician is impaired. Our approach aims to facilitate the doctor/patient relationship, with clinical decision making in the hands of patients and their physicians. It is designed to support the physician's treatment plan while helping patients navigate through the complex and ever changing health care system. For example, we do not require physicians to obtain pre-authorization for inpatient procedures. Instead, we provide members with education, support and resources both prior to and following the hospitalization to help them achieve the best possible outcomes. We are also supporting physicians with innovative efforts, like our Clinical Profiles program, which provides them with personalized reports about their current practice patterns in comparison to nationally accepted best practices.

We are very excited about this stage of our evolutionary process. Care Coordination crystallizes UnitedHealthcare's desire to innovate, continue to improve, and to facilitate a better and more positive health care experience for consumers and physicians.

We hope that our announcement reminds people of the positive contributions that have been made to the health care system and the many steps made to improve the lives and health of Americans. We look forward to further advances as we work with you to address the needs and challenges facing our people in pursuit of a vibrant and healthy nation.

Sincerely,

William W. McGuire, MD
Chairman and Chief Executive Officer

UnitedHealth Group℠

NEWS RELEASE

UNITEDHEALTHCARE INTRODUCES CARE COORDINATION

MINNEAPOLIS, Minn., November 9, 1999 – UnitedHealthcare, a subsidiary of UnitedHealth Group (NYSE: UNH), today announced that it is further advancing its philosophies on consumer choice and physician autonomy through an initiative called Care Coordination. Care Coordination obsoletes certain programs associated with traditional medical management, such as pre-authorization for inpatient hospital procedures, and enhances clinical decision-making between the patient and physician.

"Care Coordination is part of our continuing vision to facilitate a better, more positive health care experience for consumers and physicians," said William McGuire, M.D., UnitedHealth Group Chairman and CEO. "After a decade of focused interaction between providers of care and third parties, we believe it is appropriate to expand on the critical needs of patient education and advocacy, physician support and assistance, complex care coordination, availability of specialized resources, and simplification of the health care system. This initiative has evolved over the last six years and will further our commitment to enhancing the health and well-being of people through all stages of their life."

Care Coordination focuses on improving the health of individuals by offering education, accelerated access to care, coordination of complex and fragmented services and measurement of outcomes, and careful monitoring of members who have chronic and complicated medical

conditions. Seven core clinical activities are utilized. These are Health Education, Admission Counseling, Inpatient Care Advocacy, Readmission Prevention, Disease Management, Complex Illness Support and Pharmacy Management. Care coordinators work with both the patient and the doctor to facilitate access to needed care and offer new dimensions of health education and disease management.

"Millions of dollars are spent every year on reviewing the treatment decisions made by physicians. Over the last decade we have seen the value to patients and employers of these efforts diminish as runaway health care costs have been slowed and services expanded. The vast majority of reviews support the clinical decision, so it makes sense to focus on other programs and efforts," said Dr. Archelle Georgiou, Chief Medical Officer for UnitedHealthcare. "Based on the many beneficial programs and efforts available today, our desire is to fully direct our resources at keeping patients healthy and from falling through the cracks of the complex health care system. We want to make it easier for every patient to get care– at the right place and at the right time - and help physicians improve services to their patients," she said.

Care Coordination helps doctors and patients reach the best decisions together with the support of UnitedHealthcare's extensive knowledge and resources. To accomplish this, UnitedHealthcare is leveraging its database of more than 14 million patients to provide its doctors with data and information that compare the treatments they are recommending for their patients against national treatment norms. The innovative Clinical Profiles program, initiated in 1997, offers physicians personalized reports and reminders for patients who may benefit from these procedures along with information to take action. The company has shown that this program has clearly improved health care interventions and results.

"We seek to add value to the doctor-patient relationship by helping patients navigate through the health care system so that they can follow through on the treatment plan that they have developed with their physician. We provide support and resources that physicians are often not equipped to offer. Furthermore, we can encourage best practices and support sound treatment decisions using the power of UnitedHealthcare's information technology, clinical research capabilities and consumer communication tools," said Georgiou.

The Care Coordination initiative was begun in 1998 and tested in six markets prior to national implementation. Results from these markets indicated that Care Coordination was able to improve the entire health care experience without additional cost to the employer or member.

UnitedHealthcare provides a full spectrum of resources and services to help people achieve improved health and well being. The company designs and operates organized health

systems with commercial, Medicare and Medicaid products. Today, UnitedHealthcare and its sister company Uniprise, which focuses on services to large companies with over five thousand employees, serve over 14.5 million individual consumers as members of its health service systems. On behalf of these individuals, the company arranges access to care with more than 340,000 physicians and 3,500 hospitals across 35 U.S. markets and four international markets.

UNITED STATES DEPARTMENT OF LABOR

FACSIMILE TRANSMISSION

OFFICE OF CONGRESSIONAL AND INTERGOVERNMENTAL AFFAIRS

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TO: CHRIS JENNINGS
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DEPARTMENT/COMPANY: WHITE HOUSE

FACSIMILE NUMBER:

FROM: ALICE WEISS

NUMBER OF PAGES INCLUDING COVER: 4

FACSIMILE REPLIES: CONGRESSIONAL AFFAIRS (S-1325) (202)693-4644

MESSAGE: MORE MATERIALS ON PEBP AM

November 17, 1999

Memorandum for: **Chris Jennings**

From: **Leslie Kramerich**

Subject: **Pegram v. Herdrich Brief**

As promised, we are sending you the Q&As on the Pegram brief to provide you with more information about the case and the Government's position. We wanted to caution you that this brief is **still not final** and is **subject to change in the Solicitor General's final version** which will be filed on **Friday, November 19.** We apologize for the delay in getting these to you, but wanted to give you the most up-to-date information in this very fluid process.

Please call if you have any questions.

DRAFT 11/17/99 - Subject to Change

Q&As on Pegram v. Herdrich

Q: What is Pegram v. Herdrich?

A: Pegram v. Herdrich is a case pending before the Supreme Court which raises the issue of whether an HMO's physician incentive arrangement could trigger a fiduciary violation under ERISA. The case was brought by Cynthia Herdrich, a woman who was injured when her appendix burst as a result of her HMO doctor's delay in treating her abdominal pain so that she could be seen at a participating facility. Herdrich sued her doctor and HMO for medical malpractice and also claimed that the HMO's physician financial incentive program constituted a breach of fiduciary duty under ERISA by influencing fiduciaries to withold benefits owed under the plan. At the trial level, Herdrich received compensation ($35,000) for her medical malpractice claims from the doctor and the HMO, but her ERISA claim was dismissed. The 7th Circuit Court of Appeals reversed the lower court in a divided opinion, finding that Herdrich could still bring her ERISA claim. The HMO appealed and the Supreme Court agreed to hear the case. The Government plans to file an Amicus Curiae ("friend of the Court") brief because of the case's policy implications with respect to ERISA fiduciary requirements and the patients' bill of rights debate.

Q: What is the Government's position in its amicus brief?

A: The Government's position is pro-patient and supportive of the States' unique role in regulating health insurance. In its brief, the Government argues as it has in prior briefs that whether ERISA or state laws apply in a given case depends on which of its various roles an HMO is performing: (1) provider of medical care; (2) insurer; or (3) administrator of benefit claims. While acting in their first two roles, HMOs are governed by State law, particularly medical malpractice law. However, in their role as plan administrators, they are also regulated under ERISA, including its fiduciary rules. **Thus, the Government argues that in this case, the HMO's financial incentive arrangements that are part of its attempt to control costs as a provider of medical care are only subject to State requirements, not ERISA. However, the HMO's arrangements that impact a fiduciary's ability to fairly decide benefit claims are subject to ERISA's rules and could constitute a violation.** This position is pro-patient in that it assures that patients will receive the maximum extent of protections available under State and Federal laws. It is also respectful of existing State regulation in this area and preserves States' traditional role as regulator of insurance and medical care.

Q: Is the Government's position in Pegram consistent with the Administration's position in the patients' bill of rights debate?

A: Yes. The House-passed PBOR bill that has Administration support, H.R. 2990, imposes new restrictions on physician financial incentive arrangements consistent with those in

place under Medicare and requires disclosure of such arragements to consumers. If patients are injured as a result of these financial incentive arrangements, they are permitted to bring suit under State law; to the extent that such injuries result from a benefit denial, they are also permitted to bring suit under ERISA. While the Government's brief argues that certain financial incentives can violate ERISA, the Patients Bill of Rights provides greater certainty that all arrangements will be covered and clearly deliniates what designs can be used and what must be disclosed to patients. The Government's brief protects the rights patients have today. The Patients' Bill of Rights can give HMOs, doctors, and patients the clear rules of the road that can help restore the trust in managed care that is so sorely needed.

Q: Does the Government's brief side with the patient, Cynthia Herdrich, or the HMO?

A: Although the Government's brief in this case supports the HMO at this stage of the case, the Government's position is pro-patient. In this case, the patient had alleged that the HMO's incentive scheme was a fiduciary breach in two respects: (1) it provided incentives for physicians to minimize referral and treatment at non-participating facilities; and (2) it provided incentives for physicians' benefit determinations. The Government's brief states that the first type of incentive scheme is not subject to ERISA because it involves the HMO's function as a provider of medical care. The Government argues that the second type could constitute an ERISA violation if the scheme impedes the ability of the fiduciary to make a fair and unbiased decision. In this case, the Government found that the facts alleged by Herdrich here are not enough to make out this claim. This position is nonetheless pro-patient because it assures that State medical malpractice law and other consumer protections will still apply in most cases, and provides that Federal law may apply in cases subject to ERISA's fiduciary requirements. In addition, the brief continues to clarify that both State and Federal laws have important roles to play in the regulation of employer-based health plans.

Q: Who are the stakeholders in this debate?

A: AAHP, HIAA, APPWP, and the Chamber of Commerce jointly filed an amicus brief in support of the HMO's request for Supreme Court review arguing that financial incentives related to deciding health care claims could never violate Federal law. At least one consumer advocacy group, Health Law Advocates, The AAHP brief argues that the 7th Circuit's decision would invalidate common and necessary cost-containment techniques and would tear at the very heart of managed care. They argue that the decision could have devastating results if not reversed, including a dramatic increase in health inflation, the end of managed care and employer-based health coverage, and an increase in the number of uninsured. The Government's brief argues that HMOs can use incentive arrangements, so long as they do not improperly influance individual coverage decisions. The Government believes abuses can and must be remedied without eliminating the appropriate use of managed care.

Q: What is the status of the Government's brief?

A: The final draft of this brief must be filed with the Court by COB Friday, November 19. The Government's brief has been drafted and approved by DOL's solicitor's office and sent to the Solicitor General for review. The Solicitor General has returned their draft to DOL, which it has reviewed and provided comments to the Solicitor General. The Solicitor General has the final word on the content of the Government's brief.

THE WHITE HOUSE

WASHINGTON

November 4, 1999

The Honorable J. Dennis Hastert
Speaker of the
House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

I am writing to underscore my deep disappointment with the unusual procedure employed in naming participants to the joint House-Senate conference on H.R. 2723, the Bipartisan Consensus Managed Care Improvement Act of 1999. The decision to appoint members that fail to reflect the overwhelming vote of 275 to 151 on the Norwood-Dingell bill sends the wrong message to the American people, and the wrong messengers to the conference committee.

The Norwood-Dingell Patients Bill of Rights legislation is the only patient protections bill in this Congress that has received strong bipartisan support. Yet, out of the 13 Republican members appointed as conferees, only one voted for this legislation, and only one voted in favor of yesterday's successful motion in the House that instructed conferees to insist on including the provisions of the Norwood-Dingell bill.

It is clear that the public longs for us to reach across party lines to address issues of national concern. There are few matters that are more important than enacting a strong Patients Bill of Rights. In this regard, I am asking you to use your authority under the House rules to expand the conference committee to include members who accurately reflect the will of the House.

We need to make certain that the results of this conference will be in the public interest; as currently constituted, this committee is weighted heavily in favor of the special interests that oppose this bill. Over the years, we have worked together on drafting and passing bipartisan health care legislation, including the Health Insurance Portability and Accountability Act of 1996. I hope we can build on that record that this Congress can respond to the public's need for patients' protections as our nation's health care delivery system undergoes change.

Sincerely,

Bill Clinton

THE WHITE HOUSE

Office of the Press Secretary
(New York, New York)

For Immediate Release October 7, 1999

STATEMENT BY THE PRESIDENT

Sheraton Towers
New York New York

5:35 P.M. EDT

THE PRESIDENT: This afternoon the House of Representatives took an important and encouraging step in the effort to give the American people a real patients' bill of rights. After rejecting watered-down legislation by substantial votes, the House voted by a large margin to approve a strong bipartisan patients' bill of rights, sponsored by Congressmen Norwood and Dingell.

The passage of this bill represents a major victory for every family and every health plan. It says you have the right to the nearest emergency room care and the right to see a specialist. It says you have the right to know you can't be forced to switch doctors in the middle of a cancer treatment or a period of pregnancy. And it says you have the right to hold your health care plan accountable if it causes you or a loved one grave harm.

It shows that America is no longer willing to allow unfeeling practices of some health plans to add to the pain of injury or disease. It proves that America is committed to putting patients first.

But let me be clear: We still have a lot of work to do before this bill becomes the law of the land. When the House and the Senate negotiators meet, we must be sure the bill is paid for; and when they meet in conference, the Republican leaders must resist the urge to weaken the patient protections guaranteed in the Norwood-Dingell bill, and they must not undo behind closed doors what has been done in the public. They must also resist the urge to load up the final legislation with poison pill provisions that they know I can't sign.

But today, let's just congratulate the members of both parties in the House of Representatives for making a responsible choice in the face of significant pressure to do otherwise.

I especially thank Congressman Norwood and Congressman Dingell for their leadership and for their dogged determination. We have shown once again that when we work together across party lines, we can use this moment of prosperity to meet the greatest needs of the American people. Thank you very much.

Q Sir, what do you think made the difference? Yesterday you were almost conceding defeat.

THE PRESIDENT: I think a lot of work was done by a lot of people, but I think in the end, most people just went up there and voted for what they thought was right. Now, you know, there's kind of an unusual parliamentary maneuver of which you're all aware in which they've tied another bill to it and sent them both to conference. The other bill is one I don't support; it would cost an awful lot of money and help less than one percent of the uninsured in America, most of whom can afford

their own health care policies anyway. And so we have to watch things like that being done in the final legislation. But a big majority of the House did vote for this bill, just as it was written, and I'm very proud of them.

This is the sort of thing America wants us to do. We can work together across party lines; we can get things done. There will still be plenty for the two parties to argue about in good conscience in the coming election. No matter what we do -- we can deal with every challenge before the Congress now, and there will still be things to debate next November.

So I would hope that this is an omen of more good things to come. And I'm certainly prepared to do my part, and I'm very grateful today. I talked to some Republican and Democratic House members before the vote and encouraged them. And I'm very proud of all of them. And I thank them.

Q Could you tell us about your talks with Hoffa?

THE PRESIDENT: Excuse me?

Q Could you tell us about your talks with Jimmy Hoffa --

THE PRESIDENT: Oh, sure --

Q -- and did you ask him to not stand in the way of an early endorsement of the AFL-CIO for Gore?

THE PRESIDENT: Actually, we didn't talk much about that. We talked about -- this is the first long personal visit we've had, although we've worked on a lot of things. He thanked me for the work that I'd done over the last six and a half years. We talked a little about that.

We talked about -- interestingly enough, we talked about Franklin Roosevelt and Frances Perkins, and the rise of the American labor movement for some good amount of time. Said he was glad I was coming tonight, and that President Roosevelt was the last President to talk to the Teamsters.

And we talked quite a bit about trade, and about his strong feeling that we ought to make sure that the safety provisions of NAFTA are met. And I assured him that we were doing everything we could to do just that, and that we would continue to do so.

He said he was deeply concerned that ever since the recession in Mexico, and then the recession in Asia, countries with whom we had had a balance of trade or a small surplus we now seem to be running large deficits with. He was concerned about the rise of protectionism in Europe. And we talked about that.

And that was -- most of our conversation was about that. We also talked about golf for probably too long. We had a good talk about golf. We didn't talk too much about other politics and I said I looked forward to seeing him tonight.

Thank you.

Q Mr. President, do you have any reason to believe the Senate will allow the right to sue?

THE PRESIDENT: Sure, if they listen to the American people. That's what happened today. I mean, 70 percent of our citizens want it; 70 percent of Republicans want it. And there's a way to do it -- if

they just look at their own estimates -- not mine, the Congressional Budget Office -- says it will add, at the most, two dollars a month a policy to have all the protections of the patients' bill of rights. And that's a good investment in our future.

END

5:43 P.M. EDT

THE WHITE HOUSE

Office of the Press Secretary
(New York, New York)

For Immediate Release October 7, 1999

STATEMENT BY THE PRESIDENT

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New York, New York

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END
5:43 P.M. EDT

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release September 17, 1999

STATEMENT BY THE PRESIDENT

I am pleased that the House of Representatives will have an opportunity in just a few weeks to vote on a strong, enforceable patients' bill of rights. This will, at long last, give members of Congress an opportunity to put patients' interests ahead of the special interests.

A bipartisan majority of the House has already expressed support for the Norwood-Dingell proposal, a plan that would provide for an enforceable set of meaningful patient protections that would be extended to all Americans in all health plans. I am confident that the Norwood-Dingell patients' bill of rights will be adopted, if the House leadership permits a fair process for debating and voting on this important issue.

30-30-30

THE WHITE HOUSE

Office of the Press Secretary
(Martha's Vineyard, Massachusetts)

For Immediate Release August 23, 1999

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.

Sound from the President is available on the White House Press Office Radio Actuality Line at 202-456-5671.

30-30-30-

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release August 5, 1999

STATEMENT BY THE PRESIDENT

With today's announcement led by Drs. Ganske and Norwood and Congressmen Dingell, it is clear that there is now a bipartisan majority of House members ready to vote for a strong and enforceable Patients' Bill of Rights. Unlike the partisan Senate-passed bill, this bipartisan initiative is a Patients' Bill of Rights not just in name but in reality. It provides meaningful patient protections to all Americans in all health plans, and it holds plans accountable when their actions cause harm to patients.

Today's action proves that patient protections need not and should not be a partisan issue. It is time to do what this bipartisan coalition has done - put the well-being of patients before politics and special interests. I call on Speaker Hastert to schedule a vote on this long-overdue legislation immediately upon return from the Congressional recess in September.

30-30-30

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release July 15, 1999

STATEMENT BY THE PRESIDENT

Tonight's party line vote for a weak, unenforceable patients' bill of rights is the wrong course for America. The Republican Leadership's bill is a patients' bill of rights in name only.

It fails to protect more than 110 million Americans -- including the vast majority of Americans in HMOs. For those it does cover, this bill fails to ensure patients' access to the specialists they need; fails to ensure patients the right to keep their doctors throughout a course a treatment; fails to prevent insurance company accountants from making final calls on medical decisions; and it fails to hold health plans accountable for actions that harm their patients.

If Congress insists on passing such an empty promise to the American people, I will not sign the bill. Passing a strong, enforceable Patients' Bill of Rights should not be a partisan issue. This should be about protecting patients, not insurance companies.

We will not stop working on this critical issue until we provide patients the protections they need. The American people know the difference between a good and bad bill. Every major doctors', nurses', and patients' organization in the country knows the difference. I believe that the will of the people will still prevail in this Congress.

30-30-30

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release November 3, 1999

STATEMENT BY THE PRESIDENT

Today's overwhelming vote in the House is an encouraging step toward passage of a strong, enforceable Patients' Bill of Rights. Unfortunately, the House Republican leadership is seeking to defeat the will of the House -- now expressed clearly for a second time -- by refusing to appoint conferees who support this legislation. Despite the Leadership's action, the message of the House vote to the conference could not be more clear: reject the false promise of the Senate-passed bill, and send me the bipartisan measure that delivers the real protections that patients deserve.

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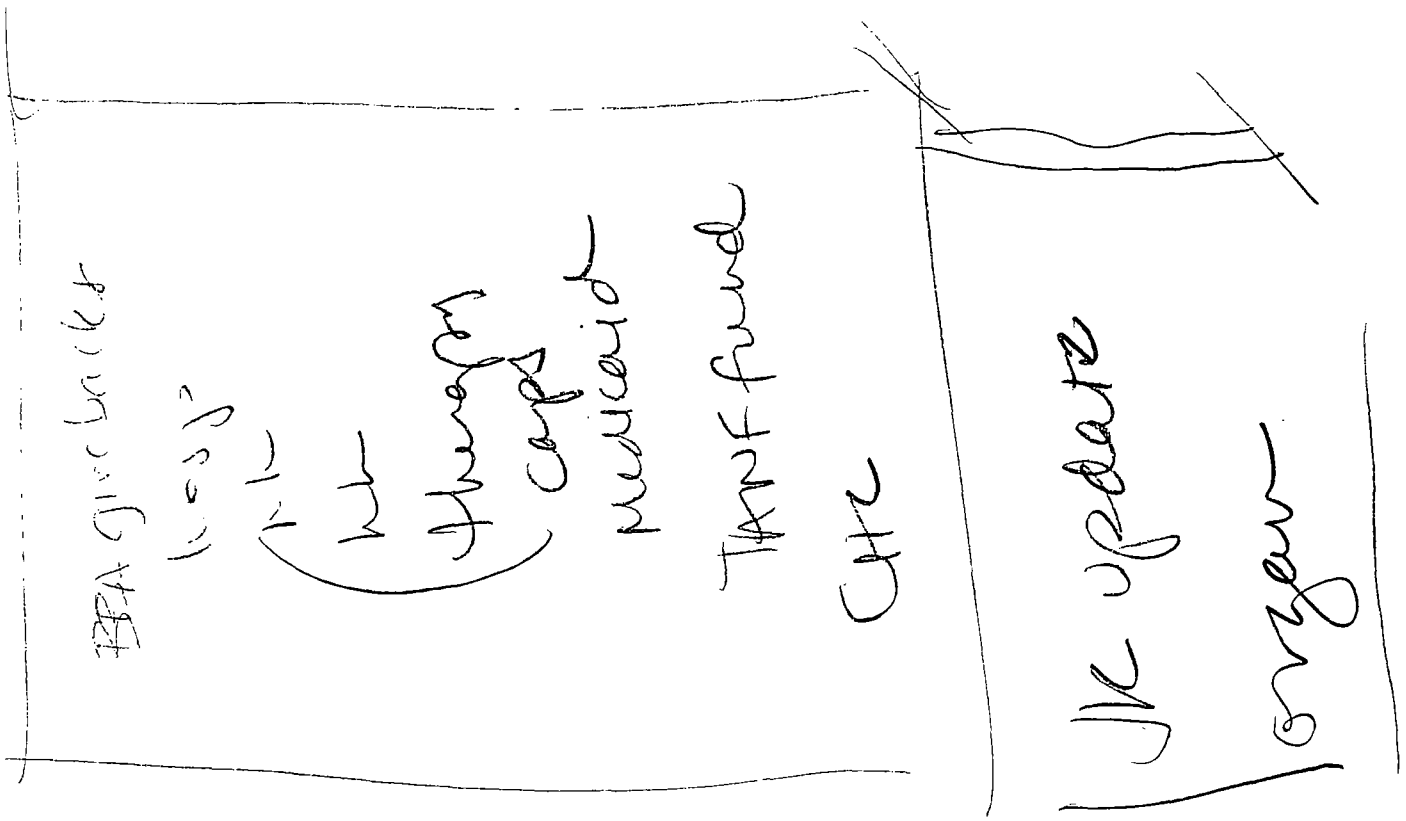

LINDY L. PAULL
CHIEF OF STAFF
BERNARD A. SCHMITT
DEPUTY CHIEF OF STAFF
MARY M. SCHMITT
DEPUTY CHIEF OF STAFF
RICHARD A. GRAFMEYER
DEPUTY CHIEF OF STAFF

Congress of the United States

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

OCT 20 1999

Honorable Tom Daschle
United States Senate
SH-509
Washington, DC 20510

Dear Senator Daschle:

This is in response to your letter of October 14, 1999, requesting revenue estimates for the tax provisions contained in S. 1344, the "Patients' Bill of Rights Plus Act," as passed by the Senate, and H.R. 2990, the "Quality Care for the Uninsured Act of 1999," as passed by the House of Representatives. The enclosed tables provide revenue estimates for the tax provisions in these bills.

I hope this information is helpful to you. Please let me know if we can be of further assistance in this matter.

Sincerely,

Lindy L. Paull

Lindy L. Paull

Enclosure: Tables #99-3 214, #99-3 215

#99-3 214
VERY PRELIMINARY
20-Oct-99

ESTIMATED REVENUE EFFECTS OF TITLES V. THROUGH IX. OF S. 1344,
THE "PATIENTS' BILL OF RIGHTS PLUS ACT,"
AS PASSED BY THE SENATE ON JULY 30, 1999

Fiscal Years 2000 - 2009

[Millions of Dollars]

Provision	Effective	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2000-04	2000-09
V. Enhanced Access to Health Insurance Coverage Provisions													
1. 100% deduction of health insurance for self-employed	tyba 12/31/99	-245	-1,007	-1,040	-657	---	---	---	---	---	---	-2,949	-2,949
2. Full availability of medical savings accounts	tyba 12/31/99	-93	-281	-326	-370	-414	-458	-502	-546	-590	-634	-1,483	-4,213
3. Federal employee participation in MSAs	pybo/a 1/1/00	*Negligible Revenue Effect*											
4. Carryover of unused benefits from cafeteria plans, flexible spending arrangements, and health flexible spending accounts	tyba 12/31/99	-324	-511	-590	-678	-748	-856	-931	-988	-1060	-1126	-2,851	-7,811
Total of Enhanced Access to Health Insurance Coverage Provisions		**-662**	**-1,799**	**-1,956**	**-1,705**	**-1,162**	**-1,314**	**-1,433**	**-1,534**	**-1,650**	**-1,760**	**-7,283**	**-14,973**
VI. Provisions Relating to Long-Term Care Insurance													
1. Inclusion of qualified long-term care insurance contracts in cafeteria plans, flexible spending arrangements, and health flexible spending accounts [1]	tyba 12/31/99	-69	-84	-74	-87	-108	-131	-156	-184	-215	-247	-402	-1,336
2. Deduction for premiums for long-term care insurance	tyba 12/31/99	-132	-933	-1157	-1399	-1554	-1670	-1787	-1906	-2025	-2143	-5,175	-14,707
3. Study of long-term care needs in the 21st century	---	*No Revenue Effect*											
Total of Provisions Relating to Long-Term Care Insurance		**-201**	**-997**	**-1,231**	**-1,486**	**-1,662**	**-1,801**	**-1,943**	**-2,090**	**-2,240**	**-2,390**	**-5,578**	**-16,043**
VII. Individual Retirement Plans - Increase the income limit for conversion of an IRA to a Roth IRA to $1 million	**tyba 12/31/99**	**1,151**	**2,991**	**2,031**	**450**	**-1,080**	**-2,233**	**-4,056**	**-3,267**	**-1,901**	**-451**	**5,544**	**-6,364**
IX. Revenue Offset Provisions													
1. Modify foreign tax credit carryback	tyba 12/31/01	---	---	94	596	533	496	464	431	295	269	1,223	3,178
2. Limit use of non-accrual experience method of accounting	tyea DOE	77	60	33	28	10	12	14	16	18	20	208	288
3. Information reporting on cancellation of indebtedness by non-bank financial institutions	coia 12/31/99	---	7	7	7	7	7	7	7	7	7	28	63
4. Extend IRS user fees through 9/30/09	9/30/03	---	---	---	---	50	53	56	59	61	64	50	343
5. Property subject to a liability under section 357	ta 10/19/98	*Previously Enacted*											
6. Deny deduction and impose excise tax with respect to charitable split dollar life insurance arrangements	[2]	*Negligible Revenue Effect*											
7. Allow employers to transfer excess defined benefit plan assets to a special account for health benefits of retirees (through 9/30/09)	tmi tyba 12/31/00	---	19	38	39	40	41	42	42	43	44	136	348

Provision	Effective	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2000-04	2000-09
8. Impose limitation on prefunding of certain employee benefits	cpa DOE	69	141	147	149	140	129	118	105	90	74	647	1,163
9. Repeal installment method for accrual taxpayers and modify pledge rules	iselo/a DOE	477	677	406	257	72	8	21	35	48	62	1,889	2,063
10. Include the Streptococcus Pneumoniae vaccine in the Federal vaccine insurance program	[3]	4	7	9	10	10	10	10	10	10	11	39	91
Total of Revenue Offset Provisions		**627**	**911**	**734**	**1,086**	**862**	**756**	**732**	**705**	**572**	**551**	**4,220**	**7,537**
NET TOTAL		**915**	**1,106**	**-422**	**-1,655**	**-3,042**	**-4,592**	**-6,700**	**-6,186**	**-5,219**	**-4,050**	**-3,097**	**-29,843**

Joint Committee on Taxation

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

Legend for "Effective" column:

cola = cancellation of indebtedness after
cpa = contributions paid after
DOE = date of enactment
iselo/a = installment sales entered into on or after
pybo/a = plan years beginning on or after
ta = transfers after
tmi = transfers made in
tyba = taxable years beginning after
tyea = taxable years ending after

[1] Estimate assumes concurrent enactment of the deduction for premiums for long-term care insurance (item VI. 2.).
[2] Effective for transfers made after 2/8/99 and for premiums paid after the date of enactment.
[3] Effective for vaccine sales the date after the date on which the Centers for Disease Control make final recommendation for routine administration of conjugate Streptococcus Pneumonia vaccines to children.

#99-3 215
VERY PRELIMINARY
20-Oct-99

ESTIMATED REVENUE EFFECTS OF TITLE I. OF H.R. 2990,
THE "QUALITY CARE FOR THE UNINSURED ACT OF 1999,"
AS PASSED BY THE HOUSE OF REPRESENTATIVES ON OCTOBER 6, 1999

Fiscal Years 2000 - 2009

[Millions of Dollars]

Provision	Effective	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2000-04	2000-09
Title I. Tax-Related Health Care Provisions													
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	-5,878	-8,299	-8,848	-3,300	-31,264
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	-2,146	-741	-7,323
3. Accelerate 100% self-employed health insurance deduction; extend eligibility for self-employed health insurance deduction to those who choose not to participate in employer-subsidized health plans	tyba 12/31/00	---	-274	-1,040	-657	---	---	---	---	---	---	-1,971	-1,971
4. Expand availability of MSAs	tyba 12/31/00	---	-109	-326	-370	-414	-458	-502	-546	-590	-634	-1,217	-3,947
5. 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	-1,484
6. Provide an additional personal exemption to caretakers of elderly family members	tyba 12/31/00	---	-171	-265	-269	-273	-279	-282	-281	-281	-279	-977	-2,379
7. Increase the time period for measuring eligible expenses qualifying for the orphan drug tax credit	epoia 12/31/00	---	-6	-9	-10	-10	-11	-12	-13	-14	-15	-35	-101
8. Add certain vaccines against Streptococcus Pneumoniae to the list of taxable vaccines in the Federal vaccine insurance program; study of Federal vaccine insurance program; reduce excise tax on all taxable vaccines to $0.50 per dose beginning in 2005 [2]	[3] & tyba 12/31/04	4	7	9	10	10	-24	-36	-36	-37	-37	39	-131
9. Tax credit for clinical testing research expenses attributable to certain qualified academic institutions including teaching hospitals	tyba 12/31/00	---	[4]	-1	-1	-1	-1	-1	-1	-1	-1	-2	-10
NET TOTAL OF TITLE I.		4	-553	-2,228	-3,155	-2,700	-3,183	-4,849	-8,274	-11,464	-12,207	-8,630	-48,610

Joint Committee on Taxation

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

Legend for "Effective" column: epoia = expenses paid or incurred after tyba = taxable years beginning after

[1] Estimate assumes concurrent enactment of the above-the-line deduction for long-term care insurance (item 2.).
[2] This estimate reflects the recent withdrawal of the rotavirus vaccine from the market.
[3] Effective for vaccine sales the date after the date on which the Centers for Disease Control make final recommendation for routine administration of conjugate Streptococcus Pneumoniae vaccines to children.
[4] Loss of less than $500,000.

News Release

THE HENRY J. KAISER FAMILY FOUNDATION

2400 Sand Hill Road
Menlo Park
California 94025

For further information contact:
Missy Krasner
Jennifer Morales

Tel 650 854-9400
Fax 650 854-4800

EMBARGOED FOR RELEASE UNTIL:
Thursday, October 28, 1999, 9:00 a.m. EDT

NEW ANNUAL SURVEY OF EMPLOYER HEALTH BENEFITS SHOWS HEALTH INSURANCE PREMIUMS RISING; COVERAGE AND CHOICE REMAIN ABOUT THE SAME

Cost Increases Hit Small Businesses Especially Hard

Most Employers Favor Hotly Debated Patient Protections

MENLO PARK, CA – A new annual employer health benefits tracking survey released today by the Kaiser Family Foundation and the Health Research and Educational Trust (HRET) reveals that health insurance premiums rose faster than in previous years -- though still by relatively modest amounts -- but with premium increases hitting small businesses especially hard. Despite the best economy in three decades, there were no real changes in the number of firms offering health insurance coverage and the number of employees who had a choice of more than one health plan. The survey also found that a majority of employers favor hotly debated patient protections, including the right to sue health plans.

The survey found that health insurance premiums increased 4.8% from the Spring of 1998 to Spring of 1999. While still a relatively modest increase compared with the past era of double digit health cost increases, this is the biggest annual increase since 1994 and is more than double the economy-wide inflation rate of 2.1%. Small businesses, defined as firms with 3-199 workers, experienced substantially higher premium increases than larger businesses, defined as firms with 200 or more workers (6.9% compared to 4.1%). The smallest of firms, those with 3-9 workers, reported the highest increase in premiums (9.2%).

Even in this strong economy, the number of uninsured Americans continues to grow -- to 44.3 million, according to recently released Census Bureau figures -- and the availability of employer health coverage shows no signs of increasing. The survey found little change over the last two years in the percentage of employers offering coverage to their workers. While virtually all large employers continue to offer coverage, just 60% of small businesses do so.

At the same time, more employers are taking actions to control the cost of retiree health insurance. Of the 41% of large firms that offered retiree health coverage in 1999, 35% report capping the maximum amount they contribute to a retiree's health plan within the last two years. Just 8% of firms with fewer than 200 workers provide retiree health benefits.

"Premium increases are hitting the smallest of businesses the hardest, most of whom already have a difficult time affording health insurance. These increases will make it even harder for small businesses to provide health insurance for their employees in the future," said Drew Altman, Ph.D., president of the Kaiser Family Foundation.

The *1999 Annual Employer Health Benefits Survey* was formerly conducted by KPMG Peat Marwick from 1991 to 1998. The survey tracks changes in employer-based health care coverage and has become a widely used measure of trends in health care benefits. The Kaiser Family Foundation and HRET took over and expanded the survey in 1999 and will continue to conduct it annually.

-more-

PREMIUM INCREASES ARE BIGGER FOR SOME AND LESS FOR OTHERS

Premium cost increases depend not only on the size of the employer, but also on the type of funding arrangement and coverage provided. Employers who fund their own health insurance (self-funded plans), which represent about half of all covered workers, had substantially lower premium increases (3.7%) than those firms that purchased health insurance from insurance companies (5.8%). For all employers, Health Maintenance Organizations (HMOs) (5.7%) and conventional (fee-for-service/indemnity) plans (5.6%) had the highest rate of premium increases, followed by Preferred Provider Organizations (PPOs) (4.3%) and Point-of-Service (POS) plans (3.6%).

"For many years, insurance companies have under-priced their health plans to get a bigger share of the market. But after three years of financial losses, health insurers are restoring their profitability through catch-up pricing," says Jon R. Gabel, vice president for Health System Studies, Health Research and Educational Trust. Mr. Gabel directed the Annual Survey of Employer-Sponsored Health Benefits at KPMG Peat Marwick before moving to HRET and is a lead researcher on the project.

PLAN CHOICE AND ENROLLMENT

Choice of Plans: While the extent of plan choices available to employees remains stable -- 65% of covered workers are offered a choice of two or more plans -- it continues to vary substantially by the size of the employer. In 1999, 88% of firms with 5,000 or more workers offered a choice of two or more health plans, while just 10% of firms with 3-199 workers offered a choice of plans.

HMOs (56%) and PPOs (62%) were the most common types of plans that employees could choose from in 1999. Conventional plans were the least frequently offered type of plan, with only 26% of employees being offered them in 1999, down from 52% in 1996.

Plan Enrollment: Employers report PPOs as having the highest rate of enrollment (38%), followed by HMOs (28%), POS plans (25%), and conventional insurance (9%). Since 1988, PPO enrollment among workers has more than tripled (from 11% to 38%) while HMO enrollment has increased more slowly (from 16% to 28%).

"Whether or not you get health insurance on the job, and the kinds of choices you have if you get it, depends on where you work. The disparities between large and small companies are likely to get even worse as small businesses are hit with big premium increases," said Larry Levitt, director of the Changing Health Care Marketplace Project at the Kaiser Family Foundation and a principal analyst on the project.

CHANGES IN BENEFITS OFFERED

In general the level of benefits offered to employees remained relatively stable from 1998 to 1999. However, there were some changes in key areas:

- **Pre-Existing Condition Exclusions**: Since the passage of the Health Insurance Portability and Accountability Act (HIPAA) in 1996, the use of pre-existing condition clauses has declined considerably for all types of plans. For example, the percentage of workers in PPO plans with pre-existing condition exclusions dropped from 64% in 1996 to 42% in 1999.

- **Reproductive Health Services**: Most employees have coverage for oral contraceptives, though fewer are covered for all forms of reversible contraception. Employees in HMOs (80%) are more likely to have oral contraception coverage than those in conventional (54%), PPO (64%), or POS (67%) plans. In contrast, 37% of employees with job-based health insurance are covered for abortion services. Employees in large firms are three to four times more likely to be covered for abortion services than employees in small firms.

- **Mental Health Services**: Mental health benefits have declined over the last several years. Today only 21% of employees in large firms have mental health benefits with unlimited outpatient visits, compared to 36% in 1991.

EMPLOYER SUPPORT FOR PATIENTS' RIGHTS

Mirroring public views, the survey found that a majority of employers support key provisions in the patients' rights debate. Eighty-five percent (85%) of all employers support the "prudent layperson" definition for emergency care, and 94% support the right for patients to get an independent review when denied coverage. Sixty percent (60%) support the right to sue a health plan, an increase since 1998 when 46% supported the provision. Support for consumer protections is generally higher among small employers, particularly for the right to sue – support among small firms is 61%, in contrast to the 52% of large firms who oppose the measure.

The survey also revealed that state legislation and voluntary efforts by health plans and employers appear to have improved patient protections in some areas. For example, the percentage of employees enrolled in HMO plans who can designate an OB-GYN as their primary care physician increased from 49% to 67% over the past year. About one-quarter of employees in HMOs are now able to designate a specialist other than an OB-GYN as their primary care physician if they are chronically ill.

CONCERNS OVER COST AND QUALITY

The cost of health care is more worrisome to employers than the quality of care. When asked about their concerns for the following year:

- 72% of all employers said they are "somewhat" or "very" worried that health care costs will increase faster then they can afford, and 65% said they are "somewhat" or "very" worried they will have to switch health plans because of concerns about cost;
- By contrast, only 26% said they are "somewhat" or "very" worried they will have to switch health plans because of concerns about quality of care.

Efforts to accredit health plans and provide data comparing the quality of different plans continue to play a relatively minor role in the selection of plans by employers. Only 18% of covered workers are in firms that cited a plan's accreditation status by the National Committee for Quality Assurance (NCQA) as being "very important" to the health plan selection process; 10% of covered workers are in firms that cited performance measures such as the Health Plan Employer Data and Information Set (HEDIS) as "very important." By contrast, about two-thirds of covered workers are in firms that said the cost of a health plan and the size and reputation of the physician network are "very important" when selecting a health plan.

Copies of the full report are available online at www.kff.org or by calling the Kaiser Family Foundation Publications Request Line at 1-800-656-4533 (ask for document #1538). Multiple copies of the report (three or more) can be ordered through HRET by calling 1-800-242-2626 (ask for catalog number 097501).

Methodology

The *1999 Annual Employer Health Benefits Survey*, formerly conducted by KPMG Peat Marwick, is now a joint product of the Kaiser Family Foundation and HRET. The survey was designed and analyzed by researchers at HRET and the Kaiser Family Foundation and administered by National Research LLC. The survey findings are based on a national random sample of 1,939 telephone interviews with human resource and benefit administrators in firms with 3 to 5,000 or more workers from February to June of 1999. An additional 755 firms were interviewed solely to determine whether they offered health insurance coverage to their workers. The sample was drawn from the Dun & Bradstreet list of the nation's private and public employers with three or more workers. The overall response rate was 60%. The margin of error for responses among all employers is +/- 3%. For results based on subsets of respondents, the margin of error is higher.

For the purposes of reporting the data, firm sizes were aggregated into the following subgroups: Small firms were defined as those with 3-199 workers; 25% of all workers covered by employer-sponsored health insurance are in firms of this size. Small firms were split out further into the following categories: 3-9 workers (6% of all covered workers); 10-24 workers (4% of covered workers); 24-49 workers (4% of covered workers); and 50-199 workers (10% of covered workers). Large firms were defined as those with 200 or more workers; 75% of all covered workers are in firms of this size. Large firms were split out further into the following categories: 200-999 workers (19% of covered workers); 1,000-4,999 (17% of covered workers); and, 5,000 or more workers (40% of covered workers). To analyze changes in employer-sponsored health plans, the survey report compares data from KPMG's 1993, 1996 and 1998 Annual Surveys of Employer-Sponsored Health Benefits and from a similar survey conducted by the Health Insurance of Association of America in 1988.

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

The Health Research and Educational Trust is a private, not-for-profit organization involved in research, education, and demonstration programs addressing health management and policy issues. Founded in 1944, HRET, an affiliate of the American Hospital Association, collaborates with health care, government, academic, business, and community organizations across the United States to conduct research and disseminate findings that help shape the future of health care.

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FACSIMILE

U.S. Department of Health and Human Services, Office of the Secretary, Public Affairs

Name: Deborah Adler
Fax: 202/456-5557
Phone:
Date: 10/29/99
Subject: Immunization Paper
Pages: 7

From: *Bob Jasak*
202/690-6637
202/690-5673 (f)
rjasak@os.dhhs.gov

This is all that I found

+ press release for adults to get flu shots
+ April Fact sheet National Infant Immunization week

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE
Thursday,Oct. 7, 1999

Contact: CDC Press Office
(404) 639-3286

SECRETARY SHALALA URGES OLDER AMERICANS TO GET 1999 FLU SHOT

HHS Secretary Donna E. Shalala today urged older Americans to start getting their 1999 flu shots to help protect against potentially life-threatening influenza infections.

Each winter, a flu epidemic sweeps the country and is responsible for killing on average 20,000 Americans, most of them over age 65. While 65 percent of seniors receive the flu shot, millions more remain unprotected, even though the vaccinations are free under Medicare.

"The flu poses a serious potential hazard to older Americans, but it's a hazard we can all protect against," Secretary Shalala said. "Every senior citizen needs to know that flu and pneumonia shots are convenient, free under Medicare, and sometimes lifesaving. Tragically, many serious cases of flu and even deaths could be prevented through immunizations. Flu shots work, but not when the vaccine sits on the shelf."

Pneumococcal disease, a common cause of pneumonia, kills more than 10,000 Americans each year, many of them age 65 and older. "Together, influenza and pneumococcal disease are the most common causes of death in Americans from diseases that can be prevented by vaccines," Secretary Shalala said.

Flu shots must be given every year because the influenza virus changes from year to year and because antibody protection from the vaccine wanes over time. Flu vaccine is specifically recommended for people who are at high risk for developing serious complications as a result of influenza infection. These groups include all people aged 65 years or older; all people in nursing homes; and people of any age with chronic diseases of the heart, lung, or kidneys, diabetes, immunosuppression or severe forms of anemia.

Adults with diabetes are three times more likely to die from influenza. This is the second year of a Centers for Disease Control and Prevention (CDC) campaign encouraging people with diabetes to get an annual flu shot. The campaign consists of public service announcements in English and Spanish, information for health-care providers and health systems interventions to ensure that patients with diabetes are reminded to get a flu shot.

The CDC recommends that the best time to conduct annual vaccination campaigns is between October and mid-November. However, after mid-November, people may still benefit from influenza vaccination, even after flu cases begin to occur in the community. Pneumococcal shots are recommended for most of the same people who should receive flu shots. Pneumococcal shots are usually given once and do not need to be repeated annually.

The CDC reports today that influenza A(H3N2) viruses continued to predominate worldwide during May through September, 1999. In the United States, summer influenza activity included an outbreak of influenza A(H3N2) virus infections among tourists to Alaska and the Yukon Territory. The surveillance data are contained in CDC's Morbidity and Mortality Weekly Report (MMWR) this week.

Also in the MMWR is a report on reasons given by Medicare beneficiaries for not receiving influenza or pneumococcal vaccinations. Not knowing vaccination was needed was the most commonly reported reason for not receiving influenza (19 percent) or pneumococcal (57 percent) vaccination. Cost was a

factor for less than 2 percent.

"We must be vigilant during this time of year to take every opportunity to vaccinate our older adults and people with chronic illnesses to protect them from influenza and pneumococcal disease. These vaccines are critical to the health of our older Americans," said CDC Director Dr. Jeffrey Koplan.

Overall, 45 states have already surpassed the Year 2000 goal of having 60 percent of seniors immunized against the flu. But while 68 percent of white Americans over age 65 usually receive flu shots, statistics from 1997 show that only 50 percent of African Americans and 58 percent of Hispanics were vaccinated.

Medicare coverage for flu shots for the elderly began in 1993, as the Clinton Administration launched an effort to increase immunization rates among older adults. The shots are free for those enrolled in Medicare Part B from physicians who accept Medicare payment as full payment. Medicare also covers vaccinations against pneumonia. A beneficiary who has not previously received the pneumococcal vaccine can obtain it at the same time as the flu shot.

"Millions have benefited from the flu and pneumonia shots that Medicare provides, but millions more still need them," said Michael Hash, deputy administrator of the Health Care Financing Administration (HCFA), the agency that runs Medicare. "Too often, people don't get the immunizations that could save their lives. People age 65 and over are more likely to get flu or pneumonia and to experience serious complications. That's why we're reaching out to remind beneficiaries that it's important to get their shots and that they are covered by Medicare."

HCFA has undertaken an aggressive outreach program to remind seniors of Medicare's free flu vaccination benefit. The agency is mailing nearly 8 million postcards in four languages to remind Medicare beneficiaries to get immunized and is distributing posters to senior centers, clinics and other places where Medicare beneficiaries are likely to see them. In addition, HCFA plans to air two 30-second television public service announcements in six target cities during flu season this year, and television and radio announcements have been produced in English and Spanish for local outlets to use across the country.

As part of its efforts, HCFA also is reaching out to African American communities to raise awareness about the need for flu shots. Medicare's quality-review organizations have begun a three-year project to measurably reduce death rates among Medicare beneficiaries. These organizations also have joined with historically black colleges and universities to develop strategies for boosting immunization rates among African American beneficiaries. HCFA also is distributing a half-hour video documentary on the 1918 flu epidemic that took a heavy toll on Baltimore's African American population.

For more information about receiving a flu shot covered by Medicare, call toll-free 1-800-638-6833 or visit Medicare's Web site at http://www.medicare.gov. For more information about influenza disease and CDC's recommendations for influenza vaccination, call the CDC National Immunization Information Hotline at 1-800-232-2522 (English) or 1-800-232-0233 (Spanish), or visit CDC's Web site at http://www.cdc.gov/nip. For weekly updates on influenza cases during the season, visit http://www.cdc.gov/ncidod/diseases/flu/weekly.htm.

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Note: For other HHS Press Releases and Fact Sheets pertaining to the subject of this announcement, please visit our Press Release and Fact Sheet search engine at: http://www.os.dhhs.gov/news/press/.

HHS FACT SHEET

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

April 20, 1999

Contact: CDC Press Office
(404) 639-3286

NATIONAL INFANT IMMUNIZATION WEEK

"The Clinton Administration has achieved remarkable success in raising childhood immunization rates, but too many children still are not fully immunized, putting them at risk for vaccine preventable diseases. We must redouble our efforts to make sure every child is fully immunized by age two - with a special emphasis on reaching minority children." --HHS Secretary Donna E. Shalala

Overview: *Childhood immunization was one of the earliest priorities of the Clinton Administration. Vaccination has been one of the 20th Century's most effective tools for preventing disease and death. Today, the world is free of smallpox; polio has been eradicated from the Western Hemisphere and we are on the verge of eliminating polio from the world community; childhood vaccination levels in the United States are at an all-time high; and diseases and death from diphtheria, tetanus, measles, mumps, rubella and Haemophilus influenzae type b are at record lows. Before vaccines these diseases were common, causing hundreds of thousands of cases, and thousands of deaths per year in the United States. Fortunately, today most Americans no longer have first-hand knowledge of most of these diseases. Childhood immunization rates have reached all-time highs, with 90 percent or more of America's toddlers receiving the most critical doses for children by age 2. While childhood immunization are at a record high of 78 percent, about 900,000 children under age 2 still have not received all their immunizations. National Infant Immunization Week (April 18 - 24) is a critical part of the Clinton Administration's effort to ensure that all children get the shots they need, when they need them.*

National Infant Immunization Week

In 1994, President Clinton declared the last week in April as "National Infant Immunization Week" to focus attention on the importance of proper immunization for infants and toddlers. Communities across the country use this week to increase awareness of and access to immunization services by expanding clinic hours; distributing information at supermarkets, movie theaters, and other public places; canvassing neighborhoods; holding immunization fairs; and creating new partnerships with businesses and community groups. In 1998 there were more than 500 NIIW events held across the United States.

National Infant Immunization Week - 1999

Events are planned across the country in all 50 states to commemorate the 1999 National Infant Immunization Week (April 18-24). This year's theme is "Immunization: Our Work Has Just Begun." The health status of Hispanic children in the United States has become an important national issue as a result of the rapid growth of the Hispanic population and because over 50 percent of Hispanic children live below the poverty line. Because the media is a primary source of immunization information for the Hispanic community, HHS Secretary Donna E. Shalala announced a new Spanish-language public awareness campaign at an event in Washington, D.C. The 1999 Spanish-language PSAs are part of a nationwide effort to create and distribute educational materials that are culturally relevant and language appropriate to help raise Hispanic immunization rates to the national average. The Spanish-language theme, "Vacunelo A Tiempo...Todo el Tiempo" or "Vaccinate your children on time, every time," conveys the importance of immunizing children *on time, every time*, and encourages parents and caregivers to talk with their health care provider to make sure their child is up to date by the age of 2 years. The Spanish-language radio PSA is narrated by John Secada, a popular Spanish-speaking musician.

The official kick-off event of the 1999 National Infant Immunization Week (NIIW) was in Chicago Illinois on April 17th at a rally involving the Centers for Disease Control and Prevention (CDC), State, and local officials and partners, and community groups. Following the rally, over 3,000 volunteers went into some of Chicago area's most difficult to motivate neighborhoods and approximately 40,000 homes to remind parents and caregivers to have their children immunized on time. Chicago was chosen by CDC for the national kickoff because of strong partnerships between public and private organizations, ongoing efforts to raise immunization coverage rates, and is one of 11 cities designated as a "pocket of need" by CDC's National Immunization Program.

Other Childhood Immunization Outreach Efforts

Over the past five years, CDC's National Immunization outreach program has worked to increase community participation, education and partnerships through the following activities, in addition to NIIW:

By the year 2000, the President's Racial and Ethnic Health Disparities Initiative will work to achieve and maintain childhood immunization rates of 90 percent for all population groups. We are already closing the gap in immunization rates among the poor and racial and ethnic groups. But we will not rest until the gap has been totally eliminated.

As part of this effort, in FY 1999, CDC has $10 million for a community-based demonstration program in up to 30 communities, which will focus on eliminating racial and ethnic health disparities. The President has requested $35 million for this program in FY 2000, and the President's FY 2000 budget also includes $70 million for Community Health Centers to enhance services targeted to reducing health disparities.

New partnerships have been formed throughout the country. McDonald's, Proctor and Gamble, K-Mart, and the Kiwanis and Rotary clubs are just a few of the organizations that have joined the outreach effort.

A special partnership with Americorps (the Corporation for National Service) provides volunteers for a wide range of immunization outreach activities, including review of vaccination records in public health departments, placing calls to remind parents when shots are due, and traveling door-to-door to identify under-immunized children.

Extended clinic hours during NIIW and throughout the year are enabling health departments and providers to reach under-immunized children.

The national Dr. Seuss campaign, launched in October 1997, features a series of six immunization posters, three in Spanish, each featuring a different Dr. Seuss character telling an immunization story in rhyme. The art for all six posters was donated by Mrs. Audrey Geisel, widow of Dr. Suess author, Theodore Geisel. The Centers for Disease Control and Prevention has distributed nearly 100,000 of the limited-edition posters to health care providers, medical clinics, community centers, and schools for display.

Access to immunization information and immunization schedules are available on CDC's homepage at http://www.cdc.gov. A toll-free information service refers callers to local immunization providers and provides prerecorded information in both English and Spanish. The toll-free number in English is: 1-800-232-2522, and the number in Spanish is: 1-800-232-0233.

During 1998, public service announcements in both English and Spanish were distributed to more than 1,800 television stations, 8,000 radio stations and 15,000 print publications. The Spanish-language PSAs were part of a nationwide effort to create and distribute educational materials to help raise Hispanic immunization rates to the national average and the English-language PSAs reminded parents and caregivers that potentially life-threatening diseases do exist today and children are at risk because nearly one in four is not properly immunized.

The Childhood Immunization Initiative

National Infant Immunization Week and other year-long outreach efforts are all part of the Clinton Administration's comprehensive Childhood Immunization Initiative (CII). The Initiative

aims to increase childhood immunization rates now, and put in place a system to sustain high rates in the future.

The national initiative addresses five areas:

1. Improving the quality and quantity of immunization services
2. Reducing vaccine costs for parents
3. Increasing community participation, education and partnerships
4. Improving systems for monitoring diseases and vaccinations
5. Improving vaccines and vaccine use.

The Clinton Administration has increased the resources devoted to immunization efforts. In all, funding for childhood immunization has more than doubled since FY 1993. The President's FY 2000 budget includes $704 million for vaccine purchase and $367 million for immunization program activities.

Today, the number of preschool children properly immunized in the United States is at an all-time high. President Clinton announced in July 1997 that the nation had exceeded its childhood vaccination goals for 1996, with 90 percent or more of America's toddlers receiving the most critical doses of vaccines.

Childhood vaccines prevent 11 infectious diseases: polio, measles, diphtheria, mumps, pertussis (whooping cough), rubella (German measles), tetanus, Haemophilus influenzae type b (a cause of spinal meningitis), varicella (chicken pox), rotavirus, and hepatitis-B.

Each day 11,000 babies are born. To be fully protected, each of these children need to receive 15 - 19 doses of vaccine by the age of two.

Children are required in many states to be immunized in order to enter school, and 95 percent or more of American children are adequately vaccinated by kindergarten. Yet hundreds of thousands of pre-school children are not adequately protected against all possibly fatal illnesses.

With increasing numbers of children more readily exposed to infectious disease in day-care settings and elsewhere, complete immunization by age 2 is critical.

Failure to immunize can lead to new outbreaks of disease. In 1989-91, a measles epidemic resulted in more than 55,000 reported cases, 11,000 hospitalizations, and more than 120 deaths. Over half of the deaths were children under 5 years of age.

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FEINSTEIN AMENDMENT NO. 737 (Senate - June 24, 1999)

[Page: S7609] Link to GPO's PDF version for this page. NEW

Mrs. FEINSTEIN proposed an amendment to the bill, S. 1233, supra; as follows:
At the appropriate place, insert the following:

SEC. XX. PROMOTING GOOD **MEDICAL** PRACTICE.
(a) **In General**: Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.) is amended by adding at the end the following:

`SEC. 714. PROMOTING GOOD **MEDICAL** PRACTICE.
`(a) **Prohibiting Arbitrary Limitations or Conditions for the Provision of Services**:

`(1) **In general**: A group health plan, or a health insurance issuer in connection with health insurance coverage, may not arbitrarily interfere with or alter the decision of the treating physician regarding the manner or setting in which particular services are delivered if the services are medically necessary or appropriate for treatment or diagnosis to the extent that such treatment or diagnosis is otherwise a covered benefit.

`(2) **Construction**: Paragraph (1) shall not be construed as prohibiting a plan or issuer from limiting the delivery of services to one or more health care providers within a network of such providers.

`(3) **Manner or setting defined**: In paragraph (1), the term `manner or setting' means the location of treatment, such as whether treatment is provided on an inpatient or outpatient basis, and the duration of treatment, such as the number of days in a hospital. Such term does not include the coverage of a particular service or treatment.
`(b) **No Change in Coverage**: Subsection (a) shall not be construed as requiring coverage of particular services the coverage of which is otherwise not covered under the terms of the plan or coverage or from conducting utilization review activities consistent with this subsection.
`(c) **Medical Necessity or Appropriateness Defined**: In subsection (a), the term `medically necessary or appropriate' means, with respect to a service or benefit, a service or benefit which is consistent with generally accepted principles of professional **medical** practice.
`(d) **Plan Satisfaction of Certain Requirements**: Pursuant to rules of the Secretary, if a health insurance issuer offers health insurance coverage in connection with a group health plan and takes an action in violation of any provision of this subchapter, the group health plan shall not be liable for such violation unless the plan caused such violation.
`(e) **Applicability**: The provisions of this section shall apply to group health plans and health insurance issuers as if included in--

`(1) subpart 2 of part A of title XXVII of the Public Health Service Act;

`(2) the first subpart 3 of part B of title XXVII of the Public Health Service Act (relating to other requirements); and

`(3) subchapter B of chapter 100 of the Internal Revenue Code of 1986.

`(f) **No Impact on Social Security Trust Fund**:

`(1) **In general**: Nothing in this section shall be construed to alter or amend the Social Security Act (or any regulation promulgated under that Act).

`(2) **Transfers**:

`(A) **Estimate of secretary**: The Secretary of the Treasury shall annually estimate the impact that the enactment of this section has on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401).

`(B) **Transfer of funds**: If, under subparagraph (A), the Secretary of the Treasury estimates that the enactment of this section has a negative impact on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401), the Secretary shall transfer, not less frequently than quarterly, from the general revenues of the Federal Government an amount sufficient so as to ensure that the income and balances of such trust funds are not reduced as a result of the enactment of such section.
`(g) **Limitation on actions**:

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United States of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 106th CONGRESS, FIRST SESSION

Vol. 145 WASHINGTON, WEDNESDAY, JUNE 23, 1999 No. 90

Senate

Senator Dianne Feinstein

EMPOWERING DOCTORS TO MAKE MEDICAL DECISIONS

Mrs. FEINSTEIN. Mr. President, I am on the floor because I anticipated that at 2 o'clock we would be returning to the agriculture appropriations bill. I indicated this morning that I would be proposing an amendment to that bill that has to do with giving the physician the right to provide medically necessary services in a setting which that physician believes is best for the patient. I now see that this has been postponed an hour, so I would like to speak to the amendment now and then introduce it at 3 o'clock. I hope there will be no objection to that.

Let me begin by saying, once again, what this amendment does. Essentially, the amendment says that a group health plan or a health insurance issuer, in connection with health insurance coverage, may not arbitrarily interfere with or alter the decision of the treating physician regarding the manner or the setting in which particular services are delivered if the services are medically necessary or appropriate for treatment or diagnosis, to the extent that such treatment or diagnosis is otherwise a covered benefit.

I read that specific language because it is important to understand that because most people buying a health insurance plan believe that their doctor is, in fact, going to be prescribing the treatment that is best for them, not the treatment that is the least cost effective, not the treatment that might run a risk to the patient but be good for somebody else, but the treatment or the procedure, in an appropriate setting, that is right for that patient. What is right for a patient who is 18 years old may not be right for a patient who is 75 years old, and so on. I will read from the legislation the definition of "medical necessity" or "appropriateness":

> The term "medical necessity" or "appropriate" means, "with respect to a service or a benefit, a service or benefit which is consistent with generally accepted principles of professional medical practice."

That is something that everyone expects, that everyone is accustomed to in this Nation, and I believe that is the way medicine should, in fact, be practiced. I am very pleased to say the Patients' Bill of Rights (S. 6) is supported by some 200 organizations all across the United States, including the American Academy of Emergency Medicine; the American Academy of Neurology; American Academy of Pediatrics; American Association of University Women; American Cancer Society; American College of Physicians; American Heart Association; American Lung Association, and the American Medical Association, which is the largest association of practicing physicians in the country.

Then there is the American Psychological Association; the American Public Health Association; the American Society of Clinical Oncology; virtually every breast cancer organization; the Consumer Federation of America; the Epilepsy Foundation; the Leukemia Society; the National Alliance of Breast Cancer Organizations; the National Association of Children's Hospitals; the National Association of People with AIDS; the National Council of Senior Citizens; the National Black Women's Health Project; the National Breast Cancer Coalition; the Older Women's League; the Paralyzed Veterans of America—on and on and on.

This is a widely accepted amendment that virtually has the support of every professional and patient organization that deals with health care anywhere in the United States.

Let me read a statement from the American College of Surgeons, certainly the most prestigious body for surgeons, and one to which my husband, Bert Feinstein, belonged:

> We believe very strongly that any health care system or plan that removes the surgeon and patient from the medical decision-making process only undermines the quality of that patient's care and his or her health and well-being.

Similarly, the American Medical Association has said, "Medical decisions should be made by patients and their physicians, rather than by insurers or legislators."

I have worked on this now for 3 years. In the last Congress, I introduced legislation to allow doctors to decide when to discharge a woman from the hospital after a mastectomy. I did this with Senator D'Amato in the in this Congress. And I introduced a bill that would allow doctors to decide when to discharge a person from the hospital after any procedure or treatment, with Senators D'Amato and SNOWE.

Why do we need these bills? Senator MIKULSKI from Maryland this morning made a very impassioned case about mastectomies. And we learned in 1997 that women were being pushed out of the hospital on the same day after a mastectomy.

I was amazed to hear from a woman named Nancy Couchot of Newark, CA, who wrote me in 1997 that she had a modified radical mastectomy at 11:30 in the morning and was released from the hospital by 4:30 that afternoon. She could not walk to the bathroom without help. She said in her letter:

> Any woman, under these circumstances, should be able to opt for overnight stay to receive professional help and strong pain relief.

Victoria Berck of Los Angeles wrote that she went in at 7:30 a.m. and was released at 2:30 p.m. with drains attached to her body. She said, "No civilized country in the world has a mastectomy as an outpatient procedure."

It was a very large health care network in California that was doing these "drive-through" mastectomies on the same day.

I believe "drive-through" mastectomies have been largely stopped, but patients had to rise up, and patients had to say you can't do this to me. You can't push me out a few hours after an anesthetic with drains in my body, having had a radical mastectomy and not being able to take care of myself.

What if the woman is 75 instead of 25? It makes no sense.

We also learned that insurance plans were insisting one-night hospital stays if you had a child.

We learned that babies—infants—were going home with jaundice, and they had to come back to the hospital for treatment once, twice, or three times. There was a lot of "tsk-tsking." What a terrible procedure. How could they do this? Now it has changed be-

cause Congress acted, requiring a minimum of two days for childbirth, for a normal delivery. What if you need 5 days for care, or 6 days for care?

The point is that it should be a decision made by the physician. It should not be countermanded by someone unqualified to make that decision.

A California neurologist told us about a 7-year-old girl with an ear infection who went to the doctor with a high fever which developed into pneumonia, and she was hospitalized. The HMO insisted that she be sent home after 2 days. She ended up returning to the hospital three times, sicker each time to the point where she developed meningitis. The doctor said that if she had stayed in the hospital for 5 to 7 days the first time that she could have been given antibiotics, been monitored, and would not have gotten meningitis.

What is the problem?

Let me read the definition of medical necessity in an insurance contract provided to me by the American Medical Association. This is from the Aetna/U.S. Healthcare standard Texas contract. I quote: "Health care services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards and which are likely to result in demonstrable medical benefit," and here is the point, "and which are the least costly of alternative supplies or levels of service."

It is not "and/or." It is "and which are the least costly."

So if you belong to that plan and there is a drug that is the least costly, perhaps not as effective or perhaps not good for you with your present condition, or because of your age, that is the drug you are forced to take because the insurance plan says so, despite what the doctor says. If there is a diagnostic process that may be less effective than an MRI, that MRI is very often prohibited for you.

What is happening out there? What is the problem?

The problem is that doctors are finding insurance plans overriding their decisions, dictating their decisions, second-guessing their decisions about what is medically necessary.

We aim in this amendment to give that basic right of medical practice back to the physician.

In fact, today doctors all across this Nation will tell you that they spend hours hassling with insurance company accountants and adjusters to justify medical necessity decisions —why a person needs another day in a hospital, why a person needs an MRI, why a patient needs a blood test, why a patient should get this drug instead of that drug.

Seventy percent of doctors across this great Nation say they are forced to exaggerate a patient's symptoms to make sure HMOs don't discharge patients from hospitals prematurely.

Is this the kind of medical care that we want to see HMOs press us toward where a doctor has to lie, fabricate, or exaggerate the condition of the patient to be sure that patient gets what is medically appropriate for that particular patient? I truly think not.

Every patient is different. Every patient brings to a situation his or her own unique history and biology. Doctors should be able to use their best professional judgment in each individual case based upon the needs or

Pneumonia in a 30-year-old patient is different from pneumonia in a 70-year-old patient. Doctors know the difference, and most of us do, too.

A Maryland nurse said: I spend my days watching the care in my unit be directed by faceless people from insurance companies on the other end of the phone. My hospital employs a full-time nurse whose entire job is to talk to insurance reviewers.

I myself in 1989 had to have a hysterectomy. I was extraordinarily anemic. As I was in the hospital for a blood transfusion, the phone rang. I picked up the phone. It was my insurance company. What they said to me is: Why are you still in the hospital? You are supposed to be out of there by now.

My only response was: I am here because I am currently having a blood transfusion.

A patient shouldn't have to go through this. It happened to me. You can be sure it is happening all across this country.

Doctor Robert Weinman told the San Jose Mercury News that a doctor prescribed a brain wave test for a convulsing epileptic child. The HMO board—consisting of one accountant, the chief financial officer, and one doctor—refused coverage, depriving the doctor of the necessary diagnostic information.

On June 14, just a couple of weeks ago, a California nurse practitioner told my staff that insurance plans will allow people with ulcers to take Prilosec for only 4 to 6 weeks, even though the gastroenterologists say that it is needed for a longer period. Plans say patients can take Tagamet, which is cheaper but not as effective for this particular condition.

This is what this amendment seeks to avoid.

The doctor should be able to prescribe based on medical necessity what is appropriate to each patient—a hallmark of good medical care.

A California doctor told us about a patient who needed a total hip replacement because her hip had failed. The doctor said that patient should remain in the hospital for 7 days. The plan would only authorize 5 days.

Let me quote once again from a Los Angeles physician.

> Many doctors are demoralized. They feel like they have taken a beating in recent years. . .physicians train years to learn how to practice medicine. They work long hours practicing their field. Under this health care system, that training and hard work often seem irrelevant. A bureaucrat dictates how doctors are allowed to treat parties. . . When I tell someone he is fit to leave the hospital after an operation, I am often given an accusing stare. Sometimes my patients even say: "Is that what you really think or are you caving in to HMO pressure to cut corners on care?"

Medicine shouldn't have to be practiced this way in the United States of America.

Over 80 percent of the people of my State are in some form of managed care. California has been a laboratory for managed care. Californians are speaking out on the issue. Over one half of Californians say that major changes are needed in our health care system. Californians say they have to wait for care longer, they are rushed through appointments, they have to navigate impersonal systems when

A survey of 900 doctors in California found that 7 out of 10 were dissatisfied with managed care organizations. Insurance companies have invaded the examining room, the emergency room, and the hospital room. The "care" is rapidly going out of health care. Getting good health care should not be a battle.

I think everyone in this body understands HMOs can be effective good, they can reduce costs in a medically acceptable way. And that is the key—in a medically acceptable way, without adversely impacting the patient. The way to do this is not to countermand the physician, not to tell the physician what drug he or she can or cannot give a patient based on the cost, not to tell a physician he has to conduct a radical mastectomy at 7:30 in the morning, removing sometimes both of a woman's breasts and lymph nodes, and push her out on the street with drains in her chest and pain coursing through her body. That isn't good health care for anyone.

This is a simple amendment. It is supported by virtually over 200 health organizations.

Some might say why not wait until we work out an agreement so a Patients' Bill of Rights—whether it be Democrat or Republican—can come to the floor. I have waited for 3 years for an opportunity to move this kind of legislation. We cannot wait any longer. Senator D'AMATO and I, 3 years ago, held a press conference urging this kind of legislation. Senator SNOWE and I, in this Congress, have introduced similar legislation.

The beauty of this amendment, that I want to bring before the Senate for a vote, is that it states very simply that health insurance coverage may not arbitrarily interfere or alter the decision of the treating physician regarding the manner or setting—hospital, emergency room, outpatient clinic, whatever it is—in which particular services are delivered, if the services are medically necessary or appropriate for treatment or diagnosis.

Every single patient in managed care anywhere in the United States of America will be better off the sooner this amendment becomes law.

I believe to wait is wrong. I believe to wait will cost lives. I believe to wait will increase morbidity. I believe to wait is unfair to the physicians who are trained, able, and ready to carry out their profession.

I am hopeful I will have an opportunity, in 25 minutes when the agricultural appropriations bill is on the floor, to offer this amendment which is broadly and widely supported all across the United States. Once and for all, the physician and the patient will together make the medical decisions—not a green eyeshade somewhere in a remote HMO office.

I yield the floor.

Mrs. FEINSTEIN. I thank the Chair, and I thank the Senator from Nevada.

Mr. President, when we return to the bill, it will be my intention to offer an amendment to the agriculture appropriations bill. I think that my amendment will deal with one of the most fundamental concerns in health care today: that is, the restoration to the physician of the basic right of patient care, patient treatment, and to be the determinator of patient care and the length of hospital stay.

I think one of the things we have seen emerge in health care throughout the United States in the past 2 to 3 years is the development of the so-called green eyeshade of an HMO determining what is appropriate patient care, regardless of the physical condition of an individual patient.

The amendment I will offer essentially says that a group health plan or a health insurance issuer, in connection with health insurance coverage, may not arbitrarily interfere with or alter the decision of the treating physician regarding the manner or setting in which particular services are delivered, if the services are medically necessary or appropriate for treatment or diagnosis to the extent that such treatment or diagnosis is otherwise a covered benefit. In other words, if you have coverage for a treatment in your plan, the physician determines that treatment based on you, based on your needs, based on your illness—not based on the calculation of a green eyeshade in a health insurance plan.

My father was a surgeon. He was chief of surgery at the University of California. My husband, Bert Feinstein, was a neurosurgeon. I grew up and lived a good deal of my life in a medical family. In all of that time, the doctors determined the appropriateness of care, the doctors determined the length of hospitalization, the doctors determined whether a particular treatment was suitable for an individual—not an arbitrary HMO, not physicians out of context of an individual physician and patient.

Every person sitting in this gallery today is different, one from the other. They are different in how they react to drugs. They are different in how they react to radiation—

The PRESIDING OFFICER. The time allotted to the distinguished Senator from California has expired.

Mrs. FEINSTEIN. If I may finish my sentence.

Mr. NICKLES. If I might just interrupt. I apologize. I was not on the floor earlier.

EXTENSION OF MORNING BUSINESS

Mr. NICKLES. I ask unanimous consent that each side have 20 minutes of additional time for morning business.

The PRESIDING OFFICER. Is there an objection?

Mr. REID addressed the Chair

The PRESIDING OFFICER. The time has expired in regard to the Senator from California.

Hearing none, without objection, it is so ordered.

Mr. REID. Mr. President, I ask through the Chair to the Senator from California, how much additional time

Mrs. FEINSTEIN. If I could have another 7 to 10 minutes at this time, I would appreciate it very much.

Mr. REID. How about 7 minutes?

Mrs. FEINSTEIN. I will do my best with 7 minutes.

Mr. REID. Okay.

The PRESIDING OFFICER. The distinguished Senator is recognized for 7 minutes.

Mrs. FEINSTEIN. I thank the Chair. I thank the Senator from Nevada.

At an appropriate time, I will submit that amendment.

Let me tell you some of the things we are increasingly told: That is, that doctors have to spend hours hassling with insurance company accountants and adjusters to justify medical necessity decisions—why a person needs another day in a hospital, why a patient needs an MRI, why a patient needs a blood test, why a patient should get a particular drug, this drug rather than that drug. Doctors increasingly say they have to exaggerate or lie so their patients can get proper medical care.

In USA Today, an article was run saying that 70 percent of doctors interviewed said they exaggerate patients' symptoms to make sure HMOs do not discharge patients from hospitals prematurely. Seventy percent of doctors indicate that they do not tell the truth about a patient's condition so they can be assured that that patient gets adequate hospital care.

Now, is this what we want? I don't think it is. I think the doctor's decision, based on an individual's condition, should be the overriding decision that determines medical necessity. The amendment I will introduce will ensure that that happens.

In the HHS inspector general's report of June 1998, the following finding was made: Most doctors think working in a Medicare HMO restricts their clinical independence and that HMOs' cost concerns influence their treatment decisions. Mr. President, every patient is different and brings to a situation his or her own unique history and biology. Only a physician who is trained to evaluate the unique needs and problems of a patient can properly diagnose and treat an individual.

A Los Angeles doctor by the name of Lloyd Krieger said:

> Many doctors are demoralized. They feel like they have taken a beating in recent years. Physicians train years to learn how to practice medicine. They work long hours practicing their field. Under this health care system, that training and hard work often seems irrelevant. A bureaucrat decides how doctors are allowed to treat patients.

Dr. Krieger says:

> When I tell someone he is fit to leave the hospital after an operation, I am often given an accusing stare. Sometimes my patient asks: Is that what you really think or are you caving in to HMO pressure to cut corners on care?

Here's another example: A California pediatrician treated a baby with infant botulism, a toxin that spread from the intestine to the nervous system so the child really couldn't breathe well. The doctor prescribed a 10- to 14-day hospital stay. That doctor thought that length of stay was medically necessary for that particular baby. The insurance plan cut it short, saying the maximum that baby could remain in the hospital was I week. That shouldn't be.

The amendment I will introduce at the appropriate time, and that I so hope this body will agree to, will ensure that medically appropriate and necessary treatment is prescribed by the physician and not contradicted by a green eyeshade.

I very much hope this body will accept it. I have introduced this kind of amendment now with Senator D'AMATO as a cosponsor and with Senator OLYMPIA SNOWE as a cosponsor. Perhaps the time has come to have the opportunity to pass this amendment and to get it done once and for all.

I thank the Chair, I thank the Senator from Nevada, and I thank the Senator from Massachusetts as well.

I yield the floor.

DRAFT -- NOT FOR RELEASE

July 9, 1999
(Senate)

S. 1344 - Patients' Bill of Rights Act of 1999
(Sens. Lott (R) MS and Nickles (R) OK)

The President strongly supports enactment of S. 1344, which is identical to S. 6, the original Senate Democratic Patients' Bill of Rights. This bill is a strong and enforceable patients' bill of rights. It includes important patient protections, such as the right to emergency care wherever and whenever a medical emergency arises; the right to talk freely with doctors and nurses about all the medical options available, not only the cheapest; and the right to an internal and external appeals process that allows patients to address their concerns and grievances. The President is particularly pleased that this legislation includes every patient protection recommended by the Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

Since November 1997, the President has been calling on the Congress to pass a strong, enforceable, and bipartisan patients' bill of rights. S. 1344 represents the first test of whether this Congress is serious about providing Americans with a strong, enforceable, bipartisan patients' bill of rights to ensure high quality health care. The President is committed to working with the Congress to pass a strong, enforceable, bipartisan patients' bill of rights this year.

The Republican Leadership may seek to amend S. 1344 by substituting the provisions of S. 326, as reported by the Senate Committee on Health, Education, Labor, and Pensions. Unfortunately, S. 326 is seriously flawed. It covers too few people, it provides insufficient 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 S. 326, as currently drafted. If the text of S. 326 as reported were presented to the President, his senior advisers would recommend that he veto the bill.

S. 326 contains numerous shortcomings. First, most of S. 326 applies to only a narrow segment of health plans, leaving more than 100 million Americans without these patient protections. The President has repeatedly stated that every enrollee should have access to the protections in the patients' bill of rights.

Second, S. 326 does not include many critical provisions that are necessary to ensure high quality care. The following protections are either absent from this legislation or are insufficient:

> External appeals. The weaknesses of the external appeals process are numerous and significant. For example, S. 326 would: (1) allow plans to limit what issues are

appealable; (2) allow plans to select the review entity; (3) not expressly require that external review be *de novo*; (4) not provide access to external review for claims involving violations of the bill's consumer protection provisions; (5) allow external review entities to use the plan's definition of medical necessity, making it extremely difficult for an enrollee to prevail on appeal; and (6) not hold health plans accountable for patients that are harmed by an unreasonable delay or denial of benefits or services.

Emergency room services. The emergency room services provision is insufficient, as it does not: (1) prohibit plans from limiting access to an emergency room that is outside the plan's network; (2) prohibit plans from imposing higher cost-sharing requirements on patients who obtain emergency care without prior authorization; and (3) address coverage of post-stabilization care, which puts patients at risk for huge costs when a plan fails to timely respond to a request for post-emergency services.

Access to specialists. S. 326 does not require plans to allow a woman to designate her ob/gyn as her primary care physician. In addition, it does not ensure individuals with chronic or serious conditions access to specialists as primary care physicians. Moreover, it does not
require that a plan cover a specialist that is not in its network of providers, even if the network does not have sufficient providers available to treat the condition. As such, patients would not be ensured access to needed specialists to treat, for example, cancer or heart conditions.

Continuity of care protections. The bill's continuity of care protections would apply only to individuals in institutions, women in their second trimester of pregnancy, and the terminally ill -- not to persons with chronic or ongoing illnesses who are in the middle of a course of treatment when their provider is dropped from the plan's network. For example, S. 326 would not protect a person in the middle of a course of chemotherapy or radiation.

Third, we understand that the Republican Leadership's planned substitute for S. 1344 will contain 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. For example, the bill would expand medical savings accounts (MSAs). Expanding MSAs before studying the current demonstration project enacted in the Health Insurance Portability and Accountability Act of 1996 is premature. Under the Manager's Amendment, the MSA tax break will likely 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.

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 S. 326 is insufficient and does not provide patients with the protections they need and deserve. While the Administration has serious concerns with S. 326, the President remains committed to passing a strong, enforceable, and bipartisan patients' bill of rights this year. His hope is that Republicans and Democrats can work across party lines to put progress

ahead of partisanship and pass legislation that gives Americans the health care protections they need.

Pay-As-You-Go Scoring

Both S. 1344 and S. 326 would affect both direct spending and receipts; therefore, both bills are subject to the pay-as-you-go requirement of the Omnibus Budget Reconciliation Act of 1990. OMB's preliminary scoring estimates of these bills are under development.

* * * * * * * * * *

David's comments - he also wants to talk to you about Mon's mtg w/ Chafee.

D.

DRAFT – NOT FOR RELEASE

July 8, 1999
(Senate)

S. 326 - Patients' Bill of Rights Act
(Sen. Jeffords (R) VT and 10 cosponsors)

Since November 1997, the President has been calling on the Congress to pass a strong, enforceable, and bipartisan patients' bill of rights. S. 326 represents the first test of whether this Congress is serious about providing Americans with a strong, enforceable, bipartisan patients' bill of rights to ensure high quality health care. S. 326 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 a strong, enforceable, bipartisan patients' bill of rights this year.

Unfortunately, S. 326 is seriously flawed. It covers too few people, it provides insufficient 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 S. 326, as currently drafted. If the bill were presented to the President, his senior advisers would recommend that he veto it.

S. 326 contains numerous shortcomings. First, most of S. 326 does not apply to the fully insured group market or the individual insurance market, leaving more than 100 million Americans without these patient protections. The President has repeatedly stated that every health plan should have to provide its enrollees with a patients' bill of rights.

~~Any~~ ~~we may~~ ~~Administration~~ ~~are~~ ~~saying~~ ~~on~~ ~~substance~~.

Second, the bill does not include many critical provisions that are necessary to ensure high quality care. ~~The following protections are either absent from this legislation or are insufficient:~~ the many provisions that are missing or inadequate:

Among

External appeals. The weaknesses of the external appeals process are numerous and significant. For example, S. 326 would: (1) allow plans to decide what issues are appealable; (2) allow plans to select the review entity; (3) not require that external review be *de novo*; (4) prohibit enrollees from appealing decisions regarding violations of the bill's consumer ~~protection provisions~~; and (5) require external review entities to use the plan's definition of medical necessity, making it extremely difficult for an enrollee to prevail on appeal

needs to be pulled out and highlighted - also Dr. Decides instead of insurance Co. accountant

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. In addition, S. 326: (1) would allow plans to impose higher cost-sharing requirements on patients who obtain emergency care without prior authorization, and (2)

Add liability

does not address coverage of post-stabilization care, which puts patients at risk for huge costs when a plan fails to timely respond to a request for post-emergency services

Access to specialists. S. 326 does not require plans to allow women to designate their ob/gyn as their primary care physician. In addition, it does not ensure individuals with chronic or serious conditions access to specialists. Moreover, it does not require that a plan cover a specialist that is not in its network of care providers, even if the network does not have sufficient providers available to treat the condition. As such, patients would not be ensured access to needed specialists to treat, for example, cancer or heart conditions.

Continuity of care protections. The bill's continuity of care protections would apply only to individuals in institutions, women in their second trimester of pregnancy, and the terminally ill -- not to persons with chronic or ongoing illnesses who are in the middle of a course of treatment when their provider is dropped from the plan's network. For example, S. 326 would not protect a person in the middle of a course of chemotherapy or radiation. Moreover, the bill provides for continuity of care only when a provider is dropped from the plan's network, but not when the employer changes plans.

Third, we understand that the Manager's Amendment to S. 326 will contain 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. For example, the bill would expand medical savings accounts (MSAs). Expanding MSAs before studying the current demonstration project enacted in the Health Insurance Portability and Accountability Act of 1996 is premature. Under the Manager's Amendment, the MSA tax break will likely 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.

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 S. 326 is insufficient and does not provide patients with the protections they need and deserve. While the Administration has serious concerns with S. 326, the President remains committed to passing a strong, enforceable, and bipartisan patients' bill of rights this year. His hope is that ~~Republicans and Democrats can~~ work across party lines to put progress ahead of partisanship and pass legislation that gives Americans the health care protections they need.

~~the Republican Leadership in the Senate will be willing to~~

Pay-As-You-Go Scoring The Republican Leadership in the Senate will be willing to

S. 326 would affect both direct spending and receipts; therefore, it is subject to the pay-as-you-go requirement of the Omnibus Budget Reconciliation Act of 1990. OMB's preliminary scoring estimate of the bill is under development.

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UNITED STATES SENATE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS
WASHINGTON, DC 20510-6300

DATE: 4/22/99

TO: Chris Jennings

FAX NUMBER: 456-5557

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NUMBER OF PAGES: 4 (including cover)

MESSAGE:

Per our discussion

If you have trouble receiving this fax, please call (202) 224-7675

DAILY AP WIRE

Managed Care Proponents Spend $60M

By JONATHAN D. SALANT Associated Press Writer

WASHINGTON (AP) – Insurance companies and their allies in the fight against new regulations for managed health care spent an average $112,000 per lawmaker to lobby Congress in the first half of this year.

The $60 million lobbying outlay was four times the $14 million-plus spent by medical organizations, trial lawyers, unions and consumer groups to press for passage of the so-called Patients Bill of Rights, disclosure reports filed with the secretary of the Senate show.

Not all of the money went for lobbying on managed care, because many groups opposed to the changes also talked to members of Congress about other issues. Lobbying reports do not break down spending by issue.

The $60 million lobbying tab is enough to pay salaries of everyone in the U.S. transportation secretary's office or finance for almost two months the childhood immunization program of the Center for Disease Control and Prevention. It's 50 percent higher than the $40 million that tobacco interests spent between January and June to kill legislation to raise cigarette taxes to curb teen-age smoking.

The figure does not include $11 million spent on advertising against the managed care legislation, nor millions of dollars in campaign contributions that opponents of new regulation made in the just-concluded congressional campaigns.

"It certainly does show that the industry spared little effort to try to defeat patients' rights that are so popular all across the country," said Ron Pollack, executive director of Families USA, a health-care advocacy group.

Dan Danner, chairman of the anti-regulation Health Benefits Coalition, said the money was well spent.

"We didn't have legislation pass in the last Congress, and that was our objective," said Danner, also vice president of federal relations for the National Federation of Independent Business, the small-business lobbying group.

The proposed regulations, which would govern health plans known as managed care or health maintenance organizations, are supposed to give patients more power to challenge decisions about their care.

Opponents said the restrictions would push the cost of health insurance plans so high that small businesses could no longer afford to insure their workers.

They rolled out big guns to argue against the legislation, including Haley Barbour, former chairman of the Republican National Committee; Kenneth Duberstein, White House chief of staff under President Reagan; and Daniel Meyer, former chief of staff for outgoing House Speaker Newt Gingrich.

"They're high-paid lobbyists walking the halls of Capitol Hill, getting access to members in order to make their pitch on managed care reform," said Jim Manley, a spokesman for Sen. Edward M. Kennedy, D-Mass., a leading proponent of the legislation.

While most of the organizations supporting and opposing new managed-care

regulation had other issues on their plates, all listed managed-care rules as a priority.

The U.S. Chamber of Commerce spent more money lobbying than any other group in the health-care debate, $8 million.

"That's not just health care, it's environmental issues, it's labor policy, it's tax policy, it's work force training issues, and it's health-care policy," chamber spokesman Frank Coleman said. "Stopping trial lawyers and their agenda of allowing patients of HMOs to sue the companies that provide them the health care was a chamber top priority."

Both the chamber and the small business federation were with the Health Benefits Coalition, as were the Blue Cross-Blue Shield Association, the Health Insurance Association of America and the HMO trade group the American Association of Health Plans.

On the other side, the American Medical Association spent $8.3 million on lobbying during the first half of 1998, the AFL-CIO $1.4 million and the Association of Trial Lawyers of America $940,000.

In addition, several groups of health specialties, including the American Chiropractic Association, American College of Emergency Physicians and American Association of Nurse Anesthetists, formed their own pro-reform coalition that spent $3.3 million.

Both sides are gearing up to fight the battle again in the 106th Congress. President Clinton and Democratic congressional leaders have said the first order of business should be to pass new HMO regulations, and several Republican lawmakers also support new rules.

Meanwhile, the same coalitions that successfully beat back the legislation are planning strategy for next year. "This will be a large effort once again," the Health Benefits Coalition's Danner said. "The stakes are very high."

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I called Jonathan Salant, the AP reporter you asked about.

He did not know how much of the $60 million was spent on lobbying against managed care reform specifically. Furthermore, he doesn't think the information is easy to track down since lobbying groups are not required to disclose the issue break-out of their expenditures. The $60 million, he said, simply represents the sum total that was spent by the opponents of managed care reform. However, some of the groups he identified, like the U.S. Chamber of Commerce, likely devoted lobbying energies to many issues other than the Patients' Bill of Rights.

The other figure at issue was the $11 million that he cited as the amount spent advertising against managed care reform. This figure was calculated using a website run by the Annenberg Public Policy Center (APPC). This site, (http://appcpenn.org) tracks the issue ads run during the 1997-1998 election cycle. According APPC, 15 organizations ran issue ads relating to health care. Of those organizations, 8 ran advertisements opposing managed care reform. For 4 of those 8, APPC listed the amount that they spent on this issue alone. The groups and numbers are as follows:

American Association of Health Plans: $2 million Coalition for Affordable Quality Health Care: $6 million Coalition for Patient Choice: $250,000
Health Benefits Coalition: $2 million

APPC did not specify how much was spent by the remaining four groups opposing managed care reform, but the organization names are as follows:

Business Roundtable
Citizens for a Sound Economy
Patient Access to Responsible Care Alliance Republican Party (soft money spending)

As you can see, the first four organizations alone account for $10.25 million of the $11 million that Salant claims was spent on anti-reform advertising. He accounted for the balance by calling the second four organizations individually and asking them to estimate their corresponding expenditures.

If you have any more questions, David, let me know!

Christina Ho