



The Voice for Health Care Consumers

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HIT AND MISS

Table 1

As of July 1998

THE VARIABILITY OF STATE MANAGED CARE CONSUMER PROTECTION LAWS

STATES	E.R. SERVICES	ACCESS TO PROVIDERS				CONTINUITY OF CARE
	Prudent layperson Standard	Referral to Out of Network Providers	Specialists vs Primary Care Providers	Standing Referrals to Specialists	OB-GYN Direct Access	When Physicians Leave Plan
ALABAMA				•	•	
ALASKA						
ARIZONA						
ARKANSAS	•				•	•
CALIFORNIA	•			•	•	
COLORADO	•	•			•	•
CONNECTICUT	•				•	
DELAWARE					•	
DISTRICT OF COLUMBIA	•					
FLORIDA		•		•	•	•
GEORGIA	•				•	
HAWAII	•				•	
IDAHO	•				•	
ILLINOIS					•	
INDIANA	•	•	•		•	•
IOWA	•					
KANSAS	•			•		•
KENTUCKY	•	•			•	
LOUISIANA	•				•	
MAINE	•	•				
MARYLAND	•					
MASSACHUSETTS						
MICHIGAN	•					
MINNESOTA	•			•	•	•
MISSISSIPPI					•	
MISSOURI	•	•	•	•		•
MONTANA		•			•	
NEBRASKA	•				•	
NEVADA	•					
NEW HAMPSHIRE						
NEW JERSEY			•		•	•
NEW MEXICO	•	•	•	•	•	
NEW YORK	•	•	•	•	•	•
NORTH CAROLINA	•	•			•	
NORTH DAKOTA						
OHIO	•	•	•	•		
OKLAHOMA						
OREGON	•				•	
PENNSYLVANIA	•		•	•	•	•
RHODE ISLAND						
SOUTH CAROLINA	•				•	
SOUTH DAKOTA						
TENNESSEE		•	•	•	•	•
TEXAS	•	•	•		•	•
UTAH		•				
VERMONT	•	•	•	•	•	•
VIRGINIA	•				•	•
WASHINGTON	•				•	
WEST VIRGINIA	•				•	
WISCONSIN	•					
WYOMING						

NOTE: This table differs from the table in the report in the states listed as having laws providing direct access to ob-gyn's. Kentucky was mistakenly included in the chart on the report and Maine and Maryland were inadvertently left off.

STATE MANAGED CARE LAWS

As of July 199

PREScription DRUG ACCESS	APPEALS PROCEDURES	CONSUMER ASSISTANCE	PATIENT-PROVIDER RELATIONSHIP		CLINICAL TRIALS	LIABILITY	STATES
Access to Non-Formulary Prescriptions	Independent External Reviews	Independent Ombuds Programs	Disclosure of Treatment Options	Prohibit Physician Financial Incentives	Clinical Trials	Right to Sue Health Plans for Damages	
							ALABAMA
			•	•			ALASKA
	•		•				ARIZONA
•			•				ARKANSAS
•			•	•			CALIFORNIA
			•				COLORADO
	•		•				CONNECTICUT
			•				DELAWARE
			•				DISTRICT OF COLUMBIA
	•	•	•				FLORIDA
•			•	•	•		GEORGIA
	•		•				HAWAII
			•	•			IDAHO
			•				ILLINOIS
•			•				INDIANA
			•				IOWA
			•	•			KANSAS
			•				KENTUCKY
			•	•			LOUISIANA
			•				MAINE
	•		•	•	•		MARYLAND
			•				MASSACHUSETTS
	•		•				MICHIGAN
	•		•				MINNESOTA
			•				MISSISSIPPI
•	•		•			•	MISSOURI
			•	•			MONTANA
			•	•			NEBRASKA
			•	•			NEVADA
			•				NEW HAMPSHIRE
	•		•	•			NEW JERSEY
	•		•	•			NEW MEXICO
			•				NEW YORK
			•				NORTH CAROLINA
			•				NORTH DAKOTA
•			•	•			OHIO
			•				OKLAHOMA
•			•				OREGON
	•		•	•			PENNSYLVANIA
	•		•	•	•		RHODE ISLAND
			•				SOUTH CAROLINA
			•				SOUTH DAKOTA
	•		•				TENNESSEE
	•		•	•		•	TEXAS
			•	•			UTAH
•	•	•	•	•			VERMONT
			•				VIRGINIA
			•				WASHINGTON
			•	•			WEST VIRGINIA
			•				WISCONSIN
			•				WYOMING

FACSIMILE COVER PAGE

Date: 3/15/99
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To: Chris Jennings
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From: Bruce Lesley
Title: Director, Congressional Relations
Company: National Assoc. of Children's Hospitals
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Alexandria , VA 22314
USA
Fax #: 703-684-1589

Message:

The National Association of Children's Hospitals is sending the following letter to all 20 members of the Senate Health, Education, Labor and Pensions (HELP) Committee urging their support for amendments by Senator Jack Reed (D-RI) on pediatric-specific managed care protections at the mark-up of S. 326, the "Patients' Bill of Rights," on the morning of March 17.

The last five pages are attachments to the letter to help staff with talking points and background for the Reed amendments.

-Bruce Lesley
National Association of Children's Hospitals

LAWRENCE A. McANDREWS, FACHE
President & Chief Executive Officer

March 15, 1999

The Honorable Jim Jeffords
Chairman
Senate Health, Education, Labor and Pensions Committee
United States Senate
Washington, D.C. 20510

**RE: Senate Health, Education, Labor, and Pensions Committee Mark-Up on
S. 326, "Patients' Bill of Rights"**

Dear Chairman Jeffords:

The National Association of Children's Hospitals (N.A.C.H.), which represents more than 100 children's hospitals across the country, **urges you to support pediatric managed care amendments that will be offered by Senator Jack Reed** during the scheduled mark-up of S. 326, "Patients' Bill of Rights," in the Senate Labor, Education, Labor, and Pensions Committee on March 17.

N.A.C.H. commends Senator Mike DeWine, Senator Bill Frist and you for the inclusion of some important provisions in the underlying bill and Chairman's mark. In particular, Senator DeWine has made a significant improvement to the bill by ensuring the recognition of the unique health needs of children in several instances.

These improvements include: (1) clarification in the appeals language that ensures the reviewer of the appeal is someone with age-appropriate expertise; (2) clarification of the continuity of care provision; (3) the prioritization of children in health services research; and, (4) inclusion and clarification of language to give families the choice of a pediatrician as a primary care provider for children.

Although these provisions have improved S. 326, the bill still fails to address the unique health care needs of children in several extremely important places and we **strongly urge support for amendments to be offered by Senator Reed** to make the bill more child-appropriate.

Over 130 national, state and regional organizations have endorsed the children's health protections, as proposed in legislation that has been introduced by Senators Reed, John Chafee, Tom Daschle and Christopher "Kit" Bond. As the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry writes, "Children have health and developmental needs that are markedly different from adults and require age-appropriate care. Developmental changes, dependency on others, and different patterns of illness, disability and injury require that attention be paid to the unique needs of children in the health system."

SUPPORT THE REED AMENDMENTS TO IMPROVE CHILDREN'S HEALTH

The amendments we strongly support include:

Access to Pediatric Specialty Care – Children are Not Little Adults

N.A.C.H. recommends, first and foremost, that the Committee provide children with access to pediatric specialty care. Children are not little adults and should not be treated as adults in the health care system. Appropriate pediatric referrals to specialty care are critical for children, particularly children with special health care needs. They are at risk of being inappropriately referred to adult specialists who have little or no experience treating children and fail to understand children's unique health conditions and requirements.

Moreover, the American public strongly support such a provision. According to a 1999 national poll commissioned by N.A.C.H. and conducted by the bipartisan polling team of Lake Sosin Snell Perry and Associates and The Tarrance Group, 86 percent of American voters favor "Congress requiring HMOs and other insurance companies to provide children with access to pediatric specialists, like pediatric health specialists and surgeons, and to hospitals that specialize in treating children."

Expedited Review if the Life, Health or Development of a Child is Threatened

Particularly for infants and toddlers, early and appropriate health intervention is critical to their normal development. Developmental milestones include such things as sucking, swallowing, respiratory function, crawling, walking, speech, dressing and feeding oneself.

Plans may deny access to pediatric rather than adult specialists, deny coverage for home-based care to a family for its child, or deny or arbitrarily limit rehabilitative and habilitative services for children. Plans may also threaten a child's development by failing to understand or recognize the significance of a child's failure to reach early developmental milestones and the need to avoid regression from such milestones. While this failure by a plan may not result in immediate

consequences that "seriously jeopardize life or health of the enrollee" (as S. 326 requires to get an expedited review), it can have series long-term consequences for a child's ability to meet important developmental milestones.

Staci Froelich testified before the Health, Education, Labor and Pensions Committee last summer about her child's congenital heart problems and talked about the numerous delays and constant reviews that precluded her child from getting the heart surgery from a pediatric cardiologist that she needed for over a year. While the delays did not result in the loss of the child's life, the delays have created an enormous problem with respect to her normal development – forcing Ms. Froelich to leave her job as a registered nurse and face bankruptcy in an effort to be with her child and help her "catch up."

N.A.C.H. urges Congress to recognize the importance of early childhood development. This provision does nothing more than ensure that a health plan provides children under the age of 6 an expedited review of their appeal if the decision may threaten a child's development. The health plan may still deny treatment or services, as the appeals process will determine, but the family would then have an opportunity to seek alternative treatments or services without a significant delay.

Pediatric-Specific Information

Health care information is often provided in a manner that emphasizes the benefits, processes and outcomes of care for adults. Families need information that is child-specific to make appropriate health care decisions on behalf of their children.

The underlying bill does not provide such information. If changes are made to give families more information by which to make plan choices, including comparative information, we encourage language to be included to ensure that information is "delineated separately for children and for adults where feasible and appropriate."

CHILDREN DO NOT COMMAND MARKETPLACE ATTENTION

Children have a special and long-standing place in society that requires us, both individually as parents and collectively as a society, to pay special attention to their health, safety and development.

Managed care offers great promise, both to improve access to appropriate health care and to achieve sustainable health care spending. The fulfillment of this promise will depend in part on reaching agreement on minimum standards for how health plans should meet consumers' needs. This promise is especially important for children, who can benefit so much from managed care's focus on primary and preventive care, but who also require assurance of access to

pediatric specialty care services for their unique health care needs. If health problems for children are identified and corrected early in an appropriate manner, they will be more likely to grow up as healthier and more productive adults.

However, given that children account for such a small part of total health care spending in the economy – less than 15 percent of personal health care spending – their needs alone will not command the economic focus of the competitive marketplace. "Children's health is the poor stepchild in the HMO business," says David Lansky, president of the nonprofit Foundation for Accountability (FACCT), in a *Smart Money* article. "Kids are ignored for simple economic reasons."

For this important reason, we encourage you to support the Reed amendments to S. 326, the "Patients' Bill of Rights" at the mark-up on March 17.

If you have any questions or need additional information, contact Bruce Lesley at 703-684-1355.

Sincerely,

Lawrence McAndrews

SUPPORT THE REED AMENDMENT***Access to Pediatric Specialty Care – Children are Not Little Adults***

N.A.C.H. recommends that the Committee provide children with access to pediatric specialty care. Children are not little adults and should not be treated as adults in the health care system. Appropriate pediatric referrals to specialty care are critical for children, particularly children with special health care needs. They are at risk of being inappropriately referred to adult specialists who have little or no experience treating children and fail to understand children's unique health conditions and requirements.

Study after study has shown patient outcomes are significantly improved with providers and facilities that have substantial case volume and experience in the health services measured. Data further supports improved outcomes with greater pediatric experience and volume of services measured.

One such example is pediatric congenital heart surgery, where the hope of survival is much higher in institutions with the highest annual case volumes. Congenital heart defects include diverse malformations. Like children's cancers, and many other childhood diseases, they are often rare. Many diseases are either not the same as in adults or their progression and treatment may vary significantly. For these reasons, in the case of a child, access to and care review by health providers with appropriate pediatric expertise is essential and, in some cases, life-saving.

Moreover, the American public strongly support such a provision. According to a 1999 national poll commissioned by N.A.C.H. and conducted by the bipartisan polling team of Lake Sosin Snell Perry and Associates and The Tarrance Group, 86 percent of American voters favor "Congress requiring HMOs and other insurance companies to provide children with access to pediatric specialists, like pediatric health specialists and surgeons, and to hospitals that specialize in treating children."

The depth of support for the proposal is also strong. In fact, 80 percent of voters responded that they believe it is "extremely important" or "very important" to them "personally to have Congress require HMOs and other insurance companies to provide children with access to pediatric specialists, like pediatric health specialists and surgeons, and to hospitals that specialize in treating children."

Support for this proposal is across the board, with only minor variation in support by gender, race and party affiliation.

GENDER

- 89% of women are supportive
- 82% of men are supportive

RACE

- 84% of white adults are supportive

- 94% of African-American adults are supportive
- 93% of Hispanic adults are supportive

PARTY AFFILIATION

- 92% of Democrats are supportive (94% support among Democratic women)
- 90% of Independents are supportive (92% support among Independent women)
- 77% of Republicans are supportive (82% support among Republican women)

As Celinda Lake (Lake Sosin Snell Perry and Associates) and David Sackett (The Tarrance Group) note, "Overall there is at least 70 percent support for this proposal among every demographic and political subgroup."

The pollsters add, "...proposals leading with pediatric care have consistently tested the strongest – almost as valence terms."

SUPPORT THE REED AMENDMENT

Expedited Review if the Life, Health or Development of a Child is Threatened

Particularly for infants and toddlers, early and appropriate health intervention is critical to their normal development. Developmental milestones include such things as sucking, swallowing, respiratory function, crawling, walking, speech, dressing and feeding oneself.

Plans may deny access to pediatric rather than adult specialists, deny coverage for home-based care to a family for its child, or deny or arbitrarily limit rehabilitative and habilitative services for children. Plans may also threaten a child's development by failing to understand or recognize the significance of a child's failure to reach early developmental milestones and the need to avoid regression from such milestones. While this failure by a plan may not result in immediate consequences that "seriously jeopardize life or health of the enrollee" (as S. 326 requires to get an expedited review), it can have series long-term consequences for a child's ability to meet important developmental milestones.

In the case of neonates, a delay of 15 days or 60 days is a *lifetime* for these children and hinders their ability to meet immediate developmental milestones such as sucking, swallowing or the development of motor skills. Any appeals review in the neonatal period must be fast and immediate to ensure proper development and growth.

In the case of children with injuries (injury is the number one cause of death in children), the need for speech therapy and rehabilitation is also immediate. Delay results in the regression in the child's overall development. In short, development is extremely time sensitive for children – particularly for children under the age of 6.

As the Institute of Medicine writes in its report entitled *Paying Attention to Children in a Changing Health Care System*:

Critical differences between children and adults include the complex and continuing developmental changes that occur between birth and adulthood. Care for children emphasizes protecting and promoting healthy physical and psycho-social development...with certain vulnerable periods in which appropriate care is essential for optimal developmental progress...whereas much adult care responds to illness.

Renowned child-health experts Paul Newacheck, Jeffrey Stoddard, Dana Hughes and Michelle Pearl add in a *Health Affairs* article entitled "Children's Access to Health Care: The Role of Social and Economic Factors":

When access to care is denied, there are implications for people of all ages, but the impact can be especially profound for children, who undergo rapid growth and development. When these processes are interrupted by illness or injury, permanent consequences may ensue. Indeed, untreated childhood illness and injury may affect a child's lifelong health and well-being.

In addition, in the book *Health Care for Children: What's Right, What's Wrong, What's Next*, United HealthCare Corporation executives Sheila Leatherman and Douglas McCarthy wrote an article entitled "Opportunities and Challenges for Promoting Children's Health in Managed Care Organizations." They write, "To meet these dual community health and marketplace challenges, our country needs to define health plan accountabilities for performance in meeting children's needs." This includes, among other things:

Health plans should recognize the unique developmental needs of children in covering and coordinating appropriate care.

In a young child's life, time can add up quickly if you need constant reviews for a series of decisions. Again, it can result in a lifetime of reviews for children, particularly children with special health care needs.

Staci Froelich testified before the Health, Education, Labor and Pensions Committee last summer about her child's congenital heart problems and talked about the numerous delays and constant reviews that precluded her child from getting the heart surgery from a pediatric cardiologist that she needed for over a year. While the delays did not result in the loss of the child's life, the delays have created an enormous problem with respect to her normal development – forcing Ms. Froelich to leave her job as a registered nurse and face bankruptcy in an effort to be with her child and help her "catch up."

State governments, such as Minnesota, are rapidly beginning to recognize developmental concerns of children in their managed care contracts. The State of Minnesota in its document *Service Delivery Standards for the Demonstration Project for People with Disabilities* notes:

Disruption of developmental patterns during childhood may result in delayed long-term consequences that can present themselves later in adulthood. Thus, while the goal for an adult is to meet medical needs, the same goal for a child will be understood to mean both medical and developmental necessity, requiring an additional set of considerations.

N.A.C.H. strongly agrees with Karen Ignagni, President and CEO of the American Association of Health Plans, when she says:

Investing in the early development of children is the most important commitment any parent, health plan or the nation can make.

N.A.C.H. urges Congress to recognize the importance of this commitment as well. This provision does nothing more than ensure that a health plan provides children under the age of 6 an expedited review of their appeal if the decision may threaten a child's development. The health plan may still deny treatment or services, as the appeals process will determine, but the family would then have an opportunity to seek alternative treatments or services without a significant delay.

SUPPORT THE REED AMENDMENT
Pediatric-Specific Information

Health care information is often provided in a manner that emphasizes the benefits, processes and outcomes of care for adults. Families need information that is child-specific to make appropriate health care decisions on behalf of their children. A plan could have a general patient satisfaction rating of 90 percent, and yet, receive poor ratings from families for the delivery of care to children, particularly children with special health care needs. Without separate information on children's experience, families would never know that fact.

For example, *Newsweek* published an annual ranking earlier this past year of 150 health plans on 43 key activities. It noted, "To make the ratings more useful, we assessed kids' care and adult care separately." Some plans perform well for adults but poorly for children and vice versa. The State of New Jersey also publishes its information separate for children and adults to allow families to recognize such disparities.

Furthermore, the public wants such child-specific information, as the Lake/Tarrance poll demonstrates. In fact, 87 percent of respondents favor "Congress requiring HMOs and other insurance companies to measure and report to the public specifically on the quality of children's health they provide."

The underlying bill does not provide such information. If changes are made to give families more information by which to make plan choices, including comparative information, we encourage language to be included to ensure that information is "delineated separately for children and for adults where feasible and appropriate."

Chris -- attached is:

- (1) Summary of Administration actions on the Patients' bill of rights
- (2) Press release from November event detailing what we have done to implement these protections for the 85 million Americans covered by Federal health plans
- (3) Outstanding issues on the patients' bill of rights
- (4) The President's (and my) favorite chart -- which still appears to by and large by the case for House plan.
- (5) Summary of patient protections
- (6) SAP on last year's House Republican proposal -- which details some of the flaws.
- (7) Political analysis of what the new changes in the House mean for the passage of the patients' bill of rights.

Hope helpful. Page with questions.

Sarah B.

PRESIDENT CLINTON HAS BEEN A LONGSTANDING LEADER IN PROVIDING PATIENTS THE PROTECTIONS THEY NEED

- **September 1996.** The President announced his intention to create a Quality Commission to advise him on the changes in the health care system and make recommendations on how best to assure patient protections and quality health care.
- **April 1997.** The President announced the Members of his Quality Commission, which included all of the representatives players in the health care industry, including businesses, insurers, consumers, labor, doctors, and nurses. At that time, he asked the Commission to develop a patients' bill of rights as its first order of business.
- **November 1997.** The President endorsed the Quality Commission patients' bill of rights and asked Congress to make it the law of the land.
- *November 1997. Senate Majority Leader Trent Lott reportedly told health-insurance lobbyists to "get off your butts, get off your wallets" to help defeat the patients' bill of rights.*
- **January 1998.** In his State of the Union address, the President focused the nation on this issue and reiterated his call on Congress to pass a patients' bill of rights before they adjourned this year.
- **February 1998.** The President issued an Executive Memorandum directing the Federal health plans (Medicare, Medicaid, DoD, FEHBP, and VA), which cover 85 million Americans to implement the patients' bill of rights.
- *February 1998. Speaker Gingrich appointed a task force that promised to move rapidly to produce a patients' bill of rights. After promising each month to release a patients' bill of rights, they finally issued a press release announcing their intention to unveil legislation that has yet to be seen.*
- **March 1998.** The President reiterated his call on Congress to pass a patients' bill of rights this year in a speech to the American Medical Association. Doctors, nurses, patients and other consumers strongly believe that the Congress should pass a strong, enforceable patients' bill of rights this year.
- **March 1998.** The President accepted the final recommendations of his Quality Commission. At that time he, yet again, called on Congress to pass a patients' bill of rights.
- **April through July 1998.** The President and the Vice President, at every opportunity, continued to urge Congress to pass a patients' bill of rights.
- *June 1998. In late June, eight months after the President called on Congress to pass a patients' bill of rights, the House Republicans finally issued a press release on principles for patient protections.*
- *July 1998. The Senate Republicans introduced a proposal that is more of an insurers' bill of rights than a patients' bill of rights.*
- *July 1998. The House Republicans pass their patients' bill of rights proposal that has more loopholes than patient protections.*
- *August 1998. Senate Republicans adjourn without taking up the patients' bill of rights.*

- **August 1998 - November 1998.** The President, Vice President, and First Lady all highlighted the need to pass a strong enforceable patients' bill of rights in their travels around the nation on behalf of Democratic candidates.
- **November 1998.** The Vice President delivers report to the President summarizing the status of the Federal governments efforts to implement the patients' bill of rights for the 85 million Americans in Federal health plans, including an Interim Final rule implementing these protections for Medicare beneficiaries, an NPRM implementing them for Medicaid beneficiaries, OPM's efforts to implement these protections for Federal employees.
- **November 1998 - January 1999.** The President and others in the Administration consistently stated publicly and in discussions with Democratic leaders that passing a strong patients' bill of rights will be one of the Administration's top priorities in the new Congress.
- *January 1999. The Republicans introduce patients' bill of rights that still leaves many holes with regard to patient protections.*
- **January 1999 -- State of the Union Address.** In his address, the President made clear again that passing a strong enforceable patients' bill of rights is one of his top priorities in the upcoming Congress.

PRESIDENT CLINTON RELEASES REPORT DOCUMENTING ACTIONS FEDERAL GOVERNMENT IS TAKING TO IMPLEMENT A PATIENTS' BILL OF RIGHTS AND URGES VOTERS TO SEND BACK A CONGRESS THAT SHARES HIS COMMITMENT TO PASS LEGISLATION TO ASSURE PROTECTIONS FOR ALL HEALTH PLANS

November 2, 1998

Today, President Clinton urged voters to send back a Congress that shares his commitment to passing a strong enforceable patients' bill of rights next year. The President also emphasized that while the Republican Leadership has stalled on the patients' bill of rights, the Administration has been doing everything possible to implement these protections in Federal health plans. To that end, he unveiled a report from the Vice President documenting action that the Federal government is taking within its authority to implement the patients' bill of rights in the health plans it administers or oversees. Today, the President:

Criticized Republican Leadership for allowing Congress to adjourn without passing a strong patients' bill of rights. For a full year, the President has been calling on the Congress to pass a strong enforceable patients' bill of rights. For months, the Republican Leadership used every possible stall tactic to thwart the patients' bill of rights. When the Republican Leadership finally did introduce a bill, their proposal contained more loopholes than patient protections. It did not contain critical protections such as access to specialists and offered false promises such as an appeals process that left the decisions in the hands of HMO accountants. In fact, Senator Lott would not even allow an up or down vote to be held on this issue.

Urged voters to choose a Congress committed to passing a meaningful patients' bill of rights. President Clinton committed to doing everything possible to pass a strong patients' bill of rights in the next Congress and urged Americans to go to the polls tomorrow to elect a Congress that shares this commitment. This legislation should include enforceable patient protections, such as access to specialists, coverage of emergency room services when and where the need arises, continuity of care protections, an internal and independent external appeals process to appeal decisions made by HMO accountants, and protections to assure that HMOs are held accountable when patients are harmed or injured due to a health plans' decisions.

Released report from the Vice President that highlighted that while the Republican Leadership delayed, the Administration is acting to implement patient protections in Federal health plans. In February, the President directed Medicare, Medicaid, the Federal Employee Health Benefits Program, the Department of Defense Military Health Program, and the Veteran's Health Program -- which serve over 85 million Americans -- to, where possible, come into compliance with the patients' bill of rights outlined by the President's Quality Commission. Today, the Vice President released a report highlighting that these agencies have taken all the action within their statutory authority to implement patient protections. As a result, the Federal health plans are now, or soon will be, in virtual compliance with the patients' bill of rights. The report documents that:

- **The 285 participating health plans, covering nine million Federal employees and their dependents, have been directed to implement new patient protections this year.** The Office of Personell Management (OPM), which oversees the Federal Health Employees Benefits Program (FEHBP) serving nine million Federal employees and dependents, has directed their 285 participating health plans to come into compliance with the patients' bill of rights. Through their annual call letter, OPM has specifically requested that plans implement new protections including access to specialists, continuity of care, disclosure of financial incentives, and access to emergency room services. Finally, OPM has issue new regulations to prevent "gag clauses." OPM is also sending information to beneficiaries to assure they are fully aware of their new patient protections.

- **The 39 million Medicare beneficiaries are benefitting from critical patient protections.** Building on Medicare's commitment to provide essential patient protections, HHS published an Interim Final rule, in June, that includes a series of new patient protections for Medicare beneficiaries. When this rule is fully implemented, Medicare will be virtually in compliance with the patients' bill of rights including new protections such as access to emergency services when and where the need arises, patient participation in treatment decisions, and access to specialists.
- **The 38 million Medicaid beneficiaries are being assured essential protections in the patients' bill of rights.** In September, the Health Care Financing Administration published a Notice of Proposed Rulemaking (NPRM) adding new patients protections for Medicaid beneficiaries, such as access to specialists and an expedited independent appeals process to bring the program in compliance with the patients' bill of rights, where possible.
- **Over eight million Americans will receive the protections in the patients' bill of rights by the end of this year as a result of the new policy directive assured by the Defense Department's Military Health System (MHS).** In response to the President's directive, DoD issued "The Patients' Bill of Rights and Responsibilities in the Military Health System," a major policy directive to all participants in the MHS. This directive outlined new protections for the over 8 million beneficiaries served by MHS, including access to appropriate specialists for women's health needs and chronic illnesses and rights for the full discussion of treatment options and of financial incentives. With this directive, which will be fully implemented by the end of this year, DoD will now be in compliance with the patients' bill of rights .
- **Over three million veterans are or will soon be assured virtually all patient protections.** In July, the Department of Veteran Affairs (DVA) issued an Information Memorandum to participating health providers announcing its intention to have an external appeals process in place by the end of the year. Similarly, DVA established a task force to make recommendations as to how best implement information disclosure requirements consistent with Commission's recommendations and has developed a new brochure to provide beneficiaries the necessary information. With the implementation of these new protections DVA is in virtual compliance with the patients' bill of rights
- **The 125 million Americans covered by ERISA still are not assured critical patient protections because the Department of Labor does not have the authority to implement them without legislation.** DoL oversees the Employee Retirement Income Security Act (ERISA), governing approximately 2.5 million private sector health plans, that cover about 125 million Americans, issued a new regulation to implement an expedited internal appeals process and information disclosure requirements. However, DoL's report underscores that unless Congress passes Federal legislation, they do not have the authority to implement most patient protections.

Outstanding Issues on the Patients' Bill of Rights

- **Enforcement -- Liability.** Possible acceptable compromises on where bills are still not determined.
- **Legislation with Strong Enforceable Patient Protections.** There are a number of patient protections still missing in the new Republican bills. For example, the House bill still is missing critical patient protections such as:
 - Still leaves out the ten million Americans in the individual insurance market;
 - Still no direct access to specialists;
 - Still no access to out-of-network providers if plan does not have an adequate provider for covered service;
 - Still no continuity of care protections important for cancer patients and people with disabilities;
 - Still moves backwards in privacy legislation -- as it appears to override many state privacy laws without putting adequate protections in their place;
 - Still insufficient external appeals -- appealing still requires a fee, and other loopholes that prevent fair and expedited process;
 - Still insufficient enforcement provision with per day penalties that do not assure those who have been injured as a result of a health plans' actions will be compensated.
- **Cost --** offsets to pay for the costs of the patients' bill of rights are still to be determined.

AMERICANS DESERVE A REAL PATIENTS' BILL OF RIGHTS

PATIENT PROTECTION	GINGRICH/LOTT REPUBLICAN PLAN	PRESIDENT CLINTON/ BIPARTISAN PROPOSAL
PROTECTING MEDICAL PRIVACY LAWS	NO	YES
GUARANTEEING DIRECT ACCESS TO SPECIALISTS	NO	YES
ASSURING BEA COUNTERS DON'T MAKE ARBITRARY MEDICAL DECISIONS	NO	YES
PROVIDING REAL EMERGENCY ROOM PROTECTIONS	NO	YES
HOLDING HEALTH PLANS ACCOUNTABLE FOR HARMING PATIENTS	NO	YES
PROTECTING PATIENTS FROM SECRET FINANCIAL INCENTIVES	NO	YES
KEEPING YOUR DOCTOR THROUGH CRITICAL TREATMENTS	NO	YES
COVERING ALL HEALTH PLANS	NO	YES

*As Drafted in the House Republican Plan

PATIENTS' BILL OF RIGHTS

A strong enforceable patients' bill of rights includes some of the following critical protections:

- **Access to specialists**, assuring consumers with complex or serious medical conditions direct access to the specialists they need and assuring an adequate number of direct access visits, as necessary.
- **Access to specialists for women's health needs**, giving women access to qualified providers, including gynecologists, certified nurse midwife and other providers, to provide routine and preventative women's health care services.
- **Access to continuity of care**. Providing continuity of care for consumers who are undergoing a course of treatment for a chronic or disabling condition. For example, this would assure that patients do not have their treatment abruptly altered, in the middle of cancer therapy or a pregnancy, just because their employer changes health plans.
- **Access to emergency services when and where the need arises**. This requires health plans to cover emergency services in situations where a "prudent layperson" could reasonably expect that the absence of care could place their health in serious jeopardy.
- **Requiring disclosure of financial incentives**. This provision requires providers to disclose any incentives, financial or otherwise -- that might influence their decisions affecting patient care.
- **Access to accurate, easily understood information** about consumers' health plans, facilities and professionals to help them make informed health care decisions. This would include information, such as the accreditation status of the health care facilities and health plans and consumer satisfaction with health care professionals.
- **Prohibiting "gag clauses"** which restrict health care providers' ability to communicate with and advise patients about medically necessary options. This provision ensures consumers' right and ability to participate fully in decisions essential to their health care.
- **Internal and independent external grievance and appeals processes** for consumers to resolve their differences with their health plans. This includes expedited timely appeals when necessary.
- **Enforcement to make these rights real**, by requiring health plans to be held accountable when consumers' suffer serious injury or death because of wrongful action committed by the health plans.
- **Cover all health plans**. These protections should be extend to all health plans rather than leaving the tens of millions of Americans, including millions of Americans in small businesses, that are left vulnerable by the Republican Leadership bills.



July 23, 1998
(House)

STATEMENT OF ADMINISTRATION POLICY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Pay-As-You-Go Scoring

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

* * * * *

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

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

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

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

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

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

189 Democratic Supporters Returning

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

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

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

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

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

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

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

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

Summary Of Other Possible Votes:

Narrowly Re-Elected Incumbent Republicans Who Faced Patients' Rights Issue: **5**

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

Newly Elected Republicans Who Campaigned On Patients' Rights: **3**

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

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

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

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

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

2. **Hostettler: Opponent Ran TV Ads And Made Patients' Rights The "Key Issue":**

"Gail Riecken, the Democrat trying to unseat Rep. John Hostettler in southwestern Indiana's 8th District congressional race, has tried to make HMOs a key issue."

[Associated Press, 10/19/98 (emphasis added)]

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

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

3. **Northrup: Opponent Made HMO Reform "No. 1 Issue."** According to the National

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

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

4. **Rogan: Said It Was "Essential" To Pass A Patients' Bill Of Rights.** When asked by

the Los Angeles Times, "If you go to Washington, what kind of agenda will you pursue?"

Rogan responded *"I would want to work to pass an HMO patients' 'bill of rights.' I think it's essential."* [Los Angeles Times, 11/1/98 (emphasis added)]

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

5. **Wilson: Opponent Made Patients' Rights A Key Issue.** According to CongressDaily,

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

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

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

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

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

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

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

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

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

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

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

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

Overview

Defeated

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

Democrats who voted "Yea" (201)

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

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

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

(10)

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

Independent who voted "Yea"
(1)

Sanders (VT)

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

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

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

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

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

DATE: 3-23-99



**U.S. DEPARTMENT OF
HEALTH & HUMAN SERVICES**

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[] EDWARD WHITLEY
[] FRANKIE MELTON

REMARKS:

Immediate Attention

Initial Consultations RE: Medicare

Leadership

Gephardt -

Daschle -

House Medicare Task Force

(Senate Leadership Group - none yet. Do we want to suggest Daschle set one up?)

Committees

House Ways and Means -

House Commerce -

Senate Finance -

Caucuses/Groups

Congressional Black Caucus -

Congressional Hispanic Caucus -

House Budget Task Force -

Blue Dogs -

New Democrats -

Chafee/Lieberman Group (staff) -

Individual Members

* Moynihan
Breaux
* Rockefeller
* Conrad
* Graham
* Bryan

Robb
Kerrey
Lieberman
Kennedy
Lautenberg
Chafee
Grassley
Hatch
Jeffords
Snowe
Collins

* Dingell
* Rangel
* Stark
* Cardin
* McDermott
Kleczka
Tanner
Thurman
Waxman
Brown
Spratt
Johnson (CT)
Houghton
Bilirakis
Upton
Greenwood
Ganske
Lazio

Note: Given the upcoming recess, we should try to meet this week with members of the leadership and committees, if possible. While we don't need to meet individually with all of the members listed in the last category, we should do as many as possible after the recess.

DATE: 3-23-99



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* Rockefeller	* Stark
* Conrad	* Cardin
* Graham	* McDermott
* Bryan	Kleczka
Robb	Tanner
Kerrey	Thurman
Lieberman	Waxman
Kennedy	Brown
Lautenberg	Spratt
Chafee	Johnson (CT)
Grassley	Houghton
Hatch	Bilirakis
Jeffords	Upton
Snowe	Greenwood
Collins	Ganske
	Lazio

Note: Given the upcoming recess, we should try to meet this week with members of the leadership and committees, if possible. While we don't need to meet individually with all of the members listed in the last category, we should do as many as possible after the recess.



Facsimile

To: Jeanne / Chris

Fax: 456-5557

Phone: _____

From: Bonnie Hope per Cybele

Phone: (202) 224-3232 Fax: (202) 228-3432

Notes: Medicare amendments

NOTE: I'm not positive this is
final language.

of pages including cover: _____

Date: _____

AMENDMENT NO. _____

Calendar No. _____

Purpose: To ensure that Congress saves Social Security and strengthens Medicare before using projected budget surpluses for new spending or tax breaks.

IN THE SENATE OF THE UNITED STATES—106th Cong., 1st Sess.

S. CON. RES. 20

Setting forth the congressional budget for the United States Government for fiscal years 2000 through 2009.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by _____

Viz:

1 At the appropriate place, add the following new sec-
2 tion:

3 SEC. _____. SAVING SOCIAL SECURITY AND MEDICARE FIRST.

4 It shall not be in order in the Senate to consider—

5 (1) a reconciliation bill that would reduce reve-
6 nues without offsetting them in accordance with the
7 Congressional Budget Act of 1974 until Congress
8 first enacts legislation that—

9 (A) ensures the long-term fiscal solvency of
10 the Social Security Trust Funds and extends

1 the solvency of the Medicare Hospital Insurance
2 Trust Fund by at least 12 years; and

3 (B) includes a certification that the legisla-
4 tion complies with subparagraph (A); or

5 (2) any bill, resolution, motion, amendment, or
6 conference report that would increase spending
7 above the levels provided in this resolution, unless
8 such spending increases are offset in accordance
9 with the Congressional Budget Act of 1974 until
10 Congress first enacts legislation that—

11 (A) ensures the long-term fiscal solvency of
12 the Social Security Trust Funds and extends
13 the solvency of the Medicare Hospital Insurance
14 Trust Fund by at least 12 years; and

15 (B) includes a certification that the legisla-
16 tion complies with subparagraph (A).

DRAFT

AMENDMENT NO. _____

Calendar No. _____

Purpose: To use any Federal budget surplus to save Social Security and Medicare first.

IN THE SENATE OF THE UNITED STATES—106th Cong., 1st Sess.

S. CON. RES. 20

Setting forth the congressional budget for the United States Government for fiscal years 2000 through 2009.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENTS intended to be proposed by Mr. CONRAD

Viz:

1 After section 206, insert the following:

2 SEC. ____ . SAVE SOCIAL SECURITY AND MEDICARE FIRST

3 LOCKBOX.

4 (a) DEFINITION.—In this section, the term “Social
5 Security and Medicare lockbox” means with respect to any
6 fiscal year, the Social Security surplus (as described in
7 section 311(b)(1) of the Congressional Budget Act of
8 1974), and the Medicare surplus reserve, which shall con-
9 sist of amounts allocated to save the Medicare program
10 as provided in subsection (b).

11 (b) MEDICARE SURPLUS RESERVE.—

(1) IN GENERAL.—Subject to adjustment pursuant to paragraph (2), the amounts reserved for the Medicare surplus reserve in each year are—

(A) for fiscal year 2000, \$0;

(B) for fiscal year 2001, \$3,000,000,000;

(C) for fiscal year 2002, \$26,000,000,000;

(D) for fiscal year 2003, \$15,000,000,000;

(E) for fiscal year 2004, \$21,000,000,000;

(F) for fiscal year 2005, \$35,000,000,000;

(G) for fiscal year 2006, \$63,000,000,000;

(H) for fiscal year 2007, \$68,000,000,000;

(I) for fiscal year 2008, \$72,000,000,000;

(J) for fiscal year 2009, \$73,000,000,000;

(K) for fiscal year 2010, \$70,000,000,000;

(L) for fiscal year 2011, \$73,000,000,000;

(M) for fiscal year 2012, \$70,000,000,000;

(N) for fiscal year 2013, \$66,000,000,000;

and

(O) for fiscal year 2014, \$52,000,000,000.

(2) ADJUSTMENT.—

(A) IN GENERAL.—The amounts in paragraph (1) for each fiscal year shall be adjusted each year in the budget resolution by a fixed percentage equal to the adjustment required to those amounts sufficient to extend the solvency

1 of the Federal Hospital Insurance Trust Fund
2 based on the most recent Report of the Board
3 of Trustees of the Federal Hospital Insurance
4 Trust Fund (intermediate assumptions)
5 through fiscal year 2020 or 12 years after the
6 date of insolvency specified in the 1999 Report,
7 whichever date is later.

8 (B) LIMIT BASED ON TOTAL SURPLUS.—

9 The Medicare surplus reserve, as adjusted by
10 subparagraph (A), shall not exceed the total
11 budget resolution baseline surplus in any fiscal
12 year.

13 (c) MEDICARE SURPLUS RESERVE POINT OF

14 ORDER.—It shall not be in order in the Senate to consider
15 any concurrent resolution on the budget (or amendment,
16 motion, or conference report on the resolution) that would
17 decrease the surplus in any of the fiscal years covered by
18 the concurrent resolution below the levels of the Medicare
19 surplus reserve for those fiscal years calculated in accord-
20 ance with subsection (b)(1).

21 (d) ENFORCEMENT OF MEDICARE SURPLUS.—After

22 a concurrent resolution on the budget is agreed to, it shall
23 not be in order in the Senate to consider any bill, joint
24 resolution, amendment, motion, or conference report that
25 would cause a decrease in the Medicare surplus reserve

1 in any of the fiscal years covered by the concurrent resolu-
2 tion.

3 (e) SOCIAL SECURITY OFF-BUDGET POINT OF
4 ORDER.—It shall not be in order in the Senate to consider
5 a concurrent resolution on the budget, an amendment
6 thereto, or a conference report thereon that violates sec-
7 tion 13301 of the Omnibus Budget Reconciliation Act of
8 1990.

9 (f) SUPERMAJORITY WAIVER.—

10 (1) WAIVER.—A bill, resolution, amendment,
11 motion, or conference report violating this section
12 shall be subject to a point of order that may be
13 waived or suspended only by the affirmative vote of
14 three-fifths of the Members, duly chosen and sworn.

15 (2) APPEALS.—An affirmative vote of three-
16 fifths of the Members, duly chosen and sworn, shall
17 be required to sustain an appeal of the ruling of the
18 Chair on a point of order raised under paragraph
19 (1).

20 On page 42, strike section 204.

21 At the end of section 101, insert the following:

(7) MEDICARE SURPLUS RESERVE.—The amounts of the surplus that shall be reserved for Medicare are as follows:

(A) Fiscal year 2000: \$0;

(B) Fiscal year 2001: \$3,000,000,000;

(C) Fiscal year 2002: \$26,000,000,000;

(D) Fiscal year 2003: \$15,000,000,000;

(E) Fiscal year 2004: \$21,000,000,000;

(F) Fiscal year 2005: \$35,000,000,000;

(G) Fiscal year 2006: \$63,000,000,000;

(H) Fiscal year 2007: \$68,000,000,000;

(I) Fiscal year 2008: \$72,000,000,000;

and

(J) Fiscal year 2009: \$73,000,000,000.

Increase the levels of Federal revenues in section 101(1)(A) by the following amounts:

(1) Fiscal year 2000: \$0;

(2) Fiscal year 2001: \$3,000,000,000;

(3) Fiscal year 2002: \$25,000,000,000;

(4) Fiscal year 2003: \$13,000,000,000;

(5) Fiscal year 2004: \$18,000,000,000;

(6) Fiscal year 2005: \$31,000,000,000;

(7) Fiscal year 2006: \$57,000,000,000;

(8) Fiscal year 2007: \$58,000,000,000;

1 (9) Fiscal year 2008: \$59,000,000,000; and

2 (10) Fiscal year 2009: \$56,000,000,000.

3 Change the levels of Federal revenues in section
4 101(1)(B) by the following amounts:

5 (1) Fiscal year 2000: \$0;

6 (2) Fiscal year 2001: \$3,000,000,000;

7 (3) Fiscal year 2002: \$25,000,000,000;

8 (4) Fiscal year 2003: \$13,000,000,000;

9 (5) Fiscal year 2004: \$18,000,000,000;

10 (6) Fiscal year 2005: \$31,000,000,000;

11 (7) Fiscal year 2006: \$57,000,000,000;

12 (8) Fiscal year 2007: \$58,000,000,000;

13 (9) Fiscal year 2008: \$59,000,000,000; and

14 (10) Fiscal year 2009: \$56,000,000,000.

15 Reduce the levels of total budget authority and out-
16 lays in section 101(2) and section 101(3) by the following
17 amounts:

18 (1) Fiscal year 2000: \$0;

19 (2) Fiscal year 2001: \$0;

20 (3) Fiscal year 2002: \$1,000,000,000;

21 (4) Fiscal year 2003: \$2,000,000,000;

22 (5) Fiscal year 2004: \$3,000,000,000;

23 (6) Fiscal year 2005: \$4,000,000,000;

- 1 (7) Fiscal year 2006: \$6,000,000,000;
- 2 (8) Fiscal year 2007: \$10,000,000,000;
- 3 (9) Fiscal year 2008: \$13,000,000,000; and
- 4 (10) Fiscal year 2009: \$17,000,000,000.

5 Increase the levels of surplus in section 101(4) by the
6 following amounts:

- 7 (1) Fiscal year 2000: \$0;
- 8 (2) Fiscal year 2001: \$3,000,000,000;
- 9 (3) Fiscal year 2002: \$26,000,000,000;
- 10 (4) Fiscal year 2003: \$15,000,000,000;
- 11 (5) Fiscal year 2004: \$21,000,000,000;
- 12 (6) Fiscal year 2005: \$35,000,000,000;
- 13 (7) Fiscal year 2006: \$63,000,000,000;
- 14 (8) Fiscal year 2007: \$68,000,000,000;
- 15 (9) Fiscal year 2008: \$72,000,000,000; and
- 16 (10) Fiscal year 2009: \$73,000,000,000.

17 Decrease the levels of public debt in section 101(5)
18 by the following amounts:

- 19 (1) Fiscal year 2000: \$0;
- 20 (2) Fiscal year 2001: \$3,000,000,000;
- 21 (3) Fiscal year 2002: \$26,000,000,000;
- 22 (4) Fiscal year 2003: \$15,000,000,000;
- 23 (5) Fiscal year 2004: \$21,000,000,000;

- 1 (6) Fiscal year 2005: \$35,000,000,000;
- 2 (7) Fiscal year 2006: \$63,000,000,000;
- 3 (8) Fiscal year 2007: \$68,000,000,000;
- 4 (9) Fiscal year 2008: \$72,000,000,000; and
- 5 (10) Fiscal year 2009: \$73,000,000,000.

6 Decrease the levels of debt held by the public in sec-
7 tion 101(6) by the following amounts:

- 8 (1) Fiscal year 2000: \$0;
- 9 (2) Fiscal year 2001: \$3,000,000,000;
- 10 (3) Fiscal year 2002: \$26,000,000,000;
- 11 (4) Fiscal year 2003: \$15,000,000,000;
- 12 (5) Fiscal year 2004: \$21,000,000,000;
- 13 (6) Fiscal year 2005: \$35,000,000,000;
- 14 (7) Fiscal year 2006: \$63,000,000,000;
- 15 (8) Fiscal year 2007: \$68,000,000,000;
- 16 (9) Fiscal year 2008: \$72,000,000,000; and
- 17 (10) Fiscal year 2009: \$73,000,000,000.

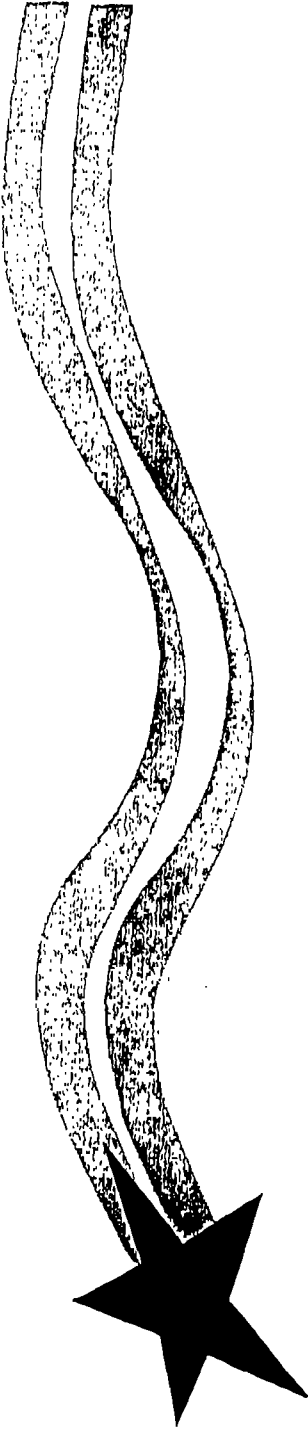
18 Reduce the levels of budget authority and outlays in
19 section 103(18) for function 900, Net Interest, by the fol-
20 lowing amounts:

- 21 (1) Fiscal year 2000: \$0;
- 22 (2) Fiscal year 2001: \$0;
- 23 (3) Fiscal year 2002: \$1,000,000,000;

- 1 (4) Fiscal year 2003: \$2,000,000,000;
- 2 (5) Fiscal year 2004: \$3,000,000,000;
- 3 (6) Fiscal year 2005: \$4,000,000,000;
- 4 (7) Fiscal year 2006: \$6,000,000,000;
- 5 (8) Fiscal year 2007: \$10,000,000,000;
- 6 (9) Fiscal year 2008: \$13,000,000,000; and
- 7 (10) Fiscal year 2009: \$17,000,000,000.

8 Reduce the levels in section 104(1) by which the Sen-
9 ate Committee on Finance is instructed to reduce revenues
10 by the following amounts:

- 11 (1) \$0 in fiscal year 2000;
- 12 (2) \$59,000,000,000 for the period of fiscal
13 years 2000 through 2004; and
- 14 (3) \$320,000,000,000 for the period of fiscal
15 years 2000 through 2009.



Democrats Create a Lockbox for Both Social Security and Medicare

The Republican Budget Resolution does not contain a lockbox for Social Security or Medicare. During the debate on the Budget Resolution, Democrats will offer an amendment to protect Social Security and Medicare.

The **Conrad** lockbox amendment would create a super majority point of order against a Budget Resolution that does not save approximately 40 percent of the on-budget surplus for Medicare over the next 15 years. The amendment also would add a new super majority point of order against a Budget Resolution that violates the off-budget treatment of Social Security. The *Budget Act* already contains super majority points of order against a Budget Resolution or any legislation that reduces the Social Security surplus.

The lockbox amendment does not transfer the surplus to the Medicare HI trust fund, because that cannot be done in the context of the Budget Resolution. The amendment reserves the surplus for Medicare. Any transfer could be accomplished in the context of legislation to modernize and strengthen the Medicare program.

The **Conrad** lockbox amendment reserves 100 percent of the Social Security surplus and 15 percent of the unified surplus for Medicare over the next 15 years. The lockbox amendment:

- saves 100 percent of the Social Security surplus in each and every year, and approximately 40 percent of the on-budget surplus for Medicare;
- saves 15 percent of the unified surplus for Medicare, amounts sufficient to extend the Medicare HI trust fund for 12 extra years;
- reduces publicly held debt by \$300 billion more than the Republican plan over ten years;
- includes a procedure to adjust the Medicare reserve to make certain it is sufficient to extend trust fund solvency through 2020 or for 12 years;

Democratic Policy Committee
United States Senate
Washington, D.C. 20510-7050

Tom Daschle, Chairman
Byron Dorgan, Co-Chairman

- restores the current pay-as-you-go point of order, which makes certain that no on-budget surplus can be used; and
- relies on current discretionary limits and pay-go procedures to preserve the surplus for Social Security and Medicare.

The Republican budget offers no new protection for Social Security and does nothing for Medicare. The Republicans have asserted that their budget reserves a portion of the surplus to pay for Medicare reform and to pay for unexpected emergencies. In fact, the Republican budget saves nothing for Medicare, does nothing to extend solvency, and adds no new protections for Social Security.

The Republicans do nothing to extend solvency. The Republican budget cuts taxes by nearly \$800 billion, but does not reserve a penny to modernize or strengthen Medicare. The number of Medicare beneficiaries will grow from 39 million today to 78 million in 2032. This growth will require new financing for Medicare along with efforts to modernize and strengthen the program.

No surplus saved for Medicare in the Republican plan. The Republican budget uses all but \$100 billion of the surplus over ten years for tax cuts and designates this unused surplus for a number of uses. The Democratic plan reserves \$376 billion for Medicare over the same time period, approximately 15 percent of the unified surplus.

Emergencies would consume the unused surplus. There is nothing to preclude the Congress from spending the entire amount of the Republican contingency reserve on emergency legislation. In fact, over the past nine years, emergency appropriations have averaged \$9 billion per year. Over ten years, emergencies plus associated interest costs would consume \$116 billion, more than 100 percent of the unused surplus in the Republican plan.

Republicans do not create a Medicare lockbox. The Republican Budget Resolution contains no procedure to reserve the surplus for Medicare. Republicans argue that to save Medicare we need to cut benefits rather than rely upon on-budget surpluses. The fact is that Republicans want to cut Medicare to leave more room for Republican tax cuts. Without a change in law, the Republican tax cuts will result in a pay-as-you-go sequester, which will come largely from Medicare.

The Republican “reserve” for prescription drugs is a false promise. The Republican budget includes a reserve fund that they claim will fund a prescription drug benefit. However, this reserve can be triggered only in conjunction with a bill that extends the life of the Medicare trust fund significantly, described in the committee report as 9-12 years, without using any general fund transfers and without relying on any revenue offsets (e.g., a tobacco-related excise tax). That means the drug benefit would be held hostage to a bill that cuts Medicare Part A spending on hospitals, home health agencies, skilled nursing facilities and hospice care by \$350 billion over the next ten years.



Democrats Save Social Security and Medicare First

The Republican Budget Resolution spends the surplus on tax cuts and does not protect Social Security and Medicare first. The **Lautenberg** amendment would make it out of order for the Senate to consider any tax cuts or new spending that is not offset until after legislation is enacted to extend the solvency of the Social Security and Medicare trust funds.

Republican budget does nothing for solvency. The Republican budget does not extend the solvency of either Social Security or Medicare by a single day. The Medicare trust fund is expected to become insolvent within a decade and the Social Security trust fund is expected to go bankrupt in 2032. Republicans provide tax cuts to the wealthiest of Americans instead of using the projected surpluses to extend the life of these programs and to allow for responsible changes. Democrats believe Americans who rely on Social Security and Medicare should be our first priority.

Democrats save the surplus for Social Security and Medicare first. Democrats are committed to Social Security and Medicare, and will continue to honor this commitment to ensure the viability of these programs for older Americans. Democrats believe that Social Security and Medicare should be secure before the surplus is used for other purposes such as tax cuts for wealthy Americans.

The need to preserve Social Security and Medicare is real. Social Security has made retirement possible for tens of millions of Americans. Without Social Security, 16 million more Americans would live in poverty. Social Security is the principal source of income for two-thirds of older Americans and Social Security is the only source of income for nearly one-fifth of our seniors. By 2032, the entire baby boom generation will be eligible for Social Security. However, in that year, Social Security revenues only would be sufficient to finance approximately three-fourths of promised Social Security benefits.

The Medicare program currently provides health care to 39 million Americans. By 2032, the number of Medicare beneficiaries will double to 78 million as the baby boom retires. With the increase in the number of Medicare beneficiaries, the strain on Medicare will become even greater. Using the surplus to bolster the trust fund is a necessary part of making responsible structural changes to the Medicare program. Investing now will prevent larger problems later as the baby boomers join the Medicare rolls.

Democratic Policy Committee
United States Senate
Washington, D.C. 20510-7050

Tom Daschle, Chairman
Byron Dorgan, Co-Chairman

Democrats support tax relief. Democrats support tax relief for working families. Democrats believe our first priority should be Medicare and Social Security. Once we have acted to save Social Security and Medicare, any remaining surpluses would be available for tax cuts and other priorities. Tax relief before these goals have been achieved remains possible under this amendment, as long as it is offset.

Republican tax breaks are back loaded. In 2001, the net tax cut in the Republican budget is only \$7 billion. Over the next eight years, however, the tax breaks grow substantially until they reach a ten-year total of \$778 billion. Over 15 years, these tax breaks could reach \$1.25 trillion. The back loaded nature of the tax cuts means that in the future there will be even fewer resources available to address the long-term needs of Social Security and Medicare.



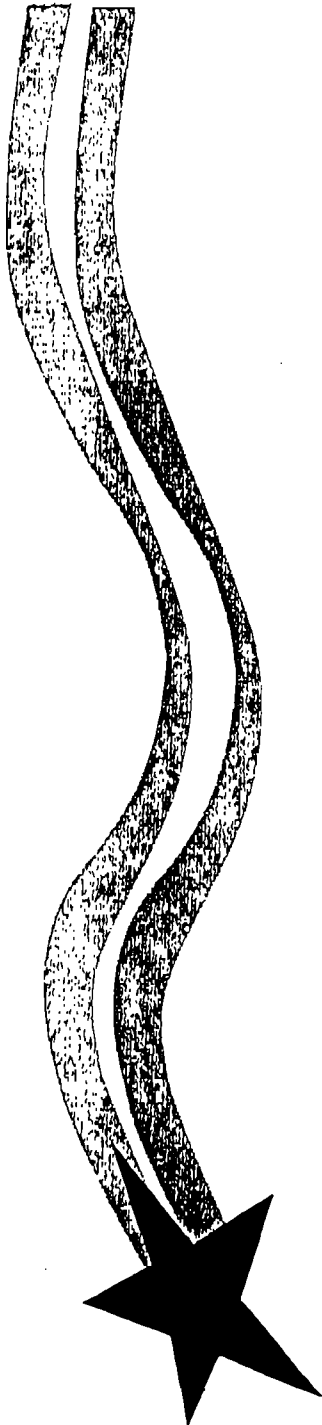
DEMOCRATIC POLICY COMMITTEE

TALKING POINTS

TP-12-Budget/Health (revised)

Staff Contact: Bonnie Hogue (202) 224-3232

March 24, 1999



Democrats Support Saving the Surplus for Medicare

The Republican Budget Resolution invests nothing in Medicare and makes tax cuts a priority over strengthening the Medicare program.

The **Kennedy** amendment to the Republican Budget Resolution would reduce the tax breaks provided to the wealthiest taxpayers under the Republican budget and reserve the savings for Medicare. Democrats believe that Medicare should be secure before the surplus is used for other purposes, such as tax cuts for wealthy Americans.

Democrats will continue to honor our commitment to provide high-quality health care to older Americans. The Republican budget invests nothing in Medicare, ignoring the fact that under current law, the Medicare Part A Trust Fund is projected to become insolvent by 2008.

Medicare is a Democratic priority. This amendment saves 15 percent of the unified surplus—about \$376 billion—for Medicare over the next ten years. By locking up a portion of the surplus for Medicare, Democrats ensure that there will be sufficient resources to reform and strengthen the Medicare program.

The aging of the baby boomers creates challenges for Medicare. Today, the Medicare program provides health care to 39 million Americans. By 2032, the number of Medicare beneficiaries will double to 78 million as the baby boom retires. With this increase, the strain on Medicare will become even greater. Investing now will prevent larger problems down the road, including large benefit cuts and tax increases, as the baby boomers join the Medicare rolls.

The Republican budget leaves no room for Medicare. The Republican budget does nothing for the Medicare program, and would allow the program to go bankrupt within the next decade. By not ensuring new revenues for Medicare, Republicans are leaving themselves with few alternatives: eliminating or limiting benefits; increasing Medicare beneficiaries' out-of-pocket costs; cutting payments to hospitals and doctors; or raising the payroll tax.

Saving the surplus for Medicare is the first step. Democrats support saving the surplus for Medicare because they know that investing surplus funds in the program is the first step toward Medicare reform. The Budget Resolution is not a law and cannot transfer surpluses directly into the Medicare HI trust fund. However, the Budget Resolution should be the first step by ensuring that 15 percent of the surplus is reserved for Medicare and not tax cuts. Modern-

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United States Senate
Washington, D.C. 20510-7050

Tom Daschle, Chairman
Byron Dorgan, Co-Chairman

izing and strengthening Medicare will be a difficult but necessary process. Setting aside these funds for Medicare is a critical part of that effort. Structural reform, taken alone without additional revenues, cannot compensate for the vast increase in the number of Medicare beneficiaries.

Once again, Republicans choose tax cuts over Medicare. The Republican budget uses all but \$100 billion of the surplus over ten years for tax cuts. This unused surplus is set aside for emergencies, other contingencies, and health care reform. This plan is hardly comparable to the President's plan to transfer \$707 billion over the next 15 years to the Medicare program. There is nothing to preclude the Congress from spending the entire amount of the Republican contingency reserve on emergency legislation. Over the past nine years, emergency appropriations have averaged \$9 billion per year. Over ten years, emergencies plus associated interest costs would consume \$116 billion, more than 100 percent of the unused surplus in the Republican plan.

The Republican "reserve" for prescription drugs is a false promise. The Republican budget includes a reserve fund that they claim will fund a prescription drug benefit. However, this reserve can be triggered only in conjunction with a bill that extends the life of the Medicare HI trust fund significantly (described as 9-12 years) without using any general fund transfers and without relying on any revenue offsets (e.g., a tobacco-related excise tax). That means the drug benefit would be held hostage to a bill that cuts Medicare Part A spending on hospitals, home health agencies, skilled nursing facilities and hospice care by approximately \$350 billion over the next ten years.



Cybele Bjorklund @ labor.senate.gov (Cybele Bjorklund)
03/24/99 12:09:09 AM

Record Type: Record

To: See the distribution list at the bottom of this message
cc: Jeanne Lambrew/OPD/EOP
Subject: 3 Medicare amendments -- and how they differ

FYI--THIS MAY BE HELPFUL IN QUICKLY DISTINGUISHING AMONG THE THREE BIG
MEDICARE AMENDMENTS TOMORROW.

[JEANNE--CAN YOU SHARE WITH CHRIS, PLEASE? I DON'T HAVE EMAIL FOR HIM, AND I
THINK HE WANTED SOMETHING LIKE THIS. THANKS!]

Forward Header

Subject: 3 Medicare amendments -- and how they differ
Author: Sue Nelson at Budget
Date: 3/23/99 11:40 PM

Guys,

Cybele asked me to write something for press folks that distinguishes
our 3 Medicare amendments. Please feel free to use/edit/ these
descriptions.

...

Democrats will offer three distinct Medicare amendments tomorrow that
underscore the fundamental differences between the Democratic and
Republican approaches for allocating the budget surplus. The
amendments highlight the central defect in the Republican budget -- it
spends nearly every penny of the surplus on tax breaks and reserves
nothing for Medicare.

The first amendment, offered by Senator Lautenberg, requires the
Congress to put thier fiscal house in order before they enact tax
breaks or create new spending programs. The Democratic priority is to
put Social Security and Medicare reform first, before tax cuts or new
spending. The Republican budget calls for tax cuts first... and tax
cuts only. Even the extra surplus anticipated in July is pre-reserved
for tax cuts.

The second amendment, offered by Senator Kennedy, modifies the
Republican budget by skimming off less than half of the proposed tax
cut (the portion going to taxpayers who make more than \$200,000 a
year) and reserving these amounts for comprehensive Medicare reform
and debt reduction. The Republican budget earmarks nothing for
Medicare and contains tax cuts that will explode just when the baby
boom retirement reaches its peak. This amendment reserves
approximately 40 percent of the on-budget surplus for Medicare (WHICH
EQUALS 15 PERCENT OF THE UNIFIED SURPLUS). These amounts can be used
to strengthen the program in the context of comprehensive reform, for
a prescription drug benefit, or to simply allow reform to proceed at a
more measured, gradual pace.

The third amendment, offered by Senator Conrad, take the final step by establishing a set of procedures that actually lock away the Medicare and Social Security surpluses in the Senate, with supermajority points of order. The Republicans failed to offer a lockbox either in Committee or on the floor. When and if they do, it will apply to Social Security only, and will rely on a debt crisis, rather than on our existing enforcement mechanisms, to save Social Security. The Democratic lockbox is a more responsible approach, reduces public debt by more than \$300 billion more than the Republicans, and relies on responsible leadership rather than government shutdowns to preserve and protect Social Security and Medicare.

Message Sent To:

David_Nexon @ labor.senate.gov (David Nexon)
Michael_Myers @ labor.senate.gov (Michael Myers)
Jim_Manley @ kennedy.senate.gov (Jim Manley)
WILLIAM_KEYSER @ kennedy.senate.gov (WILLIAM KEYSER)
Beth_Haugland @ kennedy.senate.gov (Beth Haugland)
Carrie_Coberly @ labor.senate.gov (Carrie Coberly)

House Panel Kicks Off Debate On Managed Care Reform

HEALTH

A KEY House Commerce subcommittee Wednesday kicked off a series of hearings on the politically potent managed care issue amid accusations from those with competing bills that the panel is trying to stall rather than move a managed care measure.

That the subcommittee would begin its deliberations in disagreement is no surprise. The panel's membership includes the sponsors of the four major managed care bills in the House.

Commerce Health and Environment Subcommittee Chairman Michael Bilirakis, R-Fla., is the sponsor of the GOP leadership-backed Patient Protection Act, while **Commerce ranking member John Dingell**, D-Mich., authored the Democrats' Patients' Bill of Rights.

Also members of the subcommittee are two renegade Republican healthcare professionals: **Rep. Charles Norwood** of Georgia, a dentist who shelved his popular Patient Access to Responsible Care Act in 1998 to work with Republican leaders — but this year has introduced the Access to Quality Care Act; and **Rep. Greg Ganske** of Iowa, a plastic surgeon who worked with Democrats last year, but who this year has drafted his own Managed Care Reform Act.

In his opening statement, Bilirakis said the hearing was "the first in a series of bipartisan, informational subcommittee hearings on managed care and the problem of the uninsured in this country."

Bilirakis added that future hearings will be held outside Washington "so we can gain a better perspective on the every day problems facing those who live outside the Beltway."

But Democrats, who complained in 1998 that GOP leaders sent their bill directly to the floor without committee consideration, Wednesday complained that the process already was taking too long.

"Years have passed, and we all know what the problems are because every one of us hears it from our constituents every day," said **Rep. Ted**

Strickland, D-Ohio. The real problem, Strickland said, is that "we have been too timid to do anything about it."

Rep. Frank Pallone, D-N.J., complained that the focus of the first hearing — access to emergency room care, to specialists, and to comparative information about health plans — are issues on which everyone already agrees.

Pallone said the subcommittee should instead be focusing on the issues of whether patients should be able to sue health plans for damages and whether physicians or health plans should determine whether care is medically necessary.

"These are the issues that there is no agreement on and really cut to the core of the managed care debate," he said.

Ganske, who has been pushing various managed care bills since 1996, compared the building pressure for action on the managed care issue to "water building up behind the dam."

He also said that the committee should set a timetable for action, contending, "We ought to have as a goal moving this to the floor under an open rule by July 1."

One time-honored way to bridge differences within the House is to complain about the Senate, which was the tack Norwood took.

"Last week's markup of a rotten bill in the Senate HELP Committee was disgraceful," said Norwood, referring to the party-line approval of the GOP-sponsored leadership bill by the Health, Education, Labor and Pensions Committee last Thursday.

"Apparently our colleagues in the Senate decided last week we are a nation of 48 million people," Norwood said of the bill that extends its patient protections only to those in "self-insured" plans exempt from state regulation.

"Perhaps the next census will set them straight," Norwood giped.

— BY JULIE ROVNER

Med Students Share Doctors' Disdain For Managed Care

■ A NEW SURVEY of medical students and faculty members shows physicians in training strongly dislike health maintenance organizations — mainly because their teachers do, the *Associated Press* reported.

"We pretty well conclude that the students and residents are strongly influenced by the faculty culture in medical schools ... what's been described by others as a hidden curriculum," said Steven Simon, a researcher at the study's sponsors: Harvard Medical School and Harvard Pilgrim Health Care, a large not-for-profit HMO.

Students and faculty members ranked traditional fee-for-service medicine superior to managed care in most areas, especially in allowing access to care, minimizing ethical conflicts and preserving the doctor-patient relationship.

However, 57 percent said a single payer health system, such as the Canadian government-sponsored insurance, would give the most people the best care for a fixed cost. Only 19 percent chose fee-for-service, while 22 percent preferred managed care.

The study, reported in today's edition of the *New England Journal of Medicine*, is based on 1997 telephone interviews with 2,162 people affiliated with all 121 U.S. medical schools, including medical students, residents, faculty members, deans, department heads and residency training directors.

Among students and residents, 74 percent said faculty members teaching primary care gave them a negative opinion of managed care. Ninety-six percent said faculty members teaching specialties — where physicians have lost the most income and independence to HMOs — gave them a negative impression.

Kerrey Questions Clinton Opposition To Medicare Plan

HEALTH

SEN. BOB KERREY, D-Neb., a member of the now-defunct National Bipartisan Commission on the Future of Medicare, earlier this week called into question President Clinton's reasoning for not embracing the Medicare reform plan authored by the commission's chairman, **Sen. John Breaux**, D-La., and supported by Kerrey.

In an interview Tuesday with *CongressDaily* while visiting the White House, Kerrey declined to charge Clinton outright with seeking to politicize the issue — but he accused White House officials of “saying some things that are not right.”

And in questioning the validity of several problems Clinton said he had with the Breaux plan — problems Kerrey indicated the commission could have quickly resolved to the satisfaction of the needed supermajority of panel members — Kerrey suggested Clinton was voicing objections mainly to help sell to the public his refusal to back the proposal.

The Breaux proposal failed to muster support from 11 of the commission's 17 members, the number needed for the panel to make a formal

recommendation. All of Clinton's appointees opposed Breaux.

Breaux repeatedly attempted to convince Clinton to prod his appointees to come to terms with panel Republicans.

White House officials said that because Clinton viewed the panel as independent, he decided not to exercise any influence. Some critics said Clinton chose not to work for a deal and instead made Medicare a political football by proposing his own plan. The White House rejects the charge.

Noting the Breaux plan contemplated a very gradual increase in the retirement age from 65 to 67, Kerrey indicated White House officials have in recent days intentionally issued overheated complaints that the idea would swell the ranks of the uninsured unless there were a “buy-in” plan for those younger than 65.

“To use rhetoric saying it's a dangerous and drastic change — that's too much,” Kerrey complained. “We were that far apart,” Kerrey said — holding two fingers an inch apart — on a deal “for a reasonable buy-in.”

Similarly, conflict over a prescription drug benefit would have been

“easy to resolve,” according to Kerrey. “The Republicans wanted to do it,” he said. “We had provided \$60 billion” for the benefit, he added.

The White House wanted wider coverage than that offered by the Breaux plan, which would have guaranteed a prescription drug benefit for all Medicare recipients earning up to 135 percent of poverty.

The one significant issue where Kerrey acknowledged commission members were not close to a supermajority was Clinton's insistence on reserving 15 percent of the surplus for Medicare.

White House officials “really have only one” argument against the Breaux plan, Kerrey insisted, adding, “It's a bit misleading to emphasize other things.”

But Clinton would not have wanted “to say he was against the plan just because of the 15 percent issue,” Kerrey contended.

On the other hand, White House speeches “emphasizing more eligibility [are] an easier way to get an audience upset” about the Breaux proposal, Kerrey quipped.

— BY KEITH KOFFLER

Census Battle May Be Delayed Until Later This Year

GOVERNMENT OPERATIONS

House Commerce-Justice-

State Appropriations Subcommittee Chairman Harold Rogers, R-Ky., said Wednesday that House Republicans may wait until the FY2000 appropriations process later this year to oppose the administration's plan to use sampling in the 2000 census — but added that suggestion has yet to be accepted as a GOP strategy.

“The June 15 [deadline] is not very important because there is very little in the balance of the fiscal year that can be done as far as sampling is concerned,” Rogers told *CongressDaily*.

Congress must release the rest of the FY99 Commerce-Justice-State funding by June or the three departments could be shut down.

Before Republicans settle on a strategy, Rogers said the GOP is waiting for the Census Bureau to present its revised FY2000 budget request — which must include more funding to comply with a January Supreme Court decision that mandates a traditional count for apportionment purposes.

At a subcommittee hearing Wednesday, Rogers repeatedly asked Census Bureau Director Kenneth Prewitt for the bureau request, saying the administration has already begun to manipulate the census.

“I want to know it. The time is up,” Rogers declared. “What's the cost? Please tell us the cost. Tell me your cost.”

Prewitt responded the bureau

would not produce a number until it had a final request — which he said would not be before mid-April.

“Mr. Chairman, the accurate number is not ready,” Prewitt responded, eliciting a stern response.

“I do not trust the operatives in the White House, and the way they are manipulating you is shameful. It's sad,” Rogers said. “I know you can't answer that because you've been told not to.”

Based on a compromise reached in the FY98 C-J-S budget, Republicans contend the bureau should have prepared full operational plans and budgets for both a sampling and traditional count — giving the Supreme Court time to rule.

After question- *continued on page 12*

U.S. DEPARTMENT OF LABOR**SECRETARY OF LABOR
WASHINGTON, D.C.**

March 9, 1999

The Honorable Thomas A. Daschle
United States SenateThe Honorable Richard A. Gephardt
U.S. House of Representatives

Dear Senator Daschle and Congressman Gephardt:

I want to commend you on the introduction of S.6 / H.R.358 and your continuing commitment to ensuring that American workers and their families receive the quality health care they deserve and have been promised through a strong, comprehensive and enforceable Patients' Bill of Rights.

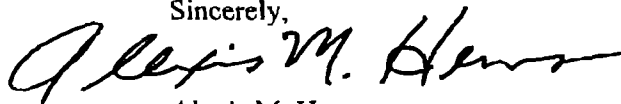
Some opponents of managed care reform legislation have attempted to confuse the issues and intent of the legislation. Some have said that the legislation would subject employer plans to all kinds of benefit mandates and destroy the advantages of simple plan design and administration that ERISA was intended to provide. Others have said that it would rush participants into court to sue their employers and inappropriately empower doctors and enrich lawyers. These statements and others like them are just plain wrong.

A strong, comprehensive and enforceable Patients' Bill of Rights is not about mandates. It is about fundamental fairness once a plan tells a participant that a treatment is covered. The legislation says that managed care companies can't make phony promises -- they can't promise someone a benefit and then effectively take it away by forcing participants to jump through extremely complex and confusing administrative hoops to get it. They can't claim to have made a promise of a benefit and then secretly condition it in a way that takes the promise back just when it is really needed. The legislation isn't about doctors and lawyers -- it is about fundamental fairness for patients and families. Its focus is not the right to sue, but the right to know.

There are many specific complex issues to address in the legislation. But the heart of this issue is straightforward and simple -- American workers and their families need to understand better and earlier just what health care coverage they have been promised. They must be able to rely on the promised benefits in times of need. They must be able to hold the promise makers accountable if something goes wrong.

Senator Daschle and Congressman Gephardt, you have been leaders in this very important area. I look forward to continuing to work with you and other dedicated Members like Senator Kennedy and Congressman Dingell to do what it takes to get a strong, comprehensive and enforceable Patients' Bill of Rights enacted into law.

Sincerely,



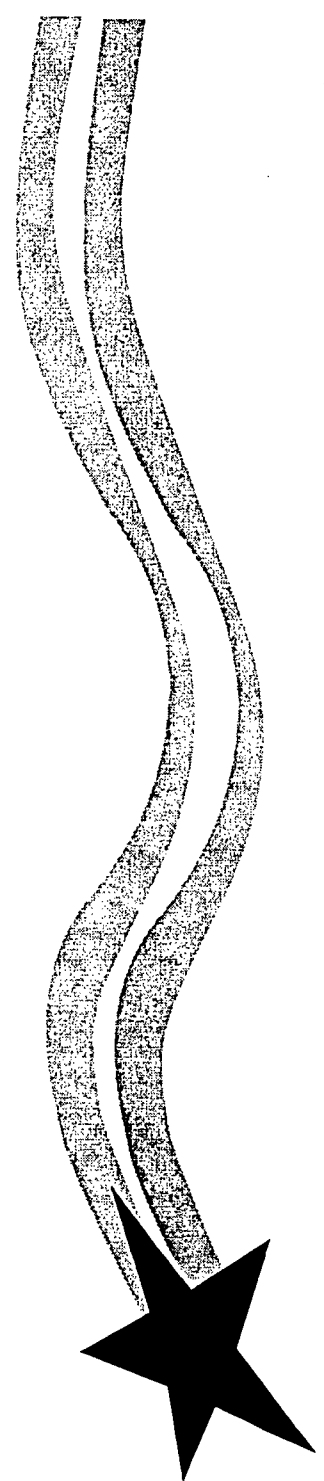
Alexis M. Herman

WORKING FOR AMERICA'S WORKFORCE

Chris/Awarah

Fy11 - Sen. DPC distributed
to their Members

-mindy



The Patients' Bill of Rights: Democrats Offer Comprehensive Protections for All Americans

Today, nearly 161 million Americans obtain health coverage through some form of managed care. These Americans face continuous barriers from a system that too often is more interested in lowering costs and increasing profits than in providing quality health care. The problems and fears faced by these individuals have only increased in the time that Republicans have delayed action on the Patients' Bill of Rights.

While Republicans stall, Americans face more and more problems from managed care. A recent Kaiser Family Foundation/Harvard University survey reported that problems with managed care are growing and that Americans are increasingly worried about how their health plan will treat them. Based on those survey findings, we know that in 1998, as many as 115 million Americans either had a problem or know someone who had a problem with their health plan—compared to 96 million people who reported problems in 1997.

Congress should pass a real Patients' Bill of Rights. The Republican bill is a far cry from meaningful reform. Among other gaps, the Republican bill still leaves medical decisions in the hands of insurance company accountants, does not provide a right to needed specialty care for children or adults, and provides no effective mechanism to hold plans accountable when plan abuse kills or injures patients. Further, almost two-thirds of privately insured Americans—100 million people—are not covered by the Republican plan.

The Democratic bill, supported by more than 200 leading organizations, offers real managed care reform that covers all privately insured Americans. Central elements of a meaningful, comprehensive Patients' Bill of Rights are:

- patients will have access to needed care;
- doctors are free to practice medicine without improper HMO and insurance company interference;
- a health plan's decision to deny care can be appealed by patients to an independent entity; and
- health plans are held accountable for their medical decisions that lead to harm.

For two years, American families have been waiting for Congress to end managed care abuses by passing a Patients' Bill of Rights. Action on the Patients' Bill of Rights deserves high priority in this Congress. Democrats are ready to act on legislation that will bring all patients the peace of mind that their health care will be there when they need it.

UNITED STATES SENATE
COMMITTEE ON LABOR AND HUMAN RESOURCES
WASHINGTON, DC 20510-6300

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DATE:

3/12

TO:

Chris Jennings

FAX NUMBER:

456 5557

FROM:

Cybele

(202) 224-7675 phone

(202) 224-3533 fax

NUMBER OF PAGES: 2 (including cover)

MESSAGE:

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Patients' Bill of Rights

GOP

Profits before Patients

DEMOCRATS

Patients before Profits

- | | |
|---|---|
| 1. Protects all Patients with Private Insurance | ✓ |
| ✓ 2. Prohibition on Gag Rules | ✓ |
| ✓ 3. Emergency Room Access | ✓ |
| ✓ 4. Access to Ob/Gyn | ✓ |
| ✓ 5. Keep Your Doctor | ✓ |
| 6. Guaranteed Access to Specialists | ✓ |
| 7. Access to Out-of-Network Providers | ✓ |
| 8. Guarantee Network Meets Needs | ✓ |
| 9. Specialists for Primary Care | ✓ |
| 10. Standing Referrals to Specialists | ✓ |
| 11. Access to Doctor-Prescribed Drugs | ✓ |
| 12. Access to Clinical Trials | ✓ |
| 13. Protection for Patient Advocacy | ✓ |
| 14. No Arbitrary HMO Interference | ✓ |
| 15. Information on Plan Quality | ✓ |
| ✓ 16. Independent External Appeals | ✓ |
| 17. Ability to Hold Plans Accountable | ✓ |

U.S. House of Representatives
1711 Longworth HOB
Washington, DC 20515
ph: (202) 225-1790 / fx: (202) 225-5617

Rep. Donna Christian-Christensen

Fax

To: Christopher C. Jennings **From:** Brian Modeste, Legislative Director

Firm: White House Office of Health Policy Dev. **Pages:** 02

Phone:

Date:

Re:

Fax: 456-5557

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• **Comments:**

DONNA M. CHRISTIAN-CHRISTENSEN
DELEGATE, VIRGIN ISLANDS

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TRAVEL AND TOURISM CAUCUS

Congress of the United States
House of Representatives
Washington, DC 20515-5501

March 5, 1999

Mr. Christopher C. Jennings
Deputy Assistant to the President
Health Policy Development
216 Old Executive Building
1600 Pennsylvania Avenue, N.W.
Washington, DC 20500

Dear Mr. Jennings:

I read with great interest, but also with increasing consternation, the article on health in yesterday's National Journal's Congress Daily AM. (see enclosed copy of the article.) As a supporter and cosponsor of the Patients' Bill of Rights and as a physician, I began to register increasing discomfort as I read the statements attributed to you which suggested the White House's willingness to negotiate away medical necessity as a standard for determining coverage for medical tests and treatment in managed care.

The concerns which were expressed in the article by Dr. Woody Myers, which you seem to embrace, are totally unfounded and misleading. The only thing that would be impeded by the proposed language is the million dollar profits that major Managed Care organizations, their CEO's and top level executives are boasting. Unlike you and apparently Dr. Myers, the American people trust their doctors a whole lot more than they do insurers and HMO's to make decisions about their health care. And with good reason. In addition to their own experiences, they also recognize that the dollars and years we spend in training, provide us the knowledge base, and practical training to do just that: determine what care constitutes "medical necessities".

If the comments that were attributed to you in the article are true, then you owe all physicians, including myself, an apology. Your statement that "Doctors make crazy decisions sometimes" is insulting and disrespectful to me and to those who share my profession.

Sincerely,


Donna M. Christian-Christensen
Member of Congress

PLEASE RESPOND TO:

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ROUTING SLIP

DATE: 3/9/99

FROM: Stephanie Streett
Assistant to the President and Director of Presidential Scheduling

SUBJECT: Patients' Bill of Rights Event with Members of Congress to highlight bipartisan support for a comprehensive strong patients' bill of rights.

Virginia Apuzzo	___	Capricia Marshall	___
Paul Begala	___	Thurgood Marshall Jr.	___
Lisa Berg	___	Minyon Moore	___
Samuel Berger	___	Bob Nash	___
Sidney Blumenthal	___	Jennifer Palmieri	___
Phil Caplan	___	John Podesta	___
Davis/Redington	✓	Clark Ray	___
Maria Echaveste	___	Steve Ricchetti	___
Tim Emrich	✓	Bruce Reed	✓
Jeff Forbes	___	Dan Rosenthal	___
George Frampton	___	Charles Ruff	___
Nancy Hernreich	___	Patti Solis-Doyle	___
Mickey Ibarra	___	Craig Smith	___
Ron Klain	___	Doug Sosnik	___
Neal Lane	___	Gene Sperling	___
Lisa Levin	___	Larry Stein	___
Ann Lewis	✓	Todd Stern	___
Bruce Lindsey	___	Melanne Verveer	___
Joe Lockhart	✓	Michael Waldman	✓
		Karin Kullman	✓
		Chris Jennings	✓

FILE: Pending

COMMENTS: _____

SCHEDULING PROPOSAL
3/2/99

TODAY'S DATE:

99 MAR 4 PM 2:33

☐ ACCEPT

☐ REGRET

☒ PENDING

TO:

Stephanie Streett
Assistant to the President
Director of Presidential Scheduling

FROM:

Bruce Reed
Assistant to the President for Domestic Policy and
Director of the Domestic Policy Council

Chris Jennings
Deputy Assistant to the President for Health Policy

REQUEST:

Patients' Bill of Rights Event with Members of
Congress to highlight bipartisan support for a comprehensive strong patients'
bill of rights.

PURPOSE:

To demonstrate the bipartisan support for a strong
comprehensive Patients' Bill of Rights. This event would underscore the
many similar patient protections that are contained in some of the Republican
and Democratic PBOR bills under consideration in the Congress. It would
also highlight that there is bipartisan support for a comprehensive approach,
rather than the piecemeal approach that some Republicans on the Hill have
been advocating.

This event would also highlight that many of the
consumer and provider groups that might be
thought to be supportive of a piecemeal approach
in fact advocate a comprehensive bill. For
example, the emergency physicians and ob-gyns
could underscore that they do not want to see a
bill that has their specific provisions, but rather a
strong comprehensive bill.

BACKGROUND:

Last year the President consistently urged the
Congress to pass a strong enforceable Patients' Bill of Rights through
numerous events and speeches. Several versions PBOR legislation have been

introduced on the Hill this year, including bills by Dingell-Kennedy, Congressman Ganske, and Senators Chafee and Graham. These bills contain many similar patient protections and illustrates that there is bipartisan support to pass a strong enforceable Patients' Bill of Rights.

PREVIOUS PARTICIPATION: The President has participated in several Patients' Bill of Rights events in the last year.

DATE AND TIME: March 1999 -- before Congress adjourns on March 26, 1999

BRIEFING TIME: 30 minutes

DURATION: 45 minutes

LOCATION: The White House

PARTICIPANTS: The President
Members of Congress
Providers and consumers

REMARKS REQUIRED: To be provided by speech writing.

OUTLINE OF EVENTS: The President would participate in an event with Members of Congress and Health care Advocates who would speak to the importance of passing a Patients' Bill of Rights.

MEDIA COVERAGE: Open

FIRST LADY'S ATTENDANCE: N/A

VICE PRESIDENT'S ATTENDANCE: If possible.

SECOND LADY'S ATTENDANCE: N/A

RECOMMENDED BY: Bruce Reed
Chris Jennings

CONTACT: Karin Kullman
X61732

THE WHITE HOUSE
WASHINGTON

March 8, 1999

The Honorable Donna M. Christian-Christensen
U.S. House of Representatives
Washington, D.C. 20515-5501

Dear Dr. Christian-Christensen:

It was with great concern that I read your March 5th letter to me about the March 4th "National Journal's Congress Daily A.M." article on the medical necessity provisions in the Patients' Bill of Rights. I appreciate having this opportunity to set the record straight on the Administration's position on the medical necessity issue as well as to share with you my feelings toward the medical profession in general and physicians in particular.

The President has been, and will continue to be, one of the nation's greatest advocates for a strong, comprehensive and enforceable Patients' Bill of Rights. He has been actively pushing for changes in how the managed care industry oversees the delivery of health care since 1996, when he called for the establishment of the Advisory Commission on Quality and Consumer Protections. As you know, since that time, he has extended patient protections throughout Federal health plans and has repeatedly urged the Congress to pass long overdue legislation in this area.

The only legislation that the President has consistently and explicitly indicated that he would sign would include the full range of patient protections, including access to specialists, continuity of care, internal and external appeals process and, in that context, a medical necessity standard. As his primary White House health care advisor since 1995, I have been proud to be associated with the President's strong record in this area and can assure you will continue to help him and interested parties such as yourself in the Congress work toward passing and enacting a strong and enforceable Patients' Bill of Rights.

I do share your concern about the context with which my comments were used in the article you cite. I would like to point out, however, that the only legislation that I referenced positively were the Dingell/Gephardt, Daschle/Kennedy, and the Ganske bills -- bills that have very strong medical necessity provisions. Moreover, as I stressed, "(t)here need to be provisions that ensure that HMO managers are not making arbitrary decisions." The comments about being "open" to how best to draft the provision were in no way meant to suggest that there be weak or no provisions in this area. To the contrary, they were simply referencing the need to come up with the best way to draft needed legislation in this area.

file copy

Donna
Your copy

As for my remark that doctors sometimes make inappropriate decisions, I sincerely regret that it offended you or any other physician. I have the utmost respect, admiration and appreciation for your profession and, indeed all health care professionals. Physicians literally saved my and my brother's lives. They delivered the three things I hold most dear in my life -- my three sons. And they have been my and the Administration's partners in working to pass a Patients' Bill of Rights. My comments were never intended to reflect anything except my belief that the medical necessity provisions would not always validate the original decision by the patient's physician. I can assure you that I will be much more careful in the future in this regard.

I hope this letter adequately clarifies my and the Administration's position on the medical necessity issue. As always, we look forward to working with you and all Members of Congress seriously committed to passing a strong and enforceable Patients' Bill of Rights.

Sincerely,

A handwritten signature in black ink, appearing to read "Chris C. Jennings", with a long horizontal flourish extending to the right.

Christopher C. Jennings
Deputy Assistant to the President for Health Policy



CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES

FAX COVER SHEET

To: Chris Jennings
From: Jon Trumb
Re: _____
Fax Number: _____
Number of Pages to Follow: 6

COMMENTS

Congressman Ganske wanted you to see a
copy of this letter he is sending to
his colleagues.

PLEASE CALL 202/225-4426 IF YOU DO NOT RECEIVE ALL OF THE PAGES OF THIS FAX



CONGRESS OF THE UNITED STATES HOUSE OF REPRESENTATIVES

Dear Colleague:

On May 30, 1996, a small, nervous woman testified before the House Commerce Committee. Her testimony was buried in the fourth panel at the end of a long day about the abuses of managed health care. The reporters were gone, the television cameras had packed up, most of the original crowd had dispersed.

She should have been the first witness that day, not one of the last. She told about the "choices" that managed care companies and self-insured plans are making everyday when they determine "medical necessity." Linda Peeno had been a claims reviewer for several HMOs. Here's her story:

"...I wish to begin by making a public confession. In the spring of 1987, as a physician, I caused the death of a man.

"Although this was known to many people, I have not been taken before any court of law or called to account for this in any professional or public forum. In fact, just the opposite occurred: I was 'rewarded' for this. It brought me an improved reputation in my job, and contributed to my advancement afterwards. Not only did I demonstrate I could do what was expected of me, I exemplified the "good" company doctor: I saved a half million dollars!"

As she spoke, a hush came over the room. The representatives of the trade associations who were still there averted their eyes. The audience shifted uncomfortably in their seats, both gripped and alarmed by her story. Her voice became husky and I could see tears in her eyes. Her anguish over harming patients as a managed care reviewer had caused this woman to come forth and bare her soul.

She continued, *"... Since that day I have lived with this act, and many others, eating into my heart and soul. For me, a physician is a professional charged with the care, or healing, of his or her fellow human beings. The primary ethical norm is: do no harm. I did worse: I caused death. Instead of using a clumsy, bloody weapon, I used the simplest, cleanest of tools—my words. This man died because I denied him a necessary operation to save his heart. I felt little pain or remorse at the time. The man's faceless distance soothed my conscience. Like a skilled soldier, I was trained for this moment. When any moral qualms arose, I was to remember: I am not denying care; I am only denying payment."*

By this time, trade association representatives were staring at the floor. The Congressmen who had spoken on behalf of the HMO's were distinctly uncomfortable,

and the staff, several of whom subsequently became representatives of HMO trade associations, were thanking God that this witness came at the end of the day.

Dr. Peeno's testimony continued, "*...at the time, this helped me avoid any sense of responsibility for my decision. Now I am no longer willing to accept the escapist reasoning that allowed me to rationalize this action. I accept my responsibility now for this man's death, as well as for the immeasurable pain and suffering many other decisions of mine caused.*"

She then listed the many ways managed health plans deny care to patients. But she emphasized one particular issue--the right to decide what care is medically necessary. "*There is one last activity that I think deserves a special place on this list, and this is what I call the **smart bomb of cost containment, and that is medical necessities denials**. . . Even when medical criteria is used, it is rarely developed in any kind of standard, traditional, clinical process. It is rarely standardized across the field. The criteria is rarely available for prior review by the physicians or members of the plan. . . .*"

"*We have enough experience from history to demonstrate the consequences of secretive, unregulated systems that go awry. . . .*" After exposing her own transgressions, she closed by urging everyone in the room to examine their own conscience. "*. . . One can only wonder: how much pain, suffering, and death will we have before we have the courage to change our course? Personally, I have decided even one death is too much for me.*"

The room was stone-cold quiet. The Chairman mumbled: "Thank you, Doctor."

Linda Peeno could have rationalized her decisions as so many do: "I was just working within guidelines" or "I was just following orders" or "we have to save resources" or "this isn't about treatment, it's really just about benefits." Dr. Peeno refused to continue this denial and will do penance for her sins the rest of her life by exposing the dirty little secret of HMO's determining "medical necessity."

My friend, if there is only one thing you read before voting on patient protection legislation, I beg you to read the following. Before voting on any patient protection legislation, please keep in mind the fact that **no amount of procedural protection or schemes of external review can help patients if insurers are legislatively given broad powers to determine what standards will be used to make decisions about coverage.**

As Dr. Peeno so poignantly observed, insurers now routinely make treatment decisions by determining what goods and services they will pay for. The difference between clinical decisions about medically necessary care and decisions about insurance coverage are especially blurred. Because all but the wealthy rely on insurance, the power of insurers to determine coverage gives them the power to dictate professional standards of care.

Make no mistake, along with the question of health plan liability, the **determination of who should decide when health care is medically necessary is the key issue in patient protection legislation.**

Contrary to the claims of HMOs that this is some new concept, for over two hundred years most private insurers and third-party payers have viewed as medically necessary those products or services provided in accordance with the "prevailing standards of medical practice." This is the definition used in many managed care reform bills, including my own--the Managed Care Reform Act of 1999. The courts have been sensitive to the fact that insurers have a conflict of interest because they stand to gain financially from denying care and have used "clinically derived professional standards of care" to reverse insurers' attempts to deviate from these standards.

This is why it is so important that managed care reform legislation include an independent appeals panel with no financial interest in the outcome. A fair review process utilizing **clinical standards of care** guarantees that the decision of the review board is made without regard to the financial interests of either the HMO or the doctor. On the other hand, if the review board has to use the health plan's definition of "medically necessary," there is no such guarantee.

In response to the growing body of case law and their own need to demonstrate profitability to shareholders, insurers are now writing contracts that threaten even this minimal level of consumer protection. They are writing contracts in which standards of medical necessity are not only separated from standards of good practice but are also essentially not subject to review. Here is one example, of many, of a health plan's definition of "medically necessary services."

"Medical necessity means the **shortest, least expensive, or least intense level** of treatment, care or service rendered, or supply provided, as determined by us (the health plan), to the extent required to diagnose or treat an injury or sickness. The service or supply must be consistent with the insured person's medical condition at the time the service is rendered, and is not provided primarily for the convenience of the injured person or doctor." (emphasis added)

Contracts like this demonstrate that some health plans are manipulating the definition of medical necessity to deny appropriate patient care by arbitrarily linking it to saving money, not the patient's medical needs.

On the surface, some may say, "So what's wrong with the 'least expensive treatment'?"

Here's just one example out of the thousands I could cite: as a reconstructive surgeon, I treated children with cleft palates. "Clinical standards of care" would determine that the best treatment is surgical correction, but under this HMO's definition, the plan could limit coverage to a piece of plastic to fill the hole instead. After all, this plastic obturator would be cheaper. However, instead of condemning children to a

lifetime of using a messy prosthesis, the proper treatment--reconstruction using the child's own tissue--would give that child the best chance at normal speech and a normal life.

Paradoxically, insurers stand to benefit from misguided legislative changes that displace case law! Last year, legislation that passed the House and the GOP bill in the Senate would have granted insurers the explicit power to define medical necessity, without regard to current standards of medical practice. This would have been accomplished by allowing them to classify as medically unnecessary any procedures not specifically found to be "necessary" by the insurer's own technical review panel. The Senate bill would have even given insurers the power to determine what evidence would be relevant in evaluating claims for coverage and would have permitted insurers to classify some coverage decisions as exempt from administrative review.

I know that many of our colleagues who supported those bills last year had no idea of the implications of the medical necessity provisions in them.

Specifically, insurers now want to move away from clinical standards of care applied to particular patients to standards linking medical necessity to "population studies." On the surface this may seem "scientific" and rational. However, as a former medical reviewer myself who worked with many insurers large and small, let me explain why I think it is critical that we stick with medical necessity as defined by clinical standards of care:

- First, sole reliance on broad standards from generalized evidence isn't good medical practice;
- Second, there are practical limits to designing studies that can answer all clinical questions; and
- Third, most studies aren't of sufficient scientific quality to justify overruling clinical judgment. Let me explain these points further (I also recommend the article on these shortcomings by Rosenbaum, et al, in the January 21, 1999 edition of the New England Journal of Medicine).

First, while it may sound counter-intuitive, it isn't good medicine to solely use "outcome-based" studies of medical necessity, even when the science is rigorous. Why? Because the choice of the outcome is inherently value-laden. The medical reviewer for the HMO is likely, as shown by the above mentioned contract, to consider cost the essential value. But what about quality?

As a surgeon I treated many patients with broken fingers simply by reducing the fracture and splinting the part. For most patients this would restore adequate function. But for the musician who needs a better range of motion, surgery might be necessary. Which outcome should be the basis for the decision about insurance coverage: playing the piano or routine functioning? My point is this--taking care of patients involves much variation.

Definitions of medical necessity must be flexible enough to take into account the needs of each patient. "One size fits all" outcomes make irrelevant the doctor's knowledge of the individual patient and is bad medicine, period.

Second, there are practical limitations on basing medical necessity on "generalized evidence," particularly as applied to HMO's. Much of medicine is the result of collective experience, and many basic medical treatments haven't been studied rigorously. Furthermore, aside from a handful of procedures that are not explicitly covered, most care is not specifically defined in health plans because the number of procedures and the circumstances of their application are limitless.

In addition, by their very nature many controlled clinical trials study treatments in isolation, whereas physicians need to know the benefits of one type of treatment over another. Prospective, randomized comparison studies on the other hand are expensive. Given the enormous number of procedures and individual circumstances, if coverage is limited to only those that have scientifically sound generalized outcomes, care could be denied for almost all conditions. Come to think of it, maybe that is why HMO's are so keen to get away from prevailing standards of care!

Third, the validity of HMO guidelines and how they are used is open to question. Medical directors of HMOs were asked to rank the sources of information they use to make medical decisions. Industry guidelines generated by the trade associations representing health plans ranked ahead of information from national experts, government documents, and NIH consensus conferences. The most highly ranked respected source—medical journals—was used less than 60% of the time!

Industry guidelines are frequently done by Milliman and Robertson, a strategy shop for the HMO industry. This is the same firm that championed "drive through deliveries" and outpatient mastectomies. Many times, these practice guidelines aren't grounded in science but are cookbook recipes derived by actuaries to reduce health care costs. Here are two examples of the errors of their guidelines:

- A National Cancer Institute Study released in June found that women receiving outpatient mastectomies face "significantly higher" risks of being re-hospitalized and have a higher risk of surgery-related complications like infections and embolisms.
- A 1997 study published in the Journal of the American Medical Association showed that babies discharged within a day of birth faced increased risk of developing jaundice, dehydration, and dangerous infections.

Objectivity of medical decision making requires that the results of studies be open to peer review. Yet much of the decision-making by HMO's is based on unpublished, "proprietary," and unexamined methods and data. Such secret and potentially biased guidelines simply can't be called scientific.

This is not to say that outcomes-based studies don't make up a part of how clinical standards of care are determined. They do. But we are all familiar with the ephemeral nature of new "scientific" studies such as those on the supposed dangers of alar!

Clinical standards of care do take into account valid and replicable studies in the peer-reviewed literature, as well as the results of professional consensus conferences, practice guidelines based on government funded studies, and guidelines prepared by insurers that have been determined to be free of any conflict of interest. But most importantly, they also include the patient's individual health and medical information and the clinical judgment of the treating physician.

Congress should pass legislation defining this standard of medical necessity because: 1) ERISA shields plans from the consequences of most decisions about medical necessity, 2) under ERISA, patients generally can only recover the value of benefits denied, and 3) even this limited remedy is being eroded by insurance contracts that give insurers the authority to make decisions about medical necessity based on questionable evidence. And to ensure these protections, Congress must provide patients with a speedy, external review of all coverage decisions, not merely those that insurers decide are subject to review.

It is time for Congress to defuse the "smart bomb" of HMO's.

Sincerely,

Greg Ganske
Member of Congress

FACSIMILE COVER PAGE

Date: 3/4/99
Time: 16:15:16
Pages: 3

To: Chris Jennings
Company: White House
Fax #: 202-456-7431

From: Bruce Lesley
Title: Director, Congressional Relations
Company: National Assoc. of Children's Hospitals
Address: 401 Wythe Street
Alexandria , VA 22314
USA
Fax #: 5484907

Message:

Results from our most recent poll on pediatric managed care standards.

-Bruce

Fact Sheet

Americans Strongly Support Managed Care Protections for Children

According to a February 1999 survey by Lake Sosin Snell Perry and Associates, Inc. and the Tarrance Group on behalf of the National Association of Children's Hospitals:

Strong Public Support for Access to Pediatric Specialists

- **86%** of voters surveyed favor having "Congress require HMO and other insurance companies to provide children with access to pediatric specialists, like pediatric heart specialists and surgeons, and to hospitals that specialize in treating children."
- **87%** of voters in HMOs support pediatric specialty care protections – a level of support that is slightly higher than the general population. Over half (56%) of those in HMOs strongly favoring such pediatric protections.
- **80%** of voters responded that they believe it is "extremely important" (43%) or "very important" (37%) to them "personally to have Congress require HMOs and other insurance companies to provide children with access to pediatric specialists...." Only 8% of American voters respond that it is "not too important" or "not important at all."

In other polls, support for managed care protections drops fairly dramatically if the public is told that costs may increase. However, this is not the case for pediatric protections:

- **76%** of voters continued to express support for congressional legislation requiring managed care plans to provide access to pediatric specialty care "even if it increased health insurance costs for families with children by \$100 a year." The favorable-to-unfavorable margin for this provision, even when told it might increase costs, remained at 76 to 16 percent – an almost **5-to-1** continued margin of support.

As the pollsters add, "...proposals leading with pediatric care have consistently tested the strongest – almost as valence terms."

Support for Access to Pediatricians & Pediatric-Specific Information

In a February 1998 survey, voters indicated strong public support for other pediatric protections as well. In fact, almost nine out of ten Americans support Congress requiring HMOs and other health plans to allow parents to choose a pediatrician as their child's primary care physician and to measure and report to the public specifically on the quality of children's health care the plans provide. Specifically:

- **89%** of adults surveyed favor having "Congress require HMO and other insurance companies to allow parents to choose a pediatrician as their child's primary care physician."

- 90% favor having "Congress require HMO and other insurance companies to allow parents of children with special health care needs, like cerebral palsy, cystic fibrosis, or severe asthma, to choose a pediatric specialist to be their child's primary care physician."
- 87% favor "Congress requiring HMO and other insurance companies to measure and report to the public specifically on the quality of children's health care they provide."

Strong Public Support for Managed Care Protections for Children Cuts Across Gender, Race and Party Affiliation

Support for children's health protections is across the board, with only minor variation in support by gender, race and party affiliation. For example, 86% of adults surveyed in the February 1999 poll support Congress requiring HMOs to provide children access to pediatric specialists. The breakdown by gender, race and party affiliation are:

GENDER

- 89% of women are supportive.
- 82% of men are supportive.

RACE

- 84% of white adults are supportive.
- 94% of African-American adults are supportive.
- 93% of Hispanic adults are supportive.

PARTY AFFILIATION

- 92% of Democrats are supportive (94% support among Democratic women).
- 90% of Independents are supportive (92% support among Independent women).
- 77% of Republicans are supportive (82% support among Republican women).

As Celinda Lake (Lake Sosin Snell Perry and Associates) and David Sackett (The Tarrance Group) note, "Overall there is at least 70 percent support for this proposal among every demographic and political subgroup."

March 1999

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Technical Comments on Ganske Proposal to Amend External Review and Remedies Provisions of HR 3605

Summary of Proposal:

The Ganske proposal offers changes to the external review and remedies provisions of the Democrats' Patients Bill of Rights (PBOR). The proposal builds on the existing provisions in the PBOR, but makes important changes that would limit a claimant's ability to exercise the right to judicial review of a disputed benefit determination. Key elements of these changes include:

External Review Provisions:

- Claims involving more than \$100 are externally appealable.
- De novo standard language clarifies that determinations of medical necessity should be made by the reviewer without deference to the plan or issuer.
- Emergency timeframe for external review requires reviewer to make determination within 24 hours.
- Notice requirements specifically require reviewer to notify claimants of any limitations on their rights to seek further review.
- Changes to definition of "clinical peers" who must participate in external review.
- External reviewers, their employees, fiduciaries, and others providing services to them, are protected from liability, so long as they exercise due care and there is no malice or misconduct.
- External review determinations are binding on plan and not subject to judicial review, but may be vacated or changed by a court under certain circumstances (i.e., bias, corruption, fraud, prejudicial misconduct, beyond authority, etc.)

Remedies Provisions:

- Exhaustion of external review process required for all "externally appealable decisions."
- No punitive damages available where plan/issuer complied with recommendation of external review entity.
- Clarification that "personal injury" claims (brought under the exception to ERISA preemption) include claims involving physical injury and injuries arising from treatment of mental illness.
- Prohibits application of state laws that require mandatory alternative dispute resolution of litigation against health insurance issuers.

Technical Comments on External Review:

1. **Right to External Appeal (§ 133(a)(1)):** The proposed change would also allow the plan or issuer to bring an appeal (in addition to the claimant or her representative). It is unclear why this addition is needed, given that the plan and issuer would decide the internal appeal determination being appealed - presumably, they would not seek to

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contest their own determination.

2. **New Medical Necessity Language in De Novo Standard (§ 133(b)(2)(A)):** The proposed change clarifies that the “fair, de novo determination” provision requires that “the determination of medical necessity shall be made under the process without regard to the definition used by the plan or issuer.” This language includes some ambiguities which could be clarified to achieve the provision’s intended effect. First, the application of the de novo standard is fairly narrow, applying only to determination of medical necessity for which the plan or issuer has used a definition, rather than applying more broadly to all determinations involving medical judgment. Second, the language refers to “the process,” but does not specify which process (i.e., external appeals process). Finally, the language requires that the reviewer make a determination “without regard” to the plan’s or issuer’s definition - it is unclear what this means in practice. We recommend that the following changes be made to achieve the presumed intended effect:

~~In carrying out this subparagraph, the determination of medical necessity~~ *A de novo determination in this context shall include, among other things, that determinations involving medical judgment shall be made under the external appeals process without regard deference to the definition used recommendation made by the plan or issuer.*

3. **New Notice Requirement for QEAEs (§ 133(b)(2)(E)):** The proposed change would require the qualified external appeal entity (QEAE) to inform the claimant of “any limitation” on her right to seek further judicial review. This is a fairly broad requirement which could be construed to require the QEAE to inform the claimant of any legal barriers to bringing a claim in state or federal court, including procedural rules, statutes of limitations on claims, and other technical issues. If it was intended that the QEAE be required to inform the claimant of the specific limitations created by this Act, then we recommend the language be changed as follows:

(v) inform the participant, beneficiary, or enrollee of the individual’s rights (including any limitation on such rights *created under this Act*)

4. **Limits on QEAE Liability (§ 133(c)(3)):** The proposed change provides that QEAEs and those affiliated with them are not civilly or criminally liable for their actions as external reviewers if they exercised due care in performing their function and there was no actual malice or gross misconduct in such performance. It does not appear that these provisions provide substantially greater relief from state law liability than already exists under the basic requirements for civil or criminal liability in most state courts. If it was intended that greater protection from liability be created, then these provisions should be

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strengthened. In addition, it is unclear what group is intended to be included in the category of individuals who have a "fiduciary relationship" with the QEAE. Although this group should not include ERISA plan fiduciaries (because of the requirement that the QEAE be certified as unbiased), it should be noted that the standard of care required of the fiduciaries named in this context is much lower than the standard of care that is required under ERISA ("prudence") or possibly other state trust laws.

5. **Limits on Legal Rights (§ 133(d)(1)):** The proposed change provides that the QEAE's determination is binding on the plan (and issuer, if any) and claimant, and that such determination is not subject to judicial review. The practical effect of this change is unclear, especially in light of the later changes affirming a claimant's right to bring an action in state court once the external appeal process has been exhausted. Because the scope of the QEAE's decisionmaking authority is not clearly addressed, either in the original bill language or the proposed changes, it is unclear whether QEAEs would have the authority to make determinations relating to whether damages should be awarded or the amount of such damages. However, if QEAEs could make such determinations, this would foreclose the ability of a claimant to seek further judicial review in state court on this issue. Therefore, it is unclear how the prohibition on judicial review in this section may be reconciled with the later provisions in section 302 that allow claimants to bring certain actions in state court.
6. **Limitations on Punitive Damages (§ 133(d)(3)):** The proposed change would protect plans and issuers from liability for punitive damages in any related subsequent legal action so long as the plan or issuer follows the QEAE's determination. This provision does not address whether the plan or issuer must comply within a certain time frame, leaving open the possibility that plans and issuers could delay compliance until the commencement of litigation on the issue and still avoid punitive damages. If the intention was to provide an incentive that would encourage plans and issuers to comply with the QEAE's determination in a timely manner, then some mention of timing of compliance should be included in this provision.
7. **Ability to Bring Judicial Action to Enforce the QEAE's Determination (§ 133(d)(4)):** This proposed change clarifies that these provisions should not be construed to prevent any person from bringing a judicial action to enforce the QEAE's determination. However, this provision does not specify a cause of action under which these enforcement actions could be brought. With respect to plan participants and beneficiaries and fiduciaries, such an action could be brought under section 502(a)(3) of ERISA, which allows these parties to bring a civil action in state or federal court "to enjoin any act or practice which violates any provision of this title..." To clarify that these parties could bring this type of judicial action, we recommend the following addition to the existing language:

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With respect to plan participants, beneficiaries, and fiduciaries, such an action may be brought pursuant to section 502(a)(3) of ERISA.

Technical Comments on Remedies:

1. **Exhaustion Requirement (§ 302(a), amending ERISA § 514 (e)(1)):** The proposed change requires that claimants bringing a state law claim relating to an externally appealable decision complete the external appeal process before they seek judicial review in state court. However, the provision does not address whether exceptions to the exhaustion requirement could exist where requiring the claimant to pursue exhaustion would be unfair or subject her to undue hardships. For example, should claimants be forced to complete the external review process when the QEAE or the plan has delayed the process and failed to comply with the deadlines? Should claimants be forced to exhaust where the QEAE is known to be biased or corrupt, or where pursuing review would be futile because the plan has refused to submit its records? Should the survivors of claimants who died as a result of a wrongful delay or denial of a benefit be forced to undergo the external appeal process when they are clearly no longer seeking the benefit that was denied?
2. **Scope of State Cause of Action (§ 302(a), amending ERISA § 514 (e)(1)):** This provision would allow claimants to bring a cause of action in state law to recover damages for personal injury or wrongful death against certain parties. As discussed above, in comment 5, it is unclear how this provision would work with the prohibition on judicial review of the QEAE determination in section 133. Issues which appear unresolved include whether the state cause of action would be limited in scope to a discussion of appropriate damages, not whether a benefit should have been provided. This would seem to foreclose judicial review to those who received an adverse determination from the QEAE, unless the decision could be vacated for one of the stated reasons. It is also unclear whether state law damages would be available for all claims brought by those who were injured. For example, individuals who were injured or killed as a result of an erroneous benefit determination that was merely wrong, but did not involve negligence, would not be able to meet the state tort standard for negligence and would therefore not be eligible to be compensated for their injuries.
3. **Punitive Damages (§ 302(a), amending ERISA § 514 (e)(1)):** The proposed change would provide that plans or issuers that complied with the recommendations of the QEAE would not be liable for any punitive, exemplary, or similar damages. The need for provisions relating to the timing of compliance is noted above in comment 6. It is also unclear why similar provisions relating to this issue appear in both the external review

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(section 133) and remedies (section 302) sections of the bill. If it was not intended that these provisions be interpreted differently, then their language should be conformed so that there are no discrepancies.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

Date:

FACSIMILE

**PLEASE NOTIFY OR HAND-CARRY THIS
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Terri Shaw @*Assistant Secretary for Planning & Evaluation*205-8681Number of pages being transmitted (including fax sheet): 17 5COMMENTS: replacement pages for
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**COMPARISON OF CONSUMER PROTECTIONS:
PRESIDENT'S ADVISORY COMMISSION, MEDICARE+CHOICE, AND PROPOSED LEGISLATION**

PROVISION	Advisory Commission	Medicare+Choice (Interim Final Reg.)	Daschle/Dingell (S6/HR358)	Ganske (HR719)	Chafee (S374)	Senate Republican (consumer protection provisions only) (S300)	House Republican (consumer protection provisions only) (HR448)
	Reporting.						
16. Experimental therapies	No	Medicare excludes coverage for experimental therapies. M+C organizations may cover experimental therapies through supplemental benefits.	No coverage mandate. Plan must disclose how it decides if treatment is experimental.	No coverage mandate. Plan must disclose how it decides if treatment is experimental.	No coverage mandate. Plan must disclose how it decides if treatment is experimental.	No coverage mandate. Plan must disclose whether experimental therapies are covered.	No coverage mandate. Plan must disclose whether experimental therapies are excluded from coverage and the definitions it uses.
17. Clinical trial coverage mandate	No	No	Yes, if enrollee has a serious illness for which no standard treatment is effective plan must pay routine costs.	Yes, if enrollee has a serious illness for which no standard treatment is effective plan must pay routine costs.	Yes, if enrollee has a serious illness for which no standard treatment is effective plan must pay routine costs.	No	No
18. Enforcement	No	HHS/Department of Justice have authority to seek civil money penalties (\$10,000 - \$100,000, or \$25,000 per violation plus \$10,000 for each week the deficiency	HIPAA enforcement provisions: Under PHSA, HHS may impose CMPs of up to \$100/day/violation. Under ERISA, DoL may impose CMPs of up to \$1000/day for certain violations	HIPAA enforcement provisions: Under PHSA, HHS may impose CMPs of up to \$100/day/violation. Under ERISA, DoL may impose CMPs of up to \$1000/day for certain violations	In addition to HIPAA enforcement provisions, grants HHS same investigative and injunctive relief authority as DoL has under ERISA. HHS and DoL may impose CMPs equal	Current ERISA enforcement provisions. Under ERISA, DoL may impose CMPs of up to \$1000/day for certain violations (generally limited to information disclosure	DoL may impose CMPs against a fiduciary for a pattern or practice of 1) adverse coverage decisions in violation of the terms of the plan or bill, 2) violations of ERISA §503 notice

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

PROVISION	Advisory Commission	Medicare + Choice (Interim Final Reg.)	Daschle/Dingell (S6/HR358)	Ganske (HR719)	Chafee (S374)	Senate Republican (consumer protection provisions only) (S300)	House Republican (consumer protection provisions only) (HR448)
		remains uncorrected), criminal penalties, intermediate sanctions (e.g., suspension of enrollment or marketing) and exclusion from the Medicare Program. A single violation may be prosecuted (i.e., a pattern or practice is not required).	(generally limited to information disclosure violations); for other ERISA violations, the IRS may impose excise taxes on group health plans. Individual may bring action to recover CMPs up to \$100/day for failures to provide required notices.	(generally limited to information disclosure violations); for other ERISA violations, the IRS may impose excise taxes on group health plans. Individual may bring action to recover CMPs up to \$100/day for failures to provide required notices.	to the greater of \$250,000 for pattern and practice or \$50,000 per individual for statutory violations that result in unreasonable denial or delay in benefits. For other statutory violations, CMPs equal to the greater of \$50,000 for pattern or practice or \$10,000 per individual. The maximum CMP is increased by \$10,000 for each week the problem remains uncorrected.	violations); for other ERISA violations, the IRS may impose excise taxes on group health plans. Individual may bring action to recover CMPs up to \$100/day for failures to provide required notices.	of denied claim requirements, or 3) violations of ERISA §503 full and fair review requirements. Penalties may not exceed the lesser of 5% of the aggregate value of benefit or \$100,000. The fiduciary may be removed by court.
19. Liability	No	Beneficiaries can sue M+C plans for damages for personal injury, wrongful death, breach of contract, and similar claims as	Amends ERISA (sec. 514) to permit suits for damages against plans for personal injury or wrongful death, as allowed by state law.	Amends ERISA (sec. 514) to permit suits for damages against plans for personal injury or wrongful death, as allowed by state law.	Adds Federal cause of action under ERISA (sec. 502(c)) to permit suits for economic damages against coverage decision-makers for	No change to ERISA pre-emption of state law suits. Adds failure to abide by decision of external reviewer to allowable actions	No change to ERISA pre-emption of state law suits. Tort reform provisions limit damages available in Federal and state law suits

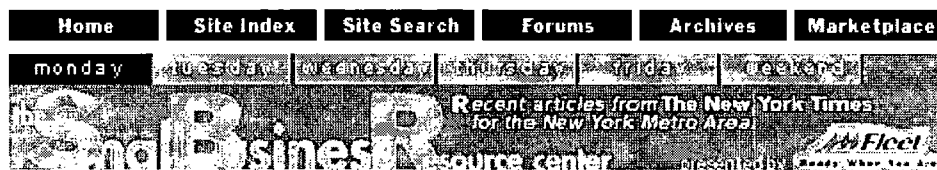
**COMPARISON OF CONSUMER PROTECTIONS:
PRESIDENT'S ADVISORY COMMISSION, MEDICARE+ CHOICE, AND PROPOSED LEGISLATION**

PROVISION	Advisory Commission	Medicare+Choice (Interim Final Reg.)	Daschle/Dingell (S6/HR358)	Ganske (HR719)	Chafee (S374)	Senate Republican (consumer protection provisions only) (S300)	House Republican (consumer protection provisions only) (HR448)
		allowed by state law. State law suits cannot be brought to obtain the actual Medicare benefit.	Exempts employer, employees, and plan sponsor if they did not exercise discretion to make a decision on the claim.	Exempts employer, employees, and plan sponsor if they did not exercise discretion to make a decision on the claim. No punitive damages when plan follows external appeal decision.	personal injury resulting from coverage determinations not made on a timely basis or in accordance with the terms of the plan or bill. Economic damages do not include punitives, pain and suffering, emotional distress, etc.	under ERISA sec. 502(c)(1).	against health plans (and providers and others), including M+C plans, but not to claims under ERISA. In lieu of liability, adds civil money penalties under ERISA sec. 502, where court finds a benefit was delayed or denied against the recommendation of the external reviewer. The fiduciary may be required to pay to the participant a civil fine of \$500/day up to \$250,000.
20. Ombudsman/Consumer Assistance	No recommendation, outlines desirable characteristics of such programs.	Nothing in BBA. HHS funds Statewide Insurance Counseling and Assistance (ICA) programs, and the	Yes, States (or federal if no State program). HHS to award grants to States.	Yes, States (or federal if no State program). HHS to award grants to States.	Yes, States (or federal if no State program). HHS to award grants to States.	No	No

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

PROVISION	Advisory Commission	Medicare+ Choice (Interim Final Reg.)	Daschle/Dingell (S6/HR358)	Ganske (HR719)	Chafee (S374)	Senate Republican (consumer protection provisions only) (S300)	House Republican (consumer protection provisions only) (HR448)
		Administration on Aging operates a Nursing Home Ombudsman program.					
21. Provider Protections	No	Plans must provide written notice of the rules of participation and of adverse participation decisions. Plans must provide a process for appealing decisions adverse to participating physicians.	Plan must provide written notice of rules of participation and of adverse participation decisions. Plans must provide a process for appealing adverse decisions of participation.	Plan must provide written notice of rules of participation and of adverse participation decisions. Plans must provide a process for appealing adverse decisions of participation.	Plan must provide written notice of rules of participation and of adverse participation decisions. Plans must provide a process for appealing adverse decisions of participation.	No	No

* Deadline stated, but is contingent upon receipt of information plan deems necessary. There is no deadline for providing the information, and there is no consequence to plan for failing to meet the deadline.

Breaking News
FROM A.P.The New York Times
ON THE WEB

February 23, 1999

HMO Group Urges External Reviews

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Filed at 3:34 a.m. EST**By The Associated Press**

WASHINGTON (AP) -- Fearful that Congress will give patients the right to sue HMOs, an HMO trade group is for the first time showing support for an alternate plan that would give patients who are denied care the right to appeal to outside experts.

The American Association of Health Plans is also urging its members to voluntarily offer independent appeals as prospects in Congress brighten for "patients' rights" legislation.

"Consumers ... (should) have access to independent review processes that are well-designed, fair and objective," the group said in a "statement of principles" approved Monday at a meeting focusing on congressional efforts to regulate the industry.

While the group is not endorsing any particular legislation, its action Monday represents the first time it has said it could support any new federal rules.

"We want to be part of the discussion," said Karen Ignagni, the group's president.

Last year, Ignagni said, the group spent its energies fighting legislation mandating benefits and expanding the right to sue. It argued that any new requirements would drive up costs and force employers to drop insurance coverage. Now, with Congress set to act, things have changed, Ignagni said.

"As we enter a year when people are looking at policy, we want to be clear on what we're prepared to say yes to," she said.

External appeals give patients the right to challenge decisions to doctors not associated with the insurance company. In recent months, many large health insurance companies have adopted these procedures on their own.

LEVEL 1 - 4 OF 5 STORIES

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SHOW: MORNING EDITION (11:00 AM on ET)

March 1, 1999, Monday

LENGTH: 1398 words

HEADLINE: FUTURE OF **MANAGED CARE** IN AMERICA

ANCHORS: BOB EDWARDS

REPORTERS: FRANK BROWNING

BODY:

BOB EDWARDS, host:

This is NPR's MORNING EDITION. I'm Bob Edwards.

The 1990s began with intense political debate over how to control health-care costs and extend coverage to the millions of uninsured. Increasingly, it looks like the decade will end with the same debate. Forty-three million Americans now lack health insurance, according to the Census Bureau, and the number continues to rise by a million people a year; that's despite several years in which health-care inflation has been modest.

Managed care and HMOs have gotten much of the credit for controlling inflation, but there are signs that that's about to change. In the first of four reports this week, Frank Browning examines the future of **managed care** in America, beginning with the turmoil now under way in the industry.

FRANK BROWNING reporting:

The big news in health care this winter is mergers, not just big companies buying up small ones, which has been a steady trend for the last decade, but health insurance mammoths, like Aetna, swallowing up elephants, like Prudential. Health-care corporations, of course, are not alone. The swallowers of the AT&T, AOL/Netscape, Exxon and Mobil cases know the 1990s may well go down as the hallmark decade of megamergers.



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But the advent of health-care mergers, in a decade that was supposed to be the apogee of health-care competition, touches us directly and immediately in ways that other Wall Street maneuvers often don't,' says Larry Levitt, an economist who studies the national health-care market for the Kaiser Family Foundation.

Mr. LARRY LEVITT (Kaiser Family Foundation): I think what it means for consumers, which I think is probably the most important thing, is less choice. As enrollment consolidates into these very large national companies, it means that consumers and employers, for that matter, have a choice of fewer and fewer plans. And I think choice is very central to what consumers are looking for in the health-care system today.

BROWNING: Choice--here is the hot-button word, just as it was during the battle six years ago over the Clinton reform plan. Then, the health-insurance industry launched a \$ 10 million attack on the White House plan for universal care, including the famous Harry and Louise TV ads.

(Excerpt from television ad)

LOUISE: This was covered under our old plan.

HARRY: Oh, yeah. That was a good one, wasn't it?

Unidentified Announcer: Things are changing, and not all for the better. The government may force us to pick from a few health-care plans designed by government bureaucrats.

LOUISE: Having choices we don't like is no choice at all.

HARRY: And if they choose...

LOUISE: We lose.

(End of excerpt)

BROWNING: But, in fact, now 60 percent of all insured American workers have no choice of health plans, and another 20 percent have only two plans to choose from. After Aetna announced in December that it was buying Prudential in New York state, doctors raised loud complaints because they regarded Aetna as the most restrictive insurance company in the state. If the merger goes through, Aetna could end up with about a third of the New York health-care market, and that, argues Princeton University health economist Uwe Reinhardt, effectively eliminates any real competition.

Mr. UWE REINHARDT (Health Economist, Princeton University): If these plans keep buying each other up, that's no longer competition because the executives of those plans can pretty much regulate everything they want in one golf game.

BROWNING: Should consolidation of the mega health plans continue as it has, Reinhardt sees doctors and hospitals forming new alliances to bargain directly with the two or three giant **managed-care** companies in their locales.



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Mr. REINHARDT: So that, basically, in every area, you have two huge blocks, providers and payers, hashing out deals. If that happens, I think the consumer will be sent a stiff bill. If that should happen, I'd tell the industry people sooner or later the government will convert you into a regulated utility. So my advice to the industry is, don't be too exuberant in consolidating. Allow there to be some competition.

BROWNING: Merger and consolidation, however, may be very hard for **managed-care** companies to avoid if they're to satisfy their stockholders. Cost cutting, combined with high levels of employment, enabled huge companies like Cigna, United Health and Prudential to make reasonable profits during most of the 1990s, but those days now seem to be over. Most of the savings gained from forcing hospitals to be more efficient seem to have already been taken, and renewed cost increases, driven by double-digit inflation in breakthrough drugs and high-tech treatment, have eaten away at insurers' profits in the last two years.

Result? Pharmaceutical stocks have soared; health-care stocks for companies like Prudential and United plummeted. Even non-profit Kaiser Permanente hemorrhaged \$ 1/4 billion in losses last year. As ever, weaker players sell out to stronger ones that have been more effective at cost cutting, and rates go up; this year, by an average of 10 percent to 12 percent, and for small employers, as much as 30 percent to 60 percent. Further result? More Americans than ever are going without health insurance,' says economist Larry Levitt.

Mr. LEVITT: About one in six people under age 65 are uninsured, and that number's growing by about a million a year.

BROWNING: In 1993, when the Clinton reform plan was proposed and defeated, about 37 million people were uninsured. Now about 44 million are uninsured, and the steady increase further fuels a vicious cycle of price hikes.

Mr. LEVITT: When people do get very sick and go to the hospital, those costs end up getting spread, put on to other people, who pay higher insurance rates, higher hospital rates, higher physician fees.

BROWNING: Those higher rates drive more people away from getting insurance, which pushes the price cycle higher. The uninsured also get sicker because they don't get preventive care themselves or immunization for the children, which means their health care, when they do get sick, costs more.

Consumer anger has already turned against conventional **managed care** and toward tougher regulation. Last year, Congress failed to pass tougher regulations on **managed care**, but both Republican and Democratic bills to do just that have been reintroduced this year. And in California, the nation's largest health-care market, new legislation is expected this year that will give consumers financial and health-care quality information about all the state's HMOs, says former Assistant Secretary for Health Phil Lee.

Mr. PHIL LEE (Former Assistant Secretary for Health): Now you can't get the same information from one HMO and another. They'll have to disclose information that will be available to the public so that the people can make choices about health plans.



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BROWNING: What kind of information?

Mr. LEE: Well, information about outcomes of care, quality of care, costs of care.

BROWNING: Lurking beneath all these issues is a still-greater anxiety that used to only be whispered among the health planners: the R-word, rationing. The more insurers and consumers demand to know which doctors, which hospitals, which treatment regimes are most effective at keeping us healthy, the more high-tech drugs and treatments emerge with very high price tags, the more we consumers will be forced to decide how much we're willing to pay for the care we get.

Whether it's a government-regulated system or vouchers and tax credits going to individuals, says economist Reinhardt, we will soon all be forced into making new kinds of health-care choices.

Mr. REINHARDT: A health plan will say to a woman, 'If you're 40 years old, we will not routinely screen for breast cancer. However, if you wish to purchase it, we will provide the test for you at a reasonable price.' That's rationing by income class, and I think we will have it. We have, of course, rationing now. The uninsured are brutally rationed. That's not the kind of rationing I'm talking about. I would think there will be one package or system to which everyone should have access, and then if people want Disneyland, if they want that extra test, then maybe they can have it but pay for it out of their own pocket. People will then say that means the rich get better than the poor, and the answer is yes.

They do when it comes to jails. They do when it comes to justice. They do when it comes to education, to food, housing. And that'll be so in health care. It already is that way in health care. We just don't want to admit it to ourselves.

BROWNING: How soon any of these changes come about is a tough guess. To put all Americans under age 65 into basic HMO care would cost about \$ 100 billion, Reinhardt says, and that doesn't seem likely soon. But two things are sure: that cost of care will continue to rise and individual consumers will carry a bigger share of the burden. For NPR News, I'm Frank Browning.

EDWARDS: Tomorrow employers search for a way to shift the burden of health coverage to workers.

LANGUAGE: English

LOAD-DATE: March 3, 1999



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SHOW: MORNING EDITION (11:00 AM on ET)

March 2, 1999, Tuesday

LENGTH: 1288 words

HEADLINE: EMPLOYER-PAID HEALTH INSURANCE IS CHANGING RAPIDLY AND IT IS EXPECTED WORKERS WILL BE PAYING MORE OF THEIR PREMIUMS IN THE NEAR FUTURE

ANCHORS: BOB EDWARDS

REPORTERS: FRANK BROWNING

BODY:

BOB EDWARDS, host:

This is NPR's MORNING EDITION. I'm Bob Edwards.

Middle-class working Americans used to take health care for granted. It was something the boss paid for. An insurance card in your pocket meant most, if not all, trips to the doctor or hospital were free. That era is ending fast. In the second part of the series on the future of health care in America, Frank Browning finds that many employers want to stop paying for health care and are considering ways to shift the insurance burden to workers.

FRANK BROWNING reporting:

It all began during World War II. Major corporations whose employees' salaries were frozen by wage and price controls started offering extra benefits that weren't called wages and, therefore, weren't regulated. One of the first of these was health insurance. And in the view of economist Uwe Reinhardt, it was right there that today's health insurance morass began.

Mr. UWE REINHARDT (Economist): I think that is the foundation of our problem. Any fringe benefit ultimately comes out of the paycheck of the worker, because the maximum the company can afford to pay is take-home pay plus the fringes. If you put more in fringes, you will get less take-home pay, which is



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exactly what happened in the '70s and in the '80s. But workers are firmly convinced that the, quote, "company," unquote, pays for health care.

BROWNING: A bigger problem with employer-based health care, says Dr. Peter Juhn of Kaiser Permanente, the nation's largest non-profit HMO, is how it divides the actual consumer from the purchaser of health care.

Dr. PETER JUHN (Kaiser Permanente): We have the paying customer, i.e., the employer, if you will, or employer group, and then you have the using customer, who is the patient.

BROWNING: That division, says Princeton economist Uwe Reinhardt, is a formula for medical inflation.

* Mr. REINHARDT: Because the worker then takes very little interest in cost containment. And you can see it now. The workers want the patient protection act, which says, We don't ever want anything denied to us. And if it is, we want to have appeal mechanisms to make sure that in the end we get it anyhow. What workers may not realize is that these patient protection acts will raise the premium of health insurance that the employers have to pay, and the employers will do one of two things. Either they'll tell the worker explicitly, I'll knock it off your paycheck, or they'll pretend to absorb it but ultimately raise take-home pay more slowly than otherwise they would have. But the workers will pay the bill. There's no question.

BROWNING: That, in fact, is already happening. From 1980 to 1993, the American gross domestic product increased only 17 percent per capital, but corporate spending on health care went up 218 percent per worker. To hold their costs down, companies did two things. They forced their employees to switch to HMOs and other tightly controlled **managed-care** plans, and they made the employees pay directly for more and more of the monthly premiums, says Sarah Rosenbaum, a health policy analyst at George Washington University Medical Center.

Dr. SARAH ROSENBAUM (George Washington University Medical Center): Most families with family coverage have to pick up probably on average now between 40 percent and 50 percent of that premium. So, in fact, we're in an ironic situation where the partner at the purchasing table, i.e., the individual, or all the individuals, are having their contracts negotiated for them without any role whatsoever.

BROWNING: And, in fact, says Dr. Nancy Dickey, president of the American Medical Association, the employer-based system has all but eliminated serious choice in health-care coverage.

Dr. NANCY DICKEY (President, American Medical Association): Sixty percent of the people who get their insurance from their employer get only the choice of, 'Take it or leave it.' The employer says, 'Here, this is all I can afford to offer as one plan.' For another substantial group of people who get their insurance through their employer, the choice is HMO A or HMO B, kind of like, 'Do you want a black car or do you want a black car?' And so we get down to a very small percentage who have any meaningful choice. In reality, it doesn't exist.

BROWNING: The question is: How could individual consumers have choices over



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both the cost and the quality of their plans? Peter Juhn, who directs the **Managed Care** Institute(ph) at Kaiser Permanente, favors bringing individual consumers directly in to the purchasing decision.

Mr. JUHN: My employer has defined a benefit package for me, and I have to choose between health plan A, B or C. Most of what's driving my decision is, 'What's going to be my out-of-pocket expense?' The question of the quality of the health plan matters less to me. When I think about quality of health care, I think about it when I need health care.

BROWNING: What Juhn wants consumers to do is to think about the quality of the care they will get at the same time they're reaching into their pockets.

Mr. JUHN: If it is your dollars and it's not just choosing between three health plans, but you, if you will, customizing a health plan that's right for you and your family, then, like you're shopping for other things, you're going to spend a lot more time and energy figuring out, 'Do I really want to sign up for this particular plan? And do the physicians who belong to that plan have a good track record and have good quality ratings?'

BROWNING: Fair enough, to a point, says Sarah Rosenbaum. But to expect each individual employee to negotiate a contract with a **managed-care** company like Kaiser or Aetna or United Health is absurd.

* Dr. ROSENBAUM: The average employee could not make heads or tails out of the contract. Let me give you a hypothetical. Let's say that the contract said in it that we cover medically necessary care and defines medical necessity as care that's needed to restore you to full functioning following an illness or injury. You would view that as a positive: We will give you everything that it takes to restore you to full functioning following an illness or an injury.' Actually, that clause is used quite precisely in the opposite fashion: We will deny any care that's needed by a person who cannot be restored to full functioning.' And so my feeling is that most lay people couldn't even begin--by lay, I mean people who are teachers, doctors, economists, you name it--would not even know what that phrase meant or how lawyers use that phrase.

BROWNING: Nancy Dickey of the AMA believes patients can make smart medical decisions if they're given the right information.

Dr. DICKEY: I have great faith in the American public. I sit down with them one on one in my exam rooms every day and have to interpret extraordinarily complex medical issues in a fashion that allows them to make choices of treatment. But I would also say to Dr. Rosenbaum that having individuals select plans might be the single best motivation for telling plans to get rid of the boilerplate and tell us in common English what it is you cover and what you don't cover. After all, the American people ought to know what's covered when they sign up, not when they sign in at the emergency room.

BROWNING: In any case, health-care analysts and insurance industry executives believe that most employers will soon quit negotiating health-care contracts for their workers. Lee Newcomer, medical director of United Health, the nation's largest **managed-care** company, expects major changes.

Mr. LEE NEWCOMER (United Health): I think it's very likely that consumers will be buying their own health plans in the next five to 10 years.



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BROWNING: Newcomer sees a gradual shift during which employees will pay out a fixed sum per employee to an independent association or health purchasing alliance, which the workers themselves will choose. Then there will be further options and cost shares the worker can choose based on how much he or she wants to pay. Membership in those associations or alliances might be available to broad groups of employees or even to individuals who now have very limited access to affordable health plans. The major questions will be how to make all the options understandable to individual consumers so that they can customize their own plans while still getting the protection and bargaining clout that only large groups can wield. For NPR News, I'm Frank Browning.

EDWARDS: Tomorrow, holding health plans, hospitals and doctors accountable for their claims of quality.

It's 11 minutes before the hour.

LANGUAGE: English

LOAD-DATE: March 3, 1999

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SHOW: MORNING EDITION (10:00 AM ET)

March 3, 1999, Wednesday

LENGTH: 1355 words

HEADLINE: MEASURING THE QUALITY OF CARE GIVEN AT HOSPITALS AND BY DOCTORS

ANCHORS: BOB EDWARDS

REPORTERS: FRANK BROWNING

BODY:

BOB EDWARDS, host:

This is NPR's MORNING EDITION. I'm Bob Edwards. Most Americans get their health insurance through an employer or a professional association. But within five to 10 years, health planners predict most employers will drop out of the health insurance business. Employers instead may give workers vouchers and employees will be forced to shop for their own health-care coverage. In his third report on the future of **managed care**, Frank Browning examines whether consumers will have enough information to choose the best plan.

FRANK BROWNING reporting:

You start out with trust. You trust that your doctor is knowledgeable, that your nurse is well-trained, that your hospital is safe, sanitary and well run. But chances are that very people listening right now have ever seen a cold scientific evaluation of the doctors, nurses and hospitals in their health-care plans. If they had,' says Michael Millenson author of "Demanding Medical Excellence," their trust in the health-care system might be lower, but their ability to choose medical providers would be a lot better.' He cites the matter of heart bypass surgery.

Mr. MICHAEL MILLENSEN (Author, "Demanding Medical Excellence"): If you have someone with heart disease, the fact is that very, very simple information that you don't even need to be an expert to evaluate--the medical experts say that in



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order to have minimum proficiency to do bypass surgery, a hospital should do 200 of those procedures every year. Nearly one-third of the hospitals in this country that do bypass procedures don't do the minimum 200. Why don't we publish that data which is available from the government and consultants have it, but the public doesn't have it? Why not publish that data and if I need bypass surgery or my dad needs bypass surgery, if the hospital is under 200 a year, at least let me ask them, Excuse me. The profession says this is the minimum for competence and you're not there. Why not?'

BROWNING: Millenson is in the vanguard of the movement to force greater accountability on doctor groups and hospitals. He points out that some measures of health-care quality are off limits to the public. For example, the National Practitioner Data Bank, which monitors such basics as malpractice and professional sanctions against doctors. A number of **managed-care** companies also produce internal report cards on their doctors, but generally they don't release them to the patients.

Lee Newcomer, medical director of United Health, says report cards are vital because independent research shows that about a third of all procedures performed are either wrong or unnecessary.

Mr. LEE NEWCOMER (Medical Director, United Health): We're finding that no matter where we look across the United States, when we look at a very standard care that it's not done somewhere between a third and a half of the time.

BROWNING: One measure they looked at was how often the doctors gave their patients drugs called beta-blockers after a heart attack.

Mr. NEWCOMER: And that's important because a beta-blocker reduces the chance of having a second heart attack by 20 percent to 40 percent. And yet when we measured that across the country, we found that three out of 10 patients who should have had that drug after their heart attack did not get a prescription.

BROWNING: Even the American Medical Association favors measuring doctor performance and credits **managed care** with improving medical evaluations. Dr. Nancy Dickey, a family practice physician, is president of the AMA.

Dr. NANCY DICKEY (President, AMA): To simply say Hey, I'm pretty good at what I do, 'isn't adequate for **managed care**. If you want to get into one of the competitive programs, then you have to be able to show them that you're top of the line in terms of what you do. So measuring what it is we've said we do is increasingly important. And again, that's important for patients to be able to say, How does this practice or this doctor function?'

BROWNING: Part of the reason the AMA now supports doctor evaluation is that not much of anybody is happy about the current state of affairs among patients, doctors, employers and insurance companies. Patients worry about dwindling levels of choice in the midst of national **managed-care** mergers and distant evaluators who reverse doctors' decisions. But if individual consumers are to become the architects of their own health care, they will need evaluation reports more than ever, both to guarantee quality and to conserve their own money. Beth Horowitz(ph), an internist on the faculty of George Washington University Medical Center, agrees, but she questions the kind of report cards now being produced.

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Ms. BETH HOROWITZ (Internist, George Washington University Medical Center): It's the nature of the data that matters. What some of the companies are doing now with their physicians is they are basing their reimbursement to the doctor on the results of these report cards. So, for example, they will give out a certain number of points to each physician based on his or her number of referrals, number of tests ordered, number of prescriptions written inside and outside of the formulary. And then, based on the number of points, a doctor gets--he or she gets reimbursed on a particular scale.

BROWNING: Too many referrals, too many tests, too many prescriptions off the approved list or formulary of drugs and the doctor's reimbursement per patient is cut. So far, most detailed report cards are still produced by the **managed-care** companies themselves and are only available to each participating doctor and hospital.

Mr. PHIL LEE (Former Assistant Secretary of Health): Now, people put out these reports--so called report cards, but they're basically public relations efforts.

BROWNING: Phil Lee, who served as assistant secretary for health in both the Johnson and Clinton administrations, is a staunch proponent of report cards, but not those made up by insurance companies.

Mr. LEE: Where they do well they put out the good news. Where they don't do well they don't put out the good news. We need a structure at the state level and in the national level for regulating--now people don't like to use the word regulation. We need to regulate **managed-care** plans. We need to prevent deceptive advertising. We need to provide the information consumers need to make choices.

BROWNING: Choice in the future, however, may not mean the same thing as it has in the past. Surveys consistently show that the main thing patients want is unfettered freedom to choose their own doctor. However, Pat Powers, who runs the Pacific Business Group on Health, which independently evaluates doctor groups, hospitals, HMOs and health plan in California, says consumers will have to think about choice in new ways.

Ms. PAT POWERS (Pacific Business Group on Health): Our job is to say, You can ask your neighbor, your co-worker, your spouse what they think about a given doctor. But we just want you to know that there is scientific information on satisfaction surveys from a representative sample of this doctor's population. And we also want you to know that your doctor does these certain kind of surgeries and here's the mortality rate for those surgeries. And by the way, your doctor keeps X percent of his people that he takes care of out of the hospital because he's really good at providing preventive care.'

BROWNING: That kind of evaluation eventually comes back to cost, quality and choice. But too often,' Powers says, Americans confuse the freedom to choose any doctor they can find with choosing the best health-care program they can find.'

Ms. POWERS: You need to look at choice vs. quality.

BROWNING: As an example, she cites the Bay Area division of Kaiser-Permanente, the nation's largest non-profit HMO, where all doctors and



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nurses are on staff and which has been providing preventive medical screenings since World War II.

Ms. POWERS: They are looking internally at their populations and what kind of care they're delivering. So they have the highest mammography rate, the highest prenatal care rate, good diabetic retinal exam rates. They are looking at what they're doing and improving it over time. So that kind of choice, even though it's restricted in the eyes of the patient, is a better choice than going to a traditional indemnity plan where you can go to any doctor and any hospital, but who's managing your care--managing in the positive sense of understanding that you may have multiple problems and they can make sure that you're seeing the right specialist and getting your care coordinated?

BROWNING: To that end, she, Phil Lee and many other patient advocates argue that with real medical report cards, a consumer-driven system may be better able to push costs down and quality up more effectively than the sort of **managed-care** contracts currently negotiated between corporations and the insurance industry. The trick, they say, will be turning money management into real health management.' For NPR News, I'm Frank Browning.

EDWARDS: Tomorrow, how one HMO saves money by making coverage decisions based on scientific evidence, not economics.

It's 11 minutes before the hour.

LANGUAGE: English

LOAD-DATE: March 3, 1999

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SHOW: MORNING EDITION (10:00 AM ET)

March 4, 1999, Thursday

LENGTH: 1280 words

HEADLINE: BASING INSURANCE COVERAGE DECISIONS ON SCIENTIFIC PROOF OF WHAT WORKS

ANCHORS: BOB EDWARDS

REPORTERS: FRANK BROWNING

BODY:

BOB EDWARDS, host:

This is NPR's MORNING EDITION. I'm Bob Edwards.

More than 80 percent of all employee health plans are **managed care** contracts. One reason for their popularity is that they have helped keep health costs under control for the past few years. But patients and health providers often complain about the restrictive coverage policies of HMOs, leading to continued pressure on Congress to regulate. Some insurers and HMOs have begun to move away from purely financial management of costs. In the final part of his series on the future of **managed care**, Frank Browning reports on evidentiary medicine, an approach to prevent and manage disease by relying on scientific evidence of what works.

FRANK BROWNING reporting:

Here at the Keiser Permanente Hospital just north of San Diego, a steady stream of presumably healthy Keiser members shows up every day at the Preventive Medicine Center to be poked, puffed, tapped, bled and measured.

Unidentified Man #1: We're going to be doing a test on you today for glaucoma, actually. If you'll just gently place your chin in the cup, place your forehead...



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BROWNING: The glaucoma test is one of several screening stations that patients walk themselves through that Keiser uses to monitor and manage all their members' health.

Man #1: Now the next thing we're going to be doing is a pulmonary function test.

Unidentified Woman: OK.

Man #1: Now what we're doing here is we're measuring the capacity of your lungs, so it's how much air you can move...

BROWNING: After all the body tests are complete, the patients take home questionnaires about family medical history and personal habits, then send them back to the preventive medicine staff. Two weeks later they come in for 45-minute interviews to talk about their overall health profile. Dr. Vincent Falitti(ph) directs the Preventative Medicine Center, which is something of a showcase in the Keiser Permanente system, the nation's largest non-profit HMO. A middle-aged man named Dan arrived the morning we were there for his follow-up interview, only to discover that he had been diagnosed with hemochromatosis, an oversaturation of iron, which in later life can cause several serious diseases.

Dr. VINCENT FALITTI: But--but why don't I stop right now and see if you have any questions to ask me.

DAN (Patient): Would this be a permanent treatment? Would this go on for the rest of my life, or...

Dr. FALITTI: OK, the first goal of treatment would be to take a pint of blood from you every week until the total load of iron in your body is returned to normal.

BROWNING: Keiser screens 50,000 adults a year for hemochromatosis, and is the only **managed care** company in the country to do so. Roughly four of every 1,000 Americans suffer hemochromatosis, though very few know it. Most die of the other diseases it causes--diabetes, cirrhosis, cancer and heart failure.

Dr. FALITTI: We found that to diagnose one patient was costing us about \$ 1,100. We calculated our lifetime treatment cost for hemochromatosis at about \$ 6,000, and we calculated that an undiagnosed case would probably cost us lifetime about \$ 46,000.

BROWNING: Screening and early treatment for hemochromatosis, therefore, costs less than one-sixth as much as letting the disease go undetected. That proactive approach touches the core controversy around the term **managed care**. Is it coordinated health management or simply bottom line cost control? Critics say that most for-profit HMOs have chosen the easy way, cut costs by lowering payments to doctors and hospitals and call that **managed care**. Only Keiser and a few others do what most HMOs started out doing, which was preventing disease as way to save both money and lives. Keiser has been, by almost all accounts, the national leader in pursuing the large-scale preventive medicine. Now it is turning another corner to what is called evidentiary medicine. Peter Juhn, executive director of Keiser's **Managed Care** Institute(ph), believes that by marrying clinical and epidemiological research to treatment and prevention programs, medical care will be made cheaper and more effective in the future.



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Mr. PETER JUHN (Keiser **Managed Care** Institute): If you think of the research as being the science of creating the evidence for medical practice, what the Care Management Institute does is takes that science and engineers tools from those insights.

BROWNING: As a further example, Juhn sites the procedure known as sigmoidoscopy for colon cancer screening. Relying largely on a study of its own patient population, Keiser recommends screening all people over 50 with a sigmoidoscopy once every 10 years.

Mr. JUHN: The original research was done in our Northern California Division of Research(ph), and through the studies that they did, the epidemiological studies they did, they came out with the insight that screening at this rate is the best way to detect colorectal cancer.

BROWNING: Using that research, Keiser developed what it calls the COCAP, or colorectal cancer screening program, to train nurse practitioners in colorectal cancer screening.

Mr. JUHN: So that they went from one year screening--I think had 5,000 of these screens; the next year they had 60,000. So you went from doing the science, engineering the tools and then deploying the tools to actually affect patient care.

BROWNING: Programs like Keiser's are more aggressive than most. Furthermore, because most **managed care** companies have high patient turnover, they cannot conduct the sort of long-term research on which evidentiary medicine is based. More to the point, few medical practice groups are organized around multiple specialties such as Keiser's is, and they are not set up to do the sort of outcome research on their own patients. That according to Phil Lee(ph), founder of the University of California's Health Policy and Research Institute, is one of the major flaws in both the practice and financing of contemporary **managed care**.

Mr. PHIL LEE (University of California Health and Policy Research Institute): Most **managed care** plans in this country are really a variance of fee-for-service, solo practice medicine, and as such we have not taken advantage of the integration that can occur with a group practice. The doctors are still in their solo offices, they still maintain their own records. There isn't a unified medical record; there isn't an integration of the care of those individual patients. There's still far too much fragmentation, and too much management of the care occurs at the health-plan level instead of the doctor-nurse delivery level.

BROWNING: A comprehensive rebuilding of the health system, Lee says, wouldn't necessarily look like Keiser Permanente, with its nationwide network of HMO facilities. But it would be based on a coordinated approach that encourages healthy living through exercise and better diet, along with regular preventive screening and integrated record keeping for each patient. Yet that sort of approach requires patients to make new kinds of decisions, says Peter Juhn. He sites the control of cholesterol. Patients with very high cholesterol would be medicated immediately because research evidence shows that reduces heart attacks dramatically. Other patients whose cholesterol is only slightly elevated might

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National Public Radio (NPR), March 4, 1999

be encouraged to eat less fat and exercise vigorously. If you wanted quicker results, you could ask your doctor for an anti-cholesterol prescription, but you'd have to pay for it.

Mr. JUHN: If it's in that murky zone, then you should make that tradeoff as to do you want to pay that extra amount.

BROWNING: As individuals become active consumers who have to make real financial choices, Juhn argues, they also become more actively involved in owning their own health rather than acting as passive beneficiaries of medical expertise.

Mr. JUHN: It creates a joint decision between you, the patient, and the doctor. Secondly, it reviews the evidence, and in reviewing the evidence it is clear-cut where the benefits are, and also clear-cut where the benefits might be but are not for certain. And then the third thing is that it gives the choice to you, the patient, to make that tradeoff whether you want to pay the extra co-pay and get this drug.

BROWNING: Underlying that consumer world of choice and tradeoff are two assumptions that the medical consumers are well enough educated to understand the choices before them and that they have enough money to afford sound, basic coverage. For NPR News, I'm Frank Browning.

EDWARDS: It's 11 minutes before the hour.

LANGUAGE: English

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CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

July 16, 1998

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

As modified by the sponsors

SUMMARY

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

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

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

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

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

ESTIMATED COST TO THE FEDERAL GOVERNMENT

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

BASIS OF ESTIMATE

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

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

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

SOURCES: Congressional Budget Office and Joint Committee on Taxation.

NOTES: HI = Hospital Insurance

FEHBP = Federal Employees Health Benefits Program

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

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

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