U.S. House of Representatives
Committee on Commerce
Room 2125, Rayburn House Office Building
Washington, DC 20515–6115

DEMOCRATIC STAFF

FAX COVER SHEET

DATE: 2/10/00

TO: Chris Jennings 456-5557

FROM: Bill Vaughn/Debbie Curtis 6-4969

FAX NUMBER: David Nexon 4-3533
~~Dennis Fitzgibbons 5-2525~~

NUMBER OF PAGES:
(Including Cover)

COMMENTS: "No access pieces yet-in the next few days."

(If there are problems with this transmission,
please phone 202-226-3400, Democratic Staff, 564 FHOB.)

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, DC 20515

Dan L. Crippen
Director

February 10, 2000

Honorable John D. Dingell
Ranking Minority Member
Committee on Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Congressman:

At the request of several Members, the Congressional Budget Office is preparing cost estimates for S. 1344, the Patients' Bill of Rights Act, as passed by the Senate, and the Bipartisan Consensus Managed Care Improvement Act, contained within H.R. 2990, as passed by the House.

Although CBO and the Joint Committee on Taxation have not yet completed estimates of the budgetary effects of those bills, CBO has estimated their long-run effects on the premiums for employer-sponsored health plans. We estimate that enacting S. 1344 would increase such premiums by an average of 1.3 percent, and that enacting H.R. 2990 would increase premiums by an average of 4.1 percent. The attached tables delineate the impact on premiums of various provisions of the two bills.

I hope this information is helpful to you. The CBO staff contacts are Tom Bradley and Judith Wagner, who can be reached at 226-9010 and 226-2653, respectively. We expect to transmit the completed cost estimates shortly.

Sincerely,

Dan L. Crippen

Attachments

Identical letters sent to Honorable James M. Jeffords, Honorable Don Nickles, Honorable Tom Bliley, Honorable Bill Archer, Honorable John A. Boehner, Honorable Charlie Norwood

ATTACHMENT 1

ESTIMATED ULTIMATE EFFECT OF S. 1344, THE PATIENTS' BILL OF RIGHTS ACT, ON PREMIUMS FOR EMPLOYER-SPONSORED HEALTH INSURANCE
(In percent)

Provision	Increase in Premiums
Title I	
Subtitle A—Right to Medical Advice and Care	
Access to emergency care	0.2
Offering choice of coverage options	0.2
Access to obstetric and gynecological care	a
Access to pediatric care	a
Access to specialists	0.1
Continuity of care	0.2
Protection of patient-provider communications	a
Right to prescription drugs	a
Self-payment for behavioral health care services	a
Coverage for cancer clinical trials	0.1
Prohibiting discrimination against providers	a
Subtitle B—Right to Information About Plans and Providers	a
Subtitle C—Right to Hold Health Plans Accountable	0.3
Title II	
Women's Health and Cancer Rights	0.2
Title III	
Genetic Information and Services	a
Total	1.3

SOURCE: Congressional Budget Office.

NOTE: S. 1344, as passed by the Senate on July 15, 1999.

a Less than 0.05 percent.

February 10, 2000

ATTACHMENT 2

ESTIMATED ULTIMATE EFFECT OF THE BIPARTISAN CONSENSUS MANAGED CARE IMPROVEMENT ACT ON PREMIUMS FOR EMPLOYER-SPONSORED HEALTH INSURANCE (In percent)

Provision	Increase in Premiums
Title XI[a]	
Subtitle A—Grievances and Appeals	
Utilization review activities	0.2
Internal and external appeals	1.3
Establishment of grievance process	b
Subtitle B—Access to Care	
Consumer choice	0.2
Choice of health care professional	b
Access to emergency care	0.4
Access to specialty care	b
Access to obstetric and gynecological care	0.1
Access to pediatric care	b
Continuity of care	0.3
Access to needed drugs	b
Clinical trials	0.5
Subtitle C—Access to Information	b
Subtitle D—Protecting the Doctor-Patient Relationship	
Prohibition of interference with communications	b
Prohibition of discrimination based on licensure	b
Prohibition against improper incentive arrangements	b
Payment of claims	b
Protection for patient advocacy	b
Title XIII	
ERISA Liability Preemption	1.0
Total	4.1

SOURCE: Congressional Budget Office

NOTES: The Bipartisan Consensus Managed Care Improvement Act, as passed by the House of Representatives on October 6, 1999 (as part of H.R. 2990).

ERISA = Employee Retirement Income Security Act

a. Figures include impacts on group health plans and group health insurance coverage under the Public Health Service Act (resulting from the provisions of Title XII) and the Employee Retirement Income Security Act of 1974 (resulting from the provisions of Title XIII).

b. Less than 0.05 percent.

February 10, 2000

J. Wagner
2/10/00

Differences between S6 (Kennedy/Dingell revised) and HR2990 (Norwood/Dingell passed)

S6: Total Estimate as percent of ESI plan costs		**4.8%**
Subtractions from S6:		
Deleted Section 108 (Adequacy of Network)	-0.2	
Deleted Section 112 (standardized data)	-0.2	
Deleted Section 111 (Internal Quality Assurance)	-0.2	
Deleted Section 143 (participation of health care profs)	-0.2	
Deleted Section 151 (medical necessity)	-0.8	
Liability Estimate reduced (punitive damages; futility of exhaustion)	-0.4	
Subtractions subtotal:		**-2.0%**
Additions to S6:		
Utilization Review (S6-115<0.05; HR2990 =0.2) (tight deadlines; some activities of s6-111)	+0.2	
Internal and External Appeals (S6: 0.3; HR2990=1.3) (tight dealines for external appeals; 3 clinical peers; clinical peers active must be practice specialists; criteria include medical necessity)	+1.0	
Miscellaneous technical corrections (adjustments For new data on enrollment & unit costs; Misc. small changes in bill)	+0.1	
Additions subtotal:		**+1.3%**
Norwood Net Cost Estimate:	(4.8-2.0+1.3)	**4.1%**

U.S. House of Representatives
Committee on Commerce
Room 2125, Rayburn House Office Building
Washington, DC 20515–6115

DEMOCRATIC STAFF

FAX COVER SHEET

DATE: February 11, 2000

TO: Chris Jennings

FROM: Bridgett Taylor

FAX NUMBER: 456-5557

NUMBER OF PAGES:
(Including Cover) 3

COMMENTS:

(If there are problems with this transmission,
please phone 202-226-3400, Democratic Staff, 564 FHOB.)

United States Senate

WASHINGTON, DC 20510

February 9, 2000

Dear Conferees:

As we begin the second session of the 106th Congress, the leadership of both parties has emphasized that adoption of managed care legislation should be one of our top priorities.

We strongly believe Congress should act early this year to address the challenges confronting our nation's system of managed health care. Last October, the House of Representatives approved managed care legislation, authored by Representatives Norwood and Dingell (HR 2723), with strong bipartisan support (275 to 151). This bill represents the most promising legislative vehicle to strengthen managed care, and we urge you to adopt the patient protection provisions it contains.

This legislation would restore consumer confidence in our managed care system, while holding down costs. Any weakening of the provisions approved by the House will undermine these goals. Critically, Norwood-Dingell would give patients an effective external review process to resolve coverage disputes and would hold managed care companies accountable for their actions. Without credible accountability mechanisms, patient protection legislation is a hollow promise.

Americans desire a debate that can result not in a stalemate and an election issue, but a process of compromise producing real reform. We believe the Norwood-Dingell proposal can form the basis for a consensus document that can be signed by the President. If acceptance of Norwood-Dingell is not achievable, we encourage you to consider the enclosed "Chafee-Graham" proposal as a compromise. Based on the Promoting Responsible Managed Care Act (S. 374), it blends key features of both House and Senate proposals and is bipartisan in nature.

If the conferees adopt these recommendations, 161 million Americans would gain the protections they deserve, and Congress would demonstrate its ability to rise above partisanship in order to solve divisive problems. This Congress would address a major concern of most Americans with legislation based on good policy and sound principles.

Thank you for considering our views.

Sincerely,

Attachment

F A X

From the desk of...
Robert Greenstein
Executive Director

202-408-1080
Fax: 202-408-1056

Center on Budget and Policy Priorities

To: Chris Jennings

Fax #:

Subject: MSA Expansion in Patients' Bill of Rights

Date: February 24, 2000

Pages: 10

COMMENTS:

Thought you would be interested in this new paper. Ellen is talking to people on the Hill about this. We would be interested in speaking with you about this issue.

CENTER ON BUDGET AND POLICY PRIORITIES

February 23, 2000

MSA EXPANSIONS IN PATIENTS' BILL OF RIGHTS COULD DRIVE UP HEALTH INSURANCE PREMIUMS AND CREATE NEW TAX SHELTER

by Iris J. Lav

Summary

When the "Patients' Bill of Rights" legislation emerges from conference, it is likely to include major expansions in Medical Savings Accounts that risk driving up health insurance premiums for individuals who are less healthy than average in order to fund benefits that, in significant part, would be a tax cut for the affluent.[1] Both the House and Senate bills include such provisions.

The proposals likely to emerge from conference would both allow universal access to MSAs and remove a number of safeguards included in the MSA demonstration project that Congress established in 1996 and that is scheduled to end this year.

- The House and Senate bills include major expansions of MSAs, including universal access, despite the fact that the General Accounting Office's report on the current demonstration finds evidence that MSA availability encourages "adverse selection" in insurance markets. Adverse selection is a circumstance in which healthy and less healthy segments of the population become segregated in different types of insurance plans. When adverse selection occurs, health insurance premiums rise for the less-healthy individuals (because they are no longer pooled with the healthier individuals), and the resulting increase in costs may cause some individuals to lose insurance coverage because it becomes unaffordable for them.

- If MSAs are expanded from the current limited demonstration to universal access, it is highly likely that the types of problems the GAO found during the demonstration period would become widespread and result in substantially higher premium costs for conventional insurance.

Premiums for conventional insurance would be higher because of the effect of MSAs on the insurance market, the phenomenon known as adverse selection.

[1] Medical Savings Accounts are tax-advantaged personal savings accounts that may be used by persons covered by high-deductible health insurance policies. Funds in MSAs may be used to pay for a wide range of health care expenditures, including types of expenditures not covered by the MSA-holder's insurance policy

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- Adverse selection would occur because substantial numbers of young, healthy people with low medical costs would choose to use the high-deductible insurance policies and MSAs and thereby to retain their unspent dollars in their own accounts. This would leave people who are less healthy and have higher medical costs in conventional, low-deductible health insurance plans.

- Such a division of the market would drive up the cost of low-deductible insurance for the less healthy segments of the population who most need it. Research conducted by the Urban Institute, RAND, and the American Academy of Actuaries suggests that premiums for conventional insurance could *more than double* if MSA use becomes widespread. According to the American Academy of Actuaries, "The greatest savings [from MSAs] will be for the employees who have little or no health care expenditures. The greatest losses will be for the employees with substantial health care expenditures. Those with high expenditures are primarily older employees and pregnant women."[2]

When Congress was debating MSAs in 1996 as part of its deliberations on the Health Insurance Portability and Accountability Act, there was concern about the effects that widespread adverse selection could have on the insurance market. Accordingly, Congress allowed MSAs only as a limited demonstration policy so it could secure more information on this matter. The demonstration period is scheduled to expire at the end of this year, but limited use of MSAs during the demonstration period has made it impossible to conduct the comprehensive evaluation of MSAs the 1996 law envisioned. Despite the absence of information indicating that MSAs would not cause serious problems, the provisions in the Patients' Bill of Rights would make MSAs universally available and relax a number of other safeguards in the 1996 demonstration design. Any negative consequences MSAs may have for the insurance market consequently could become pervasive and difficult to reverse.

- Evidence suggests adverse selection in the usage of MSAs already is occurring under the demonstration project. A survey of insurers offering MSA plans notes that "Insurers expect relatively better health status and lower service utilization by enrollees selecting high-deductible plans and *price their products accordingly*." [Emphasis added.] In other words, the insurers can afford to set lower premiums for insurance policies used with MSAs, because they know it will be healthier people who are attracted to using MSAs. This survey of insurers was conducted by Westat under contract with the General Accounting Office in partial fulfilment of the terms of the demonstration project Congress established in 1996.

- The MSA provisions that the House and Senate versions of the Patients' Bill of Rights include would make the accounts universally available. If MSAs become

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[2] American Academy of Actuaries, *Medical Savings Accounts: Cost Implications and Design Issues, May 1995*, p. 23.

> widely popular among consumers with relatively better health, an adverse selection cycle could be triggered that would drive up the cost of conventional, more comprehensive insurance. The resulting premium increases are likely to be large enough to make such insurance unaffordable and unavailable for substantial numbers of Americans.

In addition, the changes in the Patients' Bill of Rights could create a major new tax shelter. The tax shelter would come about because of the similarities between MSAs and Individual Retirement Accounts. Under current law, married taxpayers who are covered by an employer-sponsored pension plan may deduct from their income up to $4,000 a year for deposits to an IRA if their income is below $62,000. By 2007, they will be able to make such deposits if their income is below $100,000.[3] Earnings on funds deposited in an IRA compound free of tax; no tax is due on either the deposits or the earnings until funds are withdrawn after retirement (or for a limited number of other purposes).

Taxpayers with incomes above these limits who have pension coverage under employer-sponsored plans are not eligible to use deductible IRAs. When IRA policies were revised in 1986 and again in 1997, Congress determined that such income limits were appropriate largely because the evidence indicates that higher-income individuals can and will save without a taxpayer subsidy; giving high-income taxpayers a tax subsidy for saving is not an efficient use of government funds.

Nevertheless, MSAs could be used by high-income taxpayers as a means to circumvent the income limits that govern tax-advantaged deposits to Individual Retirement Accounts. Under the proposed MSA expansion, *all* high-income taxpayers who choose to use MSAs would be allowed to make tax deductible deposits, and the earnings on these MSA deposits would compound free of tax. Like funds deposited in an IRA, funds on deposit in an MSA may be invested in stocks, bonds, or similar types of assets. MSA deposits and earnings are never taxed if MSA funds are used to pay medical costs. Moreover, the tax advantages of MSAs can be substantial even if the funds in the accounts are later withdrawn and used primarily or exclusively for *non*-medical purposes. If deposits are held until retirement age, for example, there is no penalty for withdrawal for non-medical purposes. Even if funds are withdrawn for non-medical purposes before retirement age, there are a number of circumstances under which the value of the tax-free compounding of the deposits over a number of years would outweigh the penalty that must be paid for a non-medical withdrawal.

The Westat survey of MSA insurers indicates that the market may indeed be developing in this manner.

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[3] Single taxpayers with incomes below $42,000 may deduct up to $2,000 a year. These income limits apply for tax year 2000; the limits are increasing gradually though 2007 under legislation enacted in 1997.

- According to the Westat survey, "Insurers reported targeting some segments of the insurance market, including highly-paid professionals, farmers and ranchers, partnership firms, and association groups."

- In discussing changes in the ways MSAs were marketed between 1997 and 1998, the Westat report noted: "The entry of Merrill Lynch and other investment firms into the MSA trustee arena and the maturing of the market have led to increased investment choices for MSA holders. This trend may be affected as well by some insurers' perceptions that MSA enrollees are using their accounts primarily as tax-sheltered savings vehicles rather than as sources of tax-sheltered funds for paying medical expenses."

- Universal availability of MSAs, along with a number of the proposed changes in the House and Senate bills that would allow larger deposits into MSAs and more flexible use of the tax-sheltered funds, would likely accelerate this trend.

- The Senate version of the Patients' Bill of Rights would be particularly troublesome in this regard, because it would allow funds to be withdrawn from MSAs *for any purpose* without penalty, so long as an amount equivalent to a single year's insurance deductible remained in the account. This contrasts sharply with current-law MSA provisions, which impose a penalty for withdrawal prior to age 65 for purposes other than paying medical expenses. In other words, under the proposed changes, a high-income taxpayer could use the benefits of the tax deferral on MSA deposits and the tax-free compounding of earnings on MSA accounts to accumulate funds for purchase of a yacht, an extended vacation, or any other purpose.

The House version of the legislation includes yet another disturbing provision, which would undermine the rules under the current MSA demonstration that prevent employers from setting up MSAs in a manner that primarily benefits highly paid executives and effectively discriminates against lower-paid employees.

- Under the MSA demonstration now underway, deposits can be made to an MSA account by either an employer or an individual, but not by both in the same year. The demonstration also includes nondiscrimination rules requiring employers to make comparable contributions for all participating employees.

- The House bill would allow both employees and employers to make deposits to an MSA in the same year. That would make the nondiscrimination rules meaningless. An employer could make small, token deposits to the MSA accounts of all employees. Higher-income employees could add substantial additional funds to their accounts and exclude these additional amounts from their

taxable income. Most lower-paid staff would not be able to afford substantial additional contributions.

The Patients' Bill of Rights is supposed to be legislation that makes health care more accessible and responsive to consumers' needs. The Medical Savings Account expansions included in the bill move in the opposite direction. They risk driving up the cost of comprehensive, conventional insurance to the point where many Americans, including those most in need of health services, cannot afford to buy coverage. Moreover, the MSA expansions would allow public funds intended to expand health coverage to be diverted to supporting tax shelters for higher-income individuals. The MSA provisions could well turn out to injure consumers significantly more than the other provisions of the legislation might assist them.

The MSA Demonstration

The bipartisan Health Insurance Portability and Accountability Act of 1996 established a demonstration to test and evaluate Medical Savings Accounts, which are tax-advantaged personal savings accounts that may be used by persons covered by high-deductible health insurance policies. The demonstration was designed to provide information about the effects of MSAs on workers, employers, and insurers and to do so without creating widespread, irreparable harm to the participants or the insurance market as a whole. Participation in the demonstration was limited to no more than 750,000 participants who are either employees of small businesses (businesses with 50 or fewer employees) or self-employed individuals. In addition, a number of the rules governing use of MSAs during the demonstration were designed to assure that these tax-advantaged savings accounts were used largely for the purpose of obtaining medical care and would not become a general-purpose tax shelter. The demonstration is scheduled to run through December 31, 2000.

The legislation required an evaluation to determine the effects of MSAs on the insurance market and on consumers. Among other issues, the evaluation was to study the extent to which MSAs fostered "adverse selection" — a situation in which younger and healthier individuals find MSAs financially advantageous and choose MSAs while older and less healthy individuals remain in conventional insurance. The evaluation also was to study the effect of MSAs on health care costs, including any impact on the premiums of individuals with comprehensive coverage. The intention was that Congress would be able to examine the results of the evaluation and, on the basis of those results, determine future policy regarding MSAs.

Few consumers, however, have chosen to use MSA during the demonstration period; fewer than 75,000 policies were sold through 1998. As a result of the light usage, a full evaluation of the effects of MSAs could not be conducted. One portion of the evaluation was completed — a survey of insurers, which was conducted by Westat under contract to the General Accounting Office.

MSA proponents attribute the lack of popularity of MSAs during the demonstration period in part to various safeguards included in the demonstration legislation that were intended to prevent abuse of the accounts. Almost as soon as the demonstration was put in place, bills were introduced in Congress to relax the safeguards.

Another possible interpretation of the sparse usage of MSAs during the demonstration project is that MSAs are not attractive as a health insurance product per se and can gain acceptance only if MSA policies allow substantial abuse of the accounts as tax shelters. The provisions now being considered in conference would remove many of the anti-abuse protections while also making MSAs universally available.

MSAs and Adverse Selection

A major concern is that universal access to MSAs would trigger widespread adverse selection in the insurance market. Adverse selection in the health insurance market takes place when healthy and less healthy segments of the population become segregated in different types of insurance plans. If healthier people choose high-deductible insurance with MSAs, the pool of people covered by comprehensive health insurance will tend to be sicker on average than it would be without MSAs. And if the pool of people who are conventionally insured incurs higher-than-average health care costs because some of the healthier people are no longer in the pool, the premiums for conventional insurance will rise. MSAs pose a strong risk of engendering this type of effect.

Young, healthy people who anticipate having low health care costs in the near future would likely choose to participate in MSA plans. They would do so because the MSA legislation allows participants to retain unspent health care dollars in their own accounts. Thus, people with low health care costs can accumulate tax free earnings on those funds and use them as retirement savings or for other purposes.

On the other hand, older and less healthy people who judge they are likely to incur significant health care costs would be better off financially if they remained covered by conventional health insurance, which generally has lower deductible amounts and relatively low caps on out-of-pocket expenditures. As a result, the pool of workers who will retain conventional insurance if MSA use becomes widespread could incur much-higher average health care costs than the larger pool of workers who are covered by conventional insurance today. To accommodate those higher average health care costs, the premiums charged for conventional insurance policies would have to increase, perhaps dramatically.

Research suggests that the premiums for coverage under a conventional health insurance policy could nearly double or even increase as much a four-fold, depending on the degree of

adverse selection that MSAs trigger in the insurance market.[4] At those increased premium rates, it is likely that significant numbers of employers would be unwilling to offer their employees conventional insurance and also that the resulting decline in the market for conventional insurance would lead some insurers to cease selling it.

Provisions in the Patients' Bill of Rights

Both the House and Senate versions of the Patients' Bill of Rights (H. R. 2990) would end the MSA demonstration. They would open up MSAs to use by all individuals and employees, removing the numerical cap on participation and eliminating the sunset date for MSAs contained in current law.

- Universal availability for MSAs would mean that any negative consequences that MSAs may have for the insurance market could become pervasive and difficult to reverse.

- The available evidence from the survey of insurers conducted under the demonstration project suggests that insurance companies set premiums for MSAs based on the assumption that adverse selection will take place. According to the report, "Insurers view high deductible plan enrollees as presenting a lower claims risk than enrollees in traditional low deductible plans....*Insurers expect relatively better health status and lower service utilization by enrollees selecting high deductible plans and price their products accordingly.* Insurers confirmed this conclusion in the survey."[5] [Emphasis added.]

The House and Senate versions of H.R. 2990 also would increase the maximum amount allowed to be deposited each year in the tax-advantaged Medical Savings Accounts. The current demonstration project places strict limitations on such deposits to prevent use of MSAs as general-purpose tax shelters.[6]

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[4] Emmett B. Keeler, et. al., "Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?" Journal of the American Medical Association, June 5, 1996, p. 1666-71; Len M. Nichols, et. al., *Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers*, The Urban Institute, April 1996; and American Academy of Actuaries, *Medical Savings Accounts: Cost Implications and Design Issues*, May 1995.

[5] U.S. General Accounting Office, Medical Savings Accounts: Results From Surveys of Insurers, December 31, 1998, GAO/HEHS-99-34, Appendix, p.14.

[6] For individuals, the maximum amount that can be contributed annually under current law is 65 percent of the insurance policy's deductible amount; for family coverage, it is 75 percent of the deductible amount. The House and Senate bills would allow annual contributions equal to the full deductible amount.

- MSAs are similar to conventional Individual Retirement Accounts: contributions are deductible from income, and tax is deferred on the amounts the accounts earn. While deposits and earnings are never taxed if MSA funds are used to pay medical costs, the tax advantages of MSAs can be substantial even if the funds in the accounts are later withdrawn and used primarily or exclusively for *non*-medical purposes. If deposits are held until retirement age, for example, there is no penalty for withdrawal for non-medical purposes. Even if funds are withdrawn for non-medical purposes before retirement age, there are a number of circumstances under which the value of the tax-free compounding of the deposits for a number of years would outweigh the penalty that must be paid for a non-medical withdrawal.

- MSAs differ from IRAs in one key respect — there are no income limits on MSAs that prevent wealthy people from using them as tax shelters. As a result, opening up MSAs to all individuals and increasing the amounts that may be deposited in them, as the proposed legislation would do, would enable high-income taxpayers who cannot use IRAs because of the income limits to begin using MSAs as significant tax shelters.

- When the MSA demonstration was established, a number of financial experts pointed out the possibilities for use of the accounts as tax shelters. An Associated Press article cited Eclipse MediSave America Corp., an MSA servicing company, as having calculated that "a family making $3,375 annual MSA contributions (the maximum allowed under federal guidelines), and earning 8 percent interest a year could accumulate $1.4 million in the account over 45 years. Even if they withdrew $1,000 a year, they still would accumulate $991,000."[7] The family would have accumulated these amounts tax-free. A *New York Times* article at that time included an example of a relatively well-off MSA holder who chose to pay medical expenses with other funds, leaving his MSA deposits to grow tax-free.[8]

- The Westat Report indicates the MSA market may indeed be developing in this way. According to the survey, "Insurers reported targeting some segments of the insurance market [for MSAs], including highly-paid professionals, farmers and ranchers, partnership firms, and association groups."

- In discussing changes in the ways MSAs were marketed between 1997 and 1998, the Westat report noted: "The entry of Merrill Lynch and other investment firms into the MSA trustee arena and the maturing of the market have led to increased investment choices for MSA holders. This trend may be affected as well by some

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[7] Associated Press release by Vivian Marino, August 15, 1997.

[8] Margaret O. Kirk, "Medical Accounts: Mixed Reviews," *The New York Times*, July 5, 1998.

insurers' perceptions that MSA enrollees are using their accounts primarily as tax-sheltered savings vehicles rather than as sources of tax-sheltered funds for paying medical expenses."[9]

The Senate version of H.R. 2990 includes a provision that would make MSAs even more attractive as tax shelters. The Senate bill would allow an individual to withdraw funds from an account for *non*-medical purposes *at any time* without a penalty, so long as an amount equivalent to the individual's insurance deductible remains in the account. In the name of providing health coverage, the Senate bill thus would create a new flexible, tax sheltered savings vehicle that could be highly attractive to healthy segments of the population. It would essentially allow taxpayers barred from using deductible IRAs because their incomes are too high to use MSAs in ways that are *even more advantageous* to such high-income taxpayers than access to IRAs would be.

- As noted, MSAs can be used in ways that are similar to deductible IRAs, particularly by people who have few medical bills and by high-bracket taxpayers for whom it can be advantageous to leave deposits to grow in an MSA, whether or not there are medical bills to pay. To reduce the extent to which this occurs, current law requires taxpayers who have tax-advantaged savings in an MSA either to wait to age 65 to withdraw the funds or to pay a 15 percent penalty for early withdrawal.[10]

- Under the Senate version of the patients' bill of rights, however, MSA deposits could be withdrawn at any time for any purpose without penalty, so long as an amount equivalent to a single year's deductible under the individual's insurance policy remains in the account. Thus, individuals could deposit several thousand dollars a year in an MSA and allow those funds to grow free of tax. The funds could be withdrawn if desired for any purpose, including purchase of luxury goods, vacations, and the like. This turns the MSA into a general-purpose tax shelter.

- If Congress wants to create such a tax shelter, it should be considered on its own merits and not be confounded with the issue of health insurance. Furthermore, if Congress wants to create such a tax shelter, it should do so in a manner that does not threaten the insurance coverage of less-healthy segments of the population.

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[9] U.S. General Accounting Office, Medical Savings Accounts: Results From Surveys of Insurers, December 31, 1998, GAO/HEHS-99-34, Appendix, pp. 15-16.

[10] Funds in IRAs may be withdrawn without penalty after age 59½. Early penalty-free withdrawal is permitted for a limited number of other purposes such as purchase of a first home.

FAX TRANSMISSION

NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES
1875 CONNECTICUT AVE., NW, SUITE 710 CONNECTICUT AVE., NW, SUITE 710
WASHINGTON, D.C. 20011
202-986-2600
FAX: 202-986-2539

To: Chris Jennings **Date:** February 16, 2000

Fax #: 456-5557 **Pages:** 5, including this cover sheet.

From: Joanne L. Hustead

Subject: patients' rights and right to sue

COMMENTS:

We wanted to share with you the letter (with chart) that we just sent to the entire Senate on the Coburn/Shadegg approach to liability.

National Partnership for Women & Families

CHALLENGE 2·0·0·0

February 15, 2000

The Honorable
United States Senate

Dear Senator:

The conference committee on managed care legislation will soon get underway. One of the major issues before the conference committee is how to hold health plans accountable.

The National Partnership strongly supports the compromise approach taken in the bipartisan Norwood/Dingell bill. **The approach in the Norwood/Dingell bill is a compromise on the issue of liability.** The Norwood/Dingell bill is different in critical respects from S.6, the bill introduced by Senators Daschle and Kennedy. Unlike S.6, the Norwood/Dingell bill requires exhaustion of internal and external appeals, except in cases where injury or death already has occurred. Unlike S.6, the Norwood/Dingell bill prohibits punitive damages in cases where the plan complies with the recommendations of the external reviewer. The Norwood/Dingell bill and S.6 are similar in their general approach to liability, in that both are structured to remove the ERISA roadblock that now prevents patients from pursuing such causes of action under state law -- but their differences are real and important.

While we prefer the approach to liability taken in S.6, in the spirit of compromise and in the desire to get a strong bill to the House floor, we accepted the changes made by Representatives Norwood and Dingell. Their calculations proved correct, and the Norwood/Dingell approach to liability was approved overwhelmingly by the House (275-151) last October. In voting for the Norwood/Dingell compromise, the House resoundingly defeated all other approaches, including a leadership-backed amendment offered by Representatives Goss, Coburn, Shadegg, Thomas, and Greenwood.

As shown on the attached chart, the approach to liability in the Goss/Coburn/Shadegg amendment is not a compromise. The liability provisions in the Goss/Coburn/Shadegg amendment are intentionally riddled with loopholes that would make it virtually impossible to hold health plans accountable. Injured patients would only be able to sue to recover damages if:

(1) the basis of the suit is the plan's negligent failure to follow the plan's own requirements or definitions regarding what care is medically necessary or appropriate (or experimental), no matter how inconsistent with best medical practice the plan's definitions may be;

(2) the patient has exhausted internal and external appeals in all cases -- even when injury or death already has occurred;

(3) the patient suffered "substantial harm." "Substantial harm" is narrowly defined in the amendment as "loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, or severe and chronic physical pain" -- a formulation that excludes mental or psychological injury; and

(4) the external reviewer agrees with the patient that the plan improperly denied care.

These prerequisites mean that very few injured patients will be able to bring an action in court to recover damages for injury or death.

The first prerequisite lets plans completely off the hook as long as they follow their own rules, however arbitrary or profit-driven they might be. Medical decisions should be made on the basis of the best medical evidence. We need to hold plans to a high standard of conduct. Plans should not be able to ignore the best medical evidence and deny care by writing arbitrary rules into the plan contract, but this prerequisite allows plans to do just that.

The second prerequisite irrationally requires injured patients (or their survivors) to go through internal and external appeals even though they have already been injured (or killed) by the plan's wrongful denial of care. When a patient has already been injured or killed due to a health plan's wrongdoing, it makes no sense to force the patient to go through a process designed to obtain care that will no longer do the patient any good.

The third prerequisite disallows lawsuits based solely on mental or psychological injury and takes an issue that should affect the amount of damages and makes it the determinant of whether a patient can sue at all. This prerequisite puts a serious roadblock in the way of patients seeking to hold their health plan accountable. Under this approach, plans would get away with making improper decisions as long the patient isn't hurt "too" badly. Instead of focusing on the plan's conduct and the patient's medical needs, the focus of the action will be the nature and extent of the patient's injury. Every patient will have to fend off a motion to dismiss the case, right off the bat, and will have to spend precious time and resources at the outset proving that he or she has suffered enough to get in the courthouse door.

The fourth prerequisite lets external reviewers shut the door to the courthouse. This prerequisite ties the hand of the court by preventing the court from awarding damages whenever a private non-judicial body (the external reviewer) has concluded that the plan acted properly. A court cannot award damages for injury sustained no matter what evidence is presented to the court about the plan's improper conduct. Courts are better positioned than external reviewers to determine if an award of damages is appropriate because they will have the benefit of fuller development of the evidence and the presentation of testimony.

And these are just prerequisites that determine whether a patient can even get in the courthouse door. The rare patient who overcomes these hurdles will find other roadblocks in the way -- one trick that leads to automatic dismissal and one that requires patients to put forth more evidence than normally is required in civil cases. For the even rarer patient who can overcome these roadblocks, damages will be capped or not available at all. For example, non-economic damages are always capped, an approach that penalizes people like stay-at-home parents and children who are not wage earners, and punitive damages (capped also) are **never** available in cases alleging wrongful denial of care.

And if that isn't enough, the Goss/Coburn/Shadegg amendment contains language that could well make patients **worse** off than they now are. Even with existing ERISA loopholes, some courts have held health plans liable under state law for delivering substandard care. The Goss/Coburn/Shadegg approach could stop the development of this case law in its tracks, leaving patients with no legal rights when health plans make decisions based on the balance sheet rather than the patient's chart.

We urge you to adopt the liability provisions in the Norwood/Dingell bill -- a solid compromise that passed the House overwhelmingly in a bipartisan fashion and that is fair to patients and plans alike.

If you have any questions, please contact Joanne Hustead, Director of Legal and Public Policy.

Sincerely,

Judith L. Lichtman
President

Liability Provisions of Goss/Coburn/Shadegg/Thomas/Greenwood Substitute Are Riddled With Loopholes

Bipartisan Bill (H.R. 2990)

Before filing suit

Complete internal and external review except when injury or death has already occurred.

→ **File Lawsuit** →

Trial/ Judgment

Patient wins if patient can prove his/her case in court.[1]

→

Patient recovers damages

No federally set limit on compensatory or punitive damages. Punitive damages cannot be recovered if plan complies with external review.

Goss/Coburn/Shadegg/Thomas/Greenwood Substitute

Before filing suit:

Complete internal and external review in all cases, even when injury or death has already occurred.

→

File Lawsuit[2]

The substitute only allows injured patients to sue to recover damages if:

(1) the external reviewer agrees with the patient that the plan improperly denied care;

(2) the basis of the suit is the plan's negligent failure to follow the plan's own "requirements" or definitions regarding what care is medically necessary or appropriate (or experimental), no matter how inconsistent with best medical practice the plan's definitions may be; and

(3) the patient suffered "substantial harm." "Substantial harm" is narrowly defined as "loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, or severe and chronic physical pain."

↓

Case automatically dismissed if: *another* external review - obtained by the plan - concludes that the patient isn't injured or the plan's conduct did not cause the injury. This means that a determination normally made by a court would be made by a private entity hired by the plan.[3]

↓

Evidence/Trial

In the trial, patient must be careful not to submit any evidence that is relevant only to whether punitive damages are appropriate, no matter how difficult it would be to separate evidence relevant to liability and damages generally from evidence relevant to punitive damages.[4]

↓

Evidence/Trial

Patient loses case if patient fails to prove by "clear and convincing" evidence that initial external review (decided in favor of plan) is incorrect. (Generally, patients need only prove their own case by a majority of the evidence (a "preponderance" of the evidence).)

If ALL the previous hurdles are overcome, patient wins, and:

Recovers compensatory damages

Economic damages-- not capped.

Non-economic damages -- capped at lesser of 2 times the amount of the economic loss or $500,000.

May be able to recover punitive damages in limited circumstances

1. Punitive damages are available only when the lawsuit is based upon the plan's negligent failure to meet the decisional time frames specified in the bill, not when the dispute concerns the wrongful (but timely) denial of care.
2. Punitive damages would be decided in a separate legal proceeding.
3. As a matter of federal law, a heightened standard for recovery is established: proof of "conscious, flagrant indifference to the rights or safety of others." Common standards like reckless indifference or malice would apparently not suffice.
4. Punitive damages are available only when the plan fails to follow the initial external review.
5. Punitive damages are capped at the greater of 2 times the amount awarded for economic loss or $250,000. Special lower caps for defendants who are individuals or small businesses.[5]

/8/00 For additional information, contact Joanne Hustead, National Partnership for Women & Families (202) 986-2600; .drienne Hahn, Consumers Union (202) 462-6262; or Vicki Gottlich, Center for Medicare Advocacy (202) 216-0028.

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1 Generally, patients must prove their case by a majority of the evidence (a "preponderance" of the evidence). Since the bipartisan bill opens the door to suits based on state law, the type/amount of evidence could be higher if a state chose to require more (or different) evidence from the patient.

2 The Coburn/Shadegg bill creates a shorter time frame for initiating a lawsuit than is generally the case under existing state laws.

3 Recourse to this second external review is at the option of the plan. Patient can avoid dismissal only by bringing forth "clear and convincing" evidence. If patient tries to make such a showing but fails, the patient must pay the plan's legal fees and costs.

4 Either party may opt to require separation of the punitive damages phase of the trial from the rest of the trial.

5 The bill also creates a special exception, which allows the court to award additional punitive damages in limited circumstances, but any additional award is subject to the same cap.

U.S. House of Representatives
Committee on Commerce
Room 2125, Rayburn House Office Building
Washington, DC 20515–6115

DEMOCRATIC STAFF

FAX COVER SHEET

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White House Reveals Patients' Bill of Rights Talks Under Way

HEALTH

A WHITE HOUSE health policy aide said Wednesday there are ongoing discussions about a possible Patients' Bill of Rights compromise that closely resembles the House bill that passed last year — but which prevents class action lawsuits against health care entities.

The White House has recently indicated its willingness to discuss "alternate enforcement mechanisms" to lawsuits for people to address their problems with health maintenance organizations.

But Chris Jennings, special assistant to the president on health policy, did not specify alternatives. At a luncheon for Women in Government Relations Inc., Jennings acknowledged "people are talking" about limiting class action lawsuits.

Jennings was generally positive on the potential for other health reforms in Congress this year, although the Patients' Bill of Rights is a top priority.

"Reforms could be done, [such as] fee for service plan improvements, more competition in reimbursement, [reducing] fraud and abuse," he said. "We can make steps toward reform, but how far?"

Jennings suggested that anything slowing down the Patients' Bill of Rights would not please the administration, but that the White House is open to discussing broader Medicare reform, medical error legislation and ensuring the solvency of Medicare. The White House also is pushing a prescription drug coverage bill for seniors this year and expects to report on the rising cost of prescription drugs to the elderly, he said, "in the next few weeks."

Staff-level discussions are taking place among House and Senate conferees on the Patients' Bill of Rights in preparation for the first member meeting next week. The House bill, known as the Norwood/Dingell bill, would expand patient rights to sue HMOs and set a federal standard of patient rights.

The Senate bill does not expand a patient's right to sue beyond what is allowed under existing law, but would be less intrusive in terms of states' ability to regulate private insurance.

— *By April Fulton*

Presidential Campaign Advisers Square Off Over Budget Policy

BUDGET

IN A SEMINAR convened by the National Association for Business Economics, economic advisers to the presidential campaigns of Texas GOP Gov. George W. Bush, **Sen. John McCain**, R-Ariz., and Vice President Gore Wednesday discussed their candidates' respective approaches to managing the budget surpluses expected over the next 10 years.

Former **Sen. Bill Bradley**, D-N.J., did not have a member of his budget team present.

In a nod to the current strong economy, Gore adviser Alan Blinder, a visiting scholar at the Brookings Institution, stressed that a Gore administration would provide "more of the same" policies that Blinder credited with spurring the record economic expansion under Clinton's watch.

In particular, Blinder — a former vice chairman of the Federal Reserve — said Gore envisions using a portion of the on-budget surplus to provide a "doable and practical" package of targeted tax cuts that would cost roughly $250 billion over 10 years.

Blinder also said that given the optimistic nature of current non-Social Security surplus projections — which he said do not factor in the cost of renewing the so-called tax extenders or indexing the alternative minimum tax — Bush would not be able to provide his $483 billion five-year tax cut and keep his pledge not to spend the Social Security surplus.

The Bush and McCain economists, on the other hand, used their presentations to echo themes from their candidates' increasingly aggressive contest for the Republican nomination.

Reflecting the McCain campaign's push to reassure Republican primary voters of the senator's conservative voting record, American Enterprise Institute resident scholar Kevin Hassett, a McCain adviser, told the NABE audience that the difference between the McCain and Bush budget plans is "tiny" compared to the difference between McCain's and Gore's.

Hassett said both GOP contenders favor allowing workers to invest a portion of their payroll taxes in private retirement accounts, while Gore opposes any privatization of Social Security.

But Hassett said that while Bush would devote the bulk of the on-budget surpluses to his proposed $483 billion tax cut package, McCain would use the money to make the transition to private Social Security retirement accounts by using some of the surplus to finance a cut in payroll taxes.

Hassett also charged that Gore would spend a good chunk of surpluses on government programs.

Bush adviser Lawrence Lindsey, an economics scholar at the American Enterprise Institute, opposed using corporate and personal income tax revenues from the on-budget surplus to finance Social Security reform — at least as a first option.

Lindsey said Bush has not committed to any specific Social Security reform plan — but rather has promised to convene the best minds on the subject to formulate a plan based on a number of principles, such as protecting current retirees, getting a better rate of investment returns for the program than government bonds provide, and allowing beneficiaries to choose whether to create private accounts.

— *By Lisa Carlso*

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The Washington Post

Wednesday, February 23, 2000

OP-ED

For the Record

From remarks yesterday by White House spokesman Joe Lockhart:

Q: Sens. Frist and Jeffords are interested in taking whatever compromise legislation is reached on medical records and medical errors and putting that in the health care--the Patients' Bill of Rights. Is that something the administration would support?

Joe Lockhart: Well, I think the administration. . . . It's a high priority for the administration to get a strong and forceful Patients' Bill of Rights. It's also a high priority to make sure that we deal with this important issue of medical errors. If we can move forward--because these are complementary issues--in a way that doesn't slow down one or the other, these things can work together. But we don't want one issue to impede progress on the other issue. So we'll do them separately. There is a chance we can do them together. The important thing is that we get it done this year.

Q: Republicans are also considering placing the liability in the federal court system and making sure that the Patients' Bill of Rights would not have liability in the state court system. Does the administration have an opinion on that?

A: It's something that we have been looking at. We want to make sure that people do have a real redress to wrongs within the system or wrongs as they perceive them. I think there has been some discussion about the advantages and comparative disadvantages to federal vs. state. I don't know that we've made a final decision, but it's certainly something that we're looking at.

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Q Joe, Senators Frist and Jeffords are interested in taking whatever compromise legislation is reached on medical records and medical errors, and putting that in the patients' bill of rights. Is that something the administration would support?

MR. LOCKHART. Well, I think the administration -- it's a high priority for the administration to get a strong, enforceable patients' bill of rights. It's also a high priority to make sure that we deal with this important issue of medical errors. If we can move forward -- because these are complementary issues -- in a way that doesn't slow down one or the other, these things can work together. But we don't want one issue to impede progress on the other issue So we'll do them separately. There is a chance we can do them together; the important thing is that we get it done this year.

Q And related to that, Republicans are also considering placing the liability in the federal court system, and making sure that the patients' bill of rights would not have liability in the state court system. Does the administration have an opinion on that?

MR. LOCKHART: It's something that we have been looking at We want to make sure that people do have a real redress to wrongs within the system, or wrongs as they perceive them. I think there has been some discussion about the advantages and comparative disadvantages to federal versus state I don't know that we've made a final decision. But it's certainly something that we're looking at, and --

Q It's not a deal-breaker, in other words?

SENIOR ADMINISTRATION OFFICIAL. Well, not at this point. We want to make sure that at the end of the day, the public feels that they are entitled to a process where they do have some redress within the system, and we have been looking at this I don't know that any final decision has come, but it's not something on the face of it, which strikes us as something that we can't work with

Q Joe, on that same topic, will you seek compromise with the Hospital Association and the AMA on the mandatory reporting provisions of the measure, or will you force them to swallow this pill regardless of how they feel about it?

SENIOR ADMINISTRATION OFFICIAL. It's always best to let people characterize their positions themselves, but if I understand the characterization of their position, I think those organizations believe that there is a lot in this proposal There are a number of elements, and I know our previous briefers went through in great detail that they can find the support

We just -- the President's come down and made the decision that this will work best if it's mandatory rather than voluntary, and we will work with them on how we do this and how this is implemented, because these are important elements in making sure that this system works properly, but the bottom-line decision that the President had to make, he has made, and he believes it should be mandatory.

Q Do you agree with them that it may have a chilling effect on

the reporting of medical errors?

MR. LOCKHART: We don't believe, at the end of the day, that it has to. We think we can work together to find a way to move forward that has mandatory reporting, but that also gives confidence for patients and they can address the concerns of the hospitals and the doctors.

Q Joe, let me get back to medical mistakes. It's only mandatory reporting if these additional 32 states, where it's not mandatory now, decide to make it mandatory. Does the President plan to jawbone on that? I mean, how do you get them to come along?

MR LOCKHART: Basically, my understanding of the President's announcement is we will phase in mandatory to the states, providing the states the tools they need and the information they need to provide it. And if, at the end of three years we don't have 100 percent participation, we will take a different legislative route that will require states either to participate or there are other ways -- for instance, you know with the Brady law, the states that don't participate operate a different way through the federal government.

But the end game on this, at the end of three years, is that we will either have mandatory participation -- mandatory reporting from 50 states, or we will take steps to make sure that reporting is done in the 50 states on a mandatory basis.

Q The states have to voluntarily agree to do something that's going to be mandatory. So is your threat, then, that the federal funds which go out to hospitals, for example -- we know the carrot; what's the stick?

MR LOCKHART: I have no reason to believe at this point, given the bipartisan support that we've seen, particularly today on the Hill on this issue, that there's going to be any significant problem. But we can take further steps -- and I'm just not going to get into what those steps might be -- to make sure that all states participate, just like we do on a number of other programs.

Q Joe, was the President disappointed today that the AHA and the AMA did not stand with him as he made the announcement?

MR. LOCKHART: Listen, we have worked very hard on this issue and we have worked very hard with those groups. And all things being equal, I think the President would like as many groups that are important in this process to stand with him on an issue of this importance.

But we have to make a decision -- the President has to make decisions based on what he believes is in the best interests of this country, not any specific constituency group. And that's why he took the position, took the decisions that he did in this case. And we will push -- with, as I earlier noted, a significant bipartisan support -- to get this done

Q But when you look at the important groups that could stand with him, though, these two would probably rank number one and number two.

MR. LOCKHART: No. No, I think the most important group would be the American public, who want something done. I think particularly on television, you know, when this IOM report came out, it got a lot of coverage, and that was appropriate because this is a real problem that we need to address We now have put together serious steps toward solving the problem. I expect that to get a good bit of attention. And this is really about patients, not necessarily the narrow interests of a particular hospital or a particular group of doctors.

Q Were they invited?

MR. LOCKHART: Yes, they were. Yes, they were. And I will -- this is an overall package, which, my understanding is, they support many elements of. I think they have a problem with the mandatory nature of the reporting. That's an issue that, while taking their position into account, the President made a decision that in order for this to be useful for the public and have the confidence of the public, that you needed mandatory reporting.

Q Joe, the medical mistakes thing, how solid is that bipartisan support? Does it go much deeper than the committee that we've seen this morning?

MR. LOCKHART: Oh, my guess on that is yes. I mean, I think we had people, the important people from the committee, saying positive things today, there is a hearing today But I do think that when this report came out, there was not a partisan reaction to it There was a singular and unified reaction that we have to do something about it. I think the President has moved quickly to address this problem Congress stands ready to move quickly, as evidenced by their hearing today, a hearing that has support on both sides of the aisle, to do something about it. And I think the public is expecting that action to be taken.

Q Joe, aside from the 32 states that don't have any mandatory reporting rules, are you going to be looking at the 18 states that do to see if they need improving --

MR. LOCKHART: Yes. I think one of the things that we need to do is to provide a sort of comparative base for states as they move forward. It's certainly our view that even among the states that do have mandatory reporting, that we can all do better And I think the states have indicated that themselves So part of this effort will be to not only add to the states that are not doing this reporting now, but to improve the value of the data, and ultimately the value to patients, of the states that are currently doing the reporting.

60 minutes 2 3rd week in Feb

STATEMENT

1. State Farm Insurance Company maintains a Group Medical Health Plan (the State Farm Plan) for its employees, under which eligible employees may choose a group medical insurance plan or, "as an alternative health care choice," a health maintenance organization (HMO). J.A. 101. Respondent Cynthia Herdrich is married to a State Farm employee who enrolled in an HMO, Carle Care HMO, offered under the State Farm Plan. Pet. App. 84a.

The Carle Care HMO is "a product of" petitioner Health Alliance Medical Plans (HAMP), a for-profit Illinois domestic stock insurance corporation. Pet. App. 84a, 93a. HAMP, in turn, is a wholly-owned subsidiary of petitioner Carle Clinic Association, an Illinois professional medical corporation owned by its physician shareholders. HAMP contracts with Carle Clinic to furnish the medical services provided by the HMO. *Id.* at 86a. The net effect of this arrangement is that the physicians who provide care through the HMO are also the owners of the HMO.

2. Respondent sought treatment for abdominal pain from petitioner Laurie Pegram, a Carle Clinic physician, who scheduled her for an ultrasound procedure eight days later at a distant hospital affiliated with the HMO. Pet. App. 2a n.1, 23a-24a. Respondent's appendix ruptured in the interim, resulting in peritonitis. *Id.* at 2a n.1. Respondent then brought a two-count complaint in Illinois state court alleging medical negligence by Pegram and seeking to hold Carle Clinic liable under the doctrine of respondeat superior. *Id.* at 3a, 66a.

Subsequently, respondent amended her state court complaint to add a claim (Count III) against Carle Clinic, alleging that it violated the Illinois Consumer Fraud and Deceptive Business Practices Act, 815 Ill. Comp. Stat. Ann. § 505/1 (West 1999), by failing to advise her of material facts

Mark Flegan
Alan Feldman 3

regarding the ownership of HAMP and by failing to inform her that the compensation of the HMO's physicians was increased to the extent they did not order diagnostic tests, did not utilize facilities not owned by Carle Clinic, and did not make emergency or consultation referrals. Pet. App. 3a & n.2. She also brought a claim against HAMP (Count IV) alleging that by implementing those cost-containment measures, HAMP breached its state-law duty of good faith and fair dealing. *Ibid.*

Petitioners removed the case to federal court, on the ground that Counts III and IV were completely preempted by ERISA. Pet. App. 2a, 3a. The district court thereupon ruled that both counts were preempted and granted summary judgment on Count IV, but it gave respondent leave to amend Count III. *Id.* at 80a.[1]

Respondent then amended Count III to assert the claim now at issue, *i.e.*, that HAMP and Carle Clinic breached fiduciary duties under ERISA.[2] Respondent alleged that petitioners had the exclusive right to decide all disputed and non-routine claims under "the Plan," which she defined as

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[1] The district court ruled that Count IV was preempted and could not properly be amended to state an ERISA claim because respondent sought extra-contractual damages that were not available under ERISA. Pet. App. 67a-68a, 70a-76a. The court also ruled that Count III "relate[d] to" an employee welfare benefit plan, 29 U.S.C. 1144(a), and thus was preempted because it sought to impose additional disclosure requirements on an ERISA plan administrator under state law in addition to those expressly enumerated in ERISA's comprehensive disclosure scheme. Pet. App. 76a-80a. As explained below, when respondent subsequently amended Count III to assert a fiduciary breach claim under ERISA, the amendment did not allege any failure to disclose information.

[2] Respondent also brought her fiduciary breach claim against Carle Health Insurance Management Co., Inc. (CHIMCO), a management entity, which like HAMP is alleged to be a wholly owned subsidiary of Carle Clinic. Pet. App. 84a. CHIMCO is not a petitioner in this Court.

the Carle Care HMO,[3] and exercised discretionary control of claims management, property management, and administration of "the Plan." Pet. App. 85a.

On the basis of those factual allegations, respondent asserted that petitioners breached fiduciary duties under Section 404 of ERISA, 29 U.S.C. 1104, because Carle Clinic physicians receive a year-end distribution paid out of "supplemental medical expense payments" that HAMP and CHIMCO pay to Carle Clinic based on contractual provisions requiring the physicians to minimize the use of diagnostic tests, of facilities not owned by Carle Clinic, and of referrals to "non-contracted" physicians. Pet. App. 85a-86a. Respondent also asserted that petitioners sought to fund the year-end payments by "administering disputed and non-routine health insurance claims," and determining, *e.g.*, "which claims are covered under the Plan and to what extent" and "what the applicable standard of care is." *Id.* at 86a. Respondent alleged that "the Plan" had been wrongfully deprived of amounts comprising the supplemental medical expense payments made by HAMP and CHIMCO to Carle Clinic and sought an order requiring reimbursement by Carle Clinic of the supplemental medical expense payments received from HAMP and CHIMCO as well as such other equitable relief as the court deemed just. *Id.* at 87a.

Petitioners moved to dismiss amended Count III under Federal Rule of Civil Procedure 12(b)(6) for failure to state a claim upon which relief can be granted. The district court granted the motion on the ground that respondent had "fail[ed] to identify how any of the [petitioners] is involved as a fiduciary to the Plan." Pet. App. 63a (magistrate's report); see *id.* at 59a-60a (adopting magistrate's report). Respondent's state-law medical malpractice claims were

[3] As we explain below, pp. 9-11, *infra*, respondent's use of the term "plan" to refer to the HMO differs from the term's meaning under ERISA.

then tried to a jury, which rendered a $35,000 verdict in her favor. *Id.* at 6a, 81a-82a. After entry of final judgment, respondent appealed the dismissal of her ERISA fiduciary breach claim.

3. a. A divided panel of the court of appeals reversed. Pet. App. 1a-38a. The panel majority held that respondent had adequately alleged that petitioners were fiduciaries. *Id.* at 11a-15a. Noting that the complaint alleges that petitioners "have the exclusive right to decide all disputed and non-routine claims under the plan," the court concluded that "this level of control satisfies ERISA's requirement that a fiduciary maintain 'discretionary control and authority.'" *Id.* at 14a (emphasis omitted).

The panel majority also held that respondent's allegations, if accepted as true, were sufficient to demonstrate that petitioners breached their fiduciary duty because they acted in their own interest, rather than "with an eye single to the interests of the [plan's] participants and beneficiaries." Pet. App. 16a (quoting *Donovan* v. *Bierwirth*, 680 F.2d 263, 271 (2d Cir.), cert. denied, 459 U.S. 1069 (1982)). The court noted that the complaint alleged that the plan "dictated that the very same HMO administrators vested with the authority to determine whether health care claims would be paid, and the type, nature, and duration of care to be given, were those physicians who became eligible to receive year-end bonuses as a result of cost-savings," thus creating the incentive for them to limit treatment to ensure a larger bonus. *Id.* at 18a-19a (emphasis omitted).

The majority stated that it was not adopting a per se rule "that the existence of incentives *automatically* gives rise to a breach of fiduciary duty," but only that such "incentives *can* rise to the level of a breach where, as pleaded here, the fiduciary trust between plan participants and plan fiduciaries no longer exists." Pet. App. 20a. Addressing the dissent's view that imposition of incentives to limit care should con-

stitute a fiduciary breach only when there is a "serious flaw" in the manner in which the incentive arrangement is established, the majority concluded that there was such a flaw in that the "physician/owners of Carle * * * simultaneously control the care of their patients and reap the profits generated by the HMO through the limited use of tests and referrals." *Id.* at 21a (emphasis omitted). The majority referred to the treatment of respondent's appendicitis as an example of the effects of the incentive scheme, *id.* at 24a, 32a-33a, and expounded its view that managed care is having a deleterious effect on the quality of health care in this country, *id.* at 24a-33a.

Finally, the majority concluded that respondent alleged a loss to the plan attributable to the petitioners' alleged breach, in that the plan was deprived of the amounts paid as incentives. Pet. App. 38a. Accordingly, the majority concluded that respondent had alleged the requisite elements of a claim for fiduciary breach under ERISA.

b. Judge Flaum dissented. Pet. App. 38a-47a. In his view, respondent's allegations about the structural incentives for cost containment did not in themselves make out a case of fiduciary breach, because ERISA tolerates some conflict of interest on the part of ERISA fiduciaries, as by permitting the employer or plan sponsor's officer or employee to serve as fiduciary. *Id.* at 40a. The mere existence of such incentives was not enough, in his view, to establish a fiduciary breach because market forces protect the interests of beneficiaries by making it unlikely that the HMO would wish to alienate the employer-sponsor by maintaining an unduly restrictive approach to coverage. *Id.* at 40a-42a. Moreover, Judge Flaum stated his concern that the majority's decision would lead to "untethered judicial assessments of permissible incentive levels in health care plans." *Id.* at 44a.

4. The court of appeals denied rehearing en banc. Pet. App. 48a-49a. Judge Easterbrook, joined by three other judges, filed an opinion dissenting from the denial of rehearing. *Id.* at 49a-58a. Judge Easterbrook concluded that Carle Care's decision to establish one set of cost-saving incentives rather than another is not an exercise of discretion in the administration of the employee benefit plan, but rather is an exercise of discretion by Carle Care in providing medical services. *Id.* at 52a-53a. He deemed respondent's complaint to allege that the benefit offered by State Farm to its employees was the Carle Care HMO, in which petitioners are acting as suppliers of a service to the plan, not plan fiduciaries. *Id.* at 56a. Judge Easterbrook also stated that in his view the majority's rule was "impossible to cabin, for the plan attacked in this case is an ordinary HMO." *Id.* at 56a.

INTRODUCTION AND SUMMARY OF ARGUMENT

The Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, "was enacted 'to promote the interests of employees and their beneficiaries in employee benefit plans,' * * * and 'to protect contractually defined benefits.'" *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 113 (1989). The statute thus does not "requir[e] employers to provide any given set of minimum benefits, but instead controls the administration of benefit plans, * * * as by imposing reporting and disclosure mandates, * * * participation and vesting requirements, * * * funding standards, * * * and fiduciary responsibilities for plan administrators." *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 651 (1995). Among the various duties that ERISA imposes on fiduciaries of employee benefit plans is a duty of loyalty, under which a "fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries." 29 U.S.C. 1104(a)(1); see also 29 U.S.C. 1104(a)(1)(A)(i).

The court of appeals held that respondent stated a claim of breach of the duty of loyalty owed by a fiduciary by alleging that petitioners provided profit-based financial incentives for HMO physicians. Liberally read, as they must be in the context of a motion to dismiss for failure to state a claim, *Conley* v. *Gibson*, 355 U.S. 41 (1957), respondent's allegations challenge a bonus ("year-end distribution") allegedly paid by petitioner HAMP to Carle Clinic physicians that is "fund[ed]" by profits derived from two types of conduct. Pet. App. 86a. The first type is the provision of medical services by "owner/physicians" who allegedly "minimize the use of diagnostic tests," "minimize the use of facilities not owned by Carle," and "minimize the use of emergency and non-emergency consultation and/or referrals" to non-HMO physicians. *Ibid.* The second type is "administering disputed and non-routine health insurance claims." *Ibid.*

The first of these allegations—the "treatment" allegations—fails to state a claim because it does not allege conduct by petitioners in their capacity as ERISA fiduciaries. An HMO acts as a medical care provider, rather than an ERISA fiduciary, when it establishes and implements an arrangement for paying its physicians to treat their patients, even if the arrangement includes incentives for using less costly treatment regimens. If the court of appeals were correct that the law of fiduciary duty under ERISA governed the treatment of patients by HMO doctors, then traditional state regulation of the practice of medicine—along with traditional state-law malpractice and professional licensing regulations—would necessarily be preempted insofar as they applied to ERISA plans. In *Travelers* and subsequent cases, this Court has rejected that overly expansive view of ERISA's scope, and it should do so again here.

By contrast, the activities involved in the second set of allegations—the "administration" allegations—may involve conduct by petitioners as ERISA fiduciaries, because an

entity such as an HMO that exercises discretion in determining whether claims for specific benefits are covered by an ERISA plan is an ERISA fiduciary. Respondent, however, has alleged only that petitioners generate income by performing their roles as fiduciaries under ERISA. That allegation is insufficient to state a claim of breach of fiduciary duty under ERISA, because fiduciaries under ERISA are expected to be compensated for the performance of their duties. Cf. 29 U.S.C. 1108(c). Indeed, even if the complaint could be read to include an allegation that petitioners employ a profit-based system that permits those who assist in claims administration to share in the petitioners' general profits, it would still fail to state a claim of breach of fiduciary duty under ERISA. Unlike an incentive scheme in which claims administrators are directly paid for denying (but not for allowing) claims, a general profit-based compensation arrangement does not in itself conflict with the duties owed by fiduciaries under ERISA. Because none of respondent's allegations therefore states a claim of breach of fiduciary duty under ERISA, the decision of the court of appeals should be reversed.

ARGUMENT

A. An HMO Is Not Itself An ERISA Plan, Although It May Function At Various Times As The Provider Of Medical Services To Such A Plan Or As Administrator, And Therefore Fiduciary, Of Such A Plan

1. In order to determine whether an entity acts as an ERISA fiduciary, it is critical to distinguish between the ERISA plan itself (the administration of which by either the plan sponsor or an outside entity confers fiduciary status on an individual or other entity) and a provider of services to the plan (usually an independent entity not subject to ERISA's fiduciary duty standards). ERISA defines an "employee welfare benefit plan" as "any plan, fund, or

set mtg — Peter Rundlet
~~Jim Marks~~ James Kennedy
Bill Marshall

- defend existing laws
- malpractice
- PBOR

FRIDAY
after 8:00

set up conf call w/ DOL Counsel —
set up Thurs policy people?
Counsel's OC to set it up.

Kitty Haber

DATE: 3/19

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

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

FROM:

[ ] JANE HORVATH
[ ] HOLLY BODE
[ ] SHARON CLARKIN
[ ] BOB GUIDOS
[ ] GREG JONES
[ ] ANDREA LEVARIO
[X] ROGER MCCLUNG
[ ] TANISHA PARKER
[ ] JON RETZLAFF
[ ] MARC SMOLONSKY
[ ] STEPHANIE WILSON
[ ]

TO: Chris J.

OFFICE: _____

ROOM: _____

PHONE: _____

FAX: 456-5557

PBOR
And Rack-up +
Copy of adopted amds.

(INCLUDING COVER): 27

REMARKS:

PATIENTS BILL OF RIGHTS [S. 326] MARKUP IN HELP COMMITTEE
MARCH 17-18, 1999

The Chairman brought up S. 326 in the nature of a substitute and the Chairman's technical amendment was adopted without objection:

Actions Taken on Amendments

March 17

1. Kennedy substitute for Chairman's mark. Defeated 8-10.

2. Harkin, Frist et al., To provide for collection of data in rural areas. Adopted by voice vote.

3. Mikulski [#1], To provide for a transitional period for certain patients. Defeated, 8-10.

4. Reed, Wellstone, Harkin; To provide grants to states to establish an ombudsman to assist consumers insured in managed care plans. Defeated, 8-10.

March 18

5. Collins; To provide patient access to prescription drugs off-formulary when medically necessary and appropriate. Adopted 18-0

6. Dodd [#1]; To provide access to FDA approved drugs and devices without regard to any postmarketing requirements that may apply. Defeated 8-10.

7. Harkin; To ensure the adequacy of provide networks and that individuals have a choice of health care providers. Defeated 8-10.

8. Dodd [#3]; To prevent certain disclosures of genetic information, to prohibit discrimination in the workplace on the basic of genetic information, and to provide for strong remedies. Defeated 8-10.

9. Frist [#2]; To improve provisions relating to external reviews. Adopted 11-7 [Bingaman].

10. Kennedy [#3]; To ensure the right to a timely and independent appeal of an adverse coverage determination. Defeated 8-10.

11. Kennedy [#2}; To ensure that protections provided apply to all patients with private insurance. Defeated 8-10.

12. Frist [#1]; To provide for a comprehensive independent study of patient access to clinical trials and coverage of associated routine costs. Adopted 10-8.

13. Dodd [#4]; To provide coverage for routine patients costs for individuals participating in approved clinical trials. Defeated 8-10.

14. Bingaman [#1]; To prohibit discrimination against health care professionals. Defeated 8-10.

15. Kennedy [#5]; To prohibit arbitrary limitations or conditions for the provision of services and to ensure that medical decisions are made with the best available evidence or information. Defeated 8-10.

16. Frist [#3]; To provide access to specialists. Adopted by voice vote.

17. Harkin [#1]; To guarantee access to specialty care. Defeated 8-10.

18. Mikulski [#2]; To protect the right of a patient to receive continuing care at a facility selected by the patient. [right to return home]. Defeated 9-9 [DeWine]

19. Hutchinson; To modify provisions relating to access to emergency medical care. Adopted 12-6 [Bingaman; Wellstone].

20. Murray [#1]; To provide for coverage of emergency medical care. Defeated 8-10.

21. Wellstone; To prohibit a plan from discriminating against providers or patients based on self-payment for certain behavioral health care services.
Adopted 15-1 [Sessions].

22. Wellstone [#1]; To provide protection for patient advocacy. Defeated 8-10.

23. Murray [#2]; To provide coverage for certain items and services related to treatment of breast cancer. Defeated 8-10.

24. Wellstone [#2]; To provide for point of service coverage. Defeated 8-10.

25. Reed [#1]; To ensure access to pediatric specialists. Defeated 8-10.

26. Kennedy [#4]; To permit persons covered under ERISA plans to hold such plans accountable for actions that result in injury or death. Defeated 8-10.

Final passage of S. 326 as amended 10-8.

Adopted/Voice

AMENDMENT NO. ____ Calendar No. ____

Purpose: To provide for the collection of data concerning rural areas.

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

S. 326

To improve the access and choice of patients to quality, affordable health care.

Referred to the Committee on H.E.L.P and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Senators Harkin, Frist, Mikulski, Jeffords, Bingaman, Gregg, Dewine, Collins, Enzi, Hagel, Hutchinson, Sessions, Brownback

Viz:

On page 98 of the amendment, line 21, insert "including rural residents" after "population".

On page 98 of the amendment, line 15, insert ", including rural residents" before the semicolon.

On page 112 of the amendment, line 20, insert ", including at least 1 individual specializing in rural aspects in 1 or more of these fields" after "public policy".

O:\BAI\BAI99.380 S.L.C.

Adopted/18-0

AMENDMENT NO. ____ Calendar No. ____

Purpose: To provide patients with certain rights with respect to prescription drugs.

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

S. 326

To improve the access and choice of patients to quality, affordable health care.

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 Ms. COLLINS (for herself and Mr. JEFFORDS)

Viz:

On page 17 of the amendment, after line 25, insert the following and redesignate all subsequent sections accordingly:

"SEC. 727. PATIENT'S RIGHT TO PRESCRIPTION DRUGS.

"To the extent that a group health plan (other than a fully insured group health plan) provides coverage for benefits with respect to prescription drugs, and limits such coverage to drugs included in a formulary, the plan shall—

"(1) ensure the participation of physicians and pharmacists in developing and reviewing such formulary; and

"(2) in accordance with the applicable quality assurance and utilization review standards of the plan, provide for exceptions from the formulary limitation when a non-formulary alternative is medically necessary and appropriate.

A plan that establishes a special copayment system for non-formulary drugs would meet the requirements of paragraph (2). and these will be part of reporting requirement to enrollees.

O:\BAI\BAI99.351

S.L.C. Adopted 11-7

FRIST #2

AMENDMENT NO. ____ Calendar No. ____

Purpose: To improve provisions relating to external reviews.

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

S. 326

To improve the access and choice of patients to quality, affordable health care.

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 FRIST/Gregg/Domenici

Viz:

On page 53 of the amendment, line 23, strike "be experts" and insert "have expertise (including age-appropriate expertise)".

Beginning on page 54 of the amendment, strike line 15 and all that follows through line 9 on page 55, and insert the following:

"(A) IN GENERAL.—An independent external reviewer shall—

"(i) make an independent determination based on the valid, relevant, scientific

and clinical evidence to determine the medical necessity, appropriateness, experimental or investigational nature of the proposed treatment; and

"(ii) take into consideration appropriate and available information, including any evidence-based decision making or clinical practice guidelines used by the group health plan or health insurance issuer; timely evidence or information submitted by the plan, issuer, patient or patient's physician; the patient's medical record; expert consensus; and medical literature as defined in section 556(5) of the Federal Food, Drug, and Cosmetic Act.

On page 56 of the amendment, between lines 11 and 12, insert the following and redesignate the subsequent paragraphs accordingly:

"(7) REBUTTABLE PRESUMPTION.—With respect to the determination of an external reviewer under this subsection, there shall be a rebuttable presumption, in any judicial or administrative proceeding where such determination is at issue, that such determination and report on the final deter-

minations of the review are correct, so long as the external reviewer has conducted the review according to the standards of review under paragraph (4).

O:\BAI\BAI99.331

S.L.C. Adopted 10-8

FRIST #1

AMENDMENT NO. ____ Calendar No. ____

Purpose: To provide for a comprehensive independent study of patient access to clinical trials and coverage of associated routine costs.

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

S. 326

To improve the access and choice of patients to quality, affordable health care.

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 FRIST / ENZI

Viz:

On page 19 of the amendment, before line 1, insert the following:

SEC. 102. COMPREHENSIVE INDEPENDENT STUDY OF PATIENT ACCESS TO CLINICAL TRIALS AND COVERAGE OF ASSOCIATED ROUTINE COSTS.

(a) STUDY BY THE INSTITUTE OF MEDICINE.—Not later than 30 days after the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall enter into a contract with the Institute of Medicine to conduct a com-

prehensive study of patient access to clinical trials and the coverage of routine patient care costs by private health plans and insurers.

(b) MATTERS TO BE ASSESSED.—The study shall assess the following:

(1) The factors that hinder patient participation in clinical trials, including health plan and insurance policies and practices.

(2) The ability of health plans and investigators to distinguish between routine patient care costs and costs associated with clinical trials.

(3) The potential impact of health plan coverage of routine costs associated with clinical trials on health care premiums.

(c) REPORT.—

(1) IN GENERAL.—Not later than 12 months after the date of the execution of the contract referred to in subsection (a), the Institute of Medicine shall submit a report on the study conducted pursuant to that contract to the Committee on Health, Education, Labor and Pensions of the Senate.

(2) MATTERS INCLUDED.—The report submitted under paragraph (1) shall set forth the findings, conclusions, and recommendations of the Institute of Medicine for—

(A) increasing patient participation in clinical trials;

(B) encouraging collaboration between the public and private sectors; and

(C) improving analysis of determining routine costs associated with the conduct of clinical trials.

(3) COPY TO SECRETARY.—Concurrent with the submission of the report under paragraph (1), the Institute of Medicine shall transmit a copy of the report to the Secretary.

(d) FUNDING.—Out of funds appropriated to the Department of Health and Human Services for fiscal year 2000, the Secretary shall provide for such funding as the Secretary determines is necessary in order to carry out the study and report by the Institute of Medicine under this section.

O:\BAI\BAI99.329

Adopted - Voice S.L.C.

FRIST #3

AMENDMENT NO. ____ Calendar No. ____

Purpose: To provide for access to specialists.

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

S. 326

To improve the access and choice of patients to quality, affordable health care.

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 Frist / DeWine

Viz:

On page 12, between lines 8 and 9, insert the following and redesignate the subsequent sections accordingly:

"SEC. 725. ACCESS TO SPECIALISTS.

"(a) IN GENERAL.—A group health plan (other than a fully insured group health plan) shall ensure that participants and beneficiaries have access to specialty care when such care is covered under the plan. Such access may be provided through contractual arrangements with specialized providers outside of the network of the plan.

"(b) TREATMENT PLANS.—

"(1) IN GENERAL.—Nothing in this section shall be construed to prohibit a group health plan (other than a fully insured group health plan) from requiring that speciality care be provided pursuant to a treatment plan so long as the treatment plan is—

"(A) developed by the specialist, in consultation with the primary care provider, and the participant or beneficiary;

"(B) approved by the plan; and

"(C) in accordance with the applicable quality assurance and utilization review standards of the plan.

"(2) NOTIFICATION.—Nothing in paragraph (1) shall be construed as prohibiting a plan from requiring the specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all other necessary medical information.

"(c) REFERRALS.—Nothing in this section shall be construed to prohibit a plan from requiring an authorization by the primary care provider of the participant or beneficiary in order to obtain coverage for speciality services so long as such authorization is for an adequate num-

ber of referrals under an approved treatment plan if such a treatment plan is required by the plan.

"(d) SPECIALITY CARE DEFINED.—For purposes of this subsection, the term "speciality care" means, with respect to a condition, care and treatment provided by a health care practitioner, facility, or center (such as a center of excellence) that has adequate expertise (including age-appropriate expertise) through appropriate training and experience.

Adopted 12-6

AMENDMENT NO. ____ Calendar No. ____

Purpose: To modify provisions relating to patient access to emergency medical care.

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

S. 326

To improve the access and choice of patients to quality, affordable health care.

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 SENS. HUTCHINSON, ENZI

Viz:

On page 4, line 19, strike "REQUIRED.—Nothing" and insert the following: "REQUIRED AND OUT-OF-NETWORK CARE.—

"(1) UNIFORM COST-SHARING.—Nothing".

On page 5, between lines 6 and 7, insert the following:

"(2) OUT-OF-NETWORK CARE.—If a group health plan (other than a fully insured group health plan) provides any benefits with respect to emer-

gency medical care (as defined in subsection (c)), the plan shall cover emergency medical care under the plan in a manner so that, if such care is provided to a participant or beneficiary by a nonparticipating health care provider, the participant or beneficiary is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating provider.

O:\KIN\KIN99.124

ACCEPTED (w/ modification) 15-1 (Sessions)

S.L.C.

AMENDMENT NO. ____ Calendar No. ____

Purpose: To prohibit a plan from discriminating against providers or covered individuals based on self-payment for certain behavioral health care services.

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

S. 326

To improve the access and choice of patients to quality, affordable health care.

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 WELLSTONE

Viz:

On page 18 of the amendment, strike line 1 and insert the following:

"SEC. 727. SELF-PAYMENT FOR BEHAVIORAL HEALTH CARE SERVICES.

"A group health plan (other than a fully insured group health plan) may not—

"(1) prohibit or otherwise discourage a participant or beneficiary from self-paying for behavioral health care services once the plan has denied coverage for such services; or

"(2) terminate a health care provider because such provider permits participants or beneficiaries to self-pay for behavioral health care services—

"(A) that are not otherwise covered under the plan; or

"(B) for which the group health plan provides limited coverage, to the extent that the group health plan denies coverage of the services.

"SEC. 728. GENERALLY APPLICABLE PROVISIONS.

O:\BAI\BAI99.359 S.L.C.

Adopted - U.C.

AMENDMENT NO. ____ Calendar No. ____

Purpose: To make various technical amendments to improve the bill.

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

S. 326

To improve the access and choice of patients to quality, affordable health care.

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 Mr. JEFFORDS

Viz:

Beginning on page 9 of the amendment, strike line 1 and all that follows through line 8 on page 12, and insert the following:

"SEC. 723. PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE.

"(a) GENERAL RIGHTS.—

"(1) WAIVER OF PLAN REFERRAL REQUIREMENT.—If a group health plan described in subsection (b) requires a referral to obtain coverage for subspeciality care, the plan shall waive the referral requirement in the case of a female participant or

beneficiary who seeks coverage for routine obstetrical care or routine gynecological care.

"(2) RELATED ROUTINE CARE.—With respect to a participant or beneficiary described in paragraph (1), a group health plan described in subsection (b) shall treat the ordering of other routine care that is related to routine obstetric or gynecologic care, by a physician who specializes in obstetrics and gynecology as the authorization of the primary care provider for such other routine care.

"(b) APPLICATION OF SECTION.—A group health plan described in this subsection is a group health plan (other than a fully insured group health plan), that—

"(1) provides coverage for routine obstetric care (such as pregnancy-related services) or routine gynecologic care (such as preventive women's health examinations); and

"(2) requires the designation by a participant or beneficiary of a participating primary care provider who is not a physician who specializes in obstetrics or gynecology.

"(c) RULES OF CONSTRUCTION.—Nothing in this section shall be construed—

"(1) as waiving any coverage requirement relating to medical necessity or appropriateness with re-

spect to the coverage of obstetric or gynecologic care described in subsection (a);

"(2) to preclude the plan from requiring that the physician who specializes in obstetrics or gynecology notify the designated primary care provider or the plan of treatment decisions; or

"(3) to preclude a group health plan from allowing health care professionals other than physicians to provide routine obstetric or routine gynecologic care.

"SEC. 724. PATIENT ACCESS TO PEDIATRIC CARE.

"(a) IN GENERAL.—In the case of a group health plan (other than a fully insured group health plan) that provides coverage for routine pediatric care and that requires the designation by a participant or beneficiary of a participating primary care provider, if the designated primary care provider is not a physician who specializes in pediatrics—

"(1) the plan may not require authorization or referral by the primary care provider in order for a participant or beneficiary to obtain coverage for routine pediatric care; and

"(2) the plan shall treat the ordering of other routine care related to routine pediatric care by such

a specialist as having been authorized by the designated primary care provider.

"(b) RULES OF CONSTRUCTION.—Nothing in subsection (a) shall be construed—

"(1) as waiving any coverage requirement relating to medical necessity or appropriateness with respect to the coverage of any pediatric care provided to, or ordered for, a participant or beneficiary;

"(2) to preclude a group health plan from requiring that a specialist described in subsection (a) notify the designated primary care provider or the plan of treatment decisions; or

"(3) to preclude a group health plan from allowing health care professionals other than physicians to provide routine pediatric care.

On page 25 of the amendment, line 11, strike ", and" and all that follows through "cations" on line 13.

On page 33 of the amendment, line 11, strike ", and" and all that follows through "cations" on line 13.

On page 39 of the amendment, line 7, insert ", in accordance with the medical exigencies of the case," after "hours".

On page 40 of the amendment, line 17, strike "all".

On page 40 of the amendment, lines 24 and 25, strike ", and" and insert "and,".

On page 41 of the amendment, line 16, strike "(1)" and insert "(2)(C)".

On page 41 of the amendment, strike lines 23 and 24, and insert "of the determination."

On page 42 of the amendment, line 4, strike "(1)" and all that follows through "The" on line 6, and insert "(2)(D), the".

On page 42 of the amendment, line 16, strike "or electronic".

On page 43 of the amendment, line 22, strike "and" and insert "or".

On page 46, line 7, insert "of the case" after "exigencies".

On page 46 of the amendment, line 22, strike "tise involved" and insert "tise, including age-appropriate expertise,".

On page 50 of the amendment, line 14, strike "if" and all that follows through "review" on line 16.

On page 51 of the amendment, line 2, strike "all".

On page 53 of the amendment, line 23, insert ", including those with age-appropriate expertise," after "experts".

On page 67 of the amendment, line 4, strike "information derived from".

On page 67 of the amendment, line 10, strike "information derived from".

On page 67 of the amendment, lines 12 and 13, strike "information concerning".

On page 74 of the amendment, line 17, strike "information derived from".

On page 74 of the amendment, line 23, strike "information derived from".

Beginning on page 67 of the amendment, line 25, strike "information" and all that follows through "ing" on page 75, line 1.

On page 85 of the amendment, line 23, strike "information derived from".

On page 86 of the amendment, line 4, strike "information derived from".

On page 86 of the amendment, lines 6 and 7, strike "information concerning".

On page 87 of the amendment, line 23, strike "Healthcare" and insert "healthcare".

On page 99 of the amendment, line 21, strike "title)" and insert "title,".