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RESTRICTION CODES

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P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
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P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
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b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Congress of the United States
Washington, DC 20515

May 23, 2000

The Honorable Don Nickles
United States Senate
Room 133 Hart Senate Office Building
Washington, D.C. 20510

Dear Don:

Last Thursday the members of the managed care reform conference committee discussed for the first time since the conference began the issues of scope and liability. Even though there was no discussion or offer of any alternative to the House bill, the discussion was helpful because it was the first time you expressed to us your concerns on these subjects.

Since there has been no progress since that meeting, and we have received no offer of an alternative to the House bill, we are offering a proposal on behalf of all Democratic conferees today that is an attempt to respond to the three specific concerns you raised: the liability of employers, how best to cover all Americans, and exhaustion of appeals. We request a meeting to discuss our proposal on Wednesday, during which we hope that you will be able to accept these suggestions or respond with a proposal of your own that can form the basis for expedited negotiations.

As always, these proposals depend on agreement on a complete package, and the conference has yet to reach agreement on the majority of provisions in the House and Senate bills to prohibit specific managed care abuses.

At our White House meeting May 11, President Clinton expressed his strong hope that the conferees would be able to reach at least conceptual agreement on the issues of scope, liability, and external appeals before the Memorial Day recess. Given the limited time remaining in this Congress, prompt action is essential if this important legislation is to be enacted this year.

Thank you for consideration of these proposals.

Sincerely,

JOHN D. DINGELL

EDWARD M. KENNEDY

enclosure

cc: All House and Senate Conferees

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DEMOCRATIC OFFER
May 23, 2000

LIABILITY

Modify House Bill as follows:

(1) Responsibility of the employer. Clarify that an employer may only be sued if the employer makes a decision denying a specific claim for benefits and that decision results in the injury or death of the patient.

(2) Exhaustion of internal and external appeals.

- For externally appealable decisions, the plan could request the completion of the external appeals process concurrent with court proceedings, even if exhaustion was futile, to determine how an external appeals entity would have ruled on the appeal. Results of the external appeal process could be used as evidence in court.

- Modify exhaustion language by inserting language to the effect that the injury must be one in which provision of the benefit at this time would have no effect.

SCOPE

Agreement on scope would provide that provisions of legislation apply to all individuals covered by House Bill. Democrats would consider proposals to:

(1) Clarify method for determining whether or not a competing state law is as protective of beneficiaries as the Federal law. Some deference could be given to states in cases of ambiguity.

(2) Provide for an alternative enforcement mechanism in the event that State laws or enforcement do not meet the standards of the act.

EXTERNAL APPEALS

(1) Choice of entity. Return to tentative agreement to accept House language with no accompanying report language.

(2) State autonomy. Accept paragraph "D", p. 169 of House language, regarding state choice of entities. General language regarding Federal preemption apply to state external appeals programs, as modified by that paragraph. Nothing in the external appeal section shall be construed to modify ERISA preemption under current law.

(3) Ability of external appeal entity to affirm, deny, or modify. We would suggest changing this to allow the external appeal entity to affirm or deny, in whole or in part.

(4) Other outstanding concerns. Staff will resolve a number of other outstanding concerns, including agreement on legislative language, time frames on appeals, utilization review, internal appeals process and other relevant issues.

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From Chuck

LINCOLN D. CHAFEE
RHODE ISLAND

COMMITTEE ON
ENVIRONMENT AND PUBLIC WORKS

COMMITTEE ON
FOREIGN RELATIONS

United States Senate

WASHINGTON, DC 20510-3902

March 2, 2000

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The President
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear Mr. President:

Thank you for bringing together members from the Senate and House today to reiterate the need for passage of a comprehensive Patients' Bill of Rights this year.

Mr. President, in your State of the Union address last January, you stated: "For too long, this Congress has been standing still on some of our most pressing national priorities. So, let's begin tonight with them. I ask you to pass a real Patients' Bill of Rights. I ask you to pass common-sense gun safety legislation. I ask you to pass campaign finance reform. I ask you to vote up or down on judicial nominations and other important appointees. And, I ask you to raise the minimum wage."

Encouraging the Senate and House conferees to support a Patients' Bill of Rights which you will sign into law will help advance that agenda.

However, in order to do so, it is my strong hope that you will meet with House Speaker Hastert and Senate Majority Leader Lott. As I joined Congressman Norwood in stating three weeks ago, it is imperative that a meeting of this nature take place in order to create a common ground on the "make-or-break" issues before the conference committee begins the bulk of its work.

As the Senate and House conferees begin reconciling the differences between the two very different patients' rights proposals, it is important that a clear message is sent to the leadership of both parties that a basic framework leading to an acceptable legislative proposal must be found which can receive your signature this year. As you know, the late Senator Chafee and Senator Bob Graham authored a proposal which might be explored in such discussions.

You have demonstrated your concern about this issue, and we rely on you now to work in good faith with the Senate and House leadership to achieve a result. After four years of debate spanning two Congresses, we need to develop a bill which will bridge the partisan divide and restore consumer confidence in our managed care system.

I look forward to your continued leadership on this issue.

Sincerely,

Lincoln D. Chafee
U.S. Senator

202-462-6262

CONSUMERS UNION

Fax

To:	Chris Jennings	**From:**	Gail Shearer
Fax:	456-5542	**Pages:**	4
Phone:		**Date:**	02/29/00
Re:	"Access" Provisions	**CC:**	\

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

• **Comments:** Attached, fyi, is a letter that we sent to all Members of the House and Senate about the "access" provisions in the managed care bill. We think they should be OUT of the bill!

February 24, 2000

Dear Representative/Senator:

Conferees are working to reconcile differences between the House and Senate managed care bills, H.R. 2990 and S. 1334. We urge you to support the strong consumer protection provisions embodied in H.R. 2990 while rejecting all of the so-called "access" provisions that jeopardize health care quality and access. Specifically, we urge you to oppose expansion of medical savings accounts, HealthMarts, Association Health Plans, and tax deductions for health insurance premiums paid by individuals. As representatives of consumers, persons with disabilities, seniors, labor organizations, women's organizations, and the religious community, we believe that Congress *should* make access to affordable health care a high priority, but this should proceed on a separate track from the managed care legislation, particularly given the major consumer concerns.

Medical Savings Accounts should NOT be expanded.

While medical savings accounts have proved a hard sell in the marketplace (reaching only about 6 percent of the level of accounts allowed by the original legislation), they continue to pose a threat to the health care system. MSAs appeal disproportionately to the healthy. When the healthy enroll in MSAs, premiums increase substantially for people left behind in traditional low deductible coverage. With the proposed changes, MSAs (over time) could crowd-out traditional health insurance coverage. During the transition years, consumers seeking traditional coverage could face premiums 60 percent to 300 percent higher as a result of MSAs. Eventually, when the "crowd-out" is completed, *all* health insurance policies could have high deductibles ($1000 to $2250 for individuals and $2000 to $4500 for families). Many families will face burdensome out-of-pocket costs and many will be *underinsured* if MSAs are expanded.

HealthMarts should NOT be established.

HealthMarts are voluntary purchasing alliances that would negotiate and purchase health insurance for participants. HealthMarts would be exempt from state benefit mandates. In order to hold premiums down, HealthMarts could offer skimpy benefits. With barebones policies, and a voluntary marketplace, HealthMarts (like MSAs) will fragment the market and divide the risk pool into healthy and sick. HealthMarts could enable insurers to cherry-pick the healthy, and drive up the cost of health care for high risks left outside of the HealthMart. Consumers with skimpy HealthMart coverage will face higher out-of-pocket costs, as their coverage shrinks and health care costs rise. The Boards of HealthMarts would have built-in conflicts of interest, with representatives of insurance companies serving on them. HealthMarts are untried and untested mechanisms, and they could undermine state efforts to establish successful purchasing alliances that do play by the rules (without exemptions from regulation). We note that the Congressional Budget Office recently found that HealthMarts would lead to an extremely modest increase in

the number of insured; HealthMarts would result in replacement of fully regulated traditional policies by less comprehensive, less-regulated coverage for millions of people.[i]

Federally-certified Association Health Plans should NOT be allowed.

H.R.2990 would create federally-certified Association Health Plans, in which small employers and self-employed people could band together to purchase health insurance while escaping certain state regulation. Like HealthMarts, AHP's could escape state benefit mandates such as mammography screening, well-child care, cervical cancer screening, drug abuse treatment, mental health benefits, and bone marrow transplants. The Congressional Budget Office recently found that AHP's could result in premium reductions **because they could attract healthier risks and would reduce benefits.** We believe that cherry-picking the healthy and skimping on benefits are not desirable means of lowering health care premiums.

Individual-paid health insurance premiums should NOT be deductible, as proposed.

While we recognize that individuals who lack employer based health coverage need improved access to affordable health care, we do not believe that an individual tax deduction is an efficient or equitable mechanism to do this. The tax deduction in H.R. 2990 would *not* make coverage affordable to low-income families; families with income of $25,000 or less do not have any income tax liability and would not benefit from the proposed deduction. 61 percent of the expenditure would benefit people with income of $50,000 or more.[ii] The annual cost of the proposed deduction would be about $8 billion (once fully in effect), and only about 320,000 (of the 44 million uninsured) would gain coverage.[iii] In addition, in the absence of market reforms to protect high risk individuals, an individual-based tax preference could further fragment the risk pool, undermine employer-based coverage, and reduce the options and affordability of coverage for high risks.

In conclusion, we urge you to move forward on legislation to improve the quality of managed care in the United States, without including "access" provisions that threaten to split the healthy from the sick, drive up premiums for those in traditional coverage, create new untested insurance mechanisms that depend on skimpy benefits and cherry-picking the healthy, and increase the ranks of *underinsured* Americans. The managed care bill is not the right place for provisions designed to improve affordability of health care. The proposed provisions do not achieve the goals of broad spreading of risk and equitable sharing of costs.

Sincerely,

Adapted Physical Activity Council
AIDS Action Council
Alliance for Children & Families
American Federation of State, County, and Municipal Employees
American Federation of Teachers

American Public Health Association
Brain Injury Association
Center on Disability and Health
Center for Medicare Advocacy
Center for Women Policy Studies
Church Women United
Committee for Children
Communication Workers of America
Consumer Coalition for Quality Health Care
Consumer Federation of America
Consumers Union
Families USA
HIV Managed Care Network
Lutheran Office of Governmental Affairs, ELCA
Public Citizen
National Association for People with AIDS
National Association of Developmental Disabilities Councils
National Association of Protection and Advocacy Systems
National Association of Social Workers
National Council of Senior Citizens
National Education Association
National Mental Health Association
National Partnership for Women & Families
National Women's Health Network
Neighbor to Neighbor
Network: A Catholic Social Justice Lobby
Research Institute for Independent Living
Service Employees International Union
Summit Health Coalition
Title II Community AIDS National Network
United Church of Christ, Office for Church & Society
Universal Health Care Action Network

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[i] *Increasing Small-Firm Health Insurance coverage Through Association Health Plans and HealthMarts,"* Congressional Budget Office, January 2000, p. 3.

[ii] John Sheils, Paul Hogan and Randall Haught, The Lewin Group, Inc., *Health Insurance and Taxes; The Impact of Proposed Changes in Current Federal Policy*, prepared for The National Coalition on Health Care, October 1999.

[iii] Joint Committee on Taxation, letter of October 6, 1999 to Hon. Edward M. Kennedy, *Congressional Record*, October 6, 1999, page H9449.

CENTER ON BUDGET AND POLICY PRIORITIES

Revised March 2, 2000

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

by Iris J. Lav

Summary

Few would propose a tax cut for the affluent paid for with increased health insurance premiums on the sick. That is the probable consequence, however, of provisions related to Medical Savings Accounts contained in both the House and Senate versions of the Patients' Bill of Rights.[1]

The conference between the House and the Senate on the Patient's Bill of Rights legislation starts March 2. With both the House and Senate versions of the bill containing provisions to expand MSAs very substantially, it is quite likely such provisions will be part of the legislation to emerge from conference.

The legislation the conference produces is likely to allow universal access to MSAs and also to 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.

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

- 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.

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

- 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 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.

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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.

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

- 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.

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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.

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- 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."

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[6] (...continued)
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.

[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.

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."[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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- Under the MSA demonstration now underway, deposits can be made in 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 in 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, but most lower-paid staff would not be able to afford substantial additional contributions.

The provisions in the House and Senate bills would make MSAs substantially more attractive and likely lead to more widespread use of these accounts, with the dangers that would entail, in no small part because these bills would greatly increase the potential for MSAs to be abused and turned into lucrative tax shelters for healthy, affluent individuals.

CENTER ON BUDGET AND POLICY PRIORITIES

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FAX COVER SHEET

DATE:	
TO:	Chris Jennings
FAX NUMBER:	456-5594
FROM:	Ellen Nissenbaum
SUBJECT:	
NUMBER OF PAGES: (including cover)	

Comments: Here is the MSA paper (again). Zoe is supposed to talk w/ you about setting up a time to meet.

CENTER ON BUDGET AND POLICY PRIORITIES

Revised March 2, 2000

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

by Iris J. Lav

Summary

Few would propose a tax cut for the affluent paid for with increased health insurance premiums on the sick. That is the probable consequence, however, of provisions related to Medical Savings Accounts contained in both the House and Senate versions of the Patients' Bill of Rights.[1]

The conference between the House and the Senate on the Patient's Bill of Rights legislation starts March 2. With both the House and Senate versions of the bill containing provisions to expand MSAs very substantially, it is quite likely such provisions will be part of the legislation to emerge from conference.

The legislation the conference produces is likely to allow universal access to MSAs and also to 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.

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

- 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.

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

- 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 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.

[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.

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

- 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.

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Defending Liberty
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Chris / Jeanne - Assume you seen. Send to me if other staff

February 4, 2000

Dear Conferee:

The American Bar Association urges you to support efforts to include language in the conference report for H.R. 2990, the "Bipartisan Consensus Managed Care Improvement Act of 1999," protecting the rights of patients in their dealings with their HMOs. While the House-passed version of H.R. 2990 provides effective remedies to patients who have been harmed by their managed health care plans, the Senate version of the bill (previously known as S. 1344) suffers from a number of serious flaws and does not adequately protect patients' rights. In the absence of adequate remedies in the legislation, patients covered by employer-sponsored health care plans often will have no effective means of redress when the plans improperly refuse to provide appropriate medical services.

As the national voice of the legal profession in the United States with over 400,000 members, the American Bar Association has a strong interest in working with Congress and the Administration in order to ensure that our nation's health care laws protect the legal rights of all patients.

The ABA supports managed health care legislation that will protect patients by: (1) creating a system of internal and external review to resolve coverage disputes between HMOs and their patients, consistent with certain due process principles, and (2) removing the ERISA shield to allow the states to hold employer-sponsored plans accountable under the health care liability laws in the same way as other health care plans are held accountable. Because H.R. 2990, as passed the Senate, does not adequately address these issues, we urge you to include Section 1103 of Title XI and Section 1302 of Title XIII of the House-passed version of H.R. 2990 in the final conference report.

Internal and External Review

The ABA supports the right of all consumers to a fair and efficient process for resolving differences with managed health care plans, health care providers, and the institutions that serve such plans and providers, including: (1) timely written notification and explanation of a decision to deny, reduce or terminate services or deny payment for services; (2) a rigorous system of internal review; and (3) an independent system of external review. The ABA also supports enactment of legislation establishing alternative dispute resolution procedures--including the use of external review--as one remedy for resolving these disputes between patients and their managed health care plans.

Both the House and Senate versions of H.R. 2990 contain provisions that would give HMO patients the right to have adverse coverage decisions by HMOs reconsidered--and in some cases reversed--through a system of internal and external review. While both bills provide effective internal review procedures, we believe that the external review provisions contained in the House-passed bill will better protect patients' rights by ensuring the independence of the external review entities that review their claims.

Section 1103 of the House-passed version of H.R. 2990 contains numerous safeguards designed to guarantee the independence of the external review entities and hence the impartiality of the review process itself. In particular, the House bill requires that all such entities retained by HMOs must be certified, and then periodically recertified, by the appropriate federal or state authorities or by qualified private standard-setting organizations (which in turn must be certified by the appropriate authorities). The House-passed bill also provides for periodic audits of the external review entities in order to determine whether their decisions regarding patients' claims have been fair and unbiased over time. Furthermore, the House bill also promotes impartiality by specifically allowing state authorities to select the external review entities that will decide coverage disputes arising between patients and those insurance companies that are already subject to state regulation. Although the Senate-passed version of H.R. 2990 contains different and less extensive provisions designed to encourage impartiality of external review entities, it does not include the same strong procedural safeguards that are contained in the House version of the bill.

In addition, Section 1103 of the House bill also guarantees the independence of the external review process by granting the review panels greater authority to review certain coverage disputes that would not be reviewable under the Senate bill. For example, under the House-passed version of H.R. 2990, the external review panel is given the power to decide whether the care denied by the HMO was "medically necessary" based on all relevant factors. The Senate-passed version of the bill, on the other hand, only permits an external review panel to determine whether the denied care was "medically necessary" as that term is defined in the HMO's plan. Therefore, because the Senate bill would grant HMOs the power to determine which procedures

are "medically necessary," external review panels often would have little to review other than whether an HMO followed its own written procedures when it denied coverage to a patient.

Section 1103 of the House-passed bill is also preferable to the Senate version because it would make more disputes subject to the external review process. Although the House bill would permit all of the estimated 161 million privately insured Americans to file external appeals, the Senate bill would only allow the estimated 124 million patients in employer-sponsored plans to do so. In addition, the Senate bill only permits external review when the HMO refuses to cover a medical procedure on the grounds that it is experimental, investigational, or not medically necessary. In the case of disputes involving "medical necessity," the Senate bill further limits external review to those disputes that exceed a significant financial threshold or that involve a significant risk to the life or health of the patient. The House-passed bill, on the other hand, authorizes external review of any coverage dispute, irrespective of the amount in controversy, where the coverage decision "involves a medical judgment" or was based in whole or in part on a decision that the medical procedure was not medically necessary or appropriate or was investigational or experimental. Therefore, even though the House bill requires the patient to pay a filing fee of up to $25 for each external review, the bill generally makes external reviews more accessible to patients than the Senate bill.

By creating an effective system of internal and external review, Congress can help patients to receive the care to which they are entitled under the HMO policy. While both the House and Senate versions of H.R. 2990 provide for these procedures, the House-passed version of the bill would create a far more meaningful external review system than would the Senate version.

Removing the ERISA Shield

The ABA also supports amending ERISA to allow causes of action to be brought in the state and territorial courts against employer-sponsored health care plans under state and territorial health care liability laws. While the Senate-passed version of H.R. 2990 does not contain provisions to do this, Section 1302 of Title XIII of the House bill does contain such provisions. The ABA supports and encourages utilization of alternative dispute resolution mechanisms prior to the filing of such causes of action. However, it is crucial that any legislation that is enacted must address the inequities under current law by amending ERISA in this manner. Internal and external review of health care disputes, though useful, is not adequate if conducted in the absence of any ultimate consequence for denial or delay in providing necessary care. By removing the ERISA shield, there will be accountability for those plans that do not act appropriately.

Under ERISA, companies that contract with ERISA employers to provide health care coverage have largely been able to shield themselves from liability for health care treatment decisions that cause harm to enrollees. ERISA was motivated by abuses in some private sector pension systems and was enacted primarily to protect working Americans from fraud and

mismanagement in their pension benefit plans. Unfortunately, some managed care plans have taken advantage of ERISA to avoid accountability under state health care liability laws.

Since ERISA was passed, traditional fee-for-service insurance, in which the doctor makes the decision about a patient's care, has given way to managed care. Because managed care plans, with their emphasis on cost containment, did not exist when Congress passed ERISA, the legislation was not written to address such plans. More and more courts are finding ways to lift the ERISA shield and hold managed care entities accountable for their actions. However, in those cases in which the courts find that ERISA preempts the state laws, a patient who is injured because appropriate care was denied or delayed by an ERISA-regulated health care plan cannot bring an action in state court under the state tort laws. He or she can bring an action in federal court, but damages are limited to the payment of the costs of health care services that were improperly denied.

The remedies available under ERISA are clearly inadequate. Some HMOs have denied coverage for treatments or tests despite the recommendations of the patients' treating physicians. By the time an HMO is ordered to pay for a benefit that should have been provided initially, the patient may be irrevocably harmed or may have died because of the delay. HMOs that consistently provide appropriate coverage are not rewarded under this system and may find themselves at a competitive disadvantage against those who do not provide necessary care in a timely manner.

HMOs and other kinds of employer-sponsored managed care companies should be held responsible if their decision to deny or delay medically necessary care that is covered under the insurance policy results in harm to a patient. These entities should be held to the same standards of accountability we expect of doctors, nurses, hospitals, and other health care providers. Enrollees in such plans should be able to bring a state cause of action under state liability laws in the state courts -- just as enrollees do now who either buy insurance directly (rather than through an employer) or are covered as employees of a state or local government.

The House-passed version of H.R. 2990 includes provisions that would amend ERISA to allow suits against employer-sponsored health plans, and the bill specifically protects employers from suits as long as the action that led to the suit did not result from a decision made by the employer. The House bill does not establish any liability for managed care organizations and does not create a new federal cause of action; it merely allows the individual states to hold employer-sponsored health care plans accountable under the health care liability laws in the same way as other heath care plans are held accountable.

Opponents of legislation, such as the House-passed version of H.R. 2990, that would permit patients to sue their employer-sponsored health plans for damages under state law argue that such legislation will discourage employers from providing health care benefits to their employees due to increased litigation costs. We are convinced that this would not be the case.

The House-passed version of H.R. 2990 will facilitate the prompt and informal resolution of disputes -- and control costs -- by creating a strong system of internal and external review designed to resolve coverage disputes short of litigation. Furthermore, past experience has shown that litigation over coverage disputes is rare. A 1998 study by the Henry J. Kaiser Family Foundation examined the extent of litigation brought by patients who currently have the ability to sue health plans (including state and local government employees and patients who buy insurance directly rather than through an employer). The study found very low rates of litigation against the public insurance systems it researched, ranging from 0.3 to 1.4 cases per 100,000 enrollees per year (with estimated monthly costs from $0.03 to $0.13 per enrollee). There is simply no reason to believe that the patients covered by the House-passed version of H.R. 2990 would be any more likely to bring a cause of action against their HMOs than the patients examined in the Kaiser study.

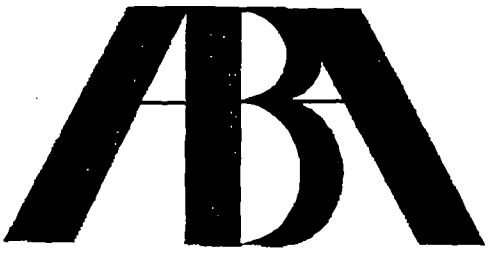
We believe that the House-passed bill appropriately permits a cause of action to be brought in the state courts rather than in federal courts. The state courts are the right bodies to handle these actions. They have been handling health care liability claims for over 200 years. It makes no sense to add an additional burden to the federal courts when the state courts are perfectly capable of handling these cases. As Chief Justice Rehnquist has said in his year-end reports, the federal judiciary is already overburdened. In addition, the House bill will promote judicial economy -- and avoid wasteful duplicate proceedings in federal and state court -- when there are multiple defendants. Because malpractice suits against doctors and hospitals will continue to be brought in state court, related actions against employer-sponsored health plans should be resolved in the same forum. Requiring patients to pursue two separate lawsuits regarding the same dispute is a waste of all parties' time and resources.

Thank you for considering the views of the ABA on these important matters.

Sincerely,

Robert D Evans

Robert D. Evans



AMERICAN BAR ASSOCIATION
Governmental Affairs Office
740 Fifteenth Street, NW
Washington, DC 20005-1009
Phone: 202/662-1768
Fax: 202/662-1762 or 202/662-1032

TO:	Sarah Rosen	FAX #: 202/456-2223
FROM:	Lillian B. Gaskin Senior Legislative Counsel	
DATE:	03/02/00	TIME SENT: 9:45a.m. EST

Trouble/Confirmation: Elizabeth Waterstraat @ 202/662-1776

MESSAGE: Attached are the ABA's letters regarding H.R. 2366 and H.R. 2990.

Number of Pages Including Cover 8

ATLA
For The People

ASSOCIATION OF TRIAL LAWYERS OF AMERICA

FACSIMILE TRANSMITTAL SHEET

DATE: 2-29-00

NUMBER OF PAGES:
(Including Cover Sheet) 2

TO: Chris Jennings

FAX #: 456-5557

FROM: Randy White

PHONE #: 944-2884

COMMENTS:

You may already have this, but if not, this is very good chart.

Randy

If you have trouble receiving this transmission, please call the ATLA Public Affairs Department, 202-965-3500, ext. 305

1050 31st Street N.W., Washington, D.C. 20007-4499 (202) 965-3500

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]

2/8/00 For additional information, contact Joanne Hustead, National Partnership for Women & Families (202) 986-2600; Adrienne Hahn, Consumers Union (202) 462-6262; or Vicki Gottlich, Center for Medicare Advocacy (202) 216-0028.

---

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.

ATLA
For The People

ASSOCIATION OF TRIAL LAWYERS OF AMERICA

FACSIMILE TRANSMITTAL SHEET

DATE: 2-28-00

NUMBER OF PAGES:
(Including Cover Sheet)
4

TO: Chris Jennings

FAX #: 456-5557

FROM: Randy White

PHONE #: 944-2884

COMMENTS:

If this not what you need, please let me know.

Rod

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ATLA Public Affairs Department, 202-965-3500, ext. 305

1050 31st Street N.W., Washington, D.C. 20007-4499 (202) 965-3500

NON-ECONOMIC DAMAGES ARE REASONABLE & NECESSARY

A full ERISA remedy includes compensation for non-economic damages. Non-economic damages compensate injured patients for the most egregious injuries, for real loss and suffering. Under ERISA, a family who loses a child, a mother who is left infertile, and a minimum wage worker who can no longer work because of excruciating, debilitating pain all have no remedy for their non-economic loss. *ERISA remedies that do not allow recovery for non-economic damages discriminate against the most vulnerable.*

Managed care legislation that does not allow recovery for non-economic loss has a disproportionately negative impact on women, minorities, the poor, children, the elderly, and other patients who often cannot show substantial "economic" loss–i.e, lost wages or salary. A lack of remedy for non-economic loss also leaves those who have lost a spouse or child due to the callousness of managed care virtually without a remedy.

I. <u>Non-economic damages are necessary for full compensation.</u>

- **Non-economic damages compensate patients for very real injuries.** Although they may be harder to quantify than economic damages, non-economic damages compensate patients for real loss and suffering (i.e., loss of sight or other sense, inability to use one's legs or arms, gross disfigurement, excruciating pain, the loss of fertility or mental faculties, the loss of a spouse or a child, etc.).

- **Managed care is the only entity in America that enjoys virtual immunity.** The tobacco industry, the gun industry, even the President of the United States can be held accountable for wrongdoing. The managed care industry can get away with denying patients needed medical care. Suppose a patient is denied cancer treatment by a managed care bureaucrat and dies. The bureaucrat is later struck dead by a drunk driver. The bureaucrat's family could hold the drunk driver accountable for its loss. Under ERISA, the patient's family has no remedy for their loss. It is extremely unfair for managed care to profit at the expense of patients' health.

- **Non-economic damages are necessary compensation for persons with little or no income.** The elimination of non-economic damages would be a heavy burden to place on the most vulnerable members of our society–children and the elderly–who do not have lost wages or salary. Women who are not in the workforce also need non-economic damages to ensure that their compensation for the worst managed care abuse is equal to men's. *See* Koenig and Rustad, *His and Her Tort Reform: Gender Injustice in Disguise*, 70 Washington L. Rev. 1995).

II. <u>Non-economic damage awards are reasonable.</u>

- **Numerous studies show that the amount of non-economic damages is related to the severity of injury.** More severe injuries are compensated at greater levels than less severe ones. Jurors are able to assess these damages reasonably. In one study, jurors awarded about the same amount of non-economic damages as judges and professional arbitrators. In fact, compared to judges or arbitrators, jury verdicts in medical malpractice cases are very consistent, resulting from the combined judgments of six or 12

people. (*See* Galanter, *Real World Torts: An Antidote to Anecdote*, 55 Maryland L. Rev. 1093 (1996) ; Vidmar and Rice, *Assessments of Non-Economic Damage Awards in Medical Negligence: A comparison of Jurors with Legal Professionals,* 78 Iowa L. Rev. 883 (1993)).

- **Evidence shows that jurors award reasonable non-economic damages in medical malpractice cases.** Although there are no studies on what percentage of jury awards are non-economic damages, studies have shown that jurors are concerned about the personal and social costs of large jury awards and award appropriate damages. Studies showing that jurors assess damages based on the so-called "deep pockets" of the defendant have been widely discredited. *See* Vidmar, *Are Juries Competent to Decide Liability in Tort Cases Involving Scientific/Medical Issues? Some Data from Medical Malpractice*, 43 Emory L.J. 885 (1994); Hans and Lofquist, *Jurors' Judgments of Business Liability in Tort Cases: Implications for the Litigation Explosion Debate*, 26 Law & Society Rev. 85, 93 (1992).

III. <u>Caps on non-economic damages are unfair.</u>

- **Caps hurt those with the most serious injuries.** Since 1975, California, for example, has limited non-economic damages in medical malpractice cases to $250,000. No matter how catastrophic or permanent the injury–a painful death, complete paralysis, brain damage, etc.–the most that can be awarded is $250,000. The California cap has been seriously devastating to severely injured patients, especially children. Severely injured persons need to have their compensation based on the seriousness of their injury, not on some arbitrary cap. Even the American Medical Association has testified that caps effect only those cases involving severe injury where the patient faces the greatest need for compensation.

- **The government ends up footing the bill when compensation is inadequate.** It is simply bad public policy for the government to use taxpayer dollars to bear the costs of inadequate compensation rather than holding negligent managed care companies responsible.

- **Damage caps increase the likelihood of litigation.** Caps diminish the defendant's incentive to settle a case efficiently by removing the element of uncertainty as to the maximum possible verdict. The worst case scenario is the defendant will have to pay the amount of the cap. Like ERISA, which only requires managed care to pay for the treatment it should have provided in the first place, caps on non-economic damages provide defendants an incentive to drag out litigation proceedings.

IV. <u>Medical malpractice insurance costs are a small part of the cost of health care.</u>

- **Liability costs are minuscule.** A study by Bob Hunter, formerly the Insurance Commissioner for the State of Texas and the Federal Insurance Administrator during the Ford and Carter Administration, found that if medical malpractice liability to doctors and hospitals was totally abolished, it would drop health care costs by <u>65 cents for each $100</u> of health costs in the country. In fact, medical malpractice insurance is an insurance industry profit center. *See* J. Robert Hunter, *Medical Malpractice Insurance: A Report of*

the Insurance Group of the Consumer Federation of America, Sept. 1995.

- **Caps on non-economic damages in medical malpractice cases don't lower health care costs.** Between 1980 and 1993, health care costs rose at virtually the same rate in states which had imposed and states which had not imposed caps. Although health care costs rose during this period, medical malpractice insurance premiums decreased across the United States. The smallest decrease in insurance premiums occurred in California , which has a stringent $250,000 cap on non-economic damages. *See Health Care Statistics and the Effect of Caps on Non-economic Damages,* Report by Citizen Action, 1994.

V. **Claims by the insurance industry that patients will lose their health benefits if accountability measures are passed are completely unfounded.**

- **The ability to hold managed care accountable will not affect premiums.** The only independent study on the costs of holding managed care accountable found that premiums would increase between *three and 13 cents a month per enrollee, or 0.03% to 0.11% of premiums if patients.* The study conducted for the Kaiser Family Foundation by Coopers & Lybrand found that the costs associated with the ability to sue have been virtually zero for those patients in state and local government plans, who currently have the right to hold managed care accountable. Just as importantly, the Texas law allowing injured patients to hold managed care accountable has not caused premiums to skyrocket, as predicted by the insurance industry. Insurance companies report an increase of only 0.1% in spending on medical services. (*New York Times,* 9/13/98.)

- **The insurance industry is making record profits.** Don't let industry claims fool you! The insurance industry wrongly contends that it will have to drop patients if legislation passes allowing injured patients to hold managed care accountable. Nothing could be further from the truth. The largest insurers–Aetna, Cigna, and U.S. Healthcare–continue to buy smaller companies. At the same time, their earnings are at record levels from rate increases whose costs are being borne by consumers and employers alike.

UNITED STATES SENATE

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

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DATE: 5/10/00

TO: Chris Jennings, Len Berman, Leslie, Rich

FAX: 456-5557, 622-0605, 219-5526, 690-7380

FROM: JACKIE GRAN / DAVID NEXON
(202) 224-7675 phone
(202) 224-3533 fax

NUMBER OF PAGES: 3

MESSAGE:

ISSUES IN THE PATIENTS' BILL OF RIGHTS CONFERENCE

April 5, 2000
(revised May 5, 2000)

Resolved
-Access to pediatricians
-Provider non-discrimination
-Access to emergency care (language not resolved)
-Access to specialists (haven't seen language)
-Continuity of care (haven't seen language)

Pending
-External appeals
-Access to OB-GYN providers
-Access to prescription drugs
-Information requirements
-Point-of-Service

Unresolved/undiscussed or no offers pending
-Internal appeals
-Clinical trials
-Gag
-Prohibition on improper financial incentives
-Protection for patient advocacy
-Accountability
-Scope
-Access/tax provisions
-Genetic non-discrimination
-Mastectomy/second opinions
-Prompt payment
-Self-payment for behavioral health services

****

Total issues = 22

Total issues on which agreement in principle has been reached = 5

Total issues on which full agreement has been reached (both agreement in principle and legislative language) = 2

Issues fully resolved since April 5 = None

CHRONOLOGY–PATIENTS' BILL OF RIGHTS CONFERENCE

DATE/EVENT	ELAPSED TIME BETWEEN EVENT AND MAY 11
10/7/99–Passage of Norwood-Dingell (275-151)	7 months, 4 days
10/15/99–Senate appoints conferees	6 months, 26 days
11/3/99–House appoints conferees	6 months, 8 days
2/23/99–First meeting of bipartisan/bicameral staff	2 months, 18 days
3/2/00–First members' meeting of conferees	2 months, 9 days

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. press release	re: phone number (partial) (1 page)	05/25/2000	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20465

FOLDER TITLE:
PBOR [Patients' Bill of Rights] [Folder 5] [1]

2012-0463-S
rc805

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

AN ADDRESS BY U.S. REP. CHARLIE NORWOOD

CONTACT: JOHN STONE PHONE (202)225-4101 FAX (202)226-5905 After-Hours P6/(b)(6) John.Stone@mail.house.gov

May 25, 2000

4:00pm News Conference, 1539 Longworth Building, Washington, DC

Progress Of The Conference Committee On Managed Care Reform

The House passed a comprehensive managed care reform bill, HR 2723, on October 7, by an overwhelming bipartisan majority. We have waited on the results of the conference with the Senate since that time.

What does the HMO lobby hope to accomplish by delay?

I believe they feel that the entire issue will fade from the media's attention and the public's mind, so that they can quietly kill the bill, while their supporters in the House and Senate slither through the fall election unscathed.

If that is the strategy, then the stacks of letters we have here today should serve as a wake-up call to this Congress. I would like to read from just one:

- **This from a 36-year old mother of three in New Jersey, who is also an RN:**

"Two years ago, after pursuing removal of a mole for seven months I finally found out that I had malignant melanoma cancer with metastasis to my lymph system which according to my oncologist occurred during the seven months that I fought for treatment but was denied....when I found out, I was eight weeks pregnant and had to live with the horror of the possibility of my baby having the cancer. My HMO had no specialist in its network to threat me for the cancer. I pursued treatment, only to have them deny payment...I remain in debt to the tune of near the hundred thousand dollar mark."

Every one of these letters say to include the Norwood-Dingell provisions on liability, scope, and external appeals, and that the Senate bill is inadequate.

Those 24,000 letters are just the tip of the iceberg. The latest public opinion poll that we are releasing here today makes clear that the American voter won't stand for a conference failure.

None other than the chief Republican pollster in the country, Frank Luntz, now reports the following:

- **85% of Americans believe HMO reform is important**
- **65% say it is VERY important**
- **60% say they will vote against a member of Congress who won't support HMO reform**

Now, Senator Nickles has long maintained he doesn't want to pass anything that increases premium costs. He knows full well that any bill that truly reforms managed care is going to be scored by CBO with a premium increase.

So Mr. Nickles really needs to listen to this one:

- **72% of Americans still want HMO reform even if it costs them an extra $15 a month in premiums.**

The overwhelming majority of the American people, as certified by Republican pollsters, disagree with the good Senator's position. The Senate has to change, or face the public in November.

I'm here today to say time's up on the conference committee. We've waited eight months for this committee to approve a compromise bill. Senate Republicans have yet to even offer a compromise liability proposal – they have only demanded that the House Conferees abandon their position.

Today I call on the 275 members of the House who voted yes on HR2723, and the 400 members who voted yes on liability to prepare for additional floor action.

If we don't get a bill, or at least a tentative agreement in writing by the week we come back from Memorial Day, we must move past the conference.

Starting today, I am working as if that will be the case. I am willing to pass this measure through any means necessary. Thank you.

###

U.S. REP. CHARLIE NORWOOD 1707 LONGWORTH BUILDING WASHINGTON,DC 20515
www.house.gov/norwood

American Medical Association
Physicians dedicated to the health of America

1101 Vermont Avenue, NW
Washington, DC 20005

FAX TRANSMISSION SHEET

Date: 5/15/00

To: Chris Jennings

From: Richard A. Deem
Vice President
Government Affairs
Tel: (202)789-7413

Message: Think this is what you were looking for last week.

Total Pages (including cover sheet): 2

Reply Fax Number: (202)789-4692
Government Affairs

THE WASHINGTON POST 11/7/99

What Worries Americans

With the 2000 elections one year away, The Washington Post undertook a survey to better understand Americans' concerns. More than 2,000 people were asked about 51 things that might be worrying them. Below are the top and bottom of that list of worries, ranging from intense concern about the health care system and the quality of family life, to a marked lack of concern about military spending and strict immigration policies. Respondents were asked if each item worried them a great deal, a good amount, just a little, or not at all. The items below were ranked according to the percentage of respondents who worried about each "a great deal."

Top 10 Worries

66% Insurance companies are making decisions about medical care that doctors and patients should be making.

60 Children in America are no longer safe at their own schools.

59 Elderly Americans won't be able to afford the prescription drugs they need.

56 Because of work and other pressures, parents don't have enough time to spend with their children.

55 Medical benefits that you and your family now receive will be reduced or eliminated.

55 Crime will increase.

53 A good college education is becoming too expensive.

52 Use of illegal drugs will increase.

51 The American educational system will get worse instead of better.

51 Pollution and other environmental problems will get worse.

The Least of Our Worries

14% The United States spends too much on its armed forces.

17 We will shut the door to new immigrants and the dream of a melting-pot nation will be lost.

18 Affirmative action may have gone too far to give some blacks unfair advantages over whites.

18 Vouchers for private and religious schools will erode the public school system.

19 The religious right has too much political power.

21 Labor unions have too much political power.

22 The United States doesn't spend enough on its armed forces.

22 It will become harder for a woman to obtain a legal abortion.

24 We will elect another president who will embarrass the country with scandals while in office.

25 It's becoming too hard for a law-abiding citizen to own a gun.

25 This is no longer an English-speaking nation; too many people don't know or use the language.

Top Five Concerns by Party I.D.

Concerns about health maintenance organizations top the list of worries for Republicans, Democrats and independents alike.

Rank*	Republicans	Democrats	Independents
1	Concerns about HMOs	Concerns about HMOs	Concerns about HMOs
2	School violence	Elderly not getting medicines	School violence
3	Sex and violence on TV	Losing own medical benefits	Elderly not getting medicines
4	Illegal drug use	School violence	Educational system worsening
5	Not enough family time	Cost of college	Not enough family time/Crime

*Ranked by percentage who answered that each worried them "a great deal."
Items listed above are abbreviated versions of longer survey questions.

Figures are based on two separate Washington Post surveys conducted Oct. 13-17 and Oct. 27-31. Slightly more than 1,000 randomly selected adults nationwide were interviewed by telephone for each survey. Across the two polls, respondents were asked how much they worried about a total of 51 national concerns. These concerns were culled from voter interviews as well as this year's ongoing political debate. The margin of sampling error for reported results is plus or minus three percentage points. Sampling error is only one of many potential sources of error in this or any other public opinion poll. Interviewing was conducted by ICR of Media, Pa.

UNITED STATES SENATE

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

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DATE: 5/10/00

TO: Chris Jennings, Len Berman, Leslie, Rich

FAX: 456-5557, 622-0605, 219-5526, 690-7380

FROM: JACKIE GRAN / DAVID NEXON
(202) 224-7675 phone
(202) 224-3533 fax

NUMBER OF PAGES: 3

MESSAGE:

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

ISSUES IN THE PATIENTS' BILL OF RIGHTS CONFERENCE

April 5, 2000
(revised May 5, 2000)

Resolved
-Access to pediatricians
-Provider non-discrimination
-Access to emergency care (language not resolved)
-Access to specialists (haven't seen language)
-Continuity of care (haven't seen language)

Pending
-External appeals
-Access to OB-GYN providers
-Access to prescription drugs
-Information requirements
-Point-of-Service

Unresolved/undiscussed or no offers pending
-Internal appeals
-Clinical trials
-Gag
-Prohibition on improper financial incentives
-Protection for patient advocacy
-Accountability
-Scope
-Access/tax provisions
-Genetic non-discrimination
-Mastectomy/second opinions
-Prompt payment
-Self-payment for behavioral health services

****

Total issues = 22

Total issues on which agreement in principle has been reached = 5

Total issues on which full agreement has been reached (both agreement in principle and legislative language) = 2

Issues fully resolved since April 5 = None

CHRONOLOGY–PATIENTS' BILL OF RIGHTS CONFERENCE

DATE/EVENT	ELAPSED TIME BETWEEN EVENT AND MAY 11
10/7/99–Passage of Norwood-Dingell (275-151)	7 months, 4 days
10/15/99–Senate appoints conferees	6 months, 26 days
11/3/99–House appoints conferees	6 months, 8 days
2/23/99–First meeting of bipartisan/bicameral staff	2 months, 18 days
3/2/00–First members' meeting of conferees	2 months, 9 days

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

DEMOCRATIC STAFF

FAX COVER SHEET

DATE: 5/10/00

TO: Chris Jennings

FROM: Bridgett Taylor (Heren Folk)

FAX NUMBER: 456-5557

NUMBER OF PAGES:
(Including Cover)

COMMENTS: Liability Principles document Bridgett mentioned on conference call.

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

Principles for Accountability:

1. HMOs and other health plans should no longer be treated as exempt from the duties of care and accountability that are required of all other providers of goods and services.

2. Accountability should fall to the actors that exercise responsibility and cause harm.

3. Federal law should not shield HMOs and other health plans from remedies available under state law when patients are injured or killed as a result of the plan's conduct.

4. Any new remedies should not supplant, restrict or narrow current federal or state remedies.

5. Any new remedies should not restrict or narrow state tort reform efforts or otherwise provide for federal preemption of state law.

6. The forum for accountability must be easily accessible, free from unnecessary barriers for patients, and provide timely resolution of disputes.

7. As under current law, employers should retain the ability to design their own health plans without being subject to liability for their plan design.

8. There should be strict penalties and effective enforcement by the appropriate regulatory body for HMOs and other health plans that fail to comply with the requirements of the statute.

UNITED STATES SENATE

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

DATE: 5/10/00

TO: Chris Jennings, Len Berman, Leslie, Rich

FAX: 456-5557, 622-0605, 219-5526, 690-7380

FROM: Jackie Gran/David Nexon
(202) 224-7675 phone
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NUMBER OF PAGES: 2

MESSAGE: REVISED CHRONOLOGY

2/5/00
+201

CHRONOLOGY–PATIENTS' BILL OF RIGHTS CONFERENCE

DATE/EVENT	ELAPSED TIME BETWEEN EVENT AND MAY 11
10/7/99–Passage of Norwood-Dingell (275-151)	7 months, 4 days
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2/23/00–First meeting of bipartisan/bicameral staff	2 months, 18 days
3/2/00–First members' meeting of conferees	2 months, 9 days

F A X

From the desk of...
Bob Greenstein
Executive Director

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Center on Budget and Policy Priorities

To: John Podesta 456-1907
Chris Jennings 456-5557
Gene Sperling 456-2878
Jack Lew 395-1005
Jeanne Lambrew 456-7431

Date: May 11, 2000

We understand the Republican staff of the House Ways and Means and Senate Finance Committees have held meetings and reached "agreement" on the health tax provisions to be included in the conference report on the Patients' Bill of Rights. We have been particularly concerned with the Medical Savings Accounts provisions in both the House and Senate bills. These provisions would both make eligibility for MSAs universal and substantially increase their attractiveness by weakening or eliminating important provisions of current law that limit the degree to which MSAs can serve as lucrative tax shelters. Apparently, the Republican agreement on the MSA provisions that would go into the conference report combines egregious MSA provisions from the House bill with egregious provisions from the Senate bill.

If enacted, these MSA provisions would likely lead to substantial adverse selection in the health insurance markets, which could result in substantial increases in premiums for conventional health insurance. Earlier work by the American Academy of Actuaries, RAND, and the Urban Institute indicates that if use of MSAs becomes widespread, as could well occur under these provisions, premiums for conventional insurance *could double*. If that occurred, some employers undoubtedly would drop coverage, and the ranks of the uninsured would rise significantly. In short, under these provisions, healthy, more affluent individuals would be able to use generous tax shelters, while less-healthy individuals could face serious harm.

In March, the Center issued an analysis of the House and Senate MSA provisions. That analysis has now become quite timely; I'm enclosing a copy. I'm also enclosing an op-ed on this issue by the Center's deputy director Iris Lav, which the *Los Angeles Times* ran today. We urge you to take a strong stand on this matter, which could have serious consequences and affect the Administration's legacy in the health insurance area.

Health Care, but Only for the Young and Healthy

■ **Politics:** Medical savings accounts would cause insurance rates to rise for the old and sick.

By IRIS J. LAV

Bills moving through Congress often become a tangle of complicated provisions, the import of any one of which can be hard to discern. The medical savings accounts expansion grafted onto the Patients' Bill of Rights, a bill that extends new rights to managed care patients, is a good example. The White House is hosting a meeting today to push congressional conferees to finish their work on the underlying bill.

Medical savings accounts may seem benign, but they pack a powerful potential for trouble. That's because they benefit the young, the healthy and the wealthy at the expense of the elderly, the sick and the less affluent.

MSAs are for use only with high-deductible health insurance policies, policies that pay nothing until a family incurs between $3,000 and $4,500 annually in covered medical costs. A current experiment allows some taxpayers buying such policies or their employers to make tax-deductible deposits into an MSA. Earnings on funds on deposit in these accounts are tax-free. Funds that are withdrawn to pay medical expenses are not taxed. If funds are not used and are left on deposit until retirement, taxes are deferred and funds may be withdrawn for any purpose without penalty.

Currently, MSA use is limited to people who are self-employed, work in small businesses or are uninsured. Additional restrictions are placed on amounts deposited to the accounts and on the terms of the high-deductible insurance policies.

The restrictions were put in place because research suggested that MSAs lead to "adverse selection," in which one type of insurance is selected by young, healthy people with low medical costs. When healthy people congregate in the policies used with MSAs, the insurers can charge lower premiums for these policies than they would have to if they were insuring a broader cross-section of the population with varying health statuses.

So what happens to older, less-healthy people, as well as those who do not have the wherewithal to make MSA deposits? They would increasingly be segregated in conventional, low-deductible plans, which would become more expensive. Many individuals who most need insurance could be forced into high-deductible plans and become underinsured or could get priced out of the market and join the uninsured.

Research suggests that if use of MSAs becomes widespread, premiums for conventional insurance could more than double over time. 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." The General Accounting Office conducted a survey of insurers now offering policies with MSAs and found evidence of the beginnings of just this type of adverse selection.

Despite these concerns, Congress is charging ahead to make MSAs universally available and to relax other safeguards on their use. Both the House and Senate versions of the managed care legislation, currently in conference committee, contain such provisions.

Moderate- and middle-income taxpayers get little tax benefit from making MSA deposits; because of their relatively low income-tax rate, the tax deduction isn't worth much. By contrast, MSAs can be attractive for high-income taxpayers even if they have substantial medical expenses. The tax-free compounding of investment earnings on the funds in the MSA accounts along with deferral of taxation can be advantageous for the well-to-do even if the MSA is primarily used as an investment vehicle and health care costs are paid out-of-pocket.

Indeed, some MSA providers already tout the advantages of MSAs as an investment vehicle. In discussing the entry of Merrill Lynch and other investment firms into the MSA arena, the GAO report took note of "insurers' perceptions that MSA enrollees are using their accounts primarily as tax-sheltered savings vehicles."

MSAs have been sparsely used during the experimental period, partly because the restrictions on MSAs made them less attractive and inhibited marketing. This may lull policymakers into a belief that an MSA expansion is harmless, something that could be traded for better patient protections in other parts of the bill. Such a belief would be mistaken.

The Patients' Bill of Rights has important provisions. But the risks that the MSA provisions pose are so great that it would be better to have no bill than to have a bill that includes them.

Iris J. Lav is deputy director of the Center on Budget and Policy Priorities, a Washington-based advocacy group.

[redacted]

LA Times 5/11/00

CENTER ON BUDGET AND POLICY PRIORITIES

May 11, 2000

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

by Iris J. Lav

Summary

Few would propose a tax cut for the affluent paid for with increased health insurance premiums on the sick. That is the probable consequence, however, of provisions related to Medical Savings Accounts contained in both the House and Senate versions of the Patients' Bill of Rights.[1]

The conference between the House and the Senate on the Patient's Bill of Rights legislation starts March 2. With both the House and Senate versions of the bill containing provisions to expand MSAs very substantially, it is quite likely such provisions will be part of the legislation to emerge from conference.

The legislation the conference produces is likely to allow universal access to MSAs and also to 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.

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

- 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 widely popular among consumers with relatively better health, an adverse selection cycle could be triggered that would drive up the cost of conventional,

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

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.

- 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

[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.

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.

American Medical Association
Physicians dedicated to the health of America

1101 Vermont Avenue, NW
Washington, DC 20005

FAX TRANSMISSION SHEET

Date: 5/12/00

To: Chris Jennings

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Government Affairs
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Total Pages (including cover sheet): 3

Reply Fax Number: (202)789-4692
Government Affairs

As of 5/9/00

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Quality Health Care Coalition Act of 1999

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Marcy Kaptur (D-9)
Dennis Kucinich (D-10)
Stephanie TubbsJones(D-11)
Sherrod Brown (D-13)
Tom Sawyer (D-14)
James Traficant (D-17)
Robert Ney (R-18)
Steve LaTourette (R-19)

OKLAHOMA
Tom Coburn, MD (R-2)
(withdrawn 10/14/99)
Wes Watkins (D-3)
Ernest Istook, Jr. (R-5)
Frank Lucas (R-6)

OREGON
David Wu (D-1)
Peter DeFazio (D-4)
Darlene Hooley (D-5)

PENNSYLVANIA
Robert Brady (D-1)
Chaka Fattah (D-2)
Robert Borski (D-3)
Ron Klink (D-4)
Tim Holden (D-6)
Curt Weldon (R-7)
Paul Kanjorski (D-11)
John Murtha (D-12)
Joe Hoeffel (D-13)
Michael Doyle (D-18)
Frank Mascara (D-20)

RHODE ISLAND
Patrick Kennedy (D-1)

SOUTH CAROLINA
Lindsey Graham (R-3)
James Clyburn (D-6)

TENNESSEE
John J. Duncan, Jr. (R-2)
Zach Wamp (R-3)
Bart Gordon (D-6)
Harold Ford, Jr. (D-9)

TEXAS
Max Sandlin (D-1)
Jim Turner (D-2)
Joe Barton (R-6)
Nicholas Lampson (D-9)
Mac Thornberry (R-13)
Ron Paul (R-14)
Ruben Hinojosa (D-15)
Charlie Stenholm (D-17)
Sheila Jackson Lee (D-18)
Lamar Smith (R-21)
Martin Frost (D-24)
Ciro Rodriguez (D-28)

UTAH
James Hansen (R-1)
Merrill Cook (R-2)

VERMONT
Bernard Sanders (I-AL)

VIRGINIA
Owen Pickett (D-2)
Bobby Scott (D-3)
Virgil Goode, Jr. (I-5)
Jim Moran (D-8)
Rick Boucher (D-9)
Tom Davis (R-11)

WASHINGTON
Jay Inslee (D-1)
Jack Metcalf (R-2)
Brian Baird (D-3)
George Nethercutt (R-5)
Norm Dicks (D-6)
Jim McDermott (D-7)

WEST VIRGINIA
Bob Wise (D-2)
Nick Rahall (D-3)

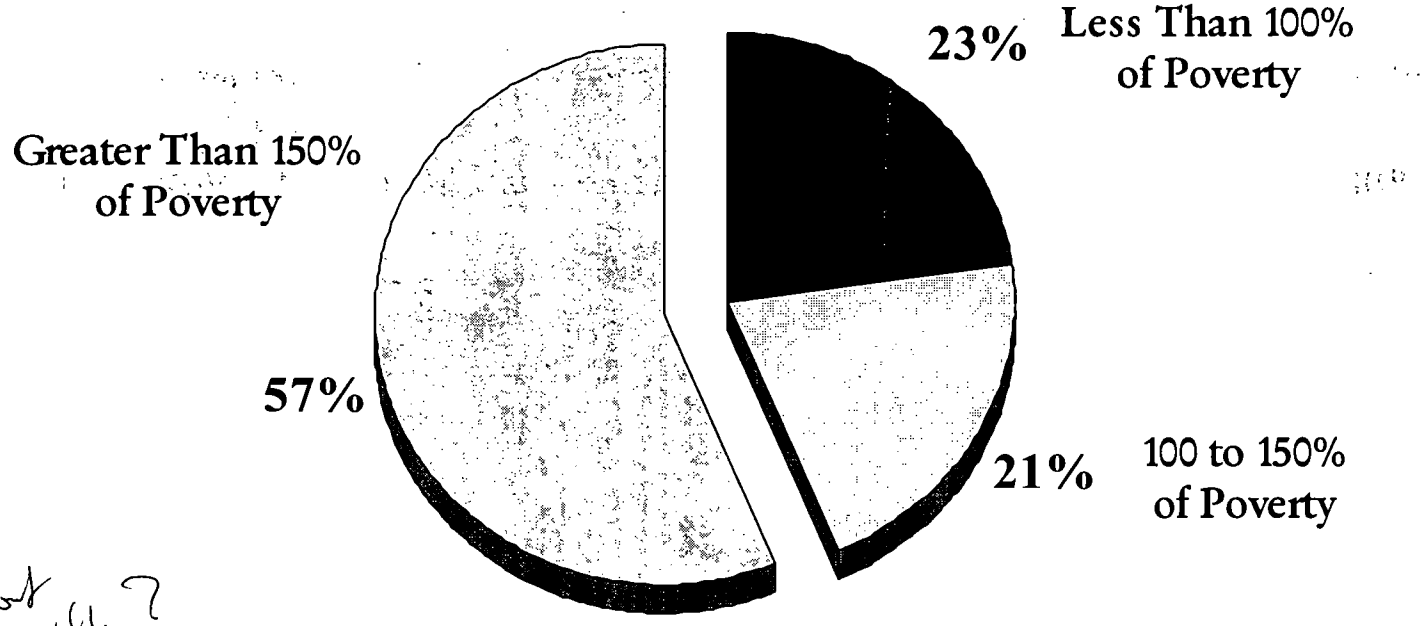
WISCONSIN
Tammy Baldwin (D-2)
Ron Kind (D-3)

WYOMING
Barbara Cubin (R-AL)

Most Uninsured Are Not Low-Income

Over Half of the 12 Million Medicare Beneficiaries Who Lack Drug Coverage Have Incomes Greater Than 150 Percent of Poverty (nearly $17,000 for a couple)

Income of Beneficiaries Without Drug Coverage, 1996
(As A Percent Of Poverty)



How Bad?

SOURCE: Data from DHHS (April 2000). Prescription Drug Coverage, Spending, Utilization, and Prices. Washington, DC: U.S. DHHS[7]
In 2000, 150 percent of poverty for a single person is about $12,525, for a couple is about $16,875

1. Seriously concerned about lack of progress of conference.

- Supposed to be done by March
- Now May and there hasn't even been one discussion about scope & enforcement
- Even alleged minor agreements aren't agreements. (Get Kennedy & Pingull to confirm)

2. Consequences of delay or weak bill are real.

- Cite examples
- why delay harms patients

3. Need to push Congress to act now

(news of)

> Thrilled with President's commitment and invitation for Monday meeting w/ lead conferees for status report

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A 1 2 3 4

Open your mouth and say...

ARGH!!!

Isn't it time that all working families have a real Patients' Bill of Rights?

Senator Abraham said "NO".

Senator Spencer Abraham

Last July, Senator Abraham voted for a so-called "Patients' Bill of Rights" that left 2/3 of all families out in the cold and left their health care decisions in the hands of HMO accountants. Senator Abraham's kind of reform leaves the majority of families abandoned.

Abraham said "No" to AFSCME members and their families.

Senator Abraham's vote did not cover state and local government workers - leaving AFSCME members and their families with no protection.

Abraham said "No" to holding health plans accountable for their decisions.

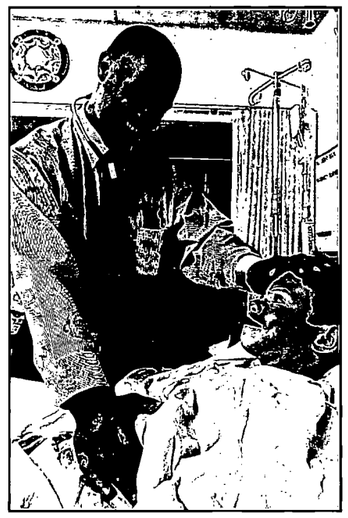
Senator Abraham's vote failed to hold health care plans accountable when they injure patients by delaying or denying care. He also voted to allow insurance company accountants to continue to reverse treatment decisions made by doctors. That's just not right; medical decisions should be made by medical experts, not insurance company bureaucrats.

Abraham said "No" to whistleblower protections.

Senator Abraham's vote lacked necessary "whistleblower" protections for health care workers who report quality care problems. AFSCME members who work in health care should not be silenced for fear of job loss or other forms of retaliation by their employers. Health care workers should not have to pay a price when they stand up for their patients—it's their job.

It's time to put health care decisions back in the hands of doctors.

Now is the time for Senator Abraham to reconsider his position and stand up for working families and vote for a *real* Patient's Bill of Rights that provides protections for *all* working families and their health care workers.



- It's time we tell Senator Abraham that working families deserve a true Patients' Bill of Rights that:
- Provides protections to all people covered by managed care plans, including state and local government workers.
- Gives patients a chance to fight for care when it is denied or limited.
- Holds health plans legally accountable if they harm patients by wrongly denying or limiting care.
- Makes sure that patients have access to emergency services and specialists when needed.
- Includes whistleblower protections which prohibit employers and plans from retaliating against doctors, nurses or other health care professionals who report quality problems.

It's time to put health care decisions back in the hands of doctors.

Call Senator Spencer Abraham at 1-877-722-7494 or 1-517-484-1984. Tell him you that you will accept nothing less than meaningful reform of managed care with protections for patients and health care workers.

Then let us know that you called your Senator. Send this card back to AFSCME and we'll keep you informed on how Senator Abraham votes in the future.

YES, I called my United States Senator and told him now is the time to put health care decisions back in the hands of doctors. Please keep me informed on how Senator Abraham votes in the future.

Name

Local union or retirement chapter

Address

City

State Zip

Email

AMERICAN
PSYCHOLOGICAL
ASSOCIATION

THE MYTHS AND FACTS ABOUT THE NORWOOD-DINGELL BILL
The Bipartisan Consensus Managed Care Improvement Act
(H.R. 2723)

Myth 1: H.R. 2723 will lead to a flood of litigation.

Fact: Including H.R. 2723's legal accountability provision will not create a widespread rush to the courthouse.

H.R. 2723 ensures that the vast majority of disputes between managed health plans and patients will be resolved without the need for judicial intervention through the bill's strong, independent external appeals process. Under the bill, patients must complete the internal and external appeals process before proceeding to court unless real injury or death has already occurred.

The Texas experience shows that a good external review process will resolve most disputes. In Texas, the very first state to enact a patient protection law containing legal accountability for managed care, no more than 12 lawsuits have been brought since that law was enacted nearly three years ago.

Myth 2: Employers can be sued under H.R. 2723.

Fact: Employers CANNOT be held liable unless they make medical decisions about the care patients receive.

H.R. 2723 provides that an employer *only* can be held legally accountable when it exercises discretionary authority to make a decision on a claim for benefits covered under the plan. The bill is absolutely clear that an employer cannot be sued except in the unusual situation where the employer negligently denies or delivers treatment to a particular employee. In these rare instances, employers should be held accountable. Further, the bill expressly states that employers *cannot* be sued for: (a) choosing to contract with a particular health plan; (b) deciding which benefits to include in the plan; or (c) deciding to provide additional benefits not generally covered by the plan.

Myth 3: With a strong appeals process, there is no need for legal accountability for managed care.

Fact: Although a strong and independent appeals process is essential, it will not always suffice.

Even under an expedited appeals process with a 72-hour deadline as contained in H.R. 2723, patients can sustain injuries that warrant appropriate compensation. Consider the following

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factual summaries drawn from actual cases where an appeals process alone would not have been able to prevent the negligent denial or delivery of treatment:

- A patient sustained injuries to his neck and spine from a motorcycle accident after which he was taken to a hospital. The hospital's physicians recommended immediate surgery but the health plan refused to certify the procedure and the surgery had to be cancelled. Soon after, the insurer did agree to pay for the surgery but it was too late; the patient was paralyzed.

- A patient was admitted to the emergency room of his community hospital complaining of paralysis and numbness in his extremities. The treating emergency room physician concluded that the gravity of the patient's neurological condition necessitated his immediate transfer to an academic hospital and made the arrangements. The health plan, however, denied authorization for transfer to the hospital the physician had selected and instead recommended three others. By the time the physician was able to have the patient transferred to one of these hospitals *three hours later,* the patient had sustained permanent quadriplegia.

Myth 4: H.R. 2723's legal accountability provision will significantly increase the cost of health insurance and the number of uninsured.

Fact: H.R. 2723's legal accountability provision will not add significantly to the cost of health insurance premiums or to the number of uninsured.

The Congressional Budget Office has scored H.R. 2723's legal accountability provision as raising premiums only 1% when fully implemented. A one-percent increase is the equivalent of employers paying a mere four cents per day for individual coverage with employees contributing just one additional penny per day.

Opponents have cited an ever-changing and ridiculously wide range of job loss figures for every one-percent increase. First, opponents of legal accountability cited figures that 400,000 individuals would lose their health coverage for every one-percent increase in premiums. When the General Accounting Office (GAO) challenged this figure, saying that it was based on outdated information and did not account for all relevant factors, opponents lowered the job loss figure to 300,000 for every one-percent increase in premiums. Subsequent criticism again from GAO caused opponents to lower their estimate a second time to 200,000. However, none of these dire predictions have come to pass as recent studies cited by GAO show. For example, between 1988 and 1996, the number of workers offered coverage actually increased despite premium increases each year.

Myth 5: The real problem is not negligent care being made by managed care, but medical errors being made by physicians.

Fact: Congressional action on medical errors is not a substitute for congressional action on patient protection legislation.

The American Association of Health Plans' last ditch effort to divert attention from the need for patient protection legislation is irresponsible and reprehensible. Health care professionals do

sometimes make mistakes that can and should be reduced. H.R. 2723, however, is needed to prevent and provide redress for the negligent denial and delivery of care by managed health plans. Under existing law, health care professionals are held responsible for the errors they make, but ERISA-regulated managed health plans are not. Only Congress can close this loophole and give consumers the right to hold these plans legally accountable.

Although of great importance, the issue of medical errors has not yet been fully explored by Congress and warrants additional examination. The need for congressional action on medical errors should not delay congressional action on patient protections in managed care. They are two separate and distinct concerns.

Myth 6: Consumer support for patient protection evaporates when they learn it will cost them money.

Fact: Patients want real, enforceable protections and are willing to pay for them when they understand what they will get for their money.

A 1998 nationwide survey by Penn, Schoen & Berland showed *86% support* for a bill that would give patients health plan legal accountability, access to specialists, emergency services and point-of-service coverage. When asked if they would support such a bill if their premiums increased between $1 and $4 a month, *78% supported the bill.* The House-passed bill would raise insurance premiums an average of 4.1% according to the Congressional Budget Office, which would mean increases in employee premiums of only $1.36 per month (individual) and $3.75 (family).

Myth 7: Patients and health care professionals are satisfied with the quality of care being provided by managed health plans.

Fact: Patients and health care professionals definitely are not satisfied with the quality of care being provided by managed health plans.

A recent public opinion survey found that most Americans believe problems with managed care have not improved (74%), and most think that legislative action is either more urgent or equally as urgent as it was when this debate began (88%) (Kaiser Family Foundation, Feb. 2000).

A 1999 survey of physicians and nurses reported that:

- 72% of physicians and 78% of nurses believe that managed care has decreased the quality of care for people who are sick;
- 65% of physicians who reported denials for mental health services for their patients said that the most recent denial had resulted in a "very serious" or "somewhat serious" decline in the patient's health;
- 18% of physicians reported denials for mental health services for their patients on a weekly or monthly basis (Kaiser Family Foundation and Harvard University School of Public Health, Survey of Physicians and Nurses, July 1999).

PRESIDENT CLINTON URGES THE CONGRESS TO ACT NOW ON THE NATION'S HEALTH CARE PRIORITIES
April 29, 2000

Today, in his weekly radio address, President Clinton will urge the Congress to take long overdue action and pass a strong, enforceable Patients' Bill of Rights and a voluntary Medicare prescription drug benefit. He will point out, that despite an overwhelming bipartisan vote in support of the Norwood-Dingell Patients' Bill of Rights, the legislation has been languishing in the Congress for over six months. He will also reiterate his challenge to the Congress to move beyond rhetoric and pass, in the context of broader reform, a long overdue and voluntary prescription drug benefit for all Medicare beneficiaries. The President will urge the Congress to come back from their recess and get back to work on improving health care for Americans of all generations.

Today, President Clinton will urge the Congress to:

PASS A STRONG, ENFORCEABLE, PATIENTS' BILL OF RIGHTS WITHOUT FURTHER DELAY.

Patients need protections now. Unnecessary delay in passing legislation to curb insurance company abuse results in harm to thousands of patients daily and millions of patients annually. Recently released data indicates that each day without a strong Patients Bill of Rights results in: 14,000 physicians seeing patients harmed because a plan failed to provide coverage for a prescription drug; 10,000 physicians seeing patients harmed because a plan refused a diagnostic test or procedure; and 7,000 physicians seeing patients harmed because their insurance plan refused a referral to a specialist. In the last three State of the Union Addresses, the President has called on the Congress to pass strong patient protections for over two years. Despite the passage of the Norwood-Dingell bill, a strong, enforceable, bipartisan Patients' Bill of Rights that the President has repeatedly indicated he would sign, the Congress has delayed action on this critical legislation for over six months.

Stats From Democratic staff of Labor Committee based on Kaiser Family Foundation data that they will stand behind.

The Norwood-Dingell legislation is the only real Patients' Bill of Rights. This legislation, endorsed by over 200 health care provider and consumer advocacy groups, is the only proposal currently being considered that meets the Administration's fundamental criteria: that patient protections be real and that court enforced remedies be accessible and meaningful. The legislation includes critical protections such as:

- Guaranteed access to needed health care specialists; access to emergency room services when and where the need arises
- Continuity of care protections
- Access to a fair, unbiased and timely internal and independent external appeals process
- Guaranteed protections for all Americans in all health plans
- An enforcement mechanism that ensures recourse for patients who have been harmed as a result of a health plan's actions

ENSURE THAT A NEW MEDICARE PRESCRIPTION DRUG BENEFIT OPTION IS AFFORDABLE AND ACCESSIBLE FOR ALL BENEFICIARIES.

Millions of Medicare beneficiaries have no prescription drug coverage. President Clinton put out a detailed proposal to modernize and reform the Medicare program over 9 months ago, and since then, seniors and Americans with disabilities have been waiting for the Congress to act. The President will challenge the Republicans to move swiftly to amend their proposal to assure that all Medicare beneficiaries have access to an affordable prescription drug benefit option that is:

- Voluntary. Medicare beneficiaries who now have dependable, affordable coverage would have the option of keeping that coverage.

- Accessible to all beneficiaries. Beneficiaries who join the program would pay the same premium and get the same benefit, no matter where they live, through a private, competitively selected benefit manager or, where available, through managed care plans.

- Designed to give beneficiaries meaningful protection and bargaining power. A reserve fund in the President's budget helps Medicare beneficiaries with catastrophic prescription drug costs. The plan also gives beneficiaries bargaining power they now lack; according to CBO, discounts would average 12.5 percent.

- Affordable to all beneficiaries and the program. According to CBO, premiums would be $24 per month in 2003 and $48 per month in 2009, when fully phased-in. Low-income beneficiaries – below 150 percent of poverty ($17,000 for a couple) – would receive extra help with the cost of premiums; those below 135 percent would have no cost sharing.

- Consistent with broader reform. The new, voluntary prescription drug benefit is part of a larger plan to strengthen and modernize Medicare. This plan would make Medicare more competitive and efficient, reduce fraud and out-year cost increases, promote fair payments, and improve preventive benefits in Medicare. The plan would also dedicate $299 billion from the non-Social Security surplus to Medicare to help extend its solvency to at least 2025.

Republican policy does not meet their stated goals. Although the House Republican leadership recently recognized the need for an affordable, optional prescription drug benefit available to all Medicare beneficiaries, the President will note that the policy advocated by the House Republicans does not achieve their stated goals. The current House Republican proposal:

- Reneges on funding commitments for a meaningful prescription drug benefit. Earlier this year, the Republicans indicated they would commit $40 billion for a prescription drug benefit, but their budget resolution dedicated as little as $20 billion to improve the Medicare program to include a prescription drug benefit. Moreover, their failure to release 10-year numbers on their prescription drug proposal raises serious concerns that their tax policy consumes virtually all revenue necessary to adequately fund a drug benefit into the future.

- Does not assure availability of prescription drug coverage. Because the Republican plan relies on private insurers to offer a drug-only benefit voluntarily, this policy cannot be guaranteed to be available to all seniors in need of a drug benefit. In testimony before the Congress, the insurance industry itself has expressed skepticism about the effectiveness of the Republican approach.

- Not affordable for most seniors, even if it is available. Furthermore, because it provides direct premium assistance only to beneficiaries with annual incomes of under $12,600, the Republican benefit will almost certainly fail to be an affordable option even if it's available. If enacted, the Republican proposal would mark the first time in the program's history that Medicare would not provide universal premium assistance for benefits, and it would undermine the social insurance concept of the program.

REPUBLICAN CONGRESS HAS DELAYED ACTION ON NATIONAL PRIORITIES FOR TOO LONG. So far this year, the House of Representatives has been in session 39 days this year, and the Senate has been in session 33. There are just 73 working days left until the target adjournment date of October 6. The House and Senate struggled to pass the FY2001 budget resolution and the Congress has failed to:

- Reduce gun violence with common sense gun legislation, buckling under the pressure of the powerful gun lobby and allowing sensible gun safety legislation to languish for over 9 months.

- Give American families a needed increase in the minimum wage, spending over a year delaying action on this legislation and attaching costly and unnecessary poison pill tax cuts to this common-sense measure.

- Fund urgent needs in the President's supplemental request, causing delays that could have devastating effects at home and abroad – curtailing military training activities essential to peace and stability in Kosovo; eroding international support for Colombia's effort to fight drug traffickers; leaving more than 2,300 families without funds to relocate after their homes were destroyed by Hurricane Floyd; providing debt relief to the poorest nations; and leaving low-income elderly nationwide vulnerable to summer's high temperatures.

American Medical Association
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News Release

FOR IMMEDIATE RELEASE May 2, 2000

AMA INITIATES AD CAMPAIGN TO ENACT PATIENTS' BILL OF RIGHTS

"Congress is making decisions this month that will affect the health of patients for years to come."

In its continuing fight to ensure that Congress passes a strong patients' bill of rights, the American Medical Association (AMA) placed ads in newspapers in key states across the country today urging senators to support legislation that protects patients from health plan abuses.

The ads appear as patients' rights legislation reaches a critical stage in Washington. Currently, a conference committee of House and Senate lawmakers is drafting a bill that must decide between provisions contained in a House-supported bill that has strong patient protections or a Senate-supported bill that protects insurance companies.

"The conference committee is making decisions this month that will affect the health of our patients for years to come," said Timothy T. Flaherty, MD, Vice Chair of the AMA Board of Trustees. "We are urging the senators to do the right thing --- to pass a bill that puts patients first – not health plans."

The ads ask Senators Spencer Abraham (R-MI), Conrad Burns (R-MT), Bill Frist (R-TN), Slade Gorton (R-WA), Rod Grams (R-MN), William V. Roth, Jr. (R-DE), Rick Santorum (R-PA), and Arlen Specter (R-PA) to support patients' rights legislation that includes the following provisions:

- Protect all 168 million Americans covered by managed care plans;
- Hold health plans accountable when they make decisions that harm patients;
- Provide patients an independent, timely appeal if care is delayed or denied;
- Allow physicians to make medical decisions, not insurance companies; and
- Give patients a choice for their treating physicians, including specialists.

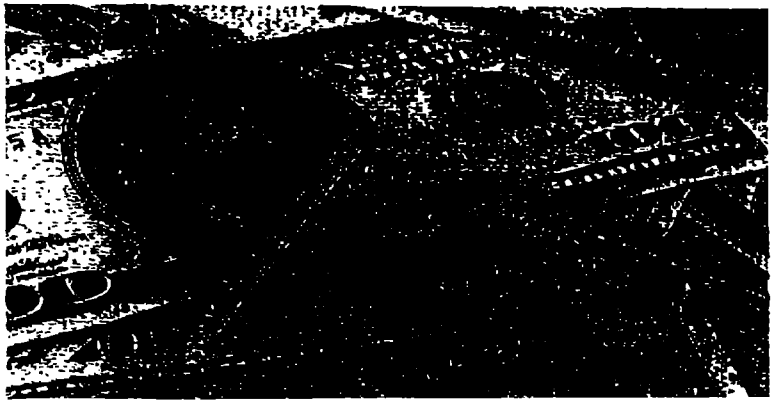
Recent polls indicate that 70% of American voters say protecting patients' rights will be "very important" in deciding how to vote this November. The ads ask each senator "Can the people of (your state) count on your support?"

For more information, please call: **Brenda L. Craine**
202/789-7447

70% of American voters

versus

Hundreds of millions of dollars from HMOs & big insurance companies



Senator Frist, Can the People of Tennessee count on your support?

In a recent national poll, 70% of American voters said protecting patients' rights was "very important" in deciding how to vote this fall.

For six years, HMOs and big insurance companies have spent hundreds of millions of dollars to kill a real patients' bill of rights.

Last summer, the U.S. Senate passed an HMO protection act instead of a real patients' bill of rights. But in the House, 275 Representatives did vote for strong managed care reforms. Now, a small group of Senators and Representatives is drafting a final bill.

The time is now, Senator Frist, to stand up for patients.

Call Senator Frist at 1-800-833-6354 and ask him to support these principles in a real patients' bill of rights:

- Protect all 166 million Americans covered by managed care plans;
- Hold health plans accountable when they make decisions that harm patients;
- Provide patients an independent, timely appeal if care is delayed or denied;
- Allow physicians to make medical decisions, not insurance companies; and
- Give patients a choice for their treating physicians, including specialists.

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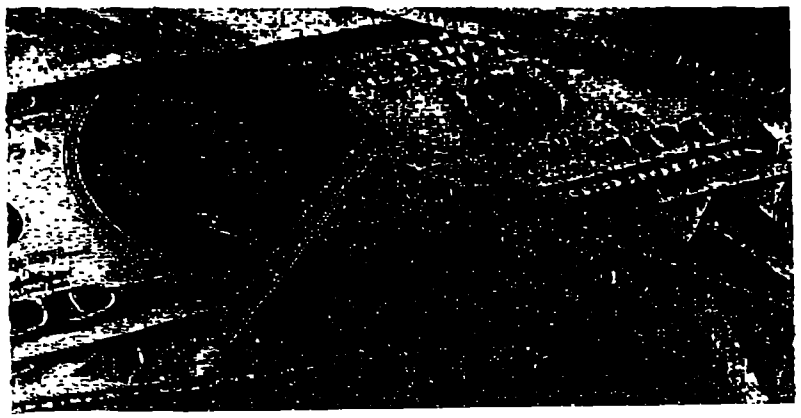
70% of American voters

versus

Hundreds of millions of dollars from HMOs & big insurance companies



CONFIDENTIAL

Senators Santorum and Specter, Can the People of Pennsylvania count on your support?

In a recent national poll, 70% of American voters said protecting patients' rights was "very important" in deciding how to vote this fall.

For six years, HMOs and big insurance companies have spent hundreds of millions of dollars to kill a real patients' bill of rights.

Last summer, the U.S. Senate passed an HMO protection act instead of a real patients' bill of rights. But in the House, 275 Representatives did vote for strong managed care reforms. Now, a small group of Senators and Representatives is drafting a final bill.

The time is now, Senators Santorum and Specter, to stand up for patients.

Call Senators Santorum and Specter at 1-800-633-6354 and ask them to support these principles in a real patients' bill of rights:

- Protect all 168 million Americans covered by managed care plans;
- Hold health plans accountable when they make decisions that harm patients;
- Provide patients an independent, timely appeal if care is delayed or denied;
- Allow physicians to make medical decisions, not insurance companies; and
- Give patients a choice for their treating physicians, including specialists.

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go to www.ama-assn.org/grassroots

Senator Burns, Can the People of Montana count on your support?

In a recent national poll, 70% of American voters said protecting patients' rights was "very important" in deciding how to vote this fall.

For six years, HMOs and big insurance companies have spent hundreds of millions of dollars to kill a real patients' bill of rights.

Last summer, the U.S. Senate passed an HMO protection act instead of a real patients' bill of rights. But in the House, 276 Representatives did vote for strong managed care reforms. Now, a small group of Senators and Representatives is drafting a final bill.

The time is now, Senator Burns, to stand up for patients.

Call Senator Burns at 1-800-833-6354 and ask him to support these principles in a real patients' bill of rights:

- Protect all 168 million Americans covered by managed care plans;
- Hold health plans accountable when they make decisions that harm patients;
- Provide patients an independent, timely appeal if care is delayed or denied;
- Allow physicians to make medical decisions, not insurance companies; and
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70% of American voters

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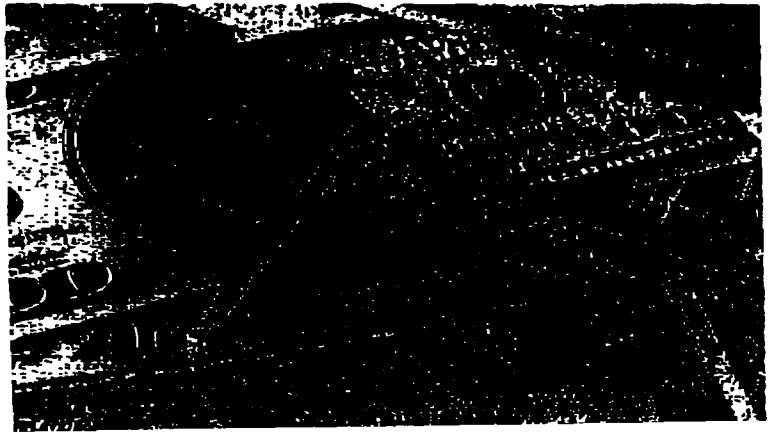
Hundreds of millions of dollars from HMOs & big insurance companies



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70% of American voters

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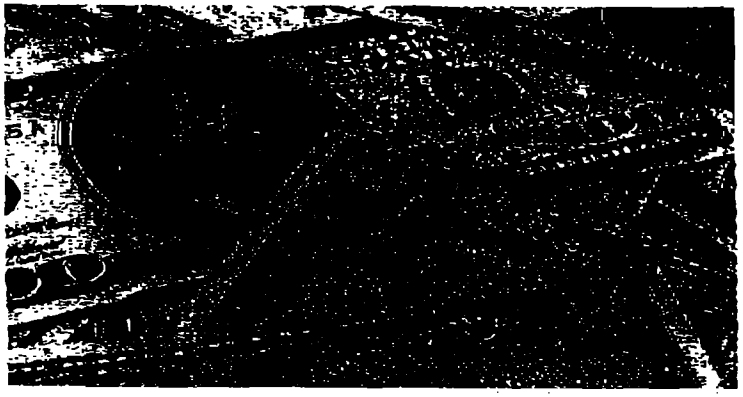

Senator Gorton, Can the People of Washington count on your support?

In a recent national poll, 70% of American voters said protecting patients' rights was "very important" in deciding how to vote this fall.

For six years, HMOs and big insurance companies have spent hundreds of millions of dollars to kill a real patients' bill of rights.

Last summer, the U.S. Senate passed an HMO protection act instead of a real patients' bill of rights. But in the House, 275 Representatives did vote for strong managed care reforms. Now, a small group of Senators and Representatives is drafting a final bill.

The time is now, Senator Gorton, to stand up for patients.

Call Senator Gorton at 1-800-833-6354 and ask him to support these principles in a real patients' bill of rights:

- Protect all 168 million Americans covered by managed care plans;
- Hold health plans accountable when they make decisions that harm patients;
- Provide patients an independent, timely appeal if care is delayed or denied;
- Allow physicians to make medical decisions, not insurance companies; and
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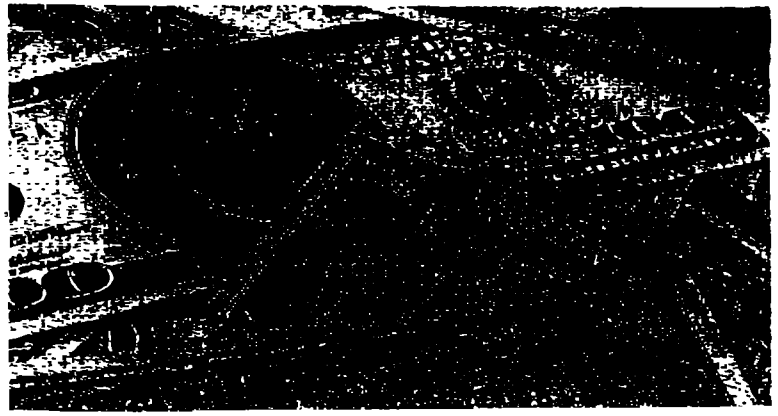

CONFIDENTIAL

Senator Roth, Can the People of Delaware count on your support?

In a recent national poll, 70% of American voters said protecting patients' rights was "very important" in deciding how to vote this fall.

For six years, HMOs and big insurance companies have spent hundreds of millions of dollars to kill a real patients' bill of rights.

Last summer, the U.S. Senate passed an HMO protection act instead of a real patients' bill of rights. But in the House, 275 Representatives did vote for strong managed care reforms. Now, a small group of Senators and Representatives is drafting a final bill.

The time is now, Senator Roth, to stand up for patients.

Call Senator Roth at 1-800-833-6354 and ask him to support these principles in a real patients' bill of rights:

- Protect all 168 million Americans covered by managed care plans;
- Hold health plans accountable when they make decisions that harm patients;
- Provide patients an independent, timely appeal if care is delayed or denied;
- Allow physicians to make medical decisions, not insurance companies; and
- Give patients a choice for their treating physicians, including specialists.

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go to www.ama-assn.org/grassroots

70% of American voters

versus

Hundreds of millions of dollars from HMOs & big insurance companies

Senator Abraham, Can the People of Michigan count on your support?

In a recent national poll, 70% of American voters said protecting patients' rights was "Very Important" in deciding how to vote this fall.

For six years, HMOs and big insurance companies have spent hundreds of millions of dollars to kill a real patients' bill of rights.

Last summer, the U.S. Senate passed an HMO protection act instead of a real patients' bill of rights. But in the House, 275 Representatives did vote for strong managed care reforms. Now, a small group of Senators and Representatives is drafting a final bill.

The time is *now*, Senator Abraham, to stand up for patients.

Call Senator Abraham at 1-800-633-6354 and ask him to support these principles in a real patients' bill of rights:

- Protect all 168 million Americans covered by managed care plans;
- Hold health plans accountable when they make decisions that harm patients;
- Provide patients an independent, timely appeal if care is delayed or denied;
- Allow physicians to make medical decisions, not insurance companies; and
- Give patients a choice for their treating physicians, including specialists.

American Medical Association
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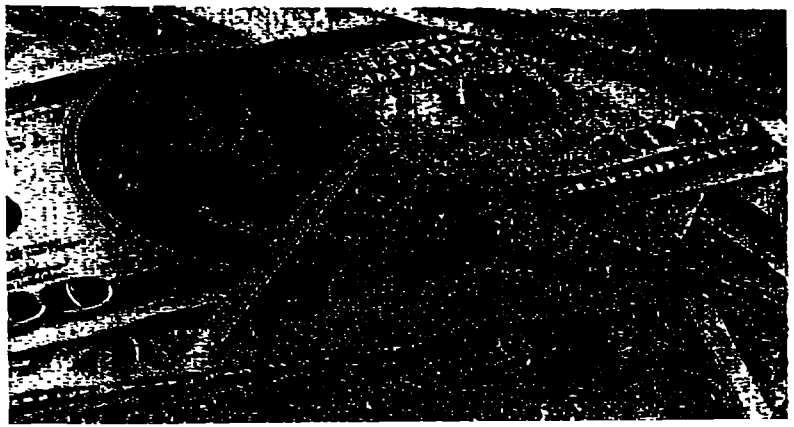

Senator Grams, Can the People of Minnesota count on your support?

In a recent national poll, 70% of American voters said protecting patients' rights was "very important" in deciding how to vote this fall.

For six years, HMOs and big insurance companies have spent hundreds of millions of dollars to kill a real patients' bill of rights.

Last summer, the U.S. Senate passed an HMO protection act instead of a real patients' bill of rights. But in the House, 275 Representatives did vote for strong managed care reforms. Now, a small group of Senators and Representatives is drafting a final bill.

The time is now, Senator Grams, to stand up for patients.

Call Senator Grams at 1-800-833-6354 and ask him to support these principles in a real patients' bill of rights:

- Protect all 168 million Americans covered by managed care plans;
- Hold health plans accountable when they make decisions that harm patients;
- Provide patients an independent, timely appeal if care is delayed or denied;
- Allow physicians to make medical decisions, not insurance companies; and
- Give patients a choice for their treating physicians, including specialists.

American Medical Association
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National Partnership for Women & Families

News Release

FOR IMMEDIATE RELEASE
Tuesday, May 2, 2000

CONTACT: Kirsten Weeks
202/986-2600

Patients' Rights Coalition Leader Calls on Senator Nickles to Follow the Lead of His Own State

Statement by Judith L. Lichtman, President
National Partnership for Women & Families

Sen. Don Nickles (R-OK) is so caught up in politics on Capitol Hill that he's lost touch with the voters who put him there in the first place. Oklahoma Gov. Frank Keating recently signed a bill allowing citizens of his state to hold health plans accountable if they harm a patient. This common-sense legislation is a response to an urgent demand from the people of Oklahoma for strong patient protections -- the same kind of protections being stalled in Washington, DC by Oklahoma's own Sen. Don Nickles.

Sen. Nickles leads the Congressional conference committee charged with sending a strong patients' rights bill to President Clinton. After 9 weeks of meetings, the conference committee hasn't even addressed the issue of holding health plans accountable when they harm a patient.

Oklahoma isn't the only state trying to do what Congress won't. Texas, Georgia, California, Arizona and Washington have passed accountability legislation because it's what their citizens demanded. But, even with state laws in place, federal accountability is needed to provide protection for people in all health plans. Without corresponding changes in federal law, approximately 130 million people nationwide will be left without this essential right and remedy.

We need Congress to do its job, and to listen to the American people. Conference committee members should get moving and send a strong, enforceable patient protection bill to the President now.

###

The National Partnership for Women & Families (formerly the Women's Legal Defense Fund) is leading a coalition of patient and provider groups that support strong, enforceable patient protections. The National Partnership is a nonprofit, nonpartisan organization that promotes fairness in the workplace, quality health care, and policies that help women and men meet the dual demands of work and family.

For more information on patient protection legislation, including a comparison of the House and Senate bills, please visit www.nationalpartnership.org.

podesta.com

Fax Cover Sheet

Date: April 21, 2000

Code: 111

To: Chris Jennings,
Deputy Assistant to the President for Health Policy

Phone:
Fax: 202-456-5557

From: Jeff Ricchetti

Phone: 202-879-9310
Fax: 202-393-2758

Number of pages, including cover sheet: 8

MESSAGE:

Dear Chris:

Here is some background on the problems associated with Association Health Plan (AHP) provisions under consideration by the Conference Committee on patient protection legislation.

The AHP provisions would exempt business association health plans from a broad range of state laws, including mandated benefits, consumer protections and insurance reforms. This would:

- *Exempt AHPs from benefit mandates that help women, children and the mentally ill:* The majority of state benefit mandates – about 40 percent – assure coverage of services for women and children. This proposal also would preempt state mental health mandates that are more stringent than federal law (including 26 state mental health parity laws).

- *Leave AHPs virtually unregulated:* Thousands of business associations could establish AHPs that would be exempt from state law. A Congressional Budget Office (CBO) report estimated that nearly one-quarter of insured small employers would avoid state regulation, in whole or in part, under the AHP proposal. As such, this provision would return the market to the troublesome days of the 1980s, when insurers "cherry picked" the healthy and the most vulnerable citizens were left without affordable coverage.

- *Increase premiums for small employers:* The CBO found that 4-in-5 small employers and their workers would pay higher premiums if AHP legislation were enacted. In all, 20 million workers and their families would face higher premiums under this proposal.

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- *Not help the uninsured:* The CBO report found that only 330,000 uninsured individuals would gain coverage under AHPs, but 10,000 of the sickest individuals would lose coverage. The CBO found that any savings from AHPs would come from excluding mandated benefits and pulling healthy groups out of the state regulated market.

The AHP provisions have garnered opposition from a significant number of groups, including every major organization representing governors, state legislators and insurance commissioners. A broad coalition representing consumers, women and children, the disabled, providers and mental health professionals also oppose the AHP exemption.

I have attached a summary of the groups opposed to this legislation, a table outlining the mandated benefits that AHPs could avoid, a summary of the CBO report on AHPs and a letter from the Mental Health Liaison Group for your consideration. Please let me know if you have any questions or would like additional information. Thank you again for taking my call and giving this matter your attention.

Jeff

The Blues are working on a study to show the "cherry picking" opportunity for AHPs & expect to hold an event in May. Any help stressing the interest of consumer groups would be appreciated. They would also like to coordinate with any of your activities on the topic.

Thanks Again.

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Suite 900 East
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Oppose the Association Health Plan Provision of H.R. 2990 In Conference Agreement

The following organizations strongly oppose the inclusion of the Association Health Plan provision in the Conference Agreement on patient protection legislation (H.R. 2990). This provision would allow Association Health Plans to circumvent important state laws. It would result in higher premiums for small businesses and individuals and an unstable health insurance market.

Alliance for Children and Families
American College of Nurse-Midwives
American Counseling Association
American Association on Mental Retardation
American Association of Pastoral Counselors
American Family Foundation
American Federation of State, County and Municipal Employees (AFSCME)
American Managed Behavioral Healthcare Association
American Mental Health Counselors Association
American Nurses Association
Bazelon Center for Mental Health Law
Blue Cross Blue Shield Association
Center on Disability and Health
Clinical Social Work Federation
Communications Workers of America
Delta Dental Plans Association
Families USA
Federation of Families for Children's Mental health
Friends Committee on National Legislation
Health Insurance Association of America
National Alliance for the Mentally Ill
National Association of Health Underwriters
National Association of Protection and Advocacy Systems
National Association of School Psychologists
National Association of Social Workers
National Association of State Mental Health Program Directors (NASMHPD)
National Council for Community Behavioral Health
National Mental Health Association
National Partnership for Women and Families
National Womens Health Network
Neighbor to Neighbor
Service Employees International Union
United Auto Workers

April 13, 2000

Letters from State Officials Opposing the Association Health Plans Provisions of H.R. 2990

Governors' Associations

National Governors' Association (letter signed by)-	October 6, 1999
• Governor Michael O. Leavitt (UT), Chairman	
• Governor Parris N. Glendening (MD), Vice Chairman	
Democratic Governors' Association (letter signed by)-	March 30, 2000
• Governor Paul E. Patton (KY), Chair	
Republican Governors Association (letter signed by)-	November 5, 1999
• Governor Frank Keating (OK), Chairman	
• Governor Ed Schaefer (ND), Vice Chairman	
• Governor Don Sundquist (TN), Chairman, Health Issues Team	
National Governors' Association	June 22, 1999
National Conference of State Legislaturers	
National Association of Insurance Commissioners (letter signed by)-	
• Governor Thomas R. Carper (DE), Chairman, NGA	
• State Senator Kemp Hannon (NY), Chair, NCSL Health Committee	
• Commissioner George Reider (CT), Chair, NAIC Special Committee on Health Insurance	

Governors

Governor Mike Huckabee (AR)	March 30, 2000
Governor Thomas J. Vilsack (IA)	January 26, 2000
Governor Bill Graves (KS)	March 9, 2000
Governor John Engler (MI)	March 10, 2000
Governor Marc Racicot (MT)	September 21, 1999
Governor Jim Hodges (SC)	August 13, 1999
Governor Tommy G. Thompson (WI)	March 31, 2000

Insurance Commissioners

Commissioner Charles R. Cohen (AZ)	April 6, 2000
Commissioner Mike Pickens (AR)	March 6, 2000
Commissioner William J. Kirven, III (CO)	March 31, 2000
Commissioner Donna Lee H. Williams (DE)	March 27, 2000
Commissioner Therese M. Vaughan (IA)	March 24, 2000
Commissioner Kathleen Sebelius (KS)	March 9, 2000
Commissioner Paula T. Rogers (NH)	March 27, 2000
Commissioner Jim Long (NC)	March 27, 2000
Commissioner Carroll Fisher (OK)	March 28, 2000
Commissioner Mary C. Neidig (OR)	March 31, 2000
Commissioner Merwin U. Stewart (UT)	March 30, 2000
Commissioner John P. McBride (WY)	March 24, 2000

State Officials

Representative Kathleen Keenan (VT)	March 20, 2000

State Laws Requiring Health Plans to Cover Benefits and Health Care Providers

(Number of States Requiring Each Class of Mandated Coverage)

BENEFITS	# of States
Alcoholism Treatment	44
Ambulance Transportation	6
Ambulatory Surgery	8
Blood Lead Screening	4
Bone Marrow Transplants	10
Bone Mass Measurement	8
Breast Reconstruction	51
Cervical Cancer Screening	22
Cleft Palate	8
Clinical Trials	7
Contraceptives	11
Dental Anesthesia	19
Diabetic Supplies / Education	35
Drug Abuse Treatment	31
Emergency Services	39
Formula for PKU	24
Hair Prostheses	3
Home Health Care	18
Hospice Care	8
Invitro Fertilization	8
Other Infertility Services	6
Long Term Care	3
Mammography Screening	49
Maternity	11
Mental Health (General)	34
Mental Health (Parity)	24
Minimum Mastectomy Stays	21
Minimum Maternity Stays	51
Off-Label Drug Use	29
Orthotics/Prosthetics	6
Prostate Cancer Screening	20
Rehabilitation Services	5
Second Med / Surgical Opinion	7
TMJ Disorders	17
Well-Child Care	30
TOTAL	677

PROVIDERS	# of States
Acupuncturists	7
Chiropractors	44
Dentists	36
Dieticians	3
Licensed Health Professionals	7
Marriage Therapists	8
Massage Therapists	2
Naturopaths	4
Nurses	9
Nurse Midwives	31
Nurse Anesthetists	14
Nurse Practitioners	24
Nurse, Psychiatric	16
Occupational Therapists	10
Optometrists	38
Oral Surgeons	4
Osteopaths	17
Pastoral Counselors	2
Physical Therapists	12
Physician Assistants	8
Podiatrists	31
Professional Counselors	14
Psychologists	42
Public and Other Facilities	21
Social Workers	26
Speech/Hearing Therapists	14
PERSONS COVERED	
Adopted Children	27
Continuation/Dependents	36
Continuation/Employees	36
Conversion to Non-Group	39
Dependent Students	8
Handicapped Dependents	35
Newborns	51
Non-Custodial Children	9
TOTAL	685

Source: Blue Cross and Blue Shield Association, December 1999

January 14, 2000

CBO Study: AHPs Would Increase Premiums for 20 Million People

An analysis by the Congressional Budget Office found that most small employers and workers would pay higher premiums if a preemption from state law for Association Health Plans (AHPs), as contained in H.R. 2990, is enacted. The report reveals that AHPs would save costs by skimming the healthy from the existing state-regulated small group market, making coverage more expensive for the sick. Specifically, the report found that:

- **AHPs would not significantly reduce the number of uninsured:** Contrary to proponents' claims that AHPs could cover up to 8.5 million uninsured, the CBO estimated that coverage would increase by only 330,000 individuals. However, CBO also notes that the overall number of individuals insured would be lower, "because some of those who gained coverage through AHPs and HealthMarts would have otherwise obtained coverage in the individual market."

- **Four in five workers would be worse off under AHPs/HealthMarts:** According to the report, 20 million employees and dependents of small employers would experience a rate increase under AHPs, while only 4.6 million would see a rate reduction. In addition, 10,000 of the sickest individuals would lose coverage if AHP provisions were enacted.

- **AHPs would save money primarily by "cherry picking":** The CBO estimated that nearly two-thirds of the cost savings for AHPs would result from attracting healthier members from the existing insurance pool, thereby increasing costs for those who remain in the non-AHP market. The report states that, "In the long run, one would expect the most successful AHPs to be sponsored by associations whose members had lower-than-average health care costs."

- **AHPs would eliminate benefits to cut costs:** Contrary to proponents' claims that AHPs could offer generous benefits (e.g., comparable to those offered by Fortune 500 firms) while lowering insurance costs, the CBO found that dropping state mandated benefits would be the second major method that AHPs would use to reduce costs (after cherry picking). The CBO estimated that one-third of costs savings in AHPs would come from eliminating benefits.

- **AHPs would not reduce overhead costs:** Contrary to claims that AHPs could reduce overhead by 30 percent, "...CBO assumed that cost savings arising from the group purchasing feature of AHPs and HealthMarts would be negligible." The CBO found "...no substantial evidence that joining a purchasing cooperative produced lower insurance costs for firms."

- **States with aggressive insurance reforms would see the most damage:** The report indicates that states with strict insurance reforms (such as Massachusetts, New Jersey, and New York) would be most attractive to AHPs. The report concludes that "in states with more tightly compressed premiums – where the most cross-subsidization occurs – low-cost firms would face the greatest potential difference in price between traditional and AHP/HealthMart plans."

The full report, entitled "Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and HealthMarts," is available at CBO's Web site (www.cbo.gov).

Mental Health Liaison Group

September 30, 1999

The Honorable J. Dennis Hastert
Speaker of the House of Representatives
H-232 Capitol Building
Washington, D.C. 20515-6501

Dear Speaker Hastert:

With the full House nearing a debate on patient protection legislation, the undersigned members of the Mental Health Liaison Group (MHLG) are writing to urge that you not take up extraneous matters that will jeopardize serious consideration of managed care measures this year. In particular, the MHLG would strongly object to a rule permitting consideration of the Small Business Access and Choice for Entrepreneurs Act (H.R. 2047) or related legislation authorizing Association Health Plans and easing current restrictions on Medical Savings Accounts (MSAs).

The mental health community applauds efforts to expand the availability of private health insurance in the United States. However, we vigorously oppose Association Health Plans (AHPs), as well as HealthMarts, because these proposals preempt virtually all state health care laws for employers that participate in such arrangements.

Due to the widespread societal discrimination faced by children and adults with mental illnesses, clinicians, consumers, family members and volunteers have worked together in state capitals across America to level the playing field and improve the availability and quality of mental health care. These efforts have borne considerable fruit. To date, an estimated thirty (30) states have passed laws which require insurance plans to offer mental health benefits, or specify minimum mental health benefits coverage. Similarly, in a bipartisan fashion, twenty-six (26) states have passed some form of parity legislation ending discriminatory insurance practices imposed against people with mental disorders. In 1999 alone, Gov. John Rowland (R-CT), Gov. Marc Racicot (R-MT), Gov. Mike Johanns (R-NE), Gov. Christine Todd Whitman (R-NJ), Gov. Frank Keating (R-OK), and Gov. James Gilmore (R-VA) have all signed parity bills into law. Unfortunately, H.R. 2047 poses a direct threat to this bipartisan progress.

MSAs pose similar problems. Numerous independent health analysts have concluded that these accounts – if made widely available – could threaten the stability of the private insurance marketplace in the United States, while imposing stiff premium increases on Americans with chronic health conditions.

The MHLG looks forward to working closely with the House leadership – in the second session of the 106th Congress – to pursue proposals that expand access to health care without the unintended consequences of H.R. 2047 and related legislation.

Sincerely,

American Association for Psychosocial Rehabilitation
American Association of Pastoral Counselors
American Counseling Association
American Group Psychotherapy Association
American Occupational Therapy Association

American Psychological Association
Association for the Advancement of Psychology
The Judge David L. Bazelon Center for Mental Health Law
National Alliance for the Mentally Ill
National Association of Protection and Advocacy Systems
National Association of Psychiatric Treatment Centers for Children
National Association for Rural Mental Health
National Council for Community Behavioral Healthcare
National Mental Health Association

UNITED STATES SENATE

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

DATE: June 14, 2000

TO: Chris Jennings
Rich Tarplin
Alice Weiss
Jeanne Ireland
Sabrina Corlette/Katie Corrigan
Abby Brandel
Deborah Veres/Jon Haifitz
Jane Loewenson

FAX: 456-5557, 690-7380, 693-4644, 4-7475, 8-0404, 4-7665, 4-7895

FROM: David and Cybele
(202) 224-7675 phone
(202) 224-3533 fax

NUMBER OF PAGES: 4

MESSAGE:

FYI, the final signed copy was delivered at 10:55am today.
If others in your shop need to know, we assume you can get this to them.

Congress of the United States
Washington, DC 20515

June 13, 2000

The Honorable Don Nickles
United States Senate
133 Hart Senate Office Building
Washington, D.C. 20510

Dear Don:

We want to see the President sign patient rights legislation into law this year. But to this point, the conference committee on managed care reform has failed to achieve appreciable progress, and that is why supporters of meaningful reform placed the bipartisan House bill before the Senate last week. We were gratified that the vote on this legislation fell only one vote short of passage and demonstrated growing bipartisan support in the Senate for genuine reform.

We have spent two months discussing external appeals, with no resolution. We have made progress in concept, but have not resolved, access to specialists and emergency care, and continuity of care. We have made no measurable progress toward an agreement on holding health plans responsible when their actions kill or injure patients, or on how to guarantee protections for all Americans with private health insurance. We have yet to start negotiations on access to clinical trials, prohibition of gag clauses and improper financial incentives, appeals within health plans, consumer information, and many other important issues. In fact, we have fully resolved only two out of 22 patient protection issues before the conference.

We remain eager to produce legislation that will guarantee every American with private health insurance an effective and independent appeal process when they are denied care and allow them to hold decision-makers accountable when the denial of care results in injury or death. We presented the conference with a proposal on these matters that responded to specific concerns expressed by Republican conferees in our closed door meetings and assured that these protections would be satisfactory. In response, we received a staff memo that ignored our proposals, and contained suggestions that would actually weaken the few protections that patients already have under current law. Our staffs' analysis of this memo is attached.

It is plain that the process of closed meetings involving a limited number of members discussing concepts and generalities is a failure. In the limited number of legislative days remaining, the conference can only succeed if we meet in open sessions, pursuant to a defined schedule and agenda, working from legislative language, with the participation of all members. We stand ready to meet with you at any time to discuss serious, detailed proposals that provide a basis for achieving strong, effective patient protections.

Sincerely,

JOHN D. DINGELL

EDWARD M. KENNEDY

FRANK PALLONE, JR.

CHRISTOPHER J. DODD

CHARLES B. RANGEL

TOM HARKIN

PETE STARK

BARBARA A. MIKULSKI

WILLIAM (BILL) CLAY

JOHN D. ROCKEFELLER IV

ROBERT E. ANDREWS

HENRY A. WAXMAN

MARION BERRY

Democratic Staff Analysis of June 4th Republican Staff Document

- The Republican staff document fails to provide a realistic base from which to work for consensus in the conference. It would be a step backwards from the House-passed Norwood-Dingell bill and, in some instances, it would be a step backwards from current law.

- To date, we have reached full agreement on just two of 22 general provisions in the conference – access to pediatricians and non-discrimination against providers. Critical components of the external appeal program, one of the cornerstones of a real patient protection bill, remain unresolved. Discussions on vital common-sense protections such as access to ob-gyn care, access to clinical trials, internal appeals, prohibition of gag clauses and improper incentive arrangements have not been discussed or have languished without resolution for months.

- Democratic members submitted an offer on May 23rd that offered modifications or clarifications of the House-passed liability and scope provisions, and included proposals to conclude negotiations on external appeals. On June 4th, the Republican staff offered a document that failed to provide a meaningful response to the Democratic offer and instead only generally discussed "remedies," scope and the tax provisions.

- On liability, the June 4th Republican staff memo did not include a serious proposal. It provided vague generalities on an additional mechanism to enforce external appeals, but it failed to offer any provision to hold health plans accountable when their inappropriate decisions to deny or delay care wrongfully results in injury or death. In fact, under the GOP staff memo, a health plan could never be held accountable for its abuses if it complied with the recommendation of the external review, even if the patient was injured by the health plan's initial delay or refusal to provide care and could not be helped by compliance with the reviewer's decision.

- On scope, the June 4th Republican staff memo does nothing to provide meaningful guarantees for any individual not covered by the original Senate Republican bill. In fact, the proposal would reduce current internal and external appeal protections for millions of Americans in state-regulated employer-sponsored HMOs by preempting state laws in these areas for those plans.

- On the tax provisions, rather than attempt to address concerns that have been raised with the Republican proposals, the GOP staff document merely lists the current tax provisions in both the House- and Senate-passed bills. This is clearly not an effort to bridge differences and move forward productively. These tax provisions are sure to exceed $70 billion in taxpayer dollars over 10 years, yet result in very little new coverage for the uninsured. The Medical Savings Account provision, in particular, would provide new tax breaks for the healthy and wealthy, and could substantially raise the cost of traditional insurance.

- Finally, the Republican memo fails to respond to the Democratic offer on external appeals, leaving critical provisions necessary to assure an effective, independent appeals process unresolved.