UNITED STATES SENATE

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

DATE: June 5, 2000

TO: Jeanne Ireland
Sabrina Corlette
Abby Brandel
Deb Veres
Jane Loewenson
Jim Manley
Chris Jennings
Gary Claxton et al
Alice Weiss et al
Sara Rosenbaum

Rich T.

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

NUMBER OF PAGES: 4 (including cover)

MESSAGE:

Following is the GOP "offer" from yesterday. Please consider it close hold for now, though we expect they may leak it today. We'll meet or talk later today to discuss.

Gary and Alice, can you please distribute to appropriate folks at your departments? Thanks.

United States Senate

WASHINGTON, DC 20510

TO: Bridgett Taylor
David Nexon
FR: Eric Ueland EU
DT: June 4, 2000
RE: Remedies, Scope, Tax Access

Bipartisan, bicameral work has produced good progress on responsible, balanced Patients Bill of Rights legislation. Meeting the goal of meaningful patient protections has animated much of the labor over the past several months; and the exhaustive staff work creating the external appeals process represents a significant bipartisan breakthrough that would empower many patients nationwide.

The letter from Congressman Dingell and Senator Kennedy of May 23, 2000, assisted the majority staff in further understanding your views on liability and scope. In the spirit of your principals' letter, majority staff wish to respond, as attached.

- On remedies, staff have been encouraged to hear your repeated assurances of your wish to protect employers from a tort system that could tip out of control.

- As to scope, your staff acknowledgements that the Health Care Financing Administration suffers from many competing demands has reinforced our belief that health insurance regulation should remain the province of the states.

The majority staff is also transmitting an initial position on access. Overlooked throughout many of our conversations so far this year has been the key question of the uninsured. Both chambers committed to the conference thoughtful policies to increase access to health care insurance throughout the country. Many of the access provisions are highly similar in both bills; they are powerful steps forward in reducing the number who go without health care coverage in our country.

Please know that these proposals should carry no inference that items not reflected in them have been "dropped," or "taken off the table." As staff work toward common recommendations in these and other areas, other questions and issues will arise as the subject of negotiation.

Thank you for your careful consideration of these proposals.

Republican Staff Offer (Note: This is not intended to be an exhaustive list of issues related to these areas.)

June 4, 2000

Modify Senate bill as follows on Remedies:

- **A new federal statutory cause of action would be created in ERISA to allow for lawsuits for failure to comply with the decision of the independent medical reviewer.**

- **In order to protect access to employer-sponsored health insurance, a strict employer exemption would be created.**

- **Participants or beneficiaries would be required to exhaust all administrative remedies prior to filing suit.**

- **Economic damages would be fully recoverable. Noneconomic damages would be available with reasonable monetary limitations.**

- **Punitive damages would be available with reasonable monetary limitations under limited circumstances. Some percentage of any punitive award would be allocated to a fund to improve the quality of health care or access to health care.**

- **The new federal statutory cause of action created in ERISA would not be available as a class action lawsuit.**

Modify Senate bill as follows on Scope:

The Patients' Bill of Rights will extend new patient protections to all 193 million Americans covered by health insurance. Protection would be provided under specific federal provisions or under qualified state laws.

The legislation would provide federal patient protections for the 56 million Americans in self-insured employer plans that state patient protections cannot reach. The legislation would also add new federal internal and external appeal rights for the 131 million Americans covered by group health plans.

In order to provide these protections to individuals in plans subject to state regulation, the Governor of each state, through a certification process, may certify

to the Secretary on a provision-by-provision basis that:

- **Their state had adopted a provision(s) that, taken as a whole and considering the need for state flexibility, is as protective of the relevant patient protections or the new internal and external appeal rights;**

- **Consideration of market composition/fee for service issues.**

Tax Access provisions:

- **An above-the-line deduction for health insurance costs.**

- **Accelerate the 100-percent self-employed health insurance deduction.**

- **Expansion of the Medical Savings Accounts.**

- **A new above-the-line deduction for long-term care insurance expenses.**

- **A new additional personal exemption for caretakers.**

- **Other tax access provisions.**

THE WHITE HOUSE

WASHINGTON

ABOARD AIR FORCE ONE

June 8, 2000

The Honorable Thomas A. Daschle
Democratic Leader
United States Senate
Washington, D.C. 20510

Dear Mr. Leader:

I am writing to express my strong support for your effort to give the Senate its first opportunity to vote for the bipartisan Norwood-Dingell Patients' Bill of Rights. It is long past time that the Congress acted to deliver real patient protections for all Americans in all health plans.

It is my understanding that the members of the Senate/House Conference who support a strong, enforceable, Patients' Bill of Rights have reluctantly concluded that the likelihood of an acceptable bill emerging from the conference is remote. After 8 months of inaction since the House passed the Norwood-Dingell Bipartisan Consensus Managed Care Improvement Act, and with very few scheduled legislative days remaining, it is time for the Congress to act to pass this legislation and give Americans the patient protections they deserve.

Congress has failed to pass this measure for years, and this delay has real consequences. According to a recent study, each day without a strong Patients' Bill of Rights results in harm to thousands of patients because insurance companies refused a patient a diagnostic test, a necessary procedure, or a referral to a specialist.

It is my hope that the Senate will approve this legislation today and take the next important step toward the enactment of a strong, enforceable Patients' Bill of Rights. I urge the Senate to put the interests of patients before those of the special interests and replicate last fall's bipartisan achievement by the House of Representatives.

Sincerely,

Bill Clinton

THE WHITE HOUSE

WASHINGTON

ABOARD AIR FORCE ONE

June 8, 2000

The Honorable Thomas A. Daschle
Democratic Leader
United States Senate
Washington, D.C. 20510

Dear Mr. Leader:

I am writing to express my strong support for your effort to give the Senate its first opportunity to vote for the bipartisan Norwood-Dingell Patients' Bill of Rights. It is long past time that the Congress acted to deliver real patient protections for all Americans in all health plans.

It is my understanding that the members of the Senate/House Conference who support a strong, enforceable, Patients' Bill of Rights have reluctantly concluded that the likelihood of an acceptable bill emerging from the conference is remote. After 8 months of inaction since the House passed the Norwood-Dingell Bipartisan Consensus Managed Care Improvement Act, and with very few scheduled legislative days remaining, it is time for the Congress to act to pass this legislation and give Americans the patient protections they deserve.

Congress has failed to pass this measure for years, and this delay has real consequences. According to a recent study, each day without a strong Patients' Bill of Rights results in harm to thousands of patients because insurance companies refused a patient a diagnostic test, a necessary procedure, or a referral to a specialist.

It is my hope that the Senate will approve this legislation today and take the next important step toward the enactment of a strong, enforceable Patients' Bill of Rights. I urge the Senate to put the interests of patients before those of the special interests and replicate last fall's bipartisan achievement by the House of Representatives.

Sincerely,

Bill Clinton

THE WHITE HOUSE

WASHINGTON

ABOARD AIR FORCE ONE

June 8, 2000

The Honorable Thomas A. Daschle
Democratic Leader
United States Senate
Washington, D.C. 20510

Dear Mr. Leader:

I am writing to express my strong support for your effort to give the Senate its first opportunity to vote for the bipartisan Norwood-Dingell Patients' Bill of Rights. It is long past time that the Congress acted to deliver real patient protections for all Americans in all health plans.

It is my understanding that the members of the Senate/House Conference who support a strong, enforceable, Patients' Bill of Rights have reluctantly concluded that the likelihood of an acceptable bill emerging from the conference is remote. After 8 months of inaction since the House passed the Norwood-Dingell Bipartisan Consensus Managed Care Improvement Act, and with very few scheduled legislative days remaining, it is time for the Congress to act to pass this legislation and give Americans the patient protections they deserve.

Congress has failed to pass this measure for years, and this delay has real consequences. According to a recent study, each day without a strong Patients' Bill of Rights results in harm to thousands of patients because insurance companies refused a patient a diagnostic test, a necessary procedure, or a referral to a specialist.

It is my hope that the Senate will approve this legislation today and take the next important step toward the enactment of a strong, enforceable Patients' Bill of Rights. I urge the Senate to put the interests of patients before those of the special interests and replicate last fall's bipartisan achievement by the House of Representatives.

Sincerely,

Bill Clinton

[redacted]

- Argued
- 60 minute

Pegram v. Herdrich

What's this case all about?

On a very basic level, this case is about the limits of a federal law known as ERISA in regulating managed care abuses. The case asks: does ERISA prohibit HMOs from imposing financial incentive systems that encourage doctors to deny medical care or benefits? The government's position is that, while ERISA may restrict some types of arrangements, ERISA was not violated by the ones described in this case. In taking this position, the government preserves many important state protections for American workers and their families, preventing these rights from being eclipsed by a weaker ERISA.

What are the facts of the case?

The case was brought by Cynthia Herdrich, a woman injured when her appendix burst after a needed sonogram was delayed so she could be seen at an in-network facility. Herdrich sued her doctor and HMO, claiming malpractice and arguing that the HMO's physician compensation arrangement violated ERISA's fiduciary duty rules by creating incentives to withhold medical care and benefits owed under the plan. Herdrich won $35,000 at the trial level on her state law malpractice claim, but her federal ERISA claim was dismissed. She appealed and the appeals court reversed the decision in a divided opinion, finding that Herdrich could still bring her ERISA claim. The HMO appealed and the case is now pending before the Supreme Court for argument on February 23.

What is the government's position? Does the government brief say that HMO financial incentives to hold down costs and care, are OK?

The government's brief takes the position that the financial incentive arrangements at issue in this case are currently either beyond the reach of ERISA's fiduciary rules or do not violate those rules, but that financial incentive arrangements for physicians in connection with an HMO's furnishing of medical care are subject to regulation by the states. The brief does not otherwise address financial incentive arrangements as a general matter.

HMOs perform at least two functions in our health care system - they deliver medical care and they administer benefits (i.e., decide whether a benefit is covered by a health plan). However, ERISA's fiduciary duty rules only cover HMOs when they are acting as fiduciaries for an employer-sponsored health plan (e.g., administering benefits) - medical care issues are beyond the reach of ERISA. Thus, HMO incentive arrangements affecting benefit administration for an employer plan are covered by ERISA. And these arrangements will violate ERISA's fiduciary rules requiring a duty of loyalty if they taint the fairness of the benefit decisionmaking process.

In this case, Ms. Herdrich claims that the HMO violates ERISA's fiduciary duty rules by using two sets of incentives: (1) providing a bonus to physicians who provide medical care in a manner that minimizes diagnostic tests and referrals and (2) providing a bonus to physicians who determine whether benefits are covered under the plan. The government's brief responds that

ERISA was not violated by either incentive here. ERISA does not reach the first incentive because it relates to medical treatment, an area that is not covered by ERISA's fiduciary rules, but rather is covered by state law. The second incentive, while it is within ERISA's reach, does not violate ERISA's rules because the incentive arrangement Ms. Herdrich describes, involving physician ownership of the HMO and sharing in the HMO's profits, does not impair the fairness of the benefit determination process to make out a violation of ERISA's rules.

To more effectively regulate these arrangements we'd need a change in the law. That's why we need the Patients' Bill of Rights.

How does the Administration-supported patients' rights bill address physician financial incentives?

The House-passed patients' rights bill that has Administration support, H.R. 2990, imposes new restrictions on physician financial incentive arrangements similar to those in place under Medicare. It bars health plans from making specific payments to induce doctors to limit medically necessary services, and requires plans that place doctors at substantial financial risk for services the plan doesn't cover to provide stop-loss protection for the doctors and to survey enrollees and disenrollees regarding access to care. It also requires full disclosure of incentive arrangements to consumers. If patients are injured as a result of these arrangements, they are permitted to sue under state law; to the extent that such injuries result from a benefit denial, they can also sue under ERISA. While the government's position protects the rights patients have today, the Patients' Bill of Rights can give HMOs, doctors, and patients the clear rules of the road that can help restore the trust in managed care that is so sorely needed.

Why is the government siding against this victim of managed care? How is this consistent with the Administration's support for patients' rights?

We agree that Ms. Herdrich and others like her need help, but she is looking in the wrong place. ERISA does not provide meaningful protections for victims like Ms. Herdrich and others who have already been harmed. Under current law, only state law damages can provide compensation, which Ms. Herdrich has already won.

The government's position in this case will help many other consumers who could be hurt if Ms. Herdrich wins her case - people like Mrs. Shea of Illinois. Mrs. Shea's husband, Patrick, suffered a heart attack and died after her doctor refused to refer him to a cardiologist. Mrs. Shea later sued the HMO in state court, claiming that the HMO's financial incentives caused the refusal. A federal appeals court found that Mrs. Shea's claims for damages were preempted by ERISA. However, under ERISA there are no money damages available, no compensation for those already injured. If Ms. Herdrich wins her case, and the Supreme Court rules that ERISA fiduciary rules apply to medical treatment, then state remedies and consumer protections would likely be displaced by ERISA. People like Mrs. Shea will have no meaningful remedy under ERISA and they will be barred from suing under state law. In addition, as many as 16 states have already enacted laws that limit physician incentives which would likely be preempted if Ms. Herdrich prevails. The government's brief supports patients' rights by preserving these state

Can you differentiate between wage & app financial incentive provisions?

protections to help those injured by HMO incentives; by pointing out ERISA's limits, the brief also clarifies the need for greater protections at the federal level.

The New York Times reported that the Administration "agreed with the industry" on this case - is this true?

While it is true that the government and industry groups are both arguing against Ms. Herdrich's position in this case, we do not agree with the industry on fundamental issues raised by this case. The industry argues that ERISA does not apply to any of the HMO financial incentive arrangements challenged by Ms. Herdrich. As we say in our brief, we believe that ERISA could prohibit an HMO's financial incentive arrangements if they rise to the level of compromising an ERISA fiduciary's duty of loyalty when deciding benefit claims. Most importantly, we do not "agree with the industry" on the fundamental issue underlying the current legislative debate. Unlike industry groups that have argued against the need for this bill, we believe that a strong Patients' Bill of Rights is needed to protect patients harmed by HMO practices.

Have the consumer groups, doctors, and the states supported the government's position in this case?

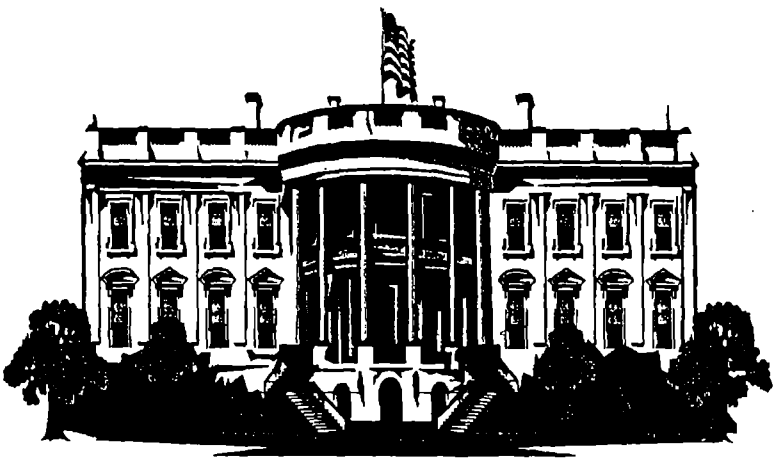
A number of consumer, legal and medical groups, and state attorneys general have agreed with the government on the fundamental view that ERISA does not apply to the HMO's incentives relating to medical care. Briefs filed by the Washington Legal Foundation and the American Medical Association both support this view. The brief filed by AARP, National Employment Lawyers Association, and National Senior Citizens Law Center, and the brief filed by 18 state attorneys general, also support this view, but find that ERISA could have been violated by the scheme relating to benefit determinations. On this point, the AARP and state attorneys general briefs differ from the government's view, which was that the incentive arrangements relating to benefit determinations did not violate ERISA's fiduciary rules, because they did not provide a specific incentive to decide claims unfairly. HIAA, AAHP, APPWP, and U.S. Chamber of Commerce also supported the government's view that ERISA does not apply here.

Four groups have sided with Ms. Herdrich, in opposition to the government's view: (1) a coalition of health care advocacy and legal rights groups; (2) a group of health law policy and ethics scholars; (3) a physician named Dr. Self who was fired by his HMO for providing too much care to patients; and (4) the plaintiffs in another case, Ehlmann, in which an appeals court recently decided that ERISA does not generally require HMOs to inform consumers about physician financial incentives. Although these briefs differ in their arguments, they generally agree that ERISA should apply in this case because they are frustrated by the lack of meaningful protections for consumers at the federal level. We share their frustration and have strongly supported the passage of a strong patients' bill of rights that would provide such protections. However, we differ with their views on how far ERISA can go under current law to resolve these problems. It is our view that ERISA does not reach the lion's share of these incentive schemes, and that, for those it does reach, the remedies available will do little to help those already hurt.

does the PBOR prohibit the use of the type of incentives included in contract

Regardless, Admin POS allow HMOs to have support activity to utilize provisions plans

If so, why?



FAX COVER SHEET

KAREN A. TRAMONTANO
ASSISTANT TO THE PRESIDENT AND
COUNSELOR TO THE CHIEF OF STAFF
THE WHITE HOUSE
FIRST FLOOR, WEST WING
WASHINGTON, DC 20500
PHONE: 202/456-1987 • FAX: 202/456-2030

DATE: Chris Jennings

PLEASE DELIVER TO:

FAX NUMBER: 65557

SENT BY: ✓ Karen Tramontano _____ Carolyn Wu

NUMBER OF PAGES: 5
(including cover sheet)

_____ For your information _____ Per our conversation

LABORERS' INTERNATIONAL UNION OF NORTH AMERICA

Chris —
B&CT stopped by — they are concerned that we NOT leave them hanging out there. Let's talk.
Karen

May 19, 2000

The Honorable William J. Clinton
President
The White House
1600 Pennsylvania Avenue, NW
Washington, D.C. 20500

Re: Patients' Bill of Rights (S. 1344 / H.R. 2990)

Dear Mr. President:

As the General President of this Union, I have the honor of representing the more than 800,000 workers who are its members.

I read with great interest your Press Secretary's May 11th release concerning your views on the patients' rights legislation, and on the House-Senate Conference Committee that is considering that legislation, in advance of your meeting with the conferees. I took particular notice of your strong endorsement of the Norwood-Dingell bill as passed by the House.

We strongly object to the inclusion of new, monetary liability provisions in the patients' rights legislation, at least to the extent that they would apply to labor-management, multi-employer health and welfare trust funds maintained under the Taft-Hartley Act. Such an expansion of liability would severely damage the health and welfare trust funds on which our members and their families depend for health care coverage. In particular, the Norwood-Dingell bill would cost many thousands of our active members, retirees, and dependents their health care coverage.

HEADQUARTERS:
905-16th Street, NW
Washington, D.C.
20006-1765
(202) 737-8320
Fax: (202) 737-2754

One of the proudest achievements of this Union is the health care coverage that our members and their families receive through labor-management health and welfare trust funds established by the Union with various employer groups under the Taft-Hartley Act. But for these pooled multi-employer trust funds, hundreds of thousands of our members and their dependents would lack health care coverage because of the transient nature of employment in the construction industry. The vast majority of employers is small and, in any event, would not maintain health plans for workers who might work for them for only a brief period or from time-to-time. By providing in collective bargaining agreements for a portion of each laborer's compensation to be contributed by the employers to a health and welfare fund, the members, through the Union, are able to provide pooled, portable health care coverage for themselves.

Let me underscore that a health and welfare trust fund is really a pool of workers' money. The only sources of financing are the collectively bargained contributions and investment income, if any, on those contributions. All of a health and welfare fund's costs – benefits and administrative expenses – must be paid from the pool of workers' money.

The Norwood-Dingell bill's liability provisions would, if enacted into law, destroy Taft-Hartley health and welfare funds and, thereby, cost untold numbers of working families their health care coverage. The bill would subject health and welfare trust funds, their trustees, and their administrators to lawsuits in State courts for whatever remedies the State law allows. Our health and welfare funds that cover workers and dependents in multiple States would be subjected to multiple, conflicting State regulation, contrary to ERISA's sound fundamental purpose of ensuring a uniform, national regulatory scheme for employee benefits.

A court award of money damages against a health and welfare trust fund could bankrupt the fund and cause the loss of health care coverage for all of the workers, retirees and dependents covered by the fund. Multi-million dollar judgments against health care providers have been reported in the media. No Taft-Hartley health and welfare trust fund could afford to pay such a judgment.

Even if a health and welfare fund could find the money to pay a judgment, whose money would it be paying? The workers' money is the answer, because all that a health and welfare trust fund has is workers' money. And, the workers covered by the fund would have to make-up this loss to their fund by paying more of their wage package into the fund, by accepting lower benefit levels or less types of benefits, by paying increased deductibles and co-payments, by meeting tougher benefit eligibility requirements, and by other means.

In short, an individual plaintiff might be benefited by an award of damages against a health and welfare fund, but the whole of the workers, retirees and dependents covered by the fund – perhaps many thousands of individuals – would either lose their health care coverage or be compelled to pay more for that coverage. Where is the justice in that result?

The current remedial scheme of ERISA reflects a sound policy balance between the interests of an individual fund participant and the interests of the fund's participants as a whole. In addition to other remedies, ERISA entitles any participant or beneficiary to sue a fund to recover benefits due under the terms of the fund's health plan or under law, to compel compliance with plan terms, and to recover attorneys fees and costs. The legislative proposals requiring faster internal health plan decisions and for external expert review of benefit denials would adjust that balance to provide even more protection for individuals. These proposals are well focused on quickly getting to patients the care (or payment for care) to which they are entitled under their health plan.

But, proposals to add money damages remedies–for compensatory damages, punitive damages, pain and suffering damages, etc.–would upset the balance to a destructive degree.

The serious concerns of the Taft-Hartley health and welfare fund community were raised early and throughout the legislative process in the House and the Senate. We understood that those concerns might not be addressed before a House-Senate conference because of the politically charged environment. However, we also understood they would be resolved by no later than during the House-Senate conference.

I recently received renewed assurances from Senator Kennedy that our concerns will be favorably resolved during the Conference Committee proceedings. I am advised that a representative of your Administration gave the same assurances shortly before the Senate floor debate began. However, there have been some suggestions that the Administration may be willing to sacrifice these trust funds to gain the legislation that it wants. These rumors greatly concern me. Accordingly, I ask that you personally support a favorable resolution of the Taft-Hartley health and welfare trust funds' concerns about expanded liability for money damages.

Thank you for your support.

Respectfully,

Terence M. O'Sullivan

TERENCE M. O'SULLIVAN
General President

UNITED STATES SENATE

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

JAMES M. JEFFORDS, VERMONT, CHAIRMAN

JUDD GREGG, NEW HAMPSHIRE
BILL FRIST, TENNESSEE
MIKE DEWINE, OHIO
MIKE ENZI, WYOMING
TIM HUTCHINSON, ARKANSAS
SUSAN COLLINS, MAINE
SAM BROWNBACK, KANSAS
CHUCK HAGEL, NEBRASKA
JEFF SESSIONS, ALABAMA

EDWARD M. KENNEDY, MASSACHUSETTS
CHRISTOPHER J. DODD, CONNECTICUT
TOM HARKIN, IOWA
BARBARA A. MIKULSKI, MARYLAND
JEFF BINGAMAN, NEW MEXICO
PAUL D. WELLSTONE, MINNESOTA
PATTY MURRAY, WASHINGTON
JACK REED, RHODE ISLAND

DATE: 8/2/00

TO: Chris J., Richt.

FAX: 456-5557, 690-7380

FROM: Jackie/Cybele

(202) 224-7675 phone
(202) 224-3533 fax

NUMBER OF PAGES: 4

MESSAGE:

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

February 10, 2000

Honorable Don Nickles
Assistant Majority Leader
United States Senate
Washington, DC 20510

Dear Senator:

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

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

I hope this information is helpful to you. The CBO staff contacts are Tom Bradley and Judith Wagner. We expect to transmit the completed cost estimates shortly.

Sincerely,

Dan L. Crippen

Attachments

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

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

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

SOURCE: Congressional Budget Office.
NOTE: S. 1344, as passed by the Senate on July 15, 1999.
a. Less than 0.05 percent.

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

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

SOURCE: Congressional Budget Office.

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

ERISA = Employee Retirement Income Security Act

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

b. Less than 0.05 percent.

QUESTIONS AND ANSWERS ON PATIENTS' BILL OF RIGHTS

Q: What is your response to today's Supreme Court ruling stating that patients cannot HMOs giving doctors financial bonuses to hold down treatment costs?

A: Today's ruling provides further evidence that we need to pass a strong, enforceable Patients' Bill of Rights without delay to ensure that every American in every health plan has the patient protections they need to navigate through an increasingly complex health care system, and it must include court enforced remedies to ensure these rights are real. Action from the Congress is long overdue on this issue. It is time to pass strong enforceable legislation and send it to the President for his signature. This will be the only way we can achieve the sorely needed increase in the public's confidence in the ability of the nation's system to provide needed health care.

Q: Isn't that a little hypocritical? Didn't the Administration file against her case?

A: There are very complicated issues associated with this case. In fact, if we had supported the legal interpretation supported by Cindy Herdrich, we might have taken away the limited state-based rights that currently exist to provide protections and remedies to individuals in managed care plans. The only way to effectively address this issue is to pass a strong, enforceable, Patients Bill of Rights.

Q: What do you think of yesterday's Supreme Court decision? Does it increase or decrease the chance of passing a Patients' Bill of Rights?

A: We're not surprised by yesterday's decision. We have long indicated that there is a need for Federal legislation to ensure that patients have the protections they need, including provisions to assure accountability. We agree with the Court itself when it suggests that the best place for the issue to be resolved is in the Congress. It is long past time that Congress acted.

old but provides summ of facts.

PEGRAM v. HERDICH - GOVERNMENT'S BRIEF

QUESTION:

In the Pegram case to be argued before the Supreme Court tomorrow, did the Administration take the position in its brief siding with the HMO and against the victim of managed care? Isn't this inconsistent with the Administration's support for patients rights legislation?

ANSWER:

- The position taken in the government's brief demonstrates why we need the Patients' Bill of Rights so that we can more effectively regulate physician financial incentive arrangements and help consumers like Ms. Herdich.

- We agree that Ms. Herdich and others like her need help, but unfortunately she is looking in the wrong place. Currently, federal law does not provide meaningful protections for victims like her who have already been harmed.

- In taking this position, the government preserves many important state protections for American workers and their families, preventing these rights from being eclipsed by a weaker federal law.

- And although our brief, like the industry groups, is arguing against Ms. Herdich's position in this case, unlike the industry groups, we believe that a strong Patients' Bill of Rights is needed to protect patients harmed by HMO practices.

BACKGROUND:

- The government filed a friend of the court brief in this case to be argued before the Supreme Court on February 23.

- Although the government's brief sides with the HMO, it is consistent with our prior positions and the Administration's support of the patients rights legislation. The position taken preserves state protections for workers and their families, preventing these rights which go farther than those under federal law, from being eclipsed by the weaker federal law. This is consistent with the Administration's position for a stronger federal law through a comprehensive and meaningful Patients' Bill of Rights.

- Cynthia Herdich brought this case after she was injured when her appendix burst after a needed sonogram was delayed so she could be seen at an in-network facility. She sued her doctor and the HMO, claiming malpractice and arguing that the HMO's physician compensation arrangement violated federal law by creating incentives to withhold medical care and benefits owed under the plan. She won $35,000 at the trial on her state malpractice claim but her federal law claim was dismissed. She appealed and the appeals court reversed. The case is now before

the Supreme Court.

- A number of consumer, legal and medical groups and state attorneys have agreed with the government on the fundamental view that the federal law (ERISA) does not apply to the HMO's incentives relating to medical care. These groups include AARP, 18 state attorney generals, the US Chamber of Commerce, and the key groups representing HMOs (HIAA and AAHP).