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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. fax	re: Motion for judgement (10 pages)	04/07/1999	P6/b(6)
002a. report	re: motion for judgement (8 pages)	n.d.	P6/b(6)
002b. report	re: medical incident history (17 pages)	n.d.	P6/b(6)

COLLECTION:
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PBOR [Patients' Bill of Rights] [Folder 1]

2012-0463-S
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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]

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

Dan L. Crippen
Director

April 23, 1999

Honorable Edward M. Kennedy
Chairman
Committee on Health, Education,
Labor and Pensions
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

At your request, we have completed a cost analysis of S. 6, the Patients' Bill of Rights, as introduced. Consistent with our understanding that you will supply CBO with legislative language clarifying your intent with regard to certain issues, we estimate this legislation, revised to accomplish these changes, will add 4.8% to private health insurance premiums over a period of years.

Sincerely,

Dan L. Crippen

Identical letter sent to Honorable Tom Daschle, Democratic Leader.

MEMO

TO: Chris
Devorah

FROM: Leslie Kramerich, PWBA

I thought this might be helpful on Unum. Also, we're working on a map of states that would illustrate where and how many patients rights are in effect (HHS shared with us data they are working on to update this) and a map that shows insured versus self-insured populations by state, i.e., the populations NOT reached by the kinds of state insurance laws protected under Unum, the populations for whom only a comprehensive federal change can make a difference. I think there are a number of great uses that could be made of maps like that, and I think mid-to-late May is the time for a variety of reasons. I look forward to talking with you and HHS about this further.

MEMORANDUM

FROM: LESLIE KRAMERICH
Deputy Assistant Secretary, PWBA

SUBJECT: Today's Supreme Court decision in Unum Life Insurance Co. v. Ward

This memo will summarize the employee story that led to the case decided today by the Supreme Court, and the ERISA arguments that were made to the Court. It will also note how the decision touches on patients rights and remedies, as well as our patients rights regulation. Finally, it shows the great number of interested parties who are not only watching this case but have gotten actively involved.

The Employee's story:

John Ward resigned his job in May, 1992 when he became permanently disabled by a painful disorder which was later diagnosed to be a result of diabetes. He asked about the possibility of continuing health insurance, and he kept his employer posted when he was found disabled under Social Security (which is often a prerequisite for other kinds of disability coverage). He had worked for the company for 9 years and had disability premiums deducted from his paycheck during that time.

In April of 1994, he came across an old booklet describing the disability coverage his employer had offered through the Unum insurance company. He asked the employer if his disability would be covered under the policy, and the employer said yes, so Mr. Ward submitted a claim to the insurance company. The company refused to pay, saying claims had to be filed within 180 days of the onset of the disability, so Mr. Ward had 6 months from May of 1992 in which to submit his claim. Mr. Ward sued to get the benefit promised to him. Unum argued that the lawsuit could not proceed because it was "preempted" or prevented by ERISA.

The Supreme Court said Mr. Ward's lawsuit is not blocked by ERISA:

Mr. Ward argued that the 180-day clock Unum wanted to impose on his ability to file a claim was satisfied because he told his former employer of his condition within that time-frame, and notice to the employer should count as if it were notice to the insurance company. In other words, he argued that the employer should be considered an agent of the insurance company and he cited a California case as standing for that rule. The Supreme Court rejected his request to rely on this argument, saying that it would affect ERISA plans too greatly and that it is not the kind of insurance law that ERISA permits to have that kind of effect. (In ERISA terminology, it would be said that the agency rule "relates to" ERISA plans and is preempted, and that it does not "regulate the business of insurance" so it is not "saved" from preemption.)

Mr. Ward also argued that a different kind of California law should be considered to fall within the category of "insurance laws" that is permitted to affect ERISA plans. On this argument, he won. California has a law, developed by court cases rather than statutes, which says that insurance companies cannot reject claims that are filed late unless that lateness hurts the insurance company's ability to process the claim (to know whether it should really be paid or not). This is the ground on which the Court permitted his case to go forward. The case now goes back to the district court so the court can determine whether or not Unum suffered any prejudice to its ability to analyze the claim by virtue of the lateness with which it was filed.

Patients rights and remedies

Unum tried to argue that Mr. Ward's suit should not proceed because he was looking for some kind of remedy or enforcement under state law, and the Supreme Court has already stated in the 1987 case of Pilot Life that ERISA is the exclusive source of any remedy or enforcement. In our brief, we argued that the Supreme Court should revisit whether Pilot Life made the correct statement about ERISA's "exclusive" nature. In today's decision, the Supreme Court decided that it was not necessary to revisit Pilot Life in this case because Mr. Ward was not looking for a "remedy" under California law. Instead, he is proposing to use a California law that helps to enforce a benefit promise and that is not something that conflicts with ERISA so it is not preempted by ERISA.

The Patients' Rights Regulation

Unum also argued that the California rule about claims that are filed late (called the "notice-prejudice rule") is something that differs from ERISA's provisions on claims processing and appeals and differs from our proposed regulation updating those provisions. The Court said that didn't matter. Because the California law "complements" ERISA's requirements and does not frustrate them or make compliance with them impossible, both remain valid.

There are a great number of interested parties participating in this case:

Mr. Ward's arguments were supported by:

- The Department of Labor
- the Council of State Governments, National Governors' Association, National Association of Counties, National League of Cities, U.S. Conference of Mayors, and International City/County Management Association;
- National Employment Lawyers Association;
- AARP;

- the States of Texas, Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Utah, Vermont, Washington, West Virginia, Wyoming and the Territory of Puerto Rico; and

- National Association of Insurance Commissioners.

Unum's arguments were supported by:

- the Business Roundtable; and

- the American Council of Life Insurance,

- the Health Insurance Association of America

- and Standard Insurance Company.

Q: Isn't the UNUM decision further evidence that the courts have made a great change in their view of ERISA preemption of state laws. When you add this case to other recent decisions such as Pappas, Shea, and Giles, don't patients have much better access to remedies for benefit denials as a result?

A: No. The courts have begun to limit the reach of ERISA preemption by adopting a more common sense analysis to issues of whether a particular state law is preempted, but this does not really change the situation for plan participants who have been injured due to a denial or delay of promised benefits.

- At best, the general trend of cases in the last few years, has been to put up some fences around the reach of ERISA preemption.
  - They have helped keep ERISA from preempting everything that might have some relation to employee benefit plans, no matter how tangential, but they have not made serious inroads on preemption of state laws that guarantee rights to promised employee benefits.
  - For example, the Giles v. NYLCARE decision is one of several recent cases that have kept plans and insurers from using ERISA preemption to insulate themselves from liability when they or their agents commit medical malpractice.
  - Moscovitch v. Danbury Hospital, 25 F. Supp. 2d 74 (D. Conn. 1998) is another case where the court ruled that ERISA does not preempt state law claims for failure to properly diagnose and treat a medical condition.
  - These types of cases do not help the people like the plaintiffs in Corcoran v. United Health Care, Inc., 965 F.2d 1321 (5th Cir. 1992) or Bedrick v. Travelers Ins. Co., 93 F. 3d 149 (4th Cir. 1996) who were injured by medical decisions made in the context of benefit determinations. In those cases, and in many others, the courts held that the state law claims were preempted even though the benefit determinations involved the exercise of medical judgment.
  - The holding in Ward v. UNUM is similarly limited. It merely allows a federal court hearing a benefit claim dispute case to use a state insurance law as a rule of decision. It does not open the door to state tort remedies for a participant who is hurt due to an unreasonable benefit denial.
- Some of the cases, blur the line between the provision of medical care and claims administration, but these hardly represent a trend that will help most people whose benefit claims are improperly delayed or denied.
  - E.g., Pappas v. Asbel, 724 A.2d 889 (Pa. Supr. Ct. 1997). HMO refused to immediately authorize patient's transfer to hospital recommended by emergency room physcian. [*Note: we don't think that this case was correctly decided.*]

- As the court in Moscovitch recognized, "it is often difficult to determine when an entity . . . is arranging, supervising or providing medical treatment of a plan participant – which would be outside the scope of ERISA § 502(a) – or merely making benefit determinations – which would be within the scope of ERISA § 502(a)."

- The courts may be able to decide close cases in favor of the patient but, the language of the statute and the existing precedent will not allow major changes in the legal analysis of these situations.

- Shea v. Esentein, 107 F.3d 625 (8th Cir. 1997), actually went against the widow of a participant who was seeking to use state remedies for a failure to disclose an arrangement that gave doctors an incentive to restrict referrals to specialists. The court found a duty under ERISA to make such disclosure, but ERISA provides no real remedy for the widow in this situation.

J. Dennis Hastert
Fourteenth District
Illinois

http://speaker.house.gov

Speaker's Press Office
United States House of Representatives
Washington, DC 20515

FOR IMMEDIATE RELEASE:
May 27, 1999

CONTACT: 202-225-2800
Pete Jeffries or John Feehery

SPEAKER'S STATEMENT REGARDING HEALTH CARE REFORM AND COVERAGE FOR UNINSURED PATIENTS

Washington, D.C. — Speaker J. Dennis Hastert (R-Ill.) today released the following statement:

"At the beginning of this Congress, I pledged to work with all members of the House to come up with solutions to problems that face working Americans. In fact, I sent a letter to my House colleagues in January promising to bring this important issue to the Floor this year. I have been concerned about the ongoing problems regarding accessibility and affordability to health care since 1991, and I have worked on a bipartisan basis to find solutions to those problems. I'm particularly concerned about ways we can expand health care coverage to the uninsured.

"That is why I am deeply disappointed that my good friend from Michigan, Mr. Dingell, has chosen to politicize the important issue of health care reform through the use of a discharge petition. Mr. Dingell should know that the Commerce, Ways & Means, and Education & Workforce Committees have been holding numerous hearings and discussions with Democrats and Republicans alike. I had hoped that these discussions would lead to common-sense reform. This discharge petition effort signals a new, more ominous direction for the Democrat leadership regarding this issue. It is a disappointing maneuver that tells me the Democrat leadership has more interest in playing partisan political games than in enacting real reform.

"As I have said all along, we must make sure that any health care reform should address the key concepts of accessibility and affordability because if people can't afford to purchase health care they won't be covered. That's why, in this process, we must focus on new ways to deliver coverage to the uninsured, such as Association Health Plans, HealthMarts, and Medical Savings Accounts – common sense ideas to make sure patients are protected. Unfortunately, the Democrat leadership's answer to the 43 million uninsured Americans is: sit tight because our legislation won't help you-in fact, it will make your situation dramatically worse. The Congressional Budget Office estimates the Kennedy/Dingell Patient Bill of Rights would raise premiums by either 4.8 or 6.1%. Either way-most studies assume at least 1.4 million Americans would lose coverage if Kennedy/Dingell were enacted.

"As some on the other side of the aisle focus on playing politics rather than making progress, I will be working to enact common sense health care reform this year that protects America's uninsured. I wish Mr. Dingell and the Democrat leadership shared my goal."

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U.S. CONGRESSMAN MAX SANDLIN
PRESS RELEASE

U.S. CONGRESSMAN MAX SANDLIN
214 CANNON HOUSE OFFICE BUILDING
WASHINGTON, D.C. 20515-4301

MAY 27, 1999
FOR IMMEDIATE RELEASE
CONTACT: ROSEMARY ADDY (202) 225-3035

SANDLIN SIGNS DISCHARGE PETITION ON MANAGED CARE REFORM

Washington, D.C. -- Today, U.S. Representative Max Sandlin announced his strong support for the newly-unveiled discharge petition effort providing for fair and prompt consideration of managed care reform. The House GOP leadership has blocked action on managed care reform to date.

Today, Rep. John Dingell (D-MI), Commerce Committee Ranking Democrat, began the discharge petition process by filing a rule providing for an open debate on all major managed care reform proposals, including the Patients' Bill of Rights. After seven legislative days have elapsed, Members will be able to file a discharge petition on this rule and then sign the discharge petition. Once the discharge petition has been signed by 218 Members, the House could consider the legislation within two weeks.

"Despite the best efforts of some special interest groups to derail the Patients' Bill of Rights, I am committed to keeping managed care reform at the forefront of the Congressional agenda," Sandlin said. "Since the Republican leadership appears unwilling to bring up this important piece of legislation, supporters of the Patients' Bill of Rights have been left no choice other than to move forward with a legislative vehicle that will allow us to vote on meaningful managed care reform."

In January, House and Senate Democrats introduced the Patients' Bill of Rights Act to respond to widespread concerns about health care quality under HMOs by guaranteeing basic rights to health care consumers. The proposed legislation ensures the right to have treatment decisions made by one's doctor and not insurance company bureaucrats, the right to see specialists whose care one needs, the right to emergency room care when and where one needs it, the right to appeal a health care decision with which you and your doctor disagree, and the right to hold managed care companies accountable.

"As we increase access to health care, we must not allow unqualified parties to make critical decisions about patient treatment. Patients need to feel confident that their doctors are giving them all necessary information and not restricting information because of requirements issued by a health insurance provider. The Patients' Bill of Rights will allow patients and their physicians to make their critical care decisions," Sandlin stated.

"I vow to continue to fight for meaningful patient protections as the debate in Congress continues," concluded Sandlin.

###

Congressman

9th District, Florida

Mike Bilirakis

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For Immediate Release
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BILIRAKIS: DISCHARGE IS WRONG APPROACH TO MANAGED CARE

Washington, D.C., May 27, 1999 – Congressman Mike Bilirakis, Chairman of the Commerce Subcommittee on Health and the Environment, issued the following statement today in reaction to the discharge petition filed on Democrat-sponsored managed care legislation:

"I am eager to work with my Democratic colleagues on health reform, but bringing a health bill to the floor without having vigorous debate on the issue is a recipe for disaster. These bills should be considered by the appropriate Committees of jurisdiction, so we can receive the input of our colleagues as managed care legislation moves through the legislative process."

"Let me assure everyone that we will consider health reform legislation this year. My Subcommittee has already held one managed care hearing, and a number of Subcommittee members have introduced reform measures. We are currently reviewing these proposals to identify areas of consensus.

"Since the beginning of this Congress, and over the last several years, I have reached out to my Democrat colleagues on health reform. I do not believe a discharge petition is the right approach to resolve an issue of such magnitude. I urge my friends on the other side of the aisle to work with us – not against us – so we can improve the quality of health care for patients across the country."

-30-

Statement of Congressman John D. Dingell
Ranking Democrat, House Commerce Committee
May 27, 1999

My colleagues and I today filed a rule to guarantee every Member of Congress an opportunity to vote on the Patients Bill of Rights.

We are doing this because we are left little choice. We have repeatedly asked the majority for a commitment to schedule managed care reform for a vote. In response, the Commerce Committee Chairman has committed only to holding hearings throughout the summer.

The leisurely pace he envisions is outlined in the letter I'm making available to you. That schedule means that legislation won't be considered in Committee until the fall, at the earliest. That's the very same time we'll be playing serious poker over appropriations bills and the budget. And that means that the full House won't see a vote on patient rights until next year, at the earliest -- placing the issue in the middle of the high Presidential season in Iowa, New Hampshire, and every other state that has moved its primary to the front of the year.

We may be forced to pursue a discharge petition on this rule because we have no other recourse. I continue to hope that a discharge petition will be unnecessary. I would prefer to write legislation in the regular process, but as of this date, there is no process.

There is no reason for delay. We've been pursuing this issue for three years. There are no fewer than four comprehensive patient rights proposals on the table, and three of them have been drafted by Republicans. We've filed an open rule to guarantee that every Member -- Democrat, Republican, left, right, Whig, Tory, Luddite or Anarchist -- will have a fair opportunity to amend the bill, to offer a substitute, and to vote up or down on the issue of patient rights.

I'm prepared to defend my bill and my vote when I stand for reelection. Those who oppose meaningful and comprehensive patient rights should be willing to do the same. If the leadership is unwilling to schedule a vote, they'll have to explain for themselves exactly why they are running scared from the electorate.

WALL STREET JOURNAL

21

LAW

High Court Rules That States Can Ease Insurers' Deadlines on Disability Claims

WSJ 4-21-99B19

By ROBERT S. GREENBERGER
Staff Reporter of THE WALL STREET JOURNAL

WASHINGTON — The Supreme Court ruled unanimously that states can loosen certain deadlines that insurance companies impose on people filing disability claims.

The court said that a California law that says that late filings don't necessarily result in a forfeiture of benefits overrides rules under the federal Employee Retirement Income Security Act, or Erisa. Lawyers on both sides called the decision a victory for insurance-policy holders.

In the case under review, Unum Life Insurance Co. of America, Portland, Maine, had rejected a claim that it received after the one-year, 180-day limit set by Erisa. The time period begins with the diagnosis of disability. California's law says an insurer must show it was harmed by the delay before it can deny the claim.

John Ward had to step down as president and chief executive officer of Management Analysis Co. when he was disabled in 1992 by diabetic neuropathy. In 1993, he began receiving California disability benefits. A year later, in April 1994, he discovered that he also was covered by the company's long-term disability plan, which was offered by Unum. Mr. Ward applied for the coverage, but Unum rejected his claim, saying he missed the deadline for filing.

Mr. Ward sued the insurer, but the federal court in San Diego, citing Erisa, upheld Unum's position. The federal appeals court in San Francisco reversed that ruling, saying that if a state law regulates insurance, it pre-empts Erisa in this area. In general, Erisa overrides state laws that relate to employee-benefit plans, but Congress made an exception for state laws that regulate the business of insurance and certain other fields.

"California's insistence that insurers show [injury] before they may deny coverage because of late notice is grounded in policy concerns specific to the insurance industry," Justice Ruth Bader Ginsburg wrote in the opinion for the court. "That grounding is key to our decision."

But some lawyers worry that some state laws may be too flexible. "The concern is how far does it get extended," says Larry Gallagher, a lawyer who heads the employee-benefits practice at D'Ancona & Pflaum, a Chicago firm. "What this rule is basically saying is, if you can prove you're hurt, [the insurance company] can't come up with a staleness rule. That can eventually, collectively, through all the nickels and dimes, become a very expensive item."

The high court rejected Mr. Ward's second argument, that he had given timely notice of his disability to his employer. That should have been considered notice to Unum, because Management Analysis was acting as Unum's agent, he contended. The court disagreed.

Still, Jeffrey Ehrlich, Mr. Ward's lawyer, declared victory. The decision, he said, "is significant because some courts have interpreted some of these cases as imposing a rigid, three-part test as to what constitutes 'the business of insurance' and hence what the states could do to regulate insurance."

Labor Secretary Alexis Herman called the decision "an important step forward in the effort to protect patients' rights." In a statement, she said, "This decision means that more people covered by their employers' benefit plans will have the protection that state insurance laws provide and which they deserve." (*Unum Life Insurance Co. of America vs. Ward*)

Separately, the Supreme Court may decide, perhaps as early as next week, whether it will review a decision concerning whether the Food and Drug Administration has regulatory jurisdiction over tobacco. The federal court in Greensboro, N.C., had said the FDA has such authority, but the decision was reversed by the Fourth Circuit Court of Appeals in Richmond, Va.

News Release

U.S. Department of Labor

Office of Public Affairs
Washington, D.C.

OFFICE OF PUBLIC AFFAIRS

CONTACT: MYRA DANDRIDGE
PHONE: (202) 219-8211

USDL: 99-106

FOR RELEASE: IMMEDIATE
TUESDAY, APRIL 20, 1999

STATEMENT OF SECRETARY REGARDING TODAY'S SUPREME COURT DECISION

"Today's unanimous Supreme Court decision is an important step forward in the effort to protect patients' rights. This decision means that more people covered by their employers' benefit plans will have the protection that state insurance laws provide and which they deserve.

"ERISA, the federal law governing employee benefits, is too often interpreted as wiping out protections provided by state insurance laws. Today's decision moves us closer to the goal of ensuring that America's working families can rely on the benefits they were promised.

"The Court was not required in this case to take the added step of also preserving remedies provided under state laws for workers and their families who have been harmed by health plan decisions. But the Court did note this Administration's view, expressed in our friend of the court brief, that ERISA should not be read to prevent these state remedies from applying, as it often is was under the *Pilot Life* decision. The Court left the door open for us to present this argument again.

-more-

"We will continue to protect patients' rights in courts around the country. However, even with better understanding of federal law, tens of millions of Americans in self-insured plans who are not covered by state insurance laws will still be without remedies unless new and long-overdue Federal legislation is passed. Only strong patient protection legislation can truly achieve that goal."

Note to Editors

ERISA governs approximately 2.5 million private sector health plans, covering 123 million Americans. It is the federal law intended to protect the health and pension benefits that employers voluntarily provide to their workers.

In 1986, the government argued to the Supreme Court in the Pilot Life case that ERISA barred the states from establishing procedures and remedies for enforcing claims for health care benefits because ERISA set forth the exclusive procedure for doing so. The brief filed by the government in November departs from the views expressed in Pilot Life. In this Administration's view, ERISA should not be read to restrict the states' ability to provide insurance remedies for employees or their dependents who have been denied benefits by their employers' health care plans. In this case, the government's brief alerted the Court that the government's views regarding preemption have changed, and that we have serious doubts about the reasons stated in the Pilot Life decision for the Court's ruling.

Patients' Rights in the 50 U.S. States
Description of Planned Report

Summary

The report will demonstrate the need for federal patients' rights legislation by illustrating the patchwork, incomplete nature of patients' rights today. It will:

1. **Document gaps and variations in state patients' rights laws.**
2. **Illustrate state-by-state enrollment in self-insured ERISA plans (which are outside states' regulatory reach).**
3. **Calculate a "Patients' Rights Index for each state, illustrating the large proportion of enrollees who are not currently guaranteed certain key rights.**

would be consistent w/ fam-USA how diff? what's the source? timing? we did s-b-s last year both ERISA and self-insured same #s!

Background

The Administration has called for legislation to guarantee patients' rights for all Americans. Currently, few rights are guaranteed under federal law. State laws provide varying levels of protection for some. But even these incomplete state patient protections laws do not apply to many Americans — namely, those enrolled in ERISA-covered, self-insured health plans.

Framework

The report will compare patients' rights today to 14 key guarantees included in proposed, comprehensive patients' right legislation (see listing at attachment 1). It will utilize new estimates of enrollment in self-insured ERISA plans by state to determine how many ERISA plan enrollees are or are not protected under current state patients' rights laws.

Structure and Content

The report will be organized into four major parts.

- Part 1 will summarize the 14 key rights and explain how ERISA blocks states from guaranteeing these rights to some enrollees.
- Part 2 will profile patients' rights in the nation. Bar graphs will show how many states guarantee each key right, how many enrollees are covered by each guarantee, and related

information (see mock-ups at attachment 2).

- Part 3 will examine cross-state variations in patients' rights. It will include U.S. maps ranking states according to how many rights they guarantee and how many resident ERISA plan enrollees are in self-insured plans and therefore outside their regulatory reach.

  Putting these concepts together, it will construct a "Patients' Rights Index," in which states providing all 14 rights to everyone score 100% and states providing no protections to anyone score 0% (actual scores are likely to range from 10% to 70%). (See mock-ups at attachment 3.)

  Finally, for each of the 14 key rights, it will include one or more separate U.S. maps showing cross-state patterns.

- Part 4 will consist of 50 state fact sheets. Each fact sheet will give the state's score and rank, and detail how the state stands with respect to each of the 14 key rights. See mock up at attachment 4.)

The report will also include an Executive Summary, and an Appendix containing detailed tables and explanations of estimates and analytic methods.

Attachment 1

Key Patients' Rights Protections

1. **Coverage of Emergency Services Under Prudent Layperson Standard**: Plans that provide emergency care benefits must cover emergency care under a "prudent layperson standard" and must provide such coverage without requiring pre-authorization or applying network restrictions.

2. **Access to Specialists**: Plans must allow individuals in need of specialty care access to out-of-network specialists at no additional costs if the plan network is inadequate. For individuals with ongoing special medical conditions, plans must provide standing referrals to a specialist or allow the specialist to act as a primary care provider would in ordering treatment and coordinating care where appropriate.

3. **Access to Women's Health Care Providers**: Plans that require designation of a primary care provider must allow women to designate health care professionals who specialize in Ob-Gyn care as their primary care provider and must allow women who do not designate these professionals as their primary care provider to have direct access for routine or pregnancy care.

4. **Continuity of Care**: When a health care provider or health insurance coverage is terminated by the plan, the plan must provide individuals undergoing a course of treatment at the time of termination notice of the termination and continuity of care for a transitional period.

5. **Access to Prescription Drugs**: Plans that limit prescription drug coverage to a formulary must allow for exceptions from the formulary when a non-formulary alternative is medically indicated.

6. **Independent External Review**: Plans must allow individuals access to independent review of benefit determinations.

7. **Ombuds Program**: Individuals should have access to an ombuds program that will provide them with assistance in choosing among coverage options and negotiating health care claims. This program should be independent from the plan.

8. **Anti-Gag Rule**: Plans must not prohibit or restrict health care providers from communicating freely with patients regarding the patient's health status, medical care, or treatment options, or about the plan's utilization review requirements or financial incentives that could affect treatment.

9. **Prohibition on Physician Financial Incentives**: Plans may not make specific payments to induce physicians to limit medically necessary services.

10. **Protection for Provider Advocacy**: Plans may not retaliate against a health care provider because of a provider's use of, or participation in, a utilization review or grievance and appeal process.

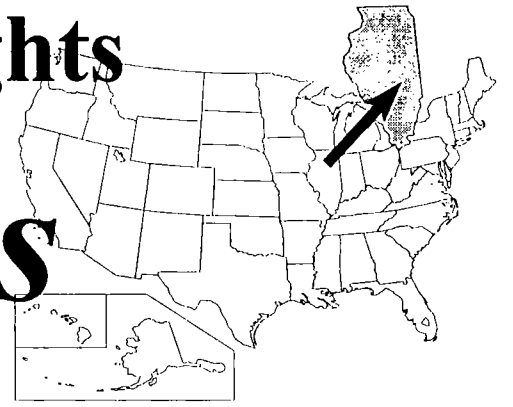
11. **Point-of-Service Option**: Plans that restrict access to providers to a closed network must offer individuals a coverage option that allows them to see a non-participating provider of their choice.

12. **Access to Clinical Trials**: Plans must allow individuals with life-threatening diseases who meet the criteria to participate in approved clinical trials.

13. **Information Disclosure**: Plans must disclose written comprehensive information about the plan, including benefits covered, coverage exclusions, and plan policies for exercising rights to benefits, in a clear understandable format to current and prospective enrollees.

14. **Nondiscrimination**: Plans may not discriminate against individuals in the delivery of covered health care services.

Patients' Rights in *Illinois*



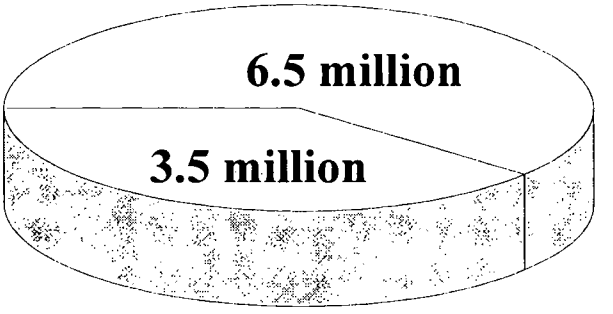
What is Guaranteed?

Rights guaranteed: 2 of 14
50-state average: 5.5

- ✘ Emergency coverage
- ✘ Access to specialists
- ✓ Access to OB-Gyns
- ✘ Continuity of care
- ✘ Access to drugs
- ✘ External review
- ✘ Ombudsman
- ✓ Anti-gag rule
- ✘ Physician incentives prohibited
- ✘ Provider advocacy protected
- ✘ Point-of-service option
- ✘ Access to clinical trials
- ✘ Information disclosure
- ✘ Nondiscrimination

Guaranteed for Whom?

Insured (guaranties apply)



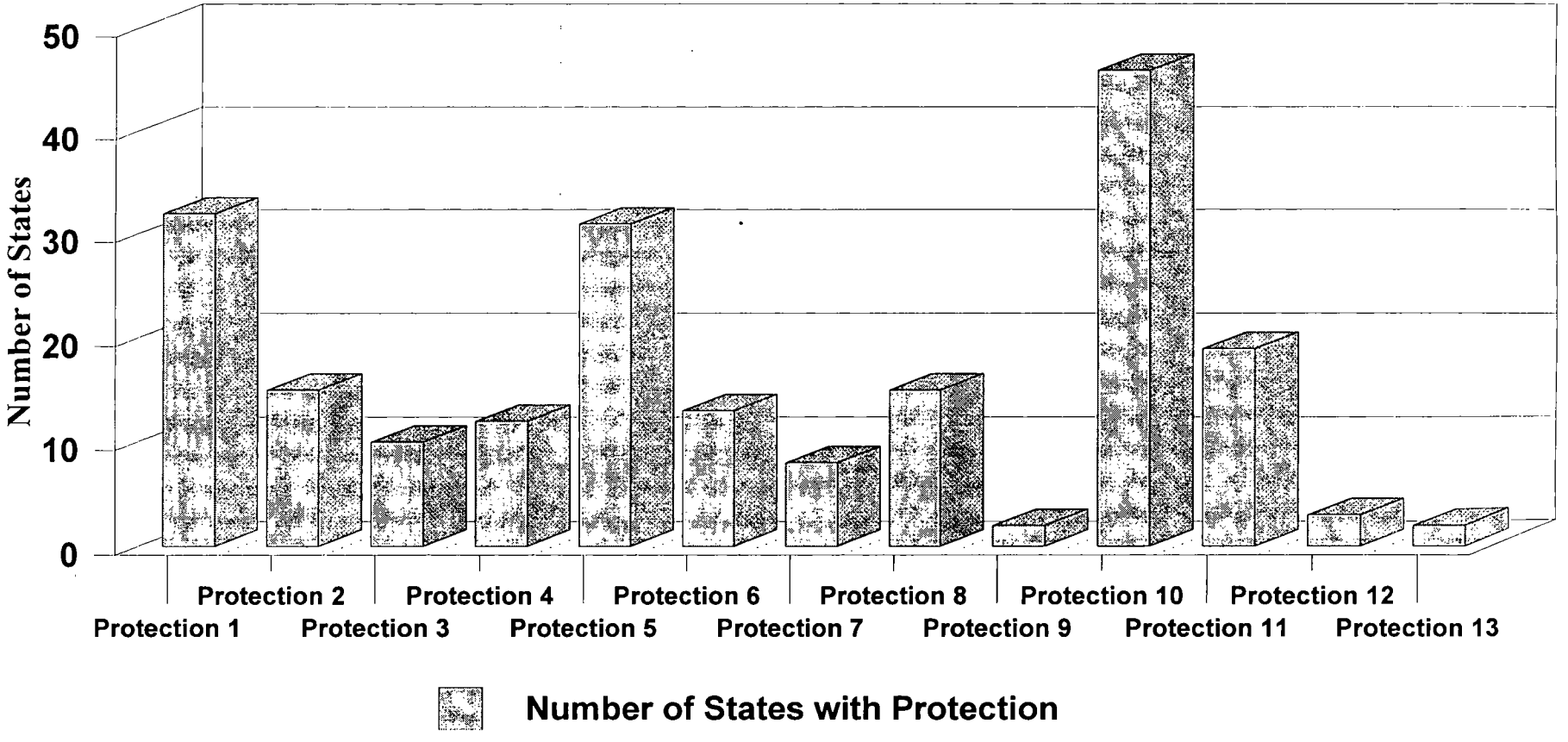
Self-insured (guaranties preempted)

% Self-insured: 35%
50-state average: 39%

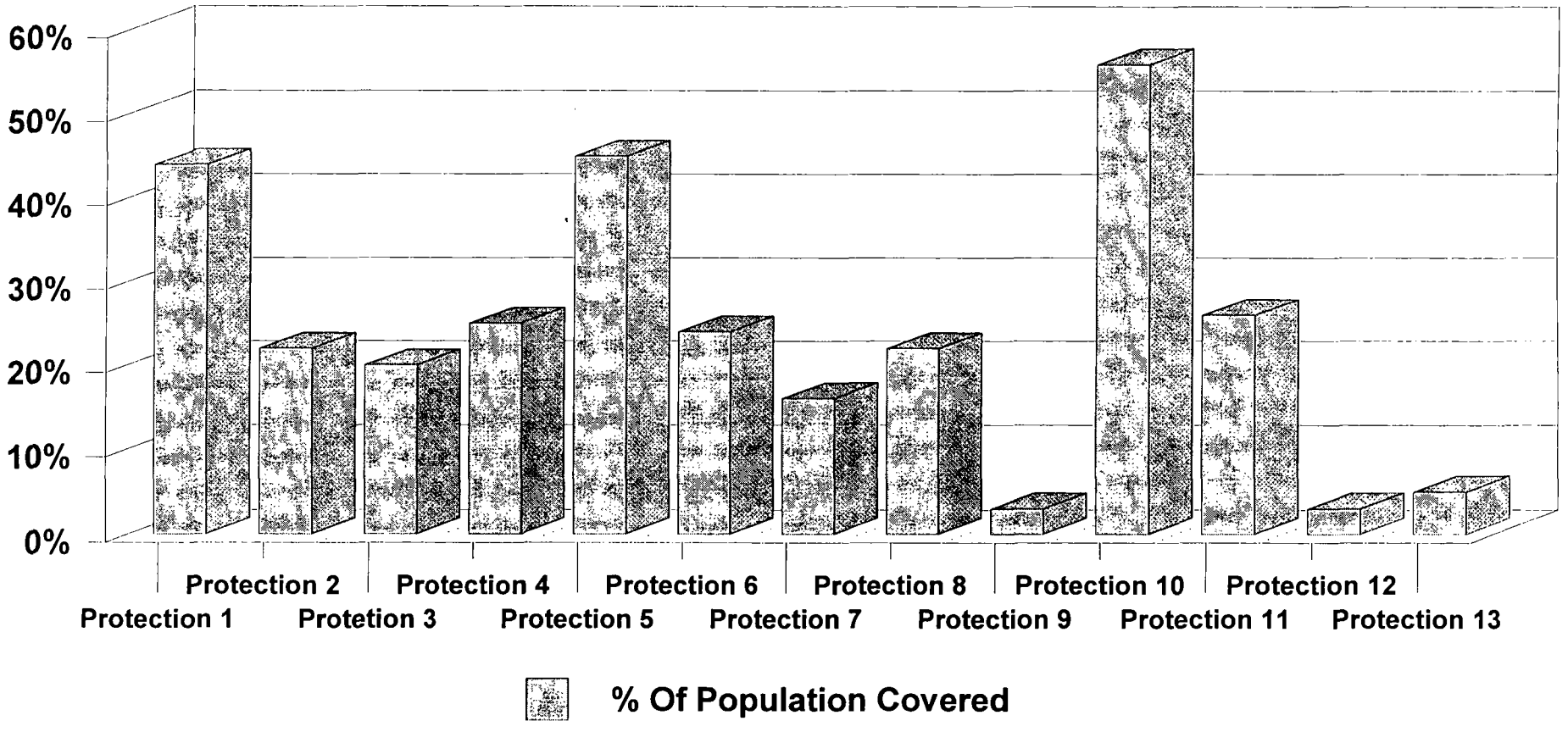
Patients' rights index 9%
50-state average: 22%
Illinois rank: 43 of 50

Not All Protections are Created Equal

Number of States Having Passed Specific Protections

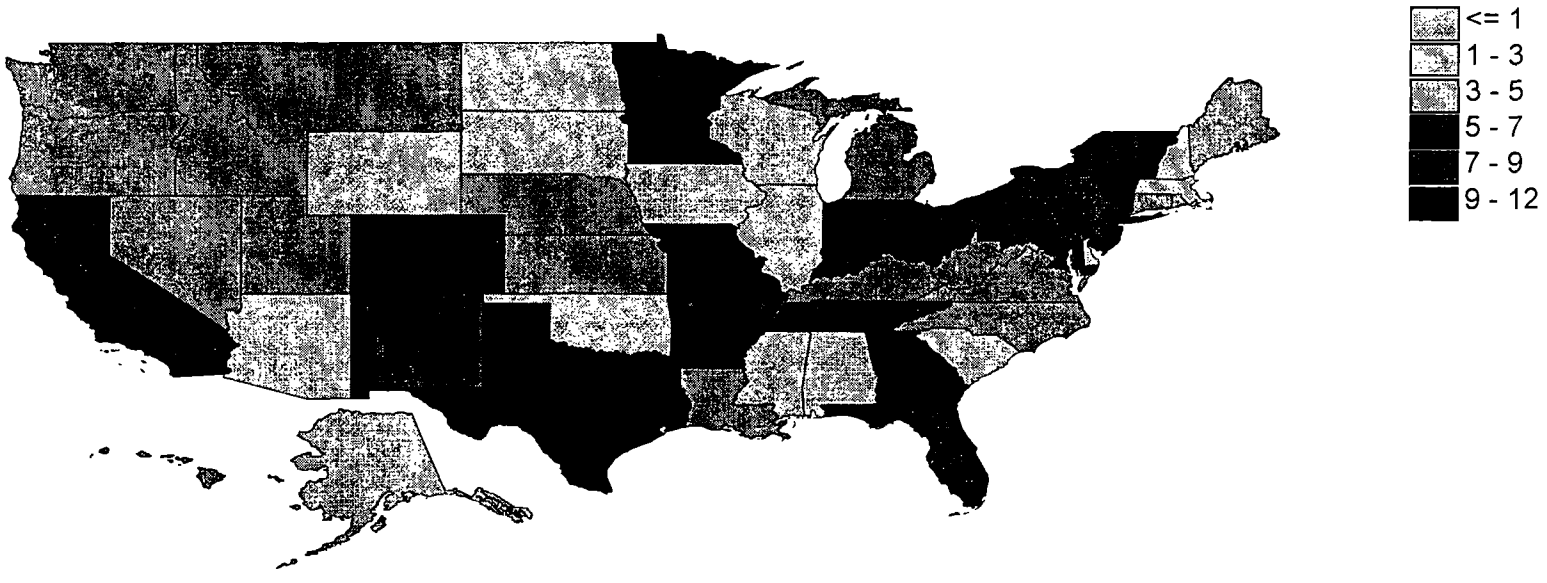


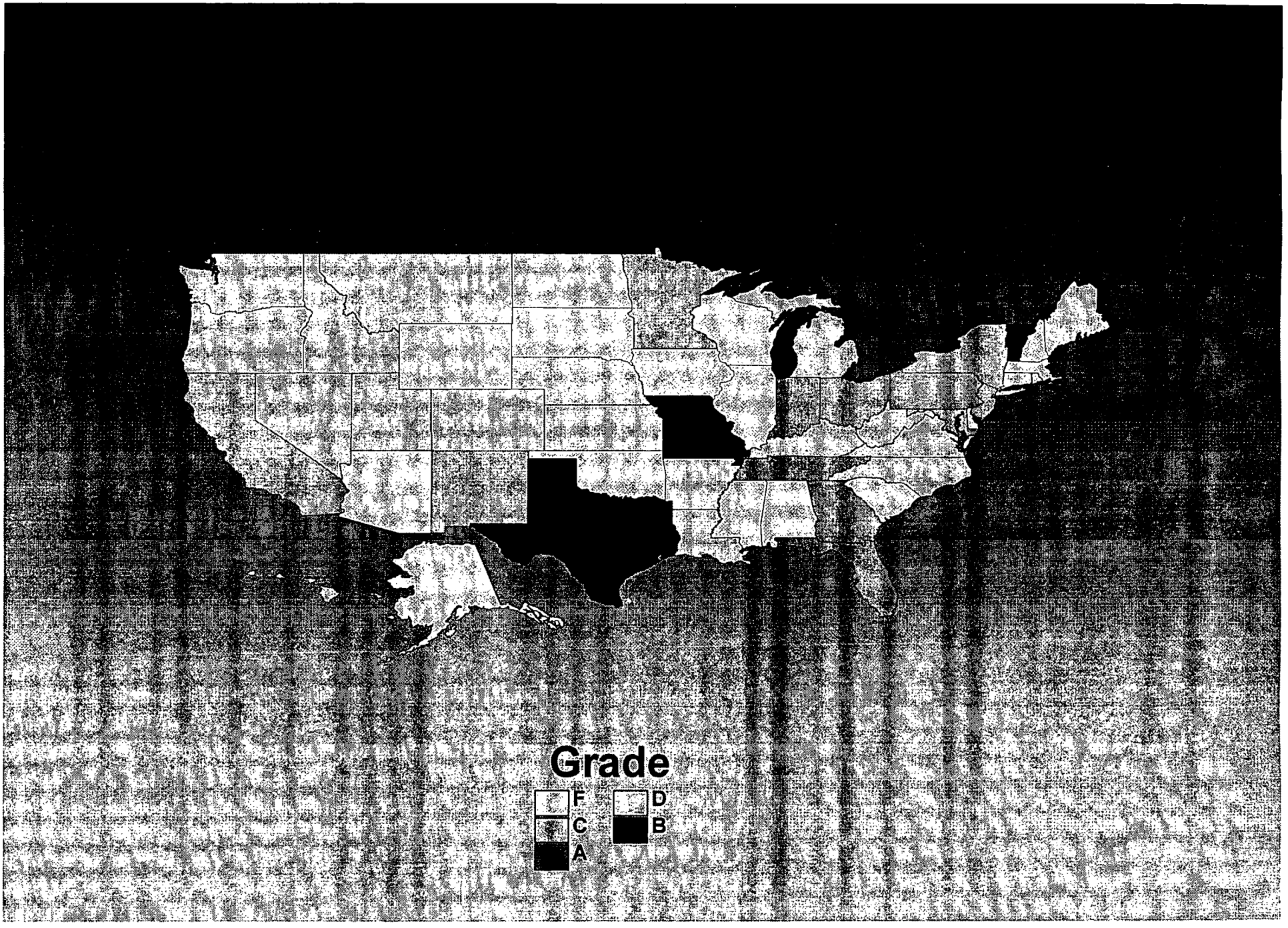
The Proprtion of the ERISA Population Covered Varies Along with the Number of Protections



Consumer Protections

Number of Protections




Grade
F
C
A
D
B

U.S. Department of Labor

Pension and Welfare Benefits Administration
Washington, D.C. 20210

Date: 5/24/99

TO: Chris Jennings

TELEPHONE: _____ FAX: _____

FROM: Leslie B. Kramerich
Deputy Assistant Secretary for Policy
U.S. Department of Labor
Pension and Welfare Benefits Administration
200 Constitution Avenue, NW - Room S 2524
Washington, DC 20210
(202) 219-8233 - voice
(202) 219-5526 - fax

COMMENTS: FYI

Should you experience any difficulties in receiving this transmission, please call (202) 219- 8233.

There are 6 pages including this page.

We Need a Federal Patients' Bill of Rights

America's workers deserve a strong and enforceable patients' bill of rights. As more and more health care becomes "managed care," all Americans must be assured that they will be treated fairly and provided quality health care when they need it.

Today, millions of American workers are without many basic rights. Despite considerable progress in recent years, State patients' rights laws remain incomplete, producing an uneven patchwork of protection. Where state laws do exist, federal law often blocks their application to the 127 million Americans who receive health benefits through a private-sector employer. More than 57 million Americans are not guaranteed any of ten basic patients' rights and none of the 127 million are assured of them all.

The only way in which Americans who receive health benefits through a private sector employer can achieve these rights is through the enactment of a strong and enforceable Federal Patients Bill of Rights.

To assess the need for a federal bill of rights, the Department of Labor compared current state laws with ten basic patients' rights (see box). The Department then estimated the number of residents in each state for whom federal law blocks the application of state laws. In this way, the Department was able to determine the extent to which American workers are currently guaranteed basic patients' rights.

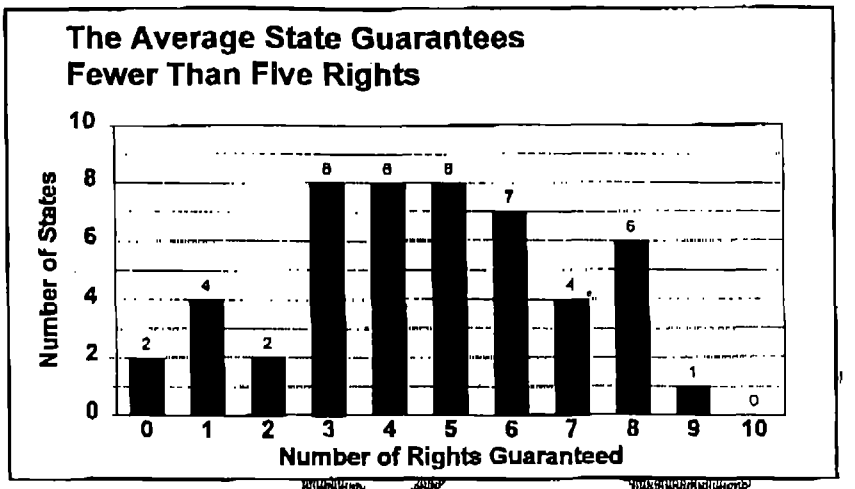
Ten Basic Patients' Rights All Americans Deserve

1. Fair coverage for emergency care.
2. Adequate access to specialty care.
3. Direct access for women to OB-GYNs.
4. An opportunity to select a "point of service" plan that will cover any doctor.
5. Freedom from harmful interference in the doctor-patient relationship.
6. Access to doctor-prescribed drugs.
7. Access to information.
8. Freedom from discrimination.
9. Independent review of decisions to deny care.
10. Meaningful compensation for wrongs.

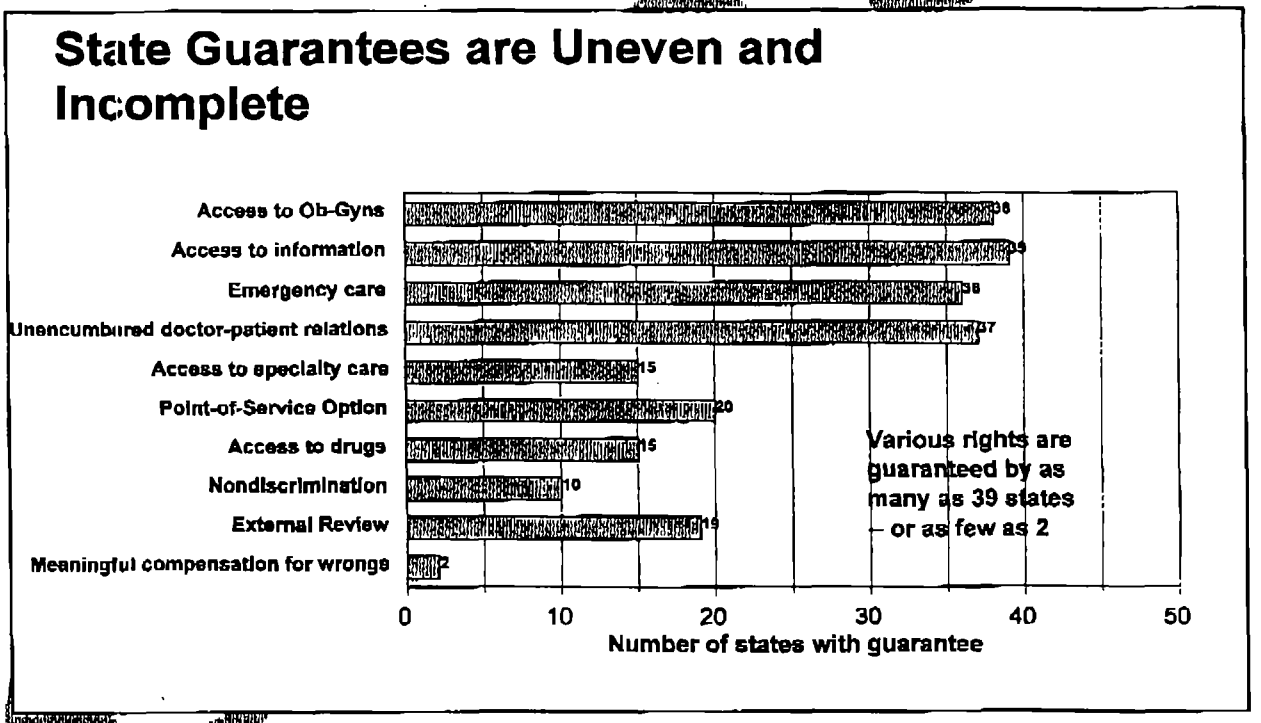
What the States Have Done

In response to the rapid growth of managed care states have, to varying degrees, enacted patient protection laws. Some states have successfully passed comprehensive laws while others have been more limited in their action. The result is a widely varying levels of protection. Workers' rights depend on where they happen to reside and for whom they happen to work..

Two states guarantee none of the basic rights, and just eleven guarantee seven or more. No state has enacted all ten basic patient protections. The average number of protections enacted by states is fewer than five of the ten.



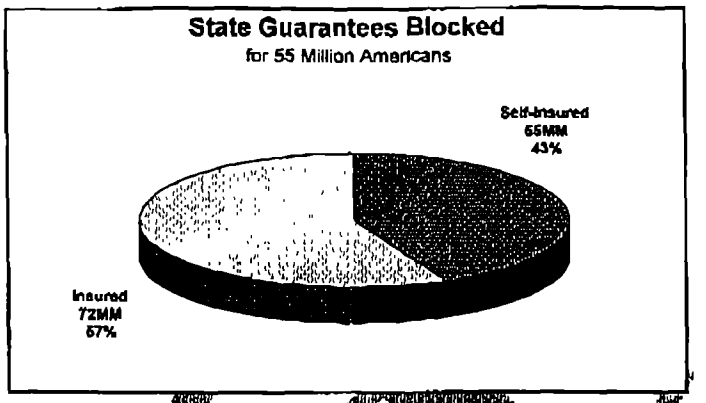
The most widely-guaranteed rights, which include the right to information, a woman's right to direct access to obstetricians and gynecologists, fair coverage for emergency care and freedom from interference in the doctor-patient relationship, are each guaranteed in 36 or more states. The remaining six rights are guaranteed in 20 or fewer states.



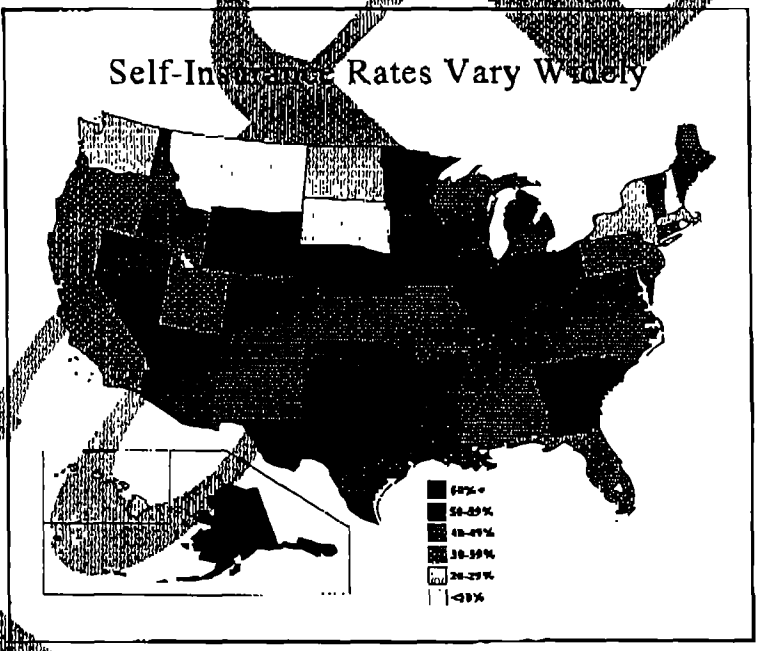
Why States Can't Do It All

Even if all fifty states enact laws providing the full breadth of patient protections, millions of workers will be without access to these rights. This is because health benefits provided by private employers are governed by the Employee Retirement Income Security Act, usually known as

ERISA. This federal law blocks states from guaranteeing rights for millions of workers.



Over the past 20 years, employers increasingly elected to "self insure" rather than to purchase state regulated health insurance policies. ERISA specifically places these arrangements outside of the reach of all state insurance and consumer protections laws. Recent data indicate that about 43% of those receiving health benefits from private-sector employers are now covered by such self-insured arrangements. ERISA effectively bars states from guaranteeing any of the ten basic rights for these 55 million people.



The extent to which employers self insure varies significantly across states. New data indicate that the proportion of the ERISA population in self-insured arrangements ranges from less than one in ten to more that two thirds of persons covered by a private-sector employer sponsored health plan.

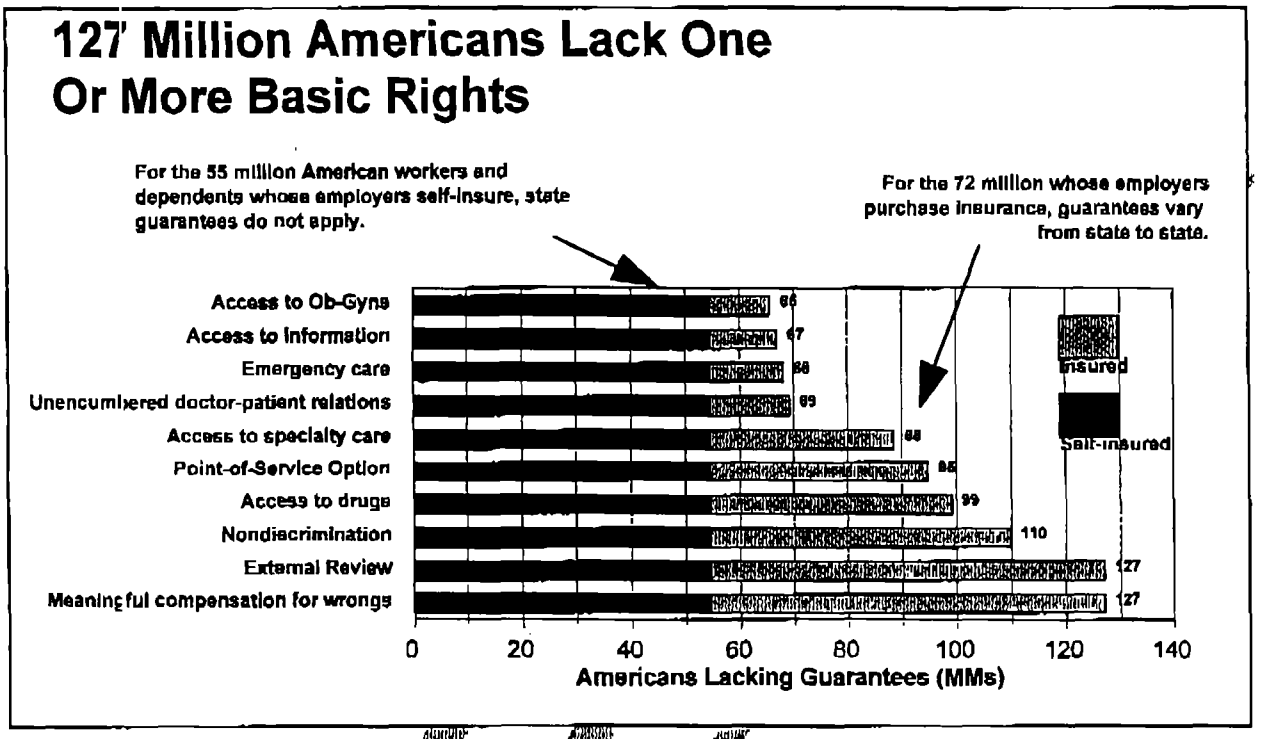
ERISA additionally may block states from guaranteeing two of the ten basic even for the 72 million covered by state regulated insurance policies. State guarantees of independent review and fair compensation of providers may not apply to all of 127 million Americans with health coverage from private-sector employers.

Millions Lack A Guarantee Of Each Basic Patients Right

Cross state variations in laws and rates of self insurance interact to create the current patchwork of patient protections. With all of those in self insured arrangements excluded from any guarantee of protections and most others lacking some significant elements of a complete bill of rights the average enrollee in an ERISA plan currently is guaranteed fewer than three of the ten basic rights.

Even the most widely guaranteed of the rights, women's access to obstetricians and

gynecologists, is not assured for more than 65 million people with private health insurance. With ERISA precluding the application of independent review and compensation laws even to those covered by state regulated insurance policies, the full 127 million remain without these basic rights.



A Federal Patients' Bill of Rights Would Cover Everyone

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. fax	re: Motion for judgement (10 pages)	04/07/1999	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20471

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

2012-0463-S
rc806

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]

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002a. report	re: motion for judgement (8 pages)	n.d.	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20471

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

2012-0463-S
rc806

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b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002b. report	re: medical incident history (17 pages)	n.d.	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20471

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

2012-0463-S
rc806

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President Clinton Announces That Federal Employee Health Benefits Plan Coming Fully Into Compliance with the Patients' Bill of Rights and Joins Democrats To Launch Petition Drive to Urge Congress to Pass a Strong Enforceable Patients' Bill of Rights

April 9, 1999

Today, President Clinton is announcing that the Federal Employees Health Benefits Plan (FEHBP) is coming fully into compliance with the patients' bill of rights by asking all 285 participating health plans to implement new patient protections through their annual call letter. The President made this announcement at an event in Philadelphia with House and Senate Democrats and major consumer advocates and provider organizations where they launched a nationwide petition drive in support of a strong enforceable patients' bill of rights. Supporters urged Congress to reject a watered-down, piecemeal approach to this legislation advocated by the Republican Leadership that would leave patients vulnerable, and urged the Congress to pass a strong enforceable patients' bill of rights to assure patients the protections they need. Today, the President is:

Announcing That Federal Health Benefits Plan Coming Into Compliance With the Patients' Bill of Rights for Only $.25 per year. The President announced that today the Office of Personell Management (OPM) that oversees FEHBP is sending out its annual call letter to the 285 participating health plans to notifying them that by the end of next year they will have to implement new protections, including continuity of care and information disclosure requirements. With these new protections, combined with the protections OPM implemented last year, (which included access to specialists, access to women's health specialists, and emergency room protections) FEHBP will be in full compliance with the patients' bill of rights. OPM has estimated that it will cost health plans only $.25 per year to come into compliance with the patients' bill of rights. The President underscored that most of the 285 plans that are coming into compliance for Federal employees without significant burden can offer these same protections for the private plans if Congress enacts legislation.

Launching a Nationwide Petition Drive In Support of the Patients' Bill of Rights. To urge the Republican Leadership to pass strong, enforceable legislation, today the President, Democratic Leaders, House and Senate Members over 100 major health care organizations are launching a nationwide petition drive in support of the patients' bill of rights. They announced that Americans will all be able to sign a national petition through dozens of web sites that will be centrally coordinated by Families USA. There are over XX events in XX districts around the country that are being held to help kick off this petition and urge the Republican Leadership to act.

Highlighted Strong Patients' Rights Legislation That Would Assure Patients the Protections They Need. The President and the Democrats have been calling for a patients' bill of rights for over two years. In 1996, the President appointed a Quality Commission and made its first charge developing a patients' bill of rights; in November of 1997, he accepted their patients' bill of rights and called on Congress to pass it into law. The Democrats introduced a strong patients' rights legislation in the last Congress and have reintroduced their proposal this year. A strong enforceable patients' bill of rights would include 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 to assure patient care if a patient's health care provider is dropped;
- Access to a timely internal and independent external appeals process;
- Assurance that doctors and patients can openly discuss treatment options;
- An enforcement mechanism that ensures recourse for patients who have been harmed as a result of health plan actions.

Criticized Watered Down, Piecemeal Approach Offered by the Republican Leadership. The President also highlighted the fact that the Senate GOP plan recently passed by the Senate Labor Committee, fails to include many basic consumer protections that will assure patients high quality health care. For example, it:

- Does not assure patients access to specialists
- Leaves ~~millions of patients~~ without protections, as it only applies to self-insured plans
- Fails to assure that patients do not have to abruptly change doctors in the middle of treatment.
- Does not provide patients who are harmed or die as a result of a health plans' actions adequate recourse.

Similarly, in the House, Speaker Hastert has indicated he may choose a watered-down, piecemeal approach. ~~Democrats are~~ ready to work to pass a real bill immediately so we can provide Americans with the critical patient protections they have been waiting for -- for far too long.

UNITED STATES DEPARTMENT OF LABOR

FACSIMILE TRANSMISSION

OFFICE OF CONGRESSIONAL AND INTERGOVERNMENTAL AFFAIRS

200 Constitution Avenue,
N.W.
Room S-1325
Washington, DC 20210

Confirmation:
202/219-6141

To: Devora

DEPARTMENT/COMPANY:

FACSIMILE NUMBER: 456 5557

FROM: SHAMINA SINGH

NUMBER OF PAGES INCLUDING COVER: 3

FACSIMILE REPLIES: CONGRESSIONAL AFFAIRS 202/219-5736

MESSAGE:

FYI - LA event - Please

Let me know if you have any +P's

we could look at...

PATIENTS' BILL OF RIGHTS
PRESS CONFERENCE/RALLY

LOS ANGELES COUNTY-USC HOSPITAL
1200 North State Street, Los Angeles, CA.
April 9, 1999

Tentative Agenda

Meet & greet
8:15am Secretary Herman greeted in parking basement by Rep. Grace Napolitano and Xavier Becerra. Walk up stairs to hospital foyer for brief meet and greet with SEIU Local 660 Stewards and select members.

Front Steps of Hospitals

I. (8:40) Welcome
Dr. Ronald L. Kaufman, LAC+USC Chief of Staff

II. (8:43) Introductions
Grace F. Napolitano, U.S. Representative (D-34th)

III. (8:45) Alexis Herman, U.S. Secretary of Labor

IV. (8:50) Congressional Democrats: Members talking points, Patients' Bill of Rights

(8:50) Xavier Becerra Speaks on Bill of Rights
(Incorporate story of victims #2. Victims standing near.)

(8:55)Grace Napolitano Speaks on Bill of Rights
(Incorporate story of victims #1. Victims standing near.)

Napolitano introduces Annelle Grajeda

IV. (9:00)Annelle Grajeda, General Manager, SEIU Local 660
-County Worker

Napolitano introduces Angie Millan

(9:05) Angie Millan, Rn, MSN, President, L.A. Chapter of National Organization of Hispanic Nurses

V. (9:08)Close: Grace Napolitano

VI. (9:10-9:30) Press Availability (in designated area to the side)

Rally Attendees: 100-150

SEIU Local 660	LAC+USC Medical Students
SEIU Local 434	Joint Council of Interns and Residents (JCIR)
SEIU Local 535	

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e-mail: grace@mail.house.gov
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COMMITTEES:
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SMALL BUSINESS
TAX, FINANCE AND EXPORTS

Congress of the United States
House of Representatives

GRACE F. NAPOLITANO
34TH DISTRICT OF CALIFORNIA

April 7, 1999
UPCOMING EVENT ON April 9, 1999

MEDIA CONTACT: MICHAEL J. TORRA
PHONE: (323) 728-0112

MEDIA ADVISORY

U.S. LABOR SECRETARY ALEXIS HERMAN AND MEMBERS OF CONGRESS NAPOLITANO AND BECERRA HOLD PATIENTS' BILL OF RIGHTS PRESS CONFERENCE

Congresswoman Grace F. Napolitano will host a press conference in support of the Patients' Bill of Rights on the front steps of LA County + USC Medical Center's General Hospital, 1200 N. State Street, Los Angeles, at 8:30am on April 9, 1999.

The press conference will feature U.S. Secretary of Labor Alexis Herman, U.S. Representatives Grace F. Napolitano (D-Norwalk) and Xavier Becerra (D-Los Angeles), and SCIU Local 660 General Manager Annelle Grajeda. The Hispanic Nurses Association President and a high-level staff member of LA County + USC will also participate.

The press conference, which is expected to last 30 minutes, will be immediately followed by press availability with the Labor Secretary and Members of Congress.

In the event of inclement weather, the press conference and availability will be held in the foyer to the lobby of the General Hospital (at the top of the steps).

- - END - -