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001a. bio	re: personal medical (partial) (1 page)	04/06/1999	P6/b(6)

COLLECTION:
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Domestic Policy Council
Devorah Adler
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FOLDER TITLE:
PBOR [Patients' Bill of Rights] [Folder 2]

2012-0463-S
rc807

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]

July 14, 1998

PATIENT'S BILL OF RIGHTS ROUND TABLE DISCUSSION

DATE:	July 15, 1998
LOCATION:	American Medical Association
BRIEFING TIME:	1:15 pm - 1:45 pm
EVENT TIME:	2:00 pm - 3:00 pm
FROM:	Bruce Reed/Chris Jennings

I. PURPOSE

To highlight your commitment to pass a strong, enforceable Patient's Bill of Rights and to hear first hand accounts on the need for federal legislation. You will also announce that the Veteran's Administration is taking new steps to implement an external appeals process for the 3 million veterans they serve.

II. BACKGROUND

You will chair a round table discussion with doctors, nurses, and family members of patients around the nation who highlight the critical need for Congress to pass a strong enforceable patients' bill of rights this year.

This event will be hosted by the American Medical Association, which strongly supports pass an enforceable patients' bill of rights and has endorsed the Dingell/Ganske/Kennedy legislation.

You will announce that the Federal government is continuing to lead the way in implementing the patients' bill of rights for the 85 million Americans in Federal health plans. You will announce that today the Department of Veteran Affairs is sending a letter to all veteran's health facilities stating that they are implementing an external appeals process for the 3 million veterans served by the VA. This new external appeals process builds on the other protections already in place at VA, including one of the most extensive internal appeals processes in the country. In February, you signed an Executive Memorandum to bring all Federal health plans, which serve 85 million Americans, in compliance with the patients' bill of rights.

There has been more activity on the patients' bill of rights in the last three days than in the last seven months. The House Republican Leadership is planning to release statutory language on their bill no later than Thursday. Senators Graham and Chafee intend to

release their proposal soon after the Senate Republican Leadership introduce their bill, which we just heard will occur tomorrow. The Hill is also holding two patients' bill of rights events in the next two days: tomorrow, they are holding a mock hearing in the morning with patients; and Thursday the Democratic Leadership and Congressman Ganske are participating in an event with you on the Hill to highlight the differences between the bipartisan legislation (Ganske/Dingell/Kennedy) and the Republican proposals.

Because the Senate Leadership will be unveiling their legislation tomorrow, you may be asked to comment on this proposal. Currently, we do not have the details of their legislation, except that we expect that it will have more patient protections than the House Republicans and a stronger enforcement mechanism. We will brief you on the substance of their proposal tomorrow. Although you will likely have to comment on the new Senate proposal, we would recommend you use tomorrow's event to emphasize the problems of managed care that the patients' bill of rights addresses, rather than the differences in various legislative proposals.

As you know, the legislation you have been calling for would include the following patient protections: 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 will not abruptly change if their provider is dropped; access to a timely internal and independent external appeals process for consumers to resolve their differences with their health plans; a limit on financial incentives to doctors; assuring that doctors and patients can openly discuss treatment options; assuring that women have direct access to an OB-GYN.

III. PARTICIPANTS

Briefing Participants:
Secretary Shalala
Bruce Reed
Chris Jennings

Event Participants:
Mary Kuhl, her husband died at age 45 after being delayed necessary heart surgery because the hospital that could perform the surgery was out of his network, even though doctor after doctor said no doctor in the health plan was prepared to do this surgery. By the time the surgery was finally approved, his heart had deteriorated too much to withstand surgery and his only option was a heart transplant. He died three months later while waiting for a heart transplant. The patients' bill of rights would have assured this man access to the specialist he needed in time to save his life.

David Garvey, his wife was in Hawaii on vacation when she was diagnosed with 'aplastic anemia'. Her HMO in Chicago would not allow her to receive the treatment she needed unless she returned to Chicago, despite the fact that the doctor caring for her in Hawaii said she should not be moved in this emergency situation. She flew back commercially to Chicago, and due to pressure changes had a stroke on the plane. As a result, she then developed a fungal disease which ultimately killed her 7 days later because she did not have the immune system to protect herself from contaminants in the airplane. It was later uncovered that the physician assigned to the case from the HMO also recommended the Ms. Garvey not be moved. However, 40 minutes after that recommendation was filed, that physician was transferred off the case and the new physician assigned recommended that she return to Chicago. This case highlights the need for a protection that assures that patients can be treated for an emergency when and where the need arises. Ms. Garvey was clearly in an emergency condition where she should not have been moved to an in-network hospital.

Mick Fleming, his sister, Rhonda Bast, was diagnosed with breast cancer, and then lung cancer. Her doctors prescribed a bone marrow treatment in conjunction with chemotherapy, which, after 3 months of review, the HMO denied. Mr. Fleming is a lawyer and became involved in his sister's review. After discovering that the HMO had been required to provide this coverage as part of its standard medical policy, Mr. Fleming sent a letter to the HMO requesting immediate review. Two weeks later, the HMO agreed that the treatment Ms. Bast was seeking was, in fact, covered under her policy and that discovered that the hospital allegedly contracted with the HMO received was not allowed to notify that the HMO covered this treatment. However, at this point 6 months had passed and her cancer had spread to her brain, and she was no longer eligible for the life-saving treatment.

Carol Anderson, Billing Manager for Oncology practice. Carol interacts with HMOs on behalf of patients nearly every day. She regularly submits requests for treatment recommended by the doctors in her office, and sees many of these treatments denied without any recourse for patients. She will discuss specific instances where denials have led to unnecessary suffering, including delays and denials that ended up costing a 12-year-old cancer patient his leg.

Dr. Jack Evjy, a Medical Oncologist and Ameritus Medical Director of the Holy Family Hospital Cancer Management Center in Methuen, MA, and Clinical Professor of Medicine, at Boston University School of Medicine in Boston. He is also President-elect of the Massachusetts Medical Society, which publishes the New England Journal of Medicine. Dr. Evjy has been an Oncologist for 30 years and will discuss the many patients he has seen that have been denied access to a specialist by their health plan.

Dr. Nancy Dickey, President of the American Medical Association. Dr. Dickey is a family physician and is the first women elected President of the AMA. She will discuss the AMA's support for a strong, enforceable Patient's Bill of Rights, as well as her personal experiences with patient's insured by managed care.

Beverly Malone, President of the American Nurses Association. She will discuss the impact she has seen on individuals denied the protections in the patient's bill of rights proposal. The ANA supports the passage of a strong enforceable Patient's Bill of Rights. Beverly served as a member of your Advisory Commission on Quality and Consumer Protection.

Seated at table without speaking role:
Secretary Shalala
Secretary Herman

Seated in Audience
Dr. Ken Kizer, Director of Veteran's Health Agency at the Veteran's Administration
Members of victims families
Counsel for victims
Members of the Board of the AMA

IV. PRESS PLAN

Open Press.

V. SEQUENCE OF EVENTS

- **YOU** will be announced into room accompanied by round table participants.
- AMA President Nancy Dickey will make welcoming remarks.
- **YOU** will deliver an opening statement.
- **YOU** will then call on participants to speak individually. You will have the opportunity to ask follow up questions for each participant. **[*Specific sequence attached.]**
- At the conclusion of the discussion, you will make informal closing remarks and thank Dr. Dickey, AMA President, for hosting the event.
- **YOU** will then briefly greet members of the audience and depart.

VI. REMARKS

Opening Remarks Provided by Speechwriting.

SEQUENCE FOR ROUND TABLE ON PATIENTS' BILL OF RIGHTS

- **Dr. Nancy Dickey**, AMA President, will make brief welcoming remarks.
- **YOU** will deliver opening remarks, and call on each participant to speak about their personal experiences with their health plan or in their role as health care providers.

Mary Kuhl, Kansas City, Kansas

Mary Kuhl's husband, Buddy Kuhl, died at age 45 after being denied necessary heart surgery because the hospital that could perform the surgery was not in his HMO's network. Months later, after several doctors recommended the same treatment, the health plan finally scheduled the surgery - but it was too late. He was no longer able to withstand the surgery.

Applicable patient protections:

- Access to specialists outside of a network when in-network specialists cannot provide the approved services.
- Information disclosure requirements to assure patients are aware of their benefits or any timely appeals process.
- No remedy for compensation under ERISA.

Suggested Question: You seem pleased with the doctors that treated your husband. Do you believe that the health plan was micromanaging your relationship with your doctors?

David Garvey, Chicago, Illinois

Mr. Garvey's wife, Barbara, was in Hawaii on vacation when she was diagnosed with 'aplastic anemia'. Her HMO insisted she be flown back to Chicago in order for her to receive treatment by a hospital within her HMO network, despite the pleading of the doctor treating her in Hawaii. She had a stroke on the plane and died one week later.

Applicable patient protections:

- Patients should be assured access to services out-of-the-network if there is not a sufficient in-network specialist available for a necessary treatment.
- Patients should have the right to emergency room services when and where the need arises.
- Patients should be assured that they are being told all of their treatment options not just the cheapest.

Suggested Question: Did your health plan give you confidence that your wife would be able to travel back to Chicago healthy?

Dr. Jack Evjy, Oncologist and Medical Director of the Holy Family Hospital Cancer Management Center in Methuen, MA, and Clinical Professor of Medicine, at Boston University School of Medicine. He is also President-elect of the Massachusetts Medical Society, which publishes the New England Journal of Medicine. Dr. Evjy will discuss the many patients he has seen that have been denied access to needed specialists by their health plans.

Applicable patient protections:

- Patients should have access to the specialists they need.

Suggested Question: ***You have been oncologist for 30 years, what do you do when an health plan refuses your request for a patient to see a specialist? Are there options? What are your greatest concerns when a patient is denied access to a specialist?***

Beverly Malone, R.N., President of the American Nurses Association.

Beverly Malone will discuss the impact she has seen on individuals denied the protections in the patient's bill of rights proposal. The ANA supports the passage of a strong enforceable bipartisan Patient's Bill of Rights. Beverly served as a member of the President's Advisory Commission on Consumer Protections and Quality in the Health Care System.

Suggested Question: ***Nurses are on the front lines of our nation's health care system. What impact do these types of experiences have on the confidence Americans have in their health care? How are the patients you are seeing being affected?***

Mick Fleming, Seattle, Washington

His sister, Rhonda Bast, was diagnosed with breast and lung cancer. After three months of reviewing her case the health plan denied her the bone marrow/chemotherapy treatment prescribed by her doctors, even though the treatment was covered under her policy. By the time they approved her claim, the cancer had spread to her brain and she could no longer withstand treatment. She died within a year.

Applicable patient protections:

- Timely and responsive expedite appeals process, so that these cases are resolved.
- Information disclosure so that patients know what benefits are covered and that they may have access to an appeals process.
- Had no remedy for compensation under ERISA.

Suggested question: ***Mr. Fleming you are well-educated as an attorney. Did you find it easy to navigate the system? Did you know all of the options that might be available to your sister? What do you think is the most important patient protection to ensure that your sister's situation does not happen to others?***

Carol Anderson, Billing Manager at Oncologist office.

Ms. Anderson requests authorization from health plans on a daily basis for treatments and sees numerous claims denied -- even when doctors are urging the treatment.

Applicable patient protections:

- Access to a timely appeals process when disagree with health plans decisions.
- Access to the specialists they need.
- Access to ob-gins.

Suggested Question: ***How many of the claims you submit are denied? How many are accepted the second time? What do you do when these people are denied the care they need or access to specialists?***

Participants for Presidential Round Table on Patients Bill of Rights
July 15,1998

Mary Kuhl, Kansas City, Kansas

The night of the Kuhl's 25th wedding anniversary, Buddy Kuhl had a heart attack. As a result of subsequent tests, his doctor discovered that he had Ventricular Tachycardia, which could be successfully treated through a specialized heart surgery. Buddy's doctor knew that the closest hospital with the appropriate equipment for this procedure was in St. Louis, and he scheduled an appointment for the surgery. The doctor also told them that Buddy was a candidate for sudden death and he needed the surgery immediately. One week before the surgery was to take place, the HMO notified Buddy that they had canceled the surgery appointment and had rescheduled him for an appointment with another physician in Kansas City for the same date. This physician also confirmed that Buddy needed immediate surgery and that St. Louis was the best place for the operation. This second physician called the HMO and confirmed that he needed to be scheduled for the surgery in St. Louis immediately. Unfortunately, the HMO waited two weeks for the physician to return from vacation so that they could obtain his request in writing. By the time Buddy arrived at the St. Louis hospital for his surgery, more than four months had passed, and the doctors were no longer able to operate on him because his heart had degenerated. They sent Buddy back to Kansas City and put him on the list for a heart transplant. He died in December waiting for a transplant. The survivors of Mr. Kuhl have remedy against the managed care plan under ERISA.

David Garvey, Chicago, Illinois

Mr. Garvey's wife, Barbara, was in Hawaii on vacation when she was diagnosed with 'aplastic anemia'. Her HMO in Chicago would not allow her to receive the bone marrow treatment she needed unless she returned to Chicago, despite the fact that the doctor caring for her in Hawaii pleaded that she should not be moved in her condition. Despite repeated calls by Mr. Garvey and Barbara's doctor in Hawaii, the HMO refused to cover her medical costs if she remained in Hawaii. She flew back commercially to Chicago, and due to pressure changes had a stroke on the plane. She then developed a fungal disease which ultimately killed her 7 days later because she did not have the immune system to protect herself from contaminants in the airplane. It was later uncovered that the physician assigned to the case from the HMO in Chicago also had recommended that Ms. Garvey not be moved. However, allegedly, after that recommendation was filed, that physician was transferred off the case and the new physician assigned recommended that she return to Chicago.

Mick Fleming, Seattle, Washington

Mr. Fleming's sister, Rhonda Bast, was diagnosed with breast and lung cancer. After taking three months to review her case, the HMO decided to deny Rhonda the bone marrow/chemotherapy treatment prescribed by her doctors. As a concerned brother and lawyer, Mr. Fleming undertook a thorough investigation of her situation and the health plan's policies and discovered that the treatment was covered under her policy. Ultimately, the HMO approved her claim, but by this time the cancer had spread to her

brain and she could no longer withstand the treatment. She died within a year. Because of ERISA, her husband and son had no remedy.

Carol Anderson, Billing Manager at local oncologist office.
Ms. Anderson requests authorization from health plans on a daily basis for treatments. She will discuss how claims are frequently denied access to a specialist -- even when doctors are urging the treatment. She has witnessed numerous cases where the denials by the HMO have lead to unnecessary suffering by patients.

Dr. Jack Evjy, a Medical Oncologist and Ameritus Medical Director of the Holy Family Hospital Cancer Management Center in Methuen, MA, and Clinical Professor of Medicine, at Boston University School of Medicine in Boston. He is also President-elect of the Massachusetts Medical Society, which publishes the New England Journal of Medicine. Dr. Evjy has been an Oncologist for 30 years, and he will discuss the many patients he has seen that have been denied access to a specialist by their health plan.

Dr. Nancy Dickey, President of the American Medical Association, Texas.
Dr. Dickey is a Family Physician and the first women to be elected President of the AMA. The AMA strongly supports passing a strong, enforceable Patient's Bill of Rights by the end of this year.

Beverly Malone, R.N., National President of the American Nurses Association.
Beverly Malone will discuss how nurses every day, on the front lines of our health care system, witness individuals denied the protections in the patient's bill of rights proposal. The ANA supports passing a strong, enforceable Patient's Bill of Rights this year. Beverly served as a member of the President's Advisory Commission on Quality and Consumer Protection.

PRESIDENT CLINTON ANNOUNCES FEDERAL HEALTH PLANS LEAD THE WAY AT AN AMA PATIENTS' BILL OF RIGHTS ROUND TABLE UNDERSCORING NEED FOR PASSING STRONG LEGISLATION
July 14, 1998

Today, at the American Medical Association (AMA), the President met with doctors, nurses, and families from around the nation who highlighted the critical need for Congress to pass a strong enforceable patients' bill of rights this year. The President of the AMA, Nancy Dickey, praised the President Clinton's leadership and pledged the AMA's continuing efforts to pass a meaningful patients' bill of rights before Congress adjourns. The President also announced that the Federal government is leading the way by implementing the patients' bill of rights for the 85 million Americans in Federal health plans. Today, the Department of Veteran Affairs announced that it is beginning its implementation of an external appeals process for the 3 million veterans served by the DVA. Today, the President highlighted that:

- **Doctors, nurses, families of patients, and benefits managers from around the country endorsed the critical need for Congress to pass a patients' bill of rights.** The individuals that met with the President in today's round table discussion with the AMA include: (1) a man from Chicago whose wife died after her HMO forced her to travel from Hawaii to Chicago in an emergency to be treated at an in-network hospital; (2) a woman from Kansas whose husband died because he was delayed and denied access to specialist for heart surgery until it was too late; (3) a man from Seattle Washington whose sister died after her health plan reversed a treatment decision it should have covered in the first place after it was too late for the treatment to be effective; (4) a Massachusetts oncologist who has seen countless patients who are denied access to the specialists they need; (5) the President of the American Nurses Association who spoke on behalf of thousands of nurses around the country who every day see the devastating health consequences for patients who have been denied access to specialists, or has an abrupt transition in care; and (6) a woman who reviews claims in an oncologists' office and has witnessed, again and again, health plans who deny patients access to the care they need.

- **While Congress delays passing legislation, the Clinton Administration is implementing the patients' bill of rights for Americans in Federal health plans, including unveiling a new external appeals process for veterans.** Today, the Department of Veteran Affairs is announcing that they are beginning the implementation of an external appeals process for the three million veterans served by DVA. This new external appeals process builds on the other protections already in place at DVA, including assuring patients full participation in treatment decisions, access to specialists, access to women's health services, preventing anti-gag clauses, preventing financial incentives to limit care, and one of the most extensive internal appeals processes in the country. In February, the President signed an Executive Memorandum to bring all Federal health plans, which serve 85 million Americans, in compliance with the patients' bill of rights.

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

Dan L. Crippen
Director

April 23, 1999

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

Dear Senator:

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.

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

Dan L. Crippen
Director

April 23, 1999

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

Dear Mr. Chairman:

At your request, the Congressional Budget Office (CBO) has prepared the enclosed cost estimate for S. 6, the Patients' Bill of Rights Act of 1999, as introduced (Star Print) on January 19, 1999.

CBO estimates that the ultimate effect, over a period of years, would be to increase premiums for employer-sponsored health insurance by an average of 6.1 percent. However, the sponsors have indicated their intention to clarify the bill in ways that could reduce the premium increase to 4.8 percent.

Sincerely,

Dan L. Crippen

Enclosure

cc: Honorable Edward M. Kennedy
Ranking Minority Member

Honorable Tom Daschle

Singh Shamina

Subject: FW: msg to devora
Importance: High

TO: Devora Adler 456-5557 (fax)
FROM: Shamina Singh per Leslie Kramerich

Quick Update:

-PBR: in the process of analyzing new House GOP bill with primary focus on internal/external review, preemption and remedies provisions...early read from dems is generally positive...GOP leadership not looking to mark up until October. AFL happy with whistleblower provision concerned with independence of external review process (along with Consumers Union and Natl Sr Citizens Law Ctr).

-Unum: draft Dear Colleague requested by Nexon -- will fax to you first.

-Reg: notice published in Federal Register with September final date.

Shamina Singh
202-219-6141 x. 45

THE PRESIDENT HAS SEEN
4-27-99

(202)225-6760 phone (202)226-0938 fax www.house.gov/democrats

Democ

Regional Press Report

April 13, 1999

Democrats Take Managed Care Reform Issue on the Information Highway and Interstate 95

National Clips:

APR 19 1999

- *New York Times*: **Clinton Urges Petition Drive to Pass Health Plan**, Saturday, April 10, 1999, page A11.
- *New York Times* Editorial: **Reconsidering Patients' Rights**, Saturday, April 10, 1999, page A26.
- *Washington Post*: **Clinton renews Drive for Patients' Rights**; Democrats Say Lobbyists for HMO's Have Been Swaying Votes of Hill Republicans, Saturday, April 10, 1999, page A4.
- *Washington Post* Editorial: **Managed Care: The Fine Print**, Friday, April 9, 1999, page A38.
- *Los Angeles Times*: **Clinton Pushes Patients' Bill of Rights**, Saturday, April 10, 1999.
- *The Hill*: **Philly Bound**, Monday, April 12, 1999, page 3.
- 3 *Associated Press* Stories: **Clinton Pushes Patients' Rights**, Friday, April 9, 1999.
- *Reuters*: **Clinton Presses to Expand Health Coverage Rights**, Friday, April 9, 199
- *Congress Daily*: **Clinton, Dems Launch Internet Health Reform Campaign**, Friday, April 9, 1999, page 1.

Regional Clips:

- *Philadelphia Inquirer*: **President touts Democrats' HMO bill**, Saturday, April 10, 1999, page A1.
- *Philadelphia Daily News*: **Plea for patients: President stumping for passage of HMO rights legislation in Congress**, Saturday, April 10, 1999, page A1.
- *Hartford Courant* (Rep. DeLauro): **Patient-Rights Campaign Employs Internet**, Saturday, April 10, 1999.

Reuters

Pushing his health care plan, President Clinton spoke yesterday in Philadelphia with Joan Bleakley, who lost partial sight and nearly died after her health care provider refused to pay for an aneurysm treatment.

Clinton Urges Petition Drive to Pass Health Plan

By KATHARINE Q. SEELYE

PHILADELPHIA, April 9 — With Congress reconvening next week, President Clinton flew here today to try to whip up public enthusiasm for the Democratic proposal to establish a "patient's bill of rights."

Mr. Clinton told a group of about 400 union workers and health care providers that he had advocated the patients program until he was "blue in the face," but he wanted the public to express its support by signing a petition on the Internet to counter the opposition of large health maintenance organizations and insurance companies.

"Unless there is a clear, unambiguous signal from the people of the United States — not just that we want this, not just that we need this, not just that we believe in this — the organized forces of the status quo will do nothing," the President said.

He said opponents were counting on the fact that today's public relations campaign, coordinated with 100

A plea for a 'signal from the people' to regulate H.M.O.'s.

Democrats in Congress across the country, would not be able to "break through on the evening news tonight because of Kosovo," and so the Republican-controlled Congress would not feel any pressure to pass the legislation, which is one of the Democrats' top priorities.

The Democratic proposal for new regulations on H.M.O.'s died last year with the 105th Congress. This year, a Senate committee has approved a Republican bill of rights, which Democrats say is not strong enough. Republicans say the Democratic plan is too expensive and overly restrictive.

Last year Mr. Clinton imposed some aspects of the Democratic bill, like access to specialists and emergency treatment, on the 285 private insurance companies that provide coverage for the nation's nine million Federal employees and their families. Today he announced he was requiring the plans to come into full compliance with the bill, meaning they must add two more provisions: give patients more information about their plan and their doctor's fees, and guarantee them continuity of care if they are in the middle of a treatment or pregnancy and are forced to change health plans.

Mr. Clinton said a yearlong study of the bill showed that its provisions would cost patients less than $10 a year on top of what they pay now, which varies by patient. He does not have the authority to extend to patients what could be the most expensive element of the Democratic proposal, the right to sue health plans and collect damages.

New York Times
Saturday, April 10th
Page A22

The New York Times

Founded in 1851

ADOLPH S. OCHS. *Publisher 1896-1935*
ARTHUR HAYS SULZBERGER. *Publisher 1935-1961*
ORVIL E. DRYFOOS. *Publisher 1961-1963*
ARTHUR OCHS SULZBERGER. *Publisher 1963-1992*

Reconsidering Patients' Rights

Just about everyone on Capitol Hill professes interest in producing legislation that protects patients from unfair health insurance practices. But the prospect of actually passing meaningful protections, as opposed to talking about it, is uncertain. President Clinton tried to whip up support for Democratic proposals yesterday, but the Republicans are balking at Democratic plans as too burdensome on the managed-care industry.

Yet it is the Democratic proposals that more fully reflect the recommendations of a Presidential advisory commission to improve health plan quality. The Senate Republican bill, S. 326, sponsored by James Jeffords of Vermont, is too limited to accomplish that purpose. The bill, which was approved by the Senate Health, Education, Labor and Pensions Committee on a straight party-line vote of 10 to 8, contains some consumer protections. It includes provisions that require health plans to pay for emergency-room care if a prudent person has reason to believe an emergency exists, allow patients to go directly to gynecologists and pediatricians, and safeguard medical privacy. But it is unacceptable because most of its provisions would apply only to 48 million individuals covered by plans in which large employers act as their own insurers, leaving 110 million people in other plans unprotected.

The bill would grant appeal rights to an additional 75 million privately insured individuals, but those rights would be quite restrictive. Appeals to an external reviewer would be allowed only when an insurer refused to pay for a procedure on the grounds that it was not medically necessary or was experimental. Critics say this would give health plans power to limit appeals by simply asserting that a denial is not based on medical necessity. It would exclude appeals where a plan unilaterally decided that the benefit was not covered under the contract, even if medical judgment was involved in that contract interpretation. The external reviewer may also be bound by the plan's own definition of medical necessity, however narrow it may be.

The Republican bill does not adequately insure access to specialty care by allowing a patient to see an out-of-network specialist if the plan has an insufficient number of specialists available. Unlike the Democratic plan, it does not amend the Federal Employee Retirement Income Security Act to give enrollees the right to sue health plans provided through employers for injuries caused by improper denials of care. Current law allows for no meaningful recovery.

Both the Senate Democratic proposal, which has White House support, and a bipartisan bill sponsored by Senators John Chafee, Joseph Lieberman, Bob Graham, Arlen Specter and Max Baucus would be substantially stronger in allowing external review of coverage disputes, in defining "medical necessity," and in giving enrollees greater rights to take health plans to court.

The insurance lobby is already embarked on a media blitz to defeat any new regulations as too costly. But consumer protections under the Democratic plan would increase health plan costs by only a tolerable 2.8 percent, according to Congressional Budget Office estimates made last year, or slightly more if lawsuits against Erisa plans are permitted in state court. Health plans should be made to deliver what they promise their enrollees, and held accountable when they fail.

Clinton Renews Drive for Patients' Rights Bill

Democrats Say Lobbyists for HMOs Have Been Swaying Votes of Hill Republicans

By CHARLES BABINGTON
Washington Post Staff Writer

PHILADELPHIA, April 9—President Clinton and congressional Democrats hit the road today to pressure Republicans into expanding the rights of patients when dealing with health insurers, an issue on which Democrats believe public opinion is on their side.

Clinton traveled to this birthplace of American independence to renew his call for a Democratic-backed "Patients' Bill of Rights," which would give consumers several new powers, including the right to sue health maintenance organizations for decisions to deny what patients regard as needed care.

Taking a break from the war in Yugoslavia to deal with a favorite domestic issue, the president portrayed Congress's GOP leaders as captives of the insurance industry.

"This is not a partisan issue anywhere in America but Washington, D.C.," Clinton told about 300 people at Philadelphia's 123-year-old Memorial Hall. "That's because the people who are against it—basically the large HMOs, the insurers—have got the ear of the congressional majority. And they have a lot of political influence."

Congressional Republicans lashed back, saying Democratic proposals on patients' rights would add costs and bureaucracy to the health care system. "Republicans are determined to improve the quality, affordability and accessibility of health care in America today," said Rep. J. C. Watts (Okla.), chairman of the House Republican Conference. "But first Congress must do no harm."

Clinton's appearance here, coupled with other Democratic rallies and the launching of an Internet petition drive, were intended to boost the Democratic vision of how to protect patients who belong to HMOs—an issue that has stirred considerable interest, and divisions, on Capitol Hill.

Last year the House adopted a more limited GOP "patients' rights" measure, while the Senate squabbled over the question for months without voting on it.

This year the Senate Health, Education, Labor and Pensions Committee already has passed a Republican bill, which does not include a patient's right to sue an HMO. House Speaker J. Dennis Hastert (R-Ill.), a main architect of the legislation approved by that chamber last year, also has pledged to revive the issue.

Major health insurers and employers argue that expanded patients' rights would significantly drive up the cost of health care. But Clinton and congressional Democrats tried to counter such criticisms by citing what the president said was the minimal impact of patient protection measures on insurance costs for federal workers.

About 285 companies provide health coverage for more than 4 million federal workers and their dependents, or 9 million people. Clinton said a new study by the Office of Personnel Management has concluded that those employees will pay only $10 a year more in premiums to gain several of the main benefits called for in the Democratic legislation.

Last year the Clinton administration mandated a number of patient protections for federal employees, including such measures as allowing pregnant women and persons with chronic health problems to retain their doctor even if they have to change health providers.

The new rights for federal employees, however, do not include the right to sue a managed care company for damages allegedly caused by its decisions on medical coverage, a point glossed over in Clinton's speech.

The American Association of Health Plans said today the $10 increase cited by Clinton is misleading because the new protections for federal workers do not address either malpractice suits or the question of who decides medical necessity. The AAHP estimates each of those provisions would increase the yearly price of insurance by an average of $200 per person.

BY SCOTT APPLEWHITE—ASSOCIATED PRESS

President Clinton, speaking in Philadelphia, said patients' rights legislation is "not a partisan issue anywhere in America but Washington, D.C."

Appearing with Clinton was Joan R. Bleakley of Woodbridge, Va., who lost her left eye because of what she says was an unwarranted delay in proper treatment by her HMO. Bleakley, wearing an eye patch, told the audience that her aneurysm was first misdiagnosed as a "small stroke," and her HMO forced her to wait three weeks before seeing a neurologist.

Staff writer Amy Goldstein in Washington contributed to this report.

The Washington Post

AN INDEPENDENT NEWSPAPER

Managed Care: The Fine Print

SENATE REPUBLICANS have produced a managed care reform bill that sounds much the same as the Democratic alternative. But the fine print that determines whether a bill is strong or weak is different. The clearest example lies in the part having to do with so-called external appeals. To help ensure fairness, both the Republican and Democratic proposals would require health care plans to set up first an internal and then an external appeals process to which patients who felt they had been unfairly denied care could turn. Because in theory they would be impartial, and in most cases their decisions would be final, external panels would play an important role.

The Republican bill would limit that role in ways the Democratic proposal would not. It would have the insurance plan choose its own outside reviewer. How independent the reviews would then be is unclear. The bill is also written in such a way that many coverage decisions would be exempt from review, and the reviewers would be limited to narrow questions. The most important difference has to do with the standard of appropriate care that plans either would, or would not, be required to meet.

One limit in most insurance plans is that they will pay only for what is medically necessary. Both these bills pick up that term, but the question then becomes, what does it mean? In times past, "medically necessary" tended to be whatever the doctor prescribed. Now, in the name of cutting costs, insurance and managed care companies often impose their own definitions. The Republican bill, according to its critics, is written to leave the insurers largely in control. The Democratic bill, by its critics, is written to shift control back to the doctors, or at least to create a presumption in their favor. It's odd to have the American Medical Association and some of the Democratic sponsors of this bill on the same side, but so they are.

Our sense is that the bill should give neither doctors nor controllers a free hand. A clumsily written provision could do great harm. If Congress feels the need to pronounce on medical necessity, it should probably do so in only the most general terms.

The cost containment that is the business of the managed care industry is not just an economic issue. The higher the price of health care is allowed to go, the larger will be the share of the population forced to go without. A seventh of the population already is uninsured. Congress needs to pass a forceful bill that will keep the cost controllers within bounds without putting them out of business. It's good news if the Republicans are prepared to join in.

Los Angeles Times

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DAILY
DESIGNATED AREAS HIGH

Clinton Pushes Patients' Bill of Rights

By EDWIN CHEN
and NANCY TREJOS
TIMES STAFF WRITERS

PHILADELPHIA—President Clinton on Friday renewed his call on the Republican-led Congress to enact a sweeping health care "patients' bill of rights," as he took an out-of-town break from monitoring the crisis in Yugoslavia.

Joined by more than a dozen House Democrats, the president told several hundred supporters at a rally in historic Memorial Hall here that the war in the Balkans is no excuse "to let this thing slide."

The bill, which would give patients the right to sue their health plans for withholding treatment, is stalled in Congress.

House and Senate Democrats staged rallies in 32 states and launched a nationwide petition drive to renew public support.

In Los Angeles, Secretary of Labor Alexis M. Herman, local politicians and health care professionals spoke as about 50 people carried signs that read, "Put patients first."

"Health care decisions belong back in the hands of patients and doctors, not insurance company administrators who are only watching the bottom line," said Rep. Grace Napolitano (D-Norwalk).

Steve Silen of Irvine clutched a picture of the 16-year-old daughter he lost to leukemia six months ago. He said that his daughter, Serenity, was misdiagnosed four times because her health maintenance organization was not willing to pay for a complete blood count.

"We saw a focus on money versus patient care," he said. "Children deserve to live."

Clinton made no effort to hide his frustration at the lack of progress on the legislation. "I've talked about this until I am blue in the face," he said at one point.

But House Republicans immediately fired back, arguing that the Democratic bill would mean, as House GOP conference chairman J.C. Watts Jr. of Oklahoma put it, "higher costs and more bureaucracy."

Arguing that the Democratic bill would expose employers to malpractice liability for the actions of doctors they do not supervise, Watts said: "If employers faced medical malpractice liability, health care costs would skyrocket, pricing many employers, consumers and families out of the health care market altogether."

Republican National Chairman Jim Nicholson argued: "When the trial lawyers say 'Jump,' President Clinton and the liberal Democrats ask, 'How high?' "

The partisan exchange came as Congress prepared to return to session next week after a two-week recess.

Both parties want to enact consumer safeguards for patients enrolled in health maintenance organizations, affording them greater protection against HMO practices that stint on medical care to increase profits.

But the parties differ on specific approaches, especially over the right to appeal HMO treatment decisions and whether consumers would be permitted to sue for damages, with Democrats favoring more stringent protections.

The insurance industry has resisted the Democratic bill, arguing in part that the legislation could cause insurance premiums and overall health care costs to soar, as they did at the start of the decade for other reasons.

But Clinton on Friday came armed with ammunition of his own. Noting that the federal employees' health insurance program already has instituted, at his direction last year, most of the provisions sought by the Democratic bill, Clinton said that a just-completed study by the Office of Personnel Management shows that the additional cost of those safeguards amount to less than $10 a year per enrollee.

"I think that's worth it," Clinton said.

Among those who flew here from Washington with Clinton was Rep. John D. Dingell (D-Mich.), sponsor of the Democratic bill. The measure fell short of House passage last summer by five votes.

Instead, House Republicans passed their own version of a "patients' bill of rights" but without conferring on consumers certain legally enforceable rights.

Chen reported from Philadelphia and Trejos reported from Los Angeles.

Monday, April 12
p. 3

PHILLY BOUND

Photo by Rebecca Roth

Connecticut Rep. Rosa DeLauro (far left) and other Democratic Members of Congress get ready to board a bus to join President Clinton at a Philadelphia rally promoting the Democratic health care reform plan on Friday.

CYBERCONGRESS

MICHAEL TEMCHINE

Rep. Rosa DeLauro (D-Conn.), with aide Jim Papa, starts on-line petition for the Patients' Bill of Rights Friday.

AP BREAKING News

Clinton Pushes Patients' Rights

By Terence Hunt
AP White House Correspondent
Friday, April 9, 1999; 4:29 p.m. EDT

PHILADELPHIA (AP) -- President Clinton portrayed Republicans as handmaidens of insurance and health-care companies today as Democrats launched a novel Internet petition drive to mobilize support for the ``patients' bill of rights."

``The people who are against it -- basically the large HMOs and the insurers -- have got the ear of the congressional majority, and they have a lot of political influence," Clinton charged in a speech in one of Pennsylvania's most Democratic congressional districts.

Across the nation, House and Senate Democrats staged rallies and speeches in 32 states to ask Americans to raise their voices by petition for new health-care rights.

Republicans warned Democrats against trying to ``poison" the health-care reform process with ``partisan rhetoric and political gamesmanship."

The most controversial, and most expensive, provision sought by Democrats would give patients the right to sue health plans and collect damages when they withhold treatment.

A modest crowd of perhaps a couple of hundred people had to strain to hear Clinton because of poor acoustics in historic Memorial Hall, built for the 1876 Centennial World's Fair in Philadelphia.

But Clinton delighted the audience as he attempted to imitate Italian movie director Roberto Benigni's heavily accented lament in accepting a second Academy Award that, ``This is a terrible mistake, because I used up all my English." Clinton used the same language to say that earlier speakers had said all that needed to be said at Memorial Hall.

The historic surroundings were chosen to invoke memories of the Declaration of Independence, the Constitution and the Bill of Rights. Clinton recalled that citizens of Philadelphia, in 1701, launched the first successful petition drive in the New World and won the right to practice any religion they chose.

Responding to Clinton's speech, Republicans said they have been working hard with Democrats to come up with an acceptable HMO bill.

"If there's a way to make health care more accountable to patients without raising costs and limiting access, we have a responsibility to do it, and do it this year," said Rep. John Boehner, R-Ohio, chairman of the House employer-employee relations subcommittee.

GOP presidential hopeful Steve Forbes criticized Clinton for wanting "to pile on all kinds of new rules and regulations" that would drive up the cost of health care.

"When the trial lawyers say 'jump,' President Clinton and the liberal Democrats ask, 'How high?'" Republican National Committee Chairman Jim Nicholson said.

Clinton said polls show that more than 70 percent of Americans support the health-care changes, but "the system in Washington is resisting it."

He said the Democrats' proposal would fail "unless there is a clear, unambiguous signal from the people of the United States."

Clinton said opponents were consoling themselves that the Democrats "probably can't break through on the evening news tonight because of Kosovo," and "that's another excuse we'll have to let this thing slide."

The president said new figures show his executive action last year extending HMO protections to federal employees and their dependents costs less than $1 per person per month.

The president lacks the power to unilaterally extend to federal workers the right to sue health plans and collect damages when they withhold treatment. Nor has Clinton required the plans to pay for "medically necessary" care, as determined by doctors.

But Clinton directed the government to proceed with plans to require federal workers' health plans to adopt two popular provisions:

--Mandatory release of information about customer satisfaction, the quality of doctors and hospitals and how doctors are paid.

--Allowance for patients to stay with their doctors for 90 days if the doctor is dropped from the network while patients are in the middle of a treatment or pregnancy.

----- Internet address for the petition is http://www.familiesusa.org/pbr/

BREAKING News

APRIL 08, 19:34 EDT

Clinton To Push Patients' Rights

By LAURA MECKLER
Associated Press Writer

WASHINGTON (AP) — Prodding Congress to pass a ``patients bill of rights,'' President Clinton will use a Philadelphia pep rally Friday to extend new health care protections to federal workers.

The president will also announce a new ``Internet petition,'' where computer users can register their support for new regulations that would mandate that HMOs and other managed care plans provide the same benefits to all covered patients.

Figures that Clinton intends to release show that a package of several new benefits for 9 million federal employees will cost less than $10 per person each year.

One of the new provisions requires health plans to release a host of information about how they pay doctors, customer satisfaction and the quality of doctors and hospitals.

The other requires plans to let patients stay with their doctors for 90 days, even if the doctor is dropped from the network, if they are in the middle of a treatment or pregnancy.

Clinton has already extended the same provisions to patients in Medicare and Medicaid.

The White House hopes that the real-life experience with federal workers will blunt GOP arguments that new requirements drive up costs. The 285 health plans that serve federal workers also serve private citizens, officials note, and they are providing these guarantees for just a few dollars.

``The world has not stopped turning,'' said Chris Jennings, Clinton's top health policy aide. ``The same things can be applied for all Americans.''

``Democrats are going to take this fight on the road,'' said Rep. Rosa DeLauro, D-Conn. ``We're going to use the latest technology, this information superhighway, to give voice to the people in this country.''

The most controversial — and most expensive — provision that Democrats are pushing would give patients the right to sue health plans and collect damages when they withhold treatment.

An equally contentious provision that would require health plans to pay for ``medically necessary'' care, as determined by doctors. Clinton doesn't have the power to unilaterally extend either of those provisions to the federal workforce.

But the administration already has required that health plans covering government workers pay for reasonable emergency room trips and allow patients to see specialists outside the network if needed and obstetricians-gynecologists without a referral.

A Senate committee approved a more limited HMO bill last month, but there's been no action in the House yet. Democrats complain that bill would cover only about 48 million Americans who are in health plans regulated solely by the federal government.

Opponents of new federal legislation complained that any increase in costs is significant for many Americans and said the Democratic bill would simply ``open the door to more lawsuits.''

``This helps trial lawyers who pocket most of the money, but does nothing to help patients get proper care when needed,'' said Dan Danner, chairman of the Health Benefits Coalition, which has run television ads in 19 states over the last two weeks.

The new petition Clinton is announcing is housed on the Web site of the consumer group Families USA. Up for about a week, it had more than 4,000 signatures Thursday afternoon.

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The Internet address for the petition is http://www.familiesusa.org/pbr/

Clinton Rallies for Patients Rights

By SANDRA SOBIERAJ
Associated Press Writer

WASHINGTON (AP) -- President Clinton and more than 100 Democrats are staging old-fashioned pep rallies and a newfangled Internet petition drive in this year's fight for the ``patients' bill of rights.'' The president was flying to Philadelphia today to renew his argument for new regulations on HMOs and other managed care plans. A dozen or more House Democrats were joining him by bus from Capitol Hill, where they were starting the day by unveiling a new Web site where computer users can sign a petition supporting the package.

Another 90 Democrats are fanning out across 32 states for their own campaign-style rallies. ``Democrats are going to take this fight on the road,'' said Rep. Rosa DeLauro, D-Conn. ``We're going to use the latest technology, this information superhighway, to give voice to the people in this country.'' Their no-holds-barred push for legislation that died in the Republican-led Congress last year is emboldened by Democratic gains in November's congressional elections.

``The patients' bill of rights is one of the president's highest priorities for the year, and given the changes in the Congress this year, we believe we have an excellent chance of getting a serious, real bill enacted,'' White House spokesman Barry Toiv said.

A Senate committee approved a more limited HMO bill on a party-line vote last month, but there has been no action in the House yet. Democrats complain the Senate bill would only cover about 48 million Americans who are in health plans regulated solely by the federal government.

Clinton headed to Philadelphia armed with new figures that show his executive action last year extending such protections to 9 million federal employees is costing less than $10 per person per year. The president was being joined at Memorial Hall today by Joan Bleakley of Woodbridge, Va., the latest person to be trotted out by the administration in its attempt to put a human face to the policy argument. Bleakley says she sustained permanent vision loss in one eye after her HMO delayed approval for her to see a specialist for what turned out to be a developing aneurysm.

Opponents of the legislation argue new regulations will drive up health costs and ``open the door to more lawsuits.'' ``This helps trial lawyers who pocket most of the money, but does nothing to help patients get proper care when needed,'' said Dan Danner, chairman of the Health Benefits Coalition, which has run television ads in 19 states over the past two weeks.

But White House officials contend that the 285 health plans that serve federal workers also serve private citizens and are providing these guarantees for just a few extra dollars. ``The same things can be applied for all Americans,'' said Chris Jennings, Clinton's top health policy aide. The president does not have the power to unilaterally extend to federal workers the most controversial -- and most expensive -- provision that Democrats are

pushing: the right to sue health plans and collect damages when they withhold treatment. Nor has Clinton required the plans to pay for ``medically necessary'' care, as determined by doctors.

But today, Clinton was newly requiring federal workers' health plans to adopt two popular provisions:

-- The mandatory release of information about customer satisfaction, the quality of doctors and hospitals, and how doctors are paid.
-- The allowance for patients to stay with their doctors for 90 days, even if the doctor is dropped from the network, if patients are in the middle of a treatment or pregnancy.

Requirements already in place -- for Medicare and Medicaid patients as well -- include the right to coverage for reasonable emergency room trips, the right to see specialists outside the network if needed and referral-free access to obstetricians-gynecologists.

The petition is housed on the Web site of the consumer group Families USA. Up for about a week, it had more than 4,000 signatures by Thursday afternoon.

Clinton Presses To Expand Health Coverage Rights

REUTERS

By LAURENCE MCQUILLAN, Reuters

Need to print or save the entire story? Select the long format.

PHILADELPHIA--President Clinton, hoping to pump new life into a stalled bid to expand health care protection under a "Patients Bill of Rights," urged Americans Friday to join a petition drive to overcome industry opposition.

"The political reality is that the system believes it can resist the opinion and the desire of the American people," Clinton said at a rally in Philadelphia, as Democrats kicked off a nationwide petition drive to build pressure on Republicans.

"The whole country is for it," Clinton said of the Democratic plan. "The system in Washington is resisting it and the people still rule if they will make their voices heard loud enough."

Clinton challenged critics who claim the Democratic plan would bankrupt employers, saying legislation now before Congress was similar to changes he ordered in the health benefits that cover federal workers. That coverage for 4.1 million people enrolled cost the federal government $29.5 million, and individuals an added $10 in premiums for one year.

White House officials said Clinton intended to press on with domestic issues, despite the fact that the war over Kosovo was consuming much of his attention.

In his speech, Clinton said he believed that critics of the Democratic health plan were hoping Kosovo would defuse the pressure for action on expanding protections. "That's another excuse we'll have for letting it slide," Clinton said of the bill's opponents.

Democrats around the country were leading a petition drive they hope will demonstrate a groundswell of support for the legislation and pressure Republicans into concessions as both parties prepare to stake out issues in next year's general elections.

"The people who are against it -- basically the large HMOs, the insurers -- have got the ear of the congressional majority, and they have a lot of political influence," Clinton said.

After falling victim to a partisan stalemate last year, the issue of patient rights has reemerged in what appears to be another party-line battle.

Both the Republican and Democratic bills deal with some of the biggest complaints that patients have made about HMOs and other managed care plans, including access to emergency rooms, greater access to doctors outside a specific health network and a grievance process when a health plan denies care.

Last year, a Senate Republican task force wrote a similar bill. Democrats produced an alternative, but the two sides were so far apart that they never even managed to agree on how to start the debate.

Clinton Presses To Expand Health Coverage Rights (cont'd)

The House did narrowly pass a different Republican bill last summer. House leaders want to revisit it this year.

The Democrats say the Republican plan has good slogans but not enough substance; Republicans say the Democrats devised an overly regulatory approach that will spawn lawsuits.

The two parties also disagree over how many people should be covered. The Republican plan, which leaves most regulation to the states, would affect the 48 million people covered under a particular type of nationally regulated insurance plan.

Democrats say that leaves 120 million people unprotected, because most states have not enacted a broad menu of patient protections. Clinton has been trying to build momentum for his domestic agenda, even as the NATO air war over Kosovo dominates the news. Earlier this week he devoted a White House event to equal pay for women and Saturday plans to use his radio address to deal with welfare-related issues.

"We have not forgotten the important domestic agenda," said presidential adviser Ann Lewis in Washington, adding, "this is a decision to open a second front."

NATIONAL JOURNAL'S
CongressDaily
SEARCH CONGRESSIONAL CALENDAR RECENT ISSUES
Friday, April 9, 1999

▶ HEALTH

Clinton, Dems Launch Internet Health Reform Campaign

As President Clinton today touted managed healthcare reform at a rally in Philadelphia, House and Senate Democrats across the country held more than 100 town meetings on the issue and asked people to sign an "Internet petition" calling for legislation. Before heading to Philadelphia to join the president, **House Minority Whip Bonior, Rep. Rosa DeLauro** of Connecticut and other House Democrats at a news conference in the Capitol called on House Republican leaders to schedule a vote on "genuine managed care reform." Democrats said House GOP reform plans are incomplete because they do not guarantee doctors will make medical decisions for patients, and do not give patients the right to sue their health insurer. "Democrats are committed to passing real managed care reform," Bonior said. "It will allow doctors to determine what is medically necessary — not an insurance company bureaucrat with no medical degree, no experience with a patient, no understanding of anything other than the company's bottom line." The Internet petition, which was "signed" by House Democrats at the news conference, is run by FamiliesUSA.

Meanwhile, **House Ways and Means Chairman Archer** is having the Joint Committee on Taxation score a proposal by the National Association of Health Underwriters that would give each adult an $800 credit per year, and each child $400 per year, to purchase health insurance. Every person would receive the credit, regardless of income, except Medicare and military beneficiaries. NAHU leaders today briefed congressional staff on their proposal. It would retain the employer-based system of health insurance, but also equalize tax breaks for individual buyers not receiving insurance from an employer. To help pay for the credit, the employer share of health insurance premiums or the cost of care for self-insured companies would be considered as unearned income to the employee, and thus would be subject to taxation. Other funding for the credit would come from reducing the amount of the credit for Medicaid recipients and reducing provider tax deductions for uncompensated care. NAHU officials said that, in addition to scoring by the JCT, a private firm also is scoring their proposal. An Archer aide confirmed the joint committee is scoring the proposal, but emphasized the referral does not mean Archer has endorsed it.

NAHU officials set the credit at $800 because, they believe, that level is high enough to induce uninsured individuals to purchase a policy without causing employers to abandon coverage they already provide to workers. Because the same credit would be available to everyone, the government would not have to set up a large bureaucracy to administer it, and there would be little incentive for people to "game the system" in order to qualify, NAHU officials said. The credit would not be paid to the individual, but would be sent directly to an insurance company, employer, or other organization maintaining the person's insurance account. Individuals could use the credit to buy their own insurance, or to pay the premiums of insurance provided by an employer. — *by Matthew Morrissey*

▶ THE FINAL WORD

"It's a defining political issue that will separate the sheep from the goats."

— ***Rep. Ted Strickland**, D-Ohio, speaking at a news conference today on managed healthcare reform.*

State Edition

The Philadelphia Inquirer

Health care brings Clinton to Phila.

AKIRA SUWA / Inquirer Staff Photographer

At Memorial Hall in Fairmount Park, President Clinton shakes hands with Joan Bleakley, who spoke to support the Democrats' version of a patients' rights bill. Among those applauding were Democratic U.S. Rep. Rosa DeLauro (left) of Connecticut and Mayor Rendell (right).

President touts Democrats' HMO bill

By Stacey Burling, Mark Davis and David O'Reilly
INQUIRER STAFF WRITERS

Without a mention of Kosovo, President Clinton breezed through Philadelphia yesterday to focus on a favorite domestic challenge: health care.

Flanked by Mayor Rendell and 15 ... abers of Congress, the President spoke briefly to an enthusiastic audience at Philadelphia's Memorial Hall about the need for strong new rules to regulate HMOs. He urged members of the crowd, most of whom were affiliated with groups that have actively supported Democratic reform proposals, to make themselves heard and sign an online petition launched yesterday on 40 Web sites.

"Don't you think it won't make a difference," he told the crowd of about 400 people, who were sitting on folding metal chairs under the soaring dome of the ornate, 123-year-old building.

"Stand up and be heard."

His appearance here was part of a nationwide campaign to focus attention on the Democratic version of the Patients' Bill of Rights, a proposed bill intended to strengthen protections for HMO patients. Throughout the country, about 90 Democrats staged events yesterday in 32 states to support the bill, which has been introduced in both houses of Congress.

Supporters in the crowd said they hoped all this attention gives the bill the momentum it needs.

"This is going to get the message to Washington that this is what we want," said Lory Chalk, a New Jersey nurse who belongs to Health Professionals and Allied Employees AFT/AFL-CIO.

Clinton wants a bill that includes better coverage for emergency-room visits, timely access to specialists, outside oversight of HMO decisions, continuity of care for patients whose doctors are dropped from

See CLINTON on A13

Clinton visits Philadelphia to tout patients' rights bill

CLINTON from A1

health plans, assurance that doctors can discuss all treatment options, regardless of cost, with their patients, and the right to sue managed care plans for damages.

Republicans have their own patients' rights bills, but speaker after speaker said yesterday that those are too weak.

Joan Bleakley, of Virginia, told the crowd that she believed she lost sight in her left eye because her HMO did not let her see a specialist quickly enough.

"Every day, families are being victimized by our current health-care system, and we cannot wait any longer to act," said Rep. Rosa DeLauro (D., Conn.).

Standing in front of a banner that read, "The *Real* Patients' Bill of Rights," Clinton said the protections outlined in the Democratic bill have wide support among people throughout the country, regardless of their party affiliation.

"This is not a partisan issue anywhere in America but Washington, D.C.," said Clinton, who has sought the legislation for two years. The Democratic bill failed to gather enough support last year, but Democrats, fueled by November's election gains, are now optimistic.

Republicans, Clinton said, have been influenced by powerful HMOs.

"Unless there is a clear, unambiguous signal from the people of the United States," Clinton said, "the organized forces of the status quo will do nothing."

The presidential visit drew about 20 demonstrators. None seemed especially concerned about health issues.

Two carried signs protesting NATO's bombing of Yugoslavia, one peddled conspiracy theories about Vice President Gore, and others complained about the administration's cuts in military retirement benefits, the Lewinsky sex scandal, and the loss of nuclear missile secrets to the Chinese.

President Clinton never saw their placards and banners. His motorcade arrived on the far side of the hall. Minutes later, a cloudburst followed by a thunderclap sent the demonstrators scurrying.

Critics of Clinton's patients' rights plan say that it reaches too far and so costly that it would force many people to lose coverage.

Yesterday Clinton announced that he was ordering the 285 health plans that provide coverage to federal employees to come into full compliance with his Quality Commission's Bill of Rights. They will now have to offer continued coverage for patients whose doctors are dropped from a plan during a patient's illness or pregnancy, and provide information about patient satisfaction, quality and incentives offered to doctors.

A new study has found that extending such protections will cost an additional $10 per person per year, Clinton said.

Federal employees, however, will not have the most expensive right in the Democratic proposal: the right to sue HMOs for damages. That, a White House spokeswoman said, is the only major difference between what the federal employees are now getting and what is proposed for everyone else. That change would add about 1 percent to insurance premiums, she said.

VICKI VALERIO / Inquirer Staff Photographer

President Clinton and Mayor Rendell have a moment to talk at yesterday's rally for HMO regulation, at Memorial Hall.

Joseph Karpinski, communications director for the Senate Health, Education, Labor and Pensions Committee, which last month passed a Republican patients' rights bill, said the Democratic bill would make insurance premiums about 4 percent higher. Business groups have estimated the cost at about $200 per person per year.

Karpinski said Americans are generally happy with their HMOs and do not want extensive regulation.

"Their basic concerns revolve around essentially guaranteeing that they're treated fair, that they have prompt and independent appeal rights, that they have access to information about their plans, and also that their premiums not be increased a great deal," he said.

Though the Republicans would extend the right to appeal HMO decisions to everyone, most of their Senate bill applies only to people covered by plans that are regulated solely by the federal government, usually those who work for large companies. That leaves out about 120 million Americans, the Democrats said.

Yesterday's speeches drew teachers, labor leaders and representatives from a variety of health-care groups. Several nurses in the crowd supported the Democratic bill because it protects whistleblowers.

Some just lucked into getting tickets and jumped at the chance to see the President. They were rewarded by a crowd-friendly Clinton, who spent a little more than 15 minutes talking, followed by 10 minutes of hand-shaking.

Kashif Hardy, 15, a freshman at William Penn High School, had come with 10 other participants in the Citywide Improvemont & Planning Agency, a nonprofit youth-leadership organization. He got a front-row seat.

"I'm here to take my picture with the President," Hardy said. "I'm anxious to greet him, to shake his hand."

When Clinton slipped out of the hall more than a hour later, he left at least one 15-year-old with an indelible memory.

"I did it!" said Hardy, smiling. "I shook the President's hand."

Philadelphia Daily News

Clinton Visit

Plea for patients

President stumping for passage of HMO rights legislation in Congress

by Dan Joseph

Daily News Staff Writer

When pain struck Joan Bleakley's left eye, she asked her Health Maintenance Organization if she could see a neurologist.

Her HMO directed her to an internist who gave her a bottle of pills and told her to come back in a week.

When the pain got worse, she asked again to see a neurologist. Her HMO got her an appointment for 24 days later.

Finally, she insisted on seeing a neurologist and a few days later, she did.

He sent her to a hospital immediately, where she was diagnosed with an aneurysm.

She was lucky to be alive, doctors told her, but it was too late to save the sight in her eye.

Bleakley, of Woodbridge, Va., was exhibit A yesterday as President Clinton made his pitch for a "patients' bill of rights."

Clinton spoke at Memorial Hall in Fairmount Park to an audience of health-care advocates, public officials and union leaders. The additional protections for HMO users have already been extended to federal workers and the new Office of Personnel Management's study shows the cost is less than $1 per person per month," Clinton said. "I think that is worth it to stop the stories like the one Joan just told us."

The legislation Clinton favors would allow patients greater access to specialists and emergency rooms, allow patients to keep the same doctor even when their employer switches HMOs and give patients the right to appeal when an HMO denies care and the right to sue for damages.

The bill died in Congress last year because of opposition by Republicans who say it will ratchet up medical costs and lawsuits.

The GOP has introduced its own bill, but it is "a bait-and-switch tactic," said AFL-CIO President John Sweeney, who, along with 15 Congress members and Mayor Rendell, joined Clinton on stage.

ALEJANDRO A. ALVAREZ/ Daily News

Joan Bleakley, (left) President Clinton and Mayor Rendell at session in Memorial Hall in Fairmount Park yesterday

Raymond Webb (left), Taje Glasco and William Mackey applaud during President Clinton's speech. Mackey is executive director of City Wide Improvement and Planning Agency.

The Republican bill omits the right to sue for damages and greater access to specialists and experts.

U.S. Rep. John Dingell, D-Mich., author of the Democratic bill, said a doctor who is a Republican called him to tell how he'd been fired by an HMO because he "was making medical decisions and not insurance decisions."

"Well what kind of decision do you want your doctor to make?" Dingell said.

The rally was one of more than 32 state events hosted by 90 members of Congress to launch a petition drive to pressure the Republicans on the issue.

The petition drive is being waged largely through a variety of advocacy sites on the Internet.

Clinton argued that most Americans favor the legislation.

"The system in Washington is resisting it, but people still rule if they stand up and make their voices heard," Clinton said.

U.S. Sen. Rick Santorum, R-Pa., was not enthusiastic about the Democrats' proposal, but said that "it was in everyone's desire to get a health-care reform bill."

"We've got to look at things that will help the health-care system work better, and the president's bill doesn't do that," said Santorum, who did not attend the event.

Beyond the GOP opposition, Clinton has to worry about the war in Kosovo overshadowing his message. He said opponents were consoling themselves that his message "probably can't break through on the evening news tonight because of Kosovo," and "that's another excuse we'll have to let this thing slide."

Clinton's visit provided a thrill for Taje Glasco, of Germantown, who got to shake Clinton's hand after the speech and pronounced him an "excellent" president. Glasco is a member of the City Wide Improvement and Planning Agency, a nonprofit group that helps build character in young people and helps them avoid drugs and crime.

"I know our grandparents really need good health care and with me coming up, if he can make it easier for them, it will be good for me, too," she said.

Send e-mail to [redacted]

The Hartford Courant

Saturday, April 10, 1999

Patient-Rights Campaign Employs Internet

Democrats, labor and others have launched a petition drive on a Web site to push for federal legislation expanding patients' rights in dealing with HMOs.

By JOHN A. MacDONALD
Courant Staff Writer

HC 4/10

WASHINGTON — President Clinton joined House Democrats, organized labor and other groups Friday in launching a high-tech petition drive for legislation giving patients more rights in dealing with health-maintenance organizations.

Speaking at a rally in Philadelphia, Clinton said Americans can show their support and give Congress a nudge by signing the petition on the Internet.

"We need this petition drive because unless there is a clear unambiguous signal from the people of the United States ... the organized forces of the status quo will do nothing," Clinton said.

The petition is on the Web site of Families USA, a consumer advocacy organization: www.familiesusa.org

The Philadelphia rally and an earlier event in Washington were organized by Rep. Rosa L. DeLauro, D-3rd District.

"We are taking [on] the fight for strong and enforceable HMO reform and not a watered-down approach," DeLauro said in Washington. "We're going to take it to the information highway and the old-fashioned highway."

DeLauro then joined about a dozen House Democrats and other supporters on a bus that took them to meet Clinton in Philadelphia, where she made a second speech. She said more than 100 Democrats were holding petition-signing parties nationwide as part of a renewed effort to pass the legislation that died in Congress last year.

The Democratic legislation would give all consumers easier access to emergency rooms and specialists, require insurers to have appeals procedures and allow patients to sue in disputes over coverage denials.

In his remarks, Clinton waded into the argument over the cost of the Democratic legislation. The president said recent figures show executive action he took last year extending patient protections to 9 million federal employees have cost less than $10 per person.

A recent TV-radio ad campaign run by opponents of patient protections said the Democratic bill would cost a family of four $200 a year. Officials at the Congressional Budget Office, which made the estimate, said the cost would be phased in over two to three years.

Ron Pollack, Families USA executive director, said the cost would be only a few dollars a month for each family member and would enable consumers to be sure they were really getting coverage. "I think that's a bargain," he said.

Pollack also took a swipe at the business-insurance industry coalition that paid for the $2 million broadcast campaign. Asked if patients' rights supporters were at a disadvantage, Pollack said: "I actually like the equation. They've got the money and we've got the people."

Chairman Dan Danner said the coalition opposes any legislation that increases health insurance premiums because that would lead to an increase in the number of Americans who are uninsured, now about 43 million.

A Senate committee last month passed a Republican alternative to the Democratic plan that does not include the right to sue. It provides some protections for the 48 million Americans in health plans that are exempt from state regulation; another 113 million in state-regulated plans would not have the benefit of federal protections.

Clinton called the measure inadequate.

CONNECTICUT POST

Saturday, April 10, 1999

REGIONAL NEWS

Congress pressed on patients' rights

By PETER URBAN
Washington bureau CP 4/10

PHILADELPHIA — Claiming that Republicans have stymied their efforts at HMO reform, President Clinton and House Democrats Friday joined labor and health care organizations to launch an Internet petition drive to pressure GOP leaders in Congress to hold a vote on a "Patients' Bill of Rights."

"The system believes it can resist the opinion and desire of the American people. This petition drive, don't you think it won't make a difference," Clinton told about 500 appreciative health care workers and politicos gathered inside Memorial Hall.

The afternoon rally was the marquee event to kick off the petition drive, which began earlier in the morning when a contingent of House Democrats boarded a bus at the U.S. Capitol for the ride to Philadelphia to meet Clinton, who made the trip aboard Air Force One.

The roadshow rally and the on-line petition drive were the brainchild of Rep. Resa DeLauro, D-3, who as an assistant to Minority Leader Richard Gephardt, D-Mo., was looking for a way to ignite Democrats to action on health care.

On stage with Clinton, Joan Bleakley of Woodbridge, Va., wearing a black patch over her left eye, said she lost her vision after her HMO refused to allow her immediate access to a neurologist to treat a brain aneurysm.

"After a 15-minute examination, the neurologist said I was lucky to be alive," Bleakley said.

AFL-CIO President John Sweeney said there is a "real problem in this country with giant HMOs," which he said could be solved with managed care reform.

"Give us the right to have medical decisions made by doctors and not insurance company bureaucrats," Sweeney said.

DeLauro pumped her fists and applauded with every call for managed care reform. "Sign this petition at www.familiesusa.org," she urged. "Join this battle, my friends, and together we will win."

House and Senate Democrats staged dozens of smaller petition drive rallies around the nation. Rep. James Maloney, D-5, was at Seymour Town Hall Friday afternoon to collect signatures for the on-line petition. "It's hard to pretend you are for reform if you won't allow a vote on the bill," Maloney said.

By 10 p.m., the online petition had more than 8,000 signatures.

Last year, the House narrowly defeated the Democrats' "Patients' Bill of Rights," which among other things would permit patients to sue their managed care providers, allow them more freedom to see specialists and prohibit "gag orders" that keep doctors from discussing all treatment options.

The bill lost by five votes, but Democrats believe they can win this year because they picked up five seats in the last election.

Clinton also tried to deflate Republican opposition to HMO reform by releasing new figures that show that his decision last year to allow 9 million federal employees the same rights contained in the "Patients' Bill of Rights" cost less than $1 a month per employee.

Opponents of the legislation say it will drive up health costs and create more lawsuits without improving the quality of care.

"We don't want to create a situation where the first place you go for medical care is a courtroom and not a doctor's office," said John Feehery, press secretary for House Speaker Dennis Hastert, R-Ill.

Feehery said that Republicans are not stalling health care reform but are focusing on the budget for the next few months.

New Haven Register
FOUNDED 1812
INCORPORATING THE JOURNAL-COURIER, FOUNDED 1755

Saturday, April 10, 1999

HMO reform hits highways, both online and asphalt

DeLauro joins Democrats in Philadelphia rally Friday

By Lolita C. Baldor
Register Washington Bureau NHR 4/10

WASHINGTON — The battle for health care reform hit the highways Friday — both on line and by bus.

In a nationwide effort to spur on a grassroots campaign for HMO reform, Congressional Democrats and President Clinton staged a rally in Philadelphia that was linked to smaller events all around the country.

"We're taking the fight for strong and enforceable HMO reform to the information highway and the old-fashioned highway," said U.S. Rep. Rosa DeLauro, D-3, just before she and other lawmakers boarded a bus to Philadelphia.

There, they got a boost from Clinton. "The people who are against it — basically the large HMOs and the insurers — have got the ear of the Congressional majority," Clinton told the crowd gathered in Memorial Hall. "Unless there is a clear, unambiguous signal from the people of the United States, the organized forces of the status quo will do nothing."

Clinton and others said Congress must pass the Democratic "Patients' Bill of Rights," rather than any of the Republican versions that don't allow patients to sue their insurers. Dubbing the Democratic bill "real" reform, a host of consumer and health groups added their voices of support.

As the bus wheeled from Washington, D.C., to Philadelphia, other home- and office-bound reform advocates were burning up the information superhighway.

Early Friday morning, DeLauro and others unveiled an Internet petition that computer users can sign and send in to show they support the reform bill.

With a few awkward shifts of the computer mouse and some quick typing, DeLauro added her name to the petition just before launching the road trip.

And as members of Congress spoke briefly before boarding the bus, the number of petition signers slowly, but steadily, inched higher. A few days ago, about 2,500 people who heard about the web site in advance had signed on, and when the lawmakers began speaking, the number had risen to 5,090. By the end of the event, that number had crept to 5,169.

Opponents of the Democratic bill have said that putting more mandates on health-care companies will just boost rates and hurt patients even more. And Republicans have developed their own legislation that carves out additional patients' rights, but doesn't go quite as far as the Democratic plan.

The Senate passed an HMO reform bill last month, but the House has yet to act.

Getting the House to move on the Democratic bill, said supporters, will take public outcry.

"We need your help to win," DeLauro told the Philadelphia crowd. "In this city, more than 200 years ago, our founding fathers put this government in your hands. They gave you the power. Today, we're asking you to use that power to make a difference."

To see the petition, Internet users can go to: www.familiesusa.org/pbr

At UPMC McKeesport

McKeesport Daily News

P.3 4.10.99 DN

Doyle, Costa Rally for Patients Bill of Rights

BY JENNIFER SABOL-GRINBERG
Daily News Staff Writer

If the process of insurance billing has been vexing patients, then why are they petitioning Congress for another one?

Ellen Gasparovic of Pleasant Hills has a pretty good idea why.

As a 34-year-old women diagnosed with breast cancer, Gasparovic was one of the initial people to sign an on-line petition urging Congress to support a Patients' Bill of Rights.

Accompanied by doctors, nurses and U.S. Rep. Mike Doyle, D-Swissvale and state Rep. Paul Costa, D-Wilkins Twp., Gaparovic, along with her husband Paul Gasparovic, gathered at UPMC McKeesport yesterday in hopes of bringing the Patients' Bill of Rights to the House floor.

"This legislation confronts the real problems Americans face in their relationships with HMO's and it contains key principles that are the basis for managed care reform that will make a difference for American families," Doyle said.

When Gasparovic was diagnosed with cancer, her insurance company denied surgery to remove tumors, even though both the insurance consultant and her own physician. sustained it was genuinely a matter of life or death.

Paul Gasparovic said his wife's surgery was deemed "unnecessary"; the type of mastectomy needed was considered "cosmetic" under the policy, he said, and she was allegedly "choosing to have this (surgery)."

As a wife and mother of two, Ellen Gasparovic and her husband borrowed money for the procedures, which included all medications, surgery, chemotherapy and radiation, to name a few items.

— Photo by Cindy Shegan Keeley/Daily News

Paul Gasparovic, Ellen Gasparovic, State Rep. Paul Costa and U.S. Rep. Mike Doyle signed the Patients' Bill of Rights petition yesterday at UPMC McKeesport.

"I was willing to do anything for the children. They need their mother," she said.

Realizing treatment procedures were and would continue to financially drain the family, Gasparovic wrote a letter to Doyle's office pleading for his intervention.

Tina Maggio, field representative for Doyle's office in turn drafted a letter to the insurance company reiterating what doctors already told Gasparovic.

Within less than a month, Gasparovic was informed she would be fully reimbursed.

"People shouldn't have to contact their congressman about this," Doyle said, who, along with Rep. John Dingell, D-MI, and Sen. Edward Kennedy, D-MA, co-sponsor the Patients' Bill of Rights.

The bill, Doyle said, "ensures the right to have treatment decisions made by doctors and not insurance company bureaucrats, the right to see specialists, the right to emergency room care when and where needed, the right to appeal a health care decision and the right to hold managed care companies accountable."

Doyle said the current review process for procedures takes extremely long, and that "a 30-day delay is critical" for people with serious health conditions.

Costa deemed the patient protection law passed by the state last year "has serious gaps and omissions."

"It is a perfect example of why millions of people whose health plans already regulated by state governments also need federal protections as well."

Costa said major additions to the state law should entail: the right to choose your own doctor, including specialists; a clear definition of what constitutes "medically necessary" care and treatment; giving patients the power to take HMO's to court; an improved appeal procedure; state-compiled "report cards on HMO's and the right to choose a pharmacy.

"When the state shifted Medicaid patients in the Philadelphia are to "Health Choices" managed care, many of them could not longer use independent or community pharmacies.

"That forced about 140 small pharmacies in that region to close," Costa said, "and 'Health Choices' is being implemented in western Pennsylvania this year."

Doyle said an increase in patient protection would be an affordable change for insurance companies.

"For every one person that calls asking a congressmen for help, there are probably 100 that don't," Doyle said.

Decisions for the patient need to return to the physicians, Doyle concluded.

If interested in signing the Patients' Bill of Rights on-line, the Web site can be accessed at: www.familiesusa.org/pbr/

Local woman pushes for 'Patient Bill of Rights'

Democrats start petition drive to boost stalled health care protection plan

From staff and wire reports

Ellen Gasparovic wants to be around to see her 4- and 5-year-old sons grow up.

So when doctors located more than 20 breast tumors in her and told the 34-year-old Whitehall nurse and mother she needed a double radical mastectomy right away, she didn't hesitate.

Even after her health insurance plan told her they wouldn't cover it.

"I had to come up with the money for the operation before I could even be admitted to the hospital," said Gasparovic, who joined U.S. Rep. Mike Doyle, a Swissvale Democrat, at a Friday morning press conference in McKeesport to help jump-start the "Patient Bill of Rights" that's been languishing in Congress.

"Everyone said this (operation) is the only way I'm going to live," Gasparovic said. "I have two little boys that need a mom. I wasn't going to fool around with it."

Democrats kicked off a nationwide petition drive yesterday to pump new life into their stalled bid to expand health care protection under the rights bill.

President Clinton joined a rally in Philadelphia and urged Americans to sign the petition to build pressure on Republicans and overcome insurance industry opposition.

"The political reality is that the system believes it can resist the opinion and the desire of the American people," Clinton said.

"The whole country is for it," Clinton said of the Democratic plan. "The system in Washington is resisting it, and the people still rule if they will make their voices heard loud enough."

Clinton challenged critics who claim the Democratic plan would bankrupt employers, saying legislation now before Congress was similar to changes he ordered in the health benefits that cover federal workers.

That coverage for 4.1 million people enrolled cost the federal government $29.6 million, and individuals an added $10 in premiums for one year.

"The people who are against it — basically the large HMOs, the insurers — have got the ear of the congressional majority, and they have a lot of political influence," Clinton said.

After falling victim to a partisan stalemate last year, the issue of patient rights has re-emerged in what appears to be another party-line battle.

The Republican and Democratic bills deal with some of the biggest complaints patients have made about HMOs and other managed care plans, including access to emergency rooms, greater access to doctors outside a specific health network and a grievance process when a health plan denies care.

Last year, a Senate Republican task force wrote a similar bill. Democrats produced an alternative, but the two sides were so far apart that they never even managed to agree on how to start the debate.

The House did narrowly pass a different Republican bill last summer. House leaders want to revisit it this year.

Pittsburgh Tribune-Review

Brown backs online effort for health care bill

By Ted Gotsch
Daily Bulletin

SAN BERNARDINO — A national effort to pass a Democrat-sponsored Patients Bill of Rights brought about 20 people to Rep. George E. Brown Jr.'s office to fill an online petition drive on Friday.

Worried the quality of health care is slipping in an age dominated by HMO providers, health care, elderly rights and labor leaders signed onto the list as part of a coordinated public effort that also featured events in Philadelphia and Washington, D.C.

Brown, D-42nd District, was a co-sponsor on the Patients' rights legislation last year, when it failed in the House by five votes. He has again signed onto it this year.

The bill would broaden those services that are available to every insured person, including a choice of plans, specialists for the chronically ill and prescription medications tailored specifically to the patient.

Suffering from his own health problems Friday, Brown was not in attendance. In a statement, he said pressure needed to be applied to GOP lawmakers to make sure the legislation passes.

"The insurance companies and the majority Republican Congress are spending millions to block this legislation," he said, "and committed to keeping managed care reform at the forefront of the Congressional agenda."

Democrats are facing competition from a GOP bill. Brown said others, however, argue that consumers are offered more flexibility with doctors and to appeal medical decisions under the Democratic plan.

Bill Fry, a patient's rights advocate with the San Bernardino County Behavioral Health Department, said the focus of the industry needs to be changed.

"The bottom line situation for HMOs is that they make money by not providing services," he said.

Sandra Waters, president of the Inland Empire Black Nurses' Association, said that while the current system is not completely broken, it needs help. And more choices would give the public additional needed information.

"As a nurse, we need to be an advocate for patients," she said. "It used to be hospitals were non-profit. Now, it is a business."

Some in the insurance industry, however, say they have been responsive to requests for change.

Richard Bruno, chief executive officer of Inland Empire Health Plan in Colton, said his company has put together its own bats of patients rights.

Insurance customers have duties they should follow also, he said.

"One of your responsibilities should be that you come in for checkups, that you get your children immunized," Bruno said. "This thing goes both ways."

In search of better HMOs

■ Officials debate the medical insurance groups' merits; patients recount problems they've had.

H. T. 4/8/99

BY ROBIN BIESEN
Times Staff Writer

MERRILLVILLE – Concern over the complexities of health insurance prompted more than 150 people to pack a town hall meeting Wednesday evening at Merrillville High School.

The two-hour forum, sponsored by Rep. Peter Visclosky, D-Ind., focused on emerging legal and ethical issues concerning the 81.3 million Americans insured by health maintenance organizations.

Visclosky, an advocate of a federally mandated patient bill of rights that would give patients guarantees they might be denied under current regulations, said while HMOs had been successful in controlling runaway health care costs, the system was in need of repair.

See HMOs, A-7

BRETT HENDRICKSON / THE TIMES

U.S. Rep. Peter Visclosky addresses a large crowd Wednesday during a forum he sponsored at Merrillville High School about health maintenance organizations.

HMOs

Continued from A-1

"I believe that doctors and patients should make health care decisions, not insurance company bureaucrats," Visclosky said. "Certainly not all HMOs abuse their patients, but there are far too many horror stories from patients to think that all HMOs act in a responsible and reasonable manner."

Visclosky, along with Dr. Barney Maynard, president of the Indiana State Medical Association, Dr. Thomas Brubaker, a Munster internist and chairman of the board of directors of the ISMA, and Dr. Vidya Kern, a Michigan City internist, helped explain how federal legislation under consideration could make HMOs more accountable.

Merrillville physician Raymond Doherty credited HMOs with keeping health care costs under control.

"We only hear of people who bad-mouth HMOs," Doherty said. "Medicine in the past was not perfect."

Vivian Wainberg, of Merrillville, said she and her husband were forced into an HMO because of the high cost of heart medicines that were prescribed for the couple following their heart surgeries.

Wainberg said the gatekeeper policy of her HMO – which forces her to see a family practice doctor to get permission to see her cardiologist – has kept her from receiving the care she wants from her cardiologist.

"You have to hope the first doctor will go along with you," she said. "This has been frustrating for us. We wouldn't have chosen an HMO if it wasn't for the cost of the medicines. We want to see our cardiologist a couple of times a year, and right now we can't."

Visclosky said he hoped Congress would vote this year to enact legislation that would curb problems people have with HMOs.

"We don't consider HMOs bad," he said. "Prior legislation, though, has had some unintended consequences. What we're looking for is balance and reasonableness in all HMO plans."

Printable text version of this story

April 07, 1999

Berkley prods doctors to speak up on medical issues facing Congress

By Kristen Peterson
<kristen@lasvegassun.com>
LAS VEGAS SUN

Doctors need to fight for their right to make medical decisions, and they need to do so by making their views known to their representatives in Congress and in other political arenas, Rep. Shelley Berkley told members of the Clark County Medical Society Tuesday.

Speaking at the society's 1999 Legislative Dinner, Berkley, D-Nev., who married nephrologist Larry Lehmer one week ago Sunday, said dating a doctor during her campaign led to a deep appreciation for issues confronting the medical community.

Medical professionals, she said, need to ensure that medical decisions are made by them rather than the government or insurance companies.

She also touched on women's health care issues, focusing on osteoporosis, a deteriorating bone disorder that Berkley has. It affects mainly women as they grow older.

Providing Dexascan, a simple five-minute test that can detect osteoporosis in the early stages, can save millions of tax dollars through corrective measures, she said. Ten months since she was diagnosed, she said, she's not only seen a stop in the deterioration but her bone mass has actually improved.

Berkley received applause when she expressed

confidence that a bill establishing a federal Patients' Bill of Rights would become law this year. It failed by five votes in the last Congress, she said, but Democrats have made it one of their priorities for this session.

"We're going to get this through this time," she said. "It's a very important piece of legislation."

Berkley also talked about her experience over the last 12 weeks as a freshman in Washington representing the "most unique district in the country."

Las Vegas has the fastest-growing senior population, the fastest-growing veteran population and the fastest-growing school-age population, she said.

Recently appointed to the House Veterans Affairs Committee, Berkley said she is eager to bring relief to the veterans community. Nevada, Florida and Arizona are the only states in the country with increasing veterans populations, she said.

Berkley said protecting the Social Security system and Medicare and providing long-term care for older Americans are important issues in Nevada because of the growing senior population.

Berkley, who is a co-sponsor for the Prescription Drug Fairness For Seniors Act, added that coming up with a method to provide medication for uninsured seniors without price-fixing is a challenge.

Printable text version of this story

Las Vegas SUN main page

Patients' Rights Backers Launch Online Petition

Rep. David Price, D-N.C., signed the national petition for the Democratic bill on Friday in Chapel Hill.

By Asta Vtbe
Staff Writer

More than 12,000 people had signed an online petition to pass a patients' bill of rights by Sunday afternoon, just two days after the project's kickoff with more than 90 events nationwide.

Rep. David Price, D-N.C., signed the petition urging Republican Speaker of the House Dennis Hastert to pass the Democratic version of the Patients' Bill of Rights on Friday at the state office of the American Heart Association in Chapel Hill.

The Democratic initiative came within six votes of passing the House last year. The Republican equivalent was passed in the House but shot down in the Senate.

The Democratic bill, sponsored by Rep. John Dingell, D-Mich., includes guaranteed access to specialists, the right to sue insurance companies for damages and access to out-of-network providers.

Bridget Taylor, a member of Dingell's staff, said the bill had a better chance of passing this year. "The idea of the bill has been around long enough," she said. "The momentum is definitively there."

Adam Searing, project director for the N.C. Health Access Coalition, said the Democratic version provided the most protection for patients. "If passed, this bill is a huge stride forward ...," Searing said. "It would provide a fundamental change in how people look at health care."

But John Feehery, an aid to Hastert, said the Democrats' patient bill of rights made it easier to sue but did not make health care more available. "Some kind of health-care legislation will most likely pass this year," he said. "But it will be a bill that makes it easier to get into the lawyer's office than the doctor's office."

Price said the bill would increase the legal accountabilities of those making medical decisions, but it was not about lawsuits. He said people would find health plans more accountable if the bill was passed. "At the national level, the plan will ensure that no matter what kind of plan you have, you won't have to worry about the fine print," he said.

Carol Kirschenbaum, a physician intern in Durham, said there had also been some resistance from insurance agencies.

She said the insurance agencies were around to make money, not to care about patients. "If there is a chance to implement the bill to serve their purpose, they will do it," she said.

But Price said the conditions in the bill were not that stringent. He said the bill would "weed out" the bad agencies, and that the good ones would benefit. "Of course not all insurance agencies see it this way," he said.

Kirschenbaum said insurance agencies would not enforce the bill unless it was in their favor. "If the enforcement could interfere with their cashflow, they will not do it," she said.

But Price said the bill would be enforced if passed. "It will be clear what services will be required, and there is a potential for legal action in the end.

"There are a lot of things that need to be addressed and this is not a cure-all for the system," Price said. "It is still a significant step for those who have insurance."

The State & National Editors can be reached at statedesk@unc.edu.

Daily Tar Heel

Elyria Chron.-Telegram

Officials push for patient rights

Chrissy Kadasek
The Chronicle-Telegram

ELYRIA — Miguel Castro believes people have to have faith — in the Lord, their physician and themselves — if they want to win the battle against a disease like cancer.

Castro, 40, of Lorain said his fight against non-Hodgkin's lymphoma was not half as bad as his fight to find a physician he trusted.

"The HMOs (health maintenance organizations) force physicians to practice insurance medicine instead of patient medicine," he said Friday to a group of nearly 30 people at Lorain County Community College.

The gathering was held along

See HMOS, C2

BRUCE BISHOP / CHRONICLE

SIGNING UP: Miguel Castro of Lorain, left, a cancer survivor, watches as Elizabeth Thames, a district coordinator for Rep. Sherrod Brown, D-Lorain, helps him sign an electronic petition Friday after a meeting at Lorain County Community College.

(1)

HMOS

From C1

with similar events in 32 states around the country as part of Patients' Bill of Rights Day. U.S. Rep. Sherrod Brown D-Lorain, led the event by calling for managed care reform and asking supporters to join an online campaign in support of legislation known as the Patients' Bill of Rights.

"We have all heard horror stories about the mother who must drive her child to an 'in-network' hospital 40 miles away or the man who believes he's suffering from chest pains but is denied immediate emergency room care," Brown said.

"We need responsible change now. While some managed care plans have done a good job for its customers, too many HMOs have been denying needed services and are putting profits ahead of patients."

Brown, the ranking Democrat of the House Subcommittee on Health and the Environment, said 130 national organizations have endorsed the legislation, including the American Medical Association, American Nurses Association, American Cancer Society, American Heart Association and the AFL-CIO.

President Clinton was at a Philadelphia pep rally Friday where he announced a new "Internet petition," where computer users can register their support for new regulations that would mandate that HMOs and other managed care plans provide the same benefits to all covered patients.

The U.S. Department of Labor estimates that nearly 6 million Ohioans in HMOs do not have enforceable patient protections such as those in the Patients' Bill of Rights.

Some safeguards in the proposed bill include:

- Ensuring access to specialists; having a fair and timely appeal process when a health plan denies care.
- Having protection for provider-patient relationships, such as bans on gag clauses, bans on bonuses and other financial incentives to deny care, and protections for providers who advocate on behalf of their patients.
- Holding health plans accountable for medical decisions that result in harm, just as doctors and hospitals are accountable today.

"The only groups, literally, in this country that can't be sued are foreign diplomats and HMOs," Brown said.

Ann and Glen Lehman of Amherst have reached the point where legal action might be the only avenue to pay Glen's medical bills.

After months of frustration weaving through the insurance system, learning the loop holes and the guidelines for dropping coverage and ensuring coverage, Ann Lehman plans to write letters to every Republican in Congress urging them to support the Democratic initiative.

"They (HMOs) act like a stupid button is turned on when you turn 65," Ann Lehman said. "We do know what is going on, probably better than they do."

Kathryn Boylan, Elyria health commissioner, said the legislation will provide a much-needed guideline for health care.

"HMOs are not evil things," Boylan said. "We've just completely gone to a business. We need some quality injected here — we need some guidelines."

The Internet address for the petition is http://www.famil-kaiser.org/pbr.

(2)

Rep. Brown joins backers of 'Patients Bill of Rights Day'

By KAREN HENDERSON
PLAIN DEALER REPORTER

ELYRIA — Rep. Sherrod Brown, a Lorain Democrat, yesterday joined local health care advocates in calling for managed-care reform and passage of a Patients' Bill of Rights.

Brown and other Northeast Ohio leaders yesterday met at Lorain County Community College to help launch a nationwide on-line petition drive that asks Congress to take immediate action on the pending bill. The event coincided with 40 similar gatherings taking place around the country on what President Clinton designated as "Patients' Bill of Rights Day."

Brown said the bill is especially important because U.S. Department of Labor statistics show that nearly 6 million Ohioans in HMOs do not have enforceable patient protections — for example, the right to have treatment decisions made by a doctor. Nationally, 43 million American workers have no health coverage at all.

While leading Democrats gathered here and elsewhere in the partisan event, U.S. Rep. John Boehner, a Republican, praised the bipartisan health care work of Democrats and Republicans on the House Subcommittee on Employer-Employee Relations. Boehner also warned leading Democrats against tainting the health care reform process with partisanship.

"We want to work with our Democrat counterparts to expand access to care for all Americans — not to make coverage less affordable and accessible for those who already have it. But finding solutions starts with building bipartisan consensus — not with partisan podium pounding," Boehner said. Health care reform hearings in the subcommittee began Feb. 24. The subcommittee will hold its third health care hearing of the year on April 20.

"If there's a way to make health care more accountable to patients without raising costs and limiting access, we have a responsibility to do it and do it this year," Boehner said.

Brown said that while some managed care plans have done a good job, too many have been denying essential services and are putting profits ahead of patients.

"We've all heard horror stories about the mother who must drive her child to an in-network hospital 40 miles away or the man who believes he's suffering from chest pains but is denied immediate emergency room care," Brown said. "We need responsible change now."

Brown, who helped design the Patients' Bill of Rights, said the measure ensures the right to have treatment decisions made by a doctor, the right to see specialists when needed, and the right to emergency room care when and where the patient needs it. The measure also bans financial incentives that reward physicians for prescribing less care and it guarantees access to clinical trials for cancer patients.

The Flint Journal A3 4/10/99

Abraham, Stabenow bring different issues to area

By Linda Angelo
JOURNAL POLITICAL WRITER

GENESEE COUNTY

U.S. Sen. Spencer Abraham and U.S. Rep. Debbie Stabenow – rivals in the 2000 Senate race – were in Genesee County on Friday promoting two very different issues: saving Social Security and implementing a "Patient Bill of Rights."

Abraham stopped by the Fenton Community Center to tout proposed legislation that would "lock up" every penny of the Social Security surplus to ensure that future baby boomers have money when they retire.

About two hours later, Stabenow and U.S. Sen. Carl Levin were at the Genesee Free Medical Center in Flint demonstrating how the public can sign petitions supporting new regulations on HMOs and other managed care plans via the Internet (http://www.familiesusa.org/pbr/).

Stabenow and Levin were among 90 Democrats across the country promoting the "Patient Bill of Rights," which they say would give consumers more power to challenge the decisions of health maintenance organizations. It also is designed to provide better access to specialists and coverage of emergency room care.

"In a country with the best health care available in the world, we should not be struggling for people to get the care that they have been paying for," Stabenow said.

"They are paying health care premiums and too many times we are seeing situations where the doctor makes a recommendation, it's overturned by the HMO or insurance company and it takes months ... to get care that should be available right away in a medical emergency."

The issue is one that Democrats and Republicans fought over in the past session with each party putting forth their own plan.

Opponents of the legislation argue new regulations will drive up health costs and open the door to more lawsuits.

But Stabenow and Levin said the Congressional Budget Office issued a report showing that the difference in rates would only be 0.04 percent.

At his news conference, Abraham stressed the importance of making sure money from the Social Security Trust Fund is not spent on other budget issues.

"I'll be leading the Senate effort to save Social Security dollars for Social Security. ... The top priority we have is to protect the Social Security trust fund from being spent on other priorities," he said.

Stabenow described Abraham's lock box plan as a "gimmick."

"It doesn't do any good if we don't take the majority of the total budget surplus and put it back to pay back Social Security and Medicare," she said.

But Abraham said only the surplus from Social Security should be used to make the program solvent.

How Social Security should be reformed likely will be one of many issues the two will delve into as they square off in next year's race.

"I expect a competitive race and always have, but that's next year," Abraham said.

"This year I'm worrying about protecting Social Security money, letting working families keep more of what they earn, which is going to be my principal goals this year, and we'll let the campaign take care of itself next year."

Linda Angelo covers politics. She may be reached at (810) 766-6340 or by e-mail at langelo@flintj.com.

The Daily Reflector

Date: April 10, 1999

FYI: EMC & Darryl

A little high-tech support

Clayton uses Net to gather signatures for patients' rights bill

By Jennie Hunt
The Daily Reflector

U.S. Rep. Eva Clayton used a four-county teleconference to gain support and signatures for an Internet petition on patients' rights legislation Friday.

Ms. Clayton, D-N.C., co-sponsored House Resolution 358, titled the Patients' Bill of Rights Act, which seeks to guarantee certain rights to consumers of managed health care programs.

Ms. Clayton attended the videoconference at Pitt Community College, which linked Wilson, Halifax and Martin counties in the 1st Congressional District.

The goal for her "grassroots" effort Friday was to get 1,000 online signatures posted on the Internet from the four counties by the end of the day, Ms. Clayton said.

"I think it is unique to be in Pitt County and be able to talk to other counties," Ms. Clayton said. "Using technology for the benefit of citizens is a unique way to have our collective voices heard."

A total of 6,166 people signed the petition as of Friday night.

This petition effort was part of a nationwide drive to urge Congress to adopt the bill, and it was launched early Friday by President Bill Clinton and Vice President Al Gore, who held a press conference in Washington and a rally afterward in Philadelphia, Ms. Clayton said Friday.

"The president signed the petition earlier — he got ahead of me," Ms. Clayton said as she signed the petition while people in all four counties observed.

After the teleconference, audience members had a chance to sign the Internet petition. Also, local libraries in all four counties have the Internet Web site for the petition is bookmarked for public convenience and access, Ms. Clayton said. She said many area churches are also participating in the petition drive over the weekend. At the end of the one-hour videoconference, about 100 people from the four counties had signed on.

The United States has the best health care system in the world, but it still leaves many people without access to needed services, specialists and adequate emergency care, Ms. Clayton said. In addition, she stated that many hard working Americans are uninsured and

See PATIENTS, B2

The Daily Reflector

Date: April 10, 1999

FYI: EMC & Darryl

Greg Eans/The Daily Reflector

U.S. REP. EVA CLAYTON, D-N.C., gestures after signing a petition on the Internet for a patients' bill of rights Friday at Pitt Community College's Fulford Building.

PATIENTS

Signers: Cost shouldn't hold people from care

Continued from B1

don't qualify for Medicaid, because they earn too much.

"All too often we don't have the care or protection we think we have with insurance," she said. "Managed care needs to be reformed, and I wanted to do my part in North Carolina."

Managed care is one term, but it represents a wide array of approaches to organizing the delivery of health care. Health Maintenance Organizations and Preferred Provider Organizations are the two types of managed care organizations in the United States.

At the teleconference, PCC had four television monitors, and one large screen divided into four sections showing all four counties at one time.

During the event, health care professionals, PCC and East Carolina University educators, local government officials and audience members voiced their concerns about managed care and insurance providers.

"It is important that during an emergency the patient doesn't have to think about calling an HMO before seeking treatment," said Phyllis Turner, ECU nursing school associate dean for academic affairs. "We need to know about all the options available — we don't need to have our health care providers gagged."

Don Ensley, ECU associate professor of the community health department, agreed with Turner about access to health care and all treatments regardless of cost open to the patients.

"It's a bill needed to protect and empower the citizens," Ensley said.

Greenville City Councilwoman Mary Alsentzer said she is aware of many of the current insurance issues because she is married to a health care professional.

"We are both adamant supporters of this type of health care reform, and we hope it works and everyone will get involved and sign the petition," she said.

The Internet address for the petition is http://www.familiesUSA.org/pbr.

COLUMBIAN, B-1

4/11/99

HOTZLIP

Baird, other Democrats push for HMO reform

'Patients' Bill of Rights' would clip powers of insurance companies

by JEFF MUIS
Columbian staff writer

While President Clinton and more than a dozen House Democrats attended a Friday rally in Philadelphia, Congressman Brian Baird staged a much smaller event in Vancouver to support the "Patients' Bill of Rights."

Baird held a news conference to call on Congress to curtail the power of health maintenance organizations, or HMOs, and other managed care programs.

"It is in their financial interest to deny care rather than to provide care," the Vancouver Democrat said about HMOs.

> **"It is in their financial interest to deny care rather than to provide care."**
>
> CONGRESSMAN BRIAN BAIRD, *on the need for HMO reform*

Baird was one of more than 100 House Democrats to hold rallies, meetings and other gatherings across the country Friday to focus public attention on health care reform.

"This is one of our highest priorities in Congress," Baird said. "The American people have waited too long."

Baird is a co-sponsor of the Patients' Bill of Rights, which is designed to ensure that patients can select their own doctors, see medical specialists and have access to emergency care.

The legislation also aims to return power to physicians and other health care providers and to hold managed care companies accountable for decisions to limit medical care.

"Currently, the only people in America who are immune from lawsuits are foreign dignitaries and heads of HMOs," Baird said.

He warned that House Speaker Dennis Hastert, R-Ill., maintains close ties to the insurance industry, which is willing to pump big money into the political system to kill reform.

"Powerful insurance interests would like to see this bill go nowhere," he said.

Insurance companies are trying to scare Americans by predicting a 20 percent to 40 percent increase in medical costs if the legislation is enacted, Baird said.

Congressional Budget Office estimates there would be only a 3 percent to 5 percent increase in insurance premiums, he said.

Also attending Friday's news conference were Ed Cote, a Vancouver resident whose daughter was diagnosed

REFORM/ *Story on B3*

Reform

Baird seeks passage of "Patients' Bill of Rights"

From Page B1

with leukemia eight years ago, and Rodie Renn-Lasher, a representative from the Washington State Nurses Association.

Cote, supervisor of the Division of Children and Family Services of the state Department of Social and Health Services in Vancouver, said his professional training as a social worker didn't prepare him for the battle with HMOs over his daughter's medical treatment.

Too many decisions are made by people who don't have medical training and don't understand the complexities of someone with a serious illness, Cote said.

"Some people just give up," he said. "They can't fight the HMOs to get what they need anymore."

People can appeal decisions, but those are reviewed by the HMOs themselves, not by impartial third parties.

"It's sort of like watching the henhouse approach here, which I think is terribly wrong," Cote said.

Renn-Lasher, a cancer survivor who has worked as a registered nurse for nearly 23 years, said health care providers no longer have the final say over medical decisions.

Nurses and other providers who report problems with the quality of care or insist on medical tests considered unnecessary by HMOs can be branded as trouble makers and face retaliation, Renn-Lasher said.

"If I were to continue to push, I could be fired very easily," she said. "You don't want to rock the boat."

Democrats nationwide have launched an Internet petition drive to build public support for the Patients' Bill of Rights.

Internet users can add their names to the petition by calling up: http://democrats.house.gov//public/petition/.

Baird said people can also sign the petition by calling his Vancouver office: 695-6292.

The Connersville News-Examiner Newsstand

Wednesday, March 31, 1999

Social Security rescue at top of Hill's agenda

By MIKE SELKE, Staff Writer

U.S. Rep. Baron Hill talked about Social Security during a public meeting Tuesday at the Fayette County Senior Center.

Social Security is an important issue facing present and future generations, said Hill, the Seymour Democrat who won Indiana's 9th District seat following Lee Hamilton's retirement.

Hill said by 2032 the Social Security trust fund will not be able to afford to pay 100 percent benefits, according to projections, and that the figure will be reduced to 75 percent.

"The United States Congress has an historic opportunity to fix Social Security," he said. "I want to make sure Social Security is there for me, my daughters and someday my grandchildren."

Hill said it is time to save Social Security with the surplus and to pay down the debt.

The nation's debt in 1980 was about $750 billion, which took 200 years to accumulate, Hill said. During the past 19 years the figure climbed to $4 trillion, he said.

"There's a big debate going on in Washington, D.C., as to what to do with the surplus," he said. "Do we save Social Security and pay down the debt or do we offer a 10 percent tax cut across the board to all Americans?"

Privatizing Social Security — creating small individual accounts to be invested — is being discussed in Congress, he said.

"I'm opposed to this," Hill said. "Social Security is not a 401(k) or an IRA. It's a defined benefit program that guarantees a monthly benefit to senior citizens."

President Clinton's suggestion to take 25 percent of the budget surplus and let professional business managers invest in ventures other than treasury bills has Hill's support, he said.

On another topic, Hill said medical decisions should be made by patients and doctors, and not by health maintenance plan staff members.

The Patients' Bill of Rights would ensure decisions are made by the patient, he said.

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Congressman Crowley Supports Patients' Bill of Rights

Recognizing that millions of hardworking Americans have entrusted their health to managed care organizations, and that HMOs have far too often failed these individuals during the most desperate times in their lives. Congressman Joseph Crowley joined 174 of his Democratic Colleagues as an original co-sponsor of H.R. 358, the Patients' Bill of Rights.

Speaking on the House Floor, Congressman Crowley said. "Working Americans have become increasingly frustrated with a system that seems to be more interested in increasing profits than in providing quality health care. It is time to find a balance between reasonable cost and reliable care."

congressman Crowley joined other Democrats in supporting this landmark legislation that guarantees patients basic rights by allowing people to choose their own doctors, ending oppressive "gag rules," there by giving patients access to all critical treatment options, and establishing health care quality and information standards.

The Patients' Bill of Rights also responds to widespread complaints that when doctors or patients appeal a decision managed care plans are slow to act. "This lack of responsiveness can have profound consequences because the decisions of a health plan makes about a patient's care can be a matter of life and death," Congressman Crowley said. The legislation would hold HMO's accountable by giving patients who are denied necessary medical coverage the right to appeal those decisions to an independent board, and requiring timely resolution of those appeals.

"It is Congress' responsibility to address the public's concerns about our nations system of health care," said Congressman Crowley. "I will work hard to ensure that Congress passes the Patients' Bill of rights to protect the health care of the hardworking families of Queens and the Bronx, and throughout our country."


www.familiesusa.org
REAL

THE BUREAU OF NATIONAL AFFAIRS, INC.
HEALTH CARE INFORMATION DIVISION

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THE HEALTH BENEFITS COALITION
for Affordable Choice & Quality

For Immediate Release
April 26, 1999

Contact: Suzy DeFrancis
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COSTS OF KENNEDY-DINGELL BILL ON THE RISE

New Congressional Budget Office numbers raise the cost of Kennedy Care by 50%

Washington, DC, April 26, 1999 – The Kennedy-Dingell "Patients' Bill of Rights" will increase health care costs even more than originally expected and will have "a significant effect on the costs of private insurance," according to revised estimates released today by the non-partisan Congressional Budget Office (CBO). The new CBO estimate is 6.1 percent – a 50 percent increase over its last estimate of 4.1 percent nine months ago. CBO estimates that the cost of private-sector mandates would total about $56 billion over the 2000-2004 period and would greatly exceed the annual threshold established in the Unfunded Mandates Reform Act.

"If the CBO estimate went up by fifty percent after just nine months, in the real world how much higher will premiums go up when this bill is actually enacted?" stated Dan Danner, chairman of the Health Benefits Coalition. "The fact is, Congress is gambling with the health care costs of hard-working Americans, and the Kennedy-Dingell bill is a bad bet."

Another study by the Barents Group found the liability provision alone in the Kennedy-Dingell bill could increase premiums by as much as 8.6 percent – resulting in nearly 2 million more uninsured Americans and as much as $120 billion more in health care costs nationwide over the next five years.

Moreover, the CBO estimate does not take into account the fact that one costly lawsuit could wipe out a small business entirely – or that costs for small businesses, which typically pay more for health care, are likely to go up more than the 6.1 percent national average predicted by CBO.

This year, U.S. employers already face a predicted 7-10 percent rise in health care costs (Hewitt Associates). For small businesses the impact is even greater – in some cases increases of 20 percent or more. A 6.1 percent increase on top of the already predicted increase would prove too much for many businesses. The additional costs would force many employers to either pass the costs on to their employees or forego providing coverage altogether.

"With health care costs already on the rise, the last thing Congress should do is make things worse," said Danner. "We urge Congress to oppose any legislation that adds to the burden of families and businesses by raising costs and forcing millions more into the ranks of the uninsured."

The Health Benefits Coalition is a broad-based organization representing three million employers providing health care coverage to more than 100 million employees and families. The coalition believes affordable, quality health care is best achieved through broader coverage, choice and competition in the marketplace — not government mandates.

600 Maryland Avenue, S.W. • Suite 700 • Washington, DC 20024 • phone 202.554.9000 • fax 202.484.1566 • www.hbcweb.com

HIAA

Health Insurance Association of America

FOR IMMEDIATE RELEASE
April 26, 1999

CONTACT: Richard Coorsh
(202) 824-1787
e-mail: rcoorsh@hiaa.org

REVISED 6.1 PERCENT CBO ESTIMATE UNDERSCORES NEED TO REDUCE NUMBER OF UNINSURED AMERICANS

The following statement was released today by Chip Kahn, President of the Health Insurance Association of America (HIAA):

It comes as no surprise that the Congressional Budget Office (CBO) has increased its estimate of the likely hikes in premiums due to the so-called patient protection legislation sponsored by Senator Kennedy and Representative Dingell. If anything, research sponsored by HIAA and other organizations shows that even this latest CBO estimate understates the adverse effects on consumers that would accompany this legislation.

Congress should set as "job one" reducing the number of uninsured Americans, not adding new regulations that would increase the number of people without all-important health insurance protection. The CBO also estimates that each one percent increase in premiums results in at least 200,000 Americans losing or not getting health coverage. Consequently, the CBO's latest estimate that the Kennedy/Dingell bill would raise premiums by 6.1 percent emphasizes that the most important patient protection should be protection against cost increases brought about by expensive, unnecessary government mandates.

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NFIB SMALL BUSINESS NEWS

National Federation of Independent Business www.nfibonline.com
600 Maryland Avenue, SW, Suite 700 • Washington, DC 20024 • 202-554-9000 • Fax 202-554-0496

FOR IMMEDIATE RELEASE:
April 26, 1999

Contact: Mary Mead Crawford
or McCall Cameron 202-554-9000

CBO: Kennedy's Health-Care Bill Increases Costs

The National Federation of Independent Business (NFIB) today asserted that health-care legislation put forth by U.S. Sen. Ted Kennedy (Mass.) would force many small businesses to drop health coverage all together, pointing to a new study showing Kennedy's bill would increase costs for small business.

Today the nonpartisan Congressional Budget Office (CBO) released its estimate for Kennedy's bill, the Patients' Bill of Rights. The CBO says the bill would increase premium costs 6.1% over five years, a 50% increase over the 1998 CBO estimate.

"The number one problem for small-business owners is the cost of health care. If Congress were to enact Senator Kennedy's health-care legislation, many small businesses would be forced to comply with expensive mandates and increased liability. As a result, a majority of small-business owners would no longer be able to afford health-care benefits for their employees and stop offering health insurance," said NFIB's Vice President of Federal Public Policy Dan Danner.

"Currently 43 million Americans do not have health coverage," said Danner. "Hopefully the new CBO numbers will deter Congress from enacting legislation that would increase health-care costs and push even more Americans into the ranks of the uninsured."

Making health care more affordable for small business is a priority in *NFIB's Small Business Growth Agenda for the 106th Congress*. NFIB represents over 600,000 small- and independent-business owners in all fifty states. To learn more about NFIB or the *Agenda*, log onto the web site at www.nfibonline.com.

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NAM National Association of Manufacturers

99-134

FOR IMMEDIATE RELEASE

NEWS CONTACTS:
KERRY LYNN SCHMIT (202) 637-3089
NEIL TRAUTWEIN (202) 637-3127

NEWS ALERT

HIGHER CBO ESTIMATE COMES CLOSER TO SHOWING TRUE COST IMPACT OF PATIENTS' BILL OF RIGHTS, NAM SAYS

New Estimate Shows Bill Will Raise Costs More Than 50 Percent Higher Than Originally Expected

WASHINGTON, D.C., April 26, 1999 – New, higher Congressional Budget Office estimates on the cost of the Patients' Bill of Rights are further evidence that legislation will raise the number of uninsured Americans, according to the National Association of Manufacturers.

"Even the Congressional Budget Office's somewhat low figure of a 6.1 percent health care cost increase due to the Patients' Bill of Rights will mean that 1,830,000 more Americans will have to go without insurance if the bill becomes law," said NAM President Jerry Jasinowski.

"We also need to be concerned about CBO's continually rising estimate on costs. Just last year, CBO pegged the increase at four percent, and there is always the risk that the figure will run even higher in future estimates.

"Without question, the CBO is underestimating the cost impact of the Patients' Bill of Rights," Jasinowski continued. "Barents has estimated the cost of liability expansion alone at 8.6 percent, and other credible estimates put the cost increases associated with the bill as high as 23 percent.

"With even the CBO unsure about how much pending health reform will actually cost or how many people will be priced out of insurance, it is clear we need to tread very lightly when it comes to changing our health care system. We simply must not make any move that leaves more people without insurance," concluded Jasinowski.

-NAM-

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facsimile transmittal

To:	Chris Jennings	**Fax:**	456-5557
From:	Adrienne Hahn	**Date:**	04/28/99
Re:	Speaking to Kennedy about External Appeals	**Pages:**	5
CC:	Gail Shearer		

X Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycl

Dear Chris:

Thanks so much for meeting with us today on Medicare, we really look forward to working with you on this issue. As promised, attached are the materials outlining the problem with the Patients' Bill of Rights Act (PBRA) external appeals structure. Simply put, PBRA allows a state to decide whether it will select the external entity or permit the plan to select the external entity. Under the PBRA, the plans pay for the appeals and can select the reviewer, this structure creates an inherent conflict of interest: reviewers could jeopardize future business if they decide against the plan. A whole host of organizations including the AFL-CIO, AARP, Consumers Union, and others have advised against this approach and even went further advocating for ONLY the state to select the reviewer. (Please see attachments.)

The Department of Labor recognized this shortcoming in the PBRA as well and advised Democratic staff to at least require a randomized process if the plan selects the reviewer to ensure that the appeal is truly independent. We would really appreciate it, if you could speak to Senator Kennedy about this matter and urge him to adopt DOL's suggested change for the selection of the reviewer which is a compromise between consumer, senior, and labor organizations and Democratic staff's approach. We understand Congressional staff are considering redrafting the medical necessity language in the bill and this might be a good opportunity to fix the external appeals process as well.

If you have any questions, please do not hesitate to give me a call. Thanks for your consideration on this matter.

AARP

March 31, 1998

The Honorable Edward M. Kennedy
315 Russell Senate Office Building
United States Senate
Washington, D.C. 20510

Dear Senator Kennedy:

AARP is deeply committed to assuring quality and consumer protections in managed care. We commend you for your leadership in the effort to develop effective consumer protections in managed care through legislation. It is our hope that you will continue your efforts and that meaningful bipartisan legislation that sets enforceable standards will be enacted this year.

"The Patients' Bill of Rights Act" is a good step toward assuring that Americans can rely on quality health care no matter what type of plan they use. We believe this bill includes several basic safeguards for the nation's managed care consumers. Among these are: improved access to emergency services; prohibiting "gag clauses" and providing consumers with information to make appropriate treatment decisions; and increased disclosure of information to consumers about plans, health care professionals, and facilities.

AARP is especially pleased with the attention given to the grievances and appeals process and the inclusion of both a rigorous system of internal review and an independent system of external review. An external appeals process will provide an objective review of denials, terminations, and reductions of care; and it will help to ensure that consumers have a fair and efficient process for resolving differences with their health plans and health care providers.

While your bill addresses several important standards, more will need to be done. In particular, we believe consumers would benefit from: a strong quality assurance provision that includes external review; a requirement that States choose the outside reviewing entity for external appeals; and, a meaningful framework for enforcement of national standards to assure that the rights and protections will apply to all consumers no matter what type of plan they use.

601 E Street, NW Washington, DC 20049 (202) 434-2277

We look forward to your continued leadership in the effort to win adoption of effective and enforceable consumer protection standards. If there is anything we can do to move the debate forward, do not hesitate to call me or have your staff call Tricia Smith or Mila Becker of our Federal Affairs Department at 202/434-3770.

Sincerely,

Horace B. Deets

Consumers Union

Publisher of Consumer Reports

Independent External Appeals
A Necessary Ingredient for Managed Care Reform

Approximately 161 million Americans are currently enrolled in a form of managed care. All of those patients deserve patient protections, enforceable through a fair external review process. An impartial external grievance and appeals system is necessary for all other consumer protections aimed at providing the delivery of quality care.

Today, many consumers are trapped *within* their health plan, which is totally in control of treatment decisions. The result: consumers risk *not* getting the medical care they need when bottom-line considerations, not medical appropriateness, have undue influence on decision-making. A truly independent external appeals process acts as a safety valve to ensure that consumers receive the appropriate care when a plan wrongly denies care. It also gives plans an incentive to improve their internal decision making processes (since they will be subject to external review).

Below are the elements necessary for a truly independent external appeals process:

Request for an Appeal

- ***An external appeal should be available upon written or oral request.***
  An enrollee (or doctor/individual acting on behalf of the enrollee with the consent of the enrollee) who desires to have an external appeal shall have an external review made available upon oral or written request for the review.

Scope of the Appeal

- ***An external appeal should be available for the denial of any medical service or payment.***
  A managed care enrollee who has had an adverse determination (of any grievance or appeal under the issurer's internal review process), should have the right to an external appeal if that decision denies, reduces, limits, terminates or delays a covered benefit or if the decision denies payment for a covered benefit (with no monetary or treatment threshold).

Selection of the Reviewer

- ***The external appeal entity should be appointed by the State or through a random process conducted by the State.***
  For an external review process to be truly independent, the entity selecting the reviewer must not have a stake in the outcome of the decision-making process. If plans pay for the appeal and select the reviewer, there is an inherent conflict of interest: reviewers could jeopardize future business if they decide against a plan. Having the State select the reviewer eliminates the financial incentive for the outside entity to be biased in resolving the dispute.

Washington Office
1666 Connecticut Avenue, Suite 310 ▪ Washington, D.C. 20009-1039 ▪ (202) 462-6262

Safeguards to Ensure Fairness

- ***The external appeals process should provide safeguards against any conflict of interest by an entity or individual selected to conduct an external review.***
  Within the external appeals process, a mechanism must exist to identify all real or apparent conflicts of interests, and to disqualify all individuals or entities with any such conflict.

- ***The external appeals process must provide for a de novo review.***
  A managed care enrollee's right to an external appeal must provide for a fair, de novo, evidence-based review by a neutral review entity of the internal appeals decision.

Rule of Construction

- ***The external appeals process must provide for an expedited review.***
  The external appeals process must provide for an expedited review process in the event of a medical emergency or where speed is essential to the medical treatment. Most treatment decisions should be made within a few weeks, and some within a few days or even hours.

- ***The external appeals process must be binding on the plan.***
  The determination of a review panel must be binding on the plan to ensure that the process is not an exercise in futility. The final decision of the external reviewer should neither limit nor prevent the managed care enrollee from bringing a civil action based upon the coverage involved.

- ***The plan must pay for the cost of the external appeals process.***
  The health insurance issurer must be financially responsible for any and all reasonable costs associated with the conduct of an external review, including those incurred by the applicable State authority – except any filing fee (which should be minimal, and waivable for hardship). If the enrollee (or an individual acting on behalf of the enrollee) prevails in the external review, the issurer shall also pay the enrollee's reasonable preparation costs, including attorneys' fees for the representation during the review process.

Reporting By Review Entity

- ***A review entity must submit information for an annual report.***
  A review entity should submit information for an annual report to the appropriate State body containing the number of reviews performed, the health plans involved, and their outcomes. The information contained in the annual reports, excluding any personally identifying patient information, shall be made accessible to the general public. The State shall have a duty to review these annual reports and take appropriate action.

For further information contact Adrienne Hahn or Gail Shearer at 202-462-6262.

DATE: 5-07-99

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
200 INDEPENDENCE AVE., SW
WASHINGTON, D.C. 20201

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TO : Gary Claxton / Chris Jennings

FROM: 456-5557

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PHONE NO : _____

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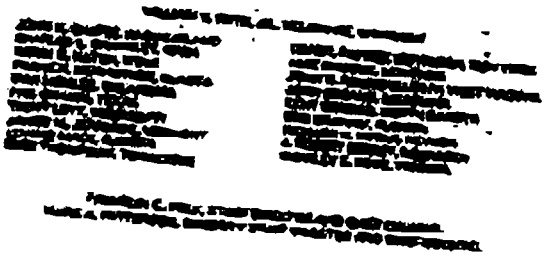
Fax: Gary
Chris J.



United States Senate

COMMITTEE ON FINANCE
WASHINGTON, DC 20510-6200

May 5, 1999

The Honorable William V. Roth, Jr.
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

We understand that you are considering whether the Finance Committee should mark up the tax title to S. 300, the Patients' Bill of Rights Plus Act, as reported by the Committee on Health, Education, Labor and Pensions (HELP). We write to express our serious reservations about this legislation, and to state our opposition to taking action on such a bill in the Finance Committee at this time.

We are concerned that Finance Committee action on this legislation may adversely affect the prospects for enacting a meaningful patient protection bill this year. S. 300 was reported by the HELP Committee on a straight party-line vote. Addition of a tax title, even if it were to avoid controversial tax proposals, would not avert the likelihood of gridlock when the bill reaches the Senate floor. Yet the tax title of S. 300 includes a provision for expansion of Medical Savings Accounts, which are highly controversial and have in recent years been the subject of partisan divisions in the Finance Committee and on the Senate floor.

We want the Congress to consider and enact meaningful patient protections, a goal we believe you share. To accomplish this objective, Senators must work together on a bipartisan basis to craft a set of patients' rights that will benefit health care consumers and not jeopardize the availability of health care to all Americans. Perhaps the members of the Finance Committee offer the best chance for developing consensus legislation. Our members should have the opportunity to address the underlying patient protection provisions of the bill. To ignore our responsibilities in that regard could jeopardize the Committee's jurisdiction in the future.

In our view, marking up a tax title to append to the HELP Committee bill will make it more difficult for the Senate to reach bipartisan agreement on this important issue. If the Finance Committee is to consider a managed care bill, then we would urge you to schedule a markup of comprehensive legislation that can pass the Senate and be signed into law.

Sincerely,

Max Baucus

Daniel Patrick Moynihan

John Breaux

John D. Rockefeller IV

Bob Graham

Kent Conrad

Robert Kerrey

Richard Bryan

Charles S. Robb

TRENT LOTT
MISSISSIPPI

United States Senate

OFFICE OF THE MAJORITY LEADER
WASHINGTON, DC 20510-7010

June 3, 1999

The Honorable Tom Daschle
Senate Minority Leader
S 221
The Capitol
Washington, D.C. 20510

Dear Tom:

Thank you for your recent letter expressing your interest in debating the Patients' Bill of Rights. As you know, Senate Republicans are committed to providing needed patient protections and increasing access to care. We believe that our plan would accomplish these goals without adding significant new costs, causing many Americans to lose their health care coverage.

During the first weeks of the 106th Congress, we introduced health care protections, supported by fifty Senators. It was the second bill considered by the Health, Education, Labor and Pensions Committee and was reported favorably by that committee in March. I am pleased by the progress we have made on this important issue during the early months of this Congress.

As we both know, our differences over the Patients' Bill of Rights are clear, well defined and limited. I propose that you or your designee work with Senator Nickles, chairman of the Republican Health Care Task Force, to come to a reasonable agreement on time and amendments for floor consideration. Your leadership in this matter will help ensure that we proceed expeditiously to patient protection legislation.

The Senate needs to act quickly to protect the Social Security trust fund for our seniors, to enact meaningful liability protections for Y2K, and to work through our appropriations bills. I am confident that we can also move forward quickly on patient protections when such an agreement is reached. I look forward to your assistance on this matter.

Sincerely,

Trent

Trent Lott

Chris-
FYI

Joel

TOM DASCHLE
SOUTH DAKOTA

United States Senate
Office of the Democratic Leader
Washington, DC 20510–7020

May 25, 1999

The Honorable Trent Lott
Majority Leader
United States Senate
Washington, DC 20510

Dear Mr. Leader:

On April 19, we wrote to request that you schedule for floor consideration before the Memorial Day recess four measures of critical importance to working families. At the top of that list was the Patients' Bill of Rights (S.6), a bill to provide urgently-needed basic protections for the 161 million Americans who rely on private health insurance.

We are disappointed that not a single day of the seven-week work period now ending was devoted to addressing the Patients' Bill of Rights or any of the other legislation mentioned in our letter of April 19. While we supported your decision to take up the juvenile justice legislation and the supplemental appropriations bill, we note that consideration and passage of those two measures required less than six full days of floor time. The remaining time, in our view, could have accommodated consideration of the legislation described in our last letter.

Senate Democrats are committed to working with you in the 106th Congress to enact all of the legislation on our agenda. We are particularly interested in taking early action in June on patient protection legislation, which enjoys support in both parties and should not be a partisan issue. We are prepared to begin work on the floor using as a vehicle either S. 6, the Democratic bill, or S. 300, the bill recently ordered reported by the Committee on Health, Education, Labor, and Pensions.

Therefore, we ask that you schedule the Patients' Bill of Rights for the floor as soon as possible after the Senate reconvenes on June 7, and that the bill be considered without restrictions on the opportunity for either side to offer amendments. Since the legislative schedule often becomes crowded near the close of a legislative work period, we seek your assurance that the Patients' Bill of Rights will be taken up promptly in June, and that Senators will be afforded ample time for a full debate and amendment process appropriate to a measure of such clear and immediate importance to the nation.

Sincerely,

Harry Reid

Tom Daschle

Barbara A. Mikulski

John B. Breaux

Byron L. Dorgan

Richard J. Durbin

John F. Kerry

J. Robert Kerrey

Patty Murray

John D. Rockefeller IV

Robert G. Torricelli

DEMOCRATIC TECHNOLOGY & COMMUNICATIONS COMMITTEE
619 Hart Senate Office Building
Washington, D.C. 20510-7050
Phone: (202) 224-1430 Fax: (202) 224-1431
http://www.senate.gov/~dpc

FAX TRANSMISSION COVER PAGE

Date: 4/8/99 This page and 3 others.

To: Karen

Fax Number:

From: Laura Quinn

Message: as you can see - quite an interesting mix of organizations -- I checked a few of the most impressive.

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Alliance for Children & Families
http://www.alliance1.org/policy.asp
American Optometric Association
http://www.aoanet.org/members/
Resolve
http://www.resolve.org/pbr/pbr.htm
American Trial Lawyers Association
http://familysafety.atla.org/whatnew/pbr2.htm
Lutheran Office for Governmental Affairs
http://www.loga.org
Network
http://www.networklobby.org
✓ AFL-CIO
http://www.aflcio.org/publ/patbill.htm
FamiliesUSA
http://www.familiesusa.org/pbr/
National Partnership for Women and Families
http://www.nationalpartnership.org/healthcare/petition.htm
American Association of University Women
http://www.aauw.org/1000/petition.html
National Association of People with AIDS
http://www.napwa.org/pbor.htm
American Counselling Association
http://www.counseling.org/government_relations/petition.htm
✓ League of Women Voters
http://www.lwv.org/pbr_sign.htm
Paralysis Society of America
http://www.psa.org/pbr.htm
✓ American Nursing Association
http://www.ana.org/
✓ American Small Business Alliance
http://www.asbanet.org/
National Association for People With AIDS
http://www.napwa.org
✓ United Methodist Church
http://www.umc-gbcs.org/
Human Rights Campaign
http://www.hrc.org/issues/aids/106congs.html
CAMPC
http://www.campc.com

American Society of Plastic and Reconstructive Surgeons
http://plasticsurgery.org
Brain Injury Center
http://www.biausa.org
Coalition League of Union Women
http://www.cluw.org/pbr.htm
National Paitent Advocate Foundation
http://www.patientadvocate.org
National Mental Health Association
http://www.nmha.org/new/index.cfm
Bazelon Center
http://www.bazelon.org/alerts
SEIU
http://www.seiu.org/
American Academy of Physical Medicine & Rehabilitation
http://www.aapmr.org
American Academy of Neurology
http://www.aan.com/resources.html
American Association for the Advancemnet of Orthotics and Prosthetics
http://www.oandp.com & http://www.oandp.com/naaop
National Coalition for Cancer Survivorship
http://www.cansearch.org/whats_new
/protection_for_all_patients_withv2.htm
✓ American College of Emergency Physicians
http://www.acep.org/PUBLIC/pbr/pbr.htm
American Medical Rehabilitation Providers Association
http://www.amrpa.org/
Religious Action Center for Reform Judaism
http://www.rg.org/rac
✓ American Heart Association
http://www.nw.dc.us/aha/petition.html
Alliance for Children and Families
http://www.alliance1.org/policy/asp
American College of Obstetricians and Gynecologists
http://www.acog.org/from_home/departments/govtrel/petition.htm
American Association for Marriage and Family Therapy
http://www.aamft.org/members/advocacy/petition.html
American Association of Nurse Anesthetists
http://www.aana.com
Friends Committee on National Legislation

http://www.fcnl.org

American Academy of Neurological Surgeons

http://www.aans.org/pubpages/patres/billofrights/billofrigts.html

FEHB Program Carrier Letter

All Carriers

U.S. Office of Personnel Management
Office of Insurance Programs

11-2 11[15] to 43

Letter No. 1999-016 (Draft—March 31, 1999) **Date: April 2, 1999**

Fee-for-service [13] Experience-rated HMO [13] Community-rated HMO [14]

SUBJECT: Annual Call Letter for Contract Year 2000

This is the annual call for proposed benefit and rate changes from plans participating in the Federal Employees Health Benefits (FEHB) Program. As in the past, this call letter states our goals and procedures for the upcoming negotiations. From now through May 31, 1999, we will consider requests for changes for the contract term beginning January 1, 2000. While the end of May is the regulatory deadline for your written submission, I strongly encourage you to discuss with your contract specialist any changes you are considering, including those necessary to bring about the outcomes discussed in this letter.

To assure a timely Open Season, we will begin negotiations upon receipt of your request for benefit and rate changes. Specific instructions concerning information required to support requests for rate changes will follow shortly. We will operate under a schedule that will ensure completion of all negotiations -- benefits and rates -- by August 27, 1999.

This call letter covers program initiatives for contract year 2000. It also gives you advance information on mental health and substance abuse parity, which we plan to address for contract year 2001.

Contract Year 2000

The significant initiatives for contract year 2000 include:

- The Patients' Bill of Rights,
- Quality Healthcare,
- Family-Centered Care,
- Customer Service,
- Provider Contracts (Fee-for-Service plans),
- The DoD/FEHB Demonstration Project, and
- Y2K Compliance.

Lisa Rovin
Lisa Lang
Ed Flynn

FRANK TITUS

Patients' Bill of Rights

The President signed an Executive Memorandum on February 20, 1998, directing the Office of Personnel Management (OPM) to take steps necessary to bring the FEHB Program into contractual compliance with the Patients' Bill of Rights requirements by the end of 1999. Enclosure 1 summarizes the

requirements vs. implementation

information you arranged to disclose and the benefit changes you implemented at the beginning of 1999. FEHB plans gave the Patients' Bill of Rights their full support, implementing the requirements for 1999 (and in many cases, 2000) at an annual cost of less than 25 cents per enrollee. We deeply appreciate your cooperation in this important effort.

OPM is reluctant to do this →

insert 1: Accomplishments PP

We discuss the remaining benefit and information requirements below and in Enclosure 2. The program-wide cost of implementing these should be small, as you have already completed many of the requirements. We look forward to working with you over the negotiation cycle to ensure that all of these important protections are in place by January 2000.

- Information Disclosure. Plans that have remaining provisions to implement must meet all the requirements no later than at the beginning of the Open Season for 2000 (November-December 1999), or at the beginning of contract year 2000 (as indicated below).

  The Patients' Bill of Rights requires that certain information be available to a member, or potential member, while he or she is considering an enrollment decision; and that other information be made available upon request. Enclosure 2 lists the information that must be available to members beginning with the Open Season for 2000. Some of this information will be incorporated into the brochure language we send you this spring for the year 2000 plan brochures. You should make the rest available on your web site, in information sheets, in plan guides, in provider directories, by telephone, or through other means of communication. During the negotiation cycle, we will work with you to develop brochure language that describes the information that members are entitled to receive, and the means by which they can access that information.

Last year the call letter recognized that certain Patients' Bill of Rights changes might require provider contract changes that you could not effect immediately. Accordingly, we gave you until 2000 to make necessary changes or to adopt other compliance strategies. Your response to this letter should reflect the strategies you will put in place for 2000.

- Transitional Care. Members undergoing treatment for chronic or disabling conditions (or in the second or third trimester of pregnancy) at the time they involuntarily change health plans, or at the time their provider is terminated by the plan for reasons other than cause must be able to continue seeing their specialty providers for up to 90 days (or through completion of postpartum care). When providers continue to treat such patients, the patients will pay no more than previously, providers will give all necessary information to the plan for quality assurance purposes, and promptly transfer all medical records with patient authorization during the transition period.

  An "involuntary change" is (1) when a plan terminates the member's provider from the plan's network for other than cause, or (2) when a plan leaves the FEHB Program. These two situations could occur at any time during a contract period. If a plan terminates a provider from its network for other than cause, the plan must pay for or provide the member's transitional care. If a plan leaves the FEHB Program, the member may enroll in a new plan.

  ↑benefit does not apply to open season;

If the member is eligible for transitional care, the new plan must pay for or provide the transitional care.

- Medical Records. The Patients' Bill of Rights requires that members be allowed to review and copy their medical records and to request amendments to their records. Federal members must be able to review and obtain copies of their medical records. They also may request that their physician amend the record if they identify errors. The physician will have sole discretion on whether to make the requested change. While the member may not delete, strike, or change any existing information, the member must be allowed to add a statement to clarify or rebut the record.

Quality Healthcare

The Institute of Medicine defines *quality healthcare* as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." In an environment where managing patient populations is also important, quality healthcare also must encompass how well a plan performs in meeting members' non-clinical needs and expectations. Our view of the broad range of quality includes the following:

- Accreditation. We believe accreditation is a valuable indicator of a plan's capacity to provide quality care and therefore strongly encourage you to seek accreditation from an external organization.

- Health Plan and Employer Data Information Set (HEDIS). Health plan comparisons are facilitated by standardized plan performance measurements. We will begin to collect and analyze audited HEDIS data in 2000 and expect to provide our enrollees with plan data on specific measures no later than 2002. We will ask plans that report HEDIS to other purchasers to report the same information to us in 2000. We will expect non-reporting plans to collect and report data on HEDIS and HEDIS-like measures that we specify. We intend to work closely with you to facilitate implementation.

- Outcome Measures. This year we sponsored a pilot project in conjunction with the Foundation for Accountability (FACCT) and several health plans to gather data on the care provided asthma patients. We intend to replicate this study in 2000 in selected regions to produce data that is comparable across fee-for-service and comprehensive plans in specific geographic areas.

- Consumer Assessment of Health Plans Study (CAHPS). In 2000, we will continue to use the CAHPS Adult and Child Core Questionnaires, following the NCQA Protocols, as our survey instrument.

Family-Centered Care

The Vice President's 7th Annual Family Reunion focused on Families and Health. As a participant in last year's event, the Institute for Family-Centered Care promoted the idea that "the family has significant

influence over an individual's health and well-being, and that because of this influence, families must be respected and supported in their roles as care givers and decision-makers." Spurred by the initiative, we featured a discussion of family-focused health care at least year's plan conference and contracted with the Gallup Organization to conduct focus groups to assess our Program from a family-focused perspective. The following items grew out of these initiatives.

- Childhood Immunization Schedule. We expect participating plans' benefits to be consistent with the American Academy of Pediatrics's recommended schedule for childhood immunizations. In January, the Academy issued a policy statement that recommended inactivated poliovirus vaccine (IPV) at 2 and 4 months of age. For the third and fourth doses of poliovirus vaccine, either IPV or oral poliovirus vaccine can be administered. We expect your practice to be consistent with these recommendations.

- Non-FEHB Dental and Vision Benefits. Enrollees participating in focus groups consistently said that expanding dental and vision benefits would make the FEHB Program more family-centered. We are considering a variety of options in these areas for future years. For 2000, we encourage you to offer dental and vision coverage to FEHB members as non-FEHB benefits and to list such coverage prominently on the non-FEHB page of your plan brochure.

- Colorectal Cancer Screening. All plans currently provide annual coverage of one fecal occult blood test for members age 40 and older. Following guidelines recommended by the American Cancer Society, The American Gastroenterological Association, and others, we want coverage extended to a screening sigmoidoscopy every five years starting at age 50.

- Other Screenings. The American Medical Association defines "screening" as, "health care services or products provided to an individual without apparent signs or symptoms of an illness, injury, or disease for the purpose of identifying or excluding an undiagnosed illness, disease, or condition." Your approach to screenings and diagnostic tests must consider risk assessment and family history when making coverage determinations.

- Other Family-Centered Issues. Focus group participants also shared their feelings about customer service. Some perceive that plans need to strengthen their role in communicating information and collaborating with providers in the delivery of care. Although we are not aware of Program-wide problems in these areas, we agree that plans should play a positive role as facilitators in behalf of their members.

  Some FEHB enrollees view the referral process as a barrier to seeing specialists, rather than as a way to assure that necessary and appropriate care is provided. FEHB enrollees with chronic conditions reflect this perception. The Patients' Bill of Rights requirements regarding access to specialists for patients with complex or serious medical conditions should address this concern. Nevertheless, we also encourage you to develop authorization systems that allow you to monitor referral rates and patterns while providing the least disruption to enrollees.

  Because coverage decisions are made on a medical or contractual basis, enrollees' expectations are sometimes not met. We believe that increasing enrollee awareness about

health coverage through a well-established patient education program and clearly written benefit explanations may promote more realistic expectations.

Family-centered care should be a collaborative effort between the patient, provider, and health plan. Well-informed case managers can help resolve problems with ancillary providers (e.g., a home health care agency or durable medical equipment provider) when members are not satisfied with the services they receive. Bereavement benefits and benefits for a family member to travel with a patient to a center of excellence outside a commuting area are examples of family-centered benefits some plans provide. We encourage you to review and emphasize your family-centered programs. Tell us about positive activities you undertake and give us examples of family-centered communication you develop for enrollees. We will share best practices with other plans.

Customer Service

- Plain Language. The President and Vice President have made plain language a top priority for Federal agencies. Plain language sends a clear message about what the Government is doing, what it requires, and what services it offers. It saves time, effort, and money. In Carrier Letter 1999-001, we announced an initiative to rewrite FEHB brochures in plain language. Along with a group of plan representatives, we are developing guidelines for written communication. We will forward the guidelines to you this spring and ask you to begin using them to shape correspondence between you and your enrollees. When you receive guidance on brochure development, you will see that the Plain Language Work Group has rewritten a number of mandatory brochure sections. We are excited about this project and believe it will improve our relationships with customers and the clarity of our brochures.

- Electronic Enrollment. Increased electronic processing of health benefits enrollment changes through the use of Employee Express and Annuitant Open Season Express remains a high priority. Last year, a number of plans failed to follow guidelines for reducing paperwork and ensuring a rapid and smooth flow of enrollment and related information. Some plans did not process electronic transmissions even though we sent out specific instructions and tested transmissions. Other plans failed to honor confirmation letters generated by electronic enrollment systems. Some plans even failed to accept electronic enrollments without corroborating paperwork, although these systems are specifically designed to replace paper forms.

  Plans must be proficient in electronic communication. The capability to produce brochures, to receive and send information, and accept enrollment information electronically is critical. Your ability to meet these requirements is an important element of your performance.

Provider Contracts (Fee-for-Service plans)

- Full Disclosure in Use of Provider Discounts. During 1997, the medical community raised concerns about payment schemes that create discounts for payers who are not entitled to the discounts. In 1998, the independent inspector general for OPM reported on a special

investigation into the use of provider discounts in the FEHB Program and found no unethical conduct on the part of the plans or intermediaries who arrange for provider discounts. We expect plans that secure fee discounts through intermediaries will continue to ensure that discounts are consistent with contracts between the vendor and provider networks, and are properly disclosed to the providers who are the source of discounts.

- Benefits for Services of Non-Physician Providers. As you know, the FEHB statute has been amended a number of times to reference certain non-physician providers as a means of assuring enrollee access to them for covered services. Some plans limited access to non-physician providers to those referenced in statute. Public Law 105-266 clarified this situation by expressly stating that nothing prevents health plans from providing benefits to providers other than those previously listed in statute. The use of qualified health providers in addition to physicians can widen health care options and reduce costs for plans and patients. We encourage plans to provide access to non-physician providers who are qualified to provide covered services, such as audiologists or physician assistants, when it is appropriate and cost effective to do so.

Department of Defense Demonstration Project

We informed you in Carrier Letter 1999-005 that we will be conducting a demonstration project with the Department of Defense (DoD) beginning January 2000. The demonstration, which was mandated by the Congress, will make coverage available to up to 66,000 Medicare eligible military retirees and related beneficiaries. The demonstration will last through the end of the 2002 contract year.

All open Fee-for-Service plans are required to participate in this project. We will identify the HMOs that will also be required to participate, based on their service areas and the defined boundaries of the eight demonstration sites listed in Carrier Letter 1999-005. We also will identify HMOs that may participate but will not be required to do so because their FEHB enrollment is very small, or their service area overlaps only a small portion of a demonstration area.

The legislation requires that a separate risk pool be established for DoD demonstration project enrollees. Therefore, participating plans must submit separate rate proposals, based on benefits identical to those available to all other FEHB enrollees. Affected plans must submit their DoD rate proposal along with their regular rate proposal by May 31, 1999.

Y2K Compliance

Your 1999 contract requires that you report your Y2K compliance status along with your benefit and rate proposal on May 31. You must ensure that the hardware and software that you use in the performance of your FEHB contract will accurately process date/time data involving dates later than December 31, 1999. On May 31, you must either assure your Contracting Officer that your system is compliant or provide a contingency plan that details how the system will remain operational after December 31, 1999. You also must include a copy of your company's purchasing policy specifying that all hardware and software acquisitions will be Year 2000 compliant. You should take all necessary steps to provide uninterrupted, complete services to enrollees. If you are unable to meet these service

expectations, you must report the failure to us as a significant event.

Finally, toward the end of 1999, you should anticipate all kinds of increased demands because of enrollee apprehension about year 2000 system breakdowns. For example, you almost certainly will receive a significant number of "premature" requests for prescription refills. There also may be heightened anxiety about receipt of new ID cards. Please plan accordingly. Take whatever steps in advance that you think might allay consumer concerns, but be sure provisions are in place to relax restrictions on access to prescription refills and other services if necessary. In your May 31 submission, tell us how you will deal with these customer concerns.

Planning for 2001

HHS wants to keep the mental health stuff in.

~~Mental Health and Substance Abuse Benefit Parity~~

~~Over the past several years, the FEHB Program has been moving toward mental health and substance abuse benefit parity. The movement has been incremental. For example, we have not accepted proposed reductions in the value of mental health benefits covered, we have encouraged utilization management to help compensate for modest improvements in benefits, and we have allowed mental health benefit improvements as an exception to our normal policy of only accepting cost-neutral benefit changes. We have eliminated lifetime and annual maximums in the FEHB Program and have negotiated with health plans to move away from contractual day and visit limitations and high deductibles for mental health coverage. We have encouraged the use of Preferred Provider Organizations so that increased mental health benefits could be achieved on a cost-neutral basis. For 1999, we directed that pharmacotherapy and medical visits and testing to monitor drug treatment for mental conditions be covered at the same benefit level as medical/pharmaceutical management of a physical disease. While we have had some success in achieving voluntary compliance, we have yet to achieve the goal of benefits parity.~~

We have reviewed research by the National Advisory Mental Health Council, the National Alliance for the Mentally Ill, the Substance Abuse and Mental Health Services Administration, and others. We have also considered recommendations of the National Institutes of Mental Health. These reviews and considerations, along with other factors such as legislative action at the State level, insurance industry trends, recent advances in treatment, and the proven ability of managed behavioral health care organizations to control costs, have convinced us that it is now time to request parity across the entire FEHB Program.

- Parity Under the FEHB Program. So that you will have adequate lead time, we are not requiring any changes to your mental health or substance abuse benefits for 2000, but we intend to implement parity in 2001. Our goal is to make plan provisions for medical care and behavioral health services identical with regard to deductibles, coinsurance, copays, and day or visit limitations. We recognize that there are a variety of benefit-design approaches that can achieve this goal.

  We expect that parity will apply to benefits provided in a fully coordinated managed behavioral health environment that incorporates case management, authorized treatment plans, gatekeepers and referral mechanisms, contracted networks, pre-certification of inpatient services, concurrent review, discharge planning, retrospective review, and disease

can't tell what's permissive & what's mandatory

HHS doesn't understand this ?? Confirm OPM

management. You can arrange for such services through a managed behavioral health organization or establish the necessary structure within your plan.

We encourage you to start planning now since new contractual arrangements take time to put into place. We will work with you to ensure a smooth transition to parity in 2001.

Administrative Issues

- Effective Date for Rates and Benefits. On August 31, 1998, we published a proposed regulation that would adopt January 1st as the effective date of new enrollments and changes in enrollments made during the annual open season. In response to concerns raised by Federal agencies, we decided to postpone implementation of this regulation. We still believe the move to a standard open season effective date will simplify administration of the FEHB Program and reduce the potential confusion and error. However, we want to give agencies ample time to complete their Y2K activities before they undertake new systems reprogramming efforts. We anticipate an implementation date of January 1, 2001. We will issue a Carrier Letter when the regulation is final.

- Enrollment Code Data Field. Given the size and nature of the FEHB Program, the 3-digit enrollment code data field is no longer adequate. Please plan now for expansion to a 10-digit field to allow for maximum flexibility in the future. Is this in compliance w/admin simp NPRM

Specific Guidance

1. All plan-initiated proposals for benefit changes must be cost neutral. For OPM-initiated proposals, we will consider actuarially-sound rate adjustments.

2. As in past years, we will not accept proposals for second options. We will consider proposals for three-tiered Point of Service products that differentiate between self-referrals to in-network versus out-of-network providers.

3. We would like to see proposals to consolidate rating areas where only small numbers of Federal employees or annuitants are enrolled. You must include any new rating area or service area changes in your May 31 submission. Include these proposed changes in the cover letter as well as your rate submission.

4. This call letter does not affect existing benefit guidelines and policies. New plans should contact their contract specialist for information on these benefits and policies.

Proposal Submission

1. OPM must receive your signed requests for benefit changes and clarifications by May 31, 1999. These requests must be signed by an authorized plan contracting official.

2. Precisely describe your proposed benefit changes and support them with actuarial justification. Additional benefit proposal instructions are discussed in your Enclosure.

3. Use the attached format instructions to submit benefit changes and clarification submissions. This format is mandatory.

4. You must submit your proposed brochure language with your request for benefit changes and clarifications. See the enclosed instructions. You must include language for a "How Benefits Change in 2000" page (except for new plans), as well as language describing how the proposal affects benefits, exclusions, limitations, definitions and procedures. Your proposed language should be clear, in plain language, and explain how the change will affect the customer from the customer's point of view.

5. Send your proposals to the attention of your contract specialist at:

(Overnight delivery)
U.S. Office of Personnel Management
Office of Insurance Programs
Attn:
1900 E Street, NW, Room 3414
Washington, DC 20415

(Regular mail)
U.S. Office of Personnel Management
Office of Insurance Programs
Attn:
P.O. Box 707
Washington, DC 20044

Evaluation of Proposed Benefit Changes

We will evaluate your benefit proposal according to the quality and balance of your overall health benefits package, the effectiveness of your utilization and cost controls, the economic consequences of the proposal, and the efficiency of your administration of the FEHB contract.

Brochures

Brochure production is <u>your</u> responsibility. We expect a timely, professional document that follows our guidelines. Unless you make other arrangements with your contract specialist, we expect you to incorporate mandatory brochure language changes, together with changes that you propose, to the unformatted text file of your 1999 brochure as the basis for development of the 2000 brochure. You must transmit a copy of this file to us with proposed benefit changes and/or clarifications inserted by May 31, 1999. Please note that the file you transmit to us must be an unformatted text file. If you do not have an unformatted text file which represents your 1999 brochure, request one from your contract specialist. We will work with you to develop brochure language using this file. We will make revisions to it and return it to you electronically. Once benefit negotiations have been completed, we will transmit the final agreed-upon text to you for use in typesetting the 2000 brochure. This text will also be included in your 2000 FEHB contract. Once the contract has been executed, we will give you authorization to print and distribute the 2000 brochure.

Disclosure Policy Under the Freedom of Information Act

Any information included in your proposal will be subject to public disclosure after negotiations with all plans are completed and new contracts are announced. Please identify each item in your proposal that you believe is exempt from disclosure under the Freedom of Information Act. Also, specify which exemption you believe applies to that item and give full justification for your belief that the exemption applies.

We will decide on disclosure if we receive a request for information. We will base our decision on the nondisclosure justification you submit with your proposal. If we intend to release any information that you believe is exempt from disclosure, we will inform in advance.

2000 Contract Execution

We will send the 2000 FEHB contract to each FEHB plan in time for the contract to be fully executed no later than October 15, 1999. We will send you additional information and requirements shortly.

Enclosures

There are separate enclosures for Fee-for-Service, Health Maintenance Organization and newly approved Health Maintenance Organization plans. You will receive only the appropriate enclosure.

Sincerely,

Frank B. Titus
Assistant Director
for Insurance Programs

Enclosures

Enclosure 1
Page 1 of 2

Information Disclosure and Benefit Changes For 1999

This checklist is being provided to provide context for the year 2000 requirements. The following measures should already be in place.

HHS has questions about the * ones

Information Disclosure

A. About the Plan and Care Management:

- Formulary drug inclusion and exception process
- Experimental/investigational determination process
- * Compliance with State or Federal licensing or certification requirements if applicable, including the date the requirements were met. Note where the plan is out of compliance with a requirement and the reason for noncompliance *
- Disenrollment rate for 1998 (FEHB open season losses / Dec 31 enrollment = %)
- Accreditation status and dates received
- Years in existence (corporate)
- Plan's corporate form (profit/non-profit, private/public)
- * Whether plan meets State and Federal requirements for fiscal solvency *
- Whether the plan meets standards (State, Federal, and private accreditation) that assure confidentiality of medical records and orderly transfer to caregivers
- Plan preauthorization and utilization review procedures
- Clinical protocols, practice guidelines and utilization review standards pertinent to patient clinical circumstances
- Disease management programs or programs for persons with disabilities (this information should indicate whether these programs are mandatory or voluntary or if a significant benefit differential results)
- * Whether a specific prescription drug is included in the formulary and procedures for considering requests for patient-specific waivers *
- Qualifications of reviewers for reviews and appeals

separate avail upon request = standard

Benefit Changes

Women should have access to plan gynecologists, certified nurse midwives, and other qualified providers for routine and preventative women's health care services.

To the extent that certified nurse midwives are eligible to practice under existing State law and meet credentialing requirements, we expect plans to contract with them, and provide access to them, for the provision of covered services within the scope of their license or certification. We expect that plans will either allow plan OB/GYNs to act as primary care providers or allow members direct access to them for routine gynecological examinations.

Consumers with complex or serious medical conditions who require frequent specialty care should have direct access to a qualified specialist of choice within the plan's network of providers. Authorizations, when required, should be for an adequate number of direct access visits under an approved treatment plan.

You must use the standard brochure language that was distributed to you in May of 1998 to describe this benefit.

Access to Emergency Services

You must be using the "prudent layperson" standard when reviewing emergency care visits for coverage eligibility. Standard brochure language to describe this benefit was distributed to you in May of 1998.

In-Network Provider Access

The Patients' Bill of Rights requires that if a health plan has an insufficient number or type of providers to provide covered benefits with the appropriate degree of specialization, the plan should ensure consumers obtain benefits outside the network at no greater cost than if obtained from in-network providers.

We recognize that under some PPO arrangements there may be limited access to some types of providers and/or providers in certain geographic areas. Where this is the case under a PPO, the plan is responsible for describing such limitations in its brochure as well as its provider directory. There will be no requirement to provide the enhanced PPO benefit where the limitations about provider availability are appropriately described. The description of such limitations must be straightforward and in plain language so that consumers will understand exactly what to expect. However, OPM expects plans to aggressively expand their current PPOs and to establish PPOs in areas where they do not now exist so that enrollee access to preferred providers is maximized.

HHS question about this

Enclosure 2
Page 1 of 2

Information Disclosure For 2000

We recognize that some planss have implemented a number of the following requirements.

Information That Must Be Available During The Open Season for 2000:

A. About the Plan:

- Service, and clinical quality performance measures
- Customer satisfaction measures

B. About Networks and Providers:

- Aggregate information on the numbers, types, board certification status, and geographic distribution of primary care and specialty providers
- Detailed lists of names, board certification status, and geographic location of all contracting primary care providers; whether they are accepting new patients; language(s) spoken and availability of interpreters (for non-English speaking and those with communication disabilities); and whether facilities are accessible to the disabled
- Provider compensation, including basic payment method (e.g., capitation, salary, fee schedule) and additional financial incentives (e.g., bonus, withhold, etc.)
- Whether provider ownership or affiliation arrangements with a provider group or institution would make it likely that a consumer would be referred to a particular specialist, or facility or receive a particular service

Information That Must Be Available Upon Request By January 2000:

A. About the Plan:

- Methods of compensation, ownership or interest in health care facilities, or matters of conscience that could influence advice or treatment decisions

B. About All Professional Providers:

- Corporate form of provider practice
- Education, board certification, and recertification status
- Names of hospitals where physicians have admitting privileges
- Years in practice as a physician and as a specialist if so identified
- Accreditation status
- Cancellation, suspension, or exclusion from participation in Federal programs or sanctions from Federal agencies; any suspension or revocation of medical licensure, Federal controlled substance license, or hospital privileges
- Experience with performing certain medical or surgical procedures (e.g., volume of care/services delivered), adjusted for case mix and severity
- Consumer satisfaction, clinical quality and service performance measures
- The availability of translation or interpretation services for non-English speaking and those with communication disabilities

C. Specific to Specialty Providers (some info must be made available during Open Season for 2000 for PCPs):

- Detailed list of names, board certification status, and geographic location of contracting specialists and specialty care centers; whether they are accepting new patients; language(s) spoken and availability of interpreters (for non-English speaking and those with communication disabilities); and whether facilities are accessible to the disabled

D. About Facilities:

- Detailed list of names, accreditation status, and geographic location of hospitals, home health agencies, rehabilitation and long-term care facilities; whether they are accepting new patients; language(s) spoken, and availability of interpreters (for non-English speaking and those with communication disabilities), and whether they are accessible to the disabled
- Corporate form
- Consumer satisfaction, clinical quality and service performance measures
- Whether facility specialty programs meet guidelines established by specialty societies or other bodies
- Complaint procedures
- Whether facility has been excluded from any Federal health programs
- Volume of certain procedures performed
- Numbers and credentials of providers of direct patient care
- Whether the facility's affiliation with a provider network would make it more likely that a consumer would be referred to health professionals or other organizations in that network.

CHRIS' questions

where we were

where we are

how much did last year & 9o (.25)

list of everything in Dem bill that's NOT part of this

med necessity - how legislation

right to sue - what Fed employees have (none is okay) & of course OPM won't mind new remedies

① external appeals process — how reviewers make a decision doing appeals OPM 2 yrs or no

② ~~1~~ #

people in FEHBP

any reduction in complaints

any pos or neg rxn

plans in FEHBP

April 5, 1999

Dear Mr. President:

Monica DeCarlo was a 55 year-old disabled woman who lived on her own, was very articulate, and active in disability rights issues. She had been a librarian for 15 years, raised two children, and was a grandmother.

On July 29, 1998, she was rushed to the hospital and they determined she had a brain aneurysm. She was alert and recognized her family, but was unable to speak. On August 1st, Monica had respiratory failure and was put on a respirator. By the end of August, she was transferred to a Center to be weaned off the respirator and subsequently was placed in a nursing home. She weaned off the respirator in one month and was put into a nursing home (the worst fear of her life). She was hospitalized three times while in the nursing home. Her family and friends tried to get her into a rehabilitation facility, but were told she did not meet the protocols and the HMO would not pay for her.

By her third hospitalization, Monica was very sick due to a serious infection she sustained at the nursing home due to lack of care. While in the hospital, her advocates were able to get a rehabilitation hospital to take Monica on a trial basis with a guarantee "buy back" to the original hospital if she could not achieve rehabilitation goals based on established expectations. When I visited her at the rehab hospital, she was smiling and she seemed so happy to be there. By the second day, her arm was broken as a result of physical therapy, and by the eighth day, she aspirated and had to be transferred to the "buy back" hospital in serious condition. All hopes of returning to her prior life were gone and four days later, she died. This is an American tragedy. Health care in this country is not "managed health care", but "**mis-managed** mangled care."

Sincerely,

Nancy Salandra

Nancy Salandra
(215) 634 2000 Ext 272

FAX TRANSMISSION

OFFICE OF CONGRESSWOMAN ROSA DELAURO

436 CANNON BUILDING
WASHINGTON, DC 20515
PHONE: (202) 225-3661
FAX: (202) 225-4890

To: Karin Kallman **Date:** 4/6

Fax #: _____ **Pages:** 6

From: Maura Keefe

Comments:

If you'd like our office to call either Janet or Sharon, let us know.

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. bio	re: personal medical (partial) (1 page)	04/06/1999	P6/b(6)

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

FOLDER TITLE:
PBOR [Patients' Bill of Rights] [Folder 2]

2012-0463-S
rc807

RESTRICTION CODES

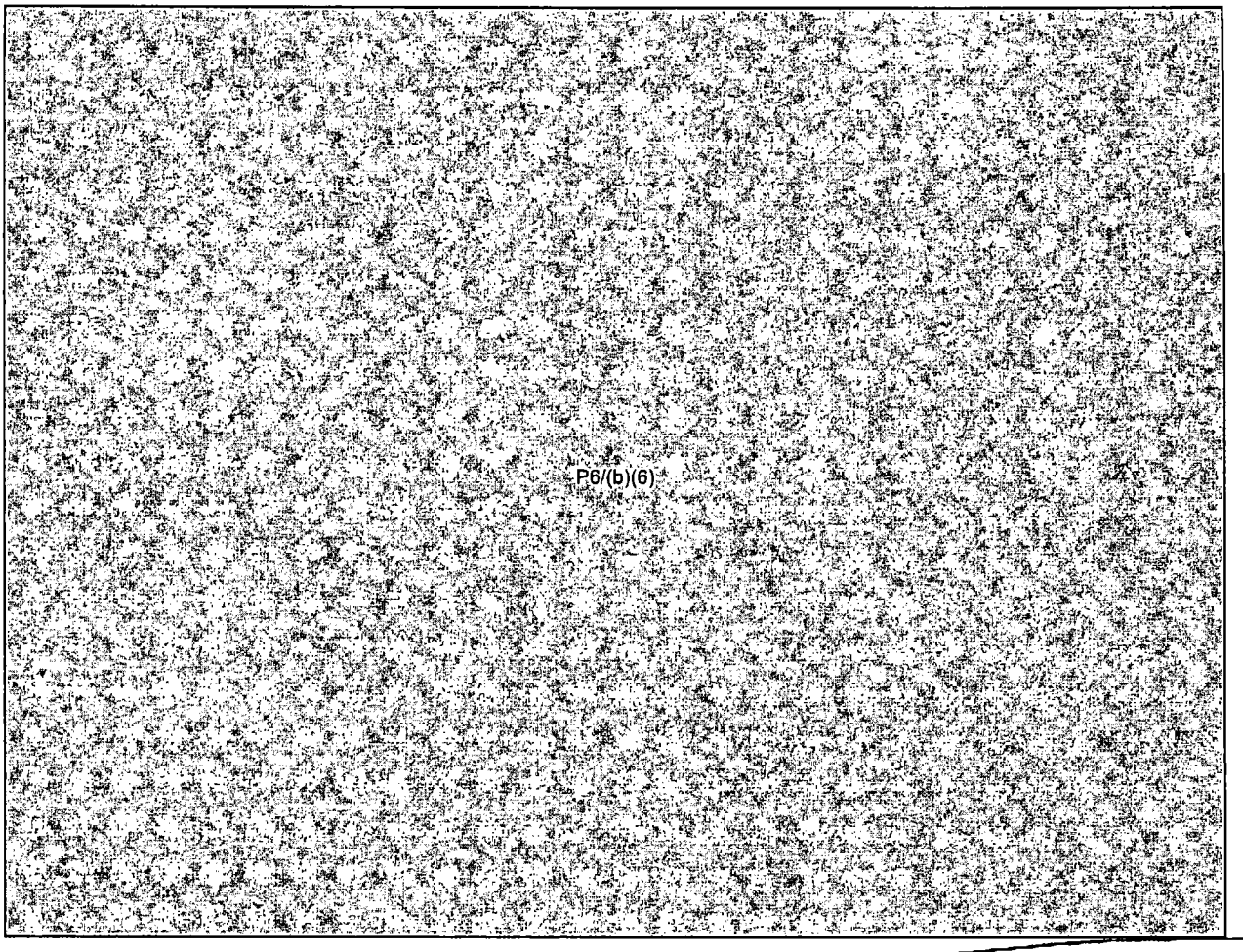
Presidential Records Act - [44 U.S.C. 2204(a)]

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]



[001]

Sharon Crossley P6/(b)(6)

- Gave nominating speech for Rosa in 1998 at Ct Convention
- Attached is her speech with her story
- Great speaker
- Knows issue, good advocate

NOMINATING SPEECH
SHARON CROSSLEY
MONDAY, JULY 13, 1998

I'm privileged to be here tonight to nominate Congresswoman Rosa DeLauro for re-election to the U.S. House of Representatives.

My name is Sharon Crossley and I'm a member of an HMO. In December of 1997, I was diagnosed with breast cancer. Approximately 180,000 women and 1,000 men are diagnosed with breast cancer each year. Medical science continues research to find a cause and cure for breast cancer. However, until a cure is found, only 60% of those diagnosed will survive.

During the 1st phase of my diagnoses, I followed the guidelines set forth by my HMO. First, I contacted my primary physician and a referral was made to radiology for a mammogram. It showed a suspicious mass. My primary care physician referred me to a surgeon. A biopsy was performed in the surgeon's office. Since I was a member of an HMO, the

sample had to be sent to an outside laboratory, instead of the hospital pathology department. Hospital pathology could have given me results within 48 hours, but the outside lab would take between 7-10 days. It made a world of difference to me. Waiting to hear whether you have cancer or not is a time of great anxiety. It's difficult to get through the day's routine, never mind the countless hours of lost sleep. It's a time when, not only the patient but the entire family sits on pins and needles.

Within the next 6 days, I received a verbal report that everything looked okay. But, two days later, I was in the surgeon's office confronted with a 3 page lab report that indicated that everything was not fine. There was strong indications of a malignant mass or tumor.

A surgical biopsy was scheduled for December 15, 1997. I spent about 20 hours with the surgeon over the next few weeks planning options, procedures and courses of treatment. But, by Thursday December 11th, just four days before surgery was scheduled, I still had not received

approval from my HMO for the procedure. That afternoon, at 4:30 pm, my surgeon faxed another request to my HMO for approval of the surgery. At 4:50 pm, the so-called medical doctor employed by my HMO denied the surgical request. I was devastated. I felt this doctor had just condemned me to death.

I had some experience dealing with HMOs and I knew I had to get busy and advocate for myself. After making countless calls to the HMO that evening and into the next day, I was told by Customer Service Representatives that if I didn't agree with the medical review officer's decision, I would have to follow the written appeals procedure, but there was no way I could speak to anyone by phone. HMO members were not allowed the privilege of speaking to medical review officers, they were simply too busy. When I asked to speak to the corporate director, I was given the same response. Meanwhile, time was running out. I was 3 weeks into a biopsy and after a biopsy is performed there is only a 3 to 4 week window to take the next course of action, or you risk spread of the

disease.

I knew I needed help to get through. I contacted Senator Lieberman and Congresswoman DeLauro's offices. Thanks to the many concerns and diligent efforts from these people and their staffs, I was put in contact the same day with the Corporate Officer of the HMO. He worked on my behalf to a surgeon take my case as an emergency. On December 27, 1997 I had an excissional biopsy confirming I had Stage 1 Breast Cancer.

As any cancer survivor will tell you, cancer is a chronic illness you live with for the rest of your life. The earlier it is diagnosed, the better your chances of survival. The delays and red tape I had to navigate through, put my life in danger. It's wrong and it's happening to thousands of people everyday.

HMOs have doctors on staff who are not there to guard patients, but are there to guard corporate profits. And, there is no accountability. There is

MINYON TO DO BRIEFING
5 TICKETS DPC

10^15 STAFF VAN
11^15 LEAVE
12^20 PHILLY - MEM HALL
MEET & GREET W/ MEMBERS (18), GROUPS, and REAL PERSON
1^15 EVENT (400)
NURSES IN UNIFORM IN CUT-AWAY SHOT
BACKDROP "A REAL PBOR" W/ SCROLL
· MAYOR RENDELL (T)
· SWEENEY (2)
· BORSKI (3)
· FATTAH (3)
· BRADY (3)
· DELAURO (3)
· BONIOR (3)
· RP (3)
· POTUS (15)
2^30 END

PEOPLE SPEAKING TO PRESS BEFORE -
HEAD OF HOSP WKRS UNION

3^10 LEAVE
3^40 LEAVE PHILLY
4^45 ANDREWS ARR

SPEECH (ES) FINAL CALL LETTER
LIST MEMBERS
BRIEFING PAPER
CHEAT SHEET
PRESS PAPER

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 Philadelpiha 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 <u>real</u> bill immediately so we can provide Americans with the critical patient protections they have been waiting for -- for far too long.