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Devorah Adler
OA/Box Number: 20471

FOLDER TITLE:

PBOR [Patients' Bill of Rights] [Folder 3]

2012-0463-S

rc808

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]

**COMPARISON OF CONSUMER PROTECTIONS:
PRESIDENT'S ADVISORY COMMISSION, MEDICARE+ CHOICE, AND PROPOSED LEGISLATION**

PROVISION	Advisory Commission	Medicare+Choice (Interim Final Reg.)	House Republican (consumer protection provisions only) (HR448)	Senate Republican (consumer protection provisions only) (S300) [and S326, as passed out of HELP]	Daschle/Dingell (S6/HR358)	Chafee (S374)
1. Entities Regulated	Recommendations apply to all health care consumers.	All plans participating in the Medicare+Choice program.	All group health plans, and health insurance issuers in the group market only (i.e., where state rules are preempted by ERISA, plus some but not all areas where states could regulate). For POS provisions, only issuers that are HMOs. For Privacy provisions, all plans, providers, schools, etc.	Only where state rules are pre-empted by ERISA: All ERISA plans for Information Disclosure and Appeals, self- insured plans only for all other consumer protection provisions. For Privacy provisions, all plans, providers, schools, etc.	All group health plans, and health insurance issuers in both the group and individual markets (i.e., both where state rules are preempted by ERISA and where states could regulate).	All group health plans, and health insurance issuers in both the group and individual markets (i.e., both where state rules are preempted by ERISA and where states could regulate).
2. Information Disclosure	List of information to be disclosed automatically, additional information to be disclosed on request. Information should be provided at "appropriate times (i.e. decision points)."	List of information to be disclosed automatically, additional information to be disclosed on request. HHS provides information prior to each open season, plans provide information at time of enrollment and updates	List of information to be disclosed automatically, additional information to be disclosed on request. Uses existing SPD time frames. Does not fix current ERISA law that allows notice of material reductions in	List of information to be disclosed automatically, additional information to be disclosed on request. Disclosure is one time only, within a year of enactment. Does not fix current ERISA law that allows notice of	List of information to be disclosed automatically, additional information to be disclosed on request. Information must be issued at time of enrollment and at least annually thereafter. Gives Secretary	List of information to be disclosed automatically, additional information to be disclosed on request. Information must be issued at time of enrollment and at least annually thereafter. Gives Secretary

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		at least annually.	benefits to be provided after the effective date of the changes, except requires advance notice of exclusions from formulary.	material reductions in benefits to be provided after the effective date of the changes.	authority to require notice of changes be provided to enrollee before the effective date of the changes.	authority to require notice of changes be provided to enrollee before the effective date of the changes.
3. Network Adequacy						
a. Basic standard for network adequacy	Yes	Yes	No	No	Yes	Yes
b. Enrollees can go out of network if network not adequate for their particular needs	Yes, at no additional cost beyond that for participating providers.	Does not address situations where network is not adequate, but mandates coverage of out-of-network services in limited specified situations, at no additional cost to enrollee.	No	No	Yes, at no additional cost to enrollees beyond that for participating providers.	Yes, at no additional cost to enrollees beyond that for participating providers.
4. Direct Access to Specialists						

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a. Complex/ serious conditions requiring on-going care	Authorization should be "for an adequate number" of visits.	Treatment plans must provide an adequate number of visits.	No	No	Standing specialist referrals and specialists may serve as primary care physicians.	Standing specialist referrals and specialists may serve as primary care physicians.
b. Routine and preventive Ob/Gyn	Yes	Yes	Yes	Yes	Yes, and plan must allow Ob/Gyn to be designated as primary care physician.	Yes
c. Pediatricians	~~No~~ <i>Yes</i>	No	No. Plan must allow pediatrician to be designated as PCP.	Yes	No. Plan must allow pediatrician to be designated as PCP.	No
5. Continuity of Care/ Transitional Care	When the provider is dropped from the plan or the employer changes health plans. For people in a course of treatment for a chronic or disabling condition (for 90 days) and pregnant women beyond their first trimester (through	No provision for an enrollee to continue with managed care provider. Enrollee can return to original Medicare (the ability to do this will be limited after 2001 and is further limited by lack of access to MediGap policies).	No	When the provider is dropped from the plan. For inpatients and terminally ill persons (for 90 days), for women past first trimester of pregnancy (through postpartum care).	When the provider is dropped from the plan or the employer changes health plans. For persons in a course of treatment (for 90 days), inpatients (through discharge), women past first trimester of pregnancy (through postpartum	When the provider is dropped from the plan or the employer changes health plans. For persons in a course of treatment (for 90 days), inpatients (through discharge), women past first trimester of pregnancy (through postpartum

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	postpartum care).				care), and terminally ill persons (for remainder of life).	care), and terminally ill persons (up to 180 days).
6. Mandatory POS Option	No	BBA permits, but does not mandate, a POS option.	Yes, with exception if POS premium will be more than 1% greater than the closed panel premium or if HMO would need new license.	Yes, with exception for small employers	Yes	No
7. Access to Emergency Services						
a. Bans prior authorization requirements	Yes.	Yes	Yes	Yes	Yes	Yes
b. Bans in-network requirements	Yes	Yes	Yes	No (may be drafting error)	Yes	Yes
c. Prudent layperson standard for coverage of screening and stabilization	Yes	Yes	For screening exam only. Any additional emergency medical services covered under "prudent emergency medical professional"	Yes	Yes	Yes

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d. Emergency medical condition includes "Severe Pain"	Yes	Yes	standard (unclear is this includes stabilization care). No	Yes	Yes	Yes
e. Post-stabilization care	Emergency department should contact the plan or provider to discuss post-stabilization care and promote continuity of care.	ER required to contact organization to obtain authorization for post-stabilization care; if the organization fails to respond or cannot be contacted within 1 hour, authorization is deemed.	Not addressed	Not addressed	Mandates process consistent with Medicare guidelines	Mandates process consistent with Medicare guidelines
8. Limits on Physician Incentives	No	Prohibits specific payments to physicians "as an inducement to reduce or limit medically necessary services." Where physician is at substantial financial	No	No	Same as Medicare	Same as Medicare

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		risk for services not provided by those physicians, requires stop loss coverage, disclosure, and surveys of enrollees and disenrollees.				
9. Anti-Gag Rule						
a. Communication about condition and treatment	Yes	Yes	Yes, but only applies to direct contract between plan and provider	Yes	Yes	Yes
b. Protection for advocating on behalf of patient	Yes	No	No	No	Yes	Yes
10. Non-discrimination	Yes	Yes	No	No	Yes	Yes
11. Confidentiality of Health Information	Individually identifiable health information cannot be used without the written consent of	A M+C organization must establish procedures to safeguard the privacy	Nothing in consumer protection provisions. A Separate Privacy Title requires plans to	Nothing in consumer protection provisions. A separate Privacy Title requires plans to	Plan must safeguard the privacy of individually identifiable information, and allow	Plan must safeguard the privacy of individually identifiable information.

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	the enrollee except for research, fraud investigations, and public health reporting. Consumers have the right to review, copy, and request amendments to their medical records.	of any individually identifiable enrollee information.	safeguard the privacy of health information, and provide access for individuals to inspect, copy, and amend their health information. The Title overrides many State protections without providing adequate Federal protection.)	safeguard the privacy of health information, and provide access for individuals to inspect, copy, and amend their health information. [S326 removed this subtitle]	timely access for individuals to their health information.	
12. Coverage determinations						
a. Deadline	"Timely"	Yes	Only for decision on physician's request for prior authorization for specialty care. Not for other determinations.	For pre- and concurrent authorization.	For decisions covered by broad definition of UR	For prior authorizations, continued care, and previously provided services.
b. Expedited Process and/or tied to medical exigencies of the case	Yes	Yes	No*	Yes (but plan decides), not tied to medical exigencies of case.	Yes	Yes

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13. Internal appeal						
a. Decisions that can be appealed	Denial of coverage, reduction or termination of services, or denial of payment for services.	Denial or discontinuation of benefits, payment, or services.	Adverse benefit payment decisions, advance determinations of coverage, and required determinations of medical necessity	Adverse initial coverage determinations – does not include failure to meet determination deadlines, or disputes regarding items and services specifically listed as excluded in the coverage documents.	Denials or discontinuation of benefits, payment, or services, adverse UR determinations, certain violations of the statute.	Adverse initial coverage determinations and imposition of prohibited manner or setting limitations.
b. Deadline	"Timely"	Yes	No*	Yes	Yes	Yes
c. Expedited process and/or tied to medical exigencies of the case	Yes ("consistent with Medicare")	Yes	No*	Yes	Yes	Yes
14. External appeal						
a. Decisions that can be appealed	Any decision to deny, reduce or terminate coverage or payment	Any determination which is, in whole or in part, adverse to the	Adverse re whether care meets plan's definition of medical	Disputes re whether care meets plan's definition of medical	Same as internal appeals, but not including denials for	Same as internal appeals, including contractual exclusions.

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b. Failure to meet internal review deadline moves dispute to external review	based on determination that treatment is experimental or not medically necessary. "Timely"	enrollee. Yes	necessity or experimental, and no ERISA §502 suit has been initiated. In theory only, because internal "deadlines" can be indefinite.	necessity, and experimental treatment where there is significant risk to life or health. No	services specifically listed in plan documents as excluded from coverage. Yes	Yes. If plan fails to meet deadline, must automatically forward case file to external reviewer. Expedited disputes not resolved wholly in favor of the enrollee must also be automatically forwarded for external review.
c. Barriers / thresholds	For medical necessity decisions, a "significant threshold" unless the denial jeopardize life or health.	None -- all disputes not resolved wholly in favor of the enrollee are automatically forwarded to the external review entity.	Non-Medicaid/CHIP enrollees may be required to pay a fee (the greater of the lesser of \$100 or 10% of the care under dispute or \$25).	For Medical Necessity disputes, the amount involved must exceed a significant financial threshold. Enrollee has only 30 days to appeal.	A "significant threshold" unless the denial jeopardizes the life or health (including development, in the case of a child) of the patient.	A "significant" threshold unless the denial jeopardizes the life or health or ability to regain or maintain maximum function (including development, in the case of a child under 6)

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d. Review entity selection	External review should be "independent" and "fair to all parties"	HCFA chooses entity	Enrollee has only 30 days to appeal. Plan chooses intermediary, which chooses reviewing expert.	Plan chooses entity	Selected either by appropriate authority, or by plan under rules developed by appropriate authority to prevent bias.	of the patient. Selected either by appropriate authority, or by plan under rules developed by appropriate authority to prevent bias.
e. Protections against reviewers' bias/ conflict of interest	External review should be "independent" and "fair to all parties"	Review entity chosen by HCFA, not plan.	Reviewers/entity must not be affiliated with any party to the dispute, receive only reasonable compensation not contingent on decisions, not be subject to retaliation from the plan, be free from conflict of interest as determined by regulation, and in some cases reviewer is blind to identity of plan and enrollee, and vice versa.	Reviewers must not have any affiliation with the case, the enrollee, or the provider. Affiliation with plan or employer is not prohibited. Reviewers can receive only reasonable compensation not contingent on decisions.	Certified by appropriate authority as having no conflict of interest and meeting any other regulatory requirements. If more than one certified entity is available to a plan, rules of the applicable authority assure that the selection process creates no incentives for bias.	Certified by appropriate authority as having no conflict of interest and meeting any other regulatory requirements. If more than one certified entity is available to a plan, rules of the applicable authority assure that the selection process creates no incentives for bias.

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f. Deadline	"Timely"	Yes	No*	No	Yes	No. Review entity establishes time frames similar to internal appeal time frames.
g. Expedited process and/or tied to medical exigencies of the case	Yes ("consistent with Medicare")	Yes	No*	No	Yes	No. Review entity establishes time frames similar to internal appeal time frames.
h. Binding v. Advisory	Silent	Binding on plan	Advisory. If offered by plan, enrollee can agree to binding ADR in lieu of external appeals process.	Binding on plan	Binding on plan	Binding on plan
i. De Novo standard	"Objective and credible"	Yes	No, review based on plan's definition of medical necessity and experimental.	No, review based on plan's definition of medical necessity, and must take into consideration plan's guidelines [S326 requires reviewer to make "independent" determinations based on a variety of	Yes	Yes

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				evidence]		
15. Quality Advisory Board	Commission recommends creation of the Advisory Council for Health Care Quality and the Forum for Health Care Quality Measurement and Reporting.	No	No	No, gives some of the relevant responsibilities to AHCPR.	Creates Health Care Quality Advisory Board.	No
16. Experimental therapies	No	Medicare excludes coverage for experimental therapies. M+C organizations may cover experimental therapies through supplemental benefits.	No coverage mandate. Plan must disclose whether experimental therapies are excluded from coverage and the definitions it uses.	No coverage mandate. Plan must disclose whether experimental therapies are covered.	No coverage mandate. Plan must disclose how it decides if treatment is experimental.	No coverage mandate. Plan must disclose how it decides if treatment is experimental.
17. Clinical trial coverage mandate	No	No	No	No [S326 requires a one year IOM study re clinical trials]	Yes, if enrollee has a serious illness for which no standard treatment is effective plan must pay routine costs.	Yes, if enrollee has a serious illness for which no standard treatment is effective plan must pay routine costs.
18. Enforcement	No	HHS/Department of	DoL may impose	Current ERISA	HIPAA enforcement	In addition to HIPAA

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		Justice have authority to seek civil money penalties (\$10,000 - \$100,000, or \$25,000 per violation plus \$10,000 for each week the deficiency remains uncorrected), criminal penalties, intermediate sanctions (e.g., suspension of enrollment or marketing) and exclusion from the Medicare Program. A single violation may be prosecuted (i.e., a pattern or practice is not required).	CMPs against a fiduciary for a pattern or practice of 1) adverse coverage decisions in violation of the terms of the plan or bill, 2) violations of ERISA§503 notice of denied claim requirements, or 3) violations of ERISA§503 full and fair review requirements. Penalties may not exceed the lesser of 5% of the aggregate value of benefit or \$100,000. The fiduciary may be removed by court.	enforcement provisions. Under ERISA, DoL may impose CMPs of up to \$1000/day for certain violations (generally limited to information disclosure violations); for other ERISA violations, the IRS may impose excise taxes on group health plans. Individual may bring action to recover CMPs up to \$100/day for failures to provide required notices.	provisions: Under PHSA, HHS may impose CMPs of up to \$100/day/ violation. Under ERISA, DoL may impose CMPs of up to \$1000/day for certain violations (generally limited to information disclosure violations); for other ERISA violations, the IRS may impose excise taxes on group health plans. Individual may bring action to recover CMPs up to \$100/day for failures to provide required notices.	enforcement provisions, grants HHS same investigative and injunctive relief authority as DoL has under ERISA. HHS and DoL may impose CMPs equal to the greater of \$250,000 for pattern and practice or \$50,000 per individual for statutory violations that result in unreasonable denial or delay in benefits. For other statutory violations, CMPs equal to the greater of \$50,000 for pattern or practice or \$10,000 per individual. The maximum CMP is increased by \$10,000 for each week the problem remains uncorrected.
19. Liability	No	Beneficiaries can sue	No change to ERISA	No change to ERISA	Amends ERISA (sec.	Adds Federal cause of

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		M+C plans for damages for personal injury, wrongful death, breach of contract, and similar claims as allowed by state law. State law suits cannot be brought to obtain the actual Medicare benefit.	pre-emption of state law suits. Tort reform provisions limit damages available in Federal and state law suits against health plans (and providers and others), including M+C plans, but not to claims under ERISA. In lieu of liability, adds civil money penalties under ERISA sec. 502, where court finds a benefit was delayed or denied against the recommendation of the external reviewer. The fiduciary may be required to pay to the participant a civil fine of \$500/day up to \$250,000.	pre-emption of state law suits. Adds failure to abide by decision of external reviewer to allowable actions under ERISA sec. 502(c)(1).	514) to permit suits for damages against plans for personal injury or wrongful death, as allowed by state law. Exempts employer, employees, and plan sponsor if they did not exercise discretion to make a decision on the claim.	action under ERISA (sec. 502(c)) to permit suits for economic damages against coverage decision-makers for personal injury resulting from coverage determinations not made on a timely basis or in accordance with the terms of the plan or bill. Economic damages do not include punitives, pain and suffering, emotional distress, etc.
20. Ombudsman/ Consumer Assistance	No recommendation, outlines desirable characteristics of such	Nothing in BBA. HHS funds Statewide Insurance Counseling	No	No	Yes, States (or federal if no State program). HHS to award grants	Yes, States (or federal if no State program). HHS to award grants to

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	programs.	and Assistance (ICA) programs, and the Administration on Aging operates a Nursing Home Ombudsman program.			to States.	States.
21. Provider Protections	No	Plans must provide written notice of the rules of participation and of adverse participation decisions. Plans must provide a process for appealing decisions adverse to participating physicians.	No	No	Plan must provide written notice of rules of participation and of adverse participation decisions. Plans must provide a process for appealing adverse decisions of participation.	Plan must provide written notice of rules of participation and of adverse participation decisions. Plans must provide a process for appealing adverse decisions of participation.

* Deadline stated, but is contingent upon receipt of information plan deems necessary. There is no deadline for providing the information, and there is no consequence to plan for failing to meet the deadline.

EXECUTIVE SUMMARY

Quality First: Better Health Care for All Americans

Every day, millions of Americans receive high-quality health care that helps to maintain or restore their health and ability to function. Skilled physicians, nurses, and other health care practitioners offer expert compassionate care to people in need. High-caliber hospitals, nursing homes, and other health care institutions provide care to patients in need of acute and chronic care. Academic health centers educate and train new generations of health care practitioners and house many of the finest scientific minds who advance the science of health care. Federal, State, and local governments, private employers, labor unions, and others purchase health care coverage for millions of American families, offering security and peace of mind. And public and private quality oversight organizations work to make sure that the care provided is of the highest quality in the world.

A central goal of quality improvement is to maintain what is good about the existing system while focusing on the areas that require improvement. While most Americans receive high-quality care, too many patients receive substandard care. Quality problems include wide variation in health care services, underuse of some services and overuse of others, and an unacceptable level of errors.

Efforts by leaders of the health care professions, the health care industry, major employers, and State and Federal agencies have significantly improved our ability to identify quality problems and begin to address their causes. What is needed now is a national commitment to quality improvement that begins with the President and the Congress and extends to every level of the health care industry.

In seeking to improve the quality of care for all Americans, we cannot forget that there are more than 41 million Americans who live day to day without the security of health insurance. For them, access to quality care often is severely limited. Addressing this issue is critical to improving the health and functioning of all who live in our communities.

A Clear Statement of Purpose

The first step in this effort should be the establishment of a clear Statement of Purpose for the health care system. The Commission recommends that the President articulate and continue to emphasize the following statement:

The purpose of the health care system must be to continuously reduce the impact and burden of illness, injury, and disability and to improve the health and functioning of the people of the United States.

Evidence of Quality Problems

Several types of quality problems in health care have been documented through peer-reviewed research. They include:

- **Avoidable errors.** Too many Americans are injured during the course of their treatment, and some die prematurely as a result. For example, a study of injuries to patients treated in hospitals in New York State found that 3.7 percent experienced adverse events, of which 13.6 percent led to death and 2.6 percent to permanent disability, and that about one-fourth of these adverse events were due to negligence.¹ A national study found that from 1983 to 1993, deaths due to medication errors rose more than twofold, with 7,391 deaths attributed to medication errors in 1993 alone.²
- **Underutilization of services.** Millions of people do not receive necessary care and

suffer needless complications that add to health care costs and reduce productivity. For example, a study of Medicare patients with myocardial infarction found that only 21 percent of eligible patients received beta blockers, and that the mortality rate among recipients was 43 percent less than that for nonrecipients.³ An estimated 18,000 people die each year from heart attacks because they did not receive effective interventions.⁴

- **Overuse of services.** Millions of Americans receive health care services that are unnecessary, increase costs, and often endanger their health. For example, an analysis of hysterectomies performed by seven health plans estimated that one in six was inappropriate.⁵
- **Variation in services.** There is a continuing pattern of wide variation in health care practice, including regional variations and small-area variations.⁶ This is a clear indicator that the practice of health care has not caught up with the science of health care to ensure evidence-based practice in the United States.

¹ Brennan, Troyen, et al. "Incidence of Adverse Events and Negligence in Hospitalized Patients." *JAMA* 324:370-376, 1991.

² Phillips, David P., Nicholas Christenfeld, and Laura M. Glynn. "Increase in U.S. Medication-Error Deaths Between 1983 and 1993," *Lancet* February 28, 1998.

³ Soumerai, Stephen, Thomas McLaughlin, Ellen Hertzmark, et al. "Adverse Outcomes of Underuse of Beta Blockers in Elderly Survivors of Acute Myocardial Infarction." *JAMA* 277:115-121, 1997.

⁴ Chassin, Mark R. "Assessing Strategies For Quality Improvement." *Health Affairs* 16(3):151-161, May/June 1997.

⁵ Bernstein, S.J., Elizabeth A. McGlynn, Albert L. Siu, et al. "The Appropriateness of Hysterectomy: A Comparison of Care in Seven Health Plans." *JAMA* 269:2398-2402, 1993.

⁶ Wennberg, John E., and Megan McAndrew Cooper, eds. *The Dartmouth Atlas of Health Care in the United States*. (Chicago: American Hospital Publishing, Inc., 1998).

Major Recommendations

In total, the Commission's Final Report to the President includes more than 50 recommendations to advance these core purposes. (A complete summary of those recommendations follows this section.)

Public-Private Partnerships

To focus the entire health care industry on this Statement of Purpose, the Commission recommends the creation of two complementary entities, one public and one private, to provide ongoing national leadership in health care quality improvement.

The Advisory Council for Health Care Quality.

A public Advisory Council should identify national aims for improvement and specific objectives for improvement and track the Nation's progress in meeting those aims and objectives.

The Advisory Council also should establish goals and objectives for quality measurement and reporting by health care organizations and providers and track industry compliance with the Consumer Bill of Rights and Responsibilities.

The Advisory Council should include representatives of the public and private sectors with expertise in health care quality, patient and consumer needs, the purchasing and delivery of health care services, the management of health plans, research, public health, and the education and training of health care practitioners. The Advisory Council should report annually to the President and Congress on the Nation's progress in improving health care quality.

The Forum for Health Care Quality

Measurement and Reporting. A private body of public and private purchasers of health care services, consumers, health plans, health care

practitioners, and others should be created to implement a comprehensive plan for measuring health care quality and reporting the results of such measures to the public. The Forum should identify core quality measures for standardized reporting and promote the focused development of enhanced core measures for the future. The Forum should coordinate its efforts with the Advisory Council for Health Care Quality.

National Aims for Improvement

A major component of this national strategy is the establishment of a concise set of core aims for improvements that are accompanied by specific, measurable objectives for improvement throughout the system. The Commission recommends the following initial set of six National Aims for Improvement:

- Reducing the underlying causes of illness, injury, and disability;
- Expanding research on new treatments and evidence of effectiveness;
- Ensuring the appropriate use of health care services;
- Reducing health care errors;
- Increasing patients' participation in their care; and
- Addressing oversupply and undersupply of health care resources.

Quality Measurement and Reporting

A key element of improving health care quality is the Nation's ability to measure the quality of care and provide easily understood, comparable information on the performance of the industry.

4 *Quality First: Better Health Care for All Americans*

Advances in quality measurement and reporting have enabled us to determine the flaws in the current system. But the absence of a systematic approach to quality measurement has hampered the health care industry's ability to track and sustain quality improvement.

The Commission is recommending a series of steps that should be taken—primarily by the private sector—to bring order to the current system of quality measurement while continuing to encourage development and innovation in this important field:

- Core sets of quality measures applicable to each sector of the industry (i.e., health plans, hospitals, nursing homes, individual physician practices, etc.) should be identified for standardized reporting.
- The health care industry should support the focused development of quality measures that enhance the Nation's ability to evaluate and improve health care.
- Steps should be taken to ensure that comparative information on health care quality is valid, reliable, comprehensive, and available in the public domain for use by consumers, purchasers, practitioners, quality oversight organizations, and others.

Strengthening the Market To Improve Quality

The health care market is rapidly transforming itself. Many of these changes bode well for quality improvement, but some may impede that progress. The Nation must harness the positive forces of change and guard against impediments to quality improvement.

Group purchasers. Public and private group purchasers of health care coverage and services must become more active and more coordinated in demanding high-quality services for those they represent. Group purchasers have tremendous influence over the health care industry's ability and willingness to focus on quality improvement. Private employers, in small but increasing numbers, have been pushing for a greater focus on quality, while public purchasers also have been emphasizing quality.

Consumers. Patients and other consumers of health care services need greater access to easily understood information and the ability to exercise greater choice in the health care market. With this assistance, consumers can have much greater influence over the industry's emphasis on quality.

Vulnerable populations. The needs of our most vulnerable citizens—the poor, the frail elderly, those living with disabilities, the mentally ill, children, and others—require special attention. To ensure high-quality care for all Americans, the needs of vulnerable citizens must be taken into account in the design of systems for health care delivery, quality measurement, and financing. Attention to the quality of health care for children is especially important given their health and developmental needs and their promise for the future.

Accountability. All participants in the health care industry must be accountable for improving the quality of health care in the United States.

Public and private sector quality oversight organizations have a longstanding and strong track record of leadership in assessing, ensuring, and encouraging improvement in health care. This role should be preserved and extended as a key component in a total system of accountability. In addition, better coordination and focus on shared

aims and methods of accountability will increase the impact of existing oversight organizations.

The Commission has proposed a Consumer Bill of Rights and Responsibilities for all Americans. Assurance of such rights will strengthen consumer confidence in the health care industry and help to improve the quality of care that consumers receive. Group purchasers as well as public and private sector quality oversight organizations should work expeditiously to incorporate the provisions of the Consumer Bill of Rights and Responsibilities into their contractual and oversight requirements.

The Commission is pleased that the President has acted to ensure accountability in Federal public programs covering an estimated one-third of Americans and that employers and health plans have voluntarily committed to assure these protections to an additional 60 million Americans. In the year 2000, the Advisory Council should issue a comprehensive evaluation of the extent to which public and private sector leaders have been successful in ensuring compliance.

Reducing errors and increasing safety. Current systems to reduce and prevent errors in health care tend to focus too much on individual practitioners and not enough on system problems. Interested parties should develop a health care error reporting system to identify errors and prevent their recurrence. Internal and external appeals systems should be enhanced to assure speedy and accurate decisions. Policymakers and other stakeholders should engage in a national dialogue regarding current remedies for consumers who are injured as a result of inappropriate health care decisions. Such a dialogue should consider the cost and consequences of both the status quo and any revisions to existing policies.

Building the Capacity To Improve Quality

Improving quality requires commitment at all levels of the health care industry. Health care organizations, professionals, and other participants in the health care system must make quality improvement the driving force of the industry. Recommendations include:

Research and evidence-based practice. Greater investment is needed in basic, clinical, preventive, and health services research. The continued development and dissemination of evidence-based information can help to guide practitioners' actions and the development and implementation of management policies that can influence practice to improve quality.

Adapting organizations for change. Health care organizations (i.e., health plans, hospitals, nursing homes, quality oversight organizations, and others) must be flexible enough to change at the same pace as does the science of health care.

Health care workers. Greater collaborations among health workers, along with better education and training of workers in quality improvement skills, are needed. The estimated 10 million health care workers in the United States can be a powerful tool for improving quality.

Information systems. The health care industry will need to make a significant investment in health information systems to provide data on the individual and comparative performance of plans, facilities, and practitioners; help improve the coordination of care; advance evidence-based health care; and support continued research and innovation. Existing information systems are not adequate for these purposes.

Addressing the Uninsured

Consumer protection and quality improvement often are meaningless to Americans who cannot obtain health care when they need it. The fact that 41.7 million Americans—including nearly 10 million children—currently are uninsured and millions of others are underinsured confounds attempts to improve quality and protect consumers. Most uninsured Americans hold full-time jobs or are the spouses or children of such workers. Others are early retirees who have lost their employer-based coverage but are ineligible for Medicare. Many Americans who are living with disabilities or need help in performing essential activities of daily living have inadequate insurance to cover the costs of their acute and long-term care.

There is strong evidence that uninsured and underinsured individuals have less access to primary and preventive care, integrated social services, and continuity of care. They often are at the greatest risk of receiving care that is substandard and inadequate to their needs.

Ensuring that all Americans receive the care they need has been an elusive goal. But this pressing national concern is too important to ignore. Enactment of the State Child Health Insurance Program is an important first step.

The Commission urges the President, Congress, and all other stakeholders to engage in meaningful and continuing efforts to systematically reduce the number of Americans who are uninsured or underinsured. Such an effort should include specific goals and timetables and should have as its ultimate goal access to affordable, comprehensive health care for all Americans.

more than 40
websites are
up
more than 100
support the
leg.
almost 4,000
sig
close to 5,000
by COB Friday

► **Elisa Millsap**
04/08/99 09:31:31 AM
.....

Record Type: Record

To: See the distribution list at the bottom of this message

cc:

Subject: April 9

I will send the bus manifest around as soon as I get it.

----- Forwarded by Elisa Millsap/WHO/EOP on 04/08/99 09:31 AM -----



"Molstre, Kim" <Kim.Molstre @ mail.house.gov >
04/08/99 08:32:05 AM

Record Type: Record

To: Elisa Millsap/WHO/EOP

cc:

Subject: April 9

Here is an updated list of participants in Philadelphia and then also people who will be in D.C. at the Press Conference but are unable to come to Philadelphia. If there are any changes I will let you know. I also included a list of District Events (both of Members just signing on to the petition as well as Members doing district events.) In addition, there is list of Senators who are planning to participate. There are still a few unconfirmed Senators, and I will let you know about them. Following these lists is the list of "exceptional" events on April 9. I will probably have a few additions to this list in the morning. Call me if you have any questions. Thanks.

Members in Philadelphia:

- 1 Rep. Rosa DeLauro
- 2 Rep. David Bonior
- 3 Rep. Frank Pallone
- 4 Rep. Ted Strickland
- 5 Rep. Carolyn Maloney
- 6 Rep. Carolyn McCarthy
- 7 Rep. Joe Crowley
- 8 Rep. Bob Brady
- 9 Rep. Bob Borski
- 10 Rep. Chaka Fattah
- 11 Rep. Ron Klink
- 12 Rep. Joe Hoeffel

- 13 Rep. Rob Andrews
- 14 Rep. Donald Payne-possibly
- 15 Rep. Sheila Jackson-Lee-possibly

Members participating in the D.C. Press Conference only:

Rep. John Dingell
Rep. Jim Clyburn
Rep. Eliot Engel

Coalition members participating in D.C./Philadelphia Event:

Ron Pollock- Families USA
Judy Lichtman- National Partnership for Women and Families
Beverly Malone- American Nurses Association
Harley Thomas- Paralyzed Veterans of America
Nancy Starnes -Paralysis Society of America
Bob Haliburton- Nurse Anestheists
Donna Crane- American Public Health Association
A. Cornelius Baker- National Association of People with AIDS
Lisa Cox- AIDS Action
Jay Whitter- American Chiropractic Association
Nancy Davenport-Ennis- Patient Advocate Foundation
Barbara Cofal- AFSCME
Kristen Nelson- American Physical Therapy Association
Kim Musheno- Association for Retarded Citizens

Senate Participation:

Senators hosting a town meeting/event:

- 1 Senator Bryan NV
- 2 Senator Durbin IL
- 3 Senator Feingold WI
- 4 Senator Levin MI
- 5 Senator Wellstone MN
- 6 Senator Wyden OR

Senators signing the petition or issuing a press release:

- 1 Senator Boxer CA
- 2 Senator Byrd WV
- 3 Senator Conrad ND
- 4 Senator Daschle SD
- 5 Senator Dodd-unconfirmed CT
- 6 Senator Dorgan ND
- 7 Senator Feinstein CA
- 8 Senator Harkin IA
- 9 Senator Landrieu LA
- 10 Senator Mikulski MD
- 11 Senator Reed RI
- 12 Senator Reid
- 13 Senator Rockefeller

Members doing District events on April 9:

Rep. Gary Ackerman-New York
Rep. Tom Allen- Maine
Rep. John Baldacci-Maine
Rep. Tammy Baldwin-Wisconsin

Rep. Xavier Becerra-California
Rep. Ken Bentsen-Texas
Rep. Shelly Berkeley-Nevada
Rep. Marion Berry-Arkansas
Rep. Rod Blagojevich-Illinois
Rep. Earl Blumenauer-Oregon
Rep. Rick Boucher- Virginia
Rep. Leonard Boswell-Iowa
Rep. George Brown-California
Rep. Corrine Brown-Florida
Rep. Sherrod Brown-Ohio
Rep. Lois Capps-California
Rep. Michael Capuano-Massachusetts
Rep. Julia Carson-Indiana
Rep. Donna Christian-Green-VI
Rep. Eva Clayton-North Carolina
Rep. John Conyers-Michigan
Rep. Bill Coyne- Pennsylvania
Rep. Elijah Cummings-Maryland
Rep. Danny Davis-Illinois
Rep. Peter DeFazio-Oregon
Rep. Diana DeGette-Colorado
Rep. Bill Delahunt-Massachusetts
Rep. Lloyd Doggett-Texas
Rep. Mike Doyle-Pennsylvania
Rep. Anna Eshoo-California
Rep. Lane Evans- Illinois
Rep. Harold Ford Jr.-Tennessee
Rep. Martin Frost-Texas
Rep. Richard Gephardt-Missouri
Rep. Sam Gejdenson-Connecticut
Rep. Charlie Gonzalez-Texas
Rep. Gene Green-Texas
Rep. Tony Hall-Ohio
Rep. Maurice Hinchey-New York
Rep. Ruben Hinojosa-Texas
Rep. Joe Hoeffel-Pennsylvania
Rep. Rush Holt-New Jersey
Rep. Darlene Hooley-Oregon
Rep. Steny Hoyer-Maryland
Rep. Jay Inslee-Washington
Rep. Bill Jefferson-Louisiana
Rep. Eddie Bernice Johnson-Texas
Rep. Paul Kanjorski-Pennsylvania
Rep. Marcy Kaptur-Ohio
Rep. Patrick Kennedy-Rhode Island
Rep. Carolyn Kilpatrick-Michigan
Rep. Ron Kind-Wisconsin
Rep. Nick Lampson-Texas
Rep. John Larson-Connecticut
Rep. John LaFalce-New York
Rep. Barbara Lee- California
Rep. John Lewis-Georgia
Rep. John Maloney-Connecticut

Rep. Ed Markey-Massachusetts
Rep. Frank Mascara-Pennsylvania
Rep. Jim McDermott-Washington
Rep. Jim McGovern-Massachusetts
Rep. Marty Meehan-Massachusetts
Rep. Bob Menendez-New Jersey
Rep. Juanita Millender-McDonald-California
Rep. Dennis Moore-Kansas
Rep. Grace Napolitano-California
Rep. Eleanor Holmes Norton-DC
Rep. John Olver-Massachusetts
Rep. Nancy Pelosi-California
Rep. Silvestre Reyes-Texas
Rep. Lynn Rivers-Michigan
Rep. Steve Rothman-New Jersey
Rep. Jan Schakowsky-Illinois
Rep. Ronnie Shows-Mississippi
Rep. Louise Slaughter-New York
Rep. Debbie Stabenow-Michigan
Rep. Pete Stark-California
Rep. Bart Stupak-Michigan
Rep. Mark Udall-Colorado
Rep. Nydia Velazquez-New York
Rep. Bruce Vento-Minnesota
Rep. Pete Visclosky-Indiana
Rep. Bob Wise-West Virginia
Rep. Lynn Woolsey-California
Rep. David Wu-Oregon
Rep. Al Wynn-Maryland

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8/2/07

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Highlighted Patients Bill of Rights District Events- April 9

Rep. Lois Capps (CA) will be hosting an event at Santa Barbara City College. She will be speaking with a group of nursing students in a computer lab, discussing managed care reform, asking them all to sign on to the petition.

Rep. Carolyn Cheeks Kilpatrick (MI), Rep. Debbie Stabenow (MI) and Rep. John Conyers (MI) will host a rally and on-line discussion about legislation aimed at protecting the rights of medical patients under managed care programs at the Wayne County Medical Society building in Detroit, Michigan.

Secretary Alexis Herman will join Rep. Grace Napolitano (CA), Rep. Xavier Becerra (CA), and SEIU Local 660 General Manager Annette Grajeda at the Los Angeles County/University of Southern California Medical Center's General Hospital in Los Angeles, California for a press conference in support of the Patients Bill of Rights.

Rep. Eva Clayton (NC) will be hosting a video conference between four sites in her district to discuss Patients Bill of Rights, encouraging citizens to sign the on-line petition. In addition, she will make computer terminals available for her constituents to sign the petition.

Rep. Sherrod Brown (OH) will join residents of northeast Ohio and health advocates at a managed care reform press conference at Lorain County Community College's (LCCC) Health Sciences Building. Rep. Brown, LCCC students, faculty, and local residents will be singing the on-line petition, which will be projected on to a large-size screen.

Message Sent To:

Karin Kullman/OPD/EOP
Stacie Spector/WHO/EOP
Beverly J. Barnes/WHO/EOP
Julie B. Goldberg/WHO/EOP
Cecily C. Williams/WHO/EOP
Craig Hughes/WHO/EOP
Barbara D. Woolley/WHO/EOP
Charles M. Brain/WHO/EOP
Lisa M. Kountoupes/WHO/EOP
Janet Murguia/WHO/EOP
Mindy E. Myers/WHO/EOP

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.

The Lockerbie Deal

IDEALLY, Moammar Gadhafi would himself be tried for blowing up Pan Am Flight 103, with the loss of 289 lives, 10 years ago. The two Libyan intelligence agents now finally about to be tried in the case surely acted under his lead. The Libyan president was engaged in a deadly duel of wills with the United States: American bombs, dropped in response to earlier Libyan attacks, had killed his adopted daughter. Then came Lockerbie. Not only is he now avoiding trial for those murders; he is engaged in broad political bargaining that will accomplish some part of his international rehabilitation as well.

Practically, however, the handover for trial of two criminal suspects—even suspects who may remain under the discipline of their president—marks progress in the struggle to establish accountability for acts of international terrorism. Kofi Annan got it right when he said Libya's transfer of the two suspects for trial in the Netherlands under Scottish law, with Scottish judges, is "a small victory in the scheme of things." A long decade had gone by. These days sanctions are widely criticized, but in this case they had been carefully targeted to keep their political edge sharp. They had helped to mobilize world opinion against an accused state terrorist, but they were becoming a wasting asset.

Libya, caught by slumping oil prices, badly needed sanctions lifted. Some speculate as well that President Gadhafi may have been considering alterations in his revolutionary, terrorist strategy. As much was suggested by last month's Paris trial in absentia of six Libyans, including his brother-in-law, in the 1989 bombing of a French airliner in Africa: The French expect Libya to jail the six and compensate their families. Meanwhile, the United States and Britain stopped insisting on a trial on their territory, while Mr. Gadhafi agreed on what he called a "neutral" site. The Scottish compromise made possible the deal that Mr. Annan announced the other day.

It is satisfying that two suspects are now in the dock. President Gadhafi did not succeed in his effort to ensure that the process would spare him all harmful disclosures. The rigors of Scottish justice ensure that a trial will penetrate at least some part of the dark enveloping this case. Some among the families of the American dead believe that scrutiny of the small fry leaves unaddressed the larger guilt of their chief. But others seem ready to accept the trial as a psychological and legal bottom line. Moammar Gadhafi's reputation as a terrorist is going to remain with the public no matter how the trial comes out.

Death Row Reprieve

THE SUPREME Court has stepped into the case of Terry Williams, the Virginia death row inmate who was scheduled to die on Tuesday. The high court last week stayed his execution, and on Monday it agreed to consider his case in the court's next term.

Mr. Williams is a repeat offender who was condemned to death for a killing that police did not initially even know was a murder. Authorities learned that Harris Thomas Stone had been killed only when, months later, Mr. Williams confessed to the crime and described its circumstances. Two district courts have held that Mr. Williams received ineffective assistance of counsel in his sentencing. His lawyer failed to introduce mitigating evidence concerning his borderline mental retardation and bad childhood. Both courts, including the judge who originally sentenced him to death, ruled that he should get a new sentencing hearing. Both decisions were overturned.

The immediate question that Mr. Williams's case will present the high court is whether the 4th Circuit Court of Appeals applied the right

standard in assessing whether the mitigating evidence withheld from the jury would have been likely to sway it. But the case also offers the court an opportunity to give broader guidance to the lower courts concerning the meaning and implications of Congress's 1996 law limiting federal death penalty appeals. In recent years, the Supreme Court has been eager to roll back habeas protections, and there is some reason to fear the high court will use the current case to read the 1996 legislation as restrictively as possible.

At least in the short term, however, the decision means a reprieve for Mr. Williams—who otherwise would have been at the mercy of Gov. Gilmore's decision on his petition for clemency. Valuable as well is the fact that the Supreme Court will take responsibility for the eventual disposition of this case. If our justice system is going to execute somebody despite the second thoughts of the judge who sentenced him to die, the responsibility for such a grotesque outcome should properly lie with the highest court in the land.

Poultry Politics on the Shore

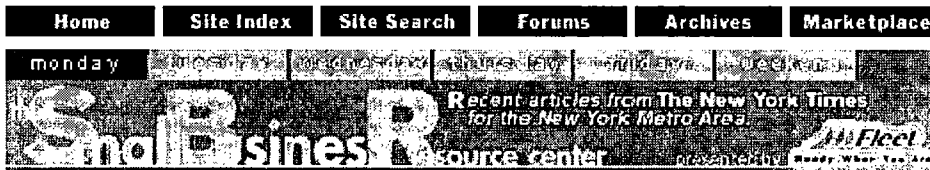
CHICKENS ARE big business on the Delmarva peninsula, and so are this region's waterways—especially the Chesapeake Bay. The millions of chickens have presented all sorts of problems for the waterways, however; political battles over anti-pollution measures have been raging for years on the Eastern Shore. Now Maryland is moving to become the first state to make companies assume responsibility for pollution caused by the chickens. As reported by staff writer Peter S. Goodman, rules will be added as a condition of state permits governing poultry plants.

The new rules, aimed at closing loopholes in state regulations, follow disclosures in The Post last summer that a slaughterhouse operated by Tyson Foods Inc. was dumping liquid matter filled with nitrogen and phosphorous. These nutrients fuel algae that choke off oxygen in the water—and that may be linked to the toxic

microbe *Pfiesteria piscicida*.

Virginia and Delaware regulate this problem as an industrial waste issue; but Maryland has considered it an agricultural product requiring no permits or inspections. Last month, Maryland Secretary of the Environment Jane Nishida reported that her agency would regulate these matters through permit changes.

Industry leaders have maintained that such policies put Maryland producers at a competitive disadvantage, and they are planning legal challenges. In the past, state leaders have talked about ways to hold the producers more responsible but have backed off in the face of suggestions that the firms would move out of the state. Now state and federal officials believe Maryland has authority under the Clean Water Act to take these actions—steps that the poultry processors can live with, for the health of Marylanders as well as of their famed waterways.

Breaking News
FROM A.P.The New York Times
ON THE WEB

April 9, 1999

Clinton Rallies for Patients Rights

A.P. INDEXES: [TOP STORIES](#) | [NEWS](#) | [SPORTS](#) | [BUSINESS](#) | [TECHNOLOGY](#) | [ENTERTAINMENT](#)

Filed at 2:17 a.m. EDT**By The Associated Press**

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.

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

White House Expands Patients' Rights Effort

Federal Work Force Test Was Cost-Effective

By JUDITH HAVEMANN
Washington Post Staff Writer

A year-old administration initiative imposing a broad set of patient protections on private companies providing health coverage to federal workers has added little to the overall cost of the insurance, according to the White House.

President Clinton will announce new figures today showing that the initiative added less than \$10 a year per individual enrolled in the plan, as he sets the stage for a renewed effort on Capitol Hill to pass a "bill of rights" to ensure patients better treatment and greater clout in the nation's changing health care system.

Clinton will travel with members of Congress to Philadelphia to drum up support for a Democratic measure to provide more protection for patients. A Senate committee recently approved a Republican version of the "patients' bill of rights." However, the GOP plan has fewer regulations and covers fewer Ameri-

cans. The Republicans say the president's plan would increase health care costs substantially and thereby drive up the number of uninsured.

Last year, Clinton imposed patient protections on the 285 private insurance plans that cover the nation's 9 million federal workers and their families. Those protections included access to specialists and to emergency room treatment when and where the need arises.

Today, Clinton will order insurance companies participating in the federal program to come into "full compliance" with the Democratic version of the patients' bill of rights. This will mean that federal workers insured through the Federal Employees Health Benefits Program must be given more information about their plan and be guaranteed "continuity of care."

Continuity of care means that patients who are pregnant or who suffer from chronic conditions would not be required to switch doctors in mid-treatment

if they are forced to change health plans. Moreover, the president will require the health plans to disclose information about doctors' compensation, comparative information about the quality of treatment and data on consumer satisfaction.

The health insurance industry contends that White House figures are wrong and misleading. "I think the numbers bear no relationship to the facts that would occur from implementing the so-called patient protection bills," said Charles N. "Chip" Kahn III, president of the Health Insurance Association of America. He said that the biggest cost would arise from Democratic provisions that would allow patients to sue health plans.

Federal employees do not have the same rights to legal redress included in the Democratic bill.

Joe Karpinski, communications director of the Senate health and education committee, said that the president is not comparing "apples to apples." The Congressional Budget Office has estimated that the Democratic patients' bill of rights would raise premiums by 4 percent, he said.

"What the president is comparing is far short of the mandates [in the Democratic bill] or he is using a new math that the Congressional Budget Office is not using," Karpinski said.

The Washington Post

FRIDAY, APRIL 9, 1999

In Plain English, Unresolved

Pennsylvania Republican Struggles With Kosovo Questions

By MICHAEL GRUNWALD
Washington Post Staff Writer

EVANS CITY, Pa.—America is at war, and Rep. Phil Sheridan English (R-Pa.) is at a loss.

Doves complain that America has no national interest in Kosovo, and so does English. Hawks say abandoning Kosovo would damage American credibility, and English agrees with them, too. Doves warn that sending ground troops to Kosovo could create a Vietnam-style morass, and that also rings true. Hawks reply that now that we're in the war, we need to win the war, and English could not agree more.

English simply isn't sure how to reconcile his desires for a clear (but not too broad) mission with a clear (but not too hasty) exit strategy with a clear (but not too painful) victory. So when he discussed the war at a town meeting with about 45 constituents Wednesday night, he uttered three words rarely heard from members of Congress: I don't know.

"I'm very conflicted on this, and I'm looking for direct input," said the hefty third-term representative from Erie. "I really haven't drawn many conclusions."

For the past two weeks, while Washington has been at war, members of Congress have been at home, sounding out their constituents about the crisis in Kosovo, trying to balance their anxieties about criticizing a war effort with their fears of heavy American casualties. While there are historical and constitutional reasons why Congress has taken a back seat to the Clinton administration in the debates over Kosovo and the role of American power, English's on-the-one-hand-on-the-other-hand ruminations suggest another reason: It's a complex issue, morally and politically, and many members of Congress just don't know how the United States should proceed.

The politics of war, moreover, can be hard to predict. Recent polls have suggested that Americans are warming up to ground troops in Kosovo, and English's heavily industrial district is considered a bellwether of sorts, but English was stunned when all but one member of his audience opposed the idea Wednesday. There was a pretty conservative crowd at the Evans City American Legion, but its primary concern was avoiding a reprise of Vietnam.

"It's a no-win situation, and it upsets me very much," said contractor Jack Mazzana, 58, an Air Force veteran who has voted for English in the past. "If we go in there, we'll see body bags come back."

In any case, the 90-minute meeting did not end English's uncertainty about Kosovo. In several interviews, he explained his tortured thought processes, from his suspicions about the legality of the NATO mission to his desire to support it now that it's underway, from his doubts about American involvement in humanitarian missions to his feelings of guilt about humanitarian disasters America has failed to prevent. Suffice to say that if English's ancestor and namesake, the bold Civil War general Philip Sheridan, had been this ambivalent in the Shenandoah Valley, America might be pledging allegiance to the Stars and Bars.

"Wavering is probably the right way of putting it right now," said English, 42, who won extremely close elections in 1994 and 1996 but faced only token opposition last year. "I think something should be done about the human rights violations in Kosovo. But something should have been done about the situation in Burundi, too. I just don't know what."

English has spent his entire career in politics. He served as president of the state College Republicans while at the University of Pennsylvania, then landed jobs as a committee staffer in the state Senate, as campaign manager for Sen. Rick Santorum (R) when he first ran for the House, and as the GOP controller of heavily Democratic Erie. He was elected to represent northwestern Pennsylvania in the House during the Republican landslide in 1994—replacing the popular Tom Ridge (R), who moved into the governor's office—and became the first GOP freshman awarded a seat on the influential Ways and Means committee since a Texas representative named George Bush.

English describes himself as a domestic policy wonk and an ardent tax reformer—he once tried (with limited success) to destroy the U.S. tax code with a chain saw—but he does not pretend to be a foreign policy maven. Of the 115 news releases he has issued since January 1998, the only hint of foreign policy was his announcement of his trade mission to South America. While the war was raging on Wednesday, English was holding three news conferences at hospitals in his district to blast an obscure Clinton administration proposal for Medicare funding, proclaiming that "there is no bigger issue looming on the horizon for Pennsylvania."

English's offices are receiving about 30 calls a day about Kosovo, which sounds impressive until it's compared with about 1,000 calls a day during the debate over impeachment. At the town meeting here in Evans City, a dairy-farm town still known as the City of Black Gold even though its oil derricks are long gone, constituents sounded off about Kosovo—but also about low milk prices, the Y2K crisis, large class sizes, campaign finance abuses and the IRS. (English voted for one article of impeachment, but nobody mentioned that.)

"Foreign policy is not really my thing; my constituents don't get too fired up about it either," English said. "They focus more on things like health care, and so do I."

Still, after a moment of silence for the three captured American servicemen, English began this session by explaining his vote against a resolution to authorize 4,000 peacekeeping troops in Kosovo in case of a peace treaty. He said he was worried that Kosovo would turn into a tar pit, that U.S. troops could get stuck there for decades. But he also said that he agreed with Sen. John McCain (R-Ariz.) that the United States should not tie its hands by ruling out the use of ground troops, and that he would support a resolution to authorize the bombing now that American prestige was on the line.

"We need to keep all our options

open," English said, and for a moment it was unclear if he was talking about America or congressional Republicans. "I'm still skeptical of using ground troops; I don't want us to get sucked into a morass that's going to devour all our resources. But it doesn't make sense to take the option off the table publicly."

Reaction from his constituents was polite, but it was not supportive. The rural but increasingly sprawl-bound southern part of English's district is split between Republicans and Democrats, but there was a solid consensus in Evans City against ground troops. Only Susan Vollmer wanted them in now, arguing that airstrikes alone are not enough to achieve NATO objectives; only a few others were willing to send them to enforce a peace deal. English was even peppered with questions when he hinted that he supported Clinton's proposal to accept 20,000 Kosovo refugees: "How much is that going to cost in our tax dollars?" one man asked.

"Are they going to do background checks so it's not just criminals?" another chimed in.

English gently suggested that while background checks sounded like a good idea, they might not be feasible, given that Serbian forces have been burning personal documents in Kosovo. He tried to ask questions that reminded his audience of the rationale behind the bombing: Can we just turn our backs on massacres and other human rights violations? Do you think we need a strong NATO? Hasn't Milosevic broken a lot of promises?

Most of the audience kept responding with Vietnam analogies, but Helen Oliverio was reminded more of World War II.

"Nobody wants to do anything until Pearl Harbor happens again," said Oliverio, 58, a nurse who is a Democrat but votes for English. "Well, I think that's terrible. I don't know about ground troops, but we need to do something."

English feels the same way. He is saddened by the images of refugees streaming out of Kosovo, and thought a group of Kosovo immigrants he recently met in Erie made a "very compelling" pitch for a full-scale invasion. But then he recalls that he stood aside in Rwanda, where 500,000 people were slaughtered, and he's not sure he had a better idea. "I don't think we have the resources to be a global cop," he said. "I think what we ought to do will be dictated by the situation."

In other words: I don't know.

"I'm still wrestling with this war," English said with a sigh. "It's been quite a learning experience."

WHITE HOUSE STAFFING MEMORANDUM

Date: 4/8/99ACTION / CONCURRENCE / COMMENT DUE BY: 5:30 p.m. TODAY0503
276Subject: PATIENTS' BILL of RIGHTS -- TALKING POINTS

	ACTION	FYI		ACTION	FYI
VICE PRESIDENT	☒	☐	MOORE	☐	☐
PODESTA	☒	☐	NASH	☐	☐
ECHAVESTE	☒	☐	REED	☒	☐
RICCHETTI	☒	☐	RUFF	☐	☐
LEW	☒	☐	SOSNIK	☒	☐
BERGER	☐	☐	SPERLING	☒	☐
BLUMENTHAL	☒	☐	STEIN	☒	☐
CAHILL	☐	☐	STERN	☐	☐
FRAMPTON	☐	☐	STREETT	☐	☐
IBARRA	☐	☐	TRAMONTANO	☒	☐
JOHNSON	☐	☐	UCELLI	☒	☐
KLAIN	☒	☐	VERVEER	☒	☐
LANE	☐	☐	WALDMAN	☒	☐
LEWIS	☒	☐	YELLEN	☐	☐
LINDSEY	☐	☐	<u>C. JENNINGS</u> →	☒	☐
LOCKHART	☐	☒	_____	☐	☐
MARSHALL	☐	☐	_____	☐	☐

REMARKS:

COMMENTS TO Lowell Weiss

RESPONSE:

PRESIDENT WILLIAM J. CLINTON
TALKING POINTS FOR PATIENTS' BILL OF RIGHTS EVENT
PHILADELPHIA, PA
April 9, 1999

'99 APR 8 PM2:01

Acknowledge: Reps. Bonior, DeLauro, Brady, Fatah, Borski, and all the other Members here; AFL-CIO Pres. John Sweeney; Judith Lichtman and the National Partnership for Women and Families; Ron Pollack and Families USA; leaders of the 150 other national organizations working to give all Americans the security of the Patients' Bill of Rights.

Remember that great line Roberto Benigni had at the Academy Awards? "This is a terrible mistake. I used up all my English." Today, I think you've used up all my rhetoric.

There is no better place in America to join together to talk about the importance of quality health care. Philadelphia was the home of the very first hospital in America -- thanks in large part to a public-spirited man by the name of Ben Franklin. It was home to America's very first medical school and very first training school for nurses. And today, it is still one of the most important centers of medical training in the world.

Philadelphia is also the best place in America to launch a petition aimed at securing rights too long denied. Not only was Philadelphia the nation's capital when the Bill of Rights was ratified. Not only were the Constitution and Declaration of Independence written here. Back in 1701, the citizens of Philadelphia launched what may have been the first successful petition drive in the New World. They asserted -- and won -- the full and unfettered right to practice whatever religion they chose.

Our petition today is clearly more modern -- for we are using the power of the Internet to collect names and spread the word. But the underlying mission is fundamentally the same. With this petition, we call upon the leadership of Congress to provide protections central to the lives of our citizens. We call on the Congress to heed the will of the people and pass a real Patients' Bill of Rights.

There will never be a better time to act. The time to fix the roof is when the sun is shining. Today, America is enjoying the longest peacetime expansion in our nation's 223 years -- nearly 18 million new jobs, real wages rising at twice the rate of inflation, and the lowest peacetime unemployment since 1957. You can see that prosperity here in Philadelphia -- with your large budget surplus and soaring confidence, with the influx of new businesses and good jobs.

There is no better use of this time of prosperity than giving every family the protections of a strong, enforceable Patients' Bill of Rights. You deserve right to choose the specialist you want for the care you need. The right to emergency room care, wherever and whenever you need it. The right to know that your doctor can discuss with you all your treatment options, not just the cheapest. The right to a timely and independent appeals process. The right to hold your health plan accountable if it causes you or a loved one great harm. The right to know that

you won't be forced to switch doctors in the middle of a pregnancy or a cancer treatment. The right to all the information you need to make informed health care choices.

My Administration has worked hard to do its part. As the single largest buyer of private health insurance, the federal government carries a tremendous amount of weight. We have already used that influence to help all 9 million men, women, and children who receive their health benefits through the federal government to secure many of these protections. Today, we will finish the job. We are informing all 285 companies that provide coverage for federal employees and their families that if they want to do business with us, they must add new protections for federal workers and their families: They must guarantee that you'll never have to switch doctors in the middle of a treatment. And they must provide full disclosure of what they cover, what incentives they offer doctors, and how satisfied other patients' have been with the care they provide.

The cost of complying with these new protections is remarkably small. By the industry's own estimates, it will cost only about 25 cents per person per year to provide these new protections. A quarter per person per year. You can't even get most newspapers for a quarter a day. And remember, the 285 companies that provide health insurance for federal employees are the same companies that provide coverage for citizens all over America. At only a quarter per person per year, how can any insurance plan afford not to provide these protections to all of those who are enrolled in their plans?

Unfortunately, the Republican leadership offers only a piecemeal, watered-down approach. In the House, the leadership has shown no willingness to even consider a comprehensive approach. In the Senate, the Republican leadership plan does not ensure access to specialists, does not prevent your health plan from forcing you to change doctors in the middle of a treatment, and does not give you adequate recourse if your health plan fails to provide adequate care. And because it applies only to self-insured plans, it leaves millions of patients without any protections at all.

The Patients' Bill of Rights need not be a partisan issue. No one asks your party affiliation when you visit your doctor. And no one wants to see unfeeling practices by some insurance companies add to the anguish of injury and disease. We must work together to get the job done.

Years from now, when we look back on the greatest accomplishments of this century, advances in medical science will sit at the top of the list -- childhood immunizations, organ transplants, bioengineered drugs, even gene therapy. But for all the successes of medicine, we know that parts of our medical system are in desperate need of repair. Today, the sun is shining. Let's fix the roof. Let's use this time to give all our families the protections a real Patients' Bill of Rights.

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FEHB Program Carrier Letter

All Carriers

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

Letter No. 1999-016

Date: April 9, 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.

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.

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. You gave the Patients' Bill of Rights your full support, implementing a number of important patient protections around information disclosure, access to emergency care, access to obstetricians and gynecologists, access to specialists for people with special health care needs, and access to appropriate providers, even if they are outside of the plan's network. We are pleased that you were able to implement these protections for a minimal cost -- less than 25 cents per enrollee.

In order to provide context for the year 2000 requirements, Enclosure 1 summarizes the information you arranged to disclose and the benefit changes you implemented by the beginning of 1999. 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 and potential 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, and providers will give all necessary information to the plan for quality assurance purposes. Providers continuing treatment during the transition period will promptly transfer all medical records to the designated new provider during or upon completion of the transition period, according to the patient's authorization.

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. 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 patients be allowed to review and obtain copies of their medical records on request and promptly. A patient may also request that a physician amend a record that is not accurate, relevant, or complete. The physician will have sole discretion as to whether to make the requested amendment. If the physician does not amend the record in accordance with the patient's request, the member may add a brief statement to the record. Whenever a medical record is disclosed or transferred, any such statement must be included.

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 participated in 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 last 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 expect 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 the basis of medical necessity and specific contractual provisions, 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 Inspector General at 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, software firmware and acquired information technology 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 service to enrollees. Accordingly, you should work with your partners -- including financial institutions, providers and other contractors -- to make sure they have adequate Y2K plans. If they don't, we recommend you help them develop a plan to ensure that you will be able to provide service to your FEHB members. 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- 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.

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

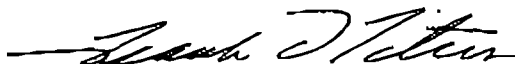
Office of Insurance Programs
Attn:
1900 E Street, NW, Room 3424
Washington, DC 20415

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

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 D. Titus
Assistant Director
for Insurance Programs

Enclosures

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 your responsibility. We expect a timely, professional document that follows our guidelines including those for the use of plain language. 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 you 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.

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.

Information Disclosure

Information That Should Have Been Available During the Open Season For 1999

About the Plan and Care Management:

- ◆ Formulary drug inclusion and exception process
- ◆ Experimental/investigational determination process
- ◆ Compliance with State or Federal licensing, certification, or fiscal solvency 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
- ◆ Accreditation status
- ◆ Disenrollment rate for 1998 (FEHB open season losses / Dec 31 enrollment = %)
- ◆ Years in existence (corporate)
- ◆ Corporate form (profit/non-profit, private/public)
- ◆ Compliance with standards (State, Federal, and private accreditation) that assure confidentiality of medical records and orderly transfer to caregivers

Information That Should Have Been Available Upon Request During 1999

About the Plan and Care Management:

- ◆ Preauthorization and utilization review procedures used to approve care
- ◆ Clinical protocols, practice guidelines and utilization review standards being used to direct a patient's care
- ◆ Mandatory or voluntary disease management programs or programs for persons with disabilities and significant benefit differentials if any
- ◆ Whether a patient's medication is included in the plan's formulary, and if not, how the patient can request a waiver to allow coverage for the particular medication at preferred cost-sharing levels
- ◆ Disclosure of the credentials of the person, or persons, involved in reviewing the patient's appeal.

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.

Information Disclosure For 2000

Carriers may refer members to providers or facilities for the disclosure of information related specifically to these entities. However, if the member is unable to obtain the information, the carrier must intervene and assist the member in securing the information.

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

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

A. About the Plan:

- ◆ Customer satisfaction measures

B. About Networks and Providers:

- ◆ Number of primary care and specialty providers
- ◆ Name, education, board certification status and geographic location of all contracting primary and specialty 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 their facilities are accessible to the disabled
- ◆ Provider compensation, including base payment method (e.g., capitation, salary, fee schedule) and additional financial incentives (e.g., bonus, withhold, etc.)

Information That Must Be Available Upon Request By January 2000:

A. About the Plan:

- ◆ Methods of compensation, ownership or interest in health care facilities.

B. About All Professional Providers:

- ◆ Corporate form of provider practice
- ◆ 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

FEHB Carrier Letter 1999-016, April 9, 1999

Enclosure 2
Page 2 of 2

C. About Facilities:

- ◆ 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.

Thank you, Congressman Bonior.

Good afternoon, Mr. President, Members of Congress, and other distinguished guests.

Everyone is here today to make a stand for the rights of managed care patients everywhere to receive the high quality health care that we deserve. I feel especially strongly about this subject and would like to share my story with everyone.

As you can see, I wear a patch over my left eye. My sight was permanently damaged because my managed care company refused to provide me with timely access to the specialty care that eventually saved my life and could have saved my sight.

One afternoon in April of 1997, I had a horrible headache. I don't really believe in running to doctors for every little ache and pain, so I waited for it to go away. A few days later, I started seeing double, and the pupil of my left eye was fixed, dilated, and off-center. That's when I knew something was really wrong, and I decided I had to go the doctor. I have a family history of aneurysms, and so I asked to see a neurologist. The plan told me that I couldn't; that I had to see an internist. The internist at first said that I had had a stroke, but then realized that I really did need to see a neurologist. Despite my complaints -- and my doctor's complaints -- I couldn't get an appointment earlier than two weeks away. I was in constant pain and extremely scared about my health. I thought I was going to die.

Once I made it to the neurologist, they took one look at me, and rushed me to the hospital for emergency surgery for a brain aneurysm. They told me that I was lucky to be alive, and I believe them.

Unfortunately, the surgery did not come soon enough to save my sight. Because the aneurysm was so large, and went unchecked for so long, my optic nerve and my upper and lower eye muscles were permanently damaged. The vision in my left eye will be blurred for the rest of my life. I used to be a writer -- now I can no longer look at a computer screen for longer than an half hour.

Cases like mine illustrate clearer than anything else the need for a strong, enforceable Patients' Bill of Rights, where the needs of patients and the opinions of physicians come first. I would like to thank you, Mr. President and the members of Congress here today, for your leadership on this issue and in the fight for patients' rights.

It is now my pleasure to introduce the man who has fought harder for the rights of patients than anyone else, the President of the United States -- William Jefferson Clinton.

Executive Orders

EO 13017

section shall be exercised in a manner to ensure interagency coordination that enhances efficiency and effectiveness."

WILLIAM J. CLINTON

THE WHITE HOUSE,
August 28, 1996.

Executive Order 13017 of September 5, 1996

Advisory Commission on Consumer Protection and Quality in the Health Care Industry

By the authority vested in me as President by the Constitution and the laws of the United States of America, including the Federal Advisory Committee Act, as amended (5 U.S.C. App.), it is hereby ordered as follows:

Section 1. Establishment. (a) There is established the Advisory Commission on Consumer Protection and Quality in the Health Care Industry (the "Commission"). The Commission shall be composed of not more than 20 members to be appointed by the President. The members will be consumers, institutional health care providers, health care professionals, other health care workers, health care insurers, health care purchasers, State and local government representatives, and experts in health care quality, financing, and administration.

(b) The Secretary of Health and Human Services and the Secretary of Labor shall serve as Co-Chairs of the Commission. The Co-Chairs shall report through the Vice President to the President.

Sec. 2. Functions. (a) The Commission shall advise the President on changes occurring in the health care system and recommend such measures as may be necessary to promote and assure health care quality and value, and protect consumers and workers in the health care system. In particular, the Commission shall:

(1) Review the available data in the area of consumer information and protections for those enrolled in health care plans and make such recommendations as may be necessary for improvements;

(2) Review existing and planned work that defines, measures, and promotes quality of health care, and help build further consensus on approaches to assure and promote quality of care in a changing delivery system; and

(3) Collect and evaluate data on changes in availability of treatment and services, and make such recommendations as may be necessary for improvements.

(b) For the purpose of carrying out its functions, the Commission may hold hearings, establish subcommittees, and convene and act at such times and places as the Commission may find advisable.

Sec. 3. Reports. The Commission shall make a preliminary report to the President by September 30, 1997. A final report shall be submitted to the President 18 months after the Commission's first meeting.

EO 13018

Title 3—The President

Sec. 4. Administration. (a) To the extent permitted by law, the heads of executive departments and agencies, and independent agencies (collectively "agencies") shall provide the Commission, upon request, with such information as it may require for the purposes of carrying out its functions.

(b) Members of the Commission may receive compensation for their work on the Commission not to exceed the daily rate specified for Level IV of the Executive Schedule (5 U.S.C. 5315). While engaged in the work of the Commission, members appointed from among private citizens of the United States may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law for persons serving intermittently in the Government service (5 U.S.C. 5701-5707) to the extent funds are available for such purposes.

(c) To the extent permitted by law and subject to the availability of appropriations, the Department of Health and Human Services shall provide the Commission with administrative services, funds, facilities, staff, and other support services necessary for the performance of the Commission's functions. The Secretary of Health and Human Services shall perform the administrative functions of the President under the Federal Advisory Committee Act, as amended (5 U.S.C. App.), with respect to the Commission.

Sec. 5. General Provision. The Commission shall terminate 30 days after submitting its final report, but not later than 2 years from the date of this order, unless extended by the President.

WILLIAM J. CLINTON

THE WHITE HOUSE,
September 5, 1996.

Executive Order 13018 of September 16, 1996

Amending Executive Order No. 12975

By the authority vested in me as President by the Constitution and the laws of the United States of America, and in order to add 3 members to the National Bioethics Advisory Commission, it is hereby ordered that the number "15" in the second sentence of section 3(a) of Executive Order No. 12975 is deleted and the number "18" is inserted in lieu thereof.

WILLIAM J. CLINTON

THE WHITE HOUSE,
September 16, 1996.

Executive Order 13019 of September 28, 1996

Supporting Families: Collecting Delinquent Child Support Obligations

The Debt Collection Improvement Act of 1996, Public Law 104-134 (110 Stat. 1321-358 *et seq.*), was enacted into law on April 26, 1996, as part of

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President

Executive Orders

EO 13040

noncommercial broadcasting in academic institutions, public intercommunity. The President shall designate the Committee.

1998, the Committee shall report on the obligations of digital television and the Assistant Secretary of Commerce, hold meetings at such times as is feasible.

permitted by law, the heads of executive instrumentalities shall provide such information as it may require.

Committee, the head of any executive shall, to the extent permitted by law, (1) make any of the facilities, or instrumentality available to the personnel of such department to assist the Committee.

without compensation for their services in the work of the Committee, or may be allowed travel expenses, as authorized by law and the Assistant Secretary of Commerce for as needed, for persons service (5 U.S.C. 5701-5707), to the

subject to the availability of appropriations shall provide the Committee with support services necessary for

for Communications and Information functions of the President under the Administrator of General

within 30 days after submitting its

WILLIAM J. CLINTON

Executive Order 13039 of March 11, 1997

Exclusion of the Naval Special Warfare Development Group From the Federal Labor-Management Relations Program

By the authority vested in me as President by the Constitution and the laws of the United States of America, including section 7103(b)(1) of title 5 of the United States Code, and having determined that the Naval Special Warfare Development Group has as a primary function intelligence, counterintelligence, investigative, or national security work and that the provisions of Chapter 71 of title 5 of the United States Code cannot be applied to this organization in a manner consistent with national security requirements and considerations, Executive Order 12171 of November 19, 1979, as amended, is further amended by adding the following at the end of section 1-205:

"(i) Naval Special Warfare Development Group."

WILLIAM J. CLINTON

THE WHITE HOUSE,
March 11, 1997.

Executive Order 13040 of March 25, 1997

Amendment to Executive Order 13017, Advisory Commission on Consumer Protection and Quality in the Health Care Industry

By the authority vested in me as President by the Constitution and the laws of the United States of America, and in order to expand membership and ensure broad-based representation for the Advisory Commission on Consumer Protection and Quality in the Health Care Industry and to revise the deadlines for the Commission's submission to the President of interim and final reports, it is hereby ordered as follows:

Section 1. Section 1(a) of Executive Order 13017 is amended by deleting the number "20" in the second sentence and inserting the number "32" in lieu thereof.

Sec. 2. Section 3 of Executive Order 13017 is amended to read as follows:

"**Sec. 3. Reports.** The Commission shall make a preliminary report to the President by January 31, 1998. A final report shall be submitted to the President by March 30, 1998."

WILLIAM J. CLINTON

THE WHITE HOUSE,
March 25, 1997.

President

Executive Orders

EO 13057

in the United States Information Group on United States Government and Training ("the Working Group") is to recommend to the President, efficiency, and effectiveness of international exchanges and training clearinghouse to improve data changes and training.

and international exchanges and between countries to promote to foster mutual understanding, directly or indirectly, with

the Associate Director for Education, United States Information Agency, who is representative appointed by the Departments of State, Defense, Education, and the United States by heads of other interested entities, representatives of the National Office of Management and Group at their discretion. The agency staff office established for the United States Information

following responsibilities:

by all United States Government international exchanges and

cooperation on, among components and agencies, common international exchanges and establishment of a clearinghouse training activities in the government

cost-effective use of Federal automatic duplication and overgovernment agencies involved management and training programs,

order, develop initially and for all United States Government training programs, and

of this order, develop recommendations, United States Government programs, and issue a report

(f) Develop strategies for expanding public and private partnerships in, and leveraging private sector support for, United States Government-sponsored international exchange and training activities.

Sec. 5. All reports prepared by the Working Group pursuant to section 4 shall be made to the President, through the Director of the United States Information Agency.

Sec. 6. The Working Group shall meet on at least a quarterly basis.

Sec. 7. Any expenses incurred by a member of the Working Group in connection with such member's service on the Working Group shall be borne by the member's respective department or agency.

Sec. 8. If any member of the Working Group disagrees with respect to any matter in any report prepared pursuant to section 4, such member may prepare a statement setting forth the reasons for such disagreement and such statement shall be appended to, and considered a part of, the report.

Sec. 9. Nothing in this Executive order is intended to alter the authorities and responsibilities of the head of any department or agency.

WILLIAM J. CLINTON

THE WHITE HOUSE,
July 15, 1997.

Executive Order 13056 of July 21, 1997

Further Amendment to Executive Order 13017, Advisory Commission on Consumer Protection and Quality in the Health Care Industry

By the authority vested in me as President by the Constitution and the laws of the United States of America, and in order to add an additional two members to the Advisory Commission on Consumer Protection and Quality in the Health Care Industry, it is hereby ordered as follows:

Section 1(a) of Executive Order 13017, as amended, is further amended by deleting the number "32" in the second sentence and inserting the number "34" in lieu thereof.

WILLIAM J. CLINTON

THE WHITE HOUSE,
July 21, 1997.

Executive Order 13057 of July 26, 1997

Federal Actions in the Lake Tahoe Region

By the authority vested in me as President by the Constitution and the laws of the United States of America, and in order to ensure that Federal agency actions protect the extraordinary natural, recreational, and ecological re-

Withdrawal/Redaction Sheet

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. list	re: phone numbers (partial) (1 page)	n.d.	P6/b(6)

COLLECTION:

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

FOLDER TITLE:

PBOR [Patients' Bill of Rights] [Folder 3]

2012-0463-S

rc808

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]

LAST NAME	FIRST NAME	TICKETS	PHONE #	CONTACT
Street	John	1	[REDACTED]	Lana Felton-Ghee
Weinberg	Marty	1		Joe Martz
Fernandez	Happy	1		David Dougherty
White	John	1		Dean Levitan
Evans	Dwight	1		
Mezvinsky	Marjorie	4		
Schwartz	Allyson	2		
Foley	Tom	1		
Kullman	Karin	5		
Kravitz	Shirley	1		
Knapp	Leo	1		
Knapp	Concetta	1		
Knapp	Katherine	1		
Diaz	Nelson	1		
Dougherty	John	1		
Pribulsky	Jay and Fran	2		
City Council		16		
St Senators TBD		6		
O'Donnell	Donna	15		
Rendell	Mayor	10		
McMeekin	Jack	1		
Wigglesworth	Andrew	1		
Donski	Donna	1		
Eyer	Joe	18		
Families USA		15		
State Dem Party		10		
AFT	Nurses	20		
DeWeese	State Rep	1		
Blaum	State Rep	1		
Bishop	State Rep	1		
Kirkland	State Rep	1		
McGeehan	State Rep	1		
Manderino	State Rep	1		
Sturla	State Rep	1		
Williams	State Rep	1		

TOTAL 146

Congressional

On Bus		30
Brady	Bob	15
Fattah	Chaka	15
Borski	Bob	15
Hoeffel	Joe	10
Andrews	Rob	15

TOTAL 100

Wooley Groups

V

DPC

Cab. Affairs

M. Murray

M. Murray

M. Murray

WH Advance offc

Nurses

Donna Cisowski

[lost]

Jeff Kirsh

Tita Tartaglione

Bill Cunningham

American Nurses Assoc	5
Ntnl Breast Cancer Coal.	6
Brill	1
Nast	1
McNanary	1
Other	16
Woolley	
TOTAL	30

AFL-CIO	120 215-665-9800	Richard Womack
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Park People	20
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Grand Total	416
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