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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. letter	Dian Bower to Sergeant Major Porteous (1 page)	02/17/1998	P6/b(6)
001b. paper	re: personal medical (2 pages)	n.d.	P6/b(6)
001c. letter	From: Dian Bower (1 page)	02/19/1998	P6/b(6)
002. note	re: address, phone number, and DOB (partial) (1 page)	n.d.	P6/b(6)

COLLECTION:
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FOLDER TITLE:
PBOR [Patients' Bill of Rights] [Folder 4]

2012-0463-S
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RESTRICTION CODES

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

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

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

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

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

TALKING POINTS: COST OF THE BILL

--The arguments of our opponents on this issue follow a familiar pattern. Whenever there is an attempt to help ordinary Americans who are victimized by powerful special interests, the special interests cook up wild and inaccurate claims of how much even the mildest and most reasonable remedies will cost.

--Let's look at the record.

o When we considered Family and Medical Leave, the U.S. Chamber of Commerce said it would cost businesses $27 billion annually, but the GAO found the actual costs would be only 2% of the Chamber's claims. And virtually no one today is arguing that fair and moderate legislation should be repealed.

o When we tried to enact the minimum wage, the special interests groups circulated all kinds of wild estimates of the job losses that would result. But we all know what happened: we passed the legislation, and the economy has created an unprecedented number of new jobs.

o When we tried to pass the Kassebaum-Kennedy insurance reform program -- legislation that passed the Senate unanimously twice -- the HIAA said that premiums would increase by 22% and might go up as much as 31%. But the American Academy of Actuaries and the Congressional Research Service said the increase would be minimal -- less than 2% per year spread over a three year period.

-There were three unbiased independent estimates of the cost of the President's Commission's recommendations -- recommendations that are largely mirrored in this bill. They were made by the Lewin Group for the President's Commission, by the accounting firm of Coopers and Lybrand for the Kaiser Family Foundation, and by the Congressional Budget Office.

-The Congressional Budget Office has officially estimated the cost of our Patients' Bill of Rights twice. Every single one of these independent estimates -- the only independent estimates in this debate -- said the cost would be minimal.

--The Congressional Budget Office confirmed just last week the cost of our Patients' Bill of Rights will add only 4.8% to health insurance premiums at the end of five years. And, reflecting CBO's conservative assumptions, that was the highest estimate of any of the independent analyses. For a typical worker, that's less than $2 a month. And the CBO said the premium impact would only be felt slowly. It would be phased in over five years. This increase averages less than one percent per year.

--Yet Republicans continue to cite a higher figure that does not relate to the bill we are proposing. They are using an estimate they know does not reflect any

legislation we will debate.

--They falsely claim that GAO has concluded that our legislation will increase the number of uninsured Americans by more than one million. But GAO actually warned against making blanket assumptions regarding the relationship between premium increases and insurance status. In fact, GAO concluded in a letter to Senator Jeffords last July that patient protection legislation could actually increase, rather than decrease, the number with insurance because people may be more likely to purchase it if they know it will be there when they need it most.

--Republicans also claim that the clarifications included in our current bill will take away rights from individuals. In fact, protections will be expanded.

--Our Republican opponents have obviously been reduced to tactics of distortion, disinformation, and desperation. These tactics will fail, just as the HMO industry's expenditure of more than $100 million dollars to defeat our legislation and confuse the public will fail.

--Most Americans would say that less than $2 a month is a small price to pay for the peace of mind of knowing that their premiums will buy them the care their doctor recommends. And since most good plans already provide these protections, many workers won't see any increase at all. The cheapest insurance policy is one that never pays any benefits--and that is what some of these insurance companies seem to prefer.

--It is ironic that these claims of gloom and doom about what will happen if we guarantee people the benefits they have promised come from the very organizations that have reaped enormous profits and paid exorbitant compensation to their chief executives.

--When Families USA analyzed the executive compensation of ten of the largest HMOs in America, they found that it accounted for as much as $40.30 per person per year of total premiums. So there you have it. If these multibillion dollar corporations would pay their executives less exorbitantly and accept reasonable premiums, perhaps they could pay the benefits they have promised without raising premiums at all. And the other side would have the American people believe that this proposal is too costly? Let's get serious.

--After all, insurance companies currently impose 6-10 percent average annual increases just to improve their bottom line. The insurance industry and their allies spent more than $100 million on advertising and lobbying to defeat this legislation last year. Money that should have been spent to provide people with the benefits they have paid for and need. And they are at it again this year.

--Some of us wonder why there should be any increase. It is time for the managed

care industry to finally stop fighting reform and provide the services their patients deserve.

--And I ask my friends on the other side, which right do they think is too costly? What do they think the American people should give up in order to swell the profits of greedy insurance companies and HMOs?

- The right to see a specialist when they have a life-threatening illness that only a specialist is qualified to treat?
- The right of a woman to stay in the hospital after a mastectomy if her doctor thinks that is medically indicated?
- The right of a man with advanced prostate cancer to have access to the latest therapy in an NIH-approved clinical trial?
- The right to appeal to an independent entity when the plan denies care?
- The right to continue chemotherapy with the oncologist who has treated them when their employer changes plans?
- The right to go to the closest emergency room if they have symptoms of a heart attack or a stroke?

Let's forget the smokescreens. This debate isn't about cost. It's about whether patient interests should take precedence over special interests.

UNITED STATES SENATE

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

DATE: 7/8/99

TO: CHRIS JENNINGS

FAX NUMBER: 456-5557

FROM: DAVID NEXON

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

NUMBER OF PAGES: 3 (including cover)

MESSAGE:

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

Short talking point

The cost of our legislation is low, and the benefits are great. For average workers, premiums would go up by less than $2 a month. That's less than the price of a Big Mac -- a small price to pay to make sure you get health care you can count on. That's what the Congressional Budget Office says our proposal will cost. The General Accounting Office -- a non-partisan Congressional agency -- says that our reforms may actually increase coverage, because people may be more inclined to purchase health insurance if they know it will be there when they need it.

Q. and A.

Q. Won't your program increase costs and raise the number of the uninsured?

A. Republicans have put forward wildly inflated claims that are just plain wrong. Here are the facts, according to the Congressional Budget Office and the General Accounting Office.

> Our legislation would result in a health insurance premium increase of less than 5 percent, phased in over five years. For a typical worker, that works out to less than $2 a month, less than the cost of a Big Mac. The suggestion by those who profit from the status quo that our proposal would contribute to the uninsured or increase unemployment is ludicrous on its face. In fact, GAO says that if we require HMOs to provide quality care, more people may buy health insurance through HMOs, not less.

LONGER TALKING POINT

Every independent estimate of the cost of genuine patient protections shows it to be minimal. The nonpartisan Congressional Budget Office said it would increase premiums by 4.8% over five years and then have no further impact. That's an average of less than one percent a year. At the end of five years the average worker's costs would increase by less than $2.00 a month--that's less than the cost of a Big Mac. When the General Accounting Office examined the claim that people would lose their coverage, they found that there was no basis for concluding that it was true and that coverage might actually increase, because people would value the additional benefits they would receive.

It is ironic to hear the HMOs and their friends in the Senate weeping crocodile tears over the cost increases they claim our legislation will cause. The top 10 HMOs made $1.5 billion in profits last year. Their chief executives were paid as much as $40 to $60 million a year. They kept 15 to 20 cents of every premium dollar for sales and administrative costs and profits. They expect to raise their premiums 5 to 10% per year for the forseeable future even while they continue to profit from the abuses of the status quo.

The cheapest insurance policy is one that doesn't pay any benefits when you get sick--and

July 8, 1999

Included is a revised draft of our patient protection bill, as well as a copy of the memo to leg counsel so you have some idea of what the changes are -- the changes are primarily to the coverage determination and appeals section, and the liability section. We have also deleted a number of sections (including the new CMP authority, unfortunately). The information section is still in play -- in this draft we have substituted the language from the Daschle bill (S. 6) for the language in our bill (S.374), but we may go back to our language or some variation of it.

I would most like your thoughts on the new sections 104-106 (based on language the Senate Finance Committee had been developing with Sara Rosenbaum's assistance) and section 302. (Roth + Moynihan)

Additionally, at this point sections 101-102 are a big mess --- they are the original sections, and will make no sense with the new language in sections 104-106 as far as cross-references etc. I would appreciate your help in figuring out how to modify those sections so that:

-they make sense with 104-106
- we make sure that coverage determinations/medical necessity decisions and the other protections we include in the bill are appealable, and that violations are enforceable through the liability provision.

Please call me at 224-6183 with any questions. Our fax number is 228-2853.

Thanks,

Lisa Layman
Office of Senator Chafee

Chris -
the attached draft has some of my notes on it - questions, changes to references I think we need, etc.
Thanks!

MEMORANDUM

To: Bill Baird
From: Lisa Layman
Re: Modifications to S.374
Date: July 1, 1999

- P.2 Make following changes to table of contents
  - Change section title for section 104 to "Claim Review Process"
  - Change section title for section 105 to "Right to Internal Review"
  - Change section title for section 106 to "Right to External Review"

- P. 19 Strike sections 104-106 (coverage determinations and appeals) and replace with attached language. I will also e-mail the language to you.

- P.46 Strike section 111(a-d) (these sections are on plan information). Replace those sections with section 121 from S.6, but do not include 121(c)(5) -- p.54 lines 8-10 as we are deleting the section that refers to (see below). Section references will also need to be changed to conform to the rest of our bill as follows:
  - the reference to section 103(b)(2) on line 13, page 50 of S.6 should be changed to 122(a)(2)(B)
  - the reference to section 112(b)(4) on line 18, page 52 of S.6 should be changed to 112(b)(3)(C)
  - the reference to section 115 on line 16, page 53 of S.6 should be changed to 102
  - the reference to section 107 on line 17, page 53 of S.6 should be changed to 123(b)

- P. 67 Strike section 113 (confidentiality of enrollee records)

- P. 67 Strike section 114 (quality assurance -- p. 67-70)

- P. 75 Amend section 122(b)(1) as follows: – ob/gyn care
  - line 20, change the word "may" to "shall"
  - line 22, strike the word "routine"
  - line 23-24 strike the phrase "(such as preventive women's health examinations)"
  - page 76, line 4, change the word "may" to "shall"
  - page 76, line 4, strike the word "other"

- P.94 Strike section 124 (nondiscrim. in delivery -- p. 94-95)

- P.98 Strike section 127(d) (general nondiscrim. for providers -- p.98-99)
- P. 99 Strike section 128 (length of stay for mastectomies -- p. 99-103)
- P. 103 Strike section 129 (promoting good medical practice -- p. 103-104)
- P. 104 Strike Subtitle D of Title 1 (fed. govt. enforcement, i.e. CMPs p. 104 line 14 - p. 111 line 7)
- P. 119 Amend section 302 as follows:
  - change section heading to read "Enforcement"
  - we want to add liability for pain and suffering (in addition to the economic loss). Perhaps by striking lines 25-26, and inserting "compensatory damages" after the word "for" on line 24.
  - we will then need to amend page 120 line 4-13 to reflect the above change...maybe something along the lines of "For purposes of subparagraph (B), the term 'compensatory damages' means damages for economic loss and pain and suffering. Such term does not include punitive damages."

Leslie Kramerich
Lisa Rorin
Dan Maguire
Sarah Bianchi
Dan Mendelson

Enforcement Talking Points

- **ERISA's Remedies Provisions are Inadequate to Enforce a Patient's Bill of Rights**: ERISA limits the remedies that would be available to a health insurance plan enrollee under traditional contract or tort law. Under ERISA, enrollees who are injured due to a plan's wrongful delay or denial of a benefit can only receive the benefit that should have been provided - they cannot be compensated for their injuries, missed workdays, or other losses. Thus, although ERISA was enacted to safeguard the interests of employees, any protections it now contains, or that may be added by a Patients' Bill of Rights, are meaningless without effective enforcement.

- **Adequate Remedies Regarding Health Benefits Exist Outside of ERISA**: ERISA effectively acts as a shield of immunity that protects health plans that cause injury to consumers through their negligent benefits decisions. No such shield exists for consumers covered by non-ERISA health plans. Individuals who buy health insurance policies directly from an insurer or who receive their health benefits as a state or local government employees have access to traditional state law remedies. Those enrollees that have been injured because of an inappropriate benefit decision could seek damages to compensate them for all of their losses. In addition, consumers who receive their health benefits through Medicare also have access to state law remedies when they have been injured by a wrongful plan decision.

- **ERISA's Enforcement Scheme is Unprecedented in Any Consumer Protection Law**: State and federal consumer protection laws seek to protect consumers from fraud and injury when they are provided or purchase such items as automobiles, mortgage insurance and many other consumer product. These laws recognize that consumers have a right to use or purchase products or services that are free of defects and will not cause harm. When harm occurs these laws hold the appropriate entity accountable for any negligent behavior that caused the harm by giving consumers the ability to enforce their rights under these laws and to enforce a promise that the relevant product or service would be provided in a certain manner. ERISA's current enforcement scheme is an anomaly because it does not give consumers access to the same kind of protections. No Patients' Bill of Rights can work without providing consumers with these protections.

- **There is Growing Evidence of the Need for Expanded Remedies**: A 1997 survey of experiences of managed care consumers conducted by the Kaiser Family Foundation found that difficulties with delays or denials of coverage was the most common problem reported by consumers, accounting for complaints by 11% of all enrollees. Delays and denials resulted in serious harm to the survey respondents: 24% reported physical injury; 3% reported permanent disability; 26% reported lost school or work time; and 41% reported financial losses. Inappropriate delays or denials of care by managed care plans have a serious impact on consumers' physical financial well-being, in addition to their impact on overall productivity and efficiency in the workplace.

- **Need for Remedies Has a Human Face**: The story of Buddy Kuhl provides an example of why ERISA remedies are not enough. Mr. Kuhl had a hear attack and required specialized heart surgery. Mr. Kuhl's doctor arranged for him to have the surgery at a hospital in St. Louis that the equipment needed for his care. Mr. Kuhl's HMO refused to preauthorized the care because the St. Louis hospital was outside of the HMO's service area. As a result, the surgery was delayed and had to be rescheduled. By the time Mr. Kuhl was to be operated on, his heart had deteriorated so much that the surgery was no longer possible. Mr. Kuhl died waiting for a transplant. Mrs. Kuhl tried to bring a claim against her husband's HMO, but was told that ERISA preempted her claim. The only remedy available to her under ERISA is the surgery, now worthless, that should have been provided to her husband.

DRAFT - 6/17/99

External Review Principles

Access to review:

- Scope of Review: At a minimum, external review should be available for all claims that involve the plan's exercise of medical judgment. This should include medical necessity determinations and those where the plan denies coverage because a benefit is excluded, where the determination of coverage involves medical judgment. (e.g., the cleft palate example - the plan's determination that plastic surgery is not covered because cosmetic benefits are excluded should be reviewable.)
  - Daschle/Dingell (D/D) allows review for all benefit denials or violation of most of the substantive provisions of the bill, but bars access for denials of coverage for benefits that are specifically excluded. However, D/D does allow the QEAE to determine whether a decision is appealable.

- Exhaustion: Exhaustion of internal review may be required before the individual can access external review, so long as an exception to this requirement exists in cases where the plan fails to comply with the time frames or unreasonably delays the process.
  - D/D requires exhaustion, but allows individuals to proceed to the next level of review if the plan has failed to comply with the timeframes.

- Time Limits: Any time limits on the individual's ability to access external review must be no less than six months from the date of the internal review decision.
  - D/D does not impose time limits. (Bilirakis and Boehner require the individual to bring claim to external review within 30 days of internal review decision.)

- Filing Fee: There should be no filing fees or other monetary disincentives which would deter an individual from seeking review.
  - D/D does not impose. (Bilirakis requires individuals to pay a filing fee; Boehner requires a filing fee which is reimbursable if the external review is favorable.)

- Dollar Threshold: Access to external review may be restricted to claims involve a dollar amount of at least $100.
  - D/D requires that claims that do not involve a significant threat to the life or health meet a "significant threshold" to be reviewable.

Review Entity Requirements:

- Qualifications: External reviewers should be required to have appropriate medical and legal expertise. This should include the participation of medical specialists that specialize in the field involved in the claim and attorneys who have expertise in interpreting plan coverage documents.
  - D/D requires QEAE to have medical, legal, and other expertise to conduct external appeal.

- Independence: The reviewer should be screened for bias or conflicts of interest that could impact the independence of the decision. Independence requirements should include prohibitions on the reviewer's affiliation with any party to the dispute, compensation arrangements that could influence the outcome of the decision, and conflicts of interest and should protect the reviewer against recourse by the plan or issuer.
  - D/D requires that QEAEs be certified by DOL or the states (HHS if they fail to enforce) as having no real or apparent conflict of interest that would impede the independence of the review. It requires the health plan to contract directly with the QEAE to pay for the review, but allows DOL and HHS to write regulations to proscribe the terms of the contract. (Consensus bill language builds on D/D to provide more explicit independence requirements.)

- Selection Process: Plans should not be permitted to select the reviewer. If plans are permitted to select reviewer, there must be adequate protections to assure against bias in the selection process which could impair the independence of the reviewer.
  - D/D provides that, where DOL or HHS certifies more than one QEAE and the plan or issuer is permitted to choose, the regulating entity must assure that the selection process does not create incentives for bias and must monitor decisions to determine that they are unbiased.

- Certification/Credentialing: DOL should certify reviewers for group health plans; the states (with HHS as fallback authority if states fail to enforce) should certify reviewers for issuers.
  - D/D requires DOL and the states to certify that QEAEs meet defined standards relating to conflict of interest, clinical peer review, and staffing requirements, and other requirements they deem appropriate.

- Preemption of Existing State Programs: New federal standards for external review should provide a floor. States external review programs that are at least as protective as the federal model should remain in effect for issuers providing coverage for group health plans.
  - The D/D bill allows states to develop standards and certify QEAEs for health insurance issuers. It also preserves state insurance laws that are at least as protective for consumers as federal law.

Process of Review:

- Timeframes: Timeframes should require reviews to be made no later than 60 days for routine claims and 72 hours for urgent claims.
  - D/D requires that decisions be made in accordance with the exigencies of the case, but no later than 60 days for routine claims or 72 hours for expedited appeals from the date of filing. No separate timeframes for emergencies.

- Determination of Appealability: The external reviewer should make determinations

regarding whether the claim is reviewable, whether it should be expedited, and whether internal review time frames have elapsed.

- D/D provides that the reviewer determines whether claim is appealable, whether it should be expedited, and appropriate deadlines for expedited internal review process and whether the internal review process has been completed.

- Admissibility of Evidence: External review should be an open process that allows for review of whatever relevant evidence the parties want to submit. The external reviewer should be permitted discretion to choose which evidence to rely upon and should not be required to consider or give more weight to a particular category of evidence.
  - D/D allows individuals to submit evidence related to the issues in dispute and requires the plan or issuer to provide timely access to all its records and all provisions of coverage (including coverage manuals) that relate to the claim.

- Due Process Requirements: The process should permit both parties to submit evidence and be represented. The individual should also have the opportunity to make an oral presentation before the reviewer. If the individual makes an oral presentation, the plan/issuer should also be given the same opportunity.
  - D/D provides that each party to an appealable decision be permitted to submit and review evidence, be represented, and make an oral presentation.

- Standard of Review: The standard of review should be de novo (i.e., no deference to the plan's coverage determination).
  - D/D requires a fair, de novo determination.

- Medical Necessity: It should be clear that the reviewer may make an independent judgment regarding whether treatment is medically necessary and should not be required to use the plan's definition of medical necessity.
  - D/D does not directly address this issue relating to external appeal decisions, but does generally prohibit a plan or issuer from arbitrarily interfering with the decision of a treating physician regarding the medcial necessity or appropriateness of the manner or setting in which particular covered services are provided. (The Senate and House amendments on external review include language that corrects this problem and clarifies that the reviewer should give no deference to the plan's definition.)

- Burden of Proof: There should be no reference to a burden of proof by either party.
  - D/D does not address.

- Binding Nature of Decision: The reviewer's decision should be binding on the plan in all cases. The standard of review in court should be very deferential to the reviewer. (I.e., arbitrary and capricious) The decision should not be vacated merely for a minor failure to follow the external review procedures.
  - D/D provides that the decision is binding on the reviewer. It does not specify a standard under which the reviewer's decision could be vacated.

Association Health Plans (AHPs) Talking Points
H.R. 2095 - Bohner (H.R. 2047 - Talent stand alone)
June 17, 1999

BACKGROUND: H.R. 1136 Affordable Health Care Act (Norwood), H.R. 1687 Patients' Health Care Choice Act (Shadegg), and H.R. 448 Patient Protection Act (Bilirakis) include provisions to establish Association Health Plans. Although these proposals have similar features and problems, this summary focuses on the specific provisions in H.R. 2095 (Bohner) incorporating H.R. 2047 (Talent's stand alone).

Employers and employees will lose protection under existing federal and state law: This legislation would federalize the regulation and oversight of AHPs by creating a new federal regulatory scheme for associations while usurping traditional authority of states to regulate the business of insurance. The bill's extensive loopholes and its broad preemption of state-based protections undermine protections now available to workers and employers under both federal and state law.

- **State-based protections don't apply**: The bill permits AHPs to have sole discretion in designing its coverage and preempts state coverage requirements. The bill preempts State laws that require insurance companies to cover critical health services such as maternity and well-child care, specialized cancer treatment and screening, and direct access to specialists. State laws protecting special populations are also preempted. For example, states protect disabled children by requiring insurers to continue covering disabled children even after these children reach the age of 18, and without this protection, would no longer be covered under their parents' policy. Why trade guaranteed state law rights for risky and questionable promises that may never materialize.

- **Weak protections against insolvency**: There is no safety net to protect consumers in cases of AHP insolvency and the reserve standards are weaker than state insurance law standards. Without a guarantee fund that pays claims of an insolvent AHP, employers and employees will be responsible for millions of dollars of unpaid claims.

- **Private health insurance market will be undermined**: The bill allows an AHP – through coverage design, pricing, and marketing practices – to attract employers with a healthy workforce (and to discourage high risk employers from purchasing health coverage through the AHP). The bill also does not guarantee to all employers access of AHP coverage.

    - **Increases health coverage costs**: The cherry picking by AHPs and broad access to the private small group market outside the AHP under HIPAA's guaranteed issue of all products requirements will result in more expensive health insurance coverage for most small employers (with costs driven up by a smaller pool of covered lives and the sickest individuals left in the commercial market while the

healthiest individuals receiving coverage through AHPs). The private small group market outside of the AHP will become unaffordable for most small employers due to cherry picking by the AHP.

- **No access to affordable health coverage**: If the purpose of the bill is to provide affordable health coverage to all employers, then an AHP should not be able to charge higher rates to employers with higher risk employees. The proposed legislation permits AHPs to set premiums on the basis of health status, age, and gender of the employer group. This results in more expensive AHP coverage for employers with unhealthy individuals or with an older workforce.

HEALTHMARTS SUMMARY
(DRAFT Consensus Health Care Access and Choice Act of 1999)
June 17, 1999

BACKGROUND

The draft Consensus Health Care Access and Choice Act of 1999, among other reforms, includes provisions amending the Public Health Service Act (PHSA) to establish "HealthMarts." This legislation would federalize the regulation and oversight of group purchasing arrangements — HealthMarts — by creating a new federal regulatory scheme.

Currently, both federal and state laws apply to group purchasing alliances and protect consumers. Group purchasing arrangements are subject to the Employee Retirement Income Security Act of 1974 (ERISA) including requirements added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and in most cases are subject to state insurance law.

H.R. 1136 Affordable Health Care Act (Norwood), H.R. 1687 Patients' Health Care Choice Act (Shadegg), and H.R. 448 Patient Protection Act (Bilirakis) include provisions to establish HealthMarts. Although these proposals have similar features and problems, this summary focuses on the specific provisions in the above referenced draft Consensus Health Care Access and Choice bill.

SUMMARY

The bill creates a new entity called a "HealthMart," which can be either a non-profit or for-profit organization. A HealthMart may not self-insure; it must contract with health insurance companies or health maintenance organizations to provide health insurance coverage to its members. Membership may be open to both small and large employers, as well as, to individuals.

The bill attempts to expand access to health insurance coverage by preempting many state law protections and by creating a new federal regulatory scheme that would be enforced by the U.S. Department of Health and Human Services. The bill has technical problems which may undermine protections now available to workers and plans under both federal and state law.

- The bill creates a confusing regulatory scheme. The proposal requires a HealthMart to comply with the notice, disclosure, and fiduciary requirements (as well as some portability and nondiscrimination requirements) of ERISA. PWBA would continue to enforce these requirements against a HealthMart. The bill creates additional requirements for HealthMarts that are added to the PHSA (enforced by the Health Care Financing Administration). This regulatory structure is confusing and results in conflicting requirements.

- The bill allows HealthMarts to "cherry pick" the healthy and segment the insurance market. For example, a HealthMart may affiliate exclusively with and be financially supported by an association. The bill does not prohibit associations from discriminating on the basis of health status. If a HealthMart only serves association members and if the association only accepts healthy members, then employers with the healthiest workforce will be insured through the HealthMart. This "cherry picking" segments the market and leaves the poorest risks in the commercial market.

Draft 6/28/99

OPTIONS FOR HEALTH CARE REFORM REMEDIES

Set forth below is a list of potential options for the enforcement of the Patients' Bill of Rights. This list covers options for the enforcement of both (1) wrongful benefit denial claims and (2) (with the exception of option one) claims regarding violations of the statute. These options are not mutually exclusive. For example, a proposal could include both improved remedies for individuals under the private right of action as well as new options for enforcement by the Secretary.

Under current law, such participants in an ERISA-covered group health plan are limited to bringing a suit under ERISA to enforce the terms of the plan. The court has no power to award relief other than to order the plan to provide the promised benefit.

I. SUMMARY

Option	Standing to Sue	Nature of Remedies
1	Participants	Existing State Law Remedies
2	Participants	New Federal Damages/Civil Penalty
3	Participants	Hybrid (State remedies for Insured/Federal Remedies Self-Insured)
4	Secretary	New Federal Damages
5	Secretary	New Federal Civil Penalty

II. OPTIONS

Option 1: **Participants may bring an action in state court to obtain any remedies available under state law.**

This option gives participants the potentially broadest array of remedies, including economic damages, pain and suffering damages and punitive damages, in addition to equitable relief that are available under existing state laws. Such relief will differ depending on the state in which the participant is able to bring the action.

Implementation of this approach would involve a major change to ERISA's preemption provisions. This would allow access to any state cause of action (statutory or common law) for personal injury or wrongful death.

Variations:

- This option could be modified by imposing federal law limits on the amount or nature of state law damages that would be available (e.g., no punitive damages; punitive damages only where failure to comply with external review decision; caps on punitive or noneconomic damages etc.).

Option 2: Participants may bring an action in federal court to obtain new federal damage remedies or a civil penalty under ERISA.

ERISA would be amended to make available economic damages, where personal injury or wrongful death occurs in connection with the improper delay or denial of health benefits.

Variations:

- Damages:
  - Add noneconomic damages, such as pain and suffering (with or without caps)
  - Add punitive damages (with or without limits set out in option 1)
- Standard of Review: De novo for cases that have not gone through external review
- Standard of Care: Vary damages depending on whether conduct of plan is negligent, reckless, intentional, or willful
- Limits on Class Actions: Limit class actions across plans or within plans.
- Civil Penalty: A mandatory civil money penalty payable to the participant in place of (or in addition to) damages. The court could be given discretion to award a civil penalty for each case with a set range (e.g., $10,000 to $50,000).
- Jurisdiction Changes: Change current requirements regarding removal of cases to federal court, so that more cases stay in state court.
- Fees: Attorney and expert witness fees to prevailing plaintiff.

Option 3: Participants in Fully-Insured Plans have a state remedy & Participants in Self-Insured Plans have a federal remedy

Combined this options 1 and 2 so that option 1 would apply to insured plans, and option 2 would apply only to self-funded plans.

Option 4: **The Secretary may bring an action in federal court for new federal remedies.**

Under this option, participants would have no right to sue for damage remedies in connection with a delay or denial of health benefits or a violation of the statute. Only the Secretary would have this authority. Participants would be able to ask the Secretary to bring individual suits on their behalf. Any damages collected by the Secretary would be payable to the participant. These suits could be subject to the same variations as listed in option 2.

Variations:

- In order to fund the additional resources needed to maintain a credible enforcement program, it may be necessary to consider the following add-ons:
  (a) specific provision for payment of costs and attorney fees to the Secretary;
  (b) imposition of a civil penalty in successful cases with dedication of a portion of the penalty to support this enforcement program; or
  (c) creation of a filing fee for all plans that file annual financial reports with the Secretary, with the proceeds used to support this enforcement program.

Option 5: **The Secretary may obtain civil penalties.**

Variations:

- Civil Penalty Assessed by Court: There would be a mandatory civil penalty for the court to impose in a stated amount (say at least $10,000 and up to $50,000) for an improper delay or denial of a benefit claim or a statutory violation. An additional penalty could be imposed by the court if it is demonstrated that it is a pattern and practice of improper delays or denials or violations.

- Civil Penalty Assessed by Secretary Through an Administrative Process: The Secretary would be given authority to assess such civil penalties through an administrative procedure much like that in existence under section 502 of ERISA. The Secretary would issue an assessment letter, and provide an administrative procedure for the plan to contest the assessment. There needs to be an opportunity for federal court review in cases where the final agency assessment is challenged.

Remaining Issues in S326, as Passed by HELP

Scope: S.326 applies only to self-insured group health plans, and the information disclosure and appeals provisions apply only to group health plans (both self-funded and insured). The bill does not apply to the individual market.

Emergency Care: S.326 does not ban in-network requirements for ER services. (S.326 includes "services furnished by a nonparticipating provider" in the definition of emergency medical care. However, because the change applies to the definition and not to the description of the protection, this change does not have the effect of banning in-network requirements. It is merely circular, because the basic protection applies only to the extent that the group health plan provides coverage for emergency medical care as defined. Therefore, the right applies to services provided by nonparticipating providers only to the extent that the plan provides coverage for emergency services provided by nonparticipating providers.) The language in other bills banning in-network requirements is standard and easily imported into S.326. In addition:

- S.326 allows plans to impose higher cost-sharing requirements on patients who obtain emergency care without a prior authorization.
- S.326 does not reference the Secretary's post-stabilization and maintenance care guidelines under section 1867 of the Social Security Act.

Access to Specialists: S.326 does not require plans to allow women to designate their ob/gyn as their primary care physician and only requires direct access to routine ob/gyn services. In addition:

- There is no provision to allow persons with serious or chronic conditions to designate a specialist as a primary care physician.
- There is no requirement for the plan to make a referral to a non-participating specialist when there is no available and accessible participating specialist.

Prescription Drugs: S.326 requires physician and pharmacist involvement in formulary development and requires a process for accessing non-formulary drugs when medically necessary and appropriate. It does not prohibit plans from denying drug or medical device coverage as investigational if the drug or device's requested use is included in its labeling authority.

Information Disclosure: S.326 fails to fix a key existing problem with the ERISA information disclosure provisions: plans are not required to notify enrollees of material reductions in benefits and coverage prior to the effective date of those changes. In addition:

- Plans are required to disclose only a summary description of specific coverage exclusions, not a full list of exclusions.

External Appeals: The weaknesses of the External Appeals process remain numerous and

significant:

- The plan decides what issues are externally appealable.
- The plan selects the external review entity. There is nothing to prevent a plan from choosing an entity that has given "good results" in the past and no mechanism to assure that reviewers not make biased decisions. The clause prohibiting conflict of interest of review panel members does not prohibit the panelist from having an affiliation with the plan sponsor, employer, their fiduciaries, or the issuer.
- S.326 does not require that the external review be *de novo*.
- Despite amended language requiring the external review entity to make an "independent determination," the appeal is based on the plan's definition of "medical necessity or appropriateness."
- The deadline for the external review decision is tied to the external reviewers' receipt of the case file from the plan, but there is no deadline for the plan to forward the file to the external reviewer. There is no allowance for emergency cases. Thus, the plan could indefinitely delay the external review decision, regardless of the medical exigencies of the case. [Note: Although S.326 requires the external review to be completed in accordance with the medical exigencies of the case, it also establishes a 30 working day time frame that applies "notwithstanding" the medical exigencies requirement.]
- The plan has 30 days to tell the enrollee how it will respond to the decision of the external reviewer. There is no requirement that the plan actually respond to the decision of the external reviewer by any deadline. There is no allowance for medical exigencies. There are no consequences for missing the notification deadline.
- The enrollee has only 30 days to file the appeal, with no provision for extensions.
- No violations of the consumer protection provisions in the bill are eligible for external appeal.

<u>Coverage Determinations and Internal Reviews</u>

- The time frame for routine prior authorizations does not take into account the medical exigencies of the case.
- For expedited prior authorizations and expedited internal appeals, the plan determines whether the normal time frame for making prior authorizations could "seriously jeopardize" the life or health of the enrollee. This determination is not externally appealable.
-
- A prior authorization and internal appeal must be expedited if a physician "reasonably documents" that the normal time frames seriously jeopardize the life or health of the enrollee. The necessary documentation is not specified. Any such requirement is likely to be a barrier to timely determinations.
- There is no deadline for concurrent review determinations.
- The time frame for retrospective determinations begins when the plan has received all necessary information. There is nothing preventing indefinite delay.

- Decisions not to provide a requested service because it is listed as a coverage exclusion are not eligible for internal appeal (nor do deadlines for coverage determinations apply).

Network Adequacy: There is no requirement that a plan have a network with sufficient number, distribution, and variety of providers who are available and accessible in a timely manner. In addition, there is no requirement that a plan cover the services of a nonparticipating specialist if the network is inadequate to treat the enrollee's condition.

Continuity of Care: Continuity of care protection applies only to persons in institutions, women in their second trimester of pregnancy, and the terminally ill -- not to persons with chronic or ongoing illnesses who are in the middle of a course of treatment when their provider is terminated. In addition:

- The continuity of care provision limits transitional care to 90 days even for persons who are terminally ill, even though the definition of terminally ill is an enrollee with six months or less to live.
- The bill provides for continuity of care when a provider is dropped from the plan's network, but not when the employer changes plans.
- S.326 requires the plan to provide the enrollee with an opportunity to notify the plan of a need for transitional care. Such notice appears to be a condition for obtaining transitional care. Such a requirement could present a substantial barrier to the enrollee (the provision does not require the plan to explain the notification process, there is nothing about whether the enrollee's notice may be oral or how the plan has to act on the enrollee's request, etc.).

Physician Incentives: S.326 does not limit physician incentives to deny care, nor impose requirements in cases where the plan places the provider at substantial financial risk.

Gag rule: The anti-gag provision still only applies to advice on medical care or treatment and does not cover advice or advocacy about utilization review or appeals or disclosures about financial incentives.

Boehner Consumer Protection Bills Mark-Up

What the Bills Leave Out

Need to Cover All Health Plans. These bills cover only people who obtain health insurance through their employer. The bills fail to extend needed patient protections to the millions of people that purchase health insurance individually. They leave out the most vulnerable insurance consumers – those who do not have an employer to negotiate for them. The protections in these bill should apply to all health plans.

Enforcement. These bills pretend to secure patients' rights, but they contain no way to enforce those rights other than the weak penalties currently available through ERISA. Currently available remedies do not reflect the nature or magnitude of harm a plan could cause by delaying or denying necessary benefits.

Comprehensive approach. These narrow, piecemeal bills are inconsistent and incomplete. For example, HR2043 - which is supposed to protect against so-called "gag clauses" - does not prohibit plans from retaliating against doctors who discuss the plan's financial incentives, even though a companion bill, HR2046, requires physicians to discuss such incentives upon patients' request. Americans deserve a comprehensive Patients' Bill of Rights that makes sense and offers real protections, including:

- **Access to Specialists.** These bills require direct access to physicians only for routine Ob/Gyn care. They do not allow persons with chronic or serious medical conditions to have direct access to specialists. Nor do the bills permit persons with conditions requiring ongoing care to obtain standing referrals to a needed specialist. Plans could require people with ongoing conditions to return to their primary care physician each time to get the necessary referral.

- **Adequate Provider Network.** These bills do not include a requirement that a plan have a provider network with a sufficient number and variety of providers who are available and accessible in a timely manner. In addition, there is no requirement that a plan cover the services of a specialist who is not in the plan's network if the network lacks the provider expertise or capacity to treat the enrollee's condition.

- **Continuity of Care.** These bills do not protect patients from abrupt changes in on-going treatment when their provider is dropped from the plan's network or their employer changes health plans. A comprehensive bill should include a provision allowing people in the middle of a course of treatment to continue with their provider during a transition period.

- **Limits on excessive financial incentives.** The bills have no provision to limit excessive provider financial incentive arrangements. This means health plans can place physicians and hospitals at substantial financial risk that could compromise their

medical judgement.

What the Bills Promise, But Fail to Provide

Ob/Gyn. HR2041 purports to guarantee women direct access to routine ob/gyn care, but it would still allow a plan to require a woman to obtain such services from a generalist. In addition:

- The bill does not allow women to designate their ob/gyn as their primary care provider. Plans can require women to see multiple providers for their routine health care needs.

- The bill only requires plans to allow direct access to *physician* specialists in ob/gyn. A woman might not be able to go to the appropriately qualified, non-physician ob/gyn specialist of her choice, such as a nurse practitioner.

Advisory Commission. HR2042 would create an advisory commission to establish many of the same guidelines already developed by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. For example, the bill lists among the proposed commission's duties the development of model guidelines for independent external review and consumer friendly information programs. The President's Advisory Commission made substantial recommendations on these topics in Chapters One and Seven of its November 1997 report. These recommendations, which were developed through consensus among patients, providers, employers, and health plans, are embodied in the comprehensive Patients' Bill of Rights, HR358. Why waste taxpayers' dollars on yet another commission when we already have recommendations that make sense, have broad support, and will guarantee that patients get the care they've been promised?

Gag Clauses. HR2043 fails to protect providers who advocate on behalf of their patients, for example, by helping them navigate a plan's utilization review process, or helping them with an appeal of denial of benefits. In addition:

- The gag clause provision applies only to arrangements between a health plan and a health care professional. This limitation leaves out many, if not most, managed care arrangements where individual physicians contract with medical groups rather than directly with health plans.

- This bill fails to protect providers who give patients information about financial incentives created by the plan to limit care.

Access to Pediatric Care. HR2044 purports to allow parents to designate a pediatrician as their child's primary care provider, but it would allow plans to require pediatric care be delivered by a generalist.

Access to Emergency Care. HR2045 fails to ensure that people can obtain emergency care when and where the need arises, without fear of excessive charges. Under this bill:

- If the plan and the ER physician disagree on what emergency care is necessary, the patient can be stuck holding the bill.

- The bill contains legal jargon that appears to permit plans to charge higher copayments and deductibles to individuals seeking emergency services outside of the plan's network or without prior authorization.

- The bill does not address the need for post-stabilization care – a person who requires follow-up care after the emergency is stabilized could be forced to wait indefinitely for their plan to approve or deny such needed care, or could be subject to excessive charges for obtaining the care they need to remain stable.

- Severe pain does not count as an emergency – an individual with severe chest pains risks having to pay for services out-of-pocket if he or she goes to an emergency room without getting prior authorization.

Medicare beneficiaries are protected from all these potential abuses. Private sector plan enrollees deserve the same protections.

Information Disclosure.

- HR2046 fails to fix a key existing problem with the ERISA information disclosure provisions -- plans are not required to notify participants and beneficiaries of material changes in benefits and coverage prior to the effective date of those changes, except for changes in drug formularies (30 days).

- Information that may be requested from treating physicians or from facilities can only be requested if care has been sought there in the past, not in advance of seeking care when it would be most useful for comparing and choosing a provider.

External Appeals. HR2089 purports to create an "independent" external appeal system, but it is biased against patients and allows health plans to control virtually all aspects of the process.

- The bill would require external reviewers to uphold plans as long as the plans follow their own definitions – no matter how arbitrary the definitions. A plan could define medical necessity to be nothing more than care defined under whatever treatment guidelines and utilization protocols the plan adopts – even if the guidelines and protocols are not backed up by any clinical evidence or good professional practice. Plans would always win under this scenario.

- HR2089 erects barriers between the enrollee and the external appeal: 1) The enrollee could have to pay the lesser of $100 or 10% of the cost of the treatment to the plan before the external appeal is initiated. 2) The enrollee has only 30 days to file an appeal. 3) In order to get an expedited appeal -- when time is of the essence -- HR2089 requires the enrollee to get a written certification by a physician.

- Only a narrow set of issues are appealable and the plan has great ability to determine which cases qualify. Even in the small set of cases where an external expert determines whether medical facts are at issue and thus whether the dispute can move to external appeal, the expert is a lawyer, not a doctor, and the plan gets to frame the question to its advantage.

- HR2089 preempts all state external review laws, even those that are more protective of patients. For example, the bill requires the plan to select the external review entity and would preempt state laws that do not allow such an inherent conflict of interest.

- The bill allows plans to determine what information the patient must submit in order to obtain external review and controls all information that goes to the reviewer. The patient does not have the right to submit evidence in their own favor.

- Though the bill claims that patients can go to external review if internal review time frames aren't met, the internal time frames don't begin until the plan has all of the information it says it needs. The plan could delay the process by continually asking for more information.

Association Health Plans. HR2047 expands the availability of association health plans and allows these purchasing groups to become, in effect, insurance companies, without the important consumer protections normally afforded by state law.

- The AHPs would significantly undermine the states' traditional role in regulating insurance. In lieu of the traditional state role, the proposal would establish a new regulatory structure under ERISA (and the Department of Labor) for AHPs, but the proposal does not provide adequate regulatory tools to assure adequate capitalization and long-term solvency, reporting, or disclosure. The Department of Labor would not have the authority or the resources to oversee the new regime effectively.

- The bill as drafted is full of internal contradictions; it is extremely difficult to determine what the policy intent is or how a court might ultimately interpret the language as drafted.

- The AHPs appear to have very broad discretion in determining who may participate and what is offered. The concern is that they could "cherry-pick" (i.e., attract the healthiest people from) the state insurance pool to the point where the state insurance pool would have a much higher concentration of relatively high risk people, resulting in higher prices. In some states, particularly smaller states, there is a very real chance that the state insurance pool would collapse.

COMPARISON OF CONSUMER PROTECTIONS:
House Bills

PROVISION	Daschle/Dingell (S6/HR358)	House Republican (consumer protection provisions only) (HR448)	HR2095 (Boehner)	Norwood, Coburn, Shadegg proposal
Entities Regulated	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 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.	All group health plans, and health insurance issuers in the group market only.	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). For POS provisions, only issuers with a closed network.
Network Adequacy				
a. Basic standard for network adequacy	Yes	No	No	No. Creates panel to establish network adequacy standards in two years. Adoption of standards would require further Congressional action.
b. Enrollees can go out of network if no appropriate, available, and accessible provider in network	Yes, at no additional cost to enrollees beyond that for participating providers.	No	No	Yes, plan must offer choice of at least three non-participating specialists, at no additional cost to enrollees beyond that for participating providers.
Direct Access to Specialists				
a. Complex/	Standing specialist referrals	No	No	Standing specialist referrals

COMPARISON OF CONSUMER PROTECTIONS:
House Bills

PROVISION	Daschle/Dingell (S6/HR358)	House Republican (consumer protection provisions only) (HR448)	HR2095 (Boehner)	Norwood, Coburn, Shadegg proposal
serious conditions requiring on-going care	and specialists may serve as primary care physicians.			and specialists may serve as coordinators of care with respect to the condition.
b. Routine and preventive Ob/Gyn	Yes, and plan must allow Ob/Gyn to be designated as primary care physician.	Yes	Direct access, no designation	Direct access, no designation
c. Pediatricians	No. Plan must allow pediatrician to be designated as PCP.	No. Plan must allow pediatrician to be designated as PCP.	No direct access. Plan must allow pediatrician to be designated as PCP.	No. Plan must allow pediatrician to be designated as PCP.
Continuity of Care/ Transitional 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 care), and terminally ill persons (for remainder of life).	No	No	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), pregnant women (through postpartum care), and terminally ill persons (for remainder of life).
Mandatory POS Option	Yes, group health plans must offer a POS option unless they offer coverage through at least two issuers or through at least	Yes, with exception if POS premium will be more than 1% greater than the closed panel premium or if HMO would	No	Yes, closed network issuers must offer POS option unless enrollees are offered such option through another issuer.

COMPARISON OF CONSUMER PROTECTIONS:
House Bills

PROVISION	Daschle/Dingell (S6/HR358)	House Republican (consumer protection provisions only) (HR448)	HR2095 (Boehner)	Norwood, Coburn, Shadegg proposal
	2 significantly different networks.	need new license.		
Access to Emergency Services				
a. Bans prior authorization requirements	Yes	Yes	Yes	Yes
b. Bans in-network requirements	Yes	Yes	Yes	Yes
c. Clear prohibition of excess cost sharing for out-of-network emergency services and emergency services obtained without prior authorization	Yes	No	No	No
d. Prudent layperson standard for coverage of screening and stabilization	Yes	For screening exam only. Any additional emergency medical services covered under "prudent emergency medical professional" standard (unclear if this includes stabilization care).	For screening exam only. Any additional emergency medical services covered under "prudent emergency medical professional" standard (unclear if this includes stabilization care).	Yes
e. Emergency medical	Yes	No	No	Yes

COMPARISON OF CONSUMER PROTECTIONS:
House Bills

PROVISION	Daschle/Dingell (S6/HR358)	House Republican (consumer protection provisions only) (HR448)	HR2095 (Boehner)	Norwood, Coburn, Shadegg proposal
condition includes "Severe Pain"				
f. Post-stabilization care	Mandates process consistent with Medicare guidelines	Not addressed	Not addressed	Mandates process consistent with Medicare guidelines
g. Definition of "emergency medical care" tied to SSA EMTALA	Yes	No	No	Yes
Limits on Physician Incentives	Same as Medicare	No	No	Same as Medicare
Anti-Gag Rule	Yes	Yes, but only applies to direct contract between plan and provider	Yes, but only applies to direct contract between plan and provider	Yes, but does not protect communications regarding UR, appeals, or financial incentives
a. Also applies to information about financial incentives on the provider	Yes	No	No	No
b. Also applies to advocacy on behalf of the patient	Yes	No	No	No
Non-discrimination	Yes	No	No	No

COMPARISON OF CONSUMER PROTECTIONS:
House Bills

PROVISION	Daschle/Dingell (S6/HR358)	House Republican (consumer protection provisions only) (HR448)	HR2095 (Boehner)	Norwood, Coburn, Shadegg proposal
Advisory Boards	Creates Health Care Quality Advisory Board.	No	Creates Health Care Access, Affordability, and Quality Commission	Creates 2 panels: one to develop network adequacy standards, one to develop a uniform claims form for use by all third party payors
Experimental therapies	No coverage mandate. Plan must disclose how it decides if treatment is experimental.	No coverage mandate. Plan must disclose whether experimental therapies are excluded from coverage and the definitions it uses.	No	No coverage mandate. Plan must disclose whether experimental therapies are excluded from coverage and the definitions it uses.
Clinical trial coverage mandate	Yes, if enrollee has a serious illness for which no standard treatment is effective plan must pay routine costs.	No	No	No
Enforcement	HIPAA enforcement 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	DoL may impose 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	Adds nothing to current (inadequate) ERISA enforcement, for patient's rights sections.	Partial HIPAA enforcement 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). Does not amend Internal Revenue Code, so IRS

COMPARISON OF CONSUMER PROTECTIONS:
House Bills

PROVISION	Daschle/Dingell (S6/HR358)	House Republican (consumer protection provisions only) (HR448)	HR2095 (Boehner)	Norwood, Coburn, Shadegg proposal
	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.	lesser of 5% of the aggregate value of benefit or $100,000. The fiduciary may be removed by court.		may not impose excise taxes. Individual may bring action to recover CMPs up to $100/day for failures to provide required notices.
Liability	Amends ERISA (sec. 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.	No change to ERISA 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.	Expands ERISA preemption such that fewer state remedies are available.	Amends ERISA (sec. 514) to permit suits for damages against plans for personal injury or wrongful death, as allowed by state law. Exempts employer and plan sponsor if they did not exercise discretion to make a decision on the claim. Shields plan from punitive damages if the plan complies with an external review decision. Plan may initiate external review after court case has been filed. Plan may also ask QEAE to assess whether alleged personal injury has been sustained. If QEAE determines no personal injury has been sustained, plan cannot

COMPARISON OF CONSUMER PROTECTIONS:
House Bills

PROVISION	Daschle/Dingell (S6/HR358)	House Republican (consumer protection provisions only) (HR448)	HR2095 (Boehner)	Norwood, Coburn, Shadegg proposal
				be held liable.
Ombudsman/ Consumer Assistance	Yes, States (or federal if no State program). HHS to award grants to States.	No	No	No
Provider 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.	No	No	No
Prompt Payment	No	No	No	Requires plans to promptly pay claims, consistent with Medicare guidelines (95% of "clean" claims paid within 30 calendar days)

The Honorable Pete Stark
House of Representatives
Washington, D.C. 20515

Dear Mr. Stark:

I am pleased to have the opportunity to address the important questions you raised in your letter of May 27, 1999 regarding welfare reform. I also appreciate the opportunity to lay out the critically important agenda that we share: ensuring that supports such as child care, Medicaid, and food stamps are available to all eligible low-income families and investing in all families on welfare, including those with the greatest barriers to employment. To achieve these goals, in addition to continuing aggressive implementation, enforcement, and technical assistance activities, I also want to highlight two key legislative next steps. First, as I noted in my testimony before the Committee on Ways and Means Human Resources Subcommittee on March 16, I believe that the President's child care proposal is enormously important to parents and children in low-income working families. Second, the proposal to extend and expand the funding authority to allow States to address the challenges created by the delinking of Medicaid from welfare is critical to ensuring access to and enrollment in the Medicaid program by all eligible families.

The many important questions you raised are part of our on-going research agenda. For some of these questions, we do not yet have sufficient evidence to reach definitive conclusions because we are awaiting findings from ongoing studies and analyses or we have only preliminary information. However, we are using what information we have and we are not waiting for each of these studies to be concluded to begin working on the issues because we believe it is important to have a strong strategy in place to help families. We will utilize results as they become available to build on and enhance our efforts.

My responses are presented in the enclosure with the questions in the order in which they were presented in your letter. We will be providing relevant reports and studies to supplement those you cite and we will continue to provide you and your staff with copies of future research reports on these and related topics as they become available.

I look forward to additional opportunities to discuss new findings from our observations and sponsored research and related activities. My staff and I are available to answer any additional questions you may have or meet with your and your staff to further discuss these important issues.

Sincerely,

Olivia A. Golden
Assistant Secretary
for Children and Families

Enclosure

1. Does DHHS agree that claims of welfare reform Asuccess@ are premature until we have answers to the following critical questions:

How many are getting jobs that provide a wage that allows them to escape poverty?
How many of those leaving welfare or those who are diverted are able to find jobs with health insurance?
How many have jobs where their kids have health insurance?
How many have access to good child care?

The Department of Health and Human Services (DHHS) believes that the success of welfare reform has to be judged based on a multiplicity of outcomes including parental employment and earnings, family income, and child and family well-being. There is clear and consistent evidence that welfare reform has been successful in increasing the employment of low-income mothers. As Howard Rolston noted in his testimony before your committee, the percentage of recipients working has increased from 14 to 18 percent. On the other issues there is currently insufficient evidence to judge success. The specific questions you raise are important ones. We agree that answering them is also central to assessing the success of welfare reform .

We have specifically targeted our research effort and funding to address many of these questions. Most of the evaluations of State welfare reform programs include data collection efforts that will provide valuable information about the families= circumstances when they are no longer receiving TANF cash assistance. This will include information on employment, wage levels, benefits such as health insurance coverage, and child care arrangements utilized. The special studies funded to track TANF Aleavers@ and those diverted from TANF will also provide important information about wage levels and earnings, benefits available from the job such as health insurance coverage, family income, and utilization of other program services, such as Medicaid and food stamps. Interim reports from several large-scale welfare reform evaluation studies and some of the first round of Aleavers@ studies have been received. Additional reports are expected to be submitted to DHHS over the coming months. We will be reviewing findings and analyzing the information produced. We would be pleased to brief you on this work as it is completed.

2. Census data suggests that the poorest families leaving welfare have *lost* economic ground in the last few years, despite our robust economy. Why is this, and what steps is DHHS prepared to take to get States to start meeting the needs of extremely poor families?

The most current post-TANF data available from the Census Bureau is the March 1998 Current Population Survey (CPS), reflecting calendar year 1997. As indicated in Howard Rolston=s testimony before the Ways and Means Subcommittee on Human Resources, analysis of all available sources of information, including the CPS, shows that the employment rate of current and former TANF recipients has increased significantly. Along with these employment gains, early analysis of the CPS data suggests substantial increases in average earnings for all female-headed families. When we look at the bottom fifth of female-headed families with children, we find that there are employment gains but the average earnings of this group did not increase from 1995 to 1997. CPS data indicate that the average annual income of all female-headed families with children increased. But when we examine differences between the top four fifths and the bottom group, those in the latter group did not fare as well. The role of welfare reform in these changes cannot be determined from these analyses. Nevertheless, the early indications of a reduction in income among those in the lowest income group are of concern to us. We will further examine these outcomes using the March 1999 CPS data as soon as they are available.

We have undertaken a number of efforts to strongly encourage States to use their existing funds to make investments in the most distressed families who are likely to have the greatest barriers to self-sufficiency. We have taken active steps to promote and encourage State and local TANF agencies to utilize the flexibility provided through the final TANF regulations, including issuance of a guidebook on the use of TANF funds (May 1999). The guidebook provides guidance and examples of how existing Federal TANF funds, as well as State Maintenance of Effort (MOE) funds, may be used to address multiple barriers faced by current or former TANF families. For example, the guide points out that Federal TANF funds may be used to provide appropriate counseling services (e.g. mental health services, anger management counseling, non-medical substance abuse counseling services) to family members with barriers to employment and self-sufficiency. Both Federal and State MOE funds may be used to provide non-medical substance or alcohol abuse services, including room and board costs at residential treatment programs. Further, TANF or MOE funds can be used to help victims of domestic violence relocate somewhere else where employment or safe housing has been secured. Among other things, these funds can be used to support collaboration with domestic violence service providers to screen and identify victims applying for TANF, establish confidentiality procedures and ensure safety, and develop appropriate staff training. Further, we have actively promoted use of the EITC and encouraged States to make significant investments in strategies that can move families who enter the workforce at low wages up to higher wage jobs.

3. Last January, a federal district judge issued an injunction against New York City, which until then had a policy of blatantly denying welfare applicants the opportunity to immediately apply for food stamps

and Medicaid. This practice is not only illegal, it=s despicable. Does DHHS have any authority to sanction New York for illegally denying Medicaid to welfare applicants? If the agency does not have the authority under TANF to penalize localities and States for this kind of behavior, does it have any other authority to impose financial sanctions on localities that are caught denying benefits? Did DHHS recommend that any sanctions be applied in the New York City case? Would you recommend that sanctions be used in the future if similar circumstances arise? Or do you think the courts and letters of guidance like the one DHHS issued on March 22, 1999, are a sufficient response, and that penalties are inappropriate?

Jeanne - I have stronger language for here that I will give Gov.

As you know, the Health Care Financing Administration (HCFA) is responsible for the Medicaid program and works aggressively with States to bring their programs into compliance with federal requirements, including requirements that Medicaid applications be furnished immediately upon request and processed quickly and without delay. When concerns are identified, HCFA begins the process by working with the State to reach a satisfactory resolution as quickly as possible. If these efforts fail, HCFA would take all steps available under the law to ensure that the State takes corrective action. This could include withholding Federal Financial Participation (FFP) for the State=s program. If HCFA determines that a State is not in substantial compliance with Federal requirements, there is authority in section 1904 of the Social Security Act, after notice to the State and a hearing, to withhold FFP from the State.

financial sanction

Should this policy guidance be a key part of [illegible]?

After court action and significant HCFA efforts to address the problems you cite, the New York City Human Resources Administration has agreed to provide Medicaid applications without delay at TANF offices in New York City. To ensure compliance, HCFA has been reviewing several aspects of New York's eligibility process. HCFA will continue to investigate all allegations of improper enrollment practices.

4. Some studies show that States using initial full-check sanctions have seen the highest welfare caseload declines. At the same time, we know that the very poorest families who need help the most are losing assistance, and are not getting jobs that pay anything close to a living wage. In DHHS= view, is it appropriate for States to use full-check sanctions against these very poor families?

TANF provides States the flexibility to establish the size of a sanction for families who fail to cooperate with work, child support, and other requirements, as long as the minimum sanction for failure to cooperate with work requirements is a *pro rata* reduction

of the TANF assistance grant. Therefore, within the overall structure of welfare reform, we believe that the amount of the sanction is appropriately a matter of State flexibility. However, we believe that it is important for States to apply fairly and accurately all sanctions, and to provide appropriate assistance and services where needed in order for parents to comply with requirements.

As we state elsewhere in our responses, we are taking various steps through regulations, policy guidance, and technical assistance to encourage States to use TANF flexibility and resources to develop policies and strategies to help TANF families who may have more barriers to self-sufficiency. For example, we are funding direct technical assistance and sponsoring conferences and workshops to allow for important information sharing about promising approaches among policy makers and practitioners. We also expect that findings from several research studies will provide important information about these families and methods to most effectively help them meet their goals for employment and meeting the needs of their children. Some of the leavers studies, for example, explicitly examine the outcomes for families that leave due to sanctions, as compared to those that leave for other reasons.

5. There are several published reports suggesting that many welfare case workers are failing to check the eligibility of TANF applicants and those leaving welfare for food stamps and Medicaid. Why aren=t all eligible families moving through the new TANF system, which emphasizes employment, getting Medicaid and food stamps, as required by law? What policy changes does DHHS recommend to ensure that crucial eligibility linkages, which are really work supports for low-income families, are promptly and consistently made?

We agree that Medicaid, food stamps, and reliable child care are critical work supports that are needed and should be available to eligible former TANF recipients and other low-income families, including those diverted from cash assistance. We have ~~strongly~~ advocated for policies that support access to and participation in these programs as reflected in the Administration's budget request. The request would extend and expand the funding authority for outreach for Medicaid and help States address other challenges associated with the delinking of Medicaid from welfare and the establishment of section 1931. Examples of the use of funds under this authority include outreach, education campaigns, and worker training.

The major changes in the organization and culture of cash assistance delivery brought about by welfare reform have created both opportunities and challenges. In many cases, State and local agencies have been innovative and creative in developing new policies and practices and utilizing the flexibility provided to link programs and help to ensure

that families have access to the supports needed as they move toward self-sufficiency. Federal law and regulations require that States that use a joint TANF-Medicaid application must furnish a Medicaid application upon request, may not impose a waiting period before providing it, and must process Medicaid applications without delay. We will continue to work with State and local TANF and Medicaid agencies to ensure that they comply with existing law and regulation and to find new ways to reach eligible children and families through the welfare system as well as outside of it.

We have sent notices to State Medicaid and TANF Directors outlining the requirements of the law and federal policy, alerting them to possible problem areas that may need attention, and providing them with guidance on ways to improve their systems and expand Medicaid coverage. Specifically, DHHS developed and issued a 24-page guide: ASupporting Families in Transition: A Guide to Expanding Health Coverage in the Post-Welfare Reform World.@ This publication was sent to all State Medicaid and TANF Directors and many other interested parties.

We have a follow-up strategy to this guide that includes an educational component, aggressive outreach, and a proactive enforcement process. In the isolated examples where specific problems have been identified, DHHS has acted aggressively. For example, in New York, HCFA has been reviewing several aspects of the eligibility process in the State. We are also undertaking research activities to find ways to promote increased participation of eligible individuals in these programs. While we believe the problems derive from State and local practices and procedures rather than from problems with current federal law and policy, we will continue to consider proposals to address these issues.

HHS is also planning to audit all 50 states by 1/1/2000 to ensure compliance with child care (CCDF) & Medicaid (HCFA)

6. There is also research documenting that food bank use is up in the last several years. At the same time, food stamp enrollment has declined nationally by 33%, or 9.1 million people, since September 1994. The Department of Agriculture says almost all of the drop in food stamp caseload is due to welfare reform. Does DHHS think this precipitous decline is due in large part to the fact that TANF recipients and leavers simply aren=t being told they=re eligible for food stamps? If so, what is the agency going to do about it?

As indicated in our response to the prior question, we believe that access to and receipt of food stamp benefits, in addition to Medicaid and child care, are critical work supports which can help meet the nutritional needs of low-income children and families, particularly former TANF families. The USDA believes that the reasons behind the rapid drop in food stamp participation are complex. Part of the drop is due to the strength of the economy and the success of welfare reform, which helped move families from

welfare to work. Part of the drop is due to new restrictions on the participation of certain legal immigrants and able-bodied unemployed adults without dependent children. But other factors may also be at work.

Between 1995 and 1997, food stamp participation fell five times as fast as poverty, a troubling sign that the nutritional needs of some low-income people may be going unmet. The number of people in poverty fell by about 850,000 over this period while the number of food stamp participants fell by 4.4 million, suggesting that many poor families have left the program despite their continuing eligibility. Some families who leave welfare for work may not be aware that they still may be eligible for food stamps; in other instances, State or local agencies may have discouraged or prevented those eligible for benefits from applying. In both of these cases, this ought not to happen. In some cases, families may have decided that participation was not worth the Acosts@ in terms of time, paperwork burden, or stigma. In any case, families that work hard and play by the rules ought to have access to sufficient and nutritious food.

The Administration believes this is a very important issue and has proposed $7 million for nutrition education and outreach in the Administration's FY 2000 budget for USDA. We will continue to work with officials within the USDA and with State and local agencies to identify and correct policies and practices that discourage or deter participation, to encourage outreach, and ensure that families have complete information about their eligibility.

7. Medicaid enrollment dropped by 2% in 1996 (600,000 people) and by another 3% (800,000 people) in 1997. A recent Families USA study argues that more than a million people who were eligible for Medicaid were not covered by the program in 1997 as a consequence of welfare reform. Families USA further calculates that 675,000 of that 1.25 million were uninsured, including nearly 420,000 children. These are children who would have been enrolled in Medicaid under the old linked AFDC-Medicaid system. This means that the rate of uninsurance among children has actually increased, according to the study B despite the fact that States have been busy passing laws in the last two years to *expand* Medicaid eligibility among children. What explains this phenomena and what does DHHS plan to do about it? What steps is DHHS prepared to take to make it clearer to States that Congress did not intend for people to lose access to Medicaid as a result of welfare reform?

While there are likely many factors that have contributed to the decline in the number of Medicaid beneficiaries, such as the robust economy and the strong job market, the

Administration and DHHS believe that people entitled to Medicaid should be enrolled and we have developed aggressive responses to address the declines, whatever the reasons.

As mentioned earlier, we are continuously promoting approaches to improve access and enrollment by all eligible families. Our technical assistance and research activities will be at the forefront of our efforts. We will offer to train staff in the States on the provisions of law and the opportunities to fund outreach and expand coverage as outlined in the "Expanding Health Coverage" guide. We are actively working with States to maximize coverage of low-income working families under Medicaid and to ensure compliance with the Medicaid statute. We will support research activities to assess program policies and practices and document lessons for program administrators and interested parties. These are important issues and we are actively taking steps to address them.

8. Section 1931 of the 1996 welfare law allows States to count income and resources far more liberally than they could under the old AFDC law for purposes of determining eligibility for Medicaid. As I understand Section 1931, this means that States can offer Medicaid to a far larger number of the working poor if they choose to do so. Indeed, an August 1998 letter to State Medicaid Directors says that the implementing regulation allows Aall States.., to provide health care coverage under Medicaid to virtually all TANF recipients and to continue that health coverage after a parent has found employment.@ How actively has DHHS been urging States to take advantage of this new flexibility to decrease uninsurance among the working poor? How many States have submitted 1931 plans, and how many are expanding Medicaid eligibility under this section to date, and how many more would you expect to see expand eligibility within the next year?

DHHS is aggressively promoting State coverage of working poor families through section 1931. As previously indicated, we issued the 24-page guide that addresses 1931 expansion options and developed a follow-up strategy to work with States. In addition, the letter you cite is just one of many that we issued that discusses the flexibility available under 1931. We have worked closely with States in the development of expansions that will assure that the TANF population is eligible for Medicaid. At this time, 45 States have submitted 1931 State Plan Amendments (SPAs). Most of these involve an eligibility expansion, though the degree of expansion varies considerably. Some have only increased the vehicle or resource exclusion. At the opposite end, the District of Columbia will effectively exclude all income below 200 percent of poverty in order to

cover all the working poor. A number of States have already revised their original 1931 amendments to add additional expansions. While we have no way of predicting how many will do so in the next year, we will continue to encourage States to expand coverage through 1931. We do expect that States will continue to use the 1931 flexibility to both simplify and expand Medicaid eligibility in the future.

As indicated elsewhere, we are taking steps through research activities, technical assistance, and information sharing through conferences and workshops to encourage States to develop policies to support working families, particularly those leaving TANF rolls.

9. In March 1998, DHHS issued a high performance bonus guidance document that proposes to reward the 10 States deemed to be doing the best job at welfare reform every year. It incorporates only work-related measures in the form of job gain, job retention and job gain earnings. Wendell Primus of the Center on Budget and Policy Priorities argues in his testimony today that additional factors that provide a measure of how many are receiving Medicaid and food stamps should be part of any assessment of how well States are doing in implementing welfare reform. Conceptually, do you agree or disagree with the Center=s approach? Are you willing to recommend that some measurement of how well States do in serving low-income families, or a measurement of childhood poverty, should be a component of a final rule for State high performance bonuses? If not, then how do you really expect to convince States that they have to do a far better job than they have been in enrolling welfare leavers in these work support programs in order to make welfare Areform@ truly successful?

We are exploring a number of possible additional measures that could be used to assess child well-being and other important outcomes, similar to those suggested by Wendell Primus. In making decisions about the measures that will be included, it is important to consider the consistency of measurement across States, the degree to which there is accurate measurement of the variable at the state level, and other similar factors. We plan to issue a proposed rule this summer regarding the High Performance Bonus in which we will address the issue of moving beyond the current work measures and hope to obtain valuable feedback and input from experts and interested parties in response to the proposed rule.

In addition, as you note, the current High Performance Bonus measures include retention and earnings gains on the job, as well as job entry. We have also been pointing out to

States that these measures are likely to reward States that do a good job of providing supports to working families such as health care and child care because these supports help families keep their jobs and move up on the job.

10. On the issue of child care, is there any evidence that are States are denying child care services to TANF recipients and leavers? I am told that in the State of Utah, parents who are being sent to work must first seek out free child care before they are allowed access to TANF-based child care services. In how many States is this practice replicated?

The availability of quality child care is critically important for all low-income working families, including those who are transitioning from welfare to work, and for their children. The Administration and DHHS are dedicated to increasing our investments in quality child care for TANF and low-income working families.

We are not aware of any States denying child care services to TANF recipients if it is needed for participation in required activities or employment. Federal law and regulations for the Child Care and Development Block Grant (CCDBG) and TANF specify that TANF agencies may not impose a sanction on a single mother of a child under age 6 for refusal to participate or work if the parent demonstrates an inability to obtain needed child care based on the State=s definitions of Aappropriate child care,@ Areasonable distance,@ Aunsuitability of informal care,@ and Aaffordable arrangements.@ Both the TANF and CCDBG regulations specify steps that the State must take to carry out this provision, including a requirement that State TANF and child care agencies must inform families about these provisions.

With regard to the practice you were informed about in Utah in which families are encouraged to find free care as a first option, we are told that the State does not require that families seek out free child care prior to approval of child care subsidies. State workers ask parents if child care is available at no cost. If the parent states that such care is not available, the TANF worker proceeds with a subsidy request. The State assures us that no parent is refused child care services or required to find free care prior to approval of child care subsidies. The practice of encouraging families to seek free child care, while not illegal, is not one that we support or encourage. We are not aware of any other State that engages in a similar practice. We will be in a better position to learn more about current State practices once the State CCDBG Plans for the 2000-2001 biennium are received and analyzed. The plans are due July 1. We would find it useful to hear if you learn of other practices that cause concern.

We also know that after families leave TANF, there is considerable variation among States in the availability of child care subsidies. Some States seek to provide child care to leavers for a set period of time, while others have moved to an income-based system

where low-income families are served on an equal basis whether or not they came from welfare. The critical issue for all the States, however, is that there are insufficient resources to serve all the low-income working families, both former TANF families and other low-income families, who need child care subsidies in order to hold onto their jobs and ensure that their children are in safe and stable care. Nationally, despite considerable State investments as described below, data from 1997 showed that only about 1.25 million of the 10 million children who met the Federal income eligibility standards for the Child Care and Development Block Grant received a subsidy in 1997.

Because the Administration believes the availability of safe, affordable, quality child care is so important to working families, the President has proposed a major initiative to ensure that America=s working parents are not forced to choose between a job they need and a child they love. We very much appreciate your and your colleagues= support for this initiative, which proposes to expand the Child Care and Development Block Grant by $7.5 billion over five years to serve an additional 1.15 million children in low-income working families; to help low and moderate income families who earn too much to qualify for subsidized care, but still need help paying for child care by expanding benefits for the Child and Dependent Care Tax Credit; to expand after-school care to one million children; and to strengthen the quality of care for our youngest and most vulnerable children through an investment of $3 billion over five years for an Early Learning Fund that communities would use to ensure healthy, safe, and high quality care for babies, toddlers, and preschoolers.

As indicated in my testimony before the Subcommittee last spring, States are making considerable investments in child care but simply cannot meet the needs of low-income working families for stable care without an additional Federal commitment. In FY 1998 States obligated 100% of the funds available to them through the CCDBG, including the matching funds that they must supply in order to draw down the Federal assistance. In 1998 12 States reported expending TANF funds for child care and 28 States transferred TANF funds to their CCDBG programs. Yet, even in the States that have made the largest resource commitments, eligibility levels are often set far below the allowable Federal level and there are long waiting lists for services among eligible families. And, States that have studied the impact on families on waiting lists of failing to get a child care subsidy report that such families often return to welfare, having problems paying their bills, and shuffle their children between unsatisfactory child care arrangements. For these reasons, we believe that it is extremely important to families that the President=s child care initiative be enacted.

11. Can you discuss the research showing that the *quality* of child care directly affects employment, and can make a difference in whether low-income women are willing and able to return to the work force for the

long term? And would you agree that care that is convenient, affordable, and of high quality may help parents succeed in their transition from welfare to work while deficits in any of these dimensions may interfere with parents= education and work activities, not to mention compromise a child=s wellbeing?

Child care is centrally important to children=s well-being and to parents= ability to work. As you note, convenience, affordability and quality of child care are all critically important dimensions that can enhance parents= ability to succeed in the transition from welfare to work and, as noted above, can also influence the ability of low-income working families to keep their jobs and succeed at work. In addition, the quality of care is important to children=s wellbeing, healthy development, and school readiness, as demonstrated by an expanding body of research. Over the past several years, in partnership with the Congress, the Administration has provided leadership by expanding public investment to serve more needy children and families, by stronger efforts to improve program quality and accountability, and by creative work to support partnerships across different early childhood programs. Yet, as noted above, there are critical next steps we must take at the Federal level to ensure quality care. These include enacting the President=s proposal for an Early Learning Fund that would enable communities to improve care for the youngest children and enacting the President=s proposed budget for Head Start, the nation=s premier early childhood program, which still serves less than half of eligible children.

Among the most important recent research findings on the impact of quality child care on children are the following:

- The National Institute of Child Health and Human Development recently reported that higher caliber child care was consistently related to high levels of cognitive and language development. In addition, research shows that higher quality child care is related to stronger pre-mathematics and social skills.

- A recent follow-up to the Cost, Quality, and Outcomes in Child Care Centers study, co-sponsored by the Department of Education and several foundations, found that children who had experienced high quality child care had higher language and mathematics skills than those who had been in poorer quality care. Most strikingly, the effects lasted into the second grade. High quality child care particularly benefited children whose mothers had lower levels of education.

- A rigorous evaluation of a Milwaukee program designed to provide child care, health care, earnings subsidies, and guaranteed jobs to low-income working families, Project New Hope, found that a key impact of the program was to substantially increase

boys= school performance and substantially reduce boys= behavioral problems. Researchers attributed this finding to several aspects of the program, including especially increased participation by the boys in preschool care, extended-day child care, and other structured activities.

Given the growing body of research that indicates the fundamental importance of quality, we have significant concerns about the quality of care that is available. As noted above, the President=s initiative includes the Early Learning Fund to support higher quality child care in communities across the country. The Early Learning Fund will provide challenge grants to communities for children aged zero-to-five to enhance the quality of early care and education services for our youngest and most vulnerable children.

A variety of research also suggests that child care makes a difference in parents= ability to sustain employment as well as their consistency and productivity on the job. For example, several studies have shown that improvements in employee absenteeism, lateness, and turnover have been shown to be related to the availability of employer provided child care services. A study sponsored by the National Conference of State Legislatures (1997) found that child care issues were cited by surveyed employers as causing more problems in the workplace than any other family-related issue.

Continued research and evaluation of issues affecting child care are essential to improve Federal, State and local policies, promote effective practice, and increase our capacity to better serve low-income children and parents. We appreciate your efforts and those of others in authorizing $10 million for child care research and evaluation that will become available in fiscal year 2000. We support continuation of this research funding authority because it provides us an important opportunity to enhance our knowledge in critical areas and in ways that will be helpful to parents, providers, employers, communities, States, and the country as a whole.

12. Testimony presented by Wendell Primus of the Center on Budget and Policy Priorities at a May 27 Ways & Means Human Resources Subcommittee hearing concludes that the average disposable income of the poorest fifth of single-mother families fell from 1995-97 by about $660, a 7.6% decline. Income in the next-to-the-bottom income quintile remained unchanged. For these families, welfare reform has not produced Asuccess,@ but dramatic failure. Part of that failure is due to these families not getting food stamps. How does DHHS think this poverty gap should be addressed?

As stated above, analysis of all available sources of information, including the CPS, shows that the employment rate of current and former TANF recipients has increased significantly and for some the analysis suggests there have also been substantial increases in average earnings. Based on early analysis of the data, the average earnings for those in the bottom fifth of female-headed families with children did not increase. We are concerned with this preliminary finding and will continue to monitor it. At the same time, we are aggressively promoting strategies to increase investments to provide supports to the hardest to employ families and to increase access to and participation in both the Medicaid and Food Stamp programs by all eligible families. Our technical assistance efforts and those of USDA, as well as our recently issued guidance on the flexibility on the use of TANF funds based on the final regulations, will encourage States to invest resources to provide needed supports for the poorest families and those with multiple problems. As we note below in response to your question about State programs and practices for the hardest to employ, there are many examples of promising strategies that State and local TANF agencies are putting in place to assist families who face more difficult challenges to self-sufficiency.

13. In other testimony by the American Enterprise Institute, it is suggested that the poorest women - those in the bottom income quintile - are doing reasonably well because they=re moving in with non-family members. In DHHS= view, is it appropriate that very low-income women are being Ahassled@ by >job centers@ to the extent that no cash assistance or other aid is extended to them whatsoever?

While we support State and local TANF agency efforts to implement strong work requirements for families applying for and receiving TANF cash assistance, work requirements must not be applied in a way that deters families eligible for Food Stamps and Medicaid from applying for and receiving them. As we have noted in responses to other questions, we are using a variety of approaches to correct inappropriate or illegal practices.

14. The Ahassle@ factor referenced in AEI=s May 27 testimony has been institutionalized in some State diversion policies. Unfortunately, these tactics can cause potential welfare applicants to walk out the door before talking at length with a caseworker, and in some cases, transformed into policies to effectively deny benefits illegally, as happened last year in New York City. Does DHHS believe this suggests that federal parameters on State diversion policies are needed?

DHHS sponsored a research project that examined State policies to divert families from receipt of TANF cash assistance and the implications for Medicaid enrollment. The study surveyed state-level administrators to gain information about policies and included case studies of five local offices to examine field operations and practices more closely. The study found that the new administrative requirements brought about by de-linking Medicaid and cash assistance and the use of diversion strategies created both opportunities and challenges for State and local policymakers and operators. While some States used the flexibility and expansion opportunities to directly support their diversion programs, the researchers found that there were also situations where applications for Medicaid could potentially Afall through the cracks@ where there were diversion programs.

As a result of these and similar findings, DHHS used issuance of the Guide to Expanding Health Coverage as well as several letters to State Medicaid and TANF Directors to emphasize the requirement for States to process applications for Medicaid without regard to eligibility factors related solely to TANF and to notify families of their continuing eligibility for Medicaid despite ineligibility or noncompliance with TANF requirements. We will continue to address the issue through a variety of approaches, including technical assistance, further research, and program monitoring. We will react quickly to any information about illegal practices. At this time, DHHS does not believe that federal parameters on State TANF diversion polices are necessary.

15. There is information from a number of sources that some families are indeed worse off since the passage of PRWORA in 1996. Wendell Primus has testified that the bottom fifth of single mothers experienced a drop in annual incomes from 1995 to 1997. Also, the Children=s Defense Fund has reported that former welfare families are reporting that they are unable to pay for food, are falling behind in rent, losing health coverage, and going without needed medical care. NETWORK, a National Catholic Social Justice Lobby, also reports that parents report that they and their children are skipping meals or eating less per meal. In light of this information, how can we deny that some families are in fact worse off?

As noted above, there is clear evidence from multiple sources that employment rates have increased and that earnings have increased for many families. But, the early, preliminary evidence from the CPS does suggest that the income picture is more complicated, that some families may have gained income while others lost, and that there is particular reason for concern about families at the bottom of the income distribution. We believe that it is important to continue to monitor this issue. In many of the leavers studies, the States are examining subgroups of families leaving welfare in order to understand which

are succeeding and which are struggling. This will enable them to target additional resources to those families who are most vulnerable.

We are aggressively encouraging States to invest TANF funds in strategies that will make a difference to these families; both strategies that support low-income working families who have left welfare, and strategies that invest in families on welfare, particularly the most disadvantaged. Further, we believe that the flexibility provided within the recently issued final regulations for TANF will make it easier for States to invest resources to support former welfare families. We are encouraged by initial State reaction and response to this new flexibility.

The Administration and DHHS have advocated for an array of important supports for working families so that families are better off when they choose work over welfare. These include the Earned Income Tax Credit, increased minimum wage, expanded Medicaid eligibility, access to food stamps, strong child support enforcement provisions, and the availability of affordable quality child care. We are pursuing an aggressive strategy to work with State and local TANF agencies to support working families.

16. An amendment was recently offered in the Senate to require DHHS to submit a report annually to Congress on how well those leaving welfare do in the first two years after leaving cash assistance. It failed by only one vote. The amendment called for DHHS to track employment status, wages, health insurance status and child care information. Do you agree that this kind of an overarching broad examination of the economic well-being of those leaving welfare is integral to a fair evaluation of welfare reform?

As we stated in response to the first question in your letter, we agree that the success of welfare reform should be judged using a multiplicity of outcomes. We will be obtaining information about the measures you mentioned from a variety of research projects that we sponsor (e.g., the Aleavers@ studies, child outcome studies, national surveys) as well as from studies sponsored by other organizations. Some relevant measures will also be expected to be available through the data reported by States participating in the High Performance Bonus.

17. States have a substantial amount of TANF monies that have not yet been obligated - about $3 billion in unobligated funds. Will DHHS recommend that it be used for helping the hardest-to-serve welfare recipients, for improving the food stamp program and for Medicaid

outreach. Are States prepared to use the money for these purposes, or should the federal government direct States to do so?

We believe that assisting the Ahardest to serve@ to become self-sufficient and facilitating job retention and advancement are two of the most central uses for directing unobligated TANF funds. We are promoting these strategies aggressively through ongoing technical assistance, information provision, and research activities. We will use the flexibility provided in the final TANF regulations and the written guidance we have provided on the use of TANF funds to aggressively encourage States to make important investments in those families facing multiple challenges in their effort to become self-sufficient.

The types of services or approaches needed to help families with multiple barriers may be different from those used with families that exited earlier. State and local agencies are using a variety of approaches to work with families with significant barriers to employment. The opportunity provided to furnish employment-focused services specifically for the hardest to serve through the Welfare-to-Work Program is critical to this goal. That is why we support reauthorization of the Welfare-to-Work Program. As mentioned elsewhere, we are working with other agencies and organizations to identify promising strategies and practices for working with the hardest to serve families (e.g., those with substance abuse and mental health problems, victims of domestic violence, individuals with disabilities) through peer-to-peer technical assistance, workshops and conferences, and research.

As noted throughout, we have taken numerous steps to encourage States to conduct outreach and to examine and correct policies and practices that result in families being deterred or discouraged from making application for Medicaid and Food Stamps. We will continue to address this issue through our technical assistance strategy, research activity, and program monitoring.

18. I understand that DHHS will soon be issuing a proposed regulation on State high performance bonuses, worth $200 million per year. Temporary guidance for 1999 focuses only on work-related measures of job entry, job earning gains, and job retention. Does DHHS think broader measures of family well-being should be included as incentives to States to bolster food stamp and Medicaid participation among welfare participants to help lift them out of poverty?

As stated above, we are exploring a number of possible types of measures for inclusion in the High Performance Bonus that could be used to assess child and family well-being. We expect that the comments we receive on the proposed rule will help us in making final decisions about the types of measures to include. In the meantime, we will continue

to use other means to assist and encourage States to increase access to and participation in the Medicaid and Food Stamp programs among former TANF families and other low-income families.

19. Does DHHS agree that caseload reductions are only one possible measure of welfare reform? What are some other markers we should be looking at to assess the success or shortcomings of welfare reform?

DHHS believes that the success of welfare reform has to be judged based on a multiplicity of outcomes including parental employment and earnings, family income, and child and family well-being.

20. The General Accounting Office points out in a report released on May 27, AWelfare Reform: Information on Former Recipients= Status,@ that Athere are no federal requirements for States to report on the status of former welfare recipients. As a result, the only systematic data currently available on families who have left welfare come from research efforts initiated by States.@ Those State studies vary considerably in the way they are conducted and are not generalizable, making it harder to do cross-comparisons. Does DHHS support a requirement for States to provide data every year in a report to Congress on uniform parameters .employment status, wages, health insurance, and child care information - in order to greatly increase the understanding of the impact of welfare reform?

As we stated above, we agree that the success of welfare reform should be judged using a multiplicity of outcomes. In addition to the state-sponsored leavers studies mentioned by GAO, we will also be obtaining information about the measures you mentioned from a variety of research projects that we have sponsored as well as from studies sponsored by others organizations. The number of studies with findings that were available to GAO at the time of their study was somewhat limited. Over time, we will have much more information when all of the studies are completed. DHHS has provided funding to support 14 Aleavers@ studies using comparable methodologies and definitions, where possible, and will fund additional projects or expansions this year. While we will not be able to generalize the findings to all States, we will have a considerable amount of information from a large number of States with different benefit levels and other program characteristics. Some relevant measures will also be expected to be available through the data reported by States participating in the High Performance Bonus.

The President=s budget has requested $27 million in mandatory and discretionary funding and an additional $5 million for policy research for FY 2000 to continue to support these and other welfare research efforts. We hope that Congress will fully fund this request. Proposals to require states to track all former TANF recipients and collect data about their employment status, wages, health insurance and child care services would be a very costly undertaking that raises a number of complex data collection issues.

21. There are now 31 States using diversion tactics in their welfare offices, according to GAO. Any comprehensive assessment of welfare reform and outcomes must determine whether these diversion practices are negatively affecting families. What State diversion policies identified by DHHS are hurting low-income families?

We believe that any policies that deny individuals the right to apply for Food Stamps and Medicaid are illegal and hurt families. Such policies need to be eradicated wherever they exist and we have taken steps to ensure that States comply with the law and regulations. Under federal regulations, families must be given the opportunity to apply for Medicaid and Food Stamps without delay.

As mentioned previously, DHHS sponsored a study of State diversion policies with a special focus on implications for Medicaid. The findings from the study highlighted both challenges and opportunities brought about by diversion programs and the Adelinking@ of Medicaid from cash assistance eligibility. We have used the findings from this study and other sources in developing the Guide to Expanding Health Coverage to provide specific recommendations and examples for State and local use and to encourage expansion of health care coverage. DHHS' follow-up strategy will help to ensure that States understand and comply with federal policies.

22. As welfare rolls shrink, some States are concerned that a growing proportion of people on the rolls are the hardest-to-employ, such as those with mental health and substance abuse problems, or victims of domestic violence. In DHHS= experience visiting States and learning about their TANF programs, what are some of the programs that have been put into place to help this population?

State and local agencies are using a variety of approaches to work with individuals with these types of problems. For example, in some areas (e.g., Oregon), the TANF agency has established an agreement with the local substance abuse or mental health agency to have a professional from such organization stationed in the TANF office to conduct assessments of applicants or recipients or to provide additional information or

consultation to workers. Some States (e.g., North Carolina and New York) are using Employee Assistance Programs to address these types of problems and increase employment. Others have committed resources specifically for treatment and services to individuals and families identified as having substance abuse problems (e.g., New Jersey) and many have taken steps to provide additional training to front-line staff in the use of tools to help identify the existence of problems which could impede the transition to self-sufficiency.

Under TANF, States have flexibility to give special treatment to the victims of domestic violence. Under the AFamily Violence Option,@ States may certify that they will assist victims by: screening for them when they apply for TANF; referring them to counseling and supportive services; and waiving program requirements (such as time limits, residency requirements, child support cooperation, or family cap provisions) if necessary. Our latest information indicates that twenty-seven States have certified that they will assist victims of domestic violence. Examples of State and local actions include authorization of special appropriations for services for TANF recipients who are victims of domestic violence (e.g., Pennsylvania); implementation of demonstrations to examine new approaches to serving battered women (e.g., Tennessee, Illinois, Texas, Massachusetts, Kansas, Arizona, Utah, Minnesota); and hiring of domestic violence experts as employees of the TANF agency to work with caseworkers and to advise on policy (e.g., Massachusetts).

In order to promote policies and practices in these areas, we have co-sponsored, with the Substance Abuse and Mental Health Services Administration, numerous conferences throughout the country which have been attended by hundreds of State and local welfare staff and practitioners from many disciplines. Attendees have participated in day-long sessions by experts on practical approaches to working with the hardest to employ, including those with mental or physical health problems, substance abuse problems, and those with very low basic skills or learning disabilities as well as those who face difficult challenges simply because they live in very rural areas. In many cases, the barriers faced by some TANF families may not be completely overcome in a short period of time. We believe the flexibility provided in the final TANF regulations will encourage State and local TANF agencies to continue to work with working families who face greater challenges to their continued self-sufficiency. (Under the final TANF regulations, the expenditure of TANF funds to provide supportive services to working families will not count towards the 60-month federal time limit on the receipt of assistance.)

We have taken active steps to promote and encourage State and local TANF agencies to utilize the flexibility provided through the final TANF regulations, including issuance of a guidebook on the use of TANF funds (May 1999). The booklet provides guidance and examples of how Federal TANF funds, as well as State Maintenance of Effort (MOE) funds, may be used to address multiple barriers faced by current or former TANF families. For example, the guide points out that Federal TANF funds may be used to

provide appropriate counseling services (e.g. mental health services, anger management counseling, non-medical substance abuse counseling services) to family members with barriers to employment and self-sufficiency. Both Federal and State MOE funds may be used to provide non-medical substance or alcohol abuse services, including room and board costs at residential treatment programs. Further, TANF or MOE funds can be used to help victims of domestic violence relocate to an area where employment or safe housing has been secured. These funds can be used to support collaboration with domestic violence service providers to screen and identify victims applying for TANF, establish confidentiality procedures and ensure safety, and develop appropriate staff training.

We will be using multiple approaches (e.g., presentations, instructional workshops on the final TANF regulations, sponsorship of conferences, provision of technical assistance) to encourage creativity, innovation and replication of promising practices.

23. GAO finds that the average hourly wage rates in leaver studies varies between $5.67 an hour in Tennessee to $8.09 an hour in Washington State. At *$5.67* an hour, annual income at 32 hours per week for 50 weeks is only $9,072. That=s not enough to break through the federal poverty level of slightly over $13,000 for a family of three in 1998. At $8.09 per hour, annual income is $12,944, still below the federal poverty level. Is this what DHHS considers a successful outcome for welfare reform?

DHHS believes that it is important that working families have a package of supports available to assist them as they transition from welfare to self-sufficiency. As indicated by the findings in the GAO study, a low-wage job may be the first step for many former welfare recipients. In fact, given the work experience and skill level of many recipients, we believe that it will be the likely first step for many parents. That is why it is critical for such families to receive other supports such as food stamps, Medicaid, the Earned Income Tax Credit, and subsidized child care. For example, for tax year 1998, for a family with two qualifying children with earnings of $9072 and no other income, the EITC would be $3,630. If the same family earned $12,944, the EITC would be $3,616.

We also believe, and have reflected in all of our activities, that a key investment area for States is employment advancement strategies that can move families who enter the workforce at low wages up to higher wage jobs.

24. In general, state evaluations of people leaving welfare all point to the fact that individuals who leave welfare for work earn low wages, with most not earning enough to raise their income above poverty. The Urban Institute points out that most of these people get jobs in low-wage industries, such as fast food restaurants, or clerical or retail positions. These aren=t positions with generous salaries, and you note that Aa key issue in evaluating welfare reform is the extent to which persons with the attributes of welfare recipients can actually become self-sufficient.@ Without work supports such as child care and health insurance, is it realistic to expect that former welfare recipients can, as you recommend, Apersist in the labor force@ until Athe gap between their earnings and those of other workers never on welfare@ narrows?

As we cited elsewhere, we believe that families transitioning from welfare to work and other low-income working families need a package of supports to help them make and sustain the transition. We have and will continue to work aggressively to see that these supports are in place and are accessible to those who need them. Adequate funding for child care is critical. High utilization of the EITC by welfare families is an important step in helping parents in low-wage jobs move out of poverty.

As we have indicated in responses above, we are actively working with States to ensure access to the Food Stamp and Medicaid Program benefits by all eligible families, including those who leave the TANF rolls. We will continue to use a variety of strategies to accomplish our goals including technical assistance and research activities.

DATE: 6/23

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
ROOM 405H, HUMPHREY BUILDING
200 INDEPENDENCE AVE, SW
WASHINGTON, D.C. 20201

PHONE: (202)690-7450 *FAX: (202)690-8425*

TO: Chris J.

OFFICE:

ROOM:

PHONE:

FAX: 456 5557

FROM:

[ ] JANE HORVATH
[ ] HOLLY BODE
[ ] SHARON CLARKIN
[ ] BOB GUIDOS
[ ] GREG JONES
[ ] ANDREA LEVARIO
[ ] ROGER MCCLUNG
[ ] TANISHA PARKER
[ ] JON RETZLAFF
[ ] MARC SMOLONSKY
[ ] STEPHANIE WILSON
[ ]

FYI →

PBOR Fact Sheet on S.326 as reported

(INCLUDING COVER): 4

REMARKS:

Remaining Issues in S326, as Passed by HELP

Scope: S.326 applies only to self-insured group health plans, and the information disclosure and appeals provisions apply only to group health plans (both self-funded and insured). The bill does not apply to the individual market.

Emergency Care: S.326 does not ban in-network requirements for ER services. (S.326 includes "services furnished by a nonparticipating provider" in the definition of emergency medical care. However, because the change applies to the definition and not to the description of the protection, this change does not have the effect of banning in-network requirements. It is merely circular, because the basic protection applies only to the extent that the group health plan provides coverage for emergency medical care as defined. Therefore, the right applies to services provided by nonparticipating providers only to the extent that the plan provides coverage for emergency services provided by nonparticipating providers.) The language in other bills banning in-network requirements is standard and easily imported into S.326. In addition:

- S.326 allows plans to impose higher cost-sharing requirements on patients who obtain emergency care without a prior authorization.
- S.326 does not reference the Secretary's post-stabilization and maintenance care guidelines under section 1867 of the Social Security Act.

Access to Specialists: S.326 does not require plans to allow women to designate their ob/gyn as their primary care physician and only requires direct access to routine ob/gyn services. In addition:

- There is no provision to allow persons with serious or chronic conditions to designate a specialist as a primary care physician.
- There is no requirement for the plan to make a referral to a non-participating specialist when there is no available and accessible participating specialist.

Prescription Drugs: S.326 requires physician and pharmacist involvement in formulary development and requires a process for accessing non-formulary drugs when medically necessary and appropriate. It does not prohibit plans from denying drug or medical device coverage as investigational if the drug or device's requested use is included in its labeling authority.

Information Disclosure: S.326 fails to fix a key existing problem with the ERISA information disclosure provisions: plans are not required to notify enrollees of material reductions in benefits and coverage prior to the effective date of those changes. In addition:

- Plans are required to disclose only a summary description of specific coverage exclusions, not a full list of exclusions.

External Appeals: The weaknesses of the External Appeals process remain numerous and

significant:

- The plan decides what issues are externally appealable.
- The plan selects the external review entity. There is nothing to prevent a plan from choosing an entity that has given "good results" in the past and no mechanism to assure that reviewers not make biased decisions. The clause prohibiting conflict of interest of review panel members does not prohibit the panelist from having an affiliation with the plan sponsor, employer, their fiduciaries, or the issuer.
- S.326 does not require that the external review be *de novo*.
- Despite amended language requiring the external review entity to make an "independent determination," the appeal is based on the plan's definition of "medical necessity or appropriateness."
- The deadline for the external review decision is tied to the external reviewers' receipt of the case file from the plan, but there is no deadline for the plan to forward the file to the external reviewer. There is no allowance for emergency cases. Thus, the plan could indefinitely delay the external review decision, regardless of the medical exigencies of the case. [Note: Although S.326 requires the external review to be completed in accordance with the medical exigencies of the case, it also establishes a 30 working day time frame that applies "notwithstanding" the medical exigencies requirement.]
- The plan has 30 days to tell the enrollee how it will respond to the decision of the external reviewer. There is no requirement that the plan actually respond to the decision of the external reviewer by any deadline. There is no allowance for medical exigencies. There are no consequences for missing the notification deadline.
- The enrollee has only 30 days to file the appeal, with no provision for extensions.
- No violations of the consumer protection provisions in the bill are eligible for external appeal.

<u>Coverage Determinations and Internal Reviews</u>

- The time frame for routine prior authorizations does not take into account the medical exigencies of the case.
- For expedited prior authorizations and expedited internal appeals, the plan determines whether the normal time frame for making prior authorizations could "seriously jeopardize" the life or health of the enrollee. This determination is not externally appealable.
-
- A prior authorization and internal appeal must be expedited if a physician "reasonably documents" that the normal time frames seriously jeopardize the life or health of the enrollee. The necessary documentation is not specified. Any such requirement is likely to be a barrier to timely determinations.
- There is no deadline for concurrent review determinations.
- The time frame for retrospective determinations begins when the plan has received all necessary information. There is nothing preventing indefinite delay.

- Decisions not to provide a requested service because it is listed as a coverage exclusion are not eligible for internal appeal (nor do deadlines for coverage determinations apply).

Network Adequacy: There is no requirement that a plan have a network with sufficient number, distribution, and variety of providers who are available and accessible in a timely manner. In addition, there is no requirement that a plan cover the services of a nonparticipating specialist if the network is inadequate to treat the enrollee's condition.

Continuity of Care: Continuity of care protection applies only to persons in institutions, women in their second trimester of pregnancy, and the terminally ill -- not to persons with chronic or ongoing illnesses who are in the middle of a course of treatment when their provider is terminated. In addition:

- The continuity of care provision limits transitional care to 90 days even for persons who are terminally ill, even though the definition of terminally ill is an enrollee with six months or less to live.
- The bill provides for continuity of care when a provider is dropped from the plan's network, but not when the employer changes plans.
- S.326 requires the plan to provide the enrollee with an opportunity to notify the plan of a need for transitional care. Such notice appears to be a condition for obtaining transitional care. Such a requirement could present a substantial barrier to the enrollee (the provision does not require the plan to explain the notification process, there is nothing about whether the enrollee's notice may be oral or how the plan has to act on the enrollee's request, etc.).

Physician Incentives: S.326 does not limit physician incentives to deny care, nor impose requirements in cases where the plan places the provider at substantial financial risk.

Gag rule: The anti-gag provision still only applies to advice on medical care or treatment and does not cover advice or advocacy about utilization review or appeals or disclosures about financial incentives.

F- KY - PBOR
Event

August 8, 1998

PATIENTS' BILL OF RIGHTS EVENT

DATE:	August 10, 1998
LOCATION:	Commonwealth Convention Center
EVENT TIME:	11:00 am - 12:15 pm
FROM:	Bruce Reed/Elena Kagan/Chris Jennings

I. PURPOSE

To highlight the critical differences between your Patients' Bill of Rights proposal and Republican proposals, and to announce that you will veto the House Republican Leadership bill if sent to you by Congress. You will also announce that the Office of Personnel Management is implementing a new regulation to prohibit anti-gag rules, as part of your ongoing efforts within the federal government to implement the patient's bill of rights for all Federal Health Plans.

II. BACKGROUND

For nine months, you have been calling on the Congress to pass a strong enforceable patients' bill of rights. Unfortunately, the Republican Leadership only recently responded with proposals that are more symbolism than substance. While the Republican Leadership stalls on providing Americans with real patient protections, the Administration continues to implement these patient protections for the 85 million Americans in Federal health plans. However, Congress must act to make these rights real for all Americans. Unfortunately, the Republican proposals:

TAKE A STEP BACKWARDS FOR SOME CRITICAL PROTECTIONS.

- **Undermine existing medical privacy protections.** The House Republican Leadership bill would increase the number of individuals who can who can review health records and give them out without consent or knowledge. It would also obliterate the medical privacy guarantees many states have on the books to protect patients today.

- **Do not have real emergency room protections.** The Republican Leadership proposals do not contain the prudent layperson standard that were implemented for Medicare and Medicaid during the Balanced Budget Act of 1997. It also does not require health plans to cover patients who have to go to an emergency room

outside of their network and does not assure coverage for any treatment beyond an initial screening. This puts patients at risk for huge costs for critical treatment that a doctor believes should take place in the facility where they were initially admitted.

CONTAIN HOLLOW PROMISES. Many of the provisions in the Republican plan are loopholes rather than real protections.

- **Let HMOs, not health professionals, define medical necessity.** The Republican Leadership proposals include an external appeals process that simply does not assure patients a fair independent review. They allow health plans to develop their own definition of medical necessity, meaning that HMOs, not health professionals, get to determine what is medically necessary. This loophole will make it extremely difficult for patients to prevail on an appeal to get the treatment their doctor believes they need. The proposal also charges patients that need to address a grievance with their health plan.

- **Allow dangerous financial incentives to limit critical patient care.** The Republican legislation does not contain important provisions that prevent patients from being put at risk through unknown destructive financial incentives to limit patient care. This means that a patient may not even know about the treatment that may prove most effective.

LEAVE OUT ESSENTIAL PROTECTIONS PATIENTS NEED AND DESERVE.

- **Do not guarantee direct access to specialists.** The Republican Leadership proposals do not guarantee patients with critical health needs direct access to the specialists they need. This means that patients with cancer or heart conditions may be denied access to the doctor they need to treat their condition.

- **Do not protect patients when physicians have been dropped from a health plan.** The Republican bills do not assure that a patient's care will not abruptly change if their provider is unexpectedly dropped from a health plan or if their employer changes health plans. Therefore pregnant women or individuals undergoing care for a chronic illness may have their care abruptly halted in the middle of their treatment, which can severely undermine their health.

- **Do not compensate patients who are maimed or who die as a result of a wrongful health plan action.** The proposed per day penalties in the Republican plans are wholly insufficient for patients who suffer serious harm or even death because of a wrongful action by a health plan. These penalties are designed to brings health plans into compliance, rather than compensate patients who have been harmed or die because a health plan's actions. A health plan that denies a service so that a child can no longer benefit from a lifesaving cancer treatment will only be penalized for the number of days it takes for the plan to comply: they do not have to compensate the family who, as a result of their denial, has a

child with a now untreatable disease.

LEAVE MILLIONS OF AMERICANS OUT IN THE COLD.

- **Does not cover all health plans, leaving out millions of Americans.** The Republican bill does not assure patient protections for all health plans, thereby leaving millions of Americans completely vulnerable from these protections.

You will also announce that the Office of Personnel Management is implementing a new regulation prohibiting "anti gag" rules, as part of their efforts to meet your Executive Memorandum directing all Federal Health Plans to come into compliance with the patients' bill of rights. Earlier this year, OPM notified all participating health plans through the annual call letter that they will have to provide new patients protections as a condition of participation, including assuring access to specialists, continuity of care, and access to emergency room services. The Federal Employees Health Benefits Program has 350 participating health plans that serve 9 million Federal Employees and their families, including over 100,000 people in Kentucky. While Republicans Leadership delays passing strong patient protections, the Clinton Administration is implementing the patients' bill of rights for the 85 million Americans in Federal health plans.

III. PARTICIPANTS

Briefing Participants:
Elena Kagan
Chris Jennings

Event Participants:
Mayor Jerry Abramson
Senator Wendell Ford
Governor Paul Patton
Dr. Kenneth Peters, President, Kentucky Medical Association
Dr. Linda Peeno, former HMO executive and currently the chair of the ethics committee of the University of Louisville Hospital.

IV. PRESS PLAN

Open Press.

V. SEQUENCE OF EVENTS

- **YOU** will be announced onto the stage accompanied by Governor Patton, Senator Ford, Mayor Abramson, Dr. Peters, and Dr. Peeno.
- Mayor Jerry Abramson will make remarks and introduce Senator Wendell Ford.

- Senator Wendell Ford will make remarks and introduce Governor Paul Patton
- Governor Paul Patton will make remarks and introduce Dr. Kenneth Peters.
- Dr. Kenneth Peters will make remarks and introduce Dr. Linda Peeno.
- Dr. Linda Peeno will make remarks and introduce **YOU.**
- **YOU** will make remarks and then depart.

VI. REMARKS

Provided by Speechwriting.

AMERICANS DESERVE A <u>REAL</u> PATIENTS' BILL OF RIGHTS

PATIENT PROTECTION	PRESIDENT CLINTON BIPARTISAN PROPOSAL	GINGRICH/LOTT REPUBLICAN PLAN
PROTECTING MEDICAL PRIVACY LAWS*		**NO**
GUARANTEEING DIRECT ACCESS TO SPECIALISTS		**NO**
ASSURING BEANCOUNTERS DON'T MAKE ARBITRARY MEDICAL DECISIONS		**NO**
PROVIDING REAL EMERGENCY ROOM PROTECTIONS		**NO**
HOLDING HEALTH PLANS ACCOUNTABLE FOR HARMING PATIENTS		**NO**
PROTECTING PATIENTS FROM SECRET FINANCIAL INCENTIVES		**NO**
KEEPING YOUR DOCTOR THROUGH CRITICAL TREATMENTS		**NO**
COVERING ALL HEALTH PLANS		**NO**

*As drafted in the House plan

WEED ARMY COMMUNITY HOSPITAL
FT. IRWIN, CALIFORNIA 92310

TO: MS KRISTA ROBINSON 19FEB/0820
NAME DATE/TIME

WHITE HOUSE 202-456-7431
ORGANIZATION FAX NUMBER

FROM: DIAN BAUER
NAME SECTION

760-380-3108 760-380-6565
PHONE NUMBER FAX NUMBER

SUBJECT: TRICARE SUCCESS

MESSAGE:

PAGE 1 OF 2

AN OASIS OF CARE

Withdrawal/Redaction Marker
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. letter	Dian Bower to Sergeant Major Porteous (1 page)	02/17/1998	P6/b(6)

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

FOLDER TITLE:
PBOR [Patients' Bill of Rights] [Folder 4]

2012-0463-S
rc809

RESTRICTION CODES

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

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

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

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

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

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001b. paper	re: personal medical (2 pages)	n.d.	P6/b(6)

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001c. letter	From: Dian Bower (1 page)	02/19/1998	P6/b(6)

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Devorah Adler
OA/Box Number: 20471

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RR. Document will be reviewed upon request.

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002. note	re: address, phone number, and DOB (partial) (1 page)	n.d.	P6/b(6)

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Domestic Policy Council
Devorah Adler
OA/Box Number: 20471

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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]

Death Results in Lung Patient Denial of Specialist

Jack Jennings
Andover, MA

Contact Information: Frances Jennings (wife)

P6/(b)(6)

[002]

Source: www.senate.gov/~dpc/patients_rights/jennings.html
Senator Kennedy
202-224-4543

Story: Mr. Jennings was hospitalized with emphysema and diagnosed with pneumothorax, a dangerous condition requiring lung reduction surgery. The HMO denied his referral to an a surgeon with expertise in performing this procedure. After hassling the HMO, another referral (to a doctor in the same group) was given by the HMO. By this time, Mr. Jennings was diagnosed with lung cancer and could no longer benefit from the treatment. He died soon after the diagnosis.

Son: Matthew Jennings

P6/(b)(6)

U.S. Department of Labor

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

Date: 5/24

TO: Chris Jennings

TELEPHONE: _____ **FAX:** 456-5557

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

COMMENTS:

FYI

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

There are 6 **pages including this page.**

We Need a Federal Patients' Bill of Rights

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

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

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

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

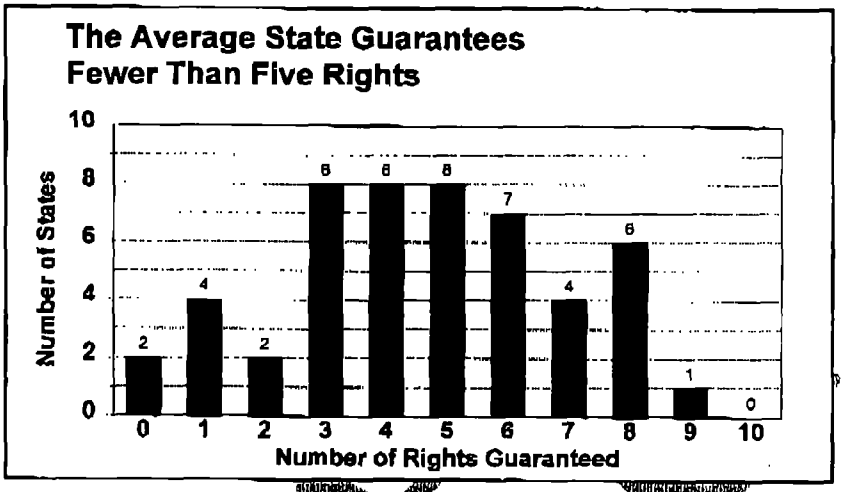
Ten Basic Patients' Rights All Americans Deserve

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

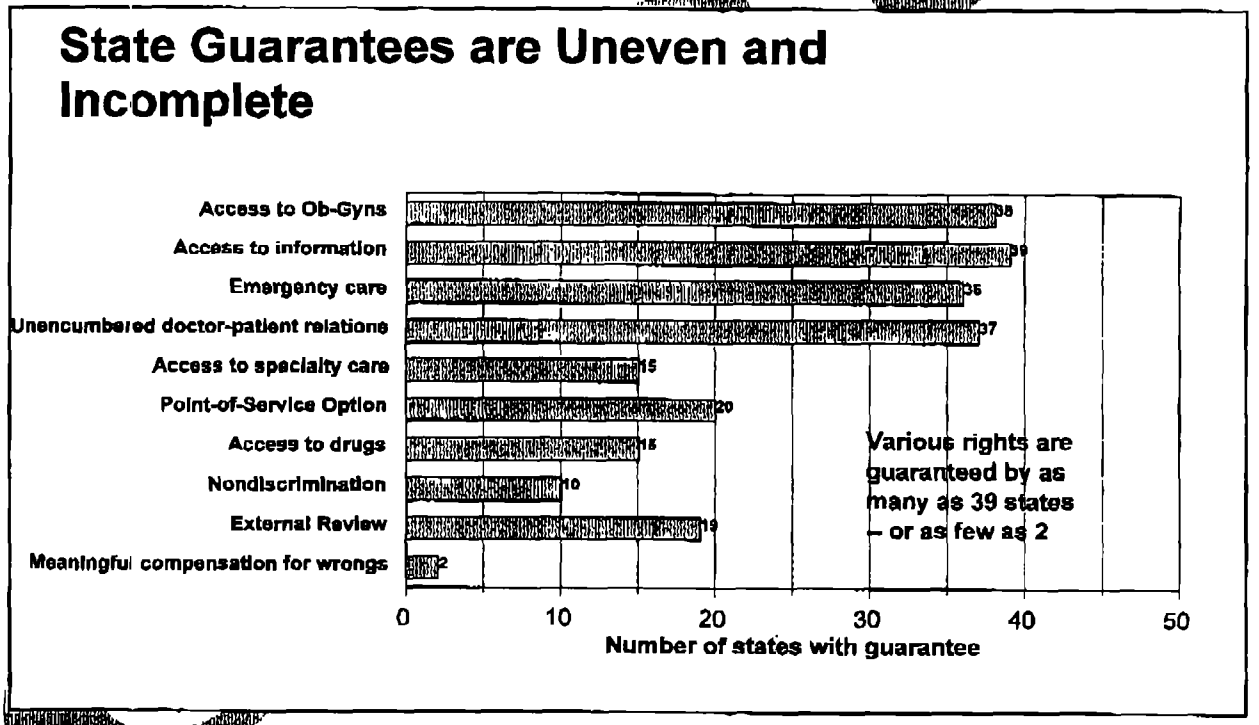
What the States Have Done

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

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



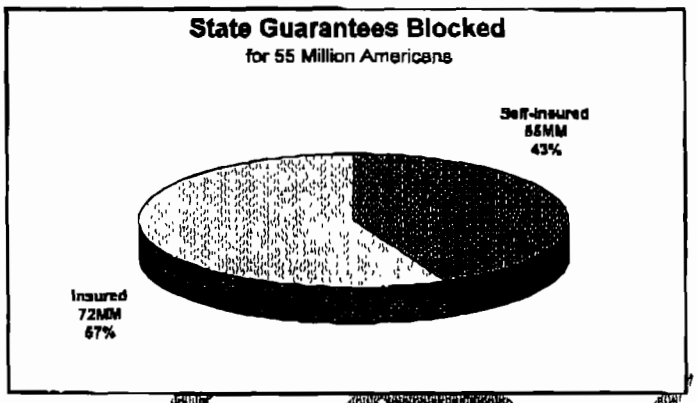
The most widely-guaranteed rights, which include the right to information, a woman's right to direct access to obstetricians and gynecologists, fair coverage for emergency care and freedom from interference in the doctor-patient relationship, are each guaranteed in 36 or more states. The remaining six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



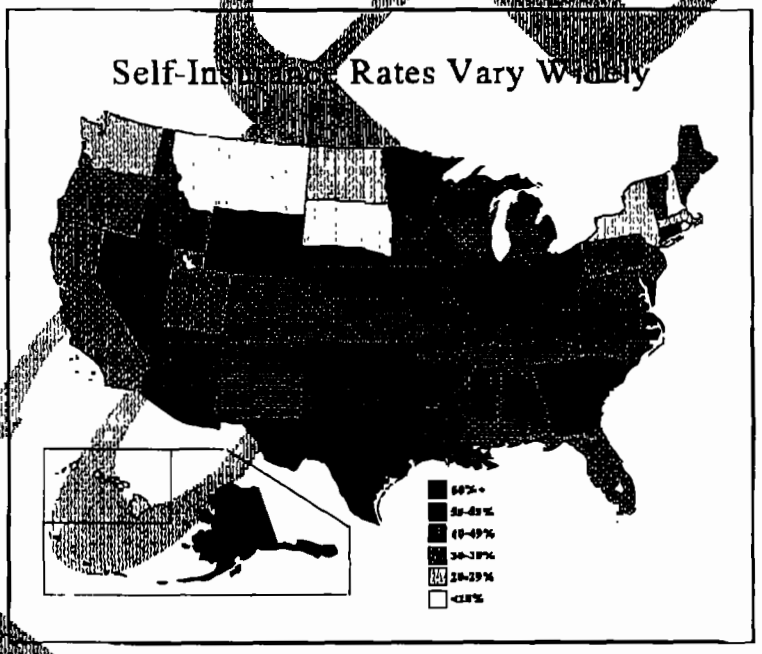
Why States Can't Do It All

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

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



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



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

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

Millions Lack A Guarantee Of Each Basic Patients Right

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

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

Baynor

external appeals
independance
standard of med necessity

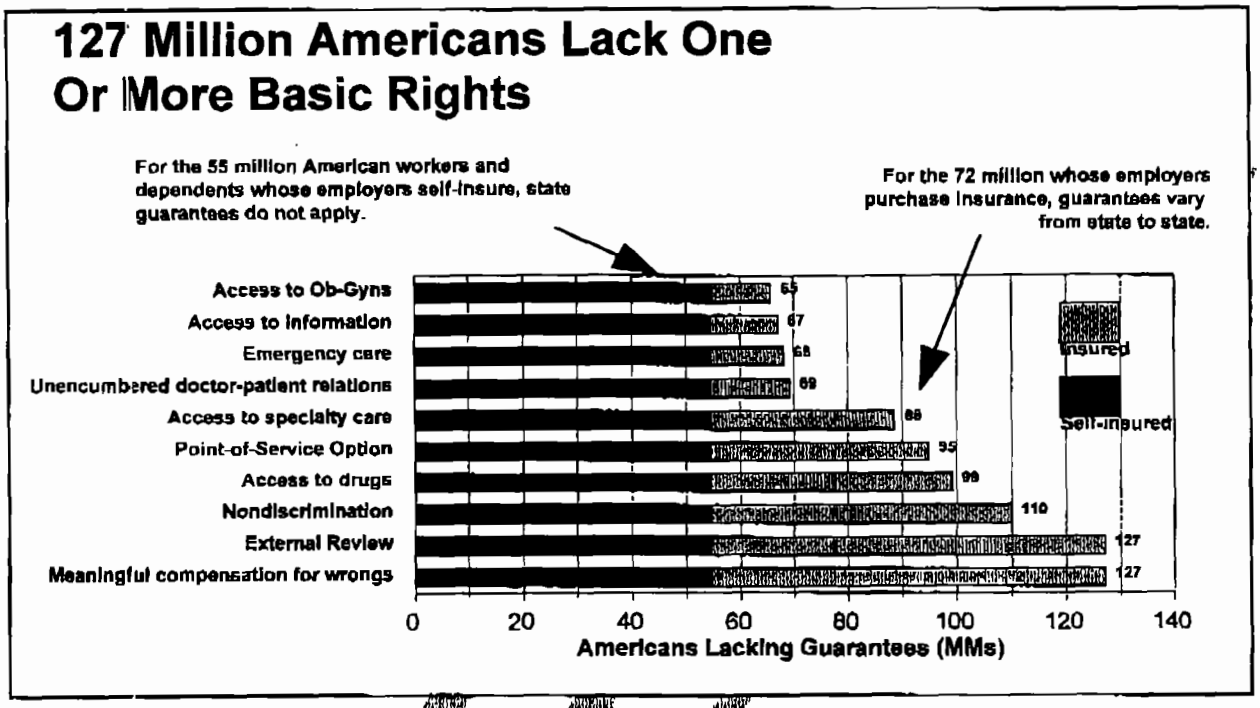
* list

specialist
ER
cont of care
pres. drugs on formulary

* ~~DR~~ physicians on ~~PBM~~ *

AHP

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



A Federal Patients' Bill of Rights Would Cover Everyone

Patients' rights should not depend on where you live or for whom you work. A strong and enforceable federal patients' bill of rights can provide security to everyone. It can secure key rights for those in self-insured plans, who have none today, and fill the gaps for those in state-regulated plans.

Timing FBOR

Senate
- bring bill before recess
- 15 amendments

Friday (am)

House
- slowing down
- Hastert – no floor action until after the 4th
- Commerce – Norwood isn't working w them; just Ed's workforce; OR join discharge petition

5. why Bayor is bad (HHS)
6. healthmarts (DOL)

To Do

1. mtg on this AFTER DOL / HHS discussion (private right of action)
2. write up on why strong enforcement is necessary (DOL)
3. step down paper (HHS)
4. external appeals DOL have list must in-

Americans With Health Coverage from Private-Sector Jobs

No State Guarantees Reach the Self-insured

	All plans	Insured plans	Self-insured plans	Percent self-insured
U.S.	126,840	72,292	54,548	43%
Alabama	2,047	1,105	942	46%
Alaska	187	62	125	67%
Arizona	1,869	934	935	50%
Arkansas	969	494	475	49%
California	13,973	9,781	4,192	30%
Colorado	1,892	1,097	795	42%
Connecticut	1,870	1,103	767	41%
Delaware	215	120	95	44%
Florida	5,820	3,783	2,037	35%
Georgia	3,360	1,344	2,016	60%
Hawaii	555	427	128	23%
Idaho	564	327	237	42%
Illinois	6,681	3,340	3,341	50%
Indiana	3,495	1,503	1,992	57%
Iowa	1,427	671	756	53%
Kansas	1,209	677	532	44%
Kentucky	1,822	929	893	49%
Louisiana	1,779	818	961	54%
Maine	592	302	290	49%
Maryland	2,359	1,274	1,085	46%
Massachusetts	3,207	2,341	866	27%
Michigan	5,553	2,943	2,610	47%
Minnesota	2,397	1,031	1,366	57%
Mississippi	1,097	570	527	48%
Missouri	2,432	1,240	1,192	49%
Montana	346	287	59	17%
Nebraska	786	385	401	51%
Nevada	868	391	477	55%
New Hampshire	668	581	87	13%
New Jersey	4,073	2,607	1,466	36%
New Mexico	596	304	292	49%
New York	7,583	5,460	2,123	28%
North Carolina	3,527	1,869	1,658	47%
North Dakota	240	178	62	26%
Ohio	6,302	2,773	3,529	56%
Oklahoma	1,375	619	756	55%
Oregon	1,540	986	554	36%
Pennsylvania	6,551	3,996	2,555	39%
Rhode Island	446	415	31	7%
South Carolina	1,768	690	1,078	61%
South Dakota	291	244	47	16%
Tennessee	2,368	1,279	1,089	46%
Texas	8,583	4,120	4,463	52%
Utah	1,035	631	404	39%
Vermont	297	178	119	40%
Virginia	3,236	1,650	1,586	49%
Washington	2,727	2,018	709	26%
West Virginia	758	394	364	48%
Wisconsin	2,900	1,653	1,247	43%
Wyoming	193	75	118	61%

① state law applies
② state law w/ caps
③ fed law
④ fed law w/ caps

States w/o remedies
Why standard is so much lower

who can do push back on this issue?
DOL — any consumer product

step down model
discussion about how far down we are going to go
Dingell
Norwood
Bayrnar — private rt of action more difficult / no govt intervention

State vs fed — more $
— less people

less $
more people

summary of problems w/ privacy