EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

July 12, 1999
(Senate)

STATEMENT OF ADMINISTRATION POLICY

(THIS STATEMENT HAS BEEN COORDINATED BY OMB WITH THE CONCERNED AGENCIES.)

S. 1344 - Patients' Bill of Rights Act of 1999
(Sens. Lott (R) MS and Nickles (R) OK)

The President strongly supports enactment of S. 1344, which is identical to S. 6, the original Senate Democratic Patients' Bill of Rights. This bill is a strong and enforceable patients' bill of rights. It includes important patient protections, such as the right to emergency care wherever and whenever a medical emergency arises; the right to access the specialists a patient needs; the right to ensure care is not disrupted during treatment; the right to a fair, unbiased internal, and independent external appeals process that allows patients to address their concerns and grievances; and the right to hold health plans accountable when their decisions cause patients serious harm or death. The President is particularly pleased that this legislation includes every patient protection recommended by the Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

Since November 1997, the President has been calling on the Congress to pass a strong, enforceable, and bipartisan patients' bill of rights. The outcome of the debate on S. 1344 will determine whether this Congress is serious about responding to the President's challenge. He is committed to working with members of both parties to pass a meaningful Patients' Bill of Rights this year; he is equally committed, however, to opposing legislation that is a Patients' Bill of Rights in name only.

Unfortunately, the Republican Leadership may seek to amend S. 1344 either by weakening key provisions of the bill or by substituting the provisions of S. 326, as reported by the Senate Committee on Health, Education, Labor and Pensions. S. 326 is seriously flawed. It covers too few people, it provides insufficient patient protections, and it contains inadequate enforcement provisions.

The shortcomings of the Republican leadership bill include:

It leaves tens of millions of Americans without adequate protections. By only providing all of its severely limited protections to self insured plans, it leaves over 110 million Americans unprotected. The President has repeatedly stated that all health plans should provide the protections in the Patients' Bill of Rights.

The Republican leadership bill either does not include or significantly waters down critical provisions that are necessary for high quality care. The following protections are either absent from this legislation or are insufficient:

External appeals and medical necessity. The weaknesses of the external appeals process are numerous and significant. For example, S. 326 would not ensure that arbitrary coverage denials by plans could be reversed by a fair appeals process because the plan's arbitrary definition of medical necessity would prevail. It also would not provide an independent appeals process, since the plan would be allowed to select the appeals entity. It would not ensure that appeals – including emergency appeals – are heard as swiftly as the patient's condition requires. Finally, S. 326 only would allow for external review for medical necessity provisions and not for other violations of the statute, such as failure to provide access to a specialist.

Emergency room services. The emergency room services provision of S. 326 is insufficient, as it does not: (1) prohibit plans from limiting access to an emergency room that is outside the plan's network; (2) prohibit plans from imposing higher cost-sharing requirements on patients who obtain emergency care without prior authorization; and (3) address coverage of post-stabilization care, which puts patients at risk for huge costs when a plan fails to timely respond to a request for post-emergency services.

Access to specialists. S. 326 does not ensure individuals with chronic, serious, and even life-threatening conditions direct access to specialists who are in the plan's participating physician network. In addition, if the plan has an insufficient number of specialists in their network, it has no provisions to ensure patients have access to specialists outside of the network. As such, patients would not be ensured access to needed specialists to treat conditions such as cancer or heart conditions.

Continuity of care protections. The bill does not have any continuity of care protections when an employer changes health plans. In cases when a doctor is dropped from a health plan these protections would apply only to individuals 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 dropped from the plan's network. For example, S. 326 would not protect a person with cancer from an abrupt disruption of their course of chemotherapy or radiation.

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For these reasons, the President agrees with virtually every major consumer organization, as well as almost every provider organization, such as the American Medical Association and the American Nurses Association, that S. 326 is insufficient and does not provide patients with the protections they need and deserve. As such, the Administration strongly opposes S. 326 as reported out of the Senate Committee on Health, Education, Labor and Pensions. If this legislation is passed and presented to the President, his senior advisers will recommend that he veto the bill.

Finally, the Administration would oppose the addition of irrelevant and unnecessary provisions that further undermine the chances for a bipartisan agreement on a Patients' Bill of Rights. It would be extremely unconstructive to amend this legislation with poorly designed options, such as an expansion of the Medical Savings Account Demonstration, that are not related to consumer protections, have received little or no serious and bipartisan review, and could undermine an already unstable insurance market.

While the Administration has serious concerns with S. 326, the President supports S. 1344 and remains committed to passing a strong, enforceable, and bipartisan Patients' Bill of Rights this year. His hope is that the Republican leadership will work with members of both parties who are committed to passing a meaningful Patients' Bill of Rights. Such legislation is long overdue. It is time to put progress ahead of partisanship and pass legislation that gives all Americans the health care protections they need and deserve.

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PBOR AMENDMENT SUMMARY [JULY 13 THROUGH NOON JULY 14]

The following votes were taken in this order:

1. ROBB AMENDMENT #1237 DEFEATED 48-52 - Repubs. crossing Chafee, Warner, Specter

Guaranteed access to ob/gyn for women and prevention of outpatient mastectomies [hospital stay following mastectomy determined by the patient's surgeon and not the HMO]

2. NICKLES #1238 ADOPTED 52-48 Repubs crossing Chafee, Fitzgerald, Abraham

Strikes the medical necessity definition and external appeals provision in S.6 and substitutes the external appeals section from S.326.

3. NICKLES #1236 ADOPTED 52-48 Repubs crossing Chafee, Specter, Fitzgerald

Amends S.6 as follows. If the bill results in insurance premium increases of 1% or more, or adds 100,000 or more to the uninsured rolls, the bill may not be implemented.

4. GRAHAM #1235 DEFEATED 47-53. Repubs crossing Chafee, Specter

Guarantees access to the nearest ER , even if out of plan.

5. NICKELS #1234 ADOPTED 53-47 Repubs crossing Chafee, Specter

Sense of the Senate amendment says that states should regulate HMOs, strikes the Kennedy/Daschle scope amendment, and provides full deductibility of insurance premiums for self-employed.

6. KENNEDY/DASCHLE #1233 ADOPTED BY VOICE VOTE AS AMENDED BY NICKLES #1234 SUBSTITUTE.

THE FOLLOWING AMENDMENTS ARE PENDING AS OF 1PM ON JULY 14:

1. DODD #1239

Provides access to clinical trials and requires HMOs to pay for routine services associated with clinical trials; also provides access to drugs off-formulary when medically necessary. [this is the same amendment Dodd offered in the HELP markup]

2. SNOWE #1239

Provides for increased hospital stays following mastectomy as determined by the surgeon and requires HMOS to pay for a second opinion for anyone with a cancer diagnosis. [This is ok on substance but it is a second degree to Dodd and would strike and substitute.]

The next Democratic amendments will be a second degree scope amendment to the Dodd as modified by Snowe and the Harkin-Bingaman amendment on access to specialists. We expect the next Republican amendments to be on ER and clinical trials.

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Guaranteeing Access to Specialists

The Senate Republican Leadership bill (S. 326) fails to guarantee persons with serious, on-going conditions the right to obtain care from appropriate specialists.

S.326 fails to guarantee patients the right to obtain care from the specialist they need. For example, under S. 326 a health plan could require a child with leukemia to see her general pediatrician for a referral every time she needed to visit the pediatric oncologist for her cancer treatment. Similarly, under this bill plans could require a man with diabetes to have his care coordinated by a primary care provider who lacks the necessary expertise to treat diabetes, rather than an endocrinologist.

S. 326 would also not require health plans to provide standing referrals to specialists for persons with life-threatening or disabling conditions and would not require plans to allow persons requiring specialized care over a prolonged period of time to designate a specialist as their primary care provider.

The Senate Republican Leadership bill does also not require plans to cover the services of a specialist who is not in the plan's network even if the network does not have a doctor who is able to treat the patient's condition. Plans cannot be expected to have specialists in their network who are able to treat each and every disease, but they should not be let off the hook to provide patients the care they deserve. Patients should not be denied quality care simply because a plan does not have the doctor qualified to treat their condition.

In contrast to the limitations in S. 326, members on both sides of the aisle have supported the Access to Specialists provision in S. 6.

S. 6 requires plans to allow persons with life-threatening, degenerative and disabling conditions to have access to standing referrals to specialists. In addition, S. 6 would require plans to allow such persons to designate a specialist as their primary care provider if the specialist could better coordinate their care. Persons with debilitating diseases, such as cancer or HIV/AIDS, have enough to worry about without having to fight their way through their health plans' maze of red tape.

S.6 also requires plans to allow patients access to non-participating providers if the plan's network is insufficient for their needs. Under these limited circumstances the plan must provide this access at no greater cost than if the benefit were obtained from participating providers. This will ensure that just because a plan does not have a doctor qualified to treat a type of cancer or a rare disease, patients do not have to suffer without quality care.

Ensuring Access to Emergency Care

The Senate Republican Leadership bill fails to provide adequate protections when patients are the most vulnerable, in emergency situations.

Medical emergencies can happen anywhere – not always near an emergency room that is covered by a patient's health plan. However, when patients have an emergency, such as a heart attack or a serious accident, waiting to get care can be a matter of life and death. Unfortunately, S.326 does not ensure that patients can get the care they need in these serious times. The bill does not prohibit plans from requiring enrollees to go to an emergency room that is in the plan's network. If an emergency happens away from home or near the wrong hospital, patients could be forced to travel long distances to a participating facility rather than go to the closest emergency room, causing delays that can be fatal.

S. 326 also allows plans to require higher cost sharing for enrollees that do not obtain prior authorization before seeking emergency care. Patients in the middle of an emergency could have to choose between dangerous delays in seeking care while waiting for health plan approval or paying excessive amounts for going directly to the emergency room. Of course, many patients are unconscious during an emergency and may not be in a condition to get authorization at all.

S. 326 also makes no provision for necessary care following the initial stabilization of a patient. Many times critical care is needed in a timely manner even after the initial stabilization in an emergency room. However, under the Republican Leadership bill, patients are at risk for devastating bills for treatment when a plan fails to respond in a timely fashion to a request for post emergency services.

The numerous serious flaws in S.326 could prevent patients from receiving the essential timely care they need in a medical emergency.

In contrast, members on both sides of the aisle have supported the protections in S. 6 that assure patients can get emergency care when and where the need arises.

S. 6 ensures that patients can get the emergency care they need when and where the need arises. It ensures that all health plans must allow patients the ability to get necessary emergency care from any emergency department, in or out of the plan's network and without prior authorization, if a prudent layperson believes that such care is necessary; it ensures that patients can seek emergency care for severe pain, if a prudent layperson would have believed such pain to be a real emergency; it ensures patients can get emergency care without excessive cost sharing; and it ensures a smooth transition between emergency care and the follow-up treatment provided by the plan. These are protections that we have already guaranteed for Medicare beneficiaries and that all enrollees should receive.

Keeping Your Doctor Through Critical Treatments By Ensuring Strong Continuity of Care Protections

The Senate Republican Leadership's bill would force many patients to find a new doctor in the middle of a course of treatment when their doctor is dropped from their plan or their employer changes plans.

S. 326 fails to protect any patients from the disruptions in the middle of treatment when their employer changes health plans. This means that patients in the middle of a course of treatment, such as cancer or a pregnancy, could be forced to switch doctors during the course of care if their employer switches health plans. Moreover, the bill only protects some patients whose doctor is dropped from their plan's network - those who are in institutions, pregnant, or terminally ill. It does not protect people in the middle of a course of treatment upon which their lives depend, unless they also happen to be in a hospital. Therefore, S.326 would not protect a person in the middle of chemotherapy or radiation, and it would not protect an accident victim in the middle of extensive rehabilitation.

Even this so-called protection, however, does not last long enough to assure full protections during the course of a treatment – but instead only "up to ninety days." It does not protect hospitalized patients for the duration of their hospitalization. It would force a terminally ill person to switch doctors or nursing homes during the last few weeks of their lives.

Members on both sides of the aisle support real continuity of care protections that apply to all patients undergoing a course of treatment.

S.6 protects all patients who are in the middle of a course of treatment for a chronic or disabling condition, whether they are forced to changed plans or their doctor is dropped from their plan's network. S.6 also requires a transitional period of care from the treating provider that is sufficiently long to address patients' needs.

Holding Health Plans Accountable When Their Decisions Cause Patients Serious Harm

The Senate Republican Leadership bill does not hold health plans accountable for harm caused to patients when they wrongfully fail to provide covered, medically necessary care.

S.326 does not include an enforcement mechanism to ensure recourse for patients who have been harmed as a result of a health plan's wrongful actions. Today, ERISA shields health plans from accountability for failing to deliver promised care -- ERISA preempts state laws that would impose such accountability, and fails to replace those state laws with any federal meaningful accountability. Under ERISA, enrollees who are injured when a health plan withholds covered care can obtain only the benefit they were denied, not compensation for harm resulting from that denial. The Senate Leadership Bill fails to hold plans accountable. It does not remove the ERISA shield, and does not adds an effective accountability mechanism into ERISA.

S. 326 adds the failure of a health plan to abide by the decision of external reviewer to allowable legal actions under ERISA. However, it does not allow enrollees to obtain compensation for actual harm incurred, they can only receive the benefit they were denied. Health plans remain immune from responsibility for their own actions.

Under this flawed approach, for example, a woman's health plan may deny her a critical breast cancer test that her doctor thinks she should have. She may appeal and appeal and only later discover that she does in fact have cancer, that it has spread during this delay, and that it is no longer treatable. In this case, the woman could sue her health plan, but if she wins the only remedy she is entitled to is the cost of the breast cancer test she was denied in the first place. This unfair denial may well cost the patient her life, but she can only receive the small fee of a test as compensation.

Members on both sides of the aisle support health plan accountability through appropriate recourse for injured enrollees.

S.6 would make health plans accountable by removing the ERISA shield, and allowing states to determine when and how health plans should compensate injured enrollees.

All Americans Deserve the Protections of a Comprehensive Patients' Bill of Rights

The Senate Republican Leadership's bill would not provide any protections to 110 million Americans.

Not only does S.326 ignore many of the fundamental protections that all Americans in managed care need, but it fails to provide what protections it does offer to the majority of insured Americans. S. 326 only applies most of its consumer protection provisions to self-funded ERISA plans. By taking this approach, S. 326 fails to guarantee a floor of consumer protection to 110 million insured health care consumers.

Who is left out? Many of the most vulnerable patients -- the people who purchase insurance themselves without their employer's help and millions of Americans who work for small employers who provide insurance benefits. These are the Americans who do not have employee benefit managers and large employers looking out for their interests. These are the Americans most at the mercy of their HMOs.

Members on both sides of the aisle believe that all Americans deserve the protections of a comprehensive patients' bill of rights to ensure that health plans deliver the care they promise their patients.

All of the comprehensive protections in S.6 apply to patients in all ERISA plans, including insurance purchased without employer assistance, regardless of how the employer arranges for the benefits. Furthermore, S.6 builds on the success of the Kassebaum-Kennedy model, which has provided a federal floor of insurance protections without interfering with states' ability to protect their consumers. Under Kassebaum-Kennedy, States can provide additional protections for consumers, but no person is left without rights because their state has failed to act.

Independent Review of Health Plan Decisions

The Senate Republican Leadership's bill pretends to offer an "independent" review of health plan decisions, but in fact completely stacks the deck in the plans' favor.

The weaknesses of the external appeals process are numerous and significant. First of all, S.326 would not ensure that arbitrary coverage denials by health plans could be reversed by a fair appeals process because the plan's arbitrary definition of medical necessity would prevail. External reviewers are bound by the definitions of medical necessity given by the plan, however flawed or random, rather than any clinical evidence or good professional practice. For example, if a patient's health plan denies her doctors' recommendation for heart surgery and the patient appeals this decision, the independent review entity may be forced to deny the surgery because it is bound by the health plan's definition of medically necessity.

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Members on both sides of the aisle support an external review process that is truly independent and ensures that patients will get the care they were promised when they enrolled in their health plan.

S.6 will ensure that patients have a strong independent external reviewers by taking the decision about whether a case is eligible for an external appeal away from the health plan. It will allow external reviewers to make their own independent judgement about what care is medically necessary rather than rubber stamp the plan's decision. S.6 will provide options and safeguards for choosing the external review entity and will not leave this decision solely up to the plan. In addition, S.6 will not allow reviewers to be affiliated with the employer or plan sponsor and will eliminate barriers to external review by lifting the short deadline for requesting external review. These are protections that we have already guaranteed for Medicare beneficiaries and that all enrollees should receive to ensure that patients who believe that their health plan has unfairly denied them the treatment they need and deserve can access fair process to appeal this decision.

Guaranteeing Access to Specialists

The Senate Republican Leadership bill (S. 326) fails to guarantee persons with serious, on-going conditions the right to obtain care from appropriate specialists.

S.326 fails to guarantee patients the right to obtain care from the specialist they need. For example, under S. 326 a health plan could require a child with leukemia to see her general pediatrician for a referral every time she needed to visit the pediatric oncologist for her cancer treatment. Similarly, under this bill plans could require a man with diabetes to have his care coordinated by a primary care provider who lacks the necessary expertise to treat diabetes, rather than an endocrinologist.

S. 326 would also not require health plans to provide standing referrals to specialists for persons with life-threatening or disabling conditions and would not require plans to allow persons requiring specialized care over a prolonged period of time to designate a specialist as their primary care provider.

The Senate Republican Leadership bill does also not require plans to cover the services of a specialist who is not in the plan's network even if the network does not have a doctor who is able to treat the patient's condition. Plans cannot be expected to have specialists in their network who are able to treat each and every disease, but they should not be let off the hook to provide patients the care they deserve. Patients should not be denied quality care simply because a plan does not have the doctor qualified to treat their condition.

In contrast to the limitations in S. 326, members on both sides of the aisle have supported the Access to Specialists provision in S. 6.

S. 6 requires plans to allow persons with life-threatening, degenerative and disabling conditions to have access to standing referrals to specialists. In addition, S. 6 would require plans to allow such persons to designate a specialist as their primary care provider if the specialist could better coordinate their care. Persons with debilitating diseases, such as cancer or HIV/AIDS, have enough to worry about without having to fight their way through their health plans' maze of red tape.

S.6 also requires plans to allow patients access to non-participating providers if the plan's network is insufficient for their needs. Under these limited circumstances the plan must provide this access at no greater cost than if the benefit were obtained from participating providers. This will ensure that just because a plan does not have a doctor qualified to treat a type of cancer or a rare disease, patients do not have to suffer without quality care.

Ensuring Access to Emergency Care

The Senate Republican Leadership bill fails to provide adequate protections when patients are the most vulnerable, in emergency situations.

Medical emergencies can happen anywhere – not always near an emergency room that is covered by a patient's health plan. However, when patients have an emergency, such as a heart attack or a serious accident, waiting to get care can be a matter of life and death. Unfortunately, S.326 does not ensure that patients can get the care they need in these serious times. The bill does not prohibit plans from requiring enrollees to go to an emergency room that is in the plan's network. If an emergency happens away from home or near the wrong hospital, patients could be forced to travel long distances to a participating facility rather than go to the closest emergency room, causing delays that can be fatal.

S. 326 also allows plans to require higher cost sharing for enrollees that do not obtain prior authorization before seeking emergency care. Patients in the middle of an emergency could have to choose between dangerous delays in seeking care while waiting for health plan approval or paying excessive amounts for going directly to the emergency room. Of course, many patients are unconscious during an emergency and may not be in a condition to get authorization at all.

S. 326 also makes no provision for necessary care following the initial stabilization of a patient. Many times critical care is needed in a timely manner even after the initial stabilization in an emergency room. However, under the Republican Leadership bill, patients are at risk for devastating bills for treatment when a plan fails to respond in a timely fashion to a request for post emergency services.

The numerous serious flaws in S.326 could prevent patients from receiving the essential timely care they need in a medical emergency.

In contrast, members on both sides of the aisle have supported the protections in S. 6 that assure patients can get emergency care when and where the need arises.

S. 6 ensures that patients can get the emergency care they need when and where the need arises. It ensures that all health plans must allow patients the ability to get necessary emergency care from any emergency department, in or out of the plan's network and without prior authorization, if a prudent layperson believes that such care is necessary; it ensures that patients can seek emergency care for severe pain, if a prudent layperson would have believed such pain to be a real emergency; it ensures patients can get emergency care without excessive cost sharing; and it ensures a smooth transition between emergency care and the follow-up treatment provided by the plan. These are protections that we have already guaranteed for Medicare beneficiaries and that all enrollees should receive.

Keeping Your Doctor Through Critical Treatments By Ensuring Strong Continuity of Care Protections

The Senate Republican Leadership's bill would force many patients to find a new doctor in the middle of a course of treatment when their doctor is dropped from their plan or their employer changes plans.

S. 326 fails to protect any patients from the disruptions in the middle of treatment when their employer changes health plans. This means that patients in the middle of a course of treatment, such as cancer or a pregnancy, could be forced to switch doctors during the course of care if their employer switches health plans. Moreover, the bill only protects some patients whose doctor is dropped from their plan's network - those who are in institutions, pregnant, or terminally ill. It does not protect people in the middle of a course of treatment upon which their lives depend, unless they also happen to be in a hospital. Therefore, S.326 would not protect a person in the middle of chemotherapy or radiation, and it would not protect an accident victim in the middle of extensive rehabilitation.

Even this so-called protection, however, does not last long enough to assure full protections during the course of a treatment – but instead only "up to ninety days." It does not protect hospitalized patients for the duration of their hospitalization. It would force a terminally ill person to switch doctors or nursing homes during the last few weeks of their lives.

Members on both sides of the aisle support real continuity of care protections that apply to all patients undergoing a course of treatment.

S.6 protects all patients who are in the middle of a course of treatment for a chronic or disabling condition, whether they are forced to changed plans or their doctor is dropped from their plan's network. S.6 also requires a transitional period of care from the treating provider that is sufficiently long to address patients' needs.

Holding Health Plans Accountable When Their Decisions Cause Patients Serious Harm

The Senate Republican Leadership bill does not hold health plans accountable for harm caused to patients when they wrongfully fail to provide covered, medically necessary care.

S.326 does not include an enforcement mechanism to ensure recourse for patients who have been harmed as a result of a health plan's wrongful actions. Today, ERISA shields health plans from accountability for failing to deliver promised care -- ERISA preempts state laws that would impose such accountability, and fails to replace those state laws with any federal meaningful accountability. Under ERISA, enrollees who are injured when a health plan withholds covered care can obtain only the benefit they were denied, not compensation for harm resulting from that denial. The Senate Leadership Bill fails to hold plans accountable. It does not remove the ERISA shield, and does not adds an effective accountability mechanism into ERISA.

S. 326 adds the failure of a health plan to abide by the decision of external reviewer to allowable legal actions under ERISA. However, it does not allow enrollees to obtain compensation for actual harm incurred, they can only receive the benefit they were denied. Health plans remain immune from responsibility for their own actions.

Under this flawed approach, for example, a woman's health plan may deny her a critical breast cancer test that her doctor thinks she should have. She may appeal and appeal and only later discover that she does in fact have cancer, that it has spread during this delay, and that it is no longer treatable. In this case, the woman could sue her health plan, but if she wins the only remedy she is entitled to is the cost of the breast cancer test she was denied in the first place. This unfair denial may well cost the patient her life, but she can only receive the small fee of a test as compensation.

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All Americans Deserve the Protections of a Comprehensive Patients' Bill of Rights

The Senate Republican Leadership's bill would not provide any protections to 110 million Americans.

Not only does S.326 ignore many of the fundamental protections that all Americans in managed care need, but it fails to provide what protections it does offer to the majority of insured Americans. S. 326 only applies most of its consumer protection provisions to self-funded ERISA plans. By taking this approach, S. 326 fails to guarantee a floor of consumer protection to 110 million insured health care consumers.

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Members on both sides of the aisle believe that all Americans deserve the protections of a comprehensive patients' bill of rights to ensure that health plans deliver the care they promise their patients.

All of the comprehensive protections in S.6 apply to patients in all ERISA plans, including insurance purchased without employer assistance, regardless of how the employer arranges for the benefits. Furthermore, S.6 builds on the success of the Kassebaum-Kennedy model, which has provided a federal floor of insurance protections without interfering with states' ability to protect their consumers. Under Kassebaum-Kennedy, States can provide additional protections for consumers, but no person is left without rights because their state has failed to act.

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