

Withdrawal/Redaction Sheet

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. article	re: phone number (partial) (1 page)	n.d.	P6/b(6)
001b. memo	Nicole Bennett to Karen Coleman and Barbara Wooley re: Patients' Bill of Rights Rally (partial) (1 page)	04/02/1999	P6/b(6)

COLLECTION:

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

FOLDER TITLE:

PBOR [Patients' Bill of Rights] [Folder 7]

2012-0463-S

rc811

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.

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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]



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.

Its enforcement provision is inadequate to ensure that the patient protections are real. The limited rights outlined in S. 326 are not meaningful because patients who have died or been seriously harmed by wrongful actions by health plans would have no ability to seek compensation for their injuries.

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.

* * * * *

Laurie McGinley

8620340

6/2/13

Mike Miller
Miller and Associates
703-519-8080

He handled a case concerning a 16-year-old girl from Stafford, Va. I have included part of an article on the case that was highlighted in *SmartMoney*. If she cannot speak publicly about the situation, perhaps Mr. Miller has other suggestions.

Dan Rosenblum
Hematology/Oncology M.D.
Kensington, MD
301-942-2212

I honestly cannot remember why I had him listed on our contact sheet. I guess you could just call him and say that you received his name from the Patient Access Coalition as an individual interested in speaking publicly about patient protection legislation.

Mark Hiepler, Atty
805-988-5833

He has been very outspoken on the issue of patient protections. There was some situation with his sister who was denied a needed service and subsequently died. He is difficult to reach and is located in California - but he is definitely worth calling.

evitably themselves apparently see no problem in this lack of focus on children. "Kids don't always need someone who specializes in pediatrics," says Arlen Collins, senior medical consultant at Scherer Management and himself a pediatrician. "Parents just think they do." (Not all experts agree: "A tracheotomy on a two-year-old is a completely different procedure than a tracheotomy on an adult, I can assure you," says Dr. Vincent Riccardi, a pediatrician and head of American Medical Consumers, a for-profit group that helps patients deal with managed-care plans.)

"Kids are ignored for simple economic reasons," explains David Lanusky. Children younger than 18 make up only about 20 to 25 percent of the general population. And the majority of them are basically healthy. Unlike heart-attack patients or the elderly, who account for huge chunks of national spending on health care, only 5 percent of all children account for about 90 percent of all pediatric health care expenditures. Those that do fall ill tend to do so with rare and difficult-to-treat conditions such as cystic fibrosis, congenital heart problems or spina bifida. These are the kinds of illnesses that require a battery of expensive specialists administering continuing care throughout a child's life—in other words, the kind of cases that are anathema to managed care's cost-conscious mandate.

In a rare look at how HMOs treat seriously ill children, Elizabeth Jameson, a senior analyst at the Institute for Health Policy Studies at the University of California at San Francisco School of Medicine, a leading health-policy group, coextensively surveyed 59 pediatricians, social workers and nurses who treat large numbers of children with three serious childhood disorders: sickle-cell anemia, spina bifida and craniofacial abnormalities. Jameson looked exclusively at HMOs that hold outside contracts with doctors, as opposed to "closed end" plans, which require all doctors to be on staff.

The forthcoming study, says Jameson, points to one overwhelming conclusion: Children in these managed-care plans are far less likely to gain access to care consistent with recognized clinical guidelines than are children insured by Medi-Cal and California Children's Service, two state public health plans for low-income families. "The results of my study are incredibly dramatic," says Jameson. "Kids who are low-income, who are qualified for state aid, are receiving better care than those in HMOs."

Kids with sickle-cell anemia, for instance, often avoid problems related to chronic lung disease by undergoing a series of pulmonary tests. But these tests are routinely denied by managed-care plans, according to Jameson's survey results, despite their preventative nature and the fact that these procedures fall under accepted medical guidelines for treating sickle-cell-anemia patients. Meanwhile, children with public insurance in California routinely receive these tests.

While Jameson's study deals exclusively with treatment of chronically ill children, in general there are three specific ways in which HMOs work that tend to undermine their potential to give even healthy children the level of pediatric care your family expects.

First is the HMO's constant restraint in allowing primary-care physicians to conduct costly tests and recommend specialists. This, of course, is a problem with adults too. But the situation is more acute with kids, because their ailments are often a mystery to doctors untrained in pediatrics or family care. "What sets children apart as patients," says Jameson, "is that they must be diagnosed and treated in the context of their rapid and continuous growth and development."

Consider 16-year-old Paige Lancaster from Stafford, Va. She started having severe headaches back when she was 12 years old. Paige was covered by her father's insurance with Kaiser Permanente of the Mid-Atlantic States. For more than a year Paige's mother, Barbara Lancaster, would take her daughter every few months to her Kaiser pediatrician, Dr. Corder Campbell, pleading with him to help find out what was causing Paige's headaches, nausea and bloodshot eyes. But the doctor insisted that this was normal for some preteen girls and prescribed adult dosages of migraine medicine. Lancaster, concerned with her daughter's complaints of pain, short-term memory loss and dramatically slipping grades, continued to lobby her doctor. "Should she see someone else? Have some tests?" she asked him. Each time, Lancaster says, he dismissed the problem as misdiagnosis.

By the time Paige was a freshman in high school, she was routinely vomiting from the headaches. Her learning problems were so extreme Paige was placed in a special program at school. Her teachers, wanting to rule out any physical reasons for Paige's difficulties, kept asking Paige's mom what tests had been done. The school psychologist even wrote a letter to Campbell requesting an MRI and an EEG. According to Lancaster, Campbell's response was less than enthusiastic. "I'd like to report them for practicing medicine without a license," Lancaster remembers him saying. When he did finally order the tests, the MRI showed Paige had a cyst that originated from a tumor covering 40 percent of her brain. It took two surgeries and severe radiation to get rid of most of it. And although she is recovering, Paige and her mom are still not sure to what extent Paige may be suffering permanent damage. "It just keeps hitting me in the face that Paige didn't have to

'Of course you want the most qualified doctors when it comes to your loved ones. But the most qualified isn't always what you'll get. That's what goes along with lower costs.'



The Christian HMO was fined \$500,000 because of the way it handled Carly's treatment.

How to Choose the Right HMO

HEALTH

The good news about HMOs: If you're stuck in a poor plan these days, chances are you can get into a better one. Employers who once restricted you to just one HMO may now offer an alternative or two. In fact, it's not uncommon for a family with two working spouses to have as many as four different plans from which to choose.

The bad news: The complexities of analyzing the differences among the various options and figuring out which is best for your family may make you long for the days of "take it or leave it."

Here's a quick primer on what to expect when you're trying to pick the right managed-care plan, and how to make the most of your managed-care plan options.

Deciphering the Code

Don't think you're necessarily going to be offered an HMO with its own staff of doctors on call. Increasingly, you'll be asked to choose among an IPA, a PPO and a POS. Huh?

Here's what it all means. An IPA, or independent practice association, is a network of doctors, hospitals and labs that are paid a set fee by the HMO and that, in turn, have some leeway in how treatments are handled and costs contained. A PPO, or preferred-provider organization, is what some insurance companies have devised as their own entry into the HMO market. These groups contract with specific doctors and hospitals at a discounted rate. A newer option, a sort of hybrid of managed care and a traditional indemnity plan, is a POS (point-of-service) plan. This allows you to see a doctor outside the HMO—but at the cost of higher deductibles and copayments.

Wait, there's more. Another trend is for doctors and/or hospitals to band together, create their own managed-care operation and then sell this service directly to self-insured employers. This option—which, fortunately, does not have its own acronym yet—has led to the creation of a handful of pediatric HMOs.

So which plan is best for you and your family? Most parents may find that a POS plan, with its greater flexibility, is the way to go. But there's a catch here. A good POS plan depends on the HMO's offering top-rate physicians and access to high-quality routine and emergency health care. If it doesn't, parents will find themselves consistently going off plan and paying higher rates. If you're deciding between a mediocre HMO with the POS option and a top-ranking HMO with a network of well-qualified pediatric specialists, you may be better off in the latter.

Which leads to our next point...

Evaluating Your HMO

Access to care is the key issue in determining which plan is best for you. Unfortunately, you won't find the answer in a plan's marketing materials or your company's employee handbook. For more revealing is the complete list of doctors affiliated with each plan. (Get a copy from your benefits department.) If you're lucky, your current physician and pediatrician may already be part of the HMO. (It's not unusual for doctors to sign up with as many as 25 or 30 plans.) If yours is not among them, it's time for a little research.

Call a customer-services representative at each of the plans you're considering and ask the following questions.

How many pediatric specialists are part of the network? Experts say, at a minimum, you should have access to a pediatric orthopedist, neurologist, cardiologist, gastroenterologist and ear, nose and throat doctor. If your health plan doesn't have the pediatric specialists you need, your primary-care physician may balk at referring you to a more costly doctor outside the plan.

Which hospitals and emergency rooms are you contracted with? It is essential that your HMO be affiliated with a local children's hospital that offers pediatric emergency room care. Beware an answer that leaves room for loopholes. "In an effort to market to more parents, HMOs have been saying they're affiliated with children's hospitals that aren't really children's hospitals," says Peter Willson, vice president for public policy at the National Association of Children's Hospitals. So ask for the specific name of the children's hospital and call that hospital directly to make sure that it does, indeed, specialize in pediatric care. Also ask your potential primary-care physician if he or she routinely makes referrals to that specific facility. "Just because a hospital is affiliated with an HMO doesn't mean that is the hospital your doctor will send you to," says Willson.

How are emergency-room visits covered? There are two policies managed-care companies use to determine whether they'll pay an ER fee. Diagnostic coverage means the HMO will pay the bill only if you got prior approval or if, after the fact, the plan determines the situation was truly an emergency. In other words, you'll be stuck with the bill for the bruised knee that you thought was broken. Preferable is the "prudent layperson" policy, which is as simple as it sounds: If an average person thinks it's an emergency, it's covered. That's what you want.

The complexities of deciding among the various HMO options available to you may well make you long for the days of 'take it or leave it.'

—WJK

Don't expect to get services you're not paying for, says one HMO official: 'It's like going to McDonald's and ordering a cheeseburger. If you want lettuce and tomato, order the Big Mac.'

contracted with the same HMO. Unfortunately for the Christies, however, Shochat was a member of a different independent practice association, or IPA, than the one the Christies had signed up with when they joined TakeCare.

"What's going on?" Harry Christie asked Carley's primary-care doctor. He says her only response was to defend the adult urologist assigned to the case. He's one of the specialists in the medical group they chose under contract with their HMO, he says she explained. Dr. Shochat simply wasn't on that list.

No way, thought Christie. "I can't risk my daughter's life by placing her in the care of someone not qualified." So Christie told the primary-care physician he was going to make an appointment with Dr. Shochat. "You have to get us a referral," he told Carley's doctor.

When the HMO refused to pay, the Christies appealed several times, then ultimately took the case to arbitration. The committee ruled that TakeCare had to pay the bill. The Christies also filed a complaint with the California Department of Corporations, the state agency that oversees HMOs. The department fined TakeCare \$300,000 three years after Carley's surgery, the largest fine ever imposed on a California managed-care organization.

TakeCare, after a series of HMO mergers, is now part of PacificCare, which won't comment on the case. But Mark Reagan, an attorney with Foley Lardner Weisburg & Aronson, who represented TakeCare in the case, stands

by the plan's initial endorsement of the adult urologist. "There is evidence out there that you don't have to know Wilms' tumor to treat it," says Reagan, "but you do need experience in removing kidneys. The TakeCare doctor assigned to the case was an expert in these surgeries." But was he the most qualified? "Of course you want the most qualified doctors when it comes to your loved ones," says Reagan. "But the most qualified isn't always what you'll get. That's what goes along with lower costs."

Another factor that leads HMOs to falter in their treatment of children is this: Most of their policies are based largely on adult care, which may not be appropriate for children. In Jameson's study, for example, one of the pediatricians surveyed referred a lupus patient to an adult urologist within his plan for a kidney biopsy. The adult urologist performed an open-back biopsy on the child. But this type of biopsy is inappropriate for children—a pediatric urologist would have performed a less invasive procedure. The open-back would result in serious complications from the anesthesia required for the procedure. Jameson also found numerous examples of spina bilda patients who were denied a wheelchair or set of braces. HMO policies often provide for these devices only once or twice during a patient's lifetime. That may be fine for adults, but it doesn't take into account children's constant need for new devices as they grow.

Denise Tyrivier knows what it's like to deal with plans that don't pay enough attention to child development. The Orlando mother of two switched her family to an HMO just this past June, when her husband's employer started offering the option. Tyrivier's seven-year-old daughter, Megan, has an autism-related disorder, and her constant care has meant plenty of medical bills. The HMO looked like the perfect, less expensive option.

Like a lot of children with this condition, Megan has trouble focusing her eyes. An optometrist using special exercises may be able to help train her vision. But the doctor group affiliated with the Tyriviers' HMO, Florida Hospital Healthcare Systems, turned down the request. Why? The HMO, American Medical Healthcare, will not cover what are called "developmental treatments."

Stunned by the refusal, Denise Tyrivier pulled out her plan's certificate of group coverage and studied it carefully. She found out her health plan did not, indeed, cover treatments such as "learning-disabled testing... speech therapy for other than acute traumatic injury or physical functional defect incurred while covered under this certificate; vision therapy, including eye exercises..." Says Tyrivier: "There it was in black and white. I couldn't believe I hadn't paid attention before."

"Most plans don't cover developmental programs," explains Dr. Edward Cabrera, chief executive of American Medical Healthcare, "because it falls in the vague category of 'not medically necessary.' It may help the individual, but

	Atlanta, Ga.	Los Angeles, Calif.	San Diego, Calif.	San Francisco, Calif.	San Jose, Calif.
Well-baby pediatric visit	\$54.00	\$85.00	\$70.00	\$72.00	\$45.00
Initial eye exam	74.00	84.00	68.00	68.00	78.00
Initial dental exam	61.00	84.00	181.00	12.00	188.00
Examinations for the first four years	188.00	188.00	188.00	88.00	112.00
Set up program	2,788.00	2,988.00	2,788.00	4,188.00	2,788.00
Immunizations and physical required before start of kindergarten	121.00	91.00	121.00	131.00	111.00
Admission fee	11.00	15.00	14.00	11.00	12.00
Developmental visit for one child	68.00	78.00	85.00	88.00	88.00
Home visit (for behavioral problems, of course)	4,708.00	3,000.00	4,388.00	3,800.00	3,000.00
At-home drug test	58.00	88.00	81.00	81.00	88.00
Lab fees (annual for year)	584.00	380.00	484.00	380.00	380.00
Monthly visit to doctor (for kid)	85.00	75.00	85.00	180.00	180.00
Weekly visit to doctor (for parent)	88.00	88.00	108.00	108.00	108.00
Weekly visit to family therapy (for the whole gang)	88.00	70.00	88.00	188.00	108.00

It may not solve a medical problem. It's just not in her plan, so it's not something she bought. It's kind of like going to McDonald's and ordering a cheeseburger. If you want lettuce and tomato, you have to order the Big Mac." ("Plans constantly use this reasoning to deny care, saying a procedure or treatment isn't medically necessary," says Carol O'Brien, an attorney at the American Medical Association. Worse, she adds, some plans have been gravitating toward even more ambiguous language, stating that they will cover "only what the plan deems medically reimbursable.")

Fortunately, cases like the Tyrtovs are starting to put a long-overdue spotlight on the problems with pediatrics and managed care. The industry itself has come up with several encouraging initiatives, such as the pediatric Asthma Patients Management Program of U.S. Healthcare (now part of Aetna), under which kids with asthma—one of the most common pediatric ailments—experienced a 25 percent decrease in hospital admissions and a 60 percent decrease in emergency-room visits. Meanwhile, a subsidiary of United Healthcare has just announced its nationwide pediatric transplant network, which includes access to specialists from all over the country in pediatric heart, lung, liver, kidney and bone-marrow transplants.

The American Association of Health Plans has stepped up its efforts to track medical outcomes in pediatric care, says President Karen Ignagni. The association recently launched a research institute that will, among other things, look at children's special needs.

Perhaps most promising, the Foundation for Accountability, David Lansky's organization, is about a year into a two-year project that will pinpoint a group of consistent pediatric measurements that companies can use to evaluate how well managed care treats children. And he'll be working with the NCQA to implement these measures. Meanwhile, the NCQA is planning to release data on treatment of ear infections—a ubiquitous pediatric problem—next year. Also, federal and state governments have stepped up efforts to regulate managed-care companies. States have passed more than 200 laws on managed care this year, covering everything from grievance procedures to who can sue.

Recognizing that more regulation is probably unavoidable, Kaiser Permanente, HIP Health Insurance Plans and Group Health Cooperative of Puget Sound—three large nonprofit HMOs—have banded together with consumer organizations to come up with 18 enforceable guidelines for managed care, among them a full disclosure of how a health plan's compensation system is structured.

So what to do if your HMO denies payment for a treatment you think your child needs or the services of a doctor who's not covered in your plan? Should you just go ahead and do it anyway, and live with the fact that the money will come out of your own pocket?

That, apparently, is what many HMOs may well be counting on. Keep in mind that in order to keep costs down, medical directors of HMOs may sometimes automatically deny a certain number of procedures each month, says Linda Peeno, a former medical reviewer at Humana who is now a full-time advocate for health care reform. "They don't really pay attention to the specifics of each case," says Peeno. "And they figure most people won't fight."

But all HMOs are required to have a grievance or appeals process that allows customers to question the plan's denial of coverage. The appeals process is actually a plus of managed care. There's nothing like it at traditional fee-for-service insurers. And it can often work. HMOs have become more generous with appeals as a way to avoid malpractice suits. Some plans have reversal rates as high as 76 percent on denials.

"A lot of patients think that once a decision is made, it's in stone," says Cabrera at American Medical Health-care, "but you can always appeal. With an appeal, we get a lot of new information about a case that we otherwise wouldn't know. I would encourage anyone who's been turned down to appeal." ■

*Karen Ignagni
denies that
the lack of data on
children implies
that HMOs
are lacking when
it comes to
pediatric care.*

Interesting medical-related web sites

The staff of the WVSMA has put together a list of wonderfully insightful and beneficial web sites that we believe are useful to our members. If you have a medical-related web site not listed below, but would like to share it with the WVSMA membership, give us a call at (304) 925-0342 and we will publish it in the July issue of WESGRAM.

Modern Healthcare: www.modern.healthcare.com/current

Physicians who care: www.hmopage.org

Managed care horror stories: www.his.com/~pico/usa.htm

(Have a box of tissues handy!)

Health Hippo: www.winternet.com/~hippo

National Library of Medicine: text.nlm.nih.gov

CS
FH
73
SPOKE 3 PEOPLE

Former Air Force Surgeon General is new AMA Chief Executive

The American Medical Association Board of Trustees selected as its new chief executive, E. Ratcliffe "Andy" Anderson, Jr., MD, the former U.S. Air Force Surgeon General and current CEO of Truman Health Systems. Dr. Anderson is a dermatologist and professor of medicine at the University of Missouri-Kansas City School of Medicine.

Dr. Anderson received his MD from the Louisiana State University School of Medicine. He completed his post-graduate work at Philadelphia General Hospital, Boston City Hospital and New York University Medical Center in dermatology. He is a past-president of the Association of Military Surgeons of the United States and a former member of the AMA's House of Delegates.

Andy Anderson will assume his responsibilities this summer. He is married with three children.

AMA Annual Meeting set for June

The 1998 Annual Meeting at the AMA House of Delegates will be held at the Hyatt Regency Hotel in Chicago, June 14-18. Four AMA Delegates and four AMA Alternate Delegates as well as the current WVSMA President, President-Elect, Vice President, Council Chairman and two WVSMA-staff members will attend. This delegation is also joined by two WV delegates, who will be representing their specialty societies.

A total of 21 doctors from around the country seek 12 vacancies on four AMA councils in next month's elections and Dr. Nancy W. Dickey will be elected and take the office of President; the first woman to be elected to that position.

State briefs

Dr. Dan Foster, a Charleston surgeon, was recently named as an associate medical director for Carelink Health Plans. Drs. Jerome D. Massenburg, Ralph S. Smith and Bobby Caldwell were also named to this position. They will be responsible for authorizing or denying treatments, participate in case management and sit on various committees...Dr. Glenn Crotty, Jr., was recently named executive vice president and chief executive officer for Camcare, Inc. He will oversee the associate medical directors and will remain as Carelink's Medical Director...Dr. Maurice A. Mufson, Infectious Disease, Huntington, was conferred with the American College of Physicians mastership, its highest level of membership. Masters of ACP are elected for their personal character, positions of honor or influence and eminence in practice or medical research. Masters of ACP may also use the designation "MACP" after their names and degrees...Dr. Deborah A. Bartholomew, a Charleston ob/gyn, has been appointed director of the obstetrics and gynecology residency training program in Charleston. She is a graduate of the Medical College of Virginia and is a specialist in pathology as well as ob/gyn.

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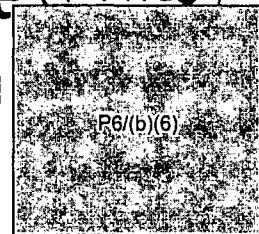
Freedom of Information Act - [5 U.S.C. 552(b)]

- 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]

HMO Denies Heart Treatment Patient Left In Vegetative State (Fiance)

court document

Lynba
Gillahan Quaker



Costa

Ver-Si-Co

~~Carolyn Verzicco~~
Philadelphia, PA

don't know

Brain Anom. Sm
Aetna

According to court records:

Carolyn Verzicco had been seeing her HMO primary care physician for 13 years when she first complained to him of chest pains. During that visit, Carolyn also informed him of mild shortness of breath and numbness in her shoulders that lasted up to twenty minutes at a time.

Carolyn's HMO doctor measured her blood pressure and administered an electrocardiogram, which revealed an abnormality in her heart. Concerned about the symptoms, the HMO doctor ordered blood tests and the use of a Halter Monitor device.

The next day, one day after prescribing use of the Halter Monitor for Carolyn, the HMO primary care physician discontinued its use. The HMO doctor had been told by the insurance company it would not pay for the service of the Halter Monitor. Carolyn's HMO primary care physician was forced to end the device's use and did not even read the results from the lone day that Carolyn wore it.

Two weeks later, Carolyn again experienced chest pains, this time extending across her shoulders, down one of her arms and up into her neck. Carolyn visited her HMO emergency room for care. Two attending HMO physicians examined Carolyn, taking her blood pressure and another electrocardiogram. The electrocardiogram

showed that Carolyn had anterior wall heart damage. She was given medication and told to contact her HMO primary care physician in two days. Carolyn was also instructed to return if her condition worsened.

The next day, Carolyn was struck with extremely severe chest pain while driving her car. Carolyn passed out and was rushed back to her HMO emergency room. At the HMO emergency room, HMO physicians performed prolonged resuscitative efforts on Carolyn. However, Carolyn remained unconscious in cardiac arrest and suffered irreversible heart damage.

Carolyn's heart damage is expected to last the rest of her life. She remains in a persistent vegetative state at a nursing home.

Carolyn's family brought a subsequent suit against the HMO in Pennsylvania state court. The family claimed medical malpractice, because of the company's refusal to authorize use of the Halter Monitor, which could have indicated Carolyn's heart complications.

Because Carolyn received her healthcare through a private sector employer, the HMO claimed ERISA preemption. The case was removed from state court to federal District Court where the judge deemed the claim was preempted by ERISA, and Carolyn's family was left without remedy.

Eric

REP. JOSEPH HOFFEL 202 228 0811 # 27

Frank

From: Bullock, Tom
Sent: Thursday, April 01, 1999 2:29 PM
To: Custer, Frank
Subject: contacts for health care rally with Clinton in Philly

Frank,

Have the White House call the following attorneys, who represent clients with HMO problems:

- 1) Jeff Kornblau of Kornblau & Kornblau, 215-576-7200
- 2) Greg Heller with Litvin, Blumberg, Matusow & Young, 215-557-3315

The White House should call these lawyers and ask them for individuals who can exemplify/illustrate problems A, B, or C with managed care, and justify the reform bill.

Tom

Need to
call

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001b. memo	Nicole Bennett to Karen Coleman and Barbara Wooley re: Patients' Bill of Rights Rally (partial) (1 page)	04/02/1999	P6/b(6)

COLLECTION:

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

FOLDER TITLE:

PBOR [Patients' Bill of Rights] [Folder 7]

2012-0463-S

rc811

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]
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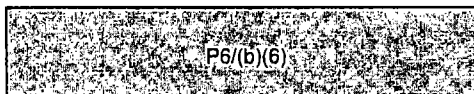
MEMORANDUM

TO: Karen Coleman and Barbara Wooley, White House Public Affairs
FROM: Nicole Bennett, Steering and Coordination Committee
RE: Patients' Bill of Rights Rally - spokesperson, April 9, 1999
DATE: April 2, 1999

Potential Spokesperson(s) -- Pennsylvania:

✓ **Attorney Greg Heller**
(ATLA)
Philadelphia, PA
(215) 557-3300

VM



(8:30pm)

[0016]

2335 1) Pregnant woman from Philly who felt she was possibly going into pre-term labor called her HMO who couldn't get her in contact w/ her doctor and told her she was just having back problems. HMO sent the woman to a chiropractor, an hour's drive away, where she ended up having a premature baby who died.

2) Person who is now a paraplegic as a result of a spinal cord injury -- not properly handled during an emergency situation.

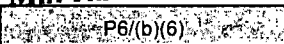
3) Head injury case - elderly gentleman (60s) who was denied proper care and now lives in a nursing home. His daughter would have to speak on his behalf.

Charles Inlander
The People's Medical Society
Allentown, PA
(610) 770-1670
left message

Jerry Rothenberger
Pennsylvania Medical Society
(717) 558-7750 ext. 1451

1) Obstetrician from Pittsburg, Pa who could not get care approved for a patient. Medical Director (and Internist) continually denied requests. The doctor left the HMO and the patient followed.

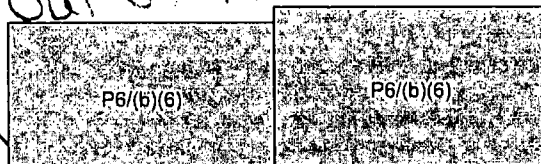
✓ **Dr. Bryant Welsch**
Attorney and Psychologist
Maryland



1) parents of a 14-year-old boy who committed suicide after improper treatment.



out of town



PBOR SOTU OPTIONS

*Kentucky
exec
for #*
Linda Peeno. Last August, I met Dr. Linda Peeno in Kentucky, who left her job as a case reviewer for a managed care company after her job was threatened if she approved treatment for patients she knew she be cared for. I challenge Congress to pass a law by this August so that Linda Peeno can go back to work and American families can rest assured that they will receive the quality health care they need and deserve.

Carol Anderson. Last July, I met Carol Anderson, a billings manager from Virginia who broke down into tears when she told me about case after case where patients were denied access to the specialists they need and of one case where the boy who lost his leg because his HMO denied the treatment he needed. Today, I am challenging Congress to pass a strong enforceable patients' bill of rights by next July so that we can tell Carol and millions of Americans they can rest assure that they have the protections in place to assure the quality care they need and deserve.

Medicare: Last June, I took executive action to extend the patients' bill of rights to the tens of millions of Americans on Medicare. Now, I challenge Congress by this June to pass a strong enforceable patients' bill of rights so that all health plans provide the quality care American families need and deserve.

NY -

Denial of Emergency Care

Vaughn Dashiell
Alexandria, VA

✓ Contact Information:

Michael Miller at Miller and Associates
703-519-8080 or 703-519-8084
Survivor: Patricia Dashiell (wife)

will call back

Source:

www.senate.gov/~dpc/patients_rights/dashiell.html
Senator Dorgan's Office Nicole Bennett 224-8994

Story:

Mr. Dashiell contacted his HMO after experiencing tunnel vision and a sore throat. The HMO nurse told him to wait to see a doctor. After his symptoms worsened, he called back and the HMO again refused to send him to the emergency room. After the nurse consulted the doctor on duty, it was decided Mr. Dashiell should go to the emergency room, but he was never notified of this decision. The next morning, his wife found him in a diabetic coma, and he later died from hyperglycemia.

maybe?

*check w/ Reg
- Devora will call tonight*

American Medical Association
Physicians dedicated to the health of America



FAX TRANSMISSION SHEET

Date: 8/23/99

From: Camilla Miree
Administrative Assistant
Division of Congressional Affairs

TO: Debra Alder

Phone # 202-789-7436
E-mail: Camilla_Miree@ama-assn.org

Fax # 456-5557

Total # of pages including cover sheet 3

Message Box

Rich Deem asked me to fax this to you.
Pls. call me if you have any problems
receiving this fax. If you would like it e-mailed
to you call me.

Reply fax # 202-789-4692

American Medical Association

Physicians dedicated to the health of America



News Release

FOR IMMEDIATE RELEASE

August 23, 1999

AMA ENDORSES NORWOOD-DINGELL PATIENTS' RIGHTS BILL

"This bill delivers the strong protections that patients need and voters want"

Washington – The American Medical Association today announced its support for the bipartisan Norwood-Dingell patients' rights bill (H.R. 2723) and called for patients, physicians and the public to mobilize behind the legislation.

"This bill delivers the essential protections patients and voters are demanding," said Thomas R. Reardon, MD, president of the AMA. "Doctors will be allowed to make medical decisions. Health plans will be held accountable for their actions. Patients can appeal if their care is delayed or denied. And the bill's protections will apply to everyone with private health insurance."

The AMA's Board of Trustees voted to endorse the bill during a meeting over the weekend in Chicago. Though the AMA has long-advocated strong patient protections, this is the first time this congressional session that AMA has endorsed a specific patients' rights bill.

"The Norwood-Dingell bill is a win-win for patients and for Congress," Dr. Reardon said.

H.R. 2723 is sponsored by Rep. Charles Norwood (R-GA) and John D. Dingell (D-MI). More than 60 Republican and Democratic members of the House of Representatives are co-sponsors.

"We are pleased that so many members of Congress from both sides of the aisle are determined to enact fair, responsible and meaningful patient protections," Dr. Reardon said. "We will support any and all bills that get the job done the right way."

"The AMA also commends Representatives Tom Coburn of Oklahoma and John Shadegg of Arizona for their efforts to develop meaningful patient protection legislation. We will continue to work with Rep. Coburn, Rep. Shadegg and the House Republican leadership as the Coburn-Shadegg proposal moves toward introduction and formal consideration. We also want to thank Speaker of the House Dennis Hastert for promising a House floor vote on patients' rights legislation in September."

-- more --

1101 Vermont Avenue, NW
Washington, DC 20005
202 789-7400

"At the same time I'd like to alert patients and the public that strong forces are at work against them on this issue. The insurance industry has diverted more than \$100 million from patient care to pay for an irresponsible propaganda campaign intended to scare patients and intimidate members of Congress.

"We find it difficult to comprehend how the politics of greed can drive insurance executives to work to kill fundamental protections that members of their own families will need when they themselves require health care."

Dr. Reardon called for a stepped-up national drive to mobilize state medical societies, national medical specialty societies, national patient groups and other health organizations around a bipartisan coalition supporting strong patients' rights legislation.

"What Are HMOs So Afraid Of?" is the theme of AMA-designed ads running this week in the hometown newspapers of 28 members of the House of Representatives. The AMA, American Dental Association, American College of Obstetricians and Gynecologists, American Academy of Ophthalmology, and the Patient Access Coalition (a national coalition of 129 patient advocacy and provider groups) are financing the ad campaign.

"We can never match the insurance industry's anti-patient war chest, but we have something better on our side – the will of the public to see that Congress enacts patients' rights legislation and our commitment as physicians to be sure patients receive necessary care," Dr. Reardon said.

#

For more information, please call:

Brenda L. Craine
AMA Washington Office
202/789-7447
Brenda_Craine@ama-assn.org

FAX TRANSMITTAL SHEET

U. S. OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
1900 E STREET, N.W., ROOM 4A10
WASHINGTON, D.C. 20415

Telephone (202) 606-0600

Number of Pages 4
(Including Cover Sheet)

TO: De Verah
(Chris Jennings)

DATE: _____

Telephone Number _____

Fax Number _____

FROM: Ed Flynn

DATE: _____

Telephone Number _____

Fax Number _____

COMMENTS:

attached is signed copy of Nica's letter



UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, D.C. 20415

OFFICE OF THE DIRECTOR

AUG 19 1999

Honorable John L. Mica
U.S. House of Representatives
Washington, DC 20515-0907

Dear Representative Mica:

I recently learned of your colloquy with Rep. Ganske about the Federal Employees Health Benefits Program, reported in the Congressional Record of May 18, 1999. Several of your remarks that day concerned implementation of the Patients' Bill of Rights in the Government's health insurance program for its employees, retirees, and members of their families. You made several assertions about the program that are inaccurate, and I would like to set the record straight.

First, you referred to a hearing held on March 17, 1998, during which you asked about the Patients' Bill of Rights. You characterized Administration officials as acknowledging that no medical benefits were associated with implementation of the Patients' Bill of Rights. Further, you indicated that implementation only imposed, "... more reporting, more mandates, more requirements, and they possibly predicted more costs."

As you know, William E. Flynn, III, Associate Director for Retirement and Insurance at the Office of Personnel Management testified at that hearing. Mr. Flynn explained in detail the benefits of the Patients' Bill of Rights provisions to the program's members. Among those benefits were such things as access to specialty care when needed, direct access to women's health providers and services, access to emergency care wherever it is needed, and information that helps participants make informed decisions when selecting their health plan or provider. In response to your question about potential costs, Mr. Flynn provided an initial estimate of \$32.5 million to achieve these protections in all of the 350 health plans then participating in the program. In a health insurance program providing almost \$20 billion annually in vital health care benefits to almost 9 million individuals, those added costs amounted to approximately 5 cents every 2 weeks for an individual, and 12 cents for a family plan. Acknowledging that the estimates were preliminary, he also emphasized that actual costs might be less.

Later in your remarks, you referred to a hearing that was held on September 24, 1998, after the Office of Personnel Management announced benefits and associated premiums for 1999. While acknowledging that prescription drug costs influenced the premium increase, you went on to say that implementation of the Patients' Bill of Rights contributed substantially to the 10 percent increase in premiums while the rest of the industry was experiencing increases in the range of 2.6 to 3 percent. In

commenting on the fact that approximately 60 health plans had ceased participating in the program for 1999, you indicated that was attributable to the role of this Office in administering the program and ensuring the protections called for in the Patients' Bill of Rights.

Mr. Flynn also testified on behalf of the agency at the hearing in September. In his statement and in responding to your questions and those of other Members, he explained the multiple factors that contributed to the premium increase. Demographics, medical technology and the rising cost and utilization of prescription drugs were the principal factors. Further, testimony from both Mr. Flynn and witnesses representing health plans confirmed these were the same trends affecting health care costs in the larger economy. Even more compelling, both Mr. Flynn and the industry witnesses provided testimony that other employers were facing exactly the same challenges and the same level of premium increases.

Most troubling, however, is your insistence that costs in this program are going up substantially as a result of implementation of Patients' Bill of Rights. That premise is simply contrary to all of the facts available. As a proportion of the 10 percent average increase for 1999, the added costs associated with implementing the Patients' Bill of Rights represented an amount essentially too small to calculate. In reality, the actual costs incurred were much less than our earlier estimate. Since only a few health plans adjusted their premiums in order to implement the protections we sought, the added costs for 1999 amounted to approximately \$250,000 for the entire program. Even taking into account the value of the patient protections already in place, the total cost of these protections in 1999 comes to less than \$10 per policyholder annually – less than \$1 a month.

Finally, there is no evidence that our actions on behalf of participants in the program are reducing competition and driving up premiums. We surveyed the plans that chose to leave the program in 1999 in order to understand the reasons for their decisions. As you know, most of the plans that decided to discontinue in 1999 were Health Maintenance Organizations, covering less than 2 percent of the total population of participants in the program. Our survey revealed a number of business reasons for the plans' departures, but not a single one cited the Patients' Bill of Rights as a reason. Indeed, at a hearing on the program on May 13, 1999, two representatives of the insurance industry praised OPM for the collaborative way it went about implementing the Patients' Bill of Rights. Neither individual associated any premium increases with those protections.

Clearly, extending the protections of the Patients' Bill of Rights to this health insurance program has been an outstanding success. Our track record demonstrates that effective protections can be implemented at minimal cost while maintaining high levels of patient satisfaction. As importantly, our collaboration with health plans yields useful and practical lessons for the entire industry. During the recent debate in the Senate on patient protection measures, much controversy centered on

Honorable John L. Mica

3

how various measures would drive up costs and increase the number of individuals without health insurance. Our experience shows that is simply not the case. The patient protections that we will have in place by the year 2000 are in most cases even more comprehensive than those required by the recent Senate Bill, as illustrated by the following:

- Our protections apply to all health plans in our program.
- Direct access to specialists for members with complex or serious medical conditions under approved treatment plans is guaranteed.
- Women in their second trimester of pregnancy and beyond can continue seeing their specialist through completion of postpartum care when they lose access to that specialist either because the health plan is no longer offered or the specialist is terminated from the plan for reasons other than cause.
- More extensive plan, care management, provider, and facility information is available to equip our members to make informed health care decisions.
- Comprehensive confidentiality provisions are in place that allow our members to review, copy, and amend their medical records.

We undertake our responsibilities to run the Federal Employees Health Benefits Program very seriously. As an important component of the compensation program offered Federal employees, as a vital source of health care protection, and as a model for other employers, this program has and will continue to succeed. As you know, all of us at the Office of Personnel Management share your concern about the increased cost of health insurance. However, it is important to publicize the real reasons for those increases. We must focus on ways to keep health insurance affordable while strengthening the scope and quality of health care itself. As we do that, it is important that everyone understand the fundamental principles and factors that drive the Federal Employees Health Benefits Program. Information that is inaccurate or misleading diverts attention from real solutions, which should be our focus.

Thank you for the opportunity to provide some additional facts about our administration of this important program.

Sincerely,

Janice R Lachance
Janice Lachance
Director



HMOs Are Spending \$100 Million to Deny Your Rights

What Are HMOs So Afraid Of?

HMOs and big insurance companies are spending more than \$100 million — money that should go to patient care — to kill a real patients' bill of rights. And their money is working.

They won in the U.S. Senate. Now their target is the House. The question is why?

- Why are they afraid to let doctors make medical decisions?
- Why are they afraid to let patients appeal when an HMO delays or denies care?
- Why are they afraid to be held accountable for their actions?

- Why are they afraid to let patients choose their own doctors?

The answer is simple. It's a case of dollars first and patients last. After all, some health insurance executives take home \$20 million a year. And they certainly don't want a \$200 test to get in the way of that.

It's time to end the politics of greed.

If you want a real patients' bill of rights and not another HMO Protection Act, call 1-800-833-6354 and tell your Representative to put "patients" back into the patients' bill of rights.

Paid for by the American Medical Association, the American Dental Association and the Patient Access Coalition's 129 Provider and Patient Advocacy Groups.

Organizations Supporting HR 2723

American Academy of Pediatrics
American College of Obstetricians and Gynecologists
American College of Physicians
American Nurses Association
American Psychological Association
American Public Health Association
Center for Patient Advocacy
Families USA
National Partnership for Women and Families
Opticians Association of America
United Church of Christ

The following have indicated they'll do a letter - we just don't have it yet

American Acad. of Neurology
American Ass. for Marriage + Family Therapy
American Ass. for Respiratory Care
Am. Ass. of Pastoral Counselors
Am. Ass. Univ. Women
American Cancer Society
American Counseling Assn.
AFSCME
AFT
American Heart Assn.
American Lung Assn
American Small Business Society
The ARC
CCD
Catholic Charities
Consumer Federation of America
Alliance for Families + Children
Nat. Assn. of Children's Hospitals
NH. Assn of People Living w/AIDS
NH Assn of School Psychologists
Ntl. Patient Advocate Foundation
Paralyzed Veterans
SEIU

(Original Signature of Member)

106TH CONGRESS
1ST SESSION**H. R. 2723**

IN THE HOUSE OF REPRESENTATIVES

Mr. NORWOOD (for himself, Mr. DINGELL, Mr. GANSKE, Mr. COOKSEY, Mr. BERRY, Mrs. CLAYTON, Mr. GRAHAM, Mr. PALLONE, Mrs. ROQUE LA, Mrs. CAPPE, Mr. SHAW, Mr. JOHN, Mr. SHAYS, Mr. TURNER, Mrs. CUBIN, Mr. BALDACCIO, Mr. FOLEY, Mr. GEPHARDT, Mr. HOUGHTON, Mr. RANGEL, Mr. HORN, Mr. CLAY, Mr. GIBBONS, Mr. BROWN of Ohio, Mr. FRELINGHUYSEN, Mr. ANDREWS, Mr. GILCHREST, Mr. STARK, Mr. LEACH, Mr. WAXMAN, Mr. GILMAN, Mr. CARDIN, Mr. LATOURETTE, Mr. FORD, Mr. LOBIONDO, Mr. SANDLIN, Mr. BARR of Georgia, Mrs. THURMAN, Mr. BOENIGT, Mr. KLINK, Mrs. MORELLA, Mr. SNYDER, Mr. ESHOO, Mr. DOYLE, Mr. McDERMOTT, Mr. BRADY of Pennsylvania, Mr. PASCRELL, Mr. HOLT, Mr. FROST, Ms. KILPATRICK, Mr. DICKS, Mr. SCHAKOWSKY, Mr. RUSH, Mrs. MCCARTHY of New York, Mr. MURPHY, Ms. STABENOW, and Mr. PHELPS) introduced the following bill, which was referred to the Committee on _____

R. Hall - TX

A BILL

To amend title I of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service



JFK Jr. His Life and the Kennedy Legacy

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Clinton Urges Vote on Patients' Rights Bill

GOP Says Deal on HMO Bill Will Take Time

Associated Press
Sunday, August 1, 1999; Page A06

Seeking to exploit Republican defections, President Clinton pressed GOP leaders yesterday to allow a House vote on legislation guaranteeing protections for managed-care patients before next weekend's summer recess.

Clinton noted that some GOP House members, led by lawmakers who are also medical doctors, have joined Democrats to urge support for a "patients' bill of rights" for Americans whose health care plans are through health maintenance organizations.

"This is very good news indeed," he said in his weekly radio address. "It means there is a bipartisan consensus emerging behind a bill that would give all Americans the health protections they need. This bill should be debated and voted on this coming week, before Congress adjourns for the summer. If that happens, I believe the bill would pass."

"If the House is brave enough to protect the American people over the intense lobbying of the health insurance companies, the Republican leadership shouldn't stand in their way," the president said.

Rep. J.C. Watts (Okla.), chairman of the House Republican Conference, said House committees are working on a compromise, but "there are still some key issues to resolve." The aim, he said, is to craft a bill that holds HMOs accountable and enables doctors to pursue the best medical treatment without permitting lawsuits.

"What the Clinton-Gore administration and the Democrats in Congress want is an issue for the 2000 election," Watts said. "Frankly, it takes longer to write a law than a campaign document."

The Senate has passed a bill that is weaker than the legislation the Clinton administration proposes and that almost all Capitol Hill Democrats support.

House GOP leaders had planned to bring a similar bill to the floor last week, but action was derailed when some Republican House members announced support for the Democratic version.

Republican leaders contend that the broader Democratic plans would be too expensive.

They advocate giving patients new rights of appeal but no right to sue

if an HMO denies care or treatment. The GOP legislation also would give doctors some new power without removing HMOs' right to determine what care is medically necessary.

In a separate radio address taped for broadcast to farm states, Clinton said current law shortchanges American farmers when times are tough, and Congress should act to "fix the underlying problem" rather than deal with crises as they happen.

Although much of the farm economy is healthy, many farmers, especially grain producers, face low prices. Clinton said he has done what he can, including buying more food for humanitarian aid, accelerating farm program payments and providing \$6 billion in emergency aid last year.

But what is needed, he said, is authority to augment incomes of hurting farmers in bad years, improve crop insurance and make it easier to obtain and expand markets abroad and police market practices at home.

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FREE TEE!



How much
on autism

Purby

65616

Liz

ONE HUNDRED SIXTH CONGRESS

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 BILL LUTHER, MINNESOTA
 LOIS CAPPS, CALIFORNIA

JAMES F. DERDEMAN, CHIEF OF STAFF

U.S. House of Representatives Committee on Commerce

Room 2125, Rayburn House Office Building
 Washington, DC 20515-6115

DEMOCRATIC STAFF

FAX COVER SHEET

DATE:

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COMMENTS:

Chris Jennings
 Condy B.
 456-5657

3

Updated list of cooperators

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Bill Summary & Status for the 106th Congress

Item 1 of 1

PREVIOUS BILL:COSPONSORS | NEXT BILL:COSPONSORS
HOME | HELP | ABOUT COSPONSORS

H.R.2723

SPONSOR: Rep Norwood, Charlie (introduced 08/05/99)

COSPONSORS(65):

<u>Rep Dingell, John D.</u> - 08/05/99	<u>Rep Ganske, Greg</u> - 08/05/99
<u>Rep Cooksey, John</u> - 08/05/99	<u>Rep Berry, Marion</u> - 08/05/99
<u>Rep Clayton, Eva M.</u> - 08/05/99	<u>Rep Graham, Lindsey O.</u> - 08/05/99
<u>Rep Pallone, Frank, Jr.</u> - 08/05/99	<u>Rep Roukema, Marce</u> - 08/05/99
<u>Rep Capps, Lois</u> - 08/05/99	<u>Rep Shaw, E. Clay, Jr.</u> - 08/05/99
<u>Rep John, Christopher</u> - 08/05/99	<u>Rep Shays, Christopher</u> - 08/05/99
<u>Rep Turner, Jim</u> - 08/05/99	<u>Rep Cubin, Barbara</u> - 08/05/99
<u>Rep Baldacci, John Elias</u> - 08/05/99	<u>Rep Foley, Mark</u> - 08/05/99
<u>Rep Gephardt, Richard A.</u> - 08/05/99	<u>Rep Houghton, Amo</u> - 08/05/99
<u>Rep Rangel, Charles B.</u> - 08/05/99	<u>Rep Horn, Stephen</u> - 08/05/99
<u>Rep Clay, William (Bill)</u> - 08/05/99	<u>Rep Gibbons, Jim</u> - 08/05/99
<u>Rep Brown, Sherrod</u> - 08/05/99	<u>Rep Frelinghuysen, Rodney P.</u> - 08/05/99
<u>Rep Andrews, Robert E.</u> - 08/05/99	<u>Rep Gilchrest, Wayne T.</u> - 08/05/99
<u>Rep Stark, Fortney Pete</u> - 08/05/99	<u>Rep Leach, James A.</u> - 08/05/99
<u>Rep Waxman, Henry A.</u> - 08/05/99	<u>Rep Gilman, Benjamin A.</u> - 08/05/99
<u>Rep Cardin, Benjamin L.</u> - 08/05/99	<u>Rep LaTourette, Steve C.</u> - 08/05/99
<u>Rep Ford, Harold Jr.</u> - 08/05/99	<u>Rep LoBiondo, Frank A.</u> - 08/05/99
<u>Rep Sandlin, Max</u> - 08/05/99	<u>Rep Barr, Bob</u> - 08/05/99
<u>Rep Thurman, Karen L.</u> - 08/05/99	<u>Rep Boehlert, Sherwood L.</u> - 08/05/99
<u>Rep Klink, Ron</u> - 08/05/99	<u>Rep Morella, Constance A.</u> - 08/05/99
<u>Rep Snyder, Vic</u> - 08/05/99	<u>Rep Eshoo, Anna G.</u> - 08/05/99
<u>Rep Doyle, Michael F.</u> - 08/05/99	<u>Rep McDermott, Jim</u> - 08/05/99
<u>Rep Brady, Robert</u> - 08/05/99	<u>Rep Pascrell, Bill, Jr.</u> - 08/05/99
<u>Rep Holt, Rush D.</u> - 08/05/99	<u>Rep Frost, Martin</u> - 08/05/99
<u>Rep Kilpatrick, Carolyn C.</u> - 08/05/99	<u>Rep Dicks, Norman D.</u> - 08/05/99
<u>Rep Schakowsky, Janice D.</u> - 08/05/99	<u>Rep Rush, Bobby L.</u> - 08/05/99
<u>Rep McCarthy, Carolyn</u> - 08/05/99	<u>Rep Murtha, John P.</u> - 08/05/99
<u>Rep Strabenow, Debbie</u> - 08/05/99	<u>Rep Phelps, David D.</u> - 08/05/99
<u>Rep Hall, Ralph M.</u> - 08/05/99	<u>Rep Weygand, Robert A.</u> - 08/05/99

Rep Berkley, Shelley - 08/05/99

Rep Tanner, John S - 08/05/99

Rep Barren, Thomas M - 08/05/99

Rep Bonior, David F - 08/05/99

Rep Wynn, Albert Russell - 08/05/99

Rep [unclear] - 08/05/99

Rep [unclear] el P. - 08/05/99

Whistleblower Protections

under the "Emergency Medical Treatment & Labor Act"

The "Emergency Medical Treatment and Labor Act" (EMTALA)(42 USC 1395 dd) includes provisions to provide for the protection of "whistleblowers." Specifically, a hospital cannot penalize or take adverse action against a physician or qualified medical personal because he or she refused to authorize the transfer an unstabilized individual with an emergency medical condition. A hospital is also prohibited from taking action against a hospital employee because the employee reported a violation of these EMTALA requirements. The requirements of EMTALA extend beyond the emergency department to all areas of the hospital, "including ancillary services routinely available to the emergency department." Hence, in addition to the "Whistleblower Protection Act of 1989," and the "False Claims Act," health care workers in hospitals are protected for reporting violations with respect to the care of patients under EMTALA.

Failure to comply with EMTALA can result in termination of the hospital's Medicare provider agreement and civil monetary penalties of \$25,000 for each violation.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

If a patient or employee has a complaint against a hospital, the Joint Commission has in place a quality incident reporting mechanism. Following an incident report, the Joint Commission evaluates the complaint, and takes needed action. If the complaint is considered a threat to patient care, the Joint Commission goes into the hospital and conducts a special survey of the facility's operations. If the survey reveals that an organization is out of compliance with national standards, the facility risks losing its accreditation status, and may be barred from participating in the Medicare and Medicaid programs.

In addition, all employees and patients have the ability to request a private, confidential interview with the Joint Commission Surveyors, if there is an ethical or patient care issue that they feel is important for the Joint Commission to be made aware of. These interviews are taken very seriously, and often provide information may serve as an important factor in a hospital's on-going accreditation status. (address required public notice publishing prior to {30 days paper of general circulation for population served} and posted throughout facility throughout survey-survey dates and process to have a PII)

Whistleblower Protections Under the False Claims Act

The False Claims Act, codified in relevant part at, 31 U.S.C. Section 3730(h), establishes:

Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in

furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this section, shall be entitled to all relief necessary to make the employee whole. . . .

This section provides broad protection for all employees—including health care employees—for any lawful actions they might take in the course of investigating or participating in any way in bringing a wide range of complaints against or about their employers involving care provided in Federal health care programs.

The protection and relief employees are afforded is broad -- "shall be entitled to all relief necessary to make the employee whole" as is the scope of its application.

This protection applies to the full range of potentially retaliatory treatment: "discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment."

And it applies to the full range of potential complaints employees of health care facilities would potentially want to make, since it would apply for any "lawful acts done by the employee on behalf of the employee or others in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this section." The scope of potential False Claims Act actions appears limitless and has been used to raise payment, health and safety, and a host of other public policy objectives or concerns.

These protections are more than sufficient to address the needs of employees of health care providers in relation to issues they have with their health care provider employers.

As an example of the application of this provision in the health care context, see *Godwin v. Visiting Nurse Ass'n Home Health Services*, E.D. Pa. 1993, 831 F. Supp. 449, affirmed 39 F. 3d 1173, appeal dismissed 39 F. 3d 1173. Employee who was unlawfully terminated under the False Claims Act was entitled to reinstatement with same seniority status, back pay, and interest on back pay as well as special damages and attorney fees and costs.

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SEC. 132. PROTECTION FOR PATIENT ADVOCACY.

(a) **[PROTECTION FOR USE OF GRIEVANCES AND APPEALS]**—A group health plan, and a health insurance issuer with respect to the provision of health insurance coverage, ~~or health care provider~~ may not retaliate against a participant, beneficiary, enrollee, or ~~health care provider~~ based on the participant's, beneficiary's, enrollee's or provider's *initiation* of, or participation in, a utilization review process or a grievance process of the plan or issuer (including an internal or external review or appeal process) under this title ~~or any public or private accreditation process.~~ *or pub. regulatory process*

(b) **RULES OF CONSTRUCTION.**—Nothing in this section shall be construed to require a group health plan or a health insurance issuer to renew a contract with a participating provider, and failure to renew a contract shall not be considered retaliation.

**American Federation of Labor
Congress of Industrial Organizations
AFL-CIO**

FAX Transmission

■ **DEPARTMENT OF LEGISLATION** ■

TO: Chris Jennings

FAX #: 456-5557

DATE: 8-4-99

FROM: Marci Nielsen

PHONE: 202/637-5057 **FAX #:** 202/508-6963

Number of pages to follow: 1

COMMENTS:

(Please call (202) 637-5057, if you have received this transmission in error)

815 Sixteenth Street, N.W. ■ Room 301 ■ Washington, D.C. 20006

From: Marci Nielsen
To: Amy Droskoski; Bridgett Taylor; Karen Folk
Date: 8/4/99 2:23PM
Subject: Patient advocacy language

The following paragraph represents changes that we have made to improve this section. This reflects changes made in the last hour. Let's talk about this when you have a chance to look it over.

SEC. 132. PROTECTION FOR PATIENT ADVOCACY

(a) [IN GENERAL]. A group health plan, a health insurance issuer with respect to the provision of health insurance coverage, or health care provider may not retaliate against a participant, beneficiary, enrollee, or health care provider based on that participant's, beneficiary's, enrollee's or provider's initiation of, or participation in advocacy on behalf of patient health and safety, including the initiation of or participation in any review, grievance or appeal, (whether internal or external) before (a) the plan, issuer, or health care provider; or (b) any public or private agency, including accrediting organizations; or (c) any judicial forum.

We would also ask that under the definition of "health care provider" (in the definitions section), the following language be inserted after the term "health care professional" [as defined herein]. This will insure that the courts will abide by this statutory definition of health care professional, rather than the definition in any other statute.

 Marci Nielsen, AFL-CIO Legislative Representative
 mnielsen@afcio.org
 Ph: 202-637-5157
 Fax: 202-508-6963

CC: barb coufal; bill cunningham; Madeleine Golde; Stephanie Reed



U.S. Department of Labor

Pension & Welfare Benefits Admn.

Washington, D.C. 20210

FACSIMILE

DATE: 8/5TO: CHRIS JENNINGS

Department: _____

Phone #: _____

Fax #: 456-5557From: Dan Majum

Office of Policy and Research

Fax Number: (202) 219-5333

Phone Number (202)219-4505

Number of pages being transmitted (including fax sheet) 2

COMMENTS: _____

WHISTLEBLOWER TALKING POINTS

- **The False Claims Act and the Whistleblower Protection Act of 1989 do not protect most health care worker.** They argue that there is no need to included a whistleblower provision because there are two federal laws that already provide these protections. From what we have review, these two laws do not protect most health care providers.
- **The False Claims Act contains a whistleblower provision, but it applies only in cases of fraud and only where the fraud involves federal funds.** In addition, the fraud must be tied to receipt of federal monies.
- **The Whistleblower Protection Act of 1989 appears to only apply whistleblower protections to federal employees.** The materials claim that this law also covered employees of any hospital that receives federal funds. However, nothing in the paper that was sent over, or in anything that we have reviewed so far confirms this.
- **It is true that some state have enacted whistleblower protection laws. These state laws vary in their protections, and have been an attempt to fill in the gap that exists in federal law.** This is why broad protections that apply to everyone in every state is needed.



U.S. Department of Labor

Pension & Welfare Benefits Admn.

Washington, D.C. 20210

FACSIMILE

DATE: 8/5

TO: CHRIS J

Department: _____

Phone #: _____

Fax #: 456-5567

From: DAN MAGUANO

Office of Policy and Research

Fax Number: (202) 219-5333

Phone Number (202) 219-4505

Number of pages being transmitted (including fax sheet) 32

COMMENTS: whistleblower language

DRAFT 1**PROHIBITION OF INTERFERENCE WITH HEALTH CARE PROFESSIONALS**

(A) *Retaliation By Group Health Plans and Issuers* - A group health plan and health insurance issuer with respect to the provision of health insurance coverage, may not retaliate against a health care professional based on the health care professional's initiation of, or participation in advocacy on behalf of patient health and safety, including the initiation of or participation in any review, grievance or appeal, (whether internal or external appeal) before (a) the plan, issuer, or health care provider; or (b) any public or private agency, including accrediting organizations; or (c) any judicial forum.

(B) *Retaliation By Other Health Care Entities* - A participating hospital, as defined in the Emergency Medical Treatment and Labor Act (42 U.S.C. 1395dd), and any other institutional based facilities, may not retaliate against a health care professional (whether they are employees or independent contractor) because the health care professional engaged in activities set out in (A) of this section.

(C) *Enforcement* - The enforcement for violations of this section shall be consistent with those in the Emergency Medical Treatment and Labor Act (42 U.S.C. 1395dd).

(Original Signature of Member)

106TH CONGRESS
1ST SESSION

H. R. 2723

IN THE HOUSE OF REPRESENTATIVES

Mr. NORWOOD (for himself, Mr. DINGELL, Mr. GANSKE, Mr. COOKSEY, Mr. BERRY, Mrs. CLAYTON, Mr. GRAHAM, Mr. PALLONE, Mrs. ROUKELA, Mrs. CAPPS, Mr. SHAW, Mr. JOHN, Mr. SHAYS, Mr. TURNER, Mrs. COBBIN, Mr. BALDACCIO, Mr. FOLEY, Mr. GEPHARDT, Mr. HOUGHTON, Mr. RANGEL, Mr. HORN, Mr. CLAY, Mr. GIBBONS, Mr. BROWN of Ohio, Mr. FRELINGHUYSEN, Mr. ANDREWS, Mr. GILCHREST, Mr. STARK, Mr. LEACH, Mr. WAXMAN, Mr. GILMAN, Mr. CARDIN, Mr. LATOURETTE, Mr. FORD, Mr. LOBIONDO, Mr. SANDLIN, Mr. BARK of Georgia, Mrs. THURMAN, Mr. BOENIGER, Mr. KLINK, Mrs. MORELLA, Mr. SNYDER, Mr. ESHOO, Mr. DOYLE, Mr. McDERMOTT, Mr. BRADY of Pennsylvania, Mr. PASCRELL, Mr. HOLT, Mr. FROST, Ms. KILPATRICK, Mr. DICKS, Mr. SCHAKOWSKY, Mr. RUSH, Mrs. MCCARTHY of New York, Mr. MURTHA, Ms. STABENOW, and Mr. PHELPS) introduced the following bill, which was referred to the Committee on _____

R.Hall-TX

A BILL

To amend title I of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service

Summary of Findings

Following are highlights from the 1999 Survey of Physicians and Nurses designed and analyzed by researchers at the Kaiser Family Foundation and the Harvard School of Public Health.

Section I: Experiences with Health Plans

- ❖ **Almost nine out of ten doctors (87%) say that their patients have experienced some type denial of coverage for health services by a health plan over the last two years.**
 - 79% of doctors say that over the last two years a plan has disapproved coverage for a prescription drug they believed a patient needed. 69% of doctors say that a plan has not approved a request for a diagnostic test or procedure, 60% say their patients have experienced a disapproval of a hospital stay, 52% report denials of specialty referrals, and 38% report denials for mental health or substance abuse referrals. [Chart 1]
 - Doctors report prescription drug denials as being the most frequent (61% say it happens on a weekly or monthly basis), followed by denials of coverage for diagnostic tests or procedures (42% say it happens on a weekly or monthly basis), hospital stays (31% say it happens weekly or monthly), and referrals to specialists (29% report it occurring weekly or monthly). They report denials of referrals for mental health or substance abuse as happening relatively infrequently (18% say it happens on a weekly or monthly basis). [Chart 1]
- ❖ **Across all types of services, doctors report that between 1/3 and 2/3 of denials result -- in their judgements -- in a "serious" decline in a patient's health status.**
 - Reported declines in health status were reported most frequently for problems related to mental health, specialist referrals, and diagnostic tests and procedures. In the mental health area, 65% of those doctors who reported a denial for their patients say that the most recent denial resulted in a "somewhat serious" or "very serious" decline in health. 50% report a similar decline in health for denials related to specialty referrals, and 46% report declines for denials of diagnostic tests. [Chart 2]

- "Serious" declines in health were reported less frequently for denials of hospital stays or prescription drugs. Of those doctors who reported a patient experiencing a hospital stay disapproval, 39% say that in the most recent case it resulted in a "very serious" or "somewhat serious" decline in the patient's health. 37% of those reporting denials related to prescription drugs say the most recent case resulted in a "serious" health decline. [Chart 2]

❖ **Many nurses also report that they see health plan decisions resulting in declines in patient health on a relatively frequent basis.**

- Almost half (48% of nurses) say that in the last two years a health plan has made a decision that resulted in a decline in a patient's health (an equal number say this has not happened). [Charts 3]
- Of those nurses who reported declines in a patient's health, almost two-thirds (63%) say it happens on a weekly or monthly basis. [Chart 3]

❖ **Many doctors and nurses say they have exaggerated a patient's condition to get coverage for them, and doctors report frequent -- and often successful -- efforts advocating on behalf of their patients with plans.**

- 26% of doctors and 30% of nurses say they often or sometimes exaggerate the severity of a patient's condition to get them care they think is medically necessary. Another 22% of doctors and 16% of nurses say they do this on rare occasions. 51% of doctors and 46% say they have never done so. [Chart 4]
- 66% of doctors say that they sometimes or often make contact with a health plan on behalf of patients for something other than a routine request for a referral (13% say they rarely do and 19% say they never do). [Chart 5]
- Among doctors who report making such interventions, 42% say that the most recent case was resolved in the patient's favor, 22% say it was resolved in the plan's favor, and 21% report the outcome was a compromise. 15% report the most recent intervention remains unresolved. [Chart 5]

❖ **Many doctors also report that health plans make efforts to aid them in improving patient care.**

- 47% of doctors say that a plan has at least sometimes provided them with guidelines or innovative tools to manage a patient's illness. [Charts 6]
- 33% of doctors say that a plan has at least sometimes helped them to encourage a patient to practice better health. [Chart 6]

❖ **Over one third (37%) of doctors say that they have dropped participation in a plan over the last two years because they were unsatisfied, frustrated, or unhappy (52% say they have not). [Chart 7]**

- Doctors who say they have dropped out of a plan also report more frequent coverage denials for their patients. For example, among those who have dropped a plan, 74% report plan disapprovals of prescription drugs on a weekly or monthly basis, compared to 52% among doctors who have not dropped out of a plan.

❖ **In reflecting on their own experiences in medicine, most doctors cite administrative issues as a great concern, while most nurses point to inadequate staffing levels.**

- 58% of doctors say spending too much time on administration rather than with patients is a great concern for them. Fewer cite lack of autonomy over clinical decisions (47%) or not making as much money as planned (26%) as great concerns. [Chart 8]
- 69% of nurses cite inadequate nurse staffing levels as a great concern, far exceeding those who cite other possible issues like insufficient autonomy (33%), inadequate training to cope with changes (28%), or not making as much money as planned (26%). [Chart 8]

Section II: Attitudes Towards Health Plans

- ❖ **Most doctors and nurses (79% and 70% respectively) say their views of managed care are shaped a great deal by their experiences as health providers. [Chart 11]**
 - Fewer cite reports of professional organizations (31% for doctors and 29% for nurses) or the media (22% for doctors and 27% for nurses) as major influences. [Chart 11]
 - Nurses are more likely than doctors to say they are influenced a great deal by their experiences as patients (38% vs. 23%) and by reports of their friends and family members (47% vs. 39%). [Chart 11]
- ❖ **Both doctors and nurses say that managed care has had a generally negative effect on the health care system, although many also report positive influences.**

The downsides

- 95% of doctors and 92% of nurses say it has increased the amount of administrative paperwork. [Charts 12 and 13]
- 83% of doctors and 85% of nurses say it has decreased time spent with patients. [Charts 12 and 13]
- 80% of doctors and 68% of nurses say it has decreased the ability of patients to get the prescription drugs they need. [Charts 12 and 13]
- 72% of doctors and 78% of nurses say it has decreased the quality of care for people who are sick. [Charts 12 and 13]
- Doctors say the biggest negative impact of managed care on their practices and patients is increased administrative paperwork; nurses say the biggest negative impact is decreased quality of care. [Chart 14]

The upsides

- 68% of doctors and 51% of nurses say it has increased the use of practice guidelines and disease management protocols. [Charts 12 and 13]
 - 45% of doctors and 42% of nurses say it has increased the likelihood that patients will get preventive services. [Charts 12 and 13]
 - Both doctors and nurses say the biggest positive impact of managed care on them and their patients is increased preventive services. [Chart 14]
- ❖ **Doctors and nurses both express greater concern than the general public about how plans balance patient care and cost concerns.**
- 59% of nurses and 46% of doctors say they would be very worried that a health plan would be more concerned about saving money than about what is the best treatment if a friend or family member were sick. [Chart 15]
 - In an April 1999 Kaiser Family Foundation/Harvard School of Public Health survey of the general public, 30% said they would very worried when asked a similar question. [Chart 15]

Section III: Physician Experiences and Attitudes for Different Physicians and Types of Practice

- ❖ **Physician experiences and attitudes vary considerably by their specialty designation.**
- Overall, 66% of primary care physicians say that managed care has had a negative impact on patient care, compared to 75% of specialists. 13% of primary care physicians and 5% of specialists say it has had a positive impact. [Chart 16]

- Specialists are more likely than primary care physicians to say that managed care had decreased the ability of patients to see medical specialists (91% vs. 79%) and decreased the likelihood of the early detection of illnesses (54% vs. 34%). [Chart 17]
- A majority of primary care physicians (52%) say that managed care has increased the likelihood that patients will get preventive services, compared to 40% of specialists. Primary care physicians are also more likely than specialists to say that a health plan has often or sometimes helped them to encourage a patient to practice better health (50% vs. 24%). [Charts 17 and 20]

❖ **Physician reports also vary based on their relationships with health plans. Physicians who are primarily affiliated with a single HMO are more likely to report positive views or experiences than those who contract with a large number of plans.**

- Overall, 52% of physicians who work primarily with a single HMO say that managed care has had a negative impact on patient care, compared to 74% of physicians who contract with multiple plans (23% and 6% respectively say it has had a positive influence). [Chart 16]
- Doctors who work primarily with a single HMO are more likely than other physicians to say that plans often or sometimes provide them with clinical data to provide more effective care (52% vs. 20%), help them to encourage patients to practice better health (58% vs. 29%), or provide them with guidelines or innovative tools to manage care (70% vs. 43%). [Chart 21]
- The more plans a physician contracts with, the more likely he or she is to report "great concern" about spending too much time on administration rather than with patients (physicians with 0 managed care contracts: 39%; 1-7 contracts: 60%; 8-14 contracts: 72%; 15 or more contracts: 75%). [Chart 19]

Summary of Findings

Following are highlights from the 1999 Survey of Physicians and Nurses designed and analyzed by researchers at the Kaiser Family Foundation and the Harvard School of Public Health.

Section I: Experiences with Health Plans

- ❖ **Almost nine out of ten doctors (87%) say that their patients have experienced some type denial of coverage for health services by a health plan over the last two years.**
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- Almost half (48% of nurses) say that in the last two years a health plan has made a decision that resulted in a decline in a patient's health (an equal number say this has not happened). [Charts 3]
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Section II: Attitudes Towards Health Plans

- ❖ **Most doctors and nurses (79% and 70% respectively) say their views of managed care are shaped a great deal by their experiences as health providers. [Chart 11]**
 - Fewer cite reports of professional organizations (31% for doctors and 29% for nurses) or the media (22% for doctors and 27% for nurses) as major influences. [Chart 11]
 - Nurses are more likely than doctors to say they are influenced a great deal by their experiences as patients (38% vs. 23%) and by reports of their friends and family members (47% vs. 39%). [Chart 11]
- ❖ **Both doctors and nurses say that managed care has had a generally negative effect on the health care system, although many also report positive influences.**

The downsides

- 95% of doctors and 92% of nurses say it has increased the amount of administrative paperwork. [Charts 12 and 13]
- 83% of doctors and 85% of nurses say it has decreased time spent with patients. [Charts 12 and 13]
- 80% of doctors and 68% of nurses say it has decreased the ability of patients to get the prescription drugs they need. [Charts 12 and 13]
- 72% of doctors and 78% of nurses say it has decreased the quality of care for people who are sick. [Charts 12 and 13]
- Doctors say the biggest negative impact of managed care on their practices and patients is increased administrative paperwork; nurses say the biggest negative impact is decreased quality of care. [Chart 14]

The upsides

- 68% of doctors and 51% of nurses say it has increased the use of practice guidelines and disease management protocols. [Charts 12 and 13]
 - 45% of doctors and 42% of nurses say it has increased the likelihood that patients will get preventive services. [Charts 12 and 13]
 - Both doctors and nurses say the biggest positive impact of managed care on them and their patients is increased preventive services. [Chart 14]
- ❖ **Doctors and nurses both express greater concern than the general public about how plans balance patient care and cost concerns.**
- 59% of nurses and 46% of doctors say they would be very worried that a health plan would be more concerned about saving money than about what is the best treatment if a friend or family member were sick. [Chart 15]
 - In an April 1999 Kaiser Family Foundation/Harvard School of Public Health survey of the general public, 30% said they would very worried when asked a similar question. [Chart 15]

Section III: Physician Experiences and Attitudes for Different Physicians and Types of Practice

- ❖ **Physician experiences and attitudes vary considerably by their specialty designation.**
- Overall, 66% of primary care physicians say that managed care has had a negative impact on patient care, compared to 75% of specialists. 13% of primary care physicians and 5% of specialists say it has had a positive impact. [Chart 16]

- Specialists are more likely than primary care physicians to say that managed care had decreased the ability of patients to see medical specialists (91% vs. 79%) and decreased the likelihood of the early detection of illnesses (54% vs. 34%). [Chart 17]
- A majority of primary care physicians (52%) say that managed care has increased the likelihood that patients will get preventive services, compared to 40% of specialists. Primary care physicians are also more likely than specialists to say that a health plan has often or sometimes helped them to encourage a patient to practice better health (50% vs. 24%). [Charts 17 and 20]

❖ **Physician reports also vary based on their relationships with health plans. Physicians who are primarily affiliated with a single HMO are more likely to report positive views or experiences than those who contract with a large number of plans.**

- Overall, 52% of physicians who work primarily with a single HMO say that managed care has had a negative impact on patient care, compared to 74% of physicians who contract with multiple plans (23% and 6% respectively say it has had a positive influence). [Chart 16]
- Doctors who work primarily with a single HMO are more likely than other physicians to say that plans often or sometimes provide them with clinical data to provide more effective care (52% vs. 20%), help them to encourage patients to practice better health (58% vs. 29%), or provide them with guidelines or innovative tools to manage care (70% vs. 43%). [Chart 21]
- The more plans a physician contracts with, the more likely he or she is to report "great concern" about spending too much time on administration rather than with patients (physicians with 0 managed care contracts: 39%; 1-7 contracts: 60%; 8-14 contracts: 72%; 15 or more contracts: 75%). [Chart 19]

**Lott Bill
(S326 as Amended)**

Provisions Included (new provisions in italics):

- | | |
|--------------------------|-------------------------------------|
| ▶ ER | ▶ Genetic Nondiscrimination |
| ▶ POS | ▶ AHCPR Reauthorization |
| ▶ Access to Ob/Gyns | ▶ MSAs |
| ▶ Access to Peditricians | ▶ <i>Provider Nondiscrimination</i> |
| ▶ Access to Specialists | ▶ <i>Cancer Clinical Trials</i> |
| ▶ Continuity | ▶ <i>Mastectomy Length of Stay</i> |
| ▶ Gag Clause | ▶ <i>Second Opinions</i> |
| ▶ Information Disclosure | ▶ <i>Self-employed deduction</i> |
| ▶ Grievances and Appeals | ▶ <i>LTC deduction</i> |

Scope

The majority of the bill still only applies to self-insured plans with some exceptions. As in S326, Information Disclosure and Grievances and Appeals apply to all ERISA plans while Genetic Nondiscrimination applies to all ERISA plans and the individual market. The provider nondiscrimination and clinical trials amendments apply only to the self-insured market, but the mastectomy length of stay and second opinions apply to the all ERISA plans and the individual market.

Emergency Services (as amended)

The Republican bill bans prior authorization requirements, but fails to ban network requirements for enrollees who seek care at an out-of-network hospital. The bill uses the prudent layperson standard for the initial screening exam and ambulance services, and provides stabilization services in accordance with EMTALA standards. The Republican bill also requires plans to reimburse for "services necessary to maintain medical stability" if the services are furnished by a nonparticipating provider and the plan fails to respond to the prior authorization request within one hour.

Point of Service (as amended)

The bill requires plans to offer a non-network options for all benefits that are otherwise limited to network providers. The Republican bill maintains the exemption in S326 for small employers (2-50 employees). The bill eliminates exemption in S326 for plans that offer 2 or more coverage options, but creates a new exemption when the point of service care would not be "available and acceptable to the participant with reasonable promptness."

Access to Ob/Gyns (as amended)

The Republican bill adds a provision that states nothing precludes a plan from allowing a ob/gyn to be a primary care physician, but it does not require it.

Access to Peditricians (same as S326)

The Republican bill provides direct access to peditricians.

DRAFT 7/16/99

Access to Specialists (as amended)

The bill added language that states enrollees must have "timely" access to speciality care and allow care to be coordinated by a "case manager." The Republican bill still does not require plans to provide standing referrals or require plans to allow specialists to be designated as primary care providers.

Continuity of Care (as amended)

The Republican bill attempts to fix a problem in S326 that limited continuity of care to 90 days even for the terminally ill, despite the fact that terminally ill is defined as a person whose life expectancy is 6 months or less. A drafting error in the bill, however, negates this fix.

Anti-Gag (same as S326)

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

Information Disclosure (same as S326)

The Republican bill did not fix the ERISA information disclosure problem that allows plans to notify enrollees of material changes in benefits after the effective date of those changes. The bill does require advance notification of changes in drug formularies.

Grievances and Appeals (as amended)

The claims procedure, coverage determinations, grievances, and internal appeals provisions are unchanged from S326. There are three major changes in the external appeals section: expedited external appeals, a timetable for the provision of the benefit, and a moderate CMP if deadlines are not followed.

- ▶ The Republican bill added expedited external review when the life or health of the enrollee is jeopardized. The review must be completed within 72 hours or the date at which all information is received, whichever is later.
- ▶ The bill requires the external review entity to establish a timetable for the plan to provide the benefit when the reviewer overturns the plan's determination.
- ▶ The bill allows the Secretary of Labor to assess a \$10,000 CMP for violation of any time frame in the external appeal section. When the plan fails to abide by the time frame the reviewer establishes for providing the benefit, the \$10,000 goes to the enrollee.

The weaknesses in the appeals section in S326 still apply: time frames are tied to the receipt of all information, the plan decides what is externally appealable, and the external review entity is bound by the plan's definition of medical necessity.

Genetic Nondiscrimination (same as S326)**AHCPR Reauthorization (same as S326)****MSAs (as amended)**

The Republican bill increases eligibility for MSAs by eliminating the cap on the number sold and the small employer restriction; reducing the deductible on a high deductible plan; increasing the contribution limit to 100% of the annual deductible; limiting the additional tax on distributions not

used for medical expenses; and allowing enrollees in FEHBP to purchase MSAs. Also allows the remaining amount (up to \$500) in a Flexible Spending Account to be carried over from one year to the next, be rolled over into an IRA, or invested in an MSA. In addition, the bill makes it clear that network-based managed care plans qualify as high deductible plans.

Provider Nondiscrimination

The Republican bill added a provision that prevents discrimination of providers based on license or certification.

Clinical Trials

The Republican bill added a provision that requires self-insured plans to cover the routine patient costs of cancer clinical trials funded by NIH, VA, and DoD. The bill requires the Secretary of Labor to define routine patient costs under negotiated rule making.

Mastectomy Length of Stay

The Republican bill added a provision that requires coverage for minimum hospital stays for a mastectomy, lumpectomy, or lymph node dissection. The length of stay is determined by the treating provider in consultation with the patient. It also prohibits the plan from offering incentives or penalizing the provider to limit the length of stay. This provision applies to all ERISA plans as well as the individual insurance market.

Second Opinions

The bill added a provision that requires all plans and issuers (ERISA plans and the individual market) to allow enrollees to request a second opinion in relation to the diagnosis or treatment of cancer. If the physician certifies in writing that the second opinion is not available in the network, the enrollee can go out-of-network at no additional cost beyond what the enrollee would have paid for an in-network specialist.

Self Employed Deduction

The Republican bill speeded up the full deduction of health insurance costs to be effective for plan years beginning January 1, 2000. Currently the full deduction for the self employed is to be phased-in over several years (60% in 1999; 70% in 2002; and 100% in 2003).

Long Term Care Insurance

The Republican bill allows long term care insurance to be included in Cafeteria Plans and Flexible Spending Accounts and allows 100% deductibility of long term care services or premiums for long term care insurance for individuals not eligible for employer subsidized coverage.

Other

Eliminates the Competitive Pricing Demonstration under Medicare+Choice.

55648

Nickles Substitute

Amendment: Provides a full substitute for S.6, the Democratic Patients' Bill of Rights.

Problems with the Amendment: The amendment leaves 113 million Americans out of the majority of its protections; wipes out key Democratic protections such as ensuring that doctors, not insurers, make medical decisions and the right to hold HMOs accountable when their decisions lead to harm; guts key protections in the Democratic bill, including such as real access to emergency care under a prudent layperson definition, an appeals process that is independent, fair and timely, and access to medical specialists, prescription drugs, and clinical trials. In place of the real protections in the Democratic bill, it provides a series of hollow, cosmetic measures that will leave insurers and HMOs in charge of medical decisions.

NEW PROVISIONS IN THE FINAL BILL

IRAs for the Wealthiest

- Provides a fiscally irresponsible tax break for the wealthiest taxpayers in the country that has nothing to do with patients' rights.
- Purports to pay for the GOP bill, but instead drains the treasury over time.
- Raises income limit on rollovers into Roth IRAs from \$100,000 to ONE MILLION DOLLARS. Earnings on these rollovers will be completely tax free to wealthy individuals.

Medical Savings Accounts

- Converts a pilot program into a full-scale program that benefits the healthy and wealthy and threatens to make insurance more expensive for sicker, older Americans.
- Creates a tax break for the wealthy while doing little to expand access to insurance.
- Expands this product before it's been tested, not only in the private insurance market, but also in Medicare.

Wipes Out Medicare Competitive Pricing Demonstration Program

- Eliminates a competitive pricing demonstration that was intended to allow Medicare HMOs in specific communities to compete on the basis of cost and quality.

PROBLEMS WITH EXISTING PROVISIONS

***Emergency Care**

- Covers only individuals in self-insured plans (48 million).
- Remains ambiguous about whether it ensures coverage under prudent layperson definition.
- Provides no guarantee people cannot be financially penalized if they go outside network.
- Includes new section on access to post-stabilization with big loopholes:
 - if the plan doesn't respond in one hour, they have to pay for services to maintain stability – but those services are defined as services in the emergency department. There is nothing requiring plans to allow a patient to be admitted to the out-of-network hospital.
 - HMO could write in their contract that they don't cover hospitalizations following stabilization, even within network

- No right to appeal denials based on prudent layperson standard.

OB/GYN

- Covers only individuals in self-insured plans (48 million).
- Does not allow designation of ob/gyn as primary care physician.
- Does not require plan to allow direct access to ob/gyn except for routine care. If a woman has an abnormal pap smear, she has to go through a gatekeeper to seek further treatment.
- American College of Obstetricians and Gynecologists (ACOG) opposes the amendment.
- No right to appeal denial of access to an OB/GYN.

***Specialty Care**

- No substantive change from original GOP bill.
- Covers only individuals in self-insured plans (48 million).
- Provides no ability to go outside HMO network at no extra cost if HMO's network is inadequate.
- Allows HMO to write contract provisions rendering the protection meaningless, e.g., specialty care is covered only under the contract when authorized by a gatekeeper.
- Provides no ability to ensure people with chronic conditions can use their specialist to coordinate their care.
- No right to appeal an HMO decision to deny specialty care.

Clinical Trials

- Covers only individuals in self-insured plans (48 million).
- Covers only cancer clinical trials – leaves out patients with mental illness, spinal cord injury, Parkinson's disease, Alzheimer's disease, diabetes and other serious conditions (only 1/3 of clinical trials are for cancer). Overall, only 10% of patients eligible to enroll in clinical trials would be protected.
- No right to appeal an HMO's denial of a needed clinical trial.
- No cancer groups support the measure.

Access to Needed Drugs

- Covers only individuals in self-insured plans (48 million).
- Allows HMOs to financially penalize the few people covered under the bill who need to obtain medicine off an HMOs approved list (formulary) because their doctor says it's medically indicated.
- Allows HMOs to deny drugs on the basis that they are experimental, even though the FDA has approved them.

Point of Service

- Covers only individuals in self-insured plans (48 million).
- Leaves out anyone who works for a small business, the group least likely to offer patients any choice at all.

Continuity of Care

- Covers only individuals in self-insured plans (48 million).
- Leaves out protection for all Americans who are not terminally ill, pregnant, or hospitalized (e.g., patients with cancer, chronic illnesses, or any other disease who are undergoing a course of treatment).
- Fails to clarify the provision in S.326 that would force a terminally ill patient to change doctors before their death or a hospitalized patient to be transferred. Coverage is still limited to 90 days. Sponsors claim they fixed this provision, but the language in the bill limits coverage to 90 days.

Medical Necessity

- Provides patients no protection against arbitrary interference by HMOs with their doctors' medical decisions.
- Continues to allow HMOs to define medical necessity, allowing contracts such one in Missouri to continue that gives the company "sole discretion to determine whether care is medically necessary. The fact that care has been recommended, provided, prescribed or approved by a physician or other provider will not establish that the care is medically necessary."

External Appeals

- Leaves out 38 million Americans, those in the individual market and those working for state and local governments.
- Remains essentially unchanged from underlying language in S.326.
- Allows the HMO to pick and pay the appeal entity, destroying any semblance of independence.
- Allows the HMO or insurer to define medical necessity, tying the hands of the independent review entity and forcing them to defer to the HMO's definition.
- Fails to provide for *de novo* review.
- Does not provide an appeal when rights under the bill are denied. As a result, there is no appeal when emergency care is denied, access to a specialist is denied, etc. The only situations requiring appeal are questions of medical necessity (which the plan defines itself) and whether a treatment is experimental.
- Restates inadequate remedy under current law available when HMO decisions to deny or delay care lead to harm (affirms current ERISA shield).

Ability to Hold HMOs Accountable

- Maintains existing protection for HMOs and insurers that injure or kill patients when they delay or deny care.

Gag Clauses

- Applies only to those in self-insured plans (48 million).
- Does not ensure doctors can talk about the HMO's financial incentives or its processes for determining whether it will approve care.

Financial Incentives to Deny Care

- Provides no limits or prohibitions on HMOs' use of financial incentives to deny care on doctors or utilization review workers.

Information

- Does not require plans to tell patients when their benefits change.
- Does not require plans to tell patients up front the specific benefits excluded from coverage.
- Does not require any information on the quality of the plan, such as patient satisfaction, immunization rates, etc.

66468

U.S. Department of Labor

Pension and Welfare Benefits Administration
Washington, D.C. 20210Date: 7/13/99TO: Chris TENNINGS

_____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:

Attached is a draft letter that I am prepared to
send to Senator Daschle (per his request).
Dan McGuire will call you to explain the
context.

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

There are 7 pages including this page.

U.S. Department of Labor

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

Senator Tom Daschle
509 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Daschle:

This letter is in response to your inquiry concerning the extent to which employers can be held liable under S. 6, "The Patients' Bill of Rights Act of 1999."

As you know, section 302 of the bill, as introduced on January 19, 1999, would permit patients to bring an action under state law against their health plan to recover damages for personal injury or wrongful death relating to the provision of insurance, administrative services or medical services.

The bill specifically exempts employers who sponsor health plans from liability in any such action, unless the employer exercised discretionary authority to make a decision on a claim for benefits in the case at issue, and such exercise of authority caused the personal injury or wrongful death.

What this means in practice is that an employer who makes a decision on a specific benefit claim will be subject to liability under the bill if that decision resulted in injury to the patient. Those employers who have no role in making a particular benefit decision are specifically exempted from any liability under the bill as to that claim.

Many employers, particularly those who have fully-insured group health plans, are not involved in making coverage decisions concerning claims made by participants and beneficiaries of the plan. These employers contract with an insurance company or HMO to provide both the medical services available under the plan and the administration of claims under the plan. In this situation, employers could not be held liable.

Some employers, mainly large self-insured employers, may retain control over the administration of claims. They can do this by administering the claims themselves or simply by exercising some discretion to intervene in claims decisions made by a third party. In this instance, the employer can be held accountable under the bill if their decision results in injury to a patient.

Thus, employers cannot be held accountable for wrongful claims decisions that they are not involved in. Even if an insurance company or HMO being sued under this bill is able to bring an employer into the lawsuit, the court cannot hold the employer liable unless it can be shown that the employer exercised discretionary authority in making the claims decision involved in the suit.

We hope this addressed your question about the employer exemption. Feel free to contact me directly if you have any additional questions.

Sincerely,

Leslie Kramerich
Deputy Assistant Secretary for Policy
Pension and Welfare Benefits Administration

1 (2) The table of contents in section 1 of the
2 Employee Retirement Income Security Act of 1974,
3 as amended by the Omnibus Consolidated and
4 Emergency Supplemental Appropriations Act, 1999
5 (Public Law 105-277), is amended by inserting
6 after the item relating to section 713 the following
7 new item:

"Sec. 714. Patient protection standards."

8 (3) Section 502(b)(3) of the Employee Retire-
9 ment Income Security Act of 1974 (29 U.S.C.
10 1132(b)(3)) is amended by inserting "(other than
11 section 144(b))" after "part 7".

12 **SEC. 302. ERISA PREEMPTION NOT TO APPLY TO CERTAIN**
13 **ACTIONS INVOLVING HEALTH INSURANCE**
14 **POLICYHOLDERS.**

15 (a) IN GENERAL.—Section 514 of the Employee Re-
16 tirement Income Security Act of 1974 (29 U.S.C. 1144)
17 is amended by adding at the end the following subsection:

18 "(e) PREEMPTION NOT TO APPLY TO CERTAIN AC-
19 TIONS ARISING OUT OF PROVISION OF HEALTH BENE-
20 FITS.—

21 "(1) IN GENERAL.—Except as provided in this
22 subsection, nothing in this title shall be construed to
23 invalidate, impair, or supersede any cause of action
24 brought by a plan participant or beneficiary (or the
25 estate of a plan participant or beneficiary) under

1 State law to recover damages resulting from per-
2 sonal injury or for wrongful death against any
3 person—

4 “(A) in connection with the provision of in-
5 surance, administrative services, or medical
6 services by such person to or for a group health
7 plan (as defined in section 733), or

8 “(B) that arises out of the arrangement by
9 such person for the provision of such insurance,
10 administrative services, or medical services by
11 other persons.

12 “(2) EXCEPTION FOR EMPLOYERS AND OTHER
13 PLAN SPONSORS.—

14 “(A) IN GENERAL.—Subject to subpara-
15 graph (B), paragraph (1) does not authorize—

16 “(i) any cause of action against an
17 employer or other plan sponsor maintain-
18 ing the group health plan or against an
19 employee of such an employer or sponsor
20 acting within the scope of employment, or

21 “(ii) a right of recovery or indemnity
22 by a person against an employer or other
23 plan sponsor (or such an employee) for
24 damages assessed against the person pur-

1 suant to a cause of action under paragraph
2 (1).

3 “(B) SPECIAL RULE.—Subparagraph (A)
4 shall not preclude any cause of action described
5 in paragraph (1) against an employer or other
6 plan sponsor (or against an employee of such
7 an employer or sponsor acting within the scope
8 of employment) if—

9 “(i) such action is based on the em-
10 ployer’s or other plan sponsor’s (or em-
11 ployee’s) exercise of discretionary authority
12 to make a decision on a claim for benefits
13 covered under the plan or health insurance
14 coverage in the case at issue; and

15 “(ii) the exercise by such employer or
16 other plan sponsor (or employee of such
17 authority) resulted in personal injury or
18 wrongful death.

19 “(3) CONSTRUCTION.—Nothing in this sub-
20 section shall be construed as permitting a cause of
21 action under State law for the failure to provide an
22 item or service which is not covered under the group
23 health plan involved.

24 “(4) PERSONAL INJURY DEFINED.—For pur-
25 poses of this subsection, the term ‘personal injury’

1 means a physical injury and includes an injury arising out of the treatment (or failure to treat) a mental illness or disease.”.

2 (b) EFFECTIVE DATE.—The amendment made by
3 subsection (a) shall apply to acts and omissions occurring
4 on or after the date of the enactment of this Act from
5 which a cause of action arises.

6
7
8 **TITLE IV—APPLICATION TO**
9 **GROUP HEALTH PLANS**
10 **UNDER THE INTERNAL REVENUE**
11 **CODE OF 1986**

12 **SEC. 401. AMENDMENTS TO THE INTERNAL REVENUE CODE**
13 **OF 1986.**

14 Subchapter B of chapter 100 of the Internal Revenue
15 Code of 1986 (as amended by section 1531(a) of the Tax-
16 payer Relief Act of 1997) is amended—

17 (1) in the table of sections, by inserting after
18 the item relating to section 9812 the following new
19 item:

“Sec. 9813. Standard relating to patient freedom of choice.”;
and

20 (2) by inserting after section 9812 the follow-
21 ing:



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.

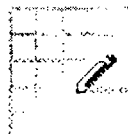
Its enforcement provision is inadequate to ensure that the patient protections are real. The limited rights outlined in S. 326 are not meaningful because patients who have died or been seriously harmed by wrongful actions by health plans would have no ability to seek compensation for their injuries.

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.

* * * * *

 Laura E. Schwartz
07/12/99 11:30:38 AM

Record Type: Record

To: Devorah R. Adler/OPD/EOP@EOP

cc:

Subject: Second Edit

THE WHITE HOUSE

**Office of the Press Secretary
(Santa Monica, California)**

For Immediate Release

July 9, 1999

**REMARKS BY THE PRESIDENT
ON HEALTH CARE**

**Harbor-UCLA Medical Center
Torrance, California**

10:54 A.M. PDT

THE PRESIDENT: Thank you very much. Well, good morning, and I want to thank Tecla Mickoseff for welcoming us here to Harbor-UCLA. Thank you, Ethel, for your powerful statement out of your personal experience. I want to thank my old friend, Jack Lewin, for, as usual, making the case. We're used to being in fights where the evidence is overcome by political power. (Laughter.) But we're determined to reverse it in this case.

I want to thank Congresswoman Juanita Millender-McDonald; my friends, Ev Gerisloski (phonetic) and Yvonne Burke, and the mayors and other local officials who are here. I thank the leaders of the health care groups that are here, both consumers and providers. Thank you, Reverend Jackson, for coming. We're glad to see you this morning. (Applause.)

I have a couple of things I want to say about health care and about how this patients' bill of rights issue fits into our larger responsibilities to deal with the health of the American people. I have just finished a trip across our country, from Appalachia to the Mississippi Delta to the Pine Ridge Indian reservation to inner-city neighborhoods in East St. Louis, Illinois, South

Phoenix and Los Angeles. The purpose of this was to shine a spotlight on the opportunity, which exists in areas that our prosperity has completely passed by.

It was a remarkable four days, and I came in contact with all the health issues that you would be concerned about in the process of pushing an economic agenda. For one thing, when we left Washington and arrived in Appalachia, and arrived in the Mississippi Delta, and arrived in East St. Louis, and arrived in Phoenix, in all those places it was 100 degrees. (Laughter.) It was cool in Dakota when we got there at night, but the next day it was a mere 94.

And I'm very worried, I must say -- I want to say this today -- I've been very concerned because a lot of poor people depend upon the LIHEAP program -- the Low Income Health Assistance program, to pay for air-conditioning or get fans in the summertime. And I have, today, directed the appropriate people in our federal government to expedite the analysis we're required to do about the effects of the recent heat wave on the need for emergency assistance under this program. We could lose a lot of people who won't even get to the emergency room if we don't do it. So I do want you to know that I hope the message will go across the country to the places I visited and the other places that we know this is going to be a problem. (Applause.)

When we went on this tour we saw an awful lot of problems, and we saw a lot of promise -- enough promise to convince us all that we actually can succeed in building a bridge to the 21st century that all Americans can walk across. When we give economic opportunity to all, we're helping to build that bridge. When we give all of our kids a world-class education, we're helping to build that bridge. When we're dealing with health care challenges, we're helping to build that bridge.

Jack mentioned the Medicare proposal that I have made to stabilize the Medicare trust fund until 2027, provide a prescription drug benefit that we can afford, and provide much more preventive services, which I think are very, very important.

Now, how does the patients' bill of rights fit into all of this? I feel in a way that I have a special right, if you will, to advocate for this bill because I have defended the role of managed care in our health care system for years. When I became President, health costs had been going up at three times the rate of inflation for many years. And all of us knew it was totally unsustainable, that eventually, if it kept going up at three times the rate of inflation, we'd be spending all our money on health care.

We all knew that was completely unsustainable, and that there was nothing wrong with managing a system properly so that you could, at the lowest possible cost, achieve the objective, which was the highest possible quality of health care. And, yes, at the margins there will always be tough decisions, but fundamentally, no one who both believes in the American health care system and the professionals who provide that health care, and who believes in proper management, believes you should sacrifice basic quality of care to the decision made by an accountant to make the bottom line of an HMO bigger.

The purpose of managed care is to enhance quality of care by making it as affordable as possible, not to undermine quality of care by making the people who provide managed care as profitable as possible. And it's very important -- (applause.)

So, as has already been pointed out, I ask the Congress a year and a half ago to pass a strong enforceable patients' bill of rights, with all the things you've heard about -- the right to see a specialist, the right to emergency room care at the nearest emergency room, the right not to have to change health care providers in the middle of treatment, the right to enforce accountability for harmful decisions. And I have used my authority as President, as you said, not only to cover by executive order those people on Medicare with the protections of the patients' bill of rights, but also those people on Medicaid, those people served by the Veterans Administration, and the people in the federal health insurance plan, the federal employees and their families.

And I want to just tell you that we actually now have some experience with the patients' bill of rights. You know, the HMOs say, well, this all sounds very good, but we can't afford it, and if you -- and they always try to make you think only of yourself, your healthy self -- if you, your healthy self -- (laughter) -- who never gets sick, but has to pay health insurance, give these patients' bill of rights to them, all those sick people, you, your healthy self, will have to pay more for health insurance, and oh, how terrible it will be. That's their argument, right?

Well, we actually have done this now, and we have evidence -- and sometimes evidence overcomes interest groups in Washington, so let's talk about the evidence. Our evidence is that when we put the patients' bill of rights into the federal employees health plan, it raised the cost of health insurance -- by less than a dollar a month.

Now, I'm going to go over this one more time. You've already heard -- I'm going to go over it one more time, and I'm going to ask every American if he or she wouldn't be willing to pay something in that range on the off-chance that their healthy self might not always be that way, and out of a genuine concern for our fellow citizens and an understanding that the wealth and power and strength and quality of life of our country depends in no small measure on the continued advances in the health of all Americans. (Applause.)

And, yes, some states have done some things in this area. But until Congress acts, there will be more than 100 million Americans who won't have these full protections. I can only give it to 85 million by executive order. So next week, at long last, the Senate is going to take this up. I'll say more about that in a moment, but thank goodness, the Senate finally is going to take this up.

Last year -- all year the leaders of the Senate kept us from bringing the bill up. And there's a good reason why they did -- they're not for it, but they know they can't afford to be caught being against it. (Laughter.) We have 200 -- 200 plus medical and consumer groups are for the patients' bill of rights. The American Medical Association has allies it has never had before. (Laughter.) This is a very big tent.

And there is only one group on the other side, the health insurers. It's 200 to one, but the one is a big one, and so far has had enough support in the majority party in the House and the Senate to keep this from coming up.

But if you go out in the country, I have said this over and over and over again, if you go out in the country, this is not a partisan issue, because Republicans get sick just like Democrats. Even stubborn independents sometimes get sick. (Laughter.) And when you walk into the emergency room -- I would really like to know whether she's got a form she fills out in the emergency room that has a check for political party. (Laughter.)

Now, before I give you this medicine, are you a conservative or a liberal? (Laughter.) You know, we're laughing about this, but it makes a very important point. This is not a partisan issue, this is not even a philosophical issue, not anywhere in the wide world but Washington, D.C.

If you explained all the options to all the people in all the communities of this country, I promise you over 70 percent of Republicans, Democrats, and independents -- you know, when you got above those stratospheric numbers, maybe there would be some partisan difference -- but you'd have over 70 percent of all groups for this. How can it be -- how can it be that for over a year the American people have been deprived of even a full debate on this in the United States Senate?

Well, as I learned and Jack learned back in 1993 and '94, these folks have a lot of clout. But let's forget about the politics and look at the facts. I want to run through this -- look at this chart over here. I wish every American could just have this chart at home. If I had the ability through the Internet to send this to every American I would do it.

Our plan says, if you need to see a specialist, you can't be denied the right to see a specialist. Their plan doesn't give you that right. Our plan says, if you get hit driving out of this event today, on a hot Saturday morning in Los Angeles, you ought to be able to go to the nearest emergency room, not show up there and be told you've got to drive 25 miles to one that your plan covers. This is a real issue, as you know.

Our plans says -- and I was so glad to hear you mention this -- that if you're being treated with chemotherapy or if you're six months pregnant and your employer changes providers, you should be able to stay with the physicians that are treating you until the treatment is completed. Hugely important issue that most Americans are not aware of. (Applause.)

Our plan assures HMO accountants don't make arbitrary medical decisions. Now, let me just say, I've listened to a lot of stories about this. I've done a lot of research on this. A lot of times the HMO decision-making tree, you finally get high enough to get a doctor who makes the right decision and it's too late.

And I've said this over and over again—I'm actually sympathetic with a lot of people at the first line of decision-making in the HMO. Why? They're not doctors and they're never going to get in trouble with the company for saying no. Right? They know—I'm sympathetic with them. A lot of them, they're making a modest income, they're looking forward to their Christmas bonus, they want to please their employer like we all do. You're my employer—I want to please you. (Laughter.) We're all like that. And these young people who are working in these companies, they know they are not going to get in trouble from saying no, because they know if they say no, the decision can always be kicked upstairs—and maybe it's three levels upstairs, but eventually, somebody who actually understands this is going to make a decision. And if they say yes, they won't get in trouble for having said no, but, ah, if they say yes, and somebody above them says, you should have said no, they can get in a world of trouble.

So we try to fix that here and change the incentive so that there is no institutional bias to deny quality care. Should the health plans be held accountable? I think so. The framers of the Constitution understand that a right without a remedy is not a right at all. And should they cover all health plans? Absolutely. The other bill leaves out 100 million folks.

So that's what this is about. The "yeses" and the "nos." It's simple evidence. It's about how people live. And, yes, the health insurance association may have some of its profit margin squeezed. And, yes, they may have to have modest increases, like we did—the federal employees health plan -- I'll tell you it's less than a buck a month for a policy. That's

what our experience is. But isn't it worth it to allow the system to work? To keep the benefits of managed care without having to shoulder these enormous burdens, these heartbreaking burdens.

I don't know how many people I have seen—I've seen nurses who work for doctors in their offices who have to make the calls to the HMOs to get told no break down and cry, telling me stories of people that they couldn't take care of. You know, these are not just isolated anecdotes. This is a systematic problem in American health care. And once we fix it, all the people will be happy—the HMOs will do just fine and they'll be happy we did. And people will wonder what in the wide world we were doing all those years not providing these basic protections.

Think of how you'd feel if you were a doctor, you'd spend all those years going to medical school, all those years in residency, you go all those years without any sleep, and you're finally out there giving health care and all of a sudden you're told, here's a straight-jacket we'd like you to wear to work every day and still figure out how to make these people well. I mean, this is a big, big, big issue. And it should not be played out in a partisan political or special interest atmosphere.

Shouldn't we err on the side of health? What are we afraid of? (Applause.)

I saw today an amusing article in the paper which said that the leaders of the majority party had decided that instead of bringing up their bill and having to deal with 20 of our amendments, which would put people -- force them to put their members on record being against these things, they would bring up our bill and just beat it, in the hope that then there would be no specific record of accountability.

I thought to myself, what kind of a weird world am I living in? If this was just about something we had an emotional opinion about and we were on different sides, I would think that would be a clever thing to do and that's just politics. This is not whether you've got an emotional thing, this is about whether some people live and some people die. This is about whether people get well, or they don't. This is about whether people feel at least comfort when they're dealing with the challenges of life, or they're just knotted in anxiety all the time.

This is about all these doctors, these nurses, these health care professionals wake up every day happy to go to work because they think they're going to be able to do their job, or they're waiting for the other shoe to fall every single day because somebody is trying to strangle their ability to make decent decisions. This is, in other words, not a typical political decision. This is about life and the quality of life, and the fundamental decency of our society.

We should err on the side of humanity. We should err on the side of quality health care. We have evidence now from our own experience that we can well afford to do this. And this is an idea whose time has long since come.

So—and there are members of Congress in the Republican Party, as well as the Democratic Party, who support this, who just want a chance to vote for it and bring the benefits of it to the American people.

You know, it's like anything else—you can argue against anything on the grounds that it's not perfect. Well, if we never did anything because it wasn't perfect, we'd never do anything. And America wouldn't be here celebrating the 21st century. We wouldn't be around after 223 years. The Constitution wasn't perfect; it had to be amended.

So it is not an argument to vote against this bill that it might not be perfect, that there might be some unforeseen consequences that we might have to fix—we take our cars to mechanics to fix things that aren't perfect, but we don't stop buying cars and go back to walking around. (Laughter.) I mean, none of these arguments make any sense at all.

We have to put people and principle and evidence ahead of raw political influence. Democracy has to work -- (applause.)

So, I thank you for being here. Remember, we're all preaching to the saved in this room

today. Reach out to other members of Congress. Send a note or an e-mail today or Monday morning to every House member that represents anywhere around here, and both your senators are for this bill -- that's great. Send it to senators from other states. Give people a chance to do the right thing. Tell them what's at stake.

If people will listen to their hearts and their heads, we'll prevail next week. Thank you and God bless you.

END

11:15 A.M. PDT

PRESIDENT CLINTON URGES CONGRESS TO PASS A STRONG, ENFORCEABLE, PATIENTS' BILL OF RIGHTS

July 9, 1999

As the Senate prepares for its long overdue debate over patient protections next week, President Clinton today challenged Congress to pass a strong, enforceable Patients' Bill of Rights this summer. While commending Senator Lott for agreeing to schedule a vote on this issue, the President criticized the Republican leadership bill as wholly inadequate because of the bill's limited number of Americans covered, insufficient protections, and weak enforcement provisions that fail to hold health plans accountable. At a forum at Harbor UCLA Medical Center, the President raised specific concerns about the current version of this bill, including the fact that it leaves unprotected over 110 million Americans – including 14.5 million Californians. He also heard the Executive Vice President and the CEO of the California Medical Association, Dr. Jack Lewin, and Ethel Edmond, a registered nurse practicing in Los Angeles County, describe the practical implications of the shortcomings of the Republican leadership bill. Today, the President:

Commended the Republicans for the Decision to Hold Next Week's Debate on the Patients' Bill of Rights. The President praised the Republican leadership for recognizing the need to debate about the best way to address the serious concerns about health care quality. He reiterated his appreciation of the Congressional Democrats' dedication to moving this important legislation through Congress and to work with Republicans to try to build a consensus to assure passage. The President also underscored his belief that this is not a partisan issue and stated his belief that this is best illustrated by the fact that thousands of doctors and nurses, over 200 medical and consumer groups, and many health care and public sector unions have all endorsed our plan for patient protections.

Reiterated that Any Patient Protections Legislation Must Assure Patients the Protections They Need. More than a year and a half ago the President accepted the recommendations of a the non-partisan broad-based Quality Commission to assure that every health plan provides strong patient protection and urged Congress to pass a Patients' Bill of Rights. Today, the President urged Congress to pass a bill in this legislative session that includes critical protections such as:

- Guaranteed access to needed health care specialists;
- Access to emergency room services when and where the need arises;
- Continuity of care protections so that patients will not have an abrupt transition in care if their providers are dropped;
- Access to a fair, unbiased and timely internal and independent external appeals process, to address health plan grievances and to help govern decisions about medically necessary treatments;
- An enforcement mechanism that ensures recourse for patients who have been harmed as a result of a health plan's actions; and
- Protections for all Americans in all health plans.

Criticized Watered Down, Piecemeal Approach Offered by the Republican Leadership. The President underscored that the Republican Leadership bill fails to include many basic protections for Americans, including: no access to necessary specialists; no effective mechanism to assure patients access to emergency room care when and where the need arises; failure to guarantee continuity of care protections leaving patients at risk of having to abruptly change doctors in the middle of treatment; has a weak, watered-down appeals process that is biased against patients and does not provide for a standard of medical necessity; and does not have a strong enforcement mechanism for patients to hold health plans accountable when they make harmful decisions. And finally, because it only covers self insured plans, the Senate Republican leadership proposal would leave over 110 million people without basic protections – 14.5 million people in California alone.

Stressed the Urgency of Strengthening and Modernizing Medicare for the 21st Century. The President emphasized that Medicare needs to be strengthened to: (1) be more competitive and efficient; (2) include a long-overdue prescription drug benefit and improvements in preventive benefits; and (3) make an unprecedented long-term financing commitment to the program that would extend the estimated life of the Medicare Trust Fund until at least 2027. The President encouraged Congress to work with him on a bipartisan basis pass this important legislation this year.

The Clinton Administration's Strong Record on Patients' Rights. The Clinton Administration has a long history of promoting patients rights and President Clinton has already used his authority to make many of these rights real for the 85 million Americans who get their health care through federal plans – from Medicare and Medicaid, to the Federal Employees Health Benefits Plan, to the Department of Defense and the Veterans Administration. The Administration's record on patients' rights include:

- Appointment of a Quality Commission to examine potential quality concerns in the changing health care industry. In 1996, the President created a non-partisan, broad-based Commission on quality and charged them with developing a patients' bill of rights as their first order of business.
- Challenging Congress to Pass a Patients Bill of Rights. In October of 1997, the President accepted the Commission's recommendation that all health plans should provide strong patient protections and called on the Congress to pass a strong enforceable patients' bill of rights. He also called on the Congress to make passing the patients' bill of rights a top priority in his 1998 and 1999 State of the Union Addresses.
- Extending Critical Patient Protections to All Federal Health Plans. In February of 1998, the President directed the Federal health plans, covering 85 million Americans, to implement the patients' bill of rights. Over the next year, each Federal Health Plan has taken critical steps to implement these protections. For example, the Office of Personnel Management issued their annual call letter notifying their 285 health plans they needed to implement patient protections to participate in the Federal Employees Health Benefits Program; the Health Care Financing Administration issued an Interim Final Rule to implement patient protections for the millions of Americans covered by Medicare; and the President announced a proposed rule to bring the Medicaid program into compliance.

DATE: July 15



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☐ FRANKIE MELTON

REMARKS:

A REAL BIPARTISAN COMPROMISE: PROMOTING RESPONSIBLE MANAGED CARE *PLUS* July 15, 1999

Overview

The Senate should not miss this opportunity to pass meaningful legislation to restore -- for all privately insured Americans -- public confidence in managed care. The Promoting Responsible Managed Care *Plus* proposal blends the best features of both the Democratic and Republican managed care reform plans, and is based upon the bipartisan managed care reform bill, S. 374, "The Promoting Responsible Managed Care Act." This compromise includes consumer information requirements to allow competition based on quality; a reasonable set of patient protection standards to ensure patients have access to appropriate medical care; an independent external process to resolve coverage disputes, and enforcement provisions which allow for reasonable compensation for individuals harmed by adverse decisions of managed care plans.

SCOPE OF PROTECTION

Basic protections for all privately insured Americans. All private insurance plans would be required to meet basic federal patient protections regardless of whether they are regulated at the state or federal level. This approach follows the blueprint established with the enactment of the Health Insurance Portability and Accountability Act of 1996, which allows states to build upon a basic framework of federal protections. Further, this approach does not preempt existing state laws nor alter state regulation of insurance.

COVERAGE DETERMINATION, GRIEVANCE AND APPEALS

Coverage determinations. Plans would be required to make decisions as to whether to provide benefits, or payments for benefits, in a timely manner.

Internal appeals. Patients would be assured the right to appeal the following: failure to cover emergency services, the denial, reduction or termination of benefits, or any decision regarding the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings. The plan would be required to have a timely internal system, using health care professionals independent of the case at hand.

External appeals. Individuals would be assured access to an external, independent appeals process to ensure that patients get a fair and appropriate review of all treatment and coverage disputes. Unlike the GOP bill, this compromise assures a *de novo* review (fresh look) by the external appeals body for all disputes over plan decisions involving "medical judgment," i.e. disputes over whether a service falls within a contractual exclusion or would be covered if medically necessary. The external appeal entity, nor the plan, would have the authority to decide whether a particular plan decision is in fact externally appealable, and allows adequate time for the patient to initiate the appeal (90 days, as allowed for federal employees). Further, the reviewers are not bound by the plan's definition of what is medically necessary, and the appeals body's decision is binding. In addition to the patient's medical record and the treating physician's proposed treatment, the range of evidence that is permissible in an external review would include valid and reliable research, studies and other evidence from impartial experts in the relevant field -- the same types of evidence typically used by the courts in adjudicating health care quality cases.

Expedited processes would be required at all stages in cases in which the standard deadlines could seriously jeopardize the patient's life, health, ability to regain or maintain maximum function or, (in the case of a child) development.

Determination of reasonable course of treatment. This proposal contains a meaningful standard of review for external appeals entities to use in making determinations as to what constitutes a reasonable course of treatment for the patient, rather than codifying a definition of "medical necessity." Therefore, this provision does not prevent plans from promoting "best practice" medicine, and does not lock in place

inappropriate regional variations in treatment. This approach balances the competing objectives of ensuring that patients receive high quality care, with the need to preserve our ability, through managed care, to contain the costs of providing that care.

ENFORCEMENT AND COMPENSATION

Compensation for individuals harmed by the decisions of managed care plans. This proposal drops the controversial state court liability provision and allows all privately insured individuals access to federal courts to recover compensatory damages, including for economic loss and treble damages for pain and suffering, once they have exhausted all administrative remedies. In instances where death or injury (resulting from a denial of care) have already occurred, the required exhaustion of administrative remedies would be waived. Economic loss would be defined as any pecuniary loss caused by the decision of the managed care plan, and would include lost earnings or other benefits related to employment, medical expenses, and business or employment opportunities. Awards for economic loss would be uncapped and attorneys fees could be awarded at the discretion of the court. Employers could not be held accountable under this provision unless they actually make the medical determination which results in harm.

CONSUMER INFORMATION

Comparative information. Consumers would be given uniform comparative information on quality measures in order to make informed choices. Data would include: patient satisfaction, delivery of health care services such as immunizations, and resulting changes in beneficiary health. Variations would be allowed based on plan type.

Plan information. Patients would be provided with information on benefits, cost-sharing, access to services, grievance and appeals, etc. A grant program would be authorized to provide enrollees with information about their coverage options, and with grievance and appeals processes.

PATIENT PROTECTION STANDARDS

Emergency services. Coverage of emergency services would be based upon the "prudent layperson" standard, and, importantly, would include reimbursement for post-stabilization and maintenance care. Requirements to secure prior authorization of services would be prohibited.

Enrollee choice of health professionals and providers. Patients would be assured that plans would:

- allow women to designate her obstetrical/gynecological services provider as her primary care provider and have direct access to obstetrical and gynecological services;

- allow plan enrollees to choose pediatricians as the primary care provider for their children;

- have a sufficient number, distribution and variety of providers;

- allow enrollees to choose any provider within the plan's network, who is available to accept such individual (unless the plan informs enrollee of limitations on choice);

- provide access to specialists, pursuant to a treatment plan;

- in the case of a contract termination, allow continuation of care for a set period of time for chronic and terminal illnesses, pregnancies, and institutional care.

Access to approved services. Plans would be required to cover routine patient costs incurred through participation in an approved clinical trial. In addition, they would be required to use plan physicians and

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pharmacists in development of formularies, disclose formulary restrictions, and provide an exception process for non-formulary treatments when medically necessary.

Prohibition of interference with certain medical communications. Plans would be prohibited from using "gag rules" to restrict physicians from discussing health status and legal treatment options with patients.

Provider incentive plans. Plans would be barred from using financial incentives as an inducement to physicians for reducing or limiting the provision of medically necessary services.

Provider participation. Plans would be required to provide a written description of their physician and provider selection procedures. This process would include a verification of a health care provider's license.

Appropriate standards of care for mastectomy patients. Plans would be required to cover the length of hospital stay for a mastectomy, lumpectomy or lymph node dissection that is determined to be medically necessary and appropriate by the physician in consultation with the physician.