To: To Whom It May Concern
From: Debbie
Date: 9/9/99
Re: Coburn/Shaddegg Bill – a very quick look

Coburn/Shaddegg introduced their managed care bill yesterday. The liability provisions in the bill are horrendous. They do not have the support of the Republican leadership. In fact, they are calling their bill "disastrous."

In sum the bill differs as follows:

LIABILITY: It is a federal right of action with severe limits.

Ability to get to court is limited to cases in which the health plan failed to exercise ordinary care in their decision, and their direct action lead to physical injury... and then the plan did not follow the decision of the external appeal entity.

Even for those limited cases that could get to court, there are caps on non-economic damages in all cases limited to a maximum of $250,000.

Punitive damages are only allowed in cases where the plan does not abide by the external appeal entity decision and their failure to do so causes injury (more stringent than our limitation). In addition, even in those limited instances, there is a general limitation on punitive damages to $250,000 though there is an ability for the court to increase that award under very specific circumstances.

A separate external review entity decision can be requested by the health plan in which the entity would need to find that the plan's actions resulted in injury to the individual. If the external entity says there was no injury, the individual has no access to court.

Binding Arbitration (without defined deadlines) can be used if the individual chooses that route as an alternative to court.

OTHER PROVISIONS NOT INCLUDED IN THE BILL:

- No protections for access to clinical trials.
- No protection for consumers to get access to non-formulary drugs.
- No whistleblower protections for health care workers.

- Women seeking ob-gyn services are limited to physicians for self-referral for those services. They would not be guaranteed the right to go to a nurse practitioner or other non-physician provider as HR 2723 allows.
- The women's groups are raising concerns about the anti-gag clause language which could be interpreted to allow employers to "gag" care that an employer or plan had moral opposition with.

U.S. House of Representatives
Committee on Commerce
Room 2125, Rayburn House Office Building
Washington, DC 20515–6115

DEMOCRATIC STAFF

FAX COVER SHEET

DATE: _____

TO: DEBORAH

FROM: Amy

FAX NUMBER: 456 5557

NUMBER OF PAGES:
(Including Cover) 4

COMMENTS: This is the best I can do for now.

-A

(If there are problems with this transmission,
please phone 202-226-3400, Democratic Staff, 564 FHOB.)

Droskoski, Amy

From: Margaret Sotham[SMTP:msotham@nationalpartnership.org]
Sent: Thursday, September 09, 1999 5:02 PM
To: healthcare2@listbot.com
Subject: statement on Coburn-Shadegg

Following is a statement that we sent out this afternoon denouncing the Coburn-Shadegg bill. I encourage groups that agree with this position and Joanne Hustead's analysis of the bill to send statements, letters to the editor and op/eds to this effect. Please contact me if you have any questions.

FOR IMMEDIATE RELEASE
Thursday, September 9, 1999

CONTACT:
Margaret Prinzavalli Sotham, 202/986-2600

COBURN-SHADEGG BILL FAILS WOMEN AND FAMILIES

Statement by Judith L. Lichtman, President
National Partnership for Women & Families

Although Congress already has a prescription to cure managed care's ills, Representatives Coburn and Shadegg are pushing a placebo instead -- one that would leave untreated many of the problems women and families face. The Coburn-Shadegg bill announced today is cynically designed to steer attention away from the strong, bipartisan patient protection legislation introduced last month by Representatives Norwood and Dingell and widely endorsed by republican and democratic lawmakers, the president, and more than 150 patient and provider organizations.

The Coburn-Shadegg proposal fails women and families in some serious ways. It:

* denies access to potentially lifesaving clinical trials that could be a woman's last, best hope for beating cancer;

* won't let patients hold managed care plans truly accountable for bad decisions;

* gives HMOs, insurance companies, and hospitals license to retaliate against health professionals who blow the whistle on bad care;

* restricts choice of ob/gyn providers;

* purports to ban "gag" clauses but may actually allow health plans and employers to keep providers from discussing services like reproductive health options;

* lets health plans deny access to drugs not on the plan's predetermined list -- even the best drug for the patient's condition

The Norwood-Dingell bill (H.R. 2723) gives women and families their best chance to win meaningful protections. Congress shouldn't be fooled by the Coburn-Shadegg placebo

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Droskoski, Amy

From: Joanne Hustead[SMTP:jhustead@nationalpartnership.org]
Sent: Thursday, September 09, 1999 2:41 PM
To: healthcare2@listbot.com
Subject: Coburn/Shadegg bill

I have reviewed the bill and compared it to the bipartisan Norwood/Dingell bill. We are planning to release a press statement later today opposing the Coburn/Shadegg bill, and we encourage other groups who agree with our analysis to do the same. There are many significant differences between the two. First and foremost, the liability provisions have been changed dramatically. The Coburn/Shadegg bill imposes federal caps on non-economic damages, limits significantly when punitive damages can be recovered (more than the bipartisan bill), caps punitive damages even in the limited circumstances where they are available, takes away the ability of judges and juries to determine whether people have been injured and what caused their injuries, and places other obstacles in the way of injured people (or their survivors) trying to hold their plan accountable. This bill does NOT contain the provisions in the bipartisan bill ensuring access to life-saving clinical trials. It does NOT contain the bipartisan bill's protections for health care professionals who advocate on behalf of patients or report quality problems to appropriate authorities Under this bill, people would NOT be guaranteed access to non-formulary drugs that are the best drug for the patient's condition. Under this bill, women seeking ob-gyn services would NOT be able to see the health care professional of their choice because the bill only provides direct access to physicians who provide ob-gyn services. Although the bill purports to ban "gag" clauses, it contains a provision that could be interpreted to allow employers (plan sponsors) or insurance companies to gag health care professionals who talk about treatment options the employer or the plan has a religious or moral objection to There are other more subtle differences between the bills that are too numerous to mention here. If you have any questions about the bill, please feel free to call me at 202-986-2600. And please email to me any analyses or press statements you release.

Joanne Hustead
Director of Legal and Public Policy
National Partnership for Women & Families
jhustead@nationalpartnership.org

Droskoski, Amy

From: Debbie Curtis[SMTP:debbie_curtis@stark.house.gov]
Sent: Friday, September 10, 1999 3.09 PM
To: Droskoski, Amy

To: Pete
From. Debbie
Date. 9/9/99
Re: Coburn/Shaddegg Bill

Coburn/Shaddegg introduced their managed care bill yesterday. The liability provisions in the bill are horrendous. They do not have the support of the Republican leadership. In fact, they are calling their bill "disastrous."

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Binding Arbitration (without defined deadlines) can be used if the individual chooses that route as an alternative to court.

OTHER PROVISIONS NOT INCLUDED IN THE BILL:

#183# No protections for access to clinical trials.
#183# No protection for consumers to get access to non-formulary drugs.
#183# No whistleblower protections for health care workers.
#183# Women seeking ob-gyn services are limited to physicians for self-referral for those services. They would not be guaranteed the right to go to a nurse practitioner or other non-physician provider as HR 2723 allows.
#183# The women's groups are raising concerns about the anti-gag clause language which could be interpreted to allow employers to "gag" care that an employer or plan had moral opposition with.

U.S. House of Representatives
Committee on Commerce
Room 2125, Rayburn House Office Building
Washington, DC 20515–6115

DEMOCRATIC STAFF

FAX COVER SHEET

DATE: _____

TO: Chris Jennings / Gary Claxton

FROM: 456-5557 401 7321

FAX NUMBER: _____

NUMBER OF PAGES: 10
(Including Cover)

COMMENTS: Score on Jeffords 0.'s

(If there are problems with this transmission,
please phone 202-226-3400, Democratic Staff, 564 FHOB.)

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

Dan L. Crippen
Director

April 21, 1999

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

Dear Mr. Chairman:

At your request, the Congressional Budget Office has prepared the enclosed cost estimate for S. 326, the Patients' Bill of Rights Act.

Sincerely,

Dan L. Crippen

Enclosure

cc: Honorable Edward M. Kennedy
Ranking Minority Member

CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

April 21, 1999

S. 326
Patients' Bill of Rights Act

As ordered reported by the Committee on Health, Education, Labor, and Pensions on March 18, 1999

SUMMARY

Title I of the Patients' Bill of Rights Act would amend the Employee Retirement Income Security Act (ERISA) to give members of self-insured health plans rights to obtain certain services, require group health plans and health insurance issuers to provide certain information to enrollees and potential enrollees, and establish internal and external review procedures for group health plans and health insurance issuers. Title II would prohibit health plans from discriminating on the basis of genetic information. Title III would redesignate the Agency for Health Care Policy and Research as the Agency for Healthcare Research and Quality and would reauthorize the agency.

The proposed patient protections and grievance procedures would increase the premiums for employer-sponsored health insurance, substitute nontaxable fringe benefits for taxable wages, and reduce federal receipts from income and payroll taxes. The Congressional Budget Office (CBO) estimates that these provisions would reduce federal tax revenues by $15 million in 2000 and by $1.0 billion over the 2000-2004 period.

S. 326 contains no intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). State, local, and tribal governments either would be exempt from the bill's requirements governing health care benefits and insurance or would be able to opt out of the requirements.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated effect of the bill on direct spending and receipts is shown in Table 1. The costs of this legislation fall within budget function 550 (health).

Table 1. Estimate of the Budgetary Effects of the Patients' Bill of Rights Act

	By Fiscal Year, in Millions of Dollars									
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Revenues										
Income and HI Payroll Taxes	-10	-70	-140	-210	-260	-290	-310	-330	-340	-360
Social Security Payroll Taxes	-5	-30	-65	-90	-110	-130	-130	-140	-150	-160
Total	-15	-100	-205	-300	-370	-420	-440	-470	-490	-520
Authorizations of Appropriations										
Study of Access to Clinical Trials	1	a	0	0	0	0	0	0	0	0
Healthcare Research and Quality	25	138	217	247	261	267	272	280	123	37
Total	26	138	217	247	261	267	272	280	123	37

SOURCE: Congressional Budget Office.
NOTE: HI = Hospital Insurance.

a. Less than $500,000.

BASIS OF ESTIMATE

Revenues

The proposed rights to medical care and advice, informational requirements, and grievance procedures would affect the federal budget through their effect on premiums for employer-sponsored health insurance. Although the rights to medical advice and care would apply only to self-insured ERISA plans, other plans are likely to be affected by them as well. Federal legislation to regulate a significant part of the health insurance market could stimulate action by states and health plans to develop consistent policies on coverage. Taking such spillover effects into account, CBO estimates that the provision for medical

care and advice, patient information, grievance procedures, and confidentiality of patient information would raise average premiums by about 0.8 percent. Table 2 shows the estimated effect of each provision on premiums, before employers modify their behavior to offset some of the increase. The effects are expressed as a percentage of total premiums for all nonfederal employer-sponsored plans, including plans that would face no increase in costs.

TABLE 2. ESTIMATED EFFECT OF THE PATIENTS' BILL OF RIGHTS ACT ON PREMIUMS FOR EMPLOYER-SPONSORED HEALTH INSURANCE (In percent)

Provision	Increase in Premiums
Title I	
Subtitle A—Right to Medical Advice and Care	
Access to emergency care	0.2
Offering choice of coverage options	a
Access to obstetric and gynecological care	a
Access to pediatric care	a
Access to specialists	a
Continuity of care	0.2
Protection of patient-provider communications	a
Right to prescription drugs	a
Self-payment for behavioral health care services	a
Subtitle B—Right to Information About Plans and Providers	0.1
Subtitle C—Right to Hold Health Plans Accountable	0.3
Title II	
Genetic Information and Services	a
Total	0.8

a. Less than 0.05 percent.

The estimate assumes that about 60 percent of the increase in premiums would be offset through decreases in fringe benefits and that about 40 percent would be passed on to employees as lower wages. CBO estimates that the increase in premiums would reduce federal tax revenues by $15 million in 2000 and by $1.0 billion over the 2000-2004 period. Social Security payroll taxes, which are off-budget, account for $300 million of the five-year total.

Right to Medical Advice and Care. Subtitle A of title I contains a number of patient protections for enrollees in self-insured ERISA health plans. Those provisions include:

- a prohibition of interference by health plans with medical communications between physicians and their patients;
- a requirement that plans pay for hospital emergency services—until the patient is stabilized—when the prudent layperson standard is met, and that beneficiaries be charged no more than would be required if such services were furnished by a participating provider;
- a requirement for direct access to an obstetrical and gynecological specialist for covered routine obstetrical and gynecological care;
- a requirement for direct access to pediatricians for covered routine pediatric services;
- a requirement that beneficiaries have access to specialty care when such care is covered by the plan;
- the right to continue care for 90 days with a provider whose contract has been terminated by a health plan;
- a requirement that plans with a formulary for prescription drugs involve physicians and pharmacists in the development of the formulary and provide for exceptions from the formulary limitation;
- prohibitions on discouraging beneficiaries from paying for behavioral health care services not covered by the plan and terminating providers because they permit beneficiaries to pay for such services; and
- a requirement that health plans offer employees a point-of-service option when the existing health plan offerings do not provide choice among provider groups.

CBO estimates that those rights to medical care and advice would ultimately increase costs across all nonfederal employer-sponsored health plans by about 0.4 percent.

Right to Information About Plans and Providers. Subtitle B of title I would require all ERISA group health plans to provide certain kinds of information on plan provisions to enrollees and to make other kinds available on request. Most of the required information is

typically provided now as part of a plan's handbook or could easily be incorporated into that document. Although some documents would have to be amended to meet the requirements of this provision, such documents are continually changed to reflect new terms. Plans would be responsible for making available to participants any data on quality or performance that they collect, but they would not be required to collect such data. Plans would have to make minor investments in personnel and systems to assure and monitor compliance with those requirements. CBO estimates that the informational requirements would increase costs across all nonfederal employee-sponsored health plans by 0.1 percent.

Right to Hold Health Plans Accountable. Subtitle C of title I would require all ERISA group health plans to abide by specific time limits for making coverage determinations and to have an internal review process for reconsidering coverage decisions within defined time limits at the request of the enrollee. For those coverage decisions involving medical necessity or investigational treatments, a physician with the appropriate expertise would have to conduct the internal review. Plans would also have to provide for external review of medical necessity decisions involving claims exceeding a significant dollar threshold or investigational treatments for life threatening illnesses. The findings of the external review would be binding on the health plan.

Most plans today have a functioning internal appeals process, but they operate with more flexibility on timing than they might have under this provision. Consequently, a few plans would have to invest in more review personnel to meet the specified time limits. Costs would also increase because of the requirement for external review, which would be new to most plans. CBO estimates that the net cost of this subtitle would be about 0.3 percent of employer-sponsored health plan costs.

Genetic Information and Services. Title II would prohibit all health plans and health insurers from using predictive genetic information in setting premiums for groups or individuals. It would also prohibit plans from requesting such information except when the information was needed for diagnosis, treatment, or payment relating to the provision of health services. Even then, plans could not require such information and would have to provide the individual with a description of the procedures in place for protecting the confidentiality of such information. Although this provision would keep health insurers and health plans from reducing their costs through favorable risk selection based on genetic information, its cost to private employer-sponsored health plans as a whole would be negligible.

Authorizations of Appropriations

Clinical Trials. Title I would require the Secretary of Health and Human Services to contract with the Institute of Medicine to conduct a study of access by patients to clinical trials and the coverage of routine health care costs by private health plans and insurers. CBO estimates that this provision would increase discretionary spending by $1 million in 2000.

Healthcare Research and Quality. Title III would redesignate the Agency for Healthcare Policy and Research as the Agency for Healthcare Research and Quality and respecify its mission. To support the activities of AHRQ, S. 326 would authorize $250 million in fiscal year 2000 and such sums as may be necessary for fiscal years 2001-2005. Assuming appropriations of the authorized amounts, CBO estimates that this title would increase discretionary spending by $25 million in fiscal year 2000 and $888 million over the 2000-2004 period.

PAY-AS-YOU-GO CONSIDERATIONS

Section 252 of the Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending and receipts. The net changes in outlays and governmental receipts that are subject to pay-as-you-go procedures are shown in Table 3. For purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

Table 3. Summary of Pay-As-You-Go Effects

	By Fiscal Year, in Millions of Dollars									
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Change in outlays	0	0	0	0	0	0	0	0	0	0
Change in receipts	-10	-70	-140	-210	-260	-290	-310	-320	-340	-360

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

The bill's amendments to ERISA and to the Public Health Services Act would establish a number of new requirements governing health care benefits and insurance. However, plans offered by state, local, and tribal governments are exempt from the requirements of ERISA,

and they may opt out of the requirements of the Public Health Service Act. Consequently, the new provisions would not be intergovernmental mandates as defined by UMRA, and they would have an impact on the budgets of states, local, or tribal governments only if those governments chose to comply.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The bill would impose several private-sector mandates as defined in UMRA. They include the rights to medical care and advice and requirements for plans to establish appeals procedures for handling patients' grievances. CBO estimates that the direct costs of those mandates to private-sector entities would significantly exceed the threshold specified in UMRA ($100 million in 1996, adjusted annually for inflation) every year after 2000.

PREVIOUS CBO ESTIMATE

On March 17, 1999, CBO provided an estimate of S. 326, as introduced on January 28, 1999. This estimate reflects changes in the bill as reported by the committee on March 18, 1999, more recent information on the health care system, and reanalysis of the impact of certain provisions in light of new information. In total, the estimated effect on premiums for employer-sponsored health insurance has increased from 0.5 percent to 0.8 percent.

The committee added a new standard for external review of denials of coverage to subtitle C. That standard would require independent external reviewers to take into account information submitted by the patient's physician and the medical records as well as scientific and clinical literature. The standard would substitute those criteria for the plan's own definition of medical necessity and would therefore lead to more decisions favorable to patients. That change adds 0.2 percentage points to the estimate.

The estimate of the prudent layperson standard for emergency care has been increased by 0.1 percentage point because the committee added a new restriction on health plans' ability to charge patients higher copayments when they seek emergency care at nonparticipating providers.

New provisions involving prescription drugs and the right to receive behavioral health care at the participant's expense add little to the estimate. In addition, the title regarding privacy of medical records and access to medical records was removed.

New information obtained about the frequency with which employers, especially those with few employees, switch plans has led to a slight increase in the estimate of the effect of the provision involving continuity of care. New data also led to a slight decrease in the estimate of the costs of offering a choice of coverage options.

ESTIMATE PREPARED BY:

Federal Cost Estimate: Linda Bilheimer (226-2673), Tom Bradley (226-9010), Jeanne De Sa (226-9010), and Judith Wagner (226-2653)

Impact on State, Local, and Tribal Governments: Leo Lex (225-3220)

Impact on the Private Sector: Judith Wagner (226-2653)

ESTIMATE APPROVED BY:

Paul N. Van de Water
Assistant Director for Budget Analysis

U.S. House of Representatives
Committee on Commerce
Room 2125, Rayburn House Office Building
Washington, DC 20515–6115

DEMOCRATIC STAFF

FAX COVER SHEET

DATE: _____

TO: Chris Jennings / Gary Claxton

FROM: 456-5557 401 7321

FAX NUMBER: _____

NUMBER OF PAGES: 10
(Including Cover)

COMMENTS: Score on Jeffords A.'s

(If there are problems with this transmission,
please phone 202-226-3400, Democratic Staff, 564 FHOB.)

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

Dan L. Crippen
Director

April 21, 1999

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

Dear Mr. Chairman:

At your request, the Congressional Budget Office has prepared the enclosed cost estimate for S. 326, the Patients' Bill of Rights Act.

Sincerely,

Dan L. Crippen

Enclosure

cc: Honorable Edward M. Kennedy
Ranking Minority Member

CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

April 21, 1999

S. 326
Patients' Bill of Rights Act

As ordered reported by the Committee on Health, Education, Labor, and Pensions on March 18, 1999

SUMMARY

Title I of the Patients' Bill of Rights Act would amend the Employee Retirement Income Security Act (ERISA) to give members of self-insured health plans rights to obtain certain services, require group health plans and health insurance issuers to provide certain information to enrollees and potential enrollees, and establish internal and external review procedures for group health plans and health insurance issuers. Title II would prohibit health plans from discriminating on the basis of genetic information. Title III would redesignate the Agency for Health Care Policy and Research as the Agency for Healthcare Research and Quality and would reauthorize the agency.

The proposed patient protections and grievance procedures would increase the premiums for employer-sponsored health insurance, substitute nontaxable fringe benefits for taxable wages, and reduce federal receipts from income and payroll taxes. The Congressional Budget Office (CBO) estimates that these provisions would reduce federal tax revenues by $15 million in 2000 and by $1.0 billion over the 2000-2004 period.

S. 326 contains no intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). State, local, and tribal governments either would be exempt from the bill's requirements governing health care benefits and insurance or would be able to opt out of the requirements.

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Healthcare Research and Quality	25	138	217	247	261	267	272	123	123	37
Total	26	138	217	247	261	267	272	123	123	37

SOURCE: Congressional Budget Office.
NOTE: HI = Hospital Insurance.

a. Less than $500,000.

BASIS OF ESTIMATE

Revenues

The proposed rights to medical care and advice, informational requirements, and grievance procedures would affect the federal budget through their effect on premiums for employer-sponsored health insurance. Although the rights to medical advice and care would apply only to self-insured ERISA plans, other plans are likely to be affected by them as well. Federal legislation to regulate a significant part of the health insurance market could stimulate action by states and health plans to develop consistent policies on coverage. Taking such spillover effects into account, CBO estimates that the provision for medical

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Provision	Increase in Premiums
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Access to emergency care	0.2
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Access to obstetric and gynecological care	a
Access to pediatric care	a
Access to specialists	a
Continuity of care	0.2
Protection of patient-provider communications	a
Right to prescription drugs	a
Self-payment for behavioral health care services	a
Subtitle B—Right to Information About Plans and Providers	0.1
Subtitle C—Right to Hold Health Plans Accountable	0.3
Title II	
Genetic Information and Services	a
Total	0.8

a. Less than 0.05 percent.

The estimate assumes that about 60 percent of the increase in premiums would be offset through decreases in fringe benefits and that about 40 percent would be passed on to employees as lower wages. CBO estimates that the increase in premiums would reduce federal tax revenues by $15 million in 2000 and by $1.0 billion over the 2000-2004 period. Social Security payroll taxes, which are off-budget, account for $300 million of the five-year total.

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- a requirement for direct access to an obstetrical and gynecological specialist for covered routine obstetrical and gynecological care;
- a requirement for direct access to pediatricians for covered routine pediatric services;
- a requirement that beneficiaries have access to specialty care when such care is covered by the plan;
- the right to continue care for 90 days with a provider whose contract has been terminated by a health plan;
- a requirement that plans with a formulary for prescription drugs involve physicians and pharmacists in the development of the formulary and provide for exceptions from the formulary limitation;
- prohibitions on discouraging beneficiaries from paying for behavioral health care services not covered by the plan and terminating providers because they permit beneficiaries to pay for such services; and
- a requirement that health plans offer employees a point-of-service option when the existing health plan offerings do not provide choice among provider groups.

CBO estimates that those rights to medical care and advice would ultimately increase costs across all nonfederal employer-sponsored health plans by about 0.4 percent.

Right to Information About Plans and Providers. Subtitle B of title I would require all ERISA group health plans to provide certain kinds of information on plan provisions to enrollees and to make other kinds available on request. Most of the required information is

typically provided now as part of a plan's handbook or could easily be incorporated into that document. Although some documents would have to be amended to meet the requirements of this provision, such documents are continually changed to reflect new terms. Plans would be responsible for making available to participants any data on quality or performance that they collect, but they would not be required to collect such data. Plans would have to make minor investments in personnel and systems to assure and monitor compliance with those requirements. CBO estimates that the informational requirements would increase costs across all nonfederal employee-sponsored health plans by 0.1 percent.

Right to Hold Health Plans Accountable. Subtitle C of title I would require all ERISA group health plans to abide by specific time limits for making coverage determinations and to have an internal review process for reconsidering coverage decisions within defined time limits at the request of the enrollee. For those coverage decisions involving medical necessity or investigational treatments, a physician with the appropriate expertise would have to conduct the internal review. Plans would also have to provide for external review of medical necessity decisions involving claims exceeding a significant dollar threshold or investigational treatments for life threatening illnesses. The findings of the external review would be binding on the health plan.

Most plans today have a functioning internal appeals process, but they operate with more flexibility on timing than they might have under this provision. Consequently, a few plans would have to invest in more review personnel to meet the specified time limits. Costs would also increase because of the requirement for external review, which would be new to most plans. CBO estimates that the net cost of this subtitle would be about 0.3 percent of employer-sponsored health plan costs.

Genetic Information and Services. Title II would prohibit all health plans and health insurers from using predictive genetic information in setting premiums for groups or individuals. It would also prohibit plans from requesting such information except when the information was needed for diagnosis, treatment, or payment relating to the provision of health services. Even then, plans could not require such information and would have to provide the individual with a description of the procedures in place for protecting the confidentiality of such information. Although this provision would keep health insurers and health plans from reducing their costs through favorable risk selection based on genetic information, its cost to private employer-sponsored health plans as a whole would be negligible.

Authorizations of Appropriations

Clinical Trials. Title I would require the Secretary of Health and Human Services to contract with the Institute of Medicine to conduct a study of access by patients to clinical trials and the coverage of routine health care costs by private health plans and insurers. CBO estimates that this provision would increase discretionary spending by $1 million in 2000.

Healthcare Research and Quality. Title III would redesignate the Agency for Healthcare Policy and Research as the Agency for Healthcare Research and Quality and respecify its mission. To support the activities of AHRQ, S. 326 would authorize $250 million in fiscal year 2000 and such sums as may be necessary for fiscal years 2001-2005. Assuming appropriations of the authorized amounts, CBO estimates that this title would increase discretionary spending by $25 million in fiscal year 2000 and $888 million over the 2000-2004 period.

PAY-AS-YOU-GO CONSIDERATIONS

Section 252 of the Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending and receipts. The net changes in outlays and governmental receipts that are subject to pay-as-you-go procedures are shown in Table 3. For purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

Table 3. Summary of Pay-As-You-Go Effects

	By Fiscal Year, in Millions of Dollars									
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Change in outlays	0	0	0	0	0	0	0	0	0	0
Change in receipts	-10	-70	-140	-210	-260	-290	-310	-320	-340	-360

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

The bill's amendments to ERISA and to the Public Health Services Act would establish a number of new requirements governing health care benefits and insurance. However, plans offered by state, local, and tribal governments are exempt from the requirements of ERISA,

and they may opt out of the requirements of the Public Health Service Act. Consequently, the new provisions would not be intergovernmental mandates as defined by UMRA, and they would have an impact on the budgets of states, local, or tribal governments only if those governments chose to comply.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The bill would impose several private-sector mandates as defined in UMRA. They include the rights to medical care and advice and requirements for plans to establish appeals procedures for handling patients' grievances. CBO estimates that the direct costs of those mandates to private-sector entities would significantly exceed the threshold specified in UMRA ($100 million in 1996, adjusted annually for inflation) every year after 2000.

PREVIOUS CBO ESTIMATE

On March 17, 1999, CBO provided an estimate of S. 326, as introduced on January 28, 1999. This estimate reflects changes in the bill as reported by the committee on March 18, 1999, more recent information on the health care system, and reanalysis of the impact of certain provisions in light of new information. In total, the estimated effect on premiums for employer-sponsored health insurance has increased from 0.5 percent to 0.8 percent.

The committee added a new standard for external review of denials of coverage to subtitle C. That standard would require independent external reviewers to take into account information submitted by the patient's physician and the medical records as well as scientific and clinical literature. The standard would substitute those criteria for the plan's own definition of medical necessity and would therefore lead to more decisions favorable to patients. That change adds 0.2 percentage points to the estimate.

The estimate of the prudent layperson standard for emergency care has been increased by 0.1 percentage point because the committee added a new restriction on health plans' ability to charge patients higher copayments when they seek emergency care at nonparticipating providers.

New provisions involving prescription drugs and the right to receive behavioral health care at the participant's expense add little to the estimate. In addition, the title regarding privacy of medical records and access to medical records was removed.

New information obtained about the frequency with which employers, especially those with few employees, switch plans has led to a slight increase in the estimate of the effect of the provision involving continuity of care. New data also led to a slight decrease in the estimate of the costs of offering a choice of coverage options.

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INITIATIVES TO STRENGTHEN THE FEHB PROGRAM

Over the last 40 years, the Federal Employees Health Benefits Program has relied on market forces to provide comprehensive benefits and competitive premiums. While this approach has been generally successful over the years, there have been periods when premium growth was substantial and market forces were insufficient to stem that growth.

We are in such a period again. Premiums rose 8.5 percent in 1998 and 10.2 percent in 1999. All of the information we have about trends for 2000 suggests that there is no relief in sight. While these increases are similar to trends in the industry as a whole, it is time for the Office of Personnel Management to take added steps to keep premiums affordable for the 9 million employees, retirees and members of their families who rely on the Program for health care coverage.

Private employers and other purchasers of health care have adopted strategies to leverage their purchasing power in the market, ensure accountability, and reward quality. As the sponsor of the largest employer-provided health insurance program in the country, OPM needs the flexibility to adopt comparable approaches so we can provide comprehensive coverage at an affordable price in the health care environment of the 21st century.

We believe that changes in three areas would provide the flexibility we need to keep the FEHB Program a model for employer-provided health insurance in the future. OPM will seek authority to:

- Raise the standards for participation in the Program
- Create incentives for participants to enroll in high-performing plans
- Achieve efficiencies and economies of scale by contracting for selected benefits on a program-wide basis.

In the following pages, we describe each of these initiatives and the program objectives it is designed to achieve. We also outline an extensive program of collaboration with the program's stakeholders – health plans, employee and retiree organizations, the Congress and others – to develop the specific legislative proposals necessary to implement them.

RAISE THE STANDARDS FOR PARTICIPATION IN THE PROGRAM

This proposed initiative would enable the Office of Personnel Management to raise the standards for participation in the Program. We would seek additional authority to set rigorous performance-based criteria for health plans. If plans did not measure up to these standards, we would not renew their contracts. For example, we could compare the actuarial value of benefits offered relative to the premium charged, examine health plan accomplishments in key areas of performance, and assess member satisfaction with the health plan. These measures would then form the basis for a determination about renewing the health plan's contract.

Today, health plans can participate in the Federal Employees Health Benefits Program if they meet very basic minimal standards. We cannot terminate contracts with health plans except under limited circumstances specified in law, primarily based on a plan's failure to attain an enrollment of at least 300 after several years of participating in the Program. Even under those conditions, an exhaustive due process procedure, including a hearing, is required if the matter is contested by the health plan.

Consumer choice is one of the main hallmarks of the FEHB Program, and we are confident that choice would be preserved under this initiative, given the array of offerings currently available. At the same time, it is only reasonable to retain health plans in the Program that serve enrollees well. It is true that given the maximum amount of the Government contribution toward the total premium, when enrollees make choices that are not cost effective, they pay the price. Nonetheless, employees and others logically assume we have evaluated all the health plans available, and all of them are good choices. This initiative would ensure that we could enforce standards to support that assumption.

From the Government's perspective, health plans that do not provide good value contribute to cost increases that are higher than they should be since their premium is used in computing the Government contribution under the Fair Share formula. Since, depending on their market share, the impact can be significant, raising the standards would ensure that Program costs accurately reflect the efficiencies that are desirable in the health care market.

Carriers can and do make business decisions each year about whether or not they will participate in the Program. As the sponsoring organization for the Program, the Office of Personnel Management should have a comparable ability to decide whether or not a given health plan meets our standards for participation.

Federal employees, retirees and members of their families, in addition to the Government itself, will benefit substantially from implementation of this initiative. Participants will have a firm basis for believing that, while desirable differences are preserved, all of the available health plan choices meet reasonable standards of operating efficiency. The Government will avoid unnecessary contribution costs and administrative expenses. Efficient health plans and their members will benefit from the added purchasing clout and risk dispersion of a larger enrollment base.

CREATE INCENTIVES FOR PARTICIPANTS TO ENROLL IN HIGH-PERFORMING PLANS

Under this proposal, the Office of Personnel Management would exercise authority to pay higher amounts toward the cost of premiums in order to encourage enrollees to choose high-performing, high quality health plans. Because the Government pays more, enrollees would pay less toward the premiums of high-performing health plans and more toward the premiums of others.

Today, the Government contributes a maximum dollar amount equal to 72 percent of the weighted average premium of all participating health plans, or 75 percent of the total premium, whichever is less.

With this authority, the Office of Personnel Management, in consultation with experienced practitioners and stakeholders, would develop a differential Government contribution level based on a broad range of criteria including quality factors, customer satisfaction, and cost effectiveness. By doing so, we would create a climate where individuals seeking quality care at the lowest cost would be encouraged to select these higher-performing plans. Those who desired to stay with a plan that is not rated as highly would continue to be able to do so, but at an added price. New members would certainly be attracted to health plans that cost them less.

This initiative parallels practices already in place in the private sector. Providing incentives for enrollees to choose high-performing, high quality health plans should generate a desirable response in the health care market. If market share is contingent on performance, plans that want to participate and prosper in the Federal Employees Health Benefits Program will have every reason to improve their performance in ways that are cost effective. Over time, this initiative will ensure that enrollees and the Government are receiving good value for their premium dollars.

ACHIEVE EFFICIENCIES AND ECONOMIES OF SCALE BY CONTRACTING FOR SELECTED BENEFITS ON A PROGRAM-WIDE BASIS

This proposed initiative would give the Office of Personnel Management the authority to use its buying power to better manage the cost of high-priced benefits such as prescription drug coverage by entering into government-wide contracts. It could also provide the flexibility to offer sought-after benefit improvements such as comprehensive dental care and vision benefits.

Today, the Office of Personnel Management contracts with carriers that offer a broad range of health benefits. At a minimum, these include benefits for costs associated with hospital care and other health services of a catastrophic nature. The statute further includes a comprehensive list of services without mandating specific benefit levels for those services. The Congress, in its report language on the enabling legislation in 1959, made clear that we needed the flexibility to respond to changes in health insurance practices in an evolving market. However, the Congress did not contemplate the Government contracting for health care services with single benefit providers or administrators. Nonetheless, the market itself has evolved to the point where many employer-sponsors use such providers as a way of controlling their health care costs.

This initiative is particularly important because a single critical benefit, such as prescription drug coverage, can put enormous upward pressure on premiums. We would retain the essential strength of the Program by contracting with providers in the private sector to administer the benefits. At the same time, we could leverage the aggregate buying power of the Program in ways that are not possible today.

In addition, our consumer research indicates that many enrollees are interested in broader coverage for services such as dental and vision care than is now available. This initiative would enable us to contract for those services at an attractive group rate and offer them to the entire Federal population.

ACHIEVING CONSENSUS

These three proposed initiatives would give the Office of Personnel Management additional tools it needs to better manage the Federal Employees Health Benefits Program. At the same time, it would further raise the level of quality in the Program, and ensure a cost-effective investment of both the Government's and participant's dollars.

Between now and January 2000, when the next session of the Congress convenes, we will work with stakeholders to develop a legislative proposal. We recognize that the success of the Federal Employees Health Benefits Program is the result of a partnership among many groups. We also know that we can learn from the experience of others with similar concerns and goals. We intend to collaborate and seek ideas and suggestions from health insurance plans and industry associations, employees, retirees and their organized representatives, employer purchasing groups, and independent accreditation and quality measurement organizations. Through such a collaborative process, we are confident we can develop proposals that will work and maintain the strength of the Program as a model for others to emulate.

These initiatives will require legislative authority. However, they would not change the basic structure of the Federal Employees Health Benefits Program - a structure that has resulted in 40 years of largely successful operation. They are designed to retain the best features of the Program while strengthening the Office of Personnel Management's ability to ensure high standards of health plan performance and cost effective operations. These proposals do not advantage any stakeholder at the expense of another, and they reflect practices that have been successfully adopted by many of the Nation's private health plan sponsors. They maintain the balance among interested parties that has worked so well over the years and benefit all those interested in the continued improvement of this model program.