THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release October 6, 1999

STATEMENT BY THE PRESIDENT

The Rose Garden

12:10 P.M. EDT

THE PRESIDENT: Good afternoon. I want to say a few brief words about three critical issues now pending before Congress. There have been major developments on all of them in the last 24 hours that demand our attention and the attention of the American people.

First, yesterday's defeat of Ronnie White's nomination for the Federal District Court judgeship in Missouri was a disgraceful act of partisan politics. Once again this creates a real doubt about the Senate's ability to fairly perform its constitutional duties to advise and consent.

Unfortunately, by voting down the first African American judge, who was already serving -- the first African American judge to serve on the Missouri State Supreme Court, the Republican-controlled Senate is adding credence to the perceptions that they treat minority and women judicial nominees unfairly and unequally.

I would just point out that that strict party-line vote included Republicans who had previously voted in the Judiciary Committee to recommend him to the full Senate.

I hope the Senate leadership will reverse this course and begin to provide timely and fair consideration of all judicial nominees. In particular, I ask the Senate to act on the nominations of Marsha Berzon and Richard Paez who has been held up for years now. They're both excellent candidates for the 9th circuit and have been waiting for quite some time to receive a vote from the Senate.

Meanwhile, I will continue to fulfill my obligation to nominate and press for the confirmation of the most qualified candidates possible for the federal bench.

The second thing I want to talk about is congressional

action on the patients' bill of rights. Today was supposed to be the day the American people have long waited for -- the day a bipartisan majority passed a strong patients' bill of rights. Now, the Republican leadership knows there is a majority for that bill. But, unfortunately, as a result of an 11th hour appeal by the insurance industry lobbyists, which all of you reported on yesterday, once again it appears that the will of the American people will be thwarted.

In the dead of the night last night the House leaders concocted a process filled with enough poison pills and legislative slights of hand to practically guarantee the defeat of this bill. This is a travesty. It's the sort of thing they did to kill common-sense gun legislation in the aftermath of Littleton. The American people want something; there is a bipartisan majority for it; the leadership makes a deal with the special interest and figures out some procedural way to tie everything up in knots to keep it from passing.

Now, a bipartisan majority is poised to pass this bill. But now they are being blocked by legislative tactics concocted by the leadership that blatantly put special interests ahead of the interests of the American people.

What is the result of this? The Republican leadership would ensure that the American people will have to wait for the right to see a specialist, wait for the right to have access to the nearest emergency room care, wait for the right to stay with their health care provider throughout a course of cancer treatment or pregnancy, wait for the right to hold their health plan accountable for harmful decisions.

Again, I ask the bipartisan majority who favor the patients' bill of rights: Don't make them wait. Reject these tactics. Insist that the leadership allow a fair up or down vote on the Norwood-Dingell bill. Insist on an up or down vote on a bill that is comprehensive, enforceable, and paid for. Don't let this 11th hour gimmick kill two years of hard work for something the overwhelming majority of Americans of all political persuasions know we need to do.

The American people deserve more than partisan posturing and legislative gamesmanship on an issue this vital. The people who think it's the wrong thing to do ought to just stand up on the floor and vote against it. But they know they're in the minority; they shouldn't be able to pull some 11th hour deal that keeps the vote the way a majority want it to come out.

Let me say, finally we also should proceed with our actions to protect Americans from the threat of nuclear weapons. Later this afternoon, I'll meet here at the White House with Nobel laureates, former Chairmen of the Joint Chiefs of Staff and

MORE

others on the Comprehensive Test Ban Treaty. I fervently believe, as all of you know, that this treaty will restrain the spread of nuclear weapons, while enabling us to maintain the effectiveness of our nuclear arsenal.

As you know, there are discussions between Republicans and Democrats on the Hill about a better process for deliberating on this important treaty. After two long years of inaction, one week is very little time for considered action. The Chemical Weapons Convention, for example, that we ratified in 1997, had 14 full days of hearings in the Senate Foreign Relations Committee after a long process of negotiations. But for now, the vote is scheduled for Tuesday, and I will continue to aggressively to the Senate and to the American people that this is in our national interests.

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THE WHITE HOUSE

WASHINGTON

November 4, 1999

The Honorable J. Dennis Hastert
Speaker of the
House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

I am writing to underscore my deep disappointment with the unusual procedure employed in naming participants to the joint House-Senate conference on H.R. 2723, the Bipartisan Consensus Managed Care Improvement Act of 1999. The decision to appoint members that fail to reflect the overwhelming vote of 275 to 151 on the Norwood-Dingell bill sends the wrong message to the American people, and the wrong messengers to the conference committee.

The Norwood-Dingell Patients Bill of Rights legislation is the only patient protections bill in this Congress that has received strong bipartisan support. Yet, out of the 13 Republican members appointed as conferees, only one voted for this legislation, and only one voted in favor of yesterday's successful motion in the House that instructed conferees to insist on including the provisions of the Norwood-Dingell bill.

It is clear that the public longs for us to reach across party lines to address issues of national concern. There are few matters that are more important than enacting a strong Patients Bill of Rights. In this regard, I am asking you to use your authority under the House rules to expand the conference committee to include members who accurately reflect the will of the House.

We need to make certain that the results of this conference will be in the public interest; as currently constituted, this committee is weighted heavily in favor of the special interests that oppose this bill. Over the years, we have worked together on drafting and passing bipartisan health care legislation, including the Health Insurance Portability and Accountability Act of 1996. I hope we can build on that record that this Congress can respond to the public's need for patients' protections as our nation's health care delivery system undergoes change.

Sincerely,

Bill Clinton

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

DEMOCRATIC STAFF

FAX COVER SHEET

DATE: 11/2/99

TO: Chris Jennings

FROM: Bridget Taylor

FAX NUMBER: 456-5557

NUMBER OF PAGES:
(Including Cover) 4

COMMENTS:

Here's the stuff on PBOR - "Listen to Norwood on the floor" he is going to blast them.

(If there are problems with this transmission, please phone 202-225-3641, Democratic Staff, 2322 RHOB.)

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

November 2, 1999

Dear Colleague:

Today conferees will be named on the health care legislation that passed the House in October. We intend to offer a motion to instruct conferees during the debate which will instruct the conferees to insist upon the House passed patient protection provisions and that the bill be paid for within the scope of the conference.

The House passed the Bipartisan Consensus Managed Care Improvement Act with a resoundingly bipartisan vote of 275 to 151, after rejecting three weaker substitutes. It gives us great pride to see the House of Representatives passed such a sensible measure, and we encourage all of our colleagues to join us in supporting this motion to instruct the conferees to insist upon the House language.

The patient protections in the House bill cover all Americans in private health plans, they let doctors decide what is the best interest of the patient, they provide for a strong independent review of HMO decisions, and they hold an HMO accountable when it causes an injury or wrongful death. The Senate bill does none of these things.

This motion to instruct that we will offer is simple. It reminds our House conferees to insist on strong patient protections in this conference. The House sent a clear message when it voted on a bipartisan basis to reject weaker substitutes and for a strong patients bill of rights. We hope that our conferees will carry that message through in conference.

If you have any questions, please call either Bridgett Taylor or Amy Droskoski at 226-3400

Sincerely,

JOHN D. DINGELL
RANKING MEMBER

CHARLIE NORWOOD
MEMBER

Statement of Hon. John D. Dingell
Motion to Instruct Conferees
On H.R. 2990

Mr. Speaker, we will soon be appointing conferees to the conference on the Bipartisan Managed Care Improvements Act. Earlier this month the House, by an overwhelming bipartisan vote of 275-151, approved a strong bill to protect patients rights. Before voting on final passage, the House rejected three weaker substitutes.

We are now going into conference with the Senate, and according to some reports, a majority of the conferees who are about to be appointed by the Speaker may not have shared the position of the House, and in fact, voted against the bill. That is why this motion to instruct is important. It is a reminder to our conferees that the House voted for strong patient protections, and rejected weaker ones. We want the House conferees to support the position of the House.

Specifically

We want a bill that covers all health plans, not just a limited few.

We want a bill that lets doctors decide what is the best interest of the patient, not health insurance bureaucrats.

We want a bill that has a strong independent review of HMO decisions.

We want a bill that in the unfortunate case when your HMO causes an injury or wrongful death, it will be held responsible like any other business in America.

Unfortunately the Senate bill does none of these things.

This motion to instruct is simple. It reminds our House conferees to insist on strong patient protections in this conference. The House sent a clear message when it voted on a bipartisan basis to reject weaker substitutes and for a strong patients bill of rights.

Vote yes on this motion to instruct to remind our conferees that we meant it.

Mr. Dingell moves that the managers on the part of the House at the conference on the disagreeing votes of the two Houses on the Senate amendment to the bill H.R. 2990 be instructed to insist on the provisions of the Bipartisan Consensus Managed Care Improvement Act of 1999 (Division B of H.R. 2990 as passed by the House), and within the scope of conference to insist that such provisions be paid for.

Table of Contents

Access to Emergency Services

Coverage for Initial Screening and Stabilization

At least 40 states and the District of Columbia have passed legislation requiring health plans to pay for initial screening and stabilization in an emergency situation. In addition, 33 states and the District of Columbia prohibit plans from requiring enrollees to obtain prior authorization before going to an emergency room and 15 states prohibit plans from requiring restricting enrollees to hospitals that participate in the plan's network.

Prudent Layperson Standard

Thirty-four states and the District of Columbia define an emergency using a "prudent layperson" standard. For example, Georgia defines an "emergency condition" as "any medical condition of a recent onset and severity, including but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in: placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part."

Determinations on Post-Stabilization Services

Many states require that plans have a procedure in place to respond to requests for post-stabilization care following initial screening and stabilization. Eight states go further by requiring plans to make a determination on post-stabilization services within a specified time frame or the services are deemed approved.

Coverage for Initial Screening and Stabilization

Provision	State	Year	Bill	Chapter/Public Act
Initial screening and stabilization	AZ[1]	1996		ARS §20-2803
	CA[1]	1994	SB 1832	Ch. 614
	CO[1]	1997	HB 1122	Ch. 238
	CT[1,2]	1996	HB 6883	Act 97-99
	DE[1,2]	1998	by regulation	2:6 Del. R.
	DC[1]	1998	Act 12-356	Law 12-145
	FL[1]	1996	SB 886, 910	Ch. 99, 223
	GA[1]	1996	HB 1575	Act 808
		1997	SB 209	Act 322
	IL[1,2]	1999	SB 251	PA 617
	IN[1,2]	1998	SB 364	PL 69
	IA[1,2]	1999	SF 276	
	ID[1]	1997	SB 1150	Ch. 204
	KS[1]	1997	SB 204	Ch. 190
	KY[1]	1998	HB 315	Ch. 304
	LA[1]	1997	HB 2206	Act 846
	MA[3]	1998	Executive Order	BCBS
	MD[1]	1996	HB 859	Ch. 503
	ME[1]	1997	by rule	Ch. 850
	MI[1]	1997	HB 4080	PA 136
	MN[2]	1997	SF 960	Ch. 237
	MO[1]	1997	HB 335	Ch. 376
	MT[1,2]	1997	SB 365	Ch. 413
	NE[2]	1997	LB 279	RRS 44-68
	NV[1]	1997	AB 156	Ch. 140
	NJ[2]	1997	by regulation	NJAC 8:38-5.3
	NM[1,2]	1998	HB 361	Ch. 107
	NY[1]	1996	SB 7553	Ch. 705
	NC[1]	1997	SB 455	Ch. 474
	ND[1]	1999	SB 2400	
	OH[1,2]	1997	HB 361	Sec. 1753
	OK[1]	1997	HB 1416	Ch. 289
	OR[1]	1997	SB 21	Ch. 343
	PA[1]	1998	SB 91	Act 68
	SC	1998	HB 3889	Act 326

[1] Bans prior authorization
[2] Bans network restrictions
[3] For state employees only
[4] If referred by a participating provider.
[5] Limits differential cost sharing for nonparticipating hospitals to $50

Provision	State	Year	Bill	Chapter/Public Act
	SD[1,2]	1999	HB 1013	

Coverage for Initial Screening and Stabilization, cont.

Provision	State	Year	Bill Number	Chapter/Public Act
Initial screening and stabilization	TN[1, 2]	1997	HB 1066	Ch. 524
	TX[2]	1997	SB 383, 385	Ch. 1024, 1026
	VA[4]	1997	HB 2062	Ch. 139
[1] Bans prior authorization	WA[1, 2,5]	1997	HB 2018	Ch. 231
[2] Bans network restrictions	WI[1]	1998	AB 675	Act 155 Ch. 632.85
[3] For state employees only	WV[1]	1998	HB 4043	WV Code §33-25A-8d
[4] If referred by a participating provider.				
[5] Limits differential cost sharing for nonparticipating hospitals to $50				

Prudent Layperson Standard

Provision	State	Year	Bill Number	Chapter/Public Act
Prudent Layperson Standard	AR	1995	FamiliesUSA, BCBS	
	CT	1997	HB 6883	Act 97-99
	DE	1998	by regulation	2:6 Del. R.
	DC	1998	Act 12-356	Law 12-145
	GA	1996	HB 1575	Act 808
	HI	1998	SB 2297	Act 178
	ID	1997	SB 1150	Ch. 204
	IL[1]	1995	SB 618	PA 177
	IN	1998	SB 364	PL 69
	IA	1998	SF 276	
	LA	1997	HB 2206	Act 846
	MD	1996		MD Code §19-701
	ME	1997	by rule	Ch. 850
	MI	1998	FamiliesUSA, BCBS	
	MN	1997	SF 960	Ch. 237
	MO	1997	HB 335	Ch. 354
	NE	1997	LB 279	RRS 44-68
	NV	1997	AB 156	Ch. 140
	NM	1996	By regulation	13 MAC10:13
		1998	HB 361	Ch. 107
	NY	1997	SB 7553	Ch. 705
	NC	1997	SB 455	Ch. 474
	ND	1999	SB 2400	
	OH	1997	HB 361	Sec. 1753
	OR	1997	SB 21	Ch. 343
	PA	1998	SB 91	Act 68
	SC	1998	HB 3889	Act 326
	SD	1999	HB 1013	
	TN	1998	HB 3244	Ch. 1134
	TX	1995	By regulation	BCBS
		1997	SB 383, 385	Ch. 1024, 1026
	VT	1997	By regulation	FamiliesUSA, BCBS
	VA	1995	HB 2583	Ch. 345
	WA	1997	HB 2018	Ch. 231
	WV[1]	1998	HB 4043	WV Code §33-25A-8d
	WI	1998	AB 675	Act 155 Ch. 632.85

[1] Prudent layperson applies only to screening, not stabilization

Determinations on Post-Stabilization Services

Provision	State	Year	Bill Number	Chapter/Public Act
Determination on Post-Stabilization Services	AZ[1]	1996		ARS §20-2803
	CT[2]	1997	HB 6883	Act 97-99
	IL[3]	1999	SB 251	PA 617
	MO[3]	1997	HB 335	Ch. 376
[1] "reasonable" or "timely" period	NE[2]	1997	LB 279	44-68
[2] 30 minutes	NC[1]	1997	SB 455	Ch. 474
[3] 60 minutes	TX[3]	1997	SB 383, 385	Ch. 1024, 1026
	WA[2]	1997	HB 2018	Ch. 231

External Appeals

Most States allow enrollees to make complaints about a health plan to the State's Department of Insurance or Department of Health. There is significant variation regarding whether the State is required to investigate and the resources and other enforcement tools available to the State to act on such complaints. In recent years, State legislatures have become more assertive in addressing adverse determinations from a health plan. At least 28 States and the District of Columbia now require health plan enrollees to have access to an independent appeals entity after completing the plan's internal review process. In all but three of these States, the independent review organization's determination is binding on the plan.

Provision	State	Year	Bill Number	Chapter/Public Act
External Appeals	AZ	1997	SB 1098	Ch. 100
	CA	1996[1]	AB 1663	Ch. 979
		1999[6]	AB 55	
	CO	1999	HB 1306	Ch. 200
	CT[2]	1997	SB 6883	Ch. 238
	DE[3]	1998	By regulation	2:6 Del. R.
	DC[3]	1998	Act 12-607	Ch. 5B Title 32
	FL	1997	HB 297	97-159
	GA	1999	HB 732	Act 281
	HI	1998	SB 2297	Act 178
	IL	1999	SB 251	PA 617
	IN	1999	HB 1309	PL 133
	IA	1999	SF 276	
	LA	1999	HB 2083	Act 401
	MD[2, 4]	1998	SB 401	Ch. 111
	MI	1978		§333.21035
	MT	1999	HB 607	Ch. 482
	MO	1997	HB 335	Ch. 376
	NJ[3]	1997	SB 269	Ch. 192
	NM	1997	By regulation	13 NMAC 10:13
		1998	HB 361	Ch. 107
	NY	1998	AB 6585	Ch. 586
	OH	1997[1]	HB 361	Sec. 1753
		1999[6]	HB 4	Sec. 1751
	OK	1999	HB 1826	
	PA	1998	SB 91	Act 68

[1] For experimental therapies only
[2] To the Commissioner
[3] Advisory
[4] Commissioner may seek advice from an independent review organization
[5] For administrative disputes only
[6] Extended to include all disputes
[7] For mental health only

External Appeals, cont.

Provision	State	Year	Bill Number	Chapter/Public Act
External Appeals	RI	1996	HB 7683	Ch. 139
	TN	1997[5]		Ch. 416
		1998[6]	SB 1587	Ch. 952
	TX	1997	SB 3279	Ch. 163
	VT	1994[7]	SB 386	Act 185
		1997[6]	H 171	Act 159
	VA	1999	H 163	Ch. 643
			SB 1235	

Disclosure of Information To Consumers

General Information Disclosure

Most States require health insurers to disclose information to enrollees and, in many cases, to prospective enrollees as well. At least 44 states and the District of Columbia have recently enacted legislation that requires plans to disclosure specified information to enrollees. The information often includes things such as plan benefits and service area, cost-sharing requirements, drug formularies, provider information, and plan procedures for accessing care.

Physician Financial Arrangements

In addition to general information about the plan, at least 27 States require plans to disclose summary information about how the plan pays its providers.

Limits on Physician Incentive Arrangements

Some states not only require disclosure of physician financial arrangements, but also impose a limit on the amount of risk a provider can maintain or types of incentives that may be used. Twenty-four states prevent a plan from providing a financial incentive to providers to limit, deny, or withhold necessary care.

General Information Disclosure

Provision	State	Year	Bill Number	Chapter/Public Act
General Information Disclosure	AL	1996	HB 395	Act 651
	AK	1998	SB 197	Ch. 60
	AZ	1997	SB1321	Ch. 251
	AR	1997	HB1843	Act 1196
	CA	1996	SB 1547	Ch. 1024
	CO	1997	HB 97-1122	Ch. 238
	CT	1997	HB 6883	Act 97-99
	DE	1998	by regulation	2:6 Del. R.
	DC	1998	Act 12-607	Ch. 5B Title 32
	FL	1997	SB 297	97-159
	GA	1996	HB 1338	Act 751
	HI	1996	HB 3785	Act 274
		1998	SB 2297	Act 178
	ID	1997	SB 1150	Ch. 204
	IL	1999	SB 351	PA 617
	IN	1997	HB 1663	PL 191
		1998	SB 364	PL 69
	IA	1999	SF 276	
	KS	1997	SB 204	Ch.190
	KY	1998	HB 315	Ch. 304
	LA	1997	HB 2228	Act 238
	ME	1996	SB 769	PL 673
	MD	1996	HB 859	Ch. 503
	MI	1996	HB 5573	PA 472
	MN	1997	SF 960	Ch. 237
	MO	1997	SB 335	Ch. 354
	MT	1997	SB 365	Ch. 413
	NE	1997	LB 279	RRS 44-68
	NJ	1997	SB 269	Ch. 192
	NM	1997	By regulation	13 NMAC 10:13
[1] Information is disclosed to the Department of Insurance who then discloses a comparative summary to consumers		1998	HB 361	Ch. 107
	NY	1996	SB 7553	Ch. 705
		1998[1]	SB 7478	Ch. 579
	NC	1997	SB 932	Ch. 519
	ND	1999	SB 2400	
	OH	1997	SB 67	Sec. 1751

	OK	1997	HB 1416	Ch. 289

General Information Disclosure, cont.

Provision	State	Year	Bill Number	Chapter/Public Act
General Information Disclosure	OR	1997	SB 21	Ch. 343
	PA	1998	SB 91	Act 68
	RI	1996	HB 8172	Ch. 41
	SC	1998	SB 310	Act 441
	SD	1999	SB 235	
	TN[2]	1997	HB 2583	Ch. 1073
	TX	1997	SB 383, 385	Ch. 1024, 1026
	VT	1996	SB 345	18 VSA §9414
	VA	1996	SB 712	Ch. 891
	WA	1996	SB 6392	RCW §48.43.095
	WV	1996	HB 4511	Ch. 33
	WY	1995	HB 175	Ch. 210

[2] Information is disclosed to the Department of Health who then discloses a comparative summary to consumers

Disclosure of Physician Financial Arrangements

Provision	State	Year	Bill Number	Chapter/Public Act
Disclosure of Physician Financial Arrangements	AZ	1995	BCBS, Families	
	CA	1996	AB 2649	Ch. 1014
	GA	1996	HB 1338	Act 751
	IL	1999	SB 251	PA 617
	IN	1996	SB 392	PL 192
	KY[1]	1998	HB 315	Ch. 304
	LA	1997	HB 2228	Act 238
	MD	1997	SB 162	Ch. 145
	MA[2]	1998	Executive	BCBS
	ME	1996	order	PL 673
	MI	1996	SB 769	PA 472
	MN	1997	HB 5573	Ch. 237
	MO[3]	1997	SF 960	Ch. 354
	NE	1997	HB 335	RRS 44-68
	NJ	1997	LB 279	Ch. 192
	NM	1998	SB 269	Ch. 107
	NY	1996	HB 361	Ch. 705
	NC	1997	SB 7553	Ch. 519
	ND	1999	SB 932	
	OR	1997	SB 2400	Ch. 343
	PA	1998	SB 21	Act 68
	RI	1996	SB 91	Ch. 41
	SD	1999	HB 8172	
	TN[1]	1997	SB 235	Ch. 324
	VT	1996	SB 629	Act 180
	VA[4]	1996	SB 345	Ch. 776
	WA	1996	HB 1393	Ch. 312
			SB 6392	

[1] Cannot prohibit providers from disclosing financial incentives

[2] For state employees only

[3] Disclosure to the Department of Insurance

[4] Disclosure is to purchaser (i.e. employer in the case of a group plan)

Limits on Physician Incentive Arrangements

Provision	State	Year	Bill Number	Chapter/Public Act
Limits on Physician Incentive Arrangements	AK	1998	SB 197	Ch. 60
	CA	1996	AB 2649	Ch. 1014
	DE	1998	by regulation	2:6 Del. R.
	GA	1996	HB 1338	Act 751
	ID	1997	SB 1150	Ch. 204
	IN	1998	SB 364	PL 69
	KS	1997	SB 204	Ch. 190
	LA	1997	SB 724	Act 897
	MD	1996	HB 1374	Ch. 548
	MA[1]	1998	Executive order	
	MO	1997	HB 335	Ch. 354
	MT	1997	SB 365	Ch. 413
	NE	1998	LB 1162	
	NV	1997	AB 156	Ch. 140
	NJ	1997	SB 269	Ch. 192
	NM	1998	HB 361	Ch. 107
	ND	1999	SB 2400	
	OH	1997	SB 67	Sec. 1751.13
	PA	1998	SB 91	Act 68
	RI	1997	HB 8172	Ch. 41
	SD[2]	1999	SB 236	
	UT[2]	1997	SB 18	Ch. 227
	TX	1997	SB 383, 385	Ch. 1024, 1026
	VT[3]			18 VSA §4089a

[1] For state employees only
[2] Applies to UR/UM.
[3] Applies to UR for mental health services only.

Choice of Providers

Access to Out-of-Network Specialists

At least 22 states require a health plan to provide referrals to specialists who are not in the plan's network when the network's specialists are not adequate to treat the enrollees condition. The referral must be at no additional cost to the enrollee beyond what the enrollee would pay for an in-network specialist.

Network Adequacy Standards

At least 22 states have standards to determine when a plan's network is adequate. These standards are often based on a combination of provider to enrollee ratios, waiting times, and distance traveled.

Standing Referrals to Specialists and Specialists as PCPs

At least 17 states and the District of Columbia require plans to provide a process, when appropriate, for patients to obtain referrals for more than one visit to a specialist. In addition, 9 states and the District of Columbia allow a specialist to act as a primary care provider for enrollees whose care would best be coordinated by a specialist. Two states, while not allowing standing referrals, do allow a specialist to act as a primary care provider.

Access to Women's Health Care Providers

At least 36 States and the District of Columbia require health plans to provide direct access to women's health care providers for reproductive and gynecological care or allow obstetricians and gynecologists to serve as a woman's primary care physician.

Access to Other Types of Specialists

In addition to direct access to women's health services, several States require health plans to allow enrollees to obtain care from certain listed specialists without obtaining a referral from a gatekeeper. One state, Wyoming, allows direct access to all types of specialists.

Point-of-Service Option

Twenty states and the District of Columbia require health plans to provide prospective and current enrollees a point of service or open panel option at the time of enrollment and/or during an open enrollment period.

Access to Out-of-Network Specialists

Provision	State	Year	Bill Number	Chapter/Public Act
Access to Out-of-Network Specialists	CO	1997	HB 97-1122	Ch. 238
	DE	1998	by regulation	2:6 Del. R.
	FL	1997	HB 297	97-159
	IL	1999	SB 251	PA 617
	IN	1998	SB 364	PL 69
	KY	1998	HB 315	Ch. 304
	ME	1997	by Rule	Ch. 850
	MD	1999	HB 182	Ch. 128
	MT	1997	SB 365	Ch. 413
	MO	1997	HB 335	Ch. 354
	NE	1997	LB 279	RRS 44-68
	NM	1997	By regulation	13 NMAC 10:13
		1998	HB 361	Ch. 107
	NY	1996	SB 7553	Ch. 705
	NC	1997	SB 932	Ch. 519
	OH	1997	SB 67	Sec. 1751.13
	OK	1999	HB 1681	
	PA	1998	SB 91	Act 68
	SD	1999	SB 236	
	TN	1998	HB 2949	Ch. 1033
	TX	1997	Sb 383, 385	Ch. 1024, 1026
	UT[1]	1997	HB 216	Ch. 44
	WA	1996	SB 6392	Ch. 312

[1] Limited to rural areas.

Network Adequacy Standards

Provision	State	Year	Bill Number	Chapter/Public Act
Network Adequacy Standards	CO	1997	HB 1122	Ch. 238
	DE	1998	by regulation	2:6 Del. R.
	IN	1998	SB 364	PL 69
	KS	1997	SB 204	Ch. 190
	KY	1998	HB 315	Ch. 304
	ME	1996	SB 769	Ch. 673
	MO	1997	HB 335	Ch. 354
	MT	1997	SB 365	Ch. 413
	NE[1]	1998	LB 1162	
		1997	LB 279	RRS 44-68
	NV	1997	BCBS	
	NH	1997	SB 178	Ch. 345
	NJ	1997	By regulation	NJAC 8:38:6-1
	NM	1997	By regulation	13 NMAC 10:13
	NY	1996	SB 7553	Ch. 705
	NC[2]	1997	SB 932	Ch. 519
	OH	1997	SB 67	Sec. 1751.13
[1] Based on NAIC standards	OR[2]	1997	SB 21	Ch. 343
[2] Must file with the Department of Insurance	RI	1996	HB 8172	Ch. 41
	SD	1999	SB 236	
	TN[2]	1998	HB 2949	Ch. 1033
	VT	1997	By regulation	Rule 10.00
	WI	1998	AB 768	Act 237

Standing Referrals and Specialists as PCPs

Provision	State	Year	Bill Number	Chapter/Public Act
Standing Referrals and Specialists as Primary Care Providers	CA	1998	FamiliesUSA, BCBS	
	DC[1]	1998	Act 12-607	Ch. 5B Title 32
	FL	1997	HB 297	97-159
	IL	1999	SB 251	PA 617
	IN[2]	1998	SB 364	PL 69
	KS	1997	SB 204	Ch. 190
	MD[1]	1999	HB 182	Ch. 128
	MN[1]	1997	SF 960	Ch. 237
	MO[1]	1997	HB 335	Ch. 354
	NE[1]	1997	LB 279	RRS 44-68
	NM	1997	By regulation	13 NMAC 10:13
	NY[2]	1996	SB 7553	Ch. 705
	OH[1]	1997	SB 67	Sec. 1753.14
	OK[1]	1999	HB 1681	
	PA[1]	1998	SB 91	Act 68
	TN[1]	1998	HB 2949	Ch. 1033
	TX	1997[2]	SB 385	Ch. 1026
		1997[1]	HB 3269	Ch. 905
	VA	1999	SB 1235	Ch. 643
	VT	1997	FamiliesUSA	by regulation
	WI[1]	1998	AB 768	Act 237

[1] Also allows specialist to serve as primary care provider

[2] No standing referral, only allows specialist as PCP

Direct Access to Women's Health Care Providers

Provision	State	Year	Bill Number	Chapter/Public Act
Direct Access for Women's Health Care Services	AL[1]	1996	HB 625	Act 671
	AR	1997	HB 1843	Act 1196
	CA	1994	AB 2493	Ch. 759
	CO[2]	1996	HB 1082	Ch. 153
	CT[1]	1995	HB 5046	PA 95-199
	DE[1]	1997	SB 78	Ch. 33
	DC	1998	Act 12-607	Ch. 5B, Title 32
	FL	1995	Families USA	
	GA	1996	SB 592	Act 820
	ID	1997	SB 1150	Ch. 204
	IL	1996	SB 1246	PA 89-0514
	IN[5]	1996	SB 392	PL 192
	KY	1998	HB 315	Ch. 304
	LA[1,3]	1995	HB 318	Act 637
	ME[4]	1996	HB 976	PL 617
	MD[1]	1996	HB 863	Ch. 580
	MN	1997	HF 447	Ch. 26
	MS[1]	1995	FamiliesUSA	
	MO[4]	1997	HB 335	Ch. 354
	MT[1]	1997	SB 144	Ch. 198
	NE[5]	1996	LB 532	RRS 44-786
	NV	1999	AB 515	Ch. 411
	NH[4]	1998		Ch. 420
	NM[1,4]	1997	By regulation	13 NMAC 10:13
	NY[1,3]	1994	BCBS	
	NC	1995	HB 773	Ch. 63
	OR[1,4]	1995	SB 814	Ch. 669
	PA	1998	SB 91	Act 68
	RI[4]	1997	SB 149	Ch. 174
	SC[3]	1998	HB 3985	Act 329
	TN[4]	1998	HB 2949	Ch. 1033
	TX	1997	SB 54	Ch. 912
	UT	1997[1,4]	By regulation	Ch.10§31A-8-105.5
		1998[1]	HB 86	Ch. 357
	VT[3]	1997	By regulation	BCBS

[1] Also permits Ob/Gyns to serve as primary care physicians
[2] guaranteed referral
[3] limited to two annual visits and care relating to pregnancy
[4] limited to one annual visit
[5] no direct access, only permits Ob/Gyns to serve as PCPs

Direct Access to Women's Health Care Providers, cont.

Provision	State	Year	Bill Number	Chapter/Public Act
Direct Access for Women's Health Care Services	VA[4] WA WV[4]	1996 1995 1998	HB 442 SB 5854 SB 25	Ch. 967 Ch. 389 WV Code §33-43-4

Direct Access to Other Specialists

Provision	State	Year	Bill Number	Chapter/Public Act
Direct Access to Specialists	WY	1985		W.S. 26-22-503
Direct Access to Optometrists or Ophthalmologists [1]Limited to one visit	TN[1]	1998	HB 2949	Ch. 874
Direct Access to Chiropractors [1] For 3 months or 12 visits	AK KY ME[1]	1998 1996 1997	SB 197 BCBS HB 179	Ch. 60 PL 99
Direct Access to Dermatologists [1] For 6 months or 4 visits, after initial referral *Direct Access to Advance Practice Nurses* [1] Permits advance practice nurses to act as PCPs	FL GA SC[1] MT[1]	1997 1995 1998 1997	SB 244 BCBS SB 124 HB 519	Ch. 171 Act 353 Ch. 404
Direct Access to Doctors of Oriental Medicine (i.e. acupuncturists) *Direct Access to Physical Therapists*	NM SC[1]	1997 1998	BCBS HB 3784	 Act 360

[1] For treatment up to 30 days				

Point of Service Option Requirement

Provision	State	Year	Bill Number	Chapter/Public Act
Point of Service Plan	AR[2]	1999	HB 1703	Act 1469
	AK	1998	SB 197	Ch. 60
	DC[1]	1996	Act 11-235	Law 11-495
	GA[3]	1999	SB 210	Act 280 modified
	ID[2]	1997	SB 1150	Ch. 204
	IN[1]	1998	SB 364	PL 69
	IA[1]	1997	HF 133	Ch. 88
[1] At employers option	KY[4]	1998	HB 315	Ch. 309
[2] All plans must offer a POS option	MD	1995		§19710.2
[3] At time of enrollment enrollee can select one or more out-of-network providers or hospitals to use	MN[5]	1996	SF 1980	Ch. 446
	MO[1]	1997	HB 335	Ch. 354
	MT[6]	1997	HB 46	Ch. 165
[4] At "contract holders" option	NJ[2]	1997	SB 269	Ch. 192
[5] All plans with more than 50,000 enrollees must offer a POS option in each market in which they operate	NM[7]	1997	By regulation	13 NMAC 10:13
		1998	HB 361	Ch. 107
	NY[8]	1995	BCBS	
[6] At employers option, but only applies to plans with more than 10,000 enrollees	OK	1997[5]	HB 1416	Ch. 289
		1999[9]	HB 1681	
	OR[1]	1995	SB 979	Ch. 672
[7] At the discretion of the Department of Insurance	SC[9]	1998	SB 310	Act 441
	TN[2]	1998	HB 2949	Ch. 1033
[8] In individual market	TX[10]	1997	SB 385	Ch. 1026
[9] Required for all employers with more than 50 employees	VA[2]	1998	HB1075	Ch. 908
[10] For dental plans				

Continuity of Care

At least 24 states and the District of Columbia provide protection for enrollees who are involuntarily forced to change providers. The following states allow enrollees, under certain circumstances, to continue seeing their provider for periods ranging from 60 to 120 days or through postpartum care.

Provision	State	Year	Bill Number	Chapter/Public Act
Continuity of Care	AR[2]	1997	HB 1843	Act 1196
	CA[2]	1998	BCBS, NCSL	
	CO[1]	1997	HB 1122	Ch. 238
	DE[3]	1998	by regulation	2:6 Del. R.
	DC[2]	1998	Act 12-607	Ch. 5B, Title 32
	FL[1]	1997	SB 297	97-159
	IL[2]	1999	SB 251	PA 617
	IN[1]	1998	SB 364	PL 69
	IA[2]	1999	SF 276	
	KS[2]	1996	SB 477	Ch. 169
	MD[2]	1996	NCSL	
	MN[3]	1997	SF 960	Ch. 237
	MO[2]	1997	SB 335	Ch. 376
	NE[4]	1998	LB 1162	
	NJ[3]	1997	By regulation	NJAC 8:38-3.5
[1] For 60 days	NY[1,5]	1996	SB 7553	Ch. 705
[2] For 90 days	OK[2]	1999	HB 1681	
[3] For 120 days	PA[1]	1998	SB 91	Act 68
[4] For plan insolvency (through discharge)	SC[2]	1998	GB 310	Act 441
	SD[2]	1999	SB 236	
[5] New enrollees with life-threatening or disabling conditions can continue to see current physician for 60 days	TN[3]	1998	HB 2949	Ch. 1033
	TX[2]	1997	SB 383, SB 385	Ch.1024, 1026
	VT[1]	1997	By rule	Rule 10.00
	VA	1996[1]	HB 1393	Ch. 776
		1999[2]	SB 1235	Ch. 643
	WI[2]	1998	AB768	Act 237 Ch. 609.24

Interference with Provider-Patient Communication

Anti Gag Clauses

At least 47 States and the District of Columbia now prohibit health plans from using contract clauses that restrict providers' communications with their patients.

Non-Retaliation Clauses

In addition to bans against "gag clauses," at least 31 states prohibit plans from retaliating against providers for engaging in protected communications with or advocating on behalf of their patients. Some states also prohibit plans from retaliating against providers who disclose concerns about quality to specified authorities.

Anti-Gag Clauses

Provision	State	Year	Bill Number	Chapter/Public Act
Anti-Gag Clauses	AK[1]	1998	SB 197	Ch. 60
	AZ	1997	SB 1098	Ch. 100
	AR	1997	HB 1843	Act 1196
	CA	1996	AB 3013	Ch. 1089
	CO	1996	HB 1216	Ch. 122
	CT	1997	HB 6883	PA 97-99
	DE	1996	SB 449	Ch. 539
	DC	1996	Act 11-	Law 11-495
	FL	1997	235	97-159
	GA	1996	SB 297	Act 751
	HI	1998	HB 1338	Act 178
	ID	1997	SB 2297	Ch. 204
	IL	1999	SB 1150	PA 617
	IN	1996	SB 251	PL 192
	IA	1999	SB 392	
	KS	1997	SF 276	Ch. 190
	KY	1998	SB 204	Ch. 304
	LA	1997	HB 315	LA Act 1232
	ME	1996	SB 528	PL 673
	MD	1996	SB 769	Ch. 548
	MA	1996	HB 1374	Ch. 8
	MI	1997	HB 5347	PA 68, 67
	MN	1997	SB 501, HB	Ch. 237
	MO	1997	4392 SF 960	Ch. 354
	MT	1997	HB 335	Ch. 527
	NE	1997	HB 27	44-68
	NV	1997		Ch. 140
	NH	1997	LB 279	Ch. 345
	NJ	1997	AB 156	Ch. 192
	NM	1997		13 NMAC 10:13
	NY	1996	SB 178	Ch. 705
	NC	1997	SB 269	Ch. 474
	ND	1997	By regulation	Ch. 248
[1] prohibits restriction of provider criticism of plan	OH	1997	SB 7553	Sec. 1751
	OK	1997	SB 455	Ch. 289
	OR	1997	HB 1418	Ch. 343

Provision	State	Year	Bill Number	Chapter/Public Act
			HB 361 HB 1416 SB 21	

Anti-Gag Clauses

Provision	State	Year	Bill Number	Public Act/Chapter
Anti-Gag Clauses	PA	1996	HB 1977	Act 85
	RI	1996	HB 8172	Ch. 41
	SD	1999	SB 236	
	TN	1996	HB 2077	Ch. 874
	TX	1997	SB 383, SB 385	Ch. 1024, 1026
	UT	1997	SB 18	Ch. 227
	VT	1996	SB 345	18 VSA §9414
	VA	1996	HB 1393	Ch. 776
	WA	1996	SB 6392	RCW §48.43.075
	WI	1998	AB 768	Ch. 628.37
	WV	1997	by rule	NCSL
	WY	1997	HB 54	Ch. 166

Non-Retaliation Clauses

Provision	State	Year	Bill Number	Chapter/Public Act
Non-Retaliation Clauses	DE	1998	by regulation	2:6 Del. R.
	GA	1996	HB 1338	Act 751
	ID	1998	SB 1150	Ch. 204
	IL	1999	SB 251	PA 617
	IN	1996	SB 392	PL 192
	IA	1999	SF 276	
	KY	1998	HB 315	Ch. 304
	LA[1]	1997	SB 528	Act 1232
	ME	1996	SB 769	Ch. 673
	MA	1996	HB 5347	Ch. 8
	MN	1997	SF 960	Ch. 237
	MO[1]	1997	HB 335	Ch. 354
	MT	1997	HB 27	Ch. 527
	NE[1]	1998	LB 1162	
	NV[1]	1997	AB 156	Ch. 140
	NJ	1997	SB 269	Ch. 192
	NM	1997	By regulation	13 NMAC 10:13
	NY[1]	1996	SB 7553	Ch. 705
	ND	1997	HB 1418	Ch. 248
	OH[1]	1997	SB 67	Sec. 1751.13
	OK	1999	HB 1826	
	OR	1997	SB 21	Ch. 343
	PA	1998	SB 91	Act 68
	RI	1996	HB 8172	Ch. 41
	SD[1]	1999	SB 236	
	TN	1998	HB 2949	Ch. 1033
[1] Protects disclosures to authorities.	TX	1997	SB 383, SB 385	Ch. 1024, 1026
	VA	1998	S712	Ch. 891§32.1-137.15
	WA	1996		RCW §48.43.075
	WI	1998	AB768	Act 237 Ch. 609.30
	WY	1997		W.S. 26-22-504

Confidentiality of Health Information

At least 25 states and the District of Columbia have recently enacted protections for individually identifiable health information, although the protections provided by these laws vary significantly across states. Some states, such as Montana, requires plans to notify its enrollees of its confidentiality procedures, give enrollees access any personal information collected and the opportunity to correct inaccuracies, and prohibit a plan from disclosing any individually identifiable information without a signed disclosure from the enrollee. Other states simply require plans to develop procedures for protecting confidential information and informing enrollees of their policies.

Provision	State	Year	Bill Number	Chapter/Public Act
Confidentiality of Health Information	CT	1997	SB 6883	PA 97-99
	DC	1996	Act 11-235	Law 11-495
	GA	1996	HB 1338	Act 751
	HI	1998	SB 2297	Act 178
	ID	1997	SB 1150	Ch. 204
	KY	1998	HB 315	Ch. 304
	MD	1997	SB 325, 545	Ch. 580, 185
	MA[1]	1996	HB 5347	Ch. 8
	MO[2]	1997	SB 335	Ch. 354
	MT	1997	SB 365	Ch. 413
		1999	SB 103	Ch. 212
	NH	1997	SB 178	Ch. 345
	NJ	1997	By regulation	NJAC 8:38-10.2
	NM	1997	By regulation	13 NMAC10:13
	NY	1996	SB 7553	Ch. 705
	NC	1997	SB 932	Ch. 519
	ND	1999	SB 2400	
	OH	1997	SB 67	Sec. 1751.13
	OR	1997	SB 21	Ch. 343
	PA	1998	SB 91	Act 68
	RI	1996	HB 8172	Ch. 41
	TN	1996	SB 2645	Ch. 862
[1] Regarding psychotherapy information	TX	1997	SB 383, SB 385	Ch. 1024, 1026
	UT	1986		Ch. 204 §31A-8-405
[2] Regarding mental health records	VT	1997	By rule	Rule 10.00
	WV	1998		WV Code §33-25A-26
	WY	1995		W.S. 26-34-130

Anti-Discrimination

At least 23 states ban discrimination on the part of health insurers against enrollees and potential enrollees. These laws do not eliminate underwriting practices, but rather these provisions protect enrollees against willful discrimination. Recently several states, such as Missouri, have passed legislation specifically protecting victims of domestic violence and prohibiting genetic testing.

Provision	State	Year	Bill Number	Chapter/Public Act
Anti-discrimination	AZ[1]	1997	SB 1098	Ch. 100
	CO	1997	HB 1122	Ch. 238
	CT	1997	SB 6883	PA 97-99
	ID	1997	SB 1150	Ch. 204
	KS[1,2]	1997	SB 204	Ch. 190
	KY[1,2]	1998	HB 315	Ch. 304
	LA[1,2]	1997	HB 1590	Act 1418
	MS[2,3]	1998	BCBS	
	MO[2,3]	1998	SB 722	
	NE[3]	1998	BCBS	
	NJ[4]	1997	By regulation	NJAC 8:38-15.2
	NM	1997	By regulation	13 NMAC 10:13
		1997[2]	HB 346	Ch. 141
		1998[3]	HB 331	Ch. 77
	NC	1997	SB 932	Ch. 519
	OH	1997	SB 67	Sec. 1751.18
	OK	1997[5]	HB 1416	Ch. 289
		1998[1,2]	BCBS	
	RI	1996	HB 8172	Ch. 41
		1998 [2]	BCBS	
	SC[2]	1998	BCBS	
	TN[2]	1997	HB 413	Ch. 121
	TX	1995	HB 1367	Ch. 415
	VT[1,2]	1998	BCBS	
	WA[1]	1983		RCW §48.44.220
	WI[2]	1998	BCBS	
	WV	1998		WV Code §33-25A-14

[1] Applies to enrollment practices only
[2] For genetic information or testing
[3] For victims of domestic violence
[4] Prevents providers from discriminating
[5] Against persons with high cost illnesses

Quality Assurance Program

At least 23 states and the District of Columbia require plans to establish and maintain an internal quality assurance program. Some states, such as New Hampshire, require plans to maintain a program based on written standards, developed in consultation with physicians, and require plans to make its program available for review by the state.

Provision	State	Year	Bill Number	Chapter/Public Act
Internal Quality Assurance Program	DE	1998	by regulation	2:6 Del. R.
	DC	1996	Act 11-235	Law 11-495
	GA	1996	HB 1338	Act 751
	HI	1998	SB 2297	Act 178
	IL	1999	SB 251	PA 617
	KY	1998	HB 315	Ch. 304
	LA	1997	HB 2228	Act 238
	ME	1996	SB 769	Ch. 673
	MT	1997	HB 365	Ch. 413
	NE	1998	LB 1162	
	NV	1997	AB 156	Ch. 140
	NH	1997	SB 178	Ch. 345
	NJ	1997	By regulation	NJAC 8:38-7-1
	NM	1997	By regulation	13 NMAC 10:13
	NC	1997	SB 932	Ch. 519
	OR	1997	SB 21	Ch. 343
	RI	1996	HB 8172	Ch. 41
	SD	1999	SB 236	
	TX	1997	SB 383, SB 385	Ch. 1024, 1026
	VA	1998	BCBS	
	VT	1997	S 143	18 VSA §9414
	WV	1996		WV Code §33-25A-17a
	WI	1998	AB 768	Act 237, Ch. 609.32
	WY	1995		W.S. 26-34-108

Access to Off-Formulary Prescriptions

At least 14 states require plans to provide a process for obtaining off-formulary prescriptions under certain conditions. States may or may not prohibit plans from imposing additional cost sharing for such access.

Provision	State	Year	Bill Number	Chapter/Public Act
Access to Off-Formulary Prescriptions	AR	1997	HB 1843	Act 1196
	CA	1998	FamiliesUSA	
	GA	1996	HB 1338	Act 751
	IN	1998	HB 364	PL 69
	ME[1]	1998	BCBS	
	MD	1999	HB 182	Ch. 128
	MN[2]	1998	BCBS	
	MO[3]	1997	HB 335	Ch. 354
[1] For HIV/AIDS drugs	OK	1999	HB 1681	
[2] For cancer drugs	OR	1997	SB 21	Ch. 343
[3] Requires coverage for any FDA approved drug recognized for treatment in a standard reference compendia or in accepted peer-reviewed medical journals	RI	1998	HB 8024	Ch. 290
	VT	1997	by rule	Rule 10.00
	VA	1999	SB 1235	Ch. 643
	WI	1998	AB 768	Act 237 Ch. 632.853

Participation in Clinical Trials

Four states have passed laws requiring plans to allow their enrollees to participate in clinical trials, under certain conditions. Plans are required to pay for the routine costs of patient care during the trial.

Provision	State	Year	Bill Number	Chapter/Public Act
Participation in Clinical Trials	GA[1]	1998	SB 603	Act 801
	MD	1998	SB 137	Ch. 118
	RI[2]	1997	SB 1	Ch. 92
[1] For children's cancer therapies	VA[2]	1999	SB 1235	Ch. 643
[2] For new cancer therapies				

Ombudsman Programs

At least eight states have recently passed legislation authorizing the establishment of a state Ombudsman program to assist health care consumers. For example, the Office of Consumer Health Assistance in Utah provides education, investigates complaints, and assists enrollees with filing a grievance or an appeal.

Provision	State	Year	Bill Number	Chapter/Public Act
Ombudsman Programs	CT	1999	HB 7032	Act 99-284
	FL	1996		FL Stat §641.60
	IL	1999	SB 251	PA 617
	KY	1998	HB 315	Ch. 304
	MA	1998	Executive order	BCBS
	UT	1999	SB 56	Ch. 143
	VT	1998		8 VSA §4089
	VA	1999	HB 871	Ch. 649

Liability

Many states have laws exempting corporations from medical malpractice liability. Missouri has removed this exemption, thereby allowing health plans to be held liable for malpractice. In addition, four other states have created specific causes of action for enrollees to sue their health plans. The Texas statute was challenged but upheld in federal district court. An appeal is pending.

Provision	State	Year	Bill Number	Chapter/Public Act
Liability	CA	1999	SB 21	
	GA	1999	HB 732	Act 281
	LA	1999	HB 2083	Act 401
	MO	1997	HB 335	Ch. 538
	TX	1997	SB 386	Ch. 163

Medical Necessity Defined

Six states have defined "medical necessity or appropriate" in statute. Virginia, for example, defines medical necessity as "appropriate and necessary health care services which are rendered for any condition which, according to generally accepted principles of good medical practice, requires the diagnosis or direct care and treatment of an illness, injury, or pregnancy-related condition, and are not provided only as a convenience."

Provision	State	Year	Bill Number	Chapter/Public Act
Definition of Medical Necessity	GA	1999	HB 732	Act 281
	MT	1997	SB 365	Ch. 413
	NM	1997	By regulation	13 NMAC 10:13
	ND	1999	SB 2400	
	NC	1997	SB 932	Ch. 519
	VA	1998	SB 712	Ch. 891 §38.2-5800

Utilization Review Standards

At least 38 states have standards for Utilization Review Organizations operating in their state. In addition, 17 states have passed legislation establishing standards for plans' internal utilization review process.

Provision	State	Year	Bill	Chapter/Public Act
Utilization Review Standards	AL[1]	1994	BCBS	
	AZ[1]	1993	BCBS	
		1997	HB 1098	Ch. 100
	AR[1]	1989	BCBS	
	CA[1]	1995	BCBS	
	CT[1]	1991	BCBS	
	DE[2]	1998	by regulation	2:6 Del. R.
	FL[1]	1990	BCBS	
	GA[1, 4]	1991	BCBS	
	HI[1]	1991	BCBS	
	ID[1,2]	1998	SB 1150	Ch. 204
	IL[1,2]	1999	SB 251	PA 617
	IN[1, 4]	1992	BCBS	
	IA[1,2,4]	1999	SF 276	
	KS[1, 3, or 4]	1994	BCBS	
	KY	1990[1,3]	BCBS	
		1998[2]	HB 315	Ch. 304
	LA	1991[1, 3]	BCBS	
		1997	HB 2228	Act 238
		1999[1,2]	HB 2083	Act 401
	ME[1, 2]	1996	SB 769	Ch. 673
	MD[1]	?	BCBS	
		1998[2]	SB 401	Ch. 111
	MN[1, 3]	1992	BCBS	
[1] For independent UR organizations	MS[1, 3]	1990	BCBS	
		1998	BCBS	
[2] For a plan's internal UR activities	MO	1991[1]	BCBS	
		1997[2]	HB 335	Ch. 374
[3] Requires state license or certification	MT[1]	1992	BCBS	
[4] Requires accreditation	NE	1992[1, 3, 4]	BCBS	
		1998[2]	LB 1162	

Utilization Review Standards

Provision	State	Year	Bill	Chapter/Public Act
Utilization Review Standards	NV	1991[1, 3]	BCBS	
		1997[2]	AB 156	Ch. 140
	NH	1991[1, 3]	BCBS	Ch. 345
		1997[2]	SB 178	Ch. 192
	NJ[2]	1997	SB 269	13 NMAC 10:13
	NM[1, 2]	1997	By regulation	Ch. 705
[1] For independent UR organizations	NY[2]	1996	SB 7553	
[2] For a plan's internal UR activities	NC	1991[1, 3]	BCBS	Ch. 519
		1997	SB 932	
[3] Requires state license or certification	ND[1, 3 or 4]	1991	BCBS	
	OK	1991[1, 3]	BCBS	
[4] Requires accreditation		1999[1,2]	HB 1681	
	OR	1983[1, 3]	BCBS	Ch. 343
		1997[2]	SB 21	Act 68
	PA[2, 3]	1998	SB 91	
	RI[1, 3 or 4]	1992	BCBS	Ch. 139
		1996	HB 7683	
	SC[1, 3]	1990	BCBS	
	SD[1, 2]	1996	BCBS	
		1999	HB 1012	
	TN[1, 3]	1992	BCBS	
	TX	1991[1, 3]	BCBS	
		1996[2]	BCBS	
	VA	1990[1, 3]	BCBS	
		1998[2]	BCBS	

Coverage of Second Opinions

Provision	State	Year	Bill Number	Chapter/Public Act
Coverage of Second Opinions	CA[1]	1999	AB 12	
	IN[1]	1998	SB 364	PL 69
[1] From another participating provider.	KY	1998	HB 315	Ch. 304
	WI[1]	1998		Ch. 609.22

California SB 21 (1999)
Managed Care Accountability
Summary of Provisions

- Creates a duty on health care service plans and managed care entities to exercise ordinary care to arrange for the provision of medically necessary health care services. The service must be a covered benefit. The bill does not contain a definition of "medically necessary" care, unlike the Georgia law.

- Holds entities liable for failure to exercise ordinary care if: 1) the failure resulted in the denial, delay or modification of the service; and 2) the subscriber or enrollee was substantially harmed.

- "Substantial harm" is defined as loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, severe and chronic physician pain, or significant financial loss. The "substantial harm" standard means this has a narrower application than either Texas or Georgia, which allow recoveries by anyone who is harmed by the denial or delay of medically necessary care.

- Allows for the recovery of punitive damages. The Texas law allows for such recoveries, but the Georgia law does not.

- Prohibits plans and entities from seeking indemnity from a provider for liability under the law. This is similar to the Texas and Georgia laws.

- Exempts employers and employer group purchasing organizations that purchase coverage or assume risk on behalf of their employees or on behalf of self-funded employee benefit plans. Employers are also generally insulated from liability under the Texas and Georgia laws.

- Requires enrollees or their representatives to exhaust external review mechanisms prior to maintaining a cause of action, unless:

    - Substantial harm has occurred before external review has been completed; or

    - Substantial harm will imminently occur prior to completion of the external review.

  Georgia and Texas generally require exhaustion of the external review process prior to filing suit.

5:40 pre-brief.

THE WHITE HOUSE

WASHINGTON

October 4, 1999

MEETING WITH THE DEMOCRATIC CONGRESSIONAL LEADERSHIP

DATE:	October 5, 1999
LOCATION:	Yellow Oval
TIME:	6:00 pm – 7:00 pm
FROM:	Larry Stein Jack Lew Chris Jennings

I. PURPOSE

To meet with Members of the Democratic Congressional Leadership and discuss the status of the FY 2000 appropriations process and Patient's Bill of Rights.

II. BACKGROUND

Though most members now believe that little of magnitude is going to be legislated in the last phase of the year, the Democratic Leadership group will understand that you have to keep up the pressure for serious achievements in Social Security, Medicare, tax cuts, and, within the appropriated accounts, education, health, community policing, national security, and the environment. The leaders will also be looking to you, however, for focus on the Appropriations end-game, a clear plan for vetoing unacceptable bills, and a strong education message strategy. You might frame the issues along these lines:

> "The Republicans may have given up for the year, but I don't think we should let them off easily. The American people want to see us doing our jobs, not abandoning opportunities to do things they want done. We need to make it clear that we're still here pushing while the Republicans rush to get out of town. For that reason, I intend to continue to call publicly for a lock-box that extends the life of the Social Security Trust Fund, for comprehensive Medicare reform that includes an affordable prescription drug benefit, extended solvency, and restoration of some cuts for providers, for a tax cut targeted at the middle class and for investments in our children, health, cops, national security, and the environment.
>
> Our insistence on dealing with the things people care about enhances our ability to win the battle over the more particular priorities we share in the budget. Beneath the broader frame, we have to stick together on the appropriations bills and fight for the continuation of 100,000 teachers plus accountability, the next

phase of the community policing program, and against the Republican attacks on the environment."

The Appropriations Bills and Patients Bill of Rights are dealt with in this memo. The other two most pressing issues -- BBA add-backs and the tax extenders -- are covered in the memo for the meeting with Senators Roth and Moynihan.

APPROPRIATIONS

To date, only four bills have been signed into law. The Republicans would clearly like to finish the appropriations bills as quickly as possible and end this congressional session. Their strategy is to provide acceptable levels of funding, complete action on the appropriations bills, and accuse the Administration of spending the Social Security surplus when we do not sign bills because of unacceptable levels of funding. The Republicans are attempting to pass bills by:

- Allocating CBO's estimated $14.4 billion non-Social Security surplus to discretionary spending;

- Directing the use of the lower OMB scoring of the appropriations bills, rather than CBO scoring, without acknowledging that this would normally count against the CBO baseline surplus (the effect will show up in CBO's revised estimates that will be released in January); and

- Declaring Census, LIHEAP, and other spending as emergency and hoping that no one notices that this spends the Social Security surplus.

This would allow the Republicans to provide spending levels that would be tight compared to our FY 2000 budget, but would be increases compared to the FY 1999 levels which were viewed as a big win for Democrats. The exception is Foreign Operations, which would continue to be funded below FY 1999 levels. This creates a situation where Republicans will argue that we are proposing to spend the Social Security surplus to fund foreign aid. We have sought to create a situation where Foreign Operations is not isolated by leaving open issues on other bills, like Labor/HHS/Education, Commerce/Justice/State, and Interior. Over the coming weeks, for the bills where we believe we can maximize our ability to fix issues by negotiating (e.g., get housing vouchers), we will pay for our adds without leaving Foreign Operations isolated.

Currently, Republicans insist that they will not spend the Social Security surplus even as CBO projects over $18 billion of such spending in the pending bills. Moreover, there is very little enthusiasm among Democrats to use transparently any portion of the Social Security surplus to offset other priorities, like discretionary spending, tax extenders, or Medicare BBA fixes (Last week, Senator Daschle announced that he would offset his BBA proposal and not use the Social Security surplus).

While there is little enthusiasm for offsets in principle, they should get a second look as an alternative to spending the Social Security surplus. Over the last two weeks, both Senator Daschle and Representative Gephardt have spoken very forcefully in favor of offsets as the preferred approach. At a minimum, we need to insist on offsets (i.e., the tobacco tax or a youth tobacco penalty) to avoid assuming responsibility for spending the Social Security surplus and we may achieve at least partial success.

To date, four bills -- Military Construction, Energy/Water Development, Treasury/General Government, and Legislative Branch – have been signed into law. To ensure the continuation of funding for the rest of the Federal government, last week you signed a three-week continuing resolution that is free of extraneous riders and operates programs at current rates, terms, and conditions. Over the last week, we have publicly urged the Congress to "get on with the business of governance" by sending you acceptable appropriations bills for signature as soon as possible.

It is likely that the Agriculture/Rural Development and Transportation bills will be coming to you soon in a signable form. It is also possible that Congress may produce signable VA/HUD and Defense bills. After your veto of the District of Columbia bill, the Congressional majority has been threatening to cut District funding. We hope to work out a compromise on revised bill that is signable. The remaining bills -- Foreign Operations, Labors/HHS/Education, Commerce/Justice/State, and Interior -- will require significant work and are likely to warrant vetoes. In the final bills, we will need to identify several high profile issues that define the fight (e.g., Class Size, COPS II, environmental riders, and national security). A significant issue in this process will be teachers and teaching accountability.

We should send a strong signal that we intend to stand firm on our education funding request and on the class size reduction program. We have threatened to veto both House and Senate versions of Labor/HHS/Education over inadequate funding levels (teachers, after-school, education technology) as well as over block granting the class size program and subjecting it to authorization. At the same time, we should make clear that it's not enough to invest more in education, we need to demand more results in return. Both the House and Senate versions fail to fund our $200 million Title I accountability fund to turn around failing schools; we should insist on including it.

A summary of the remaining bills is attached below:

Signable Bills:

- Agriculture/Rural Development: The $14 billion bill passed by Congress (roughly $500 million below the request and a freeze at FY 1999 levels) is tight, but signable. The bill includes $8.7 billion for agricultural disaster assistance. Unfortunately, much of it is allocated based on the AMTA payment structure contained in the Freedom to Farm Act. Last week, we sent a letter strongly urging the House to adopt a motion to recommit the conference report so that funding could be included to fully meet the needs of that nation's farmers affected by Hurricane Floyd (we supported an additional $500 million) and a targeting mechanism for disaster payments could be added to address some of the fundamental problems with the Freedom to Farm Act. RU 486 limitations were dropped.

- Transportation. Last week, Congress passed a Transportation bill that fully funds the significant increase for highways and mass transit contained in TEA-21. In addition, a mass transit formula provision that would have cut assistance to New York and California was dropped on the Senate floor. However, the conference report includes a provision extending the current restriction on changing CAFÉ standards and funding levels for FAA are only modestly above FY 1999, well below the request. The NEC is currently coordinating a strategy to address the long-term issues of safety and modernization through the FAA authorization and we will use the signing of the bill to highlight the Republicans under funding of the FAA that could lead to delays.

Bills Where Acceptable Conference Action is Possible:

- Defense. We have expressed our strong opposition to funding levels for defense expected to be $5 billion above the request. It is unclear how we will deal with these funding levels, as the additional $5 billion for Defense above your request will create additional pressure on non-defense discretionary spending levels. The Senate has been planning to designate the funds as an emergency, but the House appears to be resisting. We are also insisting that the F-22 be in the bill. We will need to evaluate the final bill and whether a veto would be tenable.

- VA/HUD/Independent Agencies. The House bill is totally unacceptable. For example, the National Service terminated, NASA is cut by $900 million, and there are no housing vouchers. The Senate bill is significantly better (restoring funds for National Service and NASA), but there are still problems. We are in conversations with the House and Senate committees to address some of the problems with offsets. If they are willing to address our priorities like housing vouchers, community builders, EZs, and APIC; maintain last year's levels for Americorps and CDFI; and get $2.5 billion in FEMA contingency funds that could be used for Floyd, we may sign.

- District of Columbia. Last week, you vetoed the District of Columbia bill based on a number of objectionable provisions that would undermine home rule (e.g., restrictions on Federal and DC funding of abortion, domestic partners, limit on attorney's fees in special education cases, needle exchange programs, voting representation). We have been working with Delegate Norton on an offer to improve the riders. We would prefer to complete this bill to avoid the risk that the Congress will take punitive action in terms of D.C. funding, where we have no objections with the original conference report.

Bills Where Vetoes are More Likely:

- Interior. There is a senior advisers veto recommendation over environmental and other objectionable riders and inadequate funding for major portions of the Lands Legacy Initiative, Energy Conservation, key tribal programs such in the Indian Health Service, and there is no funding for the millennium project. It is likely that at a minimum, the oil royalty provision will remain in the bill even if other environmental riders are removed and that we will recommend you veto the bill.

- Labor/HHS/Education. The Labor/HHS/Education bill is currently pending on the Senate floor and awaiting House floor action. The Senate bill fixes many of our concerns, however we have issued a veto threat over Class Size being subject to authorization and funding levels, Afterschool funding, and education technology funding. Should each House pass its bill, the prospects for conference are unclear at best. The bill was temporarily funded in the Senate with about $8 billion from the Defense bill (which will have to be restored if the Defense conference is to move) and in the House with the objectionable EITC timing shift (which appears to have fallen apart).

- Commerce/Justice/State. There is a senior advisers veto recommendation due to inadequate funding for high-priority programs including law enforcement; the environment; economic development; small business; civil rights; and UN payments and other international programs. Conferees on the Commerce/Justice/State bill will have difficulty producing a signable bill unless additional funding is provided in key areas. For example, they would need about $1.0 billion over the House and Senate bills to fully fund our highest profile request, COPS II (the House provides no funding for the COPS II initiative, only the $268 million authorized for the old program). In addition, Commerce/Justice/State is the vehicle for UN arrears (which under the 1997 budget agreement are funded outside the caps through FY 2000). As you know, UN funding has in the past fallen apart on the shoals of the Mexico City policy dispute. Conferees are expected to fully fund the decennial census, but it is not clear whether they will take the House approach of funding it as an emergency.

- Foreign Operations. Last week you advised Congress that you would veto the bill as approved by Congress. The bill is $2 billion (14 percent) below FY 1999 your request and underfunds Threat Reduction, the Wye Agreement, debt relief, Africa, and the Multilateral Development Bank.

As we discussed last week, there will be a number of bills left at the end and we will most likely offer offsets to pay for the increases as long as the amount stays manageable.

PATIENTS BILL OF RIGHTS

The Democratic Party has been remarkably unified behind its support for a strong, enforceable Patients Bill of Rights. Unlike the normal tendency of maverick Democrats to attempt to negotiate a substandard compromise that weakens our negotiating ability with the Republicans, the Democratic leadership has succeeded in encouraging centrist Democrats to vote against attempts by the Republicans to pass a weak version of a Patients Bill of Rights. They are very proud of this achievement and it would be advisable of you to commend them for it.

The Senate Republican leadership made it easier for Democrats to oppose their version of the Patients Bill of Rights because of its numerous shortcomings, including the fact that it leaves more than 100 million Americans without the guarantee of any basic protections and oversees less that 10 percent of HMOs nationwide; fails to provide access to specialists, such as oncologists and cardiologists; fails to guarantee continuity of care protections; fails to provide effective protection to assure patients access to emergency room care when and where the need arises; has a weak, watered-down appeals process that is biased against patients; and has a meaningless set of enforcement provisions.

The House Republican leadership, on the other hand, has been forced to consider more comprehensive approaches, primarily because over 20 Republicans, led by Congressman Norwood, have already indicated their support for the Norwood-Dingell Patients' Bill of Rights. Ever since this occurred in early August, the leadership has attempted to develop policy and parliamentary gimmicks to defeat the Norwood-Dingell bill.
On Friday, Republicans filed a series of amendments designed to thwart the ability of Congressmen Norwood and Dingell to have a free-standing up or down vote on their bill. Some Republicans are trying load the bill up with controversial poison pill provisions (such as MSAs and multi-employer welfare associations that policy analysts fear would do more to segregate the healthy from the unhealthy than to cover uninsured) to diminish the bill's strong support.

Other Republicans, sanctioned by the Republican leadership are apparently developing comprehensive approaches designed solely to undermine the enforcement provisions in Norwood-Dingell by throwing up numerous roadblocks to prevent patients who have been harmed by plan decisions from being able to sue HMOs. This Republican alternative would require patients to go through a separate certification process to affirm that they have actually been harmed prior to allowing any court proceeding (which may well be unconstitutional) and require a separate arbitration process be completed prior to any lawsuit. Fortunately, Republicans who support the Norwood-Dingell bill are reportedly continuing to back the stronger bill even in the face of these amendments.

The latest report is that the Rules Committee will issue a rule that only permits debate on the Patients Bill of Rights if the Republican access legislation can be added on to the Norwood-Dingell Patients Bill of Rights legislation at the end of the debate. The Republican leadership is clearly attempting to get Republican supporters of the Norwood-Dingell bill to support this condition. However, because they oppose any attempt to weigh down the chances of the bill for passage in a form that you will sign into law, most of these Republicans are resisting appeals for support from their leadership. Congressman Dingell and Norwood are contemplating parliamentary and other approaches designed to secure an up or down vote on their underlying legislation.

In the interim, they are preparing their supporters to vote against any amendment to the Norwood-Dingell bill regardless of whether they would support it under normal circumstances. We will have more updated information immediately prior to your meeting with the Democratic leadership on the status of this debate.

TALKING POINTS ON PATIENTS BILL OF RIGHTS

- First, I want to commend all of you for your impressive achievement in maintaining Democratic unity behind strong patient protection legislation. Your efforts in this regard have enhanced the likelihood that we will either get a strong bill signed into law or ensure that a Republican-only Patients Bill of Rights will be viewed by the public as not being worth the paper it is written on.

- This issue is a great example of what we can accomplish working together and I can assure you that I will continue to do everything possible to create the kind of environment that pressures the Republicans to act responsibly and validates our opposition to meaningless reform.

- I have done everything I can do administratively in this area, and have used this office to continue to underscore the importance of this issue. As you know, I did a radio address to promote this issue this weekend and will hold another event tomorrow. Beyond continuing the technical assistance we are providing to your staff, is there anything else we can do to assist you on this issue?

III. PARTICIPANTS

Pre-brief
The President
John Podesta
Secretary Summers
Jack Lew
Larry Stein
Gene Sperling
Steve Ricchetti
Maria Echaveste
Joel Johnson
Sylvia Mathews
Chris Jennings
Chuck Brain

Meeting

Administration:

The President
John Podesta
Secretary Summers
Jack Lew
Larry Stein
Gene Sperling
Steve Ricchetti
Maria Echaveste
Joel Johnson
Sylvia Mathews
Chris Jennings
Chuck Brain

Members Confirmed:

Senator Tom Daschle (D-SD)
Senator John Breaux (D-LA)
Senator Byron Dorgan (D-ND)
Senator Bob Kerrey (D-NE)
Senator Patty Murray (D-WA)
Senator Harry Reid (D-NV)
Senator Robert Torricelli (D-NJ)
Senator Jay Rockefeller (D-WV)

Representative Richard Gephardt (D-MO)
Representative David Bonior (D-MI)
Representative Rosa DeLauro (D-CT)
Representative Chet Edwards (D-TX)
Representative Steny Hoyer (D-MD)
Representative John Lewis (D-GA)
Representative Patrick Kennedy (D-RI)
Representative Bob Menendez (D-NJ)
Representative Maxine Waters (D-CA)

Members Pending:

Senator Dick Durbin (D-IL)
Senator John Kerry (D-MA)
Senator Barbara Mikulski (D-MD)

Representative Martin Frost (D-TX)
Representative Ed Pastor (D-AZ)

IV. PRESS PLAN

None.

V. SEQUENCE OF EVENTS

As usual.

VI. REMARKS

None.

just need cites thx so much.

LEGISLATIVE CITES FOR BOEHNER AND COBURN-SHADEGG AMENDMENTS

BOEHNER

Limited protections only apply to employer sponsored plans, leaving at least 15 million Americans unprotected. §201(a), p 104, l 10-12 amends only the group market section of PHSA

No requirement to assure access to specialists when the plan's provider network is inadequate
omission, no cite

Allows plans to provide excessive financial incentives to providers to limit medically necessary care
omission, no cite

Requires parents of newborns to receive prior approval before receiving emergency care.
§ 714(b)(1)(B)(i)(II) p 7 l 10

No individual remedies that can be accessed through the courts to hold plans accountable for actions that have harmed patients.
omission, no cite

COBURN-SHADEGG

Newborns are unable to access emergency care where and when the need arises. Parents are required to get prior approval before they can receive emergency care for their newborns. Section (page 22 line 36) 2813(a)(2)(A)(ii)

No protections against plans limiting access to necessary medications. This bill limits access to medically necessary medications even when recommended by health care providers.
this is an omission, so there is no cite.

An external review process that is biased against low-income patients. All patients, even if they are unable to afford it, must pay a $25 filing fee to have their case considered by an external review entity. If the patient cannot pay the filing fee, the appeals entity will not hear their case.
(page 13 line 17) Section 2803(a)(4)(A)

Meaningless information disclosure requirements that leave patients in the dark about their rights. Plans are not required to inform enrollees of their limited new rights. Moreover, plans may meet their information disclosure requirements by providing patients with technical billing and diagnostic codes, which are intended for use by health care professionals, not patients.
(page 36 line 16) section 2821(b)(2)

A flawed enforcement provision that severely limits patients' ability to hold plans accountable.

Imposing a health care cost cap that must be exceeded to sue or even appeal a harmful plan decision. Under this provision, a woman who was denied a mammography and subsequently had her cancer spread would not be able to sue the plan B let alone appeal the original denial of service.
(page 12 (line 22) Section 2803(a)(2)(A)(ii)

Requires patients who have already been harmed to exhaust all levels of appeals before seeking redress. Under this provision, a patient who by any definition has been injured as a result of a plan decision must go through an unnecessarily time consuming appeals process even though the outcome is clear. §502(n)(7), p 86, l 29

Requires time consuming and burdensome certification in order for a patient injured by a plan decision to file a case. This requirement may be without precedent, and is certainly implements an extraordinary hurdle for enrollees seeking redress. § 502(n)(8), p 87, l 5

THE WHITE HOUSE

Office of the Press Secretary
(Las Vegas, Nevada)

Embargoed For Release
Until 10:06 A.M. EDT
Saturday, October 2, 1999

RADIO ADDRESS BY THE PRESIDENT
TO THE NATION

Paris Hotel
Las Vegas, Nevada

THE PRESIDENT: Good morning. Although my voice has been a little hoarse, I want to speak with you this morning about your voice, about how you can make the difference this week to help secure the vital health care protections you've long deserved.

Like many of you, I've been appalled by the tragic stories of men and women fighting for their lives, and at the same time forced to fight insurance companies focused only on the bottom line. I've met the husbands and wives of those who have died when insurance companies overruled a doctor's urgent warnings. I met a former HMO employee who broke down in tears when describing how callous delays wound up costing a 12-year-old cancer patient his leg. If we work together, we've got the power to put patients first once again.

Just this week, Governor Gray Davis signed into law an ambitious health care reform package, giving 20 million residents of California a strong and enforceable patients' bill of rights. Now, it's time to do the same for every American, because it doesn't matter whether you're from California or Connecticut or anywhere in between; families all across our nation need greater patient protections at this time of great change in medical care.

My administration has worked hard to do its part. Through executive action, we've granted all of the patient protections we can give under law to more than 85 million Americans who get their health care through federal plans.

Today, I'm pleased to announce that this month, we'll propose rules to extend patient protections to each and every child covered under the Children's Health Insurance Program. These children are from some of our hardest-pressed working families. That's why I feel so strongly about giving them not only access to health care, but also the guarantee of quality care.

Yet, some in Congress still seem intent on moving in the opposite direction. Republican leaders recently have attached language to a budget bill to deprive 120 million employees of the right to a timely internal appeal of any coverage decision that denies them care they were promised. Blocking this basic right is simply unacceptable. It puts special interests first and patients last.

But this week, the House of Representatives has a chance to effectively erase this action as they sit down to vote at long last on whether to give all Americans in health plans all the protections of the patients' bill of rights. This vote is critical. For all of the steps this administration and many states have taken to extend patient rights, we don't have the authority to protect every family unless Congress acts.

So I encourage you to urge your representatives to vote for the comprehensive bipartisan patients' bill of rights, sponsored by Congressman Charlie Norwood and John Dingell. This legislation will give every American the right to emergency room care and the right to see a specialist; the right to know you can't be forced to switch doctors in the middle of a cancer treatment or pregnancy; the right to hold your health care plan accountable if it causes you or a loved one great harm.

The bill has already been endorsed by more than 300 health care and consumer groups all across America. I'm convinced the votes are there to pass this patients' bill of rights this week. But we need your help to make it clear to the Republican leaders that we can't tolerate any attempt to kill this bill with legislative poison pills.

Together, let's tell them to give this legislation the straight up or down vote it deserves. Let's not allow anything to jeopardize the remarkable bipartisan consensus we have worked so hard to build. If you make your voice heard and Republican leaders permit every member to vote on the strong bipartisan bill that stands today, this week can bring the most important health protections in years. Partisan posturing and delay will only make matters worse. To me, it's the same choice patients face every day. Active, preventive medicine now or expensive, last-minute interventions later. The American people are counting on the Congress, and especially the Republican leaders, to make the responsible choice.

Thanks for listening.

DATE: _____

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TO: Chris Jennings [X] RICHARD J. TARPLIN

OFFICE: 456-5557 [ ] KEVIN BURKE

ROOM: _____ [ ] HAZEL FARMER

PHONE: _____ [ ] ROSE CLEMENT LUSI

FAX: _____ [ ] ALICE ARTIS

TOTAL PAGES (INCLUDING COVER): _____ [ ] FRANKIE MELTON

REMARKS: FYI

Donna's talking points for the caucus tomorrow.

Talking Points for Democratic Caucus
October 6, 1999
Patient's Bill of Rights

GENERAL MESSAGE

- The Republican leadership has spent months trying to figure out a way to deny the American people the health care protections they need and deserve. Last night, only hours before the start of the debate in the House, the Republicans were rewriting their bills trying to find an alternative that could compete with the Norwood-Dingell bill on the floor. However, we and the 300 plus organizations that support this bill know that there is no other alternative.

- Last night too, the Republican Leadership used the Rules Committee process to try to cripple our chances for passing a strong, bipartisan Patient's Bill of Rights.

- First, the Rule denies our friends a way to pay for the cost of the Norwood-Dingell bill. Of course, the Republicans do not appear concerned about paying for their own costly access bill should it pass the House.

- Second, the Rule combines the Patient's Bill of Rights with H.R. 2990, the access bill introduced by Congressman Talent. We need to be clear with each other and the public that this is not a legitimate debate about improving access to insurance. The Republican effort to combine these bills is a poison pill designed to sabotage the Patient's Bill of Rights – pure and simple.

- **It will be a sad day if the American people lose the protections they need because of the Republican Leadership's parliamentary maneuvering. We hope the Rule can be defeated and a fair process established instead. If the Rule passes, we would strongly urge you to hold together as a caucus and vote for the Norwood-Dingell patient's bill and against the so-called access measure.**

REPUBLICAN ACCESS BILL

Now I want to be more specific about our objections to the Leadership access bill, HR 2990:

- The Administration does not support H.R. 2990 either as a substitute or a stand alone bill.

- We do not believe that the Republican insurance bill will actually improve coverage in this country.

- In fact, most experts believe that key provisions of the Republican bill, including Health Marts, Medical Savings Accounts, and Association Plans, will actually make insurance more unaffordable for the people who have it now and who need it the most.

- Association Plans become in effect, insurance companies, without the important consumer protections normally afforded by state law. The latitude provided under the Talent bill would allow 'cherry-picking' of the healthiest people, and undermine the stability of the current insurance market.

- Medical Savings Accounts were created by federal law in 1996 as a 3 year demonstration. The Talent bill would expand these products before the demonstration is complete and health policy experts have deep concerns about their effect on the overall market.

- Health Marts, like Association Plans, would have the latitude to attract only the healthiest people, thereby raising rates for people who stay in the regular state-regulated insurance market.

- We cannot support legislation designed to split the existing insurance market into healthy and ill, and to make obtaining coverage more difficult that it already is.

- Even the insurance industry does not support key provisions of the Republican bill.

- Finally, we do not support letting certain employers and insurers avoid important state level consumer protections as the Republican bill would do. This Republican bill goes in the wrong direction.

THE WHITE HOUSE

WASHINGTON

October 7, 1999

Dear Mr. Leader:

I am writing in response to your request about my current position on H.R. 2723, the Norwood-Dingell Bipartisan Consensus Managed Care Improvement Act of 1999, particularly with regard to the financing of this important and long-overdue legislation.

First, I share your deep concerns about and disappointment with the partisan manner in which the Republican Leadership has stacked the process against the Norwood-Dingell patients' protections bill. It is extremely troubling that the Leadership refused the House the ability to vote on a bipartisan-supported amendment to ensure that H.R. 2723 would be explicitly financed. It is certainly worth noting that it appears that one of the reasons they denied this request is that it would underscore the fact that all of the Republican Leadership alternatives have no financing and rely on funding from the Social Security surplus.

Notwithstanding the Leadership's refusal to allow for offsets to be used to finance H.R. 2723, I remain strongly supportive of the important patient protections in the bill. I therefore believe the House should vote for this legislation -- and against any and all substitutes -- so as to keep the hope of this necessary legislation being enacted. I cannot support a bill that is a Patients' Bill of Rights in name only.

While I endorse this legislation without reservation, I want to assure you that I will not sign it unless its costs are fully offset by the conference committee.

I hope this information is helpful. I look forward to working with you and the bipartisan majority of the Congress who wish to vote for a strong, enforceable, and paid for Patients' Bill of Rights.

Sincerely,

Bill Clinton

The Honorable Richard A. Gephardt
Democratic Leader
House of Representatives
Washington, D.C. 20515

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Democratic Leader
House of Representatives
Washington, D.C. 20515

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

October 6, 1999
(House)

STATEMENT OF ADMINISTRATION POLICY

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

H.R. 2990 - Quality Care for the Uninsured Act
(Rep. Talent (R) MO)

The Administration strongly opposes House passage of H.R. 2990, legislation explicitly designed to interfere with the passage of a free-standing Norwood-Dingell Patients' Bill of Rights. This legislation is completely unfunded and would therefore spend the social security surplus. The spending of the surplus would have virtually no impact in expanding coverage to the uninsured. If H.R. 2990 were presented to the President, his senior advisers would recommend that he veto the bill.

Although we look forward to continuing to work with the Congress on a bipartisan basis to increase access to health insurance coverage, H.R. 2990 is not the answer. While H.R. 2990 contains certain provisions that the Administration supports, such as a 100 percent deduction for health insurance premiums for the self-employed, it also includes numerous controversial provisions, such as expanding the availability of Medical Savings Accounts and association health plans, that independent health policy analysts fear would do more to segregate the healthy from the unhealthy than to cover the uninsured. In fact, preliminary analysis indicates that the bill's costs would lead to a coverage expansion of less than one percent of the currently uninsured. These provisions are unrelated to the purposes of the Patients' Bill of Rights, and would further undermine the chances for a bipartisan agreement on meaningful legislation to provide all Americans the health care protections they need and deserve.

In addition, the Administration is seriously concerned that H.R. 2990 fails to include adequate offsets for the bill's significant pay-as-you-go costs. Failure to provide adequate offsets for these costs is likely to force spending of surplus dollars that should go to Social Security and Medicare.

Pay-As-You-Go Scoring

H.R. 2990 would affect receipts; therefore, it is subject to the pay-as-you-go requirement of the Omnibus Budget Reconciliation Act of 1990. OMB's scoring of H.R. 2990 is under development. Preliminary estimates based on scoring of similar provisions indicate that H.R. 2990 would result in paygo costs of more than $50 billion over 10 years.

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

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OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

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(House)

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Congress of the United States
JOINT COMMITTEE ON TAXATION
1015 LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6453
(202) 225-3621

OCT 06 1999

Honorable Edward M. Kennedy
United States Senate
SR-315
Washington, DC 20510

Dear Senator Kennedy:

This is in response to your letter of October 4, 1999, requesting revenue estimates and other information concerning several of the health care tax provisions in the conference agreement on H.R. 2488 and two of the health care tax provisions in S. 1344.

The conference agreement on H.R. 2488 contains an above-the-line deduction for health insurance expenses and long-term care insurance expenses for which the taxpayer pays at least 50 percent of the premium. The deduction would be phased in at 25 percent for taxable years beginning in 2002 through 2004, 35 percent for taxable years beginning in 2005, 65 percent for taxable years beginning in 2006, and 100 percent for taxable years beginning in 2007 and thereafter. Taxpayers enrolled in Medicare, Medicaid, Champus, VA, the Indian Health Service, the Children's Health Insurance Program, and the Federal Employees Health Benefits Program would be ineligible for the deduction for health insurance expenses.

The conference agreement on H.R. 2488 also contains a provision that would allow long-term care insurance to be offered as part of cafeteria plans, effective for taxable years beginning after December 31, 2001.

For the purpose of preparing revenue estimates for these provisions in H.R. 2488, we have assumed that the provisions will be enacted during calendar year 1999. Estimates of changes in Federal fiscal year budget receipts are shown in the enclosed table.

We estimate that in calendar year 2002 about 9.1 million taxpayers would claim the 25-percent deduction for health insurance expenses. About 100,000 of these 9 million taxpayers would be new purchasers of health insurance. Assuming an average of two persons covered by each policy, about 200,000 persons would be newly insured as a result of the 25-percent deduction for health insurance expenses.

We estimate that in calendar year 2002 about 4.7 million taxpayers would claim the 25-percent deduction for long-term care insurance expenses, and an additional 300,000 taxpayers

Congress of the United States
JOINT COMMITTEE ON TAXATION
Washington, DC 20515–6453

would use cafeteria plans to pay their share of premiums for employer-sponsored long-term care insurance. About 80,000 of these 5 million taxpayers would be new purchasers of long-term care insurance.

S. 1344 contains a provision that would increase the deduction for health insurance expenses of self-employed individuals. Under present law, when certain requirements are satisfied, self-employed individuals are permitted to deduct 60 percent of their expenditures on health insurance and long-term care insurance. The deduction is scheduled to increase to 70 percent of such expenses for taxable years beginning in 2002 and 100 percent in all taxable years beginning thereafter. S. 1344 would increase the rate of deduction to 100 percent of health insurance and long-term care insurance expenses for taxable years beginning after December 31, 1999.

S. 1344 also contains provisions that would eliminate certain restrictions on the availability of medical savings accounts, remove the limitation on the number of taxpayers that are permitted to have medical savings accounts, reduce the minimum annual deductibles for high-deductible health plans to $1,000 for plans providing single coverage and $2,000 for plans providing family coverage, increase the medical savings account contribution limit to 100 percent of the annual deductible for the associated high-deductible health plan, limit the additional tax on distributions not used for qualified medical expenses, and allow network-based manage care plans to be high-deductible plans. These provisions would be effective for taxable years beginning after December 31, 1999.

For the purpose of preparing revenue estimates for these provisions in S. 1344, we have assumed that the provisions will be enacted during calendar year 1999. Estimates of changes in Federal fiscal year budget receipts are shown in the enclosed table.

We estimate that in calendar year 2000, about 3.3 million taxpayers would claim the 100-percent deduction for health insurance expenses of self-employed individuals. About 60,000 of these taxpayers would be new purchasers of health insurance. Assuming an average of two persons covered by each policy, about 120,000 persons would be newly insured as a result of the 100-percent deduction for health insurance expenses.

Congress of the United States
JOINT COMMITTEE ON TAXATION
Washington, DC 20515–6453

Honorable Edward M. Kennedy
United States Senate

We do not have an estimate of the number of individuals who would be newly insured as a result of the medical savings account provisions of S. 1344.

I hope this information is helpful to you. If we can be of further assistance, please let me know.

Sincerely,

Lindy L. Paull

Lindy L. Paull

Enclosure: Table #99-3 206

- Senator Kennedy -

ESTIMATED REVENUE EFFECTS OF VARIOUS PROVISIONS RELATING TO HEALTH CARE

Fiscal Years 2000 - 2009

[Millions of Dollars]

Provision	Effective	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2000-04	2000-09
Health Care Provisions in the Conference Agreement for H.R. 2488													
1. Provide an above-the-line deduction for health insurance expenses - 25% in 2002 through 2004, 35% in 2005, 65% in 2006, and 100% thereafter	tyba 12/31/01	---	---	-444	-1,379	-1,477	-1,803	-3,137	-5,878	-8,299	-8,648	-3,300	-31,264
2. Provide an above-the-line deduction for long-term care insurance expenses - 25% in 2002 through 2004, 35% in 2005, 65% in 2006, and 100% thereafter	tyba 12/31/01	---	---	-48	-328	-364	-417	-677	-1,315	-2,027	-2,148	-741	-7,323
3. Allow long-term care insurance to be offered as part of cafeteria plans; limited to amount of deductible premiums [1]	tyba 12/31/01	---	---	-104	-151	-171	-190	-202	-204	-215	-247	-426	-1,484
Total of Health Care Provisions in the Conference Agreement for H.R. 2488		—	—	-595	-1,858	-2,012	-2,410	-4,016	-7,397	-10,541	-11,241	-4,467	-40,071
Health Care Provisions in S. 1344, as passed by the Senate													
1. Immediate 100% deductibility of health insurance and long-term care insurance premiums for the self-employed	tyba 12/31/99	-245	-1,007	-1,040	-657	---	---	---	---	---	---	-2,949	-2,949
2. Liberalization of conditions for enrolling in MSAs	tyba 12/31/99	-93	-281	-326	-370	-414	-459	-502	-546	-590	-634	-1,483	-4,215
Total of Health Care Provisions in S. 1344, as passed by the Senate		-338	-1,288	-1,366	-1,027	-414	-459	-502	-546	-590	-634	-4,432	-7,164

Joint Committee on Taxation

NOTE: Details may not add to totals due to rounding.

Legend for "Effective" column: tyba = taxable years beginning after

[1] Estimate assumes concurrent enactment of the above-the-line deduction for long-term care insurance (item 2.).

Congress of the United States
JOINT COMMITTEE ON TAXATION
1015 LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6453
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OCT 06 1999

Honorable Edward M. Kennedy
United States Senate
SR-315
Washington, DC 20510

Dear Senator Kennedy:

This is in response to your letter of October 4, 1999, requesting revenue estimates and other information concerning several of the health care tax provisions in the conference agreement on H.R. 2488 and two of the health care tax provisions in S. 1344.

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The conference agreement on H.R. 2488 also contains a provision that would allow long-term care insurance to be offered as part of cafeteria plans, effective for taxable years beginning after December 31, 2001.

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We estimate that in calendar year 2002 about 4.7 million taxpayers would claim the 25-percent deduction for long-term care insurance expenses, and an additional 300,000 taxpayers

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would use cafeteria plans to pay their share of premiums for employer-sponsored long-term care insurance. About 80,000 of these 5 million taxpayers would be new purchasers of long-term care insurance.

S. 1344 contains a provision that would increase the deduction for health insurance expenses of self-employed individuals. Under present law, when certain requirements are satisfied, self-employed individuals are permitted to deduct 60 percent of their expenditures on health insurance and long-term care insurance. The deduction is scheduled to increase to 70 percent of such expenses for taxable years beginning in 2002 and 100 percent in all taxable years beginning thereafter. S. 1344 would increase the rate of deduction to 100 percent of health insurance and long-term care insurance expenses for taxable years beginning after December 31, 1999.

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We do not have an estimate of the number of individuals who would be newly insured as a result of the medical savings account provisions of S. 1344.

I hope this information is helpful to you. If we can be of further assistance, please let me know.

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3. Allow long-term care insurance to be offered as part of cafeteria plans; limited to amount of deductible premiums [1]	tyba 12/31/01	---	---	-104	-151	-171	-190	-202	-204	-215	-247	-428	-1,48
Total of Health Care Provisions in the Conference Agreement for H.R. 2488		—	—	-595	-1,858	-2,012	-2,410	-4,016	-7,397	-10,541	-11,241	-4,467	-40,07
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Total of Health Care Provisions in S. 1344, as passed by the Senate		-338	-1,288	-1,366	-1,027	-414	-459	-502	-546	-590	-634	-4,432	-7,16

Joint Committee on Taxation

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Congress of the United States

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S. 1344 contains a provision that would increase the deduction for health insurance expenses of self-employed individuals. Under present law, when certain requirements are satisfied, self-employed individuals are permitted to deduct 60 percent of their expenditures on health insurance and long-term care insurance. The deduction is scheduled to increase to 70 percent of such expenses for taxable years beginning in 2002 and 100 percent in all taxable years beginning thereafter. S. 1344 would increase the rate of deduction to 100 percent of health insurance and long-term care insurance expenses for taxable years beginning after December 31, 1999.

S. 1344 also contains provisions that would eliminate certain restrictions on the availability of medical savings accounts, remove the limitation on the number of taxpayers that are permitted to have medical savings accounts, reduce the minimum annual deductibles for high-deductible health plans to $1,000 for plans providing single coverage and $2,000 for plans providing family coverage, increase the medical savings account contribution limit to 100 percent of the annual deductible for the associated high-deductible health plan, limit the additional tax on distributions not used for qualified medical expenses, and allow network-based manage care plans to be high-deductible plans. These provisions would be effective for taxable years beginning after December 31, 1999.

For the purpose of preparing revenue estimates for these provisions in S. 1344, we have assumed that the provisions will be enacted during calendar year 1999. Estimates of changes in Federal fiscal year budget receipts are shown in the enclosed table.

We estimate that in calendar year 2000, about 3.3 million taxpayers would claim the 100-percent deduction for health insurance expenses of self-employed individuals. About 60,000 of these taxpayers would be new purchasers of health insurance. Assuming an average of two persons covered by each policy, about 120,000 persons would be newly insured as a result of the 100-percent deduction for health insurance expenses.

Congress of the United States
JOINT COMMITTEE ON TAXATION
Washington, DC 20515–6453

We do not have an estimate of the number of individuals who would be newly insured as a result of the medical savings account provisions of S. 1344.

I hope this information is helpful to you. If we can be of further assistance, please let me know.

Sincerely,

Lindy L. Paull

Lindy L. Paull

Enclosure: Table #99-3 206

- Senator Kennedy -

ESTIMATED REVENUE EFFECTS OF VARIOUS PROVISIONS RELATING TO HEALTH CARE

Fiscal Years 2000 - 2009

[Millions of Dollars]

Provision	Effective	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2000-04	2000-09
Health Care Provisions in the Conference Agreement for H.R. 2488													
1. Provide an above-the-line deduction for health insurance expenses - 25% in 2002 through 2004, 35% in 2005, 65% in 2006, and 100% thereafter	tyba 12/31/01	---	---	-444	-1,379	-1,477	-1,803	-3,137	-5,878	-8,299	-8,848	-3,300	-31,264
2. Provide an above-the-line deduction for long-term care insurance expenses - 25% in 2002 through 2004, 35% in 2005, 65% in 2006, and 100% thereafter	tyba 12/31/01	---	---	-48	-328	-364	-417	-677	-1,315	-2,027	-2,148	-741	-7,32
3. Allow long-term care insurance to be offered as part of cafeteria plans; limited to amount of deductible premiums [1]	tyba 12/31/01	---	---	-104	-151	-171	-190	-202	-204	-215	-247	-426	-1,48
Total of Health Care Provisions in the Conference Agreement for H.R. 2488		—	—	-595	-1,858	-2,012	-2,410	-4,016	-7,397	-10,541	-11,241	-4,467	-40,07
Health Care Provisions in S. 1344, as passed by the Senate													
1. Immediate 100% deductibility of health insurance and long-term care insurance premiums for the self-employed	tyba 12/31/99	-245	-1,007	-1,040	-657	—	---	---	---	---	---	-2,949	-2,94
2. Liberalization of conditions for enrolling in MSAs	tyba 12/31/99	-93	-281	-326	-370	-414	-459	-502	-546	-590	-634	-1,483	-4,21
Total of Health Care Provisions in S. 1344, as passed by the Senate		-339	-1,288	-1,366	-1,027	-414	-459	-502	-546	-590	-634	-4,432	-7,16

Joint Committee on Taxation

NOTE: Details may not add to totals due to rounding.

Legend for "Effective" column: tyba = taxable years beginning after

[1] Estimate assumes concurrent enactment of the above-the-line deduction for long-term care insurance (item 2.).