

March 1, 2000

PATIENTS' BILL OF RIGHTS EVENT

DATE: March 2, 2000
LOCATION: Presidential Hall – OEOB 450
BRIEFING TIME: 10:15am – 10:30am
EVENT TIME: 10:35am – 11:20am
FROM: Bruce Reed, Mary Beth Cahill, Chris Jennings

I. PURPOSE

Today, you will urge the Congress to learn from the bipartisan action of the House last fall and move quickly to report to Congress a strong, enforceable, Patients' Bill of Rights.

II. BACKGROUND

Today, you will urge the Congress to move quickly to report to Congress a strong, enforceable, Patients' Bill of Rights and underscore your belief that the Norwood-Dingell bill is a strong basis for final legislation and should not be watered down. Joined by bipartisan members of Congress, including Representatives Norwood, Dingell, Ganske, and Berry, as well as Senators Specter, Kennedy, Chafee, and Graham, you will urge the Congress to act now to pass a patients' bill of rights that provides critical patient protections to all Americans in all health plans and holds health plans accountable for decisions that harm patients.

THE NORWOOD-DINGELL LEGISLATION IS THE ONLY REAL PATIENTS' BILL OF RIGHTS. The Norwood-Dingell Patients' Bill of Rights, endorsed by over 200 health care provider and consumer advocacy groups, is the only bipartisan proposal currently being considered that includes critical protections such as:

- Guaranteed access to needed health care specialists;
- Access to emergency room services when and where the need arises;
- Continuity of care protections so that patients will not have an abrupt transition in care if their providers are dropped;
- Access to a fair, unbiased and timely internal and independent external appeals process; to address health plan grievances;
- Assurance that doctors and patients can openly discuss treatment options; and
- An enforcement mechanism that ensures recourse for patients who have been harmed as a result of a health plan's actions.

THE SENATE BILL IS A PATIENTS' BILL OF RIGHTS IN NAME ONLY AND PROVIDES FEW REAL PROTECTIONS. You will underscore your belief that the bill passed by the Senate is a Patients Bill of Rights in name only. It would:

- Leave more than 110 million Americans without the guarantee of any basic protections and oversee less than 10 percent of HMOs nationwide (as it only covers self-insured health plans);
- Fail to provide access to necessary specialists, such as oncologists and cardiologists;
- Fail to guarantee continuity of care protections leaving patients at risk of having to abruptly change doctors in the middle of treatment;
- Fail to provide effective protection to assure patients access to emergency room care when and where the need arises;
- Construct a weak, watered-down appeals process that is biased against patients;
- Fail to provide strong enforcement mechanism for patients to hold health plans accountable when they make harmful decisions.

REFUSAL TO SIGN A PATIENTS' BILL OF RIGHTS THAT REPRESENTS AN EMPTY PROMISE. Today, you will reiterate your refusal to enact legislation that does not provide strong patient protections for all Americans in all health plans and include meaningful enforcement mechanisms. To date, there is no legislation other than the Norwood-Dingell bill that meets the Administration's fundamental criteria: that patient protections be real and that court enforced remedies be accessible and meaningful.

OPTIMISM THAT A STRONG PATIENTS' BILL OF RIGHTS WILL BE ENACTED THIS YEAR. You will underscore your optimism that a strong Patients' Bill of Rights will be enacted this year. Citing the Norwood-Dingell legislation, you will highlight your belief that the momentum for this legislation is undeniable. You believe that the Congress will respond the will of the public and pass a strong enforceable Patients' Bill of Rights this year.

III. PARTICIPANTS

Briefing Participants:

Secretary Alexis Herman
Secretary Donna Shalala
Bruce Reed
Chuck Brain
Mary Beth Cahill
Loretta Ucelli
Chris Jennings
Sam Afridi

Stage Participants:

Secretary Alexis Herman
Secretary Donna Shalala
Sen. Bob Graham (D-FL)
Rep. Marion Berry (D-AR)
Rep. Greg Ganske (R-IA)
Rep. Rosa DeLauro (D-CT)
Rep. Connie Morrella (R-MD)
Sen. Lincoln Chafee (R-RI)

Members of Congress Pending:

Sen. Christopher Dodd (D-CT)
Sen. Barbara Mikulski (D-MD)
Rep. Frank Pallone (D-NJ)

9 Doctors and Nurses from Patients' Bill of Rights Coalition organizations

Program Participants:

YOU

Senator Edward Kennedy (D-MA)
Senator Arlen Specter (R-PA)
Representative John Dingell (D-MI)
Representative Charles Norwood (R-GA)
Dr. Mary Herald, Internist/Endocrinologist, Westfield, NJ

IV. PRESS PLAN

Open Press.

V. SEQUENCE OF EVENTS

- Secretary Shalala, Secretary Herman, and Members of Congress are announced onto the stage.
- **YOU** are announced onto the stage, accompanied by Senator Edward Kennedy, Senator Arlen Specter, Representative John Dingell, Representative Charles Norwood, and Dr. Mary Herald.
- Dr. Mary Herald is announced to the podium, makes brief remarks and introduces **YOU**.
- **YOU** make remarks and introduce Representative Charles Norwood.
- Representative Charles Norwood makes remarks and introduces Representative John Dingell.
- Representative John Dingell makes remarks and introduces Senator Arlen Specter.
- Senator Arlen Specter makes remarks and introduces Senator Edward Kennedy.
- Senator Edward Kennedy makes remarks.
- **YOU** work a ropeline and depart.

VI. REMARKS

To be provided by speechwriting.

**THE CLINTON-GORE ADMINISTRATION: WORKING FOR A STRONG,
ENFORCEABLE, PATIENTS' BILL OF RIGHTS**

March 2, 2000

Today, President Clinton will urge the Congress to learn from the bipartisan action of the House last fall and move quickly to report to Congress a strong, enforceable Patients' Bill of Rights. He will underscore his belief that the Norwood-Dingell bill is a strong basis for final legislation and should not be watered down. Joined by bipartisan members of Congress, including Representatives Norwood, Dingell, Ganske and Berry, as well as Senators Specter, Kennedy, Chafee and Graham, the President will urge the Congress to act now to pass a patients' bill of rights that provides critical protections to all Americans in all health plans and holds health plans accountable for decisions that harm patients.

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- Construct a weak, watered-down appeals process that is biased against patients;
- Fail to provide strong enforcement mechanism for patients to hold health plans accountable when they make harmful decisions.

PRESIDENT CLINTON WILL NOT SIGN A PATIENTS' BILL OF RIGHTS THAT REPRESENTS AN EMPTY PROMISE. Today, the President will reiterate his refusal to enact

legislation that does not provide strong patient protections for all Americans in all health plans and include meaningful enforcement mechanisms. To date, there is no legislation other than the Norwood-Dingell bill that meets the Administration's fundamental criteria: that patient protections be real and that court enforced remedies be accessible and meaningful.

PRESIDENT CLINTON UNDERSCORES HIS OPTIMISM THAT A STRONG PATIENTS' BILL OF RIGHTS WILL BE ENACTED THIS YEAR. Today, President Clinton will underscore his optimism that a strong Patients' Bill of Rights will be enacted this year. Citing the Norwood-Dingell legislation, the President will highlight his belief that the momentum for this legislation is undeniable. He believes that the Congress will respond the will of the public and pass a strong enforceable Patients' Bill of Rights this year.

CLINTON-GORE ADMINISTRATION'S LONGSTANDING COMMITMENT TO PROMOTING PATIENTS' RIGHTS. The Administration has a long history of promoting patients rights, and President Clinton has already extended many of these protections through executive action to the 85 million Americans who get their health care through federal plans — from Medicare and Medicaid, to the Federal Employees Health Benefits Plan (FEHBP), to the Department of Defense and the Veterans Administration. The Administration's record on patients' rights include:

- Appointing a Quality Commission to examine potential quality concerns in the changing health care industry. In 1997, the President created a non-partisan, broad-based Commission on quality and charged them with developing a patients' bill of rights as their first order of business. The Quality Commission released two seminal reports focusing on patient protections and quality improvement.
- Challenging Congress to Pass a Patients Bill of Rights. In October of 1997, the President accepted the Commission's recommendation that all health plans should provide strong patient protections and called on the Congress to pass a strong enforceable patients' bill of rights. He also called on the Congress to make passing the patients' bill of rights a top priority in his 1998, 1999, and 2000 State of the Union Addresses.

Patients Bill of Rights
Q&A
March 2, 2000

Q: Opponents of this legislation say that the Norwood-Dingell bill, particularly the right to sue provisions, would increase costs and decrease coverage. What is your response?

A: This is nothing but a red herring argument made by special interests who oppose a meaningful Patients Bill of Rights. The most recent cost estimates by CBO of the Norwood-Dingell bill actually declined by almost 20 percent since last year. When fully phased in the cost will only be about \$2 a month for employees.

Studies of those states (such as Texas) that have enacted provisions that allow patients to hold health plans accountable have experienced virtually no lawsuits. The appeals and enforcement provisions of the Patients' Bill of Rights would clearly be used as more of a disincentive for plans to make the wrong decision in the first place rather than providing incentive for numerous frivolous lawsuits.

The Norwood-Dingell compromise limits even the possibility of access to punitive awards. In fact, access to punitive damages would only be available to those individuals whose managed care organizations ignore the ruling of an independent external appeals board. This ensures that there would be no unjustified and expensive awards.

Q: Are you taking an "all or nothing" approach to negotiations on the Norwood-Dingell bill?

A: No, not at all. There will have to be compromises on both sides.

I would note, however, that the Norwood Dingell bill is the only legislation coming into conference that has received significant bipartisan support. Sixty-eight Republicans joined with virtually every Democrat to pass this legislation by an overwhelming margin. In contrast, because the Senate-passed plan leaves over 100 million Americans unprotected, covers less than 10 percent of HMOs, does not provide access to specialists, and among other things, does not hold plans accountable for actions that harm patients, it did not receive one Democratic vote.

Since the bipartisan legislation passed by the House more clearly represents the will of the public, it is our hope that the Conferees will be deferential to that fact as they move to reconcile the differences between the two bills.

Q: The Republicans are considering adding the right to sue in Federal Court to their version of the Patients Bill of Rights rather than allowing individuals to access the state court system. Would that be a legitimate compromise?

A: We need to assure that the rights promised by this legislation are real and not just a suggestion. When health plans take action that harms patients, they should be held accountable for their actions – as is every other health care provider in the nation. We have yet to see an acceptable, workable alternative in any serious piece of legislation other than Norwood-Dingell that achieves that end. Having said this, we have always been open to alternative enforcement provisions, with the provision that such mechanisms are workable and meaningful.

Q: Are you open to the so-called access provisions in the Patients' Bill of Rights legislation? Would you be willing to accept or compromise on any of these?

A: The President believes that we need to act forcefully and quickly to expand coverage to the over 40 million American without insurance. For this reason, my budget invests over \$100 billion to expand coverage to over 5 million currently uninsured Americans. Our concerns with the Republican proposals have been that they tend to be extremely expensive, do not cover many currently uninsured Americans, segment the healthy from the sick, and could potentially undermine our current health insurance market. This applies, in particular, to their individual tax deduction proposal, their medical savings account provision, and their so-called Health Mart concept. It is our hope that we will be able to work constructively to develop policy approaches that address these concerns while significantly expanding coverage.

Q: What is your response to the health care coverage proposal unveiled by Congressman Armey and Senators Breaux, Frist, and Jeffords?

A: We welcome any proposal intended to cover the uninsured, and the President is committed to working with members on both sides of the aisle to design policies that can achieve this goal in a cost effective manner. We know that tax approaches can address equity concerns and assist targeted populations, such as people purchasing individual insurance or families with burdensome long term care costs. However, as currently structured, the Armey-Breaux tax credit does not effectively address the coverage or equity challenges that the uninsured face. It is an expensive and inefficient way to cover the uninsured and exacerbates the current inequity in the tax code for the uninsured. It also creates new incentives for employers to drop coverage and helps mostly the healthy uninsured.



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

October 7, 1999
(House)

*Health Care
Patients Bill
of Rights*

STATEMENT OF ADMINISTRATION POLICY

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

H.R. 2723 - Bipartisan Consensus Managed Care Improvement Act of 1999 (Reps. Norwood (R) GA and Dingell (D) MI and 132 cosponsors)

The President strongly supports the enactment of H.R. 2723, the Bipartisan Consensus Managed Care Improvement Act of 1999. This bipartisan legislation would provide new patient protections to all Americans in all health plans, and hold health plans accountable when their actions cause harm to patients.

Since 1997, when he received the report of his Quality Commission, the President has been calling on the Congress to pass a strong, enforceable, and bipartisan Patients' Bill of Rights. In the absence of congressional action, the President directed the Federal health plans, covering over 85 million Americans, to implement the patient protections recommended by the Commission. Many States have also passed legislation providing important protections to their residents, including requiring new protections for patients in emergency situations, establishing access to independent external appeals processes, and ensuring access to specialists.

While these actions are important, the limits on State jurisdiction and Federal regulatory authority make it impossible to ensure that all Americans in all health plans have the protections they need. States do not have the authority to regulate self-insured plans, leaving almost 50 million people unprotected nationwide. Moreover, current enforcement limitations under Federal law frequently preempt State law even for those plans regulated by the States.

Adoption of any substitute amendment other than Norwood-Dingell will demonstrate that this Congress is not serious about responding to the public's need for protection in the Nation's ever-changing health care delivery system. The President is strongly committed to working with Members of both parties to pass a meaningful Patients' Bill of Rights this year; he is equally committed, however, to vetoing any legislation that is a Patients' Bill of Rights in name only.

On August 5, 1999, the President commended Representatives Norwood, Dingell, and Ganske for their leadership in introducing a strong, enforceable Patients' Bill of Rights. He endorsed H.R. 2723 because it provides meaningful patient protections, such as the right to emergency care wherever and whenever a medical emergency arises; the right to access the health care specialists that a patient needs; the right to ensure care is not disrupted during treatment; the right to an unbiased internal appeals process and an independent external appeals process that allows patients to get the care they were promised; and the right to hold health plans accountable for actions that harm patients.

The Administration strongly opposes the amendments in the nature of a substitute to H.R. 2723. These amendments that were made in order by the Rules Committee would weaken key provisions of the bill and are designed solely to undermine the enforcement provisions contained in H.R. 2723. If these substitute amendments are adopted and presented to the President, his senior advisors would recommend that he veto the bill.

The Boehner amendment scheduled to be offered today provides clearly inadequate protections and does not even extend those protections to all Americans in all plans. Since the limited protections only apply to employer sponsored plans, at least 15 million Americans would not be covered under this legislation. Moreover, the patient protections fall short in numerous areas, including: no requirement to assure access to specialists when a plan's provider network is inadequate; allows plans to provide excessive financial incentives to providers to limit medically necessary care; and requires parents of newborns to receive prior approval before receiving emergency care. Finally, there are absolutely no individual remedies that can be accessed through the courts to hold plans accountable for actions that have harmed patients.

While the Coburn/Shadegg amendment offers some additional protections, such provisions are far too weak. The legislation is unacceptably flawed in numerous areas, including:

Newborns would not be provided the same access to emergency care protections as provided to adults. Parents would need to receive prior approval to be sure they can be reimbursed for emergency care services for their children.

No protections against plans limiting access to necessary medications. This bill allows plans to deny coverage of prescription drugs that are not part of the plan's drug formulary even when prescribed by health care providers and determined to be medically necessary.

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.

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.

A flawed enforcement provision that severely limits patients ability to hold plans accountable. Under the Coburn/Shadegg amendment, the roadblocks to accessing court based remedies include:

- 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 let alone appeal the original denial of service.

- Requiring 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.
- Requiring 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 it certainly implements an extraordinary hurdle for enrollees seeking redress.

Enacting meaningful Patients' Bill of Rights legislation is long overdue. The President strongly urges the House to pass a "clean" H.R. 2723, which enjoys broad bipartisan support, and give all Americans the health care protections they need and deserve.

As the President has already indicated in a letter, the Administration remains very concerned about the Rule that was approved for H.R. 2723 because it prohibited the consideration of revenue measures in support of H.R. 2723, many of which were passed by the House in other legislation.

October 4, 1999

STATEMENT ON PATIENTS' BILL OF RIGHTS LEGISLATION

DATE: Tuesday, October 5, 1999
LOCATION: South Portico
BRIEFING TIME: 2:45pm – 3:00pm
MEET & GREET TIME: 3:05pm – 3:10pm
EVENT TIME: 3:10pm – 3:15pm
FROM: Bruce Reed, Mary Beth Cahill, Chris Jennings

I. PURPOSE

To encourage the Congress to put politics and parliamentary gimmicks aside and pass a strong, enforceable, bipartisan Patients Bill of Rights (the Norwood-Dingell bill) to improve the quality of health care delivered to all Americans in all health plans.

II. BACKGROUND

Today, at a departure statement, you will urge the Congress to hold a fair, up or down vote on the Norwood-Dingell Patients Bill of Rights. You will be joined by Secretary Shalala, Secretary Herman, and representatives of the health care advocacy and provider community, including the American Medical Association and the American Nurses Association.

In your statement, you will highlight the fact that the Norwood-Dingell bill has already received broad-based support from over 300 health care provider and consumer groups. You will reiterate your belief that this strong bipartisan bill should not be undermined by the addition of legislative "poison pills", extraneous provisions, and procedural gimmicks designed to thwart the House's ability to hold an up and down vote on final passage of the Norwood-Dingell Patients' Bill of Rights.

The Republican leadership seek to include a number of "poison pill" provisions, such as an expansion of the Medical Savings Account Demonstration, that independent health policy analysts fear would do more to segregate the healthy from the unhealthy than to cover the uninsured. In addition, you will state that you strongly oppose any amendments that would seek to weaken key provisions of the bill, such as the approach advocated by Congressmen Coburn and Shadegg in their alternative legislation, which would require patients to undergo a separate certification process to affirm that they have been harmed prior to allowing any court proceeding (a provision that may well be unconstitutional).

Finally, you will reiterate that the time has long passed for the Congress to act on a strong Patients Bill of Rights. You will emphasize that enactment of this legislation has real life consequences for patients.

III. PARTICIPANTS

Briefing Participants:

Bruce Reed
Mary Beth Cahill
Larry Stein
Chris Jennings
Paul Glastris

Statement Participants:

YOU

Secretary Donna Shalala
Secretary Alexis Herman
Thomas Reardon, National President, American Medical Association
Beverly Malone, National President, American Nurses Association
Judith Lichtman, President, National Partnership for Women & Families
John Seffrin, CEO, American Cancer Society
Ron Pollack, President, Families USA

IV. PRESS PLAN

Open Press.

V. SEQUENCE OF EVENTS

- **YOU** will greet the statement participants in the Diplomatic Reception Room.
- **YOU** and the statement participants will proceed to the South Portico.
- **YOU** will make brief remarks and depart.

VI. REMARKS

To be provided by speechwriting.

H. case -
Patients Bill
of Rights

CC TO: RAHM
C. JENNINGS
E. KAGAN
B. REED
S. SPECTOR
A. LEWIS

FBI FROM THE A.M.A.
JAC

PATIENT PROTECTION BILLS BEFORE THE 105TH CONGRESS

| | <i>Hastert-Gingrich (HR 4250)</i> | <i>Dingell-Daschle (HR 3605/S.1890)</i> | <i>Nickles-Lott (S.2330)</i> | <i>Chafee-Graham (S. 2416)</i> |
|---|--|---|--|---|
| Scope | All beneficiaries of private insurance plans, 161 M people | All beneficiaries of private insurance plans, 161 M people | Applies only to beneficiaries in self-funded plans, 48 M people | All beneficiaries of private insurance plans, 161 M people |
| Preemption of State Patient Protection Laws | Preempts state patient protection laws for Association Health Plans | Sets ceiling for ERISA plans, floor for state-regulated plans | Preempts state law only with respect to information disclosure and appeals. Other provisions apply to self-funded plans only. | Sets ceiling for ERISA plans, floor for state-regulated plans |
| Allows Physicians to Define "Medical Necessity" | No. Grants health plans, not physicians, the right to define medical necessity | Yes | No. Grants health plans, not physicians, the right to define medical necessity | Yes |
| Prohibition of Gag Practices | Contains limited anti-gag provisions for physicians advising their own patients pursuant to contracts with plans | Contains Ganske/Kyl anti-gag provision | Contains limited anti-gag provisions on self-funded plans for health care professionals advising their own patients pursuant to contracts with plans. | Contains broad anti-gag language prohibiting plans from penalizing health care professionals for patient advocacy and for providing medical care information or referrals |
| Prudent Layperson Emergency Standard | Covers only emergency medical screening exams. Post-stabilization and treatment governed by <i>prudent medical emergency professional</i> standard. Does not eliminate financial penalties for going to closest emergency room. | Contains Cardin Prudent Layperson language for all emergency room services. Eliminates financial penalties for going to closest emergency rooms. | Covers only emergency medical screening exams. Post-stabilization and treatment governed by <i>prudent medical emergency professional</i> standard. Does not eliminate financial penalties for going to closest emergency room. | Contains Cardin Prudent Layperson language for all emergency room services. Eliminates financial penalties for going to closest emergency rooms. |
| Info Disclosure | Does not require plans to notify individual beneficiaries in writing before changing covered benefits. Plans may charge "a reasonable amount" to answer a request for information limited to once a year. Requests must be in writing and may be answered electronically. Broad disclosure requirements relating to covered services (ER, preventative, drug formularies); limitations/restrictions (excluded benefits, UR, lifetime caps, exp. Treatments, med. Necessity, 2 nd opinions, specialty care, continuity); participant's financial responsibility; dispute resolution procedures. Other info. On | Requires plans to notify individual beneficiaries in writing <i>before or after</i> changing covered benefits. Broad disclosure requirements to enrollees and potential enrollees, including service area, covered benefits, cost-sharing, mix/distribution of providers, medical loss ratio, quality assurance protections, credentials of health professionals, prior authorization rules, notice of other info available on request, including UR, method of MD compensation, formulary restrictions, disposition of appeals | Does not require plans to notify individual beneficiaries in writing before changing covered benefits. Broad disclosure required of all plans to enrollees, including covered benefits (inc. out-of-area coverage), cost-sharing, sup. Benefits, advance directives, organ donation, service area, pre-authorization and specialty referral rules, appeal procedures, rules for accessing ER services, exp. Treatments, preventative services. Notice of other info available on request, including participating providers, MD/other provider compensation summary, UR, formulary restrictions, specific coverage exclusions, public info of accrediting bodies. Study on MD-specific information release | Requires plans to notify individual beneficiaries in writing 30 days <i>after</i> changing covered benefits. Requires plans and issuers to provide information regarding service area, covered benefits, access procedures and rights, out-of-area coverage, emergency coverage, prior authorization rules, provider financial incentive information, and grievance and appeals information. Bill would also require that enrollees and potential enrollees have access to info. Regarding: UR activities, aggregate data on grievance and appeals dispositions, methods of physician compensation, participating provider credentials, confidentiality |

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| | request: network characteristics, care mgmt. info; drug formulary inclusions; ways procedures are excluded based on med. Necessity; UR procedures; accreditation; quality performance measures – if any; # of external reviews. Also, MD qualification info/ privileges/ experience on request | | | policies and procedures, formulary restrictions, participating provider list, medical loss ratio, quality info |
| Confidentiality | Preempts existing state and federal laws with respect to patient confidentiality | Requires confidentiality of medical records and establishes safeguards. Does not preempt existing patient confidentiality laws. | Requires confidentiality of medical records and establishes safeguards and fines up to \$10,000. Does not preempt existing patient confidentiality laws. | Requires confidentiality of medical records and establishes safeguards and fines up to \$5,000. Does not preempt existing patient confidentiality laws. |
| Appeals Process | Initial coverage determinations to be made w/in 30 days/10 days (urgent care)/72 hours (emergencies). Plan prevails in cases where plan fails to respond by review deadlines. Internal Review: Only applies to determinations of medical necessity or experimental treatment (as defined by plan). Coverage determinations are not subject to review. 30-day deadline (72-hours for exigent cases). None of internal reviews require independent MD involvement with specialty expert. Non-Binding External Review: Only applies to decisions related to medical necessity or experimental treatment (as defined by plan). Coverage decisions are not subject to review. Patient pays \$25-100 to start de novo external review made by independent fiduciary. 180-day deadline starts upon complete transfer of relevant information to MD not previously involved, (no specialty training required). No financial threshold for external review. Alternative Dispute Resolution: Patient may elect binding ADR by waiving external review. | Requires all plans to formulate procedures for grievances and appeals. Assures continuing use of standards throughout course of individual treatment. Internal review: allows 15 days (72 hours for exigent cases) for conduct of review by previously uninvolved clinical peer. Binding External Review: allows 60 days for conduct of review by clinical peer. Stipulates that patient prevails in cases where plan fails to respond by review deadlines. | All plans/issuers enrollees must have G&A procedure – nonappealable. Initial coverage determinations to be made w/in 30 days (72 hours in emergency). Internal Review: Only applies to questions of medical necessity and experimental treatment (as defined by plan). Only coverage decisions are subject to review. Requires both enrollee and health care professional to appeal. 30-day deadline (72 hours for exigent cases). External Review: Only applies to decisions related to medical necessity or experimental treatment (as defined by plan) over \$1000 threshold. Only coverage decisions are subject to review. 30-day deadline. External reviewers (requires medical expert rather than physician) chosen by plan and not subject to liability for decisions. Evidence-based decision making | Bill extends grievance and appeals, internal and external review to all insurance and ERISA plans. Physicians must be part of all UR, internal and external appeals relating to physicians' clinical decisions. Assures continuing use of standards throughout course of individual treatment. Internal Review: allows physicians or patients to request review of medical necessity determinations by previously uninvolved clinical peer. Sets 30-day limit (72 hours for exigent cases). External Review: allows physician or patient to request review by independent clinical peer within 30 days (72 hours for exigent cases). |

| | | | | |
|---|---|--|---|---|
| Remedies | Does not remove ERISA preemption for state causes of action. Provides HHS authority to impose fines up to \$500/day (up to \$250,000 total) for pattern or practice of repeated denial of care. Dollar amounts not indexed for inflation. | Targeted removal of ERISA preemption (allowing for suits in state courts) for actions based on the exercise of discretion regarding the denial of a covered benefit resulting in injury or death. Protects employers from imputed liability where they did not exercise discretion in denial of benefit. | Does not remove ERISA preemption for state causes of action. The "binding" External Review is not enforced by any penalty. Remedies might not apply in cases where the patient dies before external review. | Does not provide state cause of action under ERISA. Allows access to federal court for self and full-insured individuals for compensatory (economic) damages only. Creates HHS and DOL enforcement for pattern of denial of care up to \$250,000 plus \$10,000/week for failure to act. |
| Nondiscrimination based on Licensure | No provision | Contains AMA approved language on scope of practice | No provision | No provision |
| Mastectomy Length of Stay, Breast Reconstructn. | Prohibits the establishment of legal standards for minimum length of stay for mastectomy. | Contains D'Amato language to establish 48-hour mastectomy length of stay and requires plans to pay for breast reconstruction at discretion of physician. | Requires plans to pay for mastectomy and breast reconstruction at discretion of physician with no minimum stay requirement. | Contains D'Amato language to establish 48-hour mastectomy length of stay and requires plans to pay for breast reconstruction at discretion of physician. |
| Physician Choice | Limited choice provision can be circumvented by documenting potential for 1% premium increase. | Limited choice provision requiring employers who offer only one closed panel HMO to offer at least one other choice (including another closed panel HMO) with exemption for less than 50 employees. | Limited choice provision requiring employers who offer only one closed panel HMO to offer at least one other choice (including another closed panel HMO). | No provision |
| Network Adequacy | No provision | Requires "sufficient number, distribution and variety" of providers to meet enrollees needs in timely manner. | No provision | Requires plans to provide referrals to specialists when necessary. |
| OB-GYN, Pediatric Direct Access | Allows access to OB-GYN (only includes routine visits) and pediatrician as primary care. | Allows enrollees to select OB-GYN as primary care provider. No provision for pediatric care. | Allows access to OB-GYN (only includes routine visits) and Pediatrician as primary care | Requires no preauthorization for access to OB-GYN (only includes routine visits) and Pediatrician as primary care. |
| Protections for Patient Advocacy | No provision | Prohibits retaliation or discrimination for patient advocacy | No provision | Included in Gag Practices section |
| Continuity of Care | No provision | Provides for continuity of care in cases of institutional care (for up to 90 days) or for pregnancy or terminal illness (until terminated). Provides standing referrals for chronic illness | Provides for continuity of care in cases of institutional care (for up to 90 days) or for pregnancy or terminal illness (until terminated). | Provides for continuity of care in cases of institutional care (for up to 90 days) or for pregnancy or terminal illness (until terminated). Also allows standing referrals for chronic illness and provides protections against involuntary disenrollment in certain cases. |
| Access to Specialists | No provision | Requires plans to provide timely access to specialists | No provision | Requires plans to provide timely access to specialists |
| Access to Clinical Trials | No provision | Requires plans to pay routine costs associated with enrollee participation in approved clinical trials. | No provision | Requires plans to pay routine costs associated with enrollee participation in approved clinical trials. |

| | | | | |
|--|--|---|---|--|
| Drug Formulary | No provision | Allows Physicians to prescribe drugs that are not listed on health plan formularies. | No provision | Allows Physicians to prescribe drugs that are not listed on health plan formularies. |
| Physician Incentives & Payments | Requires plans to disclose method of payment. | Prohibits incentives to deny care. Requires plans to disclose method of payment of physicians. | Requires plans to disclose method of payment. | Prohibits incentives to deny care. Requires plans to disclose method of payment. |
| Genetic Nondiscrimination | No provision | No provision | Prohibits disclosure and discrimination based on genetic information. | No provision |
| Quality Review | Quality performance measures information (if any) available on request to participants. | Establishes Health Care Quality Advisory Board to collect and disseminate information on health care quality. | Establishes the Agency for Healthcare Quality Research (AHQR) to conduct/support research; promote public-private partnerships to advance/share quality measures; report annually to Congress on the state of quality and cost of nation's health care; develop state-of-the-art information systems for healthcare quality; assess new technologies in healthcare; coordinate federal quality improvement efforts, and publish/disseminate quality data. | Plans and issuers are required to establish internal quality assurance and improvement program, and disclose to the public quality criteria that are performance and patient outcomes-based. |
| Effective Date | January 1 of the second calendar year following enactment. | January 1, 1999 | January 1 of the second calendar year following enactment | January 1, 1999 |
| Access to Health Insurance Marketplace | Creates HHS- administered HealthMarts (purchasing coops) for small employers. Creates Association Health Plans. Expands MSAs: Repeals limit on # of MSAs - now available to all employers; reduced required deductibles; FEHBP could offer MSAs in some areas. | No provision | Modifies tax code to allow carry over of unused flexible spending accounts up to \$500/year to next year, roll over into 401(k), MSA, etc. Permit self-employed to deduct 100% of health insurance premiums in 1999. Expand MSAs to all individuals. MSA deductibles would be lowered and funds that exceed deductible could be withdrawn w/o penalty. FEHBP could offer MSAs. | No provision |
| Lawsuit Reform | Sets \$250,000 cap on non-economic damages (not indexed for inflation). Includes health plan in definition of health care provider | No provision. Allows states to limit awards. | No provision. Allows states to limit awards. | No provision. Allows states to limit awards. |
| Comments | *Provisions relating to MSAs and Lawsuit Reform are considered to be poison pills because they are not likely to be passed in the Senate or signed by the President. *Furthermore, provisions relating to HealthMarts and Association Health Plans, which we see here | Endorsed by AMA | *For the following reasons federal court would be a less desirable venue than state court for someone who has a minor dispute with their HMO, or someone whose life literally hangs in the balance. 1) The resources necessary to prepare a case for federal court are much greater than in state court, and 2) federal court are | This bill is described as a compromise between two competing Senate bills. However, both Nickles-Lott and Daschle-Dingell contain Point-Of-Service and Mastectomy Length of Stay provisions which were not included in this "compromise" bill. |

MEMORANDUM

Health Care -
~~Bill of Rights~~
Patients

June 29, 1998

TO: Rahm Emanuel
FR: Chris Jennings *CCJ*
RE: Patients' Bill of Rights Status
cc: Sylvia Matthews, John Podesta, Bruce Reed, Larry Stein, Gene Sperling, Ron Klain, Elena Kagan, Janet Murguia, Chuck Brain, Sally Katzen

This memo responds to your request for an up-to-the-moment status report on the House Republican Leadership's Patients' Bill of Rights. It also outlines positioning options for the President's consideration on the legislation and, more specifically, on the enforcement provisions.

House Republican Patients' Bill of Rights. The reaction to the House Leadership's announcement of their intention (they have provided no details) to introduce a Patients' Bill of Rights has been almost universally negative. The base Democrats, the consumer advocates, and the providers have labeled it a "sham;" the insurers and big business community are criticizing it as overly regulatory. Notwithstanding these reactions, it is remarkable how far the Republicans apparently have moved toward the President's position.

Status of Policy. With the exception of the access to specialist/out-of-network referral, continuity of care, and requirement for financial disclosure provisions, the House Republicans appear to have included virtually every one of the consumer protections recommended by the President's Quality Commission. They have even (reportedly) included a Federal Court-enforced remedies provision that has a damages cap between \$100,000 and \$250,000. Less than two months ago, many conservative Democrats and most Republicans would have labeled the current Republican plan as something between excessively regulatory and a Government takeover of the health care system. In fact, just 4 months ago, the President's Quality Commission would not even touch the issue of enforcement. The political ground has obviously shifted dramatically.

Administration Reaction of Republican Proposal. We have taken the position that the Republican proposal both affirms the President's longstanding position that strong, Federal, and enforceable legislation is needed and confirms (both through their bill's added and missing provisions) that the Republican Leadership is not serious. In short, we say that any bill without all of the Quality Commission's protections and a strong enforcement provision is nothing more than a "bill of goods." We also charge that any bill that piles on "poison pill" provisions (like MEWAs, arbitrary caps for medical malpractice, and MSAs) is designed to kill, rather than enhance, the chances of an acceptable bill emerging. We will find out how or if the Republicans respond to our criticism when they introduce a bill -- which will not happen until after the July 4th recess.

The Dingell/Ganske/Kennedy Bill and Democratic Positioning. The Democratic Leadership and base Members have been even more critical of the Republican plan than us. Their bill starts with more provisions than were recommended by the Quality Commission and, particularly in the absence of CBO cost estimates for their bill, they are extremely comfortable criticizing the much less comprehensive Republican plan.

The Democratic plan builds on the Quality Commission's recommendations by adding, among other provisions, requirements for ERISA remedies, a medical necessity provision (that prohibits any insurer from denying coverage for any service that a physician deems is medically necessary), mandatory clinical trial coverage, mandatory 48-hour hospital coverage following a mastectomy, mandatory coverage for breast reconstruction following a mastectomy, required access to prescription drugs that are not on a plan's formulary if a doctor deems necessary, and a "whistle blower" provision, which protects health professionals against retribution if they report and document quality problems. Although most of these provisions are generally defensible policy and certainly politically attractive, they do add costs (at least 2 percent higher premiums than the Quality Commission's recommendations.)

Congressional Budget Office (CBO) Estimate. The next big hurdle for the Democrats will be next Wednesday's or Thursday's expected release of the CBO premium estimates of the Dingell/Ganske bill. We anticipate that the premium will be projected to increase by about 4 percent for the average employee, which amounts to about \$6 a month. We are working on a positive roll-out strategy for this estimate to buttress our claim that the benefits of any such legislation are more than worth the modest cost. If all agree in the White House, we might want to have the President (next Monday?) or the Vice President announce the generally good-news estimate during the next week.

Likely Republican Response to CBO's Scoring of Dingell/Ganske Bill. The Republican (and the insurer and big business) response to the CBO estimate will be swift and critical. They will cite overall health care expenditure increases (that will amount to billions of dollars, although a small fraction of the nation's trillion dollar health expenditures base) and flawed coverage loss projections (probably in the neighborhood of 200,000 to 2 million Americans.) It is important to point out that the likely CBO cost estimate for the Republican bill will be much lower than the Dingell bill -- about one fourth of it (1 percent). If the opponents' cost and coverage argument takes hold, it could seriously undermine momentum for the Patients' Bill of Rights. We are currently in the process of working on a strong, message document, as well as some Qs & As, to help ensure that we get a positive message from the CBO numbers.

"Blue Dog" Democrats Could Create Difficulty. Finally, it is important to note that some "blue-dog" House Democrats may seriously consider joining up with the Republicans when and if their bill goes to the floor. They are generally most influenced by the small business lobby and the Republican bill has received its only real support from the NFIB. Similarly, the Senate is populated by numerous Democrats who are and always will be uncomfortable with standing by Senator Kennedy. As a consequence, if the Senate Republicans feel pressured to develop their own Patients' Bill of Rights (and Chafee is now drafting a bill), there may be a number of Democrats who could sign on, particularly if the "poison pill" provisions are dropped and a few more patients' protections are added.

Enforcement/Liability/Remedies Provision.

Because of the popularity of HMO regulation, it is probable that a consensus can be achieved on most if not all of the traditionally-desired patient protections. Decisions on what protections make it in will be linked to two variables: CBO cost estimates and perceived political pain associated with opposition to popular provisions. With the possible exception of some of the unrelated "poison pill" provisions mentioned earlier, the only seemingly apparent "line-in-the-sand" issue that could define the difference between Republicans and Democrats might be the issue of need for strong remedies for those aggrieved parties that have suffered serious health consequences or death because a health plan wrongly denied care.

To date, the Administration has consistently stated that this legislation must include a strong enforcement provision -- that a "right without a remedy is no right." To provide us with some flexibility and consistent with our directions from senior staff, we have never locked ourselves into a particular approach.

Both the Dingell-Ganske and the Norwood bills include state-court enforced liability provisions. Simply stated, the bills explicitly clarify that the Employee Retirement Income Security Act (ERISA) would no longer pre-empt or supersede state laws that provide for a right of action against a health plan that has denied care to a patient. Without this provision, the only current remedy a patient can obtain through ERISA law is payment for the cost of the benefit he or she should have had. In other words, for the 122 million Americans in ERISA covered plans, patients cannot get any compensation for treatment costs, pain and suffering, or lost wages.

Current Law Example: Dr. Welby wanted to refer Mrs. Jones to a specialist to conduct a needle biopsy to determine if she has cancer. The plan refused the referral and denied any coverage for the test. The patient, as a consequence, did not go to the specialist or take the test. Six months later, she came back with a more noticeable lump. Dr. Welby argued with the HMO to cover the specialist and the needle biopsy; this time, the HMO paid for it. The specialist then found the patient had a cancer that had spread throughout her body and that it was now untreatable. Had they had the test results 6 months earlier, they could have successfully treated the cancer. Now the patient must undergo a radical mastectomy and, even with that, her survival odds are very low. She is furious and asks her lawyer to sue the HMO. Her lawyer tells her she can, but the only thing she can get compensated for is the cost of the original cancer screening test. She can collect no damages to pay for the mastectomy, the chemotherapy and any other treatment her doctor may order. She gets no compensation for the lost wages from the job she must leave and she gets no enumeration for all the pain and suffering she is going through as a consequence of her HMO denying her treatment.

Fears of Business and Labor (Taft-Hartley) Community. The prospect of opening up health plans to law suits at the state level petrifies both the business and the Taft-Hartley plans. (Labor has been quiet to date because it is poor P.R., and would hurt our chances of passing a good bill.) They fear that the trial lawyers will ride herd over their plans and that costs will balloon (in terms of lawsuit settlements and/or because their health plans will be so nervous that they will stop making even appropriate denials).

Business-underwritten analyses are projecting an unbelievably high 10-30 percent premium increase. For the last two months, this community has used highly dubious rhetoric that state-based enforcement would leave many businesses no choice other than to drop their health benefits. But the real underlying fear is modifying, in any way, the protections ERISA affords against suits from the states and from aggrieved employees on any benefit an employer provides (health, pensions, leave, etc.).

CBO Projections Do NOT Confirm Concerns of Business Community. Notwithstanding the fears of the liability provisions of the House bills and unprecedented lobbying by the business, insurer and Republican Leadership, however, the preliminary (not for attribution or dissemination) projections from CBO seem to assume that the existence of a state-based right of action would increase premiums by only about 1 percent, about one-fourth the total premium hike projected for the Dingell-Ganske bill. (This figure will not be released by CBO until after it reports on the Dingell bill, which will take place sometime in the next week.) CBO believes that most of the suits are now being directed at doctors and that any new suits against managed care plans would generally substitute for -- not add onto -- what is already out there.

Regardless of the true number, the opponents will pull out all of the guns to stop any state-based liability provision from becoming law. They will use inflated cost projections and attempt to terrify the public into believing that the result of any Patients' Bill of Rights legislation will be more regulation, more costs, and a lot more uninsured -- as people will no longer be able to afford needed health insurance.

Enforcement Options. Although there will be numerous other provisions within any Patients' Bill of Rights bill that will be debated fiercely, the main outstanding issue is how we resolve the enforcement provision. Remarkably, the issue now is not whether there will be an enforcement mechanism, but rather what that mechanism will be. There are numerous different approaches that could be taken, but there are three primary options:

- (1) **State-Based Remedies.** The Norwood and the Dingell-Ganske et al Patients' Bill of Rights bills have a provision that precludes health plans or businesses who make illegal denials of coverage that result in death or injury from using ERISA to pre-empt state-court enforced remedies (if a state has enacted laws that authorize such remedies). As mentioned above, although this provision is expected to receive a modest premium estimate from CBO, the business community will use all their resources to kill it. No one several months ago believed that any real enforcement mechanism had a chance of passing the Congress; however, buoyed by strong polling, comfort with this provision (and the right to sue HMOs) appears to be growing in the Congress, particularly with the Democrats.

Advantages:

- Already in bills that have received bipartisan support.
- Would not require any new Federal rules (e.g., provisions regarding whether this should include punitive damages, pain and suffering, caps, etc.)
- Relatively easy to explain; opponents have more difficult burden as to why HMOs have more liability protections than practically any other industry in the nation. (Recent polls indicate strong support to allow individuals to sue HMOs).
- If we want to have the bar set at a place that the Congress is unlikely to meet, this is probably the only one that meets that criteria WITHOUT us taking a new position and looking overly political.

Disadvantages:

- Would make us the target of an all out campaign from the business and insurer industries over an issue that we could well lose in the end.
- The well-financed, largely unanswered and highly orchestrated campaign may succeed in making this an issue about greedy trial lawyers, health care costs, and loss of insurance coverage.
- There is a real chance that neither the House nor the Senate could pass this provision; pushing for such a provision would risk the whole bill, particularly if we make it a line in the sand issue.
- Could risk criticism from some elites who may charge that we are grabbing too much too soon, and blowing any real chance of getting some important patient protection standards enacted into law.

- (2) **Federal Court Enforcement.** A frequently raised alternative to the Dingell-Ganske state-court approach is to provide for a new Federal cause of action (with new rules and remedies) for aggrieved parties. This approach is being considered because it could assure greater uniformity than the state approach and to address employers fear of local bias in the state court system.

Advantages:

- Probably more likely to get passed out of the Congress.
- Although the business community would not like this approach, they could probably live with it – particularly if caps on awards were provided.
- Labor (Taft-Hartley plans) would likely support this approach.

Disadvantages:

- Would require a great deal of deliberation as to how to structure the new Federal rules (e.g., should there be punitive, pain and suffering, caps, etc.?)
- Assuming the pressure from the business community successfully produced award caps, this approach would make us much more vulnerable on similar medical malpractice cap issues.
- It will be more expensive and time consuming for consumers to have their cases heard and resolved.
- Federal courts have no experience in trying these cases.

- (3) **Civil Monetary Penalties -- either enforced through Federal Courts, Administrative Law Judges or HHS/Labor.** To avoid time-consuming, jury-involved cases, a new system of civil monetary penalties could be devised for aggrieved consumers. Unlike traditional CMPs, the penalties paid by the plans would go directly to the aggrieved party -- not back to the courts or government.

Advantages:

- Much more likely to pass the Congress as it seems to most resemble rumors about the Republican enforcement provisions. Face saving on both sides could be achieved by simply raising the CMPs that could be awarded.
- Business would support since long, drawn-out court proceedings could be avoided and there would be no unpredictable punitive/pain and suffering settlements.
- Consistent with current ERISA enforcement practices in other areas.

Disadvantages:

- Individuals could not seek and obtain punitive/pain and suffering awards, which some would argue would most influence good behavior by health plans.
- Because individuals could obtain, some would argue the remedy cannot be calibrated to actual harm.
- If the Departments were to be enforcers of CMPs, we would have to obtain more administrative resources, which the Congress would likely not fund.
- If we want to keep the bar high enough to make it impossible for Republicans to support, we would not choose this option.

In conclusion, because of the interest on the Hill on this issue, we need to fully recognize that our positioning on the Patients' Bill of Rights may not be fully adopted by the Democrats on Capitol Hill. While much of our base is taking a "keep the bar high and do not pass legislation" position, our moderate Democrats generally want to see a bill passed. There are exceptions to this rule, but it is clear that we will have to keep close tabs of our Democrats to ensure that our position -- whatever it is -- is not undermined. Larry Stein believes we will need to continue to hold meetings with the Members and the staff to assure that outcome.

I hope this information is useful. In order to assure the Administration is on same page regarding positioning and policy strategy, I would advise we hold a meeting in short order to review options. In preparation, I am enclosing a one page side-by-side document comparing the provisions of the various proposals. Please call if you have any further questions.

**COMPARISON OF NORWOOD LEGISLATION TO THE HOUSE REPUBLICAN
TASK FORCE PROPOSAL AND DINGELL/KENNEDY***

| PROVISION | REPUBLICAN TASK FORCE | QUALITY COMM. | NORWOOD | DEMOCRATS |
|---|-----------------------------|------------------|---------|-----------|
| Access to Emergency Services | Yes | Yes | Yes | Yes |
| Anti-Gag Rules | Yes | Yes | Yes | Yes |
| Access to Ob-Gyns | Yes | Yes | No | Yes |
| Internal Appeals | Yes | Yes | Yes | Yes |
| External Appeals | Yes | Yes | Yes | Yes |
| Mandatory Point-of-Service Option with same reimbursement rates and fair and reasonable premiums. | Yes | No | Yes | Yes |
| Information Disclosure | Yes | Yes | Yes | Yes |
| Confidentiality | Yes | Yes | Yes | Yes |
| Access to Specialists | No | Yes | Yes | Yes |
| Continuity of Care to assure patients that care will not change abruptly if their provider is unexpectedly dropped from a health plan. | No | Yes | Yes | Yes |
| Financial Incentives. A plan should not have incentive clauses for providers that limit medically necessary care. | No | Yes | Yes | Yes |
| Non-Discrimination Provisions | No | Yes | Yes | Yes |
| Out of Network Referral When Network Inadequate - - must have sufficient number of health providers to ensure that all services are covered. | No | Yes | Yes | Yes |
| Clinical Trials | No | No | No | Yes |
| Mastectomies | No | No | No | Yes |
| Breast Reconstruction | No | No | No | Yes |
| Medical Necessity | No | Not addressed | No | Yes |
| Enforcement | Yes, but limited provision. | Not addressed | Yes | Yes |

***POISON PILLS** — in House Republican Task Force But Not Norwood include medical malpractice caps, Multiple Employer Welfare Associations, and possibly expanding Medical Savings Accounts.

Health -
Patient Bill
of Rights

**PATIENTS' BILL OF RIGHTS
UPDATE MEETING**

June 3, 1998

LARRY: More events (EMK wants endorsement)
Senate Dems next work period
Helen Hunt 6/15

I. Hill Status

CURRIS: House faster than Senate
- GOP leadership hates, members want signing
- Dems mired behind Doyall. Blue Dogs OK.
- Dems don't want compromise.
- Gephardt: raise the bar.
- GOP join in discharge petition

II. Outstanding Controversial Provisions

Liability/Enforcement

EPS: They'll send us a bill w/ everything
but liability. Dis - AMA will want veto.

Body Parts

Clinical Trials

Rich: Poison pills like MSAs

Information Disclosure

Republicans Add-ons

III. Legislative/Communications Strategy

Hill Strategy for Democrats

Hill Strategy for Republicans

Communications/Political Strategy

Health

Continued from page 1

member **Edward Kennedy**, D-Mass. — which is referred to in the story that follows as the “Democratic” plan.

There is also a bill written by the House Republican leadership task force headed by **House Speaker Hastert** and sponsored by **Commerce Health and Environment Subcommittee Chairman Michael Bilirakis**, R-Fla., that will be referred to as the “House GOP” plan.

And there is a bill designed by the Senate Republican leadership task force headed by **Senate Majority Whip Nickles** and sponsored by **Majority Leader Lott**, which will be referred to as the “Senate GOP” plan; a bipartisan bill by **Sens. John Chafee**, R-R.I., and **Bob Graham**, D-Fla., which will be referred to as the “Chafee” plan; a plan by **Rep. Charles Norwood**, R-Ga.; and a plan by **Rep. Greg Ganske**, R-Iowa.

None of the bills spell out in great detail how these review boards might be structured. And some aides objected to the term “review board” and instead prefer “review entity” — because it could consist of one person.

All the bills would give states and the federal government general guidelines about how the boards are to be structured, but leave it up to the states and HHS to license them accordingly.

The boards could be run by state and federal agencies, state insurance commissioners, local medical boards, local colleges or university medical programs, or private companies that would be licensed by the states and federal government to review cases. Several of these “entities” already exist and are licensed by the federal government to review disputes regarding Medicare coverage.

While the external review boards could come in a wide range of shapes, sizes and types, the six proposals set some general rules for them:

■ **Internal Reviews.** Except for the Democratic bill, the remaining bills all require that before patients apply for an external review procedure they must first appeal to a review process operated by the insurer or HMO, often called an “internal review.”

While the House GOP bill would require an internal review, it would allow patients to take their case directly to a federal court in an emergency situation.

The Democratic bill does not require an internal review process before an external review appeal, but it does allow individual insurers to require it — and most insurers probably would.

If the plan’s internal review took longer than 30 days for a dispute about non-emergency care, or more than 72 hours for an emergency care decision, then a patient could jump automatically to an external review procedure.

■ **Threshold For External Review.** The Norwood bill and the House GOP bill place no limits on what could be appealed to an external review board.

The Democratic and Chafee bills would allow external reviews for disputes that reach a “significant financial threshold” — or in which the life and health of the patient is endangered.

The Ganske bill has a similar definition, but defines the monetary threshold at \$100. Those bills would allow the external panel to review anything, including disputes about a patient’s choice of providers or access to specialists.

The Senate GOP bill would limit external appeals for disputes to questions of medical necessity, what type of treatment is appropriate for a given illness or injury, and judgments about experimental treatments. Also, the dispute would have to be related to covered benefits and have a “significant financial threshold.”

Democrats claim the Senate Republicans’ lack of a life and health exemption could prove problematic for a patient who has chest pains and runs up an emergency room bill, only to find out it was something minor like heartburn.

Republicans counter that “medical necessity,” by definition, includes situations in which the patients’ life and health is endangered.

■ **Who Would Sit On The External Appeals Board?** The Ganske, Chafee, and Democratic bills call for “clinical peers” to sit on the external appeals boards. That would usually mean physicians with expertise in the illness or condition at dispute.

However, it could also include professionals such as nurses or physical therapists who are experts in the issue at hand. The House GOP bill would allow physicians only.

A Chafee aide suggested attorneys might also be eligible for external review boards, since many of the issues raised could relate more to the insurance contract of what is covered — rather than whether a treatment is medically necessary for an individual patient. Some fear that boards comprised totally of physicians would be more inclined to side with a patient.

The Norwood bill breaks external reviews into two types: in a dispute involving treatment that the plan acknowledges it covers, but is not required for the individual patient, a board of doctors would decide the case.

If the plan says the treatment needed by the patient is not covered by the plan, the case would be expedited to federal court, where patients could sue for the cost of care, attorneys’ fees, and \$750 per day, up to \$250,000, for the time denied care.

The Senate GOP plan calls for “independent medical experts” who would judge cases that related to their area of expertise.

All the bills require that reviewers be free of any conflict of interest with either the insurer or patient involved in a dispute. “There must be a firewall,” said a Senate GOP aide.

■ **Who Picks The Review Boards?** All the bills call for state agencies or the federal government to license external review boards, except the House GOP bill, which calls only for federal licensing.

The boards could be run by state or federal agencies, state insurance commissioners, state medical boards, colleges and universities, or private companies.

“There’s going to be eight or nine different ways to set up these entities,” an aide said. All the bills call for the state and federal licensing agencies to make sure the review boards remain unbiased.

Because there might be several different external re-

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Health Care - Patients
Bill & Rts

Health

Continued from page 7

view boards from which to choose in a given geographic area, proponents of external reviews want to make sure participants cannot "shop" for a venue that has a reputation as being more favorable to insurers or patients.

Most bills require a "double-blind" process, in which those on the review board would not know the identities of the patient or insurer, but only the circumstances of the case.

■ Who Decides Where To Appeal?

The Senate GOP, Ganske, and Chafee bills would allow insurers to choose which external board in their area handles a dispute with a patient.

The Democratic bill would leave it up to the state and federal governments to choose a process for assigning cases, but with criteria making it unlikely that the insurer would be able to choose. The Norwood bill would allow states to decide how to handle the assignments.

Every bill would require the insurer or HMO to pay for the external review process. An aide said some of the existing external review processes cost from \$600 to \$1,000, which will act as an incentive for health plans not to argue disputes about treatments that cost less than the external review itself.

■ **Decision Deadlines.** The Senate GOP bill would require that the "medical urgency" of a dispute determine the review time, which could be as short as 24 hours or less.

For non-emergency situations, a decision is due 30 working days after an external reviewer is designated and the reviewer receives all the relevant information. The Norwood bill calls for a decision within 14 days of the receipt of material, or two days in an emergency.

A Senate GOP aide said their decision timetable is the most "aggressive" of any bill on behalf of patients in an emergency situation. But Democrats and some Republican aides argue that waiting to "start the clock ticking" until the reviewer receives all the relevant information might create an incentive for insurers to delay sending paperwork in order to stall the process.

The House GOP bill calls for a decision within 72 hours in an emergency, 10 days for urgent care, and 30 days for a routine dispute. The Ganske and Democratic bills call for an external review decision to be made within 60 days for routine requests, and 72 hours for emergencies.

The Chafee bill calls for a 30-day period if the patient is waiting for treatment; 60 days if treatment has already been given, but there is a billing dispute; and 72 hours for emergencies.

■ **Rules For Evidence.** The Chafee, Ganske, Norwood, House GOP and Democratic bills call for any external review process to reinvestigate and conduct new research on each case, rather than just relying on the paperwork submitted during an internal review by the insurer.

The Senate GOP bill would require the external review to take into account what is "medically necessary," and consider the practice standards used by the insurer.

The Chafee bill also outlines evidence that external review boards must consider, including personal medical records, and professional studies conducted by entities without a financial interest in the care decision.

A Chafee aide said it is essential to provide independent criteria and standards to measure against individual cases.

■ **Which Plans?** Except for the House and Senate GOP plans, all the bills apply the external review process to all private insurance, whether they are state-regulated, business self-insured, individual, or state or local government plans.

Because the House and Senate GOP bills apply only to ERISA plans, the external review process would apply to state-regulated insurance or business' self-insured plans, but not individual policies or state and local government plans.

■ **Penalties For Ignoring An External Review.** If a health plan ignores the decision of an external review board, the Senate GOP bill would call for an IRS code fine of \$100 for every day they do not provide benefits.

The Ganske and Democratic bills

would allow appeals to state court and state liability laws would apply.

The House GOP bill would allow patients to sue in federal court for fines ranging from \$500 to \$1,000 per day, and capped at \$250,000, which would be awarded to the patient. The court also could add an additional \$100,000 penalty against insurers who are shown to have engaged in a pattern of abuse.

The Chafee bill would allow patients to sue in federal court for economic damages, including lost wages, and the actual benefits lost.

The Chafee bill would prohibit suing for punitive or compensatory damages, which are commonly called "pain and suffering." The Chafee bill also would allow HHS or the Labor Department to fine insurers up to \$250,000 for bad actors, and give injunctive relief to patients.

The Norwood bill would allow those without injuries to sue in federal court for the cost of care, a \$750 per day penalty for each day delayed, up to \$250,000, and attorney's fees. For cases involving injury or death, patients could sue in state court under state malpractice tort laws.

While the Senate GOP plan would not expand the ability to sue, aides argue courts are still awarding plaintiffs multi-million dollar awards against companies that purposely and improperly deny care — even though current federal law does not call for such penalties.

■ **External Review Required?** The Ganske and Norwood bills would not require an external review to be completed before a patient takes an insurer to court. The House GOP bill would allow a patient to sue at any time once care has been denied by an insurer. The Democratic bill also would not require an external review, but a patient must have suffered an injury before going to court.

The Chafee plan requires an external review be completed before a patient goes to court, except in cases of severe bodily injury or death. The Senate GOP bill does not expand any ability of a patient to sue, regardless of the decision by the external review panel.

— BY MATTHEW MORRESSEY

SENATE APPROVES REPUBLICAN PLAN FOR HEALTH CARE

SOME LIMITS ON H.M.O.'S

Democratic Effort to Expand Ability to Sue Is Killed

Clinton Threatens Veto

By ALISON MITCHELL

WASHINGTON, July 15 — In the final hours of a sharply partisan debate over health care, the Senate killed a Democratic effort to expand the ability of patients to sue managed-care providers and, in a near party-line vote tonight, approved a Republican plan to regulate the companies that provide health insurance for most Americans.

The bill, designed to grapple with the health care revolution that has shifted most Americans into managed care, passed by a vote of 53 to 47. Two Republicans, John H. Chafee of Rhode Island and Peter Fitzgerald of Illinois, broke ranks with their party to oppose the measure.

The legislation would provide \$13 billion in new tax breaks for health care and give an array of rights to consumers, most significantly creating an appeal process for 124 million Americans in employer-sponsored health plans.

The extent of the other new protections — including consumer information, the right to a hospital stay after a mastectomy if recommended by a doctor, access to an emergency room outside of a managed-care network — would vary according to a person's insurance coverage.

Many of the new rights would apply only to the 48 million people in self-financed plans offered primarily by large companies. In many cases these are not the more restrictive insurance plans that have caused the most consumer concern because they channel access to care through a "gatekeeper" doctor.

The Democrats had tried unsuccessfully over four days of impassioned debate to push through a more comprehensive plan that would have applied to all 161 million Americans with private health insurance. [Excerpts, page A14.]

But their plan was gutted through an array of Republican amendments. And this afternoon, by a vote of 53 to 47, the Senate killed the Democrats' effort to provide patients with new rights to sue managed-care plans in state courts over denied care.

After the vote, President Clinton vowed to veto any bill that resembled the Senate's plan. "If Congress insists on passing such an empty promise to the American people, I will not sign the bill," he said. "Passing a strong, enforceable patients' bill of rights should not be a partisan issue."

As the Senate struggle drew to a close tonight, Senator Trent Lott of Mississippi, the majority leader, propounded the Republican philosophy of regulation in moderation and criticized the Democrats' efforts to expand the right to sue.

"Congress should not imperil the continuing transformation of American medicine," Mr. Lott said. "It's not our job to dictate or control that transformation."

Senator Tom Daschle of South Dakota, the minority leader, called the Republican bill a fraud, saying: "The Senate has missed a golden opportunity to pass a real patients' bill of rights. Instead, the Republican majority is handing the insurance industry its version of H.M.O. reform — half measures only."

With Republicans and Democrats sharply divided over an issue they expect to resonate with the public, Vice President Al Gore also attacked the Republican bill, another indication that the parties' different approaches to health care will become an issue in next year's election.

"Nobody should be under any illusions," said Mr. Gore, who came to the Senate in the late afternoon in the event that he would be called upon to cast a tie-breaking vote. He branded the Republican bill "a charade" and a "bill of goods they've been trying to promote."

Republicans who favored less Federal regulation than the Democrats charged that the Democrats' rival plan would raise premiums and force more Americans into the ranks of the uninsured. Of the veto threat, Senator Don Nickles of Oklahoma, the majority whip, said, "We are going to find out if the White House is interested in increasing quality health care or just wants to make politics."

A handful of Democrats and Republicans tried in vain to find common ground on a compromise. "If this gamesmanship continues the only winner will be the status quo," said Senator Bob Graham, Democrat of Florida.

The most significant provision of the Republican bill would allow people in employer-sponsored health plans to appeal decisions denying them medical care. Patients could appeal to an independent medical reviewer if the health plan refused to pay for care. The reviewer would be under contract to the health care plan.

The bill enforces a decision against a health plan by allowing a patient to obtain treatment outside of a health network if treatment does not begin in the time frame recommended by the reviewer. The plan would be held liable for the charges and for a \$10,000 fine. And the plan may be assessed another fine of up to \$10,000 if it fails to comply with time frames for review.

The week's Senate debate over managed care was the most significant debate on a health issue since President Clinton's plan to provide universal health insurance died in 1994.

During the two years that managed care has been an issue in Congress, the most hard-fought question has been whether to go further and expand a patient's rights to sue in cases of malpractice. Most patients suing over decisions in managed care currently must do so in Federal court, where they can typically collect the value of the care denied but not punitive damages.

Time and again this afternoon, Republicans charged that the Democrats' proposal on the right to sue would drive up health care costs and serve as a boon to trial lawyers, an important Democratic constituency. Senator Pete V. Domenici, a New Mexico Republican, called it "Junacy" to expect the courts to solve health care problems. "I am convinced that if you let the trial lawyers solve a medical problem it is borderline useless," he said.

Protesting a Republican amendment to strip the right to sue from the Democratic plan, Senator Barbara Boxer of California said, "If this amendment passes and the H.M.O.'s cannot be held accountable in court of law, what it means is if they kill you, if they maim you, if they hurt you or your family or your children due to callous or uncaring bureaucrats they cannot be held accountable."

By a vote of 53 to 47, the Senate killed the Democrats' liability provision before the final debate.

Beyond the grievance procedures the Republican plan provides certain protections available to different groups of people depending on the nature of their insurance.

Under the plan all women with private health insurance would be able to stay in a hospital after a mastectomy if their doctor recommended it. The measure was a re-

sponse to the emotional issue of so-called drive-by mastectomies in which some insurance companies had required the operation for breast cancer to be handled as an out-patient procedure.

Other protections were granted to 48 million people covered by self-funded employers' plans, which encompass both old-style fee-for-service programs and managed care but are frequently not the kinds of restrictive H.M.O. plans that have drawn the most consumer complaints.

These protections include insured access to emergency rooms outside a provider network for services related to stabilizing an emergency condition. It requires health plans to coordinate transfers or discharges within an hour after being contacted by the out-of-service-area hospital.

The bill grants women, in these kinds of health plans, direct access to an obstetrician for pregnancy and child delivery but direct access to a gynecologist only for "routine" care.

And for these 48 million people the bill requires "timely" access to medical specialists, but only those inside a health plan's network. For patients in that 48 million who have cancers best treated through clinical trials, the plan would require payment of "routine patient costs" associated with approved cancer clinical trials sponsored by the National Institutes of Health, the Departments of Veterans Affairs and Defense.

In each of these areas the Democrats had argued for protections that were in most cases broader and that would apply to all 161 million Americans with private health insurance.

The Republican bill would create \$13 billion in new tax breaks, allowing full deduction of health insurance premiums, the full deduction of long-term care insurance that is not subsidized by employers and an expansion of tax-free savings accounts for health care.

Health Care -
Patients
Bill of
Rights

The New York Times

FRIDAY, JULY 16, 1999

Tiniest Circuits Hold Prospect Of Explosive Computer Speeds

By JOHN MARKOFF

PALO ALTO, Calif., July 13 — Plunging deeply into a Lilliputian world that promises ultrafast, low-power computers, a research team has for the first time fashioned simple computing components no thicker than a single molecule.

The achievement, being reported Friday in Science magazine, opens a new window onto a once speculative but now increasingly probable vista of molecular-scale sensors, computers and machines.

The researchers, from the Hewlett-Packard Company and the University of California at Los Angeles, say their work could be a step toward computers 100 billion times as fast as today's most powerful personal computers. And they envision a world in which supercomputing power is so pervasive and inexpensive that it literally becomes an integral part of every man-made object.

— the small switches that are the basis for all computing — have been made by etching silicon wafers with beams of light, a process known as photolithography. The ability to make these circuits smaller is ultimately limited by the wavelength of light.

But the team from Hewlett-Packard and U.C.L.A. has found a way to build circuits using chemical processes rather than light, making the switches as small as a molecule. As a result, the researchers believe that they can make components for future computers several orders of magnitude smaller than today's smallest transistors.

Over the next decade, such technology "holds the promise of vast data storage capability," said Phil Kueker, a physicist and computer designer at Hewlett-Packard, which is based here. And ultimately, he said, it could create a new class of "Fibonacci Voyage" style machines, the sensors traveling within a person's bloodstream, issuing alerts if health problems are encountered.

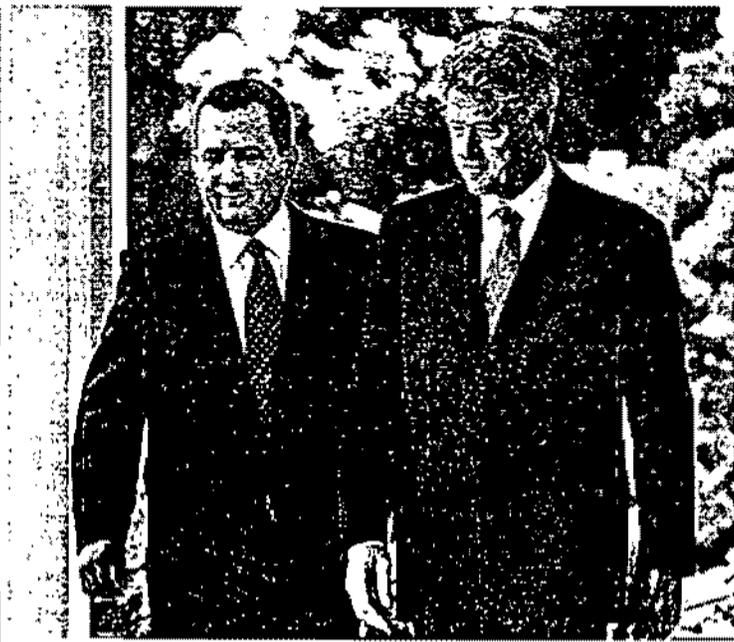
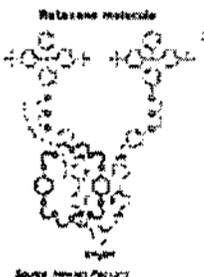
The research is also the strongest indication yet that engineers may find new ways to perpetuate the computer industry's touchstone known as Moore's Law, which has charted the steady rise in computing power using ever smaller and cheaper chips over the last three decades.

As individual transistors get smaller, they take less electrical power to switch and, in general, can switch on and off more quickly. And more of them can be produced without increasing the cost of production.

One of the next steps by the team at Hewlett-Packard and U.C.L.A. will be to come up with a chemical process to create ultrathin wires — no more than several atoms across — needed to connect all the molecular switches into a complex computer circuit.

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Atoms forming one section of a synthetic molecule move when subjected to a voltage, serving as a switch to turn from 'on' to 'off.'



Barak at the White House

Beginning his first visit to the United States as Prime Minister of Israel, Ehud Barak met with President Clinton at the White House yesterday, assuring the

President that Israel would embark on a "serious effort" to restart peace talks with Syria and setting out conditions for a peace agreement. Page A8.

Bush Forgoes Federal Funds And Has No Spending Limit

By DON VAN NATA Jr.

WASHINGTON, July 13 — Gov. George W. Bush declared today that he would not accept Federal matching funds because of his enormous \$37 million campaign war chest, giving him the capacity to far outstrip his Republican Presidential rivals in the 2000 election, especially in early and pivotal primaries and caucuses.

With Mr. Bush, the Governor of Texas, and another Republican candidate, Steve Forbes, the multimillionaire publisher, both forgoing Federal matching funds, a backbone of the post-Watergate campaign finance system has been weakened.

By refusing to accept \$16.5 million in matching funds from taxpayers, Mr. Bush, with more than \$30 million in cash reserves, will not be restricted by a spending limit of nearly \$40 million that applies to candidates who accept matching funds in the primaries.

More important, both of Mr. Bush's chief Democratic rivals, Vice President Al Gore and former Senator Bill Bradley of New Jersey, who are accepting matching funds, will probably reach the spending limit by the spring of 2000. But Mr. Bush would still have ample amounts of money left to spend through the summer conventions. The Republican and Democratic Presidential nomi-

nees would then receive about \$8 million each in public funds for the general election in the fall.

"After looking at the numbers, cash on hand of \$38 million, I've decided not to accept Federal matching funds during the course of the campaign," Mr. Bush said today in a campaign appearance in Waterloo, Iowa.

Mr. Bush decided to announce his intentions on the day that all the candidates were required to report their quarterly fund-raising totals to the Federal Election Commission.

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U.S. in a Push To Bar Vaccine Given to Infants

By LAWRENCE K. ALTMAN

Federal health officials yesterday called for the immediate suspension of a vaccine recently recommended for all infants to protect against rotavirus, the most common cause of severe diarrhea in infants and young children.

The Federal Centers for Disease Control and Prevention said it took the extraordinary action because a program that monitors vaccine side effects suggested a link between the drug, licensed last year, and 28 cases of a painful blockage of the bowel called intussusception. The disease, which can in rare cases be fatal, affects an estimated 3.5 million in the United States a year.

Although there is no conclusive evidence that the vaccine causes the bowel condition, officials at the disease-control center said the data are so strongly suggestive of a link that they considered it prudent to advise halting rotavirus vaccinations at least until November, by which time a new study at the vaccine will be completed.

"No one should now be giving rotavirus vaccine to anyone," said Barbara Reynolds, a centers spokeswoman.

The agency has an enforcement power, and its call for a suspension is only a recommendation. But doctors generally follow such warnings.

The vaccine was developed at the National Institutes of Health and is sold as Rotashield by Wyeth-Ayeris of St. Davids, Pa., a division of the American Home Products Corpora-

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SENATE APPROVES REPUBLICAN PLAN FOR HEALTH CARE

SOME LIMITS ON R.M.O.'S

Democratic Effort to Expand Ability to Sue Is Killed — Clinton Threatens Veto

By ALISON MITCHELL

WASHINGTON, July 13 — In the final hours of a sharply partisan debate over health care, the Senate killed a Democratic effort to expand the ability of patients to sue managed-care providers and, in a near party-line vote tonight, approved a Republican plan to regulate the companies that provide health insurance for most Americans.

The bill, designed to grapple with the health care revolution that has shifted most Americans into managed care, passed by a vote of 53 to 41. Two Republicans, John H. Chafee of Rhode Island and Peter Fitzgerald of Illinois, broke ranks with their party to oppose the measure.

The legislation would provide \$12 billion in new tax breaks for health care and give an array of rights to consumers, most significantly creating an appeal process for 124 million Americans in employer-sponsored health plans.

The extent of the other new protections — including consumer information, the right to a hospital stay after a doctor is recommended by a doctor, access to an emergency room outside of a managed-care network — would vary according to a person's insurance coverage.

Many of the new rights would apply only to the 48 million people in self-financed plans offered primarily by large companies. In many cases there are not the more restrictive insurance plans that have caused the most consumer concern because they channel access to care through a "gatekeeper" doctor.

The Democrats had tried unsuccessfully over four days of impassioned debate to push through a more comprehensive plan that would have applied to all 161 million Americans who have private health insurance (Healthcare, page A14).

But their plan was gutted through an array of Republican amendments. And this afternoon, by a vote of 53 to 41, the Senate killed the Democrats' effort to provide patients with new rights to sue managed-care plans in state courts if not denied care.

After the vote, President Clinton vowed to veto any bill that resembled the Senate's plan. "If Congress insists on passing such an empty promise to the American people, I will not sign the bill," he said. "Passing a strong, enforceable patients' bill of rights should not be a partisan issue."

As the Senate struggle drew to a close tonight, Senator Trent Lott of Mississippi, the majority leader, pronounced the Republican philosophy of regulation in moderation and tri-

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Religious Rights Bill Gains

Despite concerns that it could be cited as sanction for bias against homosexuals, a religious freedom bill won House passage. Page A16.

State Courts Sweeping Away Laws Curbing Suits for Injury

By WILLIAM GLABERSON

More than a decade after states began enacting laws to cut back big jury awards and curtail injury lawsuits, state courts across the country are overturning one measure after another, concluding that Americans have a powerful right to settle their disputes in court.

Top courts in such states as Illinois, New Hampshire, Kentucky and, most recently, Indiana on July 8 and Oregon yesterday, have relied on provisions of state constitutions like guarantees of fair access to the courts to strike down all or part of the new laws that were passed under the banner of "tort reform."

The new liability laws make it more difficult to bring some suits and seek to limit how much people can collect in accidents, malpractice and other injury cases.

The highest courts of at least seven states have struck down all or part of new liability laws in the last three years. Dozens of new challenges to such laws are working their way toward state supreme courts, including those in Wisconsin, Alaska and Colorado, and a decision is expected soon from the Supreme Court in Ohio, which enacted a sweeping liability law two years ago. The cases focus on state constitutional guarantees of "open courts" or the right to a jury trial.

In this second phase of the battle over the liability system, at least 17

decisions by state appeals and trial courts have found flaws in laws enacted since the mid-1980's.

"The state courts are invalidating huge parts of the tort reform legislation to the consternation of supporters of tort reform," said Prof. Mark Galanter of the New York University Law School.

The laws have also been upheld by lower courts across the country, with judges taking sides in one of the country's fiercest but least-noticed legal wars. In January, the Virginia

Continued on Page A12

On Fire in Meadowlands: Springsteen Is Back



Fans welcomed Bruce Springsteen last night for the first of 15 sold-out Meadowlands shows through Aug. 12.

By DAVID W. CHEN
EAST RUTHERFORD, N.J., July 13 — Every step of the way, it seems, Bruce Springsteen has managed to produce the perfect songs and perfect lyrics for the soundtrack to what

wonders of fatherhood. And Mr. Facendo went through a bitter divorce — just as Mr. Springsteen did — seething, but full of appreciation for the small and precious things in life.

Mr. Facendo, 33, grew up in Hazel, N.J. He works in a factory, so, too, did Mr. Springsteen. He escorted his younger brother, Doug, to his first Bruce Springsteen concert, in Pittsburgh, when Doug was 17. He became a father just as Mr. Spring-

steen was writing lyrics about the wondrous of fatherhood. And Mr. Facendo went through a bitter divorce — just as Mr. Springsteen did — seething, but full of appreciation for the small and precious things in life.

Mr. Facendo wasn't the only one who was identifying with Mr. Springsteen today. In fact, there were thousands of people who descended upon

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Town Hushed in '95 Crackdown Sees No Reason to Join Iran Riots

By ELAINE SCIGLINO

ISLAMSHAKR, Iran, July 13 — For the young men on the streets of this dusty, crowded, unexceptional town south of Teheran, the nationwide unrest of the last week is little more than a remote spectacle on the nightly news.

Unlike the students at Teheran University whose demonstrations a week ago set off violent riots, these young men seem ill-informed about the closing of a newspaper and a harsh new press law.

Unlike the pro-Government marchers who took to the streets to praise the parity of the Islamic system and rail against the United States at rallies throughout Iran on Wednesday, these men stayed home.

In their own way, these men are just as disaffected from the conservative Islamic religious Government that runs their country as the students at Teheran. They share the same desire for personal freedoms. It is just that, here, priorities are different. The men of Islamshakr want jobs.

For one thing, he will surpass the Grateful Dead as the leading draw in

At an open area with a long line of public telephones, dozens of young men compete to sell telephone cards for 100 profits as they complain about their lives.

"Look at all of us," said one young man in his 20s, pointing to his friends. "We're all jobless. We have nothing to do. We try to do a little bit of business here and there and they arrest us. As hostages. That's why there are so many drug addicts here. It's the despair," said the man, who

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INSIDE

A 'Force' in Belfast

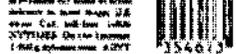
An assembly to open a new era for Ulster ended in boycotts and name-calling, with Protestants and Catholics agreeing only that the day proved to be a "force." Page A1

Studio Chiefs Resign

Robert Daly and Terry Semel, co-chairmen of Warner Brothers, resigned, ending one of the most successful relationships with a studio in Hollywood history. Page C1

'Eyes Wide Shut'

A film about sexual yearnings, Stanley Kubrick's last work is also his riskiest. A review by Janet Maslin. Weekend, page B1



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Updated news: www.nytimes.com

In the Loop

Al Kamen

Bush's Velvet Plank

Tales from the land of Compassionate Conservatism. When Texas Gov. George W. Bush (R) was looking for a little high-powered help with the media for his presidential campaign, he personally wooed David Beckwith, veteran newsman and former vice president Dan Quayle's press secretary, to come on board.

For Beckwith, that meant leaving Washington, quitting his presumably lucrative private-sector gig and moving his family down to Austin. And not to mention missing Quayle, who is, last we checked, running against Bush. But Bush wooed and won.

And when the end came, how did Beckwith hear the news that he had resigned? Word is he heard it from senior Bush campaign aides. In fact, as of Wednesday afternoon, a day after the "mutual resignation" was announced, Bush told reporters he still hadn't "had a chance to talk to" Beckwith. Been on the road, Bush explained.

But Beckwith is "a good friend," and "I'll help him in any way I can," Bush said, in terms of finding future employment.

Good thing Beckwith was such a good friend. Bush wouldn't have been so stand-up and compassionate otherwise.

Running on His Record

Meanwhile, there's a great job opening on the Hill. Rep. Helen Chenoweth (R-Idaho) is looking for a new legislative director. Her former LD since 1996, Gregory Peck, resigned Monday after his arrest in Reno last week—his ninth arrest over more than a decade for various offenses, including indecent exposure (five times), driving while intoxicated and destruction of property. The Hill newspaper reported Peck was convicted or pleaded guilty in at least four of the cases.

Time to tighten up on the vetting?

Brad Smith . . . Animal, Vegetable or Mineral?

As that hotel commercial goes, "never underestimate the value of a good night's sleep." So there was Senate Majority Leader Trent Lott (R-Miss.) parrying questions Sunday from NBC-TV's Tim Russert on "Meet the Press."

Russert asked about a "hold" that Lott had placed on the nomination of diplomat Richard C. Holbrooke to be U.N. ambassador in order to force the Clinton administration to put Lott's nominee on the Federal Election Commission.

"Who is Bradley Smith?" Russert asked.

Lott, looking temporarily stunned, kinda like he got hit with a heavy skillet, said: "Bradley Smith? Now let's see. . . That sounds familiar. . . Who is Bradley Smith?" he asked Russert.

"Roll Call: Lott's Secret. Holbrooke Holds . . ." Russert prompted.

"Holds . . . Brad Smith," Lott said, seeming to catch on. "Heh, heh, heh . . ."

"Bradley Smith is your candidate for the Federal Election Commission," Russert said.

"Right," Lott agreed.

Gingrich Tunes In FM Band

Is Freddie Mac doing Fannie Mae one better? Six months ago Fannie Mae hired Arne Christiansen, ex-chief of staff for former House speaker Newt Gingrich (R-Ga.).

Now we find that Freddie Mac has signed up Gingrich & Associates to provide "strategic consulting services on a variety of issues, primarily legislative and regulatory issues," said Freddie Mac spokesman Sharon McHale. No lobbying, she said. "It's strictly a consulting role."

How much is he being paid? McHale says there's no obligation to disclose, but "we don't anticipate it will be a lot of time or money because his role is going to be quite limited."

In Transit

Patrick Dorton, former press secretary for Rep. Peter A. DeFazio (D-Ore.) and then for Sen. Tom Harkin (D-Iowa) for the last three years, has moved to the White House to be communications director for Gene Sperling at the National Economic Council.

Jim O'Hara, head of the Food and Drug Administration's public affairs operation during the David Kessler Era and more recently senior adviser to Surgeon General David Satcher, is off to consult for the Pew Charitable Trusts, where he will design a public education campaign as part of a public health initiative.

Hair Today

The latest issue of George magazine profiles Rep. Mary Bono (R-Calif.), who speaks of many things, including a rough patch between her husband and the Church of Scientology. The

article also includes this picture of her modeling in California in 1987.

"My Sheena, the Jungle Woman From Hell" picture," Bono joked yesterday. "I guess it really was a bad hair day."

Not to mention those carpet samples stitched together for a top.

"Other members," Bono said, "have started coming up to me—I'm not saying which ones—and telling me about what they consider their most humiliating pictures and saying, 'I realize this could be me.'" We don't think so.



OF U.S. CONGRESS, GEORGETOWN STAR
FOR WOODS MAGAZINE

"Jungle Woman From Hell"

The Washington Post

FRIDAY, JULY 16, 1999

Health Care
Patients Bill
of Rights

Senate Backs Republican Patient Plan

Limited Expansion of Rights Includes Access to Specialists

By AMY GOLDSTEIN and HELEN DEWAR
Washington Post Staff Writers

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The Senate last night voted to grant patients a wide array of limited new protections devised by Republicans to help them cope with the managed-care plans that have come to dominate the nation's health care system.

The legislation, forged amid a biting four-day debate and furious lobbying, calls for the federal government to guarantee some people easier access to emergency rooms and medical specialists, help women stay in the hospital longer after breast cancer surgery and expand patients' ability to appeal if health plans won't pay for care.

But before taking final action on the bill last night, the Senate voted 53 to 47 to smash a cornerstone of Democrats' efforts to empower patients—giving people the right to sue HMOs for malpractice. And most of the protections that the Senate adopted would be available to fewer than one-third of Americans with private health insurance.

With the issue's fate uncertain in the House and the White House vowing to veto the approach the Senate embraced last night, the final 53 to 47 vote represented, as much as anything, an important political success for the Senate's Republican majority.

"This is a victory for patients with improved access to health care for Americans," declared Sen. Bill Frist (R-Tenn.), the Senate's only physician, who helped formulate the GOP approach. "It achieves a balance [for] doctors and patients ... with a cost that does not hurt access to care."

Over the course of this week, the GOP prevailed on every one of about a dozen amendments to both Republican and Democratic bills, giving the party's leaders a clean win on an issue of prime importance

to the American public. That win has particular significance, coming on top of the Senate's meager record of accomplishments so far this year and—in particular—the GOP's prominent display of disunity in late May over a Democratic proposal to strengthen gun control laws.

While the GOP handily won this week's legislative showdown, Democrats were quick to contend yesterday that they ultimately will emerge victors in the court of public opinion. They predicted that voters will be dissatisfied with Republicans' more modest steps to tilt power away from insurers and toward patients and health professionals.

"I think it's a step back," said Sen. Edward M. Kennedy (D-Mass.), who co-sponsored the Democratic legislation and managed the party's floor debate. "It gives false security."

Vice President Gore, standing in a display of solidarity yesterday afternoon with Democratic senators just outside the Senate chamber, issued the administration's strongest veto threat on the issue to date. "Nobody should be under any illusion: If the Republican leadership insists on go-

ing through a charade in passing that 'bill of goods' they've been trying to promote, President Clinton will veto it in a minute. It has zero chance of going across his desk because it is a fraud."

Regardless of which party proves able to wield the issue to greater advantage in next year's election campaigns, the Senate's action this week reflects a marked failure of compromise. The parties sought to outmaneuver one another even on those proposals—such as ones to allow women greater freedom to remain hospitalized after having a mastectomy—on which they essentially were in agreement.

In such an acrimonious, partisan climate, a bipartisan group of moderates was unable to force a vote on its own attempt to find a middle ground that would have, for instance, given patients a limited right to sue—but not one as broad as many Democrats sought. The group, led by Sens. John H. Chafee (R-R.I.), Bob Graham (D-Fla.) and Joseph I. Lieberman (D-Conn.), began a last-minute drive Wednesday to muster at least five GOP supporters—enough to prevail as long as all 45 Democrats went along. But in the end they managed to attract only two Republican votes.

At a morning news conference, called in a futile attempt to drum up broader support, the moderates said the Senate's polarization ultimately would doom its legislation. "The track we are now on is, a GOP bill will pass, the president will veto it, the veto will be sustained, and the American people won't be one bit better off than before this exercise started," Chafee lamented.

The intense sparring inside the Senate chamber this week was matched by an equally vigorous lobbying effort by well-organized constituencies with big stakes on both sides of the debate—essentially pitting insurers and employers against patients, doctors and other providers of medical care.

The Health Benefits Coalition, a consortium of insurance and business interests, has been running radio and television advertisements this week in the districts of senators facing election next year, and many top business leaders have placed calls to Capitol Hill. The Health Insurance Association of America has coordinated tens of thousands of letters and calls.

On the debate's other side, meanwhile, the American Medical Association ran radio ads around the country, flew dozens of doctors from several states to Washington for a lobbying blitz on Tuesday and set up a toll-free number that has allowed doctors and patients from around the country to be connected directly to their senator's office.

Despite those efforts, aides to several Republicans, targeted by lobbyists because they are up for election next year, said they did not feel deluged and were not swayed. A spokesman for Sen. Mike DeWine (R-Ohio) said the senator got about 100 calls on patients' rights in both his Ohio

and Washington offices—one-fifth as many as he got during the gun debate.

Before last night's vote, the Senate finished off the remaining Democratic proposals. One would have prohibited HMOs from imposing "gag rules" that prevent doctors from discussing expensive treatments with their patients. Another would have guaranteed that patients could, under certain conditions, keep the same doctor for a few months even if they are forced to switch health plans.

In contrast with Democratic efforts to protect all 161 million Americans with private insurance, most aspects of the final legislation apply only to 48 million people who get coverage through big companies that insure themselves and legally cannot be regulated by states. Republicans said the states are already doing a good job regulating health plans.

The expanded ability for an outside appeals hearing when HMOs deny care would be available to a somewhat larger group of 123 million people with private insurance.

On the other hand, all women and children with private insurance would be helped by a provision allowing them to visit obstetrician-gynecologists and pediatricians without permission of their primary doctor. All Americans also would be eligible for tax changes allowing self-employed people to deduct the entire cost of insurance premiums, expanding the availability of savings accounts to let people set aside money for medical expenses tax-free and creating new tax breaks to help individuals buy insurance against long-term care.

The Washington Post

FRIDAY, JULY 16, 1999