

Health Care -
Patients
Bill of
Rights

**COMPARISON OF THE FLAWED REPUBLICAN PATIENTS BILL OF RIGHTS AND
THE STRONG BIPARTISAN NORWOOD-DINGELL BILL**

PATIENT PROTECTION	REPUBLICAN BILL PASSED BY THE SENATE	BIPARTISAN NORWOOD-DINGELL REAL PATIENTS' BILL OF RIGHTS
Covering All Health Plans	NO. Leaves out over 110 million Americans and covers less than 10 percent of all HMOs.	YES.
Keeping Your Doctor Through Critical Treatments	NO. Does not provide meaningful continuity of care provisions.	YES.
Providing Strong Emergency Room Protections	NO.	YES.
Assuring Access to Specialists	NO.	YES.
Assuring Patients Have an Independent Appeals Process	NO.	YES.
Holding Health Plans Accountable for Harming Patients	NO.	YES.

**THE PATIENTS' BILL OF RIGHTS:
Improved Prospects For Passage In The New Congress?**

Health Care -
Patients Bill
of Rights.

On July 24, 1998, the Republican-controlled House of Representatives defeated the Democratic *Patients Bill of Rights* legislation by a vote of 217 "nays" to 212 "yeas," with 6 members "Not Voting." The following analysis takes a look at whether the prospects for passage of the bill have improved following the 1998 elections. If re-elected Members cast their votes as they did in 1998, it appears there are more than the 218 votes needed to pass the Democratic Patients' Bill of Rights in the new Congress.

The July 24, 1998 "Patients' Bill Of Rights" Vote

Summary:

House Vote #336 on HR 4250
On the Dingell (D-MI) Substitute Amendment consisting of the text of HR 3605, the Democratic-sponsored Patients' Bill of Rights legislation.

<u>Defeated:</u>	<u>212 - 217</u>
Democrats:	201 - 0
Republicans:	10 - 217
Independents:	1 - 0

**The 1999 "Patients' Bill Of Rights" Vote:
More Than A Majority For Passage At 221 Votes**

189 Democratic Supporters Returning

189 Democrats who supported the Patients' Bill of Rights on July 24, 1998 will return to Congress in 1999.

**+22 Freshman Democratic "Yea" Votes
(Running Vote Count: 211)**

22 newly elected Democratic Members of Congress, most of whom campaigned on the Patients' Bill of Rights, will take seats in Congress in 1999.

**+9 Republican "Yea" Votes Returning
(Running Vote Count: 220)**

9 of the 10 Republicans who voted with Democrats (see chart below for full list) to pass the Patients Bill of Rights on July 24, 1998 will return to Congress in 1999 -- all except for Jon Fox (R-PA).

**+1 Independent "Yea" Vote Returning
(Running Vote Count: 221)**

Rep. Bernard Sanders (I-VT) will return to Congress in 1999.

**The 1999 Patients Bill Of Rights Vote:
Other Possible Votes Beyond 221**

Summary Of Other Possible Votes:

<i>Narrowly Re-Elected Incumbent Republicans Who Faced Patients' Rights Issue:</i>	5
Richard Baker (LA-6); John Hostettler (IN-8); Ann Northrup (KY-3); James Rogan (CA-27); Heather Wilson (NM-1)	
<i>Newly Elected Republicans Who Campaigned On Patients' Rights:</i>	3
Don Sherwood (PA-10); Ernie Fletcher (KY-6); Judy Biggert (IL-13)	

WILL ONE OR MORE OF THE 5 NARROWLY RE-ELECTED INCUMBENT REPUBLICANS WHO FACED THE PATIENTS' BILL OF RIGHTS ISSUE DURING THEIR CAMPAIGNS SUPPORT THE BILL?

Name	District	Election Result	7/24/98 Vote
Baker, Richard	LA-6	51% - 49%	Nay

1. **Baker: "This Issue Is Moving Up The Ladder Of Importance."** According to the Baton-Rouge Advocate: "*The 'patients' rights' issue was caught in election-year politics and was not resolved this year. A wide gulf remains between Republican and Democratic versions of patient-protection legislation. That same gulf exists between the candidates running in the 6th Congressional District - Republican incumbent U.S. Rep. Richard Baker and Democrat Marjorie McKeithen. One of them will face the issue in the next Congress after winning the Nov. 3 election. 'This issue is moving up the ladder of importance, not going down,' Baker said.*" [Advocate (Baton Rouge, La.), 10/12/98 (emphasis added)]

Name	District	Election Result	7/24/98 Vote
Hostettler, John	IN-8	52% - 47%	Nay

2. **Hostettler: Opponent Ran TV Ads And Made Patients' Rights The "Key Issue":** *"Gail Riecken, the Democrat trying to unseat Rep. John Hostettler in southwestern Indiana's 8th District congressional race, has tried to make HMOs a key issue."* [Associated Press, 10/19/98 (emphasis added)]

According to Roll Call: *"In Indiana, Democratic House candidate Gail Riecken is running an ad similar to [Georgia Senatorial candidate Michael] Coles' [in which he attacked his opponent's record on HMOs] in which a woman asserts that her baby suffered brain damage when a C-section was refused. Riecken's campaign says she has gone from 20 points behind Republican Rep. John Hostettler to 8 points back, but the HMO issue hasn't put her into the lead yet."* [Roll Call, 10/22/98 (emphasis added)]

Name	District	Election Result	7/24/98 Vote
Northrup, Anne	KY-3	52% - 48%	Nay

3. **Northrup: Opponent Made HMO Reform "No. 1 Issue."** According to the National Journal: *"Still, Gorman -- who is seeking to unseat first-term GOP Rep. Anne Meagher Northrup -- managed to get Gephardt to attend a fund-raising breakfast with about 40 local supporters, many of them labor-union leaders, and a rally at a senior-citizens center to press for reform of health maintenance organizations, which Gorman has played as his No. 1 issue."* [National Journal, 9/5/98]

Name	District	Election Result	7/24/98 Vote
Rogan, James	CA-27	51% - 47%	Nay

4. **Rogan: Said It Was "Essential" To Pass A Patients' Bill Of Rights.** When asked by the Los Angeles Times, "If you go to Washington, what kind of agenda will you pursue?" Rogan responded *"I would want to work to pass an HMO patients' bill of rights. I think it's essential."* [Los Angeles Times, 11/1/98 (emphasis added)]

Name	District	Election Result	7/24/98 Vote
Wilson, Heather	NM-1	46% - 43%	Nay

5. **Wilson: Opponent Made Patients' Rights A Key Issue.** According to CongressDaily, *"In New Mexico, Democratic challenger Phil Maloof sought to use the issue to tie his opponent to House Speaker Gingrich, chiding Rep. Heather Wilson, R-N.M., in one ad for voting 'with Newt Gingrich' and against key patient rights like minimal hospital stays, the right to sue and guaranteed emergency room treatment."* [CongressDaily, 11/2/98]

**WILL ONE OR MORE OF THE 3 NEWLY ELECTED FRESHMAN REPUBLICANS WHO
CAMPAIGNED ON THE PATIENTS' RIGHTS ISSUE VOTE FOR THE BILL?**

1. Rep.-Elect Don Sherwood (PA-10):

A Moderate Who Campaigned On His Support For A Patients' Bill Of Rights.

According to *U.S. News & World Report*, "What the Democrats once viewed as among their brightest opportunities for gaining a congressional seat is now seen as a down-to-the-wire race where the party's best hope is to pull support from independent-minded Republicans who can be persuaded that a GOP vote will hurt education, Social Security, and health care. That's not easy when the Republican candidate, Don Sherwood, talks about his 23 years on the school board in his hometown of Tunkhannock and his support for a patients' bill of rights and for bolstering the Social Security fund. Sherwood is running so centrist that he even voices support for a minimum wage boost..." [*U.S. News & World Report*, 10/12/98 (emphasis added)]

2. Rep.-Elect Ernie Fletcher (KY-6):

A Doctor Who Ran Two TV Ads About Patients With HMO Horror Stories.

According to the *National Journal's* "1998 Political Ads" section of their Cloak Room web page: "...Fletcher is emphasizing his medical career in his efforts to defeat Democrat Ernesto Scorsone for the 6th District seat being vacated by Senate candidate Rep. Scotty Baesler. Two 60-second spots feature patients of Fletcher's, talking about their experiences. The doctor appears in a casual shirt in his living room, arguing that HMOs let them down, and vowing to pursue reform. Jack Smith says Fletcher saved him from blindness by taking on an indifferent HMO, while Kay Cockrell discusses her fight against breast cancer." [*National Journal's* "1998 Political Ads" (Cloak Room Web Page), 9/21/98 (emphasis added)]

3. Rep.-Elect Judy Biggert (IL-13):

Frm. Chair of Chicago Visiting Nurses Assoc. Who Is Concerned That Health

Decisions Are Not Being Made By Doctors. According to the *National Journal's* New Member Profile of Judy Biggert: "A former chairwoman of the Visiting Nurses Association of Chicago, Biggert is likely to make health care reform an important part of her agenda. She says that 'health care decisions are being made by someone who's not a doctor, someone who's concerned about the bottom line.'" [*National Journal's* "New Member Profiles" (Cloakroom Web Page), 11/4/98]

The July 24, 1998 "Patients' Bill Of Rights" Vote

-- In Detail --

Overview

Defeated

217 "Nay" votes

212 "Yea" votes

6 "Not Voting"

Democrats who voted "Yea" (201)

Abercrombie (HI), Ackerman (NY), Allen (ME), Andrews (NJ), Baesler (KY), Baldacci (ME), Barcia (MI), Barrett (WI), Becerra (CA), Bentsen (TX), Berman (CA), Berry (AR), Bishop (GA), Blagojevich (IL), Blumenauer (OR), Bonior (MI), Borski (PA), Boswell (IA), Boucher (VA), Boyd (FL), Brady (PA), Brown (CA), Brown (OH), Brown (FL), Capps (CA), Cardin (MD), Carson (IN), Clay (MO), Clayton (NC), Clement (TN), Clyburn (SC), Condit (CA), Conyers (MI), Costello (IL), Coyne (PA), Cramer (AL), Cummings (MD), Danner (MO), Davis (FL), Davis (IL), DeFazio (OR), DeGette (CO), Delahunt (MA), DeLauro (CT), Deutsch (FL), Dicks (WA), Dingell (MI), Dixon (CA), Doggett (TX), Dooley (CA), Doyle (PA), Edwards (TX), Engel (NY), Eshoo (CA), Etheridge (NC), Evans (IL), Farr (CA), Fattah (PA), Fazio (CA), Filner (CA), Frank (MA), Frost (TX), Furse (OR), Gejdenson (CT), Gephardt (MO), Goode (VA), Gordon (TN), Gutierrez (IL), Green (TX), Hall (OH), Hall (TX), Hamilton (IN), Harman (CA), Hastings (FL), Hefner (NC), Hilliard (AL), Hinchey (NY), Holden (PA), Hooley (OR), Hoyer (MD), Jackson-Lee (TX), Jackson (IL), Jefferson (LA), John (LA), Johnson (WI), Johnson, E. B. (TX), Kanjorski (PA), Kaptur (OH), Kennedy (RI), Kennedy (MA), Kennelly (CT), Kildee (MI), Kilpatrick (MI), Kind (WI), Kleczka (WI), Klink (PA), Kucinich (OH), LaFalce (NY), Lampson (TX), Lantos (CA), Lee (CA), Levin (MI), Lewis (GA), Lipinski (IL), Lofgren (CA), Lowey (NY), Luther (MN), Maloney (CT), Maloney (NY), Manton (NY), Martinez (CA), Mascara (PA), Matsui (CA), McCarthy (NY), McCarthy (MO), McDermott (WA), McGovern (MA), McHale (PA), McIntyre (NC), McKinney (GA), McNulty (NY), Meehan (MA), Meek (FL), Meeks (NY), Menendez (NJ), Millender-McDonald (CA), Miller (CA), Minge (MN), Mink (HI), Moakley (MA), Mollohan (WV), Moran (VA), Murtha (PA), Nadler (NY), Neal (MA), Oberstar (MN), Obey (WI), Olver (MA), Ortiz (TX), Owens (NY), Pallone (NJ), Pascarell (NJ), Pastor (AZ), Payne (NJ), Pelosi (CA), Peterson (MN), Pickett (VA), Pomeroy (ND), Poshard (IL), Price (NC), Rahall (WV), Rangel (NY), Reyes (TX), Rivers (MI), Rodriguez (TX), Roemer (IN), Rothman (NJ), Roybal-Allard (CA), Rush (IL), Sabo (MN), Sanchez (CA), Sandlin (TX), Sawyer (OH), Schumer (NY), Scott (VA), Serrano (NY), Sherman (CA), Sisisky (VA), Skaggs (CO), Skelton (MO), Slaughter (NY), Smith, Adam (WA), Snyder (AR), Spratt (SC), Stabenow (MI), Stark (CA), Stenholm (TX), Stokes (OH), Strickland (OH), Stupak (MI), Tanner (TN), Tauscher (CA),

Taylor (MS), Thompson (MS), Thurman (FL), Tierney (MA), Torres (CA), Towns (NY), Traficant (OH), Turner (TX), Velazquez (NY), Vento (MN), Visclosky (IN), Waters (CA), Watt (NC), Waxman (CA), Wexler (FL), Weygand (RI), Wise (WV), Woolsey (CA), Wynn (MD)

Republicans who voted

"Yea"

(10)

Bilbray (CA); Boehlert (NY); Forbes (NY); Fox (PA); Ganske (IA); Horn (CA); LaTourette (OH); Leach (IA); Morella (MD); Roukema (NJ)

Independent who voted "Yea"

(1)

Sanders (VT)

Republicans who voted

"Nay"

(217)

Aderholt (AL), Archer (TX), Arney (TX), Bachus (AL), Baker (LA), Ballenger (NC), Barr (GA), Barrett (NE), Bartlett (MD), Barton (TX), Bass (NH), Bateman (VA), Bereuter (NE), Bilirakis (FL), Bilely (VA), Blunt (MO), Boehner (OH), Bonilla (TX), Bono (CA), Brady (TX), Bryant (TN), Bunning (KY), Burr (NC), Burton (IN), Buyer (IN), Callahan (AL), Calvert (CA), Camp (MI), Campbell (CA), Canady (FL), Cannon (UT), Castle (DE), Chabot (OH), Chambliss (GA), Chenoweth (ID), Christensen (NE), Coble (NC), Coburn (OK), Collins (GA), Combest (TX), Cook (UT), Cooksey (LA), Cox (CA), Crane (IL), Crapo (ID), Cubin (WY), Cunningham (CA), Davis (VA), Deal (GA), DeLay (TX), Diaz-Balart (FL), Dickey (AR), Doolittle (CA), Dreier (CA), Duncan (TN), Dunn (WA), Ehlers (MI), Ehrlich (MD), Emerson (MO), English (PA), Ensign (NV), Everett (AL), Ewing (IL), Fawell (IL), Foley (FL), Fossella (NY), Fowler (FL), Franks (NJ), Frelinghuysen (NJ), Gallegly (CA), Gekas (PA), Gibbons (NV), Gilchrest (MD), Gillmor (OH), Gilman (NY), Gingrich (GA), Goodlatte (VA), Goodling (PA), Goss (FL), Graham (SC), Granger (TX), Greenwood (PA), Gutknecht (MN), Hansen (UT), Hastert (IL), Hastings, Richard (WA), Hayworth (AZ), Hefley (CO), Herger (CA), Hill (MT), Hilleary (TN), Hobson (OH), Hoekstra (MI), Hostettler (IN), Houghton (NY), Hulshof (MO), Hunter (CA), Hutchinson (AR), Hyde (IL), Inglis (SC), Istook (OK), Jenkins (TN), Johnson, Sam (TX), Johnson, Nancy (CT), Jones (NC), Kasich (OH), Kelly (NY), Kim (CA), King (NY), Kingston (GA), Klug (WI), Knollenberg (MI), Kolbe (AZ), LaHood (IL), Largent (OK), Latham (IA), Lazio (NY), Lewis (KY), Lewis (CA), Linder (GA), Livingston (LA), LoBiondo (NJ), Lucas (OK), Manzullo (IL), McCollum (FL), McCrery (LA), McDade (PA), McHugh (NY), McInnis (CO), McIntosh (IN), McKeon (CA), Metcalf (WA), Mica (FL), Miller (FL), Moran (KS), Myrick (NC), Nethercutt (WA), Neumann (WI), Ney (OH), Northup (KY), Norwood (GA), Nussle (IA), Oxley (OH), Packard (CA), Pappas (NJ), Parker (MS), Paul (TX), Paxon (NY), Pease (IN), Peterson (PA), Petri (WI), Pickering (MS), Pitts (PA), Pombo (CA), Porter (IL), Portman (OH), Pryce (OH), Quinn (NY), Radanovich (CA), Ramstad (MN), Redmond (NM), Regula (OH), Riggs (CA), Riley (AL), Rogan (CA), Rogers (KY), Rohrabacher (CA),

Ros-Lehtinen (FL), Royce (CA), Ryun (KA), Salmon (AZ), Sanford (SC), Saxton (NJ), Scarborough (FL), Schaefer, Dan (CO), Schaffer, Bob (CO), Sensenbrenner (WI), Sessions (TX), Shadegg (AZ), Shaw (FL), Shays (CT), Shimkus (IL), Shuster (PA), Skeen (NM), Smith (OR), Smith (TX), Smith, Linda (WA), Smith (MI), Smith (NJ), Snowbarger (KA), Solomon (NY), Souder (IN), Spence (SC), Stearns (FL), Stump (AZ), Sununu (NH), Talent (MO), Tauzin (LA), Taylor (NC), Thomas (CA), Thornberry (TX), Thune (SD), Tiahrt (KA), Upton (MI), Walsh (NY), Wamp (TN), Watkins (OK), Watts (OK), Weldon (PA), Weldon (FL), Weller (IL), White (WA), Whitfield (KY), Wicker (MS), Wilson (), Wolf (VA), Young (AK)

Members "Not Voting"
(1 Rep; 5 Dem)

Ford D-TN (announced "for"); Gonzalez D-TX (absent due to illness); Hinojosa D-TX (announced "for"); Markey D-MA (absent due to death in family); Yates D-IL (absent due to illness in family); *Young R-FL*

Health Care
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**PRESIDENT CLINTON AND VICE PRESIDENT GORE:
CALLING ON CONGRESS TO PASS A STRONG, ENFORCEABLE PATIENTS' BILL OF RIGHTS**

July 9, 1999

" Next week, the Senate has a historic opportunity to pass a real Patients' Bill of Rights that puts patients' needs above the bottom line...and puts politics aside for the good of our families."

President Bill Clinton
July 9, 1999

Today, in Los Angeles, President Clinton urged the Senate to hold a full and fair debate next week to pass a strong enforceable Patients' Bill of Rights. While commending Senator Lott for agreeing to schedule a vote on this issue, the President criticized the Republican leadership bill as inadequate for failing to include critical protections for American families. The President also called on Congress to move forward on a plan to strengthen and modernize Medicare for the 21st Century.

Urging Congress to Pass a Strong, Enforceable Bill. More than a year and a half ago, President Clinton accepted the recommendations of a non-partisan quality commission and urged Congress to pass a Patients' Bill of Rights to ensure that every health plan provides strong patient protections. Since then, thousands of doctors and nurses, over 200 medical and consumer groups, and many health care and public-sector unions have endorsed the President's plan for patient protections. Today, the President called on the Senate to hold a full and fair debate next week and pass a patients' bill of rights that includes critical protections such as:

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

President Clinton has already granted the protection of a Patients' Bill of Rights to the 85 million Americans who get their health care through federal plans.

Republican Approach Leaves Millions Without Protections. The President emphasized that the current Republican plan would leave over 110 million Americans without basic protections, including:

- * no access to necessary specialists, such as oncologists and cardiologists;
- * leaving patients at risk of having to change doctors abruptly in the middle of treatment;
- * no mechanism to ensure that patients have access to emergency room care when and where the need arises;
- * a weak, watered-down appeals process that is biased against patients; and
- * no enforcement mechanism for patients to hold health plans accountable when they make harmful decisions.

Stressing the Urgency of Strengthening and Modernizing Medicare. President Clinton urged Congress to work with him in the coming weeks on his plan to strengthen and modernize Medicare for the 21st Century. The President's plan would:

- * make Medicare more competitive and efficient;
- * modernize and reform Medicare's benefits, including prescription drug and preventive care benefits; and
- * extend the life of the Medicare trust fund until 2027.

THE WHITE HOUSE

WASHINGTON

November 1, 1998

PATIENTS BILL OF RIGHTS CEREMONY

DATE: November 2, 1998
LOCATION: ~~Rose Garden~~ *East Room*
BRIEFING TIME: 12:45 pm - 12:55 pm
EVENT: 1:00 pm - 2:00 pm
FROM: Bruce Reed/Chris Jennings

I. PURPOSE

To urge voters to elect a Congress that supports increasing patient protections, and to release a report detailing actions the federal government has taken to implement a Patients Bill of Rights while the Republican Leadership stalled on this issue.

II. BACKGROUND

This is an opportunity for you to urge voters to elect a Congress that shares your commitment to passing a strong enforceable Patients' Bill of Rights next year. You should emphasize that while the Republican Leadership stalled on the patients' bill of rights, the Administration has been doing everything possible to implement these protections in Federal health plans. To that end, you will be releasing a new report from the Vice President documenting action that the Federal government is taking within its authority to implement the Patients' Bill of Rights in the health plans it administers or oversees. In your remarks, you should make the following points:

Criticize the Republican Leadership for allowing Congress to adjourn without passing a strong Patients' Bill of Rights. For a full year, you have been calling on the Congress to pass a strong enforceable patients' bill of rights. For months, the Republican Leadership used every possible stall tactic to thwart the patients' bill of rights. When the Republican Leadership finally did introduce a bill, their proposal contained more loopholes than patient protections. It did not contain critical protections, such as access to specialists, and offered false promises, such as an appeals process that left the decisions in the hands of HMO accountants. In fact, Senator Lott would not even allow an up or down vote to be held on this issue.

Urge Voters to Choose A Congress Committed to Passing A Strong Enforceable Patients' Bill of Rights. You should reiterate your strong commitment to passing a Patients' Bill of Rights in the next Congress and urge Americans to go to the polls

tomorrow to elect a Congress that shares this commitment. This legislation should include enforceable patient protections, such as access to specialists, coverage of emergency room services when and where the need arises, continuity of care protections, an internal and independent external appeals process to appeal decisions made by HMO accountants, and protections to assure that HMOs are held accountable when patients are harmed or injured due to a health plans' decisions.

Announce the Release of a New Report From the Vice President That Highlights the Administration Is Doing Everything Possible to Implement Patient Protections. In February, you directed Medicare, Medicaid, the Federal Employee Health Benefits Program, the Department of Defense Military Health Program, and the Veteran's Health Program -- which serve over 85 million Americans -- to, where possible, come into compliance with the Patients' Bill of Rights outlined by the President's Quality Commission. Today, the Vice President released a report highlighting that these agencies have taken all the action within their statutory authority to implement patient protections. As a result, the Federal health plans are now, or soon will be, in virtual compliance with the Patients' Bill of Rights. The report documents that:

- **The 285 participating health plans, covering nine million Federal employees and their dependents, have been directed to implement new patient protections this year.** OPM which oversees the Federal Health Employees Benefits Program (FEHBP) serving nine million Federal employees and dependents, has directed their 285 participating health plans to come into compliance with the Patients' Bill of Rights. Through their annual call letter, OPM has specifically requested that plans implement new protections including access to specialists, continuity of care, disclosure of financial incentives, and access to emergency room services. Finally, OPM has issue new regulations to prevent "gag clauses." OPM is also sending information to beneficiaries to assure they are fully aware of their new patient protections.
- **The 39 million Medicare beneficiaries are benefitting from critical patient protections.** Building on Medicare's commitment to providing essential patient protections, HHS published an Interim Final rule in June that includes a series of new patient protections for Medicare beneficiaries. When this rule is fully implemented, Medicare will be virtually in compliance with the Patients' Bill of Rights, including new protections such as access to emergency services when and where the need arises, patient participation in treatment decisions, and access to specialists.
- **The 38 million Medicaid beneficiaries are being assured essential protections in the Patients' Bill of Rights.** In September, HCFA published a Notice of Proposed Rulemaking (NPRM) adding new

patients protections for Medicaid beneficiaries, such as access to specialists and an expedited independent appeals process to bring the program in compliance with the Patients' Bill of Rights, where possible.

- **Over eight million Americans will receive the protections in the patients' bill of rights by the end of this year as a result of the new policy directive assured by the Defense Department's Military Health System (MHS).** In response to your directive, DoD issued "The Patients' Bill of Rights and Responsibilities in the Military Health System," a major policy directive to all participants in the MHS. This directive outlined new protections for the over 8 million beneficiaries served by MHS, including access to appropriate specialists for women's health needs and chronic illnesses and rights for the full discussion of treatment options and of financial incentives. With this directive, which will be fully implemented by the end of this year, DoD will now be in compliance with the Patients' Bill of Rights.

- **Over three million veterans are or will soon be assured virtually all patient protections.** In July, the Department of Veteran Affairs (DVA) issued an Information Memorandum to participating health providers announcing its intention to have an external appeals process in place by the end of the year. Similarly, DVA established a task force to make recommendations as to how best implement information disclosure requirements consistent with Commission's recommendations and has developed a new brochure to provide beneficiaries the necessary information. With the implementation of these new protections DVA is virtually in compliance with the Patients' Bill of Rights.

- **The 125 million Americans covered by ERISA still are not assured critical patient protections because the Department of Labor does not have the authority to implement them without legislation.** DoL oversees the Employee Retirement Income Security Act (ERISA), governing approximately 2.5 million private sector health plans, that cover about 125 million Americans, issued new regulation to implement an expedited internal appeals process and information disclosure requirements. However, DoL's report underscores unless Congress passes Federal legislation, they do not have the authority to implement most patient protections.

III. PARTICIPANTS

Briefing Participants:

Bruce Reed

Chris Jennings

Karen Tramantano

Program Participants:

YOU

Beverly Malone, President of the American Nurses Association

Dr. Robert Weinmann, advocate of HMO reform

Frances Jennings, victim of HMO abuse. Her husband was delayed two months for a referral to a specialist, and died of lung cancer before being able to see the specialist finally approved by the HMO.

To be greeted before event:

Secretary Alexis Herman, Department of Labor

Director Janice LaChance, Office of Personnel Management

Deputy Secretary Gober, Veterans Administration

Gerald McEntee, President of AFSCME

Bill Lucy, Secretary Treasurer of AFSCME

Linda Chavez-Thompson, Executive Vice-President of the AFL-CIO

IV. PRESS PLAN

Open Press.

V. SEQUENCE OF EVENTS

- YOU will be announced onto the stage accompanied by program participants.
- Beverly Malone will make remarks and introduce Dr. Robert Weinmann.
- Dr. Robert Weinmann will make remarks and introduce Frances Jennings.
- Frances Jennings will make remarks and introduce YOU.
- YOU will make remarks, work a ropeline, and then depart.

VI. REMARKS

Provided by Speechwriting.

PRESIDENT CLINTON RELEASES REPORT DOCUMENTING ACTIONS FEDERAL GOVERNMENT IS TAKING TO IMPLEMENT A PATIENTS' BILL OF RIGHTS AND URGES VOTERS TO SEND BACK A CONGRESS THAT SHARES HIS COMMITMENT TO PASS LEGISLATION TO ASSURE PROTECTIONS FOR ALL HEALTH PLANS

November 2, 1998

Today, President Clinton urged voters to send back a Congress that shares his commitment to passing a strong enforceable patients' bill of rights next year. The President also emphasized that while the Republican Leadership has stalled on the patients' bill of rights, the Administration has been doing everything possible to implement these protections in Federal health plans. To that end, he unveiled a report from the Vice President documenting action that the Federal government is taking within its authority to implement the patients' bill of rights in the health plans it administers or oversees. Today, the President:

Criticized Republican Leadership for allowing Congress to adjourn without passing a strong patients' bill of rights. For a full year, the President has been calling on the Congress to pass a strong enforceable patients' bill of rights. For months, the Republican Leadership used every possible stall tactic to thwart the patients' bill of rights. When the Republican Leadership finally did introduce a bill, their proposal contained more loopholes than patient protections. It did not contain critical protections such as access to specialists and offered false promises such as an appeals process that left the decisions in the hands of HMO accountants. In fact, Senator Lott would not even allow an up or down vote to be held on this issue.

Urged voters to choose a Congress committed to passing a meaningful patients' bill of rights. President Clinton committed to doing everything possible to pass a strong patients' bill of rights in the next Congress and urged Americans to go to the polls tomorrow to elect a Congress that shares this commitment. This legislation should include enforceable patient protections, such as access to specialists, coverage of emergency room services when and where the need arises, continuity of care protections, an internal and independent external appeals process to appeal decisions made by HMO accountants, and protections to assure that HMOs are held accountable when patients are harmed or injured due to a health plans' decisions.

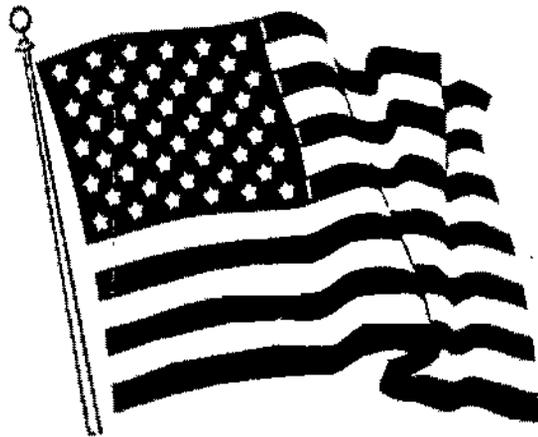
Released report from the Vice President that highlighted that while the Republican Leadership delayed, the Administration is acting to implement patient protections in Federal health plans. In February, the President directed Medicare, Medicaid, the Federal Employee Health Benefits Program, the Department of Defense Military Health Program, and the Veteran's Health Program -- which serve over 85 million Americans -- to, where possible, come into compliance with the patients' bill of rights outlined by the President's Quality Commission. Today, the Vice President released a report highlighting that these agencies have taken all the action within their statutory authority to implement patient protections. As a result, the Federal health plans are now, or soon will be, in virtual compliance with the patients' bill of rights. The report documents that:

- **The 285 participating health plans, covering nine million Federal employees and their dependents, have been directed to implement new patient protections this year.** The Office of Personell Management (OPM), which oversees the Federal Health Employees Benefits Program (FEHBP) serving nine million Federal employees and dependents, has directed their 285 participating health plans to come into compliance with the patients' bill of rights. Through their annual call letter, OPM has specifically requested that plans implement new protections including access to specialists, continuity of care, disclosure of financial incentives, and access to emergency room services. Finally, OPM has issue new regulations to prevent "gag clauses." OPM is also sending information to beneficiaries to assure they are fully aware of their new patient protections.

- **The 39 million Medicare beneficiaries are benefitting from critical patient protections.** Building on Medicare's commitment to provide essential patient protections, HHS published an Interim Final rule, in June, that includes a series of new patient protections for Medicare beneficiaries. When this rule is fully implemented, Medicare will be virtually in compliance with the patients' bill of rights including new protections such as access to emergency services when and where the need arises, patient participation in treatment decisions, and access to specialists.
- **The 38 million Medicaid beneficiaries are being assured essential protections in the patients' bill of rights.** In September, the Health Care Financing Administration published a Notice of Proposed Rulemaking (NPRM) adding new patients protections for Medicaid beneficiaries, such as access to specialists and an expedited independent appeals process to bring the program in compliance with the patients' bill of rights, where possible.
- **Over eight million Americans will receive the protections in the patients' bill of rights by the end of this year as a result of the new policy directive assured by the Defense Department's Military Health System (MHS).** In response to the President's directive, DoD issued "The Patients' Bill of Rights and Responsibilities in the Military Health System," a major policy directive to all participants in the MHS. This directive outlined new protections for the over 8 million beneficiaries served by MHS, including access to appropriate specialists for women's health needs and chronic illnesses and rights for the full discussion of treatment options and of financial incentives. With this directive, which will be fully implemented by the end of this year, DoD will now be in compliance with the patients' bill of rights.
- **Over three million veterans are or will soon be assured virtually all patient protections.** In July, the Department of Veteran Affairs (DVA) issued an Information Memorandum to participating health providers announcing its intention to have an external appeals process in place by the end of the year. Similarly, DVA established a task force to make recommendations as to how best implement information disclosure requirements consistent with Commission's recommendations and has developed a new brochure to provide beneficiaries the necessary information. With the implementation of these new protections DVA is in virtual compliance with the patients' bill of rights.
- **The 125 million Americans covered by ERISA still are not assured critical patient protections because the Department of Labor does not have the authority to implement them without legislation.** DoL oversees the Employee Retirement Income Security Act (ERISA), governing approximately 2.5 million private sector health plans, that cover about 125 million Americans, issued a new regulation to implement an expedited internal appeals process and information disclosure requirements. However, DoL's report underscores that unless Congress passes Federal legislation, they do not have the authority to implement most patient protections.

REPORT FROM THE VICE PRESIDENT TO THE PRESIDENT

*Status of the Federal Government's
Implementation of the Patients' Bill of Rights*





THE VICE PRESIDENT
WASHINGTON

November 2, 1998

Dear Mr. President:

On February 19th, I transmitted a report to you that described the extent to which the five Federal agencies with primary jurisdiction over health care were in compliance with the Patients' Bill of Rights as outlined by your Advisory Commission on Consumer Protection and Quality. The report documented that the Departments of Health and Human Services, Labor, Defense, Veterans Affairs and the Office of Personnel Management had already implemented a number of the patient protections for the health plans that they administer or oversee. However, in every case, these Agencies identified areas where they could take administrative action to implement new patient protections outlined by the Commission.

In response to this report, you issued an Executive Memorandum directing these Departments to take actions to come into compliance with the Patients' Bill of Rights to the extent possible under their statutory authority and mission. I am pleased to report that these Agencies responded aggressively and appropriately by issuing directives, regulations, and letters to health plans, providers, and consumers participating in their programs to implement these new protections. As this final report indicates, these Departments have taken all the action, within their statutory authority, to implement these patient protections. As a result, the Federal health plans, which cover over 85 million Americans, are now in or soon will be in virtual compliance with the Bill of Rights outlined by the Commission.

This report summarizes what steps these five Departments have taken to apply the Patients' Bill of Rights to their health plans, consistent with your Executive Memorandum. It also highlights which, if any, patient protections cannot be implemented without additional statutory authority.

Mr. President, you have also consistently stated that any patient protections must be enforceable. You have pointed out that a right without a remedy is no right. With this in mind, this report also summarizes what enforcement authority these agencies currently have to make these rights real. It documents that there is great disparity in the remedies available to beneficiaries in plans the Federal government administers or oversees. While Medicare beneficiaries do have access to court-enforced remedies, Federal Employees do not have adequate remedies.

Just as important, this report underscores that implementing these patient protections does not impose excessive costs or burdens on health plans. Consistent with the findings of numerous independent studies, each of the Agencies report that the protections have only a minimal impact on costs and are all worth the increase in confidence beneficiaries will now have about their coverage.

For example, Department of Labor estimates that when fully implemented, their new expedited appeals process will cost consumers less than five cents per month. Similarly, the Department of Health and Human Services expects that implementation of the Bill of Rights provisions will pose only minimal costs on Medicare plans, and State plans under Medicaid. These findings well illustrate that we can extend these protections to the private sector without imposing excessive cost burdens.

While we have been able to bring Federal health plans serving over 85 million Americans into compliance with these rights, the report by the Department of Labor, which oversees all private employment-based plans affecting over 120 million Americans, documents that the Administration does not have the statutory authority to ensure critical protections for these working Americans. As such, the Labor Department cannot assure that private plans provide protections such as access to specialists, emergency care protections, or independent external appeals.

The following summary includes highlights of the actions each of the five Agencies are taking in response to your directive to come into compliance with the Commission's Bill of Rights.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)

The Department of Health and Human Services oversees Medicare and Medicaid programs that, taken together, serve well over 75 million Americans.

MEDICARE

Following your Executive Memorandum, the Department has moved expeditiously to bring the Medicare program into compliance with the Patients' Bill of Rights recommended by the Commission. Specifically, on June 26, 1998, HHS published an Interim Final rule that includes a series of new patient protections for Medicare beneficiaries.

This proposed regulation builds on previous actions that the Department had already taken in the last two years to implement patients' rights for Medicare beneficiaries. The Health Care Financing Administration, which administers Medicare, had issued a number of policy statements to institute policies that are consistent with the Bill of Rights. These include directives to explicitly prohibit so called "gag clauses," practices through which health plans attempt to restrict physician-patient communication about medically necessary treatment options, as well as forbidding financial arrangements that have incentives for providers to limit necessary services.

The Interim Final Rule issued by the Department in June will provide new patient protections. For example, it will assure coverage of emergency services when and where the need arises, patient participation in treatment decisions, and access to specialists. Some of these patient protections, such as the emergency room protections, were passed by Congress in a bipartisan manner in the Balanced Budget Act of 1997, and others the Department had the administrative authority to implement.

The Department's report also highlights that it still lacks the authority to implement protections to assure confidentiality of health information, as recommended by your Quality Commission. The Secretary has sent the Congress recommendations outlining the type of legislation that is necessary to assure adequate privacy.

MEDICAID

Similar to Medicare, the Department took action to implement the patient protections outlined for Medicaid. On September 29, 1998 the Health Care Financing Administration published a Notice of Proposed Rulemaking (NPRM) strengthening protections for Medicaid beneficiaries enrolled in managed care arrangements. These regulations will also bring Medicaid in substantial compliance with the Patients' Bill of Rights. Specifically, Medicaid beneficiaries will be assured critical patient protections, such as access to emergency services when and where the need arises, patient participation in treatment decisions, and access to the specialists they need. Moreover, Medicaid beneficiaries will have access to a fair, internal and independent external appeals process that is expedited when necessary.

OFFICE OF PERSONNEL MANAGEMENT (OPM)

The Federal Employees Health Benefits Program (FEHBP) provides health care coverage to Federal employees, retirees, and their dependents. By far the largest employer-sponsored health benefits program in the country, the program's 285 health plan carriers provide health care coverage to almost 9 million Americans. While these plans have some flexibility to offer a range of benefits and procedures, OPM has the authority to require certain standards as a condition of participation.

In February, I reported that the FEHBP was in compliance with many of the protections in the Patients' Bill of Rights. For example, OPM already required participating health plans to provide extensive information that is generally consistent with the right to information disclosure in the Commission's recommendations and has also developed an internal and external appeals process for consumers who have grievances with health care providers or health plans.

However, your Executive Memorandum directed OPM to implement a number of new patient protections, including assuring access to specialists, continuity of care, disclosure of financial incentives, non-discrimination, and access to emergency room services. Moreover, you directed OPM to issue regulations to prevent "gag clauses."

In response, in March, OPM issued their annual call letter which sets forth the FEHB Program policy objectives for the next year. This year's letter specifically addressed new expectations for participating carriers in areas to provide these new patient protections. OPM is working with each of its 285 health plans to ensure that they fully satisfy these requirements within the next two contract years. Most of these patient protections will be fully in place starting next year.

OPM also released a new regulation prohibiting plans participating in the Federal Employees Health Benefits Program (FEHBP) from using gag clauses. This regulation will ensure that health professionals can discuss all medical treatment options with their patients.

To assure that consumers are fully aware of all of their patient protections, in September, OPM posted these new patient protections, including access to specialists, continuity of care, and access to emergency room services, on the Internet. They also have required all 285 health plans include information about these protections in their 1999 brochures.

DEPARTMENT OF VETERAN AFFAIRS

The Department of Veteran Affairs (DVA) administers the largest integrated health care system in the nation. It is comprised of approximately 1,100 sites of care, including 173 hospitals, and 600 outpatient and community-based care centers, and 133 nursing homes, providing care for over 3 million veterans. In February, the Department reported that they were already in substantial compliance with many the protections in the Patients' Bill of Rights. For example, they already assured protections such as, ensuring patients full participation in treatment decisions, providing access to women's health services, and preventing "gag" clauses.

However, the DVA identified a few rights where some their health providers were not fully in compliance and determined the administrative actions that would be necessary to bring the Department into compliance with the Bill of Rights. You directed the DVA to implement these new protections including, assuring an external appeals process is in place throughout the system and that all their consumers have sufficient information — consistent with the information disclosure recommendations by the Quality Commission.

In July, the DVA issued an Information Memorandum to participating health providers announcing its intention to have an external appeals process in place by the end of the year. DVA will contract with a non-Federal external organization to provide independent external reviews. Similarly, the DVA established a task force to make recommendations as to how best to implement information disclosure recommendations consistent with Commission's recommendations and has developed a brochure to inform these recommendations.

DEPARTMENT OF DEFENSE

The Department of Defense (DoD) provides health care to 8.4 million beneficiaries worldwide, including active duty service members, retirees, and their dependents. Prior to your Executive Memorandum, the Military Health System (MHS) already had a number of patient protections in place. For example, the DoD health programs already assured access to emergency room services and prohibited discrimination.

You directed DoD to implement a number of other critical patient protections, such as a strong grievance and appeal process, access to appropriate specialists for women's health needs and chronic illnesses; and rights for the full discussion of treatment options and of financial incentives in the Military Health System.

In response to your request, on July 30, the Secretary of Defense issued "The Patients' Bill of Rights and Responsibilities in the Military Health System", a major policy directive to all participants in the MHS that outlined the rights of beneficiaries. The directive reaffirmed the rights that were already protected in the MHS and addressed all of the new improved protections. In addition DoD has taken steps to improve continuity of care protections, information disclosure, and has created new opportunities for beneficiaries to have input on policy through Healthcare Consumer Consortia which have been established at each of our Military Treatment Facilities.

The Military Services have been directed to develop implementing instructions to make these new provisions operational throughout the military health system. The Tricare Management Activity (which is responsible for the operation of the managed care program) has also been directed to develop a plan. Full implementation throughout the MHS is expected by mid-1999.

DEPARTMENT OF LABOR

The Department of Labor (DoL) is responsible for the administration and enforcement of the Employee Retirement Income Security Act (ERISA), which governs approximately 2.5 million private sector health plans, that cover over 120 million Americans. ERISA is intended to protect the health and pension benefits that employers voluntarily provide for their workers. However, ERISA focuses primarily on the pension abuses and does not provide statutory authority for extensive standards for health care plans. As a consequence, DoL has little ability to ensure that ERISA-covered health plans have sufficient consumer protections.

The Department does have the authority to propose amendments to strengthen the internal claims processes and ensure that participants are afforded a fair and efficient benefits appeal process. In response to your Executive Memorandum, the Department released a new proposed regulation on September 9 that will ensure that patients receive a timely, fair internal review when they have a grievance against their health plan. Also under this proposed regulation, for the first time, consumers in private health plans would be extended protections to ensure that they can receive an expedited review for urgent claims. This regulation requires that plans respond to urgent appeals within 72 hours.

The Department also proposed amendments for disclosure regulations which govern the summary plan descriptions that provide consumers with information about their health plans. These regulations require plans to include information in their summary descriptions that is consistent with the Commission's recommendations, such as information on coverage of out-of-network services, conditions for access to speciality care, and preauthorization and utilization review procedures.

ERISA does not provide DoL with the authority to regulate most of the protections in the Patients' Bill of Rights. They cannot ensure that private plans assure access to specialists, access to emergency room services, participation in treatment decisions, confidentiality of information, or an external appeals process. The Department's lack of authority underscores that Federal legislation is necessary to ensure that all health plans assure participants the consumer protections they need.

CONCLUSION

The summary outlined above clearly illustrates how effective you have been in assuring that the Federal Government takes the lead in providing consumer protections for the programs it administers and/or the plans it oversees. Your leadership has provided critical patient protections for millions of Americans. Clearly, the over 85 million Americans who participate in Federal health programs are just as concerned as any American about the challenges the rapidly changing health care delivery system presents to assuring high quality care.

They want to be assured that emergency room services will be paid for when and where the need arises; they want to be confident that they will be able to see the specialists they need for heart conditions, cancer treatments, and other health needs; and they want to know they have a place to turn to appeal a decision by a health plan that they do not believe is in their best interest. In response to your directive, the Federal government has done or is doing everything possible to assure this is the case.

As the Department of Labor's report makes clear, however, without strong enforceable Federal legislation we simply cannot assure that health plans provide patients the protections they need and deserve. This report also highlights that there are a few areas where Federal legislation is necessary to assure that Federal health plans can take steps to come into compliance.

Finally, the report I am submitting today well illustrates that Federal programs can comply with the Patients' Bill of Rights in a way that does not impose excessive burdens or costs. This reality sends an essential message to the Congress that similarly important protections for the private sector can and should be passed without imposing undue burdens on the health care system.

Sincerely,

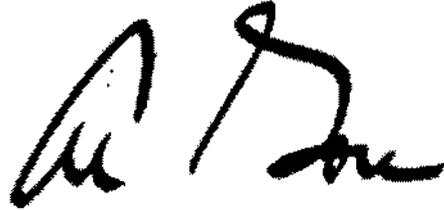
A handwritten signature in black ink, appearing to be "A. J. [unclear]". The signature is written in a cursive style with a large initial "A" and a long, sweeping tail.

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REPORT TO THE VICE PRESIDENT OF THE UNITED STATES

*Progress Report in Implementing the Patient's Bill of Rights at the
Department of Health & Human Services*

November 2, 1998



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MEMORANDUM FOR THE VICE PRESIDENT

SUBJECT: Status of Implementation of the Consumer Bill of Rights and Responsibilities in the Department of Health and Human Services

In February 1998, President Clinton directed the Department of Health and Human Services (HHS), along with the Departments of Labor, Defense and Veterans' Affairs and the Office of Personnel Management, to use their regulatory and administrative authority to bring their health programs into compliance with the Consumer Bill of Rights and Responsibilities. Our agencies were also asked to identify those aspects of the Bill of Rights for which our existing authority was insufficient for full compliance.

HHS was explicitly assigned to bring Medicare and Medicaid into compliance with the Bill of Rights within the limits of existing legislative authority. Enclosed is a report of our progress to date in accomplishing the President's directive.

Please let me know if you would like any additional information.



Donna E. Shalala

Enclosure

Status of Implementation of the Consumer Bill of Rights and Responsibilities in the Department of Health and Human Services

I. Introduction

In February 1998, the President directed the Department of Health and Human Services, along with the Departments of Labor, Defense and Veterans' Affairs and the Office of Personnel Management, to use their regulatory and administrative authority to bring their health programs into compliance with the Consumer Bill of Rights and Responsibilities, as proposed by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. Our agencies were also asked to identify those aspects of the Bill of Rights for which our existing authority was insufficient for full compliance.

The Department of Health and Human Services (HHS) was explicitly assigned to bring Medicare and Medicaid into compliance with the Bill of Rights within the limits of existing legislative authority. Medicare, a federally-funded insurance program for the elderly and disabled, covers approximately 38 million individuals, of whom approximately 6.5 million, or 17 percent, are currently enrolled in managed care. Medicaid, a State and federal insurance program for low income children, pregnant women and others, covers approximately 40 million people, of whom almost half are in a managed care arrangement for some or all of their health care at some point during a year.

The Department has moved aggressively to strengthen existing consumer protections under Medicare and Medicaid. On June 26, 1998, the Health Care Financing Administration (HCFA) published an Interim Final rule establishing new requirements for managed care arrangements participating in Medicare. On September 29, 1998, HCFA published a Notice of Proposed Rulemaking (NPRM) strengthening protections for Medicaid beneficiaries enrolled in managed care arrangements. Consistent with the President's directive, these rules, when finalized, will enable HHS to implement these new protections by no later than December 31, 1999 for Medicare. States will be required to implement all new protections within one year from the effective date of the final regulation for Medicaid, which is expected to be issued by mid-1999.

When these regulations are fully implemented, Medicare and Medicaid will be in substantial compliance with the Bill of Rights' provisions. Specifically, the Department has been able to come into compliance for managed care enrollees with critical patient protections such as information disclosure, access to emergency services, patient participation in treatment decisions, and complaints and appeals. These regulations also expand each patients' ability to choose their health care providers and to have ready access to specialists. However, both Medicare and Medicaid currently lack the authority to require plans to pay for transitional care from a particular provider for seriously ill (or pregnant) individuals in a course of treatment when their specialist is dropped from a plan or when their plan leaves the program for reasons other than cause. Current legislative authority also does not permit full implementation of the right to medical record confidentiality. The Department has, however, separately submitted a report to the Congress laying out the parameters for federal legislation to protect the confidentiality of health records. In addition, while Medicare and Medicaid managed care enrollees are currently protected to the full

extent of the Consumer Bill of Rights with regard to respect and non-discrimination, the rules that prohibit discrimination under fee-for-service address some, but not all, categories of protection and providers included in the right.

The proposed regulations give the Department a variety of monitoring and enforcement tools including suspension of payments, civil money penalties, and termination from the Medicare and Medicaid programs. The Department will take all necessary actions to enforce the protections included in the Medicare and Medicaid regulations.

II. Specific Rights

A. Information Disclosure

"Consumers have the right to receive accurate, easily understood information and some require assistance in making informed health care decisions about their health plans, professionals, and facilities."

Under the Interim Final Rule and the NPRM, Medicare and Medicaid are in substantial compliance with this right. Under the proposed regulations, Medicare and Medicaid will require plans to provide critical information to consumers, both annually and upon request, that will enable them to make more informed choices about their health plans. The Department is moving aggressively to collect and disseminate comparative information about the quality of care provided to consumers and about the level of satisfaction among consumers with the care that they receive. Medicare plans will be required and Medicaid plans and States will be encouraged to use the Consumer Assessment of Health Plans Survey (CAHPS) to survey enrollee satisfaction and experiences with care. The CAHPS instrument was developed under the aegis of the Agency for Health Care Policy and Research and is now in use in a number of public and private settings.

B. Choice of Providers and Plans

"Consumers have the right to a choice of health care providers that is sufficient to ensure access to appropriate high-quality health care."

The Interim Final rule for Medicare and the proposed Medicaid managed care regulations assure the protections outlined in the Bill of Rights with regard to provider network adequacy, access to qualified specialists for women's health services and access to specialists for consumers with complex or serious medical conditions. Medicare and Medicaid beneficiaries who obtain their care on a fee-for-service basis can choose any provider who agrees to participate in these programs.

- **Provider Network Adequacy:** The standards for Medicare and Medicaid plans in the interim final and proposed managed care regulations will require health plans to provide access to sufficient numbers and types of providers to assure that all covered services will

be accessible without unreasonable delay—including access to emergency services 24 hours a day and seven days a week. If a plan has an insufficient number or type of provider to provide a covered benefit, the plan will insure that the beneficiary obtain the benefit outside the network, at no greater cost than if the benefit were obtained from participating providers.

- **Access to Qualified Specialists for Women’s Health Services:** The standards for Medicare and Medicaid plans in the interim final and proposed managed care regulations will allow women to see a qualified women’s health specialist for the provision of routine and preventive health care services, consistent with the protections outlined in the patients’ Bill of Rights.
- **Access to Specialists:** The standards for Medicare and Medicaid plans in the interim final and proposed managed care regulations will permit beneficiaries with complex or serious medical conditions who require frequent specialty care to have direct access to qualified specialists within the plan for an adequate number of visits under an approved treatment plan.
- **Transitional Care:** The Medicare and Medicaid programs currently do not have the legislative authority to require that plans continue to pay for a patient’s care from a particular specialist when that specialist is dropped by the plan or the plan is no longer participating in the programs. The new regulations make clear however, that for individuals in the midst of a course of treatment, the dropping of the specialist does not affect the right of the enrollee to obtain needed speciality services from another provider in the plan’s network or, if necessary, out of the plan’s network. Medicare enrollees also currently retain the right to disenroll from their managed care plan and return to fee-for-service at any time.

C. Access to Emergency Services

“Consumers have the right to access emergency health services when and where the need arises. Health plans should provide payment when a consumer presents to an emergency department with acute symptoms of sufficient severity—including severe pain—that a “prudent layperson” could reasonably expect the absence of medical attention to result in placing that consumer’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.”

The Interim Final rule for Medicare and the proposed regulations for Medicaid incorporate this protection in its entirety. In addition, the regulations articulate a standard for post-stabilization services that is applicable to both Medicare and Medicaid managed care enrollees. If such patients need additional services after their emergency condition has been stabilized, their health plans would have one hour after being contacted to either affirm the need for the services or to make other care arrangements, otherwise the emergency facility could proceed to provide the

needed care. Under this policy, plans would be liable both for the post-stabilization services they authorize and for services that are provided in the absence of a timely response from the plan.

D. Participation in Treatment Decisions

“Consumers have the right and responsibility to fully participate in all decisions related to their health care. Consumers who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members, or other conservators.”

The Interim Final rule for Medicare and the NPRM for Medicaid reflect existing and new policies that are consistent with this right:

- **Information about treatment options.** Health plans will be required to provide patients with easily understood information and the opportunity to decide among all treatment options--including no treatment--consistent with the informed consent process. Discussions of treatment options must be provided in a culturally-competent manner, with sensitivity to the special communication needs of people with disabilities.
- **Advance Directives.** Managed care organizations and providers are required to discuss the use of advance directives with patients and their families and to abide by the wishes as expressed in an advanced directive, except where State law permits a provider to conscientiously object. The provision of care may not be conditioned on the presence or absence of an advance directive.
- **Financial Disclosure.** Since 1996, physicians have been required to disclose to Medicare and Medicaid any financial arrangements that expose them to substantial financial risk, since these may potentially affect care decisions. Under the Interim Final Medicare rule, upon request from a beneficiary, plans are required to disclose a summary description of the method of compensation used to pay its physicians.
- **No “Gag Rules.”** “Gag rules” have been prohibited in Medicare and Medicaid since 1996. That is, plans are prohibited from penalizing or otherwise restricting the ability of health care providers to communicate with and advise Medicare and Medicaid patients about medically-necessary treatment options.

E. Respect and Nondiscrimination

“Consumers have the right to considerate, respectful care for all members of the health care system at all times and under all circumstances.”

“Consumer must not be discriminated against in the delivery of health care services consistent with the benefits covered in their policy or as required by law based on race, ethnicity,

national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment."

"Consumers who are eligible for coverage . . . must not be discriminated against in marketing and enrollment practices based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment."

Under the Interim Final rule for Medicare and the proposed regulations for Medicaid, managed care enrollees are protected to the full extent of this right as articulated in the Bill of Rights, with regard to services, marketing and enrollment. This important protection insures that once an enrollee or potential enrollee in a managed care plan is identified as an eligible Medicare or Medicaid beneficiary, plans may not discriminate in any way against the individual.

Under fee-for-service, however, Medicare and Medicaid protections against discrimination are largely a function of federal anti-discrimination rules that apply to recipients of federal funds. These rules address some, but not all, categories of protection and providers included in the Bill of Rights. As a result, the fee-for-service aspects of Medicare and Medicaid are in only partial compliance with this right.

F. Confidentiality of Health Information

"Consumers have the right to communicate with health care providers in confidence and to have the confidentiality of their individually-identifiable health care information protected. Consumers also have the right to review and copy their own medical records and request amendments to their records."

The Interim Final regulations for Medicare and the proposed regulations for Medicaid require Medicare+Choice and Medicaid health plans to safeguard the privacy of any information that identifies a particular enrollee by ensuring that information from the plan (or copies of records) be released only to authorized individuals, that unauthorized individuals cannot gain access to or alter patient records, and that original medical records must be released only in accordance with federal or State law, court orders or subpoenas. Plans must ensure timely access to individuals who wish to examine their records. In Medicaid, plans are additionally required to establish procedures to address the confidentiality and privacy of minors, subject to applicable federal and State law.

While current federal laws (including the Privacy Act) and related regulations protect certain written records from disclosure outside of Medicare and Medicaid, it should be noted that such protections do not extend to all written records, nor to verbal communications between enrollees and providers. Protection of communication between patients and providers is a matter of State law, many of which do not afford the protections included in this right. Moreover, not all providers under Medicare and Medicaid are subject to federal laws on privacy; for example, protection of information obtained by physicians and individual providers is a matter of State, not

federal law. The Department does not have the legislative authority to reach all information covered by the Commission's recommendation. Significantly, the Secretary's Privacy Recommendations to Congress (September 1997), if enacted, would bring all beneficiary information obtained by Medicare and Medicaid providers and plans, as well as the programs and their contractors, into compliance with this right as articulated in the Bill of Rights.

G. Complaints and Appeals

"Consumers have the right to a fair and efficient process for resolving differences with their health plans, health care providers, and the institutions that serve them, including a rigorous system of internal review and an independent system of external review."

The Interim Final rule for Medicare and the proposed regulations for Medicaid managed care require establishment of meaningful processes for resolution of complaints and appeals. Similar processes already exist for resolution of disputes arising in fee-for-service settings.

- **Internal Appeals:** Both the Interim Final rule for Medicare and the NPRM for Medicaid define rigorous standards for the establishment of internal (plan-level) appeal processes, with explicit timeframes for both prior authorizations and resolution of appeals at the plan level. In general, standard prior authorizations and initial determinations must be resolved by the plan within 14 days, while reconsiderations or appeals must be completed within 30 days. Both the Medicare and Medicaid regulations establish a process for expedited review of prior authorizations and resolution of appeals by plans; that is, cases that appear to pose serious jeopardy to the patient must be resolved as quickly as the patient's condition requires, but no longer than 72 hours. Extensions for both the standard and expedited timeframes are possible but only under limited circumstances. Under the proposed Medicaid rules States may set even more stringent time frames.
- **External Appeals:** The patients' Bill of Rights proposes that an appeal process include an independent system of external review, in order to ensure its fairness and accuracy. Medicare has long had this protection and will extend the plan-level timeframes and standards to its independent external review entity. Furthermore, in Medicare, when a plan-level decision on an appeal is in any way unfavorable to an enrollee, the plan must automatically refer the appeal to the independent external review entity for review. Automatic referral is a significant addition to the protection as described in the Consumer Bill of Rights. Individuals who are dissatisfied with the determination of the independent external review entity have the right to pursue their claim for Medicare benefits further through review by a Department Appeals Board and, ultimately, federal court. While Medicare beneficiaries do not have the right to sue the federal government for malpractice in relation to Medicare benefits, they may sue others for damage or injury incurred in the course of receiving, or not receiving those benefits, subject to the causes of action recognized by the State in which they reside.

The appeals process for Medicaid, as articulated in the NPRM, differs from this right in two significant ways. The Consumer Bill of Rights calls for the establishment of a sequential process of internal (plan-level) and external review. Under the proposed rule, however, States would be permitted to design their appeals systems so that individuals would appeal either sequentially or simultaneously to the State's Fair Hearing process, which otherwise serves as the independent external review entity. Second, the State Fair Hearing process, which serves a docket of programs and issues much broader than Medicaid managed care, currently has timeframes that are not consistent with the timeframes established by the NPRM for internal review by Medicaid managed care plans; in addition, there is no provision for expedited review. The NPRM seeks comment on the applicability of the Fair Hearing process to the review of managed care appeals.

Medicaid beneficiaries may not sue the federal government for Medicaid benefits. However, State laws determine the causes of action and remedies available to Medicaid beneficiaries both for matters determined by the State Fair hearing process and those related to damage or injury.

III. Numbers of People in Health Plans Who Would be Affected

As noted above, Medicare covers an estimated 38 million individuals, of whom approximately 6.5 million, or 17 percent are currently enrolled in managed care arrangements. Medicaid covers an estimated 40 million people, of whom about half are in a managed care arrangement for some or all of their health care at some point during a year. However, the spirit of consumer protection is relevant to all Medicare and Medicaid beneficiaries, regardless of whether they obtain their care in a fee-for-service setting or under some kind of managed care arrangement. While many of the protections articulated in the Consumer Bill of Rights are most relevant to individuals in a managed care setting, such as those related to choice of providers and plans and access to emergency services, other protections, such as grievance and appeals, and participation of treatment decisions, apply to both kinds of plans.

IV. Implications of These New Protections

There will be no implementation costs to the federal government for Medicare, and we expect that plans participating in Medicare will incur only minimal costs. We expect minimal costs to States and plans for implementation of the Consumer Bill of Rights provisions in Medicaid. As noted above, however, we have not yet fully implemented the regulations, so we cannot yet report fully on their effects.

We are in the midst of developing instructions and guidance to Medicare plans, and will continue to receive comments on the Medicaid NPRM through November 30, 1998. In developing our policies, we have consulted with advocates, plans, States, providers and others. We will consider their comments and suggestions as we work to finalize the regulations and related guidance.

V. Conclusion

With the recent regulations, Medicare and Medicaid are well on the way to meeting both the letter and the spirit of the Consumer Bill of Rights and Responsibilities and the President's directive. We are acutely aware, however, that establishing policies is not the same as making them real, and we look forward to working with States, plans, advocates and others to ensure that the rights established by the regulations are enjoyed by all Medicare and Medicaid beneficiaries. We believe that the protections of the Consumer Bill of Rights, consistently applied and enforced, will benefit not just Medicare and Medicaid beneficiaries but health care providers and plans as well.

The Consumer Bill of Rights has implications beyond the Medicare and Medicaid programs. We are working in my Department to extend and strengthen the consumer protections available to the beneficiaries of other HHS programs. In addition, the Quality Interagency Coordinating (QuIC) Task Force, which I co-lead with Secretary Herman of the Department of Labor, has met several times since the President called for its creation in February 1998. The QuIC has several active workgroups, one of which will provide a venue for agencies to share best practices in the implementation of the Consumer Bill of Rights.

REPORT TO THE VICE PRESIDENT OF THE UNITED STATES

Progress Report in Implementing the Patients' Bill of Rights at the
U.S. Office of Personnel Management

November 2, 1998



UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

OCT 29 1998

The Vice President
The White House
Washington, DC 20500

Dear Mr. Vice President:

I am pleased to submit the Office of Personnel Management's (OPM) report on implementation of the Patients' Bill of Rights within the Federal Employees Health Benefits (FEHB) Program. As you know, with almost 9 million covered individuals, the FEHB Program is the largest employer-sponsored health insurance program in the nation. The Program is frequently cited as a model for others to emulate; indeed, it will soon be duplicated in a pilot program for meeting the health care needs of selected military retirees. Given the attention paid to the FEHB Program by others, we believed that a real success in implementing the Patients' Bill of Rights would have an impact well beyond the FEHB Program.

I was directed by the President in February to ensure that all health plans participating in the FEHB Program would be in full contractual compliance with the Patients' Bill of Rights by the end of 1999. I immediately took steps to tell our 350 health plans about these new requirements, and the actions necessary to guarantee they would be met. I also proposed a regulation to prohibit practices that restrict physician-patient communications about medically necessary treatment options. That regulation took effect September 9, 1998.

I am pleased to forward the accompanying report which highlights our initiatives and accomplishments. It demonstrates that a collaborative and flexible approach to implementing an important set of patient protections can produce outstanding results. The FEHB Program encompasses most of the nation's health benefits plans and the three major types of health care delivery systems: fee-for-service with preferred provider organizations, health maintenance organizations, and point-of-service plans.

We worked together and focused on ultimate outcomes not process. The result, reflected in the accompanying report, demonstrates that the Patients' Bill of Rights can be implemented in the world of commercial health care for less than 25 cents per subscriber per year. Truly, we have demonstrated that there is no reason why all Americans should not benefit from the protections that President Clinton provided to the almost 9 million people covered under the FEHB Program.

Sincerely,

A handwritten signature in cursive script that reads "Janice R. Lachance".

Janice R. Lachance
Director

Enclosure

Patients' Bill of Rights Report

I. Introduction

The Federal Employees Health Benefits (FEHB) Program is in compliance with the eight broad principles of President Clinton's Patients' Bill of Rights.

Last November the President asked the Director of the Office of Personnel Management (OPM) to assess the adequacy of the patient protections OPM provides under the Federal Employees Health Benefits (FEHB) Program. On February 19, 1998, the Director submitted, through the Vice President, OPM's compliance assessment. That assessment indicated that while most FEHB participating carriers were in substantial compliance with the eight broad principles of the Patients' Bill of Rights (PBR), not all provided full protection in all areas. On February 20, 1998, the President signed an Executive Memorandum directing OPM to ensure that all FEHB participating carriers come into compliance with regard to access to specialists, continuity of care, and access to emergency room services by no later than December 31, 1999. He also directed OPM to propose regulations within 90 days to prohibit practices that restrict physician-patient communications about medically necessary treatment options.

Comprehensive and clear consumer information, and equitable treatment across participating plans, are fundamental to the FEHB Program. Nonetheless, to meet the President's directive, enrollees needed better information about the organizational structure and operating procedures of health plans. While Federal employees enjoy choice and fundamental protections in regard to their health care providers, some additional information was needed about the characteristics of providers.

Each plan's adherence to the Patients' Bill of Rights varies only slightly at this point. By the end of 1999, all plans will have completed contractual agreements ensuring full adherence to all of the Patients' Bill of Rights provisions. There are no statutory barriers to full implementation of the President's Patients' Bill of Rights. The protections it provides apply to all 8.7 million people covered by the FEHB Program. The protections added for 1999 will cost less than 25 cents of the annual premium.

The Office of Personnel Management (OPM) has completed the following actions to bring carriers into compliance with the Patients' Bill of Rights by the end of 1999:

Policy Direction to Health Carriers

On April 3, 1998, OPM sent its annual "call letter" to prospective health care carriers desiring to participate in the FEHB Program in 1999. The call letter provided policy guidance for the 1999 contract year. We informed carriers that we expected implementation of the Patients' Bill of Rights to be a collaborative process among OPM, the carriers, other federal agencies, and private-sector

organizations. We told them that we would work together to comply fully with the Patients' Bill of Rights by the end of 1999.

Our call letter requested that carriers discuss how their plans now comply with access to specialists, access to women's health services, and emergency care requirements of the Patients' Bill of Rights. The letter asked those carriers not yet in compliance to share their strategy to attain compliance. Working with the carriers, we were able to assure that they all submitted acceptable proposals.

Recognizing that some Patients' Bill of Rights changes require a certain amount of advance notice, OPM allowed carriers until the end of 1999 to achieve compliance with the network and provider level disclosure requirements and compliance strategies that require changes to provider contracts (for example: continuity of care, access to medical records, and certain network adequacy requirements).

Standardized Brochure Language

On May 1, 1998, OPM sent standardized brochure language to the plans on topics such as information disclosure, access to specialists, direct access to Obstetrician/Gynecologists (OB/GYN), and emergency services. This ensures these protections are described clearly and understandably for all FEHB participants.

Notification to All Federal Agencies

OPM communicates regularly with Federal agency benefits administrators, our primary link with Federal employees, through Benefits Administration Letters (BAL). On June 2, 1998, we sent a BAL to the agencies notifying them of the President's directive to implement the Patients' Bill of Rights, and providing them with our implementation strategy.

FEHBP Guide and Web Page Revisions

In its Open Season enrollment guide, OPM highlighted Patients' Bill of Rights features which federal employees, retirees and their covered family members can expect from their health plans in 1999. In June, we also created a separate section on our web site devoted to information on the Patients' Bill of Rights. This site includes links to full Patients' Bill of Rights information, including summaries on objectives, rights, and responsibilities. We updated this site in September to advise the federal community about what additional information they can expect to receive through the year 2000. This is to ensure that all FEHB participants know about their rights and protections. The site address is: www.opm.gov/insure.

OPM "Gag Clause" Regulation Published on August 10

As the President directed, OPM published a final regulation which prohibited health plans from restricting patient information on all medically necessary and appropriate treatment options. The regulation was effective September 9, 1998.

Contract Compliance

At the conclusion of the negotiations cycle, OPM revised the 1999 health plan contracts and amendments to require implementation of Patients' Bill of Rights provisions. These new contracts and amendments, which are effective on January 1, 1999, also require carriers to modify, where necessary, their provider contracts to comply with the Patients' Bill of Rights by the year 2000.

Service, Clinical Quality, and Customer Satisfaction Measurement Standardization

OPM is working with other federal agencies and accrediting organizations to create standard performance measures. The implementation of performance measures will enable us to make carriers increasingly accountable for the quality of health care services they deliver. This year we will use the Consumer Assessment of Health Plans Survey (CAHPS) instrument, which has become the industry standard. Widespread use of CAHPS will give consumers uniform health plan satisfaction ratings.

II. Provision-by-Provision Summary of the Extent to Which the Federal Employees Health Benefits Program Complies With the Patients' Bill of Rights.

Information Disclosure

OPM and its carriers currently publish health benefit brochures, provider directories, and guides in multi-media formats that contain information on available plan types, premiums, benefits, limitations, maximums, exclusions, referral procedures, emergency and urgent care procedures, provider types and geographic location, quality assurance indicators, customer satisfaction survey results, and internal and external dispute resolution procedures.

To fully implement the remaining requirements of the Patients' Bill of Rights, OPM's call letter requested the following information during the upcoming Open Season for the 1999 contract period:

- How the plan administers its formulary drug inclusion/exception and experimental/investigational determination processes;
- Disenrollment rates for the year ending 1997;
- Compliance with state and federal licensing or certification requirements,

if applicable, including the date the requirements were met. We also asked carriers to note where they do not comply with a requirement and the reason for non-compliance, and to indicate all accreditations and dates those accreditations were received;

- Carrier's corporate form, and the years it has been in existence; and
- Whether the plan meets state, federal, and accreditation requirements for fiscal solvency, confidentiality, and transfer of medical records.

Our call letter asked carriers to propose a format and process for providing the following information to members upon their request, beginning in 1999:

- Plan preauthorization and utilization review procedures;
- Use of clinical protocols, practice guidelines, and utilization review standards pertinent to a patient's clinical circumstances;
- Whether the plan has special disease management programs or programs for persons with disabilities;
- Whether a specific prescription drug is included in a formulary and procedures for considering requests for patient-specific waivers; and
- Qualifications of reviewers at the initial decision and reconsideration level under the FEHB disputed claims process.

Choice of Providers and Plans

Provider Network Adequacy

OPM currently offers consumers a wide choice of health care delivery systems including Preferred Provider Organizations (PPO), Point-of-Service (POS) plans, Health Maintenance Organizations (HMO), and Fee-for-Service (FFS) plans. Within the FEHB Program, coverage and access are available to a broad range of services and providers. OPM's 300 carriers provide a choice of approximately one dozen health plans in any single geographic location. OPM reviews HMO provider networks for adequacy during the carrier application process.

Access to Qualified Specialists For Women's Health Services

Our call letter asked that carriers provide narrative descriptions of how they currently comply with this provision; and, if they did not comply, to propose benefit or process changes to bring their plan into compliance. We informed carriers that -- to the extent certified nurse midwives are eligible to practice under existing state laws and meet credentialing requirements -- we expected plans to contract with and provide access to them for covered services. We also required that plans either allow members to select an Obstetrician/Gynecologist (OB/GYN) as their primary care provider, or allow members direct access for routine gynecological examinations.

Access to Specialists

For 1999, OPM's call letter directed plans to create procedures to assure that members who require frequent or prolonged specialty care can obtain

authorization for direct access to a qualified specialist of their choice within their network of providers. We also directed plans to review their provider referral practices and revise them as appropriate to ensure that members receive approval for an adequate number of visits to specialty providers under an approved treatment plan, so as not to unduly burden members with further approvals.

Continuity of Care

Continuity of care is currently assured in the FEHB Program through temporary continuation of coverage and conversion opportunities when enrollments terminate. Hospitalized members have up to 92 days, or until discharge, to continue coverage under their current plan or option in the event of a change in plan or option. OPM's call letter asked each carrier to provide their strategy to implement the Patients' Bill of Rights continuity requirements by year end 1999.

Access To Emergency Services

All health plans under the FEHB Program currently cover members for emergency services whenever and wherever needed, 24 hours a day, seven days a week. The Emergency Benefits section of plan benefit brochures explains procedures for accessing services, the availability of urgent care centers, and lists applicable cost sharing. Many of OPM's health plans already used the "prudent layperson" standard when reviewing emergency care visits for coverage eligibility. Our call letter required all carriers to use the "prudent layperson" standard when making coverage eligibility decisions in 1999.

Participation in Treatment Decisions

OPM encourages consumers to take an active role in the decisions that affect their health and welfare. To aid in the decision-making process, OPM provides detailed multi-media information on individual plan provisions, consumer satisfaction, National Committee for Quality Assurance (NCQA) and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation, and benefit and rate comparisons. We also resolve claims disputes between carriers and consumers. OPM's carrier contracts and amendments for 1999 require carriers to modify, where necessary, provider contracts to comply with Patients' Bill of Rights provisions.

On August 10, 1998, OPM published a regulation prohibiting "gag clauses" in provider contracts serving federal members to ensure unimpeded communication between health care providers and their patients.

Respect and Non-Discrimination

The FEHB Program has a long tradition of respect for its customers and prohibits illegal discriminatory practices.

Confidentiality of Health Information

The FEHB Program currently guarantees confidentiality of health care information for federal members. OPM's carrier contracts and amendments for 1999 require carriers

to modify, where necessary, provider contracts to comply with Patients' Bill of Rights provisions regarding patient access to medical records.

Complaints and Appeals

All health plans in the FEHB Program have both internal and external appeal processes.

Internal Appeals

The internal reconsideration process, including timeframes for response to participants, is specified in both regulation and carrier contracts. Carriers must give participants a complete explanation for why a claim or service has been denied.

External Appeals

OPM's external appeal process begins after a consumer asks the carrier to reconsider a benefit denial and the carrier affirms the denial. Consumers then have up to 90 days from the date the carrier affirmed its original denial, or 30 days after the consumer requested the carrier to reconsider the denial and the carrier has not responded, to appeal the denial to OPM. OPM has an in-house staff that reviews disputed claims. It also uses outside medical consultants for cases requiring a special level of expertise. OPM makes the final decision. The agency has both statutory and contractual authority to direct a plan to pay for or provide a service.

III. Number of People in Health Plans

The FEHB Program currently covers 4.1 million enrollees and approximately 8.7 million people, including dependents. Coverage is provided to enrollees and dependents through four types of health care delivery systems, Preferred Provider Organizations (PPO), Point-of-Service (POS) plans, Health Maintenance Organizations (HMO), and Fee-for-Service (FFS) plans. The program has approximately 2.6 million members enrolled in HMOs (including HMO based POS plans) and approximately 6.1 million members enrolled in FFS/PPO plans (including indemnity-based POS plans).

All patient protections under the Patients' Bill of Rights apply to all types of plans under the FEHB Program. Before providing guidance to carriers in its annual call letter that was issued on April 3, 1998, OPM determined that network and provider level information disclosure requirements were required of all plans that maintain contracted provider networks (e.g., HMO, PPO, POS delivery systems). Since most of the plans in the FEHB Program maintain networks, the network and provider level disclosure requirements were applied to the majority of plans in the program. Plan level information disclosure requirements were applied to all plans regardless of network arrangement. OPM provided guidance to the participating carriers in the April call letter. The call letter guidance established the basis for the carrier proposals that were due to OPM on May 31, 1998, and negotiated during the summer. OPM worked with carriers to ensure that their in-network benefit structures, referral procedures and prior

authorization requirements did not unduly restrict access to specialists, women's health services, and emergency care.

VI. Implications of These New Protections

For existing contracts, the average per member per year premium increase to pay for the patient protections provided by the Patients' Bill of Rights for 1999 will be less than 25 cents.

In general, carriers were receptive to our request to implement the Patients' Bill of Rights requirements and appreciated our efforts to work with them to design implementation strategies that were reasonable and achievable. Some of the PPO carriers expressed concern with compiling certain provider-level information because of the size of their networks and their limited contractual control over providers. OPM was able to work out a mechanism that was acceptable to everyone. It places primary reliance on providers in PPO networks, but holds carriers responsible for ensuring that consumers get the information they need. OPM will monitor the reaction of its customers as these provisions go into effect at the end of 1998 and the beginning of 1999.

OPM is committed to bring carriers into contractual compliance with all of the Patients' Bill of Rights recommendations by the end of 1999. Contract clauses requiring Patients' Bill of Rights compliance do not go into effect until January 1, 1999, and much of the new information that will be available to consumers in both print and electronic format is disseminated early in November in conjunction with the annual health benefits Open Season. However, we began to receive feedback on the President's initiative last June when we conducted a half-day session for over 400 agency benefits officers on the Patients' Bill of Rights. The session included workshops to educate these key agency personnel about the protections that would be provided to all FEHB participants, the information that would be available, and the improvements in health care related services we anticipated from this effort. Their response was overwhelmingly favorable.

When we published our proposed regulation prohibiting "gag clauses" under the FEHB Program, we received many positive comments. The American Academy of Ophthalmology said that since the FEHB Program is the benchmark for measuring and providing premier health care, by setting the example of banning all gag clauses it stands to provide all Americans with a key protection outlined in the Consumer (Patients') Bill of Rights and Responsibilities. The American Society of Internal Medicine indicated support for the rule because it assures that physicians and other providers participating in the FEHB Program will not be prevented from providing information on all medically appropriate treatment options. Individual employees and retirees also applauded OPM for its work on improving patient care under the FEHB Program, and supported OPM's efforts to prohibit contractual clauses or incentives that prevent open and candid communication between physicians and patients concerning appropriate treatment options. One person praised our efforts to eliminate health plan restrictions that violate the most basic rights in a free society.

This kind of support and the high level of existing compliance among FEHB Program plans lead us to expect that full compliance by our plans will continue to be a collaborative and cooperative process. In the unlikely event that a plan is unwilling to comply with the Patients' Bill of Rights, our contracting procedures provide a mechanism by which OPM may terminate that plan's participation in the FEHB Program for failure to meet its contractual obligations. Our plan participants can be assured that at the end of the day all health plans in the Program will be in full compliance with the Patients' Bill of Rights, because OPM has the tools it needs, as well as the will, to ensure this result.

Based on our experience with implementing the Patients' Bill of Rights requirements for the FEHB Program, we believe that the private sector should have no significant problems with implementing the protections. Once the protections are in place for the FEHB Program and other federal health programs, they can easily be extended elsewhere since it is neither cost effective nor, in some cases, operationally possible for carriers to extend the protections to FEHB Program enrollees without making them available to others.

V. Conclusion

Implementing the Patients' Bill of Rights has been an extremely positive experience for OPM.

Assuring consumer protections, as well as providing consumers with the information they need to make informed health care decisions, drives our carriers to compete on the basis of quality as well as cost. As we enhance the information we give consumers about carrier performance, and they become increasingly aware of differences and make plan choices accordingly, we expect that carriers will strive to provide higher quality care for our members in order to compete effectively for market share in the FEHB Program. As our implementation effort is phased in over the next two contract periods -- beginning January 1, 1999, and January 1, 2000 -- we will assess the impact the protections have on our members' confidence in the quality of their health plans.

We at OPM continually seek to have the FEHB Program -- as an exemplary quality-driven employer-sponsored health benefits program -- set the standard for the private sector. We are pleased to have been able to implement Patients' Bill of Rights requirements in the FEHB Program in 1999 for less than 25 cents per enrollee. We believe providing quality care at minimal cost should be the highest priority of a model health benefit program.

**REPORT TO THE VICE PRESIDENT OF THE
UNITED STATES**

*Progress Report in Implementing the Patient's Bill of Rights
at the
Department of Veterans Affairs*

October 30, 1998



DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

MEMORANDUM TO THE VICE PRESIDENT

HEALTH CARE CONSUMER BILL OF RIGHTS
STATUS REPORT
DEPARTMENT OF VETERANS AFFAIRS

- I. **INTRODUCTION.** In 1995, the Veterans Health Administration (VHA) initiated the most radical redesign of the veterans health care system to occur since the system was formally created in 1946. One of the primary goals of this effort has been to ensure the consistent and predictable provision of high quality care everywhere in the system. The VA's former disease-oriented, hospital-based, professional discipline-focused paradigms are being replaced by ones that are patient-centered, prevention-oriented and community-based and which are premised on universal primary care. While VHA's transformation is still in its early evolution, the results to date are unprecedented in American health care and fit in closely to the principles and goals of the President's Health Care Consumer Bill of Rights and Responsibilities (BOR).

Last February the Department of Veterans Affairs (VA) reported to the President and Vice President on its compliance with the BOR. VA stated that it was in substantial compliance with the provisions of the Bill of Rights, except for three areas: external appeals, information disclosure and emergency care. Since that time, significant work has been undertaken to assess these issues and provide recommendations to the Under Secretary for Health (USH). The recommendations have been accepted and work is now underway to either implement the options or propose legislative remedies, where appropriate.

For **External Appeals**, a task force explored various options and recommended to the Under Secretary that VHA contract with a non-federal external organization to provide independent external reviews and make recommendations concerning complaints and appeals. On July 2, 1998, the Under Secretary accepted the recommendations and issued an Under Secretary Information Memorandum announcing this decision. The task force was assigned the responsibility for implementing this decision,

including letting the national contract and operationalizing the parameters under which an external appeal may be sought by a patient. VA expects to have its external appeals process in place before the end of the year.

For **Information Disclosure**, the Deputy Under Secretary for Health (DUSH) established a task force to assess and recommend necessary steps to comply with the BOR. The task force identified and compiled information that would meet the Information Disclosure requirements. It prepared a matrix for distribution to the field which will serve as the guide for where the necessary information can be found. The matrix was accompanied with a memorandum to field facilities directing them to ensure the mechanism was in place to get this information to veterans and their families. VA recognizes, however, that this is a first step in information disclosure. The task force also recommended and on September 9, 1998 the Deputy Under Secretary approved, a recommendation that a team comprised of Headquarters and field representatives design a VHA Patient Bill of Rights Brochure Template. In the meantime, informational brochures have been developed as part of the implementation of eligibility reform and these have been made available for distribution to veterans.

The final area, **Emergency Care**, as was indicated in the previous report, would require statutory authority to come into full compliance with the BOR. Currently, most VA facilities are not equipped to provide a full range of emergency care services and VA cannot reimburse private facilities for emergency care provided to most veterans. VA has developed legislative options that would meet the BOR standard and that are being reviewed in the FY2000 budget development process.

The primary cost for these new provisions would result from the emergency care proposal. There will also be a cost associated with the external appeals contract but that will not be known until the task force completes its work.

II. **PROVISION-BY-PROVISION SUMMARY OF THE EXTENT TO WHICH THE DEPARTMENT OF VETERANS AFFAIRS IS IN COMPLIANCE WITH THE PATIENT'S BILL OF RIGHTS**

Information Disclosure

Consumers have the right to receive accurate, easily understood information about their health plans, facilities and professionals to assist them in making informed health care decisions. This includes:

- **Health Plans**

- Health Professionals
- Health Care Facilities

The Department of Veterans Affairs (VA) has information available that would assist its consumers in making informed healthcare decisions. Although much of this information is already provided to its consumers, there is a great deal of variability within the VA healthcare system (just as there is in the private sector) on what and how information is provided to patients and their families. VA has the authority and will take action to comply with the Consumer Bill of Rights in this area to ensure more uniformity in this regard.

A number of forces are now converging which have resulted in VA examining what information it should provide and how this can be made more understandable and meaningful to our veterans and their families. Recently enacted Eligibility Reform legislation, VHA's focus on customer service, and our ongoing quality management program, are some of the major forces which are rapidly bringing information disclosure to the forefront, as envisioned in the Consumer Bill of Rights.

Under Eligibility Reform, PL 104-262, VA for the first time can provide needed medical services in the most clinically appropriate setting for enrolled veterans rather than being constrained by previous restrictions which placed limitations on care depending on a veteran's eligibility status. A brochure has been printed which provides information to veterans and their families on the requirements under eligibility reform, including priority levels and enrollment in the VA health care system, the benefits plan, urgent care and co-pays, where applicable. Information on facility licensure, certification and accreditation status is available but not routinely distributed. On measures of quality and consumer satisfaction, VA is a leader in terms of the information collected and the measures it has developed. In terms of disseminating quality information, preliminary discussions have been held with the Foundation for Accountability on developing a "Report Card for VA Consumers." For consumer satisfaction, scores on customer satisfaction surveys, which have been benchmarked to the Picker Institute, are sent to each VA facility. Facilities are required to post this information in public areas. A customer service standard brochure is also available for distribution to the public. This brochure contains ten customer service standards that were published in October 1994 as VHA's "Bill of Rights."

Information on provider network composition would mean describing the facilities access points and sharing agreements available within a Network. Decisions on access to specialists are handled at the local level. The Consumer Bill of Rights also requires information disclosure for health professionals. Much of this information, such as education, board certification and re-certification, is collected but not aggregated by facility or

certification and re-certification, is collected but not aggregated by facility or generally provided to patients and their families. All information on individual caregivers that is retrievable by name or by any other individual identifier from a system of records must be reviewed within the context of the Privacy Act. Other information, which is not so readily available, includes experience performing certain procedures and measures of quality and consumer satisfaction.

For healthcare facilities, information should be disclosed on performing certain procedures and services. Quality and consumer satisfaction information would be the same as discussed for Health Plans. The patient advocate is the focal point for handling complaints. Enrollees are informed about the role of the patient advocate in the medical facility setting.

As a result of the Health Care Consumer Bill of Rights, VA established a Task Force to ensure that all facilities know where information is located and that they are responsible for making this information available to veterans. Information has been developed to go out to field facilities. In addition, the Deputy Under Secretary approved the Task Force recommendation to set up a team comprised of representatives from both Headquarters and the field to develop a Patient Bill of Rights brochure template which will provide a consistent and effective means of meeting the information disclosure requirements of the Bill of Rights.

Choice of Providers and Plans

Consumers have a right to a choice of health care providers that is sufficient to assure access to appropriate high-quality health care. This includes:

- **Provider Network Adequacy**
- **Access to Qualified Specialists for Women's Health Services**
- **Access to Specialists**
- **Continuity of Care**

Within available resources, VA provides access to sufficient numbers and types of providers to assure that all covered services are accessible without unreasonable delay. This is an area where VA will continue to focus its energy to improve its performance. It will do this by providing more and better access through increasing the number of community-based outpatient clinics, which now number over 600 and where appropriate, entering into sharing agreements and provider contracts. It will also continue to monitor waiting times for appointments.

Performance measures have been established which focus on the time patients must wait to get a primary care and specialty appointment. Marked improvements have been made in these areas and this will remain a focal point. Access to specialty care is not constrained by policy - return visits are at the discretion of the treating physician and patient. If specialized services are not available or accessible, provisions can be made to obtain the services through contracts or on a fee-basis. Because the VA is a nationwide system, some specialized services, e.g. transplants, are offered at centralized locations. Patients are referred to these sites as necessary with travel costs paid by VA. To improve accessibility, VA is opening hundreds of community-based outpatient clinics to provide primary care services. VA is actively re-engineering the entire non-VA provided care program to enhance efficiency and effectiveness and provide seamless integration with VA-provided care. Access to emergency care services 24 hours a day and 7 days a week is limited by law when using a non-VA facility (see Part III Access to Emergency Services).

Access to Qualified Specialists for Women's Health Services is firmly established in policy and practice. The Veterans Health Care Act of 1992 authorizes VA to provide gender-specific services to eligible women veterans, excluding certain services as stipulated by law. This law mandates that officials shall be designated throughout the VA system to serve as coordinators of women's services with specific responsibility for assessing the needs of and enhancing services for women veterans. VHA Manual M-2 requires each VA medical center to ensure that eligible women veterans have equal access to necessary medical care for gender-related conditions, equal to the care male veterans receive for their gender-related ailments, and to provide appropriate gender-specific services. The goal is to provide these services in-house to the extent possible; however, all VA medical centers provide gynecology services by at least one mechanism in addition to fee-basis, such as consultants, sharing agreements, contracting, etc. Under the new benefits package, women veterans are eligible for infertility and maternity services. Legislation is required if for VA to furnish care to newborns.

Consumers with complex or serious medical conditions who require frequent specialty care have direct access to qualified specialists. This is at the discretion of the treating physician and patient. This year VA has initiated the Primary Specialist training program for subspecialty resident trainees in over 50 academically affiliated VA medical centers throughout the country. This program puts an emphasis on training for the expert healthcare management of chronically seriously ill patients while also focusing on primary care issues such as health maintenance, disease prevention, and the provision of comprehensive, coordinated and accessible care. This approach will eliminate the risk often associated

with coordinating the care between primary care providers and specialists for chronically ill patients.

At this time, Continuity of Care as defined by the Bill of Rights would not be an issue for VA. VA does not anticipate having to involuntarily disenroll any veteran except those who are guilty of enrolling under false pretenses. If a current specialty provider is terminated for other than cause, VA will ensure that there is continuity of care for the veteran.

Access to Emergency Care

Consumers have the right to access emergency health care services when and where the need arises. Health plans should provide payment when a consumer presents to an emergency department with acute symptoms of sufficient severity — including severe pain — such that a "prudent layperson" could reasonably expect the absence of medical attention to result in placing their health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

The Uniform Benefits Package allows emergency care in VA facilities. The law, however, only authorizes the provision of emergency care services in non-VA facilities at VA expense for veterans who meet special eligibility requirements. In addition, there are some authorization requirements. However, VA may be able to provide emergency care in non-VA facilities for enrolled veterans through sharing agreements with local emergency providers. Prompted by both the Bill of Rights and development of a health care benefits package under the Eligibility Reform Act of 1996, VA established a task force to explore options to allow VA to provide emergency care services to veterans enrolled in the VA Health Care system. The task force has developed legislative options that allow VA to provide emergency care services. These options are now being reviewed in the FY2000 budget development process. The proposal assumes that veterans who are currently receiving coverage through another Federal program, e.g., Medicare, would continue to do so.

Participation in Treatment Decisions

Consumers have a right to fully participate in all decisions related to their medical care. Consumers who are unable to fully participate in treatment decisions have a right to be represented by parents, guardians, family members, or other conservators.

Provide patients with sufficient information and opportunity to decide among treatment options consistent with the informed consent process.

VA clearly meets or exceeds both the letter and spirit of this section. VHA Informed Consent Regulations (38 C.F.R. § 17.32) and VHA Informed Consent Policy (VHA Handbook 1004.1) specifically require that all patient care furnished under title 38, U.S.C., shall be carried out with the full and informed consent of the patient. The provider must explain in language understandable to the patient the procedure or treatment, the expected benefits, foreseeable risks, and reasonable alternatives. Additionally, VHA has issued a paper entitled "Ethical Considerations for a Multicultural Clinical Workforce" to make the clinical provider more aware that their cultural background may affect their communication with their patients and to be sensitive to that possibility. VHA has also embarked on an innovative and ambitious initiative in shared healthcare decision-making. This is a partnership through which providers enable and encourage patients and families to actively participate in all aspects of healthcare decision-making. Various patient education strategies are being supported and encouraged in this effort. Shared healthcare decision-making will be an ongoing activity. This will be accomplished through continuing administrative actions, including contracting, if appropriate.

Discuss the use of advance directives with patients and their designated family members.

VHA policy (M-2, Part 1, Chapter 31) provides a mechanism for advance directives, including both living wills and durable power of attorney for health care. VHA policy specifically states that competent persons have the right to direct the course of their own medical care and to determine for themselves from among treatment options presented, the course of treatment which will be administered, including life-sustaining treatment.

Abide by the decisions made by their patients and/or their designated representatives consistent with the informed consent process.

Relevant regulation and policy specifically require that all patient care furnished under Title 38 shall be carried out only with the full and informed consent of the patient. The patient has the right to refuse any treatment or procedure even if it may increase the risk for serious illness or death. A previous IG study showed compliance with the advance directive policy and concluded that the program operated effectively.

Disclose to consumers any factors - including method of compensation, ownership of interest in health care facilities, or matters of conscience - that could influence advice or treatment decisions.

VA's National Center for Clinical Ethics has addressed this issue and published a paper entitled "Professional Conflicts of Interest for VHA Clinicians." The paper specifically addresses the potential conflict between the fiduciary duty of clinicians as professionals to grant primacy to the interests of their patients and their stewardship obligations as employees of a fixed-budget healthcare organization. They concluded that the interest of the patient is paramount.

Assure that provider contracts do not contain any so-called "gag clauses" or other contractual mechanisms that unnecessarily restrict health care providers' ability to communicate with and advise patients about medically necessary treatment options.

VHA regulations and policy, as previously referenced, very explicitly state that any and all relevant information must be discussed with the patient as part of the informed consent process. Because of the importance of this issue, however, the National Center for Clinical Ethics published a paper titled "Protection Against Gag Rules: Safeguarding Provider-Patient Relationship." The paper states in conclusion that anything less than open, honest and forthright discussion with patients regarding their treatment options is unethical and unacceptable. The paper was distributed to all headquarters key staff, Network Directors, and VA medical facility directors with a covering memorandum from the Under Secretary for Health emphasizing the ethical imperative of full disclosure.

Protect health care professionals from penalties or retribution related to advocating on behalf of their patients.

Persons obstructing the full disclosure process are subject to penalties within VHA. The previously mentioned "Gag Rule" paper includes a section on recourses available to healthcare professionals who feel unduly constrained from providing complete and comprehensive information for any reason.

Respect and Nondiscrimination

Consumers have the right to considerate, respectful care from all members of the health care industry at all times and under all circumstances. An environment of mutual respect is essential to maintain a quality health care system.

Consumers must not be discriminated against in provision of health care services based on race, ethnicity, national origin, religion, sex, age, current or anticipated mental or physical disability, sexual orientation, genetic information, or source of payment.

As a Federal entity, VA healthcare facilities are governed by all the equal opportunity and non-discrimination laws promulgated by Congress. VHA does not merely adhere to these laws but incorporates them in the fabric of its culture. Section 17.33 of title 38 U.S.C. is devoted entirely to Patients' Rights. The opening paragraph states: "Patients have a right to be treated with dignity in a humane environment that affords them both reasonable protection from harm and appropriate privacy with regard to their personal needs." VHA's first Customer Service Standard is "We will treat you with courtesy and dignity. You can expect to be treated as the 1st class citizen that you are." In addition, the Under Secretary for Health has articulated the core values for VHA. These are respect, trust, compassion, excellence and commitment. These define the basis of how VHA employees are expected to treat each other and the veterans we serve.

Confidentiality of Health Information

Consumers have the right to communicate with health care providers in confidence and to have the confidentiality of their individually identifiable medical information protected. Consumers also have the right to review and copy their own medical records and request amendments to their records.

In the Federal sector, information that is retrieved by an individual identifier, e.g. a name or social security number, including patient medical records is protected by the Privacy Act of 1974 (5 U.S.C. 552a). Under the Privacy Act, patients have a right to review, copy and request amendments to their treatment records. Anyone other than the subject of the records is not entitled to access those records unless specifically set forth in a Privacy Act exemption in an agency system of records notices. Any person can request access to agency records under the Freedom of Information Act (FOIA); however, release of agency records then is subject to FOIA exemptions, the Privacy Act and other Federal statutes. VA alone has three additional statutes which protect confidentiality: 38 U.S.C. 5701 protects claimants records; 38 U.S.C. 5705 protects QA records; and 38 U.S.C. 7332 protects drug/alcohol treatment, HIV status, and sickle cell hemoglobinopathy records.

VHA personnel will receive ongoing instruction on patient rights and privacy rights and individual responsibility. These educational initiatives will involve the VHA Office of Employee Education.

Complaints and Appeals

All consumers have a right to fair and efficient process for resolving differences with their health plans, health care providers, and the

institutions that serve them including a rigorous system of internal review and an independent system of external review.

All VA medical facilities have patient advocates. These individuals are the focal point to handle consumer complaints and to try to achieve a fair and equitable resolution of the complaint. The Customer Service Standards also advise veterans and their families to contact their patient advocate or another member of the medical facility staff if their expectations are not met. If they cannot resolve their concerns, they are encouraged to speak with the facility director. There is not a consistent process, including external review, to deal with clinical decisions. This is within VA's authority to correct.

A more formal avenue including independent external review exists for veterans and other claimants of VA benefits to appeal eligibility and rating decisions made by a VA Regional Office or medical center. A claimant has one year from the date of the notification of a VA decision to file an appeal. The Board of Veterans' Appeals makes the final decision on appeals on behalf of the Secretary of Veterans Affairs. A claimant may be represented by a veterans service organization, an agent or an attorney.

A VA claim may be appealed from the Board of Veterans' Appeals to the Court of Veterans Appeals. This court is independent of the Department of Veterans Affairs. Only claimants may seek a review by the court; VA may not appeal a BVA decision. The court does not hold trials or receive new evidence. It reviews the record that was considered by the Board of Veterans' Appeals. Either party may appeal a decision of the court to the U.S. Court of Appeals for the Federal Circuit and to the Supreme Court of the United States.

To address VA compliance with the right of patients to external reviews of clinical decisions, the Under Secretary for Health established a Task Force. The group recommended that VHA contract with a non-federal external organization to provide independent external reviews and make recommendations concerning complaints and appeals. This recommendation was accepted by the Under Secretary and by the end of the year an external appeals process should be in place. As a necessary part of implementing the external appeals process, the Task Force is refining and making the internal complaint/appeals process uniform throughout VHA. This work will also be completed by the end of the year. When this is finished, veterans will have access to easy to understand information explaining the process for submitting complaints and appeals to administrative and clinical decisions.

III. NUMBERS OF PEOPLE IN THE HEALTH PLAN THAT WOULD BE IMPACTED

The patient protections would apply to all veterans enrolled in the VA health care system. Although VA is not considered an HMO, under the 1996 Eligibility Reform Act VA is required to enroll users and to establish a health care benefits package. Currently there are approximately 3.3 million users of the VA system and that number is expected to increase in FY99.

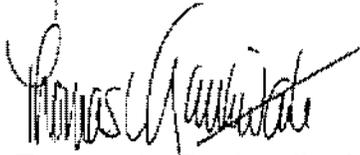
IV. IMPLICATIONS OF THESE NEW PROTECTIONS

Although there will be costs associated with contracting with an external organization for appeals, specific estimates will not be known until later this year. The major costs associated with complying with the Bill of Rights are associated with Emergency Care. Those costs are difficult to estimate. One of the complicating factors is that there is no experiential data to adjust for any cost avoidance from treating a disease process earlier in its course as a result of access to emergency room care. The new protections will apply to all the veterans who are enrolled in and use the VA health care system.

V. CONCLUSION

The Health Care Consumer Bill of Rights was completely consistent with the direction the veterans health care system is moving in. All aspects of the BOR are important elements in a system that proclaims the delivery of the Right Care, at the Right Time, in the Right Place. We believe that the fact that VA has already complied with many of the aspects of the Bill of Rights contributes to our high level of consumer satisfaction. The goal of VA is to improve on our customer satisfaction scores and the implementation of the remaining provisions of the Bill of Rights which is under way will contribute to achieving that goal. The veterans health care system – the largest fully integrated health care system in the U.S. – appears to be a microcosm of the larger American health care system with respect to quality of care.

The transformation and quantifiable results of the last 3 years show that VA is indeed in the forefront of the national health care movement. The initiatives and principles currently in place and being implemented throughout the VA healthcare system make it a model for the rest of the nation.

A handwritten signature in black ink, appearing to read "Thomas L. Garthwaite". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Thomas L. Garthwaite, MD
Acting Under Secretary for Health

REPORT TO THE VICE PRESIDENT OF THE UNITED STATES

*Progress Report in Implementing the Patient's Bill of Rights at the
Department of Defense*

November 2, 1998



THE SECRETARY OF DEFENSE
WASHINGTON, THE DISTRICT OF COLUMBIA

The Vice President
The White House
Washington, DC 20500

Dear Mr. Vice President:

I am pleased to forward to you *The Progress Report in Implementing the Patient's Bill of Rights at the Department of Defense*. The Patient's Bill of Rights reaffirms many principles and practices that are an integral part of care in the Military Health System. In our efforts to comply with the Patient's Bill of Rights, the Department has taken steps to improve access and quality of care for our 8.4 million beneficiaries. These steps include (a) strengthening of the system-wide appeals and grievance process to guarantee health care professionals are making decisions about patient care; (b) promoting the use of specialists as primary care managers for women and beneficiaries with chronic diseases, and (c) ensuring that patients have the right to discuss fully all treatment options and have information provided to them regarding financial incentives in our health system.

I believe the Patient's Bill of Rights has allowed the Department to take an important step toward providing effective care in a compassionate environment. I am confident that the implementation of the initiatives outlined in this report will provide more opportunities for our beneficiaries to participate in their health care, and will go a long way towards ensuring their confidence in military medicine.

Finally, the Department is committed to ensuring that these initiatives will be fully implemented throughout the Military Health System by mid-1999.

Sincerely,

A handwritten signature in black ink, appearing to be "Bill Clinton", written in a cursive style.

Attachment:
As Stated

I. INTRODUCTION

In November 1997, President Clinton directed the Department of Defense to review the Military Health System (MHS) for compliance with the Patient Bill of Rights. The review showed that we were in full compliance in most areas.

Based on that review, the President asked us to focus on improvements in three areas:

1. A strong grievance and appeals process
2. Promotion of the use of primary care managers (PCMs) for women, to focus on providers who have advanced training in women's health issues, as well as the use of specialists as PCMs for those beneficiaries with chronic diseases
3. Ensuring that patients have the right to fully discuss all treatment options and have information provided to them regarding financial incentives in our health system

The Military Health System (MHS) is large and complex. There are approximately 8.4 million active-duty and retired service members and their family members eligible to receive their health care through the MHS. That care is provided through TRICARE, the Department's program to integrate the military direct care facilities and networks of civilian providers into a fully integrated health care system. TRICARE is a managed care concept that allows for full utilization of our Military Treatment Facilities (MTF) complemented by regional, at-risk Managed Care Support Contracts, which provide for full benefit coverage to our beneficiaries. Most of our population has three health plan options that allow for choice from the full range of health delivery types. TRICARE Prime is our managed care option that offers guaranteed prompt access to primary and specialty health care for those enrolled. Our active duty personnel, their families, and retirees under the age of 65 and their families have access to the program. While the Department's over 65 beneficiaries are only entitled to space available care in MTFs, the Clinton Administration has supported and is implementing TRICARE Senior Prime, a partnership between Medicare and DoD to expand access of these beneficiaries to care within the MHS.

The TRICARE program also provides TRICARE Extra, a preferred provider option through which most of our beneficiaries may use the TRICARE provider network on a case-by-case basis, with reduced cost sharing. Finally, TRICARE Standard is equivalent to what our members knew as CHAMPUS, and is a point-of-service option that offers full coverage of health care services, with a 20 to 25 percent co-payment for the beneficiary. Our system still must focus on the mission readiness of our troops, who, therefore, are enrolled in TRICARE Prime.

A Department of Defense Directive was prepared to reaffirm our commitment to all of the provisions of the Patient Bill of Rights. That Directive (DoDD 6000.14) was signed by the Secretary of Defense on July 30, 1998. A DoD Directive is a broad policy document that is issued to guide the conduct of the Military Services and other DoD components and to assign authority and responsibility for action. A directive is disseminated throughout DoD.

After the Directive is signed, the office with policy oversight may, if appropriate, issue a Department of Defense Instruction (DoDI) to govern the implementation. The military services must comply with the DoDD and DoDI as guidelines for developing service specific regulations. Most Directives and Instructions are made widely available by posting them on the World Wide Web.

The implementation of this Directive is in its initial phases. The newly created TRICARE Management Activity, which is responsible for oversight of program operations, is proceeding with implementation in its areas of responsibility. We anticipate full implementation in mid-1999. As implementation of this directive is still in its early phases, it is not possible to give an exact figure on costs.

II. PROVISION-BY-PROVISION SUMMARY

Information Disclosure

Consumers have the right to receive accurate, easily understood information and some require assistance in making informed health care decisions about their health plans, professionals and facilities.

MHS patients have the right to receive accurate, easily understood information, and assistance in making informed healthcare decisions about their health plans, providers, and facilities. They will be provided accurate, understandable, and timely information about the TRICARE program. That information includes details of the covered health benefit, our three health plan options, and applicable cost-sharing arrangements. Each military treatment facility (MTF) must publish a Health Care Provider Directory, including information regarding each provider's name, degree, licensure, privileging, board certification and/or re-certification status. The directory is to be updated at least annually. Each MTF is required to issue and display in a conspicuous place a "report card" about facility performance in key areas.

All plans and facilities will have dedicated representatives available to fully explain the information available and help beneficiaries in their healthcare decisions. At each direct care facility, the Commander provides opportunities for beneficiaries to have direct input to health delivery policy by forming a Healthcare Consumer Consortium. **Virtually all MTFs are already in compliance with these provisions.**

MTF and TRICARE network providers and facilities must disclose to patients financial arrangements, contractual restrictions, ownership of or interest in health care facilities, matters of conscience, or other factors that could influence medical advice or treatment decisions. TRICARE network provider contracts shall not contain any so-called "gag clauses" or other contractual mechanisms that restrict the healthcare provider's ability to communicate with and advise patients about medically necessary treatment options. The MHS shall not penalize or seek retribution against healthcare professionals or other health workers for advocating on behalf of their patients. **Implementation instructions are currently in development to ensure consistent application across the MHS.**

Choice of Provider and Plans

Consumers have the right to a choice of health care providers that is sufficient to ensure access to appropriate high-quality health care.

MHS beneficiaries have the right to a choice of healthcare providers that is sufficient to ensure access to appropriate, high-quality healthcare. TRICARE Prime provider networks shall provide access to sufficient numbers and types of providers to ensure that all covered services are accessible within the TRICARE Prime access standards. Active duty members are enrolled in TRICARE Prime. MHS beneficiaries entitled under law to the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) have a right to choose TRICARE Standard, which permits access to all authorized providers within guidelines of the TRICARE program.

Provider Network Adequacy - TRICARE Prime access standards include emergency care 24 hours a day and seven days a week, urgent care within 24 hours, routine primary care within seven days, and specialty care within 30 days. Priority of care will be given to healthcare evaluations and services related to fitness for duty or explicit readiness requirements. TRICARE Prime (DoD's managed care option) enrollees have the freedom to choose any available primary care manager (PCM) within the responsible MTF. If no PCM is available within the MTF, or with the approval of the MTF commander, enrollees have the right to choose a civilian network PCM. In the case of active duty Service members, choice of PCMs is subject to readiness requirements of the Military Service. **The development of provider networks is a complex and continuously ongoing process. Networks are currently in place in every TRICARE region with shortages of a few specialties in some areas. The local Managed Care Support Contractor addresses these spot shortages with constant oversight by the regional DoD Lead Agent.**

Access to Qualified Specialists for Women's Health Services - The newly signed DoD Directive requires the Military Health System to promote the availability of providers who have special training in women's health issues to serve as PCMs for female Prime enrollees. **While the elements of this provision are in place in many areas, implementation instructions are currently in development to ensure consistent application across the MHS.**

Access to Specialists - Prime enrollees with complex or serious medical conditions who require frequent specialty care are authorized direct access to a qualified specialist of their choice within the MTF (or, if authorized, in the civilian provider network). Authorization is granted for an appropriate number of visits under an approved treatment plan. **While the elements of this provision are in place in many areas, implementation instructions are currently in development to ensure consistent application across the MHS.**

Continuity of Care - Beneficiaries undergoing a course of treatment for a chronic or disabling condition or who are in the second or third trimester of a pregnancy who have an involuntary change in coverage of specialty, are, to the extent possible, able to continue seeing their current specialty provider for up to 90 days (or through completion of postpartum care). Implementation instructions are currently in development to ensure consistent application across the MHS.

Access to Emergency Services

Consumers have the right to access emergency health care services when and where the need arises. Health plans should provide payment when a consumer presents to an emergency department with acute symptoms of sufficient severity - including severe pain- such that a "prudent layperson" could reasonably expect the absence of medical attention to result in placing that consumer's health in serious jeopardy or seriously impair physical functioning.

MHS beneficiaries have the right to access emergency healthcare services when and where the need arises. Emergency services are covered in circumstances where a "prudent layperson" could reasonably expect the absence of medical attention would result in serious health risks. There is no requirement for preauthorization for emergency services.

Beneficiaries are provided information on the location, availability and appropriate use of emergency services, cost sharing, provisions for civilian emergency services, and availability of care outside of an emergency department. Healthcare advisory lines are staffed by nursing personnel 24 hours a day to help beneficiaries decide if emergency care is needed. Access to a PCM is available after hours if deemed necessary by the health advisor. **These provisions are currently in place throughout the MHS.**

Participation in Treatment Services

Consumers have the right and responsibility to fully participate in all decisions related to their health care. Consumers who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members or other conservators.

MHS beneficiaries have the right and responsibility to fully participate in all decisions related to their healthcare, subject to readiness requirements for active duty Service members. To the extent practical, MTF and TRICARE Prime network healthcare professionals are expected to provide patients with easily understood information and the opportunity to decide among treatment options consistent with the informed consent process. Specifically, providers should:

- 1) Discuss all treatment options including the option of no treatment at all with a patient in a culturally competent manner.
 - 2) Ensure that patients with disabilities have effective communications with members of the health system in making such decisions.
 - 3) Discuss all current treatments a patient may be undergoing, including those alternative treatments that are self-administered.
 - 4) Discuss all risks, benefits, and consequences to treatment or non-treatment.
 - 5) Give competent patients the opportunity to refuse treatment and to express preferences about future treatment.
 - 6) Discuss the use of advance directives—both living wills and durable powers of attorney—with patients and their designated representative, and should abide by all decisions made by their patients and/or their designated representatives. A provider who disagrees with a patient's wishes as a matter of conscience should arrange for transfer of care to another qualified provider willing to proceed according to the patient's wishes within the limits of the law and medical ethics.
- These provisions are currently in place in each MTF and are subject to review by external accreditation agencies such as the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO).**

Respect and non-discrimination

Consumers have the right to considerate, respectful care from all members of the health care system at all times and under all circumstances. An environment of mutual respect is essential to maintain a quality health care system.

MHS beneficiaries have the right to considerate, respectful care from all members of the MHS at all times and under all circumstances in an environment of mutual respect and free from discrimination.

Consumers must not be discriminated against in the delivery of health care services or in marketing and enrollment practices based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

The MHS does not discriminate in the delivery of healthcare services or in marketing and enrollment practices based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, genetic information, sexual orientation, or source of payment. **These provisions are currently in place throughout the MHS.**

Confidentiality of Health Information

Consumers have the right to communicate with health care providers in confidence and to have the confidentiality of their individually identifiable health care information protected. Consumers also have the right to review and copy their own medical records and request amendments to their records.

MHS beneficiaries have the right to communicate with healthcare providers in confidence; to have the confidentiality of their individually identifiable healthcare information protected, and to review and copy their own medical records and request amendments to their records. This right is subject to limited exceptions for which there is a clear legal basis. All individual identifiable medical information is protected and its use is generally restricted for healthcare purposes only, including the provision of healthcare, payment of services, peer review, health promotion, and quality assurance. **Complete confidentiality of all healthcare information for active duty service members is subject to military requirements.**

Complaints and Appeals

All consumers have the right to a fair and efficient process for resolving differences with their health plans, health care providers, and the institutions that serve them, including a rigorous system of internal review and an independent system of external review.

MHS beneficiaries have the right to a fair and efficient process for resolving differences with their healthcare providers, MTF, or TRICARE contractor, including a rigorous system of internal review and an independent system of external review. When healthcare services are denied by an MTF or a TRICARE contractor based on a determination that the services are not medically necessary (including experimental or investigational), the beneficiary has the right to internal and external appeals. Beneficiaries with grievances about other specific treatment or coverage decisions have an opportunity to seek resolution through the MTF or TRICARE contractor. This does not apply to beneficiary disagreements with eligibility requirements, coverage exclusions, or other matters established by law or regulation or MTF determinations of space available care

Internal Appeals - Internal appeals include written notification of the decision, the reasons for the decision, and appeal procedures. There must be timely resolution, including special emergency time standards and use of credentialed providers not involved in the initial decision. Beneficiaries receive written notification of the reconsideration decision, the reasons for it, and the external appeal procedures.

External Appeals - External appeals include reconsideration by the independent National Quality Monitoring Contractor (NQMC) and appeals and hearing before the TRICARE Management Activity (TMA). NQMC procedures require determinations by appropriately credentialed specialty providers not involved in the initial decision, timely resolution, and emergency time frames consistent with Medicare's appeal process.

Most elements of this provision have been in place since 1990. Implementation instructions are currently in development to ensure consistent compliance across the MHS.

Beneficiaries who have a grievance with an MTF start with an appeal within the MTF. If the grievance cannot be resolved within the MTF, it is referred for an external appeal to the NQMC. If the grievance is not settled to the beneficiary's satisfaction by the NQMC, he or she may appeal to the Lead Agent.

Beneficiaries who have a grievance outside the MTF start with an internal appeal to the managed care support contractor. The external appeals take one of two routes. If it is a factual appeal, it goes from the managed care support contractor to TMA. If it is an appeal related to medical necessity, custodial care, or level of care decisions, it goes to the NQMC for peer review. The NQMC decision can be appealed to TMA.

Statistics are available for appeals for October 1, 1997 through June 30, 1998. The Managed Care Support Contractors received 9926 requests for reconsideration, 61% of which resulted in reversals or partial reversals. TMA performed 709 formal reviews of factual appeals, 13% were fully or partially reversed. The NQMC did 395 reconsiderations for medical necessity, custodial care and level of care determinations, 47% of which to reversal or partial reversal. TMA held 97 hearings for medical necessity, custodial care and level of care determinations. 34% of which led to reversal or partial reversal. These statistics do not include cases at the MTFs.

III. NUMBERS OF PEOPLE IN THE MILITARY HEALTH SYSTEM WHO WILL BE IMPACTED

Approximately 8.4 million people are eligible for care in the MHS and may be affected by these provisions. MHS beneficiaries belong to several groups - active duty members, retired members, and their families. All active duty members are enrolled in TRICARE Prime, the Department of Defense's managed care program. Care is provided in that program by the MTFs and by civilian contractors.

Active duty family members, retirees and their family members may choose to enroll in TRICARE Prime if they are eligible for CHAMPUS. If they do not choose TRICARE Prime, they may use a fee for service plan (TRICARE Standard) or use physicians and other providers from our network at a discount (TRICARE Extra). Beneficiaries who are not in TRICARE Prime may use the MTFs on a space available basis. Currently 3.4 million of our 8.4 million beneficiaries are enrolled in TRICARE Prime.

While the effects of the Patient's Bill of Rights will be most apparent for the TRICARE Prime beneficiaries and others who use the MTFs, these rights extend to all beneficiaries regardless of where they receive their care. All beneficiaries will receive the protection of the grievance procedures if they need them. Beneficiaries who are not in managed care but who use network providers may note improvements because of increased attention to issues such as involving patients in decisions.

IV. IMPLICATIONS OF THESE NEW PROTECTIONS

It is still too early to assess the impact of the Patient's Bill of Rights in terms of cost. The costs of measures such as increasing access to women's health specialists and improving continuity of care are still being determined. Some funds will also be needed to educate beneficiaries and providers on the provisions in the Patient Bill of Rights so that they understand and use them effectively.

The new provisions in the Patient Bill of Rights will be particularly valuable to women, persons with chronic diseases and children with special needs.

Implementation is at an early stage but the initial reaction of beneficiaries, providers and Lead Agents has been very positive.

V. CONCLUSION

The Patient's Bill of Rights reaffirms many principles and practices that are an integral part of care in the Military Health System. More importantly, it raises awareness of the importance of these principles as a basis for humane, compassionate and effective care. It also adds important protections and options for our beneficiaries. We expect that implementation of the Patient Bill of Rights will encourage them to participate much more actively in their care and increase their confidence in the Military Health System.

**REPORT TO THE VICE PRESIDENT OF THE
UNITED STATES**

*Progress Report in Implementing the Patient's Bill of Rights
at the Department of Labor*

November 2, 1998

U.S. DEPARTMENT OF LABOR

SECRETARY OF LABOR
WASHINGTON, D.C.

MEMORANDUM TO THE VICE PRESIDENT

I. Introduction

This report summarizes the progress that the Department of Labor (the Department) has made to date in implementing the recommendations of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry (the Commission) to promote and assure the quality and value of health care and to protect consumers and workers in the health care system.

The Department, through the Pension and Welfare Benefits Administration, is responsible for the administration and enforcement of Title I of the Employee Retirement Income Security Act of 1974 (ERISA). The Department estimates that there are a total of 2.6 million ERISA-covered group health plans, covering approximately 122 million participants and beneficiaries.

On February 20, 1998, the President issued an Executive Memorandum directing the Secretary of Labor to propose regulations to improve the disclosure of health care benefits information and to strengthen the internal appeals process for ERISA-covered group health plans. In conformance with these directives, the Department has exercised its limited authority under ERISA to effectuate, to the extent of its authority, the Commission's recommendations.

Specifically, the Department has promulgated two proposed regulations, which were published in the Federal Register on September 9, 1998.

The first proposed regulation would amend the disclosure requirements applicable to group health plans to ensure that, consistent with the Commission's recommendations, all participants in group health plans are provided with clear and understandable information about their rights to health care under their group health plans. The second proposed regulation would amend the requirements for benefit claims procedures that employee benefit plans must provide to participants and beneficiaries. This proposed claims procedures regulation would alter the standards for benefit claims procedures to provide a more "rigorous system of internal review," as recommended by the Commission.

As described more fully in the Department's Report to the President, dated February 19, 1998 (the February 19 Report), the Department lacks the statutory authority to implement many of the recommendations of the Commission with respect to employer-sponsored group health plans beyond the steps the Department has already taken. ERISA provides uniform national standards to protect the health and pension benefits that employers voluntarily provide for their workers. It provides for mandatory reporting and disclosure and internal claims appeal procedures for all employee benefit plans, and it sets fiduciary standards for all individuals controlling plan assets. However, since ERISA was primarily focused on pension abuses, it does not provide extensive standards for health care plans. It is silent, for example, on issues such as the benefits to be provided by plans, standards for plans, or adequate remedies. As a result, the Department lacks authority to provide health care consumers with rights to choice of providers and plans, access to emergency care, participation in treatment services, respect and non-discrimination, confidentiality of health information, and an external system of review of denied benefit claims. Because of the limited scope of ERISA itself the Department has no basis for an exercise of delegated authority in those areas. Therefore, the regulations that the Department has proposed in response to the President's directives represent all of the action the Department can take without new legislative authority.

II. Review of the Department's Response to the Commission's Recommendations

Information Disclosure

"Consumers have the right to receive accurate, easily understood information and some require assistance in making informed health care decisions about their health plans, professionals, and facilities."

The Commission called for three types of information to be disclosed to consumers: information related to health plans, to facilities, and to professionals. The Department, in the February 19 Report, stated that it had the authority only to implement those recommendations relating to health plans, including plan eligibility and the provision of benefit-related information to participants and beneficiaries.¹

On September 9, 1998, the Department published in the Federal Register proposed amendments to the regulations governing the content of the Summary Plan Description at 29 C.F.R. 2520.102-3. These regulations describe the information required to be included in the summary plan description (SPD) that must be provided by all employee benefit plans to participants and beneficiaries. The SPD is the primary vehicle under ERISA for communicating information to participants and beneficiaries about their rights, benefits, and obligations under their employee benefit plans.

¹ Accordingly, the Department does not have the authority to implement the Commission's information disclosure recommendations with respect to health facilities or health professionals and has taken no action in that respect.

The proposed amendment would clarify the extent to which group health plans must disclose in their SPDs relevant information falling within the specific categories of information identified by the Commission as necessary to ensure that all participants and beneficiaries, without regard to whether they are covered by a Federally qualified health maintenance HMO, are provided adequate health plan information. The proposed amendment provides that the SPD for a group health plan must include specific information concerning the following subjects denominated by the Commission: benefits and limits on coverage; the extent to which preventive services are covered; whether, and under what circumstances, coverage is provided for existing and new drugs; whether, and under what circumstances, coverage is provided for tests, devices, and procedures; provider network composition; coverage of out-of-network services; conditions, if any, for access to speciality medical care; conditions, if any, applicable to urgent care; and preauthorization and utilization review procedures. In addition, the proposal would eliminate the existing special treatment provided for SPDs of group health plans that provide benefits through a Federally qualified HMO. Elimination of this special treatment would ensure that all group health plan participants and beneficiaries receive the same information, regardless of the type of health provider chosen by the group health plan.

The proposed amendments constitute a rulemaking that is subject to a period of public notice and comment, as required under the Administrative Procedure Act. That comment period, originally set to close on November 9, 1998, is being extended to December 9, 1998. This extension is being granted in response to numerous requests for additional time to prepare comments on the Department's proposed benefit claims regulation (see below). Inasmuch as the two proposals are related, it was judged appropriate to extent the comment periods on both proposals. Following the close of the notice and comment process, we will work to adopt final rules in this area as soon as possible, taking into account public comments on the proposals.

Choice of Providers and Plans

Provider Network Adequacy

Access to Qualified Specialists for Women's Health Services

Access to Specialists

Continuity of Care

"Consumers have the right to a choice of health care providers that is sufficient to ensure access to appropriate high-quality care."

The Commission asserted that health care consumers should have a right to a choice of health care providers that is sufficient to ensure access to appropriate high-quality care. The Department responded in its February 19 Report that, inasmuch as ERISA does not require group health plans to provide any particular health benefit or service, the Department does not have the statutory authority to impose such a requirement on group health plans through regulations. Accordingly, it has been unable to take any regulatory action to implement this recommendation.

As noted in the February 19 Report, the Department has, however, issued interpretive guidance articulating the duty of care of fiduciaries of plans who have discretionary authority to select health care providers for their group health plans. See DOL Letter to Diana Ceresi (Feb. 19, 1998). The Department has stated that such fiduciaries must take quality into account in selecting health care service providers. Fiduciaries must consider the scope of choices and qualifications of medical providers and specialists available to participants, the ease of access to medical providers, the extent to which internal procedures provide for timely consideration and resolution of patient questions and complaints, enrollee satisfaction statistics, and rating or accreditation of health care service providers by independent services or state agencies.

Access to Emergency Care

“Consumers have the right to access emergency health care services when and where the need arises.”

The Commission stated its belief that health care consumers should have the right to receive emergency services when and where such a need arises and that health plans should be required to provide payment for appropriate emergency services. The Commission endorsed the use of a “prudent layperson” standard in determining whether emergency services are justified. The Department, in the February 19 Report, explained that, as ERISA does not require group health plans to provide any coverage for any particular services, including emergency health care services, the Department has no authority to impose such a requirement. Accordingly, the Department has been unable to take any regulatory action to effectuate this recommendation.

Participation in Treatment Decisions

“Consumers have the right and responsibility to fully participate in all decisions related to their health care. Consumers who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members, or other conservators.”

The Commission endorsed the proposition that health care consumers should have the right and the responsibility to participate fully in treatment decisions, either directly or through representatives, such as parents, guardians, family members, or other conservators. The Department, in the February 19 Report, pointed out that it is unable to effectuate this right because ERISA does not require or otherwise address patient participation in treatment decisions, and the Department therefore does not have the statutory authority to create this right on behalf of participants and beneficiaries in group health plans.

Respect and Non-Discrimination

"Consumers have the right to considerate, respectful care from all members of the health care system at all times and under all circumstances."

The Commission adopted the view that health care consumers should have a right to considerate, respectful care, free from discrimination, from all members of the health care system. This right, according to the Commission, should include the right not to be discriminated against on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment. As explained in the February 19 Report, inasmuch as ERISA does not specifically prohibit or otherwise address discrimination in the delivery or marketing of health care, the Department is without statutory authority to implement this broad right through regulatory action. However, ERISA does prohibit, through provisions added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), group health plans from establishing eligibility or contribution rules that discriminate against individuals on the basis of health-related factors, including health status, medical condition, disability, genetic information, and evidence of insurability. The Department, in conjunction with the Departments of the Treasury and Health and Human Services, intends to issue in 1999 interim final rules (providing a period for notice and public comment) that will fully implement this nondiscrimination provision. These rules will provide substantial protection against discrimination on the basis of health-related factors to participants and beneficiaries in group health plans covered by ERISA.

Further, the Department has issued interpretive guidance, described above, concerning a plan fiduciary's duty to consider quality of care in selecting service providers. This duty would include consideration of the extent to which the provider treats participants and beneficiaries fairly and respectfully.

Confidentiality of Health Information

"Consumers have the right to communicate with health care providers in confidence and to have the confidentiality of their individually identifiable health care information protected. Consumers also have the right to review and copy their own medical records and request amendments to their records."

The Commission stated that health care consumers should have the right to communicate with their health care providers in confidence and to have the confidentiality of their medical records protected. The Department, as explained in the February 19 Report, does not have the statutory authority to implement this right through regulations because ERISA does not prescribe any standards relating to the maintenance of confidentiality in patient-health provider relationships.

The Department's guidance concerning fiduciary duty to select providers, described above, includes the directive that fiduciaries consider the extent to which health care providers maintain internal procedures that protect patient privacy.

Further, the Department assisted the Department of Health and Human Services in preparing a report, required by HIPAA, that recommends standards for providers with respect to privacy of certain health care information and the application of such standards to ERISA-covered group health plans. This report, Confidentiality of Individually-Identifiable Health Information, was issued by the Department of Health and Human Services in September, 1997.

Complaints and Appeals

Internal Appeals

"All consumers have the right to a fair and efficient process for resolving differences with their health plans, health care providers, and the institutions that serve them, including a rigorous system of internal review"

The Commission recommended that all health care consumers should have the right to a fair and efficient process for resolving differences with their health plans, health care providers, and the institutions that serve them, including a rigorous internal review process. The Department has promulgated a proposed regulation, published in the Federal Register on September 9, 1998, that would amend the Department's benefit claims regulation at 29 C.F.R. 2560.503-1, *inter alia*, to strengthen the claims procedure requirements applicable to group health plans.

The proposed regulation would establish new standards for the processing of group health and disability claims. In particular, the proposed regulation should require more timely decision-making, more complete disclosure with respect to procedural rights, fuller explanations of benefit decisions, and better access to plan records relevant to decisions. Group health plan decisions generally would be required to be resolved within 15 days (30 days for appeals of denials). Disability claims would have to be decided within 30 days (60 days for appeals of denials). The proposed regulation would also improve the standards for review of benefit denials by requiring review decisions to be made by an individual different from, and not subordinate to, the initial decision-maker, by requiring plans to permit claimants to submit and have considered additional evidence on appeal, and by requiring reviewers to consult appropriate medical professionals on questions involving medical judgment.

The proposed regulation would also require group health plans to provide an expedited claims process for claims involving urgent care, e.g., claims with respect to which the application of the 15-day period prescribed for non-urgent claims could seriously jeopardize the health of the claimant or cause the claimant severe unmanageable pain. Under the expedited schedule, benefit decisions would be required to be made within not more than 72 hours and to be communicated by the most expeditious means.

The Department's proposal to amend its benefit claims procedure regulation responds directly to many of the Commission's concerns. It has been promulgated as a proposed regulation, subject to a period of public notice and comment. That period, which was to close on November 9, 1998, is being extended an additional 30 days, until December 9, 1998, in response to numerous requests for additional time to consider the proposal and to prepare comments. The Department anticipates receiving a large volume of comments in response to this proposal, which makes significant changes to current requirements. Following the close of the notice and comment process, the Department will work to produce a final rule as soon as possible, taking into account public comment on the proposal.

External Appeals

"All consumers have the right to a fair and efficient process for resolving differences with their health plans, health care providers, and the institutions that serve them, including a rigorous system of internal review and an independent system of external review" [emphasis added]

The Commission also advocated, as part of the right to a fair process for resolving disputed between health care consumers and health care providers, the creation of an independent system of external review. Inasmuch as the Department, as described in the February 19 Report, has no statutory authority to create such an external review process for benefit claims under group health plans covered by ERISA, the Department has been unable to take any administrative action to advance this goal.

III. NUMBERS OF PEOPLE AFFECTED BY THE DEPARTMENT'S ACTIONS

ERISA provides standards for all "employee benefit plans," that is, all plans, funds, or programs established or maintained by employers for their employees, or by unions for their members, to provide certain enumerated benefits, among which are group health benefits. The regulations that the Department has proposed make no distinction on the basis of the nature of the health care provider that a plan chooses to provide group health benefits. Thus, all actions taken by the Department with respect to the Commission's recommendations will affect all group health plans, whether they provide benefits through HMOs or otherwise (through insurance or by direct payment of the employer's assets). If the Department's proposed regulations are finalized in their current form, they will provide protections equally to all participants and beneficiaries of group health plans, regardless of the nature of the health care provider.

The Department estimates that there are a total of 2.6 million ERISA-covered group health plans, covering approximately 122 million participants and beneficiaries, all of whom would be affected by these regulations. Of these, approximately 39 million are enrolled in HMOs, 36 million in PPOs, 22 million in POS plans, and 26 million in fee-for-service plans.

IV. IMPLICATIONS OF NEW PROTECTIONS

The Department believes that the proposed regulations will be of great benefit to participants and beneficiaries.

In part, the proposed regulations respond to problems raised by participants and beneficiaries (and their representatives) that came to the attention of the Department as a result of its publication in the Federal Register, on September 8, 1997, of a Request for Information (RFI) asking for public comment on whether, and to what extent, the currently effective benefit claims regulation should be revised. In response to that RFI, the Department received over 90 comment letters from representative segments of the interested public. Although the majority of commenters representing employers and benefit administrators did not recommend amending the current regulation, the majority of commenters representing participants and beneficiaries asserted that problems currently exist in the processing of benefit claims, including excessive delays in decision-making, inadequate disclosure, and questionable review practices.

Under the proposed regulations, those problems will be remedied. Participants and beneficiaries will better understand their rights under their plans, and they will be better assured that those rights will be honored. The Department expects that the proposed regulation will improve the accuracy of claims determinations, with the result that some claims that would have been denied will instead be approved, either immediately or upon appeal. In addition, some claims that would have been delayed will be approved more quickly. As a result, some number of serious injuries will be averted. When claims are inappropriately delayed or denied, participants and beneficiaries sometimes delay or forgo medical treatment and as a result fall victim to avoidable injuries or even death. The cost of such injuries, which currently falls primarily on the participants and beneficiaries themselves, can be far larger than the cost of claims for coverage of the forgone medical treatments. By improving the accuracy and timeliness of claims determinations, the proposed regulations will avert some of these costly and avoidable injuries.

The Department has just recently published the proposed regulations and has not yet received any substantive public comments on the specifics of the proposals. Once the Department has completed the notice and comment period on its proposed regulations, it will have a more accurate view of the public support for these specific changes. Although the proposals respond to comments received from the public in response to the RFI published in September, 1997, at this time, it is not possible to judge the extent to which outside parties endorse these specific regulatory efforts.

There are no data available on the current incidence of delayed or inaccurate claims determinations or resultant injuries to participants and beneficiaries. Therefore, the Department was unable to quantify the dollar value of the improvements in the accuracy and timeliness of claims determinations expected under the proposed regulations.

The Department did, however, undertake to estimate the administrative cost to plans of upgrading their claims procedures and SPDs to comply with the proposed regulations. Assuming that all plans came into compliance with the proposed regulations' requirements no later than the year 2000, the added administrative costs would peak that year at approximately \$2.75 per participant per year, or less than 25 cents per month and less than one-tenth of one percent of total annual ERISA health plan costs. These costs include one-time, start-up costs of coming into compliance. The ongoing cost in later years would be lower, amounting to approximately \$0.56 per participant per year, or about one-one-hundredth of one percent of total annual ERISA health plan costs.

V. CONCLUSION

The Department will proceed expeditiously with the administrative steps necessary to bring the proposed regulation into final form. That will include a period of notice and comment and a period for deliberations and possible revisions of the proposals to respond to the comments. The Department is confident that its new regulations, which will govern all group health plans sponsored by private-sector employers, will improve the quality of health care available to participants and beneficiaries in group health plans and will increase these individuals' confidence in the reliability and availability of their health care benefits. Although recognizing its limited jurisdiction under current law, the Department hopes that its rules, within their narrow scope, will serve as models for other reform efforts to improve the quality and availability of health care to other sectors of the public.

While these contemplated reforms will significantly improve the protections provided by ERISA, they stop short of fully implementing the Commission's Bill of Rights. Because the Department lacks the authority under current law to do more, these reform measures do not include any requirement, as recommended by the Commission, for an external review of plan decisions. Nor do they alter the deferential standard of review applied by the courts in reviewing plan decisions. The absence of any independent, de novo review for claims determinations is a serious weakness in the protections offered by the existing statutory scheme.

Moreover, stronger remedies are needed to assure compliance with the enhanced protections adopted in the proposed regulations. Under current law, when a consumer suffers harm due to wrongful delay or denial of a claim for health care benefits, ERISA only provides for payment of the benefit itself; the claimant cannot recover any additional medical costs or other compensation. As a result, a plan fiduciary who fails to assure compliance with the requirements of these regulatory reforms will not be fully accountable to the individual participant for that failure. If the plan's delay in providing a decision, or recalcitrance in providing critical information, causes injury, the participant has no legal recourse, and the responsible fiduciary suffers no consequences.

As our system is currently constituted, also, there is no disincentive to applying harsh and arbitrary guidelines for the initial denial of care and no incentive to assure that the initial claims determination is fair. The wrongly denied claimant who is injured can never seek compensation for injury while his case is pending, and the discouraged participant with a meritorious claim represents pure savings to the managed care entity. Thus, under our current system, there is a strong financial incentive to delay in providing medical treatment because the only remedy that a plan will have to ultimately provide is the benefit itself that was previously denied. Only remedial legislative action can change these results.


Alexis M. Herman

cc Stephanie Street
*return

PATIENTS' BILL OF RIGHTS ACTIONS

ACTION	STATUS
<u>CBO:</u> Releasing the numbers scoring the Dingell/Ganske/Kennedy legislation.	This/next week. Possible POTUS statement.
<u>HHS:</u> Implement regulations that bring Medicaid into substantial compliance with all of the major elements of the "Consumer Bill of Rights," including access to specialists and improved participation in treatment decisions, by no later than next year.	Late July/early August.
<u>VA:</u> Implement a sufficient external appeals process is throughout the Veteran's Health System.	Late July.
<u>DOD:</u> Assure access to specialists for beneficiaries with chronic medical conditions; implement strong grievance and appeals rights consistent with the "Consumer Bill of Rights" throughout the military health system; and promote greater use of providers who have specialized training in women's health issues.	Possibly late July -- confirming status. Might have to do some of these separately.
<u>OPM/DOD:</u> OPM will issue final regulations to prohibit practices which restrict physician-patient communications about medically necessary treatment options. DoD will issue a policy directive to ensure that all patients in the military health system can fully discuss all treatments options. This includes requiring disclosure of financial incentives to physicians and prohibiting "gag clauses"	Early August -- could do in conjunction with DoD anti-gag provisions.
<u>OPM:</u> Announce that over 300 private health plans have agreed to come into compliance with the patients' bill of rights as a condition of participation in the Federal Employees Health Benefits Program, including access to specialists, continuity of care, and access to emergency room services, that will be implemented this year.	Early September

WHITE HOUSE STAFFING MEMORANDUM

HC -
Bill of Rights

DATE: 3/11 ACTION/CONCURRENCE/COMMENT DUE BY: _____

SUBJECT: Kennedy memo on upcoming health care events

	ACTION.	FYI		ACTION	FYI
VICE PRESIDENT	<input type="checkbox"/>	<input checked="" type="checkbox"/>	McCURRY	<input type="checkbox"/>	<input checked="" type="checkbox"/>
BOWLES	<input type="checkbox"/>	<input checked="" type="checkbox"/>	McGINTY	<input type="checkbox"/>	<input type="checkbox"/>
McLARTY	<input type="checkbox"/>	<input type="checkbox"/>	NASH	<input type="checkbox"/>	<input type="checkbox"/>
PODESTA	<input type="checkbox"/>	<input checked="" type="checkbox"/>	RADD	<input type="checkbox"/>	<input type="checkbox"/>
MATHEWS	<input type="checkbox"/>	<input checked="" type="checkbox"/>	REED	<input type="checkbox"/>	<input checked="" type="checkbox"/>
RAINES	<input type="checkbox"/>	<input checked="" type="checkbox"/>	RUFF	<input type="checkbox"/>	<input type="checkbox"/>
BLUMENTHAL	<input type="checkbox"/>	<input checked="" type="checkbox"/>	SMITH	<input type="checkbox"/>	<input type="checkbox"/>
BERGER	<input type="checkbox"/>	<input type="checkbox"/>	SOSNIK	<input type="checkbox"/>	<input type="checkbox"/>
ECHAVESTE	<input type="checkbox"/>	<input type="checkbox"/>	SPERLING	<input type="checkbox"/>	<input checked="" type="checkbox"/>
EMANUEL	<input type="checkbox"/>	<input checked="" type="checkbox"/>	STREETT	<input type="checkbox"/>	<input type="checkbox"/>
GIBBONS	<input type="checkbox"/>	<input type="checkbox"/>	TARULLO	<input type="checkbox"/>	<input type="checkbox"/>
STEIN	<input type="checkbox"/>	<input checked="" type="checkbox"/>	VERVEER	<input type="checkbox"/>	<input type="checkbox"/>
IBARRA	<input type="checkbox"/>	<input type="checkbox"/>	WALDMAN	<input type="checkbox"/>	<input checked="" type="checkbox"/>
KLAIN	<input type="checkbox"/>	<input type="checkbox"/>	YELLEN	<input type="checkbox"/>	<input type="checkbox"/>
LEWIS	<input type="checkbox"/>	<input checked="" type="checkbox"/>	BEGALA	<input type="checkbox"/>	<input checked="" type="checkbox"/>
LINDSEY	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
MARSHALL	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
			_____	<input type="checkbox"/>	<input type="checkbox"/>

REMARKS: This will be forwarded to the President later this a.m.

RESPONSE:

THE WHITE HOUSE

WASHINGTON

March 10, 1998

MEMORANDUM TO THE PRESIDENT

FROM: Chris Jennings

SUBJECT: Upcoming Patients' Rights/Quality Events and Legislation

cc: John Podesta, Rahm Emanuel, Bruce Reed, Larry Stein, Elena Kagan

On Friday, you are scheduled to receive the Quality Commission's final report. Next Tuesday, the Democrats are unveiling their "Patients' Rights" bill. Both of these events have potential to positively or negatively affect our chances of enacting strong consumer protection legislation this year. This memo outlines the reasons why and seeks your final decision on the advisability of appearing with the Democrats when they introduce their bill.

Background

The prospect of achieving a "Patients' Rights" legislative victory has been significantly enhanced over the last few weeks. Your Executive Memorandum directing all agencies to come into virtual compliance with the Quality Commission's Consumer Bill of Rights, your well-received speech to the American Medical Association, today's *New York Times* editorial praising your approach to the patients' bill of rights, and Speaker Gingrich's acknowledgment yesterday that consumer protection legislation will likely pass the Congress this year have positioned you extremely well on this issue. In addition, the House Republican Health Task Force (Hastert, Thomas, Bliley, etc.) has indicated that they will work with us in coordinating the development of legislation as long as we do not "overly politicize" this issue.

Final Quality Commission Meeting and Report

The Quality Commission's final report presents a good opportunity to build on the momentum you have achieved through your endorsement of their "Consumer Bill of Rights." The second part of their work product -- those recommendations dealing with quality standards -- are non-controversial, new measures designed improve health care quality. Your endorsement of the Commission's recommendations will be widely praised because there is a strong belief that developing evidence-based health care standards have great potential to improve quality and constrain costs. However, partly because these recommendations are relatively non-controversial, the news most likely to be reported will be the fact that the Commission did not achieve consensus on an enforcement mechanism for the patient protections. Although they were not expected to reach consensus, the press will likely use this to underscore the controversy surrounding this issue (further detailed below.)

Democratic Leadership's "Patients' Bill of Rights"

Your "Patients' Bill of Rights" serves as the foundation for the Democratic Leadership's bill. However, their legislation adds provisions that the business community, and in a number of cases the elite validators, would oppose because they believe they are excessively regulatory and costly. For example, it includes a number of mandated benefits such as requiring health plans to offer a mandatory point-of-service option, and to cover breast cancer reconstructive surgery and all clinical trials.

While CBO has yet to score any of these additional provisions, some could prove to be quite costly. For example, the initial estimates by the HCFA actuaries assume that applying the bill's provision to cover all clinical trials to Medicare and Medicaid -- generally consistent with your previous efforts to bring all Federal health plans in compliance with any new private sector requirements -- would cost Medicare approximately \$5 billion over five years and Medicaid \$4 billion over five years. Any costly scores from CBO would no doubt lend credence to criticisms that a patients' bill of rights would increase health care costs and, as a consequence, increase the number of uninsured.

The most controversial provision in the Democratic bill is the enforcement mechanism that relies on state-based, legally enforceable remedies. The Administration has consistently stated that patient protections must be assured but has yet to take an official position on the best enforcement mechanism. The business community strongly opposes this approach, arguing that the trial lawyers will use this new opening to sue and significantly increase health insurance costs. Because of their fear of this provision, some within the business community suggest that its very existence would leave them no other choice but to drop coverage. Although they are significantly overstating the case, their opposition would be formidable.

That being said, the Democrats' bill will be popular among most providers, physicians, and consumers who strongly support remedies, and some of the bill's mandatory benefits will have broad appeal. Moreover, the Democratic leadership strongly desires your participation in the event. Finally, notwithstanding Republican, business, and the elites' opposition to a number of the bill's provisions that go beyond the patients' bill of rights, they are likely to be popular among the general public and could potentially be helpful in developing outside public pressure for a bill.

Conversely, standing with the Democratic leadership does carry real risk. First, because CBO has not scored the Democratic Leadership's enforcement provision and other controversial provisions, taking (or suggesting) a position of support before this analysis is complete would be ill-advised. In addition, some within the Republican leadership who are currently indicating their willingness to work with us on a bill may be alienated by their almost inevitable perception that we are "politicizing" this issue. Finally, a perceived endorsement by you of the Democrats' bill will guarantee a higher level of scrutiny and well-funded opposition by the business community.

Recommendation

DPC believes that it may be difficult for your attendance at the Democrat's unveiling on Tuesday to be perceived as anything other than unqualified support. We are particularly concerned about the lack of cost estimates of the bill. Finally, we believe that it has great potential to hamper the relationship we are trying to build with those Republicans who have indicated their interest in passing a bill in this Congress.

Although recognizing the possible risks, your political and communications advisors believe that you can lend your support without giving an all-out endorsement. They believe that it is very important that you respond to the Democrats' desire for a unity event and believe that it has the potential to increase outside public pressure for Congressional action.

Regardless of your decision, we all agree that if you do choose to go, the language you use will be critically important to both sides and will have to be carefully formulated. In addition, we will need to work closely with Larry Stein to give the heads up to those Republicans, particularly on the House side, who will be distraught about your close link to the Democratic bill.

THE WHITE HOUSE

WASHINGTON

February 19, 1998

HEALTH CARE CONSUMER BILL OF RIGHTS EVENT

DATE: February 20, 1998
LOCATION: Holiday Park Multiservice Senior Center
BRIEFING TIME: 9:15 am - 9:45 am
EVENT TIME: 10:30 am - 11:30 am
FROM: Bruce Reed/Chris Jennings

I. PURPOSE

To highlight your leadership in bringing the Federal Government health plans into compliance with the Health Care Consumer Bill of Rights ("Patient Bill of Rights") and your commitment to making sure every American is afforded these rights.

You will be taking the following actions: (a) receive a report from the Vice President on the current status of compliance within the federal system with the commission's recommendations; (b) sign an Executive Memorandum directing all Federal health plans - which serve over 85 million Americans -- to come into compliance with the Quality Commission's Patient Bill of Rights; and (c) re-issue your challenge to Congress to pass legislation that assures these patients' rights for Americans in private health plans.

II. BACKGROUND

You will be making remarks to approximately 150 senior citizens, representatives from health care groups, and federal employees. The center serves on a daily basis approximately 500 Montgomery County residents over 55 years old. The center provides a multitude of services, including: educational programs, recreational, wellbeing and physical fitness, and a computer training program. The center is particularly strong in its health programs, which it provides in partnership with the Washington Hospital Center. Screening for blood pressure, diabetes, prostate cancer are some of the services provided.

(A) Report from the Vice President on Consumer Protections in Health Care

You will receive a report from the Vice President that shows that all of the Federal health programs, including Medicare, Medicaid, Indian Health Service, the Federal Employee Health Benefits Program, the Department of Defense Military Health Program, and the Veteran's Health Program are or will be in compliance with the Patient Bill of Rights. Because the Federal health plans are already largely in compliance their experience illustrates that implementing consumer protections to help Americans navigate a changing health care system, can be done without excessive costs or regulations.

(B) Taking Executive Action to Direct Agencies to come into Compliance.

You will sign an Executive Memorandum that does the following:

1. Directs HHS To Take Administrative Actions To Ensure That Medicare Comes Into Compliance With Rights, Including Access to Specialists By Next Year.

Medicare currently has in place a number of consumer protections, including an internal and external appeals process. In 1997, HCFA issued a clarifying letter explicitly prohibiting so called "gag clauses" to restrict physician-patient communication about medically necessary treatment options and a 1996 letter that forbid financial arrangements that cause providers to limit necessary services. However, there are certain protections, such as access to specialists, and improved participation in treatment decisions, which are not currently guaranteed. You will direct HHS to issue directives in these and other areas by no later than next year to bring Medicare, which serves 38 million older Americans and people with disabilities, substantially into compliance.

Directs HCFA To Take Administrative Actions To Assure Greater Compliance for Medicaid, Including Access to Specialists, By Next Year.

Similar to Medicare, you will direct HHS to issue directives to bring Medicaid -- which serves 36 million Americans -- into substantial compliance with the Patient Bill of Rights by no later than next year. These include ensuring that Medicaid beneficiaries are assured access to specialists and improved participation in treatment decisions.

Directs HCFA To Immediately Send Letter To States To Ensure That Emergency Room Services Are Covered. You will direct HCFA to immediately notify states emergency room services are covered.

2. Directs the Federal Employees Health Benefits Program (FEHBP) To Ensure 350 Participating Carriers Come Into Compliance With the Bill of Rights By Next Year. You will direct OPM, which manages FEHBP and serves 9 million people, to notify all 350 participating carriers that they must come into compliance with the Patient Bill of Rights, particularly with regard to access to specialists, continuity of care, access to emergency room services. You will also direct OPM to work with each participating carrier to ensure they come into full compliance with the Patient Bill of Rights by the end of next year. OPM issues a call letter each March which sets forth FEHB Program and policy changes. To meet this directive, this year's letter will specifically address new expectations for participating carriers in areas such as, access to specialists, continuity of care, disclosure of financial incentives, and access to emergency room services.

Directs OPM to Publish New Regulations Prohibiting "Gag Clauses." You will direct OPM to publish a regulation in the next three months to ensure that gag clauses, which restrict physician-patient communications about medically necessary treatment options, not be a part of any provider agreement that includes FEHBP enrollees.

3. Brings Veteran's Health Programs Into Compliance With the Bill of Rights Through A Series of Policy Directives. You will direct the VA to use administrative

authority to ensure that an internal and external appeals process is in place consistent with the bill of rights and to issue a new directive to ensure that VA consumers have sufficient information -- consistent with the information disclosure recommendations in the Patient Bill of Rights. The VA already assures many protections, such as access to specialists. This new actions will bring the VA system, which served 3 million veterans in 1997 alone, in virtual compliance with the Patient Bill of Rights.

4. Brings Military Health Service Into Compliance Through A Series of Policy Directives and Contractual Modifications. You will direct DOD, which serves 6 million Americans to: (1) establish a strong grievance and appeal right for beneficiaries who have been denied by managed care companies that are in contract with the Military Health System; (2) to issue a directive to promote greater use of providers who have specialized training in women's health issues to serve as primary care managers for female beneficiaries; and (3) to issue a directive to ensure that this policy is being fully implemented throughout the military health system. These actions, to be completed by this fall, will bring the Military Health System in substantial compliance with the Patient Bill of Rights.

5. Directs the Department of Labor To Comply to the Extent Possible By Ensuring Adequate Information Disclosure and Strengthening Internal Appeals. DoL is responsible for the administration and enforcement of the Employee Retirement Income Security Act (ERISA) which governs approximately 2.5 million private sector health plans, that cover about 125 million Americans. However, ERISA focuses primarily on the pension abuses and does not provide extensive standards for health care plans. As a consequence, the Department of Labor has little to no ability to ensure that ERISA-covered health plans has sufficient consumer protections. You will direct DOL to improve information disclosure rights and strengthen the internal appeals process for all ERISA plans, consistent with the Commission's recommendations, this spring to ensure that decisions regarding urgent care are resolved within not more than 72 hours and generally resolved within 15 days for non-urgent care by this spring.

(C) Urge Congress to pass a federally-enforceable Patient Bill of Rights this year.

Last November, you directed a review of the health care programs administered and/or overseen by the Federal government to assess the extent to which they are in compliance with the Patient Bill of Rights recommended by the Quality Commission. This report, which you are formally being presented with through the Vice President, underscores that the Federal government is well on its way to coming into full compliance with the consumer protections and can serve as strong models for health plans in the private sector. However, the Department of Labor which oversees the law that governs private sector plans, reported that Federal legislation is needed to ensure patient protections in the private sector. To assure these protections, Congress must act to pass a Patient Bill of Rights this year.

III. PARTICIPANTS

Briefing Participants:

The Vice President

Bruce Reed

Chris Jennings

Event Participants:

The Vice President

Beth Layton, Vice Chair of the Holiday Park Advisory Council

Marty Wish, Father whose son was denied emergency room care

Dian Bower, Spouse of Army service man, who has recently suffered a brain tumor but is successfully being treated under the military's managed care plan. She also served for 13 years in the Army.

IV. PRESS PLAN

Open Press.

V. SEQUENCE OF EVENTS

- You will be announced onto the stage accompanied by the Vice President and stage participants.
- Beth Layton, Vice Chair of the Holiday Park Advisory Council, will make welcoming remarks and introduce Dian Bower, spouse of Army service man.
- Dian Bower will make remarks and introduce Marty Wish, father of son denied emergency room coverage.
- Marty Wish will make remarks and introduce the Vice President.
- The Vice President will make remarks and introduce you. (*He will present you with the Report on Consumer Protections in federal health plans.)
- You will make remarks.
- You will then take your seat at the signing table on the stage. You will invite stage participants and a group of senior citizens seated in the front row to join you as you sign the Executive Memorandum.
- You will sign the Executive Memorandum.
- You will then work a ropeline and depart.

VI. REMARKS

Remarks Provided by Speechwriting.

VII. ATTACHMENTS

- Summary of the Commission's Consumer Bill of Rights and Responsibilities.

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

The Patient Bill of Rights consists of the following rights and responsibilities:

- (1) **Access to Accurate, Easily Understood Information** about consumers' health plans, facilities and professionals to assist them in making informed health care decisions;
- (2) **Choice of Health Care Providers** that is sufficient to assure access to appropriate high quality care. This right includes assuring consumers with complex or serious medical conditions access to specialists, giving women access to qualified providers to cover routine women's health services, and providing access to continuity of care for consumers who are undergoing a course of treatment for a chronic or disabling condition;
- (3) **Access to Emergency Services** when and where the need arises. This provision requires health plans to cover these services in situations where a "prudent layperson" could reasonably expect that the absence of care could place their health in serious jeopardy;
- (4) **Participation in Treatment Decisions** including requiring providers to disclose any incentives, financial or otherwise -- that might influence their decisions, and prohibits "gag clauses" which restrict health care providers' ability to communicate with and advise patients about medically necessary options;
- (5) **Assurance that Patients are Respected and Not Discriminated Against**, including discrimination in the delivery of health care services consistent with the benefits covered in their policy based on race, gender, ethnicity, mental or physical disability, and sexual orientation;
- (6) **Confidentiality** which assures that individually identifiable medical information is not disseminated and that also provides consumers the right to review, copy and request amendments to their own medical records;
- (7) **Grievance and Appeals Processes** for consumers to resolve their differences with their health plans and health care providers -- including an internal and external appeals process; and
- (8) **Consumer Responsibilities** which asks consumers to take responsibility by maximizing healthy habits, becoming involved in health care decisions, carrying out agreed-upon treatment plans, reporting fraud, among others.

PRESIDENT CLINTON ANNOUNCES THAT FEDERAL HEALTH PLANS ARE COMING INTO COMPLIANCE THE PATIENTS BILL OF RIGHTS AND REISSUED CHALLENGE TO CONGRESS TO PASS RIGHTS THIS YEAR

February 20, 1998

Today, the President released an Executive Memorandum directing all Federal health plans, which serve over 85 million Americans, to come into compliance with the President's Quality Commission's consumer bill of rights. He also re-issued his challenge to Congress to pass legislation that assures these patients' rights for Americans in private health plans. The Executive Memorandum followed a report that the Vice President provided to the President on the current status of compliance with the commission's recommendations.

ANNOUNCED THAT ALL FEDERAL HEALTH PROGRAMS ARE OR WILL BE VIRTUALLY IN COMPLIANCE WITH THE CONSUMER BILL OF RIGHTS BY NO LATER THAN NEXT YEAR. Today, the President announced that based on the Vice President's report all of the Federal health programs, including Medicare, Medicaid, Indian Health Service, the Federal Employee Health Benefits Program, the Department of Defense Military Health Program, and the Veteran's Health Program are or will be in compliance with the Consumer Bill of Rights. Because the Federal health plans are already largely in compliance their experience illustrates that implementing consumer protections to help Americans navigate a changing health care system, can be done without excessive costs or regulations.

ISSUED AN EXECUTIVE MEMORANDUM TO DIRECT AGENCIES TO COME INTO COMPLIANCE. While the Federal government is taking a leading role to assure consumer protections are in place, the Vice President's report concluded they can do more. The President issued an Executive Memorandum to ensure that these Federal agencies take additional steps to come into compliance with the bill of rights. It:

- ✓ **Directed HHS To Take Administrative Actions To Ensure That Medicare Comes Into Compliance With Rights, Including Access to Specialists By Next Year.** Medicare currently has in place a number of consumer protections, including an internal and external appeals process. In 1997, HCFA issued a clarifying letter explicitly prohibiting so called "gag clause" to restrict physician-patient communication about medically necessary treatment options and a 1996 letter that forbid financial arrangements that cause providers to limit necessary services. However, there are certain protections, such as access to specialists, and improved participation in treatment decisions, which are not currently guaranteed. The President directed HHS to issue directives in these and other areas by no later than next year to bring Medicare, which serves 38 million older Americans and people with disabilities, substantially into compliance.
- ✓ **Directed HCFA To Take Administrative Actions To Assure Greater Compliance for Medicaid, Including Access to Specialists, By Next Year.** Similar to Medicare, HHS has determined that there are additional appropriate administrative actions it could take to ensure that the Medicaid program, which serves 36 million Americans, comes into

substantial compliance with all of the major elements of the "Consumer Bill of Rights " These include ensuring that Medicaid beneficiaries are assured access to specialists with complex and serious medical needs and improved participation in treatment decisions, by no later than next year. The President directed HHS to issue directives to bring Medicaid into substantial compliance by no later than next year.

- ✓ **Directed HCFA To Immediately Send Letter To States To Ensure That Emergency Room Services Are Covered.** The President directed HCFA to send a letter to State Medicaid directors immediately to clarify that States are required to cover emergency room services consistent with the recommendations of the Consumer Bill of Rights.

- ✓ **Directed The Federal Employees Health Benefits Program (FEHBP) To Ensure 350 Participating Carriers Come Into Compliance With the Bill of Rights By Next Year.** The President directed OPM, which manages FEHBP which serves 9 million people, to notify all 350 participating carriers that they must come into compliance with the "Consumer Bill of Rights," particularly with regard to access to specialists, continuity of care, access to emergency room services. He also directed OPM to work with each participating carrier to ensure they come into full compliance with the "Consumer Bill of Rights" by the end of next year. OPM issues a call letter each March which sets forth FEHB Program and policy changes. To meet the President's directive, this year's letter will specifically address new expectations for participating carriers in areas such as, access to specialists, continuity of care, disclosure of financial incentives, and access to emergency room services.

- ✓ **Directed OPM to Publish New Regulations Prohibiting "Gag Clauses."** The President directed OPM to publish a regulation in the next three months to ensure that gag clauses, which restrict physician-patient communications about medically necessary treatment options, not be a part of any provider agreement that includes FEHBP enrollees. These new actions build on OPM's existing consumer protections, including an internal and external appeals process and information disclosure rights.

- ✓ **Bringing Military Health Service Into Compliance Through A Series of Policy Directives and Contractual Modifications.** The President directed DOD, which serves 6 million Americans to: (1) establish a strong grievance and appeal right for beneficiaries who have been denied by managed care companies that are in contract with the Military Health System; (2) to issue a directive to promote greater use of providers who have specialized training in women's health issues to serve as primary care managers for female beneficiaries; (3) to issue a directive to ensure that this policy is being fully implemented throughout the military health system. These actions, to be completed by this fall, will bring the Military Health System in substantial compliance with the Consumer Bill of Rights.

- ✓ **Bringing Veteran's Health Programs Into Compliance With the Bill of Rights Through A Series of Policy Directives.** The VA served 3 million veterans in 1997 alone. The President directed the VA to use administrative authority to ensure that an internal and external appeals process is in place consistent with the bill of rights and to issue a new directive to ensure that VA consumers have sufficient information -- consistent with the information disclosure recommendations in the "Consumer Bill of Rights". The VA already assures many protections, such as access to specialists. This new actions will bring the VA system, which served 3 million veterans in 1997 alone, in virtual compliance with the consumer bill of rights.

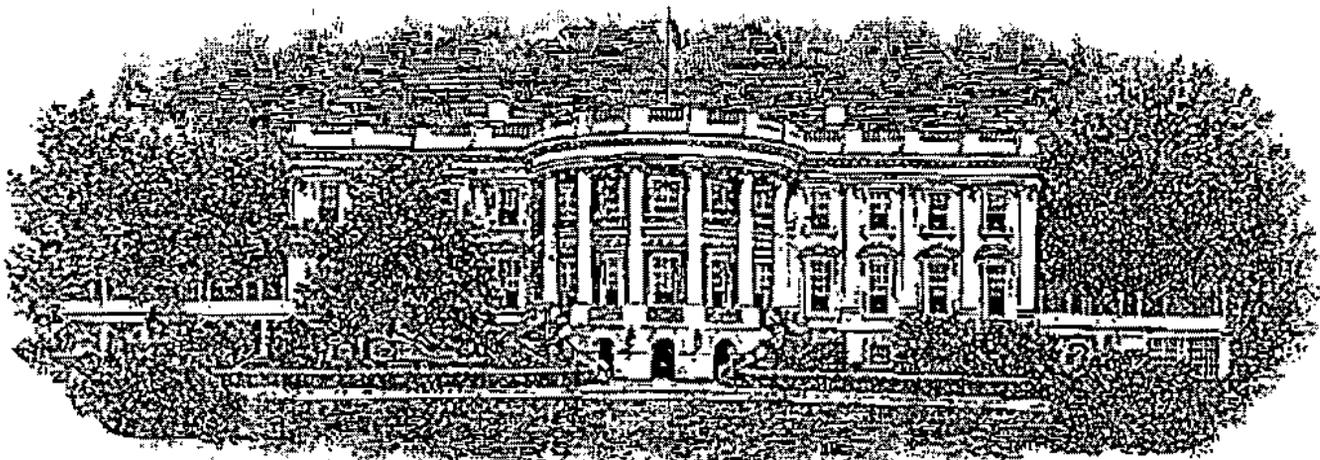
- ✓ **Directed the Department of Labor To Comply to the Extent Possible By Ensuring Adequate Information Disclosure and Strengthening Internal Appeals.** DoL is responsible for the administration and enforcement of the Employee Retirement Income Security Act (ERISA) which governs approximately 2.5 million private sector health plans, that cover about 125 million Americans. However, ERISA focuses primarily on the pension abuses and does not provide extensive standards for health care plans. As a consequence, the Department of Labor has little to no ability to ensure that ERISA-covered health plans has sufficient consumer protections. The President directed DOL to improve information disclosure rights and strengthen the internal appeals process for all ERISA plans, consistent with the Commission's recommendations, this spring to ensure that decisions regarding urgent care are resolved within not more than 72 hours and generally resolved within 15 days for non-urgent care by this spring.

REISSUED CHALLENGE TO CONGRESS TO PASS FEDERALLY-ENFORCEABLE PATIENTS BILL OF RIGHTS THIS YEAR. The Department of Labor's report underscores that most consumer protections cannot be assured to patients in private health plans without additional legislation. Their report underscores why the President's call on Congress to pass a Federally-enforceable patients bill of rights is so important. Without this legislation, the millions of Americans in private health plans will never be assured these protections. Today, the President renewed his call to Congress to pass a patients bill of rights this year.

Last November, the President directed a review the health care programs administered and/or overseen by the Federal government to assess the extent to which they are in compliance with the "Consumer Bill of Rights" recommended by the President's Quality Commission. This report, which was formally conveyed through the Vice President yesterday, underscores that Federal government is well on its way to coming into full compliance with the consumer protections and can serve as strong models for health plans in the private sector. However, the Department of Labor which oversees the law that governs private sector plans, reported that Federal legislation is needed to ensure patient protections in the private sector. To assure these protections, the President renewed his call to Congress to pass a patient bill of rights this year.

The White House

HC
B.Y. A
Rts



DOMESTIC POLICY

FACSIMILE TRANSMISSION COVER SHEET

TO: Bruce Reed

FAX NUMBER: 6-5542

TELEPHONE NUMBER: _____

FROM: Chris Jennings

TELEPHONE NUMBER: _____

PAGES (INCLUDING COVER): _____

COMMENTS: NYT story

11/22/97

Bruce - F45



The Rights of Patients, by Law

President Clinton embraced the patients' "bill of rights" issued this week by an advisory commission, but upset some of its members by proposing that Congress put the recommendations into law. The commission intends to debate how best to institute its proposals, and some felt the President's remarks prejudged the issue.

Yet Mr. Clinton's judgment was sound — Federal action will be needed — and his words measured. The President said Congress should enact those recommendations that could not be carried out in other ways, leaving plenty of room for the commission to advise him on which recommendations would best be left to the states or voluntary action by health plans. He appointed the commission earlier this year because many Americans are now covered by managed-care plans that control their choices of physicians and treatments. The insecurity bred by bureaucratic control over health care has driven many consumers to seek governmental protection.

The commission's report closely mirrors the draft version issued last month. It would require health plans to disclose key information, create appeals procedures when they deny care that patients believe is medically necessary, preserve confidentiality of medical records and provide reasonable access to specialists and emergency services. Because health plans have not done this on their own, and because states are prohibited from regulating health plans of most large employers, some of these recommendations will come about only if Congress acts.

The most controversial provision in the report would guarantee patients the right to appeal to an external authority decisions by their plans to deny treatment. The commission limits this right to patients who first exhaust their plans' internal appeals procedures, and to treatments that cost a significant amount and are not specifically excluded by their plans' contracts. The danger of outside review is that it will run around their plans' ability to manage care and weed out unnecessary procedures, thereby running up costs.

Higher costs matter because the ranks of the uninsured are swelling as companies cut back coverage and workers turn down coverage offered by employers because of its cost. Congress should not back away from the commission's proposal, but it should take care to limit external appeals to large claims covered by contract and whose denial would truly jeopardize a patient's health.

The report glaringly fails to require employers who offer their workers coverage to provide a choice of health plans. Without choice, consumers cannot punish bad plans and reward good ones. States cannot compel choice on their own because Federal law prohibits them from regulating most large employers.

Republican leaders wasted no time rejecting Congressional action, tarring the President's idea as another grandiose scheme for a Federal take-over of health care. The truth is that the commission limited itself to basic protections that any responsible plan would provide. Putting them into law would serve to reassure anxious patients.

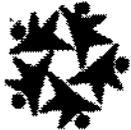
MEMORANDUM

*H. care - Consumer Bill
of Rights*

TO: Bruce Reed
Gene Sperling
John Hilley
Rahm Emanuel
Barry Toiv
Elena Kagen
FROM: Chris Jennings
DATE: November 5, 1997
SUBJECT: HIAA Internal Memo

Attached is the Health Insurance Association of America's memo that has been referred to in many articles about Republican leadership's opposition to health insurance consumer protection legislation. This is the memo that has the "get of your butts, get off your wallets" quote that was allegedly relayed to the business and insurance community by Senator Lott.

The President may do an event around the release of the Quality Commission's "Consumer Bill of Rights" final report on November 19 or 20. As a result, we will need to have a final discussion to determine the best legislation "positioning" for the President. Since the insurer's and the business communities will want this to be a debate around premium increases and accompanying coverage losses, we need to be careful. Look forward to talking soon about this issue.



National Association of
Children's Hospitals

401 Wythe Street
Alexandria, VA 22314
(703)684-1355 Fax (703)684-1589

N · A · C · H

FAX

DATE: 11/3/97 # PAGES: 2

TO: HEALTH GROUPS

FAX: _____

PHONE: _____

FROM: BRUCE D. LESLEY
DIRECTOR, CONGRESSIONAL AFFAIRS

SUBJECT: Managed Care - HIAA Internal Memo

CT - This should
be
a
major
motivator
for our
groups!

MEMO

DATE: October 22, 1997
TO: Michael Fortler
FROM: Melody Hamed
SUBJECT: Government Run Healthcare

The message we are getting from House and Senate Leadership is that we are in a war and need to start fighting like we're in a war.

Republican Leadership is now engaged on this issue and is issuing strong directives to all players in the insurance and employer community to get activated. Earlier this week, I met with Keith Hennessey (Sen. Lott) along with the NFIB coalition. Hennessey will be working with House and Senate leadership to coordinate the advocacy effort. Senator Lott is well aware of the issue of mandates, incremental health care reform, etc., and is very concerned. Lott told Senator Jeffords that he could not introduce his "Quality Bill" this session and was advised to work less with Sen. Kennedy and more with his fellow Republicans on the Senate Labor Committee. Sen. Lott has also spoken with all Republicans on the Senate Labor Committee and told them to get involved and express their concerns. Sen. Lott also said that Senate Republicans need a lot of help from their friends on the outside, "Get off your butts, get off your wallets". Keith Hennessey believes that it is critical that employer/insurer grassroots occur during recess (Nov & Dec) so that Members are prepared when they come back to town in January.

At the NFIB Coalition meeting today, Mark Isokowitz (NFIB) informed the group that he had been summoned to the Hill by Missy Jenkins (Rep. Gingrich), Dean Clancy (Rep. Arney), Stacey Hughes (Sen. Nickles) and Keith Hennessey (Sen. Lott). Staff gave him four directives to take back to the coalition: 1.) Hold a briefing for Republican health LAs in 2 weeks; 2.) Implement heavy grassroots during recess; 3.) Meet with groups of Senators (e.g., Sen. Coverdell health care coalition) to report on what each organization is doing to fight these bills; and 4.) Write the definitive piece of paper trashing all these bills. Mark Isokowitz's overall impression from the meeting was that the Leadership was looking for signs of serious commitment on our part before they go out on a limb.

Health Care -
Patients
Bill of
Rights

State Legislators Push for Safeguards For Patients Covered by Managed Care

By LAURIE MCGINLEY

Staff Reporter of THE WALL STREET JOURNAL
WASHINGTON — Turning up the heat on managed-care organizations, a bipartisan group of state legislators is pushing comprehensive legislation designed to strengthen state safeguards for patients covered by the health plans.

The legislation, developed by lawmakers in nine states and unveiled at a news conference here, will be introduced today in New Jersey and Texas, and soon in Colorado, Georgia, Delaware, Kansas, Ohio, Oregon and Tennessee. The goal, said state Rep. Jane Maroney, a Delaware Republican, is for states to "get ahead of the curve" on quality issues by beefing up protections involving appeal and grievance procedures, clinical decision-making and access to physicians.

The effort by the state lawmakers comes as the managed-care industry, facing criticism over certain practices, braces for renewed scrutiny by state and federal policymakers. Some congressional Democrats, such as Sen. Edward Kennedy of Massachusetts and Rep. Fortney Stark of California, plan to push for federal legislation to guarantee broad consumer protections for managed-care enrollees.

While that approach may fail, bills targeting individual industry practices also are expected to proliferate. For example, Rep. Anna Eshoo, a California Democrat, recently introduced legislation that would require insurance companies to cover the cost of reconstructive breast surgery resulting from mastectomies that are covered by insurance.

But the states traditionally take the lead on regulating health insurance, and in recent years have become increasingly focused on managed care. Under the state legislation described yesterday, health maintenance organizations and other types of managed-care plans would be required to:

- Provide a sufficient number of facilities and doctors, including specialists and subspecialists.
- Allow patients to see a physician outside of the network by paying an additional fee.
- Permit patients with special needs or chronic diseases to select specialists as their primary care providers.
- Define and disclose limits on coverage of experimental treatments.
- Give patients access to all federally approved drugs and devices.

Stronger Safeguards

Here are some of the provisions of the managed-care legislation unveiled by the lawmakers of nine states:

- Plans must provide a sufficient number of physicians, including specialists and subspecialists.
- Contract clauses that seek to limit communications between physicians and patients concerning all treatment options would be banned.
- Patients would be allowed access to all federally approved drugs and devices.

In the face of stepped-up state and federal interest, HMOs and other managed-care plans have been scrambling to improve their image. Last month, the industry's leading trade group, the American Association of Health Plans, announced a new initiative aimed at improving relations with physicians and patients and disclosing more information about industry practices. The trade group, for example, announced that it supported efforts to curb the use of so-called gag clauses in contracts that doctors say have hindered treatment discussions with patients. The state legislation unveiled yesterday also prohibits gag clauses.

Yesterday, the trade group said most health plans already are implementing the principles embodied in the legislation. "By and large, we support the principles but anytime you go and write the specifics of laws, it's important to see how it's done," said Rick Smith, vice president for policy.

Susan Laudicina, director of research for the Blue Cross and Blue Shield Association, said state scrutiny of managed-care plans this year will fall into two main categories: efforts to protect providers by giving consumers direct access to certain specialists; and efforts to mandate certain benefits, such as a minimum hospital stay for mastectomies.

"Sound regulations and sound standards for health plans are desirable," Ms. Laudicina said, "but what we are seeing is attempts to inject the legislatures into the realm of medical policymaking."

The panel of state lawmakers who developed the bill was convened by Women in Government, a nonprofit educational association.

Judges Slug It Out for Television K

By KYLE POPE

Staff Reporter of THE WALL STREET JOURNAL

Here come the judges.

The national obsession with the O.J. Simpson murder trial has created this year's big thing on daytime television. A clutch of new real-life courtroom shows are hot sellers in syndication this year, including a remake of "The People's Court"—with former New York Mayor Ed Koch as judge—and "Judge Judy," a "People's Court" knockoff.

Also in the works: a courtroom game show said to resemble "The Gong Show" and a half-hour series about women crime-fighters called "Lady Law," hosted by Marcia Clark, Mr. Simpson's prosecutor.

The current fascination with the genre, say people behind the shows, may stem from public frustration with delays and grandstanding in the Simpson case. "People are fed up," says Judy Sheindlin, who served as a small-claims court judge for 24 years before being tapped for the "Judge Judy" job. "They just want a sense of closure: in, out, done."

But TV executives' interest in "People's Court" and "Judge Judy"—both doing well in syndication sales at the National Association of Television Program Executives convention in New Orleans—also shows how difficult the syndication business has become, executives say.

"Judge Judy," for instance, attracts about 2.3 million viewers an episode—a number that's respectable only in the context of most other daytime shows' declining ratings.

"The state of the industry is so abysmal, this kind of program is a hit," says Dick Kurlander, vice president of Petry Inc., a New York-based company that advises local stations on which programs they should buy. "It's an example of how depressed the performance has been."

The problem, for the local stations that run syndicated, or non-network, shows, is that most of them are locked into contracts—for at least the next year—that require them to show programs that have lost their luster in daytime and early-evening

lineups. Many of these are the hot trends of year's wood news programs and talk shows like "Ent Tonight," "Hard Copy" and "American Journal." In all, high failure rate for last year's crop of syndicated shows, many producers gun-shy, leading to a scarcity of new shows.

The question now is whether the onslaught of new court shows will prove a remedy for local stations' programming woes. Already, the competition has sparked some squabbling outside the TV courtroom. Judge Joseph A. Wapner, the "People's Court" judge for its 13-year run, which ended in 1993, has told producers of the new show that he's irked he wasn't asked to make a repeat performance. (Mr. Wapner couldn't be reached for comment.)

Meanwhile, the people behind "Judge Judy," which will compete head-on against "People's Court" in some markets, question whether Mr. Koch will draw national interest. "Interesting choice, if you're a New Yorker," says John A. Ryan, president of WorldVision Enterprises Inc., distributor of "Judge Judy." He adds, "I happen to like Ed Koch, but I don't know how well he'll translate to the rest of the country."

While "Judge Judy" is a replica of "People's Court" in format (Doug Llewelyn, the reporter from the old "People's Court," helped launch it), Ms. Sheindlin is nothing like the even-keeled Judge

Wapner. Tapped for television after the show's producers saw a profile of her on "60 Minutes," Ms. Sheindlin is direct, even confrontational, in style, taking no guff from the litigants. In recent episodes, she has called a plaintiff a "nudnik" for ignoring her advice, while another litigant was forced to admit he had made up part of his case to try to squeeze more money out of his opponent. "I've seen her break people down," says Peter Brennan, the Australian-born executive producer of the show who also created "A Current Affair."

How Mr. Koch will fare remains to be seen. Stu Billett, the producer of both the old and new versions of "People's Court," said he picked the 72-year-old former mayor after months of

Please Turn to Page B8, Column 6



Martin Kozlowski

THE WALL STREET JOURNAL

TUESDAY, JANUARY 14, 1997

Continued From Page B1

trolling the country in search of judges who might be interested in the role. Production will begin later this year.

While Mr. Koch hasn't spent much time on the bench—he worked as a small-claims-court arbitrator in the late 1950s—Mr. Billett is convinced he's a natural. For his part, Mr. Koch has an offer for Ms. Sheindlin, his current competitor—and a one-time appointee. "Look, there are 250 million people who live in the U.S.," he says. "I'm willing to give her half of them."

If only that many people were watching syndicated TV shows. Their low-rated lineups have helped drag down local-TV viewership and could threaten the profits of local stations, which generate a big chunk of their revenue between 4 p.m. and 8 p.m. "People are saying that there's nothing on," says Kenneth Solomon, co-head of television at DreamWorks SKG. "We've taken our eye off the ball."

Mr. Solomon's company this week sent a mailing to TV station managers across the country, warning them that if they don't switch to better-watched shows, cable television could begin to gobble up an even bigger chunk of the nation's TV viewing. DreamWorks' pleas, of course, have a business agenda: The company is producing a new magazine show with Connie Chung and Maury Povich for 1998 that could fit in the late-afternoon time slot.

Officials in 9 States to Back HMO Patients' Rights Bills

Model Legislation Seeks to Set General Guidelines

By Spencer Rich
Washington Post Staff Writer

Members of nine state legislatures announced yesterday that they will introduce wide-ranging bills to ensure proper care for patients of health maintenance organizations (HMOs).

"The bill can be as valuable to the business of managed care as it is to consumers" by reassuring the latter that they will be protected from undue denials of services, New Jersey state Assemblywoman Barbara Wright (R) said at a news conference.

Stories of breast cancer patients being forced out of the hospital by insurers on the day they underwent surgery, of patients being denied access to specialists and ill patients being denied full information on medical options have prompted efforts in a number of states and Congress to set some rules on how HMOs operate.

The National Association of Insurance Commissioners, which has developed its own legislation on standards for managed care, said the states are expressing "great interest in these models as they continue to address managed care issues."

About 60 million people have become members of health maintenance organizations, most of them having joined in the last several years, and their numbers are growing rapidly.

The bill proposed yesterday by the state legislators would set rules on such topics as choice of health service providers, experimental treatments, quality of care, and grievance procedures and appeals.

The proposal would require an HMO to let patients use an outside doctor if they agree to pay an additional fee. It would require HMOs to give clear definitions of coverage rules for experimental treatments and timely written explanations to the patient if such treatments are denied by the HMO. It would also ease HMO rules restricting coverage of emergency care and a physician's choice of prescription drugs.

The model legislation announced yesterday was developed by Women in Government, a nonpartisan group of women elected to or working in state government, and the sponsors were nearly all women.

On Capitol Hill, Rep. Fortney H. "Pete" Stark (D-Calif.), ranking minority member on the House Ways and Means health subcommittee, and several others have introduced a bill to set consumer rules for HMOs. Rep. John D. Dingell (D-Mich.), ranking minority member on the House Commerce Committee, is working on his own bill. An aide said Sen. Edward M. Kennedy (D-Mass.) may develop a proposal of his own.

President Clinton has not said whether he will propose a bill to protect patient rights in

HMOs, but he has announced he is setting up a government commission to study quality of care issues in the health system.

Several members of Congress are already working on bills that target a single issue such as women being forced out of the hospital too soon after a mastectomy. They include Reps.

"The bill can be as valuable to the business of managed care as it is to consumers."

—N.J. Assemblywoman Barbara Wright

Rosa L. DeLauro (D-Conn.), Marge Roukema (R-N.J.) and Susan Molinari (R-N.Y.) and Sen. Alfonse M. D'Amato (R-N.Y.).

Last year Congress passed a bill to prohibit insurers from pushing women out of the hospital too soon after giving birth. Rep. Greg Ganske (R-Iowa), a physician, will resume his quest for legislation to assure that HMO doctors can tell their patients of all medical options for any condition affecting them.

The American Association of Health Plans, the trade group for the HMO industry, is urging its members to adopt policies the group has formulated on such issues as breast surgery hospital stays, on disclosure of information on how HMO doctors are paid and how an HMO judges whether to allow clinical and experimental treatments.

The policies are part of a campaign the trade group called "Patients First."

President Karen Ignagni said yesterday that "obviously we'll differ on some details" from the proposals announced yesterday, "but the general thrust of addressing consumer protections is the same."

CORRECTIONS

A story in yesterday's Metro section said that the Fairfax County Board of Supervisors ordered a county tax official to withdraw a \$25,000 tax bill owed by the Fairfax County Police Association. The bill, totaling \$25,942, remains due.

A map on Sunday accompanying an article on the proposed European currency mislabeled a country as Austria. It should have been marked Switzerland.

Health
Care -
Patients
Bill of
Rights

The Washington Post

TUESDAY, JANUARY 14, 1997

Chilled Vendors Toe the Line To Get Coveted Parade Spots

With the wind chill dipping below zero before dawn yesterday, about 100 street vendors in line outside the District government's Frank D. Reeves Municipal Center were restless, edgy and cold.

"It's below freezing, and they won't let us in the building," said David Williams, head of the Open Air Merchants Association.

Williams, who had arrived at 2 p.m. Sunday, was among scores of licensed street vendors waiting outside the center at 14th and U streets NW to sign up for vending spots along the inaugural parade route. The sites were assigned on first-come, first-served basis. But from where Williams stood—make that shivered—it seemed that "the Inaugural Committee has taken all the good spots, and the D.C. government seems to be working with them. . . . The Republicans treated us better."

The few vendors who were allowed coveted spots along Pennsylvania Avenue NW—city officials declined to say how many were allotted—must sell memorabilia provided by Financial Innovations Inc., named the official supplier by the Presidential Inaugural Committee, which controls the parade route. Financial Innovations is headed by Mark Weiner, a prominent Democratic fund-raiser.

There was much grumbling about that limitation among those waiting in line.

"The presidential inauguration is for the people, and the people should sell what they want to sell," said Clarence Miller, 32, of Camp Springs, who was hoping to be on F Street. Said Michael Johnson, a D.C. resident in his forties: "We're small guys, and we're trying to make a buck, too."

Maurice Evans II, head of vendor operations at the D.C. Department of Consumer and Regulatory Affairs, said that Pennsylvania Avenue is controlled by the National Park Service and that "the city is not in a position to do as it pleases."

Vendors not on Pennsylvania Avenue can sell any souvenirs they want—"Redskins hats, Bullets T-shirts—anything," Evans said.

Still, all Natalie Riviera could think of was being a part of the inauguration.

"It's something to do—meeting people and being part of history," said Riviera, 18, a Howard University freshman who is studying advertising. She was among about 20 Howard students who will be selling souvenirs for Presidential Heritage Inc., a private company in the District. "It's going to be cold," she said. "I'll have on five pairs of socks and two pairs of long johns."

Ticket Shopping, 'Net Surfing

Terence R. McAuliffe, co-chairman of the Presidential Inaugural Committee, said tickets remain on sale for Sunday's Presidential Gala concert at USAir Arena, Monday's parade and the 14 official inaugural balls at which President Clinton and Vice President Gore will appear. Orders are being taken on a special toll-free line: 1-888-888-1997.

Meanwhile, more than a half-dozen Web sites are now available for Internet surfers hungry to know more about the inauguration. The Presidential Inaugural Committee (www.inaugural97.org) offers an array of historical and event information. Also offering sites are the General Services Administration (www.gsa.gov/inauguration97/), the Armed Forces Inaugural Committee (www.dtic.mil/afic/), the Joint Congressional Committee (www.senate.gov/inaugural/), the Public Broadcasting Service (www.pbs.org) and The Washington Post (www.washingtonpost.com).

And there's also a Web site (www.ci.washington.dc.us/INAUG/role.htm) on the District government's role in the inauguration, described thusly: "Despite the fact that for more than 150 years . . . District residents were not allowed to vote in presidential elections, in one form or another the city has been acting as chief janitor, policeman, garbage collector, planner and general overseer of every presidential inauguration."

Wyoming Band Is Booked Solid

Remember the Cody High School band?

The 94 musicians from Wyoming had been looking forward to marching in the inaugural parade—they had been led to believe a slot was open for them, and they raised tens of thousands of dollars for the trip—but they were aced out by another Wyoming high school band recommended by a politically connected lawyer. A story in The Washington Post brought them to President Clinton's attention last week.

Well, things are looking up for the Cody kids. They won't get to march in Monday's parade, but they're coming to Washington, anyway, and their calendar is pretty full.

On Sunday, they'll play for an hour beginning at 12:30 p.m. in the Grand Foyer of the Kennedy Center, part of the center's State Days Program in which members of Congress recommend performers from their states to appear. Then from 3 p.m. to 4 p.m., they'll play outdoors at the Navy Memorial at Seventh Street and Pennsylvania Avenue NW.

On Inauguration Day, they'll be among about a dozen bands entertaining along the parade route before the parade. Their spot is in the Federal Triangle—at 14th Street and Pennsylvania Avenue NW, near Freedom Plaza—where they will play from 9:30 a.m. to 11:30 a.m. and again from 12:30 p.m. to 2 p.m.

On Tuesday, before heading home, they'll appear on the U.S. Capitol grounds from 8:30 a.m. to 9 a.m., then on the steps of the Lincoln Memorial from 11:00 a.m. to 1 p.m.

This article was written by Paul Duggan with additional reporting from Todd Beamon, Roxanne Roberts and Margot Williams.

MOST IN H.M.O.'S WOULD'N'T BENEFIT FROM SENATE BILL

Health Care -
Patients Bill
of Rts.

HELP APPLIES NARROWLY

Protection Would Largely Go to 48 Million, Few of Them in Tightly Managed Care

By ROBERT PEAR

WASHINGTON, July 16 — Despite all the talk about protecting people in health maintenance organizations, most people in H.M.O.'s would gain no tangible benefit from many of the consumer-protection standards approved by the Senate this week as part of a bill to define patients' rights, lawyers and health policy experts said.

Many of the bill's basic consumer protections would apply to 48 million people in group health plans regulated by the Federal Government. Few H.M.O.'s are in that category, according to data published recently in the journal Health Affairs.

Most of the 48 million people, it appears, get their health care through traditional fee-for-service arrangements or through loosely organized forms of managed care that are less restrictive than the H.M.O.'s whose decisions about care have angered many consumers.

Even the application of the measure to those 48 million is in doubt because President Clinton has said he will veto the measure, many aspects of which remained unclear until today, because a substitute was put forward at the last minute.

In four days of debate before the final vote on Thursday, Republican senators said repeatedly that they did not want to usurp the states' authority to regulate insurance. In general, they said, they wanted to set Federal standards for health plans that could not be regulated by the states — "self-insured" health plans established by employers for their employees.

The study in Health Affairs, by two economists at the Rand Corporation, Susan Marquis and Stephen H. Long, finds that only 2 percent of employers offer H.M.O.'s that would be covered by these standards in the Senate bill. And only 9 percent of employees are in such H.M.O.'s, the study said.

Craig Copeland, a research associate at the Employee Benefit Research Institute, a nonpartisan organization, said today that "only a small number of the 48 million people are in H.M.O.'s — at most 10 percent."

In a "self-insured" health plan, the employer insures itself, bearing the financial risk for its workers' medical costs and often paying the claims out of the business's assets. By contrast, most H.M.O.'s bear the financial risk for their members. In return for fixed monthly premiums, the H.M.O.'s promise to provide whatever care is needed and covered under the insurance contract.

Prof. Timothy S. Just of Ohio State University, the co-author of a treatise on health law, said, "Usually if a plan is an H.M.O. operation, it would be fully insured and therefore exempt from many standards in the Senate bill.

An H.M.O. is one type of managed care. In other forms of managed care, patients may receive a discount if they use certain doctors and hospitals, but they are not required to do so. Republicans said that many people in these managed-care plans would gain protection from the bill passed in the Senate.

But there have been fewer complaints about these plans because they are less restrictive and generally do not require patients to get permission to see a specialist or to go outside the network of doctors recommended by the health plan.

Democratic senators often complained that the Republican bill was a sham, but it was impossible to evaluate those assertions until the full text of the legislation became available on Thursday night. The Senate Republican leader, Trent Lott of Mississippi, offered the substitute several hours before the final vote, and that substitute was the measure passed by a final vote of 53 to 47.

As lawmakers sorted through the legislation today, one thing seemed clear. If the bill becomes law, patients could not immediately be sure of their rights, and some employers could not be sure of their obligations, because those rights and duties depend on the details and structure of a person's health insurance plan.

Employees working side by side could thus have different rights and remedies, depending on whether they were in an H.M.O., a traditional insurance plan or some hybrid.

Under the Senate Republican bill, all group health plans would have to have procedures so patients could obtain "an independent external review" of decisions to deny coverage on the ground that a particular service was medically unnecessary or experimental.

At least 18 states now require such appeal procedures, according to the National Conference of State Legislatures. Adrienne Hahn, legislative counsel for Consumers Union, said the Senate bill would supersede the state laws, including some that provide patients with more protection.

Senate Republican aides said they did not know whether the bill would pre-empt state laws that give patients more extensive appeal rights. And the bill itself does not say.

Several miscellaneous provisions of the bill, largely overlooked in the Thursday debate, drew sharp criticism from Democrats today.

One provision would kill an experimental program for H.M.O.'s in Phoenix. The demonstration project would encourage price competition among H.M.O.'s by requiring them to bid for the privilege of serving Medicare beneficiaries.

Senator Jon Kyl, Republican of Arizona, joined H.M.O.'s in opposing the

project, which they said would disrupt the local insurance market. But Senator Bob Graham, Democrat of Florida, said it was outrageous to block a program that sought to use the free market to save money for taxpayers and Medicare.

"The language to destroy this pilot project was buried in a 250-page bill, and nobody was given an opportunity to read it," Mr. Graham said today.

The effort to define patients' rights takes Congress into a legal swamp that surrounds a landmark 1974 law, the Employee Retirement Income Security Act, known as Erisa. The law, which governs health plans covering 125 million Americans, has been described by the Supreme Court as "an enormously complex and detailed statute."

A major purpose of the law was to establish uniform Federal standards for health and pension plans, on the theory that employers would be deterred from providing such benefits if they had to comply with conflicting state laws.

Many provisions of the bill passed by the Senate are framed as amendments to Erisa. But it is difficult to know for sure who would be protected under provisions of the bill that would, for example, guarantee access to emergency care, obstetricians and other medical specialists.

Each of these standards applies, in the words of the bill, to "a group health plan (other than a fully insured group health plan)."

Other standards, which establish procedures for patients to appeal a denial of coverage, apply to "every employee benefit plan." Still other standards apply to "a group health plan" or an insurance company that offers coverage in connection with a group health plan.

Sheldon Weinhaus, a St. Louis lawyer who often represents patients, said these provisions of the bill were "an invitation to mischief."

"No one really knows, with any precision, what is meant by the terms 'self-insured' and 'fully insured,'" Mr. Weinhaus said, adding that employers and insurers often share the risk of paying for catastrophic medical expenses.

One of the stronger provisions in the Senate bill would require all health plans to pay for overnight hospital stays after breast cancer treatments, including mastectomy, if a woman and her doctor agreed that such a stay was "medically necessary and appropriate."

Unlike many other provisions, this one would cover anyone with private health insurance.

television and that it would be lower than Mr. Tauzin's earlier amounts. She said of Mr. Oxley, "His stance has been to limit the funding and try to slowly increase C.P.B.'s reliance on private funds."

Mike Collins, a spokesman for the Republican National Committee, said that his organization had "never leased a public broadcasting list," but he added that in rare cases it had used lists from charities. "It's reckless," he said. "It puts these public broadcasters in a very embarrassing position with regard to their donors and a dangerous one with regard to the I.R.S."

Republicans said documents indicated that the station WQED in San Francisco had provided its membership list to a broker who in turn provided it to Democratic organizations, including the 1998 re-election campaign of Senator Barbara Boxer of California. A spokesman for the station, David Shaw, told The Associated Press that the station had leased its list, through a broker, to the Democratic National Committee in 1996.

Jenny Backus, a spokeswoman for the Democratic National Committee, said the practice was common and that the television stations had done nothing unusual. She said the committee's broker had given it a list of 123 organizations and the committee picked 62, which included WGBH, from which it wanted 20,000 names to send solicitations. "We didn't have any way of knowing that WGBH had an internal policy against this," she said. "This is standard practice conducted on the open market."

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