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**Charlie Norwood**

10th District, Georgia

**Congress of the United States**

**House of Representatives**

1707 Longworth Building

Washington, DC 20515

(202) 225-4101

DISTRICT OFFICES

1056 Claussen Road, Suite 225

Augusta, GA 30907

(706) 723-7065

101 N. Jefferson Street, Room 105

Dublin, GA 31027

(412) 275-2814

1776 N. Jefferson Street, Suite E

Milledgeville, GA 31061

(412) 453-0373

*File Quality Commission*

**Statement for the Honorable Charlie Norwood on  
H.R.1415/S.644, the Patient Access to Responsible Care Act (PARCA)**

**Before the President's Advisory Commission on Consumer Protection  
and Quality in the Health Care Industry**

**Washington Court Hotel**

**Washington, D.C.**

**June 26, 1997**

I would like to thank Secretaries Shalala and Herman for inviting me to speak before the President's Advisory Commission to discuss H.R.1415 and S.644, the Patient Access to Responsible Care Act or PARCA. I am grateful for the opportunity to discuss these important issues and I want to commend President Clinton and this Commission for focusing on the important issue of quality of care in today's health care system.

I would like to use my time this morning to urge the Commission to consider a few very important issues as it makes its recommendation to the President on a patient's rights under managed care. These issues include: (1) the fundamental problems in the way managed care operates, (2) the preemption of state patient protection laws through the Employee Retirement Income Security Act, or ERISA and (3) the federal role in creating our managed care environment today. The legislation that Mr. D'Amato and I have introduced addresses each of these important issues. To date, PARCA has 106 cosponsors, almost equally divided between Republicans and Democrats. In my opinion, this reflects the bipartisan nature of PARCA as the moderate approach to correcting problems in today's managed care environment.

In 1994, there were many proposals to greatly increase the role of the government in health care. Critics of these proposals argued that national health care would have rationed health care and reduced the ability of Americans to make their own health care choices.

While these proposals were defeated, today more and more Americans are finding themselves faced with a similar loss of freedom. This loss is not the result of a new government program, but rather due to a managed care system that limits choices, denies

the rights of patients to appeal adverse decisions, and hides behind a shield meant to protect the very people it serves. This requires the federal government to act – not in a manner that exacerbates the problems of rationing health care and limiting the ability of health care professionals to make appropriate medical decisions, but that corrects problems that exist, largely as a result of Congressional influence in the operation of the market.

H.R.1415 addresses fundamental flaws in managed care structures. In managed care, these problems arise not from the health care providers delivering the care, but rather the financial incentives that are created when an entity both delivers health care services and has a financial interest in the delivery of that care. Under fee-for-service, it is argued that health care providers had a financial incentive to increase the utilization of services because they benefited from that overutilization.

As a provider of health care for 25 years I am compelled to make some observations about this point. The physicians and dentists of this country that have practiced under fee for service for years are generally a very upright and honest group that are guided by the Hippocratic oath. Whatever the criticisms, managed care was meant to correct the excesses of fee-for-service.

However under managed care, financial incentives still exist, but are reversed. Insurance companies, health care entrepreneurs and accountants have a financial interest in denying care as frequently as possible to limit their costs. These people are not guided by the same ethical responsibilities as health care providers.

The Patient Access to Responsible Care Act restores the balance between controlling the cost of health care and ensuring that patients receive adequate medical treatment. This legislation follows some very basic principles:

- ✓ **Access:** Health plans must have enough providers to ensure patients have *timely access to the benefits* offered by the plan. Health plans will cover emergency services if such services are needed in the opinion of a prudent layperson.
- ✓ **Choice:** Patients can *choose their health care provider* within the plan, and can choose to enter into a point of service plan that allows them to go outside a network to see the patient of their choice.
- ✓ **Open Communication:** Doctors have the right to *discuss with patients* their health status, treatment options, utilization reviews, or financial incentives to deny care. It also requires health plans to consider the input of health care professionals and enrollees in the development of plan policies.
- ✓ **Due Process and Appeals:** Patients must have *the ability to appeal* adverse decisions for denial of claims or in reimbursement. To ensure that patients are guaranteed *continuity of care*, doctors and other health professionals must have the opportunity to enter into a health plan and access to reasonable notice of termination and the ability to appeal a termination decision.
- ✓ **Quality Improvement:** Health plans must allow enrollee and provider input into plan policies. Health plans must also have a program that continually assesses the quality of care provided.
- ✓ **Information Disclosure:** Patients will have *access to information* about health plan policies, including information about plan benefits, the financial obligations of the patients, and grievance and appeals procedures. Information will be published in a uniform and easily understandable manner to allow easy comparison across plans.
- ✓ **Responsibility:** Patients can hold health plans *responsible* for injuries suffered as a direct result of the policies of the health plan.

As a former health care professional and a conservative, I believe PARCA is legislation consistent with my basic core beliefs. As a dentist, I made a commitment to act as a patient advocate and provide the best medical advice and treatment. This legislation ensures that health care professionals are allowed to act in the best interest of the patient.

As a conservative, I believe the protection of freedom and the ability to choose is fundamental to the American system. I do not believe that conservatives should tolerate a loss of freedom – not from the federal government, not from foreign nations, and not from massive corporations. The principle of freedom and the proper working of the free market are beliefs that we should fight to protect. We should not turn our heads aside in any instance where freedom and liberty are lost.

A second issue that we must confront is the role of ERISA and the preemption of state patient protection laws. While ERISA is a complicated law passed in 1974, it has had an enormous impact on the health care system, and more than any other reason, justifies federally established national guidelines for managed care structures.

A key element of ERISA was the preemption of all state laws that “relate to” health benefits plans. This is important because any law that is passed by the states only applies to insured products, not self-insured health benefits plans. And, while we don’t have accurate numbers about the exact number of people enrolled in health plans that avoid state law, it is estimated to be between 40% and 60% of the insured population. To put it another way, these people do not have any real public policy to protect them under managed care structures used by self-insured plans. While the preemption of 50 state laws may have been appropriate to provide consistency in the management of employee benefits plans, it does not abdicate Congress from its responsibility to protect these patients.

PARCA is consistent with the intent of ERISA. Like the Health Insurance Portability and Accountability Act, PARCA continues to allow states to regulate insured products. Because many states have already passed protections similar to those in

PARCA, this legislation acts as a baseline for non-self insured plans. It is of interest to note that many of the patient protections in H.R.1415 have been passed in many state houses. For example, 50 states require HMOs to provide information to enrollees and prospective enrollees about health plan policies or coverage. Likewise, 10 states address issues regarding payment for emergency care, prohibit preauthorization for emergency services, or allow 24 hour access for emergency care authorization. The problem is the people aren't covered because of ERISA.

For self-insured plans, it protects patients in a manner consistent with ERISA by establishing a single set of national guidelines to protect patients regardless of the state where an employee works.

Finally, we cannot underestimate the impact that ERISA and a number of other federal laws have had on the creation of the health care environment that we have today. Congress, through the tax code, Medicare and Medicaid, ERISA, and the HMO Act of 1973, has been the single largest factor in creating the health care system that we have today. It is simply irresponsible for the federal government to ignore the fact that it is responsible for today's health care system.

Besides ERISA, the other major piece of legislation passed by Congress that helped to create the managed care environment that we have today was the Health Maintenance Organization Act of 1973. The HMO Act provided financial incentives for the creation of HMOs. It established a basic benefits package that federally certified HMOs had to offer and provided for payment on a capitated basis. This legislation also required employers of 25 employees or more to offer an HMO option along with their

traditional fee for service plan. It was not until the federal government sanctioned HMOs that we witnessed a dramatic rise in their use.

I want to clarify that I believe HMOs have effectively controlled the cost and overutilization of health care services. HMOs must continue to be an option as we search for new and innovative ways to deliver health care services and enhance the competitive nature of our health care system. However, while we must constantly be looking for ways to control the cost of health care, we must ensure that protecting patient health is the primary goal of America's health care system.

In conclusion, I would request that the Advisory Commission strongly consider H.R.1415 as the moderate, common-sense approach to correcting the problems in today's managed care environment. I am convinced that, once the Commission releases its findings, you will find that the solutions included in PARCA accurately correct the problems in health care.

Again, thank you for the opportunity to speak to you. I would be happy to answer any questions that you have.

Enclosures:

Section by Section Summary  
List of Cosponsors

*The Patient Access to Responsible Care Act (PARCA) of 1997*  
*Section by Section Summary*

*Section 1. Short Title; table of contents.*

*Section 2. Patient protection standards under the Public Health Service Act.*

*Section 2770. Notice; Additional definitions; construction*

- Clarifies that this Act is not a federal “any willing provider” law.

*Section 2771. Enrollee Access to Care*

- Health plans, including plans serving patients in rural and medically underserved areas, must have an adequate mix and range of health professionals to ensure access to those services covered by the plan.
- Patients will have access to emergency care without prior authorization if such services are determined necessary in the opinion of a person with an average knowledge of medicine (i.e. prudent layperson definition).
- Patients will have access to specialized treatment when that treatment is medically necessary in the professional judgement of the treating health professional.
- Plans will have to subscribe to current law regarding providing incentives to health professionals to deny or limit needed care.

*Section 2772. Enrollee Choice of Health Professionals and Providers*

- Patients will be allowed to select their health professionals within a plan, and change that selection as the patient feels is necessary.
- Patients will have the choice to select a plan with a point of service option, with cost sharing requirements in premiums and per service costs.
- Patients will be guaranteed continuity for health care services they receive throughout disruptions that may otherwise stop or delay needed care.

*Section 2773. Nondiscrimination against Enrollees and Health Professionals; Equitable Access to Networks*

- Patients may not be discriminated against in participation in the plan because of race, gender, language, age, disability, health status, or anticipated need for services.
- A network plan may not discriminate in participation against a health professional because of that professional’s race, gender, age, disability (if such disability does not impair the professionals ability to provide services), or lack of affiliation with a hospital.

- Clarifies that plans cannot discriminate in participation, reimbursement, or indemnification against any health professional *solely* on the basis of their license. Health professionals may be denied participation, reimbursement, or indemnification for other reasons.

*Section 2774. Prohibition of Interference with Certain Medical Communications*

Health plans may not prohibit or limit a health professional from engaging in medical communications regarding the patient's health status, medical care, treatment options, utilization review requirements, or financial incentives to deny or limit care.

*Section 2775. Development of Plan Policies*

Patients' and health professionals' views and opinions must be considered in developing health plan policies, including policies governing coverage for treatment, utilization review, quality, and management of medical procedures.

*Section 2776. Due Process for Enrollees*

- Health plans must comply with standards for the prompt delivery of health services, fair and accountable utilization reviews, and timely payment of claims.
- Prevents health plans from compensating utilization reviewers for denying care.
- Patients will have timely access to internal and external avenues of appeal for adverse decisions, including denial of claims.

*Section 2777. Due Process for Health Professionals and Providers.*

Health plans must:

- allow health professionals and providers to apply to enter the plan (does not guarantee acceptance of application) and use meaningful standards in reviewing applications, and
- provide a health professional with reasonable notice of termination and allow the health professional to appeal such a decision and take corrective action, if necessary.

*Section 2778. Information Reporting and Disclosure.*

Patients will have access to clearly understandable information about health plans, including information about plan benefits, the number and mix of network health professionals, the financial obligations of the patient for out of network/out of service area costs, utilization review requirements, grievance and appeals procedures, and quality indicators and performance measures. Information will be published in a uniform format for easy comparison across all health plans.

*Section 2779. Confidentiality; Adequate Reserves*

- Ensures confidentiality of patient medical records and other individually identifiable information according to current state and federal law.
- Ensures health plans conform to state or federal solvency requirements to provide patients continuity of care and protection in the event of plan failure.

*Section 2780. Quality Improvement Program*

Health Plans must establish a quality improvement program that systematically and continually reviews patients' health status, access to preventative care and specialized services, and a health plan's administrative efficiency.

**ENFORCEMENT**

This legislation adopts the enforcement mechanism from the Kennedy-Kassebaum *Health Insurance Portability and Accountability Act*. Following the model of the Kassebaum-Kennedy legislation, this bill allows states to enforce the provisions of this Act for all non-self insured plans. Because self insured plans avoid state laws and to ensure single unified guidelines in the spirit of ERISA, guidelines for self-insured plans will be enforced by the federal government.

Gives states the authority to pass additional requirements than are included in this bill for non-ERISA plans.

Effective date: July 1, 1998 or plan years on or after January 1, 1999

*Section 4. Non-preemption of state law respecting liability for group health plans*

Clarifies individuals are not prevented from bringing liability claims against the agents of self insured plans. Currently, patients in self insured plans have neither a state nor federal cause of action to hold the agents of self insured plans liable for wrongful death or personal injury suffered by the medical decision making policies of the plan.

This is not a complete list of is included in the Patient Access to Responsible Care Act. Please contact Congressman Norwood's office if you would like a copy of the bill. You can also download a copy of the bill at <http://thomas.loc.gov>.

Congressman Charlie Norwood  
1707 Longworth House Office Building  
Washington, DC 20515  
(202) 225-4101

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*Bill Summary & Status for the 105th Congress*

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**PREVIOUS BILL: COSPONSORS | NEXT BILL: COSPONSORS**  
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**H.R.1415**

SPONSOR: Rep Norwood, (introduced 04/23/97)

RELATED BILL(S): S.644

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**100 COSPONSORS:**

Rep Bachus - 04/23/97  
Rep Baker, R. - 04/23/97  
Rep Barcia - 04/23/97  
Rep Barr - 04/23/97  
Rep Barrett, T. - 04/23/97  
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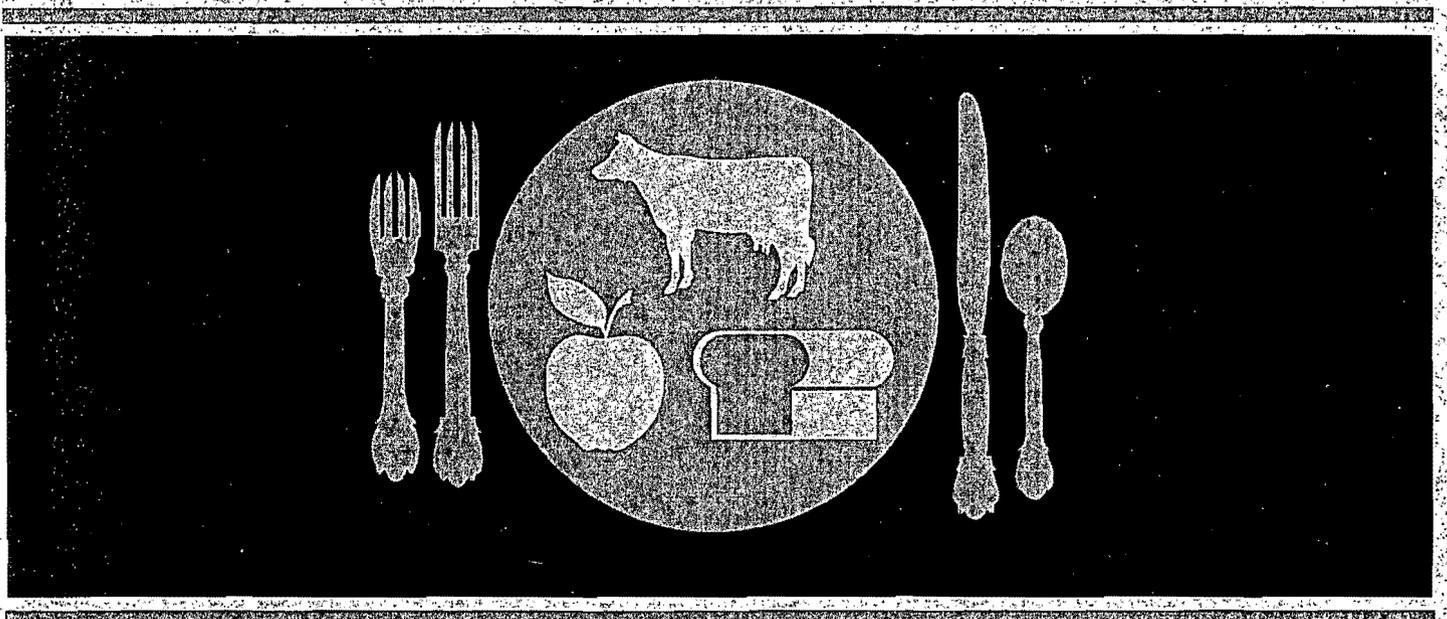
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## A National Food-Safety Initiative



A Report to the President  
May 1997



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