

# Withdrawal/Redaction Sheet

## Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Bob J. Nash to POTUS Re: Advisory Commission on Consumer Protection and Quality in the Health Care Industry (11 pages)	12/9/96	P2

### COLLECTION:

Clinton Presidential Records  
Domestic Policy Council  
Chris Jennings (Subject File)  
OA/Box Number: 23744

### FOLDER TITLE:

Quality Commission [1]

Gary Foulk

gf47

### RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advise between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

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- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

## **PRESIDENT CLINTON APPOINTS ADVISORY COMMISSION TO EXAMINE CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUSTRY**

Today, President Clinton announced the appointments of the 32 members of the Advisory Commission on Consumer Protections and Quality in the Health Care Industry. The Commission will review changes occurring in the health care system and, where appropriate, ~~to~~ make recommendations on how best to promote and assure patient protections and health care quality.

The Advisory Commission has representative members from health care insurers, consumers, health care professionals, institutional health care providers, health care purchasers, other health care workers, managed care experts, businesses, and labor experts from around the country. The 32 members have expertise on a range of health issues including, managed care, AIDS, women's health, nursing, privacy rights, aging, mental health, minority health, family planning, children's health, and health plans.

### **The Charge of the Commission**

At a time when unprecedented changes in the health care delivery system are taking place, consumers and their representatives are increasingly concerned about how these changes are affecting the quality of ~~their~~ health care services. The President believes that ~~during this time of change,~~ we must take steps to assure that our changing health care system continues to provide the highest quality health care in the world and to strengthen consumer protections.  
*contains emergency patient*

The Advisory Commission will examine ~~the~~ concerns about the availability of treatment and services in our rapidly changing health care system. It will promote a better understanding of changes which are taking place and, when necessary, make recommendations to address the impact of those changes. The Commission members will also draft a ~~Consumer~~ Bill of Rights to ensure that consumers have adequate protections.  
*patients bill of rights*

The Advisory Commission will be co-chaired by the Secretaries of Health and Human Services and Labor.

### **Continuing the President's Strong Record of Improving Quality and Patient Protections**

Since taking office, President Clinton has worked to improve quality and patient protections by:

- Directing the Medicaid and Medicare programs reminding them that "gag clauses" -- rules that restrict what health care providers may tell their patients -- are strictly prohibited and calling on Congress to pass bipartisan legislation that prohibits gag rules in all plans, public and private.
- Enacting legislation ending the practice of "drive-by" deliveries" by requiring health plans to allow mothers and their newborns to stay in the hospital for 48 hours after delivery.
- Signing the Kassebaum-Kennedy legislation into law, ending pre-existing condition exclusions and expanding access to health insurance.
- Supporting legislation to ensure that women can remain in the hospital for 48 hours after undergoing a mastectomy and 24 hours after undergoing a lumpectomy.

# ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUSTRY

## I. ADVISORY COMMISSION

The President signed an Executive Order creating an Advisory Commission on Consumer Protection and Quality in the Health Care Industry to review changes occurring in the health care system and, where appropriate, make recommendations on how best to promote and assure consumer protection and health care quality.

## II. PURPOSE

The Advisory Commission will respond to concerns about the rapid changes in the health care financing and delivery system. It will provide a forum for developing a better understanding of the changes in the health system and for making recommendations on how to address the effects of those changes.

## III. IMPACT

- The Advisory Commission will provide recommendations that will allow public and private policy makers to define appropriate consumer protection and quality standards.

## IV. SPECIFIC PROVISIONS

- The Advisory Commission will be appointed by the President and co-chaired by the Secretaries of HHS and Labor will have a membership with representatives from: health care professions, institutional health care providers, other health care workers, health care insurers, health care purchasers, state government, consumers, and experts in health care quality, financing, and administration. The Vice President will review the final report prior to its being submitted to the President.
- The Advisory Commission will study and, where appropriate, develop recommendations for the President on: (1) consumer protection; (2) quality; and (3) availability of treatment and services in a rapidly changing health care system.
- The Advisory Commission will submit a preliminary report by September 30, 1997 and a final report 18 months from the date of its first meeting.

## V. BACKGROUND

The Clinton Administration has a long history of strong support of consumer protection in all health care plans, including the Medicare program. Two such examples are his support of initiatives to assure new mothers and babies have access to necessary hospital care and to protect communications between health professionals and their patients.

## **QUALITY HEALTH CARE: A CLINTON ADMINISTRATION PRIORITY**

- Today, the President is announcing that a renewed emphasis should be placed on assuring quality and consumer protection in the nation's health care system. At a time when unprecedented changes in the health care delivery system are taking place, consumers and their representatives are increasingly concerned about how these changes are affecting the quality of health care they are receiving.
- To assure that our health care system continues to provide the highest quality health care in the world and to strengthen consumer protection, the President is issuing a challenge to the Congress to pass two consumer protection initiatives that have already received broad, bipartisan support before they adjourn for the Fall election.
- The President believes that too many health plans "gag" their doctors from even telling patients all their treatment options. And too many health plans are telling mothers of newborn children that they won't pay for the cost of hospitalization beyond 8-24 hours after birth.
- The President strongly believes that these practices must stop. He is calling on the Congress to pass two bills that would direct health plans to give mothers the opportunity to stay in the hospital for 48 hours and would prohibit plans from restricting communication between health professionals and patients.
- In addition, the President is announcing the establishment of an advisory commission, co-chaired by HHS Secretary Donna Shalala and Labor Secretary Robert Reich, to study and, where appropriate, to develop recommendations for the President on (1) consumer protection; (2) quality; and (3) the availability of treatment and services in a rapidly changing health care system.

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For a complete list of items withdrawn from this folder, see the  
Withdrawal/Redaction Sheet at the front of the folder.**

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Publisher of Consumer Reports

Testimony of

GAIL SHEARER

Director, Health Policy Analysis  
Washington Office  
CONSUMERS UNION

before the

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

HEARING ON:

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

February 11, 1997

Washington Office  
1666 Connecticut Avenue, Suite 310 • Washington, D.C. 20009-1039 • (202) 462-6262

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## SUMMARY OF CONSUMERS UNION TESTIMONY

The Health Insurance Portability And Accountability Act (HIPAA) will help hundreds of thousands, perhaps a few million consumers, get (and keep) health insurance that would not have been available without the bill and help them avoid onerous pre-existing condition exclusions. Congress should monitor the implementation of HIPAA carefully. Some of the bill's provisions, and the flexibility it provides states, could result in problems for consumers. There are early warning signs that Congress should pay special attention to the following:

***Portability.*** There are indications that the intent of HIPAA may be undermined in some states where the powerful insurance industry puts pressure on state legislatures to roll back earlier state reforms that went further than the provisions of HIPAA. In other states, the insurance industry is pushing for "minimal compliance." Congress should monitor carefully whether consumers do get the full protections that were intended in HIPAA. Congress should establish a counseling program to provide insurance counseling for people under 65, modeled on the successful Insurance Counseling and Assistance (ICA) program for seniors.

***Long-term Care Insurance.*** The HIPAA provision for tax deductibility for long-term care insurance has made a complicated market even more confusing for consumers. Consumers may have a choice between purchasing a "tax-qualified" policy that provides little long-term care coverage or a policy that is not "tax-qualified" but that provides comprehensive protection. The Department of Treasury should study the inconsistencies between HIPAA and state law, and should provide materials that will protect consumers.

***Medical Savings Accounts.*** Congress should make sure that the study of the impact of MSAs carefully measure potential selection of healthy risks into MSAs, and should require that the study be submitted on time. In oversight of the Department of Treasury implementation, Congress should monitor how the Department tracks the "previously uninsured" and assure that it enforces the cap on the size of the demonstration strictly.

***Niche Insurance Products Sold to Seniors.*** HIPAA opened the door to expanded sales of unnecessary, limited insurance policies to seniors. We urge Congress to monitor this market carefully and consider eliminating HIPAA's provisions that change the required disclosure statements and redefine "duplication" of insurance coverage.

***Criminalization of Asset Divestiture.*** Congress should monitor the implementation of the provision that could put seniors who inadvertently violate the law into jail. This provision is leading to considerable alarm among seniors.

Thank you for inviting Consumers Union<sup>1</sup> to testify today on the implementation of the "Health Insurance Portability and Accountability Act" (HIPAA). I would like to begin by commending the Members of this Committee for all of your work on health care reform -- both the work that led to HIPAA and your earlier efforts to enact national health care reform. We are grateful to Chairman Jeffords for his leadership on the issue of lifetime caps, and we want to take this opportunity to thank Senator Kennedy for his leadership in working to get a bill passed last year, resisting a full-scale medical savings account program, and successfully including important protections for MSA consumers in the final bill.

Thanks to HIPAA, hundreds of thousands, maybe a few million consumers will avoid onerous pre-existing condition exclusions and will be able to get -- and keep -- health insurance that would not have been available without the bill. In a world where comprehensive health care reform has been a long-standing unfulfilled dream, there was celebration when the bill was enacted. But I believe that there is consensus -- even among its strongest supporters -- that HIPAA was a modest bill. It should be

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<sup>1</sup>Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide consumers with information, education and counsel about goods, services, health, and personal finance; and to initiate and cooperate with individual and group efforts to maintain and enhance the quality of life for consumers. Consumers Union's income is solely derived from the sale of Consumer Reports, its other publications and from noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, Consumer Reports with approximately 5 million paid circulation, regularly carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

viewed as a first step -- not the last step -- toward health care reform.

We commend this Committee for holding this important hearing to explore implementation issues. My testimony will address several areas where there are early warning signs of problems that need the attention of Congress. Before addressing these specific concerns, I would urge this Committee to set an agenda for its work during the 105th Congress that establishes HIPAA as a first step in a series of measures that will move this nation toward universal, high quality health care coverage. We urge you to set as a high priority legislation that will extend coverage to *all* children in this country, legislation that will establish substantial, badly needed consumer protections for all enrollees of managed care plans, and the establishment of a blueprint for additional measures that will ultimately lead to comprehensive health care reform. And we urge you to do all that you can to preserve the structural integrity of the Medicare and Medicaid programs -- two programs that have provided years of health care protection for millions of elderly and poor consumers.

This is the appropriate time for the Senate Labor and Human Resources Committee to begin its oversight function. As I will describe below, there is already concern that while HIPAA holds the potential to help many consumers, it also has the potential to create new problems for others. The best way to minimize the problems is to get all appropriate federal agencies -- and the Congress -- working to make sure that ambiguities of the law are clarified and to take steps to prevent unscrupulous players in the market from exploiting consumers in order to line their own pockets.

In my statement, I will address the following issues: portability provisions, long-term care insurance; medical savings accounts; niche insurance products sold to seniors; and criminalization of asset divestiture.

## **FIVE KEY IMPLEMENTATION ISSUES**

*Portability of insurance coverage.* Perhaps the most important improvement that HIPAA makes in the health insurance market is the "portability" protection it provides consumers who are able to remain continuously insured. Consumers who switch jobs, from one employer who offers health coverage, to another that also offers health coverage, will not face new pre-existing condition periods, during which they would have been ineligible for certain health benefits. Individuals who work for an employer offering health coverage will be assured that they will not be denied coverage or charged higher premiums because of their health status. Individuals who leave the work force will be able to keep some sort of health insurance (provided they can pay the premium).

We understand that the purpose of this hearing is not to re-write the legislation, but nevertheless it is important that I point out that there are millions of consumers who will not benefit from the protections against pre-existing conditions: any consumer who can not afford to continue to pay for their coverage when "between jobs" is likely to face pre-existing condition waiting periods when and if they become eligible for a new employer's health plan. Also, there is no assurance that premiums will be affordable for consumers under the bill. In addition, the bill has exceptions.

For example, there is an exception in Section 2721 for state and local governments, that will keep certain people such as non-federal public employees from benefitting from the portability protections. (Public employees in states with state legislation may be protected, but public employees in the other states -- roughly half -- could find that they are without portability protections if their state or local government employer chooses not to provide the protections.) This exception will be a surprise to those individuals who find they are caught in a loophole that denies them protection.

Working with the bill as written, we have several concerns.

First, we believe that consumers' expectations about the protections that are offered by the bill may be out of line with the reality of the bill's impact. There has been considerable exaggeration about the scope of the protections -- and consumers, understandably, are expecting the bill to solve more problems than it will. An important role, then, for the government is to educate consumers about their rights under the bill as well as the time frame for the bill's implementation. Consumers are going to need assistance -- from the federal government and from their state government -- in navigating this new health insurance marketplace.

Second, we have serious concerns about how the insurance industry will turn the bill's provisions for state flexibility (in choosing what mechanism to use to make individual insurance available to people with prior group coverage) to its advantage, with serious implications for consumers. We are hearing reports that insurance companies are working to actually undermine and overturn state regulations and laws

that offer consumers greater protections than those of HIPAA. For example, we have heard that insurance carriers are working behind the scenes to undue the rating reforms that Colorado had enacted into law prior to enactment of HIPAA. In some states, the insurance industry is working hard to achieve "minimal" compliance; if they succeed, many consumers will not benefit from "portability" because the policies offered by insurers will be unaffordable since only high risks will be covered by them. Over the past 60 years, Consumers Union has been alarmed at the clout that insurance companies have before the United States Congress. Equally disturbing -- but perhaps not as visible to those of us inside the beltway -- is the influence that the insurance industry has in state legislatures. With the voice of the consumer quiet in comparison simply because we can't match the resources of the insurance giants, the risk is that the consumer will once again be the victim of special interest politics, a potential unintended consequence of HIPAA.

Therefore, the Congress should monitor state response to HIPAA. If, as we fear, momentum grows for states to overturn hard fought consumer protections of the health insurance market (e.g., market reforms that define groups as being size 1 to 50 and rating reforms that lower premiums for higher risks), then we would urge Congress to establish federal standards that clearly preempt state laws in order to protect consumers. We do not believe that Congress intended that HIPAA be an excuse for industry to strong-arm states into rolling back established state policies that go further than the "minimums" in HIPAA -- for example, protections that help make

health insurance affordable to self-employed groups of one or to people who are high risks.

*Long-term care insurance.* The HIPAA provision that extends a limited amount of tax deductibility to premiums paid for long-term care insurance<sup>2</sup> also raises serious implementation concerns. On January 16, 1997, Consumers Union filed comments on the long-term care issues with the Department of Treasury.<sup>3</sup> *Consumer Reports* has published reports on private long-term care insurance policies that clearly show that shopping for a long-term care policy is very confusing and filled with traps for the consumer. In June 1991, the *Consumer Reports* article "Gotcha: An Empty Promise to the Elderly?" identified numerous consumer problems in this market including: the absence of built-in inflation protection; the absence of nonforfeiture benefits (and high lapse rates); variation in definitions of benefits; agent incentives to sell policies without considering the long-range interests of policyholders; and the potential for premium increases.

Unfortunately, HIPAA makes the long-term care insurance market even more complicated and adds a new trap for consumers: HIPAA establishes a new, relatively restrictive definition for long-term care policy benefits for policies that are to be "tax qualified." What this means for *informed* consumers is that they must choose between

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<sup>2</sup>Consumers Union opposed the tax preference for long-term care insurance premiums because we believe that limited funds that are available to pay for long-term care should be targeted to help low and moderate income consumers, rather than create a new (and potentially very costly) tax preference that mostly helps the rich.

<sup>3</sup>Letter from Gail Shearer, Consumers Union, to Donald G. Lubick, Acting Assistant Secretary for Tax Policy, January 16, 1997.

(1) buying a comprehensive long-term care insurance policy that offers benefits for home care, and nursing home care, "triggered" by a range of possible disability levels, and (2) buying a long-term care policy that provides benefits only under the most extreme cases of disability.

In this market, it is very hard to be an informed consumer. While the Department of Treasury is expected to release guidance for consumers in April, consumers are being barraged with sales pitches from insurance companies already. In addition, insurance companies are using the tax preference issue as a marketing tool -- but at this point, the insurance companies are not in a position to even judge whether the policy will truly be tax deductible for the consumer. There was mention in the Wall Street Journal that, due to the tax incentive, some companies are reporting that sales of long-term care policies had already increased by 50 percent. An internet posting<sup>4</sup> lists the "fact" that "[l]ong-term care insurance is tax deductible," without mentioning that individuals' premiums are deductible only to the extent that they (and other health costs) exceed 7.5 percent of income, and that only "qualified" policies are tax deductible.

The inconsistency between the long-term care insurance provisions of HIPAA and state laws and regulations means that there is confusion all around. Clearing up this confusion and then providing useful information to consumers should be a high

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<sup>4</sup><http://jvm.com/future-care/>

priority for state and federal regulators alike.

In our comments, we urged the Department of Treasury to make use of the existing network of senior health insurance counselors -- participants in the Insurance Counseling and Assistance Programs (ICA) -- to help communicate with consumers who are trying to sort out the complexities of the long-term care insurance market. Each state now has an insurance counseling and assistance program, which trains volunteers to assist seniors with their health insurance needs -- choosing a Medicare supplement insurance policy, choosing a long-term care insurance policy, or filing Medicare claims. These programs have a ready-made network of hundreds of people who are anxious to receive accurate information about the new tax preferences for long-term care insurance. We urge all the federal departments charged with implementing HIPAA to use these programs to communicate with seniors.

*Medical savings accounts.* Perhaps the most controversial issue that surfaced during the enactment of HIPAA was medical savings accounts. During consideration of the bill, Consumers Union expressed strong concern about the potential for medical savings accounts to fragment the health insurance market, and drive *up* premiums for those people who prefer to remain in the traditional (relatively low deductible) health insurance market. In the end, HIPAA included a demonstration MSA program of limited size, and, thanks in large part to the work of Senator Kennedy, many crucial consumer protections that help make the high deductible insurance policies that are paired with MSAs more comprehensive in coverage than they would have been in the

absence of the protections.

One of our implementation concerns involving MSAs relates to the measuring of the extent to which relatively healthy people are drawn to MSAs. During the Congress' consideration of HIPAA, we pointed out that many objective studies predict that widespread adoption of MSAs in the health care marketplace will eventually lead to substantial increases in premiums in the traditional, low-deductible market. HIPAA requires the Comptroller General to contract with an outside group to study the effects of medical savings accounts in the small group market -- in particular, the effects on selection, health costs, use of preventive care, consumer choice, and scope of coverage of high deductible plans. I can not emphasize enough the importance of careful study design if this critical task is to be done properly.<sup>5</sup> It is crucial that the study carefully consider the health status of families enrolled in MSAs with the health status of families not in MSAs. Strong Congressional oversight -- as well as the insistence that the study meet the legislatively established schedule -- will be crucial.

A second area of concern is the strict adherence to the cap on the size of the demonstration program. There has been significant publicity about the introduction of MSAs -- with a federal tax deduction -- into the health care market. Once again, consumers' expectations with regard to MSAs are high. The Department of Treasury issued a notice (Notice 96-53) on November 29, 1996, that explained various elements

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<sup>5</sup>See also Katherine Swartz, PH.D., "Medical Savings Accounts and Research," Inquiry, Fall 1996.

of the MSA pilot project. The notice raised several important implementation issues. First, the notice indicated that MSA enrollees will be in charge of deciding how the MSA account funds are to be used, apparently with little (if any) oversight. In other words, based on this notice, individuals with MSA accounts will have a free hand to determine whether a particular expenditure should be considered eligible for coverage under the MSA. The notice does not indicate what records individuals should maintain. It does not indicate that MSA distributions will be subject to IRS audit. We urge the Department of Treasury to offer guidance to consumers on how to determine whether an expenditure should qualify for MSA coverage. In addition, we believe that it would be prudent to establish the same kind of verification system that exists for *other* health care expenditures that qualify as tax deductible. Without a system in place, it is possible that MSA funds will be used for purposes that should not truly be considered as health care expenses, leaving MSA enrollees with the prospect of having depleted accounts just when health care expenses occur.

Another area where we believe Department of Treasury guidelines will be important is in the area of investment options for MSA accounts. One of the reasons that Consumers Union has opposed medical savings accounts is the fear that money will be diverted from the pool of funds available to cover health care expenses and into savings accounts for the healthy. If consumers can invest their MSA account funds in the stock market, then we believe that this will intensify the perception (and the reality) that MSA programs are about investment -- not paying health care costs.

The Wall Street Journal recently reported that, as we feared, some insurers and banks are already marketing MSA accounts as a means of long-term investing.<sup>6</sup>

Another area of concern with MSA implementation involves the enforcement of the 750,000 cap in the number of MSAs allowed under the demonstration. In its November 29, 1996 notice, the Department of Treasury did not provide assurance that it will carefully monitor and verify the number of MSA enrollees who are "previously uninsured." The bill makes it clear that to be considered "previously uninsured," consumers could not have had comprehensive insurance coverage *for a six-month period* before the start of high-deductible coverage. If people who actually had insurance are counted as "previously uninsured," then the cap is likely to be exceeded. In addition, the notice raises the possibility that there will be considerable time lags between the time that the maximum is exceeded, the time the notice to the public that the cap limits have been reached issued, and the time that sales of new MSAs actually end. To the extent that limits are exceeded, more accounts than Congress intended will be opened.

*Niche insurance products sold to seniors.* Another area that bears careful oversight by Congress is the private health insurance market for seniors. In 1990, as part of OBRA-90, Congress successfully overhauled the senior health insurance market. The result was a simplified market (with ten standard benefits packages) and

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<sup>6</sup>Nancy Ann Jeffrey, "New Medical Plans for Small Businesses Carry Investment Options, but Also Risks, Wall Street Journal, January 3, 1997.

substantial reduction in the sale of wasteful, duplicative policies to seniors.

Unfortunately, HIPAA turned back the clock on these reforms by making it easier for insurance companies to sell policies to seniors that they simply don't need if they have Medicare coverage and one medigap policy. HIPAA changes the definition of what constitutes "duplication" in this market, and now allows insurance companies to sell multiple, overlapping policies to seniors *as long as all policies pay benefits*. The bill also guts the disclosure requirements that were developed by the National Association of Insurance Commissioners (and approved by the Secretary of Health and Human Services) to warn consumers against possible wasteful duplication. The disclosures will soon read: "Some health care services paid for by Medicare may also trigger the payment of benefits under this policy." Instead of a warning against duplication, consumers will get a marketing pitch saying that they could get extra benefits.

As a result of this provision, companies that market policies duplicating Medicare and Medicare supplement insurance will again be able to sell numerous policies of little value to consumers. For example, hospital indemnity insurance, cancer insurance, and intensive care insurance are policies designed to prey on seniors' fears. Companies are marketing these policies on the internet, and the insurance press is writing about these growing markets. Expansion of sales of such "niche" products to the elderly are inevitable, as a result of this provision of HIPAA, and are not in the consumers' interest. We urge you to monitor carefully the impact of these changes on the health insurance market for seniors, and take further steps as appropriate.

*Criminalization of asset divestiture.* Section 217 of HIPAA included a provision that established criminal penalties (including jail) for people who "knowingly and willfully disposes of assets" in order to gain eligibility for Medicaid. This provision came as a last minute surprise to many health policy analysts who participated in the legislative process leading to HIPAA. The intent of Congress was clear: to provide a strong incentive against the hiding of family assets that should be used to cover long-term care costs. While we share the objective of Congress to preserve Medicaid funds for the truly needy, we are deeply troubled by the prospect of HIPAA leading to the transfer of elderly nursing home residents from their nursing home to prison.

Whether or not Congress chooses to retain the criminalization provision, it is important that you understand how some people are responding to it. In Arizona, lawyers are playing on the fears of the elderly to drum up business. An ad ran in the Phoenix Daily News-Sun that said:

"You Only Have Until December 31st, 1996

To Avoid making the Mistake That Could Toss You in Jail ... Congress'

Sneaky New Law Is the Most Vicious Attack on Retirees Yet!"

The toll free number published in the full text of the ad led to a message, recorded in a woman's voice, that offered a warning about the "Grandma goes to jail law." This ad stirred up alarm in the senior community. It made seniors fear that (as the ad indicated) simply making gifts to children or grand-children, or adding an adult child's

name to a checking account (to ensure access if something happened to you) could be a felony leading to imprisonment. Unfortunately, HIPAA raises the possibility that seniors will be scared inordinately, and may deter them from some prudent financial transactions. We believe that Congress should clarify that felony charges, steep fines, and imprisonment will not apply to the average citizen who is merely trying to assure their bills will be paid in the event that they become incapacitated.

### **RECOMMENDATIONS**

In response to our concerns, we recommend that the Congress:

1. Monitor the implementation of HIPAA by the states. If states react to HIPAA by rolling back stronger state laws, or if "minimal compliance" fails to provide affordable insurance coverage, then Congress should consider stronger legislation that reduces state flexibility.
2. Monitor the implementation of HIPAA by federal agencies. Federal agencies should provide information that consumers can use about their new portability rights, long-term care insurance, and medical savings accounts. They should be required to meet the timetables established in HIPAA for submission of key reports such as the impact of MSAs on the health insurance market. They should work closely with the Insurance Counseling and Assistance Program (ICA) to educate seniors about health insurance, especially long-term care insurance.
3. Monitor developments in the health insurance marketplace. If marketing

abuses abound, if new niche product markets (especially for seniors) grow, then Congress should take corrective action quickly.

4. Establish a counseling program -- modeled on the successful Insurance Counseling and Assistance Program (ICA) for seniors -- to help consumers navigate the health insurance markets and help them benefit from the protections in HIPAA.

Holding this hearing is the first step toward successful implementation of HIPAA. Thank you for providing us the opportunity to testify. We look forward to working with this Committee in continuing to work toward a health care marketplace that serves the needs of consumers.

**THE WHITE HOUSE**

**Office of the Press Secretary**

**For immediate release**

**May 28, 1997**

**PRESIDENT NAMES CHRISTOPHER J. QUERAM TO THE ADVISORY  
COMMISSION ON CONSUMER PROTECTION AND QUALITY IN THE  
HEALTH CARE INDUSTRY**

The President today announced the appointment of Christopher J. Queram to the Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

Christopher J. Queram of Madison, Wisconsin, has been the Chief Executive Officer of Employer Health Care Alliance Cooperative (The Alliance) since 1993. In his capacity as CEO, Mr. Queram is responsible for establishing the strategic direction and operating performance of a health care purchasing co-operative owned by over 100 member companies and serving over 75,000 employees and dependents in Wisconsin. Major functions of The Alliance include provider contracting, data management and reporting, consumer education, employer/provider quality initiatives, and public policy/legislative advocacy. Mr. Queram was previously the Vice President of Programs from 1988-1993 and the Vice President of Support Services from 1986-1988 at Meriter Hospital in Madison, Wisconsin. He served as the Vice President of Administration of the Methodist Hospital from 1983-1986. From 1980-1983, he was the Assistant Vice President of Administration at Froedtert Memorial Lutheran Hospital in Milwaukee, Wisconsin. Mr. Queram received an M.A. in Health Sciences and a B.A. from the University of Wisconsin at Madison.

The Advisory Commission on Consumer Protection and Quality in the Health Care Industry was created by Executive Order. The purpose of the Commission is to advise the President on how unprecedented changes in the health care delivery system are affecting quality, consumer protection, and the availability of needed services. Through a series of public meetings, it will collect and evaluate information and develop recommendations on improving quality in the health care system. The Commission is co-chaired by the Secretary of Health and Human Services and the Secretary of Labor.

The Commission has broad-based representation from consumers, businesses, labor, health care providers, insurers, and quality and financing experts. The Commission members have expertise on a range of health issues including the unique challenges facing rural and urban communities, children, women, older Americans, minorities, people with disabilities, mental illness, and AIDS, as well as issues regarding privacy rights and ethics.

**Severe Mental Illnesses and Managed Care:  
Implications and Impact**

Testimony of Laurie M. Flynn, Executive Director, National Alliance for the Mentally Ill

before the

Advisory Commission on Consumer Protection and Quality in the Health Care Industry

June 24, 1997

An estimated 5 million American adults, or 2.8 percent of the population, suffer from severe mental illnesses, including schizophrenia, bipolar disorder, severe recurrent depression, obsessive-compulsive disorder, and panic disorder. 3.2 percent of American children and adolescents also are plagued by severe mental illnesses.

In the last 15 years, research has wrought tremendous advances in treatment and services for these illnesses. New medications, which are more effective and produce fewer side-effects are now available. And support service interventions, such as the Program for Assertive Community Treatment (P/ACT), have been clearly demonstrated to enable most people with severe mental illnesses to reside in the community. Indeed, employment services—particularly supported employment—have been shown to be effective.

The course and manifestation of severe mental illnesses do vary. Thanks to the treatment advances, for a growing proportion of individuals, appropriate therapeutic interventions permit the pursuit of a productive and independent life, with limited disability and only occasional periods of crises requiring more intensive care. And even individuals with the most severe disabilities look to better levels of recovery than possible a generation ago.

Still, severe mental illnesses produce a lifetime of illness and disability for most individuals. Typically striking in adolescence or early adulthood, these brain disorders severely impact on the productivity and independence of many individuals, by virtue of their impact on cognitive, emotional, and social functioning as well as the fact that they interrupt education and early employment experiences.

These illnesses are equal opportunity diseases, striking both men and women, people of all ethnicity and race, and individuals of all socioeconomic groups. The disabling impact of the illnesses also poses a large price tag for our nation. Recent careful estimates conservatively put the total cost of mental illnesses at \$136.1 billion (in 1991), reflecting healthcare costs (e.g., hospitalization, health care provider visits, and medications) and the costs of morbidity, mortality, and care-giver burden. In fact, people with severe mental illnesses make up between one-quarter and one-third of the enrollees receiving disability-related income from the Social Security Administration (in the form of SSI and SSDI).

The momentous changes occurring in both the private and public health care system are of obvious concern to people with such chronic and disabling illnesses. Historically, people with severe mental illnesses were relegated to a public mental health system that was essentially a system of large state institutions. This reflected both the lack of treatment options and a private health care system that did not cover mental illness treatment. While the deinstitutionalization movement in the 1960s and 70s resulted in the discharge of most individuals from state hospitals, private sector coverage of those with the most disabling illnesses did not follow, even with treatment advances. So, today, most individuals with the most severe illnesses still rely on public sector monies to access treatment and services, albeit outside of long-term institutionalization.

Changes in the health care system with the most impact on people with severely disabling mental illnesses include:

- *a move toward parity coverage in private insurance.* The National Alliance for the Mentally Ill has led the effort for nearly ten years to effect an end to private insurance discrimination, winning parity laws in several states and at the Federal level. Given the improved treatments available for these brain disorders, better private insurance coverage is absolutely essential.
- *the advancement of managed care.* Managed care has tremendously reshaped the healthcare system in America and has considerable implications for people with severe mental illnesses. Not only does managed care dominate the private sector insurance (permitting parity coverage to move forward), but it is now marching through the public sector. It is important to note that specialty managed care organizations—so-called mental health carve-outs—dominate the delivery of mental health care for people with severe mental illnesses, especially in the public mental health system. While the managed care concepts of integrated care and prevention of disability and recurrence are, in theory, to the benefit of individuals with severely disabling and chronic mental illnesses, the emphasis on cost-cutting in managed care is especially dangerous to this population, which is an expensive one. Because of the potential benefits of managed care—recovery-oriented care—and the specter of denied care due to cost-control and profit motivation, NAMI has developed a set of managed care principles (see attached “blue card”).
- *changes in the public system.* Various changes are occurring in the public mental health system with large or potentially large implications for people with severe mental illnesses. As noted, managed care is substantially altering the public mental health system. The role of states and counties—public organizations—is changing from one of direct provider and/or administrator of services to one of payer for services. This means that states and counties must become more expert in contracting for the administration and provision of services to individuals with severe illnesses and must become more active in monitoring these service delivery systems. Managed care is not the only change occurring in the public mental health system—the public administration of the system is also in the midst of change, with mental health directors and departments being subsumed into larger human services and Medicaid departments within the states. This may mean that influence on decision-making affecting people with severe mental illness is diluted and that the ultimate decisions concerning this population will be made by individuals who are not very

knowledgeable about mental illness. A final potential change of note includes ongoing discussion of and movement toward less Federal control over the use of Medicaid dollars by the states.

The evolution of parity private insurance along with the emphasis on cost control in managed care and the reduced role of the Federal and State governments make it imperative that real quality control measures and consumer protections be realized for both private and public sector health care delivery to people with severe mental illnesses. As noted above, while managed care systems offer some theoretical advantages, most notably an eye toward recovery and prevention of relapse, at this point in time the dangers of managed care weigh more heavily at this point in time. As with other populations facing long-term illness with disability, the jury is still out on whether or not managed care can (or will appropriately) serve such individuals with complex, comprehensive, and long-lasting needs. Listed below are some concerns expressed by members of our organization and seen in our own research. Quality assurance and consumer protections should address these issues.

- *"Micromanagement of care"* In our analysis of managed care systems in several state public mental health systems and our survey of managed care organizations, it has become clear to us that case management is too often simply a gate-keeping mechanism that introduces a hassle factor into each episode of treatment seeking. For individuals with chronic illnesses with multiple needs, this amounts to more than a hassle factor, but rather is a real road-block to providing effective, comprehensive care. And while many of our members report that perseverance usually pays off in these systems, vulnerable patients without a family member to advocate on their behalf may be essentially locked out by overzealous gate-keeping. People with severe and chronic illnesses require a different mechanism of care coordination and access than a simple gate-keeping model for each treatment need. Rather, case management truly focused on gaining access to the full range of care necessary for the individual is needed, as are patient advocates in managed care organizations.
- *Barriers to medication.* Many managed care organizations, be they public or private sector, throw up access barriers to the new medications so important for people with severe mental illnesses. By requiring bureaucratic prior authorization processes and having restrictive formularies, access to the new and powerful medications for severe mental illnesses is being barred. There is only one reason for such restrictions—cost-control. Patients must have unrestricted access to the medications that are most effective to them. Patients and their care-providers should make the decisions about which prescription medication will be best suited to them.
- *Adequate hospital care.* Because hospital care is so expensive, managed care severely restricts admissions and/or length of stays in such settings. While it is possible and important to optimize outpatient and community based care, people with severe illnesses sometimes require hospital care that is sufficiently long to permit stabilization. Furthermore, adequate community treatment and support may not be a reality in many communities, making access to hospital care all the more important.

Decisions about hospital admissions and length of stay must be based on clinical factors and be made by the care-provider, patient, and care-providing family member.

- *The need for authentic intensive case management.* Our review of managed care organizations demonstrate that few intensive case management services, based on the P/ACT model program, are currently offered. This is the type of service that is essential to people with the most severe mental illnesses if they are to be cared for outside of the hospital setting. A quality program for people with severe mental illnesses must offer P/ACT programs.
- *Retention of resources for people with severe mental illnesses.* As noted, managed care is first and foremost a cost-controlling intervention, at least as now practiced. States are rushing to implement managed care in the public mental health system to save money. And save money they are. In several states examined by NAMI, including Colorado, Iowa, and Massachusetts, approximately 30 percent of the dollars once spent on services for people with severe mental illnesses have been lost. States have reduced outlays and managed care organizations have absorbed some of the funds for profit, administrative overhead, and for so-called reinvestment. This loss of treatment dollars is occurring in both for-profit and not-for-profit organizations. We know from long experience that dollars lost for care are not easily replenished. Thus, true reinvestment of resources into the system of care for people with severe mental illnesses is essential as is the public reporting of profits, administrative overhead, and reinvestment activities in managed care settings. Furthermore, managed care organizations should report on a periodic basis how many enrollees have severe mental illnesses, how many received services during the time period, and how many dollars were spent on these services. Only by putting forward such information will consumers (not to mention payers) know that people with severe mental illnesses are not being discriminated against or given too little attention.
- *A definition of medical necessity appropriate for chronic, disabling illnesses.* The definition of medical necessity in managed care contracts is all important in identifying what services are covered and for whom. It is critical for a chronically disabled population that this definition extend to the full-range of treatments and services that are necessary for the best recovery possible. Afterall, access to support services and housing are known to effect hospitalization, for example,—in other words they are medically effective and necessary. While such a definition need not be applied to all consumers of healthcare, for the disabled, the definition of medical necessity must reflect the broad extent of their needs that exist because of illness.
- *Integration with support services.* Oftentimes, MCOs do not receive funding for such crucial support services as housing, in terms of rental assistance and/or supportive housing services, and employment supports. While it may not be fair to hold an MCO accountable for the delivery of these services if it is not in the contract, it is crucial that the MCO be held responsible for the effective linkage to such services, as they are critical to people with severe mental illnesses.

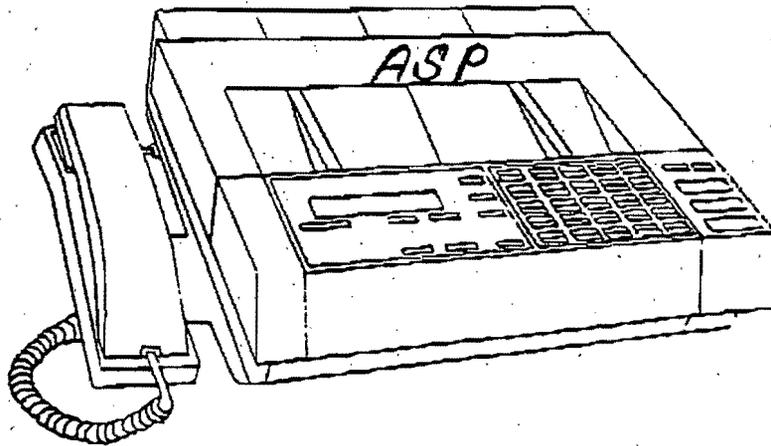
- *Protection of the most disabled population.* Recent evidence suggests that MCOs are reluctant to serve the most recalcitrant patients—those who do not comply with treatment and/or are unruly and difficult. These are however common manifestations of extremely severe mental illnesses. It is absolutely essential that MCOs who seek and gain the contracts to serve people with severe mental illnesses appropriately treat, and not discard, the most disabled who are also sometimes the most difficult patients.
- *Patient education.* In a survey of our membership, to be published this summer, it became clear that people with severe mental illnesses and their families need to be educated about managed care and need to have better knowledge about how to access care and appeal denials of care. Consumer protection begins with consumer education—especially in these extremely complicated systems that are supposed to be serving vulnerable populations.
- *Access to emergency care.* In our survey of MCOs, we were shocked to learn that a suicide attempt does not trigger, for most respondents, immediate care—rather prior authorization and gate-keeping processes are enacted in these life-threatening situations. Protections such as “prudent layperson” language governing emergency services in managed care situations must be extended to psychiatric emergencies as well.
- *Consumer and family involvement.* When you face a chronic and complicated illness, you, the patient, and care-giving family members become extremely knowledgeable about what is necessary, in terms of treatment and services, and what is effective. Patients with severe illnesses and their family members must be more integral to managed care systems, especially in terms of treatment planning, offering feedback that is heeded concerning problems in the system, and influence in the operation of systems devoted to the population. The key here is true involvement of patients and family members in the systems designed to care for them. This means listening to what patients and family members want and/or may find lacking and giving the patient a choice in providers.
- *Outcome measurement.* There is widespread acknowledgment that the outcomes of care are what ultimately matters—not simply the amount funding or processes of care. However, the requirement of outcome measurement has been slow in advancing, in part for technical reasons. We are now at a point at which we must require some key outcome measures specific to people with severe mental illness. Such basic measures include basic clinical measures but all outcomes reflecting the quality of life, such as suicide rates, employment rates, housing status, and incarceration. Ultimately consumers will be protected if they can choose an MCO based on such outcome measures.

U.S. Department of Labor

Office of the Assistant  
Secretary for Policy  
Washington DC 20210



# FAX COVER SHEET



DATE: June 19, 1997

TO: Brandon (Chris Jennings) Oboire FAX NO: 456-5557

COMPANY: \_\_\_\_\_ PHONE NO: \_\_\_\_\_

FROM: Terry Fayer PHONE NO: 219-6197

FAX NO: (202) 219-9216

NUMBER OF PAGES INCLUDING COVER: \_\_\_\_\_

MESSAGE: Sorry it took so long. we've had a crazy day.

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\_\_\_\_\_  
\_\_\_\_\_

Deborah Gannon Rly

## MEMORANDUM

TO: Janet Corrigan

FROM: Meredith Miller  
Jennifer O' Connor *JOC*

RE: June Meeting Materials

DATE: June 11, 1997

As usual, your staff did a terrific job of synthesizing a lot of material and issues. We had some comments which are summarized below. Because of the Secretary's concern that the issues identified below be included in the final outlines and also in the relevant working papers, we would like to see them before they are mailed to commission members.

## Comments

1. Remedies should be included in both the Consumer Rights subcommittee and the Roles and Responsibilities subcommittee. Since so many committee members spoke of remedies in the first meeting and indicated inclusion of it in the survey, we would like to give them the opportunity for discussion; then if they want to take it off the table, it will be their decision not ours. Remedies can be thought of as both a tool for enforcement of rights, but also as a substantive right in and of itself -- the point being that patients who are unfairly denied benefits should be able to be compensated beyond what ERISA provides for now, which is only the cost of the benefit that should have been provided in the first place.
2. The description of the scope of work and working papers to be developed for the subcommittee on Roles and Responsibilities focuses almost exclusively on how these entities should encourage quality of care. They do not address how these entities ought to encourage or guarantee protection of consumer rights -- which is a different issue. Also, they do not address issues of how the consumer bill of rights is to be enforced. Our understanding is that the Consumer Rights subcommittee is meant to develop the list of rights, and the Roles and Responsibilities subcommittee is to deal with the avenues through which to realize these rights -- but, as written, it doesn't seem to do that.
3. Emergency services are just one type of service for which the commissioners might want to guarantee access. For instance, the commissioners might want to guarantee access to ob-gyns in managed care centers, to mammograms, to clinical trials, to cancer centers or other types of specific services. Access to emergency services is a subset of access to all kinds of services that consumers in rural or poor urban settings might not be able to get from their managed care providers. A consumer bill of rights might therefore contain a list of the critical services, emergency services included, to which any patient ought to have access. Thus, the working papers, outlines, panels, etc. should step back from the access to emergency services issue and

take a broader look at access to many services, with emergency services being a piece of that discussion.

4. In the scope of work for the Performance Measures subcommittee, we want to make sure there is an opportunity for the commission members to consider the value of measures that indicate the quality of the workforce – such as staff ratios at hospitals. We think this would fit in under “system capacity/structure,” but wanted to make sure it will be included when the outlines are developed into working papers. This also is linked to financial incentives and the impact they have on quality and quantity of staff and training. Thus it could potentially be addressed in the Quality Improvement Environment subcommittee as well.

5. The scope of work for the Performance Measures subcommittee also doesn't have a section addressing reliability of data.

6. The Quality Improvement Environment subcommittee's scope of work doesn't appear to have a place to address the need for, and what constitutes, a safe environment. That needs to be worked in somewhere -- perhaps in the infrastructure needs, or perhaps in workforce issues sections.

→ Sush Gore

→ Megan

→ champagne

→ lunch -

→ Abby



File Quality

Washington Court Hotel

Commission  
ADVISORY COMMISSION ON  
CONSUMER PROTECTION AND QUALITY  
IN THE HEALTH CARE INDUSTRY

FAX TRANSMISSION

To:	Chris Jennings	Date:	6/23/97
Fax #:	456-7431	Phone #:	
From:	Janet Corrigan	Pages:	20, including this cover sheet.
Subject:			

COMMENTS: Please hand deliver  
ASAP

Thank you

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WASHINGTON, DC 20201

PH: 202-205-3333

FAX: 202-205-3347

ADVISORY COMMISSION ON CONSUMER PROTECTION  
AND QUALITY IN THE HEALTH CARE INDUSTRY

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WASHINGTON, D.C. 20201

DATE: June 23, 1997

TO: Members Advisory Commission on Consumer Protection  
& Quality in the Health Care Industry

FROM: Janet M. Corrigan, Ph.D.

RE: Additional Background Material for the June 25-26 Meeting

✓ By now you should all have received a three-ring binder containing the majority of the background materials for the June 25-26 meeting. Enclosed is an additional staff working paper pertaining to the Subcommittee on Performance Measures. The paper is entitled "Overview of Key Issues in Performance Measurement and Reporting," and should be inserted behind Tab 6.

There have also been some minor changes to the meeting agenda. Please replace the copy in your meeting book behind Tab 1 with the revised meeting agenda that is enclosed.

I look forward to seeing you on Wednesday.

ADVISORY COMMISSION ON CONSUMER PROTECTION  
AND QUALITY IN THE HEALTH CARE INDUSTRY

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WASHINGTON, D.C. 20201

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**ADVISORY COMMISSION ON CONSUMER PROTECTION AND  
QUALITY IN THE HEALTH CARE INDUSTRY**

**Agenda**

**Second Meeting -- Day One  
June 25 - 26, 1997**

**JOINT SUBCOMMITTEE SESSION**

- 10:00 Meeting Convenes
- 10:00 - 11:00 a.m. **Panel Discussion -- Consumer Choice (Tab 3)**  
Panelists: Karen Davis, The Commonwealth Fund  
Jon Gabel, KPMG Peat Marwick  
Richard Curtis, Institute for Health Policy Solutions  
Gail Shearer, Consumers Union
- 11:00 - 12:00 p.m. **Panel Discussion -- Performance Measures (Tab 4)**  
Panelists: Shoshana Sofaer, George Washington University  
Patricia Powers, Pacific Business Group on Health  
Steve Udvarhelyi, Independence Blue Cross
- 12:00 - 1:00 p.m. LUNCH
- 1:00 - 5:30 p.m. **Subcommittee Break-out Sessions**
- Subcommittee on Consumer Rights, Protections, and Responsibilities (Tab 5)**
- 1:00 p.m. Discussion -- Workplan & Framework for Bill of Rights
- 2:30 p.m. **Panel Discussion -- Emergency Services**  
Panelists: Larry Bedard, American College of Emergency Physicians  
Lauren Dame, Public Citizen's Health Research Group  
Sandra Harmon-Weiss, Aetna U.S. Healthcare  
Thomas Delbanco, Beth Israel Deaconess Medical Center
- 3:30 p.m. BREAK
- 3:45 p.m. Discussion -- Background Paper on Access to Emergency Services
- 5:00 p.m. Public Comment
- 5:15 p.m. Discussion -- Subcommittee Report to Commission
- 5:30 p.m. Adjournment

**Subcommittee on Performance Measures**

**(Tab 6)**

- 1:00 p.m. Discussion -- Workplan, timeline and products
- 2:30 p.m. Discussion -- Background Paper
- 3:30 p.m. BREAK
- 3:45 p.m. Discussion -- Priority issues for July working paper
- 4:15 p.m. Public Comment
- 4:30 p.m. Discussion -- Subcommittee Report to Commission
- 4:45 p.m. Adjournment

**Subcommittee on Quality Improvement Environment**

**(Tab 7)**

- 1:00 p.m. Discussion -- Workplan, timeline and products
- 1:30 p.m. Discussion -- Background Paper on key policy issues within QI Environment
- 3:30 p.m. BREAK
- 3:45 p.m. Discussion -- Performance Measure Issues for Internal QI
- 4:15 p.m. Public Comment
- 4:30 p.m. Discussion -- Subcommittee Report to Commission
- 4:45 p.m. Adjournment

**Subcommittee on Roles and Responsibilities of Public/Private Purchasers  
and Quality Oversight Organizations (Tab 8)**

- 1:00 p.m. Discussion -- Workplan, timeline and products
- 1:45 p.m. Discussion -- Background Paper on activities of public and private purchasers
- 3:00 p.m. BREAK
- 3:10 p.m. Continuation of the Discussion on Background Paper
- 4:00 p.m. Public Comment
- 4:15 p.m. Discussion -- Agenda for next subcommittee meeting and Report to the Commission
- 4:30 p.m. Adjournment

**Second Meeting -- Day Two  
June 25 - 26, 1997**

**GENERAL PLENARY SESSION**

- 8:45 a.m. Meeting convened
- 8:50 - 8:55 a.m. Remarks by Donna E. Shalala, Co-Chair
- 8:55 - 9:00 a.m. Remarks by Alexis M. Herman, Co-Chair
- 9:00 - 9:05 a.m. **Approval of Minutes from May Meeting (Tab 2)**
- 9:05 - 9:15 a.m. Executive Director's Report
- 9:15 - 10:15 a.m. **Panel Discussion -- Pending Federal Legislation (Tab 9)**  
-- Members of Congress
- 10:15 - 10:30 a.m. BREAK
- 10:30 - 11:30 a.m. **Panel Discussion -- Pending Federal Legislation (continued)**  
-- Members of Congress
- 11:30 - 12:30 p.m. LUNCH
- 12:30 - 1:30 p.m. **Panel Discussion -- Protecting Vulnerable Populations (Tab 10)**  
Panelists: Diane Rowland, Kaiser Family Foundation  
Deborah Klein Walker, Massachusetts Department of Health  
Laurie Flynn, National Alliance for the Mentally Ill
- 1:45 - 2:00 p.m. BREAK
- 2:00 - 2:45 p.m. **Subcommittee Reports:**  
-- Performance Measures  
-- Quality Improvement Environment  
-- Roles and Responsibilities of Public/Private Purchasers  
and Quality Oversight Organizations  
-- Consumer Rights, Protections, and Responsibilities
- 2:45 - 3:45 p.m. Discussion -- Access to Emergency Services
- 3:45 - 4:00 p.m. Public Comment
- 4:00 p.m. Adjournment

**Overview of Key Issues in Performance Measurement and Reporting\***  
**Proposed Framework for Subcommittee**

**Subcommittee on Performance Measures**

**Advisory Commission on Consumer Protection  
and Quality in the Health Care Industry**

**Draft - June 22, 1997**

The purpose of this document is to elaborate on the framework for the subcommittee's scope of work and to introduce some of the key policy issues to be considered. Future subcommittee meetings will focus in more detail on those issues, supported by background papers prepared by Commission staff and testimony and papers prepared by experts. At the June 25 meeting, subcommittee members will have an opportunity to discuss this proposed scope of work and their priorities for further analyses.

As described in the proposed work plan, the subcommittee's work would proceed along two parallel tracks to address two broad areas of interest. First, concerns have been raised that current efforts to measure and report on health care quality fail to respond adequately to the information needs of various users, in particular those of individual consumers and group purchasers. Second, concerns have been raised that the increasing ability to measure different aspects of health care quality has as yet not resulted in sufficient coordination or focusing of measurement initiatives. By examining those concerns and the policy issues associated with them, the subcommittee's work could lead to recommendations for a number of initiatives needed to address challenges for meeting quality information needs (e.g., specification of a research agenda for work in the area of performance measurement; identification of important functions to be performed, such as external auditing of performance data).

**I. What are performance measures?**

Performance measures are important components of the quality improvement and oversight toolbox. Each measure is a yardstick designed to tell us something about the quality of care or the performance of entities that furnish care. Performance measures can provide information about the technical quality of care, such as the processes used or the outcomes achieved; the interpersonal aspects of care; the amenities associated with the provision of care; or the way in

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\*This document is a preliminary draft prepared for the subcommittee on performance measurement of the Advisory Commission on Consumer Protection and Quality in the Health Care Industry. Its contents have not been reviewed, discussed or approved by either the subcommittee or the Commission as of the above date and should not be assumed or depicted as representing subcommittee or Commission views, opinions, findings or recommendations.

which health care delivery or financing is structured. They can focus on health care providers, like hospitals or nursing homes, or on organizations like health plans. They can also furnish information on care provided in particular geographic areas or markets, or to groups of people such as the chronically ill, elderly, disabled, or disadvantaged.

During the last decade, there has been a great deal of activity in the area of performance measurement and reporting. As part of their efforts to hold health plans accountable, purchasers have placed increased demands on health plans to provide comparable performance data using measurement tools promulgated by both public and private-sector groups.<sup>1</sup> In addition, a number of performance measurement initiatives pertaining to hospitals and provider groups have developed in response to different forces. More recently, there have been several efforts focused on better understanding and responding to the information needs of consumers.<sup>2</sup> Various reporting initiatives, such as *Health Pages* and the *Consumers' Checkbook*, have been developed to serve the needs of individual consumers faced with choices among health plans or providers.

Although it is too early to assess the impact of these initiatives, many people have pinned their hopes on performance measurement as a means of safeguarding and improving health care quality. There are expectations that performance measures will contribute to more informed decisionmaking on the part of consumers, purchasers, accrediting agencies, and regulators, and that providers and health care organizations will respond to those choices by striving to deliver higher quality care. Performance measures also supply the tools that enable providers to evaluate the care they furnish as part of their internal quality improvement efforts, and that allow public health planners and policymakers to assess how well care is provided and to identify areas needing improvement.

Given these great expectations, a good understanding of the potential, as well as the limitations, of these tools will be critical to the Advisory Commission's efforts to make recommendations for ensuring consumer protection and quality in the health care system. Below we consider what is needed from performance measures if they are to fulfill the functions envisioned for them, and review the policy issues raised by the interplay of users' various needs. We then review the technical challenges to performance measurement that need to be addressed so that performance measures can better meet users' needs. Addressing those technical challenges will in some cases require grappling with larger underlying policy issues that have contributed to them, and these issues are briefly raised for the subcommittee's consideration in the paper's final section.

## II. What do we want from performance measures?

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<sup>1</sup>Examples are the sets of performance measures developed by the National Committee for Quality Assurance and the Foundation for Accountability.

<sup>2</sup>A notable example is the recent development of standardized consumer satisfaction surveys developed under the auspices of the Agency for Health Care Policy and Research.

The determination of what we want from performance measures depends in large part on what we want to be able to accomplish with them. There are a number of distinct groups of performance measures users (both potential and actual), each positioned to use performance measures in a somewhat different way.

**Group purchasers** of health care want measures that can tell them and their individual members which health plans, care delivery systems, or facilities have the best overall performance in delivering good quality health care. In some instances, they also want to review evaluations of specific aspects of health care quality on an ongoing basis to ensure that their contractors are striving to continuously improve the quality of care they furnish. Group purchasers were a driving force behind the creation of the most widely used set of standardized health plan performance measures for reporting, the Health Plan Employer Data and Information Set (HEDIS) (Corrigan 1995).

Most recent studies suggest that, while many large purchasers now require their contractors to report quality information like that from HEDIS, few as yet make use of the data reported in making their contracting decisions (Miller 1996). One recent study found that many purchasers now consider the willingness to submit information on performance as a proxy for quality (U.S. General Accounting Office 1997). Another concluded that, while few employers now use data on health care quality in their purchasing decisions, some expect that competition over quality will be the next area for employer attention in areas where the limits of price competition have been reached (Lipson and De Sa 1996).

**Individual consumers** have indicated that they want specific information about the care provided to "people like me" to help them in making the health care choices available to them (NCQA 1995). This means that when a woman is pregnant, she wants to know which providers offer the best prenatal care and labor and delivery services; individuals facing surgery want to know which providers have the best records in performing that type of surgery, etc... Satisfying consumers' need for information on "people like me" can point in the direction of providing an ever expanding number of quality measures, because every person "like me" is unique; i.e., has allergies, sinus problems, obesity, smoking habits, heart disease, various forms of mental illness, gastrointestinal disorders, and the list goes on.

Another important difference between the interests of group purchasers and individual consumers is in the relevant unit of analysis. Studies of consumers have found that their primary area of interest is the health care provider. This difference likely stems from at least two sources. First, approximately half of privately insured persons do not have a choice of health plan (Cantor et al. 1995).<sup>3</sup> Second, many consumers do not view their health plans as sharing responsibility for health care quality with their providers (Gibbs et al. 1996; Hibbard et al. 1996). This latter view

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<sup>3</sup>See the working paper prepared for this month's meeting of the subcommittee on roles and responsibilities for an examination of the extent of consumer choice of health plans. A plenary panel discussion at the June 25 meeting of the full Advisory Commission will also address consumer choice.

may reflect consumers' lack of familiarity with the management techniques and financial incentives commonly employed by today's health plans that are intended to influence the health care furnished by participating providers.

While consumers have expressed an interest in measures of quality to help them select health care providers or organizations of "good quality," there is as yet little evidence of widespread consumer use of performance measures in making choices. This type of information is increasingly becoming available to them, as a number of large employees and purchasing coalitions in both the public and the private sectors now provide information on consumer satisfaction and measures of health care quality to aid in consumers' choices.<sup>4</sup>

**Health care organizations**, such as health plans; and other health care delivery systems and facilities, such as hospitals, nursing homes, and large medical group practices are also using performance measures. They do so in two ways: one, for their own internal quality improvement efforts (often required by regulators or accrediting bodies); and two, for the external reporting increasingly required by purchasers and regulators.

Many of the performance measures that a health plan uses are specified by external parties (e.g., purchasers and regulators). Oftentimes, the measures selected for external reporting provide useful information for internal quality improvement purposes, but not always. Many considerations influence the identification of priority areas for measurement, including:

- the potential impact of improvements in quality on reduced morbidity and mortality;
- the ability of health care organizations to achieve the desired improvement in quality and outcomes (e.g., health care organizations probably have less ability to improve quality in clinical areas that require extensive changes in individual or family behavior, work environment, and social support systems);
- the ability of health care organizations to measure and report on the area of interest (e.g., availability of complete and reliable data and staff with necessary education and training to carry out sometimes complex data collection and interpretation tasks); and
- the likely costs associated with measuring and improving quality.

Although purchasers, regulators, and health care organizations may consider many of the same factors when setting priorities for measurement, they may come up with very different lists of priority areas, and/or different specifications for measures within a priority area. First, different constituencies will likely weight the various factors differently. For example, employers may

<sup>4</sup>Information on the quality of care provided by health plans participating in Medicare is also expected to become available for Medicare beneficiaries' use later this year.

*Regulatory Staff Draft*

weight more heavily than other groups, reductions in morbidity that are associated with time lost from work. Second, the populations of interest to these various constituencies differ. Employers and labor unions are concerned about specific employed groups, regulators generally focus on the entire population that resides in a particular area, and health plans are most concerned about their enrolled population. Third, external demands for performance data are generally driven by what "most" health plans and provider groups are capable of responding to, while the priorities set by individual health care organizations take into consideration the strengths and weaknesses of specific organizations. It is well known that health care organizations differ greatly in automated clinical information systems, analytic capabilities and leadership qualities, all of which are important to effecting change.

**Public health planners**, by contrast, need information on the quality of care delivered to a defined population, regardless of where they received their care and what type of insurance they may or may not have had. In addition, the aspects of care that are of primary interest to planners are likely to differ from those focused on by individual consumers, health care organizations, or group purchasers. For example, public health planners may want data on areas relevant to current public health interests such as oral health, screening for many types of cancer, domestic and other types of violence, and provision of certain types of counseling or health promotion and education activities. They may also be interested in care provided to specific vulnerable groups within larger populations, such as the elderly, disabled, or poor, for whom changes in public policy may lead to changes in health care quality.

**Regulators** of health care, including state licensure agencies and private-sector accreditation bodies, seek information on the performance of health care entities as a means of holding organizations accountable to the public at large for the provision of good quality health care. Traditionally, regulators have been less interested in continuous quality improvement than in the measure of quality at a given point in time, as the emphasis of regulating entities has often been on protecting the public from bad performers.

Because there are multiple parties, all expecting performance measures to provide them with a sufficient breadth and depth of information about care quality, it is not surprising that the demands of these multiple interest groups create conflicts within the health system as it attempts to respond to various needs. Some of these conflicts may actually be hindering the improvement of health care quality. Examples follow:

**A. Infinite health care concerns and opportunities for improvement *versus* finite resources for measurement and reporting**

The number and variety of measures of health care quality are growing at a remarkable rate. The number of measures in HEDIS has grown from approximately 60 in the 1993 version to approximately 75 in the version published in 1997. The Foundation for Accountability has offered an additional 35 measures (a few of which are included in HEDIS). The Consumer Assessment of Health Plans Study has identified over 75 measurement items for inclusion in its

core consumer survey instrument and supplemental items set. Adding to this the abundance of "locally grown" measures in use by health plans and group purchasers, measures which focus on institutional care, and measures of health plan structure used individually or in the aggregate through accreditation-like reviews, yields an impressive number of measures of health care quality and capacity. This continuing growth has been so substantial that efforts are underway to create electronic data bases to catalog and describe all available quality of care measures. One of these, Project CONQUEST, has catalogued over 53 separate measurement sets containing over 1,100 quality of care measures.

The drive to measure an increasing variety of dimensions of health care quality seems likely to continue unabated for the foreseeable future. It is a reasonable response to multiple diverse interests, especially since there is little evidence that measures of quality in one area can provide any information on quality of care in general, or on quality in other areas of interest.<sup>5</sup> It also may be beneficial in the sense that performance measurement is still in its infancy, and diverse efforts may advance the state of the art without locking in current ways of approaching measurement. But there is a perception that in failing to prioritize, we run the risk of measuring too much, diluting attention on the areas being measured and devoting resources overly much to the act of measurement instead of allowing health care providers and decisionmakers to act on the findings from key measures. Also, in the rush to develop new and better measures that are relevant to the intended users, there is one issue that may be overlooked: whether or not the dimension of quality being measured is compelling from a social perspective. This is important because it is expected that improvement efforts and health care resources will be focused on aspects of health care quality that are subject to measurement.

As the science of performance measurement has advanced, there has been a parallel growth in the appetite of all parties mentioned above for performance measures to address their specific needs and interests. Because we can measure many aspects of health care quality, should we aim to measure them all? On a yearly basis? As purchasers and regulators demand more performance measurement for external accountability, there may be less resources available for the internal activities that yield quality improvement. Thus we may gain the ability to make better-informed decisions at the expense of moving further or more rapidly up the curve on overall quality.

#### **B. Public disclosure goals *versus* those for internal quality improvement**

The desire of many parties (consumers, purchasers, and regulators) to publicly disclose results of performance measurement creates incentives to measure only certain aspects of health care and makes the accurate measurement of other aspects difficult. Specifically, many performance measures in use today attempt to measure how often "the right thing" is done by a health care entity; e.g. immunizations, cancer screens, etc. This requires that every time a specific service is

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<sup>5</sup>For a discussion of this issue and the limited evidence in this area, see "Measuring Quality of Care," by Robert Brook and his colleagues (1996).

provided, it gets reported. (The incentive is to report, because it will lead to an assessment of better performance.) Certain aspects of health care that offer substantial potential benefit to improve health care (e.g. reduction in adverse medication events) require the system to report every time something "wrong" happens. Public disclosure of these types of measures creates incentives to under-report.

Quality expert W. Edwards Deming cited freedom from "blame" as a critical ingredient for real improvements in quality (1982). At the same time, there is public demand for tools to make better-informed decisions about health care. How should the public's right to know be balanced with the need for freedom from "blaming" to achieve improvements in care?

### C. Measuring care for populations *versus* "people like me"

Group purchasers, public health planners, and health plans develop their policies and operations around the needs and interests of defined populations. In addition, because the measurement of the processes and outcomes of care requires the collection of statistical data, the tendency of performance measurement experts and users is to focus on the needs of a population, as opposed to the needs of the individual. Similarly the needs of individuals with rare or infrequent conditions have not to-date been the focus of performance measurement efforts in either the public or the private sector. How can performance measurement be used in a way that does not fail to address the needs of individuals while it focuses on the legitimate need to achieve the greatest good for the greatest number?

### D. Prospectively safeguarding quality *versus* retrospectively measuring quality

Quality measurement can serve two purposes: 1) inform interested parties about the underlying quality of care of an entity, a function of safeguarding quality of care; and 2) serve in efforts to improve health care quality. Safeguarding health care quality implies a prospective function; prior to an individual receiving care, there is some assurance that care will be "good." Avedis Donabedian (1996) proposed that how a health care entity is structured and operated can be "a most important means of protecting and promoting the quality of care." That is, good structures beget good processes of care which beget good outcomes of care. Measures of **structure** thus can serve as safeguards of protections for individuals, provided that we know which structures to measure.

Structural measures are blunt instruments for assessing the actual quality of care provided, however. Thus, when using performance measures to effect improvements in care, most experts believe that **process and outcome measures** are more effective approaches to improving health care quality.

Because both protecting and improving health care quality need to occur in the health care industry, most quality experts, but not all, agree that a balance needs to be achieved between

measuring structures and processes and outcomes of care.<sup>6</sup> At present there has been no approach articulated for balancing the measurement of structures, processes, and outcomes of health care so as to meet the competing interests of the parties mentioned above. Should such an approach be developed? If so, how?

#### **E. Differences in perceived accountability for health care quality**

Many of the users of performance measures have different foci for their concerns about quality. Although many individuals have little or no ability to choose their health plan, most health care consumers with health insurance coverage have at least some choice of primary care provider and other practitioners. Many consumers, therefore, are primarily interested in comparative information on the quality of care of individual providers or medical groups. Conversely, group purchasers are typically less interested in information on the quality of care furnished by individual practitioners, because they have contracted with plans to secure a network of providers and view the health plan as accountable for the care provided by that network. In parallel with this, different regulators are interested in different levels of accountability for quality, while public health planners normally take a broader health system or population-based view.

Compounding the potential conflicts and duplication of efforts that can result from these disparate views on accountability are recent changes in our health system that have not been well documented, much less accounted for in measurement efforts. Some of these changes raise questions about the meaning and relevance of measurement at the health plan level. These changes fall into three categories: overlapping networks, expanding geographic markets, and emergence of provider subnetworks within health plans. In response to consumer demands for choice of provider, many health plans have developed expansive provider networks, and in some communities this has created a situation where all leading health plans contract with the majority of the providers (primary care providers, specialists, and hospitals) in the community. In markets characterized by sizable overlap in health plan networks, comparative performance data at the level of health plans is probably less informative than it is in markets where health plans are characterized by distinct care delivery systems.

A second, but related issue has to do with the geographic expansion of most health plans' market areas. During the last decade, there has been unprecedented growth in regional and national insurers and health plans. Although over time, health plans may (through various clinical management strategies) reduce some of the variation in practice and outcomes that currently characterizes medical care, it is likely that measurement at the health plan level (or even for state-specific divisions of plans) masks important geographic differences in the quality of care within

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<sup>6</sup>Some experts are strong advocates of either outcome or process measures. Each has advantages and limitations, as Robert Brook and his colleagues observed in a letter to the *New England Journal of Medicine* (1996). Process measures must be shown to be important predictors of outcomes if they are to be considered truly indicative of health care quality. Outcome measures may be more heavily influenced by differences in patients' characteristics or other factors outside the control of health care providers.

the network.

Lastly, as many health plans have been expanding geographically, provider organizations have become increasingly well organized and assumed greater amounts of financial risk and quality management responsibilities. Although individuals enrolling in a health plan may have access to a large number of primary care providers from which to choose, once they have selected a primary care provider, they may find themselves receiving services within a "subnetwork" -- a group of primary care providers, specialists, and one or more hospitals that generally refer patients within the group and share financial risk. Although the development of well-organized "subnetworks" has the potential to lead to better organized and more efficient care delivery systems, it does raise questions about the relevant unit of analysis for the measurement and reporting of performance data.

These health system changes seem to point to the value of moving to provider-level measures of health care quality, at least in some geographic areas. The attraction is increased to the extent that provider-level performance data can be aggregated to form plan-level measures, where those are sought. Both technical and resource constraints in measurement make this problematic, however (McGlynn 1997). First, individual practitioners or small groups of health care providers may not have enough patients to permit reliable measurements of some aspects of health care quality. Creating meaningful groups of providers for measurement purposes could also be problematic. In addition, the resources required to measure and report quality at the provider level will be considerably greater than at the plan level.

Performance measurement necessarily focuses on a specific population, organization, or provider group. Where is the appropriate locus of accountability for health care quality? How can our quality measurement efforts be designed to account for shared responsibility, and where does that exist? How can efforts to measure quality at different levels be designed to be comparable, as opposed to redundant? How should measurement efforts account for regional or local characteristics of the health care market?

### **III. Do we have the right tools? What are the impediments to using the tools in the ways we'd like to?**

Although the various users of performance measures differ a great deal in terms of their desires and expectations, they all confront a similar set of technical challenges. In this section, we turn to a brief description of some of these technical challenges, and identify some of the larger policy issues they raise.

#### **A. We don't yet have tools to measure all of the things we think are important.**

Even as an increasing number of performance measurement and reporting initiatives are launched, and as existing measurement efforts continue to expand in scope, users of performance measures are concerned that we are not measuring the "right things," and that measuring the

"right things" will require a sizable investment in developing and testing of performance measures, building more sophisticated clinical information systems, and enhancing analytic and reporting capabilities. There is a sense that we lack measures for many important dimensions of health care (e.g., chronic conditions, mental health, and substance abuse), and that measurement efforts are being driven to some extent by our capability to measure in certain areas as opposed to recognized needs for certain types of measures.

The scope of many performance measurement initiatives is also constrained by limits in the ability to define measures that are known to be indicative of health care quality. For example, many more measures of health care processes than measures of outcomes have been developed, although most believe that health care outcomes are essential in assessing and improving quality. The lack of outcome measures is primarily owed to measurement challenges. Many health care outcomes of interest occur infrequently (e.g., death), meaning that large sample sizes can be required to make reliable estimates. Other outcomes can only be assessed long after health care is provided, meaning that longitudinal analyses are required, and that there will likely be many intervening or confounding factors that must be taken into account before attributing outcomes to medical interventions.

Other measures that would be of interest are lacking due to deficiencies in the data available for quality measurement. We don't routinely collect much of the data, especially clinical data, that are needed to measure the things we are interested in, and when we do, it may not be easily accessible (automated) or available in a standard format. Sometimes a lack of specific data elements is problematic. For example, developing usable measures of the extent to which physicians counsel their patients who smoke to quit would be challenging because the provision of such advice may not be recorded in medical records nor accounted for in payment systems. A lack of data linkages -- among various data sets (e.g., medical records, payment records, administrative information, survey data), among various providers and financers of health care, and even within individual data sources over time -- also poses measurement difficulties.

The rapid development and expansion of performance measurement initiatives, coupled with the recognized lack of performance measures in a number of important areas (and recognition that addressing these shortcomings will be costly), suggests that an effort to arrive at consensus regarding priorities for measurement would be valuable. Should such a consensus be attempted? If so, how might it be accomplished? What are the appropriate dimensions to consider in evaluating the need for performance measures in specific areas? How much is society willing to pay to develop measures of aspects of quality that are difficult to measure?

**B. Our tools don't always allow us to make reliable comparisons.**

As described above, users of performance measures would like to be able to track trends in health care quality over time and to make comparisons of it among different health plans, providers, and

population groups.<sup>7</sup> The latter use is still problematic, however. For measurements of health care quality that are reported by different entities to be comparable, several conditions must be met. First, the same dimensions of quality and performance need to be measured in each entity subject to measurement. Also, measurement needs to be conducted according to the same measurement specifications at each. The data used in making the measurements need to be comparable in terms of type, accuracy, and completeness. Finally, measurement results need to be adjusted, where appropriate, to account for differences in the underlying populations being examined that are not related to health care quality but that could affect measurement results.

Current limitations in comparability of reported quality measurements are largely due to constraints posed by the the data and analytic infrastructure supporting performance measurement. Health care organizations vary greatly in the types of data they collect, the ways in which they collect their data, and the accuracy with which data are recorded. Measurement specifications often reflect those data constraints, sometimes allowing performance to be measured in several different ways for external reporting purposes.<sup>8</sup> Besides this variation in measurement specifications, the tendency of external parties requesting measurement to "tweak" measures to suit their individual interests also has a constraining effect on the ability to use those quality reports for other comparisons beyond the original intent.

Problems with comparability also arise because there has been little progress thus far in developing needed case-mix or risk adjusters. The need for these adjusters varies by individual measure, with outcome measures normally believed to be more sensitive to factors outside the control of health care providers or organizations. It is likely that the development of risk-adjusted performance measures will increase the costs of measurement, the costs of developing and testing new measures, and the costs of data collection and reporting. On the other hand, the use of measures that fail to account for important differences in the populations served by various health care organizations runs the risk of penalizing in the marketplace those health plans and providers that serve the sickest and neediest populations.

Limitations in comparability have implications for current use of measures, especially by purchasers and consumers when selecting health plans and providers. How can users of performance information be assured that available data are reasonably comparable? What efforts, if any, are appropriate to promote investment in standardized data collection efforts?

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<sup>7</sup>Given current uses for performance measures, the ability to compare the performance of various entities is especially important for purchasers, consumers, and regulators, while health care organizations and providers can benefit from comparative data that help to identify opportunities for improvement, they may focus on longitudinal or trend data that measure improvements within their organization over time.

<sup>8</sup>An example is the HEDIS 3.0 measure of diabetes care. Health plans can use either pharmacy data, claims, or encounter data, or medical record review to determine which enrollees have diabetes, the first step in calculating the percentage who have had an annual eye examination. The eye examination itself can be documented using either medical record review or claims or encounter data.

**C. It is hard to know whether our tools yield accurate information.**

Similar to problems with comparability, users of performance data are also confounded by questions about data accuracy. A recent study by the U.S. General Accounting Office (1997) suggested that one reason many large health care purchasers have refrained from making decisions based on performance data is concerns about whether they are accurate. There are numerous reasons why externally reported data may be noncomparable or inaccurate: performance measurement specifications that fail to provide detailed instructions; errors on the part of health care organizations in interpreting specifications; use of different source data sets (e.g., medical records, claims, patient reports) to undertake measurement; incomplete or inaccurate source data sets; and differences in clinical coding systems (National Committee for Quality Assurance 1995). Another reason purchasers may lack confidence is that most performance data provided by health plans and other health care organizations are self-reported and have not been audited by an independent entity.

What steps might be needed so that consumers and purchasers can better rely on data for evaluating quality? How can use of external auditing be promoted? Is there a need for greater standardization of administrative data sets? How can we improve our analytic capabilities and data infrastructures? Should greater attention be focused on specification of a standard, expanded clinical data set?

**D. We don't know enough about how to interpret the results of our measurements.**

The focus on developing new performance measures has not been accompanied by the same level of effort to assess how measures should be interpreted by potential users of information on health care quality. This concern applies to limitations in our ability both to interpret the results of specific measures and to make meaningful sense of a group of performance measures.

Although interpretation of some measures is straightforward, we also measure a significant number of things because we believe they are important and related to health care quality. But for many of those measures, there is little consensus about what constitutes best performance. For example, some sets of performance measures include specifications for measures of hospital length-of-stay for various conditions, rates of performing selected surgical procedures for health plan enrollees, nurse staffing ratios for hospitals, and physician payment approaches. Measurement of these aspects implies that there is one or more "right" ratios and approaches; while that may or may not be true, we currently have limited ability to determine, on the basis of these types of measures, whether an organization is performing optimally.

The need to develop a rational way of using a number of performance measures in conjunction with each other is another dimension of interpretability that needs to be addressed. Proper interpretation of a set of measurement data is likely to be dependent on the purpose for which the measures are to be used. It has yet to be determined how well purchasers and consumers can incorporate multiple measurement results into their health care decisionmaking process, or even

to what extent they should endeavor to do so. As discussed above, the fact that there appears to be limited ability to generalize on the basis of individual performance measures suggests that decisionmaking on the basis of one or more salient indicators may be as appropriate as an approach based on patterns or trends in the data. On the other hand, the exercise of individual choice in this way has significant implications for whether health plans will experience favorable or adverse selection, an issue that is not addressed well by current payment methods.

How can interpretability of individual measures and measurement reports be increased? Is there a need for a shift in allocation of resources to the interpretation of existing measures and sets of measures? What activities can be undertaken to foster appropriate use of performance measures?

#### **IV. Summary and Policy Issues for Subcommittee Discussion**

As illustrated in this overview paper, consideration of the development, reporting, and use of performance measures raises a number of diverse policy issues that could be explored by the subcommittee. A number of such issues relate to establishing priorities or coordinating and focusing performance measurement initiatives; others relate to the data and analytic infrastructure. Papers to be prepared for upcoming subcommittee meetings will focus on these issues in greater depth.

Examples of the many policy issues that this subcommittee could consider follow:

- Are current performance measurement efforts targeting the most appropriate areas? How can performance measurement activities be better focused to afford greater protection to consumers and to contribute more to continuous quality improvement activities of health care organizations?
- Many of the tensions that arise in competing demands for information on health care quality pertain to issues of resource allocation, priorities, and achieving balance. Until these are addressed, the health care system may be using its limited resources in ways that are not the most effective or efficient. What is an appropriate mechanism for directing public policy around these questions?
- How can the need for information on quality be weighed against the compliance burden on health plans and providers? How can the value of pluralism in measurement and reporting efforts be weighed against the problems associated with that plurality?
- What steps should be taken to promote the development of a data and analytic infrastructure that better supports health care quality measurement, reporting, and improvement?
- Is there a need for better avenues for disseminating information on quality and performance to interested parties? Are there approaches for disseminating performance

data that would be well positioned to address issues of data comparability, accuracy, and interpretation?

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BENJAMIN L. CARDIN  
3D DISTRICT, MARYLAND

COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

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ASSISTANT DEMOCRATIC WHIP

**The Honorable Benjamin L. Cardin**  
**Statement Before the President's Advisory Commission**  
**on Consumer Protection and Quality in the Health Care Industry**

June 26, 1997

First, I want to thank the Commission for inviting me to testify before you today. At this time of rapid change in our health care system, it is vitally important that we focus attention to the need to assure consumer protection and quality standards for all health plans. I commend President Clinton for appointing this Commission and you for all of your commitments to participate in this important endeavor.

As managed care penetration in the health care marketplace has skyrocketed, I have become convinced that we need national standards on quality and consumer protection for health plans. While many states have stepped forward to enact such protections, we have a health care system that does not allow states to regulate much of the health care marketplace due to ERISA. I would support amending ERISA to turn back health regulation to the states, but the political climate is not one where that is a realistic option. So, I have come to the conclusion that we must enact reasonable federal standards for all health plans so that all Americans have a basic set of consumer protection and quality standards. To that end, I have cosponsored two major bills to create such federal standards: HR 820, The Health Care Bill of Rights Act, and HR 1415, The Patient Access to Responsible Care Act.

The health care consumer protection issue that I have been most closely involved with over the past several years is access to emergency care. I would guess that each of you has heard a story -- especially once you were named to the commission -- from someone you know who's health plan has denied their emergency visit or the visit of a family member. Such denials are most often based on retroactive reviews of the medical record. If the diagnosis wasn't an emergency, then coverage is denied.

Unfortunately, not all of us are doctors and can accurately predict whether the symptoms we're experiencing are truly emergencies -- that's why we go to the emergency room. In fact, I even have accounts from doctors who have sent patients to the emergency room only to have those claims later denied after the person was examined and found out not to be experiencing a medical emergency. For example, a doctor in Pennsylvania wrote to me that his wife called him at work with symptoms that indicated meningitis. He sent her directly to the ER. It turned out that she was severely dehydrated, which is not an emergency so the plan denied coverage for her visit.

It is also important to note that the federal government has already taken steps to

protect people's access to emergency care. Congress passed a law a decade ago known as EMTALA, The Emergency Medical Treatment and Labor Act, also known as the "anti-dumping law." It protects patients seeking care at emergency departments by forbidding a hospital from turning them away. Emergency departments are required to provide a screening examination and to provide any stabilization services that are necessary regardless of a patient's ability to pay. This is an important protection and it has ended the cases where poor patients were turned away from the nearest emergency room and sent to the public or county hospital farther away. However, this law does not help people who are insured and whose health plan later decides to deny their claim.

To address those concerns, I have introduced legislation to end health plans' abilities to make these arbitrary denials. That bill is HR 815, The Access to Emergency Medical Services Act. It is bipartisan legislation with the support of more than 142 members of Congress. It's companion legislation in the Senate is S. 356, which also has strong bipartisan support.

HR 815 would enact a national definition of emergency known as the "prudent layperson" definition. Its purpose is to ensure that health plans cover emergency care based on a patient's symptoms rather than the final diagnosis. Enactment of this definition would end the phenomena of health plans denying coverage for emergency care when chest pains turned out to be indigestion rather than a heart attack. The bill would also forbid plans from requiring prior authorization for emergency care, require that they provide educational materials to their members on use of the emergency room, and would provide for coordination of care between the emergency room and the health plan once a patient is stabilized.

The core of HR 815 is the "prudent layperson" definition. It is a simple and straightforward concept and is already law in a number of states -- with Maryland being the first state to enact it. It is a legal standard derived from the long-standing "reasonable man" test that has been used in contract and tort law for decades. It means, *a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in -- 1) placing the health of the individual in serious jeopardy, 2) serious impairment of bodily functions, or 3) serious dysfunction of any bodily organ or part.*

The Access to Emergency Medical Services Act has broad-ranging support. We are especially pleased to have worked closely with Kaiser Permanente in developing the bill this year and to have gained their official endorsement for the legislation. As far as I know, HR 815 is the first managed care regulatory bill to be endorsed by any managed care plan. In addition to Kaiser, the bill is endorsed by the American College of Emergency Physicians, Families USA, the American Medical Association, Citizen Action, the American Hospital Association, the American Heart Association, the National Council of Senior Citizens, and the list goes on.

Even the managed care industry acknowledges that standards for coverage of

emergency care is a real issue. It is a key component of the American Association of Health Plan's (AAHP) "Putting Patients First" agenda. In order to join or renew membership to AAHP, plans must uphold those initiatives. Though they by no means endorse the prudent layperson standard, they do state that emergency services should be covered for "conditions that reasonably appear to constitute an emergency, based on the patient's presenting symptoms."

Again, approximately ten states have enacted the prudent layperson definition to date. In addition, we have successfully incorporated the prudent layperson standard and other provisions from the bill into both the Medicare and Medicaid sections of the Budget Reconciliation Act in both the House and the Senate versions this year.

I thank the Commission for listening to my thoughts on this important issue. It is my firm belief that access to emergency care is fundamental to ensuring a viable health care system. What is at stake here is not an issue of governmental regulation, but an issue of protecting patient safety. As the Commission looks toward making recommendations on federal standards, I would encourage you to ensure that the recommendations protect patients' access to emergency services. I would be happy to provide any additional assistance or information that would help you as this process moves forward.

June 27, 1997

Ms. Kathryn Paul  
Division President  
Kaiser Permanente  
10350 East Dakota Ave  
Denver, CO 80231

Dear Ms. Paul:

I am writing to thank you and your colleagues at Kaiser for going out of your way to give me your perspective on the HCFA competitive pricing demonstration in Denver last month. The insight you provided was extremely useful in helping me better understand all of the complex issues surrounding the demonstration.

I would appreciate hearing more of your insights as we move forward. I am also interested in keeping abreast on the progress you are making regarding health coverage for uninsured children.

Once again, thank you for all of your assistance in Denver.

Sincerely,

Christopher C. Jennings  
Deputy Assistant to the President  
for Health Policy