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Dick Knapp sent this to me
yesterday -- thought you might
want to talk with Harriett Rabb
before doing it.

JUN-26-97 THU 13:28

AAMC 2450 N ST NW WASH

FAX NO. +

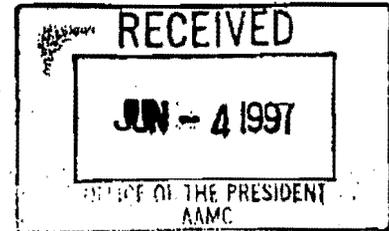
P. 02

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

JUN 3 1997



Jordan J. Cohen, M.D.
President
Association of American Medical Colleges
2450 N Street, N.W.
Washington, D.C. 20037-2217

Dear Dr. Cohen:

I am responding to your letter of May 13, 1997, regarding my assistant's response to your request for a teleconference to discuss our audit of physician services provided in the teaching setting (PATH). Evidently her response was rather blunt, and I'm sorry if you found it unsatisfactory. However, while I have met with you alone and members of the Association of American Medical Colleges (AAMC) on a number of occasions to discuss your concerns about PATH, I do not feel that additional meetings or telephonic discussions would be productive.

As you might imagine, a number of individuals and organizational representatives, AAMC included, have requested clarification of this initiative from the Secretary and me. Rather than respond individually to these requests, I thought it best to prepare one departmental response for all interested parties. Accordingly, you will be receiving a letter from General Counsel Harriet Rabb which will address issues you have raised concerning the PATH initiative.

Sincerely,

June Gibbs Brown
Inspector General

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

June 25-26, 1997

Meeting Room Assignments

The Washington Court Hotel
Washington, D.C.

-- June 25, 1997 -- Joint Subcommittee Session				-- June 26, 1997 -- General Plenary Session
10:00 - 1:00 p.m. <i>Joint Subcommittee Session</i> Ballrooms II & III (Lower Level)				8:45 - 4:00 p.m. <i>General Plenary Session</i> The Atrium (Mezzanine Level)
-- June 25, 1997 -- <i>Subcommittee Break-out Sessions</i>				
Consumer Rights, Protections and Responsibilities	Performance Measures	Quality Improvement Environment	Roles and Responsibilities of Pub./Private Purchasers & Qual. Oversight Organizations	
1:00 - 5:30 p.m. Montpelier Room (Mezzanine Level)	1:00 - 4:45 p.m. Ashlawn Room (Lower Level)	1:00 - 4:45 p.m. Senate Room (Mezzanine Level)	1:00 - 4:30 p.m. Sagamore Room (Lower Level)	

**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.



The Kaiser Commission on

THE FUTURE OF MEDICAID

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

on

“Protecting Vulnerable Populations”

by

**Diane Rowland, Sc.D.
Executive Vice President
Henry J. Kaiser Family Foundation**

and

**Executive Director
Kaiser Commission on the Future of Medicaid**

on

**June 26, 1997
Washington Court Hotel
Washington DC 20001**

I am pleased to join you today to discuss “Protecting Vulnerable Populations” in the changing U.S. health system. I am Diane Rowland, Executive Vice President of the Henry J. Kaiser Family Foundation and Executive Director of the Kaiser Commission on the Future of Medicaid. The Commission was established in 1991 to serve as a policy institute and forum for analyzing and debating Medicaid and other health reforms with the overarching goal of improving access to health care for low-income populations.

Those with low incomes and disabling conditions require particular attention in the reshaping of health financing and delivery systems. I appreciate the opportunity to share with you some of the Commission’s work on access to care for vulnerable populations and the implications of the shift to managed care for these populations.

Who are the vulnerable populations in our changing health system?

Health care coverage is a critical component of making health services accessible and affordable. Health insurance is particularly important for the 38 million Americans who are poor and the 41 million near-poor Americans with incomes between 100 and 200 percent of the Federal poverty level. For these 79 million low-income Americans earning less than \$25,000 a year for a family of three, health coverage through Medicaid or private insurance can promote improved access to early preventive and primary care as well as assist in paying medical bills when serious illness strikes.

The low-income population depends heavily on Medicaid for coverage, with 58 percent of poor and 16 percent of near-poor Americans covered by Medicaid (Figure 1). However, the low-income population also includes substantial numbers of uninsured people -- with 23 percent

of the poor and 30 percent of the near-poor without health coverage. Within the uninsured population, six in ten of those who lack coverage are low-income (Figure 2).

The uninsured face the most serious barriers to access to care -- often going without needed care or delaying care. Among the poor, nearly a half of the uninsured compared to a third of those with private insurance and 22 percent of those with Medicaid reported no physician contacts in the prior year (Figure 3). A third of the uninsured population compared to 10 percent or less of those with Medicaid or private insurance report going without needed care (Figure 4). For the uninsured, the consequences of limited access to care are seen in higher rates of hospitalization, especially for conditions treatable on an ambulatory basis, and in a greater risk of mortality.

Yet, even for the low-income population with insurance, access to appropriate health care can be a real challenge. The low-income population has poorer health status than those with higher incomes. Nearly a quarter (23 percent) of the poor compared to 10 percent of the non-poor with incomes above 200 percent of poverty report their health status as fair or poor (Figure 5). Higher levels of fair/poor health occur for both low-income children and adults with poor adults almost 3 times more likely to report fair or poor health as non-poor adults. The low-income population is more likely to experience health problems and suffer from chronic and disabling conditions, such as hypertension, heart disease, diabetes and asthma -- conditions that require on going medical care and attention and often medications (Figure 6).

Medicaid provides a wide range of services that assist the most vulnerable and frail in our society -- health insurance for impoverished children, assistance with Medicare's premiums and cost-sharing for poor Medicare beneficiaries, acute and long-term care services for persons with

chronic mental illness and retardation, medical and long-term care services for those with AIDS, and home-based or institutional care for those with severe physical and mental disabilities that require long-term care.

These populations and the challenge of serving them fall uniquely to Medicaid because this type of coverage generally falls outside the purview of most private insurance policies as well as Medicare. On average, Medicaid beneficiaries are sicker than those with private insurance, require more care and use more services. In many cases, Medicaid beneficiaries need highly specialized medical services or chronic care that is both expensive and difficult to manage.

How will the changing health system affect vulnerable populations?

For low-income people with insurance -- either private or Medicaid -- managed care is increasingly becoming the predominant coverage approach. States are now moving to enroll increasing numbers of their Medicaid beneficiaries in managed care as a way of increasing access to primary care providers, coordinating their care and controlling spending per beneficiary.

Coverage through managed care has grown dramatically with over a third of all Medicaid beneficiaries -- 13.3 million people -- now enrolled in managed care plans (Figure 7). Most Medicaid managed care enrollment has focused on low-income families and children, but many states are now looking to extend managed care to some of their elderly and disabled Medicaid beneficiaries. The extent to which Medicaid beneficiaries are enrolled in managed care plans varies widely across the states, but the trend is clearly moving toward enrollment of most, if not all, Medicaid beneficiaries in some form of managed care (Figure 8).

These changes in the delivery system have the potential to improve care and accomplish savings. However, to be effective and preserve access to needed services, these changes will require time to implement, the development of an adequate infrastructure to deliver care, oversight of program implementation, and more experience with enrolling elderly and disabled beneficiaries with complex health problems.

In accessing the health care system, the low-income population is vulnerable in several ways-- they are more likely than higher income populations to be without insurance to assist with the cost of care, but also more likely to be in poor health and need of medical care. The low-income Medicaid population is disproportionately young, poorly educated, and inexperienced in navigating a complex health care system. Medicaid patients may experience difficulties in accessing health care services under the best of circumstances. Managed care, although it may be designed to promote more efficient and effective delivery of care, may prove to be difficult for those with little experience in dealing with complex networks and new rules and limitations.

Appropriate health coverage is critical for the low-income population because their limited incomes mean that they are unable to "purchase" their way out of coverage that is inadequate or unsatisfactory. They lack the income and resources to vote with their feet -- if they cannot obtain the medications from their health plan, they do not have the money to purchase it from a pharmacy; if they need specialists that are not in the network, they do not have the resources to pay for care or even give the up-front deposits these specialists often require before rendering treatment; and if a copayment of \$5 a visit is required, on limited incomes even this becomes a barrier to care.

Take, for example, a Medicaid beneficiary with HIV/AIDS who requires expensive drugs, needs specialists with experience in the most current treatment practices for people with AIDS, and relies on a broad range of providers and services. Enrollment in a plan with limited experience in treatment of AIDS and a limited panel of physicians could seriously compromise care, especially if the payment rate established by Medicaid does not properly adjust for the higher cost of care for people with AIDS.

In situations where beneficiaries often have little choice over whether to enroll in managed care and must select from plans picked by the states, monitoring quality and adequacy of care becomes even more critical. Although most states attempt to provide Medicaid beneficiaries with a choice of plans, especially when enrollment in managed care is mandatory, choice is not always realized. In many cases, beneficiaries are poorly informed about their options or confused about how to select a health plan; or the plan they select is filled. In these cases, the state automatically assigns the beneficiaries to a plan.

We know from survey research and focus groups that choice of health plan is important to low-income people just as it is for those with higher incomes. Those who choose their health plan are more likely to be satisfied with it and more likely to have a regular physician and source of care, both measures of improved access to care. Findings from the Kaiser Survey of Family Health Experiences found that only 2 percent of Medicaid beneficiaries felt a change in doctor or place of care resulted in better care when the change was required by Medicaid in contrast to 31 percent who thought the change resulted in better care when it was their own idea (Figure 9). However, it is notable that even when the change was viewed as their own idea, two-thirds of Medicaid beneficiaries did not view the change as resulting in better care. In contrast, half of

those with private coverage thought change, whether initiated on their own or as a result of an insurance change, improved their care.

Recent data from surveys of low-income populations in Tennessee, Texas, Florida, Minnesota, and Oregon demonstrate that managed care is not an immediate remedy for the access problems of the low-income population (Figure 10). Medicaid managed care enrollees were less satisfied with overall care than those in fee-for-service and reported substantial access barriers. These early findings suggest there is no guarantee that managed care will improve care for the low-income population over their fee-for-service experience.

Because the Medicaid population includes individuals with chronic and complex health needs, the shift to managed care for this diverse population requires special attention to the needs of disabled and elderly Medicaid beneficiaries. Health plans that primarily serve non-elderly families and individuals with basic health needs may not be equipped to provide the array of services and specialties needed by a population that is both low-income and disabled. There is little experience in the states in using a capitated managed care model for the disabled population and implementation needs to be carefully planned and monitored to assure that the full range of care needs are met and the payment to plans reflects the cost of care to those with both health and long-term care needs:

Operating under tight budget constraints, Medicaid has often reimbursed providers at rates that are substantially below private sector rates. If Medicaid payments to managed care plans, especially capitated plans that are fully at risk, are set below market rates to achieve savings, the participation of mainstream plans could be compromised. The promise of managed care may not be realized if this shift in care form fee-for-service to capitation is accompanied by

payments that fail to keep pace with inflation or private sector rates, resulting in poorly financed plans and poor quality care for Medicaid beneficiaries.

What protections are needed for low-income and vulnerable populations?

The rapidly expanding enrollment of low-income populations into managed care arrangements poses many challenges for protecting consumer rights and assuring quality of care. Through Medicaid 1915(b) managed care waivers and the broader 1115 statewide waivers, almost all states have implemented or are planning to implement mandatory enrollment in managed care for some or all of their Medicaid population and many use plans that serve a predominately low-income population. Pending Medicaid legislation would substantially broaden state discretion over the implementation of managed care and eliminate the need to apply for waivers and receive federal approval for mandatory managed care programs.

With the current rapid expansion of managed care and the potential for greater flexibility for states in the future, it is especially important that the rights of low-income consumers under state Medicaid programs be protected. The same protections afforded to middle and upper-income people in private insurance plans should be assured for low-income and vulnerable populations in Medicaid managed care.

Providing better information about managed care choices and educating consumers about how managed care works are essential to assuring that quality of care is not compromised in the movement to prepaid managed care. A well-informed consumer with appeal and grievance rights is an important ally in efforts to monitor and improve quality. This is particularly

important in a prepaid system operating on fixed amounts per patient with an incentive for underservice.

Ensuring that plans have provider networks in place, educating both providers and beneficiaries about managed care, and responding to the unique needs of the Medicaid population is also important. Many health plans are only recently beginning to enroll Medicaid beneficiaries and have little experience in caring for low-income and often medically complex populations. It is critical that plans that are enrolling low-income people assure their providers are convenient and accessible to enrollees as well as sensitive to their health and cultural needs.

It is often the mix of publicly and privately insured users that provides an incentive to health plans to improve quality to be competitive with other plans. The growth under Medicaid of plans that primarily serve Medicaid beneficiaries will require careful quality monitoring by states, but also raises concerns for beneficiaries if the payment rates to these Medicaid-dependent plans fail to cover full costs.

Low provider payment rates by Medicaid can deter participation by established mainstream plans. It is critical to assure that there is equity in the rates paid for care delivered to private patients and those enrolled in Medicaid or any other plan serving low-income people. Inadequate levels of payment can result in plans skimping on services to the poor, discouraging high cost patients from enrolling, and having fiscal problems, especially if they are heavily dependent on Medicaid enrollment.

Special protections should be put in place to assure quality and access to health care for low-income enrollees. Choice of plans, ability to disenroll if dissatisfied, and grievance and appeals processes are essential components of managed care for vulnerable populations. Care

should be accessible to enrollees, and the protections on emergency room use and hospitalizations afforded to privately insured patients should also be guaranteed to low-income patients. Health plan outcomes and quality should be carefully monitored with the results made available to the public. Plans that fail to meet state standards should not be allowed to participate. Without these safeguards, the poor will continue to be vulnerable to providers with financial interests rather than their health care at stake.

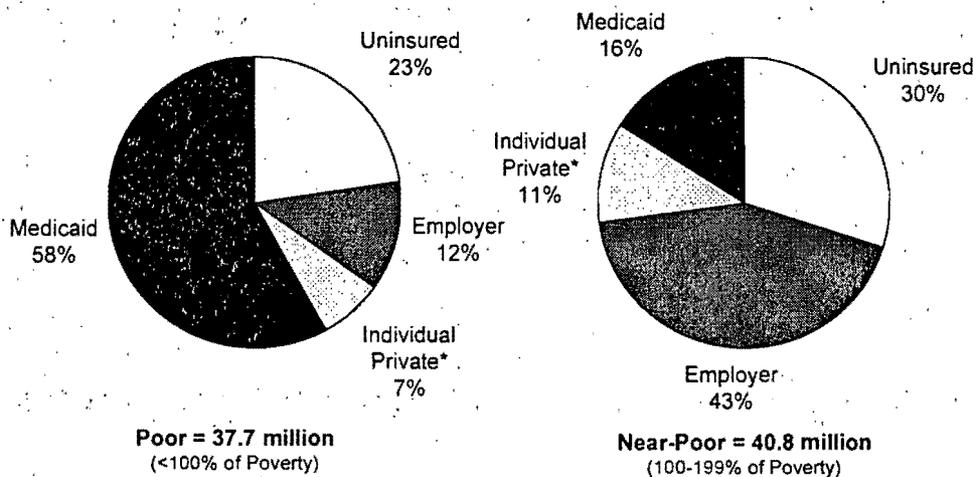
In implementing managed care, states need to be prepared to monitor implementation carefully, commit additional resources to program management, and assess the adequacy of the quality of care provided by providers and plans. These are new responsibilities that go beyond the functions performed by states under fee-for-service systems and will require additional resources at a time when most states are actively downsizing their state agencies.

The best quality protection is to allow beneficiaries who are dissatisfied with managed care to return to fee-for-service. If this option is no longer available under mandatory Medicaid managed care in the states, it is even more important that consumer rights be protected under the managed care plans to ensure that beneficiaries receive effective, high quality health care that addresses their health care needs.

Thank You.

Figure 1

Distribution of the Low-Income Population Under Age 65 by Insurance Coverage, 1994

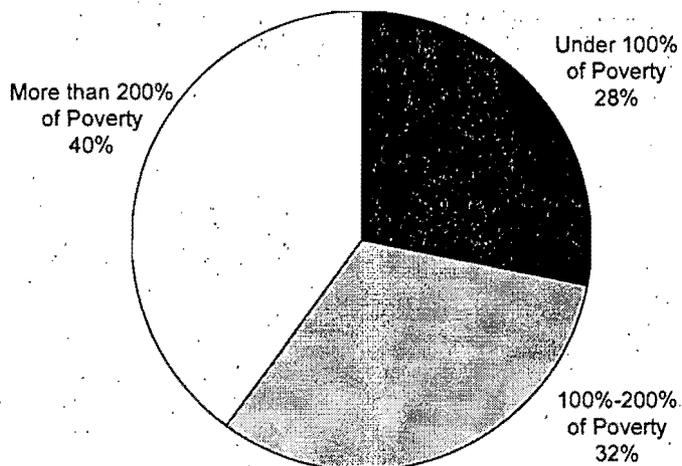


* Includes coverage for the military and veterans.
Source: Urban Institute estimates based on 1988 and 1992 CPS, 1994.

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Figure 2

Who Are the Uninsured, by Income?



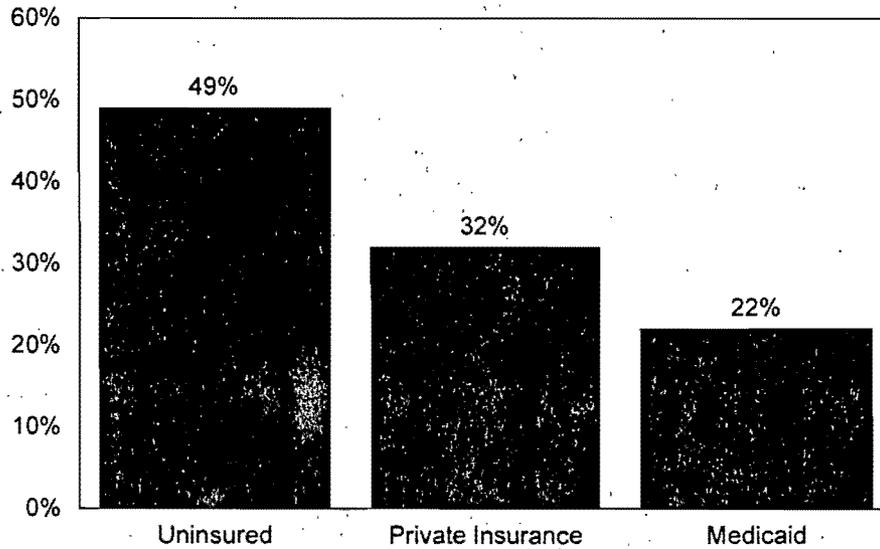
Total Uninsured Population* = 37.1 Million

* Does not include the elderly.
Source: Data are for 1992 from The Urban Institute analysis of the 1993 CPS.

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Figure 3

Poor Population Under Age 65 With No Physician Visit Within Past Year, by Insurance Status, 1987



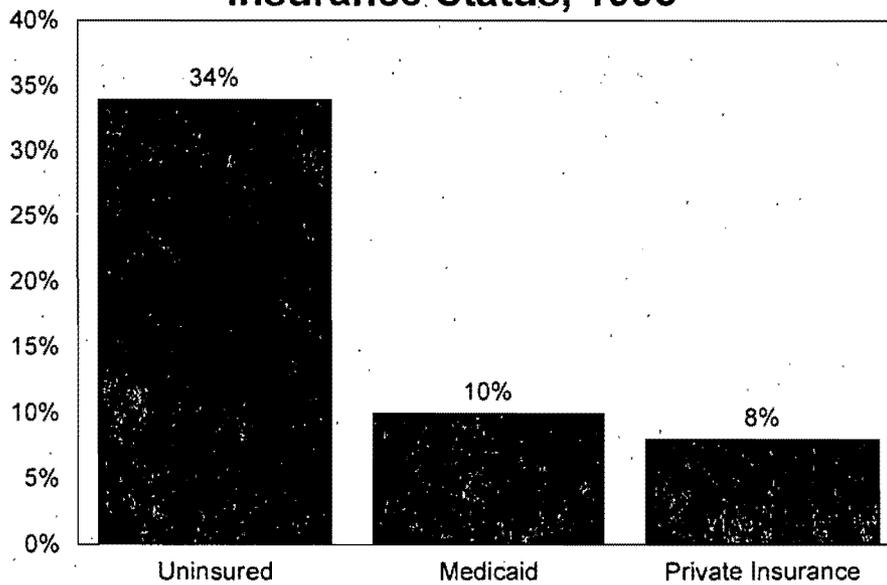
Note: Insurance coverage is for full year.

Source: Analysis of the 1987 National Medical Expenditure Survey.

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Figure 4

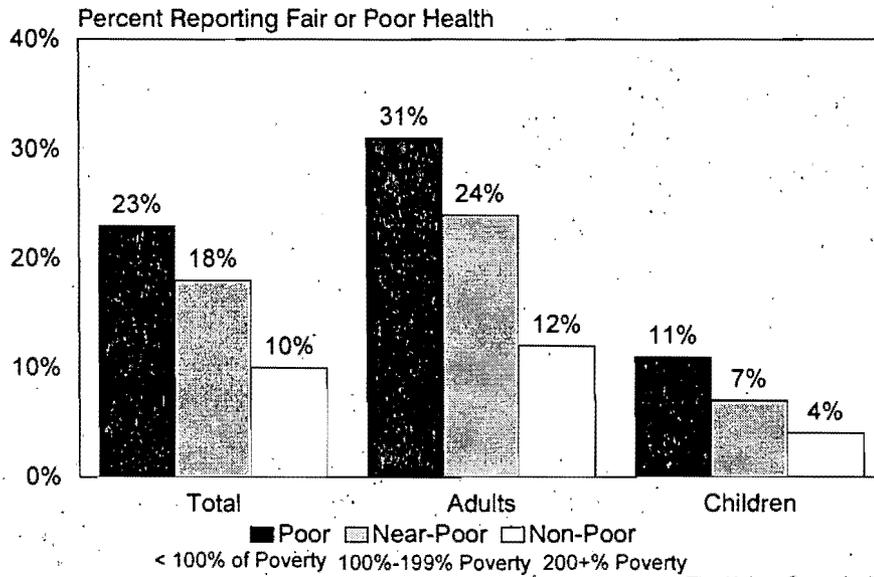
Percent Without Needed Medical Care, by Insurance Status, 1993



Source: Kaiser/Harris Poll, 1993.

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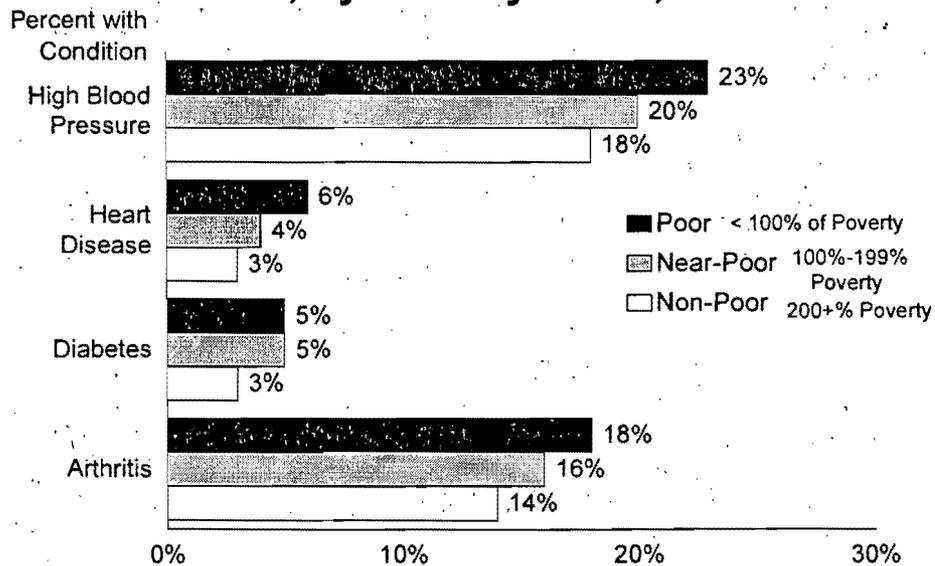
Figure 5
Population Reporting Fair or Poor Health, by Age and Poverty Level, 1987



Source: Kaiser Commission on the Future of Medicaid analysis of the 1987 National Medical Expenditure Survey.

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THE FUTURE OF MEDICAID

Figure 6
Chronic Health Conditions in Nonelderly Adults, by Poverty Level, 1987

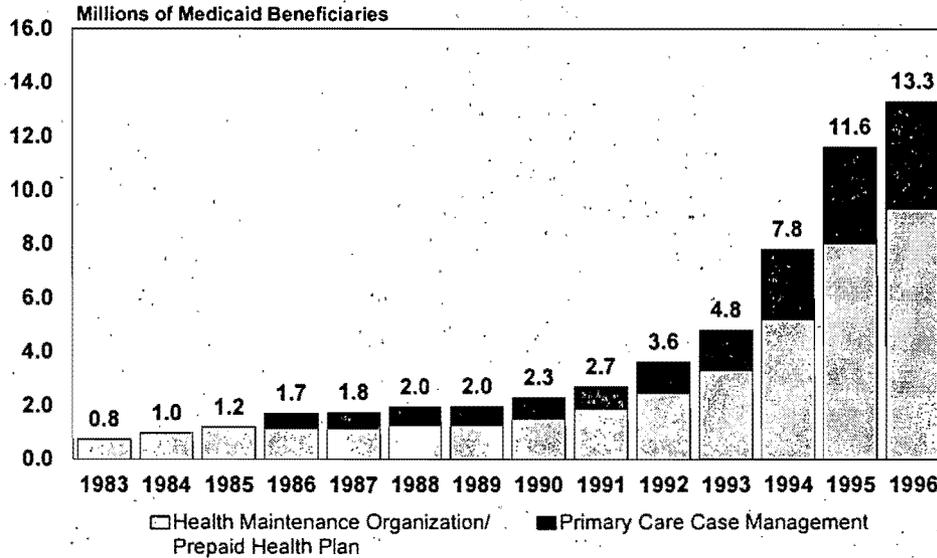


Source: Kaiser Commission on the Future of Medicaid analysis of the 1987 National Medical Expenditure Survey.

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Figure 7

Growth in Medicaid Managed Care Enrollment, 1983-1996

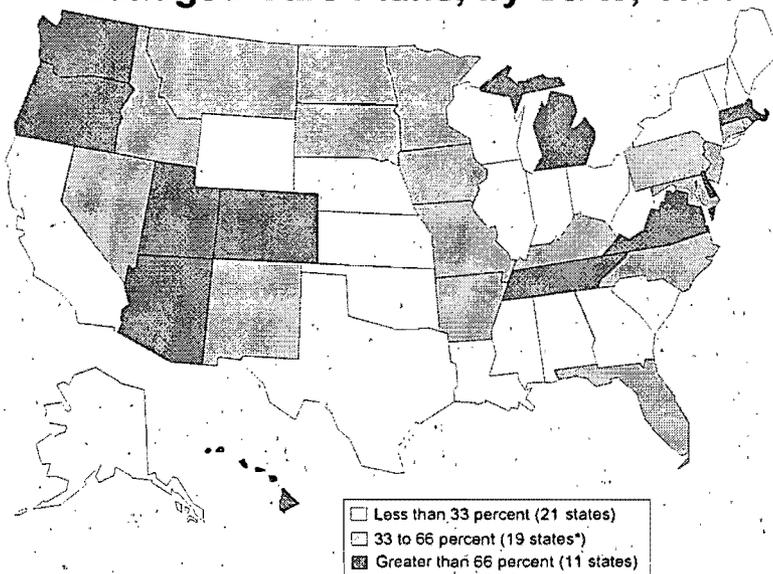


SOURCE: HCFA, 1997, and PPRC, 1997.

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THE FUTURE OF MEDICAID*

Figure 8

Percent of Medicaid Beneficiaries Enrolled in Managed Care Plans, by State, 1996

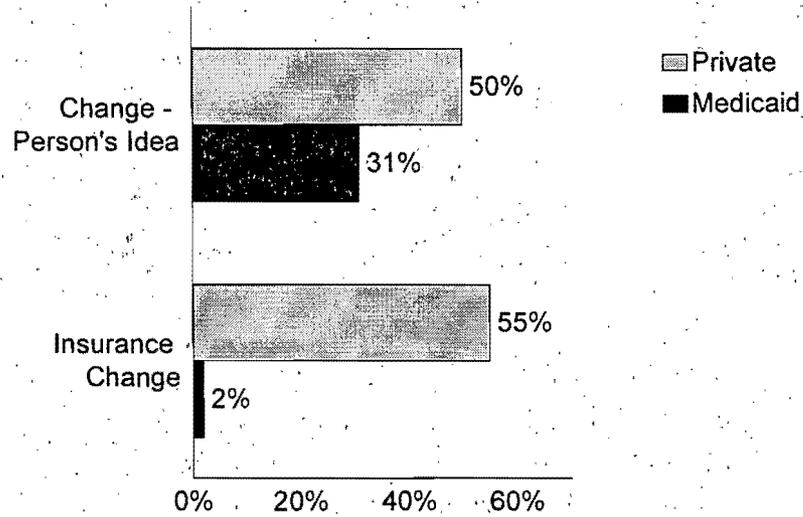


*Includes the District of Columbia.
Source: HCFA, 1997.

*The Kaiser Commission on
THE FUTURE OF MEDICAID*

Figure 9

Change in Doctor/Place of Care in Past Year Resulted in Better Care

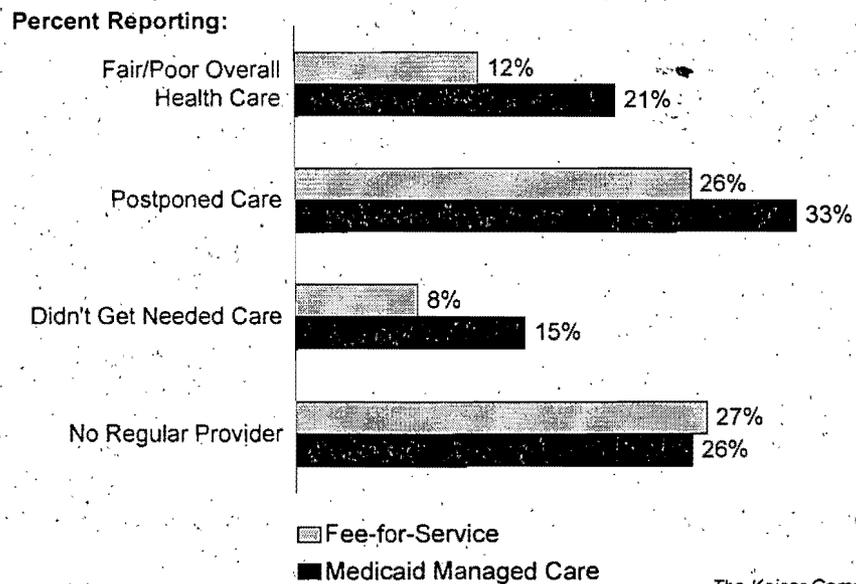


Source: Kaiser Survey of Family Health Experiences.

The Kaiser Commission on
THE FUTURE OF MEDICAID

Figure 10

Medicaid Managed Care vs. Fee-for-Service



Source: Kaiser/Commonwealth Five State Low-Income Survey, 1995-1996.

The Kaiser Commission on
THE FUTURE OF MEDICAID

Panel on Protecting Vulnerable Populations

SPEAKERS

Diane Rowland
Deborah Klein Walker
Laurie Flynn
Helen Smits

TOPIC DESCRIPTION

This panel will discuss the challenges confronting vulnerable individuals and populations in accessing high-quality health care in the U.S. As was pointed out by several members of the Commission at the May 13th meeting, the special needs of vulnerable populations (i.e., low-income, living with physical or mental disabilities) are of relevance to all of the Commission's areas of discussion. This panel will discuss the unique challenges facing vulnerable populations in gaining access to high-quality care, impediments to protecting the rights of those consumers, and approaches that can be taken to assure a proper level of protection.

BACKGROUND ON SPEAKERS

Diane Rowland, ScD., is the Executive Vice President of the Kaiser Family Foundation and the Executive Director of The Kaiser Commission on the Future of Medicaid. She also serves as Associate Professor in the Department of Health Policy and management at the School of Hygiene and Public Health of the Johns Hopkins University. Dr. Rowland specializes in issues related to access to care and financing health care for the poor, elderly, and disabled. From 1976-1981 she served as special assistant to the Administrator of the Health Care Financing Administration and later as Acting Deputy Assistant Secretary for Planning and Evaluation/Health in the U.S. Department of Health and Human Services. Dr Rowland was on the staff of the Subcommittee on Health and the Environment of the Committee on Energy and commerce in the U.S. House of Representatives from 1983 to 1987, as served as a consultant to the subcommittee from 1987 to 1991. Dr. Rowland holds a bachelor's degree from Wellesley College, a Masters in Public Administration from the University of California at Los Angeles, and a Doctor of Science degree in health policy and management from the Johns Hopkins University.

Deborah Klein Walker is an Assistant Commissioner at the Massachusetts Department of Public Health.

Laurie Flynn is the Executive Director of the National Alliance for the Mentally Ill located in Arlington, VA. In addition to her work at NAMI, Ms. Flynn is chair of the board of trustees of the Foundation for Accountability. She serves on the advisory committee to Johns Hopkins University's Health Services Center and the Interdisciplinary Advisory Board of the American Psychiatric Association's Journal on Psychiatric Services. Ms. Flynn serves on the White House National Bioethics Advisory Commission. Ms. Flynn was awarded the Presidential

Commendation Award in 1994, the 1995 APA Patient Advocacy Award, the Mental Health Section Award of the American Public Health Association, and she has received several other commendations. She has served on multiple boards dealing with mental illness. She is the co-author of *Care of the Seriously Mentally Ill: A Rating of State Programs* and, *Criminalizing the Seriously Mentally Ill: The Abuse of Jails as Mental Hospitals*. She has written numerous articles and book chapters on mental illness and the family.

Helen L. Smits, M.D., M.A.C.P., is the President and Medical Director of HealthRight, Inc., a Medicaid managed care plan located in Meriden Connecticut. She served from 1993 to 1996 as Deputy Administrator of the Health Care Financing Administration in the Department of Health and Human Services. Dr. Smits is a former member of the Board of Commissioners of the Joint Commission on Accreditation of Health Care Organizations where she served a two-year term as Chairperson. She currently serves on the Committee on Quality Health Care for the American Association of Health Plans, the Quality of Care Group of the National Academy for State Health Policy and the Board of Governors of the Clinical Center at the National Institutes of Health. She is also a member of the National Advisory Committee for the pew Charitable Trust's managed care training program. She is a Master of the American College of Physicians and a former member of its Board of Regents. She is the former Director of the John Dempsey Hospital, and served as a Professor of Community Medicine and Health Care at the University's Medical School.

THE WHITE HOUSE
WASHINGTON

June 30, 1997

MEMORANDUM TO THE PRESIDENT

FR: Chris Jennings

RE: Improper Payments in the Medicare Program

This memo is in response to your inquiry about a recent *Wall Street Journal* story that said that an upcoming HHS Inspector's General (IG) report -- not yet made public -- estimates that Medicare made \$23 billion in improper payments to medical providers in FY 1996.

You asked whether the Medicare program could do better. We believe that the IG's report confirms that the Medicare program can do better and you are taking action to make sure it will.

The Inspector General's Report

In mid July, the Inspector General will report that improper payments in Medicare amounted to 12 percent (about \$23 billion) of Medicare's \$194 billion budget last year. This report is the result of the Government Management Reform Act of 1994 (GMRA), which you signed into law, that requires every Inspector General to audit financial statements of their Department. The fact that \$23 billion was lost in improper payments was leaked either by the Department or the General Accounting Office (GAO), who is involved in the auditing process. The report will say that the \$23 billion in improper payments should not have been made for a range of reasons, including errors, lack of proper documentation, lack of proper auditing as well as fraud and abuse.

Response to the Report

The Department is planning Corrective Action Plan to be released along with the official report next month which targets the biggest problems identified by the report. The Corrective Action Plan will take steps to make sure that: Medicare payments are adequately validated; that the collection of Part B premiums, which are paid to HCFA from Social Security, are properly audited (this transaction is currently not audited); and that Medicare receivables are properly documented and reconciled.

Your Record on Fraud and Abuse

You have an extremely successful record on cutting down on fraud and abuse. Since you took office, you have implemented or proposed the following initiatives which have saved billions of dollars:

- **FY 1993 Budget.** Your first budget closed a number of loopholes in Medicare and Medicaid, tightening up on fraud and abuse. The Justice Department has also made this a major priority, dramatically increasing health care fraud investigations, criminal prosecutions, convictions, and civil recoveries.
- **Operation Restore Trust.** Two years ago you introduced Operation Restore Trust, a comprehensive anti-fraud initiative in five key states. Since its inception, Operation Restore Trust has produced returns of \$10 for every \$1 spent.
- **Fraud and Abuse Initiatives in Kassebaum-Kennedy.** Last year, you signed the Kassebaum-Kennedy legislation into law, which expanded Operation Restore Trust nationwide, for the first time, creating a stable source of funding for fraud control. The fraud and abuse provisions of the Kassebaum-Kennedy legislation contain an estimated savings of \$5.2 billion for FY 1997 alone, with a \$12 return for every \$1 spent.
- **Outstanding Fraud and Abuse Initiatives.** Your FY 1998 budget contains a number of new initiatives, including cracking down on abuses in home health services and skilled nursing facilities. CBO has estimated that the fraud and abuse savings in your budget will be worth \$9.7 billion over ten years. In March you announced a new series of anti-fraud initiatives. Some of the initiatives in your budget and subsequent legislation have been included in the House and Senate mark-up. We are working to ensure that all of these provisions are included in reconciliation.

We are working with HHS to ensure that there is a successful communications rollout strategy. To this end, your strong record in this area, in addition to the new HCFA initiatives, will be highlighted along with the release of the report.

6/12/97

Estimate of Improper Medicare Costs Soars

By GEORGE ANDERS

Staff Reporter of THE WALL STREET JOURNAL

WASHINGTON—The federal Medicare program made an estimated \$23 billion in improper payments to medical providers in fiscal 1996, according to a financial audit being prepared by government reviewers.

The new calculation by the inspector general's office of the Department of Health and Human Services represents a

Senate Medicare Plan

The Senate GOP plan to overhaul Medicare would raise the eligibility age to 67 from 65 and would seek slightly deeper cuts in payments to hospitals than the House plan. Article on page A4.

claims filed with the Medicare system. Auditors reportedly found problems with 30% of the claims.

The main recipient of the audit will be the Health Care Financing Administration, which oversees Medicare. A HCFA spokesman said he believes the audit "will be a useful roadmap to protect the Medicare program," and could help reduce flaws in the system. The spokesman said that in recent years, "we've made pretty good progress in improving Medicare integrity on all fronts."

The inspector general's office declined to comment on the audit, noting that the report is still being completed. HCFA is due to get an official draft of the report next month, with an opportunity to attach its own comments before formal publication of the audit later this year.

The audit found billing problems were common throughout Medicare, according to people knowledgeable about the study. Irregularities were especially pervasive in home-health services and skilled nursing facilities, but there weren't any areas that were deemed spotless.

The report is likely to be welcome news for federal fraud investigators, who recently have gained extra funds to pursue health-care cases. The audit may be less-welcome news for medical providers. They are likely to raise questions about whether the study's relatively small size — \$5 million in claims — is enough to justify its extrapolation to the entire Medicare program.

Fraud or Lapses?

Doctors and other providers also are likely to question whether apparent evidence of improper payments is fully justified. At this stage, people involved in drafting the report aren't saying how many of the suspected problem cases reflect underlying fraud and abuse, compared with those that simply may reflect innocent lapses in record-keeping.

The audit is being carried out under the Government Management Reform Act, which calls for rigorous review of government agencies' bookkeeping under generally accepted accounting principles. Under

that act, government auditors have taken new steps to review individual case records, rather than relying on summary data.

Historically, Medicare has delegated much of its claims-processing to private insurance companies, which pay bills for specific parts of the country. These insurers, known as "fiscal intermediaries," have their own fraud-investigation units, as well as statistical screens that look for aberrant billing patterns.

But critics, including Malcolm Sparrow, a fraud expert at Harvard University, have contended that the fiscal-intermediary system focuses mainly on making sure that claims are submitted in a standard fashion, rather than checking whether Medicare is paying for appropriate care.

big jump from traditional estimates of medical-spending irregularities. Policy analysts generally have pegged fraud and abuse at 3% to 10% of overall health spending. The inspector general's report, which hasn't yet been made public, would suggest that improper payments last year amounted to 12% of Medicare's \$194 billion budget.

The audit "verifies what a lot of people at the grass roots have been saying," remarked Charles Grassley, chairman of the Senate Special Committee on Aging. "There's a great deal of suspicion among taxpayers, particularly senior citizens, with regard to overbillings in Medicare," the Iowa Republican added.

Bill-by-Bill Review

People familiar with the audit say it is based on a detailed, bill-by-bill review of about 5,000 Medicare claims filed last year. Investigators visited doctors, hospitals, laboratories and other providers to check whether medical records corroborated

CORRECTIONS & AMPLIFICATIONS

AN ARTICLE in the Florida Journal edition last Wednesday incorrectly stated that Orlando tourism officials' data on out-of-state visitors would indicate demand for 52.4 million room-nights in 1996. A room-night is generally defined in the lodging industry as a room sold no matter how many individuals are in it. The article failed to report that an average of 2.46 individuals stay in a typical room and should have stated the number of room-nights as 21.3 million.

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

June 25-26, 1997

Agenda

-- June 25, 1997 -- Joint Subcommittee Session				-- June 26, 1997 -- General Plenary Session
10:00 a.m. Meeting Convened/Opening Remarks				8:45 a.m. Meeting Convened/ Opening Remarks
10:00 - 11:00 a.m. Panel Discussion -- Consumer Choice				
11:00 - 12:00 p.m. Panel Discussion -- Performance Measures				
12:00 - 1:00 p.m. Lunch				9:15 - 11:30 a.m. Panel Discussion -- Pending Federal Legislation Testimony by Members of Congress
-- June 25, 1997 -- Subcommittee Break-out Sessions				11:30 - 12:30 p.m. Lunch
Consumer Rights, Protections and Responsibilities	Performance Measures	Quality Improvement Environment	Roles and Responsibilities of Pub./Private Purchasers & Qual. Oversight Organizations	12:30 - 1:30 p.m. Panel Discussion -- Protecting Vulnerable Populations
1:00 p.m. Discussion-- Workplan & Framework	1:00 p.m. Discussion -- Workplan & Products	1:00 p.m. Discussion -- Workplan & Products	1:00 p.m. Discussion -- Workplan & Products	1:45 - 2:00 p.m. Break
2:30 p.m. Panel Discussion -- Emergency Services	2:30 p.m. Discussion -- Background Paper	1:30 p.m. Discussion -- Background Paper	1:45 p.m. Discussion -- Background Paper	2:00 - 2:45 p.m. Subcommittee Reports
3:30 p.m. Break	3:30 p.m. Break	3:30 p.m. Break	3:00 p.m. Break	2:45 - 3:45 p.m. Discussion -- Access to Emergency Services
3:45 p.m. Discussion -- Background Paper	3:45 p.m. Discussion -- Priority Issues for July paper	3:45 p.m. Discussion -- Performance Measure Issues for Internal QI	3:10 p.m. Continuation of Discussion	3:45 - 4:00 p.m. Public Comment
5:00 p.m. Public Comment	4:15 p.m. Public Comment	4:15 p.m. Public Comment	4:00 p.m. Public Comment	4:00 p.m. Adjournment
5:15 p.m. Discussion -- Subcomm. Report to Commission	4:30 p.m. Discussion -- Subcomm. Report to Commission	4:30 p.m. Discussion -- Subcomm. Report to Commission	4:15 p.m. Discussion -- Next Subcomm. Meeting & Report to Commission	
5:30 p.m. Adjournment	4:45 p.m. Adjournment	4:45 p.m. Adjournment	4:30 p.m. Adjournment	

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

June 25-26, 1997

Meeting Room Assignments

The Washington Court Hotel
Washington, D.C.

-- June 25, 1997 -- Joint Subcommittee Session				-- June 26, 1997 -- General Plenary Session
10:00 - 1:00 p.m. <i>Joint Subcommittee Session</i> Ballrooms II & III (Lower Level)				8:45 - 4:00 p.m. <i>General Plenary Session</i> The Atrium (Mezzanine Level)
-- June 25, 1997 -- <i>Subcommittee Break-out Sessions</i>				
Consumer Rights, Protections and Responsibilities	Performance Measures	Quality Improvement Environment	Roles and Responsibilities of Pub./Private Purchasers & Qual. Oversight Organizations	
1:00 - 5:30 p.m. Montpelier Room (Mezzanine Level)	1:00 - 4:45 p.m. Ashlawn Room (Lower Level)	1:00 - 4:45 p.m. Senate Room (Mezzanine Level)	1:00 - 4:30 p.m. Sagamore Room (Lower Level)	

Statement Of Congressman Sherrod Brown
Ranking Member, House Subcommittee On Health and the Environment
Before The Advisory Commission On Consumer Protection And Quality
In The Health Care Industry
June 26, 1997

I would like to thank Health and Human Services Secretary Donna Shalala and Labor Secretary Alexis Herman and the members of the President's Advisory Commission On Consumer Protection And Quality In The Health Care Industry for the invitation to testify before the Commission today.

As the ranking Democrat on the Subcommittee on Health and the Environment, I have been deeply concerned with the practices of many health maintenance organizations.

Last year, Congress finally began to heed the public outcries of mistreatment by managed care, and we passed legislation which prohibited the practice of drive thru deliveries.

The managed care companies fought this legislation charging Congress with legislating "body part by body part."

While I believe new moms in consultation with their doctor should be allowed to determine how long they and their babies should be allowed to remain in the hospital after delivery, I agree that legislating "body part by body part" is not good policy.

I believe more basic and fundamental reform of managed care is necessary to address managed care's core problems not merely the symptoms.

It was for this reason that I joined with my Republican colleague, Dr. Tom Coburn in introducing the Medicare Patient Choice and Access Act. This legislation, which enjoys bipartisan support in the House and Senate and includes 106 House cosponsors, was largely adopted as part of the Medicare provisions in the budget reconciliation package passed by the House Commerce Committee.

Our legislation was narrowly targeted to ensure that Medicare patients enrolled in HMOs are guaranteed access to independent, timely review of denials of medically necessary care. It bans gag clauses and financial incentives which can be used to deny patients access to specialty care.

I am hopeful that these important patient protections are included in the final budget reconciliation package passed by Congress.

With this in mind, I would like to address another issue which I hope the Commission will examine concerning the federal government's payment structure for Medicare HMOs.

In the 1970's, non-profit HMOs spent as much as 94 cents of every premium dollar on their members' medical care. Today, non-profits still spend about ninety percent of their revenues on providing health care.

For profits, however, tell a different story.

Health Net, a California-based HMO spends about 70 cents of every premium dollar on health care services for its members. Others hover around 75 cents.

As more and more insurance companies and their managed care affiliates enter the Medicare market, fewer and fewer dollars go into patient care.

In 1982, the Adjusted Average Per Capita Cost, commonly referred to as the AAPCC formula was established as a way of calculating how much Medicare pays for fee-for-service benefits by county.

Because it was presumed that HMOs would be more cost effective, managed care companies are paid 95% of the AAPCC rate per beneficiary enrolled.

However, government studies have shown that HMOs are making a tidy profit on these payments since they tend to enroll lower risk beneficiaries, thus benefiting from "positive selection."

As we work to improve Medicare, I ask the members of the Commission to keep three numbers in mind.

\$37,000. \$1,400. \$4,500.

In 1996, the most expensive 10 percent of beneficiaries cost Medicare \$37,000, for each patient.

The healthiest 90 percent of seniors cost Medicare just \$1,400 each.

HCFA pays managed care companies about \$4,500 for each Medicare beneficiary enrolled in their managed care plans.

As managed care expands, the companies will put their efforts -- obviously -- in recruiting healthy seniors who cost Medicare \$1,400 or less per year. Sure they can supply them with prescription drug benefits, glasses, and eliminate their co-pays and deductibles.

And there will be a lot of money left over -- for huge profits, exorbitant executive salaries, and highly sophisticated marketing campaigns to recruit new healthy seniors.

Every week in my district in northeast Ohio, Medicare beneficiaries are treated to full page advertisements in The Cleveland Plain Dealer from a variety of Medicare HMOs enticing seniors to join their plans.

They tout the extra benefits they provide over Medicare fee-for-service such as prescription drug coverage or eyewear benefits. But, they do not advertise that they may employ gag clauses and restrictions on access to speciality and non-physician providers.

While this represents the tip of the iceberg as far as their total marketing costs are concerned, and it is not as pricey as The New York Times, the average full page ad in the Sunday Plain Dealer costs \$20,000. Of course, this does not include the cost of seniors' dances hosted by HMOs, telemarketing, direct mail advertising, and other sophisticated marketing techniques.

Health Net, the California HMO I spoke of earlier, paid its CEO \$18.1 million in bonuses, and stock options when he left the company in 1995.

According to an April 11, 1996, article in the New York Times, the President and CEO of Health Source, a medium size HMO based in Kooksett, New Hampshire, was paid \$15.5 million.

Foundation Health's CEO was paid \$13.7 million in 1994.

An industry which preaches an imposes austerity on others too often grabs huge salaries for its executives and big profits for itself.

While I could go on with examples of corporate health industry greed and avarice, I simply ask the members of the Commission to return to the numbers I cited earlier in my testimony.

A \$1,400 cost to the HMO.

A \$4,500 payment from Uncle Sam.

The taxpayers lose.

In conclusion, I urge the members of the Commission to carefully study how we can implement a fair and equitable Medicare HMO payment structure which discourages "positive selection" of healthy Medicare patients, ensures access to quality health care, and helps safeguard the solvency of taxpayer dollars and the Medicare trust fund.

Thank you.

STATEMENT BY CONGRESSMAN HENRY A. WAXMAN
BEFORE THE ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY
IN THE HEALTH CARE INDUSTRY
June 26, 1997

Good morning. I am pleased to have the opportunity to appear before you today.

As many of you know, I am usually on the other side of the dais. I am currently the Ranking Member of the Government Reform Committee in the House. And I am also a senior member on the Committee on Commerce, where I previously served as Chairman, and then Ranking Member, of the Subcommittee on Health and the Environment.

All in all, a primary focus of my Congressional career has been health care, and access to quality care for all Americans, particularly vulnerable populations like the low-income, the aged, and the disabled.

That is why I welcome the establishment of this panel, with its broad and distinguished membership. I believe you meet at a critical time for our health care system, and the contribution you can make is enormous.

FOCUS ON CONSUMER PROTECTION AND QUALITY

I view these times as critical because in both our public and private health insurance programs, we are seeing the rapidly increased use of managed care, including forms of delivery as varied as traditional HMO's, PPO's, PSO's, hospital and physician based plans. These plans are in fierce price competition with each other, as well as with the fee-for-service system.

We all like to think that plans are also in vigorous competition in regard to quality and consumer satisfaction, but we all know that achieving this kind of competition is not always easy or effective.

So I see the challenge before us is to continue appropriate efforts to control costs without sacrificing quality and appropriate care.

That I know is your mission, and it is a large one.

FOCUS ON MEDICAID

But what I want to urge on you today is this: give your immediate priority and attention to issues of quality for Medicaid beneficiaries.

I am afraid we are in danger of accepting in this country that it is alright to have lower quality and consumer protections for the low-income population covered by Medicaid.

I feel very strongly that this is wrong. If anything, the standards and protections for the Medicaid population ought to be higher, because they are more vulnerable to underservicing.

But at a minimum, the Medicaid population should have the benefit of the same quality and consumer protections as everybody else.

Clearly, there are certain features of Medicaid and the population it serves that require us to pay special attention to it.

First, the Medicaid population is rapidly being moved into managed care. CBO estimates that about 25 percent of the nation's 44 million Medicaid beneficiaries--mostly women and children--are enrolled in managed care today. And CBO projects that Federal spending on Medicaid managed care will rise from \$7 billion to \$17 billion over the next five years.

Second, in many cases, this enrollment in managed care is happening without a choice being made by the beneficiary as to whether they prefer managed care.

The budget reconciliation bill that is now moving through the Congress is likely to accelerate this trend. In the name of state flexibility, the legislation would give states the authority to require Medicaid beneficiaries to enroll in managed care plans and to restrict the choice of plans.

It is quite possible that the only choice offered will be between one of two plans.

That is the standard suggested by the Administration in legislation. And that was the standard included by the majority in the bill we recently marked up in Committee.

I was successful in passing an amendment which would open Medicaid to all qualified managed care organizations that would accept the payment terms of the States, and I hope to see that provision survive. But it will be an uphill battle. Certainly we have to recognize the very real possibility that Medicaid beneficiaries may end up with only a choice of two plans.

Further, those plans may very well be--in fact probably will be--plans that serve only the Medicaid population. The reconciliation bill repeals the standard that requires plans to have 25% enrollment of private-pay persons.

So the market effect, if you will, the need to maintain consumer satisfaction and quality protections to attract private-

pay patients will be gone. We know that that rule, the so-called 75-25 rule, was always only an imperfect proxy measure for quality, and was waived more often than honored--but the fact remains that even the pretense of appealing to private pay patients is now gone.

Additionally, the Medicaid population is disproportionately made up of disabled and special needs populations. These are among the most costly populations in the Medicaid program, and fiscally-pressed States will have strong incentives to enroll them in managed care plans for cost containment purposes.

Yet they are also people for whom managed care may not be appropriate, at least without numerous special protections.

For that reason, I supported an amendment to the budget reconciliation bill to exempt special needs children from mandatory enrollment in managed care. Since there is support in the Senate as well, I hope this will survive in the final legislation.

However, States will still have the authority to require disabled adults to enroll in managed care plans, raising challenging quality issues.

CONCLUSION

We cannot ignore the unpleasant political reality that it often is easier for people to accept a situation for poor people that they wouldn't accept for the general population or Medicare. If we allow this approach to quality and consumer protection issues for the Medicaid population, we will make a tragic mistake.

This Commission can be a powerful force to assure that this does not happen.

You have a big job to do. And I leave you today with the plea that you focus first on the population that is at the mercy of a rapid and forced move into managed care.

Thank you.

MEMORANDUM

TO: Leon Panetta

September 5, 1996

FR: Chris J.

RE: President's Health Care Quality Initiative

Today the President was scheduled to announce a two-part initiative on health care quality. First, he is challenging the Congress to pass the 48-hour and gag rule consumer protection bills before adjournment. Second, he is announcing his intention to establish a narrowly-focused commission, by executive order, to study and make recommendations about assuring quality within a rapidly changing health care system.

Attached is a one-page background piece on the Commission. The following are some talking points for your use in discussing our "message" on the Commission with Donna Shalala and Robert Reich.

- We are concerned that the New York Times article from today makes it appear that the proposed Commission has a broader scope/mandate than it does.
- We need to make sure that all comments about the Commission stress that it has a very narrow, but important charge -- to examine quality concerns in a rapidly changing health care market place. It is NOT a Commission designed to focus on how to expand coverage or contain costs or on any other of the numerous issues involved with health care.
- Please make sure that you and all of your surrogates emphasize this point. We must not give anyone the opportunity to make this new commission bigger than it is. The Executive Order will be very narrowly drafted and we will get you the final copy of it later today.

EXECUTIVE OFFICE OF THE PRESIDENT

05-Sep-1996 02:58pm

TO: Carol H. Rasco

FROM: Christopher C. Jennings
Domestic Policy Council

CC: Jennifer L. Klein
Diana M. Fortuna
Elizabeth E. Drye
Jeremy D. Benami

SUBJECT: commission update

After someone leaked that the President would be announcing a quality initiative, Mike M. and Mary Ellen G. asked Melissa Skofield (from HHS) and me to talk to reporters to attempt to address some damaging inaccuracies that were floating around about the commission. We were largely successful in getting the facts out, but Robert Pear was bound and determined to write a story to give the impression that the commission was a bigger deal than it really is. (The other stories by the Washington Times and the LA Times were fine.)

We are trying to ensure that any subsequent portrayal of the commission is written in a way that reflects the reality that it is an advisory panel that has an important, but narrow focus -- quality. Jen and I have been working on three one-pagers that we are circulating within the White House and to the Departments: (1) a one page simple description of the commission and its functions, (which can and has been circulated to the press and beyond); (2) a brief set of our suggested talking points outlining the President's quality initiative -- which emphasizes the 48-hour and the anti-gag rule initiatives; and (3) a Q&A document that answers some of the most likely and difficult questions surrounding this commission.

We are sending this to you right away. If you have any questions, please give Jen or me a call.

p.s. The overall reaction to the commission concept by consumer groups, providers, insurers, and managed care reps has been quite favorable. We are trying to get their positive reviews on paper so that we have some solid validation.

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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.

**QUESTIONS AND ANSWERS ON
HEALTH CARE ANNOUNCEMENT IN FLORIDA**

QUESTION: How is this different from the Health Care Task Force chaired by the First Lady?

ANSWER: This advisory commission has a narrow but important task. It will be made up of no more than 20 insurers, employers, consumers, government representatives, health care professionals, and other health care workers. This commission will not be proposing comprehensive health care reform, but instead will build on work that is already being done and look at health care quality, consumer protection and availability of treatment and services in managed care and other health plans. In a rapidly changing health care market -- where there are increasing pressures to cut costs -- the President wants to be sure that quality is not sacrificed.

QUESTION: What do you mean by the "availability of treatment and services"? Isn't this your next attempt to guarantee universal coverage?

ANSWER: The President *is* committed to continuing to work to reform the health care system, but this advisory commission is not "health reform part two". It is a small panel of experts charged with looking at quality, consumer protection and the availability of treatment and services. The panel will look at availability because one of the current problems in the health care system is that some people who have insurance are being denied appropriate services. There are even some areas of the country where there is no place for people to get the care they need.

QUESTION: Is it a slight to the First Lady that she has not been asked to chair this commission?

ANSWER: As I said, this commission has a very specific task. The President has asked Secretaries Shalala and Reich to co-chair because these issues are directly relevant to their Departments.

QUESTION: Your Health Security Act was built around managed care. Why are you attacking managed care with this commission?

ANSWER: This commission is not an attack on managed care. It will bring together experts, insurers, businesses and consumers to make recommendations on quality, consumer protection, availability of treatment and services in managed care plans *as well as* other health plans. The health care market is changing quickly and this commission will allow some of the best minds in the field to analyze and make recommendations on how to ensure that people get the best quality care possible.

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

I. ADVISORY COMMISSION

The President will sign 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.

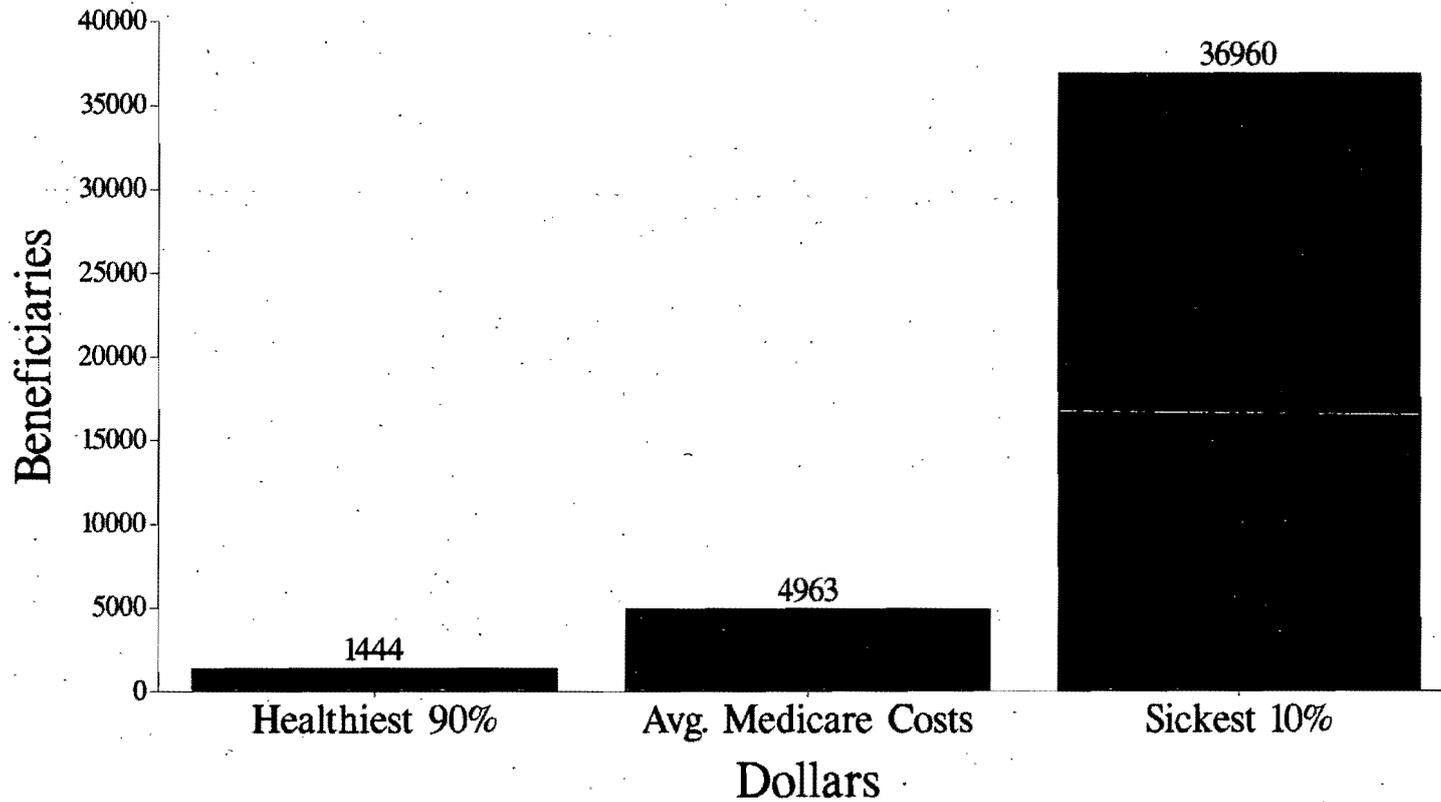
IV. SPECIFIC PROVISIONS

- The Advisory Commission will be appointed by the President and co-chaired by the Secretaries of HHS and Labor will have a membership of no more than 20 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

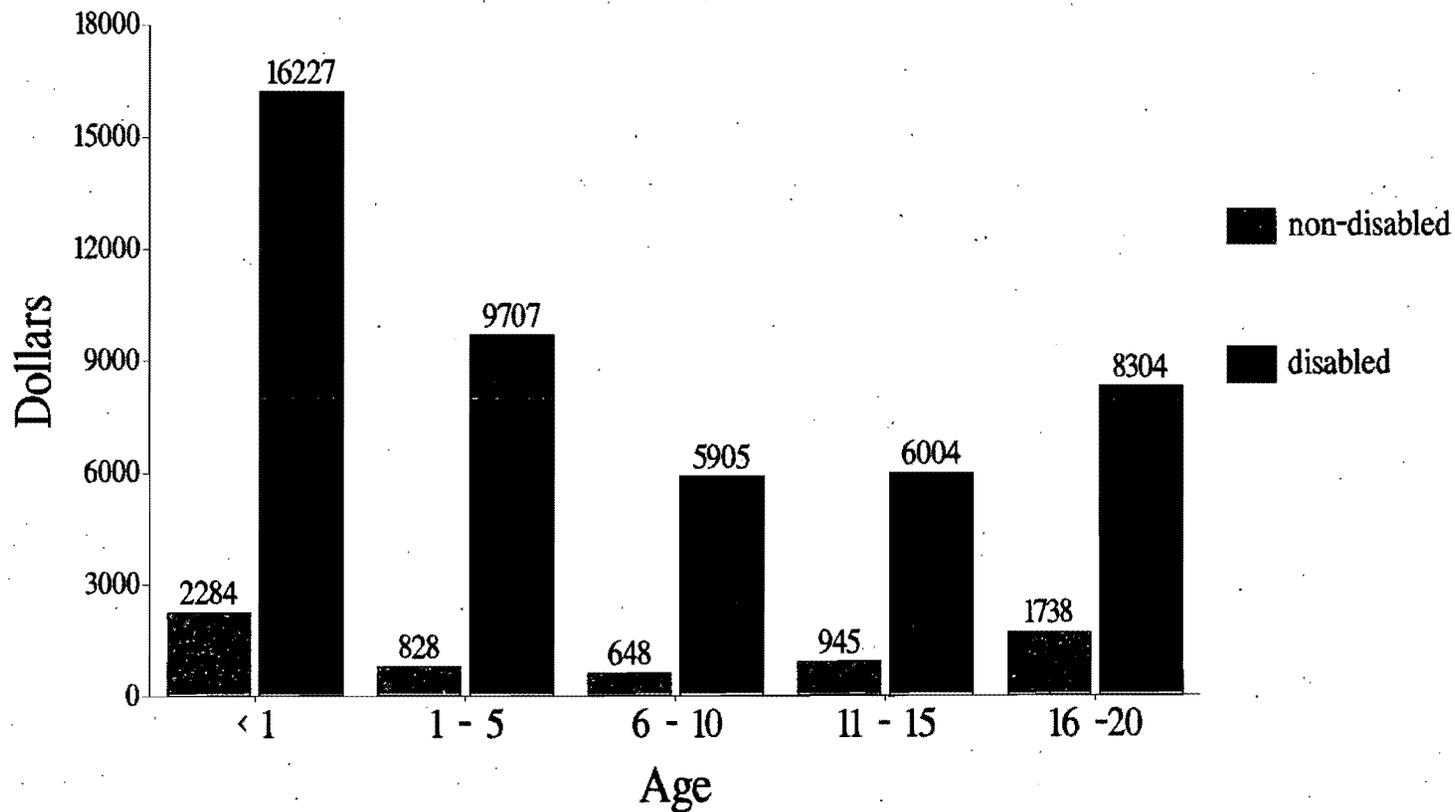
The Clinton Administration has a long history of strong support of consumer protection in all health care plans, including the Medicare program. Two such examples are his support of initiatives to assure new mothers and babies have access to necessary hospital care and to protect communications between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

AVERAGE MEDICARE OUTLAYS PER BENEFICIARY



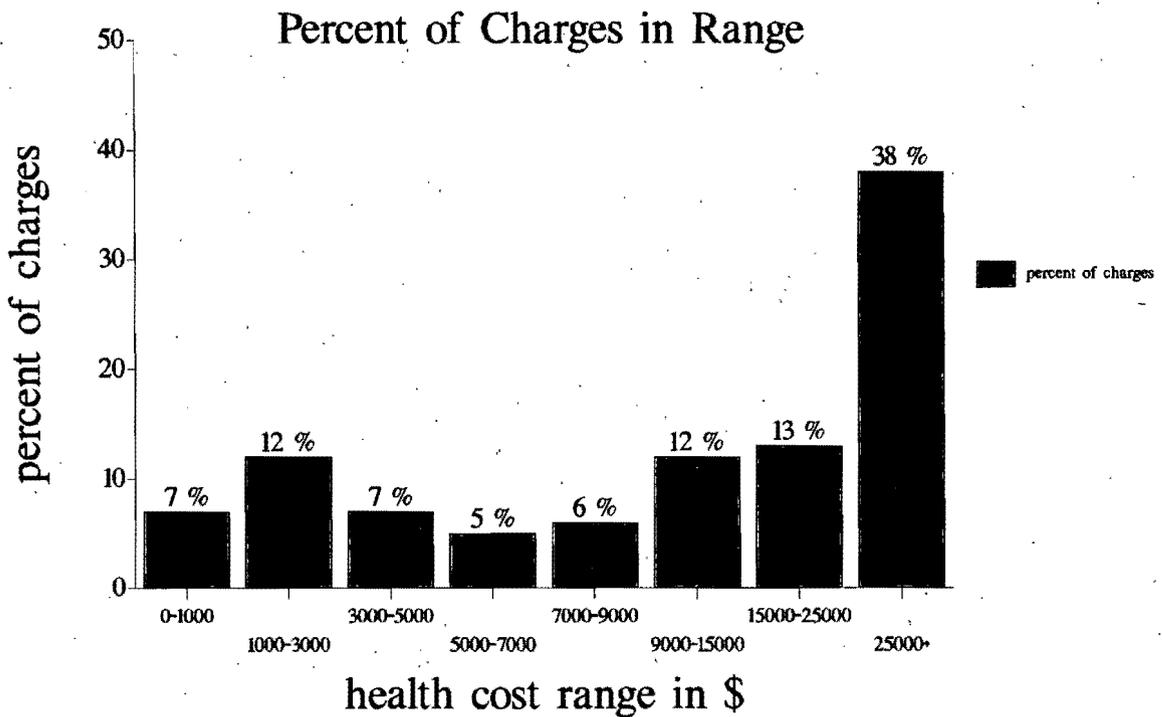
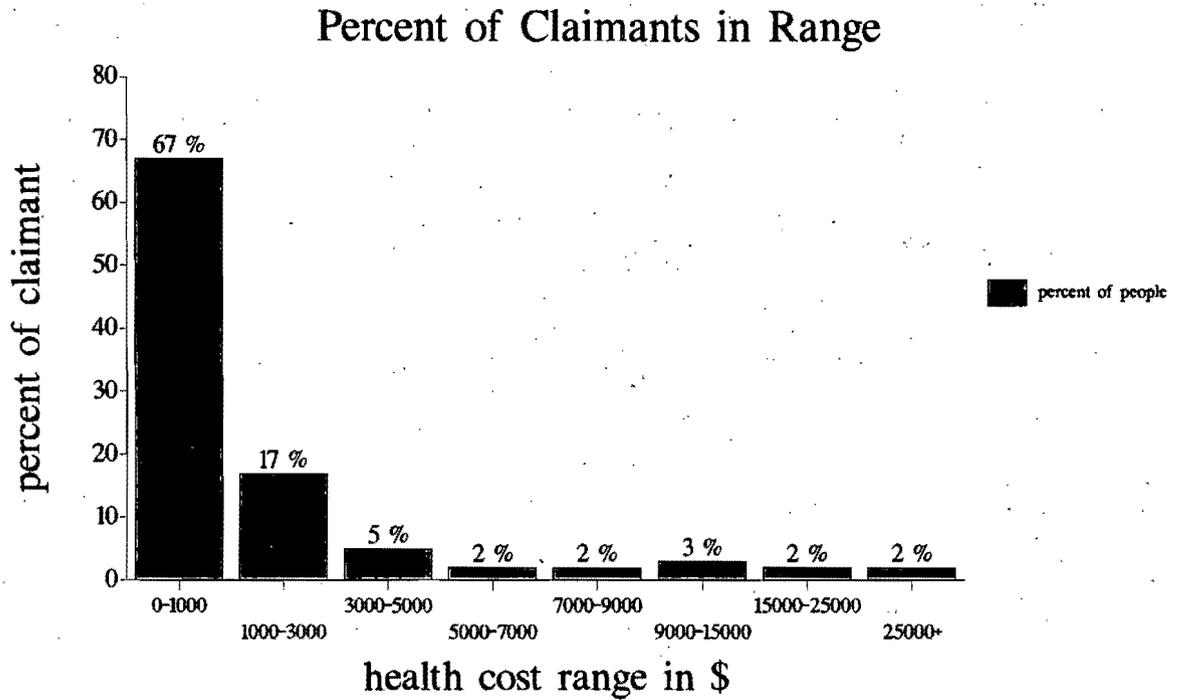
Source: "The Medicare Program," The Henry J. Kaiser Family Foundation, April 1997

Average Cost Per Medicaid Recipient Disabled vs. Non-Disabled Children



Source: National Academy for State Health Policy, HCFA, 1992.

UNEVEN DISTRIBUTION OF HEALTH COSTS



Source: Consumers Union, American Academy of Actuaries

Quality
Commission File

Memo

To: Chris

From: Steve

CC: Jen, Barb, Rick, Ken

At your request I have given some thought to the makeup of the new Advisory Commission. I have assumed:

1. That the mission of the group is to actually protect consumers from vagaries in treatment arising from changing and at times perverse financial incentives (i.e. this is not just a political exercise).
2. That the commission actually addresses many of the concerns and fears of the broad base of Americans worried about this issue, most of whom are ardent supporters, many of whom raised the nation's consciousness on the issue.
3. That gender, ethnic, professional, geographic, etc. balance is a given.
4. That any nominee would have evidenced some extraordinary expertise or activism in the area of quality management.
5. That since providers and consumers, in unusual solidarity, raised this issue, we should be cautious not to assume that their interest is necessarily parochial. In other words we should begin with an understanding that quality may, in fact, be compromised in some managed care systems.

With these thoughts in mind nominees might include the following:

- Nursing quality expert with academic credentials(RN)-1
- Nursing leader in active practice (RN)-1
- Primary care physician in practice (possibly with secondary academic appt.)-1
- Physician in specialty education, quality research, or other related academics-1
- Hospital administrator with strong quality expertise-1
- Hospital worker (union leader)-1
- Social worker, physical therapist, occupational therapist, etc-1
- A consumer activist for the elderly-1
- A consumer activist for children-1
- A consumer activist for the underserved populations-1
- Labor leaders who purchase health care-2
- Business leaders who purchase health care-2
- Health economists, health policy academics (consumer focused)-2
- Federal purchasers (Medicare and Medicaid)-1
- State purchasers-1
- Not-for-profit HMO's-1
- For-profit HMO's and/or insurers-1

Since insurers and HMO's are really providers of clerical and financial services in support of health care delivery (i.e. they are not truly purchasers), they should have representation equal to but not exceeding other service providers. Although insurers have a lot of cash and political clout in DC, a disproportionate role for them in this endeavor could result in backlash from labor, consumers, and providers when the appointments are announced.

This methodology gives consumers and purchasers a margin over providers and insurers:

- Providers: (nurses, doctors, hospital administrators and workers,
social workers, HMO's, etc. = 9 appointees
- Consumers and purchasers: = 11 appointees

With this methodology labor is strongly represented, having more representatives than any other class.

Hold

August 29, 1996

MEMORANDUM TO THE PRESIDENT

From: Chris Jennings and Jennifer O'Connor

cc: Ron Klain, Carol Rasco, and Laura Tyson

On Monday, you will participate in Labor Day events with John Sweeney and Gerry McEntee. They are likely to raise with you the establishment of a commission or board to study the impact on managed care on the health care system. As you may recall, they discussed this initiative in a previous meeting with you and the Vice President. At the close of the meeting, you asked the Vice President to look into this matter.

Mr. Sweeney, Mr. McEntee, and other union leaders believe that cost containment tools used by managed care threatens to seriously reduce the size of the health care workforce. However, they understand that raising concerns about managed care in a way that focuses on workforce issues is not likely to resonate with the public. Instead, they agree with us that the better strategy would be to focus on the issue of quality, consumer protections, and access.

We have been working with the Vice President's office, Harold Ickes, OMB, and the various Departments to develop an option for your consideration. In the Rasco/Tyson August 16th memo to you, we proposed to establish an advisory board to determine ways to more effectively evaluate quality, to recommend consumer protections and grievance procedures, and to evaluate the impact of managed care on access. All three of these issues have a significant link to workforce issues, but they focus on the issues that "connect" with the public. The suggested board would have representatives of consumers, unions, providers, insurance companies, businesses, and government. Immediately prior to the convention, we met with AFL-CIO/AFSCME staff and there was great receptivity to this concept.

We believe that your meeting with Sweeney and McEntee would be a good opportunity to advise them that you support the creation of the advisory board described above, but that you have not decided on when to unveil this initiative. You may want to seek their suggestions on an appropriate time and venue to make this announcement. We believe that they will be quite pleased with such a discussion.

Do you agree with this strategy?

Yes No Discuss

For Immediate Release

September 5, 1996

EXECUTIVE ORDER

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

By the authority vested in me as President by the Constitution and the laws of the United States of America, including the Federal Advisory Committee Act, as amended (5 U.S.C. App.), it is hereby ordered as follows:

Section 1. Establishment. (a) There is established the Advisory Commission on Consumer Protection and Quality in the Health Care Industry (the "Commission"). The Commission shall be composed of not more than 20 members to be appointed by the President. The members will be consumers, institutional health care providers, health care professionals, other health care workers, health care insurers, health care purchasers, State and local government representatives, and experts in health care quality, financing, and administration.

(b) The Secretary of Health and Human Services and the Secretary of Labor shall serve as Co-Chairs of the Commission. The Co-Chairs shall report through the Vice President to the President.

Sec. 2. Functions. (a) The Commission shall advise the President on changes occurring in the health care system and recommend such measures as may be necessary to promote and assure health care quality and value, and protect consumers and workers in the health care system. In particular, the Commission shall:

(1) Review the available data in the area of consumer information and protections for those enrolled in health care plans and make such recommendations as may be necessary for improvements;

(2) Review existing and planned work that defines, measures, and promotes quality of health care, and help build further consensus on approaches to assure and promote quality of care in a changing delivery system; and

(3) Collect and evaluate data on changes in availability of treatment and services, and make such recommendations as may be necessary for improvements.

(b) For the purpose of carrying out its functions, the Commission may hold hearings, establish subcommittees, and convene and act at such times and places as the Commission may find advisable.

Sec. 3. Reports. The Commission shall make a preliminary report to the President by September 30, 1997. A final report shall be submitted to the President 18 months after the Commission's first meeting.

Sec. 4. Administration. (a) To the extent permitted by law, the heads of executive departments and agencies, and independent agencies (collectively "agencies") shall provide the Commission, upon request, with such information as it may require for the purposes of carrying out its functions.

(b) Members of the Commission may receive compensation for their work on the Commission not to exceed the daily rate specified for Level IV of the Executive Schedule (5 U.S.C. 5315). While engaged in the work of the Commission, members appointed from among private citizens of the United States may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law for persons serving intermittently in the Government service (5 U.S.C. 5701-5707) to the extent funds are available for such purposes.

(c) To the extent permitted by law and subject to the availability of appropriations, the Department of Health and Human Services shall provide the Commission with administrative services, funds, facilities, staff, and other support services necessary for the performance of the Commission's functions. The Secretary of Health and Human Services shall perform the administrative functions of the President under the Federal Advisory Committee Act, as amended (5 U.S.C. App.), with respect to the Commission.

Sec. 5. General Provision. The Commission shall terminate 30 days after submitting its final report, but not later than 2 years from the date of this order, unless extended by the President.

WILLIAM J. CLINTON

THE WHITE HOUSE,
September 5, 1996.

#

WHAT PEOPLE ARE SAYING ABOUT MSA'S

Below are excerpts from some of the recent analyses of Medical Savings Accounts. They point out serious concerns about the attraction of healthier-than-average risks into Medical Savings Accounts, with the result of higher costs for the traditional Medicare program and higher premiums for private insurance for people under age 65.

"Changes in Medicare Program Spending Under Alternative Medical Savings Accounts Models," Prepared for the National Committee to Preserve Social Security and Medicare by John F. Sheils, Gary J. Claxton, Randall A. Haught, Lewin-VHI, Inc., September 22, 1995.

- "The MSA model creates strong incentives that would increase Medicare spending. The MSA program would be likely to attract only Medicare beneficiaries who expect to have low health expenses during the year, leaving the most expensive individuals in the traditional Medicare program. This 'selection effect' would lead to a substantial net increase in program costs." (pg. 1)
- **"The net increase in Medicare program costs over the 1996 through 2002 period would be \$15.3 billion. This estimate represents an increase in Medicare program costs over the spending levels called for in the budget resolution."** [emphasis added](pg. 4)
- "The average tax deduction per enrollee would vary from \$4.0 for those with incomes of less than \$15,000 to \$540 for enrollees with incomes in excess of \$100,000. **Over half of the tax revenue loss due to the deduction would be among MSA enrollees with annual incomes of \$75,000 or more.**" [emphasis added](pg. 11)
- "Our MSA analysis shows that an optional health coverage program that promises potential cash benefits to persons who are able to keep their health spending low will experience extreme selection bias. Even adjusting MSA plan payments by age, sex, disability status and geography as under the Average Adjusted Per Capita Cost (AAPCC) method fails to correct for the selection effects that such a program would experience.¹ Moreover it is unclear whether any other risk adjustment methodology could ever fully correct for these selection problems. Thus, the MSA model will almost certainly result in a net increase in Medicare program costs regardless of the risk adjustment model used." (pg. 15)

¹ Currently used by Medicare to pay HMO's that accept Medicare recipients on an at-risk basis. These AAPCC amounts represent the average Medicare program cost for beneficiaries in each geographic area by age, sex and disability status.

"Medical Savings Accounts for Medicare Beneficiaries," Prepared by: Jack Rodgers, Health Policy Economics Group, Price Waterhouse LLP and James W. Mays, Actuarial Research Corporation, Prepared for: The Henry J. Kaiser Family Foundation, August 1995.

- "Even if adverse selection stopped short of a death spiral, risk selection would still be a problem for less healthy enrollees. The remainder of less healthy elderly persons in the traditional program would cause the cost per case and the cost per enrollee to increase. **These cost increases would necessitate some changes in the traditional program, either in the form of increased copayments or reduced benefits, that would leave the less healthy enrollees worse off than they were before the MSA option was introduced.**" [emphasis added](pg. 21-22)
- "Because spending in the residual Medicare program would be higher, Congress would have to cut provider payments or, less likely, increase cost sharing for beneficiaries who remain in the traditional plan. These benefit reductions would make the residual Medicare program less attractive. We can assume these reductions result in an additional ten percent of enrollees joining MSA plans. In the second year, noting that those who choose to switch would be healthier than those individuals remaining in the residual program. The net result of these enrollment shifts would be a rise in expected costs to \$5,460 for those in MSA plans and \$6,360 for those in the residual program." (pg. 22-23)
- **"Despite a reduction in health care spending, Medicare outlays would not necessarily be reduced if MSA plans were introduced.** The effect of MSA plans on Medicare outlays would depend on who captures the savings: Medicare beneficiaries or the Medicare program. Several outcomes are possible. First, if the government contributes an amount equal to the actuarial value of the traditional program under the current system and if there is no favorable selection into MSA plans, then Medicare outlays would be unaffected by MSA options. In this case, the entire savings from high deductibles would go to beneficiaries in the form of higher government contributions to their MSAs. ...The illustrative beneficiary had benefits under the traditional system of \$5,200. The voucher was set at \$5,200 for the MSA plan. In that case, the Medicare program realized no savings from the MSA option. If the same beneficiary stayed in the traditional program, claims would be \$5,200 on average. Again, net savings to Medicare would be zero. Medicare outlays would not necessarily be unaffected by the MSA option. If there is favorable selection into MSA plans, total Medicare outlays would rise unless steps are taken to reduce reimbursements or increase cost sharing in the residual (traditional) program. [emphasis added](pg. 28)

Congressional Budget Office Cost Estimate, H.R. 2485, submitted by letter from June E. O'Neill to the Honorable Bill Archer, October 18, 1995.

"Costs from Enrollment in High-Deductible/MSA Plans

- ...The bill does not specify whether persons no longer in a high-deductible plan would owe any penalty on nonqualified withdrawals. If not, people could disenroll from a high-deductible plan, withdraw all funds from their MSA account without penalty (although the funds would be taxable as income), and then rejoin a high-deductible plan the following year. In addition, the bill would not require those who disenrolled from a high-deductible plan to repay remaining balances or refund amounts spent from their MSAs in earlier years for nonqualified expenses...
- ...High-deductible plans would tend to experience more favorable selection than would other Plus plans or the fee-for-service sector. In fact, the favorable selection into high-deductible plans could be very large under this bill because beneficiaries would be permitted to join or leave these plans during each open enrollment period, just as they could with other plans. Beneficiaries could take financial advantage of the system by choosing a high-deductible plan when they were healthy and moving to another Plus plan or the fee-for-service sector once they developed medical problems or wanted to schedule expensive non-emergency procedures, such as a hip replacement. The CBO estimate assumes that Medicare's risk adjusters would not fully compensate for this favorable selection into high-deductible plans and, as a result, enrollment in high-deductible plans would increase program costs...
- ...CBO assumed that 1 percent of the eligible population would select the high-deductible option initially, and that the number would grow to 2 percent by 2002. With this level of participation, **the high-deductible option would increase total program costs by about \$4 billion over 7 years....** [emphasis added]
- ...Because there is no prior experience with this type of option for the Medicare population, it is difficult to estimate how many would choose high-deductible plans. If a large percentage of low-risk beneficiaries chose the high-deductible option, participation would be substantially higher than CBO has assumed, and the cost of this option would also be higher. This could trigger additional reductions in fee-for-service payment rates through the bill's failsafe provisions. **The reductions might make the fee-for-service sector less attractive and encourage even greater participation in high-deductible or other Plus plans....**" [emphasis added]
(pgs. 16-18)

Congressional Budget Office Cost Estimate. Title VII, Subtitle A, Medicare Reconciliation Recommendations as reported by the Committee on Finance on October 17, 1995, submitted by letter from June E. O'Neill to the Honorable William V. Roth, Jr., October 20, 1995.

"Costs from Enrollment in High-Deductible/MSA Plans

- ...The bill would not require those who disenrolled from a high-deductible plan to repay remaining balances or refund amounts spent from their MSAs in earlier years for nonqualified expenses...
- ...High-deductible plans would tend to experience more favorable selection than would other Choice plans or the fee-for-service sector. Beneficiaries could take financial advantage of the system by choosing a high-deductible plan when they were healthy and moving to another Choice plan or the fee-for-service sector once they developed medical problems or wanted to schedule expensive non-emergency procedures, such as a hip replacement. However, the bill would limit favorable selection to some degree because it would require enrollees in high-deductible plans to give 12 months' notice during the annual enrollment period before they could leave the plan. The CBO estimate assumes that Medicare's risk adjusters would not fully compensate for favorable selection into high-deductible plans and, as a result, enrollment in high-deductible plans would increase program costs...
- ...CBO assumed that 1 percent of the eligible population would select the high-deductible option initially, and that the number would grow to 2 percent by 2002. With this level of participation, the high-deductible option would increase total program costs by about \$3.5 billion over 7 years...
- ...Because there is no prior experience with this type of option for the Medicare population, it is difficult to estimate how many would choose high-deductible plans. If a large percentage of low-risk beneficiaries chose the high-deductible option, participation would be substantially higher than CBO has assumed, and the cost of this option would also be higher. This could trigger additional reductions in fee-for-service payment rates through the bill's failsafe provisions.—**The reductions might make the fee-for-service sector less attractive and encourage even greater participation in high-deductible or other Choice plans...** [emphasis added]
(pg. 16-17)

"Medical Savings Accounts: Cost Implications and Design Issues," Public Policy Monograph #1, American Academy of Actuaries, May 1995.

- "If the employer decides to maintain the current level of expenditure for the combined MSA/high deductible plan, then the savings will pass through to the employee. Since the increase in copayments is smaller than the premium reduction, some employees will have to pay more for health care than under the current program. The greatest savings will be for the employees who have little or no health care expenditures. The greatest losses will be for those employees with substantial health care expenditures. Those with high expenditures are primarily older employees and pregnant women." (pg. 23)

"Medical Savings Accounts: An Analysis of the Family Medical Savings and Investment Act of 1995," Public Policy Monograph, American Academy of Actuaries, October 1995.

- "The willingness to participate in a high-deductible/MSA arrangement would vary." Some of those who would not be attracted to this arrangement include: "(1) low-income individuals -- most individuals with little discretionary income (especially if they have families) would tend to shy away from MSAs...(2) the risk averse -- many people with coverage typical of the current market would tend to avoid the risk that they might have to pay a high deductible...(3) people currently in HMOs -- many of the people now enrolled in HMOs are very satisfied with that form of coverage...and (4) high-risk individuals -- individuals and families with recurring medical care expenses would generally prefer the current forms of insurance as opposed to a conversion to a high-deductible plan. If high-risk individuals tend to remain in traditional plans and lower-risk individuals tend to opt out, this could increase adverse selection." (pg. ii)
- "The work group's May 1995 report suggested that administrative expenses for MSAs could be as low as 2 percent of the MSA contribution. However, we also noted that an expense level this low could only be achieved in an entirely unregulated context. The record-keeping necessitated for MSAs as contemplated by H.R. 1818 would increase the administrative expense to some level higher than 2 percent, but still less than the 15 percent average for insurance plans today." (pg. 4)
- "There is one significant design problem: the current FFS plans incorporate an individual deductible in the family policy. As a result, the increase to a \$3,600 deductible for an individual in a family could prove to be a significant barrier to the use of MSAs by families. For example, a typical plan today might have an individual deductible of \$200 and a family maximum deductible of \$400. An individual in a family would have to increase their risk by \$3,400 (\$3,600 less \$200) to participate in an MSA. However, an individual in non-family coverage would have only an increase in risk of \$1,600 (\$1,800 less \$200). (pg. 7)

"Description and Analysis of H.R. 1818 (The "Family Medical Savings and Investment Act of 1995"), Prepared by the Staff of the Joint Committee on Taxation, June 26, 1995.

- "The design of any proposal, including MSA's is likely to involve tradeoffs of various objectives. For example, features of an MSA that make it more attractive (and thus more likely to be used by taxpayers) may also have some negative aspects, such as greater administrative burdens or greater revenue loss." (pg. 16)
- "Estimating the revenue effects of any specific MSA proposal will be highly sensitive to the specific features of the proposal." (pg. 25) "The revenue estimate of an MSA proposal is dependent upon the following factors: (1) the effect of the MSA proposal on premiums for both catastrophic and non-catastrophic health plans; (2) the extent to which taxpayers utilize an MSA-like arrangement under present law either through an FSA or on an after-tax basis; (3) the extent to which taxpayers with other health insurance coverage under present law will utilize an MSA under the proposal; and (4) the extent to which taxpayers view the MSA as a tax-favored savings vehicle and the interaction with other forms of tax-favored savings."(pg. 26)
- "While H.R. 1818 would increase the tax benefits available to the individual, those benefits are assumed to be insufficient to induce some low-income individuals to purchase health coverage. However, the bill could provide an incentive to some high-income individuals who were perhaps voluntarily uninsured to elect to use an MSA." (pg. 31)
- **"H.R. 1818 is estimated to reduce Federal fiscal year budget receipts as follows:**

Fiscal Year
(Millions of Dollars)

1996	1997	1998	1999	2000	2001	2002	1996-2002
-131	-230	-264	-301	-341	-358	-376	-2,001

(Note: Details may not add to totals due to rounding)" [emphasis added](pg.31)



Christopher C. Jennings
02/04/97 12:39:00 PM

Record Type: Record

To: Lynn A. Jennings

cc:

Subject: Re: Health Care Commission

Message Creation Date was at 4-FEB-1997 12:39:00

I understood that there was a draft from HHS somewhere. Is there a separate draft that we did? Can I see (again) what you have? Just tell Sandy Bublick-Max of my staff to MAKE ME read it. Sorry I can't find this document now. Thanks.

cj

January 14, 1997

MEMORANDUM FOR KATHLEEN M. WHALEN

From: Bob J. Nash, Assistant to the President and
Director, Presidential Personnel

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

As you know, on September 5, 1996, 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 changes in the health care delivery system which affects quality, consumer protection, as well as the availability of needed services. Through a series of public meetings, it will collect and evaluate information in order to develop recommendations for the President's review. After working on placing representatives on the Commission for the past few months, it has become clear that there will need to be some adjustments to the Executive Order to maximize the effectiveness of the commission.

Specifically, we are considering the following amendments: (1) increasing the number of members on the Commission from 20 to 32 (Section 1(a)); and (2) compressing the time frame for the final report from 18 months to _____ months (Section 3). I am hoping that you will be able to help us draft the appropriate language to amend the Executive Order to reflect the desired changes. I have attached a copy of the Executive Order for your review.

If you should have any questions with regard to this request, please contact me at x6-7130 or Peg Clark of my staff at x6-7831.

Attachment

BN:pc:lj

JAMES M. JEFFORDS, VERMONT, CHAIRMAN

DAN COATS, INDIANA
JUDD GREGG, NEW HAMPSHIRE
BILL FRIST, TENNESSEE
MIKE DEWINE, OHIO
MIKE ENZI, WYOMING
TIM HUTCHINSON, ARKANSAS
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<http://www.senate.gov/committees/labor.html>

United States Senate

COMMITTEE ON LABOR AND
HUMAN RESOURCES
WASHINGTON, DC 20510-6300

TO: Chris Jennings + Jean Lambrieu

FR: David Nexon, Minority Staff Director for Health

DATE & TIME: 2/25

NUMBER OF PAGES: COVER + _____

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IF THERE IS TROUBLE RECEIVING THIS FAX, PLEASE CALL
(202) 224-7675.

FAX NUMBER: 456-5542

from the office of

*Senator Edward M. Kennedy
of Massachusetts*

STATEMENT OF SENATOR EDWARD M. KENNEDY
INTRODUCTION OF THE HEALTH INSURANCE BILL OF RIGHTS ACT -
QUALITY ASSURANCE & PATIENT PROTECTION

For Immediate Release:
February 25, 1997

Contact: Jim Manley
(202) 224-2633

I am proud to join Congressman Dingell in announcing the introduction of the Health Insurance Bill of Rights Act - Quality Assurance and Patient Protection. It is a needed response to the surging growth of managed care and the rapid changes taking place in the health insurance market--changes that too often put insurance industry profits ahead of patients' health needs.

Managed care has mushroomed over the past decade. In 1987, only 13 percent of privately insured Americans were enrolled in HMOs. Today, that figure is 75 percent. At its best, managed care offers the opportunity to achieve both greater efficiency and higher quality in health care. In too many cases, however, the pressure for profits leads to lesser care--not better care. Too many managed care firms and other insurance companies have decided that the shortest route to higher profits and a competitive edge is by denying patients the care they need and deserve.

Some of the most flagrant abuses by insurance plans have been documented in recent months:

Just last year Congress enacted legislation to block drive-by deliveries and prevent new mothers and their babies from being evicted from hospitals in less than 48 hours.

Breast cancer patients are being forced to undergo mastectomies on an outpatient basis, when sound medical advice requires a reasonable hospital stay.

Children are being permanently injured or even losing their lives because their parents are forced to drive past the nearest emergency room to a more distant hospital because it has the contract with their health plan.

Doctors are being subjected to "gag rules" that keep them from giving their patients their best medical advice.

People with rare and dangerous diseases are being denied access to specialists to treat their conditions.

Patients can't get needed pharmaceutical drugs, because the particular drug they need is not on the list of drugs approved for coverage by their insurance plan; sometimes such lists are developed and administered by pharmaceutical companies bent on selling their own drugs and blocking competition.

-MORE-

SENATOR KENNEDY ON THE HEALTH INSURANCE BILL OF RIGHTS 2-2-2

Patients are being misdiagnosed, sometimes with fatal results, because insurance plans cut corners on diagnostic tests.

Victims of cancer and other serious diseases are being denied participation in quality clinical trials offering the only hope of cure for otherwise incurable conditions.

Children afflicted with serious, chronic conditions are being denied access to the medical centers with the only available expertise to treat their conditions effectively.

These abuses are not typical of most insurance companies. But they are common enough that an overwhelming 80% of Americans now believe that their quality of care is often compromised by their insurance plan to save money. It is time to deal with these festering problems. Good business practices can improve health care, but health care must be more than just another business.

The legislation we are introducing today establishes basic standards for insurance plans in six specific areas:

- (1) Access to care, including specialty care, emergency care, and clinical trials
- (2) Standards for quality of care
- (3) Information that must be available to patients
- (4) Expeditious and fair appeal procedures when physicians or patients disagree with plan decisions
- (5) Protection of the doctor-patient relationship, by banning gag rules and objectionable compensation arrangements
- (6) A requirement that plan guidelines may not override good medical practice

These steps will not eliminate every abuse that occurs in the insurance industry, but they will go a long way to addressing the major problems patients confront.

At the most basic level, the legislation establishes a right to needed care. A patient facing a health emergency should not be required to go to a distant emergency room, or to obtain prior authorization for care. Someone suffering from a serious condition requiring specialty care should not be denied that care because an insurance company thinks it is too expensive. Someone with a condition that cannot be addressed by conventional therapies should have a reasonable opportunity to participate in a quality clinical trial that offers the hope of effective treatment. Plans should set up clear, fair, and timely appeal procedures for cases in which the plan fails to fulfill its obligations.

Historically, patients have relied on their personal physician to be the best source of impartial advice on needed care. This legislation maintains that critical role by prohibiting plans from restricting doctor-patient communications or from establishing compensation plans that bribe or penalize doctors into representing the plan's interest at the expense of their patients' health.

SENATOR KENNEDY ON THE HEALTH INSURANCE BILL OF RIGHTS 3-3-3

To maintain and improve quality of care, all managed care plans will be required to set up a separate unit dedicated to quality, and to collect data to verify that the plan, in fact, is providing care that meets objective quality standards.

Patients will be guaranteed full information about plan coverage, appeal rights, access to primary care doctors and other specialists, and other needed information. Plans will be required to collect and make available standardized data for consumers to compare plans.

These provisions add up to a Health Insurance Bill of Rights that will protect millions of Americans.

I look forward to working with a broad range of physician, patient, and industry groups as Congress considers this legislation. Action is essential and overdue to provide these needed protections. The bottom line in health care must be patient needs, not industry profits. Concerned citizens in all parts of the country are demanding action, and Congress owes them a response.

HEALTH INSURANCE BILL OF RIGHTS - QUALITY ASSURANCE AND PATIENT PROTECTION

Subpart 1: Access to care

Subpart 2: Quality Assurance

Subpart 3: Patient Information

Subpart 4: Grievance Procedures

Subpart 5: Protection of providers against interference with medical communications and improper incentive arrangements

Subpart 6: Promoting good medical practice and protecting the doctor-patient relationship

Subpart 1: Access to Care

Emergency care. A plan may not deny coverage for emergency care assessment and stabilization if a prudent layperson would seek such care given the symptoms experienced. Prior authorization for such care is not required. After assessment and stabilization, further needed care is covered if medically necessary.

Access to specialty care

•Obstetrician/gynecologist care

If a plan requires patients to designate a primary care physician, women have the right to choose an obstetrician/gynecologist as their primary care provider. In any case, they have the right to direct access to an obstetrician/gynecologist for routine gynecological care and pregnancy services without prior authorization from their primary care provider.

•Other specialty care

Enrollees with life-threatening, chronic, degenerative or other serious conditions which require specialty care must be provided access to the appropriate specialists or centers of excellence capable of providing quality care for the condition. If a plan does not have a participating specialist for a condition covered under the plan, the plan must refer the patient to a non-participating specialist at no additional cost.

A plan must have a procedure to allow individuals with a serious illness and ongoing need for specialty care to receive care from a specialist who will coordinate all care for that individual.

A plan must have a procedure for standing referrals for individuals requiring on-going specialty care if a primary care provider, in consultation with the patient, the medical director of the plan and specialist (if any) determine that a standing referral is needed.

Continuity of Care. If a plan or provider terminates a contract for reasons other than failure to meet quality requirements, the plan must allow an enrollee continued treatment with the provider for a transitional period. Time frames vary depending upon type of care being provided (e.g. primary, institutional, pregnancy, terminal, etc.)

Participation in clinical trials. If an enrollee has a serious condition for which there is no effective standard treatment and is eligible for an approved clinical trial that offers the potential for substantial clinical benefit, the plan must pay for the routine patient costs of participation in the trial.

Choice of Provider. A plan must provide an updated list of all participating providers and their ability to accept additional patients. Enrollees must be permitted to obtain services from any provider within the plan identified in the plan documents as available to the enrollee.

Prescription Drugs. If a plan provides benefits for prescription drugs within a formulary, the plan must allow physicians to participate in the development of the plan formulary, disclose the nature of formulary restrictions, and provide for exceptions when medically necessary.

Subpart 2: Quality Assurance

Internal quality assurance program. Every plan is required to establish and maintain a quality assurance and improvement program that uses data based on both performance and patient outcomes.

Collection of standardized data. Plans must report certain standard information to state agencies and the public. The information must be reported in accordance with uniform national standards to be specified by the Secretary. This information will include at least utilization data, demographic data, mortality rates, disenrollment statistics and satisfaction surveys, and quality indicators.

Selection of providers. The plan must have a written process for selection of providers including a listing of the professional requirements. The process must include verification of the provider's credentials. Plans may not use a high risk patient base or a provider's location in an area serving residents with poor health status as a basis for exclusion.

Drug utilization program. If the plan covers prescription medications, it must have a plan to encourage appropriate drug use and monitor and reduce illness arising from improper use.

Standards for utilization review activities. Utilization review refers to the plan's review of requests for care. It is defined as evaluation of clinical necessity and efficacy. Written clinical review criteria are required. Utilization review must be supervised by a licensed physician. Its activities must be executed by appropriately qualified staff. There can be no incentives to render adverse determinations. Deadlines for response to requests for authorization of care are established. Adverse determinations must be in writing and include the reasons for the determination. Such notices must also include instructions for making an appeal.

Subpart 3: Patient Information

Patient Information. Plans must describe and make available to current and prospective enrollees procedures for providing emergency care and care outside normal business hours, for selecting and changing physicians, and for obtaining consultations. They must also list participating providers by category and make clear which members of that list are available to a prospective or current enrollee. The plan must provide information which describes coverage, financial responsibilities of enrollees, methods of obtaining referrals, utilization review processes, and grievance procedures and must include a description of how the plan addresses the needs of non-English speaking enrollees and others with special communication needs. It must describe how providers are paid.

Protection of patient confidentiality. A program to assure compliance with state and federal confidentiality requirements must be in place.

Subpart 4: Grievance Procedures

Provisions relating to appeals of utilization review determination and similar determinations. A plan must establish and maintain a system to handle and resolve complaints brought against the plan by enrollees and providers. The system should address all aspects of the plan's services, including complaints regarding quality of care, choice and accessibility of providers, and network adequacy. The legislation specifies several components of such a system, including provisions for staffing and staff accessibility, information about appeal procedures, and the time frame within which the plan must respond to complaints. The bill provides for a two stage appeal process, with requirements for a review panel of non-involved providers and consultants employed by the plan in the second phase. Written explanation of each stage of an appeal must be provided. Timely decisions are required. Examples of adverse determinations include denial for emergency care, access to specialists, choice of provider, continuity of care, or payment for routine costs in connection with an approved clinical trial. In the case of experimental therapy to save the life of a patient, an external independent review process with mandatory decision powers is available if the plan chooses not to provide coverage for the treatment. For appeals of other important issues, the plan must either (1) participate in an independent review process established by the state (or the Secretary of Labor for self-insured plans) to make advisory determinations; or (2) establish a third stage of appeal within the plan certified by the Secretary as fair, impartial, and involving independent reviewers to make advisory decisions.

Health Insurance Ombudsman. A Health Insurance Ombudsman will be established in each state to assist consumers in choosing health insurance, and to provide assistance to patients dissatisfied with their treatment. Assistance includes aiding enrollees in filing complaints and appeals, investigating poor quality or improper treatment, and bringing such instances to the attention of the applicable state authority or, in the case of self-insured insurance plans, to the attention of the Secretary of Labor. The legislation authorizes funds to be appropriated to the Secretary to provide grants to state authorities to establish the program.

Subpart 5: Protection of Providers against Interference with Medical Communications and Improper Incentives

Prohibition of interference with certain medical communications. The plan may not prohibit or restrict the provider from engaging in medical communications with the enrollee. Such communications may include discussion of the enrollee's health status, medical care, or treatment options; provisions of the plan's utilization review requirements; or any financial incentives that may affect the treatment of the enrollee.

Ban on improper incentive arrangements. There may be no incentives to limit medically necessary services. Provider risk is limited. The Secretary shall apply the same rules which apply to the Medicare program. The plan may not have a contract which requires transfer of liability for malpractice caused by the plan from the plan to the provider.

Subpart 6. Promoting Good Medical Practice and Protecting the Doctor-Patient Relationship

Plans are prohibited from denying coverage for medically necessary and appropriate care otherwise covered by the plan, as determined by the treating physician and consistent with generally accepted principles of good medical practice. This provision would prohibit plans from arbitrarily limiting care provided, for example, by requiring that mastectomies be provided on an outpatient basis.

HEALTH INSURANCE BILL OF RIGHTS ACT - QUALITY ASSURANCE & PATIENT PROTECTION

The Goal

The legislation sets basic standards for managed care organizations and other health insurance plans to protect consumers and improve the quality of care.

The Problem

The last ten years have seen explosive growth in the managed care industry. In 1987, 13% of privately insured Americans received health care through a managed care organization. Last year, that number approached 75%. Today, 138 million Americans are enrolled in private managed care plans.

As more people join managed care organizations and the health care market becomes more competitive, reports of abuses by insurance companies are climbing. These abuses include denying patients access to timely emergency care, needed specialty care, and appropriate prescription drugs. Patients have been misdiagnosed with devastating results, because plans cut corners on diagnostic tests. Individuals with deadly diseases incurable by conventional therapies have been denied participation in quality clinical trials that could save or prolong their lives. Breast cancer patients have been forced to undergo mastectomies on an outpatient basis. Doctors have been prohibited from giving patients their best medical advice, and forced to accept compensation schemes that reward them if they deny expensive forms of care or penalize them if they order such care.

The result, according to a survey by the National Coalition on Health Care, is that 80% of Americans believe that their quality of care is often compromised to save money.

Congress acted last year to ban one flagrant abuse, the practice of forcing new mothers out of the hospital prematurely after delivery. Bills have been introduced to deal with other specific abuses, but a broader approach is needed.

The Legislation

The Health Insurance Bill of Rights Act addresses a wide range of problems in the insurance industry by establishing basic standards to protect patients.

- Plans will be prohibited from denying access to appropriate care, including specialty care, emergency care, clinical trials, and care by obstetricians and gynecologists.
- Plans are required to develop programs to assure quality care
- Plans are required to provide standardized information to enrollees, prospective enrollees, the public, and regulatory authorities. This information will include descriptions of coverage, financial responsibilities of enrollees, methods for obtaining referrals, utilization review, and grievance procedures.
- Plans are required to institute a fair, impartial, and timely complaint and dispute resolution process. The process should address all aspects of the plan's services, including complaints regarding quality of care and choice and accessibility of providers. The legislation also creates an Office of Health Insurance Ombudsman to assist patients.
- The legislation limits compensation arrangements that could penalize providers for providing quality care, or reward them for restricting care. It prohibits "gag rules" that limit doctor-patient communications.
- The legislation prohibits plans from denying coverage for care that is consistent with good medical practice, as determined by the treating physician.

QUOTES SUPPORTING THE PRESIDENT'S ADVISORY COMMISSION ON CONSUMER RIGHTS AND QUALITY IN THE HEALTH CARE INDUSTRY

Insurers/Managed Care Plans

"We believe President Clinton's creation of this Commission sets the stage for a diverse cross-section of interests to study these issues comprehensively. Such a review is an essential step toward ensuring Americans that their medical care will be provided in a manner which promotes accessibility and affordability in addition to the highest standards of quality."

-- Health Insurance Association of America, 3/26/97.

"AAHP applauds the President's initiative in recognizing the need to closely examine changes in the nation's health care delivery system."

-- American Association of Health Plans, 3/26/97.

"The nation's 59 independent Blue Cross and Blue Shield Plans share the President's concerns for preserving health care quality across a rapidly changing marketplace. We welcome the panel's thoughtful deliberations about the future health care delivery system."

-- Blue Cross Blue Shield, 3/25/97.

Business/Labor

"We are pleased that your Commission brings together a diverse group of experts in the broad field of health care, including several private sector leaders who are on the leading edge of the rapid change in the health care marketplace."

-- Association of Private Pension and Welfare Plans, 3/25/97.

"Washington Business Group on Health welcomes news of national commission on health care quality members WBGH encourages a public/private collaboration at the national level to bring clarity and direction to these important efforts."

-- Washington Business Group on Health, 3/26/97.

Your appointment of a National Advisory Commission on Consumer Protection is a well-timed response to the need for examining quality."

-- AFL-CIO, 3/25/97.

Consumers

"Your willingness to set this objective as the highest priority for our country's health care system is a testament to your vision and commitment to the consumers of health care."

-- Consumer Coalition for Quality Health Care, 3/25/97.

"AARP members are increasingly concerned that profit is overriding quality and consumer protection concerns, as our health care system continues to evolve. We strongly support the establishment of the Advisory Commission in the hope that a comprehensive approach to quality assurance and consumer protection will be in the best interest of every American."

-- American Association of Retired Persons, 3/25/97.

"Mr. President, we the disability community deeply appreciate your courageous efforts to establish quality health care for all."

-- Justice For All, 3/25/97.

"We believe that the Advisory Commission is an ideal forum to facilitate a critical dialogue among these key players leading to concrete recommendations that will protect consumers and families alike."

-- The National Mental Health Association, 3/25/97.

"Our country has experienced a revolution in the delivery of health care. Through the Commission's focus, we need to ensure that it is a bloodless revolution."

-- Families USA, 3/25/97.

"Rapid changes in the health care financing and delivery system brings the challenge of ensuring that consumers, including people living with HIV/AIDS, are adequately protected."

-- AIDS Action, 3/26/97.

Health Care Providers and Professionals

"President Clinton's new commission whose charge is to protect patients and promote high quality care is a step we wholeheartedly endorse."

-- American Medical Association, 3/26/97.

"The President shows great leadership in establishing this important commission. As the dynamic changes in our health care delivery system continue, this broad-based panel will prove essential in identifying the intended and unintended consequences of the system's transformations as well as for providing recommended ways to protect consumers and the quality of the care they receive."

-- Association of American Medical Colleges, 3/26/97.

"There is a clear need for an exhaustive study in this area. I commend the President for naming the Commission to do the work which is so vital to our Country."

-- National Association for Home Care, 3/25/97.

"We support the concept at the heart of your decision to create the commission, and bringing together national experts to study consumer protection and quality standards in an era of change is both timely and warranted."

-- American Hospital Association, 3/25/97.

"We must ensure that our health care system remains the finest in the world and in order to attain this goal we must forge a common national agenda driven by a commitment to quality. This bipartisan commission will help to raise the debate above self interest and partisan politics by putting patients first."

-- American Nurses Association, 3/26/97.

"The American Academy of Pediatrics has a vested interest in this bipartisan commission and work for one very compelling reason: it will take children's health care needs into account."

-- American Academy of Pediatrics, 3/26/97.

THE WHITE HOUSE

Office of the Press Secretary

For immediate release

March 26, 1997

**PRESIDENT NAMES MEMBERS OF ADVISORY COMMISSION ON
CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUSTRY**

The President today announced members of the Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

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 will be 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. Six individuals selected to serve on the Commission have not completed the appointment process, and will be announced as soon as they are cleared.

DONALD BERWICK, of Newton, Massachusetts, is President and Chief Executive Officer of the Institute for Healthcare Improvement. Dr. Berwick is also an Associate Clinical Professor of Pediatrics at Harvard Medical School and an Adjunct Associate Professor of Management at the Harvard School of Public Health. An expert on children's health care, Dr. Berwick has practiced medicine as a pediatrician continuously since 1976. Dr. Berwick has extensive experience on quality issues, and served as a member of the Panel of Judges for the Malcolm Baldrige National Quality Award of the U.S. Department of Commerce. He has also served on the Committee on the Future of the Patient Record at the Institute of Medicine, was Vice Chair of the U.S. Preventive Services Task Force at the Department of Health and Human Services, and currently is the Chair of the Health Services Research Review Sub-Committee of the U.S. Agency for Health Care Policy and Research. He graduated, *summa cum laude*, from Harvard College, and earned an M.P.P. from the John F. Kennedy School of Government at Harvard University, and graduated, *cum laude*, from Harvard Medical School.

CHRISTINE K. CASSEL, of New York City, New York, currently serves as Chairman of the Henry L. Schwarz Department of Geriatrics and Adult Development at Mt. Sinai Medical Center. She joined Mount Sinai in 1995 after ten years as Chief of General Internal Medicine at the University of Chicago. A renowned expert on aging issues, she is well aware of the special needs of the elderly population and the particular challenge presented by new health care delivery systems. Dr. Cassel has been actively studying demographic and epidemiologic forecasting, social concepts of successful aging, and the care of patients at the end of life. Dr. Cassel also has an extensive background in ethics. In 1992, she was elected to membership at the Institute of Medicine of the National Academy of Sciences. She is the immediate past President of the American College of Physicians, a member of the Board of Directors of the American Board of Internal Medicine, and a Trustee of the Greenwall Foundation. Dr. Cassel received a B.A. at the University of Chicago and an M.D. from the University of Massachusetts.

JAMES CHAO, of Naperville, Illinois, is the President of Metro Provider Service Corporation. The Corporation provides a variety of services to the health care industry, including the provision of health care services and the development of communications systems between providers. Mr. Chao has over 15 years of experience working with health care organizations, and has served as a health care consultant, focusing on issues of health care reimbursement and hospital financing. Mr. Chao was Financial Officer for Columbia Cabrini Medical Center in Chicago, where he was responsible for finances of a three hospital system. Mr. Chao received a B.S. from the University of Illinois at Chicago.

S. DIANE GRAHAM, of Paradise Valley, Arizona, is the Chairman and CEO of STRATCO, Inc., a mechanical and chemical engineering firm whose alkylation and grease technologies have been licensed in over thirty countries. As the chief executive of a small company, Ms. Graham is well aware of the difficulties small businesses encounter in trying to offer accessible and affordable health care services to its employees. In 1987, she was invited to join the prestigious "Committee of 200," a national organization of leading women entrepreneurs and business owners. Ms. Graham has served on the boards of over twenty non-profit organizations. She received a Bachelor's degree from Culver-Stockton College in Canton, Missouri.

VAL J. HALAMANDARIS, of the District of Columbia, currently serves as the President of the National Association of Home Care (NAHC). Under his leadership, NAHC has expanded its membership more than ten-fold. Mr. Halamandaris served for five years as Counsel to Representative Claude Pepper's House Select Committee on Aging and for fifteen years as Counsel to Senator Frank E. Moss and the U.S. Senate Special Committee on Aging. In 1987, Mr. Halamandaris founded the Center for Health Care Law, a public interest law firm advocating the rights of the elderly, the disabled, and chronically ill children. He is editor and publisher of two national magazines, *CARING* and *Caring People*, and has also published several books on aging and home care. Through his numerous and diverse professional experiences, Mr. Halamandaris is aware of the special needs of elderly citizens and the particular challenges presented by new health care delivery systems. Mr. Halamandaris received his B.A. degree from George Washington University and his J.D. from Catholic University of America School of Law.

SANDRA HERNÁNDEZ, of San Francisco, California, currently serves as Director of Health for the City and County of San Francisco in the San Francisco Department of Health. As the first Latina to head San Francisco's health department, Dr. Hernández leads the city's homeless services initiatives, which are the model for cities across the nation. In addition, she implemented one of the first Medicaid managed care programs in a major metropolitan area. Dr. Hernández has served on the National Hispanic Women's Health Initiative Steering Committee, the Breast and Cervical Cancer Prevention Committee, and the FDA Anti-Infective Drugs and Antiviral Drugs Advisory Committee. Dr. Hernández received her Bachelor's degree from Yale University and her M.D. from the Tufts University School of Medicine.

NAN HUNTER, of New York, New York, is an Associate Professor of Law at Brooklyn Law School, where she teaches Health Law. From 1993–1996, she served as Deputy General Counsel at the U.S. Department of Health and Human Services, where she worked on numerous health care issues including consumer protection rights, civil rights, and medical records confidentiality, and also assisted in the development of management policy. She is also the former Director of the AIDS Project and Lesbian and Gay Rights Project for the ACLU, where she directed national ACLU policy and litigation projects concerning health care issues. Ms. Hunter has published extensively on health care issues, including AIDS, privacy, and civil rights. Ms. Hunter received a B.A. from Northwestern University and a J.D. from Georgetown University Law Center.

SYLVIA DREW IVIE, of Los Angeles, California, currently serves as the Executive Director of T.H.E. Clinic for Women in Los Angeles, a primary health care clinic offering prenatal care, pediatrics, and clinical care for women with AIDS. Previously, she served as the Executive Director for the National Health Law Program in Los Angeles, where she worked extensively on maternal and child health issues as well as access issues for low-income populations. Ms. Ivie is a past member of the California Health Facilities Commission and served on the Board of Directors of the Medicare Advocacy Project. She won the prestigious Mandela Award. Ms. Ivie earned an A.B. from Vassar College and a J.D. from Howard Law School.

RISA J. LAVIZZO-MOUREY, of Philadelphia, Pennsylvania, is the Director for the Institute of Aging, Chief of the Division of Geriatric Medicine, Associate Executive Vice President for Health Policy, and the Sylvan Eisman Associate Professor of Medicine and Health Care Systems at the University of Pennsylvania. As an expert on aging issues, she is well aware of the particular challenges faced by elderly citizens. Dr. Lavizzo-Mourey has served on numerous Federal advisory committees, including the White House Task Force on Health Care Reform, the Task Force on Aging Research, the Office of Technology Assessment Panel on Preventive Services for Medicare Beneficiaries, the Institute of Medicine's Panel on Disease and Disability Prevention Among Older Adults, and the National Committee for Vital and Health Statistics. She is a member of the American College of Physicians. Dr. Lavizzo-Mourey earned an M.D. from Harvard Medical School and an M.B.A. from the Wharton School at the University of Pennsylvania.

SHEILA LEATHERMAN, of Minneapolis, Minnesota, is Executive Vice President of the United Health Care Corporation, which provides a broad range of health care services to purchasers, consumers, managers and providers of health care since 1974. She is the Founder of the Center for Health Care Policy and Evaluation, which evaluates the performance of health care delivery systems in the areas of quality, cost, and accessibility. Ms. Leatherman currently serves on the Advisory Committee of the International Society for Quality of Care, the National Committee on Vital and Health Statistics, the Health Advisory Board of the Institute of Medicine, and is a Senior Fellow at the Institute of Health Services Research of the School of Public Health at the University of Minnesota. Ms. Leatherman earned a B.A. degree from Tulane University and a Master's degree from the University of Arkansas.

BEVERLY MALONE, of Greensboro, North Carolina, is the President of the American Nurses Association. Additionally, Dr. Malone is Dean and Professor of the School of Nursing at North Carolina Agricultural and Technical State University. A licensed clinical psychologist, Dr. Malone also maintains a small individual, group and family therapy practice. She has served on the Governor's Task Force on the Nursing Shortage, North Carolina Commission on Health Services, the Board of Trustees of the Moses Cone Health System, and the Board of Directors of the Adolescent Pregnancy Prevention Program. Dr. Malone received a B.S.N. in Nursing from the University of Cincinnati, an M.S.N. from Rutgers the State University, and a Ph.D. from the University of Cincinnati.

GERALD MCENTEE, of the District of Columbia, is the President of the Association of Federal, State, County and Municipal Employees (AFSCME). Mr. McEntee is a Vice President of the AFL-CIO and a member of its Executive Council. He serves on the board of the Alliance to Reinvent Government, the Health Care Reform Project, the Child Care Action Campaign, and is a member of the National Commission on Children. Mr. McEntee is co-founder and Chairman of the Board of the Economic Policy Institute. He received a B.A. from LaSalle University in Philadelphia.

PHILLIP NUDELMAN, of Seattle, Washington, is the President and CEO of Group Health Cooperative of Puget Sound, a non-profit managed health care delivery system, which is the nation's largest consumer-governed healthcare organization. Dr. Nudelman served on the White House Task Force on Healthcare Reform and is a member of the board and current Chair-elect of the American Association of Health Plans. He serves on the board of directors for SpaceLabs Medical, Inc., Cell Therapeutics, Inc., and Advanced Technology Laboratories. Dr. Nudelman holds a Doctorate in Health Systems Management.

HERBERT PARDES, of New York, New York, is the Vice President for Health Sciences and Dean of the Faculty of Medicine at the Columbia University College of Physicians and Surgeons, where he oversees the College of Physicians and Surgeons, the School of Public Health, the School of Nursing, and the School of Dental and Oral Surgery. As an expert on medical schools and teaching colleges, he has developed major changes in the education of physicians, and assumed a national role as an advocate for education, health reimbursement, and support of biomedical research. He is the immediate past chair of the Association of American

Medical Colleges. During the Carter Administration, Dr. Pardes was Director of the National Institute of Mental Health. From 1989 to 1990, he served as President of the American Psychiatric Association. He is President of the Scientific Board of the National Alliance for Research on Schizophrenia and Depression, and is a member of the National Depressive and Manic Depressive Association. Mr. Pardes received a B.S. from Rutgers University and an M.D. from the State University of New York.

RON POLLACK, of Alexandria, Virginia, a long-time advocate for low income Americans, currently serves as the Executive Director of Families USA, a national consumer organization dedicated to high-quality, affordable health care. Mr. Pollack has recently issued a report on managed care that raises significant quality concerns and argues for increased consumer protection. Mr. Pollack is a founding Board Member of The Long Term Care Campaign, Americans for Health, and was also a founding member of the National Academy of Social Insurance. Mr. Pollack received a B.A. degree from Queens College and a J.D. from New York University School of Law.

MARTA PRADO, of Hollywood, Florida, is the Senior Vice President of InPhyNet Medical Management and Chief Operating Officer of InPhyNet's Managed Care and Corrections Divisions. Ms. Prado was previously administrator and CEO at Miami General Hospital. A registered nurse, she is former President of the Emergency Nurses Association and was the Legislative Chairperson of the Florida Nurses Association. She is a member of the Board of Directors of the Child Care Connection, and formerly served as a member of the Public Policy Committee on Aging and the Medicaid Reform Task Force. Ms. Prado graduated from the Jackson Memorial Hospital School of Nursing and the University of Miami Nurse Practitioner Program.

ROBERT RAY, of Des Moines, Iowa, is a former Governor of Iowa, and serves as Co-Chair of the National Leadership Coalition on Health Care. Mr. Ray is an expert on rural health issues and serves as Chair of the National Advisory Committee on Rural Health. As Governor, from 1969-1983, Mr. Ray established the Governors Commission on Health Care Costs. He retired in August 1996 as President and CEO of IASD Health Services Corporation. Mr. Ray has also served as Chairman of the National Governors' Association. He received both his undergraduate and J.D. degree from Drake University.

THOMAS REARDON, of Boring, Oregon, is the Medical Director of the Portland Adventist Medical Group. Dr. Reardon is a Trustee and Vice Chair of the American Medical Association. He is a member of the Board of Directors on the National Committee for Quality Assurance, a former Commissioner of the Physician Payment Review Commission and of the Joint Commission on Accreditation of Healthcare Organizations. Dr. Reardon earned a B.S. degree from Colorado State University and an M.D. from the University of Colorado.

KATHLEEN SEBELIUS, of Topeka, Kansas, currently serves as the Insurance Commissioner for the State of Kansas and as Vice Chair of the Health Committee of the National Association of Insurance Commissioners. Previously, she served as a Member of the Kansas House of

Representatives. Her efforts as Insurance Commissioner have resulted in new laws in Kansas, including a bill mandating a 48 hour minimum stay for mothers and newborns in the hospital, prohibition of an insurance deductible for payments of childhood immunizations, and extended portability for widows and divorcees in health care plans. Ms. Sebelius earned a Bachelor's degree from Trinity College and a Masters in Public Administration from Kansas University.

STEVEN S. SHARFSTEIN, of Baltimore, Maryland, one of the nation's leaders in mental health, is President, Medical Director and CEO of Sheppard Pratt, a non-profit behavioral health system. Dr. Sharfstein is Clinical Professor at the University of Maryland and a Professorial Lecturer in Psychiatry at Georgetown University School of Medicine and at Johns Hopkins University. He is a member of many professional associations, including the American Psychiatric Association, the American College of Psychiatrists, the American Medical Association, and the Southern Psychiatric Association. Dr. Sharfstein received a B.A. from Dartmouth College, an M.D. from the Albert Einstein College of Medicine, and an M.P.A. from the John F. Kennedy School of Government at Harvard University.

PETER THOMAS, of the District of Columbia, is a principal in the law firm of Powers, Pylers, Sutter & Verville, P.C. Mr. Thomas has a federal law and legislative practice in the areas of health care reform, managed care, reimbursement policy, Medicare and Medicaid, and rehabilitation research appropriations. Mr. Thomas has personal experience with physical disability, using two artificial legs since the age of ten and serves as Co-Chair of the Health Task Force of the Consortium for Citizens with Disabilities (CCD), a Washington-based coalition of over 100 national disability-related organizations. Mr. Thomas has served on the National Advisory Board on Medical Rehabilitation Research at the National Institutes of Health and has co-authored an employment guidebook on the Americans with Disabilities Act of 1990. Mr. Thomas received a B.A. degree from Boston College and a J.D. from Georgetown University Law Center.

MARY WAKEFIELD, of McLean, Virginia, currently serves as the Director and Professor of the Center for Health Policy at George Mason University. From 1993 to 1996, Ms. Wakefield was Chief of Staff to Senator Kent Conrad, advised the Senator on the health related issues of the Senate Finance Committee, and analyzed the impact of legislation on health care. A registered nurse, she previously served as Co-Chair of the Senate Rural Health Caucus staff organization while serving as Administrative Assistant to Senator Quentin Burdick. A native of North Dakota, Ms. Wakefield earned a B.S.N. from the University of Mary, in Bismarck, an M.S.N. and a Ph.D. from the University of Texas.

GAIL WARDEN, of Detroit, Michigan, currently serves as President and CEO of the Henry Ford Health Systems, one of the nation's leading vertically integrated health care systems and premier academic medical centers. At Henry Ford, he has spearheaded affiliations to optimize the health care services and insurance programs delivered to Detroit area residents. Mr. Warden is the past Chairman of the National Committee for Quality Assurance. He serves on the Governing Council of the Institute of Medicine of the National Academy of Sciences, is a member of the Board of the Robert Wood Johnson Foundation, is Vice Chairman of The

Hospital Research and Educational Trust, and chairs the Department of Veterans Affairs Associated Health Professions Review Committee. Mr. Warden is a graduate of Dartmouth College and earned a Master's in health care management from the University of Michigan.

ALAN WEIL, of Denver, Colorado, currently is co-director of the Assessing the New Federalism Project at the Urban Institute. This project, the largest in the Institute's 29 year history, will monitor and assess the effects of welfare reform and health care reform around the country. Mr. Weil has previously served as the Executive Director of the Colorado Department of Health Care Policy and Financing, where he was responsible for Medicaid and other medically indigent programs, health data collection and analysis function, health policy development, and health care reform. As Executive Director, he was the principal health policy advisor to Governor Roy Romer. Mr. Weil's accomplishments include implementation of a mandatory electronic claims submission system for Medicaid, and implementation of an innovative risk-adjustment system for setting Medicaid HMO rates. Mr. Weil received a B.A. from the University of California at Berkeley, a Master's in Public Policy from the John F. Kennedy School of Government at Harvard University, and a J.D., *cum laude*, from Harvard Law School.

SHELDON WEINHAUS, of St. Louis, Missouri, is an attorney who has worked extensively representing workers in health care litigation, with a practice focus on health benefit and disability claims of patients covered under employer provided group benefit plans. He has devised claims processing and litigation strategies and theories to obtain judicial reversals of coverage denials for life saving and cutting-edge medical procedures, such as double lung transplants and high dose chemotherapy. Mr. Weinhaus serves on the Board of Directors of the Patient Advocate Foundation, was on the Missouri Task Force for Breast Cancer Coverage, and is a member of the National Health Lawyers Association and the National Employment Lawyers Association. Mr. Weinhaus earned a Bachelor's degree from the University of Arizona, and a J.D. degree from the Washington University School of Law.

STEPHEN F. WIGGINS, of Darien, Connecticut, is the Founder, Chairman and CEO of Oxford Health Plans, Inc. Oxford owns and operates health maintenance organizations and insurance companies in New York, New Jersey, Pennsylvania, New Hampshire and Connecticut. Prior to his tenure at Oxford, he formed Accessible Space, Inc., in 1979, a non-profit health care company which develops and operates residential facilities for the mobility impaired and brain injured; Mr. Wiggins has continued to serve as a Board member since its founding. Mr. Wiggins received a B.A. from Macalester College and an M.B.A. from Harvard University.

The President also announced today that Janet Corrigan, of Maryland, will serve as the Executive Director of the Advisory Commission on Consumer Quality and Protection in the Health Care Industry.

Janet Corrigan, of Columbia, Maryland, will be the Executive Director of the Advisory Commission on Consumer Quality and Protection in the Health Care Industry. She currently is a

principal researcher at the Center for Studying Health System Change. The Center monitors and assesses the evolution of the health care industry and its impact on local health care markets, and consumer satisfaction, access and the utilization of health services. She has also served as Vice President for Planning and Development at the National Committee for Quality Assurance, where she was responsible for the development of a standard set of performance measures, a \$2.1 million Report Card Pilot Project, and oversight of state projects involving quality measurement and health plan accountability. Dr. Corrigan received a B.A. from Syracuse University, an M.B.A. from the University of Rochester, an M.P.H. from the University of Rochester Medical Center, a Masters of Industrial & Operations Engineering from the University of Michigan, and a Ph.D. in Health Services Organization & Policy from the University of Michigan.

Office of the Press Secretary

For Immediate Release

March 26, 1997

EXECUTIVE ORDER

ADVISORY COMMISSION ON CONSUMER PROTECTION
AND QUALITY IN THE HEALTH CARE INDUSTRY
(As Amended)

By the authority vested in me as President by the Constitution and the laws of the United States of America, including the Federal Advisory Committee Act, as amended (5 U.S.C. App.), it is hereby ordered as follows:

Section 1. Establishment. (a) There is established the Advisory Commission on Consumer Protection and Quality in the Health Care Industry (the "Commission"). The Commission shall be composed of not more than 32 *members* to be appointed by the President. The members will be consumers, institutional health care providers, health care professionals, other health care workers, health care insurers, health care purchasers, State and local government representatives, and experts in health care quality, financing, and administration.

(b) The Secretary of Health and Human Services and the Secretary of Labor shall serve as Co-Chairs of the Commission. The Co-Chairs shall report through the Vice President to the President.

Sec. 2. Functions. (a) The Commission shall advise the President on changes occurring in the health care system and recommend such measures as may be necessary to promote and assure health care quality and value, and protect consumers and workers in the health care system. In particular, the Commission shall:

(1) Review the available data in the area of consumer information and protections for those enrolled in health care plans and make such recommendations as may be necessary for improvements;

(2) Review existing and planned work that defines, measures, and promotes quality of health care, and help build further consensus on approaches to assure and promote quality of care in a changing delivery system; and

(3) Collect and evaluate data on changes in availability of treatment and services, and make such recommendations as may be necessary for improvements.

(b) For the purpose of carrying out its functions, the Commission may hold hearings, establish subcommittees, and convene and act at such times and places as the Commission may find advisable.

Sec. 3. Reports. The Commission shall make a preliminary report to the President by *January 31, 1998*. A final report shall be submitted to the President *March 30, 1998*.

Sec. 4. Administration. (a) To the extent permitted by law, the heads of executive departments and agencies, and independent agencies (collectively "agencies") shall provide the Commission, upon request, with such information as it may require for the purposes of carrying out its functions.

(b) Members of the Commission may receive compensation for their work on the Commission not to exceed the daily rate specified for Level IV of the Executive Schedule (5 U.S.C. 5315). While engaged in the work of the Commission, members appointed from among private citizens of the United States may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law for persons serving intermittently in the Government service (5 U.S.C. 5701-5707) to the extent funds are available for such purposes.

(c) To the extent permitted by law and subject to the availability of appropriations, the Department of Health and Human Services shall provide the Commission with administrative services, funds, facilities, staff, and other support services necessary for the performance of the Commission's functions. The Secretary of Health and Human Services shall perform the administrative functions of the President under the Federal Advisory Committee Act, as amended (5 U.S.C. App.), with respect to the Commission.

Sec. 5. General Provision. The Commission shall terminate 30 days after submitting its final report, but not later than 2 years from the date of this order, unless extended by the President.

WILLIAM J. CLINTON

THE WHITE HOUSE
March 26, 1997.

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**NATIONAL
MULTIPLE SCLEROSIS
SOCIETY**

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**Statement In Support Of The President's Advisory Commission on Consumer
Protection And Quality In The Health Care Industry**

The National Multiple Sclerosis Society strongly supports the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. It is part of the Society's mission to end the devastating effects of poor or inappropriate health care in the lives of people who live with MS. We must work to achieve quality health care, judged on accessibility to needed care, high standards, choice, and accountability.

The following principles are basic to any quality health care for consumers:

1. Consumers must have access to a medical provider within their health plans who is well-versed in the patient's special health-care needs, otherwise there may be no one willing or able to attest to the "medical necessity" of the services and to advocate for them resulting in important services being denied or delayed.
2. Consumers must have access to providers outside their health plans who are expert in their condition - with at least 80% coverage.
3. Where there is pharmaceutical coverage in a health plan, consumers/physicians must be allowed off-formulary requests. Health plans are increasingly using drug formularies to hold down costs. In treating a condition such as MS, a physician often must experiment and change prescriptions depending on symptoms and the patient's response. Individualized prescribing should not be discouraged by a restrictive, burdensome formulary. Nor can therapeutic substitution be allowed without physician approval.
4. Consumers must have access to specialized and rehabilitative services. Persons with MS often do well when they have access to a full range of specialized and rehabilitative services including durable medical equipment, preventive therapy and mental health counseling. It is important that the staff of managed care facilities understand this need and respond appropriately.
5. Health plans must be required to fully disclose:
 - definition of medical necessity
 - services provided and NOT provided
 - lists of doctors and specialists
 - cost-control measures
6. Consumers must have a right to speedy appeal, such as a 24 to 48 hour independent review for appeal of gatekeeper/primary care or specialist physician decisions.

The National Multiple Sclerosis Society views this Advisory Commission as an excellent forum to ensure that the health of all Americans improves.

WHSO FINAL LAYOUT

K. Widdess

HEALTH CARE QUALITY COMMISSION ANNOUNCEMENT

Wednesday, March 26, 1997

East Room, State Floor

60 guests/Open Press

NW Gate Arrivals: 12:45 p.m.

EV Gate Arrivals: 1:30 p.m.

Invite Time: 2:00 p.m.

POTUS Time: Briefing - 2:00 - 2:15 p.m. (Red Room)

Event - 2:15 - 3:00 p.m.

12:45pm Commission Members arrive at the Northwest Gate and are escorted to the Diplomatic Reception Room for event briefing. (Contact: B. Woolley, D. Wexler)

Participants: Secretary Shalala, Melissa Skofield, Chris Jennings
Manifest: Janet Corrigan
Richard Sorian
John Eisenberg
Barbara Woolley
Dan Wexler
Sarah Bianchi
Christa Robinson

1:00pm Secretary Shalala arrives at West lobby and is escorted to the Diplomatic Reception Room for briefing with Commission Members.
Contact: A. McGuire

1:30pm Acting Secretary Metzler arrives at West Lobby and is escorted to the Red Room.
Contact: A. McGuire

1:30pm East Visitor Entrance opens for guest arrival. Guests are seated in the East Room.
List Coordinator: K. Widdess
SIC: J. Schwartz

2:00pm - 2:15pm **The President** arrives in the Red Room for event briefing.

Participants (per C. Robinson): Secretary Shalala Peg Clark
Acting Secretary Metzler Carolyn Curiel
Erskine Bowles
John Podesta
Bruce Reed
Chris Jennings
Bob Nash
Maria Echaveste
Rahm Emanuel

2:15pm

PROGRAM BEGINS:

- The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry is announced and proceeds to seats on stage and at table in the East Room.

- **The President**, Secretary Shalala and Acting Secretary Metzler are announced and proceed to table.

- Acting Secretary Metzler delivers remarks and introduces Secretary Shalala.

- Secretary Shalala delivers remarks and introduces **The President**.

- **The President** delivers remarks.

3:00pm

Upon conclusion of remarks, **The President**, Secretary Shalala and Acting Secretary Metzler depart the State Floor.

Commission Members proceed to State Dining Room to hold for Press interviews.

Contact: B. Woolley, P. Lewis

Other Guests depart East Gate.

SET UP NOTES (per J. King): STAGE - Gold Stage against South wall of East Room; 16 chairs on gold stage, 12 chairs on ground level in front of stage; special chair for POTUS; Blue Goose flanked by banquet tables on ground level. AUDIENCE - 60 Chairs in audience; Audience Stanchioned off; center aisle. OTHER - Open press.

**Advisory Commission on Consumer Rights and Quality in the Health Care Industry
Questions and Answers**

Question

Why did it take so long to announce this commission? Didn't the President announce this in September of 1996?

Answer

It certainly took longer than any of us would have liked but we wanted to make sure that we cast a broad net for commission members. We received nearly 1000 nominations and suggestions for this panel and each person received full consideration. In addition, the first priority for our clearance process had to be given to the President's White House and Department team. We are very pleased with the diverse representation of this group, including businesses, consumers, labor, health care providers, insurers and quality and financing experts.

Question

Why has the commission grown from 20 members to 32?

Answer

After reviewing the more than 1000 nominations it became clear that we needed more commission slots to assure a broad-based and balanced group of representatives.

Question

What will this commission hope to accomplish?

Answer

The President is calling on the commission to develop a "consumer bill of rights." He wants it to particularly focus on consumer appeals and grievance rights. Specifically, he has asked the Commission to:

1. Review existing and planned work in defining and measuring quality in health care and build further consensus on approaches to assure and promote quality;
2. Collect and evaluate data on the availability of high quality treatment and services and make recommendations for improvements.
3. Review all available data in the area of consumer information and protection and make recommendations for improvements.

Question

The President has asked the Commission to construct a Consumer Bill of Rights. Is this real or just for show?

Answer

A Consumer Bill of Rights is an integral part of quality assurance. For example, it is part of the Federal nursing home quality law. In the last few years, many states have been adopting elements of a bill of rights. Some examples:

- At least 21 states have enacted laws requiring health plans to allow Ob/Gyns to serve as primary care physicians or to allow women to go to Ob/Gyns without prior authorization from their plan;
- At least 22 states require an external appeals process for consumers;
- 28 states require plans to provide members with a list of contracting doctors and hospitals;
- 17 states require plans to notify plan members if their primary doctor is no longer in the plan; and
- At least 12 states have commissions or task forces focusing on consumer protection issues.

We believe that the Commission's "Consumer Bill of Rights" will expand on these important and successful models.

Question

Will the Patient Bill of Rights be mandated on states and private health plans?

Answer

No. The Commission will develop a model Bill of Rights that states, health care plans, health care providers, associations, and others can use to guide their own efforts. States have already been quite active in this area and the model should help them in future efforts. Many health plans and health care professionals have adopted a form of a Bill of Rights and this should assist them as well.

Question

Is this an "anti-managed care" commission?

Answer

Absolutely not. Quality and consumer rights are issues that transcend all models of care. We need to address those issues in a comprehensive manner so that no matter what kind of insurance plan Americans join, they will know that the care they receive is of the highest quality and their rights as consumers are protected.

Question

Won't the commission serve to delay quality legislative initiatives including those that even the President has advocated? Isn't the commission going to compete with these initiatives?

Answer

This commission will complement, not compete with, legislation in the Congress that has broad-based support. The President will continue to support legislation in this area that has already received bipartisan support (e.g., barring gag rules, requiring 48-hour stays for women who have mastectomies). But this is just a start, we must go beyond these reforms to take a comprehensive look at the quality of care and how we can assure it. The Commission will work on building the consensus for more far-reaching reforms.

Question

But hasn't the train already left the station? Senator Kennedy and Rep. Dingell have a bill in the hopper and many others are already being considered. Haven't you waited too long?

Answer

No, not at all. It is still very early in the legislative calendar and there is ample opportunity for this commission to influence the course of the debate this year and next. We expect the expertise of this commission to be of great assistance as the bipartisan leadership of Congress looks for ways to protect consumer rights and improve quality.

Question

The President has called for enactment of legislation banning gag rules and requiring 48 hours in the hospital for a woman who has had a mastectomy. Isn't it contradictory to call for passage of those bills and then create a commission to study the issue?

Answer

No. The President believes we should move ahead and pass legislation when there is broad bipartisan support. Not only has he just recently stated his strong support for legislation in this area, but he has directed HHS to move ahead on patient protections in the Medicare and Medicaid programs that do not require additional legislative authority. We have a tremendous record in that regard including barring gag rules, limiting physician incentive schemes, increasing choice and consumer information, and speeding consideration of appeals and grievances. We will build on this start with the Commission's contributions.

Question

The Commission is supposed to consider ways to increase access to care. Isn't this another way to bring back health care reform?

Answer

No. The focus is on quality and consumer rights. As stated in the President's Executive Order, the commission will focus on the "availability of treatments and services." Although no health care issue is entirely unrelated to another one, the focus of this commission will clearly be on the quality and consumer protection issues. Having said this, certainly some of those issues affect access to care and we hope to be able to address those concerns as well. The President has consistently said he wants to increase access to health insurance in this country. He has proposals before the Congress as part of his balanced budget to provide assistance to families between jobs, to nearly 5 million uninsured children, and to small businesses who are forced to pay more for coverage for their workers.

Question

Did the President use this commission to reward campaign contributors and Washington-insiders who know little about what Americans in the health care system experience?

Answer

Absolutely not. By any measure, these commission members are extremely well respected experts who have broad and different experiences in the health care system. They have expertise on a range of health care 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. They come from all parts of the country and reflect the diverse population of our Nation.

Question

How much will this cost and who's paying for it?

Answer

The Commission will cost an estimated \$1.8 million over the next year and be paid for by the Department of Health and Human Services. The members of the Commission will not be paid.

Question

Will the Commission meet regularly? Will they hold public hearings? Will any of their work have to be public?

Answer

Yes, the Commission will meet regularly and will hold public hearings. No schedule has been determined at this time. Yes, the Commission's work will be made public.

Question

If people want to get information to commission members, how can they do it?

Answer

We will inform the public on how to submit information at the Commission's first meeting.

Question

Will the report make policy recommendations – legislation and/or other administration action?

Answer

Yes. The Commission will make recommendations, where appropriate, on how best to promote and assure patient protection and health care quality.

Question

Is the President bound in any way by these recommendations?

Answer

While the President will, of course, review the recommendations of Commission seriously, he is not bound by them.

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

Today, President Clinton announced the members of the Advisory Commission on Consumer Protection and Quality in the Health Care Industry. The President called on the Commission to develop a "Consumer Bill of Rights" to promote and assure patient protections and health care quality. The Advisory Commission was created through an Executive Order signed by President Clinton in September, 1996 to build on the Clinton Administration's commitment to improve the quality of the nation's health care system. The 32-member Commission will review rapid changes in the health care financing and delivery systems and make recommendations, where appropriate, on how best to preserve and improve the quality of the nation's health care system.

REPRESENTING BROAD-BASED INTERESTS AND EXPERTISE

Co-chaired by the Secretaries of Health and Human Services and Labor, the Advisory Commission has broad-based representation from consumers, businesses, labor, health care providers, insurers, and quality and financing experts. The Advisory Commission members have vast expertise on a wide 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. There are also members with extensive backgrounds in privacy rights and ethics. Advisory Commission members come from all parts of the country and reflect America's diverse population.

FOCUSING ON CONSUMER RIGHTS AND QUALITY

The President charged the Commission with developing a "Consumer Bill of Rights" to ensure that patients have adequate appeals and grievance processes. In developing the "Consumer Bill of Rights," the Commission will study and make recommendations on consumer protections, quality, and the availability and treatment of services. Using the best research to measure real outcomes and consumer satisfaction across all providers of health care, the Commission will work to give Americans the tools they need to measure and compare health care quality. It will submit a final report by March 30, 1998. The Vice President will review the final report before it is submitted to the President. In addition, the Advisory Commission will play a consultative role should relevant legislative initiatives move through the Congress prior to the due date of the final report.

BUILDING ON THE ADMINISTRATION'S COMMITMENT TO HEALTH CARE QUALITY

The Clinton Administration has a long history of strong support for consumer protection in health plans, including executive actions and legislative initiatives barring gag rules; limiting physician incentive arrangements; increasing choice and consumer information; and requiring health plans to allow women to stay in the hospital for 48 hours after a mastectomy or after the delivery of a child. The President has called for this Commission to develop a broader understanding of the numerous issues facing a rapidly evolving health care delivery system and to help build consensus on ways to assure and improve quality health care.

TALKING POINTS FOR ACTING SECRETARY CYNTHIA A. METZLER

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

*The White House
March 26, 1997*

Good afternoon.

It is a pleasure and honor to be with all of you today.

Mr. President,

it is a *great* pleasure and honor for me to be the first speaker for this program-- since I get the distinction of being the first person to thank you publicly for your leadership and bold actions to ensure that all Americans have access to quality health care.

To the members of the Advisory Commission on Consumer Protection and Quality in the Health Care Industry: *Welcome.*

This commission is made up of a broad base of interests and concerns... with members hailing from all parts of the country and reflecting the rich diversity of this Nation.

Each member has vast experiences--
and brings special insights--
on a wide range of health issues.

The Commission includes members with extensive backgrounds
in privacy rights and ethics,
as well as experts on quality information,
purchasing,
and private sector health benefits.

Individually,

each has contributed in large measure to innovation
in various health care issues.

Collectively, I'm sure,

your accomplishments will be nothing short of remarkable.

I...

on behalf of the entire Department of Labor--
look forward to working with you.

And I bring a strong and sincere message of support
from the Secretary of Labor-designate, Alexis Herman...
whose energy and commitment
will add immeasurably to the success of the Commission.

We all know
that the health care market--
and the delivery of health care services--
is going through unprecedented change.

At the Labor Department,
we've seen first-hand the tremendous growth
in innovative care arrangements,
with the majority of our nation's workers
enrolled in these plans.

The U.S. Department of Labor
has the responsibility of enforcing the federal law
that protects the health benefits
of this country's 125 million working men and women--
and their families.

These hard working people--
as well as their unions and their employers--
MUST have the tools they need
to get affordable
and high quality health care coverage.

One of the highest priorities of this Labor Department
is to make sure that happens.

The private sector has a strong record of achievement
to build from--
and build on--
as we move forward.

Clearly, employers and unions can work together--
as purchasers--
along with providers
to focus attention
on costs...
quality...
and basic protection
for America's working families.

We see that the innovations
in the delivery of health care services
hold great promise for improving the quality
and the affordability of health care...

But at the same time,
we vividly see the need to ensure that people have the ability
to protect their health care coverage.

**That is why we are here today.
And that is what this Commission is all about.**

One of the people who will play a very large role in the success of this commission is its co-chair... the U.S. Secretary of Health and Human Services who has worked tirelessly for the well-being of all Americans.

It's a delight for me to introduce her....

Ladies and gentlemen,
the Secretary Donna Shalala....