

**PRESIDENT WILLIAM J. CLINTON
PREPARED REMARKS
ADVISORY COMMISSION ON
CONSUMER PROTECTION AND QUALITY IN
THE HEALTH CARE INDUSTRY
EAST ROOM
MARCH 26, 1997**

[Following Acting Secretary Metzler; Secretary Shalala; Acknowledge: Commission members, distinguished guests.]

I am happy to be here with you today to announce the naming of our Advisory Commission that will help chart our way through a time of great change in our health care system. Their task will be focused and urgent: to find ways to ensure quality and the rights of consumers in health care.

Since I took office, my Administration has been committed to improving our health care system -- to making it more affordable, more accessible, while preserving its high quality.

We worked with the states to expand Medicaid to more than 2 million Americans who previously had no insurance. We reached across party lines to enact the Kassebaum-Kennedy law so that working families won't lose their insurance when they change jobs. At the same time, we increased the health care tax deduction for the 3 million self-employed Americans struggling to pay for insurance. We want health care coverage extended to as many as half of the 10 million children who don't have it -- and that is paid for in my balanced-budget plan.

We have worked to constrain costs. Just yesterday, I announced a new effort to combat the multi-billion dollar problem of fraud and abuse in Medicare and Medicaid. My balanced-budget proposal also strengthens Medicare through savings and long-overdue structural reforms.

We are not alone in our efforts. The private sector has found ways to rein in costs. And in many cases, changes in the health care delivery system also improved quality. For example, the growing recognition of the value of preventive care, such as mammography screening, is saving and extending lives and the quality of life. This is very encouraging.

Step by step, we have been expanding access to quality health care. Today, we take the next step.

In this time of transition in health care, many Americans worry that lower costs means lower quality and less attention to their rights. On balance, managed care health plans -- HMOs, PPOs and others -- give patients good care and greater choice at lower cost. But we must make sure that these changes do not keep health professionals from offering the best, most medically appropriate services to patients. Managed care, managed well, can be the best deal for our families. Whether they have traditional health care or managed care, none of our people should ever experience inferior care.

I am proud that the Medicare and Medicaid programs have taken the lead in responding to the quality concerns of both patients and health care providers, as Secretary Shalala just described.

But we are learning that defining, measuring and enforcing quality is no simple task. There are many complicated issues that require thoughtful study. And, not surprisingly, there are many areas where broad-based consensus on how best to proceed does not yet exist.

That is why I decided late last year to establish the Advisory Commission on Consumer Protection and Quality in the Health Care Industry. Today, I am happy to introduce the members of the Commission to the American people.

They are a highly distinguished, broad-based and diverse group, representing consumers, businesses, labor, health care providers, insurers, managed care plans, state and local governments, and health care quality experts. Their specialities are wide-ranging, including care for children, the elderly, women, and people with disabilities, mental illness or AIDS. This Commission includes some of the best health care policy minds in the nation.

Its task will be as challenging as it is critical. **Today, to assure that they get busy right away, I am charging the Commission's to develop a "patient's bill of rights," so health care patients gets the information and the care they need when they need it.** Let's assure patients and their families:

- First, that the health care professionals treating them are free to provide the best medical advice available;
- Second, that their providers are not subject to inappropriate financial incentives to limit care;
- Third, that our sickest and most vulnerable patients (frequently the elderly and people with disabilities) are receiving the best medical care for their unique needs;
- Fourth, that consumers have access to simple and fair procedures for resolving health care coverage disputes with plans;
- And fifth, and perhaps most important, that consumers have basic information about their rights and responsibilities, about the benefits that plans offer, about how to access the care they need, and about the quality of their providers and their health plan.

I am delighted that the Secretary of Health and Human Services and the Secretary of Labor will take on this task as the Commission's co-chairs. I look forward to reviewing their first report at the end of the year, and their final report next March.

The need for this Commission is real and it is urgent. We must have a road map to help make our way through this time of rapid changes in our health care system. There are few people in this nation better suited to this task than the Members of this Commission. On behalf of the American public, I want to thank the men and women who today commit themselves to this important effort. Your work will help ensure that all of America's families receive the benefits of the world's best health care system -- and I thank you.

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

March 26, 1997

Today, President Clinton will announce the members of the Advisory Commission on Consumer Protection and Quality in the Health Care Industry. The President will call 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. 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.

Acting Labor Secretary Cynthia Metzler will make opening remarks. Secretary Shalala will then make remarks and introduce the President.

Attached is a fact sheet on the Commission and brief bios on the members. In addition to those members named today, three additional individuals selected to serve on the Commission are expected to be named shortly.

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

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.

OFFICE OF MANAGEMENT AND BUDGET

*Legislative Reference Division
Labor-Welfare-Personnel Branch*

Telecopier Transmittal Sheet

FROM: Bob Pellicci -- 395-4871

DATE: 3/27 TIME: 5:45 P.M.Pages sent (including transmittal sheet): 3

COMMENTS: 30 copies of the health language was delivered today by HHS to Congress. Attached are the transmittal letters.

TO:

Bill Blackstein / Jack Lew
Chris Jennings

PLEASE CALL THE PERSON(S) NAMED ABOVE FOR IMMEDIATE PICK-UP.



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

The Honorable Newt Gingrich
Speaker of the House
of Representatives
Washington, DC 20515

Dear Mr. Speaker:

Enclosed for the consideration of the Congress are the legislative proposals necessary to carry out the health care portions of the President's FY 1998 budget.

Included are proposals to establish or reauthorize user fees for the Food and Drug Administration; to achieve Medicare savings and amend Medicare managed care provisions; to control costs and increase State flexibility under Medicaid; to authorize grants to encourage development of small group health insurance purchasing cooperatives; and to provide for grants to States for programs of health insurance for families of workers between jobs and for children's health insurance. The proposals are described in more detail in the enclosed summary.

We would bring one key change to your attention. As initially published, the President's budget provided for Medicare coverage of annual mammograms for Medicare beneficiaries age 50 or over. In light of the new recommendation announced today by the Director of the National Cancer Institute, that provision has been changed to cover annual mammograms for Medicare beneficiaries age 40 or over.

We urge the Congress to give these proposals prompt and favorable consideration.

The Office of Management and Budget has advised that enactment of this legislation would be in accord with the program of the President.

Sincerely,

Donna E. Shalala

Enclosures

WHY MEDICAL SAVINGS ACCOUNTS ARE BAD FOR CHILDREN

70 percent of children who are presently uninsured come from families that earn \$31,000 or less, and therefore will face financial barriers to care if they enroll in a high deductible health insurance policy. Few of these families will be able to pay \$1,000 or more per child to fund an MSA. Most of these families will be hard pressed to pay medical bills before a \$1,500 (or higher) deductible is met. What this means is that their children will be denied medical care because of the financial barrier faced by their parents.

MSAs for children will separate the healthy from the sick, appealing to the healthy, and leaving the sick with higher out-of-pocket costs. Health costs are not spread evenly across the children's population. They are spread very unevenly, with 5 percent of children accounting for more than 59 percent of expenditures.¹ MSAs will appeal to the healthy 95 percent more than the unhealthiest 5 percent. They will also appeal to relatively wealthy families who can afford high deductibles. If introduced as an option for all, the migration of the healthy children to MSA plans will severely erode the premium dollars in the risk pool to pay the costs of health care for the unfortunate 5 percent of relatively unhealthy children. This is a double whammy for these families who must then deal not only with a very sick child, but also with the unwillingness of society to help share the cost of medical care.

Families of all income levels will face higher premiums for low deductible (e.g., \$250 deductible) health insurance. It is important to look beyond the impact on the families who have MSAs. Analysts who have studied the total under-65 health insurance market have demonstrated that MSAs have a greater appeal to the healthy than they do to the sick. They have estimated that premiums for traditional health insurance (e.g., with deductibles of \$250) will increase as much as 300 percent if MSAs are introduced on a large scale in the health insurance market.² The same will be true for children's MSAs; premiums for traditional (low-deductible) health insurance will skyrocket if MSAs are an option.

¹"Children Without Health Insurance: Use of Health Services in 1977 and 1987, Intramural Research Highlights NMES: National Medical Expenditure Survey, Agency for Health Care Policy and Research, February 1994, No. 30.

²See, for example, "Medical Savings Accounts -- Cost Implications and Design Issues," American Academy of Actuaries, Washington DC, May 1995, p. 6; and Len M. Nichols, Marilyn Moon, & Susan Wall, "Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers," The Urban Institute, Washington DC, April 1996, p. 12.

Washington Office

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In the long-run, MSAs would drive low-deductible policies out of the market. If premiums for health insurance with low deductibles (e.g., \$250) increased between 60 percent and 300 percent (as predicted), these policies will be unaffordable for many. It is only a matter of time before insurers would decide to leave the traditional market in order to market high-deductible only policies. This means *less* choice of policies for families.

Families with a child with a chronic illness will face sizeable out-of-pocket costs if they have an MSA plan. Consider the case of a child with a serious disability such as cerebral palsy. While the average annual health care cost for an infant (under 1 year old) receiving Medicaid was \$2,284 (in 1992), the average annual health care cost for a *disabled* child of this age was \$16,227, seven times as much.³ If health care costs for a disabled child (who is not eligible for Medicaid) were \$16,227, then this child's family would face sizeable out-of-pocket costs if they have a high-deductible health insurance policy: The deductible could be \$2,000; coinsurance (at 20 percent) after meeting the deductible could be \$2,845. The family's total out-of-pocket health care costs for this child (alone) would be \$4,845. It is extremely unlikely that this family would have any balance in an MSA, since the baby is so young.

Children's MSA accounts are likely to be empty. The 1996 Kassebaum-Kennedy health bill did not require employers to put money into employees' MSAs. Since children don't have employers, it is even less likely that there would be any funding for MSAs outside the family. This is the case especially since fewer employers are providing health insurance coverage for employees' dependents, with the percent of children covered by their parents' employer-based plans decreasing from 67 percent in 1987 to 59 percent in 1995. Since most uninsured children live in families with modest incomes, it is very unlikely that their families could contribute money to a savings account for health care. Even if they could, they would find that tax benefits would be modest because of their low tax bracket.

Many children will not get preventive care. MSAs for children are likely to be packaged with health insurance policies with high deductibles of \$1,500 to \$4,500. Even if the health insurance policies covered preventive benefits, insurance will actually pay the preventive care costs for a small percent of children, since few have costs high enough to meet the deductible. Families with unfunded MSAs will have to pay the full cost of preventive care (e.g., check-ups and immunizations) out-of-pocket. Many will be unable to afford to do this.

³Marsha Regenstein and Jack A. Meyer, "Low Income Children with Disabilities: How Will They Fare Under Health Care Reform?" The Economic and Social Research Institute, National Academy for State Health Policy, August 1994.

April 22, 1997

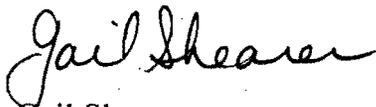
Dear Senator:

We are pleased that Congress is considering options for expanding health insurance coverage for children, but want to alert you to one policy option that should be **rejected** -- medical savings accounts (MSAs). Attached is a fact sheet that explains the key reasons why we believe Congress should reject MSAs for children. In sum:

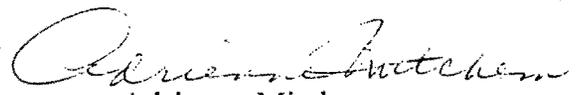
- 70 percent of children who are presently uninsured come from families that earn \$31,000 or less, and therefore will face financial barriers to care if they enroll in a high deductible health insurance policy.
- MSAs for children will separate the healthy from the sick, appealing to the healthy, and leaving the sick with higher out-of-pocket costs.
- Families of all income levels will face higher premiums for low deductible health insurance.
- In the long-run, MSAs would drive low-deductible policies out of the market.
- Families with a child with a chronic illness will face sizeable out-of-pocket costs if they have an MSA plan.
- Children's MSA accounts are likely to be empty.
- Many children will not get preventive care.

We urge you to expand health coverage for children, but don't link their coverage to medical savings accounts that will not meet children's health care needs.

Sincerely,



Gail Shearer
Director, Health Policy Analysis



Adrienne Mitchem
Legislative Counsel

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

May 1, 1997

Senate Budget Committee
United States Senate
Washington, D.C. 20510

Dear Senator:

Our organizations urge you to include language in the budget resolution calling for expanded health coverage for children and pregnant women, and that you do so without linking the expanded coverage to provisions that would do harm to the health care market, specifically Medical Savings Accounts (MSAs) or Multiple Employer Welfare Arrangements (MEWAs).

A shocking 10 million children currently lack health insurance coverage. The overwhelming majority of these children have working parents whose incomes are less than 200 percent of the poverty level -- making health insurance unaffordable. These children pay a high price, often missing out on needed preventive care, early treatment for potentially serious conditions such as asthma, and medical care after being injured. The financial barriers resulting from the absence of health insurance means denied medical treatment in far too many cases.

It is critical that Congress act to address this serious problem, and that it do so without expanding measures such as Medical Savings Accounts (MSAs) and Multiple Employer Welfare Arrangements (MEWAs) that would damage the health insurance market. If MSAs, linked with high deductible health insurance policies, are introduced into the children's health market, the premiums for policies with relatively low deductibles (e.g., \$250) are likely to increase dramatically, putting comprehensive coverage out of reach for many families. Expansion of MEWAs would mean that small employers would be allowed to band together to buy health insurance and escape state regulation. If a provision to expand MEWAs is added to a children's initiative, many more consumers (of all ages) will be enrolled in health insurance that escapes needed consumer protections. Both MSAs and MEWAs undermine the principal of sharing of risks among the healthy and the sick, moving us further from affordable coverage for the sick.

Congress should take steps to increase health coverage for children, and should do this without causing harm to the health insurance system. We look forward to working with you to expand health insurance coverage to our country's pregnant women and children.

Thank you for your consideration on this matter.

Sincerely,

American Association on Mental Retardation
American Federation of State, County and Municipal Employees (AFSCME)
American Network of Community Options and Resources
American Nurses Association
American Speech-Language-Hearing Association
Association for Gerontology and Human Development and Historical Black Colleges & Universities

Bazon Center for Mental Health Law
Center on Disability and Health
Church Women United
Citizen Action
Committee for Children
Consumer Federation of America
Consumers Union
Families USA
Gay Men's Health Crisis
National Association of People with AIDS
National Association of Protection and Advocacy Systems
National Association of School Psychologists
National Association of Social Workers
National Council of Senior Citizens
National Episcopal AIDS Coalition
National Farmers Union
National Gay and Lesbian Task Force
National Hispanic Council on Aging (NHCA)
National Organization for Rare Disorders (NORD)
National Parent Network on Disabilities
National Therapeutic Recreation Society
National Women's Health Network
Neighbor to Neighbor
NETWORK: A National Catholic Social Justice Lobby
Public Citizen
The ARC
The United Methodist Church, General Board of Church and Society
UAW
United Church of Christ, Office for Church in Society
Universal Health Care Action Network (UHCAN)

May 1997

Intro

- As you know, President has always made children -- and particularly children's health a high priority. Last month the President and First Lady hosted major Conference on Early Childhood Development and Learning to learn more about how early interventions impacted the development of the brain and other aspects of child development. The President fought hard for \$16 billion in the Budget Agreement for children coverage.

Importance of Quality

- The President knows that health coverage in and of itself is not enough to ensure high quality care but that we must look at ways to ensure high quality health care. The Quality Commission the President recently appointed is carefully looking at our changing health care system reviewing whether consumers have adequate protections in this new system and whether they have an adequate grievances process to address their concerns. One of the first charges of this Commission is to develop on a patients bill of rights that would give consumers the assurances that they need.
- Don Berwick -- one of our nation's leading pediatricians serves on this Commission. Dr. Berwick has a long history of expertise in the area of children's health care. As you know, Dr. John Eisenberg, the new Administrator for Agency for Health Care Policy and Research the Secretary's key advisor for the Quality Commission. I am also pleased to tell you that at the first Quality Commission meeting there was considerable discussion about how changes in our health care system has considerable implications for vulnerable populations -- which as you well know certainly includes children -- and that the Commission should pay special attention to how these special populations are being impacted by the changes in our health care system.

Providing health care coverage to children.

- I am pleased to see all of you are today to share your expertise and focus on the quality of care that children are receiving. As you know, we are now working -- in the context of the budget agreement -- to expand coverage to millions more uninsured children. How hard the President fought for this -- the agreement was contingent upon this agreement. As you know, 10 million children do not have health care insurance. 90% of these kids have parents who are employed. The health outcomes associated with uninsured. (I'll provide a few stats from kids study)
- Debate about children in Congress. Where it is going. What our goals are in this process. Different options we foresee -- I won't bother to fill in the details but talk a long time on this.

- As we work to implement policies which cover more children, it is extremely important that we work with you as to how to ensure that these children are receiving high quality health care.

What Federal Government is Already Doing in This Area

- We are already doing some things in the government to improve the quality of children's health care.
- While the private sector delivers most of our nations health care and have taken the lead on developing and monitoring quality, the Department has been a dedicated partner in this area -- particularly in the areas of underpinnings for quality measures and improvement strategies.
- Much of what we know about effective and cost-effective health care today comes from research supported by the Federal government especially HHS. HHS is the largest grant-making agency in the Federal government, supporting some 60,000 grants per year. In FY 1997, HHS will be supporting well over \$12 billion in intramural and extramural research. About 6-14% of this research goes to children.
- HHS is making it a priority to stress patient-centered research that focuses on the end results of care that can be quickly translated into effective patient care and more recently quality measurement and improvement. In addition, the Department is supporting the development of performance and quality measures as well information that will make these measures more easily accessible to the public.
- We have also paid particular attention to how children are uniquely impacted by the quality and health of their environment and we are taking steps to address this. Just recently, the Vice President announced an executive order that said that when agencies??? must take into special consideration the potential impact on the health and well-being of children.

However, We know we do not yet know enough about indicators

- We know that we do not yet have enough indicators to measure the quality of health care. We know that we often fall short in terms of indicators for the 30 million children in managed care plans, for the millions of children in our public health care services, in the Medicaid program. We simply do not collect and evaluate the data that we need to fully understand how our efforts are affecting the health status of children, particularly the 3%-30% of children with chronic illnesses.

For example, as more and more of the Medicaid population moves into managed care, we still lack Federal data on exactly what kind of services children are receiving.

We still do not fully understand the relationship between prenatal care and healthy

deliveries.

We also do not truly understand what the health implications are for being uninsured. Intuitively, we know that these children would receive better, more efficient, cost-effective care if they received comprehensive coverage, but do not really have sufficient data to back it up.

At this time, in particular, we need to seek the answers to these questions.

- These are critical questions that we must learn to answer in order to design programs and policies that target the real health needs of our children. These questions have enormous implications for our health care services. This is particularly important in light of the upcoming health care discussion surrounding children and Medicaid.
- With regard to children's policies, we are looking at possible new types of children's insurance, including kids-only policies as well as giving states unprecedented flexibility to expand coverage to children through possible grants. In these areas, we need to consider what guidelines are necessary so that this new coverage ensures high quality health care.
- Moreover, we are also proposing substantial new flexibility in the Medicaid program, enabling states to enact waivers without Federal approval. While this policy has the advantage of giving more authority to the states who best understand the needs of their Medicaid programs, we need to make sure that we ensure high quality services in the Medicaid program. We are looking at implementing Federal quality standards in return for this flexibility.
- What we need to know from you is what we know today and what we expect to know tomorrow about the necessary quality standards for children's health. We also need to know how we can better monitor our programs to better ensure the Medicaid recipients are getting the high quality care they need and deserve and to ensure that our public health services are providing the care that really makes a difference to health outcomes. We need to know how better to obtain this information and also how better to distribute it to researchers so that you all can do the kind of analysis that we desperately need to improve our health programs.
- As you all know perhaps better than anyone else, there are significant differences between evaluating health care quality and outcomes for children versus adults. For adults, often mortality is the key outcome that is evaluated. For children, outcomes other than mortality may be more critical for evaluating the quality of health care received including an examination of functional status and including the critical issues facing today's children--including domestic and community violence, drug abuse, and the environments in which children live.

- I reviewed some of the literature that for this conference and I am impressed by the dialogues you are having in considering how these differences are defined and should be addressed
- But we must continue and accelerate these dialogues, for the more we understand about health outcomes of children and what data needs to be collected and distributed- about what questions we need to be asking, the better that researchers like you can help us resolve the questions about what kind of services and quality requirements are really impacting health outcomes. These questions are as critical to our children -- particularly in our changing health care world -- the coverage itself.

Letters to the Editor

MSAs Could Poison Health Insurance Market

In your April 9 editorial "MSA Takeoff," you endorse expansion of Medical Savings Accounts, which link tax-free savings accounts to high-deductible health insurance policies. Unfortunately, you failed to tell your readers that many consumers who would not benefit from MSAs could see their health insurance premiums skyrocket.

Economists predict that premiums for traditional health insurance (which typically charges \$250 up front as a deductible) will increase by as much as 300% if MSAs are allowed without limits into the health insurance market. What this would mean for consumers is less choice, when traditional policies become unaffordable or are possibly driven out of the market altogether.

The MSA demonstration program in last year's health bill threatens to poison the entire health insurance market—especially if Congress breaks the deal to limit MSAs until the required General Accounting Office study of their effects is completed. MSAs are not the solution for the 10 million uninsured children, whose parents cannot afford health care if they face a steep deductible. If introduced into Medicare, they threaten to siphon off billions of dollars to help the healthy get wealthy, leaving depleted funds to care for the sick.

GAIL SHEARER
Director, Health Policy Analysis
Consumers Union

Washington

REVIEW & OUTLOOK

MSA Takeoff

The big Washington health-care story is that Ted Kennedy has lured Utah Republican Orrin Hatch into endorsing one more expansion of a federal entitlement. But outside the Beltway there's bigger news: Medical savings accounts are off to a rousing start in the private insurance market.

Kennedy Captures Hatch is, after all, a dog-bites-man headline. So is the expansion of government power the two pols propose. They want to extend the federal health-care entitlement by ordering states to subsidize health coverage for people with incomes up to 185% of the poverty line. This makes perfect sense for Mr. Kennedy, whose goal is to socialize the American medical system—by salami slices, if he can't in one big gulp. Mr. Hatch knows better but . . . well, it's hard to know sometimes what drives Mr. Hatch.

By contrast, the new accounts, MSAs, are a man-bites-dog story, a chance to restore individual choice and responsibility to health insurance. MSAs combine a high-deductible insurance policy with a tax-free savings account to pay for routine expenses. Mr. Kennedy fought MSAs like a wolverine last year because he knows they threaten his plans for government-run health care. But Congress insisted on giving MSAs a market test, which began Jan. 1.

And so far so good. Consumer interest has been strong, despite the fact that MSAs can only be sold to the self-employed and through companies with 50 or fewer workers. More than 40 health insurers have begun to offer some kind of MSA policy. The Treasury Department will make its first count of MSA policies at the end of this month, and some private analysts are estimating the number could reach more than 100,000.

This is remarkable when you consider that MSAs challenge many of the conventions of today's private insurance market. Most big insurers have huge investments in HMOs and other provider "networks" that have slowed the rise of health-care costs in part by limiting patient choice. So these big insurers aren't thrilled about offering a product that allows patients to contract with individual doctors and hospitals.

Yet customer demand is inducing even such big players as American Community Insurance, Time Insurance and some of the Blue Cross-Blue Shield companies to get in the game, according to Eclipse Medisave America, which tracks these things. Randy Suttles, president of Medical Savings In-

urance Co., an affiliate of Golden Rule Insurance of Indianapolis, says insurers are discovering "you must give this as a product."

Mr. Suttles reports selling a few hundred policies so far and says he's noticed a startling fact: About 30% of those seeking his MSA policies currently have no health insurance at all. For years liberals have tried this or that government scheme to cover the uninsured, to no avail.

Could it be that a free-market alternative is better for the working class? (Someone please pass Sen. Kennedy the smelling salts. OK, now we can continue.)

In fact, this only makes market sense. With their high deductible, MSA policies are cheaper, and cost is one big reason many people don't buy insurance. That's especially true for young people who expect to live forever. Meanwhile, the pre-tax dollars that can be put into an MSA build up tax-free over the years, another attraction for those reluctant to pay \$400 or \$500 a month for a typical, low-deductible health policy.

All of which helps explain another man-bites-dog MSA story: Democrats in Congress are now proposing to expand this policy innovation. Illinois Reps. Bill Lipinski, Glenn Poshard and Jerry Costello have introduced the Medical Savings Account Expansion Act of 1997 to remove the limits on MSAs that Senator Kennedy insisted upon last year. Their bill would prevent the MSA test from sunseting in the year 2000. It would also remove the cap of 750,000 on the number of MSA policies that can be issued—a cap that might be breached in any case before the enrollment deadline arrives this autumn.

By extending MSAs to a wider market, Mr. Lipinski says, Congress "will be giving the American people what they desperately need in health care: portability, lower costs and more choices," especially for the "unemployed and the uninsured." In this same spirit, the Blue Dog Democrat Coalition has proposed an MSA experiment of 300,000 policies as part of its Medicare reform. MSAs aren't now allowed in Medicare.

Given the current state of Republican timidity, it wouldn't surprise us to see the Democrats steal MSAs as an issue, and run in 1998 as if they discovered the innovation. If Republicans who purport to be running Congress want to "do something" on health care, this is it. It sure beats following Orrin Hatch following Ted Kennedy up the road to serfdom.

THE WHITE HOUSE

WASHINGTON

May 12, 1997

Dear Commission Members:

I enjoyed meeting many of you several weeks ago when we formally announced the members of the Commission. As you begin your first official meetings, I want to thank you once again for agreeing to serve.

I am delighted that such a distinguished group of experts, representing consumers, business, labor, health care providers, insurers and other health plans, and government, has agreed to participate on this Commission. Your work will play a crucial role in helping policymakers on all sides of the political spectrum chart a thoughtful course through a time of profound change in our health care system.

One of the Commission's most important goals is to ensure that patients and their families have appropriate consumer protections in our evolving health care system. I urge you to develop a "Consumer Bill of Rights" to be completed no later than this fall -- well before the January 31 due date of the Commission's preliminary report. Providing your recommendations in a timely manner to respond to this challenge will help in developing a long-overdue national consensus on this critical issue.

I also want to thank you for working so hard on clarifying your agenda and establishing a work plan. You well understand the need to focus narrowly enough to be effective as you review the broad range of issues that could come under your charge.

Thank you again for taking on this important challenge. I look forward to following your deliberations and reviewing your recommendations closely.

Sincerely,

A handwritten signature in cursive script, reading "Bill Clinton". The signature is written in dark ink and is positioned at the bottom left of the page, below the typed name "Bill Clinton".

File "Quality Commission"
First meeting

THE WHITE HOUSE
WASHINGTON

May 12, 1997

Dear Commission Members:

I enjoyed meeting many of you several weeks ago when we formally announced the members of the Commission. As you begin your first official meetings, I want to thank you once again for agreeing to serve.

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Sincerely,

Bill Clinton

FTR
Quality
Commission

MEMORANDUM

May 13, 1997

TO: Distribution
FR: Chris Jennings
RE: Quality Commission's First Meeting

The Quality Commission's first meeting apparently received a great deal of press attention. According to HHS, media represented at the meeting included, ABC, NBC, CNN, *The New York Times*, *The Wall Street Journal*, The Associated Press, Congress Daily, Bureau of National Affairs, and others. The media seemed particularly interested in the Commission's work plan, especially its focus on the President's charge to develop a consumer bill of rights.

Co-Chairs Secretary Shalala and Secretary Herman briefed the press, emphasizing the consumer bill of rights issue as well as the President's letter welcoming the the Commission and urging them to speed up their drafting of the bill of rights. The letter, which I have attached, was given out to all members of the press. The press also spoke to various members of the Commission throughout the day.

The Commission also had an in depth discussion about the consumer bill of rights and members had a wide variety of opinions on what it should contain. Some felt that it should be a comprehensive document, containing an extensive grievances and appeals processes, while others felt it should be limited to issues of disclosure and access. This discussion will continue over the coming weeks by a subcommittee that was formed on this issue. The subcommittee will report back to the whole Commission at the next meeting which will be held on June 25 and 26.

Please feel free to call me at 6-5560 with any questions.

Distribution

Bruce Reed
Elena Kagan
Mike McCurry
Barry Toiv
Larry Haas
Lorrie McHugh
Mary Ellen Glynn
April Mellody

THE WHITE HOUSE

WASHINGTON

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Thank you again for taking on this important challenge. I look forward to following your deliberations and reviewing your recommendations closely.

Sincerely,

Bill Clinton

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

WASHINGTON, D.C. 20201

Quality Commission File

DATE: June 9, 1997
TO: Chris Jennings
FROM: Janet Corrigan 
RE: Background Materials for the June 10th Meeting

At our meeting tomorrow, I would like to discuss with you our plans for the June 25-26 Advisory Commission meeting. Attached are the following: 1) a draft meeting agenda, 2) lists of the Commission members assigned to each of the subcommittees, 3) draft workplans and timelines for each of the four subcommittees, and 4) a copy of a letter from Secretaries Herman and Shalala to members of Congress. Commission staff are currently sharing the draft workplans and timelines with the chairpersons of the various subcommittees, so these documents will likely undergo considerable revisions later this week based on their comments.

Thanks for your ongoing support, and I look forward to our discussions tomorrow.

cc: DHHS: John Eisenberg, Anthony So, Gary Claxton
DOL: Olena Berg, Meredith Miller, Jennifer O'Connor
AC: Richard Sorian, Ann Page

Wednesday, June 25, 1997
MEETING OF SUBCOMMITTEES

Thursday, June 26, 1997
ADVISORY COMMISSION

10:00am - 12:00pm Joint Plenary Session

10:00am-11:00am-Panel Discussion - Consumer Choice
 11:00am-12:00pm-Panel Discussion-Performance Measures
 12:00pm-01:00pm-Lunch Break

08:45am Meeting convened by Secretaries Herman and Shalala
 09:00am Report by the Executive Director, Janet Corrigan
 09:15am Panel Discussion Pending Federal Legislation
 10:15am **Break**

Consumer Rights	Performance Measures	Q.I. Environment	Roles and Responsibilities
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10:30am Continue testimony on Pending Federal Legislation
 11:30am **BREAK FOR LUNCH**
 12:30pm Panel Discussion Protecting Vulnerable Populations
 1:45pm **Break**

1:00-Workplan & Framework for Bill of Rights 2:30-Panel Discussion --Emergency Services 3:30-Break 3:45-Discuss Access to Emergency Services 5:00-Plans for July Meeting 5:30 Adjournment	1:00-Workplan timeline and products 1:45-Discussion of working paper on purposes of and audiences for performance measures 3:30-Break 3:45-Discussion of priority issues for July working paper on measurement development issues 4:15 Subcommittee report to Commission 4:30 Adjournment	1:00 Workplan, timeline and products 1:30 Discussion of working paper on key policy issues 3:30-Break 3:45 Discussion of Performance Measure Issues for Internal QI 4:15 Subcommittee Report to Commission 4:30 Adjournment	1:00-Workplan, timeline and products 1:45-Discussion of working paper on activities of public and private purchasers 3:30-Break 3:45-Con't Discussion on working paper 4:15 Subcommittee Report to Commission 4:30 Adjournment
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02:00pm Subcommittee Reports
 --Quality Performance Measures
 --Quality Environment
 --Roles and Responsibilities
 --Consumer Protection

 02:45pm Discussion--Access to Emergency Services

 04:00pm Adjournment

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

<u>Consumer Rights, Protections and Responsibilities</u>	<u>Performance Measures</u>	<u>QI Environment</u>	<u>Roles and Responsibilities of Purchasers and Quality Oversight Organizations</u>
Peter Thomas <i>(Chair)</i>	Sheila Leatherman <i>(Chair)</i>	Mary Wakefield <i>(Chair)</i>	Sandra Hernandez <i>(Chair)</i> Gail Warden <i>(Chair)</i>
Christine Cassel	L. Ben Lytle	Betty Bednarczyk	Robert Georgine
James Chao	Beverly Malone	Donald Berwick	S. Diane Graham
Nan Hunter	Paul Montrone	Gerald McEntee	Val Halamandaris ✓
Sylvia Drew-Ivie	Risa Lavizzo-Mourey	Phillip Nudelman	Kathleen Sebelius ✓
Randall MacDonald	Marta Prado	Herbert Pardes	Steven Sharfstein ✓
Ronald Pollack	Thomas Reardon	Christopher Queram	Sheldon Weinhaus ✓
Stephen Wiggins	Alan Weil	Robert Ray	

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

**Subcommittee on Roles and Responsibilities of Public/Private Purchasers
and Quality Oversight Organizations**

Charge to the Subcommittee - 5/30/97 DRAFT

The subcommittee will identify the structures and processes needed within the US health care system to assure that the functions recommended by the preceding three subcommittees are carried out effectively and efficiently. In doing so, the subcommittee will address:

1. Strategies for achieving an optimal balance and complementarity between market-driven quality incentives and traditional regulatory requirements
2. Responsibilities of group purchasers in protecting and improving quality; e.g., selecting health plans based on quality and providing related support services and protections to employees / beneficiaries
3. Roles of public and private quality oversight entities, including those of federal and state regulators, and private sector quality oversight organizations, in promoting an efficient and effective market and in safeguarding consumer rights
4. Mechanisms needed to monitor how efficiently and effectively the activities described above are being implemented.

Workplan

Product(s) to be delivered: The subcommittee will produce a single document which includes:

- background analyses;
- operating framework and principles used by the subcommittee to guide its deliberations;
- findings and recommendations.

Analyses Needed

To assist the subcommittee in developing its recommendations, commission staff propose to develop the following background papers:

1. Description of current activities of public and private sector purchasers of health care to incorporate quality considerations into their health insurance plan selection and contracting decisions. Options for strengthening and encouraging widespread practice of such activities will be analyzed.
2. Description and analysis of existing public and private sector approaches to health care quality protection and improvement, with particular attention paid to the protection and

improvement functions identified by the Commission's three other subcommittees. Analysis will identify existing structures which carry out the quality protection and improvement functions identified by the subcommittees, discuss recognized strengths and weaknesses of these approaches as well as areas of duplication or unmet need.

3. Description and analysis of approaches to quality protection and improvement utilized in other industries (e.g. ground transportation, food and banking) and a discussion of their potential applicability to the health care industry, and of new models that have been proposed for quality protection and improvement in health care.

From the subcommittee's review and discussion of these analyses, subcommittee members will identify a framework and principles to guide their subsequent discussions.

Tasks and Timelines

JUNE

1. Review background paper, "*Description of Current Activities of Public and Private Purchasers of Health Care.*"
2. Discuss the potential of group purchasers for protecting and improving health care quality and issues surrounding widespread adoption of these roles by purchasers.
3. Identify principles underpinning subcommittee consensus as it emerges in the subcommittee's discussions

JULY

1. Review background paper, "*Description and Analysis of Existing Public and Private Sector Approaches to Health Care Quality Protection and Improvement.*"
2. Discuss the roles of public and private sector quality oversight entities and identify areas of: unmet need, duplicate activity, and areas where efficiency and effectiveness can be enhanced.
3. Identify opportunities for coordinating the role of public and private sector oversight entities with the activities of group purchasers to more efficiently and effectively protect and improve health care quality
4. Continue to identify principles underpinning subcommittee consensus as it emerges in the subcommittee's discussions

SEPT

1. Review and discuss third background paper: "*Description and Analysis of Approaches to Quality Protection and Improvement Utilized in Other Industries*" (e.g. ground transportation, food and banking) as well as proposed new models of quality of health care oversight.

2. Discuss principles gleaned from these models of quality protection and improvement and their potential applicability to health care.
3. Continue to identify principles underpinning subcommittee consensus as it emerges in the subcommittee's discussions

- OCTOBER:**
1. Review draft statement of principles to guide development of subcommittee recommendations on roles and responsibilities of public/private purchasers and quality oversight organizations
 2. Discuss appropriate levels of accountability for quality within the health care system, addressing complementary roles of individual consumers, group purchasers; private sector accrediting, certifying bodies; governmental regulatory bodies, and other public and private organizations.
 3. Development of recommendations regarding public/private sector roles and responsibilities for:
 - a. Safeguarding enforcement of consumer rights and protections; i.e., appeals process and remedies; and
 - b. Providing services necessary to support consumer choice;
 - education of consumers about quality, patient responsibilities;
 - provision of unbiased information to enable choice of health insurance product, providers and treatments;
 - support services to assist consumers in selecting a health plan, navigating the health care system, and resolving problems.

Subcommittee will review an option paper developed by staff which identifies alternatives for implementing the above functions. The option paper will analyze alternatives with respect to their efficiency and effectiveness, while adhering to the principles and framework previously developed by the subcommittee.

- NOV:**
1. Development of recommendations regarding public/private sector roles and responsibilities for safeguarding and improving the provision of health care of good quality through performance measurement and other accountability mechanisms.
 2. Development of recommendations regarding public/private sector roles and responsibilities for creating an environment supportive of quality improvement, including:

- a. Dissemination of information on effective health care;
- b. Need for comparative data on organization performance;
- c. Development and implementation of improved risk-adjustment approaches
- d. Supporting individual practitioners and other health care workers in continuously improving health care quality; and
- e. Other activities as identified by the subcommittee on creating a Quality improvement environment

Subcommittee will review an option paper developed by staff which identifies alternatives for implementing the above functions. The option paper will analyze alternatives with respect to how efficiently and effectively they are likely to do so, while adhering to the principles and framework previously developed by the subcommittee and endorsed by the full Commission.

DEC: Discussion of methods for assessing the effectiveness and efficiency of approaches recommended to the Commission, if implemented. Subcommittee will review an option paper developed by staff which identifies alternatives for implementing the above function.

DRAFT

June 4, 1997

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

**Subcommittee on Performance Measurement
Proposed Scope of Work**

The use of performance measures to obtain information on health care quality and other aspects of health care delivery systems will be key to future efforts to improve health care and to promote competition based on quality. A growing number of health care purchasers use performance information in their contracting decisions or provide it to consumers to facilitate their choices. In addition, providers and organized health care systems have begun to adopt quality improvement strategies that rely on performance measurement.

These developments deserve careful attention by the Commission and will be the focus of work by this subcommittee, which will make recommendations on the development of performance measures and the use of information on performance. The scope of work below outlines areas to be addressed by the subcommittee in its work. In devising its recommendations in these areas, the subcommittee will consider the level (e.g., national, regional/local, institutional) at which various functions should be performed and the relevant characteristics (e.g., public, private, nonprofit, independent) of the entities that perform them.

- I. Nature of information on quality and performance
 - A. Unit of analysis
 - community/market
 - health plan
 - provider or care delivery system
 - subsets of population (e.g., those with specific health characteristics)
 - B. Type of measure
 - system capacity/structure
 - technical quality (clinical processes or outcomes)
 - interpersonal and amenities (e.g., satisfaction)
 - C. Performance measures development issues
 - priority areas for development of measures
 - processes and resource requirements for development
 - methods for data collection
 - testing and validation
 - establishing acceptance/building consensus

- II. Roles for performance measures in fostering/ improving quality of care
 - A. Performance information needs vary by intended purpose and audience
 - informing purchasing decisions of groups and individuals

- supporting continuous quality improvement efforts of providers and health plans
 - serving in quality monitoring or assessment efforts of regulators, accreditors
 - informing planning or policy decisions
 - B. Relationship of measures to other quality improvement and oversight tools
 - C. Limitations of performance measurement
 - potential unintended effects (e.g., increasing incentives for adverse selection, incenting tradeoffs in quality by focusing attention on specific clinical areas)
 - specific measures do not provide broad or generalizable information on quality
 - ambiguity of costs and benefits/evidence for each
- III. Disseminating and facilitating use of information on quality and performance
- A. Requirements for improving source data
 - standardize data sets to enhance comparability
 - increase flexibility and sophistication of data systems
 - B. Data collection and analysis needs
 - risk adjusters that are agreed-upon and sufficient to control for differences in underlying characteristics of populations
 - external auditing mechanisms
 - credible data collectors
 - standardization of measures
 - accurate analysis and interpretation
 - training and education of data collectors and analysts
 - C. Data reporting and communication/dissemination needs
 - approaches for targeting multiple audiences
 - methods of informing users about relevant limitations of performance measurement
 - D. Creating an environment that facilitates use of performance measures
 - coordinating or consolidating performance measurement efforts
 - developing benchmarks or standards for quality and performance
 - supporting the consideration of quality in health care decisionmaking
 - fairly compensating those whose high quality attracts higher-cost patients

June 4, 1997

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

Subcommittee on Performance Measurement Proposed Work Plan/Time Line

Working papers

For each subcommittee meeting, Commission staff will prepare one or more working papers designed to:

- provide background information and analyses;
- stimulate and guide the subcommittee's discussion; and
- reflect the subcommittee's findings and views.

The working papers are intended to develop iteratively and, ultimately, to be incorporated into the Commission's final report. Initial papers in a given area will be primarily descriptive. Later versions will be revised based on the subcommittee's discussion, and may include additional background or analyses. They will also present draft recommendations or options for recommendations, together with the rationale underlying them. The revised working papers will be consolidated to form a findings report to be submitted to the full Commission following subcommittee review and approval.

To address the scope of the subcommittee's work, staff envision that working papers in at least four areas will be developed. These areas are:

Purposes of and audiences for performance measures. This paper will explore ways in which performance measures can serve the varied information needs of consumers, purchasers, providers, regulators, and others. It will address issues related to the applicability of measures to quality improvement and oversight efforts, potential future uses for performance measures, and the relationship of performance measurement to other quality oversight approaches or tools. It will also discuss the limitations of performance measures and review the evidence on the value of specific uses of performance measures.

Development of information on quality and performance. This paper will describe the state of the art and the current direction of performance measurement activities. It will review the types of measures that have been developed and will highlight priority areas in which measures are lacking and needed. It will examine processes used in the development of measures and resource requirements for doing so. It will describe data sources for performance measurement, methods for data collection, issues in analysis of the data, the need for auditing of data and analyses, and associated costs.

Facilitating use of information on performance. This paper will focus on the processes and structures needed to disseminate the results of performance measurement and to facilitate appropriate use of performance measures. It will describe various activities that need to be undertaken, from delineating the limitations of performance measures to providing the information needed to interpret measurement results. The paper will also discuss the value of coordinating or consolidating diverse performance measurement efforts, the issues of quality and performance standards, the need to support quality-based decisionmaking, and the need to fairly compensate those whose high quality attracts the worst financial risks.

Mechanisms to improve performance measurement data. This paper will examine ways to increase the validity, accuracy, and reliability of the data used for performance measurement. It will describe the need for standardization of source data sets to enhance the comparability of measurement results and the need for more sophisticated and flexible information systems. It will address the need for adequate adjusters to control for differences in populations that can affect performance, and will review the evidence on the value of external auditing mechanisms to verify data reported by health plans and providers.

Additional papers may need to be developed on issues that arise during the course of work. In addition, it is expected that each will highlight specific areas in which further research is needed to advance the state of the art in developing and using performance measures. A research agenda will be compiled based on the findings of these working papers and the subcommittee's input.

Products

The subcommittee will produce three products for the Commission's consideration:

- 1) Recommendations regarding the use of performance measures in quality improvement and oversight strategies;
- 2) A research agenda for work in the area of quality and performance measurement;
- 3) A findings report that summarizes the background information and analyses provided in working papers, reflects the Commission's findings, and supports the recommendations and research agenda.

Time line

June	Discussion of proposed scope of work, work plan, and products of the work Panel presentation on use of performance measures by consumers, purchasers, and health plans Discussion of initial working paper on performance measures uses and users Identification of priority issues for July meeting/working paper
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- July
- Panel presentation on current state of the art in performance measurement
 - Discussion of initial working paper on performance measures development issues
 - Discussion of latest iterations of working paper on use of performance measures
 - Identification of priority issues for September meeting/working paper
- September
- Discussion of initial working paper on processes for promulgating and facilitating appropriate use of performance measurement information
 - Discussion of latest iterations of working papers on topics introduced previously
 - Identification of priority issues for October meeting/working paper/draft research agenda
- October
- Discussion of initial working paper on mechanisms to improve the data used for performance measurement
 - Discussion of draft research agenda for work in the area of quality and performance measurement
 - Discussion of latest iterations of working papers on topics introduced previously, focusing on draft recommendations
 - Identification of priority issues for November meeting/draft report on findings
- November
- Discussion of draft report on the findings of the subcommittee
 - Final review, revision, and approval of research agenda and recommendations

DRAFT

June 9, 1997

**Advisory Commission on Consumer Protection and Quality
in the Health Care Industry****Subcommittee on Creating a Quality Improvement Environment***Proposed Scope of Work*

As health care is increasingly delivered in complex organizations, clinical decisions are no longer the sole purview of doctors and nurses. Often, care is influenced by the organization in which it is delivered. As a result, external demands by purchasers and regulators for accountability from health plans, facilities, and practitioners have intensified. While the call for accountability is intended to improve organizational behavior, these external demands may not always promote internal quality improvement efforts. Finally, the roles and responsibilities of various practitioners and health care workers, such as nursing aides and home health aides, have expanded, but it is unclear whether they are fully prepared to assume these responsibilities and are adequately supervised in their work.

Given the challenges described above, all participants in the health care system need to be receptive, enabled, and committed for quality improvement to take root in the health care system. This priority area will address the conditions necessary for this quality improvement environment to develop, including, but not limited to:

- I. An external environment conducive to internal quality improvement, including:
 - A. Dissemination of information on medical effectiveness
 - methods for effective dissemination of medical knowledge
 - comparative performance data for benchmarking quality improvement efforts
 - B. Identifying systemic opportunities for improving quality
 - areas of quality concern
 - systems for monitoring quality
 - C. Recognizing and limiting external constraints on internal quality improvement efforts, such as:
 - group purchaser's primary focus on price, with quality often assuming a secondary role in selecting health plans; and
 - the need for plan payments that adequately adjust for risk and provide financial incentives for quality care

- II. Internal commitment to continuous quality improvement by organizations responsible for the delivery of health care (such as health plans and hospitals), including:
- A. Organizational responsibilities and ethics, such as:
 - 1. Respecting and honoring consumer rights
 - 2. Facilitating open communication between providers and consumers
 - 3. Engaging in standardized data collection and reporting activities

 - B. Capital resources that provide a technical infrastructure for continuous quality improvement, as evidenced by:
 - 1. Information systems in support of patient care, including:
 - effective document support (e.g. medical records);
 - coordinated access to medical information for care delivered at other sites;
 - charting; electronic data; flow aids;
 - 2. Decision support systems, including practice guidelines;
 - 3. Profiling and feedback to improve individual practitioner and worker performance.

 - C. Health care professionals and other workers dedicated to providing quality care
 - 1. Education and training of health workforce
 - 2. Roles and responsibilities of professionals
 - aspects of organizational culture that support appropriate degrees of professional autonomy
 - professional responsibilities in support of health care organization with which they are affiliated
 - 3. Changing roles of practitioners and other health care workers, including the increased use of unlicensed health care workers
 - 4. Involvement of health care professionals and workers in continuous quality improvement efforts

 - D. Models for effective delivery of care
 - 1. Interdisciplinary approaches to care that maximize the contributions of various practitioners
 - 2. Continuity of patient care across different practitioners and settings

 - E. What can be achieved through internal CQI efforts? In what areas can quality improvement take place through internal efforts, and what are the implications for group purchasers and regulators?

Work Plan

Analyses Needed

To assist the subcommittee in developing recommendations for creating a quality improvement environment, Commission staff proposes to develop the following background papers:

- **Overview of Policy Issues:** This document will outline key policy issues to be considered by the subcommittee that support creating a quality improvement environment.
- **Technical Infrastructure Needs for Continuous Quality Improvement:** Various tools and systems are needed to support internal quality improvement efforts. Topics to be discussed in this paper include the use of information systems, decision support systems, and practitioner profiling and feedback in a continuous quality improvement program.
- **Professional Roles and Responsibilities and Workforce Issues.** This paper will discuss the importance health care practitioners place on professional autonomy; health care workers' involvement in continuous quality improvement; the education and training of a skilled health care workforce; and the changing roles of many health care practitioners.
- **Organizational ethics:** To assist the Commission in identifying ethical standards or guidelines for health care organizations, this paper will examine important characteristics of organizational behavior that influence care and summarize existing statements of organizational ethics.

The background papers prepared for the Commission meetings are intended to develop iteratively into sections of a final report and provide backing for the subcommittee's recommendations.

Timeline

June:

Work Plan

Discuss proposed scope of work and work plan

Reach agreement on revisions to scope of work and work plan

Policy Issues

Identify key policy issues to be considered by the subcommittee

Products for Commission

Status report on work plan, key policy issues regarding creating a quality improvement environment

July:

External Factors Conducive to CQI

Identify potential recommendations

Internal Commitment to CQI

Panel discussion on trendsetting health organizations' use of CQI

Review background paper on "Technical Infrastructure Needs for Continuous Quality Improvement"

Products for Commission:

Preliminary recommendations regarding external factors conducive to internal CQI efforts

Status report on technical infrastructure needs for CQI

September:

External Factors Conducive to CQI

Reach agreement on proposed recommendations

Submit recommendations and issue paper to Commission.

Internal Commitment to CQI

Panel discussion on professional roles and responsibilities

Review revised background paper from September meeting

Review background paper on "Professional Roles and Responsibilities and Workforce Issues"

Identify potential recommendations

Products for Commission

Recommendations and issue paper on external factors conducive to internal CQI efforts

Preliminary recommendations on internal commitment to CQI

Status report on professional roles and responsibilities

October:

Internal Commitment to CQI

Review revised background paper from October meeting
Reach agreement on recommendations

Organizational Ethics

Panel discussion on organizational ethics
Identify potential recommendations regarding organizational ethics

Products for Commission

Recommendations and background paper on technical infrastructure needs for CQI
Preliminary recommendations on professional roles and responsibilities
Status report on organizational ethics

November:

Organizational Ethics

Reach agreement on proposed recommendations regarding organizational ethics
Submit recommendations and backing paper to Commission.

Overall

Reach agreement on any open issues regarding recommendations
Discuss proposed outline for final report sections on "Creating a Quality Improvement Environment"

Product for Commission

Statement of organizational ethics and supporting working paper

DRAFT

Draft --June 6, 1997

**Subcommittee on Consumer Rights, Protections, and Responsibilities
Proposed Scope of Work -- Preliminary Draft**

Charge to the Subcommittee

The Subcommittee on Consumer Rights, Protections, and Responsibilities is charged with (1) promulgating a Consumer Bill of Rights and Responsibilities; and (2) identifying services necessary to protect consumer rights and support consumers in carrying out their responsibilities.

Products to be Delivered

The Subcommittee is responsible for producing two distinct products:

- (1) By the end of the September meeting, a Draft Consumer Bill of Rights and Responsibilities for consideration by the Full Commission.
- (2) By the end of the November meeting, the Subcommittee's recommendations on services necessary to assure consumer rights and responsibilities.

Analyses Needed

To assist the Subcommittee and Commission in developing its recommendations, Commission staff will develop the following background documents:

1. **Consumer Bill of Rights & Responsibilities.**
 - (a) Staff will prepare a master document outlining potential areas for inclusion in the Consumer Bill of Rights & Responsibilities. This document will include various approaches that can be taken. It will be continually revised throughout the process of consideration of the Bill of Rights until it is in final form for the President.

In addition, separate background papers will be prepared on:

- (b) Grievances and Appeals
- (c) Access to Emergency Services
- (d) Consumer Information on Plans, Providers, Treatment
- (e) Consumer Privacy, Confidentiality, and Non-discrimination
- (f) Coverage Decisions
- (g) Consumer Responsibility
- (h) Choice of plans
- (i) Choice of providers

2. **Services Necessary to Assure Consumer Rights and Responsibilities.** Description and analysis of approaches used to assure consumer rights and responsibilities including but not limited to:
- (a) Ombudsmen, Consumer Utility Boards and Other public/private entities
 - (b) Educational Programs and Materials

Tasks and Timelines

JUNE: **Subcommittee:** Begins consideration of Consumer Bill of Rights and Responsibilities. Hears testimony on:

- Choice of health plans

- Access to emergency services

Commission: To discuss and agree on broad categories to be covered by the Bill of Rights and the issue of access to emergency services.

JULY: **Subcommittee:** Continues consideration of Consumer Bill of Rights and Responsibilities. Hears testimony on:

- Consumer Information
- Confidentiality/Privacy, Non-Discrimination

Agree on recommendations related to confidentiality, privacy, and nondiscrimination; and consumer information on plans, providers, and treatments.

Commission: Begins consideration of Subcommittee recommendations on access to treatment; confidentiality, privacy, and nondiscrimination; and consumer information on plans, providers, and treatment options.

AUGUST: **Subcommittee:** Special meeting of Subcommittee to hear testimony on:

- Grievances and appeals
- Consumer responsibility

Commission: No meeting

SEPT.: **Subcommittee:** Gives final approval to Consumer Bill of Rights and Responsibilities, including choice of plans, choice of providers. Hears testimony on:

- Coverage Decisions

Commission: Discuss recommendations on choice of plan/provider; approve recommendation on appeals/grievances and consumer responsibility.

OCT.: **Subcommittee:** Considers recommendations on ombudsmen, consumer utility boards.

Hears testimony on:

-- Availability of consumer education materials

Commission: Considers remaining issues in Consumer Bill of Rights and Responsibilities.

NOV.: **Subcommittee:** Final Meeting. Completes action on issues related to services necessary to protect consumer rights and support consumers in carrying out their responsibilities.

Commission: Approves recommendations on ombudsmen/consumer utility boards

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

WASHINGTON, D.C. 20201

FIELD(salutation) FIELD(name)
FIELD(address)
FIELD(city) FIELD(state) FIELD(zipcode)

Dear FIELD(last name)

The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry will hold its second meeting in Washington, D.C., on Thursday, June 26, 1997, at the Washington Court Hotel. The Commission was created by President Clinton to advise him 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."

The Commission, which includes 32 members, is anxious to hear about the various proposals now being considered in Congress on these important matters. As Co-Chairs, we would like to invite you to appear before the Commission to discuss your ideas in these areas.

The Commission meets in open public session and all meetings are open to the media. Our first meeting in May was attended by approximately 225 individuals and received very broad coverage in the national media. We expect this meeting to receive similar interest.

We have set aside the hours of 9 a.m. to 11 a.m. on June 26 for this important discussion. If you are interested in joining us for that discussion, please have your office contact the Commission's Executive Director, Janet Corrigan, at (202) 205-3013.

Thank you.

Sincerely,

Alexis M. Herman
Secretary
U.S. Department of Labor

Donna E. Shalala
Secretary
U.S. Department of Health
and Human Services

Senate (43)

Finance Committee (20)

William V. Roth, Jr.

John H. Chafee

Charles E. Grassley

Orrin G. Hatch

Alfonse M. D'Amato

Frank H. Murkowski

Don Nickles

Phil Gramm

Trent Lott

James M. Jeffords

Connie Mack

Daniel Patrick Moynihan

Max Baucus

John D. Rockefeller IV

John B. Breaux

Kent Conrad

Bob Graham

Carol Moseley-Braun

Richard H. Bryan

Bob Kerrey

Labor and Human Resources (17)

Daniel R. Coats

Judd Gregg

Bill Frist

Mike DeWine

Michael B. Enzi

Tim Hutchinson

Susan Collins

John W. Warner

Mitch McConnell

Edward M. Kennedy

Christopher J. Dodd

Tom Harkin

Barbara A. Mikulski

Jeff Bingaman

Paul Wellstone

Patty Murray

Jack Reed

Others/Senate (6)

Ron Wyden
Jon Kyl
Joseph Lieberman
John B. Breaux
Ron Wyden
Bob Graham

HOUSE (57)

Commerce Health Subcommittee (27)

Michael Bilirakis
Dennis Hastert
Joe L. Barton
Fred Upton
Scott L. Klug
James C. Greenwood
Nathan Deal
Richard M. Burr
Brian P. Blibray
Edward Whitfield
Greg Ganske
Charlie Norwood
Tom Coburn
Rick A. Lazio
Barbara Cubin
Sherrod Brown

Henry A. Waxman
Edolphus Towns
Frank Pallone Jr.
Peter Deutsch
Anna G. Eshoo
Bart Stupak
Gene Green
Ted Strickland
Diana DeGette
Ralph Hall
Elizabeth Furse

Education and the Workforce Employer/Employee Relations (12)

Harris W. Fawell
James M. Talent
Joe Knollenberg
Tom Petri
Marge Roukema

Cass Ballenger
Bill Goodling

Donald Payne
Chaka Fattah
Ruben Hinojosa
Carolyn McCarthy
John F. Tierney

Ways & Means Health Subcommittee (13)

Bill Thomas
Nancy L. Johnson
Jim McCrery
John Ensign
Jon Christensen
Philip M. Crane
Amo Houghton
Sam Johnson

Pete Stark
Benjamin L. Cardin
Jerry Kleczka
John Lewis
Xavier Becerra

Others/House (5)

John D. Dingell
Edward J. Markey
Nita M. Lowey
Rosa DeLauro
Diana DeGette

TOTAL 100

**General Plenary Session
June 26, 1997
Seating Chart**

Marta Prado (tentative)

Ron Pollack

Herbert Pardes

Phillip Nudelman

Paul Montrone

Gerald McEntee

Beverly Malone

Randy MacDonald

Ben Lytle

Risa Lavizzo-Mourey

Sylvia Drew Ivie

Nan Hunter

Sandra Hernandez

Val Halamandaris

Diane Graham

Janet Corrigan

Secretary Donna Shalala

Secretary Alexis Herman

Richard Sorian

Robert Georgine

Christopher Queram

Robert Ray

Kathleen Sebelius

Steven Sharfstein

Peter Thomas

Mary Wakefield

Gail Warden

Alan Weil

Sheldon Weinhaus

Stephen Wiggins

Betty Bednarczyk

Christine Cassel

James Chao

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

WASHINGTON, D.C. 20201

Co-Chairs:

ALEXIS M. HERMAN is U.S. Secretary of the Department of Labor.

DONNA E. SHALALA is U.S. Secretary of the Department of Health & Human Services.

Commissioners:

BETTY BEDNARCZYK, of Washington, DC, is International Secretary-Treasurer of Service Employees International Union.

DONALD BERWICK, of Newton, Massachusetts, is President and Chief Executive Officer of the Institute for Healthcare Improvement.

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.

JAMES CHAO, of Naperville, Illinois, is the President of Metro Provider Service Corporation.

ROBERT GEORGINE, of Silver Spring, Maryland, is the President of the Building and Construction Trades Department of the AFL-CIO.

S. DIANE GRAHAM, of Paradise Valley, Arizona, is the Chairman and CEO of STRATCO, Inc., a mechanical and chemical engineering firm.

VAL J. HALAMANDARIS, of the District of Columbia, currently serves as the President of the National Association of Home Care (NAHC).

SANDRA HERNANDEZ, 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.

NAN HUNTER, of New York, New York, is an Associate Professor of Law at Brooklyn Law School.

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.

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.

SHEILA LEATHERMAN, of Minneapolis, Minnesota, is Executive Vice President of the United Health Care Corporation.

L. BEN LYTLE, of Indianapolis, Indiana, is President and CEO of Anthem, Inc.

J. RANDALL MACDONALD, of Connecticut, is the Senior Vice President for Human Resources and Administration at the GTE Corporation.

BEVERLY MALONE, of Greensboro, North Carolina, is the President of the American Nurses Association.

GERALD MCENTEE, of the District of Columbia, is the President of the Association of Federal, State, County and Municipal Employees (AFSCME).

PAUL MONTRONE, of Hampton Falls, New Hampshire, is the President and CEO of Fisher Scientific International, Inc.

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.

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.

RON POLLACK, of Alexandria, Virginia, a long-time advocate for low income Americans., currently serves as the Executive Director of Families USA.

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.

CHRISTOPHER QUERAM, of Madison, Wisconsin, is the Chief Executive Officer of the Employer Health Care Alliance Cooperative (The Alliance).

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.

THOMAS REARDON, of Boring, Oregon, is the Medical Director of the Portland Adventist Medical Group.

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.

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.

PETER THOMAS, of the District of Columbia, is a principal in the law firm of Powers, Pylers, Sutter & Verville, P.C.

MARY WAKEFIELD, of McLean, Virginia, currently serves as the Director and Professor of the Center for Health Policy at George Mason University.

GAIL WARDEN, of Detroit, Michigan, currently serves as President and CEO of the Henry Ford Health Systems.

ALAN WEIL, of Denver, Colorado, currently is co-director of the Assessing the New Federalism Project at the Urban Institute.

SHELDON WEINHAUS of St. Louis, Missouri, is an attorney who has worked extensively representing workers in health care litigation.

STEPHEN F. WIGGINS, of Darien, Connecticut, is the Founder, Chairman and CEO of Oxford Health Plans, Inc.

Commission Executive Staff:

JANET CORRIGAN, Executive Director

RICHARD SORIAN, Deputy Director

ANN PAGE, Associate Director for Policy