

# The New York Times

Monday, October 27, 1997

## Smart Rules for Health Plans

The "bill of rights" for patients that was tentatively approved last week by a Presidential commission would, if adopted by Congress, build in sensible consumer protections without strangling health plans with innovation-killing rules. There are important holes in the commission's work, but on the whole its draft is promising.

The rise of managed care has brought innovative coverage and a surprisingly swift deceleration of health care inflation. But managed care imposes obstacles to choosing doctors and treatments and can reward plans that skimp on care. The insecurity surrounding managed care has triggered calls for Government action, and Congress is inundated with ill-conceived bills that would dictate how health plans treat patients. President Clinton deftly cut off the rush to legislate by appointing the commission, which will reconvene in November to adopt a final report.

The draft requires disclosure of key information — such as the number of times surgeons have performed specific operations and their outcomes — so that consumers can judge which plans are best. The draft also guarantees consumers the right to appeal to an external authority their plan's decision to deny care for a treatment that the patient believes was covered by the plan's contract. The commission's focus is exactly right. Patients

can feel secure about their health plan only if they have enough information and a right to appeal denials of promised benefits.

The commission's report is also interesting for what it does not say. On the positive side, it does not delve into specific mandates, like restrictions on the right to hire and fire doctors, that would raise costs and crimp flexibility. Anything that raises medical costs leads employers — which cover most non-elderly Americans — to drop health coverage entirely. On the negative side, the plan does not say how to implement any of its recommendations.

The plan also sidesteps the crucial component of a consumer-friendly health care system: choice. The best way to achieve choice is to require that employers give employees a choice of health plans. Only when consumers can drop one plan for another will their needs drive what health plans do, rather than the other way around. The commission need not fear that employers will drop coverage when faced with a mandate to offer choices. In fact, the evidence is clear that employers save money on premiums when they set up competition among employee health plans.

Of course the biggest hole in the commission's plan is not of its doing. Nothing in a bill of rights can cover 40 million uninsured Americans.

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DATE: OCTOBER 29, 1997

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YOUR SEARCH REQUEST IS:  
COMMISSION ON CONSUMER PROTECTION

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LEVEL 1... 8

3RD STORY of Level 1 printed in FULL format.

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The New York Times

October 23, 1997, Thursday, Late Edition - Final

SECTION: Section A; Page 1; Column 6; National Desk

LENGTH: 1099 words

HEADLINE: PANEL OF EXPERTS URGES BROADENING OF PATIENT RIGHTS

BYLINE: By ROBERT PEAR

DATELINE: WASHINGTON, Oct. 22

BODY:

A Presidential advisory commission decided today to recommend a wide range of new rights for patients, including the right to appeal denials of care or coverage by insurance companies and health maintenance organizations.

The 34-member panel, which includes top executives of managed-care companies as well as doctors and consumer advocates, said patients should be able to obtain an "external review" of decisions that deny payment for services.

Many health plans now have their own procedures to deal with grievances and complaints. The commission said all patients should also have the option of appealing to an independent outside authority, as Medicare beneficiaries do.

The panel also said health plans, doctors and hospitals should be required to disclose substantial new information that could help patients assess health care providers.

For example, it said, consumers should, on request, be able to find out how often a doctor has performed a procedure and how often the treatment was successful. Also, it said, patients should be able to find out whether their doctors have been sued for malpractice, how the doctors are paid and whether the doctors get bonuses or other incentives.

Consumer advocates and some members of Congress say such financial rewards may encourage doctors to control costs by withholding care that patients need.

Kathleen Sebelius, the Insurance Commissioner of Kansas and a panel member, said, "These proposals give consumers the tools with which to empower themselves."

Another panel member, Stephen F. Wiggins, the founder and chairman of Oxford Health Plans, said: "Under these proposals, a urologist will have to disclose what percentage of his patients are incontinent or impotent after he does surgery. This type of information could produce a revolution in the health care system. Most patients have no idea if they are the first person or the 50th person to have surgery performed by a particular physician."

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Several members of the panel supported its proposals with reservations, saying that the changes could increase costs for consumers, employers and insurers.

The commission endorsed the proposals as part of a "bill of rights" for consumers and come as Congress is considering bills to regulate health plans and insurance companies.

President Clinton is expected to endorse the recommendations, adding momentum to Congressional efforts. But the commission did not say how the new rights should be enforced. It listed alternatives, including voluntary actions by health plans and new Federal and state laws and regulations. Where possible, it said, the recommendations should be carried out within three years.

The panel, called the Advisory Commission on Consumer Protection and Quality in the Health Care Industry, plans to submit its recommendations on a bill of rights to the President late next month, after a meeting here Nov. 18-19. It plans to work through March 1998.

The commission, headed by Donna E. Shalala, the Secretary of Health and Human Services, and Labor Secretary Alexis M. Herman, has been working under rules that require virtual unanimity for major recommendations. It has been unable to reach agreement on several thorny issues, like patients' eligibility for trials of new treatments, lifetime limits on health coverage, and the appointment of ombudsmen to help consumers navigate the health care system.

The panel is still debating whether to recommend a ban on various types of discrimination in the marketing of insurance. Some panel members said they believed that some health plans shunned residents of low-income black and Hispanic neighborhoods or discouraged enrollment of people with disabilities.

One member, Ronald F. Pollack, the executive director of Families USA, a consumer group, said the bill of rights would be incomplete without a ban on such discrimination.

"It would be like adopting the Bill of Rights in the Constitution, but excluding freedom of speech and freedom of religion," Mr. Pollack said.

The panel's draft report does say that "all consumers are created equal." Its recommendations would apply to people in Medicare, Medicaid and other Government programs, and also to people with private health insurance. In particular, the proposals would apply to large employer-sponsored health plans that are not regulated by the states.

The commission also approved chapters of a draft report making these points:

\*Consumers have a right to a choice of doctors within a health plan. Consumers should be allowed to go outside the health plan, at no extra cost, if they need medical expertise not available in the plan.

\*"Consumers with complex or serious medical conditions who require frequent specialty care should have direct access to a qualified specialist of their choice within a plan's network of providers." H.M.O.'s have often required patients to get permission or referrals from family doctors before they visit specialists.

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\*Health plans should be required to pay for emergency care in any situation that "a prudent layperson" would regard as an emergency. H.M.O.'s sometimes refuse to pay if, for example, chest pains are found to be a result of indigestion rather than a heart attack.

\*Patients being treated for chronic illnesses or disabling conditions should be able to continue seeing their medical specialists for at least two months if, for some reason, the patients are forced to switch to another health plan. The purpose of this recommendation is to make sure that the treatment is not disrupted.

\*Doctors should tell patients about "any factors" that could influence the doctors' advice to patients. Such factors might include the doctors' investments in hospitals, clinics, home health care agencies and diagnostic imaging centers.

L. Ben Lytle, president of Anthem Inc., a managed-care company based in Indianapolis, repeatedly told panel members that the proposals could increase the cost of health insurance and that some businesses would curtail coverage and more people would be left uninsured.

Businesses were already facing the prospect of higher costs, with benefits experts predicting that premiums would rise at least 5 percent next year for other reasons. And several big managed-care companies have reported sagging profits.

In its report, the commission said it had tried to "balance the need for stronger consumer rights with the need to keep coverage affordable."

But it said, "We recognize that, in some circumstances, these rights may create additional costs for employers," insurers and consumers.

LANGUAGE: ENGLISH

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Copyright 1997 P.G. Publishing Co.  
Pittsburgh Post-Gazette

October 23, 1997, Thursday, SOONER EDITION

SECTION: NATIONAL, Pg. A-1

LENGTH: 733 words

HEADLINE: 'BILL OF RIGHTS' FOR PATIENTS;  
PRESIDENTIAL PANEL'S PROPOSALS STRIVE TO EMPOWER CONSUMERS

BYLINE: ROBERT PEAR, THE NEW YORK TIMES

DATELINE: WASHINGTON

BODY:

A presidential advisory commission decided yesterday to recommend a wide range of new rights for patients, including the right to appeal denials of care or coverage by insurance companies and health maintenance organizations.

The 34-member panel, which includes top executives of managed-care companies as well as doctors and consumer advocates, said that patients should be able to obtain an "external review" of decisions that deny payment for services.

Many health plans now have their own procedures to deal with grievances and complaints. The commission said that all patients should also have the option of appealing to an independent outside authority, as Medicare beneficiaries do.

The panel also said that health plans, doctors and hospitals should be required to disclose substantial amounts of new information and data that could help patients assess the quality and experience of health care providers.

For example, it said, consumers should, on request, be able to find out how often a doctor has performed a particular procedure and how often the treatment was successful. In addition, it said, patients should be able to find out if their doctors have been sued for malpractice, how the doctors are paid and whether the doctors receive bonuses or other financial incentives.

Consumer advocates and some members of Congress say that such financial rewards may encourage doctors to control costs by withholding care that patients need.

Kathleen Sebelius, the insurance commissioner of Kansas, a member of the commission, said, "These proposals give consumers the tools with which to empower themselves."

Another panel member, Stephen Wiggins, founder and chairman of Oxford Health Plans, said: "Under these proposals, a urologist will have to disclose what percentage of his patients are incontinent or impotent after he does surgery. This type of information can produce a revolution in the health care system. Most patients have no idea if they are the first person or the 50th person to

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have surgery performed by a particular physician."

These and other proposals were endorsed by the commission as part of a "bill of rights" for health care consumers. They come as Congress is considering numerous bills to regulate health plans and health insurance companies.

President Clinton is expected to endorse the panel's recommendations, adding momentum to the efforts on Capitol Hill. But the commission does not say how the new rights should be enforced. It lists several alternatives, including voluntary actions by health plans and new federal and state laws and regulations. Wherever possible, it said, the recommendations should be carried out within three years.

Several members of the panel supported its proposals with reservations, saying that the changes could increase costs for consumers, employers and insurers. In recent weeks, several big managed-care companies have reported sagging profits, and experts on employee benefits have predicted that premiums will rise substantially next year.

The panel, the Advisory Commission on Consumer Protection and Quality in the Health Care Industry, will submit its recommendations on a bill of rights to the president late next month, after a meeting here on Nov. 18 and 19. It will continue work through March 1998.

The commission, headed by Donna Shalala, the secretary of health and human services, and Labor Secretary Alexis Herman, is working under rules that require virtual unanimity for major recommendations. It has been unable to reach agreement on several thorny issues, like patients' access to clinical trials of new treatments, lifetime limits on health insurance coverage and the appointment of ombudsmen to help consumers navigate the health care system.

The panel is still debating whether to recommend a ban on various types of discrimination in the marketing of health insurance. Some panel members said they believed that some health plans shunned low-income black and Hispanic neighborhoods or discouraged enrollment of people with disabilities.

One commission member, Ronald Pollack, executive director of Families USA, a consumer group, said the bill of rights would be incomplete without a ban on such discriminatory practices. "It would be like adopting the Bill of Rights in the Constitution, but excluding freedom of speech and freedom of religion," he said.

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October 23, 1997, Thursday

SECTION: Washington Dateline

DISTRIBUTION: TO NATIONAL AND HEALTH/MEDICAL EDITORS

LENGTH: 130 words

HEADLINE: AAHP Statement on Yesterday's Meeting of the Advisory Commission on Consumer Protection & Quality

DATELINE: WASHINGTON, Oct. 23

BODY:

The following is a statement from the AAHP regarding the Advisory Commission on Consumer Protection & Quality meeting held yesterday:

"America's health plans have long demonstrated leadership by making high-quality health care more affordable for working families -- particularly the estimated 5 million Americans who would be without coverage in the absence of managed care. As the Commission's work moves forward, AAHP will continue, as it has over the last several months, to advance a productive health care agenda which improves quality, further boosts access to care without increasing costs, and ultimately results in working Americans receiving high-quality, affordable health care."

SOURCE American Association of Health Plans

CONTACT: Don White, 202-778-3274 or John Murray, 202-778-8496, both of the American Association of Health Plans

LANGUAGE: ENGLISH

LOAD-DATE: October 24, 1997

6TH STORY of Level 1 printed in FULL format.

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The Washington Post

October 23, 1997, Thursday, Final Edition

SECTION: A SECTION; Pg. A01

LENGTH: 963 words

HEADLINE: Panel Outlines Protections For Health Care Consumers; Commission Would Guarantee Patient Choices

BYLINE: Amy Goldstein, Washington Post Staff Writer

BODY:

A presidential commission yesterday outlined a broad set of protections for consumers frustrated by a changing health care system, proposing that patients be guaranteed a choice of medical plans, more information to make smart decisions and new ways to protest when they become dissatisfied with their care.

Under the proposal, intended to protect all Americans with insurance, health plans would be forbidden from imposing "gag rules" that restrict the kind of treatment options physicians can mention to their patients. The confidentiality of medical records would be guarded more closely. And patients who are pregnant or chronically ill would be able to keep their own doctor for a guaranteed period of time, even if forced to switch health plans.

The proposed "bill of rights" is the first concrete plan to emerge from a diverse panel -- including representatives of insurance companies, consumers, physicians and employers -- that for months has been debating what safeguards Americans need to ensure good medical care. As a result of a quiet, ongoing revolution in health care, most patients now are covered through health maintenance organizations and other forms of "managed care," which try to constrain costs by limiting how much and what kind of care people may receive.

Even as its members found broad areas of consensus yesterday, the commission remained splintered over several important questions -- whether health plans should be able to exclude people who are sick, for example, and whether the government should create a nationwide "ombudsman" system to help patients navigate the often-bewildering ways that their health care has changed. However, only those initiatives that won unanimous approval were included in the proposals agreed to yesterday.

Health and Human Services Secretary Donna E. Shalala, one of two Cabinet members leading the commission, said the group had taken "remarkable steps" to expand patients' rights. But some commissioners disagreed. "It falls short of what the president asked us for. It excludes too much," said Ron Pollack, executive director of Families USA, a consumer-advocacy group.

The panel plans to adopt its "bill of rights" in final form next month and to submit it to President Clinton, who will have to decide whether it should become the basis for legislation, regulation or exhortations for the insurance industry

to police itself. The administration has given no indication which path it prefers.

The Advisory Commission on Consumer Protection and Quality in the Health Care System is an attempt to look comprehensively at how to help protect patients in dealing with health insurers. Its work coincides with a flurry of largely piecemeal attempts to rein in managed care that have emerged in Congress, state legislatures, and various factions of the insurance industry.

The panel also is the latest in a series of administration strategies, since the demise of its massive health reform plan three years ago, to tackle the issue in more finite ways. Last year, it backed the Kennedy-Kassebaum law that was designed to make it easier for people to get insurance after they become sick or change jobs. As part of the balanced-budget agreement, the White House gave its support to a \$ 24 billion program to expand health insurance for children.

"We aren't redoing the Clinton health plan," Shalala said yesterday, noting that the panel is not addressing the kinds of benefits insurance companies should provide or how to help the 41 million Americans who have no insurance.

Even in its more targeted debate on the rights of insured patients, the diverse, 37-member commission has become a miniature version of the deep cleavages in opinion over what changes are needed in health care, and what role government should play.

On issue after issue, representatives of consumers and health professionals argued for greater patient protections, while employers and insurance executives opposed them for fear they would cost too much.

As a result, the draft excludes a proposal to guarantee patients the right to take part in medical research to test the effectiveness of new treatments. The panel deferred until next month its decisions over ombudsmen and whether to prohibit health plans from discriminating against certain high-cost or low-income patients in their marketing and enrollment practices.

At the end of the two-day debate that ended yesterday, several commission members said they remained uncertain whether the final version will go far enough in protecting patients for them to support it. Some have talked of turning in a minority report.

Nevertheless, the panel agreed on several important protections that would exceed those currently available to most patients.

It recommended new restrictions to ensure the confidentiality of medical records, largely echoing a proposal that Shalala made to Congress last month -- with one significant difference. Shalala urged that law enforcement investigators be granted broad access to patient records, without their knowledge and with their names' attached. The commission recommended such access only for investigations of health care fraud.

The commission also proposed a major expansion of the information that doctors and health plans must give patients. If patients need surgery, for example, their doctors would have to disclose how many times they had performed that type of operation.

The Washington Post, October 23, 1997

For the first time, employers also would have to offer their workers a choice of health plans. And if consumers believed that their health plan had failed to provide or pay for the treatment they deserved, they would be able to appeal to an impartial, outside review panel -- a protection available now only in seven states.

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October 22, 1997 Wednesday, EVENING UPDATE EDITION

SECTION: NEWS; Pg. 7; ZONE: C; EVENING. Health.

LENGTH: 170 words

HEADLINE: BILL OF RIGHTS;  
PROPOSAL LISTS PROTECTIONS, RESPONSIBILITIES OF CONSUMERS

BYLINE: News items on this page are compiled from Reuters, Associated Press and Universal Press Syndicate.

BODY:

Excerpts from a draft consumer bill of rights to be considered this week by the Advisory Commission on Consumer Protection and Quality in the Health Care Industry:

- Information: Consumers have the right to receive accurate, easily understood information about their health plans, facilities and professionals.
- Choice: Consumers have a right to a choice of health-care providers that is sufficient to assure access to appropriate high-quality health care.
- Participation in decisions: Consumers have a right to fully participate in all decisions related to their medical care. Those unable have a right to be represented by family or others.
- Complaints and appeals: Consumers have a right to a fair and efficient process for resolving differences . . . including a rigorous system of internal review and an independent system of external review.
- Responsibilities: Consumers have responsibilities, including leading a healthy lifestyle, taking medicine and not knowingly spreading disease.

LANGUAGE: ENGLISH

LOAD-DATE: October 28, 1997

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October 20, 1997; Monday 16:36 Eastern Time

SECTION: Domestic, non-Washington, general news item

LENGTH: 330 words

HEADLINE: Excerpts from Health Bill of Rights

BYLINE: The Associated Press

BODY:

Excerpts from a draft consumer bill of rights, to be considered this week by the Advisory Commission on Consumer Protection and Quality in the Health Care Industry:

Information: Consumers have the right to receive accurate, easily understood information about their health plans, facilities and professionals.

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

Emergency services: Health plans should provide payment when a consumer goes to an emergency department with acute symptoms of sufficient severity such that a "prudent layperson" could reasonably expect the absence of medical attention to result in placing their health in serious jeopardy.

Participation in decisions: Consumers have a right to fully participate in all decisions related to their medical care. Those unable have a right to be represented by family or others.

Respect and nondiscrimination: Consumers have a right to considerate, respectful care. ... Consumers must not be discriminated against in the provision of health care services based on race, ethnicity, national origin, religion, sex, age, current or anticipated mental or physical disability, sexual orientation, genetic information or source of payment.

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

Complaints and appeals: Consumers have a right to a fair and efficient process for resolving differences ... including a rigorous system of internal review and an independent system of external review.

Responsibilities: Consumers also have responsibilities, including leading a healthy lifestyle, taking medicine and not knowingly spreading disease.

AP Online, October 20, 1997

LANGUAGE: ENGLISH

LOAD-DATE: October 20, 1997

DATE: OCTOBER 29, 1997

CLIENT: KMIGDAIL  
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October 22, 1997 Wednesday, EVENING UPDATE EDITION

SECTION: NEWS; Pg. 7; ZONE: C; EVENING. Health.

LENGTH: 170 words

HEADLINE: BILL OF RIGHTS;  
PROPOSAL LISTS PROTECTIONS, RESPONSIBILITIES OF CONSUMERS

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LANGUAGE: ENGLISH

LOAD-DATE: October 28, 1997

DATE: OCTOBER 29, 1997

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LEVEL 1... 202

1ST STORY of Level 1 printed in FULL format.

Copyright 1997 McClatchy Newspapers, Inc.  
Sacramento Bee

October 28, 1997, METRO FINAL

SECTION: EDITORIALS; Pg. B6

LENGTH: 590 words

HEADLINE: MAKING QUALITY COUNT

BODY:

A presidential commission to promote quality in health care has approved a draft version of a proposed "patient's bill of rights and responsibilities." It offers little comfort to reformers or lawmakers, in Congress or state capitols, who would micromanage the delivery of medical care. Instead, it holds out a series of useful measures to place quality alongside cost in the balance of health decision-making.

For more than a decade, large purchasers of health care, bedeviled by soaring health care costs, have forced a wrenching reorganization in the medical system. The old fee-for-service system has given way to a world in which health plans and medical groups operating under budgets manage and integrate care to prevent disease and minimize the need for expensive treatment. In many places, this change has raised the quality of care even as it has restrained costs. It has encouraged doctors and hospitals to reduce unnecessary procedures, measure outcomes and develop treatment protocols based on scientific research.

But the transition has sometimes been rough. Some health plans have tailored care to standards of profit, not quality. Doctor-patient relationships have been disrupted. Too many consumers, lacking a choice of health plans, cannot affect their care by voting with their premium dollars for higher quality providers and networks.

The "bill of rights" drafted by the commission, known officially as the Presidential Advisory Commission on Consumer Protection and Quality in the Health Care Industry, offers some sensible ways to ease the transition, protect consumers and advance quality. Driving all of them is the principle that a market-based health system cannot produce quality care unless patients and health purchasers have information and the ability to act on it:

- \* Require health plans, hospitals and doctors to provide more data about their experience with particular diseases and procedures and their success in dealing with them.

- \* Fully disclose to patients any financial incentives doctors may have to withhold care or deliver too much.

- \* Let patients with complex conditions have access to specialists without each time having to get the permission of a "gatekeeper."

- \* Assure that patients have a choice of doctors within health plans and

Sacramento Bee, October 28, 1997

encourage employers to offer workers a greater choice among plans.

How much of that menu of reform the nation can afford is still an open question. After several years of stable or declining costs for health insurance, experts predict costs for health coverage will rise about 5 percent next year, twice as fast as inflation or wages; the increase will be even greater for smaller businesses and their workers. None of the economic pressures that, over the last two decades, pushed up the number of workers without health insurance has disappeared.

The commission, whose 37 members represent all the constituencies affected by the health system, deserves credit for explicitly recognizing that quality concerns can't be approached in isolation from issues of cost and access to care. Unlike too many lawmakers and special-interest groups clamoring for piecemeal reforms, it has tried to look at the bigger picture and find the right balance in a policy area where tradeoffs are unavoidable. If the final version of its bill of rights can bring some of that moral and policy seriousness to the health policy deliberations in Congress and state legislatures, the commission will have provided an important service to the country.

GRAPHIC: Johnson + L.A. Times Syndicate

LANGUAGE: ENGLISH

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2ND STORY of Level 1 printed in FULL format.

Copyright (c) 1997 Roll Call, Inc.  
Roll Call

October 27, 1997

SECTION: Pennsylvania Avenue

LENGTH: 943 words

HEADLINE: It's Time for New National Debate On Health System

BYLINE: By Morton M. Kondracke

BODY:

Those who predicted that the free market, with occasional "incremental" action by the government, would fix America's health care system are being proven wrong. So, it's time to think comprehensive again.

The evidence of market inadequacy comes in daily horror stories about people dying because an HMO was saving money on their care, and from a new set of studies showing that, despite managed care, national health costs are surging again.

The studies, by the National Coalition on Health Care, also show that it's impossible to get complete information on the quality of health care being delivered in America and that the number of people lacking health insurance is climbing. The coalition, consisting of 100 groups including major corporations, unions, church and service organizations, and health care providers, favors a comprehensive national health insurance system, but has no specific plan to recommend.

Ever since the collapse of President Clinton's national health proposal in 1994, Congress and the Administration have been wary of advancing anything but incremental fixes, such as last year's Kennedy-Kassebaum bill to "guarantee" insurability, "Kidcare" for poor children this year, and various laws mandating that HMOs give adequate care.

Now it develops, however, that the Kennedy-Kassebaum provisions - that people can't be denied insurance because of pre-existing conditions and that insurance be portable - have been undercut because insurance companies have raised premiums beyond the reach of those who might benefit.

Moreover, the Census Bureau reported earlier this month that the number of Americans lacking health insurance had risen by 1.1 million during 1995 to 41.7 million, or 15.6 percent of the population.

The coalition's study, by former Clinton Health and Human Services official Kenneth Thorpe, now at Tulane University, predicts that, in spite of a growing economy and falling unemployment, the number of uninsured will rise to as many as 47 million, or 17 percent of the population, by 2005.

That's because fewer employers are covering their employees, premiums are

Roll Call, October 27, 1997

rising, Medicaid rolls are being trimmed because of welfare reform, and increased numbers of workers are being employed in the service sector or as "contingent employees" without insurance.

Another coalition study showed that, after a lull during the 1993-94 health care debate, health costs and insurance premiums are rising faster than inflation once again, casting doubt on the widespread notion that market forces would inevitably keep prices down.

Thorpe estimated that total national health costs would rise by an inflation-adjusted average of 3.5 percent a year from 1997 through 2002.

That's better than during the late 1980s, when the inflation-adjusted average was 5.9 percent - reaching a maximum of 6.3 percent in 1990 - but it's worse than the 1996 low of 1.5 percent. This year, costs are expected to rise by 3.4 percent.

According to Thorpe, one factor in the renewed increase is the fact that public attention to costs has waned since the end of the 1994 health debate, and both providers and insurance companies have begun raising fees again.

Thorpe says that past health insurance proposals by Presidents Richard Nixon, Jimmy Carter, and Ronald Reagan also slowed cost increases, but they took off again when public attention shifted.

Another factor, he writes, is a fall in operating profits for managed care plans - from 6.4 percent in 1995 to 1.1 percent last year - causing them to raise premiums by as much as 8.5 percent this year.

Thorpe's study showed that even during the overall premium lull, middle-class workers' families earning between \$40,000 and \$50,000 per year had to pay 8.5 percent more each year in insurance premiums - a number that will rise even higher in the future.

Besides costs and increases in the number of uninsured, the coalition reported that the country lacks any system for either measuring or assuring that health care is of high quality.

Reporting requirements on doctors, hospitals, and HMOs are spotty, and what snapshots have been taken indicate that some patients receive too much medicine, others receive too little, and others get inappropriate care.

A presidential commission on consumer protection and health care quality last week recommended a "bill of rights" for patients - including the right to know how hospitals and doctors perform - but set up no machinery for putting it into effect.

The "New Democrat" Progressive Policy Institute has recommended a huge national database, overseen by the government but privately managed, to provide data to consumers and providers.

Sen. Joe Lieberman (D-Conn) inserted a Medicaid database into this year's budget package, and Sen. Jim Jeffords (R-Vt) is drafting legislation for a private-sector accountability system.

Roll Call, October 27, 1997

But on cost-containment and maximum insurability, the government is moving very slowly. "Kidcare" could provide insurance for five million of the nation's 11 million uninsured children. President Clinton has proposed coverage for the unemployed, and Rep. Pete Stark (D-Calif) wants to enable early retirees to "buy into" Medicare.

It's time for politicians and their health care advisers to begin thinking big again and renewing the debate over single-payer systems, medical savings accounts, and middle-ground proposals such as expansion of the Federal Employees Health Benefit System to the public.

President Clinton got elected partly on the health care issue. The 1998 and 2000 elections can provide the forum for a new debate - maybe this time leading to real action.

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The Houston Chronicle

October 26, 1997, Sunday 2 STAR EDITION

SECTION: A; Pg. 18

LENGTH: 1476 words

HEADLINE: Is it better to be ill in East than in Alabama or Texas?

SOURCE: Newhouse News Service

BYLINE: MILES BENSON

BODY:

How good your health care is depends a lot on where you live.

A growing number of experts, bolstered by new studies, warn that the quality of medicine varies greatly from region to region across the United States.

"It's a checkerboard," admits Dr. William Jessee, the American Medical Association's vice president for quality and managed care. "There is a lot of regional variation in quality. That's the safest comment I can make."

Americans may think they all have the best health care system in the world, but "the dirty little secret" is that some parts of the country provide much higher standards of health care than others do, said John Rother, director of legislation and public policy for the American Association of Retired Persons.

That is true for patients of all ages, whether they are served by traditional fee-for-service medicine or health maintenance organizations or other managed-care plans.

Alabama, Arkansas, Kentucky, Louisiana, Mississippi, Oklahoma, Tennessee and Texas recently scored lowest in a massive study of HMOs and managed-care plans by the nonprofit National Committee for Quality Assurance. New England rated highest.

The study examined dozens of quality measures to evaluate the care provided by 329 managed-care plans, covering 37 millions Americans, fully 60 percent of the managed-care industry nationally.

Among other things, the study looked at the way children's ear infections are treated, the proportion of board-certified primary- and specialty-care physicians, breast and cervical cancer screening rates and variations in treatment styles.

For example, although scientific studies have established that treating heart attack patients with drugs called "beta blockers" can prevent further heart attacks and save thousands of lives annually, the health plans in the lowest-ranking states provided those drugs to patients an average of only 55

percent of the time (or as low as 20 percent in some plans) compared with New England, where the average was 70 percent.

The study also examined the rate of hysterectomy, Caesarean section, back and prostate surgery, all of which are sometimes performed unnecessarily.

Complicating the picture is evidence that quality of care tends to vary by condition, as well as geography, said Janet Corrigan, executive director of the President's Commission on Consumer Protection and Quality in the Health-Care Industry.

Meanwhile, researchers at the Dartmouth Medical School, led by Dr. John E. Wennberg, have examined the varying frequency of surgical procedures in different regions, including procedures of questionable value.

"There are striking differences in the likelihood of undergoing particular surgical procedures, such as prostate operations, back surgery and coronary artery bypass grafting, even among neighboring regions with very similar populations," said the Dartmouth report.

These variations, or regional "surgical signatures," as the report terms them, "reflect the practice habits of individual physicians and local medical culture rather than differences in need - or even differences in the local supply of surgeons."

In 1994, the federal Agency for Health-Care Policy and Research said that most back surgery and therapy for back pain was unnecessary.

Yet back surgery remains "a very high variation procedure" with rates 30 percent or more higher in some regions than the national average, the Dartmouth report found.

The effectiveness of surgery for herniated disks "has not been established by randomized trials," said the report, which found back surgery rates high in the Northwest and the Mountain states, parts of Texas, Florida, North and South Carolina, Alabama and California. Rates were lower in the Northeast and parts of the Midwest.

Other "high variation" procedures, the report said, were mastectomy for breast cancer, and prostate surgery or radiation therapy.

Science shows nearly identical rates of cancer cure for mastectomy, the complete removal of the breast, and lumpectomy, followed by radiation therapy, sparing the breast. Yet mastectomy rates are 30 percent above the national average in many areas, mainly in the Midwest, the study found.

"Despite the scientific evidence that the survival rate is the same for breast-sparing surgery and for mastectomy, and in spite of wide consensus that patient preferences should determine which treatment is chosen, the wide variations in surgical rates suggest that physician, rather than patient, preferences are the deciding factor in most cases," the Dartmouth researchers said.

Similarly, surgery rates for prostate cancer surgery are as much as 30

percent higher than the national average in the Northwest, Mountain and Great Plains states, Michigan and parts of Florida and Mississippi, the report found.

"Determining a benefit with radiation or surgery is difficult because most forms of early state prostate cancer are very slow growing; many men, depending on their age, never have symptoms and die from other causes," the report says. "Yet, while the benefits of active treatment are not clearly established, the complication of radiation and surgery are well documented: both carry a substantial risk of incontinence and impotence."

Failure by physicians to consider patient preferences in their decisions about alternative forms of treatment contributed to the variation, the researchers found.

Often in health care, according to Wennberg, "less is better."

"Much of medicine is performed without strong or even weak evidence that it improves the health of the population," Wennberg said.

There is no mystery about the reasons for the wide variations in the quality of medical care.

"You are much more likely to be getting better care in places paying attention and devoting resources to studying effective interventions and keeping up with medical knowledge," said Dr. Mark Chassin, professor of health policy, and chairman of Department of Health Policy at Mount Sinai School of Medicine in New York.

There is also the "practice-makes-perfect" factor. The development of particular medical skills follows a learning curve and maintaining high quality performance levels may require continued practice. Thus, doctors and hospitals that perform a large number of coronary angioplasties each year are likely to do a better job than than doctors and hospitals that perform relatively few.

Then there is the problem of "technology diffusion."

"The voluminous nature of medical and clinical literature, often with conflicting findings, poses problems for decision-makers," said a preliminary staff draft report prepared for the Advisory Commission on Consumer Protection and Quality in the Health-Care Industry.

The AMA's Jessee acknowledges the problem causes "a long gap between the time an advance comes through and the time it is widely accepted:"

"There is a desire of the public to have more precision in medicine than is really there," he said.

In an effort to deal with the problem, the government and the medical community are turning to the Internet. Since May, the Agency for Health-Care Policy and Research, the American Association of Health Plans and AMA have been working jointly to create a National Guideline Clearinghouse, a central repository of clinical guidelines, indexed by condition, to make it easier for physicians to get the most up-to-date treatment information. The system is expected to be operating by the fall of 1998.

At about the same time, the Health Care Financing Administration, prodded by Congress, will be required to produce a public study evaluating and comparing health plans and fee-for-service medicine in every area of the country by quality and performance indicators, including health outcomes.

"It's going to shock you," predicts AARP's Rother. You know what you're going to find out? Your going to find out the big difference is not between managed care plans and fee for service. The big difference is going to be between one part of the country and another. When HCFA puts out these measures of quality all the plans in Boston are going to look good, and all the plans in Mississippi are going to look bad."

But one leading national authority on medical quality, Dr. Robert H. Brook, of the RAND Corporation, believes the more shocking reality is not the variation between regions but the overall shortcoming of medicine across the country.

"There is a terrible mismatching between what we do and what we should be doing, and it's worse in some areas than others," Brook said. But it is characteristic of health care generally that "we do no more than 60 or 70 percent of all the things we think we should do, or that science suggests ought to be done," Brook said. Yet simultaneously, "We manage to do a lot of things that are almost worthless, if not worthless," Brook said.

LANGUAGE: ENGLISH

LOAD-DATE: October 26, 1997

12TH STORY of Level 1 printed in FULL format.

Copyright 1997 Capitol Hill Publishing Corp.  
The Hill

October 22, 1997

SECTION: Pg. 41

LENGTH: 795 words

HEADLINE: THE THREAT OF FEDERAL REGULATION OF THE HEALTH CARE INDUSTRY

BYLINE: Bill Gradison

BODY:

The American health care industry is undergoing dramatic changes as it responds to purchaser resistance to rapid health care inflation. An industry in transition meets with some resistance to change and it is not unusual for those impacted by change to seek to use government to slow down the rate of change.

But federal regulation of the health care industry, involving both the practice of medicine and insurance coverage for health care services, is not the solution to assure consumers appropriate protection and quality health care services.

Proposals put forth by President Clinton and members of Congress have put the health care industry on notice with a legislative agenda that calls for increased federal regulation and oversight. In the name of consumer protection, current proposals would dictate benefits and services, plan design, number and type of physicians in a plan, standardize marketing literature, and regulate specific internal plan operations, such as pricing, underwriting and marketing.

In a speech before the Service Employees International Union (SEIU) in September, the president stressed the need for federal health care legislation and reaffirmed his intent to push his health care agenda through the Congress in the months to come.

Make no mistake: health insurers share a commitment to consumer protection. But federal legislation and oversight are not the answer. Hundreds of state regulations and increasing voluntary accreditation activities (NCQA, JCAHO, and other voluntary organizations) are providing standards and consumer protections for health care and insurance coverage.

Improvements can best come from the marketplace, not through federal regulation and oversight. To quote James K. Glassman from his articulate "Bill Clinton, M.D." Washington Post commentary on Sept. 23, "Clinton's view is that insurance companies, HMOs (health maintenance organizations), drug and medical device makers, doctors and hospitals can't be trusted to provide health care to Americans on their own in a free economic and intellectual market. ... Currently 43 bills seek to micro-manage health care."

As some in the Congress have heeded the call for federal health care legislation, there is also concern that the president's Advisory Commission on

Capitol Hill Publishing Corp., October 22, 1997

Consumer Protection and Quality in the Health Care Industry will soon deliver a health care "bill of rights" to the president. These so-called "rights" are just another attempt to impose federal regulation. And all the while the commission has been deliberating, it has done so in a vacuum with no reality check as to what some of these "rights" might cost to implement. Cost always seems to be someone else's problem. The last time I checked there still was only one basic source for these costs, the purchaser of health care coverage, whether that is an employer, consumer or the federal government itself.

As we seek to find means to provide affordable health care coverage, we need to keep in mind that with each 1 percent increase in health care premium costs, small business sponsorship of health insurance drops by 2.6 percent (Morrissey, et al, "Small Employers and the Health Insurance Market," Health Affairs, 1994) and 200,000 lose coverage (Congressional Budget Office, 1996). The more we add to the cost of health plans through benefit mandates or bureaucratic requirements, the fewer citizens will have health insurance. In simple terms, the more we mandate and the more we regulate, the more we drive health coverage out of the reach of the very citizens we seek to help.

Innovation in plan designs, evolving measurements to assure quality, sound clinical practices and standards to guide physicians in delivering services, just a few components that lead to a better health care system, these cannot be legislated. Those who think that a new government entity standardizing many components of health plans is what consumers need should take a closer look at the variety of health care options and quality improvements in the industry today brought about by voluntary commitments and market forces.

Just a few years ago the public made it crystal clear they did not want a government-run health care system. Repackaging federal regulation of the health care industry by calling it a "bill of rights" doesn't overcome the fact that a quality health care system need not be government run. We owe it to the American people to see that market-based forces in a healthy environment of competition continue to create innovation to assure all citizens the consumer protections and quality in health care industry they deserve.

Bill Gradison, a former Republican House member from Ohio, is president of the Health Insurance Association of America.

LANGUAGE: English

LOAD-DATE: October 23, 1997

13TH STORY of Level 1 printed in FULL format.

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Chicago Tribune

October 22, 1997 Wednesday, EVENING UPDATE EDITION

SECTION: NEWS; Pg. 7; ZONE: C; EVENING. Health.

LENGTH: 170 words

HEADLINE: BILL OF RIGHTS;  
PROPOSAL LISTS PROTECTIONS, RESPONSIBILITIES OF CONSUMERS

BYLINE: News items on this page are compiled from Reuters, Associated Press and Universal Press Syndicate.

BODY:

Excerpts from a draft consumer bill of rights to be considered this week by the Advisory Commission on Consumer Protection and Quality in the Health Care Industry:

- Information: Consumers have the right to receive accurate, easily understood information about their health plans, facilities and professionals.
- Choice: Consumers have a right to a choice of health-care providers that is sufficient to assure access to appropriate high-quality health care.
- Participation in decisions: Consumers have a right to fully participate in all decisions related to their medical care. Those unable have a right to be represented by family or others.
- Complaints and appeals: Consumers have a right to a fair and efficient process for resolving differences . . . including a rigorous system of internal review and an independent system of external review.
- Responsibilities: Consumers have responsibilities, including leading a healthy lifestyle, taking medicine and not knowingly spreading disease.

LANGUAGE: ENGLISH

LOAD-DATE: October 28, 1997

14TH STORY of Level 1 printed in FULL format.

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The Augusta (Ga.) Chronicle

October 21, 1997, Tuesday, ALL EDITIONS

SECTION: NEWS, Pg. A6

LENGTH: 309 words

HEADLINE: PROPOSED RIGHTS

BODY:

Excerpts from a draft of the consumer bill of rights, to be considered this week by the Advisory Commission on Consumer Protection and Quality in the Health Care Industry:

**Information:** Consumers have the right to receive accurate, easily understood information about their health plans, facilities and professionals.

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

**Emergency services:** Health plans should provide payment when a consumer goes to an emergency department with acute symptoms of sufficient severity such that a "prudent layperson" could reasonably expect the absence of medical attention to place their health in serious jeopardy.

**Participation:** Consumers have a right to fully participate in all decisions related to their medical care. Those unable have a right to be represented by family or others.

**Respect and nondiscrimination:** Consumers have a right to considerate, respectful care. . . . Consumers must not be discriminated against in the provision of health care services based on race, ethnicity, national origin, religion, sex, age, current or anticipated mental or physical disability, sexual orientation, genetic information or source of payment.

**Confidentiality:** Consumers have the right to communicate with health care providers in confidence . . . and the right to review and copy their own medical records and request amendments to their records.

**Complaints and appeals:** Consumers have a right to a fair and efficient process for resolving differences . . . including a rigorous system of internal review and an independent system of external review.

**Responsibilities:** Consumers also have responsibilities, including leading a healthy lifestyle, taking medicine and not knowingly spreading disease.

LANGUAGE: ENGLISH

LOAD-DATE: October 23, 1997

DATE: OCTOBER 29, 1997

CLIENT: KMIGDAIL  
LIBRARY: NEWS  
FILE: MAGS

YOUR SEARCH REQUEST IS:  
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NUMBER OF STORIES FOUND WITH YOUR REQUEST THROUGH:  
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Modern Healthcare

October 13, 1997

SECTION: Column; Pg. 44

LENGTH: 1014 words

HEADLINE: WORD FROM WASHINGTON: MEDICARE+CHOICE+PAY UP: FEDS FORCE MANAGED-CARE PLANS TO FOOT BILL FOR MARKETING INFORMATION PROGRAMS

BYLINE: Eric Weissenstein

BODY:

To paraphrase (and clean up) one of my dad's favorite sayings: The only thing worse than being told what to do by the government is being forced to pay for it, too.

That's the way managed-care plans feel about a provision buried in the Balanced Budget Act of 1997 that would require them to fund HCFA's new annual Medicare information programs.

As part of the Medicare+Choice program, HCFA in November 1998 will distribute pamphlets to senior citizens comparing the options available to them under Medicare. Every November thereafter, HCFA will host health fairs to publicize the new program. At the fairs, seniors will be able to get information about the Medicare+Choice program and even enroll in a managed-care plan.

To lure seniors to the fairs, HCFA will show endless reruns of "Matlock" and have an old-fashioned ice cream social.

Note to HCFA: Even though I made up those last two ideas, they would definitely draw seniors. I won't charge you royalties if you want to try it.

And while I digress, what kind of name is Medicare+Choice anyway? According to congressional staff, the name came about because neither the House, which called its Medicare reform plan "Medicare Choice," or the Senate, which came up with "Medicare Plus," was willing to give up its catch phrase. So instead we end up with a name even a first-year advertising student would kill. If the automotive industry worked that way, cars would be called things like "SheetMetal+Engine."

Back to the issue at hand.

To pay for the new pamphlets, health fairs and other goodies, such as a toll-free beneficiary information hotline, the balanced-budget law calls for a "cost-sharing" program under which managed-care plans pay the costs and HCFA shares in the cost savings.

HCFA had asked Congress for \$350 million in fiscal 1998 funding for the program. After Congress balked, the amount was reduced to \$200 million for

fiscal 1998, \$150 million for 1999, and \$100 million for 2000 and thereafter.

To justify its request, HCFA released a breakdown of its estimated first-year expenses. Among the costs were \$30 million for 41 million comparison handbooks (heaven forbid couples should share them) and \$20 million for postage. The list also includes \$55.7 million to set up a toll-free call center and operate it for the first year. HCFA estimates the center will get about 6 million calls annually at \$7.50 per call. Heck, psychic hotlines charge less than that.

While less than 15% of the nation's 40 million Medicare beneficiaries are enrolled in managed-care plans, the plans will foot the bill to educate all of them. That comes out to about \$44 a year per beneficiary enrolled in managed care.

In some counties that will represent a significant portion of managed-care plans' scheduled fiscal 1998 increase in Medicare reimbursements. In Hennepin County, Minn., for example, managed-care plans will receive a per-beneficiary increase of \$8 per month, or \$96 for the year. Almost half that increase would go to pay for Medicare+Choice.

The American Association of Health Plans, which represents managed-care plans, makes no bones about its intentions to pass the charge on to the consumer. It says the \$44-per-beneficiary price tag means seniors who otherwise would have unlimited drug benefits instead will find their benefits capped at \$2,500 a year. It also means the difference between a beneficiary's free office visit and a \$5 copayment.

Managed-care plans say they should only have to pay for a percentage of the program equal to their share of Medicare beneficiary enrollment, now 15%.

But supporters of the program say managed-care plans should pay the entire cost because they are the ones that will benefit from the new Medicare framework.

According to the Congressional Budget Office, enrollment of Medicare beneficiaries in managed-care plans is scheduled to increase to about 25% in fiscal 2002, about the same level predicted before the budget law was enacted.

Still, the program supporters' argument has some merit because the health fairs and other efforts are likely to increase interest in nontraditional Medicare delivery systems. If that is the case, however, then everyone who benefits from the new Medicare system should pay, including provider-sponsored organizations, private fee-for-service plans and medical savings account plans.

It's been a long time since Word from Washington has given readers a thumbs-up and thumbs-down list, so here are a couple of each to make up for lost time:

To the American Medical Association for its gutsy support of David Satcher, M.D., the Clinton administration nominee for U.S. surgeon general. After the debacle surrounding President Clinton's 1995 nomination of Henry Foster Jr., M.D., whom the AMA also backed, it would be easy for the group to take a pass on this one.

To the Federation of American Health Systems for taking the high road by not

Modern Healthcare, October 13, 1997

responding to a recent consumer group demonstration. The Universal Health Care Action Network (UHCAN, get it?) staged a rally in front of the federation's offices at which a "people's grand jury" heard "crimes against healthcare justice." When's the last time you saw a grand jury strumming acoustic guitars?

To the AMA for putting General Counsel Kirk Johnson in charge of the investigation into the Sunbeam Corp. product endorsement deal. Johnson, whose office OK'd the Sunbeam deal, had a hand in a proposed sponsorship deal last year with pharmaceutical giant Hoffman-La Roche that fell through. What's next, putting Jack "Dr. Death" Kevorkian in charge of medical ethics?

To some members of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. When they were appointed earlier this year, the members said they were joining the commission as private citizens, not mouthpieces for particular industries or groups. So how come during last week's meeting, members Randall MacDonald of GTE and Stephen Wiggins of Oxford Health Plans left the table so often to huddle with lobbyists?

GRAPHIC: Eric Weissenstein, Washington bureau chief

LANGUAGE: ENGLISH

LOAD-DATE: October 16, 1997

2ND STORY of Level 1 printed in FULL format.

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Modern Healthcare

October 13, 1997

SECTION: News; Pg. 38

LENGTH: 454 words

HEADLINE: WASHINGTON REPORT: PANEL READING MODEST 'PATIENT BILL OF RIGHTS'

BYLINE: Eric Weissenstein

BODY:

The president's healthcare quality commission has nearly completed a patient bill of rights, having stripped the plan of some of its most controversial provisions.

The watering down of the plan isn't much of a surprise considering the makeup of the commission, which includes such natural adversaries as consumer advocates and representatives of managed-care plans and business.

At a meeting last week, a subcommittee of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry agreed on a framework for a medical information confidentiality measure. Under the proposal, patient consent would be needed to reveal any individual's medical data, while cumulative patient information would be made available only for billing, disease management or quality reasons.

The subcommittee also passed a series of minor "consumer's responsibilities" and moved to force managed-care plans to pay for emergency room visits when a "prudent layperson" would have reasonably believed the visit was necessary.

Managed-care plans, which had been concerned the panel would be a forum to bash managed care, have been pleased with the commission's direction of late. That's because they have succeeded in pulling some teeth from the commission proposal.

For example, disagreements within the subcommittee killed a proposal that would have forced managed-care plans to pay for clinical trials.

The panel also deadlocked on whether patients have a right to a standardized set of benefits, which will force the provision to be dropped, several commissioners said.

Health plan representatives, allied with members representing business interests, have made headway with their argument that any consumer "right" must be weighed against its cost to insurers and payers.

The cost-benefit argument was used successfully by several commissioners to avoid some provisions sought by consumer groups but opposed by managed-care

Modern Healthcare, October 13, 1997

plans, including a proposal that would have required plans to accept any physician willing to agree to the plan's rules.

The quality commission was formed earlier this year. While it doesn't have any legislative authority, panel co-chair and HHS Secretary Donna Shalala has said she would like to see its recommendations become federal law.

The subcommittee's proposal includes some significant consumer provisions. At a past meeting, the subcommittee agreed on a provision that covered a patient's right to appeal health plan decisions when a plan has denied that a procedure is medically necessary. The panel is also set to recommend that health plans be required to have an external appeals process. In the past, plans have opposed such measures.

GRAPHIC: Shalala

LANGUAGE: ENGLISH

LOAD-DATE: October 16, 1997

DATE: OCTOBER 29, 1997

CLIENT: KMIGDAIL  
LIBRARY: NEWS  
FILE: NWLTRS

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1ST STORY of Level 1 printed in FULL format.

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The Bulletin's Frontrunner

October 27, 1997, Monday

SECTION: WASHINGTON NEWS

LENGTH: 117 words

HEADLINE: Clinton Expected To Endorse Patient Bill Of Rights.

BODY:

Magazines.

US News (11/3, Brownlee) reported a presidential advisory board -- the Advisory Commission on Consumer Protection and Quality in the Health Care System -- last week "proposed a broad new range of protections for patients, including the rights to appeal denials of care or coverage by insurers and HMOs, to obtain more information about their doctors' expertise, and to keep their own doctors for at least 60 days even if forced to switch health plans." President Clinton is "expected to endorse the group's report when it's finished early next year, but he'll have to push if it is going to have any influence on the patchwork of health care reform bills now before Congress."

LANGUAGE: ENGLISH

LOAD-DATE: October 27, 1997

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Atlantic Information Services, Inc.  
Washington Health Week

October 6, 1997

SECTION: No. 35, Vol. 5

LENGTH: 416 words

HEADLINE: Business Community Balks at Quality Panel; Urges Cost Analysis of Protections

BODY:

Several prominent business organizations last week urged HHS Secretary Donna Shalala and Labor Secretary Alexis Herman to closely scrutinize the impending recommendations of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. The business groups' letter could be the opening salvo in the fight against the commission's recommendations, which many believe will become law next year. "We have serious concerns" about several fundamental flaws in how the consumer protection and quality advisory commission is functioning and in the tentative recommendations which the panel has reached to date," says the letter from the U.S. Chamber of Commerce, National Federation of Independent Business, National Business Coalition on Health, The ERISA Industry Committee, Assn. of Private Pension and Welfare Plans (APPWP) and others. The business community is in sync with the majority of managed care companies. Both groups worry that federal mandates and micromanagement will increase health plan costs. The business groups are asking for a "full and rigorous analysis" of the commission's proposals, as well as an extended comment period after the panel releases its recommendations next March. Neither Labor nor HHS officials have responded to the letter. The groups are planning to attend today's meeting of the subcommittee on consumer rights, protections and responsibility to see whether the panel will "give some indication of whether they will change their game plan," an APPWP lobbyist says. The business community was concerned early on when the administration named only three employer representatives to the 34-member commission. Randy MacDonald of GTE Corp., Christopher Queram of a Wisconsin purchasing group, and Diane Graham, a small business owner, represent business interests. Industry fears were exacerbated during the commission's meetings when the business members would mention cost impacts of proposals and be "steam-rolled" by other panel members. "There's a sense at times that the interests of the business community are not understood," Queram told WHW. Those fears heightened when Shalala last month said the commission's recommendations could become law. With health care mandates popular among politicians, the business community hopes to stem any onerous provisions before they're introduced on Capitol Hill.

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Washington Health Week October 6, 1997

LANGUAGE: ENGLISH

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LOAD-DATE: October 21, 1997

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*Deputy Assistant Secretary for Policy  
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# THE GREEN SHEET

from the U.S. Department of Health and Human Services

Thursday, Oct 23, 1997

Wash. Post: 10-23-97 p. 1

## Panel Outlines Protections For Health Care Consumers

*Commission Would Guarantee Patient Choices*

By Amy Goldstein  
A Washington Post Staff Writer

A presidential commission yesterday outlined a broad set of protections for consumers frustrated by a changing health care system, proposing that patients be guaranteed a choice of medical plans, more information to make smart decisions and new ways to protest when they become dissatisfied with their care.

Under the proposal intended to protect all Americans with insurance, health plans would be forbidden from imposing "gag rules" that restrict the kind of treatment options physicians can mention to their patients. The confidentiality of medical records would be guarded more closely. And patients who are preg-

nant or chronically ill would be able to keep their own doctor for a guaranteed period of time, even if forced to switch health plans.

The proposed "bill of rights" is the first concrete plan to emerge from a diverse panel—including representatives of insurance companies, consumers, physicians and employers—that for months has been debating what safeguards Americans need to ensure good medical care. As a result of a quiet ongoing revolution in health care, most patients now are covered through health maintenance organizations and other forms of "managed care," which try to constrain costs by limiting how much and what kind of care people may receive.

See HEALTH CARE, p. 18

10/23/97 16:57

NO. 827 P003/024

HEALTH CARE, from p. 1

Even as its members found broad areas of consensus yesterday, the commission remained splintered over several important questions—whether health plans should be able to exclude people who are sick, for example, and whether the government should create a nationwide "ombudsman" system to help patients navigate the often-bewildering ways that their health care has changed. However, only those initiatives that won unanimous approval were included in the proposals agreed to yesterday.

Health and Human Services Secretary Donna E. Shalala, one of two Cabinet members leading the commission, said the group had taken

noting that the panel is not addressing the kinds of benefits insurance companies should provide or how to help the 41 million Americans who have no insurance.

Even in its more targeted debate on the rights of insured patients, the diverse, 37-member commission has become a miniature version of the deep cleavages in opinion over what changes are needed in health care, and what role government should play.

On issue after issue, representatives of consumers and health professionals argued for greater patient protections, while employers and insurance executives opposed them for fear they would cost too much.

As a result, the draft excludes a proposal to guarantee patients the

"remarkable steps" to expand patients' rights. But some commissioners disagreed. "It falls short of what the president asked us for. It excludes too much," said Ron Pollack, executive director of Families USA, a consumer-advocacy group.

The panel plans to adopt its "bill of rights" in final form next month and to submit it to President Clinton, who will have to decide whether it should become the basis for legislation, regulation or exhortations for the insurance industry to police itself. The administration has given no indication which path it prefers.

The Advisory Commission on Consumer Protection and Quality in the Health Care System is an attempt to look comprehensively at how to help protect patients in dealing with health

fight to take part in medical research to test the effectiveness of new treatments. The panel deferred until next month its decisions over ombudsmen and whether to prohibit health plans from discriminating against certain high-cost or low-income patients in their marketing and enrollment practices.

At the end of the two-day debate that ended yesterday, several commission members said they remained uncertain whether the final version will go far enough in protecting patients for them to support it. Some have talked of turning in a minority report.

Nevertheless, the panel agreed on several important protections that would exceed those currently available to most patients.

It recommended new restrictions to ensure the confidentiality of medical records, largely echoing a proposal that Shalala made to Congress last

month—its work coincides with a flurry of largely piecemeal attempts to rein in managed care that have emerged in Congress, state legislatures, and various factions of the insurance industry.

The panel also is the latest in a series of administration strategies, since the demise of its massive health reform plan three years ago, to tackle the issue in more finite ways. Last year, it backed the Kennedy-Kassebaum law that was designed to make it easier for people to get insurance after they become sick or change jobs. As part of the balanced-budget agreement the White House gave its support to a \$24 billion program to expand health insurance for children.

"We aren't redoing the Clinton health plan," Shalala said yesterday.

month—with one significant difference. Shalala urged that law enforcement investigators be granted broad access to patient records, without their knowledge and with their names attached. The commission recommended such access only for investigations of health care fraud.

The commission also proposed a major expansion of the information that doctors and health plans must give patients. If patients need surgery, for example, their doctors would have to disclose how many times they had performed that type of operation.

For the first time, employers also would have to offer their workers a choice of health plans. And if consumers believed that their health plan had failed to provide or pay for the treatment they deserved, they would be able to appeal to an impartial, outside review panel—a protection available now only in seven states.

Sat. Sub. 10-23-97

# Patients' health care 'bill of rights' gets tentative OK from presidential panel

**HMOs, business reject several proposals pushed by consumer advocates**

ASSOCIATED PRESS

WASHINGTON — A presidential health commission tentatively approved most of a patients' "bill of rights" yesterday offering consumers a host of new protections in dealing with health insurance companies.

However, it rejected several proposals that consumer advocates were pushing, including the right to coverage of experimental treatments.

The commission, appointed by President Clinton in the spring, includes representatives of managed care and other insurance companies, doctors, business and consumers. It decided not to include anything in the bill of rights unless there was unanimous agreement.

That meant several items were left out because insurers and business executives objected that they cost too much. Increased costs, they argued, would force small employers to drop insurance benefits altogether, adding to the 41 million Americans who do not have insurance.

Commission members hope Clinton will propose the bill of rights as legislation. Passage by Congress would guarantee the protections.

The commission agreed to several rights that would give consumers new power in dealing with their insurance companies. Among them:

- The right to appeal denial of care, first within the health insurance company, and then, for major expenses, to an outside panel.

- The right to a massive amount of information about a health plan, its doctors and hospitals.

- The right to privacy for health records, with only a few exceptions.

- The right to have an emergency room visit paid for if a reasonable person would have concluded that health was in jeopardy, even if it turned out nothing was wrong.

These rights were enthusiastically supported in nearly every case.

Among the issues debated but not included:

- Elimination of lifetime caps: Each year, about 1,500 to 2,500 people are so sick that their plans spend the maximum agreed to on their care, and they qualify for nothing else.

- The right to participate in clinical trials. Managed care com-

panies, in particular, have refused to pay for treatment that is part of an experimental program.

- Discrimination based on health status. Commissioners are continuing to study whether a health plan can refuse to enroll particular consumers, including those with health problems.

- Establishment of an ombudsman program to help consumers navigate the health system. Commissioners agreed to reconsider this issue at their November meeting.

And several other issues re-

vived by consumers were not brought to the table at all because backers knew there was opposition. That includes equal benefits for physical and mental illnesses and development of standard benefit packages so consumers can compare products.

Consumer advocates will decide by next month whether to sign onto the final report or write a dissenting opinion asking for more items. The commission meets again next month and plans to deliver its proposal to Clinton by Thanksgiving.



REPORTS

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Thursday, October 23, 1997

TODAY'S NEWS

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PRESIDENT'S QUALITY COMMISSION NEARS APPROVAL OF CONSUMER INFORMATION CHAPTER of its consumer "Bill of Rights." though some members are reserving outright support pending review of data on the cost of information disclosure and the ability of health system participants to comply with the chapter's proposals.

The President's Advisory Commission on Consumer Protection & Quality in the Health Care Industry at its Oct. 22 meeting considered for the second time a proposed chapter on information disclosure. The panel took no formal vote; however, when HHS Secretary and panel Co-Chair Donna Shalala requested final comments from members, the majority appeared to accept the chapter.

Anthem President & CEO Ben Lytle drew applause by advising that he was "grudgingly accepting the chapter." Lytle contended that the chapter calls for providers and plans to supply information that the panel is not certain that consumers want and that may be costly.

The chapter currently states that consumers "have the right to receive accurate, easily understood information" from health plans, facilities and professionals to "assist [consumers] in making informed health care decisions."

The document states that consumers have the right to obtain from health plans information on health benefits, cost-sharing rules, dispute resolution procedures, licensure, accreditation, comparable measures of quality and consumer satisfaction, provider network compensation and procedures for access to specialists and emergency care.

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10/23/97 16:58

NO. 827 P006/024

Health News Daily

Thursday, October 23, 1997

Information from health professionals should include education and board certification, number of years in practice, number of years of experience performing certain procedures and comparable measures of quality and consumer satisfaction, the paper says. Much of the same information should be available from health care facilities. The chapter also distinguishes between information that should be provided automatically and that which should be available upon consumer request.

Commission member Diane Graham, chairman and CEO of the engineering firm STRATCO, argued that in addition to the cost of compliance, business owners may be exposed to litigation, especially if what the commission declares to be a "right" is perceived as an "entitlement."

On the other hand, Steve Sharfstein, medical director and CEO of the Baltimore health system Sheppard Pratt, commented that the health disclosure rights are costly but beneficial. The commission's draft statement is "not incremental; this is a big step, but it's the way we've got to go," he asserted.

Some commission members also expressed concern regarding how quickly providers and plans will be expected to comply with new informational requirements. Commission Executive Director Janet Corrigan noted that there is an "unevenness" of informational capabilities, and some providers and plans may need years to come into compliance. Nonetheless, previous panel discussion has indicated that there is a need to "push the envelope" on information disclosure, and the chapter would not be "meaningful" if limited to the information already provided, she observed.

Commission staff are developing a description of "detailed assumptions" about the degree of compliance that may be "reasonably expected," Corrigan said. This information will be presented at the commission's mid-November meeting. Some estimates about the chapter's cost impact will also be presented, though Corrigan cautioned that the figures will be "rudimentary."

The Consumer Rights, Protections and Responsibilities Subcommittee, which is heading the effort to draft the Bill of Rights, is expected to complete work by year's end.

Shalala postponed until the November meeting a proposal to advocate use of ombudsmen to provide health information. Outlining the case for such ombudsmen, Families USA Executive Director Ron Pollack asserted that they reduce "contentiousness" by providing an independent source of information.

Another chapter nearing commission approval addresses "participation in treatment decisions." The chapter states that consumers have a right to "fully participate in all decisions affecting their health care." The chapter discusses informed consent and opposes provider "gag rules" by health plans.

10/23/97 16:59

NO. 827 P007/024

currently has no plans to use its 57 mm. in federal funds, HESC indicates.

**HEALTH PLAN CONSUMER "BILL OF RIGHTS" MAY BE "MINIMAL" IF REPORT IS SILENT ON BENEFITS** and lifetime caps, Christine Cassel, Mt. Sinai Medical Center, asserted during an Oct. 21 meeting of the Consumer Rights, Protections and Responsibilities Subcommittee. The subcommittee's work is expected to be completed before the end of the year, with a final report to President Clinton by the full 34-member Advisory Commission on Consumer Protection and Quality in the Health Care Industry due next March.

Following extensive discussion that showed little consensus on whether the subcommittee should recommend elimination of lifetime caps or whether benefits paid for are a "right" for consumers, Cassel advised that subcommittee members concede that "this is a minimal bill of rights." She also suggested that absent a chapter dedicated to benefits (a previous version has been omitted altogether) more general comments could be included in a preamble to the "Consumer Bill of Rights and Responsibilities in Health Care."

In its current form, the preamble -- which subcommittee Chairman Peter Thomas, a principal in the law firm Powers, Pyles, Sutter & Verville said will probably be rewritten during the next several weeks -- does not include specific discussion of benefits. Rather, it outlines a series of "guiding principles" that call for giving priority to quality; equality; preservation of "what works"; and costs.

Regarding the latter principle, the commission's Executive Director Janet Corrigan said that attempts are being made by staff to analyze the potential impact on premiums and other costs associated with rights outlined in the information disclosure and external appeals procedures.

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10/23/97 16:59

NO. 027 P008/024

Wednesday, October 22, 1997

Health News Brief

The discussion of lifetime caps showed sharp divisions among commissioners on the subcommittee, with GTE Executive Vice President Randall MacDonald wanting that employee copayments, premiums and deductibles could rise if legislation is enacted that eliminates use of such limits, which are routinely used by both large and small companies. The commission has no legislative authority, but the group's comments could be important to lawmakers who support raising lifetime limits for all health plans from the current industry average of \$1 mil. to \$10 mil.

Senate Labor & Human Resources Committee chair James Jeffords (R-Vt.) has introduced lifetime limits legislation but has not yet held a hearing. Mental health parity advocates believe that the lack of GOP sponsorship is a key stumbling block for Sen. Jeffords.

On the other hand, subcommittee Chairman Thomas said that a recently completed analysis by the American Academy of Actuaries of Sen. Jeffords' bill concludes that elimination of lifetime caps would result in average premium increases of only \$5 to \$15 per person. Thomas also noted that \$1 mil. lifetime caps, which first appeared in the 1970's, now equate to caps of \$10 to \$12 mil. if medical inflation is taken into account. With no immediate consensus in sight, commissioner Nan Hunter, Brooklyn Law School, urged the subcommittee to "call for reconsideration" at the full commission level.

Similarly, little agreement was achieved during subcommittee discussion of how the "Bill of Rights" should address nondiscrimination. Families USA Executive Director Ron Pollack expressed concern that recent revisions to the chapter that delete references to marketing and enrollment parameters may make the overall chapter "misleading."

According to Pollack, the most difficult form of discrimination that consumers experience relates to acceptance by plans at affordable prices. Pointing to the lack of discussion in the chapter that health status should not be used to discriminate against consumers (deleted in earlier meetings due to concern about the impact on underwriting), Pollack said he might not be able to support the chapter in its current form. Recommendations cannot be made if reasonably broad consensus is not achieved.

However, Sylvia Drew Ivie, executive director of T.H.E. Clinic for Women in Los Angeles, urged the subcommittee not to reject the nondiscrimination chapter, but to support it for its value in affirming current law. The chapter should serve as a "teaching" guide, she said, since "there are existing laws, and they are ignored."

Discussion about whether certain revisions might be made to the chapter before presentation to the full commission on Oct. 22 were inconclusive. At present, the chapter includes discussion of sex; race; ethnicity; national origin and religion; age; sexual orientation; disability status; and source of payment. It also briefly references "protection against discrimination [in] provision of health care services based on...anticipated mental or physical disability [and]...genetic information."

10/23/97 17:00

NO. 827 P003/22-

Health News Daily

Wednesday, October 22, 1997

In Thomas' view, however, the non-discrimination chapter is far weaker in its current form than earlier iterations. For example, he said, there is no discussion of how some capitation arrangements can negatively affect coverage for consumers with disabilities. Still, he concluded, the chapter has value.

The commission's discussions featured testimony on the federal government's role in promoting quality by several former Health Care Financing Administration chiefs, including Bruce Vladeck, William Roper and Carl Wilensky. Wilensky, recently named head of the Medicare Payment Advisory Commission, testified that "it is a mistake for the federal government to take on the responsibilities of defining and creating quality and performance standards in general and particularly in taking on the role of establishing quality measures and performance standards for private sector plans."

However, Vladeck suggested that because of the federal government's purchasing clout in the health industry and its authority to set standards for Medicare and Medicaid, "expected levels of performance" for the programs could influence standards in the private sector. Conversely, he said, research in the private sector that shows measurable progress in improving health care quality might persuade the federal government to turn performance "ceilings" into "floors."

By ALISSA J. RUBIN  
Times Staff Writer

**WASHINGTON**—Reacting to mounting public dissatisfaction with managed health care, Congress is considering at least 10 proposals to regulate health insurance plans with hearings beginning this week.

The most controversial proposal would broaden workers' rights to bring medical malpractice lawsuits against managed-care companies—and, potentially, the employers who contract with them. Other proposals would require health plans to have a consumer ombudsman and grievance procedures when patients are denied care.

Bolstering the campaign is a presidential health-care commission, which is conducting its final day of deliberations today and is expected to recommend a "consumer bill of rights" that, for example, would require managed-care plans to pay for non-emergency room visits.

The nation's largest businesses, fearful that any such measures would mean higher health insurance costs for them, are mounting a massive opposition campaign combining advertising with lobbying both at the grass-roots level and in Washington.

"Is this going to improve quality or is it going to micromanage plans, drive health care up and leave fewer people with insurance?" asked Richard Smith, vice president for health policy at the American Assn. of Health Plans.

Many analysts believe that business has good cause for alarm.

"It's a very good issue for members of Congress," said health policy expert Robert Blendon, a professor at Harvard University. "It's a chance to be responsive to a very real middle-class issue."

There's been an apparent decline in consumer confidence in the health-care system and there's also a tremendous

L.A. Times; 10-22-97

## Spurred by Public's Complaints, Congress Offers Managed-Care Cures

Medicine: Proposals include broader right to sue, creation of consumer bill of rights. Business fears micromanagement, higher costs.

amount of publicity that is often negative about managed care," said Frank McArdle, director of the Washington office of Hewitt Associates, a health-care consulting firm. "From a legislator's standpoint, it means your constituents aren't happy and the firm's interest is to listen to your constituents."

Managed-care plans, which include health maintenance organizations, preferred provider organizations and point-of-service plans, control costs by limiting access to specialists and expensive tests. Such plans now cover at least 60% of people who purchase their health insurance through private employers, according to the Congressional Budget Office.

Proposals percolating in Congress would:

- Mandate that managed-care plans cover certain benefits such as emergency care and experimental treatments.
- Establish independent appeals of decisions by managed-care plans to deny benefits.
- Require plans to divulge information about their contracts with health-care providers in their networks.

But the bill that most concerns business groups and managed-care plans would make it far easier for workers to sue managed care companies and, potentially, their employers for medical malpractice. That

would give patients a weapon that they now lack when plans deny treatment or refuse to pay claims.

The bill, which is slated for its first congressional hearing Thursday, is sponsored by Rep. Charlie Norwood (R-Ga.), a conservative Southern democrat. In the Senate, Alfonse M. D'Amato (R-N.Y.), is championing a similar bill.

"Medical malpractice is the ultimate safeguard a patient has and federal laws have preempted all the state protections and replaced it with nothing," said Norwood, who has nearly 170 co-sponsors for his bill.

Norwood's legislation would make major changes in the obscure but powerful Employee Retirement Income Security Act, which exempts self-insured health plans from state health insurance regulation. That exemption was designed to help large, multi-state companies, which insure their own employees, by letting them meet a consistent set of federal regulations rather than forcing them to abide by 50 different state laws.

The courts have sent mixed signals on whether HMOs can be sued for medical malpractice.

But self-insured plans, which generally are operated by large and mid-sized companies, are exempt. Business groups said that allowing lawsuits against self-insured plans would open up the employer who contracts with the HMO to be sued as well.

"The employer would have to look over the shoulder of the HMO and would be liable for all the things that the insurer and the HMO have control over," said Anthony Kneuel, director of health policy for the ERISA Industry Committee, which represents Fortune 500 companies.

Beyond Norwood's bill, several others would open managed-care plans to various consumer protections—such as an appeals process for denial of care—but not to malpractice suits.

"Too many managed-care plans and other insurance companies have decided that the best route to higher profits is by denying patients the health care they need," said Sen. Edward M. Kennedy (D-Mass.), who is sponsoring one health-care reform bill.

The 34-member presidential Commission on Quality avoided the politically charged ERISA issue, opting instead to recommend guidelines in somewhat less controversial areas such as consumer information on access to specialists.

Among the "consumer rights" that the presidential commission has proposed:

- Regular access to specialists for treatment of chronic conditions without need for a referral from a primary-care physician each time.

- Information for patients about how a plan's financial arrangements with doctors may affect the doctors' treatment recommendations.

- Guarantees that health plans could not threaten to end their contracts with doctors who tell patients that more effective treatments are available outside the plan.

- Confidentiality of patients' medical records.

10/23/97 17:00

USA Today: 10-22-97

## Consumers' health-care rights bill urged

By Steven Flaxley  
USA TODAY

WASHINGTON — A presidential advisory commission will recommend a host of new health-care "rights" for consumers today, including a right to appeal to independent reviewers when insurers or managed care plans deny coverage.

The recommendations by the 13-member commission are not binding, but it's likely that doctors, hospitals and health insurers will either accept them voluntarily over the next couple of years, or that the rights will form the basis for new laws.

The commission also wants insurers and health plans to pay for emergency room visits if a "prudent layperson" — not an insurance or managed care employee — would agree the visit was warranted.

People with serious medical conditions to have direct access to specialists without getting approval from a primary care doctor.

Managed-care plans to be required to provide consumers with information on how they govern access to specialists, pay doctors and review doctors' treatment decisions.

The panel, appointed by the president last March, meets today to finalize its consumer bill of rights. The report is to be delivered to the White House next Tuesday. A Clinton administration official said Tuesday the president had made no decision on whether to propose or support a law based on the panel's advice.

The commission's report will fuel an already vigorous debate about the role of government in protecting consumers enrolled in health maintenance organizations (HMOs) and other types of managed care plans.

Most states have passed limited laws protecting consumers in such plans. Congress last year guaranteed women a minimum 48-hour hospital stay after giving birth. Congress is expected to take up more sweeping bills next year.

Consumer groups want most of the commission's recommendations to become federal law. But health industry and business groups aren't sure that's wise.

The action was evident at the commission's meeting Tuesday when some members pressed for more rights. One would prevent insurers from dropping cases — typically \$1 million — on what they'd pay over a lifetime for a person's care. Another would explicitly bar insurers from discriminating on the basis of race, gender and health status.

"Without these protections this bill of rights will not be complete," said Ron Pollack, president of the consumer group Families USA.

But Stephen Wiggins, CEO of Connecticut-based Oxford Health Plans, said such measures would raise costs. "Most Americans want less government regulation. This commission shouldn't be going more regulation and mandates are the solution they want."

Balt. Sun: 10-21-97

# New rights for HMO patients expected to be sought

## Presidential panel to back new minimum guarantees

ASSOCIATED PRESS

WASHINGTON — A terminally ill patient could appeal if he was turned down for an experimental treatment. A man with chest pain could go to the emergency room

without worrying so much whether his HMO would pay the bill.

Americans frustrated by managed care would have a host of new guarantees under a proposed bill of rights a presidential advisory commission is expected to recommend this week.

Because the commission includes representatives of both the managed care industry and consumer groups, many hope the

work will lay the foundation for future federal laws.

But some consumer rights advocates say the bill of rights, as written, doesn't go far enough, and they are considering a dissenting report if the commission does not expand it.

"I must say, this is a slice of a slice," said commission member Ron Pollack, president of the consumer group Families USA. He

said he likes what's in the bill, but it is inadequate.

Others are more optimistic. "If we can succeed in getting those proposals enacted into law, it will have a profound and lasting impact on health care," predicted Commissioner Stephen F. Wiggins, chairman of Connecticut-based United Health Plans.

The White House is pleased with the draft bill of rights, according to an administration official who spoke on condition of anonymity. The draft looks like "something we can embrace" and move forward as legislation, the official said.

States have approved many bills dealing with managed care health plans, although Congress has passed just one measure, guaranteeing a woman 48 hours in the hospital after childbirth.

But that bill opened the floodgate to a myriad of proposed legislation regulating how health care providers, organizations do business. In turn, it has caused some to worry that Congress could pass a regulating health care "big party busy part."

But the commission, an idea President Clinton floated during his reelection campaign, after six months of work, is set to produce a report that, for the most part, will be a big picture.

It would promise to give patients a font of information about their HMOs, but would not guarantee a certain number of days in the hospital after childbirth.

It would allow an appeal denial of care, but not in the health insurance industry, and Uwe, for major coverage, an outside panel.

It would give a reasonable right to have a reasonable number of doctors. It would have an emergency room that paid for if a reasonable person would have conditions of health care in jeopardy. — It would guarantee nothing was

But several consumer groups are expected to dissent.

John Hunter, a professor at New York Law School, said he supports the right to appeal denial of care, but not the right to equal coverage. He said an appeal process would be a "big party busy part" that would not help consumers navigate the system.

He said he would like to prevent insurance companies from imposing limits on care, but they'll pay for it. He said he would like to see more checks to other companies, but that consumers can't afford it.

And others say the commission should report what it's doing. And report will be made available through Congress.

He said he would like to have total coverage, but that's not practical reality. He said he would like to see the dis-

**RESEARCH POLICY**

**ACCESS TO CLINICAL TRIALS REMOVED FROM QUALITY SUBCOMMITTEE'S PROPOSED PATIENTS' BILL OF RIGHTS**

Patient access to clinical trials does not rise to the level of a "right" guaranteed to health plan consumers, a subcommittee of President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry agreed at an Oct. 6 meeting in Washington, D.C.

The consumer rights subcommittee is chaired by Peter Thomas of Powers, Pyles, Sutter & Verville. The full commission is due to meet Oct. 21-22 as it prepares a proposed "Bill of Rights" for health care consumers for presentation to the President early next year.

Commenting on the draft chapter "Access to Emergency Services and Clinical Research Trials," Oxford Health Plan's Chairman Stephen Wiggins asserted that "it's not financially possible" for health plans to cover clinical trial costs.

Medicare does not cover costs associated with clinical research, he added, although George Best of Memorial Sloan-Kettering Cancer Center countered during a public comment period that Medicare does pay for complications stemming from clinical trials.

Wiggins maintained that a mechanism would have to be created to protect health plans from catastrophic costs if payment for clinical research is ever translated into a requirement. At present, he concluded, "to create a right is something that I believe is premature."

Prior to the subcommittee meeting, the draft chapter called for "federal agencies and private sponsors of federally-sponsored trials" to "cover the costs of conducting research; any added medical care costs associated with tests and treatments required by the research protocol that are beyond those performed in the routine care of patients with the same degree of morbidity; and the cost of medical care for complications associated

with the experimental regimen that arise during the experimental treatment period."

Memorial Sloan-Kettering's Best said he was disappointed that the subcommittee believes that "access to clinical trials is not a right." Contrary to what some federal officials and private-sector health plans believe, he said, care received in the context of clinical trials can sometimes be less expensive than care received outside research protocols. Only 3% of eligible patients participate in clinical trials, according to Best.

The subcommittee's action is similar to legislation introduced earlier this year by Sen. Tim Wicker (D-Va.) and Connie Mack (R-Fla.), and by Rep. Nancy Johnson (R-Conn.).

The "Medicare Cancer Clinical Trial Coverage Act" (S. 381, H.R. 1628) would authorize a pilot project to assess the feasibility of Medicare reimbursement for routine medical costs incurred by the beneficiaries who are enrolled in approved clinical trials. The House and Senate bills have 29 cosponsors each.

**Panel Declines To Discuss Health Plan Coverage**

NIH has expressed hope that health plans can be persuaded to cover the additional costs of clinical trials and is discussing the issue with the American Association of Health Plans. (The Blue Sheet" Oct. 1, p. 3).

In other decisions on Oct. 6, the subcommittee agreed to omit discussion of managed care in the health care system that have led to the rise of large managed care plans, following the lead of Oxford's Wiggins.

The deleted text stated, in part, "The decade's rapid transition from a fragmented system of health care and, to some degree, from the positive elements of this change, has understandably troubled by the sudden changing relationships with physicians, hospitals, nursing homes, insurance plans and

A chapter addressing confidentiality of health information was revised slightly and stated that consumers have the right to communicate with their care providers in confidence and to have the confidentiality of their identifiable medical records protected. Consumers also have a right to obtain a copy of their own medical records and to have access to their records."

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TO

P.05

October 8, 1997

"The Blue Sheet"

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Among the parameters for the right to confidentiality, the document states, is that "with very few exceptions, individually-identifiable medical health care information should be disclosed for health purposes only." A clause was added stating that these purposes can include disease management, quality assurance and health promotion.

Written consent must be obtained in most other circumstances, the subcommittee draft states, with the exception of payment for services, medical research, investigation of health care fraud and public health reporting.

**RESEARCH OVERSIGHT**

**BAD FAITH ALLEGATIONS OF SCIENTIFIC MISCONDUCT WOULD BE SURVEYED UNDER PROPOSED ORI FORMS**

Institutional policy concerning bad faith allegations of scientific misconduct would be ascertained through the Office of Research Integrity's proposed revisions to its annual report form. The form is required of all PHS grantee or applicant institutions to renew their research misconduct assurances.

A new question in the proposal asks for "the number of bad faith allegations received" in the past year as well as "actions taken by the institution against the whistleblower" in these cases.

The question is one of five new components of the report form. A public-comment period on these revisions expired Sept. 20. ORI has indicated that no comments have been received. Pending approval by the White House Office of Management and Budget, the new forms will be used for the annual survey to be mailed in January.

More explicit information on the protective measures that institutions offer to "good-faith" whistleblowers is also sought in the ORI proposal. The new form would ask, with regard to specific "inquiries/investigations reported...did your institution take affirmative steps to protect the position and reputation of the whistleblower?"

The current annual report form asks about protective actions taken by the institution but does not survey the number of actions per allegation. The new form, in addition to this change, would ask why actions were not taken to protect whistleblowers.

These items "were added to produce a more accurate and complete account of the administrative ac-

tions taken to protect whistleblowers by giving institutions more response options relating to ORI.

Additional elements of the proposal include questions on "institutional actions on 'action(s) the institution(s) found guilty.'" The proposal also seeks the e-mail address of the institution responsible for signing the form "to facilitate ORI."

In its review of the 1996 ORI observations, ORI observes that the 1996 ORI observations also included questions about the whistleblower. The various mechanisms for reporting misconduct were maintained, including an anti-retaliation policy; and monitoring of faculty about protection mechanisms for reporting misconduct.

The highest number of misconduct reports were reported to date by the 1996 ORI's discussion of the 1996 annual report results. Institutional assurances constituted 68% of these reports.

The report also identified the goal for the 1996 annual report and ORI "over the next three years" initial response rate from 100% to 80%, thereby eliminating the need for a...

Further, the proposal addresses "erosion of confidence" through its emphasis on...

Finally, the use of a heralded by an article in the *Lancet*, 89% of the annual March 31 final deadline date in the shortest...

Together with the office will co-sponsor a responsibilities of institutions be held at Tuskegee on-promoting whistleblowers.

**OPPR... INSTITUTIONS... COMMITTEES... PRODUCT**

Institutional animal (IACUCs) will be advised from Research Ethics committees for monitoring principles. A letter will be sent within the next few months...



EXECUTIVE NEWS SERVICE

uses; access to a reasonable choice of primary care and specialty physicians, including direct access to obstetricians/gynecologists for women; allowances for exceptions to drug formularies when medical necessity dictates that a non-formulary alternative is needed; continuity of care for pregnant women and people undergoing treatment for life-threatening or disabling conditions when consumers switch plans or their physician specialists' contracts are terminated; and the provision of emergency and urgent care when plan members travel outside of the health plan's service area.

judge "concluded that the merger antitrust issue," according to Mr. [redacted] the decision to the Sixth Circuit Court of Appeals upheld the district court decision. The decision was "unprecedented action," the judge said, and would begin an administrative hearing before the agency.

The controversial "rider" to the FTC from utilizing funds for "any" concerning the merger of two hospitals. The Commission has already sought a court order to July 9, 1997. The Court of Appeals, the injunctive relief requested by use of the antitrust provisions provided pursuant to the pending administrative merger of the Grand Rapids and Blodgett Memorial hospitals. The Commission and other

### Hatch Plans to Examine Potential Refinement of FTC Hospital Merger Policy

The healthcare field "currently is undergoing very fundamental, structural changes, and must continue to undergo further change," said Chairman Orrin Hatch (R-UT) in his opening statement before the Senate Judiciary Committee on September 23. "I believe it will be important for the FTC and the Justice Department to be ever attentive to ensure that their policies to reflect market realities," continued Chairman Hatch. He referred to the joint guidelines developed by the Federal Trade Commission (FTC) and the Department of Justice (DOJ) last fall and acknowledged "that further refinement may be necessary in the area of hospital

"The whole point of having and enforcing antitrust laws is to protect the political marketplace and prevent the kind of limitations that have appeared in enforcement of antitrust laws. The Federal Trade Commission and the Department of Justice, Patrick Leahy statement. Hatch said the Senate House Judiciary Committee Chairman Henry Hyde (R-Ill.) and Chairman John Warner, Jr. (D-Virg.)

Senator John Kyl (D-Ariz.) voices precedent as well. "We are talking about two non-profit hospitals in Grand Rapids, Michigan. This happens when you have the antitrust and the potential for the hospital and the community. The antitrust laws are to be enforced. The Justice Department and the Federal Trade Commission (FTC) are to be enforced and be with the antitrust laws.

Senator John Kyl (D-Ariz.) said the rider and the view of FTC and pointed out the tremendous impact on the community, the potential damage by a separate hearing and the FTC's role in the antitrust laws after they are enforced in court.

John Kyl (D-Ariz.) said that the antitrust laws are to be enforced and be with the antitrust laws.

On a panel of witnesses that included DOJ guidelines pertaining to the merger of non-for-profit hospitals. The Federal Trade Commission (FTC) and the Department of Justice (DOJ) are to be enforced and be with the antitrust laws.

Blodgett Memorial Medical Center Corporation in Grand Rapids was in January of 1996. William Kopit, a health care and antitrust law at the Grand Rapids and counsel for the hospitals. Over 11 days of hearings in the Grand Rapids, Michigan. The district court

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Modern Healthcare

October 13, 1997

ST News; Pg. 38

AL 454 words

WASH DC: WASHINGTON REPORT: PANEL READYING MODERN PATIENT BILL

BY Eric Weissenstein

BODY

President's healthcare quality commission has nearly completed its work on a bill that would strip the plan of some of its most controversial provisions.

Watering down of the plan isn't much of a surprise considering the commission, which includes such natural adversaries as consumer groups and representatives of managed-care plans and hospitals.

At a meeting last week, a subcommittee of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry approved a framework for a medical information confidentiality measure. Under the proposal, patient consent would be needed to reveal any individual's data. The cumulative patient information would be made available only for disease management or quality reasons.

The subcommittee also passed a series of minor "consumer's rights" provisions and moved to force managed-care plans to pay for certain services when a "prudent layperson" would have reasonably believed them necessary.

Managed-care plans, which had been concerned the panel would be harsh on managed care, have been pleased with the commission's direction. That's because they have succeeded in pulling some provisions from the proposal.

But, disagreements within the subcommittee blocked a proposal to force managed-care plans to pay for clinical trials.

The panel also deadlocked on whether patients have a right to sue for medical malpractice, which will force the providers to be disciplined, several committee members said.

But plan representatives, allied with some consumer groups, have made headway with their argument that managed care should be allowed to sue its cost to insurers and patients.

The cost-benefit argument was used successfully by several consumer groups to avoid provisions sought by consumer groups.

Modern Healthcare. October 16, 1997

plans including a proposal that would have required plans to be...  
plans willing to agree to the plan's rules...  
quality commission was formed earlier this year. While in...  
an legislative authority, panel co-chair and... Secretary Donna...  
said she would like to see its recommendations... Federal law

The subcommittee's proposal includes... that consumer...  
a panel meeting, the subcommittee agreed on... that cover...  
right to appeal health plan decisions when... denied the...  
medically necessary. The panel is also set... that has...  
required to have an external appeals process. In addition, plans...  
such measures.

GA... Shelala

LANGUAGE: ENGLISH

LOAD DATE: October 16, 1997

3RD STORY of Level 1 printed in HTML format.

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Medical Information

October 8, 1997, Wednesday

SECT: N: PAYER & PROVIDER NEWS

LENG: 614 words

HEADLINE: Presidential Commission to Argue Patients Rights

BODY:

A healthcare commission that is focusing on the rights of patients and up costing consumers more money--if the so-called patient bill of rights is adopted.

A subcommittee of the President's Advisory Commission on Consumer and Quality in the Health Care Industry is expected to release a consumer rights bill that may well tip the balance of power in the medical market, according to a Washington Times report on Wednesday.

Subcommittee meeting members considered provisions to ensure access to healthcare and to protect patient privacy.

"I think we're doing it backward," said Stephen Wiggins, chairman of OXFORD HEALTH PLANS (Danbury, Conn.) and head of one of the country's largest managed care insurers, should the bill of rights be passed. "The current health care system."

Wiggins alleged the committee might be influenced by politics in the president's desires for a bill of rights. The committee has a Thanksgiving to provide a proposal to be discussed. The full committee legislative agenda has been requested by Clinton.

Among the members of the advisory commission are veterans of the 1994 health plan campaign.

The initiative is an extension of Clinton's plan to reform a policy of managed care. The plan is to reform a universal healthcare system that has fallen apart.

The commission's products will be added to the "expansion" of Medicaid passed to Clinton. The Kennedy-Kassebaum legislation is also being considered.

Clinton is pleading with private employers to cover the 6-10 million uninsured children.

"We have to ... devise a system that allows us to care for our children and a system that permits employers to do so."

# The Washington Post

MONDAY, JUNE 30, 1997

A1

File Quality  
Conduits

## Backlash Builds Over Managed Care

### Frustrated Consumers Push for Tougher Laws

By David S. Hilzenrath  
Washington Post Staff Writer

A political backlash is building against managed care across the country as doctors and patients protest what they see as potentially dangerous penny-pinching by the health-care industry. Consider:

In Missouri, the governor last week signed a bill requiring managed-care companies to pay for emergency room visits whenever a "prudent layperson" would have reason to believe that immediate care is needed, even if a managed-care administrator might disagree.

In Hartford, Conn., center of the nation's insurance industry, the state legislature last month approved a bill that would allow patients to appeal to the state insurance commissioner when health plans decide not to pay for their medical treatment.

And Texas last month made it possible for consumers to sue health maintenance organizations for medical malpractice, removing a barrier that had shielded them from liability.

The legislation reflects consumer frustration with managed care, the cost-conscious form of health insurance that has grown over the past decade from obscurity to cover an estimated three-quarters of the nation's private-sector workers. Doctors and patients have been calling for curbs on the managed-care industry's powers, arguing that some companies are profiteering at the expense of patient care, making it difficult for people to get quality medical attention.

Officials in dozens of states have responded by stitching together a patchwork quilt of new regulations. Some of the measures have passed by overwhelming, even unanimous, margins.

See MANAGED CARE, A6, Col. 1

## Legislators Get Tough on Managed Care

MANAGED CARE, From A1

On Capitol Hill, the budget bill passed by the House last week would strike at managed care's jugular by requiring Medicare HMOs to defer to doctors on key decisions about coverage. For example, the bill would give the doctor final say over the length of a covered hospital stay.

Opponents are worried that the movement threatens to undermine managed care's success in containing health-care costs. Many of the "patient protections" are more like "doctor protections," inspired by physicians who are feeling the financial squeeze, the opponents said. But even some representatives of the managed-care industry acknowledge that the campaign has gained considerable momentum.

When the Missouri legislature took up its broad managed-care bill, which included the provision on emergency room visits, "people couldn't vote against this bill," said Randy Scherr, a lobbyist for HMOs. "It had to be the number one back-home response issue for most of the legislators."

Missouri Senate Minority Leader Steve Ehlmann, a Republican, said he asked constituents about managed care in his annual legislative survey, and "I was amazed that like 85 percent basically said, 'It's broken, you need to fix it.'"

"The people who are complaining the loudest are the people you see every day on the street," said Ehlmann, who voted for Missouri's managed-care bill. "They are the doctors and the consumers, and they all have a horror story to tell you about the insurance company that wouldn't pay on the claim."

Enter Health Care Reform, The Sequel.

Four years ago, President Clinton tried and failed to overhaul a health-care system in which costs were virtually unchecked and rising faster than the nation's ability to pay. Managed care filled the void with a variety of cost-saving measures, such as re-

stricting patients' access to medical specialists; limiting patients' choice of physicians; and reducing the length and frequency of hospital stays.

Other cost-saving techniques include: giving doctors pay incentives to practice efficient—critics say parsimonious—medicine; measuring individual physicians' use of medical resources; and requiring doctors and patients to obtain approval for coverage of expensive tests and treatments.

From 1992 and 1996, the percentage of workers covered by managed care grew to 77 percent from 49 percent at businesses with 10 or more employees, according to surveys by the consulting firm Foster Higgins. The cost of health-care benefits, which was climbing by 10.1 percent in 1992, rose by 2.5 percent last year, slower than the economy's overall 2.9 percent inflation rate, Foster Higgins reported.

Now, with some voters chafing at the trade-offs, worrying less about costs and crying foul over the alleged excesses and abuses of some health plans, many contend that the solution has become the problem.

Texas Gov. George W. Bush (R) said in a statement that he had misgivings about opening the door to more lawsuits, but accepted the managed-care liability measure "to address a significant problem that impacts the health of thousands of Texans."

In a February poll by Louis Harris and Associates, 38 percent of respondents said they believe managed-care companies such as HMOs "generally do a bad job of serving their customers." In a November survey by the Kaiser Family Foundation and the Harvard School of Public Health, 54 percent said "government needs to protect consumers from being treated unfairly and not getting the care they should from managed-care plans."

Managed-care executives and lobbyists say their own research finds a high level of customer satisfaction. Nonetheless, they say, the system takes getting used to.

"This is a transition that is clearly very difficult for many people," said Susan Pisano, spokeswoman for the American Association of Health Plans, which represents HMOs and preferred-provider organizations. Part of the difficulty, Pisano said, is that consumers came to associate quality with an excess of care under the old health insurance system,

file

Quality  
Commission

August 6, 1997

The Honorable Donna E. Shalala  
The Honorable Alexis M. Herman  
Co-Chairs, Presidential Advisory Commission on Consumer Protection  
and Quality in the Health Care Industry  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Secretary Shalala and Secretary Herman:

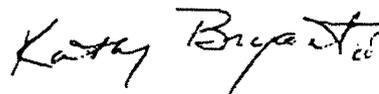
On behalf of the American College of Obstetricians and Gynecologists (ACOG), an organization representing 37,000 physicians dedicated to improving women's health, I am writing to request that an ACOG representative testify before the Commission's Subcommittee on Consumer Rights, Protections, and Responsibilities when the Commission meets on September 9 and 10 in Chicago, Illinois.

As physicians devoted exclusively to the provision of health care to women, obstetrician-gynecologists have a critical role in today's changing health system and offer a unique perspective on the issues affecting women's access to both primary and specialty care. ACOG understands that these important issues will be addressed in a background paper that will be presented to the Subcommittee members prior to the September meeting and would like the opportunity to present these issues in person to engage fully Commission members in a discussion of the complex issues of women's access to health care in today's rapidly changing health care system. These issues include efforts to require health plans to allow women to choose their obstetrician-gynecologist as their primary care provider and/or allow direct access to obstetric and gynecologic care. This issue has been the subject of much state and federal legislation. As of July 31, 29 states have enacted laws in this area and legislation is pending in Congress.

Given the Clinton Administration's ongoing efforts to improve women's health care in our country, ACOG believes that the Commission should focus on the unique issues facing women in today's health care environment. ACOG looks forward to presenting some of these issues before the Subcommittee as it devises a consumer bill of rights and responsibilities. The contact at ACOG regarding our testimony is Carol Vargo and she can be reached at (202) 863-2510.

Thank you for your efforts on behalf of women's health care. ACOG looks forward to working with the Commission on these important issues.

Sincerely,

A handwritten signature in cursive script that reads "Kathy Bryant".

Kathy Bryant  
Associate Director  
Government Relations

KB/V/fe

10/07/97.

## Chapter XX

# The Right to Consumer Choice\*

Prepared for the Advisory Commission on Consumer Protection and Quality in the Health Care Industry  
Draft - September 26, 1997

### STATEMENT OF THE RIGHT

*Consumers have a right to a choice of health care providers that is sufficient to assure access to appropriate high-quality health care. When coverage is linked to the receipt of services through a defined network of providers, health plans should assure choice as follows:*

***Provider Network Adequacy:** All health insurance products should provide access to sufficient numbers and types of providers to assure that all covered services will be accessible without unreasonable delay -- including access to emergency services 24 hours a day and 7 days a week. When a health plan has an insufficient number or type of provider to provide a covered benefit with the appropriate degree of specialization, the plan should ensure that the consumer obtains the benefit outside the network at no greater cost than if the benefit were obtained from participating providers. Plans also should establish and maintain adequate arrangements to ensure reasonable proximity of providers to the business or personal residence of their members.*

***Access to Qualified Specialists for Women's Health Services.** Women should be able to choose a qualified provider -- including gynecologists or certified nurse midwives -- for the provision of an adequate number of visits to cover routine women's health care services.*

***Access to Specialists:** Consumers with complex or serious medical conditions who require frequent specialty care should have direct access to a qualified specialist of their choice within a plan's network of providers. Authorizations, when required, should be for an adequate number of direct access visits under an approved treatment plan.*

***Continuity of Care:** Consumers who are undergoing a course of treatment for a chronic or disabling condition (or who are in the second or third trimester of a pregnancy) at the time they involuntarily changes health plans or at a time when a provider is terminated by a plan for other*

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

*than cause should be able to continue seeing their current providers for up to 60 days (or through completion of post-partum care) to allow for continuity of care. Providers who continue to treat such patients must accept the plan's rates as payment in full, provide all necessary information to the plan for quality assurance purposes, and promptly transfer all medical records with patient authorization upon completion of the transition period.*

*Public and private group purchasers should, wherever feasible, offer consumers a choice of high-quality health insurance products. Small employers should be provided with greater assistance in offering their workers and their families a choice of health plans and products.*

## **RATIONALE**

The ability of consumers to exercise choice in the health care marketplace is associated with several desirable characteristics of a health care system.

- First, choice is associated with increased consumer satisfaction. In a survey of consumers receiving health care in both indemnity and managed care plans, individuals with a choice of health products (e.g., HMO, POS, PPO, and indemnity products) report greater satisfaction with their plan and tend to rate both their health insurance product and their individual physicians of higher quality (Davis and Schoen 1997).
- Second, the ability of consumers to choose among competing products is a hallmark of a healthy marketplace. Individual consumers are responsible for 34% of all direct expenditures for health care in the United States (Cowan, et al. 1996). As the science of measuring and generating accurate and valid information on health plan, product and provider quality advances, consumers can wield their purchasing power to create incentives in the marketplace for improvements in health care quality.
- Third, consumers who have a role in the selection of their caregivers are likely to have greater confidence in those practitioners and are, therefore, more likely to seek care and follow agreed-upon care regimens.
- Fourth, having choice of providers allows consumers to take action to preserve continuity of care within the health care system by selecting products and providers that allow them to continue provider relationships when continuity of care is especially important (e.g., prenatal care, care of individuals with complex chronic or disabling conditions).

Thus, a health care marketplace that promotes satisfied consumers, continuity of care and continuous improvements in quality requires an array of choices be available to consumers. Absent consumers' ability to have and exercise choice, greater activities may need to be undertaken by group purchasers and regulators to ensure that the health care marketplace responds appropriately to consumers' health care needs.

### **Consumer Choice of Health Plans or Products**

During the last decade, there has been a marked increase in the number and types of health insurance products available in most geographic markets. Prior to the widespread development of managed care products – most Americans had limited choice of health insurance products. Indemnity products dominated the market with HMO and PPO products available primarily in certain metropolitan areas. The past 10 years have seen a significant increase of insurance products with the expansion of many health plans into new geographic markets and the development of multiple insurance product lines by indemnity insurers and managed care organizations. As a result, with the exception of sparsely populated areas, most communities now have available HMO, POS, PPO and indemnity products offering consumers a variety of options in terms of benefits, premiums, copayments, and health care delivery systems.

At the same time, there has been a steady migration from traditional indemnity plans to various managed care products in both the public and private markets. Between 1988 and 1997, the percentage of American workers enrolled in indemnity plans fell from 89% to 51% (Gabel 1997). In 1997, more than 4.9 million Medicare beneficiaries were enrolled in 336 managed care plans, an increase of 108% since 1993. Under Medicaid, 13 million, or 35% of all beneficiaries have been enrolled in managed care plans, an increase of more than 170% since 1993. The Balanced Budget Act of 1997 will increase those trends by expanding the types of products available to beneficiaries of those two public programs.

Although there is greater choice of health insurance products available in most markets, it is important to note that this choice often is exercised at the level of the group purchaser instead of by individual consumers. Between 1988 and 1996, health plan offerings by moderate and large sized employers declined (Gabel 1997). Those offering three or more plans declined from 35% to 30%, while those offering only one plan climbed from 41% to 47% over that period.

There also is evidence of variation in consumer preferences for various product characteristics. In the Kaiser-AHCPR survey (1996), 70% of survey respondents would prefer a high-cost product with a wide range of benefits over a low-cost product with a more limited range of benefits (26%). Respondents were more divided over other health product decisions. Fifty-three percent said they would pay more for unrestricted choice of physicians while 43% would opt for a lower-cost product that limited choice to a list of physicians. Forty-six percent would pay more to have direct access to any specialist, whereas more than half (51%) would choose a lower-cost plan that requires a visit to the family physician for a referral (Robinson and Brodie 1997).

The Commission is troubled by the limited choice of insurance products made available to many consumers through their employer group purchasers. Some of the reduction in choice of plan and product has resulted from conscious decisions by employers to select high-quality products at the best price in the market. Affording consumers greater choice of products would allow consumers to select the product that best meets their individual preferences and would encourage health plans to be responsive to consumers' expressed needs.

The Commission was unable to achieve consensus on creating a "right" to consumer choice of health plan or product but it is determined to find ways to encourage and assist employers and other group purchasers in providing consumers with a greater choice of health plans and products. Consumer choice of health plans and products is important and should be provided whenever possible and in a way that is affordable both to employers and consumers. In its final report, the Commission will address policy options to provide greater choice of health insurance products, including encouraging the development of purchasing coalitions and alliances.

### **Consumer Choice of Physicians and Other Health Care Providers**

The shift from indemnity coverage to managed care arrangements often has narrowed consumers' choice of physicians and other health care providers. Among managed care enrollees who have changed health plans over the last three years, 41% also changed physicians (Davis, et al. 1995). This trend may be changing. Barcents Group reports that 92% of employees who receive their coverage through employer-sponsored plans are offered a plan that includes the ability to choose doctors and hospitals outside a select network. An April 1997 survey by William M. Mercer, Inc., found 97% of respondents offered a plan or plans with a non-network component. In some cases, however, the additional cost of these products or of the option to go out of network effectively puts such choice out of the reach of some consumers.

It also is clear that consumers value some degree of choice of physicians. The 1997 Kaiser/Commonwealth National Health Insurance Survey, found that respondents with a choice of physicians registered the highest level of satisfaction with their plans (Davis and Schoen 1997). A Kaiser-AHCPR survey of consumers identified four reasons why consumers demand greater choice of physicians and other health care professionals:

- "So you can see whatever doctor you think is best qualified to treat a particular medical problem" (43%);
- "So you can change doctors if you become dissatisfied with the one you're seeing" (24%);
- "So you can continue seeing your regular doctor" (20%); and,
- "So it's easier to see someone else if your doctor is not available for an appointment" (9%).

The most frequently cited reasons speak to consumers' desire to utilize choice of physicians as a way to obtain quality care. The third is directed toward maintaining relationships with physicians with whom consumers have an existing relationship. In other words, 63% of consumers surveyed wanted a choice of physicians so that they can develop and maintain a relationship with a physician they trust to provide them high-quality care.

Therefore, it is important for all health plans and products to maintain an adequate network of physicians and other health care providers, to provide for continuity of care when consumers change plans, and to allow consumers with special health care needs to have adequate choice of physicians and other health care providers. This can lead to higher consumer satisfaction with providers and their health plans without undermining the efforts of provider groups and health plans to develop organized delivery systems.

The Commission's recommendations seek to build on these trends toward providing greater choice by taking several steps to ensure (1) network adequacy; (2) greater access for women to a qualified specialists for women's health services (3) ease of access to specialists for consumers with complex and serious conditions; and, (4) greater continuity of care for consumers who enroll in new health plans or see their provider dropped from a plan for other than cause.

### **Provider Network Adequacy**

When appropriately structured, a plan utilizing a network of providers can improve the quality and coordination of care delivered to consumers through careful selection and credentialing of providers and through coordination of care by primary care physicians and those with specialty training. The National Association of Insurance Commissioners (NAIC 1996) has adopted a broadly accepted standard for provider network adequacy. These standards have been adopted by most states and already apply to a majority of licensed health plans in the U.S. The Commission believes universal adoption of this standard will improve both the quality of care and consumers' satisfaction with their health plans and their care. Because of its strong desire to maintain the integrity of health plan networks, the Commission has rejected approaches to mandate the inclusion of providers into networks (i.e., "any willing provider" laws) or to require plans to allow enrollees to go out of plan networks at will (i.e., "freedom of choice" laws).

### **Ease of Access to Specialists**

Consumers with ongoing health needs often require regular access to physicians and other health care professionals who are specially trained to serve those needs (Bernstein, Dial, et al. 1995). This is especially true of those consumers who have disabling or terminal conditions. In such cases, the traditional "gatekeeper" approach used by some health plans can be an impediment to access to quality care and result in unnecessary inconvenience to consumers. The Commission's recommendations are designed to ease consumers access to appropriately trained specialists while maintaining the integrity of network models of care. Consumers with complex and serious medical conditions who require frequent specialty care should have direct access to appropriate specialty care within a plan's network of providers.

### **Access to Qualified Specialists in Women's Health**

Morbidity and mortality associated with breast cancer, cervical cancer, ovarian cancer, and sexually transmitted diseases in women can be significantly reduced through the provision of

preventive and routine gynecological services. The U.S. Preventive Services Task Force has issued recommendations pertaining to the provision of Pap smears, mammograms, and other preventive services for women. Women should have ready and direct access to qualified health care professionals to receive these routine and preventive services.

### **Continuity of Care**

Finally, consumers who are undergoing an extensive course of treatment (e.g. chemotherapy or prenatal care) at the time they join a new health plan should be able to continue to see their current physicians for a period of up to 60 days. Similarly, such consumers should be able to continue to see a physician who is dropped from a plan's network for reasons other than cause. Interruption of care can compromise the quality of care and patient outcomes. Continuity of care has been shown to increase the likelihood that patients receive appropriate preventive services (O'Malley, et al. 1997). Maintaining continuity of care can protect the quality of that care and improve consumers' satisfaction with a new health plan or product. The Commission's recommendations are designed to ease the impact of these transitions from one health insurance product to another and changes in the composition of health plan networks while maintaining the integrity of network models of care.

### **IMPLICATIONS OF THE RIGHT**

Health plans will need to comply with network adequacy standards. Most licensed plans already meet these requirements as laid down by the National Association of Insurance Commissioners (NAIC) in its Managed Care Plan Network Adequacy Model Act. Plans also will need to develop processes to comply with requirements regarding continuity of care and ease of access to specialists within their network of providers. Because these changes are primarily to be carried out within existing provider networks, there should not be a significant increase in costs to health plans or their enrollees.

Consumers will need to exercise their right to choice by using good judgment and providing direct feedback to plans about their level of satisfaction with the network provided for them.

Quality Oversight Organizations will need to incorporate network adequacy standards into their review activities.

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9-15-97

File

Quality

C. Cummings

SPECIAL ANALYSIS**Promises and Pitfalls in Regulating Managed Care**

As enrollment in HMOs and other managed care organizations has grown, Federal and state government interest in regulating these organizations has increased as well. Although some forms of regulation can improve consumer information and the quality of care, others may adversely affect the ability of HMOs to control costs.

**Information requirements.** One category of proposed regulations would require HMOs to disclose important information such as how doctors are paid, how the plan determines what procedures are considered "experimental," what options members have for second opinions, and how satisfied members are with the plan (using satisfaction ratings similar to those published for the Federal Employees Health Benefits Plan). These regulations should help ensure that consumers have the information they need to weigh features and costs when choosing a health plan. Moreover, requiring plans to disclose more information gives plan providers an incentive to improve the quality of care and eliminate undesirable features.

**Blurring distinctions.** Another class of regulations would alter managed care plans in ways that would make them more like traditional plans. For example, some recent proposals would require all HMOs to have an out-of-network option and ban or limit the use of financial incentives (such as capitated payments) that encourage physicians to limit treatment. To the extent that these regulations would prohibit practices that have helped HMOs control utilization and spending, they could undermine the ability to control costs in the future. They would also be unnecessary if disclosure requirements gave consumers adequate information to make their own choices about what features they want in a health plan.

**Standardization.** Regulations requiring standardization of plan features and coverage are aimed at a variety of goals: simplifying health insurance decisions, enhancing competition among plans, and improving the quality of care. By ensuring purchasers that they are getting at least minimal coverage or by presenting information in an accessible format, such regulations can help consumers navigate what is currently a bewildering array of options. Regulations that require all plans to cover particular treatments run the risk of increasing costs by inducing treatment that is not cost-effective, but they may also correct for under provision of some kinds of care. For example, with widespread plan switching, coverage of preventive care may be limited by a concern that people will have switched to another plan before the future cost savings from such care can be realized. Finally, standardization of plan offerings may facilitate competition among plans, which could keep premiums down.

**Conclusion.** Regulation of managed care must balance the benefits from better information and quality against the risks of raising costs and limiting affordability.



Health Insurance Association of America

File Quality  
Commission

**To: Commissioners, President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry**

**From: Bill Gradison, President, HIAA**

**Date: September 29, 1997**

**Re: Correspondence to Commission Co-Chairs**

My recent letter to Secretaries Shalala and Herman is attached for your review. I wanted each of you, as a Commissioner, to know that HIAA is concerned about the current proceedings of the Commission and their potential impact on the health care industry. HIAA believes there is a strong need for more analysis of many of the proposed consumer rights on the table for discussion.

HIAA stands ready to assist the Commission so that all segments of the health care industry benefit from your work. Please feel free to call me if there are any points outlined in my correspondence that you would like to discuss. I can be reached at 202-824-1623.

Thank you for your time and attention to this matter.



Health Insurance Association of America

Bill Gradison  
President

September 29, 1997

The Honorable Donna Shalala  
The Honorable Alexis Herman  
Co-Chairs  
President's Advisory Commission on Consumer Protection and  
Quality in the Health Care Industry  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W., Suite 118F  
Washington, D.C. 20201

Dear Secretaries Shalala and Herman:

The Health Insurance Association of America (HIAA) supports many of the basic objectives of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. However, HIAA has closely monitored the activities of the Commission to date. We are concerned about both the processes involving the Commission's proceedings as well as the development of the Commission's proposed consumer bill of rights and potential oversight recommendations.

At its inception, we gave full support to you and the President in creating the Commission as an advisory group with objectives that could serve the best interests of all users of health care services, not just members of managed care plans or programs. As the Commission has deliberated, HIAA is concerned about the public admission at the September session that the Commission's proposed consumer bill of rights is to be "turned into legislation". We are also concerned that many of the proposed rights have **significant cost, feasibility, as well as implementation issues** affecting employers, consumers, providers, public as well as private health care options. However, no substantial feasibility or cost analyses have accompanied issue papers or panel discussions provided to or prepared for the Commissioners. All of these activities occur as recent studies continue to stress the difficulty of employers, especially those in the small and mid-size segments, being able to provide affordable health care coverage because of increased regulatory requirements and benefit mandates.

HIAA is particularly concerned about the impact of potential Commission recommendations on the employer health benefits segment of the industry. In light of the fact the majority of Americans receive their health care coverage

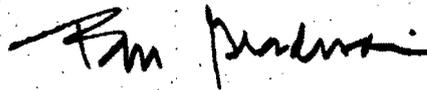
through their employer, there has been little attention paid to the concerns of the employer purchasers who could have overall responsibility for assuring their employees many, if not all, of the "rights" adopted by the Commission if they become federal law or voluntary protections.

We formally wish to communicate our concerns and urge the upcoming sessions to address issues of impact, market demand, and "reasonability" of proposed rights prior to adoption of a bill of rights for all Americans, both insured as well as the uninsured. The Commission has a responsibility to see that their recommendations are in the best interests of the American people and their health care needs. It should not be the goal of the Commission to create rights that stem from "stories" presented by special interest groups or individuals to the Commissioners which have not been validated as meeting of the needs of the nation's consumers. There could be serious adverse unintended consequences to the adoption of many of the rights now on the table for consideration by the Commission.

We urge you and your staff to provide the American people with Commission recommendations that provide a framework for consumer protections. The workings of the Commission should not lead to higher costs for existing health care programs and promises that the Federal government, group and individual purchasers cannot deliver efficiently and responsibly without asking the public to take on an even higher burden in their purchases or funding of health care coverage. If this occurs, then we have all failed the very individuals, consumers of health care services, that this Commission was created to protect.

We urge cost and impact studies, particularly on the employer segment, to become an integral part of the Commission's deliberations. HIAA stands ready to assist the Commission in providing a balanced arena for the development of recommendations for consumer protections and quality in the health care industry.

Respectfully yours,



Bill Gradison  
President

cc: Janet Corrigan, Executive Director  
Advisory Commission Commissioners

Quality Commons #4

10/20/97

John = Chris —

This info. is apparently circulating around Republican offices regarding POTUS Advisory Comm. on Consumer Protection and Quality Health Care.

Just

THE EMERGING CONSUMER BILL OF RIGHTS OF THE PRESIDENT'S ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY AS COMPARED TO NAIC MODEL ACTS, NCQA STANDARDS FOR MANAGED CARE ORGANIZATIONS, AND BLUE CROSS BLUE SHIELD QUALITY COMMITMENTS TO MANAGED CARE MEMBERS

BILL OF RIGHTS		NAIC MODEL ACTS	NCQA ACCREDITATION REQUIREMENTS	EMPLOYER REQUIREMENTS	BLUECROSS BLUESHIELD QUALITY COMMITMENTS
CONSUMERS HAVE A RIGHT TO:	DETAILS OF THE RIGHT				
Access to emergency services	<ul style="list-style-type: none"> <li>Prudent layperson standard</li> </ul>	<ul style="list-style-type: none"> <li>Consistent with NAIC provisions.</li> </ul>	<ul style="list-style-type: none"> <li>Requires timely access to emergency care.</li> <li>Prudent layperson standard currently is being monitored for possible future use.</li> </ul>		<ul style="list-style-type: none"> <li>Blue managed care plans offer access to a full range of appropriate health care services from preventive care and primary care services to highly specialized treatment and follow-up care.</li> </ul>
Remedies (i.e., ERISA Preemption)	<ul style="list-style-type: none"> <li>Should Bill of Rights include a state right to remedies?</li> <li>What kinds of remedies?</li> <li>Do self-insured ERISA firms deserve special attention?</li> </ul>	<ul style="list-style-type: none"> <li>No comparable provision.</li> </ul>	<ul style="list-style-type: none"> <li>Not applicable.</li> </ul>		<ul style="list-style-type: none"> <li>Not applicable.</li> </ul>

NOTE: According to staff, the following issues are "off the table": (1) composition of the health care benefit; (2) "any willing provider"; (3) mandatory POS option; (4) choice of health plan; and (5) community rating.

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

- A 32 member commission (\$1.8 million budget) charged by the President to study managed care practices and develop a "Consumer Bill of Rights" by the fall of 1997 and a full commission report by March 1998.
- This intensely political commission (see attached article) is intent on increasing government's role in regulating the private health insurance marketplace through enactment of the Health Security Act's (Clinton Care-I) regulatory agenda.
  - Some of the Commissioners (Ron Pollack of Families USA & Val Halamandaris, President of the National Association for Home Care) even led the Clinton Care-I bus caravan.
  - In a speech to the Service Employees International Union on Sept. 15, the President stated that he would try to revive his big health care reform plan, "a step at a time until we eventually finish this." The Commission is clearly part of this plan.
- Although the President describes the commission as being both nonpartisan and representative of the whole of the health care community, it is in fact intensely partisan and slanted towards self-described consumer interests.
  - Commission has only three business representatives and one representative of an employer-purchasing coalition. Two of the business representatives (GTE and the representative of an employer-purchasing coalition) were the last to be named to the commission. A large number of business groups such as the NFIB, the National Association of Wholesaler-Distributors, the U.S. Chamber of Commerce and the National Association of Manufacturers have NO representation on the Commission
- The commission staff has consistently refused to consider the cost of its recommendations, claiming that they have insufficient resources
  - Many of the Commissioners have said that cost should not be considered for something as fundamental as a right, ignoring the fact that the cost of these new mandates would increase the number of uninsured Americans.
- The President said in March when he appointed the Commissioners that the Bill of Rights might not necessarily have to be legislation but could be private standards. At the September meeting of the full Commission, Secretary of Health and Human Services Donna Shalala said that she expected the Bill of Rights to become legislation
- The Commission's decision-making process is flawed:

- On issues like the right to standardized benefits, the Commission's witnesses included three provider groups arguing for increased coverage for their services and one representative of a left-leaning research group. No small business representative was included.
- Commissioners who serve on subcommittees are discouraged from disagreeing with the subcommittee at the full Commission level even if there have been significant staff changes to the subcommittee's recommendations.
- There will be no opportunity for public comment after the Commission's report or bill of rights is completed.
- Consensus has been inferred where it doesn't necessarily exist; Secretary Shalala continues to rush through discussion of some of the rights.
- The Commission has not received legal counsel as to the implications of their work; most of the draft chapters of the Consumer Bill of Rights would simply create new avenues and opportunities for the plaintiff's bar
- Already, some groups are lobbying to be exempt from the Bill of Rights; the multi-employer (Taft-Hartley) plans argue that because their benefits are subject to collective bargaining, their plans should be exempt from the Bill of Rights' requirements. Fairness means that either all players -- from managed care plans to indemnity, to FEHBP, to the VA, to Medicare, Medicare and employer-sponsored plans and plans in the individual group market -- should have to abide by the Consumer Bill of Rights or no one should have to comply.

**THE EMERGING CONSUMER BILL OF RIGHTS OF THE PRESIDENT'S ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY AS COMPARED TO NAIC MODEL ACTS, NCQA ACCREDITATION STANDARDS, INNOVATIVE EMPLOYER REQUIREMENTS, AND BLUECROSS BLUESHIELD QUALITY COMMITMENTS**

BILL OF RIGHTS		NAIC MODEL ACTS	NCQA ACCREDITATION REQUIREMENTS	EMPLOYER REQUIREMENTS	BLUECROSS BLUESHIELD QUALITY COMMITMENTS
CONSUMERS HAVE A RIGHT TO:	DETAILS OF THE RIGHT				

DEBATED BY FULL COMMISSION

Nondiscrimination and respect	<ul style="list-style-type: none"> <li>No discrimination in marketing, enrollment, access, provision of services based on race, ethnicity, sex, age, current or anticipated mental or physical disability, sexual orientation, genetic information, or source of payment.</li> <li>No right to nondiscrimination on basis of health status.</li> </ul>	<ul style="list-style-type: none"> <li>Most variables consistent with NAIC rating provisions.</li> </ul>	<ul style="list-style-type: none"> <li>Right to be treated with respect and recognition of their dignity and right to privacy</li> </ul>		<ul style="list-style-type: none"> <li>Patient satisfaction is a priority.</li> <li>Blue managed care plans and participating physicians are committed to satisfying our members' most important expectation: quality health care.</li> </ul>
Information	<ul style="list-style-type: none"> <li>Benefit design</li> <li>Network characteristics (including provider compensation)</li> <li>Performance and quality (including satisfaction, performance measures, disenrollment rates)</li> <li>Health professional information (e.g., volume of services)</li> </ul>	<ul style="list-style-type: none"> <li>Consistent with NAIC provisions in general.</li> </ul>	<ul style="list-style-type: none"> <li>Right to information about the plan, its services, and its providers and members' rights and responsibilities, including: benefit design, network characteristics and provider information.</li> </ul>		<ul style="list-style-type: none"> <li>Patients have a right to information about their health care and health plan.</li> <li>Proactive member education and disclosure of health plan practices allow patients to make educated decisions about their health care options. Blue managed care plans</li> </ul>

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THE EMERGING CONSUMER BILL OF RIGHTS OF THE PRESIDENT'S ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY AS COMPARED TO NAIC MODEL ACTS, NCQA STANDARDS FOR MANAGED CARE ORGANIZATIONS, AND BLUE CROSS BLUE SHIELD QUALITY COMMITMENTS TO MANAGED CARE MEMBERS

BILL OF RIGHTS					
CONSUMERS HAVE A RIGHT TO:	DETAILS OF THE RIGHT	NAIC MODEL ACTS	NCQA ACCREDITATION REQUIREMENTS	EMPLOYER REQUIREMENTS	BLUECROSS BLUESHIELD QUALITY COMMITMENTS
	<ul style="list-style-type: none"> <li>Facility information</li> </ul>				inform our members about how to use their benefits and take the guesswork out of obtaining health care.
Appeals and Grievances	<ul style="list-style-type: none"> <li>Internal appeals with written notification and review by appropriately credentialed medical professionals.</li> <li>External appeals system when:                             <ul style="list-style-type: none"> <li>a decision is based on determination that treatment is experimental or investigational; or</li> <li>when the decision is based on determination that services are not medically necessary and the amount exceed a reasonable threshold or patient's life or health is jeopardized.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Internal appeals consistent with NAIC provisions</li> <li>No comparable external appeals provision</li> </ul>	<ul style="list-style-type: none"> <li>Similar internal complaint and appeals procedures.</li> <li>No requirement for external appeals.</li> </ul>		<ul style="list-style-type: none"> <li>Blue managed care plans provide all patients and physicians an accessible, fair, and reasonable forum for lodging and resolving complaints, grievances and appeals.</li> </ul>
STILL TO BE DEBATED BY THE FULL COMMISSION					
Choice of	<ul style="list-style-type: none"> <li>Access to specialty care for</li> </ul>	<ul style="list-style-type: none"> <li>No</li> </ul>	<ul style="list-style-type: none"> <li>Requires plan to</li> </ul>		<ul style="list-style-type: none"> <li>Blue managed care</li> </ul>

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BILL OF RIGHTS					
CONSUMERS HAVE A RIGHT TO:	DETAILS OF THE RIGHT	NAIC MODEL ACTS	NCQA ACCREDITATION REQUIREMENTS	EMPLOYER REQUIREMENTS	BLUECROSS BLUESHIELD QUALITY COMMITMENTS
providers	<p>people with particular conditions (e.g., chronic, disabling, etc.) or direct access to OB/GYNs.</p> <ul style="list-style-type: none"> <li>Continuity of care when a physician or patient leaves a network.</li> </ul>	<p>comparable provisions on access to OB/GYN or specialists.</p> <ul style="list-style-type: none"> <li>Continuity of care consistent with NAIC provision.</li> </ul>	<p>actively work to improve the health status of members with chronic conditions.</p> <ul style="list-style-type: none"> <li>Requires evidence that plan has assisted members affected by the termination of a primary care delivery site in selecting a new site.</li> <li>Currently monitoring standard to require plans to notify members being seen regularly by a specialist whose contract is terminated and</li> </ul>		<p>plans offer access to a full range of appropriate health care services from preventive care and primary care services to highly specialized treatment and follow-up care.</p> <ul style="list-style-type: none"> <li>Blue managed care plans offer choices of customized health plans that address our members' medical, financial, and geographic needs.</li> </ul>

THE EMERGING CONSUMER BILL OF RIGHTS OF THE PRESIDENT'S ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY AS COMPARED TO NAIC MODEL ACTS, NCQA STANDARDS FOR MANAGED CARE ORGANIZATIONS, AND BLUE CROSS BLUE SHIELD QUALITY COMMITMENTS TO MANAGED CARE MEMBERS

BILL OF RIGHTS		NAIC MODEL ACTS	NCQA ACCREDITATION REQUIREMENTS	EMPLOYER REQUIREMENTS	BLUECROSS BLUESHIELD QUALITY COMMITMENTS
CONSUMERS HAVE A RIGHT TO:	DETAILS OF THE RIGHT				
			assist them in selecting a new provider. (RR 5.4.2)		
Access to controlled trials	<ul style="list-style-type: none"> <li>Coverage of ancillary and related costs will facilitate consumer access to controlled trials.</li> </ul>	<ul style="list-style-type: none"> <li>No comparable provision</li> </ul>	<ul style="list-style-type: none"> <li>No requirement with respect to controlled trials.</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>	<ul style="list-style-type: none"> <li>The Blue Cross and Blue Shield National Medical Council believes that third party payors have a legitimate role in providing voluntary support for the patient care costs of well-designed, high priority clinical trials that address significant scientific questions important to the health of their members.</li> </ul>
Full disclosure of treatment options	<ul style="list-style-type: none"> <li>Participation in treatment decisions, including through advance directives.</li> <li>No prohibitions on communications between consumers and physicians.</li> </ul>	<ul style="list-style-type: none"> <li>Consistent with NAIC provision.</li> </ul>	<ul style="list-style-type: none"> <li>Right to participate with providers in decision making regarding their health care.</li> <li>Requires plan to allow open practitioner-</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>	<ul style="list-style-type: none"> <li>Treatment options are openly discussed between Blue managed care plan physicians and patients. Treatment decisions are based on the best available scientific information, clinical evidence, and</li> </ul>

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BILL OF RIGHTS					
CONSUMERS HAVE A RIGHT TO:	DETAILS OF THE RIGHT	NAIC MODEL ACTS	NCQA ACCREDITATION REQUIREMENTS	EMPLOYER REQUIREMENTS	BLUECROSS BLUESHIELD QUALITY COMMITMENTS
			patient communication regarding treatment alternatives.		<p>the unique needs of the patient.</p> <ul style="list-style-type: none"> <li>Open discussion of all information that is relevant to the patient's health is a critical component of the Blue Plan physician-patient relationship.</li> </ul>
Balanced incentive arrangements	<ul style="list-style-type: none"> <li>Incentive arrangements should encourage increased productivity and reward improved quality and efficiency.</li> <li>Plans should not transfer too much risk to individual providers or small groups so as to result in barriers to access.</li> </ul>	<ul style="list-style-type: none"> <li>Consistent with NAIC provisions in general.</li> </ul>	<ul style="list-style-type: none"> <li>Currently monitoring standard that would require compensation plans for individuals performing utilization review services not contain direct or indirect incentives to make inappropriate review decisions.</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>	<ul style="list-style-type: none"> <li>Blue managed care plans view medical ethics as the cornerstone of the successful physician-patient relationship.</li> </ul>
Consumer assistance	<ul style="list-style-type: none"> <li>e.g., Ombudsman</li> </ul>	<ul style="list-style-type: none"> <li>Consistent with NAIC</li> </ul>	<ul style="list-style-type: none"> <li>No specific requirements for</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>	<ul style="list-style-type: none"> <li>Blue managed care plans inform our</li> </ul>

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BILL OF RIGHTS					
CONSUMERS HAVE A RIGHT TO:	DETAILS OF THE RIGHT	NAIC MODEL ACTS	NCQA ACCREDITATION REQUIREMENTS	EMPLOYER REQUIREMENTS	BLUECROSS BLUESHIELD QUALITY COMMITMENTS
		provisions in seniors market.	consumer assistance.		<p>members about how to use their benefits and take the guesswork out of obtaining health care.</p> <ul style="list-style-type: none"> <li>Blue managed care plans offer choices of customized health plans that address our members' medical, financial, and geographic needs.</li> </ul>
Confidentiality and privacy	<ul style="list-style-type: none"> <li>Require written confidentiality policies.</li> <li>Consumer rights to access, review, correct records.</li> <li>Voluntary informed consent to release information.</li> <li>Define health information broadly.</li> </ul>	<ul style="list-style-type: none"> <li>Consistent with NAIC provisions in general</li> </ul>	<ul style="list-style-type: none"> <li>Requires written confidentiality policies and procedures.</li> <li>Not addressed.</li> <li>Allow members to approve or deny release of information, except when release is required by law.</li> </ul>		<ul style="list-style-type: none"> <li>Health care is personal and confidential. Patient information is handled by Blue managed care plans in the strictest confidence.</li> </ul>