

quality issue.

— consensus in some areas

complementary area by issue have received bipartisan support ongoing need body group increased consensus

Charged to  
→ March

consulted w/

public hearings, outside of DC

POTUS asked to patient bill

consumer appeals

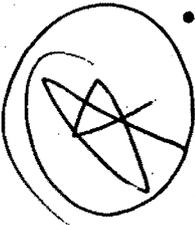
& grievance process

## **IMPROVING REMEDIES FOR IMPROPER CLAIMS DENIALS UNDER ERISA-COVERED PLANS**

### **CURRENT LAW — Need For Change**

- Persons who administer an employee benefit plan are not responsible to participants and beneficiaries for the consequences of wrongfully delaying or denying a claim for benefits.
- Under ERISA, a participant, whose request for medical services has been improperly delayed or denied by the plan administrator, can only recover the benefits that should have been provided, but not damages such as lost wages, additional medical costs, pain and suffering, or wrongful death. A successful participant is not even assured of recovering his or her costs, attorneys fees or expert witness fees.
- In addition, courts generally give deference to the plan's decision. They will not overrule a benefit denial unless the plan's decision was unreasonable (*i.e.*, arbitrary and capricious, or abuse of discretion).
- At the same time, ERISA preempts the state law remedies available to persons not covered by ERISA plans. This is true whether the plan funds its benefits through an insurance policy or directly from the employer's assets.
- These restrictions on available remedies reduce any economic incentive for an administrator to provide fair and expeditious resolution of benefit claims. The person who determines whether to approve claims may be under pressure to deny them because he or she works for the entity responsible for paying the claims.
- Improper delays or denials of claims for benefits can affect the quality of care afforded to participants.
- Persons outside of an ERISA plan (*e.g.*, in the individual insurance market, or in non-ERISA plans) can generally avail themselves of a broad range of remedies.

OPTIONS — We see four potential approaches:

- **A Federal Law Approach:** Amend ERISA to make available economic damages (e.g., cost of care, lost wages) where personal injury or wrongful death occurs in connection with an improper denial or delay in deciding health benefit claims under an ERISA plan. Additional damages, such as for pain and suffering, would be available where the delay or denial was unreasonable.
- *Penalty damages*  
**State Law Approach:** Modify ERISA preemption to permit states to apply their existing substantive laws and remedies, or enact new ones, specifically for the improper denial or delay of health benefit claims which result in personal injury or wrongful death. Under this approach, a state could decide whether or not to provide any such substantive law or remedy.
- **State Law Remedies for Insured Plans and a Federal Law Remedy for Self-Funded Plans:** Establish a federal standard for self-funded plans, and permit state insurance laws to apply to plans that are funded through insurance policies. This approach would allow the states to fully enforce their insurance laws, but would not subject self-funded plans (which are usually larger plans) to the diversity of state remedies.
- *Federal or State?*  
**Civil Penalty Approach:** Establish a scheme of dollar denominated civil money penalties for improper claims delays or denials. Various options exist under this approach depending on whether the penalty would be imposed by the courts in private actions or assessed by the Secretary, and on whether the penalty would apply to individual cases or only upon a showing of a pattern and practice of improper claims handling.

An element of any of the approaches summarized above could be that employers should be insulated from liability unless they directly engage in making determinations on benefit claims. As part of this element, agreements requiring employers to indemnify HMOs for their liability could be prohibited.

## DESCRIPTION OF POTENTIAL APPROACHES

### A. A Federal Law Approach — New ERISA Standards

- Amend ERISA to: (1) make available damages for economic losses (e.g., cost of care, lost wages) when an improper denial or delay in deciding health benefit claims under an ERISA plan results in personal injury or wrongful death; and possibly (2) make available additional damages (e.g., pain and suffering) where the delay or denial of the benefit is unreasonable (*i.e.*, arbitrary and capricious, abuse of discretion)
  - Economic damages would be available if the court disagreed with the plan's determination. No deference would be granted to the plan's decision. A finding that the plan acted unreasonably would not be required.
  - Additional damages would be available against the entity that administered the claim if the delay or denial of the claim was objectively unreasonable or arbitrary. It would not require proof of an evil motive.
  - The damages would be available for all types claims regardless of amount as long as there was a personal injury or wrongful death. (Option: Have threshold requirements, e.g., dollar amounts or qualitative.)
  - Scope of Review for Recovery of Benefits
    - Submission to the court of information that was not before the plan would be allowed.
  - Reasonable costs, attorneys fees, and expert witness fees must awarded to the successful claimant.
  - Remedies Options in Addition to Recovery of the Benefit (available under current law):
    - Economic Remedies (for Improper Benefit Denials):
      - Option A: Compensatory Economic Damages (e.g.,

cost of care, lost wages) Resulting From the Personal Injury

- Option B: Compensatory Economic Damages Whether or Not They Result from the Personal Injury (e.g., claimant sells house to pay cost of care)
- Other Types of Remedies (for Unreasonable Benefit Denials) (any combination)
  - Physical Pain and Suffering (with Caps?)
  - Emotional Distress (with Caps?)
  - Punitive Damages with Caps

## **B. A State Law Approach — Limit ERISA Preemption**

- Modify ERISA preemption to permit states to apply their existing substantive laws and remedies, or to enact new substantive laws and remedies, addressing the improper denial or delay of health benefit claims.
  - States would be able to impose any standard for awarding damages under this approach. They would also be able to award any type of damages, including damages for emotional distress and punitive damages.
  - Option: Impose federal caps on damages that a state court can award in a case involving an ERISA plan.
  - Under this approach, a state could decide not to provide any such remedy.

## **C. A Combination Approach — State Law Remedies for Insured Plans and a Federal Law Remedy for Self-Funded Plans**

- Establish the above-described federal standard for self-funded plans, and permit state insurance laws to apply to plans that are funded through insurance policies.

- This approach would allow states to fully enforce their insurance laws, but would not subject self-funded plans (which are usually larger plans) to the diversity of state standards and remedies.
- It may cause confusion for participants by creating two different legal schemes, particularly for participants of self-funded plans that are administered by an insurance company, or for employees of employers who provide both insured and self-funded coverage options.

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#### D. A Civil Penalty Approach

##### Option 1 — Mandatory Civil Penalty Awarded by Court in Cases Brought by a Participant or Beneficiary to Enforce the Terms of the Plan

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- Amend ERISA to require a court to impose a civil money penalty against the plan in an amount of at least \$5,000 and up to, at the court's discretion, \$25,000 (Option: or more) where an improper denial or delay in deciding health benefit claims under an ERISA plan results in personal injury or wrongful death.
- The penalty would be payable to the participant or beneficiary in addition to whatever equitable relief (e.g., provision of the claimed benefit) was ordered by the Court.
- Attorneys fees, expert witness fees and costs would be mandatory for successful claimants.

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##### Option 2 — Add to Option 1 a Civil Penalty in Cases of a Pattern and Practice of Improper Claims Handling

- If the court finds that the benefit denial at issue was part of a pattern and practice of improper claims denials, the court would be required to

impose an additional civil money penalty of at least \$15,000 up to, at the court's discretion, \$150,000.

- The court, in setting the penalty amount in a given case, would be permitted to take into account the penalties that the plan has already paid for the same pattern and practice.
- "Pattern and practice" would mean improperly denying or delaying claims with such frequency as to indicate an intent to materially reduce costs to the plan through the improper denial or delay of claims
- The penalty would be payable to the participant or beneficiary in addition to: (1) whatever equitable relief (e.g., provision of the claimed benefit) ordered by the court and (2) the mandatory penalty.
- Attorneys fees, expert witness fees and costs would be mandatory for successful claimants.

### **Option 3 — Option 1 and/or Option 2 for Self-Funded Plans and Penalties Set by State Law for Insured Plans**

- For plans that are not self-funded (i.e., insured plans, including plans that shift risk to HMOs, etc.) all claims dispute cases would be decided by state courts (not removable to federal court). States could enact their own penalty amounts providing that they were higher than the penalties under the Federal law.

### **Option 4 — Discretionary Civil Penalty Assessed by the Secretary of Labor in Cases of a Pattern and Practice of Improper Claims Handling.**

- If the plan has engaged in a pattern and practice of improper claims denials, the Secretary could assess a large penalty amount (e.g., up to \$10 million, at the Secretary's discretion, or an amount based on the value of claims processed by the violator).
- The penalty would be payable to the government.

- Liability for the penalty would be determined after an administrative hearing with Federal court review in cases where assessment of the penalty is challenged.

**Option 5 — Option 1 (with or without Option 3) and Option 4**

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**Option 6 — Option 1, Option 2 (with or without Option 3) and Option 4**

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Ass.

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## **OPTIONS FOR EXTERNAL REVIEW OF CLAIMS DENIALS UNDER ERISA-COVERED PLANS**

### **CURRENT LAW**

- ERISA requires that every employee benefit plan provide adequate written notice to a participant or beneficiary whose claim is denied, and afford a reasonable opportunity for a full and fair review of the denial by an appropriate named fiduciary.
- The statute does not require any external review of benefit claims other than the participant's right to file a civil action for review by a court. Although the participant may file the action in a state court, the plan may have the action removed to federal court. ERISA preempts any state law remedies that might otherwise be available.
- Regardless of the jurisdiction in which the matter is decided, the court must apply ERISA, not state law, and may only provide "equitable remedies." That is, the court may order that the denied benefit be provided. It may not award damages for any injury caused by the denial.
- In addition, the courts generally grant significant deference to the plan fiduciary's decision, overturning it only if they find that the plan acted arbitrarily. Moreover, courts often do not permit the claimant to introduce evidence that was not presented during the plan's internal decision-making and review procedure.
- Because claims determinations are generally made by persons who are employed by the entity responsible for paying the claim, an internal claims determination process is subject to an inherent conflict of interest.

## OVERVIEW OF OPTIONS

### Shortcomings of External Review Without Improving Remedies

- External review measures, by themselves, do not fully address the imbalance of incentives in the current system. Under ERISA, a plan fiduciary who fails to assure compliance with current statutory and regulatory requirements, or any future external review requirements, is not accountable for that failure.
- There are many examples of claims decisions that are simply wrong. Even if ultimately corrected, some of these wrong decisions will cause injury before they are corrected. The lack of remedies under the current statutory scheme prevents the injured parties from receiving compensation.
- An external review system without remedies would provide no disincentive for plan fiduciaries to arbitrarily deny care with the expectation that many participants will not pursue the matter to the external tribunal.
- The options described below are based on the assumption that a truly independent, expeditious and inexpensive external review process could be established.

### OPTION 1 — Provide External Review for All Claims

- Amend ERISA to provide for external review of a denied or delayed claim within a time period appropriate to the claim.
  - *E.g.*, a denial of emergency care could be reviewed within a matter of hours, other types of claims might need to be reviewed within a few days.
  - The external review organization would have appropriate guidelines or could decide on a case by case basis how quickly a request for review should be processed.

Option 1 cont'd

- The reviewer would have access to independent medical and legal expertise.
  - The external review organization would decide the claim on principles of contract law, and would issue decisions binding on the plan and the participant.
    - Option: The decision could be subject to an "appellate review" by a court limited to the record and with an arbitrary and capricious standard of review.
    - Option: No further review of the merits of the external review decision (only review of jurisdictional or procedural issues).
  - The external review organization could be authorized to:
    - Option: Award costs, attorneys fees and expert witness fees to:
      - Option: Either party
      - Option: Successful participants only
      - Option: Successful p's and to plans for frivolous claims
    - Option: Assess penalties payable to the government (without a showing of bad faith unless damages also available)
    - Option: Award compensatory damages to a participant (perhaps capped for pain and suffering and other non-economic damages)
    - Option: Award capped punitive damages (what showing would be required?)
- (If the external reviewer awards any type of damages, then, for Constitutional reasons, the plan would probably have to be given the right to *de novo* review by a court with a jury trial. The jury could be limited to reviewing the damage award, and not be able to overturn the award of the benefit)
- **Standard and Scope of External Review**
    - The standard of review would be *de novo*,
    - Submission of information that was not before the plan would be allowed.

#### Option 1 cont'd

- **Exclusivity of External Review Process**
  - Option: The external review forum would be the exclusive forum for claims denials.
  - Option: External review would be optional for the participant
  - Option: Only participants with large or serious claims could waive external review and go directly to court where they could obtain:
    - Option: state law remedies, or
    - Option: expanded ERISA remedies.
- **Cost of the External Review Process**
  - Option: borne by the plan in all cases;
  - Option: borne by the claimant if unsuccessful;
  - Option: borne by the Federal government.

#### **Option 2 — Provide External Review for Small Claims Only**

The purpose of an external review procedure for small claims would be to provide an expeditious and inexpensive forum for the great majority of claims. Federal district courts are not well suited for reviewing such matters, and the expense of going to court makes this an infeasible option for dissatisfied claimants who have small claims.

- Amend ERISA to require the external review in Option 1 for small claims only, *i.e.*, claims that meet all the following conditions:
  - (1) below a certain threshold amount (based on the \$ value of the claim, *e.g.*, \$5,000),
  - (2) no injury is alleged, and
  - (3) do not involve imminent threat to life, further serious deterioration of health or intractable pain)
- In some states, the tribunal could be existing forums such as small claims court.
- Private entities could be certified to provide external review, but development of safeguards against inherent bias may be difficult.

Option 2 cont'd

- The tribunal would have the power to order payment of the benefit.
  - Option: The tribunal could award attorneys and expert witness fees to a successful claimant.
  - Option: The tribunal could assess penalties for egregious conduct.
- The external review forum would be the exclusive forum for claims denials that meet its conditions. Claimants could not choose to go directly to court.
- Judicial Review of External Review Decision
  - Option: limited to the external review record and under an arbitrary and capricious standard.
  - Option: limited to jurisdictional and procedural issues.
- Treatment of Claims Not Subject to External Review
  - Claims larger than the threshold amount, claims where an injury is alleged and claims involving imminent threat to life, further serious deterioration of health or intractable pain would be exempt from this process, regardless of the \$ amount — the claimant could go straight to court.
  - In order for this option to make sense, the court's standard of review for such claims would need to be *de novo*, that is without deference to the plan's decision, and to allow the introduction of new evidence.
  - Option: The court would be required to award costs, attorneys fees and expert witness fees to:
    - Option: Either party
    - Option: Successful participants only
    - Option: Successful p's and to plans for frivolous claims
  - Option: The court could assess penalties payable to the government (without a showing of bad faith unless damages also available)
  - Option: The court could award compensatory damages to a participant (perhaps capped for pain and suffering and other non-economic damages)

- Option: The court could capped punitive damages (what showing would be required?)
- Option: Prohibit removal of civil actions to Federal court except for very large claims (e.g., over \$50,000)

### **Option 3 — Provide External Review for Large Claims Only**

The purpose of providing external review for large claims is to have a much smaller, and therefore, less expensive system that would decide only those matters where a great deal is a stake either for the participant or the plan. The purpose of an expeditious external review would be to decrease the likelihood of serious injury resulting from a wrong decision by the plan.

- Amend ERISA to require the external review process described in Option 1 for serious claims only, *i.e.*, claims that meet threshold conditions:
  - imminent threat to life, further serious deterioration of health, or intractable pain,
  - injury resulting from the denial is alleged, or
  - minimum dollar amount
 (The dollar threshold, which would only apply if the health or injury threshold did not, should be set fairly high, say \$5,000 or more, to avoid overwhelming the external review system.)
- **Exclusivity of External Review Process**
  - Option: The external review forum would be the exclusive forum for claims denials that meet its conditions.
  - Option: A participant with a claim that is eligible for external review could choose to go directly to court.
- **Treatment of Claims Not Subject to External Review**
  - Small Claims, and claims not involving imminent threat to life or of serious further deterioration of health or intractable pain would be exempt from the external review process, and claimants

Option 3 cont'd

could go to court to obtain payment of the benefit, but not damages. (Due to the cost of going to court, and the limited remedies available, this would have the practical effect of limiting small claims to internal review)

- Option: Require that courts not give deference to the plan's decision, and allow submission of new evidence.

**Note:** Under any of the above options, claims that do end up in court, could be decided by either Federal or State courts at the option of the participant — the plan would not be able to remove a claim filed in State court to Federal court.

go down in history as one that passed land mark legislation to save lives and strengthen America for the new century; or one that was dominated by partisan election year politics?

The calendar tells us that this is an election year. That's a good thing -- we need one every now and then. ((Laughter.) Have the debates and have the discussion. But as I have told every member of Congress in both parties with whom I have discussed this, no matter how much we get done this year there will still be things at the end of the year on which honorable people in both parties disagree -- more than enough over which to have an honest, fruitful, meaty election. This election should not be allowed to obscure the fact that the American people want it to be not only an election year, but a productive legislative year for the health and welfare of our country and our future. (Applause.)

Dr. Wootton has already talked about the Patient's Bill of Rights, but I want to say a few things about it. Because my mother was a nurse anesthetist, I grew up around doctors from the time I was a little boy. They were the first professional people that I ever knew. Most of them were the kind of people we'd all like our children to grow up to be. They were hard-working, able, kind, caring people. Most doctors today are as well. But the world of medical practice is very different today than it was 40 years ago, when I first started looking at it through the eyes of a child -- not altogether worse, of course. There are many things that are better. We have higher life expectancy, the lowest infant mortality rate we've ever recorded, the highest rate of childhood immunization, dramatic advances in medicines and medical technologies and all kinds of treatments.

We also have more than 160 million Americans in managed care plans. And while there have been some problems with them, all of us have to be glad when health care costs don't go up at four or five times the rate of inflation.

Still, it's often harder for you just to be doctors. When a doctor spends almost as much time with a bookkeeper as with a patient, something is wrong. (Applause.) If you have to spend more time filling out forms than making rounds, something is wrong. (Applause.) And most important to me, when medical decisions are made by someone other than a doctor, and something other than the best interests of the patient is the bottom line, then something is wrong. (Applause.) I think we should have a simple standard: traditional care or managed care, every American deserves quality care. (Applause.)

We all have our stories, and yours are more firsthand and perhaps fresher than mine, but I never will forget reading a few weeks ago about a woman who worked in an oncologist's office to verify insurance coverage and get authorizations for medical procedures, who told us the story of a 12-year-old boy with a cancerous tumor in his leg. The doctor wanted to perform a procedure to save the boy's leg, but the health plan said no. It seems that

for that condition, the only approved procedure was amputation. And that was the only procedure the plan would pay for. The child's parents appealed the decision, but they were turned down. They appealed again and were turned down again. Only when the father's employer weighed in did the health plan change its mind. By then, it was too late, the boy's cancer had spread, and amputation was the only choice left. Of course, it was covered by the health plan.

That is a choice no family should have to make. If the doctor had been able to do the right thing, the child would have been better off, and the system would have been better served.

We have the best-trained, best-skilled doctors in the world, the best medical education, the best medical technology. We're all getting a lot smarter than we used to be about prevention. The first thing your President said to me is, "I'm a cardiologist, take this golf club and stay in good shape." (Laughter.) We're getting better at it. But it is madness to strain at a gnat and swallow a camel. And it happens, over and over and over again.

There are no fewer than 500 stories that could come up in this audience right now within a half an hour not all that different from the one I just told. That is what we seek to address. That's what the Patient's Bill of Rights is all about -- to put medical decisions back into the hands of doctors and their patients. I have already acted, as your president said, to ensure that federal employees and their families, military personnel, veterans and their families, everyone on Medicare and Medicaid -- altogether about a third of our people -- are covered by the Patient's Bill of Rights.

And across our nation, state legislators and governors, both Republican and Democratic, are doing what they can. Forty-three states have enacted into law one or more of the basic provisions of the Patient's Bill of Rights. But state laws and the patchwork of reforms can't protect most Americans. At least 140 million of them are without basic protection. That's why we need the federal Patient's Bill of Rights with the full force of federal law. (Applause.)

The Hippocratic Oath binds doctors -- and I quote -- "to follow that method of treatment which according to my ability and judgment I consider for the benefit of my patients." That is your responsibility, and should be your patient's right -- to know all the medical options, not just the cheapest; primary care when possible, specialists when necessary. That's why the Patient's Bill of Rights lifts the gag order on our nation's doctors and allows patients to follow your best recommendations by appealing unfair decisions by managed care accountants.

Patients also should have a right to keep their medical records confidential. (Applause.) Doctors must feel free to write down the whole truth without it ending up on the Internet or in the hands of employers and marketing firms or increasing a patient's insurance rates. (Applause.)

- Since 1990 the number of Americans in managed care plans has grown from about 94 million to more than 160 million -- about a 75 percent increase.

According to a recent Kaiser Survey:

- 60 percent of Americans say they are worried that their health plan would be more concerned about saving money than about what is the best treatment for them if they were sick.
- 61 percent say that managed care has decreased the amount of time that doctor spend with patients
- 60 percent believe it has made it harder for the sick to see medical specialists
- Half believe it has decreased the quality of care for the sick.

549 million \$ 160 million

44 states

28 Rep-Id

## CONSUMER BILL OF RIGHTS AND RESPONSIBILITIES

The "Consumer Bill of Rights" consists of the following rights and responsibilities:

- (1) **Access to Accurate, Easily Understood Information** about consumers' health plans, facilities and professionals to assist them in making informed health care decisions.
- (2) **Choice of Health Care Providers** that is sufficient to assure access to appropriate high quality care. This right includes:
  - **Access to specialists:** assuring consumers with complex or serious medical conditions access to to the specialists they need;
  - **Access to specialists for women's health needs:** giving women access to qualified providers to cover routine women's health services, and
  - **Transitional care:** providing access to continuity of care for consumers who are undergoing a course of treatment for a chronic or disabling condition.
- (3) **Access to Emergency Services** when and where the need arises. This provision requires health plans to cover these services in situations where a "prudent slayperson" could reasonably expect that the absence of care could place their health in serious jeopardy;
- (4) **Participation in Treatment Decisions** including:
  - **Requiring** **Prohibiting disclosure of financial incentives:** requiring providers to disclose any incentives, financial or otherwise -- that might influence their decisions, and
  - **Prohibiting "gag clauses":** which restrict health care providers' ability to communicate with and advise patients about medically necessary options;
- (5) **Assurance that Patients are Respected and Not Discriminated Against**, including discrimination in the delivery of health care services consistent with the benefits covered in their policy based on race, gender, ethnicity, mental or physical disability, and sexual orientation;
- (6) **Medical Privacy** which assures that individually identifiable medical information is not disseminated and that also provides consumers the right to review, copy and request amendments to their own medical records;
- (7) **Grievance and Appeals Processes** for consumers to resolve their differences with their health plans and health care providers -- including an internal and external appeals process; and
- (8) **Consumer Responsibilities** which asks consumers to take responsibility by maximizing healthy habits, becoming involved in health care decisions, carrying out agreed-upon treatment plans, reporting fraud, among others.

**Michael Hudson**

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## CAMPAIGN FOR HEALTH CARE ACCOUNTABILITY

The Campaign for Health Care Accountability is an alliance of health care provider and citizen organizations, both national and state based, formed to promote public policy that will ensure equitable and adequate accountability for health care decisions. Specifically, the Campaign is supporting legislation to clarify, under the federal Employee Retirement and Income Security Act (ERISA), that *states* have the authority to enact state laws to hold managed care programs accountable for patient injuries resulting from their negligent health care decisions.

A number of federal district and circuit courts are ruling favorably in support of this premise, and an increasing number of states -- now at least 17 -- are actively pursuing legislation to establish managed care accountability. Like the Texas bill passed in 1997, the other state laws will likely be challenged based on an ERISA preemption argument. Passage of the federal amendment would make clear that the *states* have this legal authority.

The Campaign is seeking a broad base of participation from both national and state citizen and health provider groups. It will be governed by a representative steering committee of participating organizations.

Yes, you may list our organization as endorsing the Campaign.

NAME: \_\_\_\_\_

ORGANIZATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE/FAX: \_\_\_\_\_

E-MAIL: \_\_\_\_\_

For more information, contact:

Alfred Gilchrist, Texas Medical Association, 800-880-1300, or  
Michael Hudson, Consultant, 303-604-1392

# **WE SUPPORT PASSAGE OF CSSB 386!**

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- ❖ Advocacy, Inc. ❖
- ❖ American Association of Retired Persons (AARP) ❖
  - ❖ Brain Injury Association of Texas ❖
  - ❖ Center for Public Policy Priorities ❖
- ❖ Coalition for Nurses in Advanced Practice ❖
- ❖ Coalition of Texans with Disabilities ❖
  - ❖ Consumers Union ❖
- ❖ Directors Association of Texas Centers for Independent Living ❖
  - ❖ Disability Policy Consortium ❖
  - ❖ Mental Health Association in Texas ❖
- ❖ National Association of Social Workers/Texas Chapter ❖
  - ❖ National Multiple Sclerosis Society ❖
  - ❖ Texas Academy of Family Physicians ❖
- ❖ Texas Academy of Physicians Assistants ❖
  - ❖ Texas Advocates ❖
  - ❖ Texas Advocates for Special-needs Kids ❖
  - ❖ Texas AIDS Network ❖
  - ❖ Texas Alliance for the Mentally Ill ❖
- ❖ Texas Assistive Technology Partnership/University Affiliated Program ❖
  - ❖ Texas Association of Optometrists ❖
  - ❖ Texas Chiropractic Association ❖
  - ❖ Texas Clinical Society of Social Workers ❖
  - ❖ Texas College of Emergency Physicians ❖
    - ❖ Texas Dental Association ❖
    - ❖ Texas Dermatological Society ❖
    - ❖ Texas Geriatric Society ❖
  - ❖ Texas Health-System Pharmacists Association ❖
    - ❖ Texas Medical Association ❖
    - ❖ Texas Medical Foundation ❖
- ❖ Texas Medical Group Management Association ❖
  - ❖ Texas Mental Health Consumers ❖
  - ❖ Texas Nurses Association ❖
- ❖ Texas Occupational Therapy Association, Inc. ❖
  - ❖ Texas Ophthalmic Professionals Society ❖
  - ❖ Texas Osteopathic Medical Association ❖
  - ❖ Texas Physical Therapy Association ❖
- ❖ Texas Planning Council for Developmental Disabilities ❖
  - ❖ Texas Podiatric Medical Association ❖
  - ❖ Texas Society of Pathologists ❖
  - ❖ Texas Society of Plastic Surgeons ❖
  - ❖ Texas Society of Psychiatric Physicians ❖
- ❖ Texas Speech-Language-Hearing Association ❖
  - ❖ Texas Urological Society ❖
  - ❖ The Arc of Texas ❖

*Shelton*

Quality Files

## DEMOCRATIC BILL

Areas Where Further Than Quality Commission

### PRIMARY DIFFERENCES

- **ERISA Remedies.** Allows state cause of action to recover personal damages for personal injury or wrongful death.
- **Clinical Trials.** Requires plans to cover patient care costs associated with clinical trials at NIH and similar peer review process. Quality Commission did not include this provision. [\$5 billion over five for Medicare and \$4 billion over five for Medicaid].
- **Mastectomies.** Requires plans to allow women to stay in the hospital 48 hours following a mastectomy and 24 hours following lymph node removal.
- **Breast Reconstruction.** Health plan that cover breast cancer surgery, must provide coverage for breast cancer reconstruction following the mastectomy to reestablish symmetry -- including surgery on the non-diseased breast. (Rep Ecshoo main sponsor)
- **Mandatory Point-of-Service Option.** Mandates that plan provide a POS option w/ all of the same services as provided in other plans. Can have higher premiums and cost sharing.
- **Whistleblower Protections.** Currently under negotiations. Quality Commission did not include this provision.

### SECONDARY DIFFERENCES

- **Access to Women's Health Specialists.** Goes further than the Commission in that it allows women to choose OB-GYN as primary care provider in addition to allowing direct access to OB-GYNS as a specialist.
- **Financial Incentives.** Quality Commission only requires disclosure of financial incentives to physicians. Dingell bill prohibits physicians from having any of these types of incentives.
- **Drug Formularies.** Requires plans to provide exceptions from non-formulary when recommended by health professionals, (check w/ HHS how extensive this is drafted).
- **Ombudsman.** Requires states to establish a health insurance ombudsmen to assist consumers in choosing health plans and to help provide counseling for consumers who are not satisfied. Requires Federal Government to step in when states not providing.
- **Provider Protections.** Requires notification and appeals process for providers who are rejected from the plan (check with HHS as to how extensive this language is drafted) Quality Commission does not mention these provisions.
- **Internal Quality Assurance Programs.** Requires health plans to have a quality assurance program to review services, consistency, patient outcomes.

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**HEALTH PROFESSIONALS' VIEWS OF QUALITY**

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**A NATIONAL SURVEY**

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PRESENTED TO THE PRESIDENT'S ADVISORY COMMISSION ON  
CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUSTRY  
DECEMBER 17, 1997

CONDUCTED FOR SERVICE EMPLOYEES INTERNATIONAL UNION BY:

PETER D. HART RESEARCH ASSOCIATES, INC.  
1724 CONNECTICUT AVENUE  
WASHINGTON, DC 20009

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**Peter D. Hart Research Associates, Inc.**

What do health care professionals think of the quality of care being delivered in health care facilities today? What are their main concerns and what do they think is working well? Many surveys have been conducted on physicians' perspectives on satisfaction and quality, but little national work has been done to capture the perspectives of the professional caregivers who work on the front lines of hospitals, HMOs, and health clinics. How these providers feel about the quality of care is important given the tremendous changes occurring in today's health system and the central role they play in providing services and interacting with patients and their families.

To answer these and other important questions, the Service Employees International Union commissioned Peter D. Hart Research Associates to conduct a national survey of health care professionals. This report presents the findings from a survey conducted by Peter D. Hart Research Associates among a representative sample of 1,232 health care professionals, including 401 registered nurses, 404 licensed practical nurses, 108 physical therapists, and 102 occupational therapists. In addition, the survey contains an oversample of California health care professionals, including 100 registered nurses, 63 licensed practical nurses, and 54 therapists. These interviews were then weighted to reflect their actual proportions of the health care work force nation-wide, according to the Bureau of Labor Statistics. All interviews for this survey were conducted by telephone during the evenings from October 16 to October 25, 1997. To avoid any bias in the responses, the interviews were conducted on a confidential basis. The statistical margin of error associated with a sample of this size is  $\pm 4\%$ .

The respondents in this survey bring an exceptional amount of expertise to this subject area. Forty percent of the respondents surveyed have been working in the health care field for more than 20 years, and 24% have been employed at their current facility for more than 15

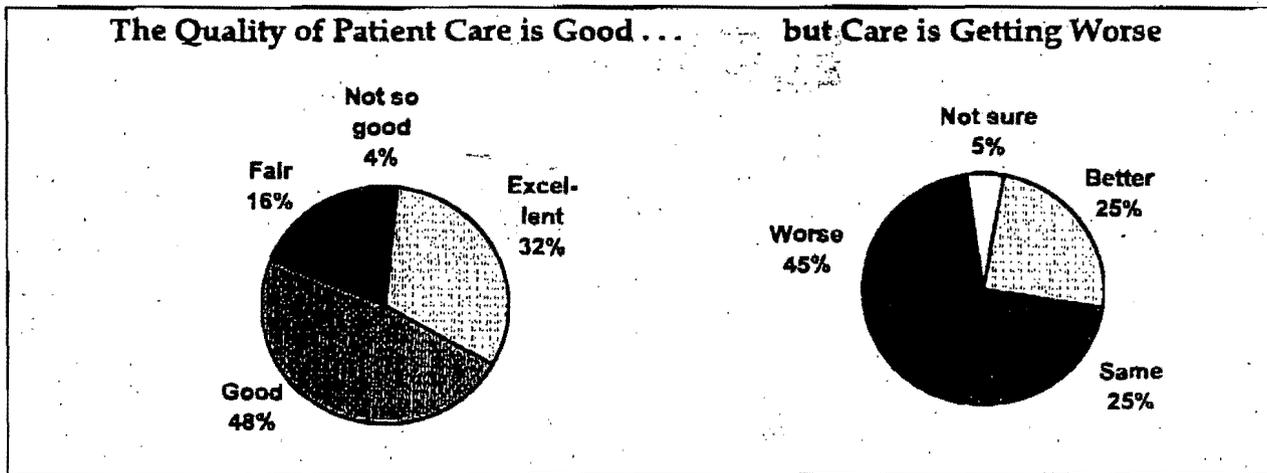
years. These respondents reflect the concerns of people who know their field of expertise and are committed to their profession.

**The key findings of the survey:**

1. A large majority of health care professionals report that the quality of patient care in their facility is good, but they see a declining trend in quality.
2. Professionals identify several national trends in health care as having a negative effect on patient care.
3. Health care professionals connect the negative trends on the national scene with problems in their own facility, especially understaffing.
4. Understaffing causes stress, low morale, and other problems in the workplace.
5. Health care professionals identify several concrete ways in which patient care can be improved.

**1** A large majority of health care professionals report that the quality of patient care in their facility is good, but they see a declining trend in quality.

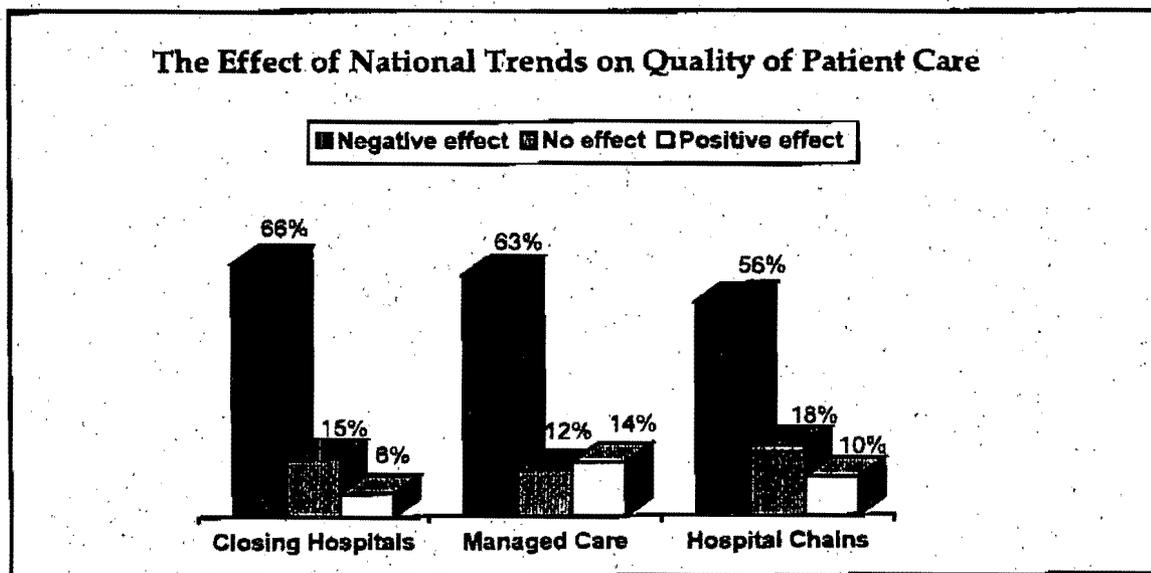
Health care professionals offer a positive assessment of the current level of patient care, with 80% saying patient care at their facility is excellent (32%) or good (48%). However, 45% say patient care has gotten worse in the past few years: 32% say it has gotten somewhat worse, and 13% say it has gotten much worse.



The situation is seen as worse in medical centers (where 51% of employees say patient care has gotten worse) and in hospitals (46%). By contrast, only 29% of clinic staff say patient care at their facility has gotten worse in the past few years. Large and medium hospitals are perceived as worse on this measure than are small hospitals: 50% of large hospital employees and 48% of medium hospital employees say patient care has deteriorated at their facility, compared to only 34% of small hospital professionals who say the same. Therapists (34%) are less likely than average to report that patient care has gotten worse at their facility.

## 2 Professionals identify several national trends in health care as having a negative effect on patient care.

The number-one negative trend identified by health care professionals is the closing of urban hospitals and clinics (66% of professionals say this has had a negative effect on patient care). This trend is perceived as a problem across the board—by professionals in large cities (70%) as well as those in small towns and rural areas (60%). Expansion of managed care is viewed as the second-most negative trend, with 63% of health care professionals saying this has had a negative impact on patient care. Professionals in private facilities (67%) are more likely than are their counterparts in public facilities (57%) to regard managed care as a negative. Among therapists, managed care is seen as the most harmful trend by far: 79% of these professionals say managed care has had a negative effect on the quality of patient care.



The growth of national hospital chains ranks third, with 56% of professionals saying this trend has had a negative impact on patient care. Professionals age 45 and over (62%) are much

more likely to view national chains as having a negative effect than are their younger colleagues (55% among professionals age 35 to 44, 43% among those under age 35).

Professionals in clinics and hospitals are more likely to regard managed care and the formation of national chains as having had a negative effect on the quality of care: 63% of hospital workers and 69% of clinic employees express a negative view of managed care, as do 52% of medical center professionals. Similarly, 57% of hospital employees and 59% of clinic professionals see national chains as a negative force, compared to 46% of medical center workers who do so. The negative effects of subcontracting and privatization are less apparent to health care professionals: 41% say subcontracting to independent agencies has had a negative effect, and 35% say privatization has been a negative.

### **3 Health care professionals connect the negative trends on the national scene with problems in their own facility, especially understaffing.**

When asked in what ways health care has declined, 38% of professionals who believe that patient care has gotten worse volunteer that their facility is understaffed. In addition, 17% feel that they do not have enough time with patients, and 16% say the patient-to-nurse ratio is too high. In a separate question, only one-third (32%) of professionals say staffing levels are excellent or good. Indeed, among eight conditions we measured, staffing receives the poorest rating, with 66% of professionals rating this aspect as fair (33%), not so good (15%), or poor (18%). Professionals in large hospitals (more than 500 beds) are much more likely than average to regard staffing levels as inadequate (47% not so good/poor). Understaffing is seen as a greater problem in medical centers (32% not so good/poor) and hospitals (35%) than it is in clinics (26%). Among professional who say staffing levels at their facility are not so good or poor, 72% say the quality of care is getting worse.

Low staffing levels leave professionals with very little time and very little margin for error. Among a series of problems tested, "not having enough time to do your charting or to take breaks" appears to be the most frequently occurring problem, as 58% of professionals report that this happens a lot (40%) or a fair amount (18%) at their facility. The second most frequent problem is another indication of understaffing: 53% of professionals say they are not able to "spend enough time with patients," including 35% who say this happens a lot and 18% who say it happens a fair amount.

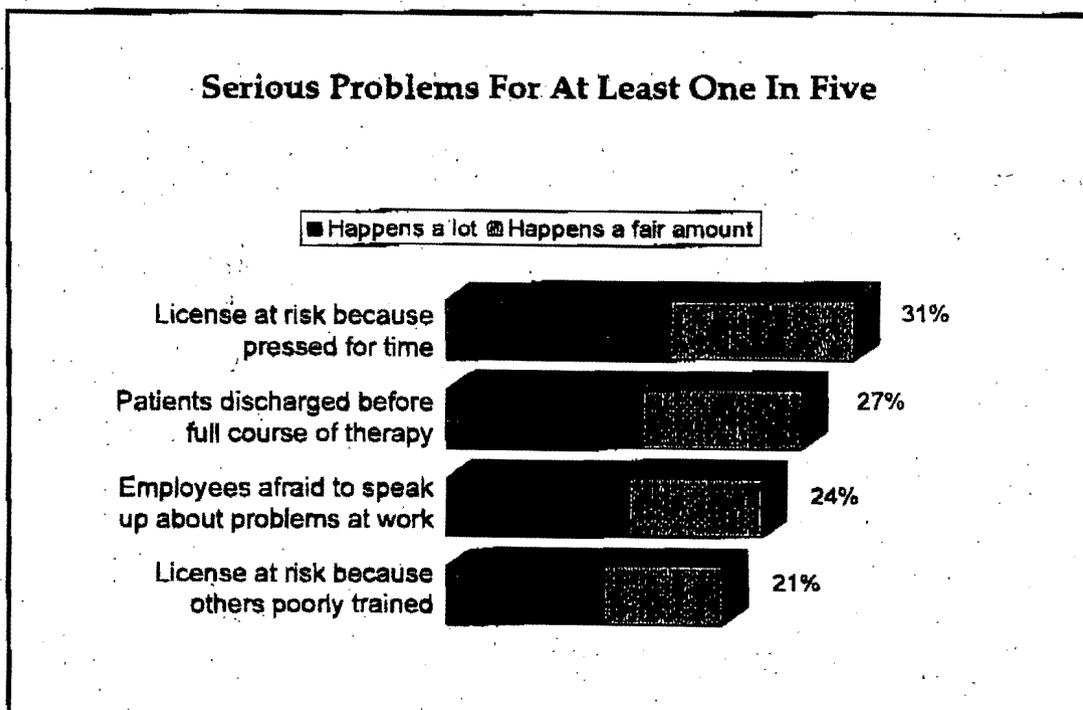
In addition to staffing concerns, therapists are very concerned about insurance companies and HMOs. Almost a third (30%) of therapists name insurance companies and these companies' practices as their top concern. An additional 25% are concerned about HMOs and the influence they have in the health care profession. Among therapists who say the quality of care at their facility has gotten worse, 27% say care has gotten worse because of insurance companies and another 10% blame HMOs. These two concerns are by far the top concerns for therapists.

#### **4 Understaffing causes stress, low morale, and other problems in the workplace.**

Low staffing levels lead to a great deal of stress. Among a series of health and safety problems tested, stress is identified as the greatest problem by far. More than half (56%) of health care professionals say stress is a major problem, and another 33% feel that it is a moderate problem. By contrast, the second most seriously regarded problem is back injuries, though only 18% see this as a major problem. Among professionals who say staffing levels at their facility are not so good or poor, 81% perceive stress as a major problem. Health care professionals are experiencing a great deal of stress because they are pressed for time and not able to complete all of their tasks as fully as they would like.

Low staffing levels also affect employee morale. Only one-third (33%) of professionals say morale at their facility is excellent or good, another one-third (34%) describe it as fair, and the remaining one-third (33%) feel that it is not so good or poor. Among professionals who believe that staffing levels at their facility are insufficient, 64% say morale is not so good or poor. One-third of professionals in hospitals (33%) and medical centers (35%) say morale at their facility is not so good or poor. Professionals in clinics and small hospitals report much higher morale: 46% of clinic professionals and 37% of small hospital employees describe morale at their facility as excellent or good.

A significant minority of professionals cite other problems in their facility. Professionals were asked about a series of items that other health care employees have identified as problems and how often each of these problems occurs at their facility -- a lot, a fair amount, sometimes, just a little, or hardly at all. Almost one-third (31%) say "feeling that their license is at risk because they are pressed for time" occurs at least a fair amount, and 21% say "feeling their license is at risk because the other people they work with are not properly trained" occurs at least a fair amount of the time. Additionally, 27% say "patients' being discharged before they complete a full course of therapy" happens at least a fair amount of the time. Finally, 24% report that "employees are penalized for, or afraid to speak up about problems in their workplace" at least a fair amount of the time.

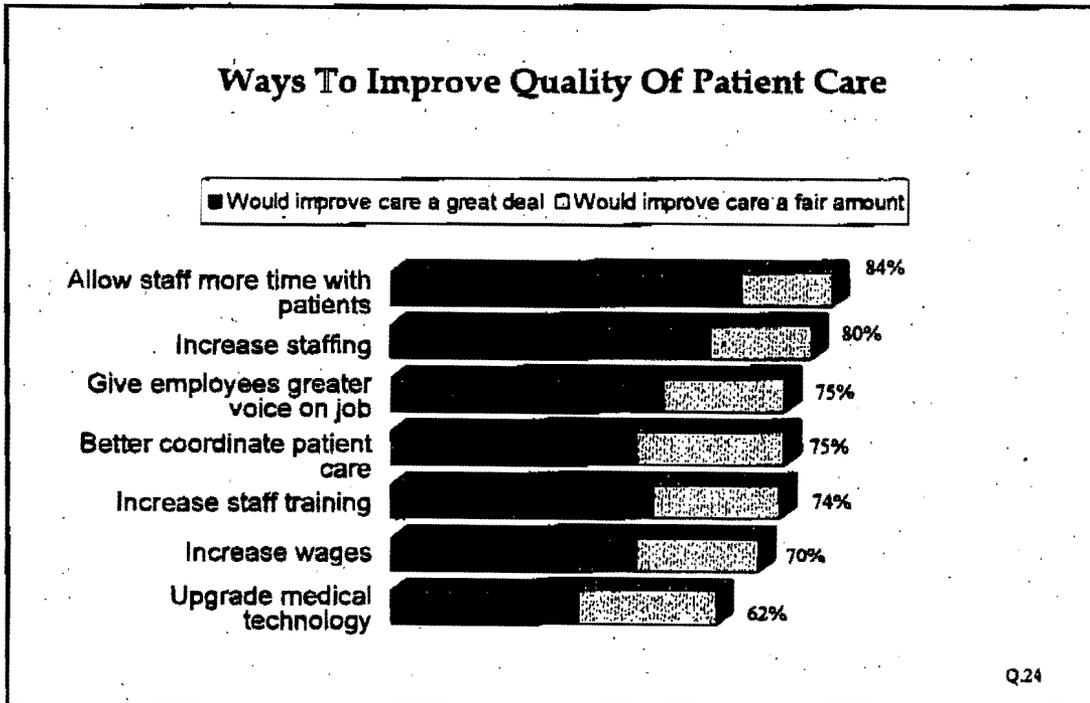


## 5 Health care professionals identify several concrete ways in which patient care can be improved.

A large majority (84%) of professionals believe that allowing staff to take more time with patients would improve the quality of patient care a great deal (67%) or a fair amount (17%). In a related item, 80% say increased staffing would improve patient care a great deal (61%) or a fair amount (19%).

Beyond increasing the size of the staff and the time spent with each patient, health care workers want more of a voice on the job: 75% believe that giving health care professionals a greater voice would improve patient care a great deal (52%) or a fair amount (23%). More than half (56%) say they are just somewhat (28%) or not at all satisfied (28%) with their input in the decision-making process. In addition, 56% feel that their suggestions for improvements are only sometimes (40%) or never taken seriously (5%), or that there is no mechanism for their input (11%). Professionals also want more input into how services are structured: 71% of

health care professionals say they have too little input in this area, and 37% of nurses feel that they are less involved than they should be in making decisions on allocating resources and personnel between departments.



Health care professionals also would like to see better coordination of patient care; 75% say this development would improve the quality of care a great deal (47%) or a fair amount (28%). Half (50%) of professionals say that improving staff training would improve patient care a great deal, and an additional 24% say this would improve care a fair amount. In addition, 70% believe that increasing staff wages would improve patient care a great deal (47%) or a fair amount (23%). Finally, 62% feel that upgrading medical technology would improve care a great deal (36%) or a fair amount (26%).

Health care professionals want to be able to provide good care for their patients, but right now their hands are tied. Short-staffing leaves professionals without enough time to give quality care to each patient, and this lack of care causes stress. In addition, not having a voice in order to help remedy short-staffing leaves professionals demoralized and frustrated. They know what is wrong with the system and see firsthand the impact it has on patient care. Giving health care professionals a voice will give them the opportunity to help remedy this problem.

Commission  
Quality File

11-22-97

# The Rights of Patients, by Law

President Clinton embraced the patients' "bill of rights" issued this week by an advisory commission, but upset some of its members by proposing that Congress put the recommendations into law. The commission intends to debate how best to institute its proposals, and some felt the President's remarks prejudged the issue.

Yet Mr. Clinton's judgment was sound — Federal action will be needed — and his words measured. The President said Congress should enact those recommendations that could not be carried out in other ways, leaving plenty of room for the commission to advise him on which recommendations would best be left to the states or voluntary action by health plans. He appointed the commission earlier this year because many Americans are now covered by managed-care plans that control their choices of physicians and treatments. The insecurity bred by bureaucratic control over health care has driven many consumers to seek governmental protection.

The commission's report closely mirrors the draft version issued last month. It would require health plans to disclose key information, create appeals procedures when they deny care that patients believe is medically necessary, preserve confidentiality of medical records and provide reasonable access to specialists and emergency services. Because health plans have not done this on their own, and because states are prohibited from regulating health plans of most large employers, some of these recommendations will come about only if Congress acts.

The most controversial provision in the report would guarantee patients the right to appeal to an external authority decisions by their plans to deny treatment. The commission limits this right to patients who first exhaust their plans' internal appeals procedures, and to treatments that cost a significant amount and are not specifically excluded by their plans' contracts. The danger of outside review is that it will run around their plans' ability to manage care and weed out unnecessary procedures, thereby running up costs.

Higher costs matter because the ranks of the uninsured are swelling as companies cut back coverage and workers turn down coverage offered by employers because of its cost. Congress should not back away from the commission's proposal, but it should take care to limit external appeals to large claims covered by contract and whose denial would truly jeopardize a patient's health.

The report glaringly fails to require employers who offer their workers coverage to provide a choice of health plans. Without choice, consumers cannot punish bad plans and reward good ones. States cannot compel choice on their own because Federal law prohibits them from regulating most large employers.

Republican leaders wasted no time rejecting Congressional action, tarring the President's idea as another grandiose scheme for a Federal takeover of health care. The truth is that the commission limited itself to basic protections that any responsible plan would provide. Putting them into law would serve to reassure anxious patients.

Quality Commission F.G.

# The DLC Briefing

A New Democrat Perspective on the Issues from the Democratic Leadership Council

November 21, 1997

*The DLC Briefing is a service providing a concise New Democrat perspective on national issues that are of immediate interest to policymakers. Please contact 202-546-0007 with comments or suggestions.*

## President Clinton's Quality Commission

### What's Happening?

Reacting to widespread concerns about the quality of health care, and stepping into a growing void of sensible positions, President Clinton this week endorsed a Consumer Bill of Rights and Responsibilities that would equip consumers with better tools to secure the health care they want and need without heavy-handed bureaucratic regulation. The first and most important plank of the proposal, which was crafted by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, promotes information disclosure. Information about a health plan's benefits, its performance *vis a vis* other plans, and how it settles disputes would empower consumers (and health professionals) to make smart health care decisions. The proposal's other seven planks touch on a variety of additional issues, including access to emergency services, complaints and appeals, and patient responsibility for health care decisions. The Commission's implementation plan for the Bill of Rights and Responsibilities is not expected until March 1998.

### New Democrat Principle

- ◆ The best role for government in the Information Age is to create public institutions that empower citizens to act for themselves. In health care, consumers need reliable information to measure the quality of care just as we use dollars to measure costs.

### The Politics

The quality of health care has emerged as a major public concern in response to the massive shift in the health care marketplace away from the traditional system of doctors practicing independently and toward a new system (usually called "managed care") in which networks of health professionals, hospitals, and insurers compete for the business of patients and enrollees.

Highly publicized horror stories and numerous complaints about managed care have contributed to the growing impression that managed care holds down costs by reducing quality—that it “puts profits above patients.” Public support for restrictions on managed care is enhanced by a lack of public understanding of its one great accomplishment—restraining the cost of health insurance—for the simple reason that employers, not workers, generally pay the bulk of insurance premiums.

Two camps have emerged in the congressional debate over managed care. Republican congressional leaders have staked out a “just say no” position to new health care regulations, leaving consumers ill-equipped to demand the health care they want and need. The other camp, led by Reps. Charlie Norwood (R-GA) and John Dingell (D-MI), and Sens. Alfonse D'Amato (R-NY) and Edward Kennedy (D-MA) would micro-

manage managed care through federal regulations.

The President's quality commission takes a "third way," embracing the federal government's responsibility to deal with public complaints and even fears about managed care, but rejecting a regulatory approach that would actually increase the public's helplessness in coping with rapid changes in the structure of U.S. health care.

There is clearly a constituency for a "third way" on managed care that emphasizes reliable information and consumer choice. A 1996 poll done by Mark Penn for the D.I.C. found that 78 percent of Americans agreed—and 53 percent strongly agreed—with the following statement: "Government should not manage Americans' health care but rather set the basic rules for competition between private health plans and help provide information about those plans so Americans can make their own responsible choices."

### **The New Democrat Take**

As RAND researcher Bob Brook wrote in this week's *Journal of the American Medical Association*, "Managed care is not the problem, health care quality is."

The President's quality commission could produce a breakthrough in what has otherwise been a sterile national debate leading to a false choice between doing nothing about managed care or reversing its most important accomplishments. Government should act to make managed care accountable to consumers, not bureaucrats. Giving consumers better information to choose health plans, health professionals, and treatments will help put consumers in the drivers' seat. But one-size-fits-all regulations that control how managed should operate will undermine the ability for managed care to be responsive to the needs of individual consumers.

The case for systematic quality measurement has been clearly made in the scientific literature. Most recently, a study published in the *American Journal of Public Health* shows that the reputation of heart bypass surgeons, even when judged by their peers, is a poor indicator of quality. According to the study, "reputation may measure a physician's skills in associating with other physicians more than it measures the physician's skill in caring for patients." Instead, patient volume may be a better indicator of how many lives a surgeon saves.

Performance measurement and dissemination of the results also address the fundamental weakness in today's health care marketplace: Managed care plans are too narrowly focused on the cost of health care because information about prices is widely available but information about quality is not.

The President's Consumer Bill of Rights and Responsibilities, however, is not without its problems. For example, the right to appeal a managed care plan's refusal to pay for a particular treatment could put regulators or the courts in charge of determining what care is appropriate for each individual. Instead, consumers should be free to choose a health plan based on how it treats patients' unique needs. The courts and regulators should make sure that managed care plans treat patients as promised.

In addition, the very language of "rights" can undermine the disciplined use of limited resources. If information is a consumer's right, how can policy makers or the marketplace set reasonable limits on the cost of producing the information? A rights-based approach to health care would move health policy into the courts, which are not equipped to balance public concerns about economic efficiency

and equity.

### Talking Points

- Managed care is not the problem, health care quality is.
- Medical care has never been subjected to systematic quality assessment. Managed care can help solve this problem if it has strong incentives to make the substantial investments in information technology that are required to track and improve the performance of health professionals.
- Regulations that gut managed care's control over costs would undermine the incentives managed care needs to create a system of performance measure and accountability to consumers.
- Government should ensure the systematic measurement of quality (e.g., how long are breast cancer victims disease-free after treatment?), analyze the results, and disseminate the information to health professionals and patients.
- Government policy should also ensure that a health plan does not commit any known abuses. The well-documented cases where managed care plans have denied coverage for necessary emergency care could be prevented with a standard that required payment for emergency care services if a "prudent layperson" would judge the care to be necessary.
- The President's quality commission, and the Consumer's Bill of Rights it proposes, is a major step in the direction of replacing the old debate between cost and quality with a new debate about information and accountability.

\* \* \*

## **MSAs: Separating the Healthy and the Sick**

MSAs will lead to the division of senior citizens into separate pools of the sick and the healthy. As shown on the graph, the overwhelming majority of seniors cost Medicare far less than the average cost per beneficiary. The Medicare program saves money because of the general good health of the majority of program participants. Individuals, however, don't reap a financial benefit from escaping illness. MSAs change this by transforming Medicare from an entitlement to health care to an entitlement to money regardless of health. With Medicare MSAs, everyone is allotted the same amount of money (with minor adjustments based on age, welfare status, and whether a senior is in a nursing home). This means that a fit 65 year-old man will get the same payment as a 65 year-old man with diabetes, regardless of the need for medical services. This turns MSAs into the antithesis of what health insurance is meant to be -- financial protection for the sick.

### **How MSAs Drain Medicare**

Consider a simple example:

10% of sickest cost Medicare per beneficiary:	\$37,000
90% of healthiest cost Medicare per beneficiary:	\$1,400
Cost of average Medicare enrollee:	\$5,000

What happens if the 90 percent of healthiest seniors -- whose actual health care costs are far lower than the average costs Medicare pays per beneficiary -- enroll in MSAs? Before the introduction of MSAs, the healthiest 90 percent of seniors cost the program \$1,400 on average. Under MSAs, they would each have payments made to them that total about \$5,000 (to pay for catastrophic insurance and an MSA). The increased cost to Medicare for the coverage for a healthy beneficiary would be \$3,600, more than double the present cost. Medicare MSAs would drain funds meant to pay for the sick and would provide a windfall to the healthy.

### **MSAs will Create a Death Spiral**

In reality, enrollment into Medicare MSAs would be gradual. Each year, a small percent of Medicare recipients would enroll in the MSA program. MSA enrollees are likely to be relatively healthy. Payments to MSA enrollees will divert funds from traditional Medicare, and leave behind higher costs for Medicare enrollees. To meet budget targets, this will lead to cuts in provider payments and possible benefit cuts. The next year, the cycle will continue. Relatively healthy seniors left in Medicare will then select MSAs. Again, those remaining in traditional Medicare will face reduced access to physicians because fewer physicians will take the low reimbursement rates offered by Medicare. The reduced access to physicians creates stronger incentives to switch to MSAs. The cycle will continue to drive relatively healthy seniors into MSAs, drive up traditional Medicare costs, cut provider payments in traditional Medicare, and drive doctors away from serving patients enrolled in traditional Medicare. This could ultimately lead to the demise of the Medicare program.

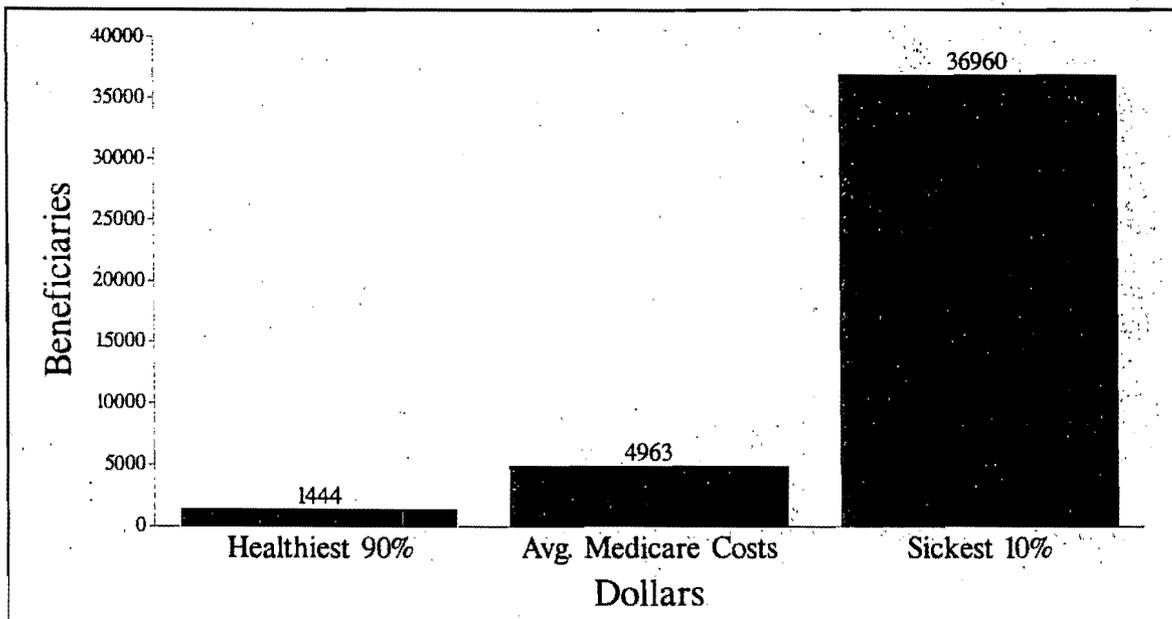
May 6, 1997

## MEDICARE MEDICAL SAVINGS ACCOUNTS: CHERRY-PICKING THE HEALTHY -- DRIVING UP MEDICARE COSTS FOR THE ILL

### Huge Variation in Health Care Costs

Seniors' health care costs differ radically. Medicare paid an average of \$4,963 per beneficiary in 1996. However, the healthiest 90 percent of seniors cost Medicare just \$1,444 in 1996. In contrast, the sickest 10 percent of beneficiaries cost Medicare \$36,960 on average.<sup>1</sup> In 1996, Medicare covered 39 million people.

### AVERAGE MEDICARE OUTLAYS PER BENEFICIARY



<sup>1</sup>"The Medicare Program," The Henry J. Kaiser Family Foundation, April 1997.



PRESIDENT'S ADVISORY COMMISSION ON  
**Consumer Protection** AND  
**Quality** IN THE  
**Health Care Industry**

**<http://hcqualitycommission.gov>**

The Commission was created by President Clinton to  
"advise the President on changes occurring in the health  
care system and recommend such measures as may be  
necessary to promote and assure health care quality and  
value, and protect consumers and workers in the health  
care system."



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