

Consumer Bill of Rights and Responsibilities



**REPORT TO THE
PRESIDENT OF THE UNITED STATES**

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



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Rehm

Quality Rule

Scott

EXAMPLES OF REPUBLICAN GOVERNORS

GOVERNOR VOINIVICH

**INFORMATION DISCLOSURE
PROVIDER NETWORK ADEQUACY
CONTINUITY OF CARE
ACCESS TO EMERGENCY ROOM SERVICES
ANTI-GAG CLAUSES
EXTERNAL APPEALS**

GOVERNOR ENGLER

**ANTI-GAG CLAUSES
INFORMATION DISCLOSURE
DISCLOSURE OF PHYSICIAN INCENTIVES
ACCESS TO EMERGENCY ROOM SERVICES**

GOVERNOR WILSON

**INFORMATION DISCLOSURE
ACCESS TO WOMEN'S HEALTH SERVICES
EMERGENCY ROOM SERVICES
EXTERNAL APPEALS
ANTI-GAG CLAUSES**

GOVERNOR BUSH

**INFORMATION DISCLOSURE
ACCESS TO WOMEN'S HEALTH SERVICES
CONTINUITY OF CARE
ACCESS TO EMERGENCY ROOM SERVICES
ANTI-GAG CLAUSES
CONFIDENTIALITY**

GOVERNOR LEVITT

**ACCESS TO WOMEN'S HEALTH SERVICES
ANTI-GAG CLAUSES**

NIFTY FACTS

- **FORTY-FOUR STATES HAVE ENACTED AT LEAST ONE OF THE PROTECTIONS IN THE PATIENTS' BILL OF RIGHTS.**
- **TWENTY-EIGHT OF THE THIRTY-TWO STATES HAVE ENACTED WITH AT LEAST ONE OF THESE PROTECTIONS.** *REPUB GOV*
- **EACH OF THESE PATIENT PROTECTIONS HAS BEEN ENACTED IN AT LEAST EIGHT STATES AROUND THE COUNTRY.**
 - TWENTY-EIGHT STATES -- INCLUDING 16 WITH REPUBLICANS GOVERNORS HAVE ENACTED PROTECTIONS TO ASSURE ACCESS TO EMERGENCY ROOM SERVICES.
 - THIRTY STATES -- INCLUDING 15 WITH REPUBLICANS GOVERNORS -- HAVE ENACTED PROTECTIONS TO DIRECT ACCESS TO CERTAIN SPECIALISTS -- INCLUDING ACCESS TO QUALIFIED SPECIALISTS FOR WOMEN'S HEALTH SERVICES.

94% of Democratic Gov.

87% of Republican Gov.

PRESIDENT CLINTON RELEASES NEW REPORT AND URGES CONGRESS TO PASS PATIENT BILL OF RIGHTS, COMPREHENSIVE TOBACCO LEGISLATION, AND THE MEDICARE BUY-IN PROPOSAL

March 9, 1998

In a speech to the American Medical Association (AMA) today, the President renewed his call to Congress to pass a patients' bill of rights, comprehensive tobacco legislation to reduce teen smoking, and his proposal to allow hundreds of thousands of Americans ages 55 to 65 to buy into Medicare. In his speech, which marks the first time a President has spoken to the AMA in fifteen years, President Clinton highlighted that he and the AMA are united on the need for a patients' bill of rights and tobacco legislation, and urged the AMA to lend its strong support to his Medicare buy-in proposal. Underscoring the bipartisan support for a patients' bill of rights, the President released a report showing that 44 states -- including 28 states with Republican Governors -- have enacted the "Consumer Bill of Rights" that the President's Quality Commission recommended and the President endorsed last year. In his speech, the President:

RELEASED NEW REPORT SHOWING THAT 44 STATES -- INCLUDING 28 STATES WITH REPUBLICAN GOVERNORS -- HAVE ENACTED AT LEAST ONE OF THE PROVISIONS IN THE PATIENTS' BILL OF RIGHTS. The President released a new report that underscores the bipartisan support for the patients' bill of rights he endorsed last year. Highlights from this report are as follows:

- **Forty-four states have enacted at least one of protections in the patients' bill of rights.**
- **Patient protection laws have been enacted by Democratic and Republican Governors alike.** Twenty-eight of the 32 states with Republican Governors have enacted at least one of these protections.
- **Each of these patient protections has been enacted in at least eight states around the country and some have been enacted in as many as forty-one states.** For example:
 - Twenty-eight states -- including 16 with Republican Governors -- have enacted protections to assure access to emergency room services.
 - Thirty states -- including 15 with Republican Governors -- have enacted protections to give direct access to certain specialists, including access to qualified specialists for women's health services.

URGED CONGRESS TO PASS FEDERAL LEGISLATION BECAUSE, DESPITE STATE LAWS, STATES HAVE NO JURISDICTION OVER MORE THAN 100 MILLION AMERICANS. A patchwork of non-comprehensive state laws cannot provide Americans with the protections they need -- especially because state laws do not even have jurisdiction over more than 100 million Americans. For example, they do not cover tens of millions of Americans in self-insured plans covered under the Employee Retirement Income Security Act (ERISA). The only way to ensure that all health plans serving all Americans provide the protections envisioned by the Quality Commission is to pass and enact bipartisan Federal legislation.

CALLED ON CONGRESS TO PASS COMPREHENSIVE TOBACCO LEGISLATION THIS YEAR. The President also reiterated his call for Congress to pass comprehensive tobacco legislation this year that includes his five key principles:

- A comprehensive plan to reduce youth smoking, including: significant price increases; tough penalties on tobacco firms that continue to market to youths; public education and counter advertising; and expanded efforts to restrict access and limit appeal.
- Full authority of the Food and Drug Administration to regulate tobacco products.
- Changes in how the tobacco industry does business, including an end to marketing and promotion to children and broad document disclosure.
- Progress towards other public goals, including a reduction of secondhand smoke; promotion of cessation programs; public health research; and the strengthening of international efforts to control tobacco.
- Protection for tobacco farmers and their communities.

REITERATED THAT THIS TOBACCO PROPOSAL COULD PREVENT UP TO ONE MILLION PREMATURE DEATHS OVER THE NEXT FIVE YEARS. The recent Treasury Department's study, based on conservative estimates from well-respected analytical models, concluded that the Administration's proposal to increase the price of cigarettes by \$1.50 per pack -- coupled with proposed sales and advertising restrictions -- would:

- Keep up to 1.9 million young Americans from smoking in 2003 -- a 39 to 46 percent reduction in youth smoking. Over the next five years, the cumulative number of young people kept from smoking would be up to 2.8 million.
- The direct result of these policies over the next five years is that as many as 1 million of today's young people will be spared from premature deaths resulting from smoking-related diseases.

URGED CONGRESS TO ACT NOW TO PASS HIS TARGETED PROPOSAL TO GIVE AMERICANS AGES 55 TO 65 ACCESS TO HEALTH INSURANCE.

- **Americans ages 55 to 65 are one of the most difficult to insure populations:** they have less access to and a greater risk of losing employer-based health insurance; and they are twice as likely to have health problems.
- **The President has a carefully-targeted, fiscally-responsible proposal that would allow hundreds of thousands of vulnerable Americans to gain access to more affordable health care coverage by:** allowing Americans ages 62 to 65 to buy into the Medicare program; allowing displaced workers age 55 and over a similar buy-in option; and allowing Americans 55 and over who have lost their retiree health benefits to buy into their former employers' health plan.
- **The Congressional Budget Office just confirmed that this proposal will help hundreds of thousands of Americans without burdening the Medicare Trust Fund or the budget.**

PRESIDENT CLINTON RELEASES WHITE HOUSE REPORT REVEALING THAT STATES HAVE ENACTED EACH OF THE PATIENT PROTECTIONS HE HAS ENDORSED -- INCLUDING MANY STATES WITH REPUBLICAN GOVERNORS

March 9, 1998

- **Thirty-four states -- including 21 states with Republican Governors -- have enacted information disclosure provisions.** At least 34 states have enacted provisions that require health plans to disclose information to help consumers make informed decisions about their health plans, health professionals, and health facilities.
- **Ten states have enacted provider network adequacy provisions -- including four states with Republican Governors.** At least ten states have enacted provisions to help ensure that health plan networks provide access to sufficient numbers and types of providers without unreasonable delay.
- **Thirty states -- including 15 states with Republican Governors -- have enacted protections to give direct access to certain specialists, including qualified specialists for women's health services.** At least 30 states have enacted provisions to give patients greater access to needed specialists, including giving women greater access to qualified specialists for women's health services.
- **Seventeen states have enacted continuity of care protections -- including ten states with Republican Governors.** At least 17 states have enacted protections to help ensure continuity of care for enrollees who are involuntarily forced to change providers.
- **Twenty-eight states have enacted protections to assure access to emergency room services -- including 16 states with Republican Governors.** At least 28 states have enacted legislation to help ensure that patients have access to emergency room services when and where the need arises. These provisions require health plans to pay for the initial screening examination and stabilization care -- regardless of whether the emergency room is in the plan's network -- when an enrolled person needs emergency services. Twenty of these states require the use of a prudent layperson standard to determine whether an emergency exists, to ensure that any person who reasonably thought they were having an emergency is covered by their health plan.
- **Forty-one states have enacted anti-gag clauses -- including 26 states with Republican Governors.** At least 41 states have enacted "anti-gag" clauses prohibiting health plans from using contract clauses that restrict providers' communications with their patients.
- **Eighteen states have enacted provisions that require health plans to disclose financial incentives -- including 12 states with Republican Governors.** At least 18 states have passed protections requiring health plans to disclose any financial arrangements with their physicians.
- **Nineteen states have enacted provisions to protect confidentiality of health information -- including ten states with Republican Governors.** At least 19 states have enacted some type of provision to help protect the confidentiality of health information for health plan enrollees

- **Eight states have enacted anti-discrimination provisions, including six states with Republican Governors.**
- **Twelve states now require that health plan enrollees have access to an external appeal process, including eight states with a Republican Governor.** At least 12 states now require that health plan enrollees have access to specially designated and independent external appeals entities, which are funded and empowered to hear and act upon such appeals.

Last November the President endorsed the “Consumer Bill of Rights” recommended by his Advisory Commission on Quality and Consumer Protection. These rights included: information disclosure; a choice of providers including provider network adequacy provisions, access to specialists (including qualified specialists for women’s health services), and transitional care provisions; access to emergency room services; participation in treatment decisions including prohibiting anti-gag clauses and requiring disclosure of financial incentives; protection of the confidentiality of health information; anti-discrimination provisions; and access to an appeals process.

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Last November the President endorsed the “Consumer Bill of Rights” recommended by his Advisory Commission on Quality and Consumer Protection. These rights included: information disclosure; a choice of providers including provider network adequacy provisions, access to specialists (including qualified specialists for women’s health services), and transitional care provisions; access to emergency room services; participation in treatment decisions including prohibiting anti-gag clauses and requiring disclosure of financial incentives; protection of the confidentiality of health information; anti-discrimination provisions; and access to an appeals process.

PATIENTS' PROTECTIONS IN THE STATES



A White House Report by the
Domestic Policy Council
March 9, 1998

TABLE OF CONTENTS

EXECUTIVE SUMMARY	i
DISCLOSURE OF INFORMATION TO CONSUMERS	1
CHOICE OF PROVIDERS	3
I. Provider Network Adequacy	4
II. Direct Access to Certain Specialists	5
III. Transitional Care	7
ACCESS TO EMERGENCY SERVICES	8
PARTICIPATION IN TREATMENT DECISIONS	11
I. Anti-Gag Clauses	11
II. Disclosure of Physician Incentive Arrangements	13
CONFIDENTIALITY OF HEALTH INFORMATION	14
ANTI-DISCRIMINATION	15
EXTERNAL APPEALS	16
POLITICAL AFFILIATION OF GOVERNORS	17
SOURCES AND APPROACHES USED IN THIS REPORT	18

EXECUTIVE SUMMARY

Last November, the President received and endorsed the “Consumer Bill of Rights” recommended by his Advisory Commission on Quality and Consumer Protection. At that time, he called on Congress to pass Federal legislation to assure that all Americans could be confident that they were covered by these protections. In February, the President released an Executive Memorandum directing all Federal health plans, operated by the Departments of Health and Human Services, Labor, Defense, Veterans Affairs, and the Office of Personnel Management, to take every Administrative action authorized under current law to come into compliance with the Quality Commission’s “Consumer Bill of Rights.”

Despite the extremely positive reception the President’s Advisory Commission’s recommendations received by virtually all affected parties, some in and outside of the Congress have indicated their opposition to Federal “patients’ protections” legislation. Critics have suggested that such legislation represents an extreme approach that is far from the mainstream and could result in a “Government take-over” of the nation’s health care system.

The Domestic Policy Council (DPC) report being released today helps debunk the myths of patient protection legislation by documenting how basic and common place these reforms are at many levels across the nation. More specifically, the report focuses on the states to determine how their Governors have been responding to concerns about the health care delivery system. As one of this nation’s most effective laboratories of reform, states frequently serve as a bellwether for policy priorities for the nation. This has certainly been the case on the issue of patients’ rights.

After reviewing recent “patients’ protections” laws that have been enacted within the states, this report concludes that virtually every state in the country has enacted some form of patient protection statute that is consistent with that advocated by the President’s Quality Commission. States have enacted protections that range from ensuring that consumers have access to emergency room services, to requiring that patients in the middle of a pregnancy or who are terminally ill can continue to see their provider even when that provider is dropped from the health plan’s network, to requiring that health plan enrollees have access to implementing external appeals process for patients to address their grievances with their health plans.

More specifically, the report finds that at least forty-four states have passed at least one of the patients’ protections the President endorsed and no protection advocated by the President’s Commission has yet to be enacted by some states. In fact, each of the provisions have been enacted in at least eight states.

Moreover, there is no significant division of political parties passing and implementing these new laws. In particular, over 87 percent of all the Republican Governors (28 out of 32) and 94 percent of all the Democratic Governors (16 out of 17) are overseeing the administration of consumer protections. By any definition, this issue has received broad, bipartisan support.

WHY STATE LAWS ARE INSUFFICIENT

The fact that so many states have already implemented the patient protections underscores that the President's Quality Commission's "Consumer Bill of Rights" recommendations are clearly within the mainstream and can and have been implemented without undermining the ability of health plans to deliver high quality, affordable health care. However, this patchwork of state laws will never provide Americans with the protections they need.

It is extremely important to note that state-enacted laws do not even have jurisdiction over more than 100 million Americans. For example, they do not cover tens of millions of Americans in self-insured plans covered under the Employee Retirement Income Security Act (ERISA). The only way to ensure that all health plans serving all Americans provide the protections envisioned by the Quality Commission is to pass and enact bipartisan Federal legislation.

SUMMARY OF STATE PATIENT PROTECTION LAWS. The following is a summary of how many states have enacted provisions similar to those recommended by the Quality Commission and endorsed by the President:

Information Disclosure. At least thirty-four states have enacted provisions that require health plans to disclose information to help consumers make informed decisions about their health plans, health professionals, and health facilities.

Choice of Providers. To ensure consumers have access to a choice of health care providers sufficient to ensure access to appropriate high-quality health care, the Commission recommended that health plans should provide the following:

Maintain an adequate network of providers. At least ten states have enacted provisions to help ensure health plan networks provide access to sufficient numbers and types of providers without unreasonable delay.

Provide direct access to certain specialists -- including access to qualified specialists for women's health services. At least 30 states have enacted provisions to give patients greater access to needed specialists, including giving women greater access to qualified health specialists for women's health services.

Assure continuity of care. At least 17 states have enacted protections to help ensure continuity of care for enrollees who are involuntarily forced to change providers.

Assure Access to Emergency Room Services. At least 28 states have enacted legislation to help ensure that patients have access to emergency room services when and where the need arises. These provisions require health plans to pay for the initial screening examination and stabilization care -- regardless of whether the emergency room is in the plan's network -- when an enrolled needs emergency services. Moreover, twenty states require the use of a prudent layperson standard to determine whether an emergency exists.

Anti-gag Clauses. At least 41 states now prohibit health plans from using "gag clauses" that restrict providers' communications with their patients.

Disclosure of Financial Incentives. At least eighteen states now require health plans to disclose any financial incentive arrangements with their physicians.

Confidentiality of Health Information. At least nineteen states have enacted some type of provision to help protect the confidentiality of health information about their enrollees.

Anti-Discrimination. At least eight states have passed some type of anti-discrimination provisions. These rules protect enrollees without eliminating underwriting practices.

External Appeals. At least twelve states now require that health plan enrollees have access to specially designated external appeals entities, which are funded and empowered to hear and act upon such appeals.

DESCRIPTION OF PRESENTATION OF DATA.

What follows is: (1) a description of each of the patient protections recommended by the President's Advisory Commission on Quality and Consumer Protection and endorsed by the President and (2) a list of states that have enacted patients' protections -- similar to the protection that was endorsed by the President; (3) the year the state enacted the patient protection; and (4) For each state, the bill number of the new law is included. For states that assign public law numbers to enacted legislation, those number are included in brackets. Where no public law number exists, the number of the new or amended state code chapter is provided. Where the source of the information did not include a Bill number or other reference, we cite the source (e.g., BCBS indicates we obtained the information from one of the Blue Cross Blue Shield Association "State Legislative Health Care and Insurance Issues" books).

DISCLOSURE OF INFORMATION TO CONSUMERS

"Consumers have the right to receive accurate, easily understood information and some require assistance in making informed health care decisions about their health plans, professionals, and facilities. This includes information about health plans, health professionals, and health facilities."

At least 34 states have recently enacted comprehensive information disclosure requirements that require health insurers to disclose information to enrollees and, in many cases, to prospective enrollees as well.

The New Jersey disclosure provisions that Governor Christine Whitman signed into law in 1997 are typical of the kinds of information that states are requiring health plans to disclose to enrollees and/or potential enrollees. In New Jersey, health plans must now disclose to consumers:

- a description of covered services and benefits;
- the financial responsibility of the enrolled including copayments and deductibles;
- information on accessing services and the need for prior authorization;
- a description of the insurer's utilization review process; a description of the enrolled's appeal rights, including the right to appeal to an independent review board.

Provision	State	Year	Bill Number or Regulation
Disclosure of Information To Consumers <i>For states listed in italics, the law or regulation may only apply to HMOs</i>	AL	1996	HB 395 [96-651]
	AZ	1997	SB1321 [Session Law 251]
	<i>AR</i>	1997	HB1843 [Act 1196]
	<i>CA</i>	1996	SB 1547 [Ch. 1024]
	<i>CO</i>	1997	HB 97-1122 [Ch. 238]
	<i>CT</i>	1997	HB 6883 [PA 97-99]
	<i>FL</i>	1997	SB 297 [97-159]
	<i>GA</i>	1996	HB 1338 [OCGA33-20A]
	<i>HI</i>	1996	HB 3785 [431, 432]
	<i>ID</i>	1997	SB 1150 [Ch. 204]
	<i>IN</i>	1997	HB 1663 [PL 191]
	<i>KS</i>	1997	SB 204 [Session Law 190]
	<i>LA</i>	1997	HB 2228 [Act 238]
	<i>ME</i>	1996	SB 769 [PL 673]
	<i>MD</i>	1996	HB 859 [Ch. 503]
	<i>MI</i>	1996	HB 5573 [PA 472]
	<i>MN</i>	1997	SF 960 [Ch. 237]
	<i>MO</i>	1997	SB 335 [Ch. 354]
	<i>MT</i>	1997	SB 365 [MT Laws 413]
	<i>NE</i>	1997	LB 279 [RRS Neb 44-68]
	<i>NV</i>	1997	AB 156 [Ch. 140]
	<i>NJ</i>	1997	S 269 [Ch. 192]
	<i>NM</i>	1997	[Regulation 13 NMAC 10:13]
	<i>NY</i>	1996	SB 7553 [Ch. 705]
	<i>NC</i>	1997	SB 932 [Session Law 519]
	<i>OH</i>	1997	SB 67 [Sec. 1751]
	<i>OK</i>	1997	HB 1416 [Ch. 289]
	<i>OR</i>	1997	SB 21 [OR Laws 343]
	<i>RI</i>	1996	HB 8172 [Ch. 41]
	<i>TX</i>	1997	SB 383, 385 [Ch. 1024, 1026]
	<i>VT</i>	1996	SB 345 [18 VSA sec. 9414]
	<i>VA</i>	1996	HB 1393 [Ch. 776]
	<i>WA</i>	1996	SB 6392 [Ch. 312]
<i>WV</i>	1996	HB 4511 [Ch. 33]	

CHOICE OF PROVIDERS

“Consumers have a right to a choice of health care providers that is sufficient to ensure access to appropriate high quality health care. To ensure such choice health plans should provide the following:”

Provider network adequacy. At least ten states have enacted provisions to help ensure health plan networks provide access to sufficient numbers and types of providers without unreasonable delay.

Access to specialists -- including access to qualified specialists for women’s health services. At least 30 states have enacted provisions to give patients greater access to needed specialists, including giving women greater access to qualified health specialists for women’s health services.

Transitional care. At least seventeen states have enacted protections to help ensure continuity of care for enrollees who are involuntarily forced to change providers.

I. PROVIDER NETWORK ADEQUACY

“All health plan networks should provide access to sufficient numbers and types of providers to assure that all covered services should be available without unreasonable delay – including access to emergency room services 24 hours a day seven days a week. If a health plan has an insufficient number of type of providers to provide a benefit with an appropriate degree of specialization, the plan should ensure that the consumer obtains the benefit outside of 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.”

At least ten states have enacted provisions to help ensure health plan networks provide access to sufficient numbers and types of providers without unreasonable delay.

Provision	State	Year	Bill Number or Regulation
Access to Out-of-Network Specialists	CO	1997	HB 97-1122 [Ch. 238]
	FL	1997	HB 297 [97-159]
	ME	1997	[Ch. 850]
	MT	1997	SB 365 [MT Laws 413]
	MO	1997	SB 335 [Ch. 376]
	NE	1997	LB 279 [RRS Neb 44-68]
	NY	1996	SB 7553 [Ch. 705]
	OH	1997	SB 67 [Sec. 1751.13]
	TX	1996	[Regulation, BCBS 1996]
WA	1996	SB 6392 [Ch. 312]	

II. DIRECT ACCESS TO CERTAIN SPECIALISTS -- INCLUDING QUALIFIED SPECIALISTS FOR WOMEN'S HEALTH SERVICES

“Consumers with complex or serious medical conditions who require frequent speciality care should have direct access to a qualified specialist of their choice within a plans network of providers. Authorizations, when required, should be for an adequate number of direct access visits under an approved treatment plan. Women should be able to choose a qualified provider offered by a plan -- such as a gynecologists, certified nurse midwives, and other qualified health providers -- for the provision of covered care necessary to provide routine and preventative women's health care services.”

At least 30 states require health plans to provide direct access specialists, including access to qualified specialists to women's health care providers for reproductive and gynecological care.

California was one of the first states to allow women direct access to Ob/Gyns. In passing this law, the legislature cited a 1993 Gallup poll which showed that women were more likely to see their Ob/Gyn on a regular basis than any other primary care physician.

Provision	State	Year	Bill Number or Regulation
Direct access for women's health care services	AL	1996	HB 395 [96-651]
	AR	1997	HB 1843 [Act 1196]
	CA	1994	AB 2493 [Ch. 759]
	CO ¹	1996	HB 1082 [Ch. 153]
	CT	1995	[PA 95-199]
	DE	1997	SB 78 [Ch. 33]
	FL	1995	Families USA, March 1997
	GA	1996	SB 592 [Act 820]
	ID	1997	SB 1150 [Ch. 204]
	IL	1996	SB 1246 [PA 89-0514]
	IN	1996	SB 392 [PL 192]
	LA ²	1995	HB 318 [Act 637]
	ME	1996	HB 976 [PL 617]
	MD*	1996	HB 863 [Ch. 580]
	MN	1997	HB 447 [Ch. 26]
	MO	1997	HB 335 [Ch. 376]
	MT*	1997	SB 365 [MT Laws 413]
	NE	1995	SB 145 [46-602, 46-659]
	NV	1997	AB 156 [Ch. 140]
	NM	1997	Regulation [13 NMAC 10:13]
	NY ²	1994	Families USA, March 1997
	NC	1995	Families USA, March 1997
	OR	1995	SB 814 [OR Laws 669]
	RI ³	1997	SB 149/HB 6254 [PL 174]
	TX	1997	S 54 [Ch. 912]
	UT	1995	Families USA, March 1997
	VA	1996	HB 442 [Ch. 967]
	VT	1997	HB 241 [8 VSA sec. 4089]
	WA	1995	Families USA, March 1997
	WV	1996	HB 4511 [Ch. 33]

¹ guaranteed referral

² limited to two annual visits and care relating to pregnancy

³ limited to one annual visit

III. TRANSITIONAL 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 change health plans or at a time when a provider is terminated by a plan for other than cause should be able to continue seeing their current speciality providers for up to 90 days (or through completion of postpartum care) to allow for transition of care.”

At least seventeen states provide some type of protection for enrollees who are involuntarily forced to change providers. There are significant differences among the states in the nature and amount of protection provided.

For example, in Florida:

“Each organization shall allow subscribers to continue care for 60 days with the terminated treating provider when medically necessary, provided the subscriber has a life-threatening condition or a disabling or degenerative condition. Each organization shall allow a subscriber who is in the third trimester of pregnancy to continue care with the terminated treating provider until completion of postpartum care.”

Provision	State	Year	Bill Number or Regulation
Transitional Care	AR	1997	HB 1843 [Act 1196]
	CO	1997	HB 97-1122 [Ch. 238]
	FL	1997	SB 297 [97-159]
	KS	1997	SB 204 [Session Law 190]
	ME	1997	[Ch. 850]
	MD	1996	[Ch. 286]
	MN	1997	SF 960 [Ch. 237]
	MO	1997	SB 335 [Ch. 376]
	MT	1997	SB 365 [MT Laws 413]
	NE	1997	LB 279 [44-68]
	NJ	1997	[Regulation Chapter 38]
	NM	1997	[Regulation 13 NMAC]
	NY	1996	10:13]
	OH	1997	SB 7553 [Ch. 705]
	TX	1997	SB 67 [Sec. 1751.13]
	VT	1997	SB 383 [TX Gen. Law 1024]
	VA	1996	[Rule 10.00]
			HB 1393 [Ch. 776]

ACCESS TO EMERGENCY SERVICES

“Consumers have the right to access emergency health care services when and where the need arises. Health plans should provide payment when a consumer presents to an emergency department with acute symptoms of sufficient severity—including severe pain—such that a “prudent layperson” could reasonably expect the absence of medical attention to result in placing that consumer’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.”

At least 28 states have passed legislation requiring health plans to pay for the initial screening examination and stabilization care -- regardless of whether the emergency room is in the plan’s network -- when an enrolled needs emergency services.

Prudent Layperson Standard

Twenty states require the use of a prudent layperson standard to determine whether an emergency exists.

For example, Georgia defines emergency services as those:

“that are provided for a condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in placing the patient’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.”

ACCESS TO EMERGENCY ROOM SERVICES

Provision	State	Year	Bill Number or Regulation
<i>This list does not address any requirements for approval of or payment for post-stabilization care.</i>	AZ	1996	SB 1286 [Ch. 132]
	CA	1994	SB 1832 [Ch. 614]
	CO	1997	HB 97-1122 [Ch. 238]
	CT	1996	H 5583 [97-67]
	FL	1996	SB 886, 910 [96-99]
	GA	1996	HB 1575 [Ch. 11 Title 31]
	ID	1997	SB 1150 [Ch. 204]
	KS	1997	S 204 [Session Law 190]
	LA	1997	HB 2206 [Act 846]
	ME	1997	[Revised Ch. 850]
	MD	1996	HB 859 [Ch. 503]
	MI	1997	H 4080 [PA 136]
	MO	1997	H 335 [Ch. 354]
	MT	1997	S 365 [MT Laws 413]
	NE	1997	LB 279 [44-68]
	NH	1997	[NH Laws 345]
	NV	1997	A 156 [Ch. 140]
	NJ	1997	[Regulation Ch. 38]
	NY	1996	SB 7553 [Ch. 705]
	NC	1997	S 932 [Session Law 519]
	OH	1997	HB 361 [Sec. 1753]
	OK	1997	H 1416 [Ch. 289]
	OR	1997	SB 21 [OR Laws 343]
	TN	1997	HB 1066 [Ch. 524]
	TX	1997	SB 383 [Ch. 41]
	VA	1997	HB 2062 [Ch. 139]
	WA	1997	HB 2018 [Ch. 231]
WV	1996	SB 465 [Ch. 5]	

PRUDENT LAYPERSON STANDARD

Provision	State	Year	Bill Number or Regulation	
Prudent Layperson Standard	<i>CA</i>	1994	SB 1832	[Ch. 614]
	<i>CT</i>	1997	HB 6883	[PA 97-99]
	<i>GA</i>	1996	HB 1575	[Ch. 11 Title 31]
	<i>ID</i>	1997	SB 1150	[Ch. 204]
	<i>LA</i>	1997	HB 2206	[Act 846]
	<i>ME</i>	1997		[Regulation Rev. Ch. 850]
	<i>MD</i>	1996	HB 859	[Ch. 503]
	<i>MN</i>	1997	SF 960	[Ch. 237]
	<i>MO</i>	1997	HB 335	[Ch. 354]
	<i>NE</i>	1997	LB 279	[44-68]
	<i>NV</i>	1997	AB 156	[Ch. 140]
	<i>NM</i>	1997		[Regulation 13 MAC10:13]
	<i>NY</i>	1996	SB 7553	[Ch. 705]
	<i>NC</i>	1997	SB 932	[Session Law 519]
	<i>OH</i>	1997	H 351	
	<i>OR</i>	1997	B 21	[OR Laws 343]
	<i>TN</i>	1997	HB 1066	[Ch. 524]
	<i>TX</i>	1997	SB 385	[Ch. 1026]
<i>VA</i>	1995	HB 2583	[Ch. 345]	
<i>WA</i>	1997	H 2018	[Ch. 231]	

PARTICIPATION IN TREATMENT DECISIONS

I. ANTI-GAG CLAUSES

“To facilitate greater communication between patients and providers, health care providers, facilities, and plans should ... [e]nsure that provider contracts do not contain any so-called “gag clauses” or other contractual mechanisms that restrict health care providers’ ability to communicate with and advise patients about medically necessary treatment options.”

At least forty-one states now prohibit health plans from using contract clauses that restrict providers’ communications with their patients.

For example, in Arizona, health insurers may not:

“restrict or prohibit, by means of a policy or contract, whether or written or otherwise, a licensed health care provider’s good faith communication with the health care provider’s patient concerning the patient’s health care or medical needs, treatment options, health care risks or benefits.”

Provision	State	Year	Bill Number or Regulation	
Anti-gag Clauses	AZ	1997	SB 1098 [431 Revised]	
	AR	1997	HB 1843 [Act 1196]	
	CA	1996	AB 3013 [Ch. 1089 sec. 2056]	
	CO	1996	HB 1216 [Ch. 122]	
	CT	1997	HB 6883 [PA 97-99]	
	DE	1996	SB 449 [Ch. 539]	
	FL	1997	SB 297 [97-159]	
	GA	1996	HB 1338 [OCGA33-20A]	
	ID	1997	SB 1150 [Ch. 204]	
	IN	1996	SB 392 [PL 192]	
	KS	1997	SB 204 [Session Law 190]	
	LA	1997	SB 528 [LA Act 1232]	
	ME	1996	SB 769 [PL 673]	
	MD	1996	HB 1374 [Ch. 548]	
	MA	1996	HB 5347 [Ch. 8]	
	MI	1997	SB 501/HB 4392 [PA 68, 67]	
	MN	1997	SF 960 [Ch. 237]	
	MO	1997	SB 335 [Ch. 354]	
	MT	1997	HB 27 [MT Laws 527]	
	NE	1997	LB 279 [44-68]	
	NV	1997	AB 156 [Ch. 140]	
	NH	1997	SB 178 [NH Laws 345]	
	NJ	1997	[Regulation Ch. 38]	
	NM	1997	[Regulation 13 NMAC]	
	NY	1996	10:13]	
	NC	1997	SB 7553 [Ch. 705]	
	ND	1997	SB 455 [Session Law 474]	
	OH	1997	HB 1418 [26.1-04-03]	
	OK	1997	SB 67 [Sec. 1751]	
	OR	1997	HB 1416 [Ch. 289]	
	PA	1996	SB 21 [OR Laws 343]	
	RI	1996	H 1977 [Act 85]	
	TN	1996	HB 8172 [Ch. 27-41-14]	
	TX	1997	HB 2077 [Ch. 874]	
	UT	1997	SB 385 [Ch.41]	
	VT	1996	SB 18 [Ch. 227]	
	VA	1996	SB 345 [18 VSA sec. 9414]	
	WA	1996	HB 1393 [Ch. 776]	
	WI	1975	S 6392 [Ch. 312]	
	WV	1997	[Chapter 628.37]	
	WY	1997	[By rule, NCSL, 1997]	
				HB 54 [Ch. 166]

II. DISCLOSURE OF PHYSICIAN INCENTIVE ARRANGEMENTS

“To facilitate greater communication between patients and providers, health care providers, facilities, and plans should ... [d]isclose to consumers factors -- such as methods of compensation, ownership of or interest in health care facilities, or matters of conscience -- that could influence advice or treatment decisions.”

At least eighteen states require disclosure of health plans’ financial arrangements with their physicians.

For example, in Minnesota:

“Health plan companies and providers must, upon request, provide an enrolled with specific information regarding the reimbursement methodology, including, but not limited to ... a concise written description of the provider payment, including any incentive plan applicable to the enrolled.”

Provision	State	Year	Bill Number or Regulation
Disclosure of Physician Incentive Arrangements	AL	1996	HB 395 [96-651]
	AZ	1995	BCBS, 1996
	CA	1996	AB 2649 [Ch. 1014]
	GA	1996	HB 1338 [OCGA33-20A]
	ID	1997	SB 1150 [Ch. 204]
	LA	1997	HB 2228 [Act 238]
	MD	1997	SB 162 [Ch. 503]
	ME	1996	SB 769 [PL 673]
	MI	1996	HB 5573 [PA 472]
	MN	1997	SF 960 [Ch. 237]
	MO	1997	HB 335 [Ch. 354]
	NJ	1997	S 269 [Ch. 192]
	NY	1996	SB 7553 [Ch. 705]
	OH	1997	SB 67 [Sec. 1751.13]
	RI	1996	HB 8172 [Ch. 41]
	VA	1996	HB 1393 [Ch. 776]
VT	1996	SB 345 [18 VSA]	
WA	1996	SB 6392 [Ch. 312]	

CONFIDENTIALITY OF HEALTH INFORMATION

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

At least nineteen states have recently enacted protections for individually identifiable health information. The protections provided by these laws vary significantly across states.

This list includes only recent enactments. There are probably additional states with similar rules, although many state health information privacy laws are disease-specific (e.g. AIDS or mental health).

Provision	State	Year	Bill Number or Regulation
Confidentiality of Health Information	<i>CT</i>	1997	SB 6883 [PA 97-99]
	<i>GA</i>	1996	HB 1338 [OCGA33-20A]
	<i>ID</i>	1997	SB 1150 [Ch. 204]
	<i>ME</i>	1996	SB 769 [PL 673]
	<i>MD</i>	1997	SB 325, 545 [Ch. 580, 185]
	<i>MA</i>	1996	HB 5347 [Ch. 8]
	<i>MO</i>	1997	SB 335 [Ch. 354]
	<i>MT</i>	1997	SB 365 [MT Laws 413]
	<i>NH</i>	1997	SB 178 [NH Laws 345]
	<i>NJ</i>	1997	[Regulation Ch. 38]
	<i>NM</i>	1997	[Regulation 13]
	<i>NY</i>	1996	NMAC10:13]
	<i>NC</i>	1997	SB 7553 [Ch. 705]
	<i>OH</i>	1997	SB 932 [Session Law 519]
	<i>OR</i>	1997	SB 67 [Sec. 1751.13]
	<i>RI</i>	1996	SB 21 [OR Laws 343]
	<i>TN</i>	1996	HB 8172 [Ch. 5-37.3]
	<i>TX</i>	1997	SB 2645 [Ch. 862]
	<i>VT</i>	1997	SB 385 [Ch. 1026] [Rule 10.00]

ANTI-DISCRIMINATION

“Consumers must not be discriminated against in the delivery of health care services consistent with the benefits covered in their policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

At least eight states ban discrimination on the part of health insurers.

These laws do not eliminate underwriting practices, but rather these provisions protect enrollees against willful discrimination. Ohio’s law, for example, outlaws discrimination based on age, sex, ethnicity, religion, sexual preference, health status, disability and source of payment. This list is based on a limited search of recent legislation.

Provision	State	Year	Bill Number or Regulation
Anti-discrimination	AZ	1997	SB 1098 [431 Revised]
	CO	1997	HB 97-1122 [Ch. 238]
	CT	1997	SB 6883 [PA 97-99]
	ID	1997	SB 1150 [Ch. 204]
	NJ	1997	[Regulation Ch. 38]
	NC	1997	SB 932 [Session Law 519]
	OH	1997	SB 67 [Sec. 1751.18]
	TX	1995	HB 1367 [Ch. 415]

EXTERNAL APPEALS

“All consumers have the right to a fair and efficient process for resolving differences with their health plans, health care providers, and the institutions that serve them, including a rigorous system of internal review and an independent system of external review.”

At least twelve states now require that health plan enrollees have access to specially designated external appeals entities, which are funded and empowered to hear and act upon such appeals.

Most states allow enrollees to make complaints about a health plan to the state’s Department of Insurance or Department of Health. There is significant variation regarding whether the state is required to investigate each complaint, and the resources and other enforcement tools available to the state to act on such complaints.

Some states have created a state run review board to hear health plan appeals. The Florida Statewide Provider and Subscriber Assistant Program is one example. Some states certify independent review organization to hear such appeals, and randomly assign cases to these organizations as such cases arise. For example, Arizona, Texas and New Jersey take this approach.

- ▶ The Texas Department of Insurance maintains a list of Independent Review Organizations. Each Independent Review Organization must be certified by the state and be under the direction of a licensed physician. An enrolled requests an independent review through the Department of Insurance who then randomly assigns the case to an Independent Review Organization. There is no filing fee to request an appeal and the cost of the review is billed to the utilization review agent, which may in turn bill the health plan.

Provision	State	Year	Bill Number or Regulation
External Appeals Entities			
• Binding	AZ	1997	SB 1098 [431 Revised]
	CA ⁴	1996	AB 1663 [Ch. 979]
	CT	1997	SB 6883 [Ch. 238]
	MO	1997	HB 335 [Ch. 354]
	OH ⁴	1997	HB 361 [1751.18.]
	RI	1996	HB 7683 [Ch. 139]
	TX	1997	SB 383, 385 [Ch. 1024,6]
	VT ⁵	1994	H 171 [Act 185]
• Advisory	FL	1997	HB 297 [97-159]
	NJ	1997	SB 269 [Ch. 192]
	NC	1997	SB 932 [Session Law 519]
	TN	1997	SB 1587 [Ch. 416]

⁴ For experimental therapies only

⁵ For mental health only

POLITICAL AFFILIATION OF THE GOVERNOR IN EACH STATE**

ALABAMA	(R)	MONTANA	(R)
ALASKA	(D)	NEBRASKA	(D)
ARIZONA	(R)	NEVADA	(D)
ARKANSAS	(R)	NEW HAMPSHIRE	(D)
CALIFORNIA	(R)	NEW JERSEY	(R)
COLORADO	(D)	NEW MEXICO	(R)
CONNECTICUT	(R)	NEW YORK	(R)
DELAWARE	(D)	NORTH CAROLINA	(D)
FLORIDA	(D)	NORTH DAKOTA	(R)
GEORGIA	(D)	OHIO	(R)
HAWAII	(D)	OKLAHOMA	(R)
IDAHO	(R)	OREGON	(D)
ILLINOIS	(R)	PENNSYLVANIA	(R)
INDIANA	(D)	RHODE ISLAND	(R)
IOWA	(R)	SOUTH CAROLINA	(R)
KANSAS	(R)	SOUTH DAKOTA	(R)
KENTUCKY	(D)	TENNESSEE	(R)
LOUISIANA	(R)	TEXAS	(R)
MAINE	(I)	UTAH	(R)
MARYLAND	(D)	VERMONT	(D)
MASSACHUSETTS	(R)	VIRGINIA	(R)
MICHIGAN	(R)	WASHINGTON	(D)
MINNESOTA	(R)	WEST VIRGINIA	(R)
MISSISSIPPI	(R)	WISCONSIN	(R)
MISSOURI	(D)	WYOMING	(R)

- **THIRTY-TWO STATES HAVE REPUBLICAN GOVERNORS**
- **SEVENTEEN STATES HAVE DEMOCRATIC GOVERNORS**
- **ONE STATE HAS AN INDEPENDENT GOVERNOR**

** This indicates the political affiliation of the Governor that is currently serving and was in office when the patient protections were passed in each state.

Sources and Approaches Used in This Report

The attached summarizes recently enacted state laws on the issues included in the "Consumer Bill of Rights" recommended by the President's Commission on Quality and Consumer Protection in the Health Care Industry.

For several of these patients' rights, states have taken various approaches to providing protections. The laws included on the attached list may not be exactly equivalent to the provisions as outlined in the "Consumer Bill of Rights." However, we included only those which have a similar thrust and intent.. Some of these laws passed in states apply only to managed care, some only to insurers, and some to all types of health plans.

States are continuing to enact laws to provide consumers with the protections they need in a rapidly changing health care system. We will continue to compile this information as it becomes available, and this list should not be considered exhaustive.

This information compiled from multiple sources, including:

- ▶ Blue Cross Blue Shield Association. "State Legislative Health Care and Insurance Issues, 1996 and 1997."
- ▶ Families USA. "Update to HMO Consumers at Risk: States to the Rescue." March 1997 and informal pre-publication update information.
- ▶ Information obtained from the Health Policy Tracking Service at the National Conference of State Legislatures (for more information contact 202-624-3567 or info@hpts.org).
- ▶ Department of Health and Human Services.

For each state, the bill number of the new law is included. For states that assign public law numbers to enacted legislation, those number are included in brackets. Where no public law number exists, we provide the number of the new or amended state code chapter. Where the source of our information did not include a bill number or other reference, we cite the source (e.g., BCBS indicates we obtained the information from one of the Blue Cross Blue Shield Association "State Legislative Health Care and Insurance Issues" books).



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

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Examples of Improving Health Care Through Quality Improvement

New England Hospitals

An effort by New England hospitals to reduce deaths among patients who have had coronary artery bypass surgery led to a 24 percent reduction in such deaths. A consortium of health care professionals, scientists, and hospital administrators in Maine, New Hampshire and Vermont launched the project in 1990. It involved training surgeons, nurses, and anesthesiologists in quality improvement techniques and sending teams of health care professionals to observe bypass surgery at participating hospitals. Based on the lessons learned from this project, hospitals refined their surgical procedures, post-operative care, training, and evaluation of care.

Kaiser Group Health Cooperative of Puget Sound

Washington State's Kaiser Group Health Cooperative of Puget Sound has helped more than 3,000 patients quit smoking each year by systematically assessing and improving how they care for smokers. At their 30 primary care clinics, all patients are routinely asked if they smoke and offered help to quit. Before the program was launched, only 20% of patients were asked about smoking. The number of quitters rose from 200 a year to more than 3,000 and smoking rates among plan members dropped from 25% to 15%.

Seattle, Washington

The Harborview Injury Prevention and Research Center sought to reduce head injuries by increasing the use of bicycle helmets. Helmet use rose from 5% in 1987 to 40% in 1992 because of efforts to increase parental awareness, reduce the cost of helmets, and give children incentives to wear helmets. As a result, the number of bicycle-related head injuries among kids age 5 to 9 decreased by 66.6% and 67.6% in 10 to 14 year olds.

LDS Hospital

In 1991, LDS sought to improve prevention and treatment of pressure ulcers (bed sores). Using practice guidelines developed by the Agency for Health Care Policy and Research, a multidisciplinary team of nurses, skin care specialists, nutritionists, physical therapists, and physicians worked together to reduce the rate of ulcers among the most severely ill patients from 60% to less than 10%.



The LEWIN GROUP

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THE LEWIN GROUP INC.

March 10, 1998

Internal Program for Complex Chronic-Disease LIBRARY Also Planned

Humana Makes DM Vendors Take Risk for All Services

Humana Inc., spearheading the trend towards "complex chronic disease patient" disease management (DM) in which companies manage multiple comorbidities, is requiring DM vendors to accept risk both for the disease being managed and all other services that patient might require, a top executive tells *DMN*.

The strategy, which according to Richard Vance, M.D., vice president and medical director of population health improvement, is just part of Humana's long-term strategic DM plan, highlights the need for DM firms to develop multiple abilities or to partner with other vendors.

"With respect to our general

philosophy of disease management, Humana has decided that the most effective solution short-term is the development of risk contracts with vendors for single chronic diseases," Vance says. "We contract with the vendor for the total cost of care."

For example, Louisville, Ky.-based managed care organization (MCO) Humana's contract with Cardiac Solutions covers class III and IV congestive heart failure, the two most severe classifications. But Cardiac Solutions then becomes responsible for all comorbidities, including chronic obstructive pulmonary disease (COPD) and end-stage renal disease (ESRD), Vance says.

"The tendency is to move towards contracting for patients" instead of for diseases, he says. "They're getting the principal disease, but the companies are still at risk for the comorbidities. In order for them to do the job well, they have to be able to manage the other diseases."

Almost all patients who are at risk for multiple hospitalizations "are going to have multiple comorbidities," says Vance, adding that "the bulk of the savings" will come from managing these patients.

Humana initially contracted with Cardiac Solutions using this full-risk method in 1996 and since has added risk contracts with Paidos Health Management Services for neonatal care, with Baxter Healthcare Corp.'s Renal Management Strategies (RMS) unit for ESRD, and with AirLogix for asthma, Vance says.

Continued on page 4

→ Vivra Posts Major Gains in CHF, Asthma Management Programs

Vivra Specialty Partners has reported major reductions in hospitalizations and emergency room (ER) visits in both congestive heart failure (CHF) and asthma management programs it conducts for managed care organizations, compared with levels before those patients entered the programs. And it has just started a diabetes management contract with the same client it achieved the CHF results for.

Newly released data through Dec. 31, 1997 for the CHF program at Foundation Health's plan in Florida show ER visits plummeted 85%, says Kathy Diekroeger, Vivra's program director in both CHF and

asthma management.

Specifically, she says, there were 72 self-reported ER visits per 1,000 member months in the year before each of the 256 active patients enrolled in the program (the earliest enrollments were in June 1997). Based on medical claims data, this figure fell to 11 per 1,000 member months in the time since the patients were in the program, which is called HeartAssist, Diekroeger adds. In terms of actual visits, the decline was from 220 to 13, although this may be misleading since there was a much shorter post-enrollment than pre-enrollment period.

Continued on page 5

IN THIS ISSUE

FHS Boosts DM Activity in East, Gets Mich. Blues Review Pact.. 2

Greenstone Changes Aid MCOs Seeking "Value-Added" Pacts.. 3

Mich. Hospital Telemanagement Effort Cuts CHF Admissions 3

Unity HMO Agrees to Pay Pharmacists for Asthma Care.. 6

DME Supplier NPCS Starts Wound-Care DM Program 7

Vivra *Continued from page 1*

Hospitalizations, according to Diekroeger, fell by 41% to 58 per 1,000 member months at baseline to 34 after enrollment. The absolute numbers fell from 177 to 41.

On areas for which there is no baseline data, there were 144 bed-days per 1,000 member months for participants in the CHF program, meaning the average length of stay (ALOS) was about four days, she says. And the 90-day rehospitalization rate, she adds, was 36%.

Diekroeger notes that there was no control group in the program, although there was one in the pilot. Vivra will do a retrospective claims study, to be completed by this summer, to gather more information on the results, she says.

On quality-of-life aspects, Vivra employed the widely used Minnesota Living with Heart Failure survey to examine changes. Patients in the program, reports Diekroeger, had a baseline score of +2 and a post-enrollment score of 33, indicating a 21% improvement within a period that was three months for some patients and six months for others.

She says Vivra is continuing to enroll Foundation patients in the program. So far, 1,066 members with CHF have been "profiled," and 855 have been "screened." Aside from the 256 active patients, Diekroeger says, there are 569 inactive ones,

with the leading of many reasons for this large number being that 355 of the profiled patients turned out not to have a CHF diagnosis.

The actual CHF program begins with a home nursing assessment and is followed up with several phone calls per month by a nurse case manager. Vivra says its nurses in HeartAssist also coordinate care for the patient regarding frequent CHF comorbidities such as hypertension and diabetes.

Like many other CHF programs, Vivra's focuses on diet, exercise, medication compliance, and self-monitoring of changes that require contact with a physician. But Vivra says that its HeartAssist nurses also provide "protocol-driven, physician-approved interventions" when needed.

The asthma program results are through Dec. 31, 1997 and from pilot work with NYLCare Health Plans of the Mid-Atlantic, with which a new contract for a full-scale program is being negotiated.

For this disease, Vivra has profiled 1,350 patients and now is managing 139 patients after similar screening-related disqualifiers to those in CHF, Diekroeger says. Vivra's goal is to enroll 2,000 in this program, which is called HealthAssist. She notes that enrollment in asthma started further back (November 1996) but has been slower than for CHF, although its speed is pick-

ing up now.

On asthma ER visits, she reports, there has been a 78% reduction among program participants from 127 per 1,000 member months at baseline to 28 after enrollment. Hospitalizations dropped 66% from 65 per 1,000 member months before to 22 after. Again, there was no baseline figure for bed-days, but the level after enrollment was 111 per 1,000 member months, indicating an ALOS of five days, according to Diekroeger.

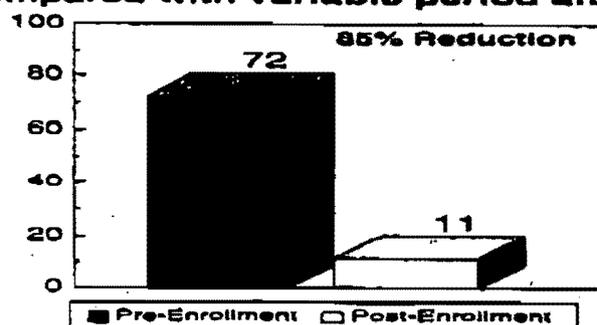
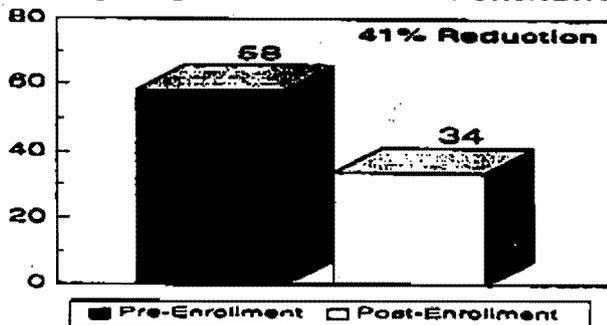
For asthma, Vivra also calculated changes in days missed from work and school and came up with impressive figures, even taking into account the "regression to the mean" associated with asthma patients.

Diekroeger says there were 305 lost work days per 1,000 member months at baseline, compared with only four after enrollment. For missed school days, the drop was from 237 to 32, she adds.

The Vivra unit's newest disease management effort is in diabetes, also with the Foundation Health plan in Florida. The statewide program began last month, notes Diekroeger, and there so far are 20 active patients. She says Vivra screened 101 members of the plan and offered the program to those whose "scores" reached certain levels.

Vivra is being paid via case rates for the diabetes program, she adds. □

Vivra Posts Big Utilization Drops Among 256 CHF Program Patients*
(for year before enrollment compared with variable period after)



*Pre-enrollment utilization data are self-reported; actual claims data are proprietary. Data are through 12/31/97. Source: Vivra Specialty Partners, February 1998

Disease Management NEWS

Independent, timely business intelligence and analysis

Volume 3, Number 5

December 25, 1997

Patient Identification, Compliance Termed Major Challenges

➔ Medicaid DM Growth Seen, But Implementation Tough

Most industry analysts agree that a major increase in Medicaid disease management (DM) programs is coming soon. But they also agree DM in the Medicaid population poses unique problems that could be tough for vendors and managed care organizations (MCOs) to solve.

The growing move to DM in Medicaid is driven in part by the states and in part by MCOs, analysts say. As of this year, more than 40% of the nation's 33 million Medicaid recipients were enrolled in MCOs. And those MCOs are finding it's difficult to turn a profit within the Medicaid program.

"For managed care companies [in Medicaid], reimbursement is so low, you really have to go out and look for what you can to manage patients," says Bobbi Weber, product manager of Access Health Inc.

That's where DM comes in. States — led by specific DM efforts in Florida and New York — increasingly are considering the potential for cost savings offered by DM programs. Moreover, MCOs are beginning to consider what DM programs they can implement themselves to control costs.

The recent move by Florida to begin procurement for four new state-wide DM programs that potentially could cover more than 100,000 Medicaid beneficiaries (*DMN*, 12/10/97, p. 1) signals growing interest by the states in such programs, says Cathy Harrington, Pharm.D., vice president at The Lewin Group, a Fairfax, Va.-based consulting firm working with

for (handwritten)

Hopkins' Moore Options AIDS Program Increases Patient Survival, Saves Money

The Johns Hopkins Moore Options AIDS program has taken on the double challenge of treating AIDS patients within the state's capitated, risk-adjusted Medicaid program, and managed to both save money and increase survival.

Hospitalization is down 40% to 50% in 1997 under the program, although "that's not because of managed care; that's because of the new drugs" available to treat AIDS patients, says John Bartlett, M.D., chief of the Hopkins division of infectious diseases and professor of medicine at the Johns Hopkins University School of Medicine.

Although Hopkins has not yet calculated specific cost savings as compared with other programs, the average cost of an AIDS admission at Johns Hopkins Hospital under the program is \$10,309, indicating the savings involved are very significant. And state risk payments are good enough that Hopkins has not needed to limit access to specialists or other aspects of pa-

Continued on page 6

Florida's Agency for Health Care Administration on the project.

Florida anticipates hiring vendors to implement the four programs — on asthma, diabetes, AIDS, and hemophilia. The state already has lowered the \$6.5 billion Medicaid budget by \$4 million in anticipation of savings generated by DM.

Texas also is in the early stages of developing a Medicaid DM pilot program for diabetes, says Philip Huang, M.D., chief of the state's Bureau of Chronic Disease Prevention and Control. The state still is setting its time lines and has not yet chosen a pilot site, but likely will use a program provided by one of its Medicaid MCOs, Huang says.

Last summer, New York lawmakers agreed to an unusual DM strategy for Medicaid patients who have HIV/AIDS — "special managed care plans" that are specific to

the disease.

Two other states — Colorado and Maryland — now use risk-adjusted capitated Medicaid rates for MCOs and DM vendors treating AIDS patients. Five states (New York, Massachusetts, Washington,

Continued on page 5

IN THIS ISSUE

- Provider Markets CAD DM Program Direct to Employers ... 2**
- New Sachs Product Identifies Chronically Ill, Projects Needs.. 2**
- Hospital Looks to Bear Risk In CHF Programs for HMOs 3**
- Access Says Phone Asthma DM Pilot Slashed Utilization 4**
- Integrated Cardiac Expands Capitated DM Program to Fla. .. 8**

(New York state plan)

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Medicaid *Continued from page 1*

California and Ohio) are considering such a move, says John Bartlett, M.D., who heads up a Medicaid AIDS program at Johns Hopkins University in Baltimore.

And the TennCare Medicaid program in Tennessee, along with other state Medicaid programs, uses Nashville-based Hemophilia Health Services to provide DM services for that disease, says Gloria Richardson-Gray, director of managed care for the company.

But this doesn't mean there's vast amounts of experience out there on the vendor side, Harrington says. As part of the Florida program, Lewin surveyed DM vendors that expressed interest in the project and found sporadic experience with Medicaid lives.

"We wanted to find out if they had any [experience]," says Harrington. "They had some, but I think Florida's the first [state] that's doing it on a broad scale."

The Lewin survey found that:

- Access Health, based in Broomfield, Colo., had experience managing asthma in a Medicaid pilot during the past nine months (see article, page 4);
- The Williamson Institute for Health Studies at Virginia Commonwealth University had some Medicaid lives in its asthma and diabetes DM programs;
- Nashville-based Hemophilia Health Services reported serving Medicaid beneficiaries in a variety of states;
- Olsten Health Services (Melville, N.Y.) has some Medicaid lives in an asthma and diabetes DM program in Massachusetts;
- Patient InfoSYSTEMS, headquartered in Rochester, N.Y., reported a diabetes contract in Alabama's Medicaid program;
- Pfizer Health Solutions listed an asthma and diabetes DM program in New Bedford, Mass. The program is not Medicaid-specific and is conducted in partnership with Harvard

Pilgrim Health Care.

There are two ways states can institute DM in Medicaid: either hire vendors, or require the MCOs that already are in place to implement specific DM programs. State Medicaid programs are considering both of those strategies.

Hemophilia Health Services has both kinds of contracts, says Executive Vice President Donna Ligda. Diseases such as hemophilia and AIDS could be the best place to start for a Medicaid program considering DM programs, Ligda says. She explains, "Because hemophilia is such a rare and costly disease, there is a higher proportion [of hemophilia patients] in Medicaid than in the general population."

But vendors and MCOs seeking to set up DM programs within the Medicaid population will dis-

"My guess is you will not see a risk-bearing contract up front."

Mike Quilty

cover that they have bigger challenges than they might find in a commercial population, experts warn.

One of the biggest challenges in DM within Medicaid programs is finding the people. Access Health has been "working with clients to find a variety of methods to locate them," which can include "welcome surveys" when beneficiaries sign up with a state Medicaid MCO and, in the case of asthma DM programs, emergency room records.

"One of the biggest issues we've dealt with [in Medicaid] is actually getting hold of people," says Weber. "Getting people into the program is the biggest challenge."

Privacy rules that are specific to the Medicaid program also hamstring efforts to identify potential patients for DM, Harrington says. The rules specify that you can't target beneficiaries based on their claims records; instead, "when you talk to

people, you have to talk to the whole population," she says.

Weston, Mass.-based DM consultant Al Lewis suggests partnering with a hospital to create a "choke point" to locate and identify beneficiaries. In addition, Lewis recommends a different business strategy for vendors considering Medicaid DM.

"In most situations, I tell my plans to do a population model of DM, where you put the vendor at risk for the entire population," he says. "In Medicaid, I tell my people to do a participation model, where you're finding people and getting them to join. There, you're getting people who are motivated already."

Companies can expect 50% to 60% savings over comparable, unmanaged populations in these cases, Lewis says.

Another challenge is compliance. "The number one issue in dealing with Medicaid patients is the issue of compliance," asserts Ligda. "The more compliant you can make the patient and the quicker you can treat the disease appropriately, the less costly in the long run."

For example, Hemophilia Health Services has had success in teaching the family members of Medicaid hemophilia patients to do infusions, thereby eliminating trips to the emergency room for that purpose, Ligda says, although she would not release actual results.

And the financial details of any Medicaid DM contract could be tricky. Mike Quilty, director of business development for Pfizer Health Solutions in New York City, says there's still too many unknowns in the area of DM for Medicaid programs for companies to jump in with a risk contract.

"My guess is you will not see a risk-bearing contract up front," he says. In the Florida project, for example, Quilty says he anticipates long negotiations with the vendors that eventually are chosen. He'd be surprised if those companies were willing to take on risk, Quilty adds. □

American Medical Association

Physicians dedicated to the health of America



RELEASE #1 of 2 RELEASES

Statement

FOR IMMEDIATE RELEASE

March 13, 1998

AMA: ALL OPTIONS, INCLUDING LEGISLATION, REMAIN OPEN TO MAKE CONSUMER BILL OF RIGHTS A REALITY

AMA Chair calls Health Benefits Coalition release 'gross distortion of facts'

Statement attributable to:

Thomas R. Reardon, MD
AMA Chair

"The press release issued yesterday by the "Health Benefits Coalition," a group of businesses and insurers, is a gross distortion of the facts surrounding the President's Quality Commission's willingness to recommend federal legislation to enforce the Consumer Bill of Rights.

"The President's Quality Commission worked for consensus. A majority of those on the commission would have favored legislation to enforce the Consumer Bill of Rights, but a few disagreed.

"When the Bill of Rights was issued last November, the following text addressed enforcement:

'The rights enumerated in this report can be achieved in several ways including voluntary actions by health plans, purchases, facilities, and providers; the effects of market forces; accreditation processes; as well as State or Federal legislation or regulation.'

"All of these options, including legislation or regulation, remain open.

"I have appreciated the opportunity to represent medicine on the President's Quality Commission, and to provide the AMA's expertise to the Commission during its deliberations. The process has been thoughtful, thorough, and open, and the Final Report is proof of that.

"The AMA looks forward to working with President Clinton, the Administration, and those in Congress interested in moving patient protections forward in this Congress, so that health care in the United States remains the best in the world. Our patients deserve nothing less."

For more information, please contact:

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**PRESIDENT ENDORSES QUALITY COMMISSION'S FINAL REPORT AND ISSUES
EXECUTIVE MEMORANDUM TO IMPROVE HEALTH CARE QUALITY
March 13, 1998**

Today, the President accepted the final report from his Advisory Commission on Consumer Protection and Quality, which calls for a health quality council to develop unprecedented national quality improvement goals and a privately-administered forum to develop new tools to empower consumers and businesses to purchase quality health care. The President praised the Commission's work and endorsed its new recommendations for a national effort to improve quality throughout the health care system.

Hundreds of thousands of Americans each year are injured and even die from avoidable medical errors in the health care system, and millions more receive unnecessary services or substandard care that cause needless health complications and increase health care costs. Establishing uniform standards which allow consumers compare health plans to help ensure that health plans finally begin to compete on the basis of quality -- not just costs and benefits.

To implement these new recommendations, the President also issued an Executive Memorandum that directs five Federal agencies to establish immediately an interagency task force to ensure the Federal government takes the lead on improving health care quality. The President also asked the Vice President to hold a planning meeting this June to kick off the work of the health care forum recommended by the Quality Commission.

NUMEROUS INCONSISTENCIES AND AVOIDABLE ERRORS IN THE NATION'S HEALTH CARE SYSTEM COST LIVES AND UNDERMINE HEALTH. Too many Americans receive substandard health care, causing avoidable injuries and death, needless complications, and increased health care costs, including:

Avoidable errors: Hundreds of thousands of Americans are injured and thousands die each year as a result of avoidable errors in hospital care.

Underutilization of services: Millions of Americans do not receive necessary care and suffer needless complications that can add to health care costs. For example, far too many Americans do not get the preventive care they need.

Overuse of services: Others receive unnecessary health care that can increase costs and even endanger a patient's health. For example, 80,000 women every year undergo unnecessary hysterectomies.

Wide variation in health care quality: There is tremendous variation in health care services including wide regional disparities and different hospitalization rates for similar conditions.

ENDORSED COMMISSION'S NEW RECOMMENDATIONS TO IMPROVE QUALITY HEALTH CARE. The President endorsed the Commission's recommendations which call for:

- **Creating an Advisory Council for Health Care Quality.** This public advisory panel would establish, for the first time, national goals to improve health care quality and develop strategies to achieve them. The Council would emphasize areas such as ensuring consumers have access to clear information to make decisions about health plans and professionals, identifying strategies to reduce avoidable medical errors, reducing variation in health care services, and promoting evidence-based medicine. Such a council, which would include representatives from both the public and private sector, would make an annual report to Congress on the nation's progress in improving health care quality.
- **Creating a Health Care Forum and Asking the Vice President to Hold the First Planning Meeting This June.** The absence of uniform quality standards means that consumers do not have the necessary information to choose health plans based on quality. The forum would bring together the public and private sectors to identify a core set of measures to be adopted by health plans across the country. This would ensure that, for the first time, consumers have a consistent set of standards so they can choose health plans based on quality -- not just on cost. The President asked the Vice President to hold a blue ribbon planning meeting this June to kick off the work of the health quality forum as recommended by the Commission.

ISSUED A PRESIDENTIAL MEMORANDUM DIRECTING AGENCIES TO DEVELOP A FEDERAL TASK FORCE TO COORDINATE AND IMPROVE HEALTH QUALITY.

The President directed the Departments of Health and Human Services, Labor, Veterans Affairs, Defense, and the Office of Personnel Management to establish the "Quality Interagency Coordination" (QuIC) task force. He directed this task force to ensure better collaboration and coordination across the Federal government, through initiatives such as developing consistent goals, models, and timetables; sharing information about evidence-based medical research and quality outcomes, and coordinating Federal programs' quality reporting and compliance requirements.

RENEWED HIS CALL ON CONGRESS TO PASS A PATIENTS' BILL OF RIGHTS

THIS YEAR. Following his speech earlier in the week to the American Medical Association, the President urged Congress to step up its efforts to pass a Patients' Bill of Rights this year. He also asked Congress to ensure that the Patients' Bill of Rights includes the health care quality council he endorsed today. With less than 70 working days in this legislative session, the President urged Congress not to adjourn without passing a Patients' Bill of Rights which includes important protections for patients such as: access to the specialists they need, access to emergency room services, and an external appeals process to address grievances with their health plans.

THE

LUNTZ RESEARCH COMPANIES

Luntz Research & Strategic Services ■ The Public Opinion Company ■ Luntz Corporate ■ Luntz Worldwide

Memorandum

To: The PASCC Committee
From: Frank Luntz and Bob Castro
Re: Focus Group and Instant Response Sessions
Date: March 19, 1998

AN OVERVIEW

The most remarkable thing about the focus group and the Instant Response Session was each group's initial reluctance to have the government intervene (in almost any aspect of their lives, but especially in health care) and their almost complete turnaround by the end of the two hours. When their perceptions of health care "crisis" were refocused from "access to a policy" to "access to the care you need," their outlook changed. People's opinions are not carved in stone, even if they seem to be at first. Here's how to present them with the information they need to see it your way.

AN AMERICAN HEALTH CARE CRISIS?

Is there a health care crisis in America?

"Too many people don't have adequate access." -Female

"Some employers come up with the lowest possible plan that their HMO offers and get you enrolled in that plan." -Female

"When the doctor refuses to let you go to a specialist because he wants to keep the money in his practice, there's a problem there." -Female

"[Yes] Because some people can't afford it. They don't have a person to pay for it." -Female

The bad news is that when you first ask people if there is a health care crisis in America, their thoughts run to issues of access and affordability. If we continue to let that happen, we will lose this debate.

What became clear in the groups is that when you get people to examine their own health care coverage, they realize that their own coverage leaves much to be desired. What is the point of having health insurance if it can't actually keep you healthy? What

if doctors can't diagnose you properly, or even see you within a reasonable period of time?

Once they started to question how safe they are in their own plan -- and to consider how limited their own information and choices are -- the *urgency of passing some "patient protections" grew*. One of the biggest obstacles to overcome in this regard is the fear of government intervention.

FROM FEAR OF GOVERNMENT INTERVENTION TO PATIENTS' RIGHTS

"I think doctors should be the ones telling us about health care, not politicians."

-Female

"Government controls. Stay out." - Male

"If Congress does get involved they may simplify the way they simplify doing taxes."

- Male

"I don't believe it should be a government answer. It should be the private sector."

-Male

Both groups we talked with expressed a fear of government involvement in the health care issue. In general, the message has gotten out that government regulation often means bureaucracy, inefficiency, and incompetence.

However, people continue to perceive the federal government to be the authority of last resort. If the issue is important enough that it absolutely has to be dealt with, and no one else is capable of dealing with it, then people are sometimes willing to let the federal government step in.

The primary question of this focus group and instant response, then, was to determine if these health care issues were important enough to override people's deep-seeded fears of government and allow for regulation. They are.

What we discovered is that once they had been presented with more information and prompted to confront their own deeply-held values and preferences for health care plans, they supported some government activity in line with *PASCC principles*.

"I think they could monitor a little bit, but not so much that there's a whole lot of government red tape." — Male

"If you want to...set up some [governmental] guidelines and monitor and not just go crazy and just start out like not enforcing but monitoring, setting up [guidelines] that everyone will follow, and like HMOs and everybody else taking it from there. At least a start. I could go for that."—Male

"Setting basic standards is great." —Female

PASCC Principles

The following principles were most popular among both the focus group and the Instant Response group, singles and parents with children.

"Health care decisions should be based on medical evaluations, not economic ones." (5 votes among singles, 16 among couples).

"Medical decisions made by someone other than a doctor and the patient are not in the best interests of the patient." (6 votes among singles, 14 among couples).

"Patients have a right to emergency services wherever and whenever they need them." (8 votes among singles, 9 among couples).

Among the six PASCC specific principles, the following two were by far the most popular.

"Health care providers should be able to give their patients full information about their condition and treatment options."

"Any basic managed care plan should allow patients to see plan specialists, when necessary."

There was a whole side discussion within the groups on a single word — "must" versus "should" -- in the Principles Language Worksheet. This exercise demonstrated that focus group members think seeking medically-necessary treatment outside the network is not just a feature or benefit, it is a *right*.

It is this pivotal shift to the language of rights—legal language—that is the break point for where people are finally willing to acknowledge the need for government to have at least some role in ensuring that health care plans live up to their promises.

THE BLAME SHIFT—FROM DOCTORS TO INSURANCE COMPANIES

The general opinion of doctors has improved since 1992-93. *Clearly there has been a "blame shift" from physicians to the insurance companies.* Managed care organizations are now the "bureaucrats," who force even those doctors with the best intentions into giving bad care and making poor treatment decisions. HMOs spoil the traditional patient-doctor trust by coming between them. PASCC can capitalize on these fears.

"Doctors want to do the right thing, and they are capable of doing the right thing, but they have such a load on them, they're so pressured when they're seeing you." — Male

"I think before people complained about the doctors charging too much, and now they're blaming it on the insurance, so the blame has shifted from the doctors to the insurance."

—Male

"Generally, you're not paying the doctor much anymore. You're paying, if anything, a small co-payment or the HMO, so you don't see the doctor as getting rich off you."

—Male

"I've had the same doctor since the 1980s... I've liked him all along." —Female

You enter this debate with some strategic disadvantages (i.e. the perception of what the health care crisis is), but with enormous image advantages. People like their doctors again. Take a look at what they think about HMOs:

"Too many people, too many bureaucrats, too many clerks, too many administrators at HMOs." —Male

"I feel like I'm really limited in what I can choose." —Female

"You kind of become a number in the system, a number who pays them, and you're not really a person with a doctor who follows your care." —Female

"I can't tell you how many times I have gone to [the doctor] and he's just plain told me I can't do this for you under this plan. And it was what he wanted to do." — Male

People are aware of the tension between doctors and HMOs, and their natural sympathy extends to the doctors. After all, it's not the HMOs who are being "gagged." The phrase "gag rule" evokes a precise, effective image for PASCC. For doctors who want to tell the truth to be silenced by powerful forces is about as un-American as it gets. In a society that supposedly values free speech, how can anyone justify preventing doctors from telling their patients what they need to know?

THE EDUCATIONAL CAMPAIGN

PASCC should be engaged at least as much in an educational campaign as a political effort. The arguments make themselves, if presented properly and with language that motivates the listener to assess his or her own "rights" in that context. *PASCC should be doing all it can to refine this message further and get it out --* and policymakers will listen when their constituents speak in these tones. These people are truly calling their representatives to action, but their voices are few and small at this point. PASCC can guide their thinking.

PASCC must redefine the "health care crisis" debate by shifting discussion from "How many people are insured or uninsured" to questioning "What it means to be insured." Do all policyholders (plan members) really have "full" coverage? Are they "safe and secure" once they join a plan or is there a "false sense of security" because they don't have all the information they're entitled to? Once health care consumers ask themselves this critical question -- including policymakers thinking of their own case as an individual -- they will decide in this context: "Isn't it our right to be informed?"

The doctor-patient relationship of trust is sacred. People are very protective of that relationship, and can be turned against any plan or agency that threatens it. Through personal stories and descriptions, PASCC must clearly articulate how perverse financial incentives, gatekeeper arrangements, and gag clauses undermine this trust. Showing how these "cost-containment techniques" *really do not save money* in the long run literally "adds insult to injury."

Although the first two sessions did not allow us the time to use the "Smith versus Jones" comparisons, future focus groups may give us the opportunity to see which arguments and phrases have the most impact.

To paraphrase the discount clothing store commercials, *an educated consumer is our best patient.* The more informed a member is, the better he can make his own choices. PASCC's core principles are about giving people *standard, basic, clear, and understandable information* -- so that individuals can choose their own health plan wisely, and so that once enrolled, they can judge for themselves if they are getting the *quality of care they are paying for.* Ultimately, *this is how a marketplace should work.*

TARGETING MEMBERS

More sessions should be part of this education/persuasion effort. Targeting key Members and media will highlight how a small group can be activated by a powerful, timely message. As journalists trumpet this message and Members carry their observations to colleagues on the Hill, policymakers will be wary to return home in November without delivering something on this issue. *PASCC's bill will be the answer to this call, and PASCC's principles are the guideposts to getting there.*

CONCLUSION

By defining the debate in your own terms and raising people's expectations, these principles will become "no brainers" for enacting a basic list of patient protections. PASCC will secure its seat at the policymaking table not when Congress turns to you for answers, but when individual Members have adopted and internalized these principles as their own -- and take them back to their home districts and into the Conference room with them.