

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

Quality Commission File

MEMORANDUM

TO: Chris Jennings
FR: Janet Corrigan, Ph.D. *Janet*
RE: April 8 Meeting on Forum for Health Care Quality Measurement and Reporting
DATE: April 7, 1998
cc: Dr. John Eisenberg

In preparation for our meeting tomorrow to discuss the planning process for a Forum for Health Care Quality Measurement and Reporting, my staff has put together a draft proposal to fund and carry out this process.

As you know, creation of the Forum was one of the major recommendations of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. In tandem with an Advisory Council on Health Care Quality, the Forum is intended to provide national direction for quality improvement in health care. It is designed to harness the power of group purchasers -- both public and private -- to demand quality and to measure and report on the quality of health plans, providers, and institutions.

At our meeting, I would like us to focus on several key questions:

- What is the proper role for the Vice President to play in this planning process? Should it be ongoing or simply serve to kick off the process and bring it to its conclusion?
- How should the participants in the planning process be selected? Should they be fully representational or will a smaller, more select group suffice? What constituencies should/must be represented?
- How should the planning process for the Forum reflect the larger priority of establishing the Council? How can we guard against a successful planning process being used to delay or defeat the Council?
- How will the planning group operate? Should it operate in public or is this a private matter? What, if any, are the implications of the Vice President's involvement as it relates to FACA and other laws?
- What is the appropriate "home" for the planning process? Should it reside in a private organization (i.e., a foundation or other nonprofit organization)? Or should it reside in a public organization (i.e., HHS)?

Again, I look forward to seeing you on Wednesday.

**PROPOSAL TO FUND A PLANNING PROCESS
FOR A NATIONAL
FORUM FOR HEALTH CARE QUALITY MEASUREMENT AND REPORTING**

DRAFT - APRIL 7, 1998

This is a proposal to fund a process for planning the development of a Forum for Health Care Quality Measurement and Reporting ("the Forum"), a private-sector entity to be established to provide coordination and guidance to the multiple public- and private-sector parties involved in evaluating health care quality. Creation of the Forum was one of the major recommendations of the Advisory Commission on Consumer Protection and Quality in the Health Care Industry ("the Quality Commission") in its final report to the President.

This proposal begins by describing the need to coordinate ongoing work in the area of health care quality measurement and reporting, and by laying out the specific objectives, activities, and organizational characteristics of an entity to be created to undertake that effort. It then describes the objectives, time line, and budget of the proposed process for convening key stakeholders to assist in operationalizing the entity.

BACKGROUND

Need for Standardized Information on Health Care Quality

Routinely generating comparable, standardized information on the quality of health care is critical for both motivating and enabling improvement. Standardized measures of quality are needed to track the health care industry's progress in achieving national quality improvement aims and to guide public planning and policy making. Comparative information on quality also is needed for individual consumers, employers, and others to use in selecting health care providers and health plans. Furthermore, valid and stable quality measures are integral to health care providers' efforts to improve their performance. When standardized, such measures provide an opportunity for health care organizations to make comparisons and identify "best performers."

Despite a growing number of efforts to measure and report on health care quality, useful information is neither uniformly nor widely available. Improving our ability to measure quality has been the object of significant public and private-sector activity over the last decade, reflecting the expectation that measurement can serve as both a catalyst and a tool for improvement as well as to facilitate consumer choice. While considerable advancements have been made in the quality measurement field in recent years, current efforts fall short of fully meeting users' needs, do not provide measures for many of the most important health burdens (e.g., chronic conditions), and often are duplicative and unduly burdensome on health care providers, health plans, and others.

Forum for Quality Measurement and Reporting

Objectives. The Forum for Health Care Quality Measurement and Reporting is being established to build the systemwide capacity to evaluate and report on the quality of care. The Forum would

develop and implement effective, efficient, and coordinated strategies for focusing incentives for quality improvement on national priorities while assuring the public availability of information needed to support the marketplace and the efforts of the various existing quality oversight entities.

Activities. To achieve its objectives, the Forum will need to:

- develop a comprehensive plan for implementing quality measurement, data collection, and reporting standards to assure the widespread public availability of comparative information on the quality of care furnished by all sectors of the health care industry;
- establish measurement priorities that address national aims for improvement and that meet the common information needs of consumers, purchasers, federal and state policy makers, public health officials, and other stakeholders;
- periodically endorse core sets of quality measures and standardized methods for measurement and reporting;
- foster an agenda for research and development needed to advance quality measurement and reporting and to encourage collaborative funding for such activities;
- develop and foster implementation of an effective public education, communication, and dissemination plan to make quality measures and comparative information on quality most useful to consumers and other interested parties; and
- encourage the development of health information systems and technology to support quality measurement, reporting, and improvement needs.

To evaluate the success of its efforts, the Forum will need to create and utilize feedback mechanisms designed to assess the feasibility and acceptance of the measurement sets it promulgates as well as the extent to which information is reported, available, and used by interested parties. Armed with this information, the Forum will be able to initiate improvement strategies as necessary.

Structure. The key organizational characteristics of the Forum that will enable it to accomplish its objectives are its status as a private-sector organization and its representation of key stakeholders from both the public and private sectors.

Operating in the private sector will provide the Forum with two needed characteristics. First, it will have greater flexibility and the means to act quickly to respond to changes in the health system and advances in technology that have implications for measurement and reporting strategies and capacity. Second, it will be well-positioned to harness and coordinate the market forces needed to drive this initiative.

Because the Forum will operate in the private sector as a voluntary initiative, its success will depend upon the commitment and influence of a critical mass of stakeholders in the health care marketplace. The Forum will therefore need to be broadly representative of stakeholders. The users and potential users of information on quality must be involved in the process of identifying core quality measures for reporting if those processes are to succeed in addressing their common information needs. The Forum also will need to include a core constituency of influential stakeholders that can assure the implementation of the measures once they are promulgated. Compliance with reporting requirements will be attained by purchasers and oversight bodies (i.e., accreditation, certification and licensure entities) by the mechanisms available to them (e.g., purchasing contracts and oversight processes). A decision to participate in the Forum would be viewed as constituting an endorsement of its work and an agreement to leverage compliance with the results to the full extent of the participant's ability.

Also critical to the Forum's efforts will be the participation of key organizations involved in promulgating quality measures and collecting information on the performance of various sectors of the health care industry. Key organizations include those that undertake efforts on a national basis, as well as those emerging and established groups organized at the regional, state, or local levels. The Forum will need to work with these organizations to determine how best to assure that information on health care quality is available, affordable, and easily accessible in the public domain. The Forum itself would not compete with the innovative work already under way in the public and private sectors by developing performance measures itself, but would instead seek to encourage the progress being made in this area and improve it through greater coordination. It would help to identify areas of needed fundamental research related to quality.

PROPOSED PLANNING PROCESS

A planning process is needed to provide key stakeholders with the opportunity to work through critical issues related to the Forum's governance, organizational structure, and source(s) of financial support. The Vice President will begin this process by inviting key stakeholders to a June meeting to form a Task Force to jump-start the planning process. He will select individuals to participate in this planning process based on their expertise and stature, as opposed to organizational affiliation. The decisions to use a neutral convener and to seek funding support from a private foundation were made as a means of ensuring impartiality and promoting participation by stakeholders.

The planning process should take place over a 6-month period, commencing in May 1998 with the issuance of invitations to participate. Over the course of that time, during which three meetings will be held, the Task Force will accomplish four critical objectives:

- define the Forum's functions, operations, working relationships and membership criteria;
- determine the composition of the Forum's governing board;
- determine the source(s) of start-up and ongoing financing; and
- recruit the Forum's Executive Director.

Objectives of the Planning Process

1) Define the Forum's functions, operations, and working relationships.

Defining the Forum's functions, operations, and working relationships will be among the most important objectives of the planning process. The Quality Commission's work provided a starting point for defining these characteristics, but additional work is needed to refine and operationalize those recommendations.

A number of issues to be addressed pertain to the manner in which the Forum will function. For instance, the planning process may identify policies and procedures designed to assure the public of the integrity of the Forum's work, promote widespread confidence in its outcomes, and minimize potential conflicts of interest. The planning process can serve to articulate specific policies and procedures that will provide for public input, public deliberation, and public access to documents produced.

Operational issues to be addressed include the Forum's organizational structure, budget, facilities, and meeting schedules. In defining these aspects, participants in the Forum's planning process may wish to look to the organizational structures of entities charged with undertaking functions that are similar in nature, scope, and scale. Entities such as the Financial Accounting Standards Board and the American National Standards Institute -- although not analogous to the Forum in all respects -- may provide alternative models for examination by the Planning Task Force.

Task Force Planning process participants will need to carefully consider how the Forum will relate to the public- and private-sector organizations whose work will influence or be influenced by the Forum's activities. Formal working relationships will in some cases need to be established; for instance, in the case of organizations responsible for the development of the health care quality measures that will be evaluated for inclusion in the core sets of measures to be periodically endorsed by the Forum. Similarly, the ways in which the Forum will interact with existing local, regional, state, and national organizations that serve as repositories of data on quality will need to be considered.

2) Determine the composition of the Forum's governing board.

The composition of the Forum's governing board is a key issue to be addressed through the planning process. Both the precise number and the allocation of slots on the Forum's governing board will need to be determined.

The Quality Commission recommended that the Forum be governed by a board that includes:

- public and private group purchasers;
- individuals and organizations focused on representation of consumers/patients;

- providers;
- labor unions;
- experts in quality assurance, improvement and measurement;
- quality oversight organizations;
- health care researchers; and
- public health experts.

Balancing the need to have a strong purchaser role and representation of the full array of key constituencies will be a delicate and challenging task for the planning process participants. Substantial representation on the board of purchasers from both the public and private sectors and of consumer organizations will be critical to provide strong incentives for organizations to participate in these efforts and to abide by the decisions of the Forum. Representation of the full array of key constituencies on the board will be equally critical, so as to assure the buy-in of all participants and the requisite expertise to effectively carry out the Forum's responsibilities.

3) Determine source(s) of start-up and ongoing financing.

Participants in the planning process will need to consider alternative sources of start-up funding to assist in establishment of the Forum. The potential for obtaining a start-up grant from a foundation or public source will need to be evaluated. Such funds may be used to allay one-time expenses that will be associated with initiating the Forum (e.g., expenditures associated with outfitting staff offices). External funding is unlikely to be made available for ongoing financing of the Forum, however.

Thus, it is essential for the Planning Task Force to establish an ongoing source of financing for the Forum. Participants in the planning process will need to estimate the Forum's first-year operating budget and develop a dues-paying schedule for members. Such a schedule will need to account for the varying levels of resources available to different categories of stakeholders. For instance, cross-subsidies may be required so that the Forum is able to attain adequate representation of consumer interests.

4) Recruit the Forum's Executive Director.

Once the planning process has resolved operational, representation, and financing issues, the Planning Task Force will need to identify an Executive Director capable of initiating the Forum and providing ongoing leadership for its efforts. This will require defining the skills and qualifications of ideal candidates for the position, seeking and reviewing candidates wishing to be considered, and selecting a qualified Executive Director.

Candidates will need to possess a variety of professional skills and expertise to be successful as the Forum's Executive Director. These include strong leadership, management, and planning skills; a high level of credibility among the diversity of stakeholders represented at the Forum; technical knowledge regarding quality measurement, oversight, and health benefits; and the

ability to effectively communicate in support of the Forum's mission. The Planning Task Force will need to determine the extent to which the Executive Director should be drawn from interests represented by the Forum. For example, a potentially highly qualified candidate may be a person with experience as a corporate benefits director with first-hand knowledge of purchasers' perspectives on the use of quality measures; negotiating experience with hospitals, clinicians, and oversight organizations; and an understanding of consumers' use of quality measurement information. Other individuals with the requisite experience and skills to serve as the Forum's Executive Director may include health plan executives, quality oversight managers, or experts in quality measurement and improvement.

The planning process for selecting an Executive Director will require identifying the desired qualifications of candidates as soon as the functions and operations of the governing body of the Forum are defined. This definition of the Executive Director position and desired skills of candidates needs to occur early in the Planning Task Force's process to allow time to recruit highly qualified candidates. The Task Force may elect to contract with an executive search firm to assist in the recruiting of suitable candidates. Once eligible candidates have been identified, the Task Force will need to review the qualifications of candidates applying for the position, interview top candidates, and select a preferred candidate for Executive Director.

Time Frame for Planning Process

May 1998	Stakeholders invited to participate in planning process
June 1998	First meeting of planning process Purpose: Define Forum's functions, operations, and working relationships
September 1998	Second meeting of planning process Purpose: Determine the composition of the governing board, sources of ongoing financing for the Forum, and qualifications of Executive Director
November 1998	Third Meeting of planning process Purpose: Name governing board, interview Executive Director candidates
December 1998	Name Forum's Executive Director, release start-up funds, announce initial meeting of Forum

Budget for Planning Process [Note: Preliminary, rough estimates]

Personnel costs	\$120,000
<i>[Estimated as 1 FTE * \$100,000 annual compensation (including benefits) * 0.8 years + 1 FTE * \$50,000 annual compensation (including benefits) * 0.8 years]</i>	
Administrative expenses and overhead	\$ 40,000

Meeting expenses (3 meetings)	\$ 85,500
-- facilities [estimated as \$3000 * 3 meetings]	
-- travel expenses [estimated as 20 people * \$800/mtg * 3 mtgs]	
-- overhead for services of contractors responsible for meeting logistics [estimated as 50 percent of total meeting expenses]	
 Honoraria for Planning Committee	 \$ 60,000
[estimated as 6 days meeting time * 20 participants in planning committee * \$500 daily rate]	
 Contract for executive search services	 \$ 39,000
[estimated as 30% of Executive Director's annual salary of \$130,000]	
<hr/> Total	<hr/> \$344,500

How much do I
 need to ask for?
 Not the whole amount, right?

→ funding cycle
 \$1,000,000
 several
 w/ chipping
 foundations

THE WHITE HOUSE

WASHINGTON

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March 31, 1998

Dear Senator Daschle and Representative Gephardt:

I am writing to commend you on the Patients' Bill of Rights Act of 1998 that you are introducing today on behalf of the Democratic Caucuses of both Houses of Congress. This bill represents a critically important step towards enacting a long overdue "Patients' Bill of Rights" that Americans need to renew their confidence in the nation's rapidly changing health care system.

States across the nation have already begun to enact reasonable patient protections. In fact, 44 states, including 28 of the 32 states with Republican Governors, have passed at least one of the protections that my Advisory Commission on Consumer Protection and Quality recommended, and that I endorsed last year. However, a patchwork of non-comprehensive state laws cannot provide Americans with adequate patient protections, particularly because state health care laws do not have jurisdiction over more than 100 million Americans. Federal standards are essential to assure that all patients get the protections they need.

You have done a remarkable job bringing a broad-based coalition of Democrats together to move this important issue forward. I would particularly like to commend Senator Kennedy and Representative Dingell for their leadership in developing this legislation.

The Patients' Bill of Rights Act of 1998 includes important patient protections, such as the right to emergency care wherever and whenever a medical emergency arises; the right to talk freely with doctors and nurses about all the medical options available, not only the cheapest; and the right to an internal and external appeals process that allows patients to address their concerns and grievances. I am particularly pleased that it includes every protection recommended by the Advisory Commission. This bill also improves on other patients' rights legislation before the Congress because it does not include expensive protections for health care providers that have the potential to increase premiums excessively.

The bill you are introducing today provides a critical step towards developing bipartisan legislation that will pass the Congress. I look forward to working with the Congress to enact a "Patients' Bill of Rights" Act that I can sign into law this year.

I am confident that, working in a bipartisan fashion, the Congress will produce a bill that achieves the important balance of providing patients the protections they need without undermining health care affordability. We must ensure that whether they have traditional care or managed care, Americans have access to quality care. Thank you again for your strong leadership and commitment to this end.

Sincerely,

A handwritten signature in cursive script, appearing to read "Bill Clinton", with a long horizontal flourish extending to the right.

The Honorable Thomas A. Daschle
The Honorable Richard A. Gephardt
United States Congress
Washington, D.C.

Quality File

Estimated Costs of Selected Consumer Protection Proposals

*A Cost Analysis of the President's Advisory
Commission's Consumer Bill of Rights and Responsibilities
and the Patient Access to Responsible Care Act*

April 1998

By Coopers & Lybrand L.L.P.

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Executive Summary

Enrollment in managed health care plans has grown dramatically in recent years, with approximately 85% of the insured population under age 65 being covered by some form of managed care. HMO enrollment now represents approximately 30% of all health insurance coverage in the U.S, compared to 25.7% in 1995.¹ This growth has contributed to lower premium rate increases in all types of health plans. In many cases, the growth of managed care has also resulted in improvements in access to services, as health plan members identify a single source of information and resources. At the same time, concerns have developed regarding the ways in which some health plans operate and the mechanisms through which information is shared between the health plan, the plan provider, and members.

Responding to these concerns, legislation and policy initiatives have been proposed at both the federal and state level. President Clinton appointed a commission to study the ways health care services are provided under managed care and to make recommendations for changes. The Commission issued a report that called for a Consumer Bill of Rights and Responsibilities (CBRR). The president has endorsed the commission's proposals and has called for legislation to implement the CBRR. Another proposal, authored by Representative Norwood and titled the Patient Access to Responsible Care Act (H.R. 1415) calls for many similar patient protection provisions, and includes some additional provisions that would change the way in which managed care plans operate. Senator D'Amato introduced similar legislation in the Senate (S. 644). These initiatives are designed to expand the range of choice available to health plan members and to increase the amount and types of information available to consumers as they make decisions regarding their health plan choices and medical treatments. The policy initiatives range from efforts to standardize information disclosure and access to certain types of services, to more significant changes. The proposal with the most significant implications relates to potential changes in liability for health plan decisions.

¹ Hoechst Marion Roussel, Managed Care Digest Series, November 1997

consumer protection provisions are spread over the entire health insurance market, the average cost effect is lower than the values shown here.

The estimated average effect on health plan premiums is nominal. However some plans, particularly those operating in areas with lower level of managed care enrollment, can be expected to show greater change in costs.

Conclusions

Many of the provisions of the CBRR and PARCA described below are similar to current managed care standards of practice or reflect standards that are rapidly being adopted, with the one notable exception of the proposed change in liability for health plans.

Information Disclosure

The information reporting and disclosure requirements are a mix of currently collected information and new information. While processes are beginning to be put into place for most of the items included in the requirements, an infrastructure will often need to be developed to collect the data. Administration of satisfaction surveys, for example, will require new data collection, although the standards for which data to collect and the proper way to administer the surveys has largely been developed. Similarly, methods for measuring health plan and provider quality have been under development for some years, but not all plans or providers have implemented the process. These requirements have the potential to improve the health care delivery system by making new information available to consumers and other providers. This information has largely been unavailable for both managed care and fee-for-service members. The information disclosure requirements for CBRR and PARCA vary. The CBRR calls for more extensive data collection and disclosure for health plans, facilities and professional providers, while PARCA requires reporting of information only related to health plans. We estimate a change in premium for HMOs ranging from \$0.45 - \$0.82 per person per month (PMPM) with a best estimate of \$0.50 PMPM for the CBRR provisions, and \$0.07 - \$0.22 PMPM with a best estimate of \$0.10 PMPM for PARCA.²

Health Care Delivery Requirements

Several of the health care delivery provisions are similar in large part to the current market standard. These include:

- Use of a prudent layperson standard for access to emergency services;
- Use of standing referrals for specialist care for persons with serious and chronic medical conditions; and

² All cost estimates shown in this report relate to HMO premiums only and are based on an average HMO premium per person per month of \$122. This cost per person per month represents both adults and children and is not the same value as a single premium.

- Direct access to OBGYNs for routine and preventative women's health services.

Most health plans comply with the prudent layperson standard for access to emergency services, although some plans use a tighter definition of need for these services. We estimate that full adoption of the prudent layperson standard for access to emergency services will have a cost effect ranging from \$0.10 to \$0.35 PMPM with a best estimate of \$0.10 PMPM.

Assuring broader access to specialist services is expected to have very limited effect on cost. The CBRR specifically identifies a requirement for both standing referrals for specialists for members with chronic conditions and for more direct access to OBGYNs for women's health services. PARCA speaks only to the requirement for direct access to specialists and does not separately identify access OBGYNs for women's health services. We estimate only nominal changes in costs for HMO plans, with a net cost estimate of \$0.02 to \$0.10 PMPM with a best estimate of \$0.02 PMPM for the CBRR proposal and \$0.02 to \$0.05 PMPM and a best estimate of \$0.02 PMPM for the PARCA proposal.³ The changes related to these provisions will be most apparent in smaller plans and plans that operate in areas that are relatively new to managed care. Plans that currently place relatively tight control on access to these types of services will see greater levels of change in costs, and the premium effect for these plans is expected to be significantly higher than the averages discussed in this report.

Third Party Appeals

The requirement for an external appeals process is also similar to the trend in the market. Numerous plans are adopting this standard, fourteen states already have this requirement, and legislation is currently pending in nearly all of the remaining 36 states. We believe the enthusiasm for voluntarily adopting this standard may relate specifically to the pending legislation. The direct costs of implementing an external review process appear to be nominal. We estimate the cost to range from \$0.02 to \$0.16 PMPM, with a best estimate of \$0.10 PMPM for this provision. Indirect costs in the form of utilization review changes and increases in permitted services to protect against cases reaching the external review process may result in higher premium rates.

Point-of-Service Option

PARCA proposes to require all network model HMOs to offer all subscribers a Point-of-Service option. CBRR has no POS requirement. Point-of-Service plans are the most rapidly growing form of managed care. Under these models, enrollees are covered by an HMO for benefits, but have the choice of obtaining services outside of the managed care network with a higher cost sharing requirement. While POS plan membership is growing rapidly and is likely to continue growing in the foreseeable future, many plans have not yet begun developing this option.

³ PARCA does not include a requirement for direct access to OBGYN services, but the cost of this provision is very small.

The requirement of a Point-of-Service option for network-model HMOs is likely to create new requirements for some plans, and may be problematic to implement. This is likely to be particularly true for those plans that pay their physicians on a salaried or capitated basis. Many large purchasers are adopting the use of POS plans as one means of offering broader choice to their members. Other purchasers offer choice in other ways, typically by offering Preferred Provider Organization plans or other options. Significant clarification of the intended language is required to correctly estimate the cost of this proposal. Assuming managed care plans are allowed to require higher cost sharing for out-of-network utilization, this provision is likely to have a nominal effect on average costs. We estimate a cost of \$0.39 to \$0.76 PMPM, with a best estimate of \$0.58 PMPM for this provision. If POS plans are not allowed to require different levels of cost sharing for out-of-network utilization, the cost estimate increases to \$7.01 PMPM.

Liability and Malpractice

PARCA proposes to amend federal law to allow for expanded application of state laws related to medical malpractice. Such an expansion could increase the kinds of defendants who may be made parties to malpractice suits and, consequently, could increase costs associated with anticipating and defending such suits as well as the amount of damages individuals could recover. Unlike many of the other proposals in the CBRR and PARCA, this provision would represent a significant change in current practices. Consequently, clear estimates of the cost effect of this provision cannot be made. Instead, we discuss the issues that should be considered in discussing this provision.

The potential changes to the ERISA provisions are significant, but difficult to quantify. The new costs of this provision range from the change in court costs associated with new litigation to increases in malpractice insurance costs. The effects depend largely on the amount of new litigation that results from the change in law, as well as whether health plans change their practices to defend against potential law suits.

Summary

The following tables provide a summary of the results of our analysis. Based on these estimates, the change in premium for an average HMO monthly **individual** policy would range from \$0.83 to \$1.87 with a best estimate of \$0.98 for the CBRR provisions and from \$0.85 to \$2.03 with a best estimate of \$1.23 for the PARCA provisions. The change in premium for an average HMO monthly **family** policy would range from \$2.24 to \$5.03 with a best estimate of \$2.62 for the CBRR provisions and from \$2.28 to \$5.46 with a best estimate of \$3.31 for the PARCA provisions.⁴

⁴ Calculations are based on a single premium of \$160 per month and a family premium of \$430 per month.

Consumer Bill of Rights and Responsibilities				
	Best Estimate		Range	
	Cost Per Person Per Month	Percent of Premium	Cost Per Person Per Month	Percent of Premium
Information Disclosure				
Plans	\$0.14	0.11%	\$0.12 - \$0.22	0.10% - 0.18%
Professionals	\$0.27	0.22%	\$0.25 - \$0.47	0.20% - 0.39%
Facilities	\$0.09	0.07%	\$0.08 - \$0.13	0.07% - 0.10%
Total - Information Disclosure	\$0.50	0.40%	\$0.45 - \$0.82	0.37% - 0.67%
Emergency Service Access	\$0.10	0.11%	\$0.10 - \$0.35	0.11% - 0.29%
Access to Specialists				
Standing Referrals for Specialists	\$0.01	0.01%	\$0.01 - \$0.05	0.01% - 0.04%
Women's Health Services	\$0.01	0.01%	\$0.01 - \$0.05	0.01% - 0.04%
Total - Access to Specialists	\$0.02	0.02%	\$0.02 - \$0.10	0.02% - 0.08%
Third Party Appeals				
Administration Cost	\$0.03	0.02%	\$0.01 - \$0.06	0.01% - 0.05%
Claims Cost	\$0.07	0.06%	\$0.01 - \$0.10	0.01% - 0.08%
Total - Third Party Appeals	\$0.10	0.08%	\$0.02 - \$0.16	0.02% - 0.13%
Total - CBRR	\$0.72	0.61%	\$0.59 - \$1.43	0.52% - 1.17%

Patient Access to Responsible Care Act				
	Best Estimate		Range	
	Cost Per Person Per Month	Percent of Premium	Cost Per Person Per Month	Percent of Premium
Information Disclosure	\$0.10	0.08%	\$0.07 - \$0.22	0.06% - 0.18%
Emergency Service Access	\$0.10	0.11%	\$0.10 - \$0.35	0.11% - 0.29%
Access to Specialists	\$0.02	0.02%	\$0.02 - \$0.05	0.02% - 0.04%
Third Party Appeals				
Administration Cost	\$0.03	0.02%	\$0.01 - \$0.06	0.01% - 0.05%
Claims Cost	\$0.07	0.06%	\$0.01 - \$0.10	0.01% - 0.08%
Total - Third Party Appeals	\$0.10	0.08%	\$0.02 - \$0.16	0.02% - 0.13%
Point of Service Option				
Administration	\$0.31	0.25%	\$0.21 - \$0.40	0.17% - 0.33%
Claims costs	\$0.27	0.23%	\$0.18 - \$0.36	0.15% - 0.30%
Out-of-Network Reimbursement ⁵	\$0.00	0.00%	\$0.00 - \$6.25	0.00% - 5.10%
Total - POS Option	\$0.58	0.48%	\$0.39 - \$7.01	0.32% - 5.73%
Medical Liability	Uncertain	Uncertain	Uncertain	Uncertain
Total PARCA	\$0.90	0.77%	\$0.60 - \$7.79	0.53% - 6.37%

⁵ We have assumed that higher cost sharing will be permitted for out-of-network utilization for the best estimate.

CBRR and PARCA				
Change in Average Premiums resulting from selected provisions				
	CBRR		PARCA⁶	
	Best Estimate	Range	Best Estimate	Range
Change in monthly costs				
Single Coverage	\$0.98	\$0.83 - \$1.87	\$1.23	\$0.85 - \$2.03 ⁷
Family Coverage	\$2.62	\$2.24 - \$5.03	\$3.31	\$2.28 - \$5.46
Change in annual costs				
Single Coverage	\$11.71	\$9.98 - \$22.46	\$14.78	\$10.81 - \$24.38
Family Coverage	\$31.48	\$26.83 - \$60.37	\$39.73	\$27.35 - \$65.53

⁶ Premium cost estimates impact for PARCA does not include the additional cost related to the change in liability for health plans, as we have not been able to calculate a cost for this provision.

⁷ For purposes of the range of premium change estimates, we have assumed the POS provision will allow higher cost sharing for out-of-network utilization to provide what we believe to be a more reasonable estimate.

Quality File - AHA

AHA STATEMENT REGARDING PROVISIONS IN THE DEMOCRATIC QUALITY BILL RELATED TO "PROTECTION FOR PATIENT ADVOCACY"

The American Hospital Association has reviewed the provisions in the Democratic quality initiative related to employee protections. The AHA would prefer these provisions not be included in federal legislation. Such provisions are unnecessary because we already give each and every hospital employee a "megaphone" to report loudly, clearly and quickly any patient care concerns they have so we can fix the problem immediately. There are existing mechanisms, both internal and external, to address these concerns. Patient safety concerns need to be dealt with directly and immediately, and employees should work within hospital procedures to quickly resolve concerns.

While we remain concerned about this provision, and will work to have it excluded from any quality initiative addressed by Congress this year, it is an improvement over previous versions of the legislation. Originally, the provision was an employee protection provision masquerading as a quality concern. The latest draft has moderated the provision and refocused on quality. We particularly commend the efforts of Rep. John Dingell (D-MI) to narrow the more onerous provisions of the original proposal.

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

April 22, 1998

**STATEMENT BY THE PRESIDENT
ON THE NEW KAISER FOUNDATION REPORT
ON THE PATIENTS' BILL OF RIGHTS**

Today, the Kaiser Family Foundation released a new report that confirms our longstanding belief that the cost of the Quality Commission's patients' bill of rights, which I have endorsed, is modest and well worth the protections it would provide. By affirming the Congressional Budget Office's (CBO) estimates, the Kaiser report convincingly rebuts the scare tactics that some have used to undermine bipartisan efforts in the Congress to pass a patients' bill of rights this year.

Many Americans today lack the protections necessary to ensure high quality health care. They may not be able to see the specialists they need, or to get emergency care wherever and whenever a medical emergency arises. They may not be able to talk freely with doctors and nurses about all the medical options available -- not only the cheapest. They may have no place to go to present grievances about their health care. The Quality Commission's patients' bill of rights guarantees Americans these and other common sense protections.

The Kaiser Report reaffirms recent estimates by the CBO that these protections would increase health insurance premiums less than one percent (less than \$3 per family per month). The improvement in the quality of health care that will result from these protections is more than worth the very modest premium increases projected by both Kaiser and CBO.

This report again shows the utter groundlessness of claims that a patients' bill of rights will significantly increase health care costs. With this new information, there is no excuse left for inaction. I therefore call on Congress again to send me legislation that gives Americans the health care protections they need and deserve. I look forward to working with members on both sides of the aisle to ensure that we pass a strong patient's bill of rights this year.

*Shw**Quality Rly*

National Standards for Health Plans

- We support national standards for two reasons: (1) to assure that all Americans have adequate protections, regardless of the type of plans in which they are enrolled; and (2) to streamline the regulatory process so that plan enrollees and purchasers are not paying the cost of unnecessary or conflicting regulation.
- The development of health plan standards should combine the best elements of public and private sector resources. Complex standards should be developed through a process that relies on the expertise of independent and private sector entities.
- There are three types of health plan standards which call for different approaches to development and enforcement.
 - "Core" standards which represent basic requirements should apply to all health plans. Examples would include standards defining covered emergency care and standards setting forth open communication between providers and patients.
 - Some standards that are complex in nature and likely to change over time also should apply to all health plans. Examples would include standards for measurement of health plan and provider performance.
 - Finally, there are standards which are complex as in the second category, but which, at this point, are not warranted as requirements for all health plans. These standards might be adopted by public purchasers, but would be voluntary for plans not participating in those programs. However, plans should have incentives to adopt them.
- The first category of standards could be enacted by Congress. However, because of their complexity, the second and third categories should be delegated for development and adoption to a process that utilizes the expertise of independent and private entities. Such a process could involve a Commission chartered by Congress adopting standards upon the recommendation of accreditation bodies and other independent entities.
- To streamline the regulatory process, national standards within any category should preempt conflicting state standards. An incentive to adopt the third category of standards noted above should be preemption of conflicting state standards.
- We do not support standards which would expand liability provisions because we believe this will lead to increased litigation expenses rather than quality improvement. Nor do we support standards which have as their primary impact, economic protection rather than consumer protection. We can support carefully crafted external review programs provided the decisions are clearly scientific-evidenced based decisions.

*like
single set
of standards*

Quality File

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GOP Members Break Ranks on HMO Bill

By *Laura Meckler*
 Associated Press Writer
 Wednesday, April 29, 1998; 7:27 p.m. EDT

WASHINGTON (AP) -- Pushing for action this year on the issue of patient rights, nine House Republicans broke ranks with their leaders Wednesday to endorse a plan introduced by the Democratic leadership.

In the meantime, GOP leaders prepared a plan of their own to satisfy the craving for health legislation this year.

Eighty-eight House Republicans had already irked their leaders by supporting a broad, Republican-written plan to regulate health maintenance organizations and other managed-care plans. But on Wednesday, nine members led by Rep. Greg Ganske, R-Iowa, signed on to a Democratic bill that would guarantee choice of doctors, access to specialists and the right to appeal denial of care to an independent panel.

Ganske said he is concerned that Congress will end the year without acting on any of the bills, which register broad support from a public concerned that managed care's effort to cut costs may deny them the care they need. The drive for new legislation is backed by consumer groups and doctors, who are also feeling the pinch of cost-cutting.

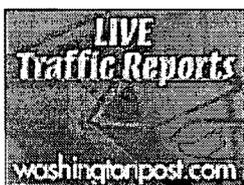
Republican leaders in Congress, backed by employers and insurance companies, counter that the bills represent unnecessary government regulation and will drive up the cost of health care, ultimately leaving more Americans without any insurance.

GOP task forces have been appointed in both the House and Senate to come up with a Republican alternative.

The House group is focusing on a proposal by Rep. Tom Bliley, R-Va., chairman of the House Commerce Committee, that would create a new option for small- and medium-sized companies to join in purchasing pools to escape state health insurance mandates and come under the umbrella of the federal law that covers most large companies.

The bill, according to an outline obtained by The Associated Press, would create organizations dubbed "HealthMarts" that would be run by providers, consumers, employers and insurance companies. These groups would compete with traditional insurance plans for business.

In addition, the GOP plan, to be discussed by the task force Thursday, would include some protections for patients, such as the



right to appeal denials, the right to choose any doctor (although the patient might have to pay extra) and the right to receive information about any insurance plan.

It would also allow individuals who buy health insurance to deduct the cost on their tax returns and would let small employers that join to form larger insurance pools be federally regulated, escaping state requirements.

In the meantime, Ganske rounded up co-sponsors for the Democratic bill as Republican leaders pressured them to stay away.

"I was happy that, considering the circumstances, I had eight other very brave and courageous congressmen," he said. He said many others are "an inch away" from joining them.

President Clinton welcomed those who crossed the party line.

"They are sending a strong signal that it is unacceptable for this Congress to adjourn this year without passing a strong patients' rights bill," he said in a statement.

The other eight Republicans backing the Democratic bill are Reps. Charles Bass of New Hampshire, Mike Forbes of New York, Jon Fox of Pennsylvania, Wayne Gilchrest of Maryland, Lindsey Graham of South Carolina, Steve Horn of California, Steve LaTourette of Ohio and Jim Leach of Iowa.

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[Back to the top](#)



Quality File

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

April 29, 1998

**STATEMENT BY THE PRESIDENT
On New Bipartisan Support for the Patients' Bill of Rights**

I am extremely pleased that today at least nine Republican Members of Congress joined as cosponsors to H.R. 3605, the Patients' Bill of Rights Act of 1998. In announcing their support for this legislation, they are sending a strong signal that it is unacceptable for this Congress to adjourn this year without passing a strong patients' rights bill.

I commend Representatives Ganske, Bass, Forbes, Fox, Gilchrest, Graham, Horn, LaTourette, and Leach for their leadership, and I look forward to working with them. We have learned again and again that when we reach across party lines we can pass important legislation that improves our nation's health care system. Making the Patients' Bill of Rights Act of 1998 bipartisan provides new momentum towards ensuring that a patients' bill of rights will become the law of the land.

The Patients' Bill of Rights Act of 1998, recently introduced by Representative Dingell, provides long overdue protections that Americans need to renew their confidence in the nation's rapidly changing health care system. It allows patients to see the specialists they need; to get emergency care wherever and whenever a medical emergency arises; to talk freely with doctors and nurses about all the medical options available -- not only the cheapest; and to appeal when they have grievances about their health care.

I urge Congress to send me legislation that gives Americans the health care protections they need and deserve. I look forward to working with Members of Congress on both sides of the aisle to ensure that we pass a strong patients' bill of rights this year.

THE

LUNTZ RESEARCH COMPANIES

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

Nationwide Health Care Poll

The Luntz Research Companies conducted 1,005 interviews of adults nation-wide from April 29 to May 1, 1998. (Margin of error :± 3.1%)

Question: Would you say the overall quality of health care in America over the last 10 years has:

Improved	34.3%
Stayed the same	15.6%
Deteriorated	46.8%

- 55% of Americans living in the Pacific think the overall quality of health care has deteriorated over the last 10 years.
- 51% of Americans making between \$20K-\$49K think the overall quality of health care has deteriorated over the last 10 years.
- 52% of HMO members think the overall quality of health care has deteriorated over the last 10 years.

Proposal: Health care providers would be required to give their patients full information about their condition and treatment options. Do you:

Support	96.6%
Oppose	1.6%

The groups most supportive of requiring health care providers give their patients full information about their conditions and treatment options:

- Women ages 50+ 100%
- Income \$50-79K 99%

Proposal: Any basic managed care plan would be required to allow patients to see plan specialists, when necessary. Do you:

Support	95.3%
Oppose	2.1%

Amongst those who support, the following groups indicated the greatest intensity by responding they "strongly support" requiring any basic managed care plan to allow patients to see plan specialists when necessary:

Total Strongly Support	79.7%
• Age over 60	87%
• Weak Democrats	87%
• Income \$50-79K	87%
• West/Midwest Region	86%

Proposal: Patients should have the right to a speedy appeal when a plan denies coverage for a benefit or service. Do you:

Support: 94.7%
Oppose 3.3%

- 99% of people making between \$50K and \$79K support patients having a speedy appeal when a plan denies coverage for a benefit or service.
- 99% of HMO members support patients having a speedy appeal when a plan denies coverage for a benefit or service.
- 96% of strong Republicans support patients having a speedy appeal when a plan denies coverage for a benefit or service.

Proposal: A complete list of benefits and costs offered by a health plan before he or she signs up for the plan. Do you:

Support 91.3%
Oppose 4.6%

- 93% of Democrats are in support of requiring a complete list of benefits and costs offered by a health plan before he or she signs up for the plan.
- 92% of Republicans are in support of requiring a complete list of benefits and costs offered by a health plan before he or she signs up for the plan.
- 88% of Independents are in support of requiring a complete list of benefits and costs offered by a health plan before he or she signs up for the plan.

Proposal: All health plans must allow their patients the option of seeking treatment outside their HMO, with the HMO covering at least a portion of the cost. Do you:

Support 87.2%
Oppose 8.8%

- Groups most in favor:
 - Ages 30-44 95%
 - Personally in an HMO plan 95%
 - Household Income of 80K and up 93%
- Groups who *most strongly* favor:
 - Household Income of 50K-79K 75%
 - Family with HMO Membership 70%
 - Ages 30-44 70%
 - Women ages 18-49 69%

Proposal: Insurance companies would be prohibited from paying doctors more money for offering less treatment or refusing referrals. Do you:

Support 67.6%
Oppose 26.1%

Groups who most favor prohibiting insurers from paying doctors more to offer less treatment or refusing referrals:

- Household Income \$50-79K 84%
- Weak Democrats 79%
- Industrial Midwest 78%
- Ages 30-44 77%
- HMO members 75%

Question: Let's say that the proposals I just read were packaged into a single piece of legislation. Would you be to vote for your Member of Congress if he or she voted for this legislation?

More Likely 85.8%
Less Likely 4.2%

- 88% of Independents would be more likely to vote for their member of Congress if he or she supported all six proposals as a piece of legislation.
- 86% of Democrats would be more likely to vote for their member of Congress if he or she supported all six proposals as a piece of legislation.
- 83% of Republicans would be more likely to vote for their member of Congress if he or she supported all six proposals as a piece of legislation.
- 93% of HMO members would be more likely to vote for their member of Congress if he or she supported all six proposals as a piece of legislation.

Question: And if you knew that enacting all six proposals as a single piece of legislation would cost you about \$17 more per month, about \$200 more per year, would you ... this legislation?

Support 67.4%
Oppose 23.1%

- 73% of Americans aged 18-44 would support paying \$17 per month, or \$200 more per year to enact all six proposals as a single piece of legislation.
- 75% of women aged 18-49 would support paying \$17 per month, or \$200 more per year to enact all six proposals as a single piece of legislation.
- 79% of people earning \$50K-79K would support paying \$17 per month, or \$200 more per year to enact all six proposals as a single piece of legislation.

Demographic: Are you or your spouse a member of an HMO?

Self only 13.0%
Spouse only 4.0
Both 24.1
No 56.8%

Laszlo & Associates, Inc.

PRESS RELEASE

FOR IMMEDIATE RELEASE
May 14, 1998

Contact: Suzy Pollack
(703) 276-1604

Nationwide Poll Shows Americans Overwhelmingly Want Congress to Step In to Protect Patients' Rights

Nationwide Health Care Poll Shows Support for Principles in GAP Bill

Washington, D.C. -- Americans expect quality from their health care plan and they are willing to pay a reasonable amount more to assure access to the specialists, procedures, and information they need to make sound judgments about their own health.

Furthermore, Americans believe that if HMO's aren't providing this themselves, it is time for Congress to step in to protect patients' rights.

Those are among the key findings of a poll, commissioned by the Patient Access to Specialty Care Coalition and conducted by the Luntz Research Companies, which tested the principles outlined in the Patient Choice and Access to Quality Health Care Act of 1998 (HR 3547), also known as the GAP Bill.

The principles proved overwhelmingly popular with the American people:	% Support
• Health care providers would be required to give their patients full information about their conditions and treatment options.	96.6%
• Any basic managed care plan would be required to allow patients to see plan specialists when necessary.	95.3%
• Patients should have the right to a speedy appeal when a plan denies coverage for a benefit or service.	94.7%
• A complete list of benefits and costs offered by a health plan would be required to be provided to every potential patient before he or she signs up for the plan.	91.3%
• All health plans must allow their patients the option of seeking treatment outside their HMO, with the HMO covering at least a portion of the cost.	87.2%
• Insurance companies would be prohibited from paying doctors more money for offering less treatment or refusing referrals.	67.6%

Susan Banes Harris, a patient advocate from the National Multiple Sclerosis Society stated, "Americans are calling on their own Members of Congress to act on their behalf to provide access to the quality health care which they are already paying for. Today's poll proves that such access is found in the GAP bill."

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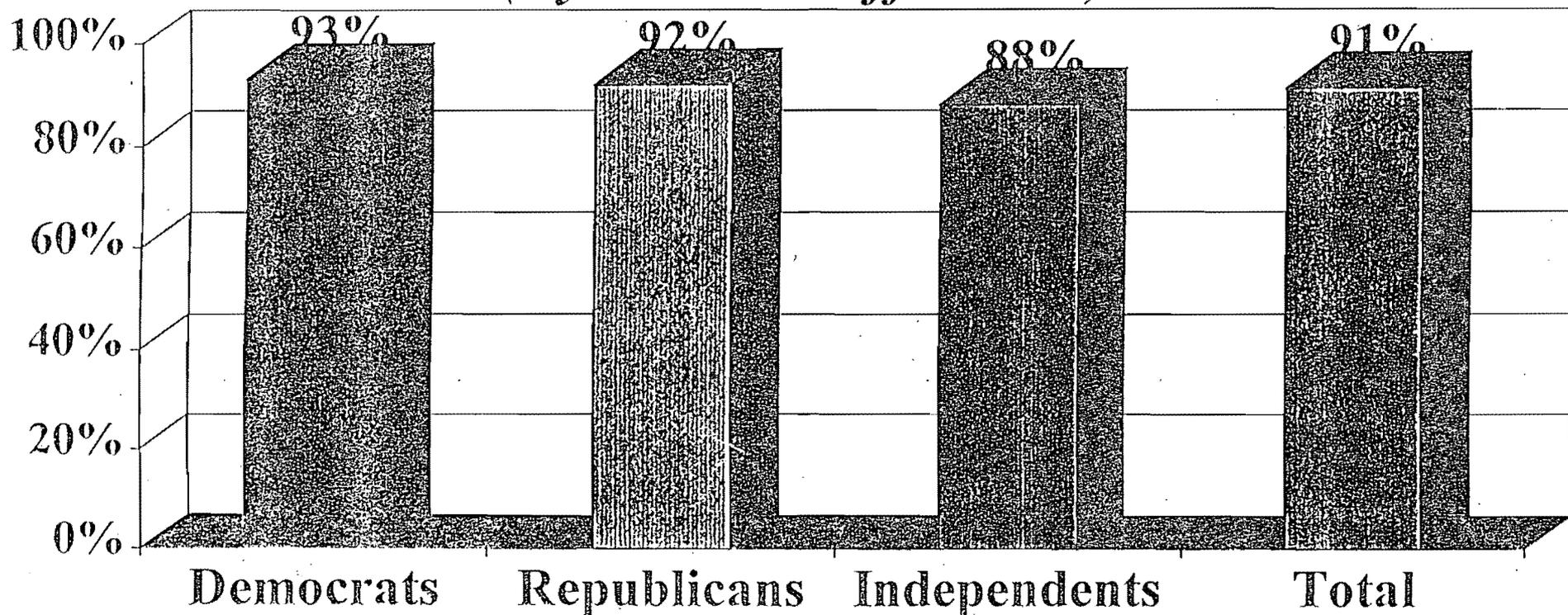


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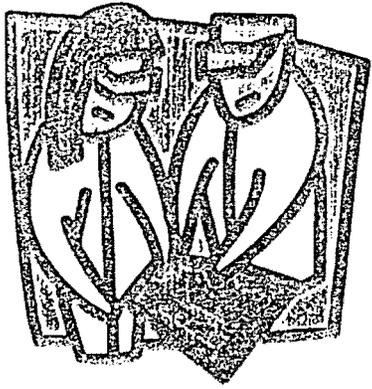
Access to Quality Healthcare

“Do you support requiring a complete list of benefits and costs offered by a health plan to be provided to every potential patient before he or she signs up for the plan?”

(By Political Affiliation)



The Luntz Research Companies

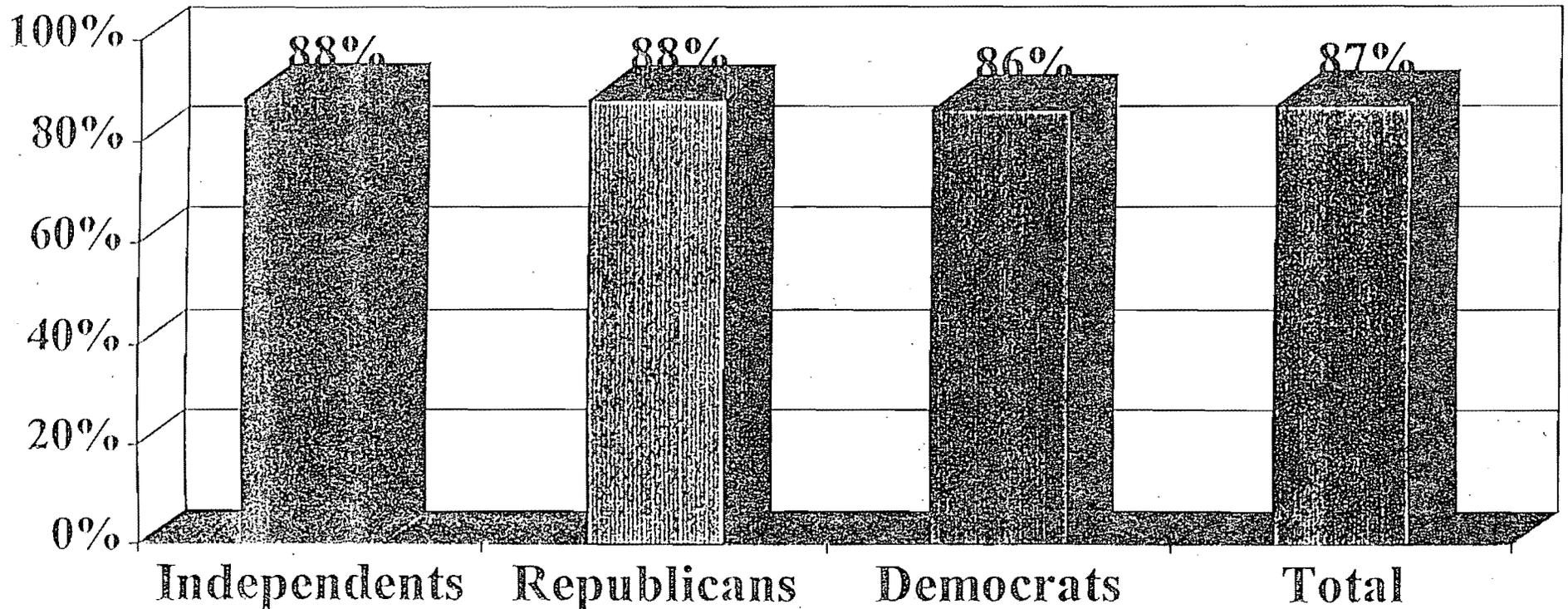


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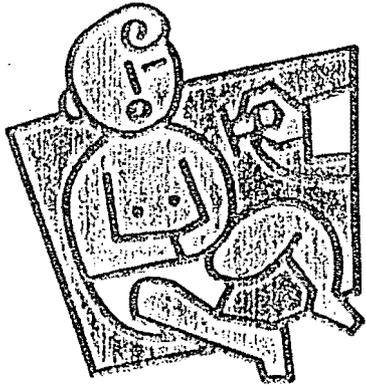
Access to Quality Healthcare

Percent who support allowing HMO patients the option of seeking treatment outside their HMO, with the HMO covering at least a portion of the cost.

(By Political Affiliation)



The Luntz Research Companies

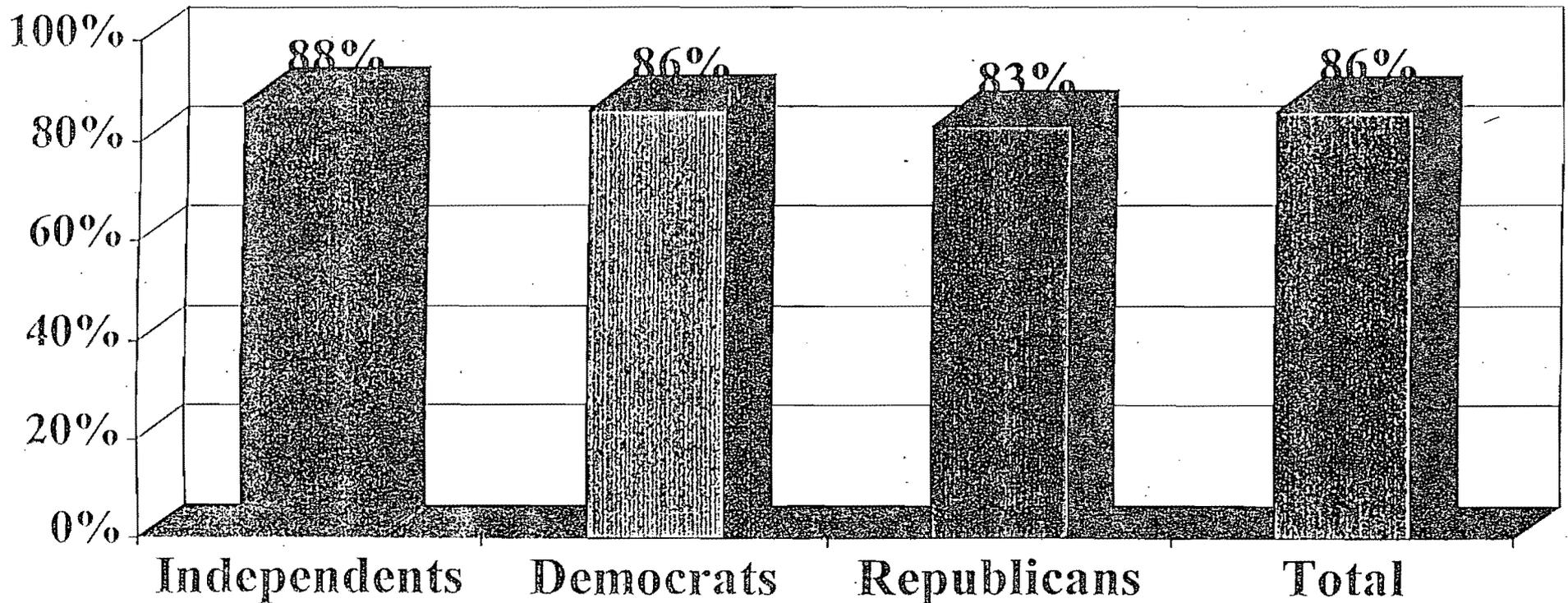


America United:

Access to Quality Healthcare

People who would be more likely to vote for a member of congress who supported the legislation if all six were in one piece of legislation,

(By Party Affiliation)



The Luntz Research Companies

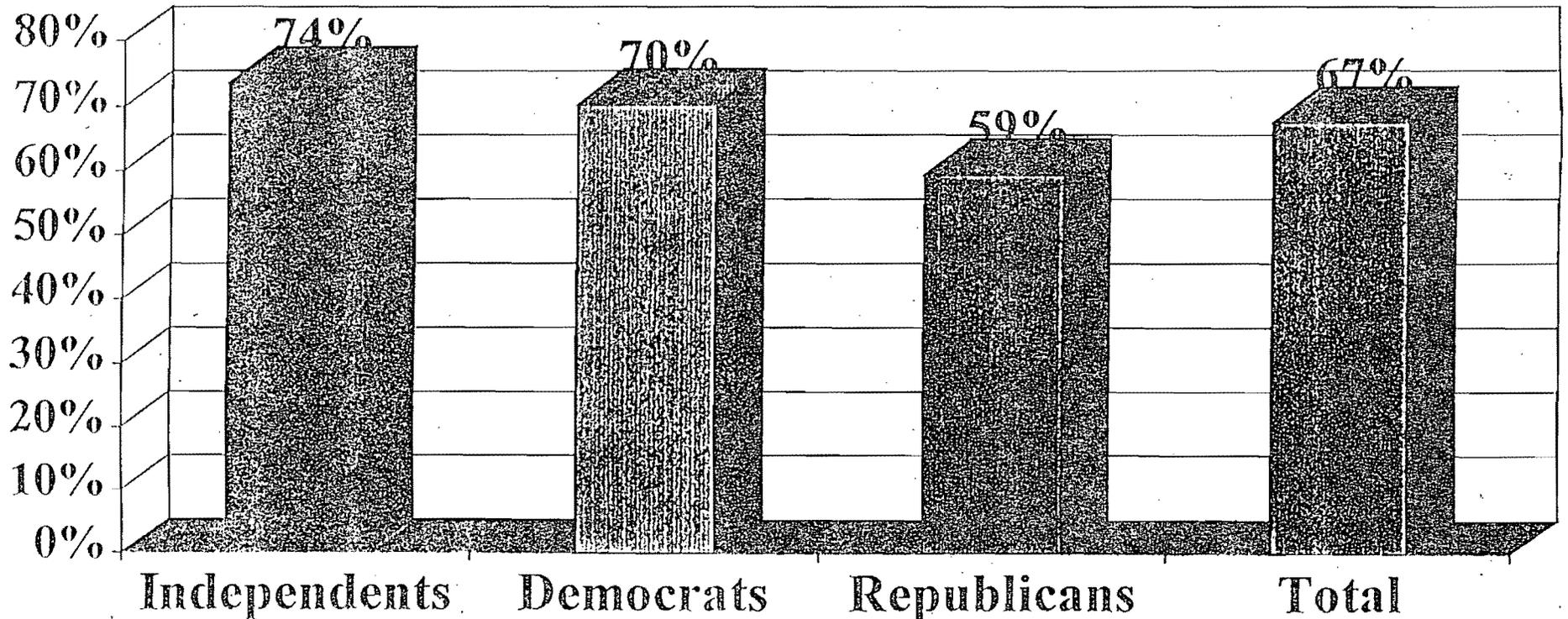


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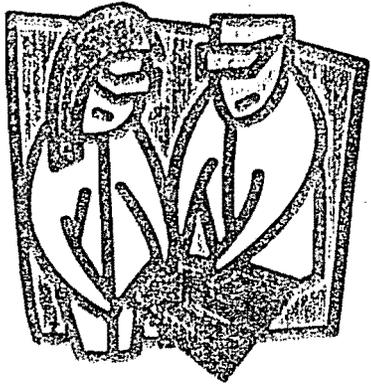
Access to Quality Healthcare

Percentage who would support all six proposals as a one piece of legislation if it would cost them \$17 more a month, about \$200 a year.

(By Party Affiliation)



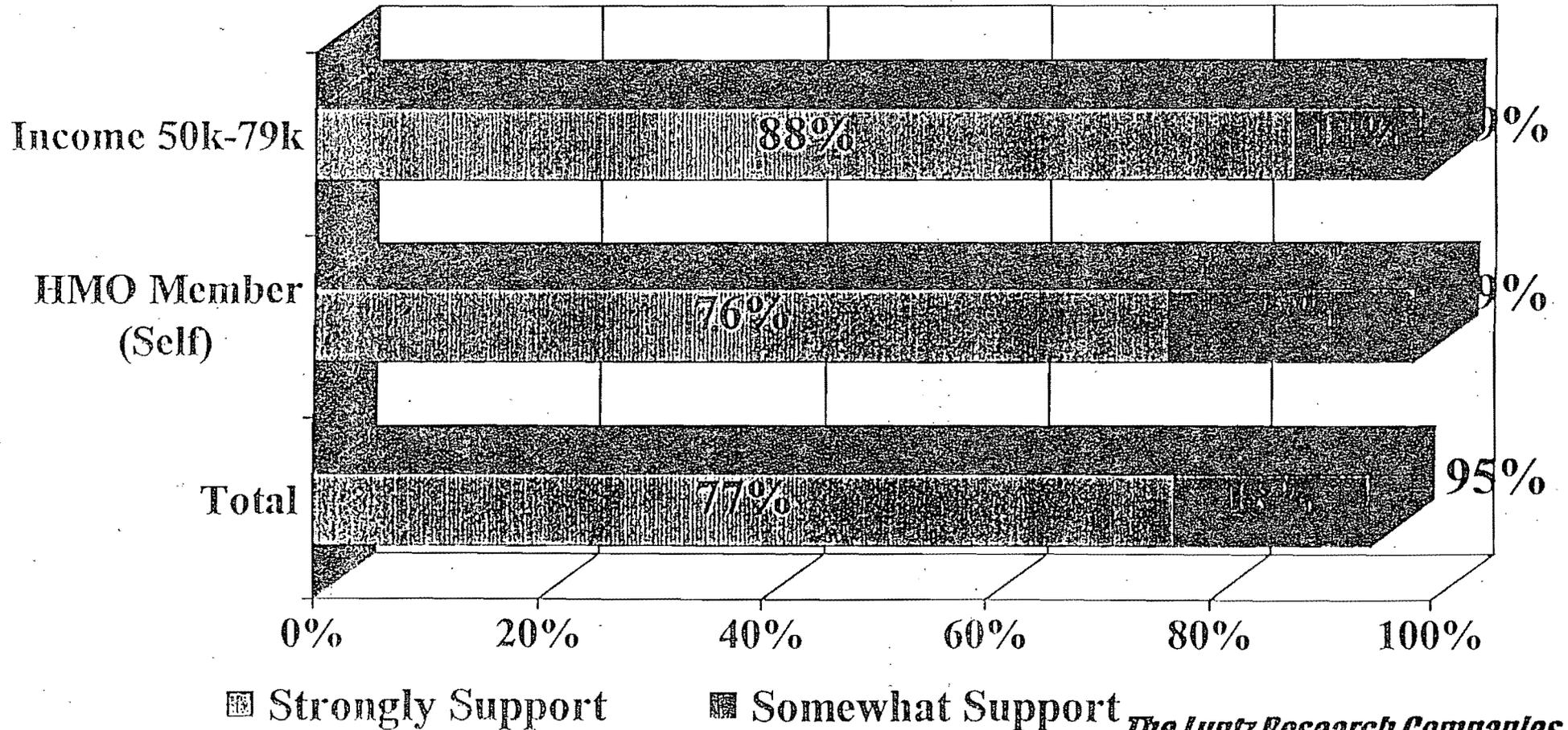
The Luntz Research Companies

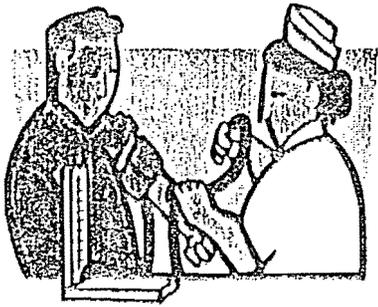


America United:

Access to Quality Healthcare

Groups who support patients having a speedy appeal
when a plan denies coverage
for a benefit or service

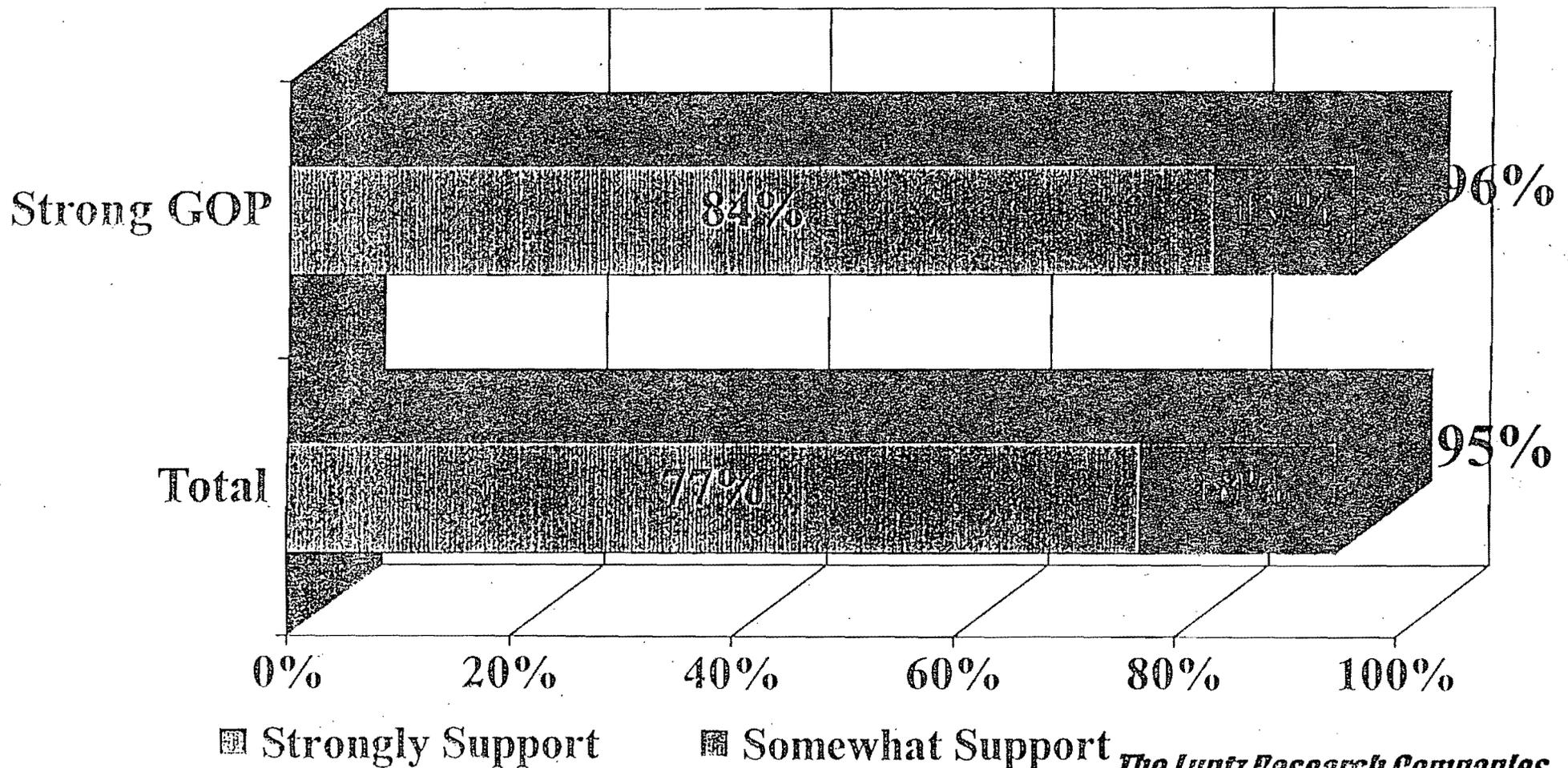


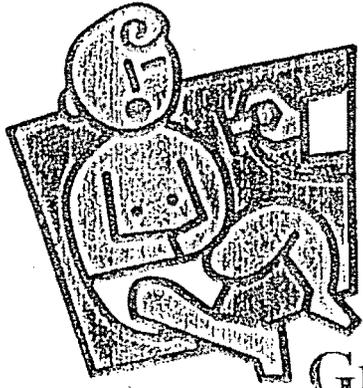


America United:

Access to Quality Healthcare

Groups who support patients having a speedy appeal when a plan denies coverage for a benefit of service

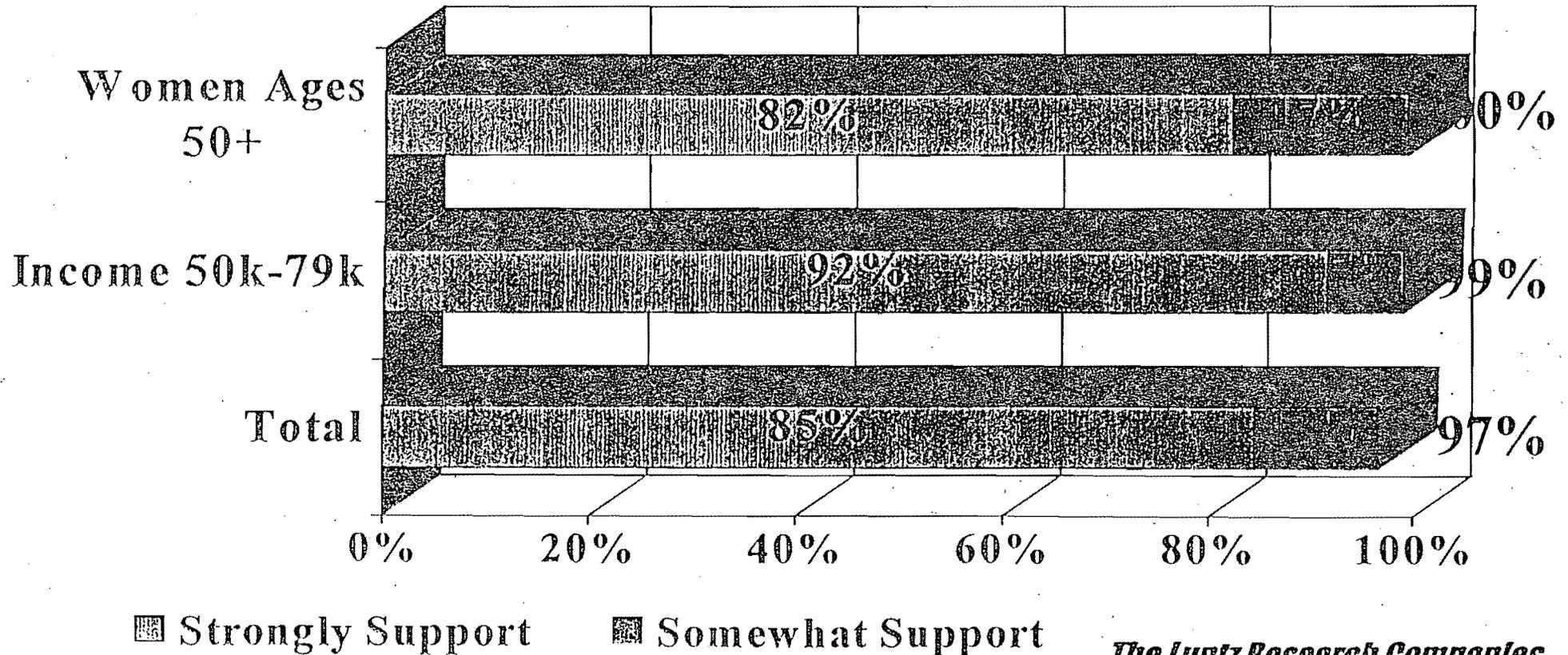




America United:

Access to Quality Healthcare

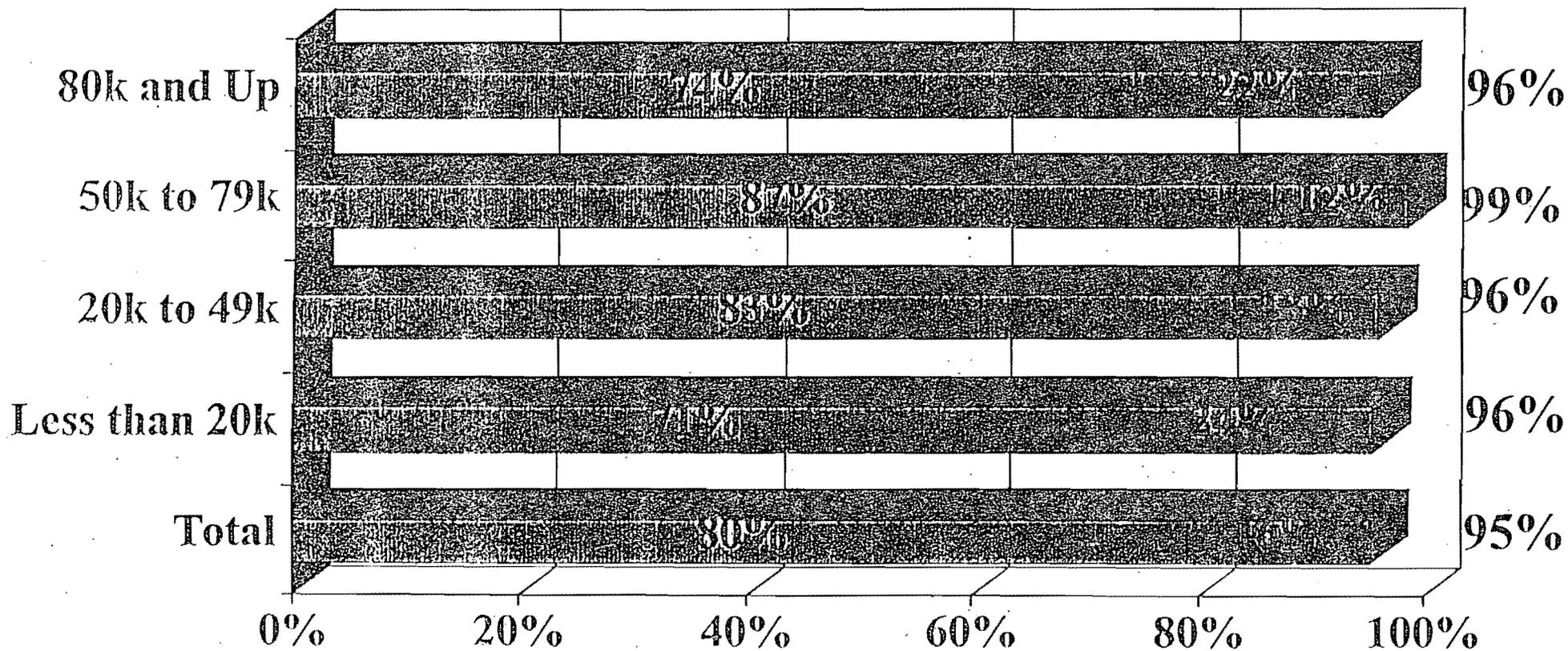
Groups who support requiring healthcare providers to give their patients full information about their condition and treatment options





America United: Access to Quality Healthcare

Groups who support requiring managed care plans to allow patients to see plan specialists when necessary.



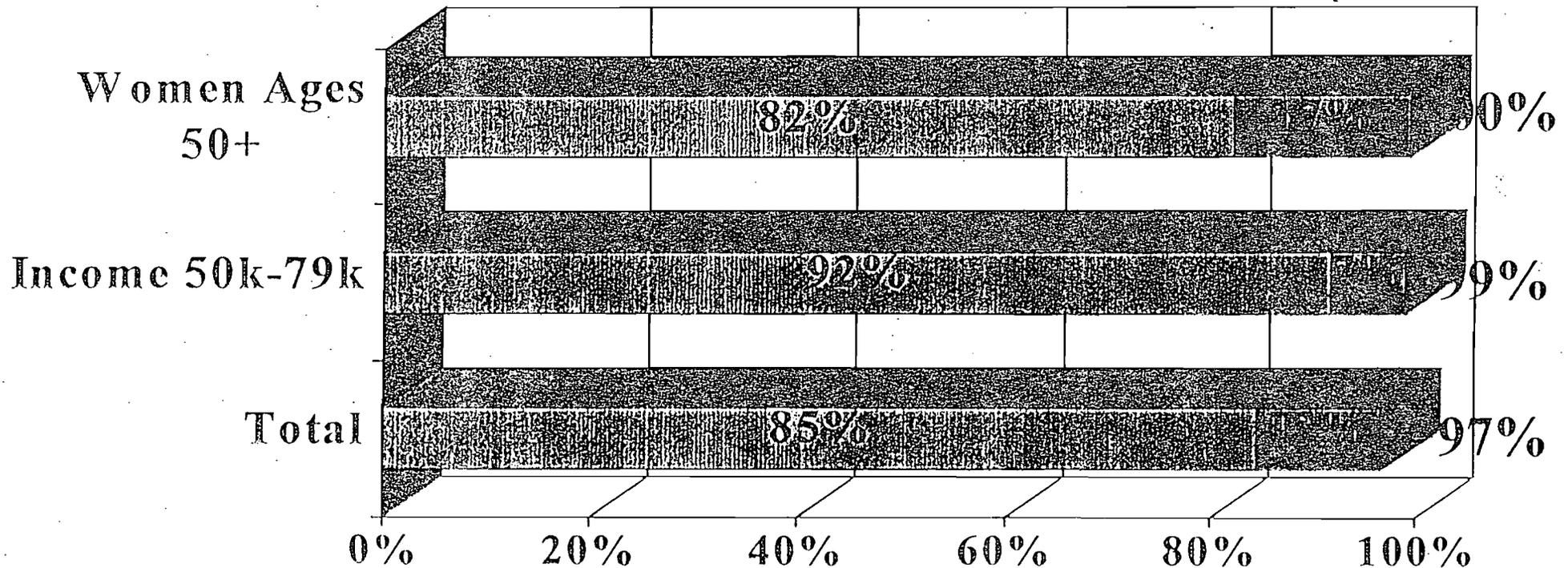
■ Strongly Support ■ Somewhat Support

The Luntz Research Companies



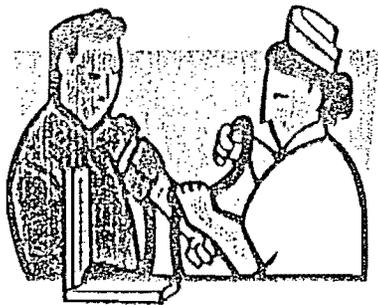
America United: Access to Quality Healthcare

Groups who support requiring healthcare providers to give their patients full information about their condition and treatment options



Strongly Support Somewhat Support

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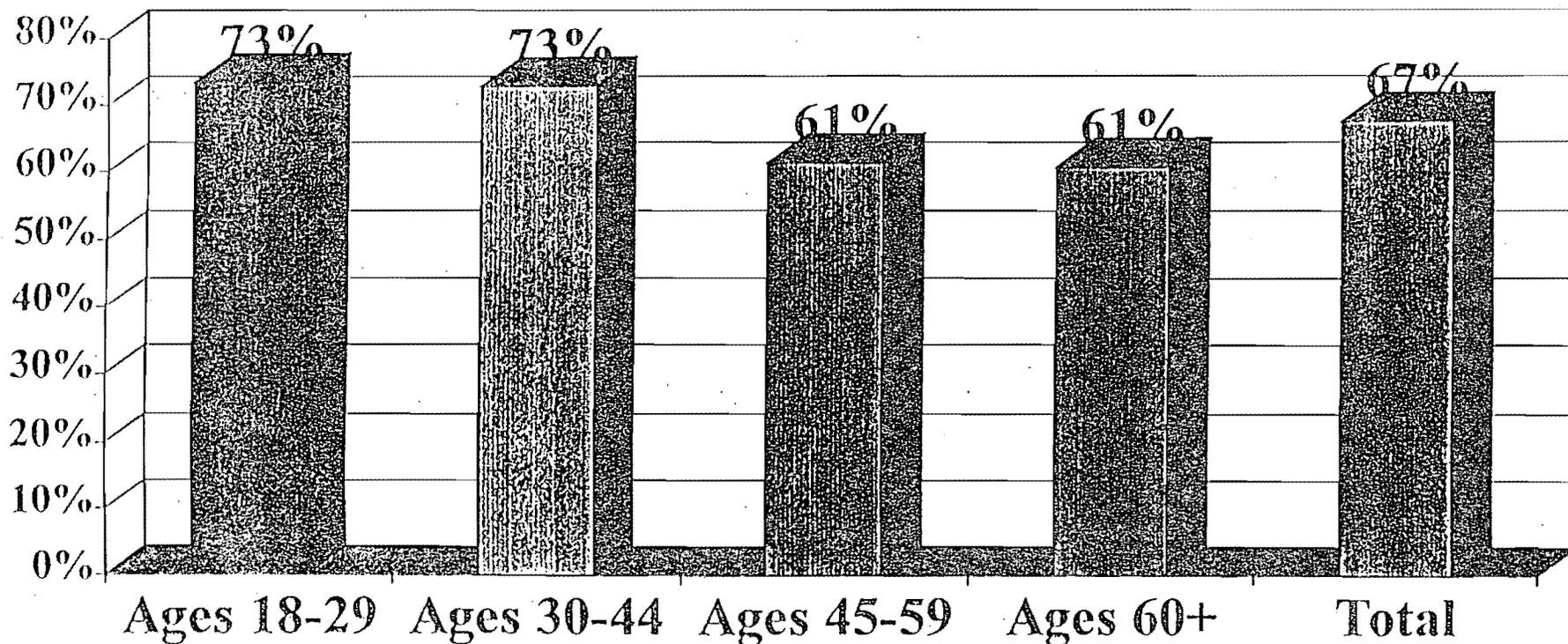


America United:

Access to Quality Healthcare

“If enacting all six proposals in a single piece of legislation would cost you an additional \$17 a month, about \$200 a year, would you support it?”

(By Age)



The Luntz Research Companies

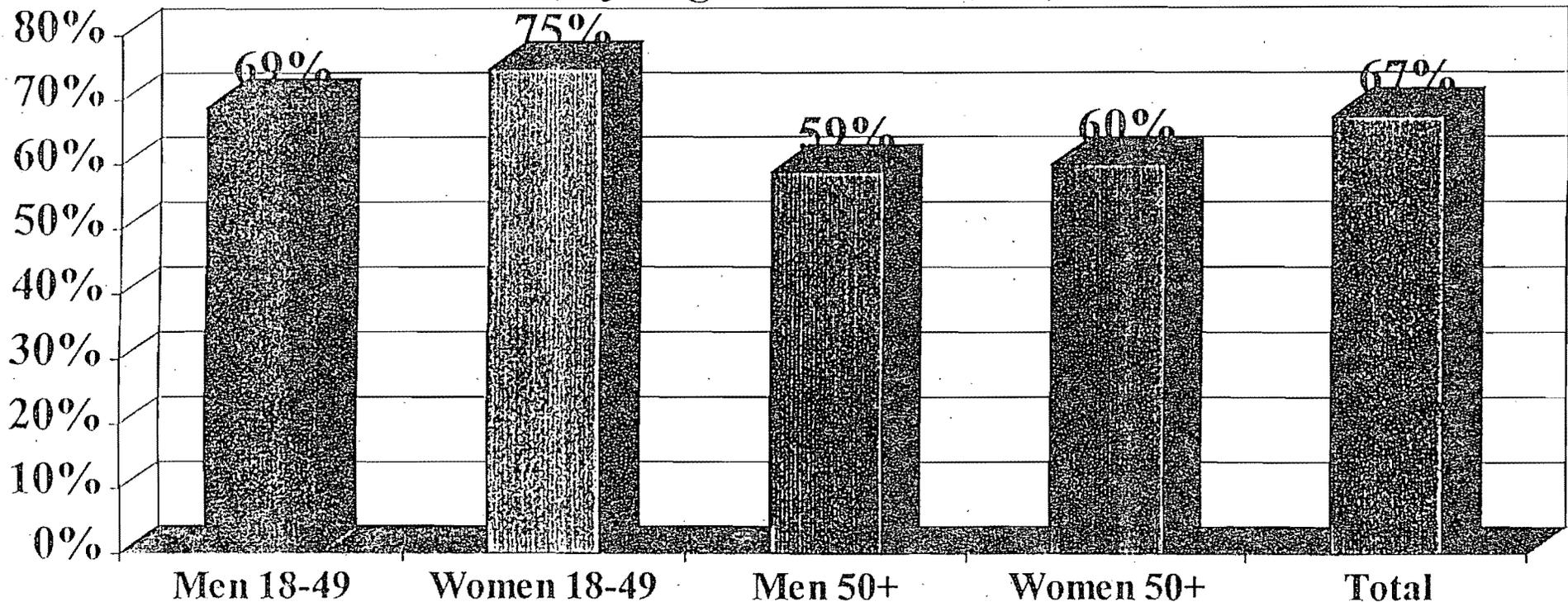


America United:

Access to Quality Healthcare

“If enacting all six proposals in a single piece of legislation would cost you an additional \$17 a month, about \$200 a year, would you support it?”

(By Age and Gender)



The Luntz Research Companies

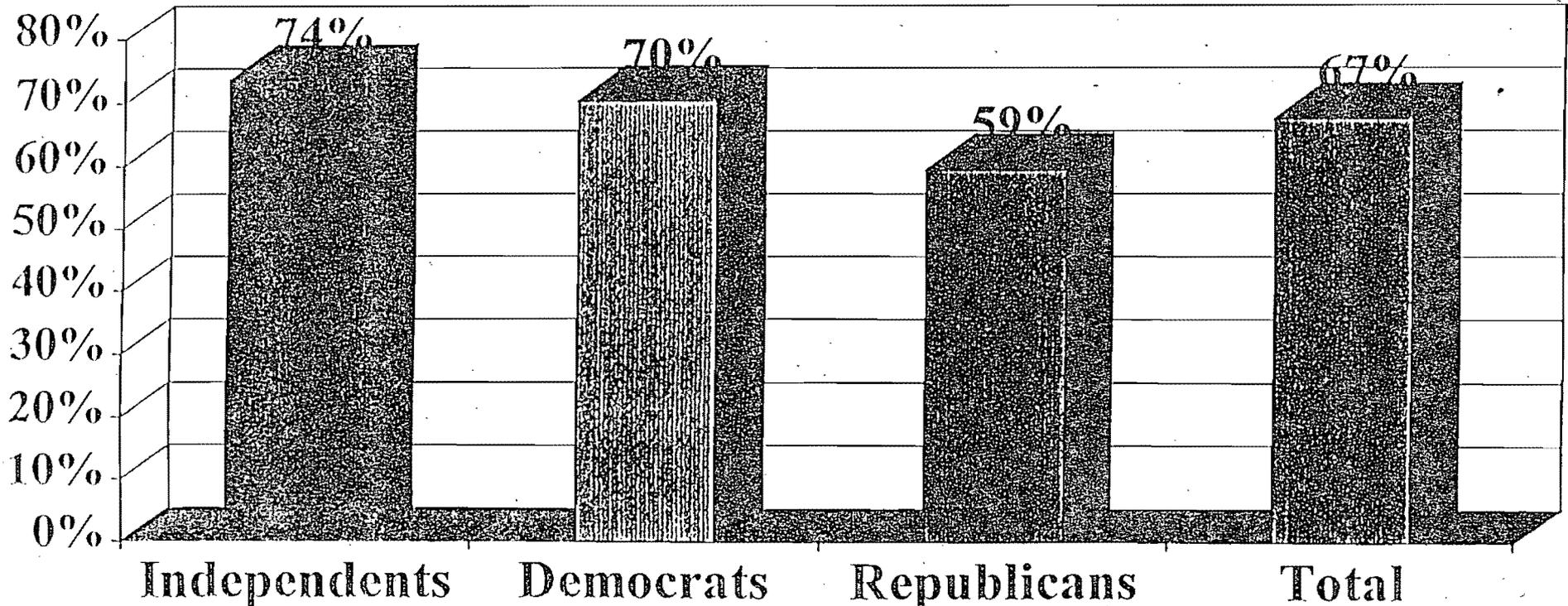


America United:

Access to Quality Healthcare

“If enacting all six proposals in a single piece of legislation would cost you an additional \$17 a month, about \$200 a year, would you support it?”

(By Political Affiliation)



The Luntz Research Companies

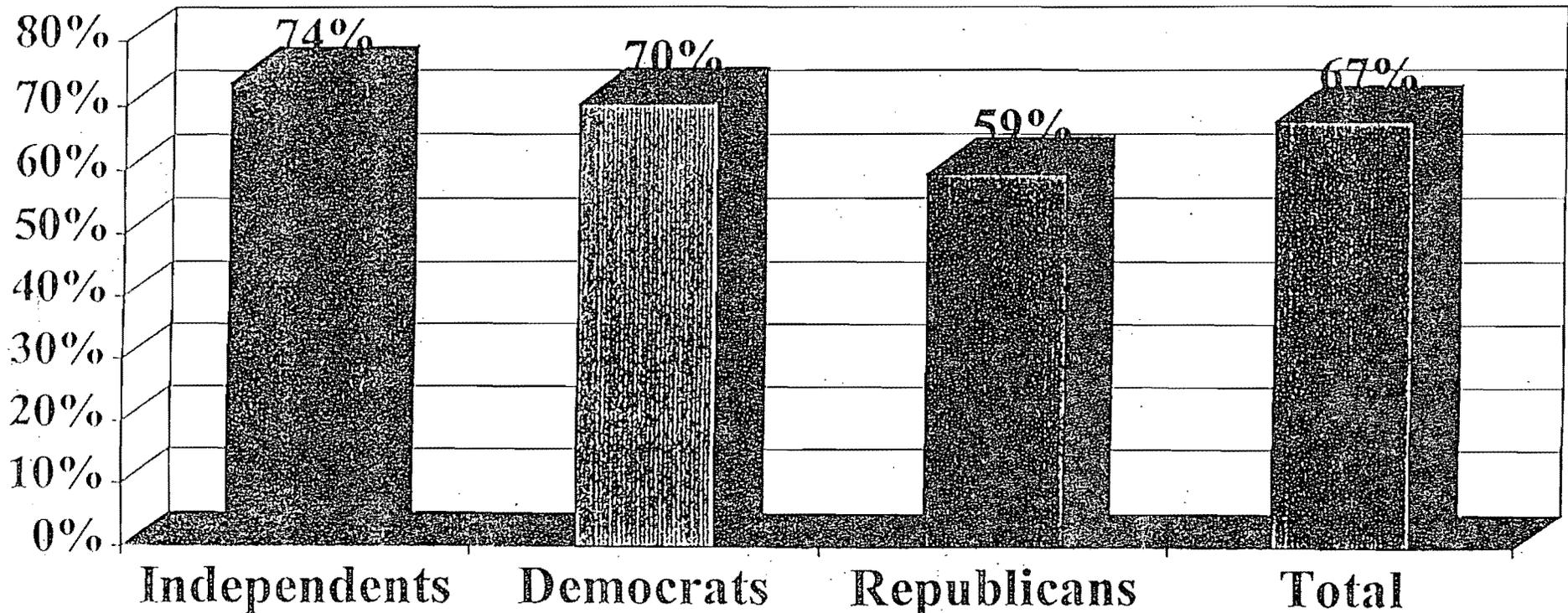


America United:

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“If enacting all six proposals in a single piece of legislation would cost you an additional \$17 a month, about \$200 a year, would you support it?”

(By Political Affiliation)



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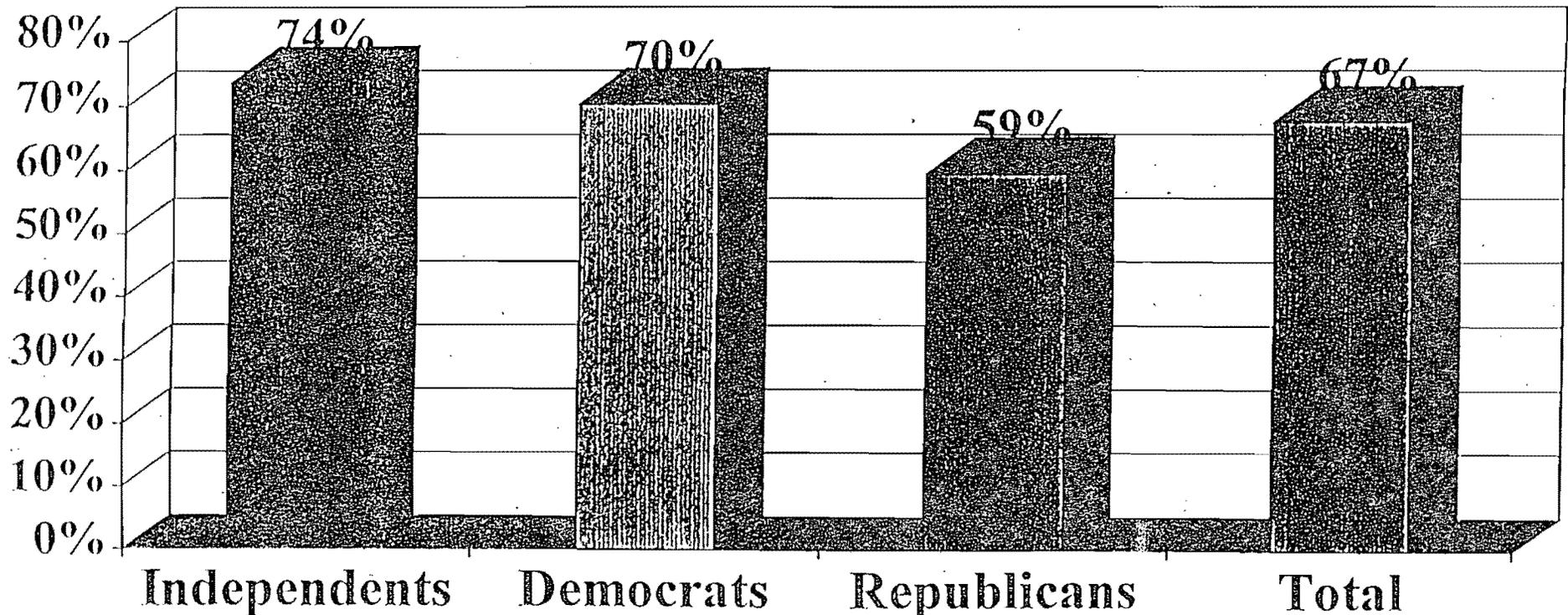


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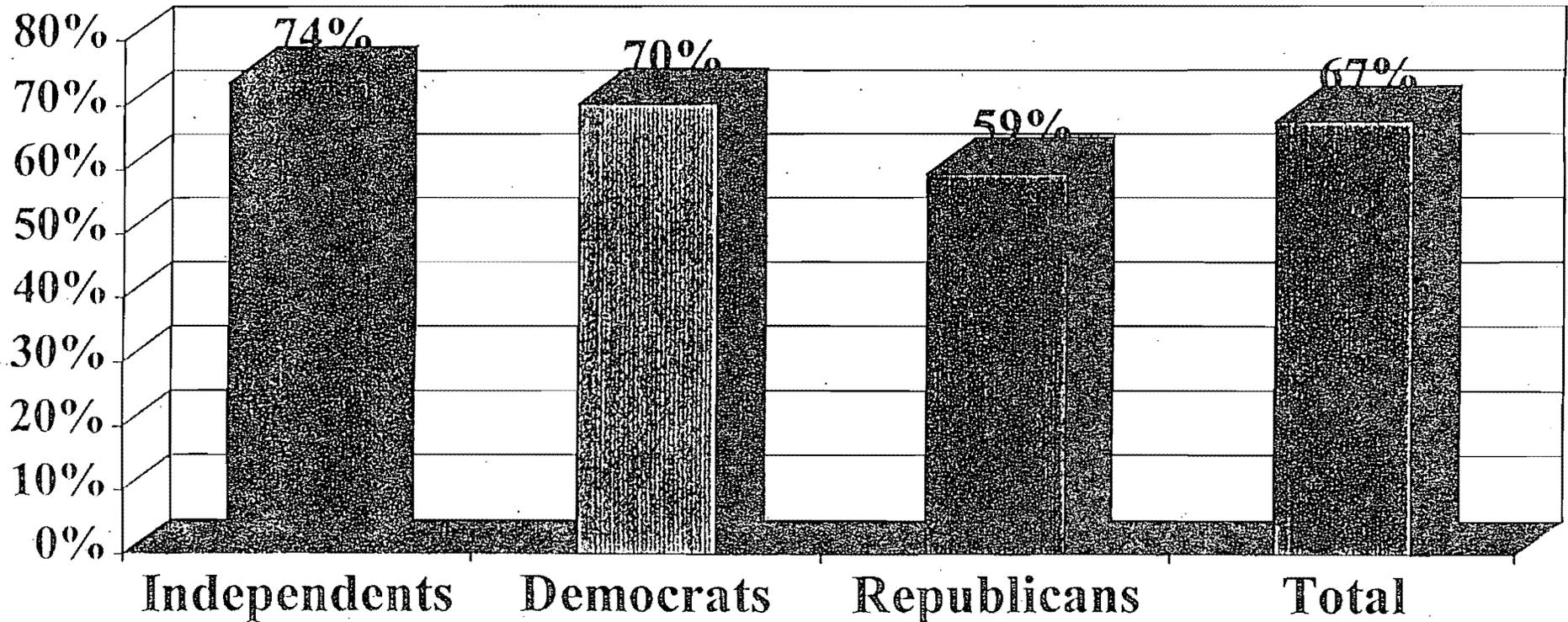


America United:

Access to Quality Healthcare

“If enacting all six proposals in a single piece of legislation would cost you an additional \$17 a month, about \$200 a year, would you support it?”

(By Political Affiliation)



The Luntz Research Companies

DRAFT**THE NATIONAL STANDARDS OPTION
FOR THE CONSUMER BILL OF RIGHTS**

A. The Secretary of HHS and the Secretary of Labor develop minimum standards for consumer information, quality, privacy and confidentiality and grievance procedures (as listed below).

B. Non-ERISA and ERISA covered plans adopt the Consumer Bill of Rights.

-- The Department of HHS enforces and monitors non-ERISA plans (via states).

-- The Department of Labor modifies ERISA to require employer-sponsored plans to adopt the Consumer Bill of Rights. The Department also enforces and monitors ERISA covered plans.

C. Unless specified, both Non-ERISA and ERISA plans must comply with the following:

1. **Consumer Information**

A. All health plans provide consumers at their request, and at the time of enrollment with the following information. Non-ERISA plans also provide this information at least once annually while ERISA plans provide the information periodically as discussed below under point 1B.

- Basic descriptions, including covered benefits and exclusions, premiums, cost-sharing, "lock-ins" by HMOs, and disenrollment rights.
- The plan's self-measurement based on the performance measures established under point 2, below. [Note: DOL is still deliberating the issue of self-measurement by plans and will need to talk further with HHS about this concept]
- The identity, locations, specialties, and availability of participating providers.
- A summary description (not including proprietary information) of the procedures used to control utilization of services and expenditures, the practice guidelines used by the plan, and the financial incentives used by the plan (i.e., the amount of risk assigned to participating physicians).
- Applicable appeals or grievance procedures, including phone numbers for designated staff and independent ombudsman offices in that service area.

B. ERISA covered plans provide information to enrollees pursuant to the following requirements:

- **Health plan sponsors provide updated summary plan description (SPDs) for employee health plans every 5 years to DOL.**
- **Plans cannot charge copying fees for providing copies of the current SPD and all summaries of material modifications (SMMs) to date to a participant or beneficiary who has requested such material and who has not received such materials previously in the same plan year.**
- **The plan administrators provide notice (either as an SMM or some other notice) to each covered individual at least 30 days before the effective date of any change to the health benefit plan (e.g. change in benefits, coverage, and cost-sharing requirements).**
- **Health plan sponsors distribute SMMs for all other changes at least 30 days before the earlier of the end of the plan year or the first date participants and beneficiaries may choose to decline coverage (open season). Examples of such amendments include a decision to self-insure a plan that previously was insured without reducing benefits, or a change in plan administrator.**
- **Insurance companies can not lapse individuals' coverage under insured employee health plans lapse due to the plan administrator's nonpayment of premium, unless the insurer notifies these individuals at least 15 days before the coverage is to lapse.**
- **Plan sponsors make the following disclosure to enrollees regarding their rights and remedies under an ERISA plan:**
 - * **If a benefit claim is denied, any rights and remedies beyond the administrative appeal process come under federal law (ERISA), not state law.**
 - * **Under federal law, the remedies available are generally limited to recovery of the benefits due under the terms of the plan, and at the court's discretion, reasonable attorneys' fees and costs of action but not expert witness costs.**
 - * **Enrollees may generally not recover compensatory consequential or punitive damages under state law (e.g., out of pocket expenses and other costs incurred such as lost wages, pain and suffering and emotional damages).**
- **Plan sponsors inform enrollees whether their health coverage is provided through insurance or from the general funds of the plan sponsor, and if unpaid**

benefits may be eligible for reimbursement from a state guarantee fund if the entity providing coverage experiences financial difficulty.

2. Quality:

Establish standards for quality and inform consumers about their plan performance.

- Department of HHS develop performance measures to evaluate competing plans.
- Health plans self-evaluate and furnish information about their performance under the standards to enrollees (States for non-ERISA plans and DOL for ERISA covered plans may develop methods to encourage health plans to comply). [Note: DOL is still deliberating the issue of self-evaluation by plans and needs to confer with HHS again on this issue.]
- Department of HHS develops national standards for utilization review procedures.
- Adopt civil and criminal penalties for falsification of information.

3. Privacy and Confidentiality: Guarantee the privacy of patient medical records.

Establish uniform confidentiality safeguards for all medical records, regardless of the form (paper or electronic).

- The safeguards allows disclosure for payment of claims, investigation of health care fraud or abuse, and for specified public health reasons or in medical emergencies, by court order, by the subject's consent or to create anonymous aggregate data.
- The safeguards ensures individual rights to inspect and modify his or her records in case of an error.
- Adopt civil and criminal penalties for violations of confidentiality.

4. Consumer Grievance Process:

Ensure consumer grievances about claims or covered benefits are addressed quickly and fairly, with access to a neutral dispute resolution system.

Non-ERISA Plans

- Grants to states to establish ombudsman offices and alternative dispute resolution systems, providing independent advice and counsel to consumers encountering difficulty with providers.
- Health plans provide prompt notice of denial, delay or reduction in services and of a right of appeal.
- Health plans provide expedited appeal procedures for pre-service denials and in urgent or emergency situations.
- Health plans submit an annual report to the ombudsman offices on the number of complaints filed, their allegations, and the dispositions.
- Trial courts review claims cases de novo, without deference to decision of administrator or fiduciary and to construe ambiguous terms in the plan contract against the drafter.

ERISA Plans

- Remedies:

Option 1: Status Quo

Option 2: Expand ERISA remedies to make people whole for economic losses suffered; no punitive damages.

Option 3: add non-economic losses (pain and suffering).

Option 4: Permit Secretary of Labor to impose civil penalties for failure to provide plan benefits without any reasonable basis.

Option 5: Make ERISA plans subject to existing state law remedies.

- Establish pilot demonstration projects in the Department of Labor for mediation of health claims.
- Health plans provide prompt notice of denial, delay or reduction in services and of a right of appeal.
- Health plans provide expedited appeal procedures for pre-service denials and in urgent or emergency situations.

- Trial courts review claims cases de novo, without deference to decision of administrator or fiduciary and to construe ambiguous terms in the plan contract against the drafter.

- 5. **Additional Rules for Multiple Employer Welfare Arrangements (MEWAs).**

- All MEWAs register initially and annually with DOL. MEWAs could register by submitting copies of their state licenses or through some other means as promulgated in DOL regulations.

- The Department of Labor may charge a registration fee, determine the content of the registration statement and cease the operations of unregistered MEWAs.

- When a MEWA fails to register, a civil penalty may be imposed on either the individual designated by the MEWA as the "administrator" or absent such a designation, on the person responsible for handling plan assets.

- Willful failure to register becomes subject to the criminal penalties under ERISA section 501 and 18 USC section 1027. Under Section 501 individuals face up to a \$5,000 fine and/or a year in jail while entities can be fined not more than \$100,000.

- Amend certain ERISA definitions (e.g., the section 3(40) regulation project on collective bargaining agreements) to prevent MEWAs from avoiding registration requirements.

VOLUNTARY CERTIFICATION OPTION FOR THE CONSUMER BILL OF RIGHTS

- A. The Secretary of HHS develops performance measures for quality to evaluate competing health plans.
- B. The NAIC (or Secretary of HHS and Labor) develops minimum standards for consumer information, quality, privacy and confidentiality and grievance procedures (as outlined in Nan's memo).
- C. The Secretary of Labor modifies the NAIC standards for ERISA covered plans.
- D. Consumer education effort initiated by both the Department of HHS and Labor on the certification.

VOLUNTARY CERTIFICATION OF NON-ERISA PLANS

The Secretary of HHS establishes a procedure to certify health plans as meeting the standards.

- The Secretary of HHS establishes a panel to review each state's insurance regulatory program and certify those that meet the minimum standards.
- Health plans sold in states that adopt the NAIC standards are deemed as meeting the standards.
- For those plans in states not adopting the standards may apply directly to the Secretary of HHS for certification.

The Secretary of HHS allows the insurers meeting these standards to print on the policy an emblem indicating that the health plan has met the voluntary standards.

VOLUNTARY CERTIFICATION OF ERISA PLANS

The Secretary of Labor establishes a procedure to certify ERISA covered health plans as meeting standards.

- Option 1: Self insured plans and MEWAs establish programs and then apply to the Department of Labor for certification.

Problem: Administratively burdensome for the Department of Labor to certify each plan. Self-insured plans and MEWAs may find the application process too complicated to seek certification voluntarily.

Option 2: Self-insured plans and MEWAs self-certify. DOL wants the self-certification process to be enforced by participants through private lawsuits and will devise legislative mechanisms to provide for such enforcement.

Problem: Potential abuses by self-insured plans and MEWAs (e.g. falsification). Also, as states adopt NAIC standards, employers may be pushed further to self-insure.

Option 3: Option 2 but if x% of them do not self-certify by 19__, then the standards become mandatory for all self-insured and MEWA plans.

Problem: Politically more difficult to pass through Congress than the other two options above.

Federal Sanctions

Federal sanctions, consisting of fines and/or imprisonment for:

1. furnishing false information to obtain certification [add] ¶

Quality File

- about trust
- Presence of assets
- Plan liability

HIP® Government Relations

Memorandum

- George Strumpf
- Bob
- Gm
- Henry - C
- Henry
- Ed
- George - MN
- Ed - Jill - 1

To: Chris Jennings
 From: David Abernethy
 Date: May 1, 1998
 Re: Conference Call with The HMO Group

As we discussed, we are looking forward to your participation by telephone in a Board of Directors Meeting of The HMO Group. We will do this on Sunday 5/3 at 6:30 pm. As I discussed with Donna; you will page me at 1(800) 381-3830 with the phone number for us to call you at that time. Everyone else involved in the discussion will be in the meeting in Chicago.

Attending this meeting will be representatives of AvMed Health Plan (FL), Fallon Community Health Plan (MA), Group Health Cooperative of Central Wisconsin, Harvard Pilgrim Health Care (MA), Health Alliance Medical Plans (IL), Health Care Plan (NY), Healthpartners (MN), HIP Health Plans (NY), Kaiser Foundation Health Plan and the Permanente Medical Groups, M Plan (IN), and Scott and White (TX). These are all non-profit, mostly group model HMOs, many with a very long history.

I believe it would be helpful for this group to hear the following message from you:

- Legislation is likely this year;
- The White House is committed to obtaining legislation;
- There is a rational scenario for how the Administration and its allies would go about achieving this goal (and it would be helpful for you to describe the scenario);
- Health plans are not doing themselves any favors by "just saying no;" i.e., there are very negative consequences which may likely occur if AAHP and the managed care industry continues on our current path;
- There is still time to influence the legislation in a positive way if a group of health plans would come forward with a proposal for federal legislation

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 - Lem
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 - George
 - Don
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 our same self fulfilling prophecy

May 1, 1998

The proposal that THMOG is considering would call for Federal legislation to establish a framework for regulation and to put into law certain core standards which we believe must be legislated. They include prudent lay person, standards for medical record data, external review, and anti-gag rules. This would be coupled with the establishment of a Federal commission that would guide and direct the quality assurance activities of plans. The Commission would oversee the standards used by private accrediting entities and plans could choose private accreditation to meet standards other than the core standards legislated into Federal law. If a plan met the Federal requirements, it would be relieved from meeting similar standards in State law. ERISA self-insured plans would be required to meet the Federal standards.

Finally, it would be helpful for you to say that the Administration is open to discussion, particularly with respect to an implementation plan for the consumer protection standards, and that you would be prepared to help those who help themselves by standing up now, as opposed to later.

Last, but not least, I didn't have anything to do with this. You worked with George Strumpf, Vice President of THMOG for Legislation, and Dan Wolfson, President of THMOG, to set this up.

As always, it is a pleasure doing business with you.



American Association of
HEALTH PLANS

AAHP Medical Affairs Department

*1129 20th Street, NW, Suite 600
Washington, DC 20036-3421
(202) 778-3222
Fax: (202) 778-3287*

FAX TRANSMISSION COVER SHEET

Date:

May 19, 1998

To:

Sara Bianci

Fax:

456-6557

Re:

Carmella Bachino

Sender:

YOU SHOULD RECEIVE 4 PAGE(S), INCLUDING THIS COVER SHEET IF YOU DO NOT RECEIVE ALL THE PAGES, PLEASE CALL (202) 778-3222.

Comments.

OK/ Did you know? SK

NATION'S THREE LEADING HEALTH CARE QUALITY OVERSIGHT BODIES TO COORDINATE MEASUREMENT ACTIVITIES

Landmark collaboration among AMAP, JCAHO, and NCQA will help ensure efficient collection of comprehensive performance information across all levels of the health care system

WASHINGTON - The nation's preeminent health care accrediting organizations -- the American Medical Accreditation ProgramSM (AMAPSM), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the National Committee for Quality Assurance (NCQA) -- today announced a collaborative effort designed to coordinate performance measurement activities across the entire health care system. The agreement establishes the Performance Measurement Coordinating Council (PMCC), a 15-member group that will work to ensure that measurement driven assessment processes are efficient, consistent and useful for the many parties that rely on them to help make important decisions about health care.

"Independently, our organizations are working aggressively to develop rigorous performance measurement programs for different levels of the health care system," said NCQA President Margaret E. O'Kane. "Working together, we can make performance measurement not only much less burdensome, but also more meaningful to consumers, employers and health care professionals."

"The work of the PMCC will start a positive chain reaction," said Randolph D. Smoak, Jr., M.D., Chair AMAP Governing Body, and Vice Chair of the American Medical Association (AMA) Board of Trustees. "More efficient measurement will lead to broader participation in accreditation programs, which will lead to quality improvement, which will lead to better care and service. Ultimately, patients and the public are the real winners."

Formation of the PMCC dovetails with the recent recommendation from President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry urging greater coordination in health care performance measurement efforts. In a related executive order, President Clinton has directed Vice President Gore to organize a "Forum for Health Care Quality Measurement and Reporting" that will seek to incorporate existing private sector efforts. The PMCC expects to work through the Forum to help shape measurement priorities and approaches that serve the needs of the American public.

The PMCC's efforts will build on a consensus statement, "Principles for Performance Measurement in Health Care," developed by the group's sponsoring organizations. The document briefly outlines:

- the rationale behind performance measurement efforts;
- appropriate uses of performance data;
- specific areas on which measures should focus;
- guidelines for using performance data for comparative purposes;
- general requirements for cost effective measurement;
- and specific opportunities for collaboration.

"This is an exciting opportunity to pool and collectively expand our quality measurement expertise in service of the public interest," said Dennis S. O'Leary, M.D., President, JCAHO. "Good measures and good data will eventually provide good information to drive improvement in health care services and to better inform consumer decision making."

5/19/98

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Currently, AMAP, JCAHO and NCQA each define performance measurement at different levels of the health care system. AMAP focuses on standards of quality for the individual physician. JCAHO accredits a range of health care facilities, including organizations providing acute care, ambulatory care, behavioral health care, home care, clinical laboratory services, long term care and managed care. In addition, JCAHO has begun integrating performance measurement into the accreditation process.

The focus of NCQA Accreditation and performance measurement program (HEDIS®) is on systems of care for defined populations, such as HMOs and point-of service plans. More than 90 percent of the nation's managed health care plans already use HEDIS to track and report their performance. NCQA recently announced a new accreditation program that will base accreditation decisions in part on a health plan's performance on key HEDIS measures such as member satisfaction, immunization rates, and mammography screening.

Each organization is committed to developing and advancing rigorous, dynamic measurement programs to improve care and help consumers and purchasers make important health care coverage decisions. The accreditation programs developed by JCAHO and NCQA already enjoy broad participation across the health care industry, and have consistently drawn upon the input of various constituencies. The new AMAP initiative, similarly, is gaining rapid acceptance from physicians, hospitals, health plans and health care purchasers.

Performance measures currently vary from one level of the health care system to the next, but there is overlap. For example, member satisfaction, immunization rates and cervical cancer screening rates have been used to assess providers, facilities and plans alike. Other broadly applied performance measures include cesarean section rates, mammography screening rates, measures of the accessibility of care, cost measures, utilization rates (e.g., coronary artery bypass graft surgeries per 1,000 members) and average office wait times.

A common criticism of performance measurement activities -- even from those who appreciate their importance to quality improvement -- is that costs for data collection and reporting can be high. The PMCC's efforts will help to reduce those costs by:

- coordinating identification and/or development of groups of 'universal' measures (i.e., measures that could be used to assess performance of physicians, facilities or health plans in the same ways)
- standardizing data requirements for different measurement systems;
- devising means of coordinating measurement activities among physicians, organizational providers, facilities and health plans;
- establishing more efficient verification and data quality assurance systems;
- and developing guidelines for the appropriate use of performance data.

"This collaborative effort represents a significant step forward toward improving the delivery of health care in this country," said David B. Pryor, M.D., Chair of JCAHO's Advisory Council on Performance Measurement and System Vice President for Information Services, Allina Health System.

The PMCC will also address other important issues such as standardization of risk adjustment techniques (adjusting for differences in the health of covered populations or patients) which is a key issue for measuring performance at the physician, facility and health plan levels. Ultimately the group expects to articulate principles to deal with risk adjustment that will help the science of

performance measurement move forward.

The PMCC will begin work on these issues at its first meeting this summer. ~~The group will meet three to four times per year.~~ Work groups addressing specific issues will meet in person and via conference call more frequently.

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The American Medical Association is the voice of the American medical profession. The AMA is a partnership of physicians and their professional associations dedicated to promoting the art and science of medicine and betterment of public health. AMAP - sponsored by the American Medical Association - is designed to enhance the health of the public by setting standards and improving the performance of individual physicians, while replacing the current duplicative and fragmented patchwork of existing physician review and assessment programs.

Founded in 1951, the Joint Commission on Accreditation of Healthcare Organizations' mission is to improve the quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations. The Joint Commission evaluates and accredits over 18,000 health care organizations and programs, including hospitals, integrated delivery network and organizations that provide home care, long term care, behavioral health care, laboratory and ambulatory care services. The Joint Commission also accredits health plans, integrated delivery networks, and other managed care entities. An independent, not-for-profit organization, the Joint Commission is the nation's oldest and largest standards-setting and accrediting body in health care.

A non-profit watchdog organization, the National Committee for Quality Assurance (NCQA) is widely recognized as the leader in the effort to assess, measure and report on the quality of care provided by the nation's managed care organizations. More than three quarters of Americans enrolled in HMOs are in plans that have been reviewed by NCQA.

5/19/98

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SENT BY :

American Nurses Association
600 Maryland Avenue SW
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FOR IMMEDIATE RELEASE
May 28, 1998

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msslatter@ana.org

AMERICAN NURSES ASSOCIATION APPLAUDS CLINTON PUSH FOR PATIENTS BILL OF RIGHTS

WASHINGTON, D.C. -- Members of the American Nurses Association (ANA) joined President Clinton and Vice President Gore at the White House today to urge Congress to pass managed care reform legislation. A key focus of nurses' call to legislative action has been the unmet health care needs of women and a demand for prompt passage of the Patients Bill of Rights Act of 1998.

The ANA strongly believes the current patchwork of state laws cannot and will not provide millions of American women and their families the basic consumer health protections recommended last year by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. In excoriating managed care plans for the many ways they fail to meet women's needs, the ANA has cited as an example requirements that women undergo mastectomies as outpatient procedures, calling such practices "unconscionable."

MORE...



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PATIENT BILL OF RIGHTS/2...

Aging women suffer the effects of prescription drug limitations that do not allow for their complex health requirements; the scourge of breast cancer requires not only humane treatment but access to clinical trials so that true progress can be met for future generations; and women who make health care decisions for themselves and for their families must have full information on which to base those decisions. Of particular urgency is the fact that the nearly quarter-century old Employee Retirement Income Security Act (ERISA) still is used to block basic health care protections to 20 million American women whose employers "self-insure."

Registered nurses are particularly concerned about the lack of protection for women because it is they -- and not insurance industry executives and lawmakers -- who confront in their daily practice the human consequences of defective and deficient health care.

###

The American Nurses Association is the only full-service professional organization representing the nation's 2.6 million Registered Nurses through its 53 constituent associations. ANA advances the nursing profession by fostering high standards of nursing practice, promoting the economic and general welfare of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public.

OWL PRESS RELEASE

666 11TH STREET, NW • WASHINGTON, DC 20001 • 202-783-6686 • FAX 202-638-2356

For further information:
Roberta Weiner / 202/783-6686

FOR IMMEDIATE RELEASE
Thursday, May 28, 1998

OWL APPLAUDS WHITE HOUSE ACTION ON MANAGED CARE PATIENTS' BILL OF RIGHTS

OWL today (Thursday, May 28, 1998) saluted President Clinton's call for early Congressional action on the Patients' Bill of Rights. "The President" asserted Deborah Briceland-Betts, OWL's Executive Director, "has already mandated some of these critical managed care consumer protections for federally-financed health care programs, and it is urgent that Congress now provide all Americans have the same guarantees of fair access and quality treatment in their health care plans."

OWL urges prompt consideration of the Patients' Bill of Rights, legislation that would provide the enforceable consumer protections in managed care that older women require. "While OWL strongly believes that all programs advancing quality women's health care are critical priorities," Briceland-Betts continued, "the passage of comprehensive legislation that meets the needs of older women for increased access and quality in managed care is an imperative."

Just one year ago, OWL issued a report showing that older women have more chronic illness than men and, as a result, need more access to specialists, leading-edge medicines and technology. According to the report, managed care plans, in attempting to save money, restrict women's access to these necessary services. "The report demonstrates," according to Briceland Betts, "that, for example, the more restrictive the pharmaceutical formulary, the more older women make trips to the doctor, to the emergency room, and to the pharmacist."

"OWL's report," she concluded, "provides a blueprint for Congressional action on these issues--this legislation would implement most of its recommendations. Because enforceable consumer protections are critically important to America's women, no matter what their age, we urge immediate Senate action on the Patients' Bill of Rights."

OWL (the Older Women's League), the only national grassroots membership organization to focus solely on issues unique to women as they age, has 73 chapters across the country. Many of its members have led successful advocacy efforts for similar managed care consumer protections on the state level.

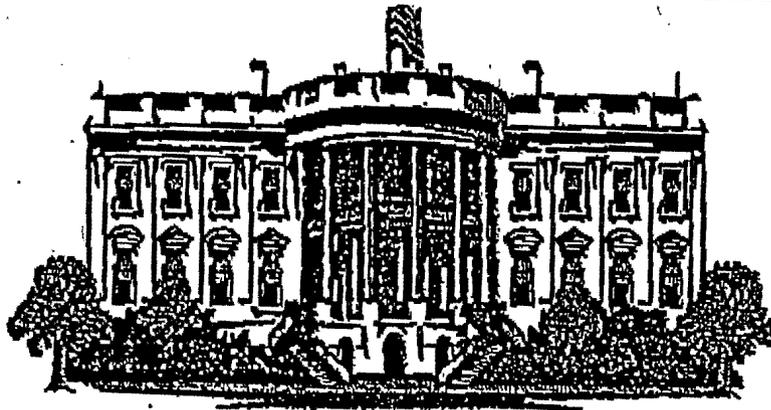
Copies of the report, **Women and Managed Care: Opportunities and Risks for Midlife and Older Women** are available from Roberta Weiner at OWL, 202/783-6686.

#

*** TX REPORT ***

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THE WHITE HOUSE

Domestic Policy Council

DATE: 5/27

FACSIMILE FOR: Wanda Mellgren

FAX: 690-6562
PHONE:

FACSIMILE FROM: Andrea Kane

FAX: 202-456-7431
PHONE: 202-456-5573

NUMBER OF PAGES (INCLUDING COVER): 3

COMMENTS: Here's list of attendees from meeting
in David Wein. CRP.

**PRESIDENT CLINTON RELEASES STATE-BY-STATE REPORT THAT
UNDERScores IMPORTANCE OF A FEDERALLY-ENFORCEABLE
PATIENTS' BILL OF RIGHTS AND RENEWS CALL ON CONGRESS TO PASS
LEGISLATION THIS YEAR**

May 28, 1998

Today, the President is releasing a state-by-state report that underscores the need for a Federal patients' bill of rights by showing that even if every state enacted all the patient protections recommended by the President's Advisory Commission on Consumer Protection and Quality into law, 122 Americans could still lack protections. The report also underscores the importance of the patients' bill of rights for women. In releasing this report, the President renewed his call on Congress to pass a federally enforceable patients' bill of rights before its adjourns this year.

Millions of Americans Do Not Have the Patient Protections Recommended by the Quality Commission. Although 44 states have enacted at least one of the protections recommended by the President's Quality Commission, millions of Americans lack many of these protections because of the extent to which the Employee Retirement Income Security Act of 1974 (ERISA) preempts state-enacted protections. Because of ERISA, state laws cannot require self-insured plans (plans directly underwritten by employers) to provide critical patient protections. Indeed, ERISA can even prevent state laws from having the full effect even in health plans directly regulated by states. In short, a patchwork of non-comprehensive state laws cannot provide Americans with all the protections they need because states do not have full authority over the 122 million Americans who are in health plans governed by ERISA.

A Patients' Bill of Rights is Particularly Important to Women. Approximately 60 million women are in ERISA health plans and therefore need Federal legislation to be assured of receiving the full range of protections recommended by the Quality Commission without Federal legislation. Women are particularly vulnerable without these protections because they are greater users of health care services, they make three-quarters of the health care decisions for their families, and they have specific health care needs that are directly addressed by a patients' bill of rights.

- **Over 60 percent of physician visits are made by women, and women make three quarters of the health care decisions in American households.** Without adequate patient protections, women will be unable to effectively navigate through the nation's rapidly changing health care system.
- **Women in managed care plans are increasingly dissatisfied with the quality of care.** Nearly 70 percent of privately insured women ages 18 to 65 are in managed care plans. Almost two-fifths of these women worry that they will not be able to get speciality care when they need it. And 27 percent of these women worry that they will be denied a medical procedure they need.

- **Without a patients' bill of rights, women may not receive important preventive services.** The consumer protection that gives women direct access to an obstetrician/gynecologist is not only necessary to make sure that pregnant women get the care they need, but is also important to ensure that women get important preventive services. Studies show that gynecologists are almost two times as likely as internists to perform timely, needed women's preventive services.

The President Renews Call on the Congress to Pass a Patients' Bill of Rights.

The President called on Congress to enact the Quality Commission's recommendations to assure high quality care for all patients. These recommendations include: providing patients with access to easily understood information; providing access to specialists, including specialists for women's health needs; ensuring continuity of care for those undergoing a course of treatment for a chronic or disabling condition; access to emergency services when and where the need arises; disclosing financial incentives that could influence medical decisions; prohibiting "gag clauses"; providing anti-discrimination protections; and providing an internal and external appeals process to address grievances with health decisions. The President is pleased that there is growing bipartisan support to pass these long overdue protections.

**Comparison of Administration Positions, Commission Recommendations and Legislative Provisions
Regarding Consumer Protection Issues**

PROVISION	Administration Preliminary Positions	Likely Commission Bill of Rights ¹	Medicare	Medicaid ^{2,3}
<p>1. Information Disclosure to Potential Enrollees and/or Enrollees</p>	<p>Health plan enrollees and potential enrollees should get information regarding:</p> <ul style="list-style-type: none"> -- coverage, benefits, limits, and exclusions (including coverage rules for experimental therapies) -- information about the available providers and network services -- financial responsibilities of enrollees (e.g., copayments, life-time limits, etc) -- care management requirements (e.g., use of gatekeepers, pre-admission certification, etc) -- financial incentives on providers -- utilization review requirements and algorithms -- grievance and appeal rights and procedures -- information about the plan/issuer (e.g., insured or self-insured, regulating authority, etc.) -- quality assurance activities, including performance measures and enrollee satisfaction 	<p>The right distinguishes between information that must be disclosed and information that should be available upon request, concerning health plans, professionals and facilities.</p> <p>Health Plans must disclose:</p> <ul style="list-style-type: none"> -- coverage (including out-of-network services), benefits (including whether and how drug formularies are used) and limits (including procedures relating to experimental therapies) -- information about the available providers and specialists (including board certification status, location, language/interpretation services availability and accessibility to handicapped individuals) -- cost-sharing responsibilities, (including premiums, deductibles, copayments, and co-insurance) -- referral procedures -- access to urgent care centers -- complaint and appeal procedures and type and extent of dispute resolution procedures -- state licensure and federal or private accreditation statuses -- customer and worker satisfaction -- clinical and service performance measures -- disenrollement rates 	<p>Medicare + Choice plans must provide standardized information to enrollees, including benefits and exclusions (including cost sharing and balance billing liability; MSAs must provide comparison to benefits under other Medicare + Choice plans), number and mix of providers, any out-of-network coverage and any POS option (including supplemental premium), out-of-area coverage, coverage of and procedures for obtaining emergency care, supplemental benefits, prior authorization rules, grievance/appeals procedures, and QA program. Upon request, Medicare + Choice plans must disclose utilization control procedures, number of grievances and disposition, description of physician compensation methods, plus info provided by HHS (as below). Plan must provide updates at least annually. (§1852c) Upon request, PSOs must provide info demonstrating fiscal soundness, and transactions with parties in interest. (§1857d)</p>	<p>Medicaid managed care organizations must make available, upon request, information about the plan's providers, enrollee rights and responsibilities, covered benefits and grievance/appeal procedures.</p>

**Comparison of Administration Positions, Commission Recommendations and Legislative Provisions
Regarding Consumer Protection Issues**

PROVISION	Administration Preliminary Positions	Likely Commission Bill of Rights ¹	Medicare	Medicaid ^{2,3}
<p>Information Disclosure(cont.)</p>	<p>Delegate to the Secretary of HHS, in consultation with the Secretary of Labor, the authority to promulgate regulations specifying: (1) the particular information that must be disclosed in each category and the formats for such disclosure, (2) the entity responsible for making the disclosure, and (3) when the disclosures must be made.</p>	<p><i>Upon request:</i> detailed information of specialists, specialty care centers, hospitals, home health agencies, rehabilitation and long-term care facilities; preauthorization and utilization review procedures; provider incentives; years in existence; corporate form of plan; fiscal solvency; standards for confidentiality of medical records and orderly transfer to care givers; use of clinical protocols and practice guidelines; any disease mgmt programs; and qualifications of reviewers at primary and appeals levels.</p> <p>Health Professionals: <i>Upon request:</i> education and board certification status and any applicable accreditation status; hospitals where provider has admitting privileges; years of practice and experience with certain medical/surgical procedures; consumer satisfaction; clinical and service performance measures; corporate form of practice; availability of translation/interpretation services; provider financial incentives; and malpractice claims for past 10 years.</p>	<p>HHS must provide general info on Medicare coverage, including a list of available plans, coverage under traditional FFS program (incl cost sharing and balance billing liability), grievance/appeal procedures, protection from discrimination based on health status, info on Medigap and Medicare Select, the fact that a Medicare+ Choice plan may terminate its contract or reduce its service area (and the effects on enrollees), and any other info as determined by the Secretary. HHS must provide add'l info on Medicare+Choice plans including coverage beyond FFS coverage, cost sharing, any maximum limits on out-of-pocket expenses, ability to obtain benefits from out-of-network providers, ability to select among in-network providers, coverage of emergency care, the beneficiary's premiums, the plan's service area, supplemental benefits and terms for such coverage, quality indicators to the extent available (incl comparison to FFS indicators) including disenrollment rates, enrollee satisfaction and health outcomes. For private FFS and MSA plans, differences in cost sharing, premiums and balance billing compared to other Medicare+Choice plans. HHS must provide updates at least annually. (§1851d)</p>	<p>A State that requires managed care through their Medicaid State Plan (§1932(a)) must provide information annually and upon request, directly or through the managed care organization or primary care case manager, on available managed care organizations or primary care case managers, comparative info about benefits and cost sharing, service area, and quality and performance indicators (if available). A State must provide information on benefits to which enrollees may be entitled under Medicaid but which are not available through the managed care organization or primary care case manager, on or before an individual enrolls with such an entity, and where and how enrollees may access such benefits. (§1932a)-</p>

**Comparison of Administration Positions, Commission Recommendations and Legislative Provisions
 Regarding Consumer Protection Issues**

PROVISION	Administration Preliminary Positions	Likely Commission Bill of Rights ¹	Medicare	Medicaid ^{2,3}
<p><i>Information Disclosure(cont.)</i></p>	<p>Information needed to support choice of plans must be provided during the enrollment period, other information must be provided upon enrollment, and changes to any information must be disclosed prior to the effective date of the change.</p>	<p>Health Facilities must disclose: -- corporate form of facility and larger health affiliations -- accreditation and compliance to speciality guidelines -- consumer satisfaction -- clinical and service performance measures -- availability of translation/interpretation services -- complaint and dispute resolution procedures -- information on providers of direct patient care -- facility's affiliation with provider networks -- exclusion from any federal health programs</p> <p>The Commission did not make any recommendations regarding the timing of disclosure.</p>		

**Comparison of Administration Positions, Commission Recommendations and Legislative Provisions
Regarding Consumer Protection Issues**

PROVISION	Administration Preliminary Positions	Likely Commission Bill of Rights ¹	Medicare	Medicaid ^{2,3}
2. Anti-Gag Rule	<p>Support an anti-gag provision, with a conscience clause.</p> <p>Also protect communications between a provider and an appropriate regulator regarding situations that put patients at risk; that is, include whistle blower protections.</p>	<p>Assure that provider contracts do not contain any so-called "gag clauses" or other contractual mechanisms that unnecessarily restrict health care providers' ability to communicate with and advise patients about medically necessary treatment options. Does not address conscience clause.</p>	<p>Yes, with conscience clause for counseling or referral services. (§1852j)</p>	<p>Yes, with conscience clause for counseling or referral services (effective 10/1/97). (§1932b)</p>
<p>3. Grievance/ Appeals Procedures</p> <p>► Internal Review</p> <p>► External Appeal</p>	<p>A basic, timely, and fair internal appeals process should be established by federal legislation, applicable to any complaint against the health plan.</p> <p>External review of some kind should be available for those decisions that affect the scope or timing of treatment, or access to providers.</p>	<p>An internal review process should be reasonable and timely in the notification of decisions and resolution of grievances regarding service or payment denials/reductions.</p> <p>An independent and timely external appeal process should be available for decisions regarding service or payment denials/reductions for experimental therapies or "medically necessary" services (not coverage decisions).</p>	<p>Yes, initial determinations and reconsiderations. Denials must be made in writing. Reconsideration of denial based on medical necessity must be by physician with appropriate expertise not involved in initial determination. (§1852f and g)</p> <p>Yes, the Secretary must contract with outside entity for appeal to plan's internal review. Only beneficiaries may appeal to the contractor, Center for Health Dispute Resolution (CHDR) for cases when service or reimbursement for service already rendered is denied.</p>	<p>Yes, for denial of coverage or payment by a managed care organization (effective 10/1/97). (§1932b)</p> <p>Yes, current law mandates a "fair hearing" before the State when "medical assistance under the plan is denied or is not acted upon with reasonable promptness." (§1902a)</p>

**Comparison of Administration Positions, Commission Recommendations and Legislative Provisions
Regarding Consumer Protection Issues**

PROVISION	Administration Preliminary Positions	Likely Commission Bill of Rights ¹	Medicare	Medicaid ^{2,3}
<p>• <i>Is External Appeal Binding?</i></p>	<p>Not addressed.</p>	<p>Intended, but not stated in current draft.</p>	<p>No, the decision by the contractor (CHDR) is not binding. Only beneficiaries may appeal CHDR's decisions, to an Administrative Law Judge (ALJ), if the amount in dispute is \$100 or more. Both beneficiaries and plans may appeal the ALJ's decisions to the Appeals Council. Only beneficiaries may appeal an adverse decision by the Appeals Council to the federal courts, if the amount in dispute is \$1,000 or more. (§1852g)</p>	<p>Yes, "fair hearing" decisions are binding for both managed care entities and beneficiaries.</p>
<p>• <i>Expedited for Emergencies</i></p>	<p>Both internal and external processes should have provisions for expedited review in emergencies.</p>	<p>Both internal and external processes should incorporate expedited consideration for emergency/urgent care cases with timeframes consistent with those required by Medicare.</p>	<p>Yes, not later than 72 hours or as specified by Secretary.</p>	<p>No federal requirement.</p>

**Comparison of Administration Positions, Commission Recommendations and Legislative Provisions
Regarding Consumer Protection Issues**

PROVISION	Administration Preliminary Positions	Likely Commission Bill of Rights ¹	Medicare	Medicaid ^{2,3}
<p>4. Direct Access to Specialists</p>	<p>Require health plans to have a procedure for determining when enrollees have direct access to specialists, with the procedure subject to rules promulgated by the appropriate regulatory authority.</p> <p>Require plans to allow women to bypass the gatekeeper for Ob/Gyn services. Also require plans to allow persons with chronic conditions to designate a specialist as gatekeeper, but define "chronic condition" narrowly.</p> <p>Authorize the appropriate regulatory authority to add additional conditions and/or criteria which the health plans' procedures must reflect.</p>	<p>Consumers with complex or serious medical conditions who require frequent specialty care should have direct access to a qualified specialist of their choice within a plan's network of providers. Authorizations, when required, should be for an "adequate" number of direct access visits under an approved treatment plan. Intended to ease consumer access to specialists while maintaining the integrity to network models of care.</p> <p>Women should be able to choose a qualified provider--including gynecologists and certified nurse midwives--for the provision of an "adequate" number of visits to cover routine women's health care services.</p>	<p>No.</p>	<p>No.</p>

**Comparison of Administration Positions, Commission Recommendations and Legislative Provisions
Regarding Consumer Protection Issues**

PROVISION	Administration Preliminary Positions	Likely Commission Bill of Rights ¹	Medicare	Medicaid ^{2,3}
6. ER Services ▶ Bans Prior Authorization and In-Network Requirements ▶ Prudent Layperson ▶ “Emergency medical condition” includes severe pain ▶ Post-stabilization Care	<p>Yes</p> <p>Yes</p> <p>Not part of discussion when HHS positions were developed (but is current Medicare policy includes such, so likely HHS would concur).</p> <p>Recommend not to engage this at this time.</p>	<p>Yes. In addition, non-network providers and facilities should not bill patients for charges in excess of health plans’ routine payment arrangements.</p> <p>Yes.</p> <p>Yes.</p> <p>ED personnel should contact the patient’s physician “as quickly as possible” to discuss post-stabilization care.</p>	<p>Yes. (§1852d)</p> <p>Yes, qualified by “who possess an average knowledge of health and medicine.”</p> <p>Yes.</p> <p>Mandates compliance with guidelines to be established by HHS.</p>	<p>Yes. (§1932b)</p> <p>Yes, qualified by “who possess an average knowledge of health and medicine.”</p> <p>Yes.</p> <p>Mandates compliance with guidelines to be established by HHS.</p>

**Comparison of Administration Positions, Commission Recommendations and Legislative Provisions
Regarding Consumer Protection Issues**

PROVISION	Administration Preliminary Positions	Likely Commission Bill of Rights ¹	Medicare	Medicaid ^{2,3}
7. Experimental Therapies	<p>Require disclosure of what plans consider experimental and how they decide (including decisions about coverage of unapproved drugs).</p> <p>Require independent review for determining when a therapy is or is not experimental, and require the determination be made within a reasonable time after an enrollee's appeal.</p> <p>Do not mandate coverage of therapies that the independent panel determines are experimental.</p>	<p>Same as Administration.</p> <p>Same as Administration.</p> <p>Same as Administration.</p>	No.	Under current law, a State has the option to cover experimental therapies. A State gets federal match for experimental items/services it deems "medically necessary."
8. Physician Incentive Plans	Same as Medicare.	Recommends disclosure of information related to provider compensation, ownership and other financial interests which could influence treatment advice or decisions, but does not limit provider incentive arrangements.	Prohibits specific payments to physicians "as an inducement to reduce or limit medically necessary services." (§1852j)	Same as Medicare prohibition, under current HCFA statute. (§1903m)

**Comparison of Administration Positions, Commission Recommendations and Legislative Provisions
Regarding Consumer Protection Issues**

PROVISION	Administration Preliminary Positions	Likely Commission Bill of Rights ¹	Medicare	Medicaid ^{2,3}
<i>If plan places physicians at substantial financial risk for services not provided by those physicians, does the plan</i>				
▶ Require Stop-Loss Protection	Same as Medicare.	No.	Yes.	Yes.
▶ Require Survey of Enrollees and Disenrollees regarding Access	Same as Medicare.	Under the information disclosure chapter, plans must provide information on customer satisfaction and service performance measures; however, such information is not linked to physician incentive arrangements.	Yes.	Yes.

1. Source: Commission's draft version of "Consumer Bill of Rights and Responsibilities in Health Care" dated October 21, 1997.

2. The new Medicaid provisions authorize two kinds of managed care entities: "managed care organizations" and "primary care case managers." Where appropriate, some consumer protection provisions in the new legislation apply to both types of Medicaid managed care entities; when such provisions apply to one type only, usually it applies to managed care organizations. However, current federal requirements and existing State Plan requirements may also provide similar protections, so the protections available to the beneficiary are not apparent solely from the new provisions. In addition, there are some ambiguities in the drafting. We will provide updated information on these issues as matters are clarified.

3. Under the BBA, children with special needs, dual eligibles, Native Americans are exempt for mandatory enrollment in managed care under §1932a.