AMERICA'S HEALTH: PROTECTING PATIENTS' ACCESS TO QUALITY CARE AND INFORMATION

HEARINGS

BEFORE THE

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HEALTH AND ENVIRONMENT

OF THE

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AMERICA'S HEALTH: PROTECTING PATIENTS' ACCESS TO QUALITY CARE AND INFORMATION

WEDNESDAY, MARCH 24, 1999

HOUSE OF REPRESENTATIVES,
COMMITTEE ON COMMERCE,
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 1:40 p.m., in room 2123, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Upton, Stearns, Greenwood, Deal, Burr, Bilbray, Whitfield, Ganske, Norwood, Coburn, Shadegg, Pickering, Bryant, Bliley (ex officio), Brown, Pallone, Green, Strickland, Barrett, Capps, Towns, and Dingell (ex officio).

Staff present: Jason Lee, majority counsel; Tom Giles, majority counsel, Penn Crawford, legislative clerk; Bridgett Taylor, minority counsel, and Amy Droskoski, minority professional staff.

Mr. BILIRAKIS. Let's have order, please, so that we can get started.

Good afternoon. I have convened this hearing to examine two basic issues related to America's health. The first concern is access to quality healthcare, and the second pertains to quality information on healthcare.

As we announced in a press release last week, today marks the first in a series of bipartisan informational subcommittee hearings on managed care and the problem of the uninsured in this country.

During these hearings, we will address all of the major areas of concern to members on both sides of the aisle, and even more important, those healthcare issues of greatest concern to our fellow Americans. I have said it before and will repeat it now, "Times are changing in the practice of medicine." I hear it all the time from physicians in my district, and especially my son who is an internist in Palm Harbor, Florida.

For many, the transition to managed care has not been easy. It represents a whole new way of medical care delivery and financing in this country. In addition, managed care patients have complained that their current health plans at times prevent them from seeing their own doctors.

Today, however, I would like to ask members of this subcommittee to focus their attention—focus their attention—on two main issues. We will ultimately, as we go forward with our hearings,

cover all of the issues, but focus our attention today on two main issues.

The first panel of healthcare experts will address access to emergency services and access to specialty care. The second panel will address medical communications between health professionals and patients. It will also cover the availability of information on the quality of care delivered by plans and providers, so very, very significant in my opinion. And, finally, the second panel will discuss the use of an ombudsman to help guide patients through the often confusing maze of modern healthcare systems.

As we listen today, I ask that members keep an open mind; I know that is difficult. But the healthcare alternatives, as we know, are so very complex, the issues so urgent, and the decisions so far reaching, that only with an open mind, can we do what is right.

In closing, I want to reiterate that today's hearing is the first in a series of subcommittee hearings on the topics of managed care and the uninsured. Some hearings will be held outside of Washington so we can gain a better perspective on the everyday problems facing those who live outside the beltway.

Subcommittee members should rest assured that medical liability, medical necessity, point of service, and other issues will be addressed in the near future.

And finally, I would like to welcome our witnesses to thank you for taking time out of your busy schedule to join us today. We all look forward to hearing your views on important health access issues facing our Nation today.

And the Chair would now yield to ranking member Mr. Brown, my good friend.

Mr. BROWN. Mr. Chairman, thank you, and thanks to our distinguished panelists on this panel and on the next panel.

The Congress has debated the merits of managed care reform for more than 3 years. The logic for reform is there; the evidence for reform is overwhelming, yet we are well into the 106th session of Congress without accomplishments, without comprehensive patient protections on the books. For the victims of our inaction, individuals whose coverage disintegrated the moment it was needed, 3 years is a lifetime.

Managed care should mean coordinated care; it should mean expert care; it should mean informed care. Application of these principles can improve quality, minimize waste, and reduce costs. But there is a faster way to cut costs and to increase profits. Health plans can skew their coverage toward what is least expensive, rather than what is most effective. The complex nature of healthcare gives them cover; the bottom line gives them incentive.

We can all name health plans that effectively self-monitor and truly put the patient first. For these plans, the protections we will discuss today should be non-issues.

These plans would not deny full coverage for a trip in an ambulance and treatment in an out-of-network emergency room if their enrollee believes she was in an emergency situation. These plans would not bypass physician and non-physician providers when their services are medically indicated, but the patient is not aware of that. These plans would not dissuade chronic care patients from receiving proper care by requiring referral, after referral, after re-

ferral, for services that are clearly needed on an ongoing basis. These plans would not create disincentives, financial or otherwise, that inhibit physician and non-physician providers from being candid with their patients. These plans would not do that, but we know that some plans do.

A continuous flow of letters and phone calls from our constituents attest to the fact that not all health plans live up to the promises that enrollees read about in their benefit booklet. Some health plans systematically obstruct, delay, and deny care. Some health plans provide excuses instead of coverage. It is to protect those enrollees that we must establish meaningful patient protections.

The protections we will discuss today—access to information, coverage for emergency transportation, and healthcare services that does not vary with the site of care or the eventual diagnoses, coverage for the services of appropriate physician and non-physician specialists alike, prohibitions on gag rules, access to ombudsman services. These protections are fundamental, and they will make a difference. But their ultimate value depends on a larger package of reforms, one that raises the stakes on those few plans that make a practice of mistreating their enrollees. Health plan accountability is critical and it is appropriate. Providers make medical decisions; health plans make medical decisions. They should be held accountable.

The most valuable product we can take from today's hearing is momentum. We need to address the remaining issues, as formidable as they may be, quickly. It is incumbent on us to move beyond the theoretical to the concrete and take advantage of the hard work already put in by Mr. Dingell and Mr. Bilirakis and others. We need to debate, mark up, and deliver a bill that finally addresses the managed care concerns borne out by millions of Americans.

I look forward, Mr. Chairman, to working with my colleagues, on a bipartisan basis, to get this job done.

Mr. BILIRAKIS. I thank the gentleman.

Mr. BROWN. Thank you.

Mr. BILIRAKIS. Mr. Bliley, for an opening statement—the chairman of the full committee.

Chairman BLILEY. Thank you, Mr. Chairman. I want to thank you for holding this important informational hearing today.

As this subcommittee announced last week, Chairman Bilirakis and subcommittee ranking member Brown will take the lead in holding a series of hearings examining issues affecting America's health. I want to commend these gentlemen for holding field hearings and taking the debate to the American people to hear from real Americans.

Last year we tried to enact legislation by task force and bypass the committee process. This year, Speaker Hastert announced his intention for this body to return to regular order. As a result, I want to reiterate that this is only the first in a series of several hearings this committee will hold addressing issues affecting America's health. Some of these hearings will be held right here in this room, while others will be held outside of Washington. We need to have a dialog with the American people to ensure that any legislation we enact is responsible and is responsive to the needs of Main Street America.

Today we will hear from experts with experience in the areas of access to emergency services, access to pediatric and OB/GYN specialists, and access to specialists for persons with chronic conditions. We will also hear from experts in the areas of medical communications, information disclosure, and ombudsman programs. Access to quality care and useful information are important subjects in the debate on America's health.

It is important to remember throughout these hearings that another type of access, access to health insurance, is sorely lacking in this country. While America can be proud that it provides the best and highest quality healthcare in the world, it is disturbing to see, year after year, the number of uninsured Americans continuing to increase. Today the number of uninsured in this country is approaching 44 million, and growing. As we consider reforms to the private health insurance market, we must be mindful of the impact such changes will have on access to health insurance for all Americans and work toward increasing access, not limiting it. To enact any reforms that could exacerbate this problem, would be irresponsible and unacceptable.

Last year, the House passed a health reform bill which included health marts as a way to make healthcare more affordable. I hope to explore this option in further detail at a subsequent hearing.

Finally, let me emphasis my commitment to continuing to work with members of this committee on both sides of the aisle to address the important health concerns facing the American people today.

I, again, want to thank Chairman Bilirakis for holding this hearing on an issue of such importance to the American people. I look forward to hearing from our panelists here today and yield back the balance of my time.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Mr. Pallone, for an opening statement.

Mr. PALLONE. Thank you, Mr. Chairman, and I want to say I do appreciate the opportunity to discuss managed care reform in committee today and your willingness to hold this hearing.

But having said that, I am concerned that the approach adopted today is not the best way to proceed. And while all of the issues that you identified for discussion today are important, the two most important issues in this managed care debate are not on the agenda. And, of course, I am referring to the right to sue, as well as who will define "medical necessity." While I understand that this is the first of a number of scheduled hearings, I think these issues need to be addressed immediately for two reasons.

The first is that none of the protections discussed today will be worth anything to anybody if they do not have the right to sue and if the insurance company is allowed to continue defining "medical necessity." The second is that these are the issues that there is no agreement on and really cut to the core of the managed care debate. So, as important as all the other issues are to discuss them before you, to discuss the framework that will make them worth anything, I think you need to talk about these other two issues of the right to sue and medical necessity.

I also want to make an observation about the fact that there are a lot of rumors out there and reports circulating that the Repub-

lican leadership is contemplating a piecemeal approach to managed care reform. And I would just say—and I am not saying it is the case, but if it is the case, it would be a huge mistake. The experience of people who have been injured for life and the countless deaths that have occurred because patients were denied needed care, demand that a comprehensive reform to the system be enacted. And fixing one aspect of the problem while neglecting another will only insure more people who could have been saved, or their lives or their health saved, unfortunately, will be profoundly changed forever. And I don't think it is the right thing to do. We need to look at this in a comprehensive way.

Now, as everyone involved in this debate knows, there is significant disagreement between the Democrats' Patients' Bill of Rights and the Republican leadership's Managed Care bill. Simply stated, in my opinion—and I am not expecting you to agree on the other side—but I believe that the Patients' Bill of Rights proposes to protect patients, and that the Republican leadership bill that we saw in the last session, and I guess we are likely to see again, basically protects the insurance industry.

For instance, the Republican leadership bill does not list "severe pain" as a legitimate reason to go to the emergency room; the Patients' Bill of Rights does. The Republican bill does not allow women to choose their OB/GYN as their primary-care doctor; the Patients' Bill of Rights does. The Republican bill does not allow people with chronic conditions to obtain standing referrals; the Patients' Bill of Rights does. The Republican bill purports to prohibit gag clauses, but in reality does no such thing. The Republican bill does not require plans to collect data on quality, and the Patients' Bill of Rights has that requirement. And the Republican bill does not establish an ombudsman program to help consumers navigate their way through the confusing array of health options, and the Patients' Bill of Rights does.

Let me just say, in conclusion, if we are going to have a hearing that addresses these issues, I think it should focus on the difference between the competing bills, not on whether aspects such as these should or shouldn't be included. And to that end, I would intend to focus my energy today on highlighting the differences between the Patients' Bill of Rights and Republican leadership bill and some of the other bills I think that have been suggested by committee members or others.

But I do appreciate the fact that we are having this hearing, and I hope there will be a lot more. I think we need to get to a comprehensive bill quickly that will pass something out of this committee.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Upton, for an opening statement.

Mr. UPTON. Thank you, Mr. Chairman. I appreciate you calling this hearing today and the whole series of hearings as we look at the managed care health issue.

This is an issue that I care very deeply about. Rarely a day goes by that I don't hear or read in my constituent mail of serious problems that individuals or their families are having with their managed care plans.

One of the issues that we are examining in this hearing is access to emergency room care. The importance of ensuring prompt access to emergency room care was brought home recently when I received a report about a Michigan woman who was experiencing severe abdominal pain. She went to the nearest hospital emergency room, but her managed care plan would not cover her care at that facility. Instead, a plan clerk directed her to another facility more distant. And, unfortunately, that facility was affected by a massive power outage in the Detroit area, and they could not see her promptly. She requested permission to return to the first hospital, but was denied. And by the time that she received care, she was very seriously ill with a massive infection from a ruptured ovarian cyst.

So I want to make sure that this a high priority that we tackle this year. And as we work on it, I want to make sure that we define "emergency services" to clearly include ambulance services. I think most would agree that ambulance services should be covered as part of emergency care when prudent laypersons would make the judgment that their condition warranted such care. And I think that most of us thought that the Managed Care Reform bill that we passed last year did that, but, sadly, it was not the case.

I am pleased that I have a constituent from Kalamazoo, Michigan, Mark Meijer, here in the audience. He is president of the American Ambulance Association. I have worked with Mark for a number of years now on emergency service issues, and I have a great deal of respect for his hands-on experience.

He recently pointed out that, while we all may have thought that we covered ambulance services in the past, in fact, we haven't actually seen it. And I intend to introduce legislation in the next couple of weeks to address this. I would hope that we could include it as part of a managed care bill as we move forward.

And by unanimous consent, I would like to include a statement from Mr. Meijer as part of my statement, and I yield back the balance of my time.

Mr. BILIRAKIS. Without objection.

[The prepared statement of Mark D. Meijer follows:]

PREPARED STATEMENT OF MARK D. MEIJER, AMERICAN AMBULANCE ASSOCIATION

Chairman Bilirakis, Ranking Minority Member Brown and members of the Subcommittee, on behalf of the American Ambulance Association (AAA), thank you for allowing us to submit written testimony for the hearing record. My name is Mark Meijer, and I am president of the American Ambulance Association and a provider of emergency ambulance services in Kalamazoo, Grand Rapids, and other parts of west Michigan. The American Ambulance Association represents more than 650 ambulance providers from all fifty states.

As president of the AAA, I hear from ambulance service providers across the country who are being denied reimbursement by managed care plans for ambulance services that any reasonable person would consider a medical emergency and cause for calling 911. As an ambulance service provider in Michigan, I have firsthand knowledge of numerous instances where managed care plans denied reimbursement for similar legitimate claims. It is with these experiences in mind that I implore Congress to pass managed care reform legislation that contains an emergency services provision applying the "prudent layperson" standard to emergency *ambulance* services in addition to the emergency *room* services expressed in the bills.

I do want to be clear on a number of points. We are not asking for a mandated benefit. We are asking that this requirement apply only to plans that provide coverage for ambulance services. In addition, we are not suggesting that every medical emergency in which the "prudent layperson" standard might be invoked would nec-

essarily require an ambulance. We propose a second "prudent layperson" standard by which, not only must there be a medical emergency, but that ambulance transportation must be considered medically necessary by a "prudent layperson." We have sought to keep our proposal deliberately narrow, but fair to those that are faced with calling for emergency medical help.

The recent growth of managed care has increased concern about whether adequate emergency medical services are being provided to participants of managed care plans. That is, as we understand it, why this legislation is before you today. Chief among these concerns is the extent to which managed care plans are second-guessing victims of perceived medical emergencies when they seek emergency medical care. This second-guessing can result in the loss of precious time that could worsen a patient's sudden illness or injury, and in fact increase mortality and morbidity as well as cost to payers. The response by Congress has been very gratifying. While there are any number of controversies attached to the various approaches to regulating managed care, there seems to be a broad consensus on the need of a provision covering emergency medical care.

The problem with ambulance coverage is that the emergency medical services provision in all of these bills is based on a law, the Emergency Medical Treatment and Active Labor Act (EMTALA), that does not address pre-hospital care and thus does not include emergency ambulance services. Even those bills seeking to broaden coverage, for instance, by including the term "ancillary services" among those services that should be provided, are inadequate, according to our counsel and more importantly real life experience. The fact is that EMTALA begins at the hospital door, so "ancillary services" would only cover services provided in a hospital. In order to ensure that emergency ambulance services are indeed covered, managed care reform legislation must explicitly refer to ambulance services.

The fact that emergency ambulance services are not covered is very troubling considering that millions of medical emergencies a year begin with a 911 call. The dispatch of an ambulance is often the very first response to an emergency medical episode. Prompt attention by emergency medical personnel from an ambulance can be every bit as critical as emergency room care in such situations. Failure to reimburse for emergency ambulance services may either discourage patients from utilizing life-saving emergency care or surprise them with bills for emergency ambulance services that they did not expect.

When a medical emergency strikes, whether real or perceived, nobody is thinking of reimbursement. Neither the individual experiencing the emergency, their family or friends or their care-givers should have to worry, at that moment, who is paying for their care. Similarly, ambulance providers respond to such emergencies with one thought in mind: the health and well-being of the patient. Ambulance providers respond to emergencies regardless of the patient's *ability* to pay or the patient's insurance company's *willingness* to pay. Managed care plans should not be allowed to take advantage of this commitment by the ambulance industry. If we require them to pay for emergency room care, we should require them to pay for ambulance care as well. As members of the House Subcommittee with jurisdiction over this issue, I hope that you will work to include language specific to emergency ambulance services. Your assistance is critical to keeping this front-line access to emergency medical services available to health care plan participants across the nation.

Once again, thank you for allowing the American Ambulance Association to submit written testimony for the record. I would be happy to respond to any follow-up written questions that members of the subcommittee may have on the issue.

Mr. BILIRAKIS. And I might at this point say that the opening statements of all members of the subcommittee can be made a part of the record.

I recognize Mr. Dingell for an opening statement.

Mr. DINGELL. Mr. Chairman, thank you, and I want to commend you and thank you for holding this hearing on patient protections, which is our first since October 1997. I also want to commend Chairman Bliley for his interest in this matter.

The issue of patients' rights has been before the Congress for a number of years. I began working on the original Patients' Bill of Rights in 1996; the bill was introduced early in 1997. The bill evolved into the measure that Dr. Ganske and I co-sponsored in the last Congress which only fell five votes short of passage during the last summer.

No fewer than four comprehensive Patients' bills of rights are pending before the Congress today. In addition to my own, three of my Republican colleagues have proposed their own legislation. Dr. Ganske's legislation, as always, closely resembles mine. Mr. Norwood takes a slightly different, but no less comprehensive, approach. While you, Mr. Chairman, introduced the leadership bill that was brought directly to the floor last year.

Today's hearings will begin to explore some but not all the issues that must be included in any basic bill of rights to protect patients.

We will hear from a number of excellent witnesses, including the president-elect to the American Medical Association, Dr. Reardon. Also, Mr. Peter Thomas and Mr. Ron Pollack, all of whom have served on the President's Quality Commission, and they should be listened to respectfully. We will hear them describe the hard experience of patients and providers in dealing with their health insurance plans.

While some rogues and scoundrels may be operating in the health insurance industry, we should readily recognize that many of the health plans are doing all the things right for their patients. Dr. Joseph Braun, from the GW Health Plan, will testify about measures that some health plans have taken to ensure that patients get timely access to proper care. But with an issue as serious as healthcare, some plans providing some protections, some of the time, may not be enough and, indeed, probably it is not.

Today's hearing will explore some, but only some, of the protections that must be included in any basic patient rights' bill—direct access to pediatricians, obstetricians, or gynecologists, emergency room care, information disclosures, and then the gag rules, and a few others.

All these issues are important to patients, but there are many others amongst them—access to clinical trials, drug formulary protections, continuity of care, point of service, and perhaps—indeed, not perhaps—but external appeals, internal appeals, medical necessity without which there could be no full protection of the rights of patients, and liability as an enforcement mechanism.

As a recent Families USA report points out, States have increasingly taken aim at some of these issues. Unfortunately, the record reveals hits as well as misses. Consumers can't count on basic protection. Even States with strong consumer protections cannot and do not cover a large number of their residents. Some 51 million Americans who receive health insurance from the self-insured employer under the Employee Retirement Income Security Act, ERISA, are not protected by State laws and have no right to sue, no matter the outrage that is perpetrated upon them.

We need comprehensive Federal legislation that provides, as a minimum, a uniform platform on which all Americans may stand. In my judgment, that means three things: one, finding independent, external appeals process with the authority to resolve disputes between patients and plans in a timely manner; two, a strong enforcement mechanism that gives patients the ability to hold their health plan accountable in the event that it caused them injury or death; and three, a standard for review that ensures that medical treatment decisions are made in accordance with prudent medical practice, based upon the patient's own medical record and available

medical evidence and the judgment of the treating physician as well as the healthcare plan. Without these protections, other rights will be meaningless.

I commend you again, Mr. Chairman. I look forward to hearing from our witnesses; they have much to tell us.

Mr. UPTON. [presiding] Thank you, my good friend from the great State of Michigan.

The gentleman from North Carolina, Mr. Burr.

Mr. BURR. Mr. Chairman, I have no opening statement.

Mr. UPTON. Okay.

Mr. Ganske, from Iowa.

Mr. GANSKE. Thank you, Mr. Chairman.

Mr. Chairman, the waters are building up behind the dam. They are roiling; they are getting closer and closer to that spillway. We have been talking about passing patient protection legislation for 3 years.

Mr. Markey and I introduced a bill 3 years ago, the Patient Right to Know Act, which had more than 295 bipartisan co-sponsors. We had a hearing on gag rules 3 years ago; couldn't get that to the floor, a bill that had around 300 co-sponsors.

Mr. Chairman, it is time to do comprehensive legislation, no itty-bitty band-aid, piecemeal legislation. It is time to timely consider this legislation. We have had hearings before; I welcome hearings, but I think we ought to set a time table for a committee markup, subcommittee and full committee. And we ought to have it as a goal, moving this to the floor under an open rule for consideration by July 1.

And, finally, Mr. Chairman, this is a great committee that we sit on. Both Republicans and Democrats have contributed to the history of this committee. This committee is the only committee that is specifically mentioned in the United States Constitution. We have jurisdiction over insurance and health. Education and Labor has jurisdiction over ERISA, as well. This comprehensive bill that we should be working on should be a product of the Commerce Committee. If other committees want to do a tax bill with radical restructuring of the way the tax code interacts with the healthcare system, then I say, "Go for it." There may be some merit in what they do, but that should not be a part of the comprehensive patient protection bill that we are dealing with. This is a bill for this committee's jurisdiction.

Mr. Chairman, 3 years ago when we had a hearing on this, toward the end of the day—it was May 30, 1996—a small nervous woman testified before this committee. Her testimony was buried in the fourth panel at the end of a long day about the abuses of managed care. She had been a claims reviewer for several HMOs. She started out her testimony by saying, "I wish to begin by making a public confession. In the spring of 1987, I caused the death of a man. Although this was known to many people, I have not been taken before any court of law or called to account for this in any professional or public forum. In fact, just the opposite occurred; I was rewarded for this. It brought me an improved reputation in my job and contributed to my advancement afterwards. Not only did I demonstrate that I could do as was expected of me, I exemplified the good company doctor."

She continued, "Since that day, I have lived with this act and many others, eating into my heart and soul. For me, a physician is a professional charged with the care or healing of his or her human beings. The primary ethical norm is do no harm." She went on to say, "I did worse. I caused death. Instead of using a clumsy, bloody weapon, I used the simplest, cleanest of tools—my words. This man died because I denied him a necessary operation to save his heart. I felt little pain or remorse at the time. The man's faceless distance soothed my conscience. Like a skilled soldier, I was trained for this moment. When any moral qualms would arise, I was to remember,"—Mr. Chairman, as this lady said, with tears in her eyes, as the hush fell over this room, she said, "I was to remember, I am not denying care; I am only denying payment."

Mr. Chairman, we are going to hear about emergency care today. We are going to hear about gag rules. But I think it will be entirely appropriate to talk about what this woman, former medical reviewer, said of the medical necessity issue, that it was the "smart bomb" of cost containment. Because without a standard definition of care for "medical necessity," none of these procedural patient protections that we are talking about will mean a hill of beans.

I yield back. Thank you, Mr. Chairman.

Mr. UPTON. Thank you, Mr. Ganske.

The gentleman from Texas, Mr. Green.

Mr. GREEN. Mr. Chairman, my colleague from California was here first——

Mr. UPTON. Oh. I just——

Mr. GREEN. [continuing] and I will be glad to follow her.

Mr. UPTON. I regret the mistake, looking at my good staff.

Ms. Capps, of California.

Ms. CAPPS. Thank you, Mr. Chairman, for calling this hearing today.

As you know, I am new to this committee, and healthcare, particularly managed care reform, is one of the major reasons I sought out this committee. So I am very happy that we are all here today, and thank you, witnesses, for being willing to testify.

Let me say, first, that I am encouraged by today's hearing and the majority's willingness to reach out to us and work with us on moving this process forward. Last week I noted with dismay, the action in the Senate Labor Committee, where the two parties were unable to come together, and hope that this committee can do better. Maybe I am too new here, but I still hold out hope.

I understand that this is the first of several hearings that the subcommittee will undertake to examine the various aspects of managed care reform. I look forward to them and encourage the majority to schedule them as soon as possible, in a timely fashion, so that we can begin to move this legislation before the House gets too consumed by other priorities in the legislative calendar.

Also, it is my hope that in future hearings, we are able to broaden the voices that the subcommittee hears, specifically, those of non-physician providers like nurse practitioners, nurse midwives, and anesthetists, among others. I have a bias here, of course, due to my background as a nurse, but I know that these voices have much to add to this debate as well, and we should hear from them.

And, also, I want to echo what Representative Ganske just mentioned. I want us to continue to address the tough issues in a timely manner. Representative Ganske had sent me his opening statement, and I am glad it is going to be entered into the record. I read it as a letter from him last week, and it underscores for me as well, the need to deal with issues such as accountability and medical necessity.

Managed care reform is, of course, one of the most important issues before this 106th Congress. For too long, patient care has been put second in line behind the bottom line. Doctors, nurses, and other healthcare providers are second-guessed in their treatment strategies by accountants, and patient access to full information about treatment options has been compromised.

It is past time that Congress pass a comprehensive—and I underscore "comprehensive"—patient bill of rights and give consumers the protection they need and are demanding.

Thank you, again, Mr. Chairman, for holding this hearing today. I look forward to hearing from our witnesses, and yield back the balance of my time.

Mr. UPTON. Appreciated the gentlelady's statement.

The gentleman from Georgia, Mr. Norwood.

Mr. NORWOOD. Thank you, Mr. Chairman, and thank you, Mr. Bilirakis, for holding these hearings.

It some days feels like it was 100 years ago since 1995 when I dropped my comprehensive managed care reform bill—and Lord knows, I didn't know what was going to happen after that. But finally, we are beginning to talk about the subject from both sides of the aisle.

And I really look forward to these hearings and hope they will be very informative.

As most of you know, I have taken somewhat of an interest in this subject about today's hearings, and I hope my views are fairly well-known, but I am not the only one who has taken an interest in this subject. My friend, Dr. Ganske, has introduced a bill, as has Mr. Dingell, as has our distinguished chairman. But, most importantly, the American people have taken an interest in patient protections. We should honor them by working together to find the common ground between us on this committee in passing a bipartisan bill that is consistent with the traditions of this great committee. And the truth of the matter is that we should be able to easily find common ground between our various bills.

These hearings will focus on many of the things we have in common. We should be able to turn quickly from these hearings to create a base bill that we can work from in this committee.

First and foremost, we should have an internal/external review process that empowers patients to get the care they paid for when they need it. External review must be independent from an insurer. Independent medical experts must be able to make decisions using an objective standard that an insurer has no control over, and the decisions made during the review must be binding.

More than anything else, Americans control quality with their feet. We must include a consumer choice provision that legitimately allows us to say to everyone, "Everyone in America, you can see

your own doctor." We need to include in a base bill many of the issues that we are going to be discussing today.

We should guarantee patients have access to obstetricians and gynecologists and pediatricians and emergency room services. I can't believe we are having a hearing on this, frankly—that I would be saying what I just said. We should guarantee patients access to a specialist when a specialist is called for, and we should guarantee continued access to that specialist in a chronic care situation.

We should guarantee patients access to a standard set of basic information about their insurance coverage.

We should guarantee doctors the rights to freely communicate with their patients, and we should institute some very basic protections for doctors so that they can advocate for the best interests of their patients.

This legislation should affect all Americans; to do anything less is to fail. Apparently our colleagues in the Senate decided last week that we are a Nation of 48 million people. Hopefully the next census will help them and straighten them out.

And the legislation we write should be inclusive of physicians and non-physician providers. Those of us in rural districts know the critical role that non-physician providers play, and our legislation must not ignore them.

We should then have an honest and in a fair amendment process that allows us to openly raise those issues where there may not be consensus among us. Whether any of us wins or loses, when we place our amendments on the table, we should be able to look each other in the eye and say, "We were treated fairly on the Commerce Committee." By passing consensus legislation in a fair process, we can ensure the quality of care patients receive and empower patients when there are disputes over what is best for them.

We have seen what happens when partisanship triumphs cooperation. Last week's mark up of a rotten bill in the Senate Health Committee was disgraceful. The people are owed a better effort from us than that, and we can do it. It only takes the willingness to work together, the perseverance to resist those who want nothing, and the courage to stand for what is right for the American people.

I thank you, Mr. Chairman, for the time.

Mr. UPTON. The gentleman's time has expired.

The gentleman from Texas, Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman, ever the southern gentleman, but I appreciate the opportunity to be here to day.

And I think most of us are always thanking the chairman for scheduling this important hearing. But today we mean it more than ever because this is probably the most important hearing I think I have seen—participated in since my three terms—now four terms—in Congress.

And I like to associate myself with the remarks of my colleague, Dr. Ganske, and, also, Dr. Norwood, although I would compare that what happened on our House floor last year with the bill that passed, with what happened in the Senate last week.

The American people have spoken loud and clear over the past few years that they want—no, they really "need"—real managed care reform.

We learned from last year's legislative experience that anyone can write a bill and put a flashy title on it, include some key words like "access" and "gag clause," and say they passed managed care reform. What we also learned is, unless these titles and key sections are backed by strong and binding legislative language, the bill is worth little more than the paper it is printed on.

Today's hearing will focus on some of the most important managed care issues—access to specialists, emergency room care, open communication, and information disclosure. While there is widespread agreement that any managed care bill must include provisions that address these issues, we are still a long way from agreeing on which approach would be best.

I believe our ultimate goal must be to tailor those provisions after the Patients' Bill of Rights legislation that was introduced by ranking member, Congressman Dingell, and similar to legislation introduced by Dr. Ganske. This bill—Congressman Dingell's bill—has over 180 co-sponsors, and it was endorsed by almost every major patient and provider group in the last Congress, because it takes the most sensible, reasonable and equitable approach to protecting patients.

I hope if there is one thing that we as Democrats and Republicans can agree on at the outset of these hearings, is that our ultimate goal must be to support the most sensible, responsible, and equitable policy that protects patients in managed care.

Mr. Chairman, again, I want to thank you for calling the hearing and getting the process started. And, hopefully, this year, we will be able to legislate in our committee—and as Dr. Norwood said, "win or lose," but we will at least be able to deal with the issue.

Thank you.

Mr. UPTON. Thank you.

The gentleman from Kentucky, Mr. Whitfield.

Mr. WHITFIELD. Mr. Chairman, thank you very much, and like the other members of this committee, I, too, am delighted that we are having this hearing to explore this subject in more detail.

The gentleman from New Jersey made the statement that the Republicans or the Republican bill, last year—I wasn't sure if he was talking about last year's bill or Republicans this year—are here to protect the insurance companies. And I would say that I think everyone on this committee, obviously, wants to protect patients and wants to make sure that they have the care that they need to take care of their medical situations.

But I also think that, not only do we need to look at the physician part of this, not only do we need to look at the patient part of this, but I think we also have a responsibility to look at any legislation that we pass, and what impact that legislation will have on the cost of a lot of small business men and women who provide healthcare for their employees.

Now all of us hear a lot about healthcare is unaffordable today. So, I think as we go through these hearings, I hope that we will take a balanced approach and do everything that we can to protect patients, but also to be aware that anything that we pass will, ulti-

mately, have an impact on the cost of healthcare. And I don't think anyone here wants to diminish the availability of healthcare to anyone.

So, I am delighted that we are having these hearings. As it says, these are educational hearings, and I think all of us will benefit from it.

Mr. UPTON. Thank you.

The gentleman from Ohio, Mr. Strickland?

Mr. STRICKLAND. Thank you, Mr. Chairman.

I am sitting here listening to my colleagues make their opening statements, and I am glad we are having this hearing, too, but I hope, you know, that we don't break our arms by patting ourselves on the back. Because the fact is that managed care needs to be reformed, but I am thinking that we have millions of uninsured in this country, and we are not dealing with that issue. We have millions of our children with no health coverage, and we are not dealing with that issue. I am glad we are dealing with managed care, but it troubles me that years have passed, Dr. Norwood—years have passed, and we all know what the problems are, because every last Member of Congress hears it from their constituents. And yet, we seem to be so timid in taking bold steps.

Last weekend, I visited the Franklin Delano Roosevelt Memorial for the first time, and I was struck, as I read the saying, "I see a Nation one-third ill-clothed, ill-fed, ill-housed." The fact is that, in the past, our country has had strong leaders who have looked at difficult situations and been willing to take strong action.

I yearn for the time when those of us who have the current responsibilities in this committee and in this Congress are willing to take the bold action that is necessary to do what we all know in our hearts to be the right thing to do.

Thank you, Mr. Chairman.

Mr. UPTON. The gentleman from Mississippi, Mr. Pickering.

Mr. PICKERING. Mr. Chairman, I, too, thank you for having this hearing.

I am new to this committee, and so I am here to listen today. I look forward to working with all the members and colleagues so that we can reach common ground and consensus that we can address the twin pillars of access and affordability, and I hope do the right thing for the country, for the healthcare and for our constituents.

Thank you, Mr. Chairman.

Mr. UPTON. The gentleman from Wisconsin, Mr. Barrett.

Mr. BARRETT. Thank you, Mr. Chairman; I appreciate your holding these hearings as well.

I am here to listen; I am here to learn. And, hopefully, we will get something done.

Thank you.

Mr. UPTON. The gentleman from Oklahoma, Mr. Coburn.

Mr. COBURN. Thank you, Mr. Chairman.

You know, we are very quick to criticize managed care. But I want to tell you, as a practicing physician, they brought a lot of positive things to our country. They have improved the practice of a lot of doctors. They have helped contain costs. There are significant problems, and the costs of managed care have been too great.

The No. 1 cost of managed care is loss of freedom and loss of quality healthcare in too many specific instances, not in total.

We can still utilize many of these concepts to help us deliver higher quality care to more people, and I think it is—to me, it is very bothersome. And I have discussed with Dr. Norwood and Dr. Ganske and several of the other physicians in the House. I think it is very dangerous that we try to apply the Soviet-style error of management of an economic model when it comes to healthcare. And my concern is, is we are forgetting the market. You know, we trust people in this country, individuals, to buy their homeowners' insurance; we trust them to make good decisions on their auto insurance; we trust them to make a wonderful number of other decisions about things that markedly affect their life, quality of life, and outcome of their life.

But we have decided we are not going to allow that. And so we are moving down a track, because of the problems that we presently see, and we are going to manage managed care more. Now, the points and the problems that are wrong with managed care can be fixed. But my caution to us, as we move into this—dare we fix it too much. You know, in 1996, we spent a trillion and 36 billion dollars in this country on healthcare. And somewhere between $150 and $200 billion of that didn't help anybody get well; $35 to $40 billion was defensive medicine, not to help anybody, but to prevent the caregiver from getting sued or to defend the caregiver.

In my practice alone, with my four partners, we have 33 employees, 11 of which do nothing but push paperwork around for either law firms, insurance companies, or the Government. That doesn't help anybody get well.

We have cost-shifted to where we can't cost-shift anymore. We have moved medicine out of the control of what is in the best interests of the patient, and put it in the best interests of pocketbooks.

I trust the market in this country; I trust that American consumers are smart. I think they ought to be given the opportunity to make decisions about their healthcare. I think we should no longer have a tax-deductibility for employers, unless it is given directly to the employee in some type of medical savings or medical IRA, so that we truly reinstitute choice. There is nothing more personal than making a choice about a physician that is going to invade your body. And to say that we live in the freest country in the world and you don't have that right in this country, is a contradiction of the term "freedom."

I appreciate that we are having this hearing. I would caution us to look at all aspects of healthcare. By and large, caregivers, physicians, managed care, insurance companies, do a great job in this country. We should not demonize any group as we go to improve the quality of product. And the one thing that should be there, that is lacking today, is utilizing the forces of supply and demand on this most precious resource, healthcare, so that it is allocated in the most proper and beneficial ways for every person in this country.

I yield back. Thank you.

Mr. BILIRAKIS. The gentleman from Florida for an opening statement.

Mr. STEARNS. Thank you, Mr. Chairman.

I think in all fairness, Mr. Chairman, that on many of these issues we can come to an agreement.

Do the patients have the access to emergency care—one of the key issues? Does managed care allow patients to choose their own physicians, including specialists? I think we can all come to some kind of agreement on this.

But I would point out to Mr. Ganske, it isn't like we didn't pass a bill. We did pass a bill, and Mr. Norwood also voted for that bill. Mr. Hastert, our present Speaker, put together a coalition, came up with a task force, and we did, indeed, out of the House, pass a bill dealing with protecting patients' access to quality care.

Did the bill satisfy everybody? No. Did it satisfy the Senate? No.

But Mr. Coburn has mentioned that 11 of his 33 employees spend all day long just with paperwork. We have got to be careful we don't pass legislation out of this committee, so that 5 years from now, 14 or 15 of his employees are just doing paperwork.

Now the crux of this bill, which as I understand is the problem is that if you allow lawyers to sue an HMO as well as the corporation behind the HMO, the corporation is going to get out of the business of selling healthcare.

For example, Wal-Mart—Wal-Mart does its own healthcare. So if I was an employee of Wal-Mart, I would get my healthcare through their HMO, which is controlled and operated by Wal-Mart. Now, if some of these bills that we have had presented in the Commerce Committee pass, Wal-Mart, the director of the healthcare plan, said it would get out of the business. Their corporation, Wal-Mart, would no longer be in the business because they don't want to be involved with suits dealing with directions that they made through their HMO. So we have got to come up with a compromise, some language that protects these corporations.

But in the end, I think we can reach an agreement, and I think Mr. Norwood's frustration that it takes so long, should be circumvented. We should get this done much quicker. And we need to urge the Senate to act, because in America, we don't necessarily have to get it right the first time. In fact, there is a book by Joshua Hammond called "The Seven Cultural Forces," that determine what our characteristics are. And, of course, the first one is "choice." All Americans want choice. But No. 5 is, we are willing to improvise; we don't have to get it right the first time, because we will come back the second time. So this idea of an incremental approach is not all bad. We don't have to have the whole enchilada in one bill; we can move it forward, get something in place, and then move a little bit further along, and get this committee to try and pass something again, on the lines of the Hastert bill, and I urge the Senate to do the same.

And, Mr. Chairman, I ask my written statement be made part of the record.

Mr. BILIRAKIS. Without objection, the written statements, I have already said, are all part of the record.

[The prepared statement of Hon. Cliff Stearns follows:]

PREPARED STATEMENT OF HON. CLIFF STEARNS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Thank you, Chairman Bilirakis, for holding this important hearing.

This is the first in a series of hearings on how to resolve some of the problems associated with managed care. The first panel will address whether patients have sufficient access to emergency care under managed care; and does managed care allow patients to choose their own physician, including specialists. This is particularly important to patients with disabilities or chronic illnesses.

One of our witnesses, Mr. Peter Thomas, will discuss why such access is vitally important to person's with disabilities or chronic illnesses.

Mr. Chairman, the American people want us to take action to address the needs of patients by enacting legislation to make health care more accessible, more affordable and more accountable. These are not unreasonable demands.

I agree with these principles and I am anxious to hear from our distinguished panel of witnesses so that we can have the benefit of their expertise about possible solutions to correct the most egregious complaints made by the public against HMOs.

Our second panel will focus on issues related to medical communication and the disclosure of health plan information. I have heard from health care providers in my district that managed care prevents them from providing their patients with the vital information they need to make truly informed decisions with respect to their options. This would include information about the basic benefits being offered by a given plan. Most patients rely on their doctors for such guidance.

This brings us to the issue of medical necessity. Should an insurance company make such decisions for individuals, or should these decisions be made by the patients in consultation with their physicians?

There is one important issue that must also be looked at in the context of patient protection.

In the 104th Congress, we enacted the Health Insurance Portability and Accountability Act, a very important provision in that legislation was the inclusion of "genetic information" in the definition of health status.

That was an important first step. However, we now need to define what we mean by genetic information.

We have an opportunity to expand this safeguard. Last year the Senate took such a step by including such language in its patient protection measure.

It is noteworthy that the Senate has again included such a provision in its Patient Bill of Rights Plus Act.

While I recognize that the bill we passed in this Committee and on the House Floor in the last Congress did contain safeguards for medical records, I do not believe it went far enough. I have drafted legislation to do just that.

The question of confidentiality of one's medical records is something that should concern us all. I believe the Subcommittee should hold hearings to ascertain whether it would be advisable to provide special protections to safeguard such sensitive information. We need to ensure that technological advances in genetic testing proceed while at the same time protecting the interests of the individual.

While we all have errors in our genetic blueprint, for most of us it does no harm—but for many the onset of disease is devastating. We owe them a level of privacy and the hope for treatment and cures.

I know that today's hearing will focus on a broad array of issues relating to managed care delivery not the least of which is a patient's right to have all their medical records protected from the misuse of such information.

Mr. BILIRAKIS. Mr. Greenwood, any opening statement, Jim?

All right, thanks.

Okay. Well, then why don't proceed with the first panel? Again, your written statements, as per usual, are parts of the record. I will turn the 5-minute——

Mr. BROWN. Mr. Chairman, I would like to ask unanimous consent to enter into the record a statement from Mr. Cardin who has been very involved in the prudent layperson issue, if I could ask unanimous consent.

Mr. BILIRAKIS. Without objection, that will be made a part of the record.

[The prepared statement of Hon. Benjamin L. Cardin follows:]

PREPARED STATEMENT OF HON. BENJAMIN L. CARDIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Good afternoon, Mr. Chairman and Members of the Subcommittee. I commend Chairman Bilirakis for holding this hearing on patients' rights. One of the most fundamental of these rights—one that this Congress seemed to have reached agreement on nearly two years ago—is the right to access needed emergency services.

In the 104th and the 105th Congresses, I introduced the Access to Emergency Medical Services Act. This legislation would establish the "prudent layperson" definition of emergency as the standard for insurance coverage for emergency services under group health plans, health insurers, and the Medicare and Medicaid programs. Health plans would be required to cover and pay for emergency care based upon the patient's symptoms rather than the final diagnosis. The examination is tied to the federal law of EMTALA, which includes the screening and any stabilization services that are necessary. In addition, the legislation would prohibit health plans from requiring that patients obtain prior authorization before seeking emergency care. The bill would also help promote quality, cost-effective care by requiring that health plans and emergency physicians work together to coordinate any necessary follow-up care. At the end of the last Congress, this bill had secured 241 cosponsors and the endorsement of 46 health care organizations.

The prudent layperson definition requires a health plan to pay for treatment rendered when a patient experiences:

> "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part."

In the Balanced Budget Act of 1997, Congress did indeed guarantee this right to Medicare and Medicaid patients enrolled in managed care plans. Then in February 1998, the President extended this right to all persons in federal health programs, including FEHBP, veterans and military enrollees. So as enrollees in FEHBP plans, all members of Congress have been guaranteed this important patient protection. Twenty-six states have also passed laws establishing this standard. But to protect residents of the twenty-four states that have not passed a prudent layperson standard, and for the 48 million persons who are enrolled in ERISA self-insured plans, Congress must act.

But simply inserting the words "prudent layperson" into a bill does not ensure access to appropriate emergency care. During the House debate on The Patient Protection Act (H.R. 4250) in the 105th Congress, some Members insisted that it contained the same emergency care standard that was provided for in the Balanced Budget Act. In October 1998, thirty Members who had voted for H.R. 4250 recognized that the language was not the same and wrote the Speaker asking that the true prudent layperson standard—reflecting the BBA provisions and consistent with EMTALA—be included in any patients' rights legislation that moved forward.

Regrettably, the 105th Congress adjourned without additional action on HMO reform. Millions of Americans enrolled in managed care plans were frustrated by our inability to send a bill to the President's desk, but remained hopeful that Congress would produce effective patients rights legislation when it convened this year.

However, The Patient Protection Act of 1999 (H.R. 448), which was introduced on February 2, is just cause for any private health plan enrollee to be alarmed. Its emergency services provisions are wholly inadequate. Its language *still* fails to replicate the benefits enumerated in BBA; in fact, the provisions in that bill are even worse than those introduced last year.

HR 448:

- defines emergency care as a situation in which "*an appropriate physician* has certified in writing that failure to immediately provide the care to the participant or beneficiary could reasonably be expected to result in placing the health of such participant or beneficiary . . . in serious jeopardy, serious impairment to bodily functions; or serious dysfunction of any bodily organ or part . . ."
- does *not* include "severe pain" as a qualifying symptom for emergency care;
- provides for only an "*initial screening examination*" and then introduces the new concept of the "prudent emergency medical professional" as the person who determines if the patient should be stabilized;
- does *not* protect patients against unreasonable copayments for care obtained at a facility that does not contract with the health insurer. To the contrary, it specifies that plans will have the ability to charge *whatever* they want for such visits.

I have reintroduced the Access to Emergency Medical Services Act in the 106th Congress, again with Rep. Marge Roukema as the original Republican cosponsor and strong bipartisan support. This year's bill number is H.R. 904; its companion bill in the Senate is S. 517. I encourage all members of Congress to study this issue carefully, talk with their constituents, and support this fundamental legislation.

I am pleased that Dr. Nancy Auer will testify today on behalf of the American College of Emergency Physicians, the organization that represents front line emergency care providers. I look forward to their statement and urge members of the subcommittee to insist on an authentic prudent layperson standard that ensures the millions of unprotected managed care enrollees access to the full range of services their acute emergency conditions require.

Mr. BILIRAKIS. So, anyhow, I will turn the 5-minute light on, and I would appreciate if your oral statement would be—could hope you could hold it as close to 5 minutes as you possible can.

Let's see, let's start out with Dr. Auer. Would you please proceed?

STATEMENTS OF NANCY J. AUER, FORMER PRESIDENT, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, MEDICAL DIRECTOR OF EMERGENCY SERVICES, SWEDISH MEDICAL CENTER; JOSEPH BRAUN, CHIEF MEDICAL OFFICER, GEORGE WASHINGTON UNIVERSITY HEALTH PLAN, REPRESENTING THE AMERICAN ASSOCIATION OF HEALTH PLANS; AND PETER W. THOMAS, FORMER CHAIR, SUBCOMMITTEE ON CONSUMER RIGHTS, PROTECTIONS, AND RESPONSIBILITIES, PRESIDENT'S ADVISORY COMMISSION, CONSUMER PROTECTION AND QUALITY IN THE HEALTH INDUSTRY

Ms. AUER. Thank you.

I am Dr. Nancy Auer; I am the immediate past president of the American College of Emergency Physicians, and I am medical director of Emergency Services at Swedish Medical Center, in Seattle. I am here today representing the concerns of nearly 20,000 emergency physicians and our patients.

Each year, 100 million people go to emergency departments—almost 1 in every 3 Americans. Emergency care is available 24 hours a day, 7 days a week, and emergencies aren't scheduled. Thanks to the advancements of the past 30 years, if you have an emergency, you will be cared for by highly trained specialists using advanced diagnostic technology and the most effective medical techniques.

Today, Congress is debating how to resolve some of the problems in managed care, one of today's most important healthcare issues. The growing sentiment about the shortcomings in managed care is what led the House to pass H.R. 4250 in the 105th Congress.

That measure would have established a narrow set of patient protections and created a second-tier test by covering emergency care only if a prudent medical professional agreed with the treating physician's judgment. In effect, it would have created a double standard—one for Americans participating in Medicare and Medicaid, and a weaker standard for those Americans who pay for their insurance.

What we need now is a uniform Federal standard. All of us want to know that when we have an emergency, we will get the best care possible without delay. That is why, almost 15 years ago, Congress passed the Emergency Medical Treatment and Active Labor Act,

otherwise known as EMTALA, in section 18-67 of COBRA, "to protect patients in emergency situations." The law guarantees that every person who comes to an emergency department will receive a medical screening exam and be stabilized if he has an emergency medical condition, regardless of ability to pay. In effect, EMTALA designates emergency departments as America's healthcare safety net.

Back in 1986, the concern was that the poor and uninsured were being "triaged" away from hospitals for financial reasons. Today, however, the new victims of "economic triage" are often the people who are fully insured. These hardworking Americans pay for their health insurance, including emergency services, and then are denied payment for those services after the fact.

Many managed healthcare plans ignore EMTALA's definition of "emergency care." They do so by denying reimbursement because prior authorization was not obtained. They use narrow and unreasonable definitions of "emergency" to justify retrospective denial of payment. They deny claims by basing coverage on the final diagnosis, rather than considering the patient's initial symptoms.

These tactics put patients in terrible dilemmas. If a patient has chest pains, should he take the precious time to call a managed care plan for approval before going to an emergency department? Or, should he try to self-diagnose the severity of the illness? If he doesn't make the right choice, it could mean being stuck with a big bill, or even worse. What if he chooses wrong and fails to get treatment for what could be a fatal heart attack?

And for anyone who doubts that this is happening, let me put a face on this problem. In my home State of Washington—the "other" Washington—the insurance commissioner found more than 700 inappropriate emergency care denials by 4 major health carriers in the first 4 months of 1998. In one case, a Seattle woman could not drive home because of chest pain and numbness and sought help at a fire station. The medics took her to the emergency department of the nearby hospital where she was treated and admitted. Yet her managed care company denied coverage because it was not pre-authorized.

For the past 4 years, ACEP has led the fight to establish "prudent layperson" as the national standard for coverage of emergency services. Congress included the standard Medicare and Medicaid beneficiaries in the 1997 Balanced Budget Act. This standard protects Medicare and Medicaid beneficiaries.

Last February, the prudent layperson standard was extended to all Federal employees via the President's Executive Order; 27 States have already adopted the prudent layperson language, but even if every State in the Union were to pass similar legislation, it would not cover everyone, especially the 48 million who are in self-insured ERISA plans. These plans are generally immune from State enactments.

Once a patient's emergency medical condition is stabilized, there are still decisions that must be made related to the patient's need for additional care. ACEP is an advocate for uniform ground rules for coordinating a patient's post stabilization services between emergency physicians and managed care plans. The attending emergency physician and the patient's health plan must work to-

gether in a timely manner to coordinate appropriate care—not via voice mail and not via answering machine.

ACEP has worked with many Members of Congress to develop appropriate language.

Mr. BILIRAKIS. Would you please summarize, Doctor?

Ms. AUER. H.R. 904——

Mr. BILIRAKIS. Thank you.

Ms. AUER. [continuing] The Access to Emergency Medical Services Act and S. 517, the Senate companion bill, best achieve the objectives consistent with EMTALA and the protections of the Balanced Budget Act. In addition, the bills proposed by Representatives Ganske, Norwood, and Dingell contain the same language.

If the language in these bills is enacted, it would establish a uniform national definition of "emergency," based on the prudent layperson standard, ensuring that health plans cover emergency care, based on the patient's symptoms rather than the final diagnosis and eliminating requirements for prior authorization.

In addition, these bills promote quality, cost-effective care by establishing a process in which the emergency physician and the health plan work together in a coordinated fashion.

We urge Congress to extend these protections to the 161 million Americans in private health insurance, as Congress did for Medicare and Medicaid beneficiaries, and not for just the 48 million in self-insured health plans, so there is a uniformed standard.

Mr. BILIRAKIS. Doctor, you are going to have to summarize.

Ms. AUER. We appreciate——

Mr. BILIRAKIS. I am sure with all the questioning——

Ms. AUER. Yes, sir.

Mr. BILIRAKIS. [continuing] you will be able to get many points across.

Ms. AUER. We appreciate these hearings, and we urge you to adopt legislation that includes the language consistent with the Balanced Budget Act, and we appreciate the opportunity to work with your committee.

Mr. BILIRAKIS. Thank you.

Ms. AUER. Thank you.

[The prepared statement of Nancy J. Auer follows:]

PREPARED STATEMENT OF NANCY J. AUER, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

Thank you very much. I am Dr. Nancy Auer, immediate past president of the American College of Emergency Physicians, and First Vice President of the Washington State Medical Association. I'm here representing the concerns of nearly 20,000 emergency physicians and their patients in the United States.

Today Congress is debating how to resolve some of the problems of managed care, one of today's most important health care issues. In recent years, more and more Americans have enrolled in managed health care plans. These plans vary in their design and in the benefits they cover.

We have all witnessed the growth of health maintenance organizations (HMOs), point-of-service plans (POSs), preferred provider organizations (PPOs), and other systems that have all but replaced traditional fee-for-service medicine.

The explosive growth in managed care affects enrollees in state-regulated insurance plans, those covered by the Employee Retirement Income Security Act (ERISA) of 1974, Medicare and Medicaid, and others.

For many, managed care has delivered on the promise of improved quality of care at restrained prices, at least initially. Of course, the changes in our health care delivery and financing systems have left untouched the 42 million Americans who have no insurance coverage at all.

Managed care's growth has not been without serious shortcomings. Many enrollees often are unclear about their coverage, the cost of in-network versus out-of-network care, which hospitals are in a plan, and which doctors they may see.

It is this confusion that has heightened their frustration with the "system" and resulted in 30 states enacting laws and promulgating regulations in the last 2 years to provide broad protections for consumers of managed health care plans. These state efforts and the demand for Congressional action are among the reasons why Congress has been challenged to take up legislation to address some of these problems.

It was that growing sentiment that led to passage of H.R. 4250 in the 105th Congress.

That measure would have established a narrow set of patient protections and created a second-tier test by covering emergency care only if a "prudent medical professional" agreed with the treating physician's judgement. In effect, it would have established a double standard—one for Americans participating in Medicare and Medicaid and a weaker standard for hard-working Americans who are paying for their insurance.

I am prepared today to discuss with the Subcommittee some of the problems that enrollees in managed care health plans are having. In particular, I want to tell you firsthand about the problems that managed care patients are having every day when they come to the emergency department.

Each year, approximately 100 million patients go to the emergency department that's almost one in three Americans. Emergency care is available 24 hours a day, 7 days a week. Strokes, car accidents, heart attacks, and other health care emergencies are of course, unpredictable. And today, thanks to the advancements of the past 30 years, if you have an emergency, you will be cared for by highly trained specialists using advanced diagnostic technology and the most effective medical techniques.

Congress historically has protected the rights of patients when it comes to emergency care, realizing that emergency situations are unique.

All of us want to know that in a life- or health-threatening emergency, we will get the best possible care without any delay. That's why, almost 15 years ago, Congress passed the Emergency Medical Treatment and Labor Act, otherwise known as EMTALA, to protect patients in emergency situations.

The law guarantees that each person who comes through the doors of an emergency department will receive a medical screening exam and be stabilized if he or she has an emergency medical condition, regardless of their ability to pay. In effect, EMTALA designates emergency departments as America's health care safety net.

Violation of EMTALA can result in a $50,000 fine for the physician and expulsion from participating in the Medicare and Medicaid programs.

Back in 1986, the concern was that the poor and uninsured were being transferred to county or public hospitals for financial reasons. This system of "economic triage" endangered many and cost some patients' their lives.

Today, however, the new victims of "economic triage" are often the people who are fully insured. These are hard-working Americans who pay for their health insurance—including emergency services—and then are denied payment for those services, after the fact.

Many managed health care plans are reluctant to follow EMTALA's definition of emergency care. They do so by denying reimbursement because prior authorization was not obtained. And in cases when additional care may be required, during the post-stabilization phase, emergency physicians often find it impossible to reach anyone at a health plan.

To be specific, the managed care industry has adopted tactics that interfere with a patient's right to access to emergency care.

They use narrow and unreasonable definitions of emergency to justify retrospective denial of payment.

They deny claims by basing coverage on the final diagnosis, rather than considering the patient's initial symptoms.

These tactics put patients in a terrible dilemma. For example, if a patient has chest pain, should he or she take precious time to call a managed care plan for approval before going to an emergency department? Or should he or she take a chance and try to diagnose the severity of the illness? If he or she doesn't make the right choice, it could mean being stuck with a big bill, or even worse, risking health and failing to get treatment for what could be a serious or life-threatening condition.

And for anyone who doubts that this is happening, let me put a face on this problem.

In my home state of Washington, the State Insurance Commissioner investigated more than 700 emergency care denials by four major health carriers in 4 months

of 1998 and found that more than half of the denials were unlawful. In one case, a Seattle woman could not drive home because of chest pains and numbness and sought help at a fire station. A firefighter took her to the emergency department of a nearby hospital, where she was treated and admitted. Yet her managed care company denied coverage, because it was "not preauthorized."

A 15-year-old girl with a broken leg was taken to a hospital emergency department by her parents. The family's insurance company denied claim, ruling it was not an emergency.

A 17-year-old victim of a beating suffered serious head injuries and was taken to an emergency department. The insurer rejected payment for a CAT scan because again there was no prior authorization.

These are not TV episodes on "ER." These are real people with real lives.

For the past four years, ACEP has led the fight to establish the "prudent layperson" as the national standard for coverage of emergency services and fought to eliminate restrictive "prior authorization" requirements.

The prudent layperson standard would require health plans to cover emergency services based on a patient's presenting symptoms rather than on his or her final diagnosis. It would also prohibit health plans from requiring patients to obtain prior authorization before seeking emergency care.

Congress included this standard for Medicare and Medicaid beneficiaries in the 1997 Balanced Budget Act. These safeguards will help protect Medicare and Medicaid beneficiaries. ACEP is concerned, however, that the provisions of the BBA are not being uniformly enforced. ACEP and others have received information that some managed care organizations under contract with State Medicaid programs and Medicaid managed care plans are failing to fully follow the provisions of the BBA.

Last February, the prudent layperson standard was extended to all federal employees via the President's Executive Order. Twenty-six states also have already adopted some form of the "prudent layperson" standard—but even if each state in the union were to pass similar legislation, it would not cover everyone, especially the 48 million who are in self-insured ERISA plans. These plans are generally immune from state enactments.

Once a patient's emergency medical condition is stabilized, there are still decisions that must be made related to the patient's care. ACEP is an advocate for uniform ground rules for coordinating a patient's "post stabilization" services between emergency physicians and managed care plans. It is important that the attending emergency physician and the patient's health plan work together in a timely manner and effectively to coordinate appropriate care.

These are issues we see every day in the emergency department.

As the nation's largest and oldest representative body for emergency physicians, the American College of Emergency Physicians urges you to adopt meaningful patient protection legislation that includes the prudent layperson standard for coverage of emergency services.

ACEP has worked with a number of members of Congress to develop appropriate language. HR 904, the Access to Emergency Medical Services Act, and S. 517, the Senate companion bill, best achieve the objectives consistent with EMTALA and the protections accorded by the BBA. In addition, the bills proposed by Reps. Ganske (HR 719), Norwood (HR 216), and Dingell (HR 358) contain the same language.

If the language of these bills is enacted, it would establish a national uniform definition of emergency based on the prudent layperson standard, ensuring that health plans cover emergency care based on a patient's symptoms, rather than his or her final diagnosis, and eliminating requirements for prior authorization for emergency care.

In addition, these bills help promote quality cost-effective care by establishing a process in which the emergency physician and health plan work together to coordinate appropriate post-stabilization care or followup care.

The treating emergency physician and the health plan would be required to make timely communications concerning any medically necessary post-stabilization care identified as a result of a federally required screening examination. Plans, in conjunction with the treating physician, may arrange for an alternative treatment plan that allows the health plan to assume care of the patient after stabilization.

We urge Congress to protect patients in emergency situations by allowing them to go to the nearest emergency room without incurring additional costs or co-payment charges.

We urge you to adopt uniform ground rules for coordinating "post stabilization" services between emergency physicians and managed care plans in order to provide patients with appropriate and timely care.

And finally, we urge you to extend these protections to all 161 million Americans in private health insurance, as the Congress did for Medicare and Medicaid bene-

ficiaries in the BBA of 1997, and not just for the 48 million people in self-insured health plans.

ACEP appreciates that hearings are being held to address the problems faced by emergency care patients, and we look forward to an appropriate remedy. ACEP is prepared to work with the Subcommittee and the full Commerce Committee toward that end.

Thank you, and I would be happy to answer any questions.

Mr. BILIRAKIS. Thank you very much.

Dr. Braun.

STATEMENT OF JOSEPH BRAUN

Mr. BRAUN. Mr. Chairman, and members of the committee, my name is Joseph Braun, and I am the chief medical officer of the George Washington University Health Plan, in Bethesda, Maryland. GW Health Plan serves 86,000 members in both its commercial and Medicaid plans throughout DC, Virginia, and Maryland.

Today, I am testifying on behalf of the American Association Health Plans, which is the national trade association representing HMO's, PPO's, and network-based plans throughout the United States.

Through their internal quality improvement programs, health plans have taken great strides in improving the health of millions of Americans. And through designing their provider networks and referral processes, health plans have effectively responded and continue to respond to their members' preferences in accessing specialty care.

Plan initiatives in this area vary greatly, but they all have a couple of things in common. They are in direct response to consumer preferences, a clear indication that the market is working, and they differ greatly from the one-size-fits-all approaches that certain legislative proposals take.

For example, GW Health Plan offers POS members the option to self-refer for a visit to a specialist. We also do not restrict referrals from the PCP to a specialist in any way and provide direct access to OB/GYN care for women. But our approach preserves the role of the primary care provider in that any treatment recommended by the specialist must be coordinated through the individual's personal physician and the plan to ensure that it doesn't conflict with other care the individual is receiving and to ensure that the care is consistent with the individual's medical history and treatment plan.

An examination of the facts clearly show how well health plans provide access to specialists. Studies on a range of conditions show that health plans provide equal or greater access to specialty care than is provided under fee-for-service coverage. And equally if not more important is the fact that studies show quality of the care delivered in health plans to be equal or better than that delivered under fee-for-service coverage.

These findings remain true, with respect to special populations as well, such as women, children, and the chronically ill.

For example, women in healthcare plans are more likely to obtain mammograms, pap smears, and clinical breast exams, and have their cancer diagnosed at an earlier and, therefore, more treatable stage, than women in fee-for-service. The vast majority of health plans offer women members self-referral for routine care.

Children in health plans are more likely to receive appropriate immunization schedules.

And, finally, teams of health professions specialized in a given illness carry out disease state management programs that have helped millions of Americans with such chronic conditions as asthma, diabetes, and congestive heart failure, manage their condition, and improve their overall health status.

To underscore our members' longstanding commitment to the quality of care, over 2 years ago, AAHP began an important nationwide initiative we now call our "Code of Conduct." AAHP's Code of Conduct sets forth specific health plan policies in a number of areas, including access to specialty care and emergency care. As a part of the Code of Conduct, health plans have pledged to have procedures to promote timely and appropriate access to specialty care and periodically evaluate these procedures with reference to selected medical conditions.

Health plans have also pledged to cover emergency room screening and stabilization as needed for conditions that reasonably appear to constitute an emergency, based on the patient's presenting symptoms.

Initiatives like AAHP's Code of Conduct are a part of a much larger vision that is being proposed by the various bills before our Congress, one that takes a broad view of quality and the challenges we face systemwide.

The issues that we face today, such as how to expand access to affordable care and how to preserve and promote innovation, can only be addressed by broadening our policy decisions and discussions that address systemic changes and challenges that extend across all types of delivery systems, providers, purchasers, and consumers.

Consistent with this broader vision, AAHP's board of directors has adopted a set of policy principles which I have also included as part of my written statement. These policy principles emphasis the importance of doing no harm, keeping coverage affordable, and expanding access to all Americans.

I urge you, the committee, to consider this broader vision, in its deliberations and avoid the micro regulation that will only serve to reduce quality, stifle innovation, increase costs, and increase the number of uninsured.

I thank you for this opportunity to address this panel.

[The prepared statement of Joseph Braun follows:]

PREPARED STATEMENT OF JOSEPH BRAUN, CHIEF MEDICAL OFFICER, THE GEORGE WASHINGTON UNIVERSITY HEALTH PLAN, ON BEHALF OF THE AMERICAN ASSOCIATION OF HEALTH PLANS

Mr. Chairman and members of the Committee, my name is Dr. Joseph Braun, and I am chief medical officer of the George Washington University Health Plan in Bethesda, Maryland. The George Washington University Health Plan has approximately 86,000 members in both its commercial and Medicaid plans throughout the District of Columbia, Virginia, and Maryland.

I am testifying today on behalf of the American Association of Health Plans (AAHP). AAHP is the national trade association representing HMOs, PPOs, and other network-based health plans throughout the United States. The Association represents approximately 1,000 member plans serving more than 140 million Americans—over half of the population of the United States. AAHP and its member plans are dedicated to a philosophy of care that puts patients first by promoting coordinated, comprehensive, quality health care.

I appreciate the opportunity to participate in today's hearing, which is intended to provide insight into Americans' access to quality medical care. I have focused my remarks in the following four areas: I. Health plans' contributions and commitment to improving quality; II. Current requirements with respect to health plan provider networks; III. Some of the prevailing myths and misunderstandings about health plans and members' access to quality care that have skewed the current debate, and examples of health plan initiatives and innovations in improving patients' access to appropriate providers and quality care; and IV. The need for a broader vision of quality and access in the health care system.

I. HEALTH PLANS' CONTRIBUTIONS AND COMMITMENT TO IMPROVING QUALITY

When evaluating patients' access to care, it is important to recognize that access to care has little meaning unless we're talking about access to *quality* care. AAHP's member plans are proud of their track record in improving quality and are concerned that the current debate often has overlooked important dimensions of quality and how it continually can be improved. To address these concerns, I would like to take a few minutes to put today's discussion in context. The fact is that health care in America is getting better. And it is getting better, in large part, because of the contributions of health plans.

Health plans have offered a different vision Bone that involves undertaking quality-enhancing activities that simply could not be done under fee-for-service coverage. For example, plans have established formal internal programs to monitor quality and are dedicated to continuous improvement. Let me be specific.

• **Health Promotion and Disease Prevention.** Health promotion and disease prevention activities improve quality by identifying members at risk of certain illnesses or eligible for certain services and reaching out to those members to educate them and encourage them to seek care. These types of activities have led to demonstrable results in numerous areas:

- Women in Medicare HMOs are more likely to have their breast cancer diagnosed at an earlier and therefore more treatable stage than women in Medicare fee-for-service. (*Journal of the American Medical Association, 1999*)
- Women in HMOs are more likely to obtain mammograms, pap smears, and clinical breast exams than women in fee-for-service plans. (*CDC/NCHS, 1994; Physician Payment Review Commission, 1996; Journal of the American Medical Association, 1999*)
- The New York State Department of Health found that immunization rates for children under age two enrolled in commercial health plans increased from 78% in 1994 to 86% in 1995. (New York State Department of Health, *1995 Quality Assurance Reporting Requirements, 1997*)
- 61% of smokers age 18 and over in health plans received advice to quit smoking from a health professional, compared with 37% of fee-for-service enrollees. (NCQA, *The State of Managed Care Quality, 1997*)

• **Disease Management.** Disease management activities improve quality by identifying members who have been diagnosed with certain chronic conditions and coordinating and monitoring their care. Through disease management activities, health plans have worked with physicians and other practitioners to improve health outcomes for millions of individuals with chronic conditions such as asthma, diabetes, and congestive heart failure, among others.

- Asthma disease management programs are designed to: inform consumers about how to manage their condition; promote appropriate use of asthma-related equipment; promote adherence to asthma care guidelines; improve overall health outcomes; reduce emergency room visits and hospitalizations; and reduce the number of absences from school and work.
- Diabetes disease management programs are designed to: inform consumers about how to manage their condition; ensure delivery of appropriate preventive screenings; promote adherence to diabetes care guidelines; improve overall health outcomes; ensure regular vision screenings and foot exams; monitor blood sugar levels; and promote nutrition education.
- Congestive heart failure disease management programs are designed to: provide lifestyle education that includes nutrition, exercise, and relaxation techniques; improve overall health outcomes; reduce hospital admissions; and monitor weight and cholesterol levels.

• **Clinical Quality Improvement and Research Programs.** Health plans also have quality improvement and research programs. These programs monitor trends in health care, determine which treatments produce the best health outcomes, establish quality improvement goals, and define the process for making any needed improvements. In addition to individual plan activities, health plans, through their

membership in AAHP, are part of a public-private partnership with the Agency for Health Care Policy and Research (AHCPR) to provide funding to researchers to assess the relationship between health plans, health outcomes, and quality of care for patients with chronic diseases. Chronic diseases to be studied include diabetes, cardiovascular disease, and HIV/AIDS. The research will also focus upon special populations, such as children and minorities, who suffer from these diseases.

Examples of how plan quality improvement and research programs have benefited and will continue to benefit millions of patients are too numerous to mention. Below are just a few:

- Medicare HMO enrollees are not only diagnosed at early stages as mentioned above, but they are also more likely to receive breast-conserving surgery (as opposed to mastectomy) and HMO enrollees receiving breast-conserving surgery are significantly more likely to receive radiation therapy. *(Journal of the American Medical Association, 1999)*
- The process and outcomes of cardiovascular care in HMOs are better than or equal to care in non-HMO settings. Of 15 measures and subscales measuring overall *process* of care, 60% indicated better care for HMO patients, 33% indicated no statistically significant difference, and only 7% indicated better care for patients in non-HMO settings. Of 43 measures and subscales of *overall* outcome measures, 10% indicated better care for HMO patients, 90% found no statistically significant difference in outcomes, and none indicated better performance in non-HMO settings. *(Medical Care, 1998)*
- Fee-for-service appendicitis patients are 20 percent more likely to suffer a ruptured appendix than HMO patients. *(The New England Journal of Medicine, 1994)*
- Prenatal care in HMOs surpasses the national average in key areas, such as women having their first prenatal care visits during their first trimester and having their blood pressure measured at every visit. *(Archives of Family Medicine, 1994)*
- HMO patients treated in intensive care units have a statistically significant lower level of mortality than patients in traditional fee-for-service. *(Journal of the American Medical Association, 1996)*

• **Member Satisfaction.** Nationwide, well over 90 percent of all health plans conduct member satisfaction surveys. Based on members' input, health plans modify their operations to meet members' changing needs. Health plans have adapted member orientation programs, providers' office hours, referral procedures, health education classes, and many other plan design features to accommodate member preferences. For example:

- Many health plans have responded to consumer input by offering women members the option to select ob/gyns as their primary care physicians or offering self-referral for routine ob/gyn care.
- Many health plans have responded to consumer input by developing streamlined referral procedures for access to specialty care.
- Many health plans have responded to consumer input by designing coverage options, such as point-of-service plans, with out-of-network benefits.
- Many health plans have revamped their member services to be more responsive to their members' needs. These initiatives include efforts to provide round-the-clock advice hotlines staffed by registered nurses and offering personal service representatives for new members.

• **Clinical Practice Guidelines.** As Robert Brook of the RAND Corporation has noted, Amedicine is largely practiced from memory, in chaotic systems without built-in safeguards. It is simply not realistic to expect a physician to recall the full breadth of his or her training and knowledge at any given time" *(The Lancet, 1995).* To help inform physicians about evidence-based exemplary practices, health plans disseminate and promote the use of practice guidelines.

• **Utilization Review.** Through utilization review, plans assess the medical appropriateness of a suggested course of treatment for a particular patient for the purpose of coverage decisions. In doing so, plans are able to monitor under- and over-utilization of services—encouraging the provision of appropriate care and discouraging the provision of inappropriate care.

• **Credentialing.** Before health plans contract with physicians and other health care providers, they examine their credentials to determine clinical competence and to ensure that the providers meet the organization's criteria. The credentialing process involves a review of providers' educational background and verification of board certification and licensure. Plans also check physicians' hospital privileges, malpractice history, and malpractice insurance. Plans recredential health care providers

regularly, typically every two years. This process is a key factor considered by individuals and employers when evaluating health plans.

• **Profiling.** Many plans use practitioner profiling as a method of quality improvement. Profiling focuses on an individual practitioner's patterns of care rather than that practitioner's specific clinical decisions and compares the patterns to those of peers and to exemplary practice patterns.

II. CURRENT REQUIREMENTS FOR HEALTH PLAN PROVIDER NETWORKS

The issue of network adequacy has been raised consistently. It is important to understand that provider network adequacy is addressed in numerous forums. For example, states require plans to contract with an adequate number and type of specialists, and further stipulate that plans make arrangements with out-of-network providers at no additional cost when a qualified network provider is not available. On the federal level, the Federal HMO Act requires HMOs to maintain a network that is adequate to provide 90 percent of the services generated by an HMO's members. In addition, private accreditation organizations, such as the National Committee for Quality Assurance (NCQA), require that plans maintain a network of sufficient number and types of providers in order to be accredited. Similarly, employers frequently include network adequacy among the requirements for health plans with which they contract.

III. THE TRUTH ABOUT HEALTH PLANS AND ACCESS TO QUALITY CARE

The results of plans' quality-enhancing efforts are demonstrable. Unfortunately, the current debate regarding health plan members' access to high-quality care has been based on a great deal of misunderstanding, and has not focused on the issue of the quality of care received by health plan members. It has become fashionable for health plan opponents to promote legislation by developing caricatures of health plan practices based on anecdotes, and rarely are the facts about the quality of medical care delivered to health plan members considered, or even offered. These omissions harm patients by misleading them about their health care system and what to expect. However, the record refutes these myths.

Proponents of some of this legislation have singled-out several specific patient populations, including women, the chronically and acutely ill, and children, in their anecdotes, claiming that these populations do not have appropriate access to the specialized and often complex care that they require. However, these claims do not hold up under closer examination. Through their continuous quality improvement activities and innovative initiatives, health plans promote high-quality, appropriate care for all of their enrollees, including women, children, and the chronically ill, and are proud of the results they have achieved so far. Some of these results are discussed in detail below.

A. Women's Experience in Health Plans

While some claim that women do not have appropriate access to obstetrical, gynecological, and other care, the facts show otherwise. National studies show that health plans provide equal or greater access to specialty care than is provided under fee-for-service coverage. In particular, the availability of obstetricians and gynecologists has resulted in positive health outcomes for women enrolled in health plans. For example:

- Women in HMOs are more likely to obtain mammograms, pap smears, and clinical breast exams (62% vs. 50%, 65% vs. 53%, 71% vs. 61%, respectively) than are women in indemnity plans, according to a study of cancer screening among women conducted by the Centers for Disease Control and Prevention. (*CDC/NCHS Advance Date No. 254,* August 1994)
- A study of survival and treatment rates among breast cancer patients aged 65 and over enrolled in two Medicare HMOs found that women enrolled in HMOs had 10-year survival outcomes at least equal to and possibly better than women in the fee-for-service Medicare program, according to research conducted by the National Cancer Institute and HCFA using data from 1985-1994. In addition, women in the two HMOs were more likely to receive breast-sparing surgery and adjuvant radiotherapy. (*Journal of the National Cancer Institute,* November 1997)
- Among elderly women with breast cancer, 72.3% of HMO patients had their cancer diagnosed at the two earliest stages, compared with 66% of fee-for-service patients. (*American Journal of Public Health,* 1994)
- A RAND Corp. study of 24,000 births to women in HMOs showed that prenatal care is "quite good" overall and that it surpasses the national average in six key areas. For instance, 87% of women had their first prenatal care visits dur-

ing the first trimester, compared with the national average of 76%. Also, infants born to women in HMOs had a low birthweight rate of only 5%, compared to 7% nationwide. (*Archives of Family Medicine,* January 1994)

- 81% of HMOs offer women the choice of an ob/gyn as their primary care provider or allow women to self-refer to one for routine ob/gyn care, according to research sponsored by the Kaiser Family Foundation (GHAA/Kaiser Family Foundation, *1994 Member Survey*)

In 1996, The Commonwealth Fund provided a grant to AAHP to identify models of delivering care to women through health plans. By collecting information from more than 1,000 health plans across the country, AAHP was able to develop a series of reports entitled *Best Practices in Women's Health: Identifying Exemplary Care.* This series showcases exemplary practices and programs in four women's health topics: breast cancer, domestic violence, obstetrics and prenatal care, and hormone replacement therapy and other mid-life issues. These reports are available in their entirety on AAHP's website at *www.aahp.org.* I would like to highlight just a few of the many innovative quality-enhancing programs identified through this initiative:

- **Blue Cross and Blue Shield of Florida** (Jacksonville, FL) developed *Healthy Additions,* a voluntary prenatal education and early intervention program designed to provide information and assistance to expectant women enrolled in either the health plan's Health Options, Inc. (HMO) or their select administrative services only (ASO) PPO group. The program emphasizes early screening, ideally in the first trimester. To achieve this goal, the plan provides an initial risk-assessment screening to all program participants, in addition to regular physician visits. Those members who are found to be high-risk or potentially high-risk through this screening are referred to the high-risk monitoring unit for telephone follow-up. Those who are not found to be at risk during the initial assessment are rescreened between 28 and 32 weeks gestation. In addition, participants are provided with educational materials that are customized to each member's specific needs. (*Obstetrics and Pregnancy Care*)
- **Keystone Mercy Health Plan** (Philadelphia, PA) established the *WeeCare* initiative in an effort to help pregnant members have the healthiest babies possible. The program, which is open to all expectant and new mothers enrolled in Keystone Mercy, combines social support services with medical services. It emphasizes the importance of prenatal care, postpartum care, and regular doctor visits during this critical time in the lives of the mother and baby. When a member decides to participate, highly skilled social workers, nurses, and lay counselors work closely with her to ensure she has the basic necessities for a healthy pregnancy, delivery, and baby, as well as for a comfortable transition home with the newborn. These relationships exist for the duration of the pregnancy and delivery. A WeeCare coordinator offers support through monthly telephone contact or in-home visits, and serves as a liaison between the expectant mother and a variety of social service support agencies. The program also offers assistance in several other ways, including providing transportation, arranging for childcare services, and scheduling doctor visits. (*Obstetrics and Pregnancy Care*)

B. The Experience of Health Plan Enrollees With Chronic and Acute Illnesses

People with chronic and acute illnesses are increasingly enrolling in health plans, because health plans offer an affordable, high-quality alternative to costly, fragmented fee-for-service coverage, where patients often fall through the cracks. National studies of a range of conditions, including arthritis, hypertension, and cancer, among others, show that health plans provide equal or greater access to the specialty care that individuals with chronic and acute illnesses need than is provided under fee-for-service coverage. For example:

- A HCFA-funded National Medicare Competition Evaluation study of HMO Medicare enrollees with hypertension found that HMOs physicians are more likely to refer for ophthalmologic, cardiac and fundoscopic exams than were fee-for-service physicians. (*Journal of the American Geriatrics Society,* 1991)
- An Arthritis Foundation-sponsored study of HMO patients with rheumatoid arthritis found no significant difference in number of office visits with rheumatologists, number of outpatient surgeries, or number of hospital admissions when compared to fee-for-service patients. (*Journal of the American Medical Association,* 1996)
- A study by the MEDSTAT Group prepared for AAHP found that the percentage of admissions to teaching hospitals, where specialists are predominant, is comparable between health plans and fee-for-service coverage. Health plans have a slightly higher admission rate to major teaching hospitals (27%) than does fee-for-service coverage (22%). (*MEDSTAT Group,* 1997)

Seriously ill and at-risk Medicare HMO beneficiaries have reported high satisfaction with access to health care services, including their access to specialty care. For example:

- A survey of over 16,000 chronically ill Medicare beneficiaries in 33 markets across the country found that, in six of seven areas comprising overall satisfaction, Medicare HMO enrollees were equally or more satisfied than Medicare members remaining in the traditional Medicare program. The seven key areas were: network access, physician access, plan benefits, costs, perceived medical quality, medical management, and member services. (Sachs Group, "Sachs/Scarborough HealthPlus 1997")

Proactive coordination and management of care is especially beneficial for health plan members with chronic or acute conditions. As a result, health plans have designed and implemented programs that facilitate coordination of the often complex services that patients receive. For example:

- **Harvard Pilgrim Health Care** (Brookline, MA) developed an asthma management and outreach program that focuses on providing patients with in-depth information about the disease, helping them understand what triggers the attack, and teaching them how to monitor and control their asthma. Patients meet at home with credentialed nurse educators and receive individualized care and education that meets their specific needs, resulting in patients who are actively engaged in the management of their asthma. Initial program results showed a 79% reduction in hospitalizations and an 86% reduction in emergency room visits. In addition, a Harvard Pilgrim survey found that the number of days lost from work decreased by 8,000 days in just one year due to the program.
- **Humana Inc.** (Louisville, KY) operates a monitoring and education program, Cardiac Solutions, for members with congestive heart failure (CHF). As of November 1997, 2,100 members in 15 Humana plans participated in the program, which combines physician-directed, home-based care with a nurse monitoring component. A recent year-long study found that hospital admissions decreased by 60%. Surveys indicate that participants are very satisfied with how the program helps them understand heart failure and what can be done to improve their condition.

C. The Experience of Children in Health Plans

The innovative services offered by health plans help parents do a better job of coping with the health care challenges that many children face. The programs summarized below illustrate some of the many ways in which health plans are working with parents and health professionals to facilitate the delivery of quality care to children.

- **Prudential Health Care of California** (San Mateo/Woodland Hills, CA) has developed a parent education initiative called *Getting Bigger* to improve its pediatric immunization rates. The program includes a *Welcome Baby* packet at enrollment, a first birthday card, and an Almost Two immunization reminder card. Physicians are provided with information about the immunization status of their pediatric patients and chart stickers to use as a manual immunization tracking system.
- **HealthPartners Research** (Bloomington, MN), in collaboration with the University of Minnesota's Center for Children with Chronic Illness and Disability is undertaking an initiative that will allow them to determine the feasibility of integrating services (medical, social, and community) for children with chronic illness and disabilities who are members of HealthPartners. This will enable them to answer important questions such as what mix of services is needed by children with different chronic conditions, what is the optimal role of the primary care physician, and who is in the best position to serve as care coordinator.

D. Access to Quality Care for All Patients

In addition to initiatives targeted to the specific patient groups discussed above, health plans are rapidly responding to their members' preferences by developing a variety of innovative streamlined referral initiatives that further broaden enrollees' options for obtaining specialty services. In fact, no other area of health plan practices is undergoing more rapid change and improvement. Approaches to modifying referral procedures include: use of electronic terminals in physicians' offices to obtain real-time referral authorizations to specialists with a swipe of a member's I.D. card; use of the Internet to provide patients access to primary care physicians for the purpose of obtaining referrals; and use of automated referral systems designed by physicians that allow treating physicians to obtain immediate referrals based on a patient's condition.

Some specific examples of plans' innovative referral initiatives include:

• **Health Alliance Plan's** (Detroit, MI) *SelfDirect* program enables members using Henry Ford Medical Centers to self-refer to many Henry Ford specialists without first obtaining a written referral from their personal care physician (PCP).

• **United HealthCare's** (Minnetonka, MN) open access products, named *United HealthCare Choice* and *United HealthCare Choice Plus,* give members greater choice by providing coverage for services received by network doctors and specialists without a referral from a primary care physician. These products are offered in 33 states as well as Puerto Rico.

• **PacifiCare Health Systems** (Santa Ana, CA) offers a streamlined referral process, *Express Referrals,* which allows primary care providers at participating medical groups to refer patients to specialists within the medical group without preauthorization from a medical committee.

These examples demonstrate the ability of accountable systems to determine what approaches to referrals work best for health plan members. No two plan initiatives are identical, but each has been developed in response to particular needs and preferences of the members of different health plans. Proposals that would set strict rules for health plan referral procedures may have the unintended and adverse consequence of forcing plans into a "one size fits all" model for referrals. It is imperative that Congress evaluate the role of health plans in meeting the specific needs and preferences of patients before acting to adopt further regulation.

It is important to point out that none of these plan examples would eliminate the role of the primary care physician (PCP), yet some of the current legislative proposals would, through implementing the "one size fits all" model, limit plans' ability to make good use of PCPs. PCPs can help promote the provision of preventive care and greater coordination of care for patients. As a result, these proposals could have unintended consequences for the quality of care that health plan members receive.

IV. A BROADER VISION

Through a number of initiatives, AAHP endorses a much larger vision than is being proposed by the various bills in Congress. This alternative vision takes a broad view of quality, health plans' role in it, and the challenges we face systemwide. The issues that we face today, such as how to expand access to affordable health care coverage for all Americans and how to preserve and promote innovation and deal with the challenges of new technology, can only be addressed by broadening our policy discussions to address systemic challenges that extend across all types of delivery systems, providers, purchasers, and consumers.

AAHP's *Code of Conduct* is a part of this much larger vision. The *Code of Conduct* sets forth specific health plan policies that promote high-quality care in a manner that meets the needs of individual patients. It is an ongoing, comprehensive program to let patients, doctors, and purchasers know what they can expect from health plans in a number of areas. Under this initiative, a task force of AAHP's Board of Directors is charged with identifying and highlighting issues that should be addressed, and each policy statement that is included in the initiative is approved by the Association's full Board of Directors. Policies adopted to date fall under three major categories: (1) Patient Access; (2) Patient Information; and (3) Physicians' Role in Quality Improvement. Included in the patient access category are specific policies regarding "Patient Access to Specialty Care" and "Emergency Care." These policies are described below.

• **Patient Access to Specialty Care.** Health plans believe that patients should have access to timely and appropriate specialty care within a plan's network.

+ Each health plan should have procedures to promote timely and appropriate access to specialty care. Plans should periodically evaluate these procedures with reference to selected medical conditions. (Because much medical care can appropriately be delivered by either primary care or specialist practitioners, plan evaluations should emphasize the appropriateness of care rather than the provider of care.)
+ Each health plan should offer members a choice, in coordination with their primary care physician, among specialty physicians who participate in the plan's network and are available to accept new patients. Plans should disclose to consumers if referrals will be within a medical group or other network arrangement.

• **Emergency Care.** Health plans have pledged to pay for emergency care if a patient reasonably believes he or she has a condition requiring immediate medical attention.

+ Health plans have pledged to cover emergency-room screening and stabilization as needed for conditions that reasonably appear to constitute an emergency, based on the patient's presenting symptoms. Emergency conditions are those

that arise suddenly and require immediate treatment to avoid jeopardy to a patient's life or health. To promote continuity of care and optimal care by the treating physician, the emergency department should contact the patient's primary care physician as soon as possible.

To demonstrate their commitment to this effort, AAHP's Board of Directors and member plans decided that health plans joining or renewing membership in AAHP should be required to uphold the *Code of Conduct* policies. A copy of AAHP's *Code of Conduct* in its entirety has been attached as Appendix A.

Consistent with this challenge, AAHP's Board of Directors has adopted a set of policy principles that offer our alternative vision. These principles, attached in their entirety as Appendix B, apply to both efforts in the public and private sector. I would like to discuss just a few of them now.

• **Health Care Access for All:** A core challenge for our nation's health care system is how to best preserve and expand access to affordable, high-quality health care. We pledge to join with consumers, employers, physicians, providers, and policymakers to pursue strategies that expand health care access to and maintain affordable health care coverage for all Americans.

• **Keep Health Care Coverage Affordable:** Discussions about how to best protect patients are meaningless for the 43 million Americans who are without health coverage. Whatever approach is taken, it is critical that our nation not take actions that we know will increase costs and the number of uninsured individuals. The first and foremost priority in Washington should be to promote and expand access to affordable and effective health care.

• **Promote Care Based on Evidence:** An ongoing challenge for our health care system is to address the wide variations in health care practice patterns within specific geographic areas and across regions. Health plans have pioneered a system of quality oversight to promote the delivery of the right care, at the right time, in the right setting. Efforts to improve our health care system should not jeopardize the progress that has been made in the area of quality assurance and quality improvement.

• **Do No Harm:** At this time, our nation faces a stark choice in health care. One path would build on what has worked in both the private market and in Medicare and Medicaid—expanded access, lower premiums and out-of-pocket costs, and more appropriate care for millions of Americans. The other path—and the wrong approach—would imperil these gains and benefit trial lawyers and provider groups at the expense of hard-working American families. We need to broaden the debate and recognize that improving health care means expanding choice in the Medicare and Medicaid programs, expanding access to affordable, quality coverage (particularly for 43 million Americans with no health care protection) and, empowering consumers—not government—by giving them the information that they need to evaluate their health care choices.

V. CONCLUSION

Health plans are working hard—and are succeeding—at providing access to high-quality care for their members. We cannot forget, however, that one of the greatest barriers to access to care is affordability. Health plans have played an instrumental role in keeping health care affordable for millions of Americans by focusing on continuous quality improvement and developing innovative strategies to provide patients with the care that they need. For example, according to a 1997 study conducted by the Lewin Group for AAHP, the growth of managed health care may save Americans as much as $383 billion this decade. Over the 1997 through 2000 period, total managed care savings for people covered by private health plans are estimated to reach between $125 billion and $202 billion. Moreover, these savings translate into fewer uninsured Americans—about 3 to 5 million fewer based on the Lewin estimate. In order to promote affordability, to improve access, and to do no harm, Congress must continue to allow health plans the flexibility to structure their options to respond to patient needs and concerns and avoid any regulations that will reduce quality, increase costs, increase the number of uninsured Americans, and stifle innovation.

Mr. BILIRAKIS. Thank you very much, Dr. Braun.

Now, Mr. Thomas.

STATEMENT OF PETER W. THOMAS

Mr. THOMAS. Thank you, Mr. Chairman, and members of the subcommittee.

Today, I wanted to focus my remarks on two basic things; I wanted to start with giving a little bit of background about the President's Commission on Consumer Protection and Quality in the Healthcare Industry. I chaired the subcommittee that worked on the Patients' Bill of Rights. And then go in and discuss in-depth the access to specialty care provisions.

The President's Commission was developed and put together initially because of a perceived sense that patients in America were having problems accessing the kind of care that they needed, when they needed it, and for fear that some of those decisions may have been being made based more on the bottom line than on the medicine.

The Commission was comprised of an extremely diverse group of people representing virtually all aspects and kind of stakeholders of the healthcare industry, including consumers and providers and health plans, quality experts, and State and local government representatives, et cetera.

The Commission spent about 6 solid months working on a Patients' Bill of Rights, trying to review all the different documents that had come out of a wide diversity of organizations that had addressed patient rights to date, and kind of culled through the common issues that were in those bills of rights—organizations like NCQA and AAHP, as well as Consumers Union and Families USA, to name a few.

We met seven times; we considered background papers and heard witnesses on a variety of different issues. And, in the end, there was a process where the subcommittee recommended to the full commission, a series of recommendations on seven basic rights.

The reason that I am going through in somewhat detail, kind of what the process was to come out with those rights, was to really try to get across the point that this bill of rights that was produced by the Commission was really a moderate approach. There was a number of people on the Commission who wanted to go much farther than the bill of rights went, and there were a few people, of course, who didn't want to go nearly as far as the bill of rights went, as well, and that is what defined "consensus."

Our operating rules were one of consensus. We had to reach consensus, but, in fact, that turned into unanimity pretty quickly. And so, really, no recommendation went forward without having virtually unanimous support from the entire Commission. And in the end, 33 out of 34 commissioners voted—well, we actually never voted—but 33 out of 34 commissioners approved of the bill of rights.

That has now made its way into a legislation, the Patients' Bill of Rights Act, which also had a number of other issues that were added to it.

What I wanted to really stress is that this is a moderate set of protections that is, in my view, a basic set of standards that the private healthcare marketplace can operate under and really base competition on quality and cost-effectiveness and service to the patient, rather than on trying to avoid risky patients, trying to avoid patients who require a lot of care and who are costly.

And so you see similar situations with the FCC laws and the antitrust laws, where there are basic sets of rules created and, in my view, the market has added.

And my view is that I am not trying to bash managed care; I am not trying to impose costs; I am not trying to micro manage. What I am advocating for is just a basic set of protections that can help structure the marketplace so, again, high-quality care is the hallmark and risky patients are not avoided.

So the Patients' Bill of Rights has been implemented and is being implemented across the Federal agencies. And by the end of 1999, one-third of the American people will be covered by it. This is a tremendous opportunity now for this body to extend those same protections to the other two-thirds of the population of this country.

On the access to specialty care piece, let me try to make a couple of basic points.

The first is the requirement that the provider network of a network plan in managed care be adequate to provide the benefits that the plan says that it will cover. It is very important for people with disabilities and chronic illnesses to have certain specialists in the network, and if they are not in the network, to be able to get an out-of-network referral to access that care.

Another very important piece is that those specialists be within a reasonable proximity to the patient's residences or businesses, and that the specialists have the appropriate degree of specialization, so that if you need a specialists for a child with a neurologic condition, they get to go to a pediatric neurologist rather than a general neurologist.

Standing referrals for people with disabilities is critical. Direct access to specialty care for people with disabilities and chronic illnesses is a major issue that I hope this subcommittee will consider very strongly.

And finally, let me say that transitional care is critical for people who have a certain set of providers that they are used to going to, are in the midst of a treatment plan, and if those providers are kind of switched for one reason or another—involuntary, not based on cause or quality concerns—they should be able to see those providers for at least a 90-day period while the plan switches that provider network.

Because my time is over, I will finish. Thank you.

Mr. BILIRAKIS. You can summarize, if you have something, very quickly.

Mr. THOMAS. The only other issue I really wanted to raise was the point-of-service option. None of the three provisions that were in the Patients' Bill of Rights addressed the point-of-service option, and that I see as an extremely important piece for access to specialty care.

If all you are given, as an employee, is the option to have one closed-panel HMO, my view is that at the time of enrollment, the enrollee should have the opportunity to purchase, through a premium and then a co-payment, a point-of-service option to get out of that closed-panel if they need to see some specialty care that is not covered by that closed panel. The cost of that can be borne, primarily, by the enrollee, him or herself, and it is a provision that

I think is critically important, especially when an employer only offers one plan, being a closed-panel plan.

Thank you.

[The prepared statement of Peter W. Thomas follows:]

PREPARED STATEMENT OF PETER W. THOMAS, FORMER CHAIR, SUBCOMMITTEE ON CONSUMER RIGHTS, PROTECTIONS AND RESPONSIBILITIES OF THE PRESIDENT'S ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUSTRY

Chairman Bilirakis, Congressman Brown, and Distinguished Members of the Subcommittee: It is an honor to testify before you today. I commend the members of this subcommittee for their extensive efforts in addressing the critical issue of consumer protection in health care. While I am testifying today in my individual capacity, I was a member of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry and chaired the Subcommittee on Consumer Rights, Protections, and Responsibilities, which drafted the Commission's Patients Bill of Rights. As Congress considers legislation in this area, I am grateful for the invitation to participate in this hearing and provide input into this process.

As a user of two artificial legs since the age of ten, I can attest to a long history of interaction with the American health care system. I have had five surgical operations and extensive medical rehabilitation from rehabilitation hospitals and other providers over the past 25 years. I have consulted numerous medical specialists and have had ten sets of prosthetic limbs provided by seven different prosthetists in five different states. I have been given the opportunity to access the health care that meets my needs. With high quality care, I have been able to live completely independently, working in a good job and raising a family.

However, for many consumers, particularly people with disabilities and chronic illnesses, the past decade has brought pressures in the health care system to limit important benefits and restrict access to specialists and specialty providers. These restrictions in the health care system are now commonplace and are having a profound impact on people's lives.

For instance, anecdotal evidence suggests that patients with traumatic physical injuries—such as spinal cord and brain injuries—who are covered by health plans that have restrictions of this nature are more likely to be sent to nursing homes rather than medical rehabilitation hospitals. Rehabilitation hospitals and units provide a far greater level of specialty rehabilitation care and generally produce better clinical outcomes for persons with severe physical disabilities. These specialty hospitals and physicians and other providers with training and experience in medical rehabilitation are critical to high quality and cost effective health care and should not be arbitrarily restricted.

The pressures within managed care networks to restrict access to specialty care manifest themselves in the continuing erosion of public confidence in our health care system. My intent is not to discredit managed care, for managed care that is managed well can lead to major improvements in quality. My intent is to stress the importance of making sure that managed care plans serve *all* users of care at comparable levels of quality, regardless of the frequency or complexity of services a particular enrollee needs. Above all, health plans, particularly managed care plans, must not sacrifice sound medical decisions to considerations of the plan's bottom line.

I would like to focus my remarks on the Patients Bill of Rights and Responsibilities that was developed by the President's Commission. As you know, Mr. Chairman, the Commission's Bill of Rights was translated into legislative language and now forms the basis of the Patients Bill of Rights Act, H.R. 358. The access to specialty care provisions in that bill closely parallel the Commission's recommendations on this issue. There are a number of other bills that also address the access to specialty care issue, some of which have been sponsored by distinguished members of this subcommittee. I commend the subcommittee for examining closely the specialty care issue, for I believe that any law that purports to protect patients must include provisions ensuring access to specialists, particularly for people with disabilities and chronic illnesses.

The Need for Federal Legislation

Other than several federal health care programs, the American health care system is largely a market-based system. The hallmark of a well-functioning marketplace is the concept of competition, and optimally, improvements in quality and consumer satisfaction that come from this competition. But the federal government

often establishes certain ground rules within which the American marketplace must function. The antitrust and securities laws are good examples of federal rules that provide structure to a well-functioning competitive market. The market in health care also requires structure in order to function well. Without the establishment of basic ground rules that will prompt the health care market to compete on quality and consumer satisfaction, the health care market will compete based on the avoidance of risky patients.

I am not an advocate of micro managing the health care marketplace or stifling some of the progress the health care industry has made in improving quality while reducing the rate of health care inflation. I am an advocate for the creation of a basic set of consumer protections at the federal level that all health plans must meet, including self-funded ERISA plans. Without *federal* legislation, health plans that operate under the Employee Retirement Income Security Act (ERISA) will be free to deny consumers basic rights that health plans subject to state laws may be required to provide.

Unless all health plans are subject to the same set of consumer protection standards, plans that do not adhere to such standards will be at a distinct competitive advantage in the marketplace. Without federal standards to level the playing field, there is actually a disincentive to improve the quality of care, because those plans that develop a reputation for high quality and good outcomes will be adversely selected by individuals who need health services the most. Competition within a framework that protects consumers will have a significant impact on the quality of care and the confidence that Americans have in their health care system.

The Commission's Recommendations

This is the underpinning behind the Patients Bill of Rights and Responsibilities recommended to the President by the Commission. The Patients Bill of Rights was drafted after months-long negotiations between a very diverse panel of representatives, including consumers, patients, providers, health insurers, health plans, large and small businesses, labor, state and local governments, and health quality experts. Virtually every major sector of health care was actively engaged in the Commission's efforts. The Commission operated under a rule of consensus, which had the practical effect of requiring unanimous support for any recommendation before it went forward.

While the Commission was able to reach consensus as to the substance of the Patients Bill of Rights, it was not able to reach consensus as to the implementation and enforcement of these rights; whether they should be enacted into law or implemented on a voluntary basis. This was not surprising, however, due to the diversity of the Commission's members and the rule of consensus, or more accurately, unanimity. It is unfortunate, though, that some of the same constituencies that were at the table, engaged in the Commission's process, and in agreement with the final version of the Patients Bill of Rights are now actively opposing the creation of these very standards for all consumers.

How the Process Impacted the Substance

The seven rights on which the Commission was able to reach consensus derive from common elements included in the previous work of numerous organizations representing the entire health care spectrum, from the American Association of Health Plans to the National Committee for Quality Assurance to Families USA. The Commission's Subcommittee on Consumer Rights met in open session on seven occasions over a six-month period, heard from numerous witnesses, and considered background papers on each subject. The Subcommittee reviewed two or three drafts of each chapter and conferred with the full Commission until refinements were made and consensus was achieved on the overall document.

The process of reaching virtual unanimity on a set of patient rights that the Commission members agreed should apply to all consumers was a difficult one. All of the major health care constituencies were engaged in the process and many compromises were made during the course of debating and drafting the substance of each patient right. Many wanted to go much farther, establishing a patient right to certain mandated benefits. This and other proposals either found their way into the preamble of the Bill of Rights or were taken off the table due to considerations of cost, lack of time for full debate, or claims of micro-managing the health care system.

The point is that the final Patients Bill of Rights that emerged from the Commission represents a consensus set of patient protections, a moderate approach to ensuring that all health care consumers have the tools they need to access the health care they require. Each of the seven rights are integral to truly protecting consumers and improving the health care system and each right is diminished when one

of the other rights is not present. In my view, any legislation that purports to adequately protect patients must include these elements.

The Bill of Rights Should Apply to Everyone

Since the announcement of the Patients Bill of Rights in November 1997, the Clinton Administration has implemented these rights across each of the federal agencies that administer federal health programs, including Medicare, Medicaid, the FEHBP, the VA health system, the Department of Defense programs, the Indian Health Service, and the Department of Labor. In total, by the end of 1999, one third of the American people will be covered by the Patients Bill of Rights. It is now in the hands of Congress to extend these basic consumer protections to the rest of the American population.

While the creation of the Advisory Commission was largely spurred by consumers' problems with managed care plans, as already stated, the Commission felt strongly that these protections should apply to *all* health care consumers in *all* health plans receiving care in *all* health care settings.

Access to Specialists

This provision in the Patients Bill of Rights derives from one of the principal complaints of consumers in managed care plans; restricted access to specialty care providers. The Commission heard testimony from a woman with epilepsy whose long term relationship with her neurologist was interrupted when she joined a network plan, even though the plan initially stated that she could continue seeing her current providers. The Commission effectively rejected the "any willing provider" approach to ensure adequate choice of provider, but established a number of provisions that assist consumers in accessing appropriate specialty care.

The Commission's choice-of-provider provisions have three aspects that are directly relevant to improving health care quality: network adequacy; standing referrals; and transitional care. The network adequacy requirement ensures that enrollees in a health plan that utilizes a network of providers will have adequate in-network access to the specialty providers and professionals necessary to provide enrollees with the full range of benefits offered by the plan. To meet this requirement, plans would have to offer in-network providers with an appropriate degree of specialization and within a reasonable proximity to enrollees. If a plan did not provide adequate in-network access to specialty care, it would be obligated to provide referrals to out-of-network specialists, but at no greater cost to the patient than in-network care.

The standing referral requirement would permit enrollees with chronic or disabling conditions to have direct access to specialists without needing repeated referrals from primary care providers. Plans would have to permit an adequate number of direct access visits but reasonable limits could be imposed before a patient would be required to revisit his or her primary care provider. For a patient with a complex or serious medical condition, direct access to specialists under an approved treatment plan can be highly cost effective, eliminating the need for unnecessary primary care visits when specialty care is required.

Some of the patient protection bills in this Congress also permit patients with "ongoing special conditions" to select a specialist as a primary care provider. While the Commission could not reach consensus on this approach, this provision makes imminent sense for people with chronic illnesses such as multiple sclerosis and similar conditions.

The transitional care provision would allow patients who are undergoing a course of treatment for a chronic or disabling condition (or who are pregnant) to continue seeing their current primary and specialty care providers for up to 90 days in the event of a disruption in care. For instance, if a health plan were to become insolvent, transfer ownership, or stop serving enrollees within a state, or if a provider were to be dropped from a plan's network for any reason other than "cause," the enrollee would be able to continue seeing his or her same providers for up to 90 days while suitable alternative providers are contacted. In addition, under the Commission's recommendations, women would have direct access to women's health services.

These policies would improve the quality of care by ensuring that managed care enrollees get all the necessary and appropriate care covered by their health plan, including specialty care. It will also be cost-effective by guaranteeing that patients with disabilities and chronic conditions will be able to access specialty providers without first being required to make an unnecessary visit to a primary care provider. Finally, ensuring that patient care is not disrupted after involuntary changes in insurance coverage will enhance quality.

Point-of-Service Option for Managed Care Enrollees

While the Commission did not reach consensus on the point-of-service option, this provision is a critical patient protection when a closed panel HMO or network plan is the consumer's only option in obtaining health coverage. The point of service provision would require closed panel plans to permit enrollees to elect to purchase an option at the time of enrollment to access out-of-network providers, at an additional premium and/or co-payment to the enrollee. The option could be structured to create minimal costs for the health plan or employer sponsor and tremendous benefits for enrollees who develop the need or desire to obtain care from providers and/or specialists of the enrollee's choice who are not within the plan's network of providers. The point of service option is an important element of effective access to specialists and maximizes patient choice of provider.

Access to Emergency Services

To build confidence among the American people that emergency care will be covered by health plans when and where an emergency arises, the Commission included provisions on access to emergency services in the Patients Bill of Rights. The Commission agreed that health plans should provide payment when a consumer presents to an emergency department with acute symptoms of sufficient severity—including severe pain—such that a "prudent layperson" could reasonably expect the need for emergency care. Similar provisions were enacted as part of the Balanced Budget Act of 1997 for Medicare and Medicaid patients.

The Commission also recommended that health plans should not impose prior authorization requirements for either in-network or out-of-network emergency care, but that reimbursement for out-of-network emergency services should be limited to the in-plan rate. These provisions will improve the quality of care by striking a balance between unnecessary use of emergency services and encouraging people who believe they are experiencing an emergency medical condition to seek treatment immediately without fear that the services may not be covered by the health plan.

Information Disclosure

This protection requires that health plans, providers, and facilities provide patients with accurate, easily understood information to be used in making informed health care decisions. Plans would be required to provide information such as covered benefits and exclusions, specialty referral rules, and cost-sharing requirements. Professionals and other providers would be required to provide information on their level of education and board certification status. Facilities would be required to provide information on their experience in performing specific procedures and accreditation status.

In a health care system that is primarily market-based, accurate and easily understood information is critical to effective consumer decision-making. Many states have already enacted laws requiring the disclosure of health care information to consumers. As consumers become more familiar with the often-complex information provided to them, they will be able to demand higher performance from providers and make decisions based on the quality of care and demonstrated outcomes.

Consumer Assistance/Health Care Ombudsperson Programs

The complexity of our health care system makes its navigation extremely difficult for many consumers, particularly for persons with little education, low incomes, and little experience with the health care system. All the information disclosure in the world simply will not be useful to a significant portion of the population without the availability of some form of consumer assistance. The Commission expressed the importance of consumer assistance programs for some consumers within the context of the right to information disclosure but stopped short of establishing consumer assistance as a right of all Americans.

In order to provide a network of independent consumer assistance or ombudsperson programs throughout the country, a stable funding source would have to be identified that would not be dependent on health plans in a way that compromised the independence of the consumer assistance. Such programs would have to be carefully structured and offer a variety of resources, including knowledgeable customer service representatives to assist patients in making informed health care decisions. These efforts could facilitate cooperation between health plans, providers, payers and consumers and would increase confidence in the health care system to a substantial degree. Consumer assistance programs would improve the quality of care by ensuring that the most vulnerable patients are able to negotiate the health care system and access the benefits, services and providers included in their health plan, without resorting to an after-the-fact appeals process.

Participation in Treatment Decisions

Concern that the sanctity of the doctor-patient relationship was being eroded prompted the Commission to act to protect open communication between providers and patients, which is necessary for effective treatment. The Commission decided that all consumers have the right and the responsibility to participate in all decisions related to their health care. Among other items, providers should disclose factors—such as methods of compensation—that could influence advice or treatment decisions and should ensure that contracts with health plans do not contain so-called "gag clauses." Patients should also be told about the risks and benefits of all treatment options, regardless of the cost or coverage of the service, and should be allowed to refuse treatment.

Full participation in health care decisions by informed, knowledgeable consumers is a key to improving the quality of health care. The Commission reviewed numerous studies that demonstrated that when people are active participants in their treatment regimen, outcomes are improved.

Non-Discrimination

The Commission recognized the significant disparities in the quality of care and outcomes between people with different races, sexes, and other characteristics. The Patients Bill of Rights includes a non-discrimination provision that applies to the delivery, marketing and enrollment of health care in order to attempt to address these disparities. The specific provision applies to discrimination based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information or source of payment. The specific recommended language, however, is limited in terms of the phrase "mental or physical disability," in that it does not mandate benefits or guarantee issue in the individual health insurance market.

Consumer protection against discrimination in the delivery, marketing and enrollment of health care is critical if health plans are to compete in the marketplace based on quality and consumer satisfaction, not based on the avoidance of risk. Non-discrimination provisions are essential to the elimination of disincentives to improve care. The Commission's non-discrimination language will not solve all of the problems of discrimination in the health care system, but it is a significant step forward.

Confidentiality of Health Care Information

One of the key aspects of effective communication between patients and providers is the bedrock understanding that one's medical records and doctor-patient communications will be kept confidential. Due to many cases of breaches or near-breaches of confidentiality in the recent past, the public's confidence that such information is fully protected has been seriously eroded. This issue has become so important that Congress is currently considering stand-alone medical privacy legislation. The Commission's provision limits the number of instances where individually identifiable health care information may be used without written consent and creates a presumption that nonidentifiable health care information should be used to the maximum extent feasible.

Ensuring that medical records and other confidential information is kept private, and making sure that patients understand and believe their information is safe, is key to improving the quality of care. If patients do not have these assurances, they may limit their candor with health care providers which, of course, has a direct negative impact on quality.

Complaints and Appeals

This recommendation alone has the potential to restore a great deal of confidence in the health care system. The concern of many Americans that health care plans may be making coverage decisions based on the bottom line rather than on the patient's best interests prompted the Commission to recommend that all health plans make available to enrollees a fair and efficient grievance and appeals process. The specific recommendation is to provide every consumer with an internal appeals process (which includes expedited review for urgent care) and, once exhausted, an independent external review of the dispute. The Commission's language would permit external review for claims involving experimental or investigational treatments as well as denials of benefits based on medical necessity that exceed a significant threshold.

The Commission's recommendation would be strengthened if enrollees were permitted to challenge denials of access to specialists as well as certain drug formularies through internal and external appeals processes. In addition, the appeals system should be available for challenges of denials based on the fact that a particular benefit is not considered a covered service under the plan's benefit pack-

age. I am not suggesting that the appeals mechanism be converted into a process where a plan's benefit package is subject to constant revision. However, many people with disabilities are denied benefits because the plan makes an arbitrary decision that the claimed medical service or device is not considered a defined benefit, when in fact the policy language is ambiguous or even contrary to the stated position of the plan. In this instance, claimants should be afforded the opportunity to use the plan's appeals process to resolve these disputes.

Conclusion

The consumer protection standards described in this testimony represent a reasonable step toward protecting consumers in the health care marketplace while improving the quality of care. Now is the time for Congress to act to ensure that all Americans receive the benefit that these basic standards offer. I again thank the Subcommittee for this opportunity to testify and will answer any questions you may have at this time.

Mr. BILIRAKIS. Thank you very much, Mr. Thomas.

Okay, I will proceed with the questions.

Let's see, Dr. Auer, you, of course, are a former president of the American College of Emergency Physicians. Under prudent layperson standard, assuming that the patient has no greater costs when treated at an out-of-network emergency room than at an in-network facility, should the provider be required to accept the payer's in-network reimbursement rate? Or should the plan be required to pay the provider's bill charges?

Ms. AUER. Well, I am not sure that is an issue that we should be considering. I think that is a marketplace decision, and it is one that providers make every day in negotiating their costs with insurers.

I think the question here today is providing access to patients when they believe they have coverage for that access.

Mr. BILIRAKIS. Well, all right; but let me ask you, then, having said that, how many patients that walk into an emergency room have true emergencies? So, I mean what is your answer to that?

Ms. AUER. All of them.

Mr. BILIRAKIS. All of them have true emergencies?

Ms. AUER. Patients—there are some patients that do come to the emergency department for a variety of reasons that you wouldn't consider perhaps life threatening. But you have to take into consideration the circumstances that surround it.

And if I could give you one example, sir. I had a woman come into my emergency department about a month ago with her three very ill children. One of the children had gotten sick with a cold, a runny nose. She had gone to her managed care physician, as she was supposed to do. They said it was just a cold, gave her some instructions; she took the child home. During the week, the child became more severely ill. Her other children got ill; she became ill. She called her provider; she got no call back. She called the next day, got no call back. She called the third day, got no call back. By then, all children were running high fevers. Three of the children were vomiting, and she, herself, was feeble and sick. She came to the emergency department to get care. Was that unreasonable? I don't think so.

Mr. BILIRAKIS. Well, all right. You have told us—I am not agreeing or disagreeing with you, but I don't intend to give that impression.

But if we had a prudent layperson standard, how would that, then, apply, in terms of—now you say that all emergencies are true emergencies?

Ms. AUER. I was being a bit facetious, sir.

Mr. BILIRAKIS. Yes, we——

Ms. AUER. There are some people who do abuse the system.

Mr. BILIRAKIS. Yes. Okay.

Well let me ask Dr. Braun; according to research—and we do have some information here to the effect of a certain percentage of emergency patients are not considered to be true emergencies. I don't know how that would effect that percentage if we use a "prudent layperson's" standard. But, Dr. Braun, according to research sponsored by the Kaiser Family Foundation, as I understand it, 81 percent of HMO's offer women the choice of OB/GYN as their primary care provider or allow women to self-refer to one. In addition, more than 75 percent of HMO's surveyed by Mathematica Policy Research allowed certain specialists to serve as primary care providers on a case-by-case basis.

So the question is, in light of these findings, do you think that the market is moving toward a solution to access problems? Or do you believe that there is a role for Federal regulation in this area?

You may recall that, in our legislation, in any case, we determined that OB/GYN's and pediatricians should be concerned primary care physicians. And I realize that there are several viewpoints regarding that, but would you respond, please?

Mr. BRAUN. Yes, sir. Well, certainly I agree that the—I, like Mr. Coburn, do believe in the marketplace as being a solution. I feel that the unfettered marketplace oftentimes comes up with a better solution than the one that is forced.

As we can see, what is happening is the plans are gradually coming around, and they have been very proactive in terms of allowing women to have access to OB/GYN care without any interference.

As for whether—if you ask some of them, they would—maybe some of the OB/GYN doctors would prefer not to be primary care doctors.

They sometimes feel that they are a little out of their league treating colds and things like that. There are other more important things.

In regards to the use of specialists to treat certain disease states, I am very much in favor of that. I mean we have a very proactive Disease State Management Program that AAHP endorses. Studies over the last several years have been appearing in very prominent medical journals show that there are some disease conditions such as heart problems and some pulmonary problems—asthma and the like that—are much better treated by specialists. The results are better; the overall use of resources is better. And probably, more importantly, the lifestyle and the quality of life for the patient member is better. So I am very much in favor of that.

Mr. BILIRAKIS. Do you—just very quickly—do you feel that the market is moving toward a solution in this area? You have indicated you favor the market approach?

Mr. BRAUN. Yes, sir, I do believe that. I believe that managed care right now is in a great period of evolution, that we are merely at a weigh station along the way, that the market will force us to

give more care, and better quality care. You know, there is a solution out there that we are all, hopefully, going to reach.

Mr. BILIRAKIS. Thank you very much.

Mr. Brown.

Mr. BROWN. Dr. Braun, you say the market is correcting some of these problems. If a woman wakes up in the middle of night and thinks that she is facing a life—she is living alone, thinks she faces a life-threatening illness, is in great pain. She calls an ambulance, picks her up, takes her to the emergency room. Should a health plan pay for that, even it is not on the list?

Mr. BRAUN. Well, I am not sure what list you are referring to.

Mr. BROWN. Even if it is not on some sort of an approved hospital list in that health plan?

Mr. BRAUN. Again, I mean I can only speak for the plans I have worked for. And a situation like that, the idea is, is it the symptoms of the patient and what the patient feels is an emergency. If someone comes, and they are in extreme pain, if it seems like the care is appropriately done in the emergency room; obviously in the middle of the night, we don't see too many primary care offices that are open, I would say that I can't think of too many plans that would turn that down. And I know ours wouldn't.

Mr. BROWN. Do you think there are plans that turn it down?

Mr. BRAUN. None that I know of——

Mr. BROWN. Dr. Auer seems to say there are.

Mr. BRAUN. Well I—again, I can only speak for the ones I have worked for, and I have worked for four of them, and we have had extremely——

Mr. BROWN. But what if she——

Mr. BRAUN. I am an emergency room doctor, myself, in fact. And I can tell you, I get involved on the other end of this. I have worked many midnight shifts where I have the patient that you talk about come in. And as an ER doctor, I am going to treat them, and I am going to worry about the payment issues later. But I can tell you, 99 percent of the time, as far as I know, the care is taken care of in the situation you——

Mr. BROWN. And the ambulance, too?

Mr. BRAUN. And the ambulance, as far as I know.

Mr. BROWN. But what if it turns out she is not really sick, that she didn't really need that emergency care. Do all those four plans you work for pay for it? And does every plan you know pay for it?

Mr. BRAUN. Well, again, the situation you are describing now is a bit different than the first one. If the patient is not really sick, then there is the question of——

Mr. BROWN. But thinks she is.

Mr. BRAUN. She thinks she is? Well, there is problem there, and that, you know, there have been incentives in certain plans in the past that would probably not pay for something like that.

But, again, what we are trying to do—we would hope that a patient in that condition would call. You know, we have something called a "Nurse Help Line," that we ask that they call to get some recommendation concerning that. We try and have people sent to the proper place for care. I mean, if somebody is not really sick, they can discuss the symptoms with trained medical professionals over the phone. We do after-hours audits of our professional, our

physicians, to make certain that they are available in case a situation like that comes up.

Again, we try and treat the patient in the most appropriate place.

Mr. BROWN. But this woman probably doesn't really want to call a nurse and call around and find the right number because she is feeling like her life might really be threatened. It might be heart attack symptoms, but not a heart attack, but she doesn't know that because she has never had one before.

And you, personally, as a physician, do you think that—should she start calling around, because she might not really be sick and spend valuable time and check on what might be on the plan and what might not be on the plan? Or do you think, as a physician, she should go directly—she should get to the emergency room as quickly as possible because she really does believe that her life might be threatened or something—that her health certainly is threatened?

Mr. BRAUN. Well, again, I would probably need to know a few more facts than we are having here. I mean we are getting into a great deal of a hypothesis here.

I can tell you that the thing I would say, that a woman in this situation should, if there is, in fact, any concern on her part to receive care, should go to an emergency room.

The sad part about it is, is, unfortunately, emergency room care, at this point, is more expensive; it is about three times more expensive than it is during the day. Now this should not be an absolute contraindication for using emergency rooms.

One of the things that I have tried to foster, being an emergency room doctor, is try to work out relationships with and partnerships between the emergency rooms and the healthcare plans, so that this very patient that you are talking about would have a way they could come in. They could be screened. That would be part of the care that is rendered by the healthcare plan. More importantly, that care would be reported back to their primary care doctor, so there would be continuity of care and follow up for that patient the next day.

Mr. BROWN. The next day?

But, again, you surely, as a physician, know of patients that have gotten very, very sick or think they are very, very sick and need that kind of—believe they need that sort of emergency care, don't have either the ability or the will or the desire to call around and find out what might be the appropriate thing to do at that time—just want to get to the emergency room. But some health plans clearly won't pay for the ambulance and won't pay for the hospital if it turns out she wasn't really that sick; correct?

Mr. BRAUN. Well, again, I can only speak for the ones I work for. I don't know that that situation would be something that wouldn't be paid for. But I know the one that I work for now would pay for it. So——

Mr. BROWN. Even if she weren't sick?

Mr. BRAUN. Well——

Mr. BROWN. Particularly?

Mr. BRAUN. Well, if she wasn't sick, there is a question of, what is she doing in the emergency room, then? I mean that is——

Mr. BROWN. Oh.

Mr. BRAUN. [continuing] I guess that is the key question.

Mr. BROWN. So you have never known a patient that, by self-diagnosis, thinks he or she is very, very sick, but it turns out had not much wrong with him or her. You have never known a patient like that?

Mr. BRAUN. Oh, I have had patients come in that have had panic attacks; I have had patients come in that have had simply crisis of confidence in the middle of the night, and I consider myself to be a very empathetic sort of person. The thing that I would hope, as I said, that there would be a vehicle predetermined beforehand that would allow that patient to come in, possibly talk to me, possibly talk to a mental health person, so that the care would be approved.

Again, the question is one of more of market and contract than I think that it is of legislation or mandates.

Mr. BROWN. Okay.

I guess my time has expired. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Mr. Burr left.

Mr. Upton to inquire.

Mr. UPTON. Thank you, Mr. Chairman.

I appreciated the testimony, and I know as you listened to all of our opening statements, you heard my statement earlier about the prudent layperson standard and whether—that we should have some standard for emergency care.

And one of the cases that I am thinking about is someone maybe in the middle of the night, chest pains. His spouse calls 911, ambulance shows up, takes him to the local hospital, and they might find out it might be some good news. Maybe it wasn't a heart attack, something like that. Maybe it was something a lot less than that. But I found out that the ambulance services are often left with the tab.

And as I indicated in my statement at the beginning, I am interested in pursuing legislation to be added to this bill, as it begins to move down the road.

And I am interested in maybe, Dr. Auer or Dr. Braun, whether you would support such language as part of the bill that would allow emergency care when that call came through, as being part of this legislation?

Ms. AUER. Today, I would like to focus on the fact that there is a need for a Federal solution because emergency physicians operate under EMTALA and there is a mandate, also, in the Balanced Budget Act.

Certainly, we are sympathetic to the concerns of the pre-hospital providers, and if this committee desires to look at that issue, ACEP would be pleased to work with you on it.

Mr. UPTON. Terrific.

Dr. Braun?

Mr. BRAUN. Likewise, I would like to focus on the fact that, again, hopefully there would be market solution to a question like this. That, you know, ambulance companies, EMS, and like that, hopefully, again, there will be prearranged contractual sorts of things that are done that are freely entered into that would cover this situation, rather than legislation.

Mr. UPTON. Okay.

With that, I will yield back the balance of my time.

Mr. BILIRAKIS. It is Mr. Pallone to inquire.

Mr. PALLONE. Thank you, Mr. Chairman.

I wanted to ask Dr. Braun, you talked about a Code of Conduct, I guess, amongst the HMO's and some kind of professional code of conduct. And the suggestion you seem to be making—you can correct me if I am wrong—is that somehow, you know, you prefer or that they go through some self-policing policy, which would perhaps negate the need for, you know, Federal legislation on some or all of the issues that we are talking about today.

How is that enforced? I mean I guess my concern is that I know at a previous hearing, we had someone who came in and talked about an HMO that had decided abruptly, apparently, to change its policy with regard to mental health visits. And contrary to, you know, the normal standards, had decided to only allow like one or two visits, as opposed to what the norm would be maybe seven or eight, just to give you an example.

And it was suggested that the reason they did is because they were about to be sold to a larger HMO, and they wanted to show that they had low costs and that they weren't spending a lot of money. So they simply changed their policy in a way that was contrary to the norm.

I am afraid that oftentimes what the HMO's do is simply money driven to save costs. And I don't understand how this self-policing mechanism can possibly work. It doesn't seem to me it does.

What enforcement is there? Do you sue the HMO if they don't meet the standards? Do you fine them? Do they just drop out and who cares?

Mr. BRAUN. Well, again, I mean—I, like Mr. Coburn, do believe that the market will punish the people that don't serve their members properly.

The fact is, is that in the situation that you are talking about, the legislation would take and tie us I think too much. I mean I am an attorney as well as being a physician. I can tell you I have been involved in court suits where the entire case turned over where a comma was placed. Now, if we have legislation where we are going to be worried about people's lives because of where a comma is placed, that doesn't allow us much flexibility.

Mr. PALLONE. Yes, but what I am asking, Dr. Braun, is what—when you mentioned this Code of Conduct, and you put a lot emphasis on it in your testimony, what enforcement mechanism is there? What happens if the HMO doesn't meet your Code of Conduct? Do you fine them? What do you do?

Mr. BRAUN. Well, again, as I said, I would hope the market would take in and there would——

Mr. PALLONE. Well——

Mr. BRAUN. [continuing] be adjustments there. The Code of Conduct—a code is an ancient and futile sort of thing. It implies that there is honor on the part of the people——

Mr. PALLONE. Well, I mean——

Mr. BRAUN. [continuing] that take part in it.

Mr. PALLONE. [continuing] this is capitalism here. This is feudalism. We are not living in the Middle Ages.

I am sorry, I don't think—I think I understand your answer, but it doesn't seem to me to mean much, in terms of, you know, the actual effect of the Code of Conduct.

Let me ask Mr. Thomas a question—or I guess Dr. Auer—either one of you, if I could.

One of the things that I keep harping on is the fact that, in many cases, the Republican bill—I think it was the Republican leadership that I think Dr. Auer mentioned—H.R. 250, that was passed in the 105th Congress. I have made the point many times that, in many cases, it actually dilutes existing standards of protections. It is actually regressive instead of progressive, with regard to managed care reform. And you seem to be suggesting that with regard to emergency care. That right now, Medicare, Medicaid, and I guess maybe even Federal employees are covered by a prudent layperson or "medical profession" standard, and that, in effect, the type of protection that is provided in the Republican leadership bill is a lot less than that, or seemingly less than that.

Could you just elaborate on that again? Because the one thing I don't want to see coming out of all of this is that we get a Republican leadership bill that is actually worse than the status quo.

Ms. AUER. Yes, sir. Thank you.

Before, when I was asked, "Are all patients emergencies?" And I somewhat facetiously said, "Yes." It is because it is that trap of looking at the final diagnosis that I think we all fall into. And I gave the example of the woman with her children who they became more ill with what could have been handled in an office, had she had appropriate access.

The Republican bill has a prudent professional second-guessing the care of the patient and the emergency physician at the time the care was delivered.

And the whole concept in the prudent layperson is that it is based on what that person believes at the time they come for their evaluation. And that protection, in fact, is there for the Medicare and Medicaid population, as provided through the Balanced Budget Act, and now extended to Federal employees.

Mr. PALLONE. Thank you; I appreciate that.

Mr. BILIRAKIS. Dr. Ganske to inquire.

Mr. GANSKE. Thank you, Mr. Chairman.

Dr. Braun, you have quite a resume. As you mentioned, you are an attorney, and you have worked for United Healthcare and PacifiCare and Santus New York Life, MedicLane Physicians, Epic Health Trust Hospitals. It says here that you practice family medicine. Are you a member of the AAFP, the American Academy of Family Physicians?

Mr. BRAUN. Actually, I'm boarded in emergency medicine, sir.

Mr. GANSKE. Okay.

Well the reason that I mentioned the American Academy of Family Physicians, Mr. Chairman, is that today the American Academy of Family Physicians endorsed the Ganske Managed Care Reform Bill of 1999, and I will just include that endorsement in the record, because it does, in their statement, deal specifically with gag clauses and sufficient and adequate information.

This organization, by the way, represents 88,000 family practitioners, those who deal most primarily with problems. And they

looked at my bill and thought that it was the best bill. It is notable that the AAFP, until today, had not endorsed any bill.

Now, just to continue, Dr. Braun, are you still practicing medicine?

Mr. BRAUN. Yes, sir.

Mr. GANSKE. So you are still seeing patients?

Mr. BRAUN. I work occasionally in emergency rooms on weekends. My full-time job is being the chief medical officer at George Washington University.

Mr. GANSKE. But you do see patients in emergency rooms?

Mr. BRAUN. Yes, sir.

Mr. GANSKE. Okay. Did you agree with the statutory language that was passed in the Balance Budget Act, 1997, as it related to emergency care and a layperson's definition?

Mr. BRAUN. I am not quite sure what you are referring to. I have a general idea, but, again, I mean the——

Mr. GANSKE. Well there was a definition for a layperson's definition, and that included "severe pain" as something that should be considered as valid. That is in current law, I should point out to the members of this committee—including the chairman of this committee, that we voted for that statutory language. And that statutory language, in fact, is the language that I have in my bill, that Congressman Norwood has in his bill, and that Congressman Dingell has in his bill. But, in order to inform some of the members of this committee who voted for the Patient Protection Act, the bill did not have "severe pain" as part of the definition of an emergency. Is that right; Dr. Braun?

Mr. BRAUN. I am not familiar with those other legislations, sir.

Mr. GANSKE. But, as a practicing emergency room doctor who still sees patients, you would have to agree that if somebody who comes in with crushing chest pain or severe abdominal pain, that that should constitute a prudent definition for an emergency; should it not?

Mr. BRAUN. Well, again, you have to look at the entire constellation. Certainly, when somebody comes in, being trained as a physician—I am also trained as a preacher, and I will tell you, there is a lot of prayer in medicine nowadays. But I mean, you know, in a condition like that, when somebody is coming in and they are having a lot of pain, I mean, you have——

Mr. GANSKE. Okay. If somebody comes in and they have crushing chest pain and they are all sweaty, would you work that patient up——

Mr. BRAUN. Certainly.

Mr. GANSKE. [continuing] for a MI?

Mr. BRAUN. Certainly. I would also take and work up someone when they came in with severe tooth pain, too. I mean, one instance——

Mr. GANSKE. Okay.

Mr. BRAUN. [continuing] we see a lot.

Mr. GANSKE. But you would agree that——

Mr. BRAUN. Yes, sir.

Mr. GANSKE. [continuing] that patient should be seen——

Mr. BRAUN. Certainly.

Mr. GANSKE. [continuing] and should be evaluated in the emergency room; right?

Mr. BRAUN. Certainly.

Mr. GANSKE. Now, ex post facto, if the health plan denies treatment because you find out that that EKG was normal, is that right that they should deny payment?

Mr. BRAUN. Well, again, it depends—I mean there are certain things like contractual relations and like that. I mean——

Mr. GANSKE. Okay. Well, let's go to the contractual relations, because——

Mr. BRAUN. Yes, sir.

Mr. GANSKE. [continuing] you are an attorney. You mentioned that your plan uses clinical practice guidelines and utilization review to ensure that patients get the best quality.

Mr. BRAUN. Yes, sir.

Mr. GANSKE. I am going to read you a contract clause, and I would like you to tell me how this promotes quality care.

This is from a contract in Texas that promises patients medically necessary care. The plan defines "medical necessity" to mean, "the shortest, least expensive, or least intensive level treatment," as determined by the plan.

Can you tell us how language like that promotes access to the best quality care?

Mr. BRAUN. Well, again, I am not sure what contract you are reading from, but the concept——

Mr. GANSKE. I will provide you with a reference.

Mr. BRAUN. Okay.

Mr. GANSKE. Would that be something that your plan would use?

Mr. BRAUN. No, sir.

Mr. GANSKE. Do you think that that is an appropriate contract language?

Mr. BRAUN. Well, the word is appropriate. What we use for—and when we are considering care for, is the appropriateness of the care, the right treatment for the right person, at the right time. And, you know, what we look at is, is this care going to do the best thing for the patient; also, will it make the best use of the resources?

Mr. GANSKE. But by this contract language, the plan can specifically exclude anything except the cheapest, shortest, least expensive, least intensive level of treatment.

Mr. BRAUN. Well, there are bad contracts out there. I can't deny that. I mean——

Mr. GANSKE. So we ought to just let the free market—just let the individual sort that out? However, most people aren't lawyers. They don't read that contract language and probably wouldn't understand the implications of that anyway; would they?

Mr. BRAUN. Well, again, I come back to the fact that we would hope—and, again, I would have to speak for the vast majority of plans. Most of us are trying to do a good job of managing care. We are trying to evolve care; we are trying to take and move care to a place where we don't have to worry about things like this, where things are arranged ahead of time. And, again, our objective is to make certain that we best serve customers who are the members.

Mr. GANSKE. Mr. Chairman, I see my time has expired. I would be hopeful that we could come back around for a second round of questions.

Mr. COBURN. [presiding.] We will let the sitting subcommittee chairman make that direction.

Mr. BARRETT. Mr. Chairman?

Mr. COBURN. I would just inquire that two things that you mentioned, did you want them placed in the record?

Mr. GANSKE. With unanimous consent, Mr. Chairman.

Mr. COBURN. If there is no objection.

Mr. BARRETT. Mr. Chairman, maybe just do—if we could get copies of the contract that Mr. Ganske just read, I would appreciate it.

Mr. COBURN. We will, and without objection, they will be entered in the record.

[The information referred to follows:]

DEFINITIONS IN USE TODAY

"*Medical necessity* means the SHORTEST, LEAST EXPENSIVE, OR LEAST INTENSE LEVEL of treatment, care or service rendered, or supply provided, as determined by us [health plan], to the extent required to diagnose or treat an injury or sickness. The service or supply must be consistent with the insured person's medical condition at the time the service is rendered, and is not provided primarily for the convenience of the injured person or doctor."

—*Low Cost HMO*
from *Medical Necessity Determinations* by AMA, 1999.

AMERICAN ACADEMY OF FAMILY PHYSICIANS
March 19, 1999

The Honorable GREG GANSKE
U.S. House of Representatives
1108 Longworth House Office Bldg.
Washington, D.C. 20515

DEAR CONGRESSMAN GANSKE: It is with considerable pleasure that I write to convey to you the support of the American Academy of Family Physicians for H.R. 719, the Managed Care Reform Act of 1999.

As the largest of the nation's primary care physician organizations, with over 88,000 members, we have felt it very important to establish, define and support the rights of patients in the managed care environment. While we have long supported comprehensive managed care reform, H.R. 719 is the first bill that we feel secures these rights successfully without overregulating the practice of medicine, or compromising the role of primary care physicians in plans.

We deeply appreciate your willingness to listen to our concerns about protecting the roles and responsibilities of family physicians and other primary care physicians.

If there is a way that we can assist you in helping to secure passage of H.R. 719, we stand ready to help in whatever way we can.

Sincerely,

NEIL BROOKS, M.D.
Chair, Board of Directors

Mr. COBURN. The gentleman from—the gentlelady from California.

Ms. CAPPS. Thank you very much.

I want to touch—these 5 minutes go really fast. I want to touch on the comment of each of you, because it was so—we covered a wide range here today.

I want to start with Dr. Braun, because you are here representing HMO's, and I have heard from many insurance providers that

99 percent of their customers, their clients, are fine and happy and getting good service. It is that blip, you know, that gets all the headlines and all the stories. Well, you happen to be the provider for one of my staff members. And this was no life-threatening issue, but he had an accident, and by the time the doctor—his provider said he was ready for physical therapy, the time allotted in the insurance had elapsed, so he didn't get that. And the disabling effect—I just want to make the point that it is not just a patient, the one individual. It is their family that bears the effect of denied care, and also, in this case, the entire office felt the burden of that.

And so, I think these are not statistics that we are talking about, and you know this as well as I do, but human life. Doctor, I would like to give you time to respond, but I also have a question for Mr. Thomas.

But my point with you is I think we here on our questioning confused giving emergency service with the payment, in some of our exchanges with you. And I think you have impressed me with the—back to the Hippocratic oath—that good service, good care is going to be given, except that with the changing climate of reimbursement.

I think you are maybe seeing—and I hope that there is time for you to comment—patients not coming in because back in their mind, they are wondering, "Is this really an emergency, and will I get the coverage?" And that to me is the crisis—one of the crises that we are facing.

Mr. Thomas, I appreciated your testimony. And I am interested in a comprehensive bill of right—or however we are going to label this; it doesn't matter what we call—that talks about the gateway provider or the primary provider. And we seem to be making much of including OB/GYN, which I am totally delighted with, and the pediatrician, as well. But I am thinking of the whole array of individuals with chronic situations and the disabling conditions that can range from diabetes to cerebral palsy to a lot of situations where having to go through that primary provider is such an expensive, both in time and energy, situation.

Can you comment on that briefly? And, hopefully, we will get to some others——

Mr. THOMAS. Yes, thank you for the opportunity to comment on that——

Ms. CAPPS. [continuing] in this time.

Mr. THOMAS. [continuing] because a list of specialty access provisions would really be devoid of merit if it didn't really address the key problem and for people with chronic illness and disabilities, and that is, you know, people with multiple sclerosis, people with ongoing medical conditions. They get to know their disability or their chronic illness better than anyone, and they know when they need to access a specialist.

I have two artificial legs and went through a number of rehabilitation specialists and prosthetists in getting artificial legs made throughout the years, and I can tell you that I know exactly when I need to go see a prosthetist and go see a rehabilitation doctor or when I need to go see a prosthetist to get an adjustment to my leg done. And anyone with a chronic, ongoing condition knows the same thing.

So my view is that this is a very cost-effective way. It is not a stake in the heart of managed care. There are ways that you can link back the primary care case manager back into that treatment regiment and treatment plan. But to allow a certain amount of direct access visits to a specialist for a person with a chronic illness or disability, is just really critical. And I very strongly encourage this subcommittee to look at that.

Ms. CAPPS. Thank you.

Ms. AUER. You are absolutely right; patients are sicker when they come to the emergency department. And I thought it was my imagination, or I was getting old or maybe a little tired as working those shifts. But we looked at it in my own practice, and we see approximately 30,000 visits a year. And, indeed, the level of intensity of the services that we are having to provide have gone up. The patients are sicker now than they were several years ago.

Ms. CAPPS. This is not really good managed care?

Thank you.

Would you care to comment, since I have maybe a couple of seconds left, Dr. Braun?

Mr. BRAUN. Well I have to agree with Mr. Thomas. I mean when you do deal with people that have chronic illnesses, you often find they are probably more of an expert sometimes than the physician is, and you know that is part of the reason why I feel that the using of specialists in certain conditions is very important.

Ms. CAPPS. Thank you.

Mr. COBURN. The gentleman from North Carolina.

Mr. BURR. The gentleman has no questions, but I thank the chairman.

Mr. NORWOOD. Would the gentleman yield?

Mr. BURR. The gentleman would be happy to yield.

Mr. COBURN. The gentleman is recognized.

Mr. NORWOOD. Thank you, Mr. Chairman. There is never enough time, as you know, and this gives me enough time to say to my good friend from New Jersey, Mr. Pallone, when you are referring to healthcare bills, managed care reform plans in this subcommittee, kindly refer to the number. There are three Republican managed care reforms bills, and it might confuse somebody if you think they are all three the same.

With that, I want to——

Mr. COBURN. Would the gentleman yield from Georgia yield?

Mr. NORWOOD. Yes, sir.

Mr. COBURN. You mean there are some people that think all three are the same?

Mr. NORWOOD. That may be true, too.

Dr. Braun, you have had a busy life.

Mr. BRAUN. Yes.

Mr. NORWOOD. How old are you, if I may be so bold?

Mr. BRAUN. Well, there is days I feel 102, sir, but I am actually only 50.

Mr. NORWOOD. Well, you have been a doctor, a lawyer, a preacher, and now you are running a healthcare plan.

Mr. BRAUN. Yes, sir.

Mr. NORWOOD. Have you been able to get more than 10 years in any one of those?

Mr. BRAUN. I have run a few of them simultaneously.

Mr. NORWOOD. Have you?

Mr. BRAUN. And don't require much sleep.

Mr. NORWOOD. Well, I want to talk to you, primarily, though I sure do have questions of the other witnesses.

But I am interested in your concept of a market. And in your present occupation, it sounds to me as if you believe a market in healthcare is made up of those who buy the healthcare and those who sell the insurance plan. And that is, indeed, a type of market. There is no question about it.

But the point I would ask you to consider in the future is that, if you are talking about healthcare and a market, therein; it really only requires a patient and a doctor. And there is no healthcare market today, generally speaking, between the patient and the doctor. And so, market forces may do a great job for the person who pays for the plan. And market forces may do a great job for the insurance company, but that is not what we are here about; is it?

We are here about today—what will market forces, Federal forces, State forces, any forces do to help the patients in this country who are clearly—not at George Washington—that are clearly being denied benefits that their employer paid for?

And I would ask that we all keep that in mind when we think about markets, because that is not what we are doing today.

You made some interesting comments, and it was a little hard for me to follow your presentation. A lot of times you would say that, "I can only speak for the ones I work for," meaning questions you were asked about emergency room. And you were not willing to go into that very far, other than those emergency rooms that you had had personal information with. Yet, many other parts of your testimony are laced with, "Well, I have to speak for the mass majority of plans." And if you are going to speak for the vast majority of the plans in other areas and speak for just what you know for in some areas, it gets a little confusing to people like me as to how much and what of this—how can you speak for mass majority of plans?

And I know your plan is great; I am not saying anything about that. But we are worried about some of those out there that aren't. And I am very impressed with the quality of work you do. I am certain that people in your plan are generally very well served.

I have been talking about this issue now for a very long time, and in all that last 10 years that I have been talking about this issue, I have never had anyone ever come up to me, including any panel of witnesses, that would say, "Gee, you know, we are really doing a rotten job in my plan, and I am here to make sure that we can continue to do a rotten job." Everybody comes in and says their plan is the greatest healthcare plan in the country, but the fact remains, there are plans out there not operating up to the standards that you operate in.

Now, our job in Congress is to set a floor that plans cannot fall below. There has got to be, for God's sake, in medicine, a bottom line there.

You are already meeting those standards you have said, so, regardless, it won't matter which one of these bills we pass. You are

not going to be affected because you are already doing it. You are currently allowing your employees to go——

Mr. COBURN. Will the gentleman yield?

Mr. NORWOOD. [continuing] to an out-of-network emergency room in an emergency——

Mr. COBURN. Your time has expired.

Mr. NORWOOD. I ask for unanimous consent for 1 more minute to finish this line.

Mr. COBURN. Objections to unanimous consent, so ordered.

Mr. NORWOOD. This won't take but—unanimous consent, guys; this is important.

Thank you, Mr. Chairman.

You presently allow your enrollees to go to an out-of-network emergency room in an emergency; right?

Mr. BRAUN. Yes, sir.

Mr. NORWOOD. Isn't that what you said?

Mr. BRAUN. That is correct.

Mr. NORWOOD. Your plans allow enrollees to see a specialist when a specialist is clinically indicated? You do that great work?

Mr. BRAUN. Yes, sir.

Mr. NORWOOD. Your plans allow women direct access to OB/GYN for routine care?

Mr. BRAUN. Yes, sir.

Mr. NORWOOD. Good work.

Your plan allows parents to take children to see a pediatrician?

Mr. BRAUN. Yes, sir; pediatricians or primary care doctors.

Mr. NORWOOD. Mr. Braun, the bill you have endorsed is H.R. 216, and we are grateful for your endorsement.

Mr. COBURN. The gentleman from Wisconsin is recognized.

Mr. BARRETT. Thank you, Mr. Chairman.

I would like to sort of look at a real world situation and get your thoughts on this.

You have a woman who is pregnant—7, 8 months pregnant. She is in an employer-sponsored plan, and she is due to give birth around the turn of the year. She receives a notice from her employer that her HMO will no longer be part of the employee package; she has to move to another HMO. So, naturally, she calls the HMO and asks whether—if the baby is delivered after the first of the year, she will be able to have that covered under current HMO policy. She is told by the HMO that, "No, she is not," and would have to switch to a physician that is covered under the HMO policy.

I look at the different plans that we have before us, and it looks to me as though Mr. Dingell's bill, Mr. Ganske's bill, Mr. Norwood's bill covers this, although it does not look as though Mr. Bilirakis' bill does cover this.

From your perspective—all three of you—is this something that should be covered? Or is this something that the market can deal with, and that an individual, a woman, in particular, who is 7 or 8 months pregnant, should be required to change her obstetrician at that stage of her pregnancy?

Mr. Thomas, we will start with you.

Mr. THOMAS. Well, the Commission looked at this question and made a very strong recommendation that that person with the

pregnancy should be able to maintain their current providers through the time of their pregnancy and some reasonable time thereafter and then have an opportunity to switch over to whatever new providers would be provided that would be available under the new plan.

That same protection was extended to people undergoing a course of treatment with disabilities or serious or chronic illnesses, and I think it is just as important in that area as well, to have some bridge, some ability to arrange for a different or an alternative provider network while that involuntary change in plan or providers occurs.

Ninety days, some would argue, is arbitrary and is just kind of a figure that was a compromise on the Commission. There are some who wanted that period of time to be much more. But it seems to me that 90 days is a reasonable point.

Mr. BARRETT. Dr. Braun?

Mr. BRAUN. Well, my wife and I have four kids. I have never quite heard pregnancy being called a chronic disability, although she might disagree with me.

In the situation that you are talking about, again, we do a case-on-case evaluations about that. I think some of the problem is people confuse the concepts of continuity of care which is what you are talking about here, with the idea of convenience of care. To the great part, when I have been involved in situations like this one, somebody has been in the last trimester of pregnancy, we have attempted, when at all possible, to continue that care with the original provider.

Mr. BARRETT. Well, let me be more specific, because my wife and I have four children, and the constituent I am referring to is my wife with our fourth child. And she was told that the plan would not cover it.

Now, would your plans cover that?

Mr. BRAUN. My plan would cover, in the last trimester, would cover the original provider; yes.

Mr. BARRETT. Do you think any comprehensive HMO bill of rights bill would cover that?

Mr. BRAUN. Well, again, I mean I feel that legislation is not always the solution to things like this and——

Mr. BARRETT. So you think it would be more preferable, then, without legislation, if the HMO decided that she would have to switch obstetricians in the eighth month?

Mr. BRAUN. Well, again, you know, the problem with legislation is that it ties you to the post, and, you know, not all legislation carries out the intent for which it was originally done.

And, you know, we have seen this in some other cases like the drive-by delivery laws. I mean there has been legislation that has been passed that didn't exactly come out the way it was originally intended.

I feel, again, that the way to resolve this is through contractual issues and through market issues.

Mr. BARRETT. So, you are going to tell a woman who is 8 months pregnant that you and your contract——

Mr. BRAUN. I am not going to tell her.

Mr. BARRETT. You want me to tell her?

Mr. BRAUN. It is your wife.

Mr. BARRETT. I will have you tell my wife, and I am much calmer about this than she would be if she were sitting here—she gave birth on December 27—but I find it unconscionable that we would tell an 8-month pregnant woman that she has got to switch obstetricians.

Mr. BRAUN. Again, I don't know which plan you were in. It wouldn't happen in the ones I know.

Mr. BARRETT. Well, and that is the point. And when Dr. Ganske reads from a bad contract, do we, as Congress, just sit there and say, "Well, that's a bad plan." We are dealing with real people.

Mr. COBURN. Would the gentleman yield for a minute?

Mr. BARRETT. I would be happy to yield.

Mr. COBURN. This is an area that I happen to have a lot of—and I will just give you an example—Blue Cross and Blue Shield of Oklahoma. Right now, in Wagoner County, they lost their only obstetrician. They have five patients that they won't assign to other qualified doctors, even though they are Blue Cross and Blue Shield doctors, but they are not their HMO-qualified doctors. So we have five patients that are going to drop in with no prenatal care in the last 12 weeks of their pregnancy. That is the kind of problem Dr. Ganske and Mr. Barrett are referring to. It is an absence of real caring for the patient, and I would see that the gentleman's time is up, and would yield.

Mr. BARRETT. It is always a pleasure——

Mr. COBURN. And I thank the gentleman for yielding.

Mr. BARRETT. It is always a pleasure to yield to you, Mr. Chairman.

Mr. COBURN. Mr. Greenwood.

Mr. GREENWOOD. Thank you, Mr. Chairman.

Let me direct a question to Mr. Thomas, and that is the President's Advisory Commission did not address a couple of issues that seems to be in most of the bills that we have referred to today. It did not address liability, as I understand it, and did not address medical necessity. Why do you think that is? And from your experiences, can you tell us why the Commission decided not to touch those two highly controversial issues?

Mr. THOMAS. Well, while the final report did not discuss those issues in great depth, the Commission certainly considered them—in particular, the liability provision. This goes back to my initial remarks that I made talking about the diversity of the panel that was assembled and the rule that we established from the outset, which was consensus, which turned into unanimity, and, therefore, you really couldn't go forward with a recommendation that didn't have unanimous support. And there were at least four health plans represented on the Commission. There were at least three or four business representatives. There were others that had questions. There was a lot of support to do something about health plan liability, but we simply could not reach consensus on it.

And so in the preamble of our Commission's report on the bill of rights, we specifically make reference to the fact that we are not recommending anything along the lines of implementing this bill of rights, but that that certainly could include Federal or State legislation, as well as voluntary means of implementing.

Mr. GREENWOOD. Okay.

Mr. THOMAS. As for medical necessity, that issue was raised in the subcommittee that I chaired and quickly degenerated into a discussion about costs and that if you established a "medical necessity" definition that we would ultimately be mandating benefits in a certain way. That is, I think, is a wild overstatement to the issue, but I do think that that was the approach that was used. And, unfortunately, with the rules that we had established, that effectively killed that debate.

Mr. GREENWOOD. Okay.

Let me address a question to Dr. Braun—and if you tell me you have a degree in psychiatry, I am going to want to start to see some diplomas.

In your plan, who makes the decisions about medical necessity, in terms of their qualifications? Are they physicians? Are they healthcare providers? Are they just trained personnel? Who makes the initial decisions?

Mr. BRAUN. We have a staff of trained medical people, nurses, that do the initial screenings. If the procedure is to be approved, they make those approvals. Anything that is in doubt is forwarded to myself or my medical director. We have certain guidelines that we apply to those determinations.

Mr. GREENWOOD. So let me just understand—in your plan, the nurses can approve procedures, but only a physician can deny a procedure; is that correct?

Mr. BRAUN. That is correct; yes, sir.

Mr. GREENWOOD. Okay. Do you know how your association that you are speaking for today would feel about a requirement that it be that way across the board? And do you have knowledge as to what extent your practice is customary?

Mr. BRAUN. I would refer you to the AAHP for their opinion on this, but I do believe that in the vast majorities of the plans, it is a physician only that can make a denial. I mean that is I think the general accepted practice in the industry.

Mr. GREENWOOD. Okay. And when you make a denial and it is questioned by a physician—if the physician requests it, do you supply the physician with a standard that you used to make that decision?

Mr. BRAUN. Yes, sir. In fact, we, and the plans that I have worked for, usually before I will issue a denial—I have got to tell you, we do hundreds and thousands of, you know, evaluations every year. The number we finally end up denying is a very small fraction—1 or 2 percent. Before I will do that, I will call, and my medical director will often call, and see if we can't get a hold of the physician involved, and have a discussion with them, and talk to them about it. Oftentimes, this will take, when we have the additional information, and turn something that might possibly be denied and turn it into something that will be approved. Or, in the alternative, there might be another course of treatment that we can mutually agree on.

Mr. GREENWOOD. And, again, the same sort of similar question—do you see a problem in terms of a policy, if it was required that every plan provide a physician, upon request, the standard with which the denial was made?

Mr. BRAUN. Again, I would like to see this be something that would be in the way of a code, in a way of something that is voluntarily enforced. I would prefer to see that rather than legislation, because, again, that would tie us too much to a standard that may not be appropriate.

Mr. GREENWOOD. I am not necessarily—I didn't necessarily imply that one would legislate the standard——

Mr. BRAUN. Yes, sir.

Mr. GREENWOOD. [continuing] only legislate the notion that whatever standard is being used, it is shared, then, with the physician.

Mr. BRAUN. Possibly.

Mr. GREENWOOD. Thank you, Mr. Chairman.

Mr. COBURN. Dr. Braun, I would like for you to go to page 8 of your written testimony.

Mr. BRAUN. Yes, sir?

Mr. COBURN. In the first paragraph, about the middle, there is a sentence that starts, "It has become fashionable."

Mr. BRAUN. On page 8, sir? Maybe I am missing that, but on my page 8, I don't see that.

Is this the one with the bullet points?

Mr. COBURN. I have got a statement on "Patient Access to Quality Care," by Dr. Joseph Braun, on behalf of AAHP. In the right-hand lower corner, it says page 8.

Mr. BRAUN. Okay, and you say that there is a—but what was the——

Mr. COBURN. It is the page before that.

Mr. BRAUN. Oh, okay. The military page 8, right? Okay.

Mr. COBURN. Is that the one that has the paragraph, about the middle of it, it says, "It has become fashionable"——

Mr. BRAUN. Hold on a second.

Mr. COBURN. It will be on your page 7.

Mr. BRAUN. Well, go ahead and ask the question, sir.

Mr. COBURN. Okay. It is at the bottom—I am sorry; it is the bottom of page 6, roman numeral III.

Can you start reading the last sentence and finish to the end of that paragraph?

Mr. BRAUN. Yes, sir.

"It has become fashionable for health plan opponents to promote legislation by developing caricatures of health plan practices based on anecdotes and rarely are the facts about the quality of medical care delivered to health plan members considered or even offered."

You want to the end of the paragraph, sir?

Mr. COBURN. To the last sentence.

Mr. BRAUN. Yes, sir.

"These omissions harm patients by misleading them about their healthcare system and what to expect. However, the record refutes these myths."

Mr. COBURN. Thank you.

I want to talk to you about medical necessity, as it relates to a specific case—one of these anecdotes and these myths that you are talking about in your paper here.

Mr. BRAUN. Yes, sir.

Mr. COBURN. A couple of years ago, a woman named Lomona Adams, 3 in the morning, had a 6-month-old baby, Jimmy Adams, crying, moaning, sweaty, looking really sick, temperature of 104. She phones her 1-800 health number and describes this situation to the reviewer. The reviewer says, "I will authorize you to go to the an emergency room, but the only one that we authorize is Scottish Rite Hospital."

So, Lomona Adams says, "Where is it?"

"Well, I don't know; find a map."

Well, it turns out the Adams' family lives east of Atlanta, Georgia. Scottish Rite is on the other side. So at 3:30 in the morning, Lomona and her husband wrap up this really sick baby. They get in the car; they start driving. The kid really looks sick.

They are driving through Atlanta; they pass three hospitals—Emery, Baptist, and another one. But you know what? They don't have authorization to stop. And they know that if they stop at that emergency room, they are liable to get stuck with a bill of thousands of dollars. So they keep pushing on.

Twenty-three miles from Scottish Rite, little Jimmy has an arrest in the car. It is rainy out, stormy night—picture that. Mom and Dad resuscitating this little 6-month-old baby in the car, on their way to the only authorized hospital, miles and miles away.

Well, little Jimmy is tough; they eventually get him alive to Scottish Rite—this is all outlined in a book called, "Health Versus Wealth."

However, because of the arrest, Jimmy ends up with gangrene of both feet and both hands which need to be amputated.

The judge which reviews this case determines that the margin of safety by that health plan is, quote, "razor thin." I would add about as "razor thin" as the scalpel that had to cut off his hands and feet.

Today, little Jimmy—I have spoken to his mother about a week ago—has bilateral hand prosthesis which Mom and Dad have to help him put on. He is able to get his bilateral leg prosthesis on himself. He will never be able to caress the cheek of the woman that he ends up loving; he will never be able to play basketball. I guess this is one of those "anecdotes" that you talk about; right?

You know what, Dr. Braun? Those "anecdotes," if you prick their finger, they bleed. Little Jimmy, the anecdote—which I never want to hear you talk about "anecdotes" in front of this panel again—little Jimmy will live the rest of his life with the mistake that that HMO made.

And you know what? They can defend themselves, because you know the plan under ERISA and under the GOP language that passed last year in the House, gets to decide what is, "medically necessary."

Imagine the dilemma that this puts a young mother in. If I stop sooner, I may be faced with thousands of dollars of bills, but if I don't, maybe my little baby will end up like Jimmy Adams.

Mr. BURR. Would the gentleman yield?

Mr. COBURN. I will be finished—I will yield back in a minute.

You know, when I see people argue against Federal legislation on the basics of anecdotes, I could give you one anecdote after another. And those anecdotes happen to be our employees, family members, friends. It is situations likes those that are why more than 80 per-

cent of the people in this country think we need Federal legislation to correct those anecdotes, those horror stories.

What kind of response do you have to a situation like that? Is this something that AAHP should just ask its plans to voluntarily fix, so that the market can work? I just point out that Lomona and her husband didn't have any choice.

That, Dr. Braun, is the reason why we are here today. I am sorry, but I deeply resent your statement that was in the record about anecdotes. And I will be happy to allow you to respond.

Mr. BRAUN. Certainly this is a human tragedy, and I really certainly feel sorry for these people. I mean, being trained as a physician, I can tell you that that certainly is a sad case. And there are human lives involved. I mean one of the reasons that I am in the profession that I am, is I feel that managed care has a way to evolve.

I can trade anecdotes with you; I have practiced medicine in a time when we had indemnity medicine. I can tell you stories about people who declared bankruptcy under the indemnity system because they couldn't afford the co-pays under the system. There were problems back then with access. People that were uninsured couldn't get access to care either.

I mean there has not yet been a suitable system developed. Where we are at in managed care is simply a weigh station along the way. I would hope that I can be part of a greater process—that the AAHP, that the industry can be part of a greater process. And there can be a public and a private partnership that will move this crisis that we have that is called the "American healthcare system" forward so this sort of story won't happen.

Mr. COBURN. Well, I thank you for those comments. I would point out that the bill that I am sponsoring deletes some of the language from last year's bill that would have been "costers"—I am sensitive to the cost argument. I would also point out that a survey by the NFIB—the NFIB has pointed out that 95-98 percent of their health plans would not drop coverage for patients if you were talking about an increase in premiums of less than $3 per month per family, and that that type of coster is well within range of the type of bill we are talking about.

And, Congressman Burr, I would yield to.

Mr. BURR. If the chair would yield for one question. And I would certainly say that when we all hear a story like that, we look for what went wrong. I don't think that even the person who made the determination on that, given that they saw the situation, would want to rethink the process they have gone through.

But I passed on an opening statement; I passed on questions to all of you, but I feel compelled to ask one very important question, so that it helps us to stay focused on why we are here and what we are doing. Let me just ask each of you to respond.

Who has a greater opportunity at quality heath care? Somebody who is insured, or uninsured?

Ms. AUER. Sir, today, it is easier for me to care for a patient who is uninsured than a patient who is covered by a managed care plan.

Mr. BURR. Doctor?

Mr. BRAUN. Well, again, this question has a lot of ramifications. I mean we are facing, again, a problem in this country in that we are finding the number of uninsured rising. And even in cases where people are working, we are finding people that are working and not being insured. This is certainly a great social calamity, and one that I, personally, am very concerned about.

I mean, in addition to the other things that were mentioned, I also teach medical ethics, and there is a concept known as "distributive justice" that I think is a very important one for this country to be thinking about. I mean, here we are, the richest country in the world, and yet we have people who through parts of the years not insured.

You know one of the things that we have always prided ourselves on is the fact though even that people who were uninsured, we had a great social conscience, and these people could find care. I know I do a lot of uncompensated care when I worked in emergency rooms. I mean, to me, it is a very sad question.

I hope, certainly, that people, especially in my plan, that our insureds get the best of care, because that is the reason I am in this business, so they can get the best of care, so their lives can be made better.

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. BURR. Could I just ask for the last one to respond?

Mr. BILIRAKIS. Well, very quickly——

Mr. BURR. This is the only question——

Mr. BILIRAKIS. [continuing] if you would, Mr. Thomas.

Mr. BURR. This is the only question I have asked in this hearing, Mr. Chairman.

Mr. THOMAS. Very quickly—I think the question really comes down to whether you can get the care when you need it and whether you are insured or not. And even—as I have seen, over the course with the Commission, even when people are insured, many people have difficulty getting the care they need, when they need it, for a variety of the reasons that we have talked about today.

Mr. BURR. Clearly, since the question was stated, who can receive a better quality of care? Let me remind all of you that we don't judge you just solely off of emergency care. This is ongoing care. It can be preventative care, and that is certainly something that is provided in many avenues for the insured, and I don't limit that just to one product or the other. But, clearly, for an individual in an tragedy who goes to the emergency room, somebody picks up the costs, and I think it is important that we understand that somebody picks up the costs.

I thank the chairman.

Mr. BILIRAKIS. Well, the concern is that we have another panel. We have three individuals just sitting there cooling their heels, and it is unfair to them.

Mr. Green to inquire.

Mr. GREEN. Thank you, Mr. Chairman. I will be as fast as I can.

Dr. Auer, and this was touched on earlier, but just as every managed care bill addresses the access to emergency care issues, I am always concerned about the details. And, for example, the bill that our chairman introduced this year, and it was the Republican leadership bill from last Congress, did not include "severe pain" as a

legitimate health emergency that would allow a person to seek treatment outside their plan—in other words, to access an emergency room. Nor did it require plans to pay for anything other than stabilizing care. Would the emergency care provision, as drafted in that bill, adequately protect patients who are faced with what could be a life-threatening emergency?

Ms. AUER. I am sorry, sir. Are you referring to the chairman's bill?

Mr. GREEN. In the chairman's bill, as it is introduced at this time; yes, ma'am.

Ms. AUER. I appreciate that the chairman has taken the time to introduce this bill and look at the subject, but it does not provide the same type of language or coverage that exists in EMTALA or the Balanced Budget Act, and that is what I would urge you all to look at—is providing that same care that exists under EMTALA and the Budget Balanced Act to the Medicare and Medicaid population, to all Americans.

Mr. GREEN. Okay. Is——

Mr. NORWOOD. Would you yield for a clarification on what you are asking?

Mr. GREEN. Yes. I asked about "severe pain," and is that included in the Balanced Budget Act? Maybe you didn't quite understand.

Ms. AUER. Yes, it does.

Mr. GREEN. Okay.

Ms. AUER. That is included——

Mr. GREEN. I will yield if——

Mr. NORWOOD. I want to point out to you that the task force bill that came out and was voted on was incorrect in its emergency room language. And I don't think any of us would disagree with that. I also don't think it came out of the task force with that intention. And the staffers who are here who blew that, are no longer here.

Mr. GREEN. Oh, okay. Now, I am glad to hear that, obviously.

Mr. BILIRAKIS. Of course that isn't the reason they are no longer here.

Mr. GREEN. Back to the question——

Mr. BILIRAKIS. Please proceed.

Mr. GREEN. The concern, as an emergency room physician, you know, do you feel like it should include "severe pain" as a legitimate health emergency for a layperson?

Ms. AUER. Absolutely.

Mr. GREEN. Okay. And I am sorry; I didn't understand the comparison you said to the Balanced Budget Act. Was that included in the——

Ms. AUER. The Balanced Budget Act does include "severe pain" as a provision that it would cover.

Mr. GREEN. So for the sake of uniformity, we probably should, too, in this committee and in this Congress?

Ms. AUER. Yes, I would urge that.

Mr. GREEN. Okay.

Dr. Braun, you state in your written testimony that proposals that would set strict rules for health plan referral procedures may have the unintended and adverse consequence of forcing plans into

a one-size-fits-all model for referrals. How does this concern apply to allowing pregnant women direct access to their OB/GYN?

Mr. BRAUN. Well, I believe I already answered. I think we endorse it——

Mr. GREEN. Well, I am sorry, because of my schedule here.

Mr. BRAUN. Yes.

Mr. GREEN. I didn't hear the response.

Mr. BRAUN. We do endorse already the direct access to OB/GYN's. I think that the thing is, again, about the referrals is we feel that this is something that we would like to see the member plans adopt voluntarily.

Mr. GREEN. Okay.

Dr. Thomas—or Mr. Thomas, in your——

Mr. THOMAS. Doctor is fine.

Mr. GREEN. We are all doctors here.

In your testimony, you advocate the creation of a basic set of consumer protections at the Federal level, and that all health plans, including self-funding ERISA plans, would be required to meet. Do you believe these protections to be applicable in both the PPO plans? And, if so, do you believe PPO's should be required to apply the same healthcare outcome data as the traditional managed care plans?

Mr. THOMAS. Yes, I do. The Commission's report applied to all consumers in all health plans. And so if you have got an indemnity plan that, obviously, doesn't have networking issues, then access to specialty care issues become less important than if you have a closed panel, and you have got some very strict reviews of that.

But, yes; the point is to apply that to all plans, including ERISA plans. And, frankly, if you don't—if you have some plans that aren't covered by the bill of rights, what you will ultimately create is a disincentive to improve quality, because plans won't be apt to develop programs and to create new, innovative ways of treating complex patients, because they will be afraid that ultimately people with those conditions will join up on their plans, and it will be more expensive for them.

So, ultimately, by applying this to all plans you level the playing field and let plans compete based on quality and consumer satisfaction, instead of avoiding risky patients.

Mr. GREEN. Okay; thank you.

Thank you, Mr. Chairman. I look forward to the next panel.

Mr. BILIRAKIS. Dr. Coburn.

Mr. COBURN. Thank you, Mr. Chairman.

Dr. Braun, I just want to visit with you and make sure I understand. Your plan allows access for emergency services?

Mr. BRAUN. Yes.

Mr. COBURN. Outside of the plan; is that correct?

Mr. BRAUN. For emergency service.

Mr. COBURN. And how do you evaluate whether or not you pay for that?

Mr. BRAUN. Well, again, you have to look at the totality of the situations. We try and take—if we are going to error, to error on the side of the patient. Part of the reason that the plan exists, that the insurance exists, is to take care of the patient, to make sure that their healthcare status has improved. We don't apply——

Mr. COBURN. I am not asking about your motives. I want to know exactly how you do it. Do you have a set of guidelines that are determined by physicians? Or do you have a set of guidelines that is a prudent layperson guideline?

Mr. BRAUN. A——

Mr. COBURN. Do you have a prudent layperson guideline?

Mr. BRAUN. No, sir; we do not.

Mr. COBURN. The answer is, "Not."

And the fact is, is lots of people go to an emergency room with what they consider, and most of their friends would consider, to be an emergency condition. So, in fact, your testimony is, your plans decides, after the fact, with a medical professional, rather than a patient, what somebody who is not used to those symptoms, who has not been in that experience, would decide otherwise?

Mr. BRAUN. Well, I believe you are kind of misconstruing what I said. We, again, look at those. I mean, in fact, what has happened with most of the healthcare plans, we have tried to do two things. We have tried to take and, again, come up with contractual arrangements with the emergency room so that patients could be seen in these emergency rooms. I mean, the sad thing——

Mr. COBURN. Do you have a contractual prearrangement with all the emergency rooms around the country?

Mr. BRAUN. We are in the process of doing that right now; yes, sir.

Mr. COBURN. Throughout the whole country?

Mr. BRAUN. Well, throughout—for George Washington, throughout the metropolitan area of DC.

Mr. COBURN. All right.

Mr. BRAUN. When I was living in Houston, I was very active in trying to set the same process up down there.

Mr. COBURN. But the point is, the guidelines aren't a prudent layperson guideline. So we are going to take somebody, after the fact, and decide that with medical personnel or professional, rather than patient; is that correct? Is that a fair statement of how that is decided?

Mr. BRAUN. Well, again, what is happening in reality is many healthcare plans are being forced into a position where they are paying for just about all the emergency room care, and there is very little medical decisionmaking being done on either side.

Mr. COBURN. Well——

Mr. BRAUN. I mean, by the patient or by the medical staff.

Mr. COBURN. I am not sure I agree with that. You know, don't misconstrue my opening statement. The reason you all are here today is because you haven't taken good care of the market. And the problems associated to access for care and quality care and specialist care have not been addressed, and so, therefore, your business is put at risk, and the Congress is looking at it because you haven't used the market.

Mr. BRAUN. Certainly, I understand that.

Mr. COBURN. And, you know, I want to make sure the record is clear, is what I heard earlier was that there wasn't a big problem with access emergency care in your plan—and I am not saying there is—but I think there is a pretty good unanimity among this panel that a prudent layperson definition is one of the things that

should decide that. And that is not a hard thing. There are lots of things—I run my patients out of the emergency room on every weekend and say, "Don't go to the ER. I'll see you in the office," or, "We will see you Monday." So, not everybody is an over-utilizer when it comes to this.

The second point that I would like to make with you, in terms of the practice—what are the problems that you see with Dr. Ganske's bill, in terms of what it says? Why couldn't the marketplace work with Dr. Ganske's bill in place, as well?

Mr. BRAUN. Well, again, what I would like to see happen is there be a public and private partnership. I mean I think—to be honest with you, I think one of the biggest problems is there is an information mismatch. What is happening in this country right now is we would like to make our patients into consumers; we would like to make our doctors into informed providers.

The problem is, is what has happened in the United States right now, is we have a system that has an awful lot of waste in it. And the reason the waste is there is because there is a lot of variation in the way people practice——

Mr. COBURN. No.

Mr. BRAUN. [continuing] medicine.

Mr. COBURN. No. The reason the waste is there is you all have destroyed the doctor/patient relationship.

Mr. BRAUN. Well, I——

Mr. COBURN. The doctor is no longer accountable to the patient, who is no longer paying the bill; therefore, a third-party is involved.

Mr. BRAUN. Well, I would——

Mr. COBURN. And everything we have done—let me finish my tirade and then I will let you have one.

We have destroyed the obligation, through third-party, of the doctors' responsibility to the patient, and the patients' responsibility to the doctor, and, therefore, we get overutilization on the part of physicians and over-utilization on the part of patients, and overutilization when it comes to paperwork to try to control something. And that is why I referred to the "Sovietization" of managing our healthcare dollars in this country. We will never manage them if we continue to destroy the doctor/patient relationship.

And, Mr. Chairman, I would just like the kindness to allow him to respond to that question—and yield back.

Mr. BRAUN. I totally concur with you about the patient/physician relationship. I feel this is a very important relationship. The relationship I would like to see built is one where the physician is informed and understands the best practices, and the patient is also totally informed, too. I mean the great, great promise that managed care holds is the fact that we are finally looking at what we do.

You and I were both trained in a system where we saw one, we did one, and we taught one; nobody ever looked at which one was the best.

What I am saying is managed care does offer the possibility of us looking to see what is the best way to do things. I mean if we don't do this, we are going to find ourselves in a position where

there is going to be more demand on this system, than the resources that are there to fulfill it.

Mr. COBURN. And I think you will see that I alluded to the positive benefits of managed care in my opening statement.

I yield back.

Mr. BILIRAKIS. Thank you.

Mr. Whitfield.

Mr. WHITFIELD. Thank you, Mr. Chairman.

Dr. Braun, how many companies would you say contract with your health plan to provide healthcare for their employees?

Mr. BRAUN. I believe it is about 400 or 500, sir.

Mr. WHITFIELD. Four or five hundred companies?

Mr. BRAUN. Yes, sir.

Mr. WHITFIELD. And are these some Fortune 500 companies?

Mr. BRAUN. I wish we were that big. The biggest one we have is the Federal Government.

Mr. WHITFIELD. Federal Government?

Mr. BRAUN. Yes, sir.

Mr. WHITFIELD. But you have some medium-sized companies, I would assume?

Mr. BRAUN. Yes, sir.

Mr. WHITFIELD. Now—and how many individuals do you provide healthcare for?

Mr. BRAUN. About 86,000.

Mr. WHITFIELD. Eighty-six thousand?

Now, I am assuming that periodically you set down with these companies and you enter into—you discuss the coverage that you will provide, and the amount of money that they are going to pay, and you enter into a contract with them.

Now, how often do they complain to you about the service that you are providing their employees? I mean I am——

Mr. BRAUN. It is very rare, in fact. I mean one of the things that we do talk to them quite a bit about is the fact that we have moved several of these plans from where they were insured with other entities to a place where they not only got better costs but better services. I mean we don't have a string of people coming in and telling us they are upset about what they are paying and what they are getting.

Mr. WHITFIELD. So, at least from the companies that you deal with, they evidently are relatively satisfied with your coverage, I am assuming?

Mr. BRAUN. Yes, sir, I would say. I have only been there 5 months, but I would, yes, sir.

Mr. WHITFIELD. Yes; Okay.

Now, Dr. Auer, I think you said that maybe you treated like 30,000 patients a year in the emergency room, or your group does. And of that, what percent would you say are covered by HMO's?

Ms. AUER. The Seattle market is a very high-penetration of managed care, as you might imagine. And we treat approximately, in my area, 72 percent of managed care patients; not all of those are HMO's, but some form of managed care.

Mr. WHITFIELD. But to help—to just have a little bit of better understanding of how pervasive this problem is, from your testimony, it appears that you do have significant problems with HMO's that

you—I mean I think you even made the statement in here that they really are proving to be an obstacle to good healthcare. I mean, is that your honest—that is your feeling about it; right?

Ms. AUER. Unfortunately, sir, there is not a day that goes by where we are not dealing with these issues. And if I could give you just one example.

Your health plan sounds great.

But, for example—and this is the reason that I think we need a Federal standard—is we had a patient come in from out-of-plan. He was diabetic, had cut his hand, came to the Seattle area on business. His hand got painful, red, and sore. He thought it was infected; he was right. He came to see us; we had to take the stitches out, give him an IV antibiotic, send him on his way with oral. And his claim was denied for payment, and we appealed it.

And the medical director sent us a letter that said, "Yes, this was medically necessary, but you were supposed to call us in 3 days and you didn't, so we have denied it." Now, how were we to know that?

Mr. WHITFIELD. Now what do you do in that situation? Do you, then, bill the individual? Or do you all just eat that cost?

Ms. AUER. Well, it depends; we do both. We will bill the individual, but we often eat the cost.

Mr. WHITFIELD. Yes.

Now, of course, you, obviously, support the prudent layperson standard, and I assume, Mr. Thomas, you would support the prudent layperson standard?

Mr. THOMAS. Yes, I do.

Mr. WHITFIELD. And, Dr. Braun, will you support it? Would you support that standard?

Mr. BRAUN. At this point, I would say that the question of emergency medicine care, again, relies on the individual cases. And, you know, for the most part, the patient is best able to determine it. But as for legislation, I wouldn't say that I am particularly in favor of one form of legislature or another.

Mr. WHITFIELD. Mr. Chairman, I yield back my time.

Mr. BILIRAKIS. All right.

I think in the interest of time here, we will go on to the next panel, but there will be—most certainly—additional questions that will be submitted to you in writing.

Are you all willing to respond to them——

Ms. AUER. Certainly.

Mr. THOMAS. Yes.

Mr. BRAUN. Yes, sir.

Mr. BILIRAKIS. [continuing] Within a reasonable period of time?

Ms. AUER. Yes.

Mr. BILIRAKIS. Mr. Bryant, you haven't had your opportunity yet? Please, feel free.

Mr. BRYANT. Mr. Chairman, thank you. That was my intent. I did have a question for Dr. Braun that I was going to ask that he submit in writing, and I will just go ahead and do that, with your permission.

And then in the interest of time and out of respect to this panel and the next panel, I will waive any further questioning.

Mr. BILIRAKIS. Thank you very much.

Okay this panel is discharged. Thank you so much. You have been very helpful. And sorry it took us as long as it did to get through all this.

Panel two consists of Dr. Thomas R. Reardon, president-elect of the American Medical Association; Ms. Mary Nell Lehnhard, senior vice president, Office of Policy and Representation, Blue Cross and Blue Shield Association; and Mr. Ron Pollack, executive director of Families USA.

Ms. Lehnhard and Dr. Reardon and Mr. Pollack, your written statement, of course, is a part of the record. I will turn the 5-minute light on and would hope that you could stay as close to it as you might be able to. And I apologize for making you wait as long as—but that is the way it goes. Anyhow, Dr. Reardon, please, proceed.

STATEMENTS OF THOMAS R. REARDON, PRESIDENT-ELECT, AMERICAN MEDICAL ASSOCIATION; MARY NELL LEHNHARD, SENIOR VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION; AND RONALD F. POLLACK, EXECUTIVE DIRECTOR, FAMILIES USA FOUNDATION

Mr. REARDON. Thank you, Mr. Chairman, and members of the committee. I thank you for allowing me to testify.

My name is Dr. Thomas Reardon; I am president-elect of the American Medical Association. I want to thank you for inviting me to testify today, and especially for holding this hearing on this critically important subject—patient access to healthcare information.

At the outset, let me emphasis that virtually all patient protections are interrelated. Whether we are discussing information disclosure or anti-gag practices, other patient rights will be affected in some way. The AMA, therefore, strongly urges Congress to address all patient protections in a single, comprehensive bill.

Consider, for instance, information disclosure requirements have prohibitions against gag practices. Congress could pass legislation to guarantee that patients have proper access to all necessary healthcare information. But if the plan can determine "medical necessity," in an arbitrary manner, the information that patients will be rendered is meaningless.

Congress could also prohibit gag clauses and gag practices to ensure open communication between patients and their physicians, but if plans can continue to arbitrarily define "medical necessity," patients will not benefit significantly from knowing their treatment options.

Among the rights which are the most closely associated with patients' access to healthcare information are the following three: information disclosure, anti-gag practice provisions, and "medical necessity" determinations.

Information disclosure requirements simply reflect that patients have a right to know what their money is buying them. Consequently, plans have an affirmative obligation to disclose to enrollees and prospective enrollees all pertinent and material information. This information needs to be in a easily understandable format and given to enrollees and prospective enrollees in a timely manner.

The second right involves protecting patients against gag clauses and gag practices. Gag provisions, in general, are designed to control physician behavior. They also greatly limit a patient's access to information that is needed to make informed decisions and to provide informed consent. Although some people have alleged that gag clauses no longer exist, we have found otherwise. Gag clauses, business clauses, and gag practices do exist, and they continue to restrict physician/patient communications and undermine trust and confidence. In fact, lawsuits continue to be filed, and they identify specific gag clauses that penalize physicians for candidly discussing coverage options.

More prevalent are business clauses. These clauses prohibit physicians from speaking negatively about the managed care organization or from discussing the organization's financial arrangement with physicians. Though not explicitly gag clauses, business clauses have a dramatic chilling effect on patient/physician discussions about legitimate non-covered treatment options.

Plans also engage in other offensive gag practices. Consider one health plan bulletin, for instance, which stated, and I quote, "Effective immediately, all healthcare plan participating physicians must telephone the pre-admission review department before conveying the possibility of an admission to the plan member."

Plans continue to implement policies and procedures that effectively gag physicians and undermine quality healthcare, and this must be stopped.

We, therefore, strongly encourage Congress to pass a comprehensive patient protection bill that will ban both gag clauses and gag practices. And to adequately protect patient/physician communications, we recommend the bill broadly define the term "medical communication." When patients and physicians are discussing the patient's condition, they should be free to discuss any factor that may affect the patient's condition, treatment option, and including the patient's financial incentives.

We also want to emphasize that any Federal patient protection bill must not preempt State laws that are more protective of patient rights. A Federal patient rights' bill must act as a floor, not a ceiling, for patient rights.

The third patient right related to a patient's access to healthcare information involves "medical necessity." Many plans in their information disclosure statements indicate that the plan will provide coverage for all medically necessary treatment. When the patient suffers an illness, though, plans sometimes deny coverage while relying on their own arbitrary definition of "medical necessity." The AMA believes that "medical necessity" decisions are ultimately medical decisions and should continue to be treated as such. "Medical necessity" decisions must always be made in the accordance with generally accepted standards of medical practice by independent, properly qualified, and licensed prudent physicians.

I thank you very much, Mr. Chair, for allowing us to testify, and thank you for allowing us to be here.

[The prepared statement of Thomas R. Reardon follows:]

PREPARED STATEMENT OF THOMAS R. REARDON, PRESIDENT-ELECT, AMERICAN MEDICAL ASSOCIATION

Introduction

Mr. Chairman and members of the Committee, my name is Thomas R. Reardon, MD. I am the President-Elect of the American Medical Association (AMA). I am also a general practice physician from Portland, Oregon. On behalf of the three hundred thousand physician and medical student members of the AMA, we appreciate the opportunity to testify on these important patient protection issues—"information disclosure" and "gag practices." The AMA has always been a strong advocate for patient rights, and in the midst of a rapidly evolving managed care marketplace, the vigilance of all of us becomes even more critical.

At the outset, we want to emphasize that virtually all patient protections are interrelated. Ensuring that patients have information about accessible grievance and appeals procedures, for instance, will mean little if the standards that the review entities would apply are arbitrarily defined by the plans. Similarly, guaranteeing that patients have access to specialty care, would be virtually meaningless if plans could arbitrarily determine that the specialty treatment was not medically necessary. And even though we may discuss only one or two patients' rights in a particular forum, we should realize that it would be inappropriate to barter or trade one set of patient rights at the expense of other legitimate patient rights. Patients deserve to have protected all of the rights which fairness and justice require.

While discussing these two patients' rights—information disclosure and anti-gag practices, we must realize that there is currently no issue more pressing than the question of who determines the "medical necessity" of patient care. Nearly all other patient protections that have been discussed in recent years—and these two rights in particular—in some way turn on this single, critical issue. In the AMA's view, properly handling "medical necessity" is the linchpin to ensuring the promise of the full range of needed patient protections, including proper information disclosure and anti-gag clause and practice provisions.

Information Disclosure

When a person purchases a product, he or she wants to know what is being purchased. Similarly, when patients contract with health plans, they should receive all material information about covered benefits and plan procedures. Patients have a right to know what their money is buying them.

The AMA believes that legislation ensuring that plans properly disclosure all pertinent and material information to prospective and current enrollees should be enacted to help restore the nation's trust in the health care system and allay the public's fear. Plans need to disclose information on covered benefits, service areas, physician and provider access (including access to specialists), plan costs, cost-sharing, financial incentives, restrictions that may limit services, and any requirements for enrollees. In selecting plans, individuals need information to understand how the plan operates, the benefits to which they are entitled, what they must do to ensure that services are covered, and where and from whom they can obtain services.

Prospective enrollees also need to know how plans compare on items such as specific coverage exclusions, patient cost information, patient satisfaction, cost control programs, loss or medical expense ratios, number and mix of physicians and other providers, disenrollment rates and grievance and appeals procedures. When patients are given the ability to choose among plans, as they should be, they can make informed decisions only when they have the necessary information. People compare plans based on all of this critical information. Consequently, plans must provide this information to prospective enrollees in an easily understandable, standard format, allowing enough time for the prospective enrollees to review the information and have any questions they may have answered promptly and thoroughly.

When considering information disclosure requirements, we urge Congress to reflect on the concerns of all enrollees, prospective enrollees, and most especially, enrollees as patients. We believe that Congress must act to require plans to actually provide and distribute essential information, rather than simply make it accessible. For prospective and actual enrollees, inconvenience and inability to locate the source of information can frequently make "accessible" information, in effect unobtainable. As a result, patients many times cannot exercise rights to which they are legitimately entitled. Moreover, when plans distribute information to enrollees and prospective enrollees, that information functions as a convenient resource to provide ready answers to patients' pressing questions.

Some proposed patient protection legislation for instance would require that plans provide only "*summaries of*" or "*statements regarding*" or general "*descriptions of*" patient benefits and benefit exclusions. Some legislation would also permit plans to

"make available," rather than actually distribute, information that most patients would consider essential in comparing plans and benefits effectively. For prospective enrollees to make fully informed decisions when selecting plans, they must have all the necessary facts—not the plans' summaries of facts. Plans have all of the requisite information easily available; requiring disclosure of this information would not burden them. Patients have a right to receive this information, particularly as a prerequisite to enrollment and once enrolled—at least annually thereafter, so they can provide an informed acceptance of the plans' proposed coverage terms.

Gag Clauses and Practices

Patients not only have a right to receive pertinent and material information regarding health benefits from their plan, they also have a right to be informed about their own health and all treatment options by their physicians. As an essential prerequisite, patients and their physicians must be able to communicate openly with each other, without unreasonable interference from the health plans.

Frequently health plans, however, have incorporated clauses in their contracts with participating physicians which prohibit or restrict the physicians from discussing certain noncovered treatment options with patients. Even if the plans do not include these explicit clauses—so-called "gag clauses," many plans maintain policies or practices that function to restrict open communications between physicians and patients—so-called "gag practices." The AMA has historically been on record as vehemently opposing both gag clauses and gag practices, because they create an inherent ethical conflict of interest and strike at the heart of the patient-physician relationship.

The AMA's *Code of Medical Ethics,* which lays out guiding principles for the entire medical profession, is very specific on this point. In it we find a very important section entitled *Fundamental Elements of the Patient-Physician Relationship.* The very first "*Fundamental Element*" is as follows:

"The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their physicians as to the optimal course of action."

In addition, the AMA's Council on Ethical and Judicial Affairs, the AMA entity responsible for maintaining the *Code of Medical Ethics* and providing authoritative interpretations of its contents, has stated that:

> "The physician's obligation to disclose treatment alternatives to patients is not altered by any limitations in the coverage provided by the patient's managed care plan . . . Patients cannot be subject to making decisions with inadequate information. That would be an absolute violation of the informed consent requirements. If these clauses are carried out and the physicians are subject to sanction, a reduction of patient quality of care will result."

The AMA staunchly believes that patients must be able to trust and rely on the information their physicians provide to them regarding appropriate medical treatment and care. In short, physicians have an ethical and legal duty to ensure that their patients are fully informed of their options regardless of cost or potential treatment limitations. Unfortunately for patients, "gag clauses" create a real or perceived potential conflict of interest for physicians by placing a wedge between them and their physician. "Gag clauses" and "gag practices" undermine two fundamental elements of the healing process—trust and confidence.

Continued Use of Gag Clauses and Gag Practices

Gag provisions are typically designed and implemented with the intent to control physician behavior and to limit a patient's access to the full range of information that is needed to make informed decisions and provide informed consent about the proper course of medical treatment. While the AMA acknowledges a legitimate business interest in addressing cost issues and avoiding unjustified disparagement of a plan's operations, we firmly believe that such efforts should not undermine the quality of care received by patients. We also readily acknowledge that not all health plan contracts contain written "gag clauses." Nevertheless, some health plan contracts still do contain these insidious provisions. More typically, though, health plans have subtle, unwritten, plan policies and procedures that effectively impede physicians from discussing treatment options if the plan does not cover those treatments.

The AMA is aware that the U.S. General Accounting Office (GAO) last year reported that based on its own study, it did not find explicit gag clauses in HMO contracts. When conducting its survey, though, the GAO asked 622 HMOs to forward to it copies of contracts they use for primary care physicians and specialists. In response, the HMOs voluntarily and perhaps selectively submitted 1,150 contracts. Of those submitted contracts, the GAO found that none of them contained "clauses that

specifically restricted physicians from discussing all appropriate medical options with their patients," according to the report.

Commenting on its own survey results, the GAO admitted, however, that "the contracts sent to us [the GAO] may not be representative; [unsubmitted ones] may contain gag clauses." Consequently, the GAO survey results do not accurately reflect the types of contracts that physicians are currently being asked to sign or may be asked to sign in the future.

Recent lawsuits further suggest that the GAO's findings may not be entirely accurate. Just a few months ago, the State of Texas sued six HMOs, and in the complaints against two of them (Aetna and Humana), alleged that their physician contracts "contain gag clauses that penalize physicians for candidly discussing the coverage provided by these HMOs."[1] Humana imposes $1,000-$2,000 penalties on physicians who counsel patients to disenroll from a Humana plan, according to the state.[2] In all of the complaints, the state claimed that the HMO contracts include illegal incentives to limit medical care to HMO patients.

Appearing to confirm some of the HMO behavior patterns alleged in the Texas suits, GAO stated in its prior report that 60 percent of the contracts which HMOs did send included "business clauses." Business clauses are contractual provisions that purport to protect the business interests of the contract drafters—the HMOs. They generally come in one of three types: non-disparagement (restricts the physician from speaking negatively about the HMO); non-solicitation (restricts the physician from encouraging patients to consider joining other HMOs); or confidentiality (prohibiting physicians from mentioning or discussing HMOs' financial arrangements with the physicians or HMOs' corporate policies).

All of these "business clauses," though not explicitly gag clauses, would likely have a dramatically chilling effect on patient-physician communications, particularly as they relate to physicians discussing legitimate non-covered treatment options for their patients. The non-disparagement provisions would especially act to silence physicians. In fact, in response to the GAO survey, 64 percent of attorneys who represent physicians, 46 percent of those who represent both managed care organizations and physicians, and 25 percent of those who represent HMOs responded that nondisparagement "stipulations 'could have a moderate to great effect on a physician's discussion of patient treatment options.'"[3]

In the past, the AMA has found various other examples of "gag practices" that also do not rely on explicit contract provisions. Some of our physician members, for instance, have told us that certain health plans were informing their participating physicians that "effective immediately, all referrals from Primary Care Physicians to Specialists may be for only one visit," and then threatening to terminate "the contracts of physicians and affiliates who fail to meet the performance patterns for their specialty." As another example, a health plan bulletin regarding preadmission review guidelines stated that "effective immediately, all [health plan] participating providers must telephone the Preadmission Review Department . . . before an admission occurs and before conveying the possibility of admission to the plan member." Although a follow-up memorandum blamed "poor wording" in the original announcement for any "misinterpretation" of the bulletin as a restriction of communication between physicians and patients, the AMA maintains that the original effect of the announcement was clearly chilling.

The GAO report also indicated that the vast majority—72 percent—of the contracts they reviewed incorporated a "without cause" or "at-will" termination clause. The GAO concluded from this that "[i]t is the contractual relationship itself—its short duration and provision for termination without cause—that may make physicians feel constrained from speaking openly with their patients." The AMA has opposed "without cause" termination clauses, for the very reason that plans can use them to unduly pressure physicians to comply with unethical managed care policies or practices.

In general, the AMA believes that the term "gag clause" should not be viewed in an overly narrow, legalistic or restrictive manner. The AMA maintains that a more common sense approach to this issue should prevail because of the fact that "gag clauses" often go beyond the mere elements of contract law and include a pattern of practice that restricts physician-patient communications. We encourage the Congress therefore to resist the urge to adopt a narrow provision protecting solely against explicit "gag clauses." The AMA believes that narrowing the important anti-

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[1] "Texas Alleges HMOs Engaged in Illegal Incentives, Deceptive Marketing Practices," *Health Law Litigation Reporter,* January 1999, Vol. 6, No. 6, p. 3.

[2] *Id.*

[3] "How HMOs Still Gag Doctors; Health Maintenance Organizations," *Medical Economics,* March 9, 1998, Vol. 75, No. 5, p. 42.

gag provisions of any patient protection bill would allow plans to neglect those concerns reported by patients, physicians and others who treat and care for patients.

The AMA further believes that if patients are to be truly free to make informed medical decisions, any patient protection legislation should be drafted to include at a minimum the following concerns:

"GAG" CONTRACTS AND PRACTICES SHOULD BE BANNED. Legislation should ensure that health plans would no longer be allowed to "gag" physicians through *policies and other unwritten conduct,* which intimidate physicians and interfere with a patient's right to receive essential medical information. Patients need to be protected from plans retaliating against its participating physicians for advocating on their behalf and following ethical medical practices.

THE DEFINITION OF "MEDICAL COMMUNICATIONS" SHOULD NOT BE UNNECESSARILY LIMITED. Legislation should ensure that physicians are free to openly communicate with their patients. Any clauses that expressly or impliedly prohibit or restrict physician-patient communications should be deemed as contrary to public policy and unenforceable. Moreover, legislation should prohibit plans from in any manner censuring physicians for medical communications or for functioning as patient advocates. To properly treat patients, physicians must be able to discuss the patients' health status, medical care and all treatment options, as well as any factors, such as financial incentives or utilization review procedures, that may affect the patient's treatment options. Patients have a right to receive this information from their physicians without undue interference from their health plans.

In response to the GAO report, some legislators have suggested that the federal government should not move "forward pre-empting state law or regulatory authority on any issue—and most especially on issues as crucial as health care—without full consideration of sound science, thorough research and data." In general, the AMA would agree with this statement, although we believe that the science and data more than adequately show the urgent need to pass federal legislation that would prohibit gag clauses and practices. We especially agree that federal patient protection legislation should NOT function to pre-empt state laws or regulatory authority which are more protective of patient rights. This protection, like all other federal patient protections, should act as a floor and not a ceiling.

Federal Legislation is Necessary To Correct "Gag" Problems

In reaction to the loud public outcry caused by local cases where physicians have been "gagged," thereby threatening patients, a number of states have begun enacting "anti-gag clause" legislation. For example, legislatures in forty-six states have already passed laws banning "gag clauses." Some states have also chosen to address this issue through regulation. The National Association of Insurance Commissioners (NAIC) adopted a non-binding model bill more than a year ago that would, in part, ban plans from contracting to limit or prohibit a participating physician from discussing treatment options with patients regardless of the health carrier's position on the treatment options, or from advocating on behalf of patients within a utilization review or grievance process.

Given the number of states that have moved forward with legislation, the NAIC's model bill and various private sector activities to educate the public about these provisions and practices, we expect some people may pose the question, "is federal anti-gag clause legislation necessary?" The AMA believes the answer is clearly "yes!" Even if all the states enacted similar "anti-gag clause" measures, not all health plans can, or will, be reached by state law. Similarly, not all of the state legislation will effectively prevent "gag practices" from continuing. Consequently, federal legislation is absolutely essential to eliminate "gag practices" and "gag clauses" from all health plans, in both private and public sectors, and ensure that every patient is adequately protected.

Information Disclosure and Anti-gag Provisions Affected by Medical Necessity Determinations

Information disclosure requirements can also be adversely influenced by how "medical necessity" is determined and by whom. For instance, many plans in their information disclosure statements indicate that the plan will provide coverage for all "medically necessary" treatment. As a result, patients and prospective enrollees believe that they are covered for all medical treatment which is clinically appropriate and reasonably necessary to treat their illnesses, conditions, or injuries, in accordance with generally accepted standards of medical practice. When the patient suffers an illness, however, plans that have arbitrarily defined the term "medical necessity" can deny coverage for a wide range of accepted treatments that do not fall within *their own* arbitrary definition of medically necessary treatment.

Or consider the importance of "medical necessity" determinations in light of anti-gag clause and anti-gag practice legislation. If managed care reform legislation were to protect patient-physician relationships by prohibiting gag clauses and gag practices, to what avail would open communications be to patients if they could still be arbitrarily denied the medical treatment they reasonably believe to be covered by the plan simply because the plan deems it "not medically necessary?" A ban on health plan gag clauses and practices admittedly would help to ensure that plans could not keep patients in the dark about their medical treatment options. But if the plan could still refuse treatment for any covered treatment option because of the arbitrary application of a plan's "medically necessary" definition, the patient would in fact have little real protection.

As In Gag Practices, Financial Considerations Affect Medical Necessity Decisions

Historically, most private insurers and third-party payers have viewed medical necessity as those health care products or services provided in accordance with generally accepted standards of medical practice. Accordingly, medical necessity decisions were typically made using specific review criteria and processes that applied generally accepted standards of medical practice and afforded clinical peer-to-peer review. Today, however, this long-standing process is being challenged on a daily basis by health plans that determine medical necessity primarily in terms of financial considerations.

Health plans have the ability to exercise tremendous leverage over physicians while influencing the care that they can render. When health plans contract with physicians, for instance, the physicians have to agree to the plan's standard contract terms, which typically require that the physicians comply with the plan's medical management program—usually termed a "utilization management" (UM) program. While the AMA does not oppose UM programs that are conducted properly, many plans have not established UM programs which adequately involve physicians or place as their top priority improving health care quality for patients. Within the UM programs, some plans have even instituted guidelines that describe or define "medical necessity" using "lowest cost" criteria. Because of gag practices, physicians are frequently prohibited from discussing with patients these criteria.

Health plan contracts and some information disclosure packets describe the terms "medically necessary" or "medically appropriate" in ways that leave most of the medical decision-making discretion with the health plan, as opposed to the patient's physician. A common plan practice is to overlap the definitions of "covered services" and "services that are medically necessary," as noted above, such that they essentially become one and the same. Then, the plan can include language in the contract granting itself final discretion over the determination of what is medically necessary. In this manner, the plan can always make the final decision of what is "medically necessary" and thereby always limit its own covered services.

In other situations, managed care plans simply incorporate financial or cost considerations into the determination of "medical necessity." Reviews of managed care contracts last year revealed that language imposing "lowest cost" criteria had been included in many contracts' definitions of medical necessity. Health plans' concern about their profits remains the driving force behind these definitions which emphasize cost and resource utilization over quality and clinical effectiveness. To say the least, this is alarming both to patients and to physicians.

The AMA believes that health plans should not be allowed to unfairly deny medical care based on the application of such unfair and arbitrary medical necessity definitions. If health plans are able to define medical necessity in a review, the appeals process will be seriously undermined, if not rendered meaningless. The AMA does not oppose the ability of health plans and employers to establish health benefits packages, however, health plans must allow prudent physicians, not health plan bureaucrats, to make individual medical care decisions. Plan enrollees must know up-front what services are covered and not covered by their health plans. If publishing lists of "covered" services is too onerous, as some plans claim, then at a minimum, enrollees must know what is *not* covered. This is also why information disclosure requirements are so critical for patients and physicians.

The AMA believes that "medical necessity" or "medical appropriateness" decisions are ultimately medical decisions and must continue to be treated as such. Permitting health plans to decide "medical necessity" according to financial or cost considerations creates a dangerous precedent. This concern led the AMA in December of 1998 to refine its policy on "medical necessity" at its Interim House of Delegates meeting. The AMA believes that "medically necessity" means:

> "Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: 1) in accordance with generally

accepted standards of medical practice; 2) clinically appropriate in terms of type, frequency, extent, site, and duration; and 3) not primarily for the convenience of the patient, physician, or other health care provider."

As indicated, this policy uses a "prudent physician" standard, which both medically and legally is an objective standard. It also requires that the treatment be "clinically appropriate" and consistent with "generally accepted standards of medical practice," which is how it has traditionally been determined. To mute allegations that physicians would recommend treatment for their patients' or their own convenience, this definition expressly prohibits such a practice.

We realize that some plans and insurers might express concern that allowing anyone other than themselves to make medical necessity decisions will eventually lead to such abuses as health club memberships being deemed "medically necessary." This "slippery slope" argument, however, is nothing more than a red herring. As the AMA has always recommended, the external appeals process must permit physicians—independent of both the plan and the treating physician—to review the treating physician's medical necessity determination. We are not advocating that the treating physician be the ultimate decision maker, rather, we are advocating that independent, properly qualified and licensed prudent physicians make final and binding decisions. We challenge the health plans to adhere to such an equitable solution.

Because "medical necessity" decisions are in fact medical decisions, the AMA firmly believes that only physicians who are properly qualified—that is, of the same specialty, actively practicing medicine in the same state as the patient or the treating physician, and having significant familiarity with the condition in question—must review other physicians' treatment decisions. In other words, the reviewer of medical treatment decisions must be knowledgeable and properly qualified—so that patients are not mistakenly or arbitrarily denied medical treatment to which they are entitled. Additionally, the reviewer must be independent of any health care professional who participated in the initial adverse benefit determination, and should not be affiliated with or employed by the same organization.

Patients are also concerned that plans and insurers frequently deny coverage for medically necessary treatment based on information they have obtained *after* the tests and treatment were rendered. Determinations of medical necessity, however, must be based solely on information that was available *at the time* that health care services or products were provided. A physician may have to admit a patient for further observation, diagnosis, and treatment, and may only be able to complete his/her diagnosis upon receiving the patient's test results. Denying coverage of the initial treatment or diagnostic tests because the plan retrospectively alleges that they were not "medically necessary" is patently unfair and not good medicine.

Conclusion

In conclusion, the AMA maintains that virtually all patient protections are integrally related, with each dramatically effecting several others. Legislation prohibiting gag clauses and practices, must also address medical necessity, for instance. Toward this end, we support legislation that would require plans to provide enrollees and prospective enrollees with essential information about the plan and its benefits, and that would prohibit plans from improperly interfering with patient-physician communications and medical decision making.

Thank you again for the opportunity to testify today on these important patient rights issues. On behalf of the AMA, I offer you our services in working further with the Congress to effectively address these important and pressing matters. The AMA would be pleased to work with the sponsors of any patient protection legislation to protect these critical patients' rights.

Mr. BILIRAKIS. Thank you very much, Doctor.

Ms. Lehnhard.

STATEMENT OF MARY NELL LEHNHARD

Ms. LEHNHARD. Mr. Chairman, members of the committee, I appreciate the opportunity to testify, and I am here representing all of the Blue Cross and Blue Shield Plans.

Blue Cross and Blue Shield Plans are committed to providing patient choice. Our customers are demanding a very broad range of products in the market. For example, Blue Cross and Blue Shield Plans have 14 million enrollees in HMO's, 7 million in point-of-

service plans, 25 million enrollees in PPO's, and 26 million enrollees in traditional indemnity products.

My message today is that a number of the bills that Congress is considering would have the unintended consequence of eliminating these broadly varied products and driving market choices to highly managed plans that have the basic design characteristics of HMO's.

The provisions I am referring to would require all health plans to collect information on a patient's medical status, information available really only from patient medical records, and produce a report card on patient outcomes. All plans would also be expected to achieve an annual improvement in these clinical performance measures, essentially by changing physician behavior—and let me elaborate on that a little bit.

In Blue Cross and Blue Shield HMO's, the expectation is that the plan is accountable for keeping enrollees as healthy as possible. Our HMO's actively engage in extensive quality assessments, quality improvement projects, and performance measurements.

The key HMO design elements necessary to support essentially a partnership of physicians are: one, a guarantee in the contract with the physician that the HMO have routine access to patient medical records in physicians' offices so they can collect the clinical information; second, a more limited number of physicians in the network because of the intensive relationship with physician; third, payment strategies that can be used to change physician behavior, performance, capitation, and risk arrangements; fourth, limited or no use of physicians outside the network; and, fifth, a physician care coordinator; without this care coordinator there is no point of accountability for the medical management of a specific enrollee; they could be going to multiple primary care physicians.

These design elements are critical, first, to effect the necessary changes to improve patient outcomes, and, second, just to support that collection of basic—of extensive patient medical record information.

Our other products, without these HMO design elements, can't be held to the same objective. That is accountability for the health status of specific enrollees. The key design elements of broad choice plans which are demanded by many consumers and employers don't support this intensive medical record collection information activity and the expectation that the plan, itself, will be responsible for improving the outcomes of physicians.

These non-HMO products are characterized by very large networks. Some of our plans have 30,000 to 40,000 physicians in the network to meet the demand for choice. They allow enrollees to use out-of-network physicians, often with nominal co-pays. They don't routinely abstract patient medical records for quality information. The cost in this size of a network would be prohibitive. They don't assign enrollees or ask them to choose a care coordinator, and they don't use physician payment strategies to influence physician behavior. For example, all of our PPO's are paid on a fee-for-service basis, not capitation.

An expectation that all types of health plans meet these requirements for clinical information, extensive clinical information, and improvements, measurable improvements and outcomes, these are really HMO accountabilities, or have the consequence of creating

overwhelming incentives for our plans—in all plans to adopt HMO design features to meet the expectations.

We urge you, rather than running the risk of limiting consumer choice through rigid Federal standards on what the health plan should be expected to do, we believe Congress should allow purchasers and private accrediting organizations to continue to develop the state-of-art in quality assurance and performance measurement.

We look forward to working closely with you on these issues.

[The prepared statement of Mary Nell Lehnhard follows:]

PREPARED STATEMENT OF MARY NELL LEHNHARD, SENIOR VICE PRESIDENT, BLUE CROSS BLUE SHIELD ASSOCIATION

Mr. Chairman and members of the subcommittee, I am Mary Nell Lehnhard, Senior Vice President of the Blue Cross and Blue Shield Association. I appreciate the opportunity to testify before you on behalf of the 52 independent Blue Cross and Blue Shield Plans throughout the nation.

Blue Cross and Blue Shield (BCBS) Plans collectively provide health care coverage to more than 71 million Americans. Significantly, BCBS Plans are in every market from large national accounts to small businesses to individual purchasers. BCBS Plans also believe in promoting patient choice. That is why our Plans offer choices that range from products that systematically coordinate care, such as Health Maintenance Organizations (HMOs), to broad access products that allow wide choice of providers, such as Preferred Provider Organizations (PPOs), to traditional fee-for-service products.

To help purchasers and consumers choose among these health plan options and promote competition, federal lawmakers have become interested in uniform measurement of health plan performance, particularly in medical outcomes. Unfortunately, proponents of performance measurement do not realize that imposing uniform measures designed for HMOs on all products (including PPOs) would have the unintended consequence of narrowing the range of health plan choices available to consumers.

In fact, several bills before the Congress could have just this effect. Some of these bills (such as S. 6/H.R. 358 and S. 374) call on *all* health plans—PPOs and well as HMOs—to collect and report detailed information from patients' medical records about health outcomes, and to improve these outcomes. Other bills, while far less proscriptive (such as the Chairman's "Patient Protection Act of 1999," H.R. 448), could still lead to regulations that require PPOs and HMOs to collect, report, and ultimately to influence physician behavior to change outcomes.

PPOs and HMOs are structured to meet very different consumer and purchaser expectations and preferences. In order to report and ultimately improve HMO-oriented performance measures, PPOs would have to restructure to become more like HMOs. This would, in essence, take choice away from the four in ten Americans currently enrolled in PPO. Put simply, you cannot impose rigid standards to collect, report, and influence medical outcomes without inadvertently eliminating choice of broad access PPOs.

In the testimony that follows, I shall elaborate on the fundamental differences between HMOs and PPOs, discuss private sector approaches to assessing health plan performance, and make apparent the consequences for PPOs of imposing rigid, clinical standards.

Fundamental Differences Between PPOs and HMOs

Health insurers have developed a wide array of innovative health plan options to meet the demands of consumers and purchasers. These health plan options offer varying care coordination strategies that range across a continuum from traditional fee-for-service benefit plans to PPOs to highly integrated, closed panel HMOs.

No one type of health plan can fit the diverse demands of the marketplace. Consumers and group purchasers have different preferences regarding provider choice, ease of access, care coordination, range of benefits, cost-sharing, and premium level. PPOs of various designs are in the middle of the product continuum. Although individual PPOs may differ in the details, they generally differ in fundamental ways from HMOs:

- PPOs and HMOs sell very different services to consumers. PPOs do not promote themselves as managing the health of their members, but rather, as providing broad and easy access to providers. In keeping with the preferences of their cus-

tomers, many PPOs have not developed care coordination strategies to manage the health of their members.

- HMOs have broader benefit packages than many PPOs. Some PPOs do not provide coverage for preventive services, well-child visits, or pharmaceuticals.
- Broad access PPOs tend to have relatively simple contracts with their physicians that do not require participation in quality management activities, submission of medical outcomes data or auditing of medical records for measurement purposes. HMO physician contracts include extensive provisions on data collection on medical outcomes and medical records auditing.
- PPOs members are free to see the physician of their choice. PPOs do not coordinate care through primary care gatekeepers and members may have multiple physicians for different conditions. No one physician maintains a comprehensive medical record and no one physician is accountable for health maintenance or improvement of the consumer. This wide access to providers—in and out of the network—makes it extremely difficult for PPOs to collect the type of patient-specific medical data from providers that is required by HMOs.
- PPOs are not structured to influence provider behavior through the mechanisms used by HMOs, such as capitation, referral systems, and care coordination.

These differences are distinctly designed to satisfy different consumer preferences. HMOs emphasize clinical accountability for the quality of care they sponsor and for the health of their members. Accountability is achieved through coordination of care by primary care physicians, use of smaller integrated networks of providers, care management initiatives such as risk appraisal and disease management programs, analysis of medical records information, and use of guidelines and incentives to influence provider practice.

In short, PPOs' key feature is broad choice of physicians at a reduced cost to enrollees and employees (i.e., negotiated payment rates and protections against balanced billing). Enrollees have an incentive to use providers—hospitals and physicians—under contract (the negotiated rates are based on the promise of volume for providers). However, enrollees can go outside the network and pay a higher level of cost sharing. PPOs usually do not expect an enrollee to select a single primary care physician to be accountable for managing all their health care needs. An enrollee can see any physician or specialist in the network or an enrollee can seek care outside the network.

Importantly, PPOs are reliant primarily on information generated from claims (bills for care provided). These claims data can indicate that a service was rendered, but do not indicate the outcome of the service. PPOs do not perform the routine collection of patient medical record information that is critical to HMOs in assessing medical outcomes.

Consumers and purchasers who give the highest priority to broad choice of provider, ease of access, and limited plan influence over the physician-patient relationship gravitate to PPOs. Among Blue Cross Blue Shield Plans' 71 million enrollees, for example, about one-third belong to PPOs, one-third belong to HMOs or point-of-service (POS) plans, and the rest to traditional, "participating physician" fee-for-service plans.

Private Sector Developments in Health Plan Performance Measurement

Over the last decade, the private sector has generated a system of health plan measurement and oversight. Voluntary accreditation organizations such as the National Committee for Quality Assurance (NCQA) and the American Accreditation HealthCare Commission/Utilization Review Accreditation Commission, (AAHC/URAC) have been established to assess and promote quality of care among various types of health plan products. At the same time, large employers have taken a lead in advancing health plan performance measures for HMOs. Indeed, large employers launched systematic health plan performance measurement in 1989 with the development of the Health Plan Employer Data and Information Set (HEDIS) measures for HMOs.

Prior to that time, large purchasers of health care routinely compared health plans largely on the basis of their benefit costs and non-standard metrics. However, the growth in HMO enrollment and the limitations that enrollment placed on patient choice of physician gave rise to concern over the quality of care members were receiving and the "value" of the health plan purchase. Because HMO members had limited ability to "vote with their feet" when unhappy with their physician panel, group purchasers felt a responsibility to monitor the medical care on the member's behalf.

In developing HEDIS measures, a group of large national purchasers reached consensus on the elements of HMO performance they wished to measure and the methods for measuring them. HEDIS was developed to meet the information needs of the

purchasers. Among other measures, HEDIS includes measures that try to offer insight into the medical effectiveness of care (e.g., the percentage of diabetic enrollees receiving a retinal eye exam, etc.).

HEDIS is controlled by NCQA, the main private sector organization accrediting HMOs. HEDIS has become the standard benchmark for medical quality indicators in HMOs. To obtain accurate HEDIS data—indeed, to obtain any accurate and meaningful data about health care outcomes—requires access to patients' medical records. The types of claims data that PPOs have readily available are simply not sufficient. Numerous studies raise caution against using insurance claims data to measure and evaluate health care outcomes because insurance claims data lack important diagnostic and prognostic information when compared with concurrently collected clinical data in patients' medical charts.[1]

In fact, private accrediting organizations and private employers hold PPOs to different standards from HMOs. For example, NCQA exclusively accredits HMO-style health plans. In contrast with NCQA, the leading private sector organization for accrediting PPOs (AAHC/URAC) does not collect HEDIS measures or HEDIS-type measures from PPOs. PPOs do not have to produce a core set of clinical performance measures to become accredited.

Federal HMO-Type Quality Standards Will Force Broad Access Products to Become More Like HMOs

What would happen if the Secretary of Health and Human Services could dictate that all health plans collect uniform data on health care outcomes and have a continuous quality improvement program to address these outcomes? Such requirements are included in several bills before the Congress, including "The Patients' Bill of Rights Act of 1999" (H.R. 358). In essence, the outcome would be similar to what we see in the Medicare+Choice program: no PPOs.

Medicare+Choice illustrates what would happen if the Congress gave the Secretary extraordinary authority to define what types of health plans are available in the private market. In the interim final regulations for Medicare+Choice, HCFA translated the law's broad quality assurance language into strict requirements for PPOs as well as HMOs to achieve arbitrary quantitative improvements in clinical outcomes. But HCFA's HMO-type quality standards are fundamentally in conflict with broad network access products, hence, HMOs are virtually the only choice in Medicare+Choice.

The Medicare Payment Advisory Commission (MedPAC) has expressed concerns about HCFA's approach. HCFAHCFAIn a letter commenting on the Medicare+Choice program, MedPAC stated, "The quality assurance system set forth in the [Medicare+Choice] rule will pose significant barriers to participation by all but the most tightly managed coordinated care plans. For example, plans with large, loosely organized networks may face challenges reporting certain types of quality measures or influencing practice behavior . . . Despite such limitations, these types of plans may be attractive to beneficiaries who value a wide variety of provider choice and minimal gatekeeper restrictions . . ."

Although some bills would allow the Secretary to vary the requirements for health plans "based upon differences in the delivery system among such plans and issuers as the Secretary deems appropriate" [Section 111 and 112 of S. 6/H.R. 358], the Medicare+Choice experience raises serious doubts about the application of this provision. Moreover, the power to define what types of plans are available in the health care market is too much discretion to leave to the Secretary.

Other bills, such as H.R. 448, appear on the surface to be far less proscriptive (i.e., "group health plans and health insurance issuers must provide the latest information, if any, relating to quality of performance of the delivery of medical care"). However, because this provision is vague in defining quality performance measure, it could be interpreted by regulation to open health plans to a plethora of requests for data—the "latest information" is very open-ended because health plans continually collect information that is arguably related to performance.

Every claim paid contains information that regulators might believe is related to the quality of performance. Moreover, health plans often collect and maintain huge amounts of information about individual physicians to profile their performance. These profiles are often proprietary and are used by health plans to educate physi-

[1] See for example, Jollis JG, Ancukiewicz M, DeLong ER, Pryor DB, Muhlbaier LH, Mark DB, "Discordance of databases designed for claims payment versus clinical information systems. Implications for outcomes research," *Annals of Internal Medicine,* 119(8):844-50, October 15, 1993 Malenka DJ, McLerran D, Roos N, Fisher ES, Wennberg JE, "Using administrative data to describe casemix: a comparison with the medical record," *Journal of Clinical Epidemiology,* 47(9):1027-32, September 1994.

cians, improve practice patterns, and develop networks. Would regulators be able to demand such information: where would they draw a line?

If PPOs and other loosely coordinated health plans were required to collect, report, and influence the same information as tightly managed HMOs, then *all* plans would invariably be pushed to act more like tightly managed HMOs. All health plans would be become accountable for continuously modifying and improving physician behavior to produce improvements in medical outcomes. All health plans would need to adopt the same tools as HMOs to effect measurable changes in physician behavior.

HMO "Tools" for Changing Outcomes

Because the key feature of an HMO is clinical accountability for a defined population, HMOs are structured to support measurement of health indicators and improvement in enrollees' health status. HMOs can achieve these goals by assuring a central point of accountability for every individuals' health care (i.e., the enrollee's primary care physician), controlling the physicians that their enrollees use (i.e., managed access to physicians in the network), and assuring (by contract) that physicians will participate in the HMOs medical management and information collection program.

HMOs achieve the improvement in health outcomes by measuring individual physician performance, assuring that physicians are following professionally accepted practice protocols, and using payment arrangements and incentives that foster improvement in patient outcomes (i.e., capitated and other payment incentives). Also, HMOs are dependent on information abstracted from patient medical records; health plan nurses work with physicians to collect the information.

PPO Compliance with HMO-Type Standards

PPOs could comply with "one-size-fits-all" federal standards *only* by eliminating the very features that make them popular products in the private sector. PPOs would have to:

1. Incorporate mechanisms, such as gatekeepers, for coordinating and managing care of patients.	A designated physician gatekeeper is necessary to coordinate care and to act as an essential collection entity for medical records information.
2. Introduce provider capitation and incentive payments into PPO network products that now use discounted or modified fee-for-service payments to pay physicians.	Performance based payments are the most effective way to change physician practices.
3. Eliminate open access to non-network providers	Open access to physician outside the network would preclude a plan's ability to capture all medical record information for a given patient.
4. Recontract with providers and enter into a much more information-intensive, managed-based relationship, including ongoing access to patient medical records.	Plans must ensure access to all their enrollees' medical records in order to collect mandated outcomes information which is simply not available through the claims data of most PPOs today.
5. Reduce significantly the number of physician and other health care practitioners available within networks.	The cost and complexity associated with extensive data collection and medical records audit would make it necessary for plans to reduce the size of their networks. In addition, a more focused network of physicians will make each physician more responsive to the health plan.

In essence, PPOs would have to redesign fundamentally to become tightly-managed health plans.

CONCLUSION

BCBSA supports the rights for patients to have information about their health care and health plan. We believe that health plans should inform their members about how to use their benefits, and provide information about benefits, premiums, contributions, and cost-sharing, as well as basic information about health professionals and facilities in plan networks. BCBSA also supports the broad range of innovative activities in the private sector to promote high quality care. But we strongly oppose giving the federal government the power to dictate the collection and improvement of medical outcomes data.

I would like to close with some observations that Professor Regina Herzlinger of Harvard University recently prepared for the Democratic Leadership Council's Progressive Policy Institute.[2] She warned that giving the government the power to dictate disclosure and analysis of health care information might inadvertently cause

[2] Regina E. Herzlinger, "Protections of the Health Care Consumer: The 'Truth' Agency," Progressive Policy Institute, March 1999.

government protection to cross the line from providing helpful information and oversight to causing "paralyzing evaluation and micromanagement."

- When disclosure requirements are dictated by governments, not the private sector, one voice may be substituted for many;
- When government agencies prepare benchmarks or standards of achievement, and thus require insurers to sing out of the same hymnal, innovations in health care may well be discouraged.
- When one managerial vision is substituted for many entrepreneurial ones, "wave goodbye" to innovation.

The potential for unintended consequences is very real. Federal mandates to collect, report, and improve medical outcomes is a blueprint for less choice for consumers. Rather than run the risk of limiting consumer choice through rigid federal standards, the Congress should allow purchasers and private accrediting organizations to continue pushing to expand the state of the art in quality assurance and performance improvement.

Thank you for the opportunity to speak with you on these important issues.

Mr. BILIRAKIS. Thank you.

Mr. Pollack.

STATEMENT OF RONALD F. POLLACK

Mr. POLLACK. Mr. Chairman, distinguished——

Mr. BILIRAKIS. Pollack—"Pollack?" Is that not correct?

Mr. POLLACK. "Pollack," yes.

Mr. BILIRAKIS. Pollack.

Mr. POLLACK. Mr. Chairman, distinguished members of the panel, thank you for inviting me to testify today, and even more importantly, thank you for the good work that so many have done on both sides of the aisle on patients' rights. We very much appreciate it.

I am going to focus on one narrow issue. And as a preface to that, I want to start from where the chairman opened the hearing. He said today we were not going to focus on perhaps the most contentious issue that is before this subcommittee—the issue of liability.

I happen to favor liability provision, but I am not going to speak to it. What I would—the reason I raise it, however, is that I recognize that this is one of the most difficult issues that will be before this subcommittee. And I think that although that issue may well turn out to be intractable, in terms of differences of different members of this panel, I think there is a matter where people who are proponents and opponents of the liability provision can come together, at least to soften some of the difficulties on that issue. And where I think people come together is, I think, irrespective of one's position on the question of liability. And, again, I say I strongly support the liability provision. Irrespective of where you come out on that issue, I think everybody agrees that it makes a great deal of sense for us to try to resolve issues as early as possible, in the least contentious setting.

Clearly, it makes a great deal of sense to try to resolve problems before the harm really gets exacerbated and before somebody really experiences such significant healthcare problems that it ultimately resorts to litigation.

And so what I would suggest to you, is that we need to strengthen the up-front mechanisms that exist. And I think there is a growing agreement that we should make sure that we have an effective external appeals mechanism that is truly independent of health

plans that tries to get matters resolved at the earliest possible moment.

Now, starting with that as a point of departure, I think it is important to note that in those States that have established these external rights to appeals, unfortunately, not that many people have availed themselves of their rights to external appeals.

The Kaiser Family Foundation recently issued a report that looked at the States that have undertaken external appeals. And what they have found is that there is a relatively small number of people who have pursued their appeals rights. And the Kaiser Foundation study finds that there are essentially two reasons for it: No. 1, a lot of people are unaware of what their appeals rights are; and, second, when you have got a grievance with a health plan, it tends to be you are sick or you are frail, and you are not in a very good position to pursue those appeals.

So, if we are going to make this right, which I think is becoming a consensus right, an effective right, we need to make sure that consumers have help when they feel that a health plan has improperly denied care to them.

And it is for that reason that I think it is crucially important that we establish ombudsman or consumer assistance programs that are designed to support the needs of consumers that include, among their functions, helping them with their internal and their external appeals, not with their litigation rights, whatever they may be, but with their internal and external appeals rights, and that it provides other kinds of services as well.

What kinds of services am I talking about? For those people who have a right to choose plans, that they have got more than one choice, they often are bewildered about those choices. They don't know the strengths and weaknesses of different plans. They need help in deciphering them. They need help once they get into a plan, when they have questions about their rights and responsibilities. They would set up 1-800 numbers; they would provide referrals to appropriate agencies, and they would document those problems that are coming into ombuds' offices so that we, all of us, can learn about what those problems are, and we can learn about it at an early stage.

I want to be clear that we have many precedents for this, and they have worked very well. In the long-term care arena, we have for more than two decades had long-term care ombudsman programs, and they have worked well to deal with problems in nursing homes. We have this now to a limited degree in the Medicare program and the Medicaid programs. I think it would be very helpful to do this in the context of the issues we are talking about today.

Thank you, Mr. Chairman.

[The prepared statement of Ronald F. Pollack follows:]

PREPARED STATEMENT OF RONALD F. POLLACK, EXECUTIVE DIRECTOR, FAMILIES USA FOUNDATION

Mr. Chairman and Members of the Committee: Thank you for the opportunity to testify. Families USA, the national organization for health care consumers, supports comprehensive, nationally enforceable managed care consumer protections. These protections must be designed to ensure that all health plan enrollees receive the care they were promised by their health plans, regardless of where they live or work. To this end, Families USA strongly supports S.6/H.R.358—the Patients' Bill of Rights Act of 1999.

Today I would like to highlight the importance of one of these protections for you, the creation of a consumer assistance or "ombudsman" program. The concept of the consumer assistance program is contained in S.6 and H.R.358 and has been more fully developed in S.496—the "Health Care Consumer Assistance Act"—introduced in the Senate by Senators Reed (D-RI) and Wyden (D-OR). We expect that comparable legislation will soon be introduced in the House by Congressman Frank Pallone (D-NJ).

Perhaps the most contentious issue facing members of Congress grappling with managed care reform is the ability of consumers to sue their health plans in court and receive a meaningful remedy. Families USA supports this right and believes it is an essential protection. However, no matter whether one supports or opposes the right of consumers to sue HMOs, there should be universal agreement that we want to solve consumer-health plan problems early—thereby reducing the impulse to litigate. That's why the establishment of effective independent, external review systems, coupled with an effective ombudsman program that enables people to pursue their appeal rights, are crucial. It is a way to provide non-litigative, non-lawyer remedies on a timely basis before significant damage is done.

Today, there is a growing consensus about the need for a meaningful and effective external appeals system. We believe such an appeals system is crucial. Yet, from the consumer's perspective, a strong external appeals process may be meaningless if sick and frail people are unaware of their appeals rights and are incapable of pursuing them. A recent Henry J. Kaiser Family Foundation report, entitled *External Review of Health Plan Decisions: An Overview of Key Program Features in the States and Medicare,* indicates how important consumer assistance programs are in making external appeals systems work. In states where external appeals processes have been in existence, the number of people who availed themselves of these processes is very low—less than 250 cases per year in the largest states and fewer in the smaller states. The report cites studies indicating that these numbers are low because consumers often are unaware of their rights to an external review and, when they are sick, they are unable to pursue their appeals rights. Consumer assistance programs are needed to make the system work properly.

I believe that one of the greatest frustrations that consumers experience today is that their problems with their health insurance companies or health plans usually begin when they get sick. Understanding the fine print on one's insurance policy is challenging in the best of times, and to have to do battle with managed care bureaucrats when one is sick or frail is in many instances a war of attrition which the HMO is well positioned to win. Most consumers don't know about the limited rights they do have and, short of turning to expensive legal advice, they have nowhere to turn for help.

In addition, as health care systems and products become more and more complex, patients across the country need help from trusted sources as they navigate their health care choices. When people choose their health plans, help is needed to identify information that is available and to sift through such information. People increasingly need assistance to understand complex terms, to decipher their options, and to assess the implications of plan choices on their families' specific health needs. This is why it is critical that Congress creates an ombudsman program.

FUNCTIONS OF OMBUDSMAN PROGRAMS

I would like to turn now to a discussion of the role and functions of such consumer assistance programs. The structure of these programs is contained in S.496, the Reed-Wyden bill.

The establishment of ombudsman or consumer assistance programs would serve the information, counseling and assistance needs of health care consumers in a number of ways. Ombudsman programs would provide consumers with the information they need to make a responsible, informed selection of insurance packages. Once consumers are in a plan, the ombudsman program could advise them of their rights and responsibilities.

A toll-free telephone hotline set up and maintained by ombudsman programs would allow consumers throughout states to request information, advice or other health insurance related assistance easily and without cost.

Consumer assistance programs would also be charged with producing and disseminating materials to further educate consumers about their rights in the health care system.

A key function of an ombudsman program would be to provide direct assistance, including representation, to consumers who are appealing—either internally within a health plan or externally to an agency authorized to handle independent appeals—decisions that deny, terminate, reduce, or refuse to pay for health care serv-

ices. This assistance and representation does not include involvement in litigation or other court proceedings.

In an effort to effectively and efficiently resolve questions, problems and grievances, consumer assistance programs would make referrals to other existing resources, including, as appropriate, employers, health plans, insurance agents, public agencies, health plan regulators and health provider organizations.

Finally, ombudsman programs would collect data regarding the inquiries, problems and grievances addressed by the office, as well as the resolution of those problems. This data would be disseminated to all stakeholders in our health system, including employers, health plans, health insurers, regulatory agencies, policymakers and the general public.

WHY PROGRAM INDEPENDENCE IS IMPORTANT

To work effectively and with the full trust of consumers, ombudsman programs need to be independent of health plans, providers of care, payers of care and state regulators. This is crucial so that ombudsman programs are, and are perceived to be, totally responsive to the needs of consumers and have no conflicts of interest. Thus, ombudsman programs should be independent entities, not connected to health plans or state agencies.

A 1995 study of Long-Term Care Ombudsman Programs conducted by the Institute of Medicine concluded that ombudsman programs should be contracted out to independent nonprofit agencies in order to ensure program effectiveness. The Institute of Medicine found that this independence elicits confidence in consumers and makes them feel that the advice and help being provided is in their best interest.

In order for consumer assistance programs to perform successfully, they must be perceived by consumers as having no interests other than informing, advising and assisting the public. It is imperative that these programs gain the confidence of consumers so that they will feel comfortable seeking assistance and be assured that this assistance will be provided impartially. Programs associated with a health plan provide the least independence in that they are staffed by health plan employees, the very entity that consumers may have complaints against. While ombudsman programs housed within a state agency offer independence from health plans, the staff of such agencies often have related, sometimes even conflicting, agendas as they regulate health plans. Thus, a real or an apparent conflict of interest may arise if state agencies operate ombudsman programs.

HOW TO ENSURE INDEPENDENCE

One process of ensuring the independence of ombudsman programs is to have states, using funds provided by the federal government, contract with non-profit organizations to serve as ombudsmen. Grants from the Department of Health and Human Services (HHS) would enable states to enter into such contracts with eligible organizations. In requesting funds from HHS, a state should be required to submit an application containing the state's plan for soliciting proposals from eligible organizations, as well as the method the state would use to ensure that organizations provide high-quality assistance services.

Grant amounts would be determined based on the ratio of the number of individuals in the state with health insurance coverage to the total number of individuals with health insurance coverage in all states.

Eligibility of the non-profit organizations should be based on a number of factors, including the organization's demonstrated ability to meet the needs of health care consumers, particularly those most in need of assistance. The organizations should prepare and submit a proposal to the state in which they outline their technical, organizational, and professional capacity to oversee and run the ombudsman program. Eligible organizations should clearly demonstrate their independence from health insurance plans, providers, payers and regulators of care, eliminating any questions of conflict of interest, and they should substantiate their ability to assist and advise consumers throughout the state, regardless of the source of their coverage.

HOW WE KNOW OMBUDSMAN PROGRAMS WORK

There are a number of different health ombudsman-type programs that serve as models for the type of ombudsman programs that should be created in patients' rights legislation.

Of the various types of health-related ombudsman programs in existence today, the oldest, largest and best known is the Long-Term Care Ombudsman Program. Created more than two decades ago under the Older Americans Act as a result of

well-publicized concerns about institutional care problems, states established ombudsman programs to serve people in long-term care facilities. These ombudsman programs are designed to advocate for nursing home residents, to help solve problems between patient/residents and institutional care facilities, and to bring systemic problems to the attention of state administrators and regulators. Long-Term Care Ombudsman Programs exist in all 50 states, the District of Columbia and Puerto Rico.

A myriad of different health-related and specialized ombudsman programs also exist around the country. The most significant types of these programs include the so-called Information, Counseling and Assistance (ICA) programs that were funded under the Omnibus Budget Reconciliation Act of 1990 to serve Medicare beneficiaries. These programs differ significantly from state to state and are also heavily dependent on the use of volunteers.

There are also a significant number of state and/or local-based ombudsman programs serving low-income people in the Medicaid program, especially those in the states of California, Michigan, Minnesota, Oregon, Tennessee, Texas and Wisconsin.

More recently, a number of ombudsman programs have been created that are designed to serve the health care information, education, counseling, referral and assistance needs of the public and patients irrespective of the source of payment for their care. Three states—Florida, Vermont, and Virginia—recently enacted legislation for the purpose of establishing ombudsman program services. Vermont enacted legislation requiring state officials to contract with a nonprofit organization to handle ombudsman functions. The ombudsman program responsibilities under the Vermont legislation include assisting people with plan selections by providing information, referrals and assistance about different health plans; helping plan enrollees understand their rights and responsibilities; identifying, investigating and resolving complaints on behalf of patients; and assisting patients with the filing and pursuing of internal and external administrative appeals concerning service delays and denials.

Since its opening on January 4 of this year, the Vermont Office of the Health Care Ombudsman has received nearly 300 calls from consumers within the state. The majority of the calls have been from consumers seeking assistance dealing with commercial insurance purchased through employers, individual plans, or Medicaid managed care.

As of mid-February, 40 percent of the consumer inquiries received by the office have required counselors to take some kind of action on behalf of the consumer, such as calling the client's insurance company or health plan, assisting consumers in preparation for plan appeals or fair hearings, and helping consumers draft letters. Of the inquiries received, only 23 percent could be answered during the initial phone call to the office.

Florida's ombudsman program is a volunteer-based entity that consists of local ombudsman committees that serve consumers in their specific areas. Consumers are referred to their local ombudsman committees by the state's Agency for Health Care Administration.

The state of Virginia enacted legislation last month that creates a state-based managed-care ombudsman to assist policyholders with appeals to health insurance companies. It is financed by a premium assessment on health plans.

There has been tremendous support for the establishment of ombudsman programs across the country. The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry made several references to the need and importance of creating ombudsman programs. Several HMO executives—including the chief executive officers of Kaiser Permanente, HIP Health Plans, and the Group Health Cooperative of Puget Sound—joined together in a statement indicating that patients "should have access to an independent, external nonprofit ombudsman program" and that health plans should cooperate with those programs. Approximately one dozen states have bills pending in their legislatures to create such ombudsman programs. Clearly, this is a mechanism that is receiving growing recognition as an effective way of helping consumers at an early time and in a nonconfrontational manner.

CONCLUSION

Consumer assistance programs help to resolve problems at earlier, less formal stages and obviate the need for more contentious proceedings, such as litigation. Consumers need to have someone to go to for help when they think they are not getting the care they need. A knowledgeable person who can explain the obligations of the patient and the plan may be able to run interference and solve a consumer's problem before a formal grievance is necessary—saving time and money for both

plans *and* consumers. Additionally, providing assistance throughout the appeals process could make the system work more efficiently and thereby lessen the need for further proceedings, such as litigation.

As a result, any legislative proposal that seeks to deal with problems early and uses external review mechanisms to achieve that objective should include a provision for the creation of consumer assistance programs. We have ample, high-quality precedents in the states for these programs, and we should implement them as part of a patients' rights system.

I would like to close by stating the obvious. A consumer assistance program designed to assist consumers cannot, *on its own,* solve the serious problems patients face today when dealing with their managed care plans. It must be part of an overall consumer protection system, such as the one that would be created by H.R.358—the Patient's Bill of Rights Act of 1999. As part of such a system, consumer assistance programs can help ensure that patients get the care they need, when they need it.

Mr. BILIRAKIS. Thank you, sir.

The issue of the gag rule is very significant, but I know there are people up here who will delve in that much deeper than I would.

And I might also add that all of us should be grateful to Drs. Norwood and Ganske, particularly. Because a lot of this is happening out there already. This is not to say that some of it hadn't been happening before they actually got involved in it, or that it would not have happened. But I think some of it is happening as a result of an interest on the part of the Congress. So we are very grateful to them.

But I would like to concentrate more on this information area and the ombudsman.

Mr. Pollack, you talked about the appeal process and liability very briefly; you said you weren't going to go into that, and I appreciate it. But I suppose if we had a better informational process, if we an ombudsman-type of a situation—perfected it in some way—that probably we wouldn't have to worry as much about the liability areas and the appeal areas. Would you agree?

Mr. POLLACK. I do agree. I——

Mr. BILIRAKIS. And we talk about the costs, and there is something in here that talks about the President's Commission. It was rejected in part, the ombudsman idea.

Mr. POLLACK. No, it did not. I want to be very clear on this, Mr. Chairman. Because I served not just on the President's Commission, but I also served on the subcommittee that crafted the Patients' Bill of Rights. And, in fact, if one takes a look at the President's Commission's report, you will see on numerous pages—and I will reference them for you rather than read the materials—if you will look on pages 2, 15, and 22, and 23, you will see that the Commission spoke very favorably about the creation of ombudsman programs.

One last point I want to make; your home State of Florida is one of the States that has developed an ombudsman program. There are three States that have enacted legislation to this effect: Vermont, Virginia, and Florida. And I think that the experiences, to date, with the ombudsman programs that are in operation show that they are an effective tool for resolving differences in early and non-confrontational ways.

Mr. BILIRAKIS. Well, all right. I was really going to refer to the fact that apparently it was rejected—at least that is the information I received—because the costs were expected to exceed $2 billion. That is not true?

Mr. POLLACK. No. No, that is absolutely——

Mr. BILIRAKIS. Well, were they adopted?

Mr. POLLACK. Absolutely incorrect.

Mr. BILIRAKIS. All right, then.

Mr. POLLACK. No. 1, there was no estimate ever about the cost of an ombudsman program, $2 billion or otherwise.

Mr. BILIRAKIS. But was it adopted?

Mr. POLLACK. Yes.

Mr. BILIRAKIS. All right.

Mr. POLLACK. If you would like——

Mr. BILIRAKIS. Okay.

Mr. POLLACK. [continuing] I am happy to read some of the appropriate provisions.

Mr. BILIRAKIS. All right. But let me ask you, who would incur the costs of that? Would it then be the insurance companies?

Mr. POLLACK. In the State of Vermont, which created a financing mechanism, and in the State of Virginia, they went about it in two different ways. And Congress can do it in more than—in at least these two ways.

In Virginia, recently enacted, there was a surcharge leveled on health plans—and it is a modest surcharge—to finance the costs of ombudsman programs.

Mr. BILIRAKIS. And that was passed on to the beneficiaries?

Mr. POLLACK. To the payers of the plans; yes. And it is a very modest sum. In Vermont, it was established through general revenues. And there, too, it was a very modest sum.

Mr. BILIRAKIS. Well, I guess what I am going to is the costs, whatever it might be—whether it be this exceeding $2-billion figure or whatever it might be.

Mr. POLLACK. I really want to put this to rest, because never——

Mr. BILIRAKIS. All right.

Mr. POLLACK. I was involved, literally, in every discussion on this issue. And not only did the Commission not find that it would cost $2 billion, there never even was a discussion about it with that dollar figure. There never was——

Mr. BILIRAKIS. All right.

Mr. POLLACK. [continuing] in the entire proceedings of the Commission.

Mr. BILIRAKIS. Okay; I am misinformed. But that is really beside the point. There is going to be a cost involved?

Mr. POLLACK. Yes.

Mr. BILIRAKIS. Okay. And somebody is going to have to incur that cost somewhere along the line.

Mr. POLLACK. Right.

Mr. BILIRAKIS. Okay. Now that is, again, another question.

But could we say that this ultimate savings, in terms of the appeals and possibly the liabilities aspects—the court, going to court, et cetera—that the costs would be considerably less, if you have an ombudsman-type of a situation?

Mr. POLLACK. I believe——

Mr. BILIRAKIS. You would think so?

Mr. POLLACK. I believe that is true, Mr. Chairman, because the savings by preventing the kinds of contentious procedures, irrespective of whether there is a liability provision or not, I think would

be considerable. And I think it is in everyone's interest—health plans, as well as consumers—to try to get these issues resolved up front, at the earliest stage as possible. And, yes, there would be considerable savings for doing that.

Mr. BILIRAKIS. Thank you, sir.

Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman.

Ms. Lehnhard, in your testimony—I understand that HMO's and PPO's are different and structured differently—and in your testimony, you state that requirements to collect uniform data on healthcare outcomes and have a continuous quality improvement program to address these outcomes would essentially eliminate PPO's. There would be no more PPO's.

Do you believe that PPO's should not be subject to any quality improvement requirements?

Ms. LEHNHARD. We believe the whole thing should be—the question of quality measurement should be left to the private sector. Right now, the private accreditation organization for PPO's does not require PPO's to do clinical improvement, because of the—you know, when you tell a health plan it is accountable for improving quality, you are telling the health plan they have to change behavior of physicians. And our plans tell us to do that, you have to have the tools that you have in an HMO.

Our plans will improve quality in PPO's, but the strategies they use are very diverse—very varied. And there is no consensus in the industry at all, in terms of what PPO's should be doing to affect quality.

Mr. GREEN. Well—and I want to follow up, then I will get onto the other part. And along those same lines, you suggest that the provision in the Patient's Bill of Rights that required group healthcare plans and health insurance officers to provide the latest information on the quality of the delivery of medical care is also a threat to the existence of PPO's—Congressman Dingell's bill?

Ms. LEHNHARD. We are concerned about that language, not so much for the language per se, but what could happen in regulations. For example, the Secretary could say that the latest information is your claims information, or the latest information is whatever you have—in PPO's we will, for example, profile physicians—very crude profiling. We look for gross outliers, for example, because all we have is claims data. That would mean we might have to make that public.

For some PPO's it might mean they might not do it, because it is a very crude tool. And you also often have to have individual follow-up with the individual physicians you have identified.

There is no state-of-the-art in PPO quality measurement like we have in HMO measurement.

Mr. GREEN. Well, and I understand, you know, but the PPO—you have your list of your physicians that are available. And shouldn't it be just prudent business practice that a provider would, if that physician is on the list, that they could have some standard. Now, granted, not as much as an HMO because of the contracting basis. But for the PPO, there should be some type of oversight from the insurance company who could list that physician or that provider on that list.

Ms. LEHNHARD. I think when you get into these very broad networks of 30,000, 40,000, 50,000 physicians, there is a very high per-physician cost in doing any of that. Even finding out when the doctors' office hours are, the background on their education, and keeping it current is a very high cost. As soon as you start down that road, you start to create incentive for health plans to narrow their network.

And there has not been a real discussion about the balance between large networks, lots of choice for subscribers, versus going down a path like we have gone down on HMO's, which is making the health plan accountable for quality rather than leaving it to the physicians.

Mr. GREEN. Okay. And, again, my concern I guess is for that physician to be on that PPO list, you had to make some decision for them to be on there, other than they were just licensed to practice medicine?

Ms. LEHNHARD. In some of our PPO's, we will have 98 percent of the licensed physicians in the State. These are very broad, very broad choices, and it is what the market wants.

Mr. GREEN. Well—and, again, my only experiences is in the Houston area, and looking at some of the PPO lists, in fact, for Blue Cross, it would get nowhere near the 98 percent of the physicians in the Houston area that would be on PPO list, you know, because I have looked at that list over a number of years and watched it change. I don't want to locate unnecessary regulation, but I also want to measure quality, and for a physician to get on that list, I would hope somebody is looking at it to make sure that, the physician is providing the highest possible level of care.

Ms. LEHNHARD. Some of our PPO's—we will have different kinds of PPO's. Some PPO's look at quality; some PPO's are strictly discount arrangements. For example, some State employee groups have said, "We want as many physicians that you can get, any physician that will take a discount and not bill the subscriber."

Mr. GREEN. I appreciate it.

Let me—Mr. Chairman, if I could just ask Mr. Pollack if—I know you were shaking your head during just now and I have run out of time and I have other colleagues you need to answer questions, but if you could just make a comment——

Mr. POLLACK. Well, I was just shaking my head at the same thing you did about the 98 percent. I am in a PPO and, Lord knows, it has quite a bit fewer percentage of physicians in it.

And really, what a PPO does is it selects its physicians largely on one major factor, and that is those that are willing to accept the discounted payment for the service they provide.

Ms. LEHNHARD. That is part of it.

Mr. GREEN. Okay. So there is no look at quality at all.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. Yes.

Of course, Ms. Lehnhard agrees. She says, "Part of it."

Ms. LEHNHARD. Well, you will have as many different kinds of PPO's—when you see one PPO, and you have seen one PPO. And it is a tremendous benefit for people to have a network of physicians who will take a discounted payment, not bill the patient, and

then you pay 20 percent to go outside the network to see any physician you want.

It is the fastest growing product, and it is what the market is saying, absolutely, that they want. And if we have to begin to impose quality-type measurements like we do in our HMO's, we can't have that large number of physicians in the network.

Mr. BILIRAKIS. Dr. Ganske.

Mr. GANSKE. Thank you, Mr. Chairman.

My good friend and colleague from Georgia here, to my right, earlier expressed a sense of frustration at the details of some of the language that came out in the Patient Protection Act—I might say, early in the morning on the day that the bill was debated on the floor. And so I want to focus some of my questions on the details of legislation, because the devil is in the details.

This question will be addressed to you, Dr. Reardon. For instance, you might think that since Congress has already dealt with, in the form of Medicare and Medicaid, banning gag rules, that it would be a "slam dunk" to adopt the language that we passed in the Balanced Budget Act, as it related to Medicare, banning that type of prohibition on patient/physician communication and simply put that language which was fully vetted in this committee into a patient protection bill that would cover all patients in the country.

But I want to point out that the language that we have in Balanced Budget Act, which the members of this committee voted for, says that health plans could not, "prohibit or otherwise restrict," medical communications between providers and patients.

But all we had in the original Patient Protection Act was "could not prohibit." Those three words, "or otherwise restrict" are those details, those devil details that make all the difference in the world whether you have a patient protection act or an HMO protection act.

Dr. Reardon, I want to ask you, whether the AMA is concerned about legislation allowing plans to restrict but not completely prohibit medical communications? In other words, is there such a thing as a little first amendment right?

Mr. REARDON. Congressman, no. We feel that physicians should have the right to discuss all treatment options and disclose fully to patients and discuss all items. What you are describing that happened in the Managed Care Act last year, we would not support.

Mr. GANSKE. Dr. Reardon, can you pull that just a little bit——

Mr. REARDON. I am sorry.

Mr. GANSKE. [continuing] closer and make sure that it is turned——

Mr. REARDON. Yes. I am agreeing with you, Congressman. We would not support what happened in the Managed Care Act last year. We think that physicians should have the right to discuss everything with the patients.

Mr. GANSKE. Thank you.

Ms. Lehnhard, we have hours of questions that I could ask you, but I want to specifically talk about some legislation that is working its way through my State of Iowa right now, dealing with a patient protection bill.

Now, Iowa Wellmark, Iowa Blue Cross Blue Shield, has been a leading member of a coalition of insurers, business interests, pro-

fessional groups, in support of a patient protection legislation that just passed the Iowa Senate with only two or three dissenting votes.

Now, in that legislation, when you are dealing with the definition of "medical necessity" as it relates to external review, the standard that was used was "clinical standards of care." That was supported by John Forsyth, the CEO of Iowa Wellmark. It will probably become law in Iowa.

My question to you is, since we already have one Blue Cross plan in the country supporting a definition of "medical necessity" that specifically includes "clinical standards of care," can national Blue Cross Blue Shield do the same?

Ms. LEHNHARD. We have a number of plans that have supported legislation in the States, and that has been one of our points—that the States are adopting these protections.

The Iowa plan is concerned about Federal legislation and is opposed to Federal legislation because of a number of issues, including the problems in dealing with two sets of regulations.

It is like the old story in Medicare, where the Federal Government would say, "Put the fire extinguisher in a blue box," and the State government would say, "Put it in a red box." So you have three fire extinguishers up there. One is a mix of red and blue.

Mr. GANSKE. Can you just address this, the question of the Iowa Blue Cross Blue Shield Wellmark support for——

Ms. LEHNHARD. I would have to get back to you. I believe they did have problems with the—I know they had problems with your "medical necessity" language, and I don't remember the specifics. But we have something in writing that we can share with you.

Mr. GANSKE. And my understanding is that they ultimately came on board with the coalition for an acceptable definition.

Ms. LEHNHARD. I don't know how that State language compares with your language. I know they had problems with the "medical necessity." I believe they had problems with "medical necessity" language in your bill, and may have had problems with the State language.

Mr. GANSKE. Maybe, Mr. Chairman, since there are so few of us, we will be able to come back for a second round?

Mr. BILIRAKIS. Well, let's play it by ear and see what is happening on the floor, et cetera.

Mr. Pallone.

Mr. PALLONE. Thank you, Mr. Chairman.

In my opening statement today, I made the point that I felt that if we did not address the issue of "medical necessity" and who defines it, that these other patient protections that we are talking about today really would be rather meaningless.

Now, Dr. Reardon, you sort of made that point in your written statement, where you said that consider the importance of "medical necessity" determinations in light of anti-gag clause and anti-gag practice legislation. And you basically said that—that if we didn't address the issue of "medical necessity," then the gag rule, per se, would be meaningless.

Would you just clarify that, again? Because that is one of the points that I have been trying to make here today, why we need to address "medical necessity," because of all these other things.

Mr. REARDON. Well, I think traditionally "medical necessity" has been determined by a physician, and we support strongly that "medical necessity" should be based on best practice, best science. If the physician does not have the right to make the "medical necessity" determinations and do that with a patient, and they are going to be second-guessed, or there is arbitrary decisions made by the health plan, then the ability to talk with the patient and make decisions to the patient is eroded.

This does not mean, however, that we do not respect utilization management and medical management and oversight. And with that, of course, with utilization management, if there is a denial, then we feel strongly there should be an appeals process, both internal and external, for that review by the health plan.

But the "medical necessity" decision is a medical decision, and should be made by medical personnel.

Mr. PALLONE. The other thing you bring up in this context in your testimony is that, basically, what you find is that the determination of "medical necessity" is increasingly being determined by financial considerations.

And that was my point in some of my questioning in the last panel which is—I mean, if the bottom line is profit here, and that is what is determining, you know, what a lot of the HMO's do, once again, it brings up the point of why we need to define, you know, who is going to define "medical necessity" in an effective way.

I don't know if you want to comment on that again.

Mr. REARDON. Just very briefly, I think what we are referring to is, one size does not fit all. And there may be multiple treatment modalities for a given condition or a given patient, but you need to match that with the patient's needs. Not every patient is the same.

Mr. PALLONE. I wanted——

Mr. COBURN. Would the gentleman yield for just a second? And I will be happy to yield some of my time to him when the time comes. I just want to ask a question that follows that same line, because it is——

Mr. PALLONE. Well, normally, I would be glad to, Mr. Chairman, but I have another couple of questions and I don't want to run out of time. Can we——

Mr. COBURN. I will yield you my time. I still have time coming.

Mr. PALLONE. All right. Let me just get through what I am doing and then I will come back to——

Mr. COBURN. All right.

Mr. PALLONE. Because, otherwise, I am going to run out of time, because I have to go to another meeting, too.

On the ombudsman issue, I just wanted to mention to Mr. Pollack, frankly, I used to work—I used to be a counsel for protective services to the elderly in New Jersey, which was like the ombudsman, so I don't even have a problem with the idea that the ombudsman, you know, were to get involved in lawsuits. But my understanding is just the opposite.

And if you could just stress, again, that it is not the intent of the ombudsman actually get involved in suing, it is the opposite. You are trying to do—you see this as a preventative measure, as a way

of trying to resolve suits beforehand. And that reflects back on the cost issue of trying to save costs in the long run.

If you would just comment on that.

Mr. POLLACK. I would even say something stronger than that, Mr. Pallone, and that is that in legislation, creating an ombudsman program, I would even prohibit the ombudsman program from being involved in litigation.

The purpose of the ombudsman program is to try to get these things resolved before litigation becomes an issue. And I think all of us agree, whether people like the liability provision or dislike the liability provision, we all agree. Let's get these problems resolved early; let's do it in a way that gets people help when they need it, as opposed to having to go to court, then wait a few years to get something resolved.

And so the ombudsman provision is designed to avoid litigation, even if you have a right to litigation.

Mr. PALLONE. Okay. Now I just want to ask Mr. Pollack and Dr. Reardon. This is a clarification. I know you were both on the President's Quality Commission. And I believe, Ron, that you were on the task force that Peter Thomas chaired. That is correct?

I would like to clarify what the task force came to recommend regarding "medical necessity." Mr. Thomas is correct that the Commission did not have a separate consumer right on "medical necessity," but it did incorporate some thinking on this issue in the grievance and appeals section.

Is that correct?

Mr. POLLACK. That is absolutely right. Actually, I was looking at the President's Commission's recommendations that was crafted in Peter's subcommittee that I served on, and one of the things we said was that the external right of appeal would apply to decisions of "medical necessity," and that these would be independent of what the plan's decision was and would be made by competent professionals who are specialists in the area that is in controversy.

I want to just make one point, because maybe that anticipates Mr. Coburn's question. I think this issue of "medical necessity" is not a question about, should we use protocols or clinical guidelines? I think everybody agrees that it is a useful thing to have those things, and the more they proliferate, the better that is. The real question is, is somebody who is actually looking at the patient involved in the process of determining "medical necessity?"

And, unfortunately, what we have today in too many instances is that the decisions albeit whether it is made by a physician or whether it is made by a nurse, that decision is made by somebody who has never seen the patient. And that is why it is very important to clarify this "medical necessity" decision so that we involve the attending physician in that process. And I think that is what this "medical necessity" issue, ultimately, comes down to.

Mr. BILIRAKIS. Before we get over to the next panelist—Doctor?

Mr. REARDON. Yes.

Mr. BILIRAKIS. Obviously, it is controversial. Are you suggesting that if we can't get that done, we should not do anything with gag and within the informational and maybe ombudsman—which really appeals to me—or some of these other things that we are talking about? Are you suggesting that, Doctor?

Mr. REARDON. Well, let me put it this way, Mr. Chairman; we look at the Patients; bill of rights as a lifeboat for patients as they navigate through an increasingly complex healthcare system.

Mr. BILIRAKIS. Yes.

Mr. REARDON. And a lifeboat without one part of it is not going to float.

Mr. BILIRAKIS. All right. So that is what you are suggesting?

Mr. REARDON. Not going to meet patients' needs and——

Mr. BILIRAKIS. That is what you are suggesting?

Mr. REARDON. [continuing] therefore, we think there should be a comprehensive bill.

Mr. BILIRAKIS. All right.

Mr. POLLACK. There is one other facet of this.

Mr. BILIRAKIS. Well, it is really not my time here, and I really shouldn't take advantage of it.

Mr. COBURN. Well, maybe the Chair will yield time to me?

Mr. BILIRAKIS. We may go around again.

Mr. COBURN. All right.

Mr. BILIRAKIS. If you are patient enough.

Let's see, Dr. Norwood.

Mr. NORWOOD. Yes, sir, Mr. Chairman; I do hope we go around again. And I will yield to Dr. Coburn to follow up on "medical necessity."

Mr. COBURN. I just wanted to make two points. What Mr. Pollack was talking about is, you know, as I tiraded about the loss of doctor/patient relationship, the thing to remember is not all medicine is science. A good portion of it is art. And a great deal more portion is art than we want to admit when you talk to good physicians. And I can tell you I have done a lot of things that people in the medical community said I was nuts, and I found disease that was there that everybody else said wasn't there because of the art of medicine.

The second point I would make in defense of managed care is, they aren't the only ones that have been greedy in healthcare. And one of the reasons that we are seeing some of the things that we are seeing is because physicians have been greedy. And all you got to do is go look at HCFA's numbers on echocardiograms by cardiologists that are done that aren't necessary. And you can see that there are two people who have played this game. So, medicine is not without some due criticism for its motivation.

Why is it there?

Because the doctor/patient relationship has been disrupted. The person paying the bill isn't the person getting the service.

And so, you know, there is a lot of blame to go around to how we found ourself in the shape where somebody, a third-party, is making a medical determination, based on a protocol that has no knowledge about the patient whatsoever, and doesn't necessarily have the patient's best interests at heart.

And so I would just thank the gentleman for yielding. I think those points are important, and I am sorry Mr. Pallone doesn't want to hear that. Because everybody has made plenty of errors as we formulated and manipulated the market, as our healthcare has come forward.

And I yield back to the gentleman from Georgia——

Mr. NORWOOD. Thank you very much, and I will——

Mr. COBURN. [continuing] and thank you very much.

Mr. NORWOOD. [continuing] follow in that same line of questioning and see if I can say this in a simpler way.

What we speak of is, who actually diagnoses and then determines the treatment for the patient? Who physically does that?

And I would think that, Ms. Lehnhard, you believe that for managed care to work, the insurance companies have to take that over?

Ms. LEHNHARD. No, not at all. And I am glad I finally get to say something on this.

Mr. NORWOOD. Then you——

Ms. LEHNHARD. I would just say, first of all, this is not a managed care issue. This is a fee-for-service issue; this is a Medicare issue, and it is the fundamental issue. And it is not solely about evening out practice patterns. This is your basic abuse.

If you were to do in Medicare what you are proposing to do in private health plans, the burden of proof would be on Medicare to prove why they shouldn't pay a physician. The physician would always be right, unless Medicare could prove they were wrong. The stacks and stacks of Medicare coverage guidelines would all end up in court because there would be charges being arbitrated.

Mr. NORWOOD. Ms. Lehnhard, I am sorry. I am going to let the chairman let you have the time; I don't. I am not going to have but a minute, and I want to make this point I am trying to make.

It is about all kinds of patients, about who determines the treatment. And you control that in every aspect of the insurance industry by denying or not denying payment.

Now my question to you, basically, is this—because I think Dr. Reardon would say, and I tend, certainly, to agree with—that the practicing physician who puts his hands on that patient, actually sees that patient, is the person most apt to get it right about what the diagnosis is and what the treatment would be?

Now I know that you think that doctor——

Ms. LEHNHARD. No.

Mr. NORWOOD. [continuing] doesn't use outcomes——

Ms. LEHNHARD. No.

Mr. NORWOOD. [continuing] doesn't use mathematical science because it is a little cottage industry, and all they have got to work with is medical science and the art of medicine, but they don't use the outcomes.

We think that all you use is outcomes. In other words, all you us is mathematical science. I know you don't touch the patient; I know you don't see the patient; yet, frequently, your people deny the treatment for the patient, that the doctor who touched the patient says, "This is what I believe, from my experience."

Now, if we defined "medical necessity," as Dr. Reardon wants to do, meaning the primary healthcare physician determines the diagnosis and the treatment, and all you do is pay for it because you are the third-party——

Ms. LEHNHARD. Nobody could afford health insurance.

Mr. NORWOOD. Wait a minute.

Now, let me finish.

What do you think that does to the term "managed care?" What does that do to managed care in America?

Ms. LEHNHARD. Again, it is not just managed care. If you look at some of the things—they haven't gone on for a few years——

Mr. NORWOOD. Humor me for this discussion, and just tell me what it does to managed care.

Mr. BILIRAKIS. And let's do it briefly now, because if we want to go to Mr. Towns before we break——

Ms. LEHNHARD. It makes all health insurance——

Mr. BILIRAKIS. [continuing] we will break for the vote, then come back for a quick second round.

Ms. LEHNHARD. It makes all health insurance unaffordable. We will go back to the days where everybody got a chest x-ray when they went to the hospital. Everybody got a whole battery of tests. If you put the burden of proof on the health plan in every single case to prove why we shouldn't pay for something, you will have procedures come out of the woodwork that you haven't seen for 20 years.

Mr. NORWOOD. Mr. Chairman, when we come back, Dr. Coburn gets his first round question. Then, maybe I can get to Dr. Reardon for an answer on that.

Mr. BILIRAKIS. Ms. Lehnhard, I heard Dr. Coburn, or I think I heard him correctly when he made comments about a lot of these cardiologists ordering "unnecessary"—I think he used that word—"unnecessary" echocardiograms. I might add that a lot of non-cardiologists, family practitioners are also ordering echocardiograms, and I have no idea whether they are necessary or not.

Mr. COBURN. I was quoting HCFA data and not my opinion.

Mr. BILIRAKIS. Not your opinion? Okay.

Mr. COBURN. I was quoting HCFA data.

Mr. BILIRAKIS. All right. But you don't agree with that opinion?

Mr. COBURN. I don't agree that most primary care physicians are ordering echocardiograms. Most of those are——

Mr. BILIRAKIS. Well, I didn't say "most," but there are many.

Are we basically saying that we no longer trust the physicians to make the right decision on behalf of the patient? And we basically think that they are just going to take advantage?

Ms. LEHNHARD. No. No, I don't want to be construed as saying that.

When we use our guidelines—first of all, the guidelines are developed by the medical professionals, and when our medical directors looks at a guideline and see the information from a physician that doesn't fall under the guideline, he will call the physician and say, "You don't meet the criteria. Is there something I am missing?"

The physician may say, "This person weighs 400 pounds."

And our medical director would say, "Fine; put him in the hospital."

I think what you have to look at is the cost of a total flipping of who is in charge of deciding what is covered.

And I use the example of Medicare. If you look at the Inspector General's reports on Medicare, the big savings yet to be achieved are in the "medical necessity" area.

We were some of the innovators, in Blue Cross and Blue Shield, but it used to be, literally, every time you went to the hospital, you got a chest x-ray and a whole battery of tests.

When we first said, "We are not going to pay unless the physician can show us that it is needed," this was a health plan saying we are going to use our burden, the fact that the physician has the burden of proof to come to us and say, "We will pay when you can show us that we need to pay."

If you flip that, you are going to have not only outmoded or inappropriate or unnecessary services, you will have cases of going back to abuse.

Mr. BILIRAKIS. Well, but again—and we are going to have to go over and vote—so we have lost complete confidence in the medical doctor making the decision for basically "medical necessity," that it is medically necessary? We have lost complete confidence——

Ms. LEHNHARD. No. We always——

Mr. BILIRAKIS. [continuing] in that?

Ms. LEHNHARD. [continuing] go back to the physician to see, you know, have we missed something in the guidelines? Have you forgotten to give us some information?

We wouldn't—our medical directors don't just say, "No." They call the physician and find out what additional information is needed or is missing.

Mr. GANSKE. Mr. Chairman, I would point out that those guidelines were ones that mandated same-day mastectomies and drive-through deliveries—which subsequent medical studies have shown have been contrary to the health of the patients—that Milliman & Robertson's guidelines were recommending. But we are not talking about doing away with the fact that managed care can do appropriate utilization review. Of course they can. Just like traditional indemnity plans have always done utilization review.

As a physician, I did utilization review for a number of insurance plans, and when recommended care steps out of bounds from clinical standards of care, you can certainly deny that. And, if you have the scientific facts, and the clinical standards of care to back up your decision, you will be just fine.

Mr. BILIRAKIS. Let's go vote. And would you mind waiting a little while longer? I mean if one has to leave, I mean we certainly understand, and we appreciate your patience.

Ms. LEHNHARD. Yes, I can stay.

Mr. BILIRAKIS. Thank you.

We are going to vote, and we will be right back.

[Brief recess.]

Mr. BILIRAKIS. The hearing is back in order.

We understand that they are going to have a few minutes of debate, and then I think it is motion to recommit and then final passage, which would mean two votes. So, hopefully, we can get this second round finished up.

Have we lost Ms. Lehnhard?

Mr. POLLACK. She just stepped out for a moment. She will be back.

Mr. BILIRAKIS. Okay. We just lost her temporarily.

All right. Mr. Towns, you are recognized, sir.

Mr. TOWNS. Thank you very much, Mr. Chairman.

You know I am having some problems moving along on this whole thing, because the point of that, I see some things that need

to be addressed before we even get to the level that we are discussing here today.

Now I am concerned about the uniformity, in terms of recordkeeping and what happens to records. You know we now have health facilities that are closing, and there is no uniform way of dealing with the medical records. You know you have physicians who, in practices, in terms of single practices and of course—and they expire. And it is not like the old days where somebody would just become a part of the estate, and then they would sell it off, and somebody would buy it and come back and take over the office. You know, those records are just sort of left hanging there in many instances. There is no uniform way to deal with this. And if a clinic closes—and let's fact it, in terms of the fact that—and there will be hospitals that are going to close because you don't need the beds anymore. There is no uniform way to deal with these records.

So we talk about information and quality care and all of these kind of things, you know, how do we get past that stage?

And the other part was, you know, I am thinking very seriously about offering some legislation, and I would like to get your input in it.

Yes?

Mr. REARDON. And I will certainly speak to that first, Mr. Congressman.

We do have a way of handling medical records at the present time, and that is a physician has a moral and ethical obligation, if he is going to close his practice, to make those records, No. 1, available to the patient as they make an orderly transfer and advise that patient ahead of time.

Mr. TOWNS. Doctor——

Mr. REARDON. Now if there——

Mr. TOWNS. [continuing] if the physician expires, in other words——

Mr. REARDON. If the physician——

Mr. TOWNS. [continuing] in other words, he dies.

Mr. REARDON. If there is suddenly the end of practice, such as the physician dies, then there is a moral obligation by the family and by the medical society to step in and maintain those records and keep them available. They aren't thrown away. And eventually they are stored in a place, a known place, so that the patient can access those and they will be shipped.

Mr. TOWNS. Doctor, who enforces that? I mean is that a law that is somewhere, or is that something that, you know, a code or ethics, in terms of the medical profession to—I mean there is no—what I am saying to you is that I know hospitals, Doctor, that have closed, and they threw the records out in the street.

Mr. REARDON. Oh, I am very sorry to hear that. But from the physicians perspective, it is an ethical obligation to make those records available.

But more, I think, what you are talking about, as we move to electronic records and better information systems, I think that will be one of the solutions to the problem we have.

Ms. LEHNHARD. I am sorry; I wasn't here when the question was asked.

Mr. TOWNS. I am sorry.

Ms. LEHNHARD. That is okay.

Mr. TOWNS. Thank you.

I am trying to get into, you know, all of the things we are talking about, but I am having trouble getting to that level because I see some very basic kinds of problems that are going on with—there is no uniform way to deal with health records. For instance, when a medical facility closes, there are different things that happen in different States, different places of doing things. Some people just walk away from them; they just leave them.

Also, the other point was that when a physician expires today, you know, it is not like the old days when that office would become a part of the estate, and the family would sell it, and another person would come in and take it over and live happily thereafter until that person expires. And then somebody else would do it. You know, that is not happening today, that once the physician expires, nobody, in many instances, are coming back into those offices. So what happens to those records? You know, nobody can tell me, in terms of a uniform way, they are being dealt with. Some States have rules; some cities have rules as how they should be dealt with, but there is no uniform way. And we are talking about Federal dollars that are going into this.

Mr. REARDON. If I may comment on that, sir. I think what you are speaking of, is a solo practicing physician, and that is becoming less and less common. Most practices are group practices or with other partnerships, partners, so the records become part of the office.

Now you are entirely right if the practitioners has to be a solo practitioner, then it creates more of a problem. But, I think there are fewer and fewer of the solo practitioners. There are more and more group practices.

Mr. TOWNS. I understand that, but what happens to those that are still out there, Doctor? That is all I am saying. I mean I agree with you, but the point is that, how do we get to the next level when we know this is going on? A doctor dies and the records die, too?

Mr. REARDON. Well, as I said, at the present time, we feel there is an ethical responsibility for the family and the estate to maintain those records and make them available for an orderly transfer.

Ms. LEHNHARD. In other words, the patients would have to notify the—hopefully, the office would be left open for awhile, and they would have to notify the office and say where to transfer your records.

And that is all I know.

I am not a—I don't know the details of State law on this.

Mr. BILIRAKIS. So the State medical societies, let's say, or the AABA, or both, don't have a responsibility, a sort of a positive responsibility to reach right on in and try to get these records protected, unless they are notified by patients or whatever?

Mr. REARDON. Actually a mechanism would be for the county, more the county society, in this instance perhaps. But most usually, as Ms. Lehnhard has said, the offices remains open for a period of weeks, and then those records that are still there are maintained by the family or by an entity until—a known entity—so they can be transferred.

But I don't think there is anything, if the question is legislation or any hard rules and regulations, I don't know of any.

Mr. BILIRAKIS. Should there be?

Mr. REARDON. Well, I think—I suppose I would rather see you turn that question to us and let us talk about it within the medical society first and see if we can't set up a mechanism through the county medical associations to deal with that. Because I think that is where it should be dealt with, is at the county level, in the local area.

Mr. TOWNS. Right. I would appreciate that, because it is a real concern, because I know of situations where hospital have closed. There was a fight between the union and the hospital, or finally, they made the decision that the hospital would close, and the records were just thrown out.

Mr. BILIRAKIS. Would you get back to us on that, Doctor?

Mr. REARDON. We will.

Mr. BILIRAKIS. Good. I know Mr. Towns—along with the rest of us.

Mr. BILIRAKIS. The Chair recognizes Mr. Dingell.

Mr. DINGELL. Thank you, Mr. Chairman. Dr. Reardon, welcome to the committee; and, you, Mr. Pollack, welcome to you, Ms. Lehnhard, thank you for being with us; we appreciate your presence.

Dr. Reardon, I want to talk to you about the question of "medical necessity." We heard testimony from two disabled individuals yesterday in this committee about the difficulty in achieving covered services or receiving treatment that the individuals concerned believed they'd paid for through their insurance premiums. I happen to know very well that the American Medical Association is much concerned about the way that some insurance companies are limiting access to covered services by addressing the question of "medical necessity," essentially saying they are not medically necessary or by creating definitions that make it impossible for those kinds of services to be delivered.

Doctor, could you please explain to everybody how some health plans are using the concept of "medical necessity" to deny treatment to patients in what I believe is an unfair way?

Mr. REARDON. Certainly, Congressman.

What happens, I think, is that they hide under the facade of coverage and they say, "Well, this is not medically necessary, therefore, it is not a covered service." In essence, though, they are making a medical decision, and either the medical director of the plan, the administrator of the plan, is making a decision, a medical decision, by hiding behind the facade of coverage.

We think it is very important that if there is any question about "medical necessity," that they deal with the physician with both an internal appeals process and, depending on the issue, an external appeals process, so they find a way so that the patient gets the necessary coverage which they are entitled to under the plan.

Mr. DINGELL. Now this question of "medical necessity" is not a new concept? It goes back, I think—I think you have been telling at one point or another, it goes back to the 1700's. Can you just describe what this really means? It describes the behavior of what

a prudent medical professional would prescribe for the patient; isn't that right?

Mr. REARDON. Well, I think—yes; the definition of a prudent medical practitioner, but more than that, we want the best clinical practice, the best science. We believe in the use of guidelines, practice parameters, as an aide to physicians to make decisions.

I think the issue is that the treating physician who sees the patient, takes the history, does the physical exam, puts hands-on to that patient, has the best knowledge of what is going on and should be the ultimate decisionmaker of what is best for that patient.

Now, there may be more than one treatment option. There may be three or four different treatment options for a given condition, but the physician is in the position of being able to determine which treatment option is best for that particular patient. So we feel very strongly.

We have no objection to working with the plans, but, ultimately, that decision should remain with the physician.

Mr. DINGELL. Now, again, Doctor, there are some who do not think we need a definition of "medical necessity" in the Patients' Bill of Rights. Without a fair and uniform definition of "medical necessity," what is the guarantee that any of the other protections that might be included, with regard to specific sets of circumstances, could be meaningful?

For example, if you guarantee access to a specialist without a definition of "medical necessity," based on the principles of good medical practice, the plan could still arbitrarily decide that access to the specialist was not medically necessary. Is that a fair statement?

Mr. REARDON. Yes. And let me use the analogy I used a few moments ago, and that is, we feel that the Patients' Bill of Rights is like a lifeboat. And that to make it complete and make it float and make it navigational through these complex healthcare systems, you need all aspects of the Patients' Bill of Rights, including "medically necessity." If you take one out, we think you are going to deprive the patients of the necessary care that they should receive.

Mr. DINGELL. Thank you.

Ms. Lehnhard, you had a comment?

Ms. LEHNHARD. If I could make a comment—and you were here when I said this is not just a managed care issue; this is a fee-for-service issue, and I would ask you to think about Medicare as an example. Medicare would be just like a private health plan in this. And there are two issues here; one is the definition of "medical necessity," which is consistent with generally accepted medical practice.

We think the bigger issue is, the language says the health plan may not interfere with the physicians' decision. It is, may not—blank—interfere, arbitrarily interfere, but that becomes a point of litigation every time you apply your guideline. And if you were to do that in Medicare, all of those stacks and stacks of coverage guidelines you—how many pairs of shoes does a diabetic get? When do you get elastic stockings? When do you get an air conditioner in your home? When do you get a chair lift? All of those are going to be—could be challenged as arbitrary. And in the worst scenario,

they could all be challenged as arbitrary at the same time and all the Medicare dollars would walk out the door. The same thing could happen in a private health plan. And that shift in the burden of proof is what is being overlooked here. The physician makes all coverage decisions and we have to prove he is wrong in every single individual case, if we think it shouldn't be paid for.

Mr. POLLACK. I just would like to illustrate what the difficulty would be if the health plan is the final and only determinate of what "medical necessity." I will give you two examples.

A health plan can say that we are only going to provide—we are only going to consider something "medically necessary" if it improves the healthcare condition of a particular individual. Now that may sound pretty reasonable. There might be an individual for whom a particular procedure is necessary so that that condition does not deteriorate. Now I would think that we would want to make sure that the plan does not determine that just because that person's condition is not being improved, but we are preventing deterioration, that we could have that reviewed.

Another kind of example—these are not issues about trying to contest what are the benefits provided in a health plan, but it can determine, as Dr. Reardon was saying, how you interpret these. For example, somebody has mouth cancer, might be determined by the health plan to need dental care, and the plan may not actually cover dental care, while I think a more careful determination may find that that person needs odontology services.

So you don't want these final decisions to be determined exclusively by the health plans. And I think the purpose of creating a standard there, is to make sure that there is a careful decision made through the preponderance of evidence by competent professionals.

Ms. LEHNHARD. And I think you could match anecdote for anecdote here. I think, for example, on cosmetic surgery. There is a fine line between plastic surgery that is medically necessary and surgery that becomes cosmetic, and there are some guidelines there. So I think you could match anecdotes on each side.

I think what you have to weigh is, what is the potential effect on premiums if all of a sudden we put the physician in charge of deciding what the health plan should cover, and would you be willing to do that for Medicare?

We will go back to the days where—and I don't mean to disparage physicians at all, but physicians put patients in the hospital because it was more convenient to go see them. That is a "medical necessity," potentially arbitrary guideline.

Mr. POLLACK. And I am so happy with this example that Ms. Lehnhard has offered, because Dr. Ganske has offered a number of examples where the plan has said this was really cosmetic surgery, and after a more dispassionate view, it was found that it was medically necessary.

I don't want the plans to be the final determiner or arbiter of whether it is medically necessary. They obviously have a role to play, but they should not be the final word.

Mr. REARDON. And, Mr. Chairman, may I respond, too?

Mr. DINGELL. I would like to hear from you, Doctor, of course.

Mr. REARDON. I don't think we are too far apart on this. We are never going back to the old days, I think, as Ms. Lehnhard said, where physicians put patients in the hospital because it is convenient to work them up, do laboratory tests.

For instance, when I went into practice, if any of you on this panel had had a hernia surgery, any of you gentlemen, you would have been in the hospital 6 or 7 days. Today, you go home in the evening. If any of you had had a heart attack when I went into practice in the 1960's, you would have been laid in bed 21 days and gone home for 21 more days; now you are home in 7 days and you are jogging in 3 weeks. When we learn that something is better for patients—better practice, better care—we are quite willing to do that. We are constantly looking for innovative, creative ways, in a cost-effective manner, to provide better care for patients.

So, we are not going back to those days. The practicing physician, whether it is fee-for-service, an HMO, PPO, we—when I started to practice for my patients, I never knew whether my patients were a HMO patient, a PPO patient, or a Blue Cross patient; I treated them the same, and I think that is the way it should be.

Ms. LEHNHARD. I would just urge the committee to be sure that you would be willing to do this for Medicare, if you do it for private plans. And it is just not physician service; it is durable medical equipment, supplies, a lot of goods that people can use just because they are nice. Cans of Ensure, for example—who gets food replacement? Some physicians would find it very hard to say "no" to people if they don't have any means to buy food, in Medicare, and they say, "Gee, this is medically necessary."

There are stories in Medicare of huge fraud and abuse, and people going to nursing homes, giving people cartons of Ensure. It is very hard to say "no;" 75 percent of physicians say "yes" when people come in and ask for a brand prescription drug. It is not abuse. It is just, how do you say "no" to somebody who could use it? And your insurance company pays for it.

Mr. BILIRAKIS. There must be an in-between here. There must be some way to——

Mr. GANSKE. Well, Mr. Chairman, let me suggest to you——

Mr. BILIRAKIS. Well—yes.

Mr. GANSKE. Let me suggest an in-between.

The in-between is in my bill.

Now, wait a minute—let me finish.

When you have a dispute on a denial of coverage, and you go to an independent peer panel for review, none of those members can have a fiduciary relationship or benefit from a determination. So the referring physician's recommendation can be taken into consideration, just like the health plan's guidelines can be taken into consideration, as long as they are public, they are not secret, they are not proprietary, they can be backed up by science, NIH consensus statements, peer review literature. All of that enters into what is a standard definition of "clinical care."

It evolves; it evolves, but what we want to get away from——

Mr. BILIRAKIS. All right, now. I don't want to let this hearing get out of hand here now.

Mr. DINGELL. Regular order.

Mr. BILIRAKIS. Regular order.

Mr. DINGELL. Mr. Chairman, I note the red light is on, but——

Mr. BILIRAKIS. Are you basically satisfied, Mr. Chairman?

Mr. DINGELL. I am sorry, Mr. Chairman?

Mr. BILIRAKIS. May I go on to others?

Mr. DINGELL. Mr. Chairman, you are the chairman——

Mr. BILIRAKIS. The chairman—I know, I am the chairman.

All right. Dr. Coburn.

Mr. COBURN. Thank you. I want to get one thing out of the way that I want to make I get into the record—and this is for Dr. Reardon.

The Office of Personnel Management state that providers, healthcare workers, health plans, sponsoring organizations are not required to treatment options that they would not ordinarily discuss in their customary course of practice because such options are inconsistent with a professional judgment or ethical or moral or religious beliefs.

The current administration has provided that language as a basic protection plan for health plans and providers who have moral objections to certain procedures.

What is the AMA position on that? Would you support that?

Mr. REARDON. Certainly. A conscience clause or whatever, we would respect the moral and ethical differences that the physicians have or hospitals have; yes.

Mr. COBURN. I want to make one more point, in terms of anecdotal. You know, a lot of my patients, the vast majority of my patients, 60 percent, are women. And much to the disagreement with Ms. Lehnhard, I had lots of patients who were denied reconstructive breast surgery who had breast cancer. And any woman who has had her breasts removed, I can tell you it is in her best physical health to have reconstructive breast surgery, just in her self-esteem and her happiness with herself. And that is a medical necessity, in terms of caring for the whole patient. And yet we fought and struggled, and we have now passed laws to say that that has to be mandated.

So the point is, is there is a somewhere in-between. And I understand; you know, I think you can tell from what I said, I understand the cost-side of this; I understand the abuse-side of this, but we should be sure that we are all honest about the motivation that money too often makes us to go the wrong direction.

And I would like to—unless you want to comment on that—I would like to yield back the balance of my time to Mr.——

Ms. LEHNHARD. I would just say——

Mr. BILIRAKIS. We do want to finish up before we run over for the votes, because it would be unfair to have you wait another 45 minutes to an hour.

So, if you have a comment, maybe make it brief, will you, please?

Ms. LEHNHARD. I would just say that peer review of the guidelines is very different than review in court of all the guidelines.

Mr. COBURN. I agree with you.

And I would yield the balance of my time to Mr. Norwood.

Mr. BILIRAKIS. All right. I will get to you.

I just wanted to say—Mr. Pollack, I would have used my 5 minutes—but I am not going to use it now—strictly on the ombudsman. I would like to know who they are, who they should be, what

States have that in practice now, and how they function, and maybe a step-by-step process of how they would function. And will you furnish that to the committee?

Mr. POLLACK. Absolutely.

Mr. BILIRAKIS. If you can do that——

Mr. POLLACK. Delighted to do it.

Mr. BILIRAKIS. [continuing] no period of time is magic, but I would appreciate that very much.

Mr. COBURN. And then I yield my time to Mr. Norwood.

Mr. TOWNS. I would like to ask Dr. Reardon to do the same thing in reference to what we might be able to do, in terms of coming up with some uniform way of dealing with records.

Mr. BILIRAKIS. Yes, okay.

Mr. REARDON. We will get back to you.

Mr. BILIRAKIS. All right. Dr. Ganske.

Mr. GANSKE. Thank you, Mr. Chairman; I will be brief.

Ms. Lehnhard, my bill drops some of the reporting requirements for plans that were in the bill of rights, in order to reduce some of the paperwork for non-HMO-type staff model entities, like PPO's.

But I would like you to just briefly answer "yes" or "no" to what you think is the type of information that a health plan should provide its subscriber.

The plan service area?

Ms. LEHNHARD. Yes.

Mr. GANSKE. Covered benefits, including limits and exclusions?

Ms. LEHNHARD. Yes.

Mr. GANSKE. Cost-sharing and any limit on out-of-pocket costs?

Ms. LEHNHARD. Yes.

Mr. GANSKE. The extent to which service is available at non-network providers?

Ms. LEHNHARD. Yes.

Mr. GANSKE. The extent to which enrollees may select from among participating providers?

Ms. LEHNHARD. Yes.

Mr. GANSKE. How the plan determines whether a treatment is experimental?

Ms. LEHNHARD. Yes.

Mr. GANSKE. Whether the plan uses a drug formulary?

Ms. LEHNHARD. Yes.

Mr. GANSKE. The number of mixed and distribution of providers?

Ms. LEHNHARD. Yes.

Mr. GANSKE. Any out-of-network coverage provided by the plan?

Ms. LEHNHARD. Yes.

Mr. GANSKE. Whether there is a point-of-service option and the cost associated with it?

Ms. LEHNHARD. Yes.

Mr. GANSKE. A description of how participants select and change providers?

Ms. LEHNHARD. Yes.

Mr. GANSKE. An explanation of how to obtain referrals to specialists?

Ms. LEHNHARD. Yes.

Mr. GANSKE. The name and location of participating providers and their credentials and whether they are accepting new patients?

Ms. LEHNHARD. I have to qualify that. It depends—some of our plans will say for their huge networks, 50,000 physicians, keeping that current is a——

Mr. GANSKE. It would be a goal.

Ms. LEHNHARD. What?

Mr. GANSKE. It would be a goal that if a patient were presented with a list of providers——

Ms. LEHNHARD. And there also would——

Mr. GANSKE. [continuing] there would be an asterisk or something that would say, "These are not accepting new patients."

Ms. LEHNHARD. In the spirit of the kinds of things you are asking, this is a plan description that certainly any plan can look at. It depends on how you define "credential" for example, how much research you have to do and to each physician.

Mr. GANSKE. How about how the plan deals with the needs of those who don't speak English?

Ms. LEHNHARD. Yes.

Mr. GANSKE. Whether a plan covers out-of-area care?

Ms. LEHNHARD. Yes.

Mr. GANSKE. How the plan covers emergency care?

Ms. LEHNHARD. Yes.

Mr. GANSKE. The percentage of premium dollars used for healthcare compared with other overhead and expenses?

Ms. LEHNHARD. I don't know the answer to that.

Mr. GANSKE. Okay.

An explanation of rules relating to utilization review or prior authorization, and a general description of how the plan does that? That is a yes?

Ms. LEHNHARD. Yes.

Mr. GANSKE. An explanation of grievance and appeal rights, and aggregate information on the number filed and their disposition?

Ms. LEHNHARD. Yes.

Mr. GANSKE. A summary of the types of financial payment incentives given to providers?

Ms. LEHNHARD. Yes.

Mr. GANSKE. Information about how participants contact the plan if they want authorization for treatment?

Ms. LEHNHARD. Yes.

Mr. GANSKE. Last one, and the plans' procedures to keep medical records private?

Ms. LEHNHARD. Yes.

Mr. GANSKE. Thank you very much.

Mr. BILIRAKIS. I thank you.

Mr. DINGELL. Mr. Chairman, could I just ask Ms. Lehnhard one question?

Mr. BILIRAKIS. If you will——

Mr. GANSKE. I yield to the chairman.

Mr. BILIRAKIS. If you will make it quick, sir.

Mr. DINGELL. I am curious. I listened to you in extensive of—I am not sure—really, two questions. One, are you for or against the doctor making a decision with regard to "medical necessity?"

Ms. LEHNHARD. First of all——

Mr. DINGELL. Just "yes" or "no." You are for the doctor making the decision or you are for the health plan making the decision?

Ms. LEHNHARD. We are for the physician making his own decision about "medical necessity." We think——

Mr. DINGELL. Well, then you are in favor of the physician making the decision? Or you are in favor of the healthplan making the decision? Which——

Ms. LEHNHARD. We are in favor of the health plan being able to use guidelines, in our case, developed by professional physician organizations——

Mr. DINGELL. Well, let me put it to you this way.

Ms. LEHNHARD. [continuing] to decide whether it is——

Mr. DINGELL. Are you in favor of the doctor making the decision, or are you in favor of the health plan making the decision?

Ms. LEHNHARD. We are in favor of the health plan having the ultimate decision about whether the health plan will pay for the service.

Mr. DINGELL. All right. Thank you.

Now just one other question. Are you—where did you see in the Patients' Bill of Rights anything about purchase of durable medical goods?

Ms. LEHNHARD. If a physician decided—under these bills, it says the health plan may not interfere with the decision of the physician, arbitrarily.

Mr. DINGELL. Does that tell you that the physician can order, then——

Ms. LEHNHARD. The physician can order all kinds of supplies and durable medical equipment, and, for example, in Medicare—if Medicare decides——

Mr. DINGELL. We are not talking about Medicare. We are talking about the health plan.

Ms. LEHNHARD. The same in health plans. It is a medical——

Mr. DINGELL. We are talking about any plan. Do you have any plan where the doctor is permitted to order the purchase of durable medical goods?

Ms. LEHNHARD. Yes, lots of health plans.

Mr. DINGELL. Are you——

Ms. LEHNHARD. And it is a "medical necessity" decision.

Mr. DINGELL. Are you, then, for or against that?

Ms. LEHNHARD. We are for the health plan being able to, subject to internal and external reviews, being able to make the decision.

Mr. DINGELL. Is that a medical decision or is that an insurance decision?

Ms. LEHNHARD. Subject to any review procedures we have and appeals procedures we have, we think it should be the health plan, and if it is not the health plan, we will see premium dollars walking out the door in mass.

Mr. DINGELL. With respect and affection, I am driven to the conclusion that you are not in favor of the doctor making the decision on "medical necessity."

Mr. Chairman, I thank you.

Mr. BILIRAKIS. I thank the gentleman.

We are going to finish up now. I would ask if, Ms. Lehnhard, I didn't really mean to overlook you as far as this ombudsman thing.

I mean, obviously, we would be very pleased to get some sort of an input from you, and from you, Dr. Reardon, on your opinion of ombudsman. The role that they might play, and how significant they might be.

Ms. LEHNHARD. I will be glad to put it in writing.

Mr. BILIRAKIS. I would appreciate that.

And then, of course, as usual, we may have further questions. We probably will have further questions, so you would be willing, I am sure, to respond to those in writing.

Thank you very much. Thanks for your patience.

This hearing is adjourned.

[Whereupon, at 5:40 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

April 27, 1999

The Honorable MICHAEL BILIRAKIS
Chairman
Subcommittee on Health and Environment
Committee on Commerce
U.S. House of Representatives
Room 22125, Rayburn House Office Building
Washington, DC 20515-6115

DEAR CHAIRMAN BILIRAKIS, I am writing to respond to your questions that arose from my appearance before the Subcommittee on Health and Environment on March 24, 1999. I would like to thank you for the opportunity to testify before the Subcommittee on behalf of the American Association of Health Plans and to answer these additional questions. I have provided my responses below.

Question 1. When health plans include non-physician providers in their networks is it fair to assume that these providers have been appropriately licensed to practice in the plans' service area?

Response. Credentialing is an integral part of a health plan's quality assurance program. Health plans review the credentials of all potential network providers, whether they are a physician or non-physician provider, to ensure that the providers meet the health plan's standards and are qualified to provide appropriate, quality medical care to health plan members. One aspect of the credentialing process is to verify that a provider, including a non-physician provider, is licensed per state regulations, which define the scope and limitations of a non-physician provider's practice.

Question 2. When health plans have included non-physician providers in their networks, do you support patients having direct access to these providers in the areas of ob/gyn services and pediatrics?

Response. State regulations define the scope of practice and limitations of non-physician providers, and these regulations vary widely among states and among types of non-physician providers. Some examples of areas in which the scope of practice differs include the ability to admit patients to the hospital and the ability to prescribe medications. For example, in a number of states, there are no restrictions on a certified nurse-midwife's (CNM) ability to prescribe medications. In other states, CNMs are not allowed to prescribe controlled substances, and still other states prohibit CNMs from prescribing medications altogether. Similar differences in prescriptive authority exist with regards to nurse practitioners (NPs).

Given this variation in scope of practice, it is imperative that individual health plans be permitted to determine whether or not direct access to non-physician providers is appropriate for their members. Because different non-physician providers are licensed to perform different activities in each state, the care delivered by non-physician providers could differ significantly among states and provider types. Health plans must be afforded the flexibility to evaluate whether or not direct access to non-physician providers in their service area(s) promotes appropriate, high-quality ob/gyn and pediatric care for their members, and whether or not the scope of practice of a non-physician provider will allow a provider to meet the plan's requirements for providers who deliver ob/gyn and pediatric care.

As I described in my written and oral testimony, health plans are responding to the needs and preferences of their individual members by developing a wide variety of innovative direct access programs. In the area of non-physician providers, for example, some plans allow members to choose non-physician providers, such as NPs

and physician assistants (PAs) as their primary care provider. However, mandating access to non-physician providers could have the unintended consequence of forcing plans into a "one-size-fits-all" model that limits plans ability to develop innovative approaches to facilitating ob/gyn and pediatric care that best meets the needs and preferences of their members.

Thank you for giving me the opportunity to respond to your inquiries. If you have any questions concerning these responses, please do not hesitate to contact me at (301) 941-2164.

Sincerely,

JOSEPH BRAUN, MD, JD, MPH
Chief Medical Officer, George Washington University Health Plan

AMERICA'S HEALTH: ACCESS TO AFFORDABLE HEALTH COVERAGE

WEDNESDAY, JUNE 16, 1999

HOUSE OF REPRESENTATIVES,
COMMITTEE ON COMMERCE,
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 p.m., in room 2322, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Greenwood, Deal, Burr, Bilbray, Whitfield, Ganske, Norwood, Coburn, Cubin, Shadegg, Bryant, Brown, Waxman, Pallone, Green, DeGette, Barrett, Capps, and Dingell (ex officio).

Staff present: Carrie Gavora, majority counsel; Patrick Morrisey, majority counsel; Jason Lee, majority counsel; and Bridgett Taylor, minority professional staff member.

Mr. BILIRAKIS. I am pleased to call this hearing to order. This is the second in the most recent series of hearings focusing on the state of our Nation's health care system and proposals for reform.

As we consider changes to improve protections for insured individuals, we must also recognize that millions of Americans have no health coverage at all. Each year the Census Bureau measures the levels and types of health coverage for Americans in the previous calendar year. Its most recent survey concluded that 43.4 million Americans, about 16 percent of the population, lacked health coverage for the entire year in 1997.

Clearly, access to affordable health coverage is a considerable problem in our Nation. Last year the House considered and approved legislation to increase protections for patients in managed-care plans, while expanding health care access to the uninsured.

Unfortunately, the Senate failed to approve similar legislation. This year, however, Congress again has a tremendous opportunity to improve the quality and availability of health care for all Americans.

A number of measures have been proposed to address problems faced by individuals and small employers in obtaining affordable health coverage. These include the formation of community health organizations, the creation of HealthMarts and Federal subsidies for State high-risk pools.

None of these proposals will solve the problem of the uninsured, but they do represent a responsible starting point in this debate. Together they have the potential to expand access to care for a sig-

nificant number of Americans without busting the budget or expanding government regulation of the health care system.

Before we begin, I would note that our colleagues in the Subcommittee on Employer-Employee Relations of the Committee on Education and the Workforce are voting today on a number of individual reform proposals. Contrary to some recent reports, it is my intention and my goal that this subcommittee will also act on a bipartisan basis to consider and approve health care legislation.

Tomorrow, majority and minority committee staff will begin meeting to discuss the development of a legislative vehicle. A time has already been established, and discussions have taken place. In the meantime, today's hearing and our hearing next week on external appeals will increase members' understanding of these issues in preparation for legislative action.

Our witnesses today represent a range of diverse perspectives in the problems facing the uninsured, as well as some possible solutions. I want to thank them in advance for joining us. I look forward to hearing their views on this key issue and now yield to the ranking member, Mr. Brown, of Ohio.

Mr. BROWN. Mr. Chairman, thank you. And thank you for doing this hearing today. All of us on this side of the aisle appreciate that. I would like to thank today's witnesses, especially extend a special welcome to Ray Arth who runs a successful business in Avon Lake not far from my home, Lorain, Ohio.

There are three ways to respond to the uninsured. One way is we can ignore them, second we could take incremental steps that may help some of them, or we can establish guaranteed universal coverage that eliminates the problem once and for all. Today's hearing will focus on incremental strategies, HealthMarts and association plans, community health centers and centers in State high-risk pools. I am sure tax credits will enter the discussion at some point also.

So let's talk about incremental steps. They can make the situation better or they can make it worse. Unless every individual in every small and large business have equal access to coverage at affordable rates, incremental solutions like HealthMarts can be a double-edged sword.

They can increase coverage for certain small businesses; but by segmenting the market, they can erode the broad pooling of risks that—of risk that makes insurance work. Fewer plans in the privately insured pool means more volatility in cost and higher rates which will drive more plans out of the pool leading to even more volatility, even higher rates, and on and on and on.

The insurance industry calls this a death spiral, and it is a function of segmenting the insurance pool. The price ever-increasing, being access to coverage for some small businesses, would be a decrease in access for many others.

The purpose of insurance is to share risk, not to avoid it. As our system has strayed further and further from this basic tenet, the gaps in coverage have grown wider. And if Congress condones the attempts of certain plans to bypass State insurance laws, we are effectively saying these laws serve no purpose.

In fact, these laws are critical and have been critical for some time. Before State insurance laws, health plans could deny preg-

nant women health benefits. They could operate without solvency standards. They could target certain small businesses, forcing them to drop coverage by imposing unlimited rate increases. State insurance laws obviously over the years have been there for a reason.

Let's talk for a moment about high-risk pools. Theoretically the United States could channel all high-risk individuals into a separate pool leaving healthy individuals and groups in the private insurance market. But why should a low-risk individual or group buy insurance when the minute they need it, they would be transferred into the high-risk pool? They might as well pay for their care out of pocket until they become sick and enter the high-risk pool.

You can see where that goes: publicly funded health care for the sick, private health care for those individuals, healthy individuals who can afford it. And who knows what for those in between, different classes of medicine for the sick and the well, the rich, and the poor. I don't think that we want to go down that road.

One more point about these approaches. If we pursue expanded coverage to more individuals without establishing fundamental patient protections, we are perpetuating insurance that can disintegrate the moment it is actually needed. That is the critical link between managed-care reform and access to insurance.

The insurance industries tried to convince us that patient protections will have such a dramatic effect on costs that employers will drop their coverage. Not only is there no reason to expect this result, but it is incredible that insurers would try to convince Americans, especially American businesses, to pay less for Russian roulette coverage rather than more for coverage that actually delivers on its promises.

It makes no sense to ignore a fundamental weakness in insurance coverage while seeking to expand that coverage to more individuals. Coverage that may or may not pay for needed care is not coverage, no matter how many individuals are enrolled. Whether you look at tax credit or HealthMarts or high-risk pools or insurance through community health centers, unless coverage is inclusive, affordable, and meaningful, the uninsured problem will persist.

There is one incremental step, Mr. Chairman, we can take that meets all of the criteria and helps a particularly vulnerable population. We can pass the Medicare Early Access Act. This self-funded proposal enables insured individuals ages 55 to 64 to buy into Medicare and extends COBRA coverage for retirees whose employer reneges on retiree benefits.

Whether covered under Medicare or COBRA, individuals would pay their own way and secure coverage at a time in their life when health care protection is particularly important, as they reach the age of 55, 60, 62. This proposal makes sense.

Unlike tax credits and HealthMarts and high-pool risks, it guarantees access to coverage and treats all individuals equally. Still, even though this proposal is on the table last year and part of the President's budget this year, the majority has chosen to ignore it for the purposes of this hearing and for the purposes of moving this bill through the process.

It is disappointing because unlike other incremental proposals this one would actually help a particularly vulnerable group of in-

dividuals, people between 55 and 64, who have lost their health insurance for a variety of reasons without hindering access for others.

But the fact that this proposal wasn't on today's agenda, and I understand not on the Ways and Means agenda today also, does not mean that this bill is a nonstarter. No one thought in this Congress we would achieve expanded coverage for children. No one thought this Congress would pass Kennedy- Kassenbaum. No one thought we would win an increase in the minimum wage 2 or 3 years ago.

In all of these cases, the public's demand for positive action ultimately won out over self-serving partisanship. This initiative, this buy-in for Medicare, should be bipartisan. We should pass it this year. Unlike many other Medicare proposals, the Early Access Act will not take us one step forward and two back. It is an unambiguous step in the right direction.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I think I thank the gentleman. Mr. Ganske for an opening statement.

Mr. GANSKE. Thank you, Mr. Chairman. I am glad we are having this hearing. I think the issue of the uninsured is important. It is also important that Congress do it right and not make things worse. In order to talk about this 43 million people who don't have insurance, I think rather than looking at sort of a global number you need to look at who they are.

Well, who are the uninsured in this country for health insurance? Twenty-five percent of them are under the age of 19. Twenty-five percent are Hispanic. Twenty-five percent are poor, below the poverty level.

Now, the number of these figures that I am giving you some of these groups are in more than one category. Twenty-five percent are noncitizens. And about 43 percent have incomes two times poverty. But who are they? They are largely those who are aged 19 to 24. So if you start looking at the groups who aren't insured, then you need to start thinking about, and if you understand who those groups are, you need to start thinking about what could be possibly effective strategies to reduce the insurance.

Okay. If you are looking at the poor, roughly speaking half of those poor qualify for Medicaid and are not on Medicaid. They should be. Why aren't they? Well, it is because a number of States have very complicated requirements for signing up.

My own State of Iowa, for instance, requires a monthly certification. I don't think that is right. I think if we are looking at providing insurance for the poor, this Congress ought to make a commitment to getting those who qualify into Medicaid, into Medicaid and start holding some oversight hearings with the States about doing that.

What about the Hispanic population that doesn't have insurance? Well, many of them are not citizens. That doesn't mean they are illegal. We ought to look at ways to encourage insurance for them. Many of them are below the poverty line. This government ought to reach out to make sure that they who are legal can take advantage of the health care systems that we have got; Medicaid is one of them.

What about those who are young, the 19 to 24 group? Many of them are in college. Some in college are still covered by their parents. Many are not. Why aren't they? You know you can buy catastrophic coverage for a college student for about $500 a year. What can this Congress do to encourage that sort of a $60 billion commitment to the insurance industry?

Well, some of the things that we could do that could be very harmful, as we look at this situation, have been mentioned by my colleague, Mr. Brown. I am not the only one who has concerns about association health plans and HealthMarts.

When they were proposed as part of the Patient Protection bill last year, they drew significant opposition from BlueCross/BlueShield plans and the National Association of Insurance Commissioners. BlueCross has traditionally been the insurer of last resort in many States.

They have the legitimate fear that multiple employer welfare associations and association health plans and HealthMarts will undermine the State programs that many of those BlueCross and BlueShield and State legislatures have worked on to try to kept health insurance affordable in those States, joined by the Health Insurance Association of America, a group that sometimes I disagree with.

They wrote: "Association health plans, MEWAs, HealthMarts would undermine the most volatile segments of the insurance market, the individual and small group markets. The combination of these with HealthMarts would lead to a massive market segmentation and regulatory confusion."

Rod Turner, a constituent of mine and an insurance industry professional, wrote to express his concerns about MEWAs. He wondered why these plans can sell whatever level of benefits they want and provide coverage for any type of plan they want and can provide coverage for any type of benefit the plan might want to cover.

Some say that these concerns might reflect a self-interest of industry insiders; but before buying into that argument, consider the editorial in the Washington Post a year ago, criticizing multiple employer welfare association—Mr. Chairman, I would ask for 1 additional minute.

Mr. BILIRAKIS. A very strict 1 additional minute without objection.

Mr. GANSKE. The Post pointed out—thank you, Mr. Chairman—"if you free MEWAs, you create a further split in the insurance market which will likely end up helping mainly healthy people at the expense of the sick." I could go on, Mr. Chairman. We have a big potential for enacting legislation that could have the opposite effect, that could actually increase the number of uninsured.

Some States have, in trying to do good, passed bills that were community-rating bills. I have opposed those. Those have had the opposite effect. They have increased the number of uninsured. Mr. Chairman, if we pass legislation that moves large groups of healthy patients out of State insurance risk pools and into a largely unregulated ERISA pool, then I guarantee you you will see more uninsured, because the prices of the premiums for those who are left in that State insurance risk pool will go up.

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. GANSKE. And they'll drop their insurance.

Mr. BILIRAKIS. Mr. Pallone for an opening statement.

Mr. PALLONE. Thank you, Mr. Chairman. Increasing access to health insurance is perhaps the most important health issue confronting Congress today. With 43 million Americans lacking health insurance and despite the passage of some well intentioned and good legislation over the last two Congresses, the problem is getting worse. The ranks of the uninsured continue to grow and the lack of affordable health insurance in this country, in my opinion, is truly a crisis.

Now you may not agree with the President and Mrs. Clinton's approach from 6 years ago, but I have to stress today that he had the right idea. The Federal Government needs to develop a system that will ensure every individual in the country has access to health insurance. We need universal coverage. The cost of ignoring the problem will be staggering in both human and financial terms if a solution is not developed.

In the wake of the failure of the President's plan, Congress has been trying to address the problem in a piecemeal fashion. In 1996, we passed the Kennedy-Kassenbaum bill. In 1997, we created the State Child Health Insurance Program. And I and my colleagues on this committee all worked hard on these bills.

Unfortunately, even these bills have fallen short in some respects. Kennedy-Kassenbaum has failed to stop price gouging in the individual market. Insurance companies are getting around the bill's requirement that coverage be offered to individuals losing group coverage by pricing individual policies so high that virtually no one can afford to purchase them. Premiums range from 140 percent to 600 percent of the standard rate or $10,000 to $15,000 a year. And this practice was detailed in a well-documented GAO report released last year.

Democrats recognized this potential problem in 1996, but Republican opposition blocked efforts to draft the bill in a manner that would prevent such abuse. And to that end, in the 105th Congress, I introduced legislation to fix this problem, the Affordable Health Insurance Act, which limits what insurance companies can charge eligible individuals to no more than 150 percent the rate charged individuals in good health. And I would like to see that bill passed.

There are also problems with the State Child Health Insurance initiative. Many States, including New Jersey, are having problems with outreach leading to the underutilization of an excellent Federal program. Another problem that has emerged with the State Health Insurance Program in my home State is an overly restrictive waiting period for enrollment.

But in the absence of any commitment by the Republicans to develop a system that provides for coverage of all Americans, we have to continue to forge ahead with efforts to make insurance more accessible for key sectors of society. And Democrats have been crafting proposals to accomplish this goal.

My colleague, Mr. Brown, mentioned the bill that was reintroduced yesterday to make insurance more accessible to individuals in the 55 to 64 age group. And I strongly support this plan. I have introduced similar legislation that would also help individuals meet

the cost of the premiums, which I think is an important aspect of that as well.

As important as the buy-in legislation is, though—and I do want to stress it is really crucial—it doesn't get to the real heart of the problem. The ranks of the uninsured continue to grow today because of the lack of health insurance on the job. People depended on their employer and employer-sponsored plan in the past to make sure that they had health insurance.

And the key to reducing the range of the uninsured is making insurance available through the work place. In short, I think what we need is a mandate for employers to offer insurance to their employees. Last year, I introduced legislation to accomplish this goal called the Health Care for Working Families Act. It would cover approximately 15 of the Nation's 43 million uninsured by requiring employers with 50 or more employees to provide health insurance to their employees.

Now I just want to say, Mr. Chairman, I know this is very partisan; but I believe that time and time again the Republicans have shown that they are not serious about addressing the Nation's most pressing health care reforms in any meaningful way.

You mentioned that the Education and Workforce Committee is marking up eight separate managed-care reform bills today. I think to me that is nothing more than an effort to deny Democrats a full fair and open debate on the comprehensive Patients Bill of Rights.

You mentioned that that committee is going to take up the issue of internal or external appeals next week. This piecemeal approach is not going to work. We need to bring up the Patients Bill of Rights. The Democrats are now forced today to duly discharge a signed petition which ripened today which we are going to more forward on in order to bring a comprehensive patients bill of rights to the floor.

When I listen to what this committee has done, it seems to me if I look at last year or this year the example is the same. Six months we do nothing, then we move to some piecemeal approach and say we are going to try to solve the problem by dealing with some piecemeal approach.

In the final endrun, rather than allowing us to bring up the Patients Bill of Rights and pass that bill, we get some kind of muddling by throwing in HealthMarts or malpractice reform or medical savings accounts. That is what is going on again here today.

This idea of HealthMarts is being pushed in this hearing. All it is going to do is drive up costs for everyone, make it more difficult and more expensive for the sick and the injured to get any——

Mr. BILIRAKIS. The gentleman's time has expired.

Dr. Norwood.

Mr. NORWOOD. Thank you, Mr. Chairman. Good morning to you. I appreciate very much you holding this hearing on the uninsured in America. And I look forward to the testimony of our witnesses and thank our witnesses for coming.

I will place most of my testimony in the record, but suffice it to say that a lot of people think that we should pass meaningful bipartisan legislation regarding health care protection of patients as well as the uninsured.

And my personal belief is that it adds nothing to the argument for the other side to make such partisan statements to the point that it makes it more difficult for us to even work together in any way.

Now, if you want to pass laws that actually do help patients, insured and uninsured, we need to work together and quit demagoguing the issue. And that is all I have heard from the other side. It is high time we worked together on this and quit trying to make political hay.

It is hard for me to believe that you want to help patients when it sounds from the opening statements thus far you are more interested in trying to obtain votes.

With that, Mr. Chairman, I will submit the balance for the record and I thank you.

Mr. BILIRAKIS. I thank the gentleman. By the way, the opening statements of all members of the subcommittee will be made a part of the record without objection. Ms. Capps for opening statement.

Ms. CAPPS. Good morning. I want to thank the Chairman for holding this hearing and the panelists for testifying before us today. The 43 million nonelderly Americans who go without health insurance in this country comprise 18.3 percent of our population. Compare that with 17.3 of the population in 1993 and 14.8 percent in 1987. Clearly this problem is not getting any better.

As a school nurse in a school district in my community for over 20 years, I dealt on a daily basis with children without health insurance. In fact, for the bulk of my professional life I have been working with families struggling to meet the needs of children without health care.

I can see clearly in front of me children coming to school with swollen cheeks from abscesses and no place to go for treatment. I have literally picked up children off the playground with fractured arms, taken them to the emergency room, had emergency services done, their arm put in a splint, and then had the family told to come back in 6 days to the county clinic when the bone specialist can be there to set this child's arm. It is expensive. It is terrifying for families. It is not a small deal.

It means when children get sick, families reach a crisis point, encountering out-of-pocket expenses that they can't afford, lack of treatment and often times poor treatment, as children are shuttled from one waiting room to another.

The good news is that many of our 11 million uninsured children are now covered under the Children's Health Insurance Program. The program provides $24 billion over 5 years and expects to increase children's coverage. Most States have implemented this program.

In my State I know we have had a lot of trouble getting it off the ground and getting children actually enrolled. We also need to keep in mind that as we begin to insure more children, we have to include the whole family. If children have health insurance and their parents have none, it is unacceptable.

The truth is that most of the growth in the uninsured has been among adults, particularly those who work for smaller companies, who are forced into early retirement, or who are self-employed.

According to the Kaiser Family Foundation, about half of working uninsured Americans experience problems with access to care and with paying their medical bills. These people are slipping through the cracks. It is costly to have this happen. Preventative early care is much less expensive than delayed treatment, resulting in emergency care later on.

Today, we are going to hear about several approaches to dealing with the uninsured such as HealthMarts associations, health plans, high-risk pools, and tax credits. Our goal is to ascertain whether these approaches will result in new individuals obtaining access to insurance.

The concern is that these approaches could encourage employers to drop health insurance as a benefit or enable them to circumvent State or Federal protections and undermine the concept of pooling that is fundamental to a health insurance market.

Finally, Mr. Chairman, I would like to state that health coverage of the uninsured is a critical issue which I know first hand and I generally do appreciate your holding this hearing. But I want to express my disappointment that this subcommittee has not continued its hearings on managed-care reform. The two should go together.

Our only hearing on this issue was in March. I believe we are losing our opportunity to make quality health care a reality for the millions who have insurance that is not working for them by delaying action on managed-care reform.

I urge the majority to bring in legislation before the committee for a hearing, both the Patients Bill of Rights and the Norwood-Coburn bill so that we can have a thorough discussion of this matter. I yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentlelady.

Mr. Bryant for an opening statement.

Mr. BRYANT. Thank you, Mr. Chairman. Good morning. I want to commend the committee for holding this hearing today, which is the second on the subject of America's health. I know the subcommittee also intends to hold additional hearings in the next 2 week. I am pleased to be a part of this effort, and I take our responsibility as legislators to address the problem within our Nation's health care system seriously.

As Ms. Capps has mentioned this morning with personal experience that she has had, I agree; and that is why I think we ought to move, as this committee is moving, in a cautious way to make sure that we get this right.

I know a couple—well, several years ago, some talked about a government-based universal care which now we all learned was genuinely an unpopular idea and something that we do not want. But I am particularly pleased today that the focus of the hearing is on the problem of the uninsured.

Current estimates, as has been said many times today, put the number at some 43 million; and to me it seems only logical that this issue should be addressed simultaneously with the issue of managed-care reform. Finding ways to get these people health coverage is at least as important as addressing the problems that some people have had with health insurance they already have in HMO's. And I think a reasonable argument can be made that the issue of the uninsured should be even given a priority.

Others this morning have indicated that perhaps Medicare expansion would be a solution to this uninsured problem. CBO has estimated that Medicare expansion would cover only 768,000 people, aged 55 to 64, this by the year 2009. That is less than 2 percent of the uninsured.

The vast majority, as we have heard, too, particularly from Dr. Ganske, of the uninsured are under the age of 55 years old. Even HealthMarts, as we have talked about today, are estimated to expand coverage by as much as 10 to 20 percent, much more so than the Medicare expansion would. That is 4 to 8 million people.

And I think we will hear testimony from Dr. Nichols on that today. But in any event, I am looking forward this morning to examining the barriers which keep people from getting health insurance and to explore several innovative proposed solutions.

I want to thank the witnesses for taking time to be here. I am eager to listen to your comments on these issues. I thank the Chair and yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman. Mr. Green for an opening statement.

Mr. GREEN. Thank you, Mr. Chairman. Just to follow up briefly before I talk about my opening statement, Mr. Norwood, concerned about the partisanship that he's hearing from the Democrat side kind of reminds me of Harry Truman saying one time he said the Republicans are telling me I am giving them hell, but I am just telling the truth. They just think it is hell.

I think the frustration we have is that this is our second hearing and both the number of even insured—and I am glad we are doing this hearing. I am glad we are going to continue it, but also the managed-care issue is important. I first want to apologize, Mr. Chairman, for not being able to stay here for the full hearing because there is a markup now in the Telecommunications Subcommittee going on, and I will have to leave.

But I want to thank you for calling this hearing on how to get affordable and quality health care coverage to over 40 million growing Americans who currently have no health coverage.

Over the past 3 years, this body has taken several important steps to help improve access to key groups, including workers who change jobs, individuals who have preexisting conditions, and low-income children.

Two key groups that have been left out are low- and middle-income workers whose employers offer no health insurance and the near-elderly, the 55 to 64. Tax credits and deductions have been proposed by several members to help offset the bills. I have—offset the cost.

In fact, I have introduced H.R. 145, the Health Insurance Tax Deduction, which would allow individuals to deduct from their Federal taxes the amount they pay for health and long-term care.

This Congress over the last few years has increased the deductions for the sole proprietor, the person buying their own, but we haven't provided any assistance for a person who works for a company and the employer may only pay for that individual but not for the dependent care. So the employee pays for that dependent care on their own without providing any tax incentives like we do for the sole proprietorship or the self-employed.

While this proposal is not the perfect solution, it would be an important step to deal with that segment of the market who would with the incentive of a tax deduction to buy health insurance or to provide it for their family.

Other proposals, like I mentioned Congressman Stark's early Medicare buy-in, would give people over 55 to 62 the option of purchasing quality health care. And again my colleague from Tennessee talked about 700,000. Well, that is 700,000 more than we would cover now, and hopefully it would be even more than that.

When this Congress considers different options to expand access to health coverage, we have to be sure not to do so at the expense of quality. Proposals that would preempt State insurance laws in favor of limited or inadequate protections under ERISA are simply inadequate. You don't get what you pay for.

That is why this committee needs to honor its commitment to the rest of Congress, especially the American people, and pass meaningful managed-care reform like the Patients Bill of Rights. If this bill is passed, every American with health insurance would be guaranteed quality health care coverage. Without it, a growing number of Americans will spend their hard-earned money on insurance that continually falls short of their expectations and their family needs. Again thank you, Mr. Chairman for holding this hearing.

Mr. BILIRAKIS. Mr. Bilbray for an opening statement.

Mr. BILBRAY. Thank you, Mr. Chairman. I would like to first compliment my colleague from Texas, Mr. Green, for talking about ways that we can sort of rethink our participation in the health care formula and looking at our tax structure. I think the biggest problem we have too often for those of us in Washington is that we are always talking about how to mandate that somebody else change their ways rather than taking a look at what we can do as government.

And a lot of times it happens to be much like Mr. Green would say, we just need to get out of the way sometimes, quit requiring that we get our pound of flesh in taxes, and start looking at the fact that sometimes the best way to be able to use money is to leave it in the consumer's pocket long enough so they can buy their own services directly in the most efficient way, and that is individually.

I would like to say, Mr. Chairman, that in following that up, there are things that my background, working in county health and providing services to the working class, I was very frustrated with the fact that those who tend to want to demagogue health issues are a lot of times the last ones who are willing to get government out of the way as an obstruction.

That is why I wanted to point out Mr. Green's proposal. I think that when we talk about how we handle this issue, we need to look at where the problems are that we have allowed historically to exist.

One of the things that in California we have tried to address is the fact that the huge overhead that physicians and hospitals have to carry just because there are those in our society who would love to make a fortune in lawsuits based on somebody else's tragedies has been a huge problem.

And I say that as somebody who has tried to provide health care to working-class women and make sure their children are born healthy. Our physicians have to carry insurance policies of $60,000 to $80,000, and this was way back in the olden days, during the 1970's and early 1980's. That is $60,000 or $70,000 or $80,000 that could have been providing public health services.

But the trouble is that traditionally, and especially in this town, there are people that basically say that the right to sue and the right for punitive damages supersede everything else, even if it means being born healthy.

The State of California just went through a real testing period, and we maintained our tort limitations. And that is going to help the working-class people get their health care. I know that makes some people around here just cringe to hear me say that. I think we got to recognize that expanding Medicare will only expand maybe 2 percent. We are talking about the HealthMarts themselves go out 10 to 20 percent, but all these things can't be looked at in isolation.

I think, Mr. Chairman, that I would ask as we talk about this we are going to have representatives from the Hispanic Business Round Table, and when you have an underserved community like the Latino community like we have in my district and my county, but at the same time have 41 percent of the public health finance burst in the State of California being to illegal immigrants, the Federal Government ought to recognize that 40 percent of the cost being born by the State of California should be paid for by the Federal Government.

That means that that money could be then used by the State in the local governments at providing health care to those who are legally in the country who are not insured today. And we can expand our services in our State to those who legally are there and asking just for help in providing their health care system. The system is so convoluted right now, those of us in California get frustrated with the fact that we are spending billions on Federal mandates and the Federal Government is still saying that we are not doing enough.

I think that this hearing ought to bring up that issue that the whole big picture should be what is the Federal Government doing wrong that can help physicians, health care systems and, yes, insurance companies provide the type of comprehensive health care that we all claim that we want for our constituents.

Mr. Chairman, thank you for having this hearing and thank you for this member being able to express his frustration with the histories of the past; and hopefully we will learn from our mistakes and in a bipartisan way work together to provide services for the next generation. Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman for that opening statement. Mr. Dingell for an opening statement.

Mr. DINGELL. Mr. Chairman, thank you. I want to thank you for your comments in your opening statement announcing that the majority and the minority staff are meeting to discuss the Patients' Bill of Rights. That is a desirable step. It is one which I applaud. I note that it comes 6 months into the Congress.

I would observe, Mr. Chairman, that I would applaud with greater fervor if the Chair could announce that we had a firm markup date so that we could begin to provide our constituents with the protections that they want and deserve within the framework of the Patients' Bill of Rights. That would afford the Congress a fine opportunity to work its will, to afford all members an opportunity to come up with an amendment within the rules which would allow them to express their particular thoughts and concerns and would allow us to finally report some kind of bill upon which the committee had worked its will to the House so that this subcommittee, the full committee, and ultimately the House of Representatives could pass a bill of some sort and send to the Senate.

I have to think that we would pass something very close to that which I have sponsored. But I am willing to cast a throw of the dice to permit any and all colleagues to have the opportunity to have their say and allow the committee after listening to the concerns of our people in proper hearing process to write the necessary piece of legislation to accomplish the purpose of moving the process forward.

In any event, I thank you. I commend you. I certainly hope that the announcement will be forthcoming at an earlier time, and I ask with that that I have opportunity to extend my full remarks into the record. They are excellent. I know everybody will enjoy reading them. And I yield back the balance of my time.

[The prepared statement of Hon. John D. Dingell follows:]

PREPARED STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Today the Health and Environment Subcommittee is discussing an issue that is of great importance to me: providing health care coverage for the uninsured. Many members of this Subcommittee have also proposed various legislative solutions to address this problem, including Chairman Tom Bliley, Subcommittee Chairman Mike Bilirakis, Rep. Sherrod Brown, and Rep. Frank Pallone. I thank the majority for holding a hearing on this crucial topic.

What motivated Congress to propose the Medicare program three-quarters of a century ago was an appalling lack of health insurance among the elderly. Today Medicare is the most popular and most successful health insurance program in the country, guaranteeing virtually every senior citizen affordable health care coverage. But millions of Americans do not enjoy a similar guarantee. I think they should, so in every Congress since 1954, I have introduced H.R. 16, a bill originally authored by my father, which would provide meaningful health care coverage to all Americans.

Today we discuss less comprehensive proposals, which are modified versions of past ideas. *First,* HealthMarts are a variation of Health Insurance Purchasing Cooperatives, which currently exist in a number of states, including California, Florida, and Ohio, and were the foundation of President Clinton's 1994 health care reform plan. *Second,* Community Health Centers have been fulfilling their mission of providing care to the uninsured for over three decades. *Third,* a majority of states fund high-risk insurance pools to subsidize coverage for people with health problems who would otherwise have to pay astronomical rates in the individual market.

Any solution to provide health insurance to more Americans must be designed carefully so that the current fabric of health care coverage is not undone. Appropriate safeguards must be in place to ensure that risk-pooling arrangements do not upset the fragile balance in the small group and individual health insurance markets. Community Health Centers are already under a great deal of strain, both from rising numbers of uninsured and payments cuts, and we must not add to their burden. Finally, high-risk pools cannot effectively serve individuals unless they are adequately funded and provide comprehensive, meaningful benefits.

Yesterday, a number of my Democratic colleagues, including ranking Subcommittee member Sherrod Brown, introduced a bill that would allow people ages 55 to 65 who are uninsured to buy-in to the Medicare program. The near-elderly are

among the most vulnerable of the uninsured. This bill builds on a successful program that has already helped millions of Americans obtain needed health care, and is worthy of this Subcommittee's attention.

However, lack of insurance coverage is not the only health care problem Americans are facing. Many Americans who are currently insured find their coverage lacking some of the basic protections that make health insurance meaningful: access to specialty care; access to emergency care; an independent external appeals procedure to resolve disputes; care provided according to good medical practice; reliable accounting principles; and a mechanism to ensure that these protections are enforceable.

I look forward to discussing options to promote meaningful health care coverage for more Americans, and I hope that our Committee will soon move from talk to action.

Mr. BILIRAKIS. Without objection. Mr. Whitfield.

Mr. WHITFIELD. Mr. Chairman, thank you very much. I can't think of any more important issue to have a hearing on than this issue because we do have such a large number of people who are uninsured. As a matter of fact, I think it is even more important than the Patient Protection Act because those people are generally covered with some insurance, and we are talking about a problem here where people are uninsured.

I must say that I am sorry that the gentleman from New Jersey left, because he, more than any other member on the other side that I am aware of, always likes to try to make this a partisan issue. And I think he talks about it as partisan because we have philosophical differences on the way you solve the problem. But the mere fact that we may differ on the way you solve the problem does not mean by any stretch of the imagination that we are not interested in trying to solve the problem.

Now, people who are 65 and above, they have the Medicare program; and we recognize that there are a lot of problems with the Medicare program, but at least they have basic health coverage. If your income is below a certain level, you have Medicaid, which is a very good program. It provides almost all the health care needs that a person has.

I notice in the testimony of the Hispanic Business Round Table they are talking about a—not the legal immigrant here who may be unemployed who may not have any income because he is even covered by Medicaid, but we are talking about people who are making just over—just enough money that they don't qualify for the government programs. And that is the sector where we have a significant problem.

And I think that one thing that has been shown clearly throughout America today is that the mandates, State-mandated benefits are not the answer. There are already over 1,000 State-mandated benefits in America. And we still have this huge segment that is unemployed.

Now, my home State of Kentucky became one of the most aggressive States on mandating health care coverage. They had a guarantee issue clause; they had community rating. They had—you can not exclude someone if they had a preexisting condition. And as a result of that, we have 107,500 people uninsured today who were insured in 1990. So the mandated benefits are not always the answer.

And contrary to my friend from Iowa who seems to be opposed to HealthMarts, the one thing that I do like about HealthMarts is

that it starts removing the decisionmaking and the control of health care from employers to give employees the opportunity to make some decisions on their own. And I think that is the kind of step that we need to make.

And I am delighted that the gentleman from Texas talked about incentives that we need to provide people health coverage for their employees. Tax benefits, tax deductions. We need to explore all of those things. So I am delighted that we are having this hearing. And I am delighted that we have so many excellent witnesses who can shed some light on how we can hopefully start solving the problem.

Mr. BILIRAKIS. I thank the gentlemen from Kentucky.

Mr. Waxman for an opening statement.

Mr. WAXMAN. Thank you, Mr. Chairman. Nobody on this committee, Democrats or Republicans, can find it acceptable that in this country we have some 43 million people without health insurance coverage, and that is a number that continues to grow. This shouldn't take us by surprise. It is a situation that has been with us for years. In fact, some 25 years ago both the Carter and the Nixon administration proposed comprehensive national health insurance plans. It was clear even then that we had a serious problem and it would only get worse if we did nothing.

President Clinton, to his credit, tried to remedy the situation with a proposal that would have assured all Americans comprehensive quality coverage; but the concerted efforts of special interest groups stopped that bill dead in its tracks. Today we see the result. We have more people uncovered, and that number of uninsured continues to grow. We face an even higher price tag to try to remedy the situation for the uninsured.

Additionally, there is a real and growing dissatisfaction among many people who have coverage, particularly in managed-care plans, who are not getting the medical care they need. We need to address both issues. Clearly we need to take action on the Patient Bill of Rights. We have to give people the tools to assure that they are treated fairly by their plans and receive the medically necessary care they need.

I would make two observations as we enter into this debate. First, we must not use the continuing problem of millions of American without coverage as a rationale to fail to act to protect the rights of persons with coverage. To do that would be cynical in the extreme.

Second, we must be sure that the actions we do take to provide coverage are effective. We cannot adopt proposals which, in fact, only help those with only a relatively high income or simply provide fiscal relief to people who are already covered, and we cannot adopt solutions that fail to reform the insurance market or make the situation worse by fragmenting the risk pool and leaving the older and sicker without affordable coverage.

And perhaps most importantly, we need to be sure that the actions we take do not have the result of exacerbating the already troublesome trend of reductions in the provisions of health care coverage by employers for their employees.

And finally, I would note that one fact about the uninsured is very clear. Older people who lose their employment-based coverage

are one group clearly in need of help. We have legislation that could help here, introduced yesterday by Congressman Stark, Brown, Dingell, and myself, among others, to allow early buy-in into Medicare. We should also act on that legislation.

The Breaux-Thomas Commission proposal to raise the age of eligibility for Medicare to 67 surely would only add to the problem of the uninsured. And I hope that would find little support in this committee.

Mr. Chairman, I look forward to hearing from our witnesses and, I am not here because of conflict, to have a chance to review their testimony and their answers to questions. And I look forward to this committee exercising its jurisdiction and its responsibility to markup a patient bill of rights and to address these very difficult issues that, left unaddressed, will only lead to hearings next year, the year after, 5 years, or 10 years from now talking about the growing problem of the uninsured. At that point, it won't be 43 million but maybe 50 million. And the effect of the rest of the health care system will be so dramatically negative. Thank you for calling this hearing. I yield back the time.

Mr. BILIRAKIS. Thank you. Mr. Shadegg.

Mr. SHADEGG. Thank you, Mr. Chairman, for holding this extremely important hearing today. The subject of health care quality, health care access, and health care affordability is an extremely important one and one which I spent considerable time during the last several years.

Mr. Chairman, there are very serious problems which need to be addressed in how health plans administer and provide service. In addition, many plans are protected by Federal legislation which provides minimal regulatory oversight and virtual complete immunity from lawsuits for consequential damages even when the plans are clearly at fault.

Congress and many States legislatures, including my own home State of Arizona, have dealt with managed-care reform liability and other types of patient protection legislation.

As we consider the myriad proposals that will come before us today, I would urge us to remember the Hippocratic Oath and first do no harm. We must recognize, I believe, that some of the most important protections we can give patients are individual choice and improved access.

Providing choice in providing improved incentives for better consumption of health care and helping the uninsured, the subject of today's hearing, obtain coverage will do more to improve quality and affordability of health care than Congressional directives which do not address the causes of our country's health care problems.

For these reasons, as many of the members of the committee know, I have introduced H.R. 1687, the Patients' Health Care Choice Act. While some groups oppose any Congressional action in the area of health care, I vehemently disagree.

Congress has a significant responsibility to reduce the problems in the health care market because it is Federal law that has led to reduced choice, has led to decline in quality, and has led to more insured—more uninsured and a lack of accountability.

But for true health care reform we must change the way we view the system. People should have the ability to choose their own health care based on their individual needs and priorities.

Until Congress removes the current tax burdens and hurdles which discourage individual ownership and control of health care coverage, we will never truly reform health care in America; we will only build a bigger, more complicated bureaucracy and further regulate a fundamentally flawed system.

My own legislation, H.R. 1687, responds to the lack of choice and the problem with tax equity that Americans have when purchasing health care. One of the most egregious problems created by our current health care laws is the unintended consequence of our tax policy creating 43 million Americans, Americans excluded from the ability of having health insurance.

The tax code is biased against these millions of uninsured Americans. Because their employers do not offer them taxpayer subsidized employer-based health care, they are punished. We say to those in the employment market we will subsidize your health care by giving your employer a deduction for the amount he spends on your health care.

But to the other side of the coin, to those not fortunate enough to get employer-based health care, we say to them as a matter of public policy we think you should be insured. Indeed, I would argue as a Nation we came to a conclusion long ago that no one in this country should go without health care.

Having said that they should be insured, Mr. Chairman, and having said they shouldn't go without health care, we give them the back of our hand because we tell them they must go out and buy coverage on their own. But we punish them—we don't subsidize them—we punish them by saying they must use after-tax dollars to buy that health care coverage.

What that means is that for America's uninsured, the people we will talk about today, the cost of obtaining insurance is anywhere between 30 and 50 percent higher than the cost for those who just happen to be lucky enough to get their health care coverage through their employer.

The Patients' Health Care Choice Act addresses this current inequity in our Tax Code, which excludes the 43 million Americans from health insurance by giving them a refundable tax credit for the purchase of health insurance. This tax credit provides tax equity to those Americans who receive their health insurance without respect from their employer. Someone who doesn't have insurance through their employer would simply have to go out and buy health insurance, and they would get the tax credit.

For low-income Americans that many people are concerned about the tax credit is fully refundable and functions through the withholding system so that even if though do not have the tax liability they can receive the credit. It is high time that we made the Tax Code fair and equitable for both those who are employed and getting employer-based insurance and those who are unemployed.

Let me tell you the story of Sabrina Roberts, a single mom living in Chandler, Arizona. Like Mary Horsley, whose testimony we will hear, Ms. Roberts is just getting by trying to provide for all the needs of herself and her four children.

Right now, she pays for private health insurance for her children with after-tax dollars 30 to 50 percent more than it is for rest of us. Unfortunately, she is not eligible for the Arizona program set up under SCHIPs, a program called kid care, because that program says that she must allow her children to go 6 months uninsured before they are eligible for the SCHIPs program. She refuses to allow her children to go uninsured.

Mr. Chairman, we can do better. We must provide tax equity, and I urge my colleagues to support this legislation; and I commend the committee for moving forward, and I commend the committee for considering the two bills which myself, Congressman Coburn, and Congressman Norwood have put before the committee to address these issues.

Mr. BILIRAKIS. I thank the gentleman. Ms. DeGette.

Ms. DEGETTE. Thank you, Mr. Chairman. I would like to submit my statement for the record.

Mr. BILIRAKIS. Without objection.

Ms. DEGETTE. And just to note that one of my neighbors, not my direct constituent, but my neighbor to the south in Englewood, Bob Morehead, is here. I know his testimony is going to be illuminating, and I thank the committee for inviting him. I yield back.

Mr. BILIRAKIS. Mr. Burr.

Mr. BURR. No statement.

Mr. BILIRAKIS. Mr. Greenwood? Dr. Coburn?

Mr. COBURN. Well, thank you, Mr. Chairman for having the hearing. We do have 43 million Americans that are uninsured but half of them don't want insurance. So let's talk about——

Mr. BILIRAKIS. Is your mike on, Tom?

Mr. COBURN. Mr. Chairman, I don't know that I control whether my mike is on or not.

So we really ought to talk about those who don't have insurance who want insurance. The other thing, the latest numbers that we have really good numbers in 1996, we spent $1.36 trillion on health care in this country. And $180 billion of that didn't go to help anybody get well. And we are going to hear all sorts of ways about addressing the unmet needs of those that are uninsured.

One the first things we ought to do as a Congress is to open up this $180 billion by lessening the stranglehold of government agencies, neutralizing the tax effects that we don't have now, and clearing the way so that the market can have some impact.

Congressman Shadegg's bill on access is designed to eventually do that, to eventually allow individuals to own ultimately—that is where we ought to be—to own their health insurance product and then allow them to make the choices that fit them rather than a group of people deciding what is best for them without their choice. We don't need more government, we don't need more HCFA.

As a matter of fact, the last two HCFA administrators, including the last one that I think is the best one we ever had, Nancy Ann DePaul said that nobody understands HCFA and we are as a Congress responsible for that. So anything that we do in terms of improving access ought to have something to do with cleaning up HCFA and making the regulations understandable, usable, and efficient.

I often wonder if a Martian came to Earth and said you are going to have health care, how are you going to design it, they would look at us and say this is the opposite way to design it, and that is just criticism in terms of what we have done in terms of government agencies and the amount of dollars that are consumed in our health care budgets each year that don't go to help people get well.

And if you take $180 billion—and that money—and I have personal insurance. I have 33 employees in my medical practice with four other doctors, and eight of those people don't do anything to help people get well. And that is a crime because that is money that is being spent to not improve somebody's health care or to treat their disease.

We continue to want to ignore those facts. But health care is too important for this Congress to ignore the inefficiencies that we have mandated through government regulation and the tort system into the health care system.

So I am happy that you are having this hearing. I am extremely pleased with the work Mr. Shadegg has done. I don't know what is going to happen with those bills. But I will tell you one thing, we have to start down the road to increasing access and restoring individual freedom about choosing.

And I want to say one last thing. We are never going to let the free enterprise model work as long as we have a middleman between the employer and the patient. And we have all these health care firms who supposedly care for patients, but their No. 1 goal is making money. And that is why they are in business. Otherwise they wouldn't be there.

And we need to keep that in our mind, that we have a profit center between the person buying the health care for somebody and the person getting the health care. And that deserves a good long, hard look at whether or not that is a legitimate way to deliver health care in this country. And I yield back.

Mr. BILIRAKIS. I thank the gentleman. I think that completes the opening statements. And as I said earlier, those who wish to submit their opening statement in writing, without objection will be made a part of the record.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF HON. CLIFF STEARNS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. Chairman, I want to thank you for holding this important hearing today. The focus of today's hearing is how to promote access to health coverage for the estimated 43 million Americans who are currently lacking health insurance.

Approximately 85% of these individuals are employed and either opt to forego such coverage (healthy young individuals) or work for companies who cannot afford to provide such benefits to their employees.

Most people who have health insurance are covered by a health insurance policy chosen for them by their employers. If they work for small companies/businesses that cannot afford to pay for health coverage, they often have no coverage at all. If they are fortunate enough to have employer provided coverage, the possibility remains that if they lose their jobs or decide to change jobs, this valued benefit can be lost. Individuals who are self-employed currently get a 60% tax credit for purchasing their own health insurance, unlike the major corporations who get a 100% credit for purchasing health coverage for their employees.

Tax benefits should be moved out of the workplace and shifted over to the individual or family. Everyone—the self-employed as well as those who work for small firms—should get a tax credit to enable them to purchase coverage for themselves and their families. These credits should be larger for those whose medical expenses

make up a greater share of their income. These credits should be refundable so that low-income individuals and families should get assistance if they have no tax liability.

One of the proposals to expand access to health coverage is through the establishment of HealthMarts which would shift the decision making power over to the individual or family. Everyone—the self-employed as well as those who work for small firms—should be allowed to purchase coverage for themselves and their families. The consumers would be given the ability of making their own choices. This gives consumers a sense of empowerment and a sense of responsibility which will encourage them to wisely use medical services.

It could be modeled after the Federal Employee Benefit Program (FEHBP). This plan would give Americans the same option of choice now enjoyed by U.S. Senators and Representatives and the President. The FEHBP's annual cost increases have averaged one third less than other private health insurance programs.

We will also look at risk pools for high risk individuals. There are some who advocate the use of risk pools to provide insurance protection to individuals who are sick and not insurable.

To afford protection to those who become sick and uninsurable while without coverage, states could establish risk pools for the uninsured. These pools would provide coverage but the costs for the insurance premiums would be above average. How such a system would be financed is still unclear.

The financing mechanism is crucial since risk pools are targeted toward individuals who are already sick and can't afford even a bare bones insurance policy, and/or individuals who wish to switch health plans but are prohibited from doing so because, in all likelihood, they would be experience rated to reflect the "true cost" they will bring to the new insurer. Risk pools also have the potential for increasing the problem of adverse selection because there is no incentive for individuals to enroll in a plan on the open market.

The other option we will look at is a pilot program to create Community Health Organizations to give community health centers greater control of their resources and to provide comprehensive coverage to the people they assist.

Community health centers offer a valuable service by providing primary health care in our rural and urban communities. I have toured these community health care centers and know full well the valuable services they provide and it is one of the most cost-effective programs in which our government invests to meet the growing demands of the uninsured and underinsured.

I look forward to hearing from our distinguished panelists and receiving their views on the reasons we have so many uninsured people. I also am interested in hearing about possible solutions to providing coverage to these individuals.

PREPARED STATEMENT OF HON. BARBARA CUBIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WYOMING

Mr. Chairman, I would like to thank you for calling this hearing today. Finding ways to improve access to health care is a vitally important, and complicated, issue that we must address. Like every other member of this subcommittee, I have heard from small business owners in my district regarding the obstacles they face in providing affordable health insurance.

I am particularly interested in learning how health marts and the other access options we are considering today will affect health care in rural areas like my home state of Wyoming. People living in rural areas don't have as many health coverage options available to them as people living in more populated areas.

I would like to know the pros and cons of exempting any health plans from state mandated benefits. In addition, I would appreciate hearing any thoughts our witnesses might have about the effects health marts and other plans might have on risk pools and long-term costs.

Congress must move carefully and deliberately so that we do not inadvertently drive up health care costs or limit access in other ways. Our common goal is to improve access to health care coverage, and I appreciate the insight and comments from our witnesses today. Your contributions to this debate will be extremely helpful to all of us.

PREPARED STATEMENT OF HON. TOM BLILEY, CHAIRMAN, COMMITTEE ON COMMERCE

I'm pleased the Subcommittee is holding this hearing today. I welcome all the witnesses, many of whom bring with them first-hand knowledge of the problems Americans face when it comes to affordable health coverage.

Access to quality health coverage is a concern of *every* American. A recent poll asked respondents which they would prefer, that federal surplus dollars go to a new drug benefit for Medicare recipients or to providing basic health insurance for the uninsured. The results are telling—most said they would want to use funds for the uninsured. Even among seniors on Medicare, the results were in favor of coverage for the uninsured.

The Commerce Committee doesn't need polls to know the importance of the topic of today's hearing. There are now over 43 million Americans without any type of health insurance whatsoever. Every year, despite our growing economy and low unemployment, this figure grows. Now it is time to address this problem with solutions that work.

As we listen to the witnesses testimony today we must keep a few thoughts in mind, access, affordability and accountability:

- The affordability of health coverage for all Americans is directly linked to consumers exercising choice in the health care market place. We should not assume there has to be a trade-off between having quality health coverage and affordable health coverage. Americans deserve the best possible coverage at the best price.

As much of today's testimony will reveal, mandates on health insurance add costs to premiums and may have the unintended consequence of reducing access to coverage for many Americans—making today's problem worse.

- Today the tax code discriminates against the waitress at the corner diner whose employer provides no health coverage. Employer-purchased health coverage is 100 percent tax free to the employer and employee, but you are out of luck if your employer cannot provide you that coverage.

Ron Pollack, President of Families USA, made the comment a while back that there was not a true marketplace to drive quality in health care today. As great as our health care system is, I believe this is true. Just like in every other sector of our economy, when consumers are given choice they will seek value in their purchases. This, in turn, forces insurers to compete vigorously for the health care consumer's business.

I urge Members to listen to testimony that will be offered today about HealthMarts. The purpose of the HealthMart is threefold:

- To increase access to health insurance by giving small businesses the opportunity to join large purchasing pools;
- To bring the major stakeholders in the health care system—insurers, employers, employees, and health providers—together; and
- To give individuals choice and the ability to "fire" a health plan if it does not meet their needs and choose a new one.

Today's hearing is a fair and deliberate approach to the problem of the uninsured. I thank the Chairman of the Subcommittee for holding this hearing and I thank our witnesses for providing their much needed insight on this critical issue. This is about access, affordability and accountability, and I am pleased to yield back my time.

Mr. BILIRAKIS. We will call the first panel. Ms. Grace-Marie Arnett, president of The Galen Institute; Ms. Terry Neese, past president and public policy advisor of the National Association of Women Business Owners; Mr. Roberto Garcia de Posada, executive director of the Hispanic Business Roundtable; Mrs. Diane Rowland, executive director of the Kaiser Family Foundation; and Ms. Mary Horsley, consumer on behalf of Families USA.

Welcome to all of you. Thank you for being here, for your patience. Your submitted written testimony, your statement is a part of the record, and the Chair will give you 5 minutes to expand upon that in any way that you wish. Obviously, there will be a lot of questions coming from the panel up here so there may be a lot of points that you wish to make that you will have the opportunity to make even if you don't have time in your opening statement. We will kick it off with Mary Horsley. Proceed.

STATEMENTS OF MARY HORSLEY, CONSUMER, ON BEHALF OF FAMILIES USA; GRACE-MARIE ARNETT, PRESIDENT, THE GALEN INSTITUTE; TERRY NEESE, PAST PRESIDENT AND PUBLIC POLICY ADVISOR, NATIONAL ASSOCIATION OF WOMEN BUSINESS OWNERS; ROBERT GARCIA DE POSADA, EXECUTIVE DIRECTOR, HISPANIC BUSINESS ROUNDTABLE; AND DIANE ROWLAND, EXECUTIVE DIRECTOR, KAISER FAMILY FOUNDATION

Mrs. HORSLEY. Mr. Chairman and members of the committee, my name is Mary Horsley; and I am from Cape Charles, Virginia. Thank you so much for inviting me to testify this morning about my family.

I hope that our story will help convince you that families need health insurance. My husband is Kenny Horsley. He has lived on the Eastern Shore his whole life. He could not join me today because he didn't want to take a day off from work. We have been married for almost 15 years and we have one daughter, Laura, who is 10 years old.

We are a classic uninsured family. My husband is employed full-time at Ewell's Furniture Store in Cape Charles, where he sells new and used furniture, appliances, and odds and ends. He makes $250 a week gross and gets no benefits through his job. The owner of the store employs two other people and cannot afford to give his employees health insurance.

I do sporadic contract work teaching in arts programs when I can get it. Health insurance has never been offered to me by any of my employers.

Our annual income is about $13,000 to $14,000. We live very conservatively. We do not take vacations or go out to eat. I sew and, therefore, we do not spend a lot of money on clothes. We have an old car, we have some bills including a loan we needed to pay for a new furnace that we must pay on a monthly basis. I am not complaining. I just want you to know we are doing okay, but just barely.

My husband had a small skin cancer about 20 years ago. But by the time we were married, we were both healthy. At that time my husband ran his family's small restaurant and we could not afford to buy coverage. Shortly after my daughter was born, I learned that health insurance is essential if someone in your family gets sick.

At that time, Laura was not getting enough milk. It took a while for the doctors to figure out what was wrong. The problem was corrected, but we wound up with a lot of bills. We learned that one health problem can be very expensive and devastating to a family's budget. I was told that Laura was eligible for Medicaid, and she has been on the program since then.

As it turned out, we have had to use Medicaid for a couple of eye surgeries for Laura. She has an inherited disease which causes one eye to move out. We are very grateful for the help Medicaid gave us because without it we could be in significant debt. Unfortunately, Medicaid does not cover adults.

About 2 to 3 years ago, my husband's cancer started growing back. When my husband suspected his cancer had returned, he knew we could not afford to pay the medical bills so he put off get-

ting care. He did not tell me about it until last fall. In February, he had surgery.

Because he delayed getting care, the damage was much worse than it might have been if he had seen a doctor earlier. The care was much more expensive also. He had part of a cheek bone, one eye and part of his skull removed. He is now facing two more surgeries, including plastic surgery and 5 weeks of radiation therapy.

We are struggling to pay the remaining medical bills. We are very fortunate that so far we have had some help. The doctors wrote off part of their bills for the first surgery and our church and the Lions Club helped out. I am also applying to the Lion's Club for additional help.

Our income and resources are low enough so that we qualify for the Virginia State Local Hospital plan, called the SLH plan, which pays the hospital bills. And, of course, I am very worried about the future. I don't know how long the doctors will be willing to write off some of their bills or how much other help I will be able to get.

I also don't know if my husband will still get paid when he takes off more and more time from work. I will try to get more contract work, but if I make much more than I do now, then we will not qualify for SLH and our bills will be overwhelming.

I feel very stuck and frustrated. Sometimes I feel like I am spinning in circles. I know that we should have health insurance, but we cannot get it. I called around to many insurance companies. They told me that my husband had a preexisting condition and they would not sell me insurance. Even if he was not sick and they would sell it to me, I was told it would cost around $400 a month. We do not have money left over each month to pay premiums of this magnitude. We cannot afford to pay about $5,000 out of our annual income of around $13,000.

I know we are not the only family in this predicament. My sister and her husband who has recently been ill are facing the same questions about how to keep the family going and pay large medical bills. We are hard-working families. Seems to us that in a country like ours, hard-working families should not have to go without health insurance.

I hope you can figure out a way to get insurance to families that need it. Thank you.

Mr. BILIRAKIS. Thank you very much, Ms. Horsley. Ms. Arnett.

STATEMENT OF GRACE-MARIE ARNETT

Ms. ARNETT. Thank you, Mr. Chairman, and the distinguished members of the committee for inviting me to testify today. I also commend you for inviting Mrs. Horsley to come to present a really poignant and real-life story that makes this work very real for all of us.

As you say, I am the president of the Galen Institute, a not-for-profit health and tax policy research organization in Alexandria, Virginia. It is frustrating to all of us; and it is even more frustrating to the American people that despite years of effort by law makers at all levels of government, and especially during a strong and sustained period of economic growth, that the problem of the uninsured not only persists but continues to get worse.

At the State level, lawmakers have been passing thousands of laws with a very good intent of trying to force health insurers to offer good coverage that contained decent benefits at reasonable costs and with protections for policyholders. Additional insurance regulations, as you well know, have been passed at the Federal level with many of the same intent.

The data, however, increasingly show that despite this good intent, the effect these laws are having is increasing the cost of health insurance and is, in fact, driving up the number of people who are uninsured.

As we have heard from Mrs. Horsley, people who are on the tightest budgets must make the hardest choices in deciding how to allocate their resource after paying the rent and the mortgage, and putting food on the table. Millions of Americans simply can't afford to buy health insurance. Some are faced with the choice between sending their children to a good school and buying health coverage, and we increasingly see the choices that they are forced to make.

When asked by the Kaiser Commonwealth Fund survey recently, a majority of Americans cite cost as a reason for not having health benefits. In fact, the cost of health insurance has grown dramatically faster than the overall consumer price index: 111 percent increase in the cost of health insurance between 1988 and 1996 as opposed to a 33 percent increase in overall prices.

The Congressional Budget Office estimates that every 1 percent increase in the cost of health insurance throws 200,000 more people off the insurance rolls. Uninsured are disproportionately young, minority, lower income, and either work for small companies or are their dependents. The research that I have done, which is validated by numerous other experts, has convinced me that there is a causal connection.

The growing benefit mandates and regulation in the health sector leads to higher cost for health insurance and in turn drives more people into the ranks of the uninsured. I would invite you to look at my testimony for specifics on the studies that I cite there.

For example, Gail Jensen of Wayne State University and Michael Morrisey of the University of Alabama at Birmingham found that as many as one in four Americans lack health insurance because of benefit mandates and yet the number of mandates has increased 25 fold in the last quarter century.

Mandates in insurance regulation don't show up on the Federal ledger, but they are not without cost to the American people. They are paid for by workers and their dependents who receive lower wages or lose coverage altogether.

Each mandate may increase cost only by a percentage or 2 but others add much more and every one of these benefit mandates can be justified by its constituency as a legitimate item for coverage, but cumulatively they are condemning more and more people to being without health insurance.

Small businesses and people attempting to buy health insurance on their own are most vulnerable because they don't have the opportunity to escape by self-insuring through the provisions of ERISA. The Galen Institute conducted a study to determine the effects of State efforts to regulate their health insurance markets and shape coverage to help their citizens get affordable coverage.

Using GAO studies, we determined that between 1990 and 1994 16 States were most aggressive in passing health laws regulating their health insurance markets with the intent of helping their citizens get better health insurance.

We found that by 1996, these 16 States were seeing their uninsured populations grow an average of eight times faster than the 34 States that did little or less. Before the health care reform legislations began, the two groups of States had been virtually equal. One of the biggest regulators was Kentucky and the Governor said in spite of good intentions and noble purposes the project didn't work. The entire cost of the system went up.

Just to conclude, Mr. Chairman, the fact that regulation has failed at the state level does not mean that Federal action is not needed. But in the battle over patient protection legislation the uninsured may very well be shoved aside in favor of a small percentage of those who have health insurance who are unhappy with it. Instead of helping the 43 million Americans with health insurance, the data strongly suggests that patients rights legislation will hurt them by driving up the cost coverage and throwing even more people off the health insurance rolls.

I commend you to look at the ideas of tax cuts for the insured. I can think of no better example than Mrs. Horsley of someone who could benefit from a targeted tax credit to an individual who does not have the option of job-based health insurance to get affordable coverage. Thank you.

[The prepared statement of Grace-Marie Arnett follows:]

PREPARED STATEMENT OF GRACE-MARIE ARNETT, PRESIDENT, GALEN INSTITUTE

Thank you, Mr. Chairman, and members of the committee for inviting me to testify today as you address the challenge of why, despite years of effort to try to reverse the trends, more and more Americans are without health insurance.

My name is Grace-Marie Arnett, and I am president of the Galen Institute, a not-for-profit health and tax policy research organization based in Alexandria, Virginia. The Galen Institute was founded in 1995 to promote a more informed public debate over individual freedom, consumer choice, competition, and diversity in the health sector. The Galen Institute also facilitates the work of the Health Policy Consensus Group, which is composed of nearly 20 health policy experts from the major free-market think tanks, whose work I will discuss later in my testimony.

For decades, policy makers at all levels of government have been searching for ways to help Americans gain greater access to affordable health care. You and your colleagues in Washington and lawmakers in the states have spent untold thousands of hours trying to achieve that goal.

It is frustrating to you and to virtually all Americans that, despite these efforts and especially during a period of strong and sustained economic growth, the number and percentage of Americans without health insurance continues to rise. In 1987, there were 32 million Americans under age 65 without health insurance at some point during the year. A decade later, the number has risen to more than 43 million or 16.1% uninsured.

At the state level, thousands of new rules and regulations have been passed with the intent of forcing health insurers to offer coverage that contained good benefits, at reasonable costs, and with protections for policyholders. Some insurance regulations and mandates recently have been passed at the federal level, as you know, and even more are being debated. However, the rule that governs the practice of medicine should also govern lawmakers in addressing health reform issues: First, do no harm.

The data show that these laws have the effect of increasing the cost of health insurance and are driving up the number of uninsured.

Insurance costs and the uninsured

People who are on the tightest budgets must make the hardest choices in deciding how to allocate their resources. After paying the rent or the mortgage and putting

food on the table, millions of Americans simply don't have enough money left to buy health insurance. Some are faced with the choice between sending their children to a good, safe school or providing the family with the security of health insurance. These are terribly difficult choices, but we see from the numbers the choice that more and more Americans are making.

When asked by a Kaiser/Commonwealth Fund survey, the majority of Americans cite cost as their reason for not having health insurance.

Over the last decade, health insurance costs have increased much faster than overall consumer prices. The General Accounting Office reported in 1997 that the average annual premium for employment-based family health insurance coverage increased by 111%, from $2,530 in 1988 to $5,349 by 1996. During this same period, overall consumer prices rose by 33%.[1] Now, after several years of leveling off, health insurance premiums are on the rise again. This does not bode well for the uninsured.

The GAO concluded that the continued erosion of health insurance coverage is directly linked to cost pressures.

The Congressional Budget Office estimates that every one percent increase in the cost of health insurance throws 200,000 more Americans off the insurance rolls. The result: Those who can least afford the inevitable premium increases will lose their health insurance. The uninsured are disproportionately young, minority, lower income, and either work for small companies or are their dependents.[2] Hispanics and minorities are the most likely to be uninsured. Among working-age Americans, 14% of whites, 24% of blacks, and 38% of Hispanics are uninsured.[3] The uninsured numbers are even higher for lower-income minority group members, reaching 52% for Hispanic families whose incomes are below the federal poverty level.

The research that I have done, which is validated by numerous other experts, has convinced me that there is a causal connection: the growing burden of mandates and regulation in the health sector leads to higher costs for health insurance which, in turn, drives more people into the ranks of the uninsured.

Mandates and the uninsured

The link between insurance mandates and the uninsured has been established by numerous researchers.

- Using data from 1989 to 1994, Sloan and Conover[4] found that the higher the number of coverage requirements placed on plans, the higher the probability that an individual would be uninsured, and the lower the probability that people would have any private health insurance coverage, including group coverage. After more than 100,000 observations, they conclusively demonstrated that the probability an individual will be uninsured increases with each mandate imposed by government.
- Gail A. Jensen of Wayne State University and Michael Morrisey of the University of Alabama-Birmingham[5] found that as many as one in four Americans lack health insurance because of benefit mandates. Each additional mandate significantly lowers the probability that a firm or an individual will have health insurance.
- Professor William S. Custer of Georgia State University[6] found that state guaranteed issue requirements, coupled with either community rating or rate bands in the small group insurance market, increase the probability that a person will be uninsured by nearly 29%. These laws hit small firms and individuals purchasing insurance in the open market the hardest.

The number of mandates has increased 25-fold over the last quarter century, with more than 1,000 state mandated benefit laws on the books today. Most are an attempt by lawmakers to correct inefficiencies or inequitable practices in the market. Unfortunately, they are having the unintended effect of increasing the ranks of the uninsured.

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[1] U.S. General Accounting Office. "Private Health Insurance. Continued Erosion of Coverage Linked to Cost Pressures," GAO/HEHS-97-122. July 1997. Washington, D.C.

[2] Hall, Allyson G., Karen Scott Collins, and Sherry Glied, "Employer-Sponsored Health Insurance: Implications for Minority Workers." The Commonwealth Fund, February 1999. New York.

[3] Commonwealth Fund analysis of 1997 *Current Population Survey.*

[4] Sloan, Frank A. and Christopher J. Conover, "Effects of State Reforms on Health Insurance Coverage of Adults," *Inquiry.* 35:280-293, 1998.

[5] Jensen, Gail A., Michael A. Morrisey. "Mandated Benefit Laws and Employer-Sponsored Health Insurance." Published by the Health Insurance Association of America, January, 1999. Washington, D.C.

[6] Custer, William S. "Health Insurance Coverage and the Uninsured." Published by the Health Insurance Association of America, December 1998. Washington, D.C.

Mandates and insurance regulations do not show up on the federal budget ledger, but they do show up in the paychecks and in loss of coverage by individual workers. Jensen and Morrisey say, "Mandates are not free. They are paid for by workers and their dependents, who receive lower wages or lose coverage altogether."[7]

In a study, conducted in 1989 even before the explosion of state mandated benefit laws in the 1990s, Acs et al found that mandates significantly raised premium costs. Even then, insurance was found to be 4 to 13 percent more expensive as a direct result of benefit laws.[8]

Each mandates may increase costs only a percentage or two, but others add much more. Every one of these benefit mandates can be justified individually, and each has a constituency that can and does argue passionately for its merit. But cumulatively, they are condemning more and more people to being without health coverage.

Hitting the most vulnerable the hardest

Small businesses and individuals attempting to purchase health insurance are hit with the full force of these mandates and insurance regulations. The small group and individual insurance markets have become fragile and expensive as a result. Most large companies avoid benefit mandates and state insurance regulation laws because they are protected by ERISA, the Employee Retirement Income Security Act of 1974 that allows companies that self-insure to escape the reach of these state insurance laws and regulations. Few small business can afford to self insure and are therefore subject to all of the mandates and regulations imposed by the states.

Surveys conducted by the National Federation of Independent Business show that the great majority of small business owners would like to offer health insurance, but say high costs make it prohibitive. About 40% of businesses with fewer than 50 workers do not offer health insurance. A person working for a company with fewer than 10 employees is three times more likely to be without health insurance than someone working for a company with more than 1,000 employees.

Even small companies that do offer insurance often must make the choice between keeping their business going and offering health benefits. Many walk the line—offering insurance but requiring employees to pay a larger share of the premiums. Unfortunately, an increasing number of people offered health insurance through their jobs are declining coverage, again citing costs as the primary reason.

For this and other reasons, the number of people with private health insurance has been declining for nearly two decades. Since 1980, the number of people with private health insurance coverage obtained either through the workplace or purchased individually has been declining, from 79.5% in 1980 to 70.5% in 1995.

State insurance regulations and the uninsured

The Galen Institute conducted a study last year,[9] which was published by The Heritage Foundation, to determine the effect of state efforts to regulate their health insurance markets and shape coverage to help their citizens get affordable health insurance coverage.

Using GAO studies, we determined that between 1990 and 1994, 16 states were most aggressive in passing laws regulating health insurance. By 1996, these 16 states were seeing their uninsured populations grow an average of EIGHT times faster than the 34 states that passed less comprehensive regulations. Compare this to 1990, before the blizzard of health-care reform legislation began, when the two groups of states had nearly equal rates of growth in their uninsured populations.

Could the increase in the number of uninsured in these 16 states be caused by something other than regulation? Not likely. The regulating states had employment and income characteristics similar to the rest of the nation. Their only distinguishing feature was the passage of these sweeping health insurance regulations.

One of the biggest regulators was Kentucky. "In spite of good intentions and noble purpose, it didn't work . . . The entire cost of the system went up," Gov. Paul Patton said last year. Kentucky citizens paid the price: 107,500 fewer citizens, out of a population of 3.4 million, had health insurance in 1996 than in 1990. "In my opinion, most of the general assembly believes that we in Kentucky have experimented enough for the time being," Patton said.

In addition to Kentucky, the other states that imposed the most aggressive regulations were Idaho, Iowa, Louisiana, Maine, Minnesota, New Hampshire, New Jer-

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[7] Jensen, Morrisey.

[8] Acs, Gregory, Colin Winterbottom, and Sheila Zedlewski, "Employers' Payroll and Insurance Costs: Implications for Play or Pay Employer Mandates," in *Health Benefits and the Workforce.* Washington, D.C. U.S. Department of Labor, 1992.

[9] Schriver, Melinda, and Grace-Marie Arnett. "Uninsured Rates Rise Dramatically in States with Strictest Health Insurance Regulations," The Heritage Foundation, August, 1998, Washington, D.C.

sey, New Mexico, New York, North Dakota, Ohio, Oregon, Utah, Vermont and Washington. Their new laws included: mandates on insurers to sell policies to anyone who applies and agrees to pay the premium—even if they wait to buy insurance until they are already sick (guaranteed issue); prohibitions on excluding coverage for some medical conditions (pre-existing condition exclusions); and requirements that insurers charge the same price to everyone in a community, regardless of the differences in risk posed by individuals (community rating); plus others.

The findings from our study have been validated in part by other studies, including the Urban Institute.[10]

Recent federal legislation—the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997—have imposed at the federal level some of the insurance rules that had been enacted by the states, including guaranteed renewal and some of the most common coverage mandates, making it difficult to do a differential study now.

However even now, 11 of the 16 states we studied still has a rising number of uninsured, and for all but two, the growth in their insured populations is under 1%.

The fact that regulation has failed at the state level does not mean federal action is unneeded. But in the battle over Patient Protection legislation, the uninsured are being shoved aside in favor of the small percentage of those who have health insurance but are unhappy with it. Instead of *helping* the 43 million Americans with no health insurance, the data strongly suggest that patients' rights legislation will hurt them by driving up the cost of coverage and throwing even more people off the insurance rolls.

More regulation is not the answer

The health sector is the most heavily regulated industry of the American economy. In every other industry, Americans recognize that regulation drives up prices, restricts innovation, dries up competition, and forces businesses to cater to regulators and not consumers. That is exactly what is happening in the health sector.

These data show that American citizens are paying a high price for the mistakes of well-intended but flawed legislation that has backfired in its intent. A poll released last year by the Charlton Research Company showed that 66% of respondents said they thought health care is regulated enough. Only 25% said more regulation was the answer, and the majority of *them* changed their minds if the regulations would increase government bureaucracy or health care costs.

A fresh approach to energize the free market

As costs and the number of uninsured continue to rise, a different approach clearly is needed. In a forthcoming book, entitled *Empowering Health Care Consumers through Tax Reform,*[11] the Health Policy Consensus Group explores the intersection of health and tax policy for solutions. This group of economists and other health policy advisers, business group and union representatives, physicians, and political leaders describes the distortions to the health care system caused by a 50-year-old provision in the tax code.

The central, structural defect impacting the market for private health insurance is the discriminatory tax treatment of health insurance. To begin to stem the flow of problems that wind up on their doorsteps, legislators can begin by providing broader access to health insurance through tax credits and other fixed incentives for individuals.

In today's information age economy, an increasing number of people work part-time, are contract workers, or are starting their own businesses. These are the people who are disproportionately likely to be uninsured because the system is working against them.

The federal tax code heavily favors workers fortunate enough to get their health insurance through the workplace. That is because workers do not pay taxes on the part of their compensation package that they receive in the form of health benefits as long as their employer purchases the policy for them. This generous subsidy, worth an estimated $111 billion a year, is the cornerstone of the system in the United States that ties private health insurance to the workplace.

However, this tax provision distorts the efficiency of the health care market in a number of ways: (1) It restricts employees' choices to the selection the employer offers; (2) It undermines cost consciousness by hiding the true cost of insurance and medical care from employees; (3) Because the full cost of health insurance is not

[10] Marstellar, Jill A., Len M. Nichols, Adam Badawi, *et al.* "Variations in the Uninsured: State and County Level Analyses." Urban Institute, June 1998. Washington, D.C.

[11] Arnett, Grace-Marie, Ed. *Empowering Health Care Consumers through Tax Reform,* University of Michigan Press, Ann Arbor. Forthcoming.

visible to employees, it artificially supports increased demand for medical services and more costly insurance; (4) As a result, inefficient health care delivery is subsidized at the expense of efficient delivery; (5) Cash wages are suppressed; (6) Many employees with job-based coverage are frustrated because they have little choice and control over their policies and their access to medical services; (7) The self-employed, the unemployed, and those whose employers do not offer health insurance are discriminated against because they receive a much less generous subsidy, if any at all, when they purchase health insurance on their own.

Trapped in the Galen Gap

The Galen logo is a conceptual depiction of a central problem in the health sector that affects Americans under age 65. The vertical axis of the graph in the logo represents the value of the taxpayer-supported health benefits a given individual may receive. The horizontal axis represents the individual's income.

Those with the very lowest incomes are most likely to qualify for taxpayer-supported health programs, especially Medicaid. But as an individual moves up the income scale, the likelihood of qualifying for public programs to receive health benefits drops off. Working Americans with incomes of less than $25,000 are most likely to be uninsured and are caught in the troth, which we call the "Galen Gap." They earn too much to qualify for public programs but are less likely to have the good jobs that provide health insurance as a tax-free benefit.

As people move up the income scale, they are much more likely to have both the good jobs and the higher incomes to qualify for the generous tax subsidy for employment-based health insurance, worth an estimated $111 billion this year.

John Sheils of the Lewin Group estimates that families making less than $15,000 a year reap just $71 in tax benefits from job-based health insurance while families making $100,000 or more get a $2,357 in tax break for the purchase of health insurance.[12] This is a highly regressive subsidy that drives many of the problems involving cost and access in the health sector today.

The great majority of the uninsured are in the "Galen Gap." Some have been trying to fill this gap from the left by creating and expanding government programs, such as the $48 billion State Children's Health Insurance Program and working to expand Medicare to middle-aged Americans.

We believe real solutions will come from exploring solutions on the right side of the chart—by focusing on tax policy. We believe that many more people would have access to medical services and health insurance that would be more affordable and more innovative if the tax treatment of health insurance were reformed.

Federal legislators can begin building incentives for a better system and also undo some of the damage done by federal and state regulation by providing targeted tax credits to the uninsured to purchase their own health insurance.

States can do their part by taking advantage of an immediate opportunity to provide tax credits and vouchers for uninsured children and their families through the Children's Health Insurance Program.

There is a need to provide alternative grouping mechanisms for individuals in purchasing health insurance to give them an opportunity to take advantage of group rates. A number of provisions are being debated today, such as HealthMarts and Association Health Plans, designed to address the supply-side of the equation.

Today, consumers are denied the choice of health plans best suited to their needs when mandates force plans to provide an array of benefits designed more to please lobbyists than consumers. Mandates also drive up health care costs making insurance more costly for individuals and families. Congress would be well advised to put a moratorium on more mandates until the cost and implications can be fully explored.

The results examined in these studies show that regulation at the state and federal level is counterproductive in responding to the challenge of increasing access to health insurance in the individual and private health insurance market. If health care access and affordability are genuine goals, a far better approach would be to empower individuals and families to make health care choices that suit their own needs, restore the independence and integrity of the medical profession, and force the health care industry and insurance companies to compete for consumers' dollars. The health care delivery system at all levels should be accountable directly to the individuals and families being served.

Thank you for the opportunity to present this testimony, and I would be happy to answer questions or provide additional information.

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[12] Sheils, John, and Paul Hogan. "Cost of Tax-Exempt Health Benefits in 1998," *Health Affairs.* March/April 1999. Volume 18, No. 2. Bethesda, MD.

Mr. BILIRAKIS. Thank you very much, Ms. Arnett.

Ms. Neese.

STATEMENT OF TERRY NEESE

Ms. NEESE. Good morning, Mr. Chairman and members of the committee. Thank you very much for holding this hearing. My name is Terry Neese, and I am a small business owner in Oklahoma. I am also past national president of the National Association of Women Business Owners and serve as a consultant to them on public policy issues.

NAWBO represents this country's 9 million women business owners. We are employing about 27.4 million workers today and generating $3.2 trillion in annual revenues.

Today, I want to discuss access to health care and ways Congress can assist small business owners with their health care needs. The Employee Benefit Research Institute, EBRI, has reported that about 80 percent of the 40 million uninsured Americans live in families with an employed worker who is likely to work for a small employer or be self-employed.

Over 80 percent of all uninsured children are in families with working parents. Clearly the problem of the uninsured, both children and adults, is predominantly a problem of small businesses lacking access to affordable coverage.

For example, at Terry Neese Personnel Services in Oklahoma City, our insurance was recently canceled. I employ 12 people and a thousand temporaries on an annual basis. In 1998, we carried health insurance with a large national insurer. Our monthly insurance premium for 12 employees was extremely high. For one employee, over $800 a month. Terry Neese Personnel Services covered 80 percent of all costs. We had been insured by a national insurance company for about 3 years with no claims being filed on the insurer. Pretty remarkable.

One day out of the clear blue we received a call from the insurer that they were canceling our insurance due to the small number of people employed in the firm. We were pretty devastated and spent 3 months trying to find a firm that would insure the staff. This incident made it clear to me and my employees that something had to be done to assist small business owners in making insurance available at a reasonable cost without unfair and unjust cancellation.

The most egregious of the inequities in the system is the fact that incorporated businesses can deduct 100 percent of their health care premiums while the self-employed business owners can only deduct 60 percent. The solution: Allow self-employed individuals to deduct 100 percent of their cost of their health insurance premiums now. Allow small business access to association health plans. New insurance coverage options for both the self-employed and those workers in small businesses will also promote competition and greater choice in the health insurance market.

By giving workers new sources of coverage through trade and professional associations, it will make it easier and cost effective for many Americans to continue coverage under the same plan when changing jobs. And last, preempt costly State benefit mandates. Mandating health benefits raises costs. Mandates, therefore,

defeat the very purpose of health care reform, which is to lower health care costs and to insure more people.

I couldn't help but think when Congressman Coburn talked about the middleman between the patient and the doctor that it was just a short, short—very short—30 years ago when I could go see my doctor and there was not a middleman between me and the doctor. And I had no problems with medical care. So we might digress just 30 years and look at what has really happened in this 30-year period of time that has brought us to where we are today.

Women-owned businesses want to recruit the best talent on the market. And with the unemployment rate at 4.2 percent, excellent benefit packages are key to attracting and retaining employees.

Thank you very much for allowing me the opportunity to present ideas to the committee. NAWBO members stand ready to assist you in finding the tools necessary to ensure the workers they care about have the insurance that they deserve. This Congress can help provide those tools. Thank you very much.

[The prepared statement of Terry Neese follows:]

PREPARED STATEMENT OF TERRY NEESE, CEO & FOUNDER, TERRY NEESE PERSONNEL SERVICES & TERRY NEESE TEMPORARIES ON BEHALF OF THE NATIONAL ASSOCIATION OF WOMEN BUSINESS OWNERS

Good morning, Mr. Chairman and members of the committee. Thank you for the opportunity to appear before you today to discuss access to health care issues.

My name is Terry Neese and I am the CEO & Founder of Terry Neese Personnel Services and Terry Neese Temporaries in Oklahoma, and GrassRoots Impact with offices in Washington, D.C.; Detroit, Michigan; and Oklahoma City.

In addition to being a small business owner, I am past national president of the National Association of Women Business Owners (NAWBO) and serve as a consultant to NAWBO on corporate and public policy issues. NAWBO represents this country's 9 million women business owners and advocates on their behalf from our city halls to international forums. Women business owners today are employing over 27 million workers (voters) and generating $3.2 trillion in annual revenues. NAWBO's sister organization, the National Foundation for Women Business Owners tells us what our women-owned business community looks like with its ongoing, ground breaking research. NFWBO's statistics are quoted by the business and mainstream media, as well as government officials. NAWB0's other sister organization, the National Women Business Owners Corporation, has established the full national certification program for women business owners and created a national database of women-owned businesses for procurement opportunities with the Federal Government and the private sector.

Today, I want to discuss access to health care and ways Congress can assist small business owners with their heath care needs.

The Problems for Small Business

The Employee Benefit Research Institute (EBRI) has reported that about 80 percent of the 40 million uninsured Americans live in families with an employed worker who is likely to work for a small employer or be self-employed. Over 80% of all uninsured children are in families with working parents. Clearly, the problem of the uninsured, both children and adults, is predominantly a problem of small businesses lacking access to affordable coverage. Sadly, the choice is too often between paying for a Cadillac health insurance package or having no health insurance whatsoever. Too many Americans are paying for benefits they do not need, and too many others cannot get even the most basic coverage.

Small businesses, unlike large firms that can self-insure, have to endure costly state insurance mandates.

Approximately 2.9 million self-employed Americans are currently uninsured.

Small firms are more likely to feet the brunt—both economic and emotion—of the preexisting condition exclusion, the 20 to 300 percent premium hike when an employee becomes sick, or the sudden cancellation of insurance.

For example, at Terry Neese Personnel Services in Oklahoma City, our insurance was recently canceled. We employ 12 people and 1000 temporaries on an annual basis. In 1998, we carried health insurance with a large national insurer. Our

monthly insurance premiums for 12 employees were extremely high, Terry Neese Personnel Services covered 80% of all costs. We had been insured by a national insurance company for about three years with no claims being filed on the insurer. Pretty remarkable! One day out of the clear blue, we received a call from the insurer that they were canceling our insurance due to the small number of people employed in the firm. We were all devastated and spent three months trying to find a firm that would insure the staff. This incident made it clear to me and my employees that something had to be done to assist small business owners in making insurance available at a reasonable cost without unfair and unjust cancellation.

The Small Business Perspective

One of the most egregious of the inequities in the system is the fact that incorporated businesses can deduct 100 percent of their health care premiums, while the self-employed business owners can only deduct 60 percent. This percentage will increase to 100%, phased in over the new few years. But I have to ask: why does small business have to wait? Why do all those employees of small business have to wait? The profit margin of a small business is so slim, 100 percent deductibility would be a huge financial relief that would lead to more insured Americans.

Small businesses do not enjoy the economies of scale that large businesses do when they purchase health insurance. The National Association of Women Business Owners (NAWBO) supports Association Health Plans. Small business that offer health benefits must comply with costly state and federal mandates. The huge companies that self-insure are exempt from those mandates. This is an enormous bias against smaller firms. The playing field must be leveled by allowing small businesses to band together, across state lines, to purchase health insurance through Association Health Plans.

Potential Solutions

Allow self-employed individuals to deduct 100% of the costs of their health insurance premiums NOW.

Allow business access to Association Health Plans. New insurance coverage options for both the self-employed and those workers in small businesses will also promote competition and greater choice in the health insurance market. By giving workers new sources of coverage through trade and professional associations, it will make it easier and cost effective for many Americans to continue coverage under the same plan when changing jobs. The ERISA law has played an important role in driving down costs for medium and large employers and allowing virtual universal coverage for their employees. ERISA also allows employers and unions the option not only to insure but also to self-insure, giving them the low cost, quality, and choice advantages of uniform health benefit plans for all of their employees.

Preempt costly state benefit mandates. Mandating health benefits raises costs. Mandates therefore defeat the very purpose of health care reform, which is to lower health care costs and to insure more people.

Statistics show that women business owners are dedicated to providing benefit packages to their employees. Fully 92% of NAWBO members with employees provide at least one among a list of benefits to their employees. Over eight in ten offer paid vacations and three-quarters offer health and medical benefits. Women-owned businesses, want to recruit the best talent. Health benefits allow small business to attract and retain qualified workers. Today, with the unemployment rate at 4.2 percent, excellent benefit packages are key to attracting and retaining employees.

Thank you for allowing me the opportunity to present these ideas to the committee. NAWBO members stand ready to assist you in finding the tools necessary to insure the workers they care about, have the insurance they deserve. This Congress can help provide those tools.

Mr. BILIRAKIS. Thank you very much.

Mr. Garcia de Posada.

STATEMENT OF ROBERTO GARCIA de POSADA

Mr. GARCIA DE POSADA. Thank you, Mr. Chairman and members of the committee. I want to thank you for highlighting the problem in the Hispanic community and particularly Dr. Ganske and Mr. Bilbray on this issue.

I am Roberto Garcia de Posada, and I am the executive director of the Hispanic Business Roundtable. And we were established in

1995 to address the policy issues that affect the well-being of Hispanics in the U.S.

When it comes to health insurance, according to the U.S. Census, the highest uninsured rate in the U.S. is among people of Hispanic origin: 34.2 percent of Hispanics were uninsured, compared with only 12 percent for non-Hispanic whites. U.S. Hispanics also have the largest percentage of the working uninsured at 37.9 percent compared to only 14.9 percent for non-Hispanic whites.

The main reason that many Hispanics do not have insurance is because they have lower incomes and work for smaller firms. As you know, employment and income level are the leading indicators of health insurance coverage in this country. And the lower the income, the more likely a worker is to not have coverage simply because he or she cannot afford it. Employees working for small firms are the least likely to provide health insurance.

Hispanic per-capita income is $10,773; and Hispanics in the U.S. disproportionately work in the service industry or small business. An overwhelming majority of the uninsured in the Hispanic community are the working poor, not poor enough to qualify for Medicaid, but too poor to afford health insurance. In addition, there is a high degree of mobility in the Hispanic workforce. The current system of employment-based health insurance is simply leaving too many people behind.

At the Hispanic Business Roundtable, we strongly promote policies to promote equality and equity between employer-based health insurance coverage and consumer-based coverage. We are here to call on Congress to end the discrimination that exists between people that buy health insurance outside the place of business.

Low-skilled workers often do not command a wage that enables them to buy health insurance, and they get little, if any, assistance in purchasing it. If a worker decides to purchase individual coverage, he will soon realize it is prohibitively expensive.

Think of it from the small business perspective. Once you hire an employee, before you consider paying health insurance, you have to pay general liability insurance, workers' compensation, unemployed insurance, Social Security, et cetera. Paying all of this, most small businesses cannot afford to provide health insurance to their employees.

From the employee's side, let me use Martha Sanchez as an example. Martha is a mother of two in Miami who works as a receptionist for a small law firm who earns approximately $10 annual hour. Her employer does not provide health insurance, and she cannot afford to buy individual health insurance.

What can Congress do to help someone like Ms. Sanchez get health insurance? First, it has to have incentives for individuals without access to employer-sponsored coverage. You can enact refundable tax credits or vouchers to help low-income workers purchase health insurance.

In order to make these tax credits truly accessible to workers in small businesses, we believe these tax credits or tax breaks could be blended into the withholding system.

Second, Congress could equalize the tax laws so that associations and community-based organizations have the same tax breaks as large businesses when they provide health insurance. This would

promote a more community-based insurance system that would have a better understanding of the community they serve.

Congress and the administration should also work closely with the Hispanic health organizations to develop a public education campaign that promotes the importance of having health insurance. As Dr. Ganske just said, many just simply do not know of the concept, do not know that they can be covered by Medicaid and some other programs.

Third, Congress should eliminate the obstacles to pooling. This would help promote a more affordable, accessible, and accountable coverage for consumers.

Congress can promote changes in our tax laws to help low-income workers and small businesses have access to health care. Small business could get a tax credit that could be phased in beginning with the smallest firms of fewer than 10 employees.

Individual purchasers of health insurance and the self-employed should be able to fully deduct their cost of premiums.

Employee contributions for health insurance should not be considered taxable income.

Finally, we cannot ignore the fact that reducing regulatory burden and government mandates, reforming liability laws, and promoting personal responsibility are also key components of any solution to this problem. Access to affordable insurance is a problem that disproportionately affects the Hispanic community, and the Hispanic Business Roundtable certainly commends this committee for addressing this issue. We look forward to working with you to break down some of the barriers and to build the necessary bridges to improve access to affordable health insurance and health coverage for the uninsured.

One last thing. Most Hispanics in this country live in districts represented by Democratic members; and I was very disappointed that not one Democratic member highlighted Hispanics in this committee. And I hope that is going to change in the near future. Thank you.

Mr. BILIRAKIS. Thank you very much, sir.

Mr. BILIRAKIS. Ms. Rowland.

STATEMENT OF DIANE ROWLAND

Ms. ROWLAND. Thank you, Mr. Chairman and members of the committee. I am pleased to be here today. I am Diane Rowland, executive vice president of the Kaiser Family Foundation and director of the Kaiser Commission on Medicaid and the Uninsured. I also am an associate professor at Johns Hopkins University.

I am very pleased that you are focusing today on the 43 million Americans without insurance. We all know too well that it is not just a matter of being without insurance, but that going without insurance makes a difference in how you receive care and when you receive care and your ultimate health outcomes and financial burdens.

I think Mrs. Horsley has clearly pointed that out and dramatically pointed out to us who our uninsured population is and why it is such a struggle to figure out ways to provide coverage.

Sixty percent come from families with incomes below 200 percent of the poverty level, that is, an income of $26,000 for a family of

three. They are largely working families as you heard. Eighty-four percent come from families with a full- or part-time worker; 72 percent from families with full-time full-year workers.

What is happening in our insurance system is that the employer-based system that we have depended on for so long to provide basic coverage is falling short, and it is falling short especially for some of the lowest-wage workers.

Today if you look at the uninsured population, 70 percent of the workers without insurance are not offered coverage in the workplace. So for them, the only options are either to qualify for the Medicaid program or to turn to the individual insurance market, which is often extremely expensive and often has a lot of restrictive underwriting policies that may not even enable them to obtain coverage.

So affordability has become a very critical issue in our health insurance system. At $5,000 for family coverage, whether you are in a regulated or a nonregulated State, it is not going to be an affordable thing for a family earning less than $26,000 a year to purchase such coverage.

In the workplace today, only 55 percent of workers earning $7 or less an hour have access to insurance through their employer, in contrast to 96 percent of higher-wage workers earning $15 or more per hour. So we are clearly not making insurance available at the lower end of the income spectrum.

When we look at trends in insurance coverage, what we see in our robust economy is that there has been some improvement in employer offerings at the higher income levels and a continued decline in offerings at the lower income levels. Moreover, in this economy that we live in, the new jobs are being created not in the large firms and manufacturing base where insurance generally came with the job, but increasingly among the self-employed and among small businesses, really leading to the fact that our employment-based system is failing not because employers are not willing to offer insurance but because we are now seeing employment in different parts of that sector.

These trends are troubling, but they are even more troubling because our safety net providing coverage for the lowest income, Medicaid, is seemingly now beginning to erode its own coverage. In the last 2 years we have seen a decline of almost 2 million people covered by the Medicaid program.

I would also point out, as Mrs. Horsley did, that while Medicaid has made many advances, along with the CHIP program to cover more and more children, we have not made similar progress in extending coverage to the parents of those children or to other low-income adults.

The reason that half of the poverty population is not covered by Medicaid largely reflects the fact that single adults and childless couples are ineligible for Medicaid under almost all circumstances except for disability or pregnancy, and most children who are in the 13- to 18-year-old age group are not covered up to the poverty level yet.

So we need to really look both at who is eligible for Medicaid and how to extend coverage to the poorest population, including low-income adults. As you have all pointed out, we also need to look at

why people don't participate in the Medicaid program; why they don't know about the program; why they cannot get through the barriers to eligibility for the program and increasingly need to look at that for CHIP.

In the absence of Medicaid and in the fallback of employer coverage, we also need to look at what is available through the individual health insurance market, and a lot of the proposals on the table today would ask people to go out and buy insurance in the individual market. That market really has been a very limited market. It is extremely expensive and very variable across the States.

So I think in looking at the future, one ought to look at how to improve our coverage through the programs we have in place today, build on the CHIP program, make it and the Medicaid program more effectively able to reach out to low-income children, and consider how to expand that coverage to their parents.

No single incremental approach to restructuring and broadening health insurance coverage is likely to address the diverse needs of the 43 million uninsured Americans, but we can begin to build on the programs in place by making them more effective in trying to do better outreach. Thank you.

[The prepared statement of Diane Rowland follows:]

PREPARED STATEMENT OF DIANE ROWLAND, EXECUTIVE VICE PRESIDENT, THE HENRY J. KAISER FAMILY FOUNDATION AND EXECUTIVE DIRECTOR, KAISER COMMISSION ON MEDICAID AND THE UNINSURED

Thank you for this opportunity to offer testimony today at this hearing on America's growing uninsured population and the options to improve coverage. I am Diane Rowland, Executive Vice-President of the Henry J. Kaiser Family Foundation and Executive Director of the Kaiser Commission on Medicaid and the Uninsured.

Despite a strong economy and sustained economic growth with historically low levels of unemployment, the number of Americans without health insurance coverage continues to grow. My testimony today will provide a profile of America's uninsured population, discuss the factors contributing to the growth in the uninsured population, and review approaches to address this problem.

The Uninsured Population

Today, 43 million Americans—18 percent of our non-elderly population—are without health insurance coverage (Figure 1). Over the last decade, the number of uninsured people has grown by nearly 10 million. In 14 states, over 20 percent of non-elderly residents are without health insurance coverage (Figure 2).

The growth in the uninsured population reflects a decreasing share of Americans with employer-sponsored health insurance coverage as a worker or dependent of a worker. Among the 43 million uninsured Americans in 1997, 84 percent were from families with a full or part-time worker (Figure 3). Only 16 percent of the uninsured have no attachment to the workforce. Until recently, expansions in Medicaid coverage of children and pregnant women helped to offset some of the decline in employer -sponsored coverage, but new data show Medicaid's role may now be declining—further fueling the growth in the number of uninsured. The recently enacted Children's Health Insurance Health Program (CHIP) offers new assistance, but is limited to children.

Medicaid and coverage policy for the low-income population is a significant factor affecting the size of the uninsured population because most uninsured people are from low or moderate income families. Over a quarter (28%) of the uninsured are from families with incomes below the poverty level and nearly a third (30%) are from families with incomes between 100 and 200 percent of poverty (Figure 4). Thus 6 in 10 of the uninsured come from families earning less than $26,600 for a family of 3—families that can ill afford to purchase an individual insurance policy costing $5,000 or more per year without financial assistance.

Medicaid provides assistance for some of the lowest income Americans, but Medicaid coverage for the non-elderly is directed primarily at coverage for children and some of their parents, most notably pregnant women. Single adults and childless

couples are ineligible for Medicaid no matter how poor unless they meet the disability criteria or live in one of the few states with a waiver permitting broader coverage. As a result, Medicaid covers only 44 percent of the poor and 16 percent of the near-poor, leaving a third of the poor and near-poor uninsured (Figure 5).

Although Medicaid's coverage of the near-poor is limited by its eligibility criteria, many working families do qualify for Medicaid. About half of Medicaid's nonelderly beneficiaries (low-income, working age adults and children) are in working families. In 1995, 18% of Medicaid's nonelderly beneficiaries were in families where the family head worked full-time and full-year, while 34% were in families where at least one adult worked part-time or part-year.

Factors Contributing to the Growth in the Uninsured

While Medicaid helps to provide some protection to the poorest Americans, it is employer-sponsored coverage that provides health insurance protection for most Americans. However, the employment based health insurance system has never covered all workers and their families and in the past decade its reach has declined.

Most uninsured workers do not have health insurance coverage because they are not offered health benefits. Over 70% of uninsured workers, and consequently their families, are not offered job-based health coverage, either through their own or a family members' jobs. Although most (53%) of uninsured workers are in full-time, full-year jobs, they are often employed by firms that do not offer health benefits to any of their employees (frequently smaller firms). Others are self-employed or not eligible for benefits in their firm because they are part-time, temporary, or new employees.

When offered health benefits by their employers, 85% of employees choose to participate in their employer's plan. Of the 15% of workers who declined to participate in their own employer's plans in 1997, most have an alternate source of coverage—a family member's employment-based health insurance, a second job, individual health insurance or coverage from Medicaid or Medicare. Only 3 percent of eligible workers elected not to participate in their employer's plans and remained uninsured.

Lack of employer-sponsored coverage is particularly a problem for low-paid workers who are also less likely to have health insurance as a fringe benefit then higher-paid workers. Only 55% of low-wage workers ($7 per hour or less) have access to job-based coverage through their own job or a family member's job, compared to 96% of higher-wage workers (above $15 per hour) (Figure 6).

Despite substantial costs, most low-wage workers participate in employer's health plans when they are available. Seventy-six percent of low-wage workers enroll for coverage compared to 94% among higher-wage workers (Figure 7). The percent of low-wage workers participating in their employer's plan has declined over the last decade, most likely due to the increasing share of insurance cost now being borne by workers themselves. As a result, only 42% of low-wage workers have employer-sponsored health coverage, compared to 90% of higher-wage earners (Figure 8).

Coverage declines have led to a widening gap between low-and high-wage workers. Low-wage and less-educated workers have borne the brunt of recent declines in employer-sponsored health insurance. Between 1987 and 1996, the gap in health insurance coverage rates between low-wage and higher-wage workers increased as coverage for the lowest paid fell markedly from 54% to 42% with coverage at the same time as coverage for the highest paid increased from 87% to 90% of workers (Figure 9).

Low-wage workers fared poorly for a number of reasons. As the cost of health insurance outpaced consumer prices generally, employers began to restrict eligibility for health benefits and also increased the share of premiums workers were required to contribute. This affected low-wage workers disproportionately, particularly because their real hourly wages have been declining while more-skilled workers have had an increase in real wages. In addition, employment has been shrinking in sectors that have historically provided better wages and benefits (in goods-producing industries) while growing in sectors that have typically provided lower wages and fewer benefits (e.g., service industries) (Figure 10).

More of the new jobs being created in our economy today are in small businesses rather than the large manufacturing firms of earlier times. These small firms are less likely to offer health coverage. Nearly half of the nation's 25 million uninsured workers in 1997 were employed by firms of less than 25 workers (Figure 11).

Although most workers do participate in employer health plans when they are offered, affordability is a major issue. Almost all employees are required to contribute to employer health premiums and for low-wage workers these costs can be prohibitive. Health insurance premiums have increased rapidly in the past decade and the share covered by workers has also increased.

Workers' average monthly contributions for single and family coverage rose steadily between 1988 and 1996 as workers paid a larger share of higher premiums. In fact workers' contributions rose more rapidly than premiums as employers shifted more of the costs of health insurance to workers, especially for non-family coverage. While average premiums for non-family coverage rose an average of 7.5% per year between 1988 and 1996, employees' contributions rose much more rapidly-increasing by 18.3% per year.

Workers in large firms pay, on average, $348 per year for worker-only coverage and $1,476 per year for family coverage in 1998. Those in small firms pay a larger share ($468 for worker-only coverage and $2,328 for family coverage annually). For low-income families, their share of employer-sponsored health insurance costs may consume over 10% of family income. For example, a family income of $20,000 from a job in a small business can make the employee contribution of over $2,300 unaffordable even though the employer has contributed toward the overall cost of the family policy.

The gap in health insurance coverage between low- and high-wage workers has widened in recent years, despite low unemployment and a dramatic slowdown in the growth rate of health insurance premiums. An economic recession or a marked increase in health premiums could result in a further decline in job-based health coverage. The gap between low- and high-wage workers' health coverage could grow even wider—further increasing the number of uninsured.

These trends are particularly troubling when coupled with recent evidence showing that Medicaid's role as safety net for the low-income uninsured may be eroding. After steady growth during the past decade, particularly for low-income women and children, Medicaid is now experiencing a fall-off in enrollment. Medicaid coverage of adults and children declined in 1996 and 1997, reflecting, in part, changes resulting from welfare reform. Prior to 1996, individuals covered by the AFDC welfare program were automatically eligible for Medicaid coverage. The welfare law eliminated the enrollment link between Medicaid and welfare. Families leaving welfare, as well as those receiving benefits under TANF, may still be eligible for Medicaid, but are not necessarily being enrolled. Individuals who leave welfare to go to work are likely to be employed in low-wage jobs that do not offer benefits, including health insurance.

For most families without access to employer-sponsored coverage or Medicaid, the individual health insurance market offers little promise. High premiums and, in many states, fairly restrictive underwriting practices make individual policies unaffordable, especially for those with modest incomes and health problems. For example, a 60 year old widow earning $20,000 annually could face health insurance premiums that exceed $300 per month, or nearly 20 percent of her income. Those with serious health problems could either be denied coverage altogether or face substantially higher premiums. The well documented problems of the individual health insurance market suggests that this source of coverage is unlikely to meet the needs of the growing uninsured population.

The Importance of Insurance Coverage

The growth in the uninsured population would not be a problem of significant magnitude if having health insurance did not make a difference in access to care or affordability of care. But, health insurance does matter; it affects access to health care, health outcomes, and the financial well-being of families. It also affects the health care providers and institutions who struggle to provided needed care to the uninsured without the resources to finance the care delivered.

The uninsured get care later, often get less care, and in many instances suffer adverse health outcomes as a result of delayed or foregone care. By all the standard measures of impaired access to care, the uninsured fare worse than those with insurance. One in 5 uninsured children have no regular source of care, and uninsured children are 30% more likely to fall behind on well-child care and 80% more likely to never have had routine care than children with insurance. Uninsured children are at least 70% more likely than insured children not to have received medical care for common conditions like asthma—illnesses that if left untreated can lead to more serious health problems.

Over half of uninsured adults have no regular source of care. In addition, 55% of uninsured adults say they have postponed care and a quarter have not filled a prescription in the past year—because they could not afford it (Figure 12). Uninsured adults are also four times more likely than the privately insured to say they have not received medical care they believed to be necessary and less likely to use preventive services like check-ups and mammograms.

Because their primary health care needs are not addressed, the uninsured are more likely than those with insurance to be hospitalized for conditions that could

have been avoided, such as uncontrolled diabetes. The uninsured are also less likely to have a procedure that is relatively costly or where physicians exercise a great deal of discretion.

Medical bills mount quickly if a person is uninsured. Over a third of adults who are uninsured report they have had a problem paying their medical bills in the past year. Fear of these debts is an important reason why many of the uninsured do not get the medical care they need.

Approaches to Broaden Coverage

Because so many of the uninsured are from low-income families, the success of any policy to expand health insurance coverage largely depends on how well it addresses the barriers to health insurance faced by the poor and near-poor. Recent efforts have targeted expansions to low-income children, but low-income adults remain particularly vulnerable—often falling outside the reach of either Medicaid or private employer-sponsored insurance.

Today, expanded coverage of children is a national priority. Expansions in public programs in the past have improved health coverage of low-income children, beginning with mandated expansions of Medicaid coverage in the late 1980s calling for a phase-in of Medicaid coverage for all children in families below the poverty level by 2002. With the enactment of the Child Health Insurance Program (CHIP) in 1997, States are provided additional resources to broaden coverage for children through Medicaid or a separate program.

The key to improved coverage of children is to translate the availability of insurance into actual enrollment in Medicaid and CHIP for low-income children. Of the 11 million currently uninsured children, nearly 43 percent are believed to be eligible for Medicaid but not currently enrolled (Figure 13). Another quarter (27%) of uninsured children are now potentially eligible for health insurance under the new CHIP program. Finding improved ways to make families aware of these benefits, simplify the enrollment process and reduce barriers and stigma are critical to reducing the number of uninsured children and realizing the full potential of Medicaid and CHIP. Children account for nearly a third (31%) of the 25 million low-income people without health insurance (Figure 14).

Extending Medicaid coverage to more low-income adults is equally important. Broadened Medicaid coverage and CHIP are essential steps to improving coverage of children, but 17 million low-income adults are uninsured and beyond the reach of existing programs. While Medicaid eligibility for children and pregnant women is tied to poverty levels, adults only qualify if they have dependent children or are disable and fit the stringent income standards for cash assistance. Since 1994, the number of families receiving cash assistance has declined markedly and with welfare reform in 1996, many adults (and their children) eligible for Medicaid coverage have been lost from the Medicaid rolls.

One approach to broaden coverage beyond the current efforts for low-income children would be to permit states to expand Medicaid to cover the parents of children eligible for Medicaid or CHIP. These low-income parents account for a third of the uninsured low-income population (Figure 14). Covering both low-income children and their parents through Medicaid or CHIP could insure ⅔ of the low-income uninsured population—8.5 million adults and 8 million children. Childless low-income adults, traditionally outside Medicaid's scope, account for the remaining third of the low-income uninsured.

Affordability is a critical issue for families with limited resources when facing premium costs for health insurance that often exceed $5,000 per year for even a modest policy. For those above Medicaid eligibility levels, experience tells us that for low-income uninsured people coverage is affordable only if a subsidy is available to cover the majority of the insurance premium. The effectiveness of direct subsidies or tax-deductions or credits to help finance coverage will be directly related to the share of the premium covered.

The structure of tax-based approaches to broaden coverage are not particularly well-suited to the needs of the low-income population. Because the tax system is retrospective, it is difficult to provide financial assistance up front to low-income people so they have the resources to purchase insurance. Some workers may be able to adjust their withholding and eliminate end of the year reconciliation, but managing these adjustments provides added complications for families and may reduce willingness to participate. A prospective system like Medicaid or CHIP provides families with guaranteed coverage for a defined period of time based on current or prior income and thus is more manageable as an approach for most low-income families.

Approaches that focus on providing incentives or financial assistance to enable the uninsured to purchase health insurance directly also require reliance on the individual insurance market for the insurance products. The individual market as cur-

rently structured does not provide affordable coverage for people with on-going health conditions. Broadening coverage through individual purchase of health insurance necessitates reform of the individual health insurance market to assure that people who are sick have access to meaningful and affordable assistance.

Conclusion

Health insurance matters for the millions of Americans who lack coverage. Decisions made by the uninsured to delay or forego needed care because of its cost, coupled with health providers who tend to order less or different treatments for patient's without coverage, ultimately can lead to poorer health outcomes. Extending coverage to the million of Americans without insurance is an important policy and health objective.

No single incremental approach to restructuring and broadening health insurance coverage is likely to address the diverse needs of the 43 million uninsured Americans. However, substantial progress can be made by improving outreach and participation in current efforts to provide health insurance to children through Medicaid and CHIP and by extending the scope of Medicaid to reach more of the 17 million low-income uninsured adults. These improvements coupled with efforts to maintain and extend employer coverage, especially for low-wage workers, will help to stem the erosion in coverage and establish a foundation for health insurance for all.

Thank you for this opportunity to testify today. I welcome any questions.

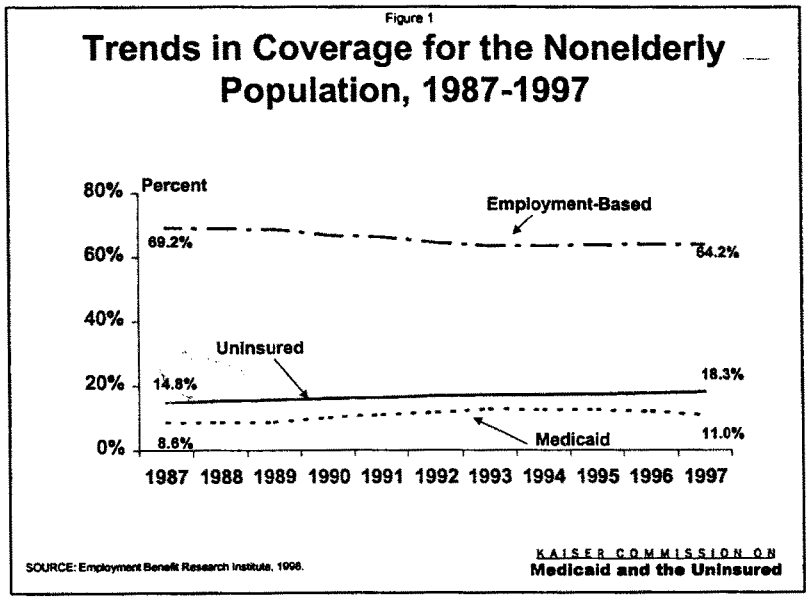
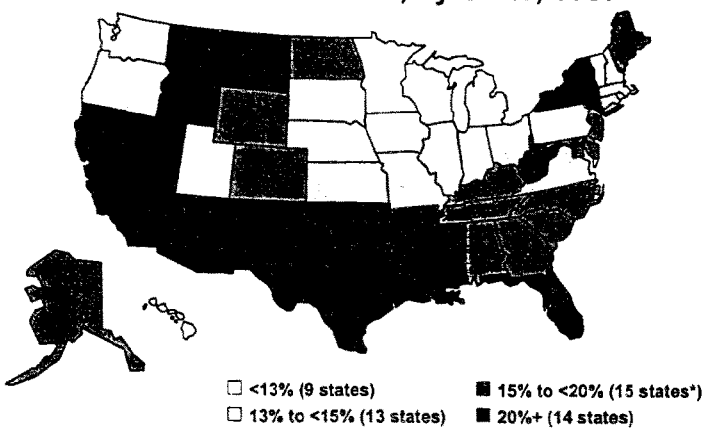


Figure 2

Percent of Nonelderly Population with No Health Insurance, by State, 1997



* Includes the District of Columbia
SOURCE: Employee Benefit Research Institute, 1998.

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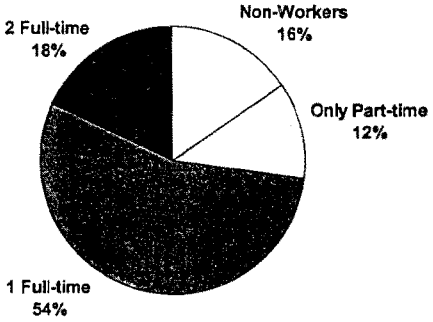
Figure 3

Profile of the Nonelderly Uninsured by Family Work Status, 1997



Total = 43 Million Uninsured

SOURCE: Urban Institute estimates of the non-elderly population based on the March 1998 Current Population Survey.

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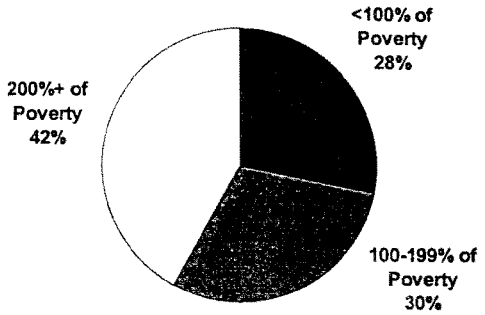
Figure 4

The Uninsured Population by Poverty Level, 1997



Total = 43 Million Uninsured

SOURCE: Urban Institute estimates of the non-elderly population based on the March 1998 Current Population Survey.

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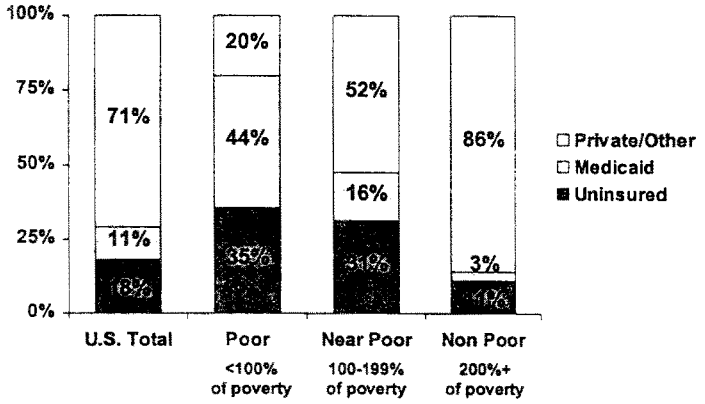
Figure 5

Health Insurance Coverage by Poverty Level, 1997



SOURCE: The Kaiser Commission on Medicaid and the Uninsured (analysis of the March 1998 Current Population Survey).

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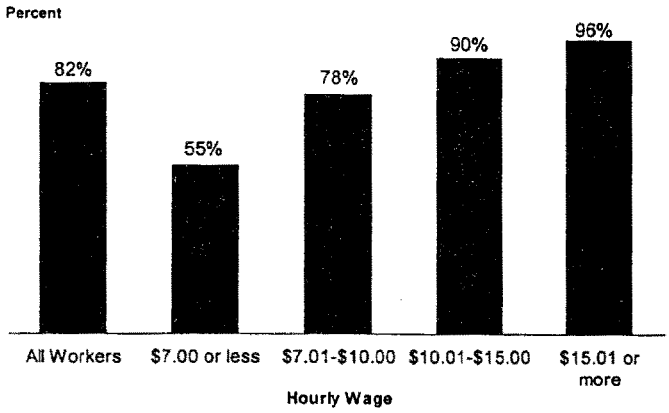
Figure 6

Workers with Access to Employer-Sponsored Health Insurance, by Wage, 1996*



* Percent of workers offered coverage from own or family member's employer.
SOURCE: Cooper and Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987-1996." *Health Affairs* 16 (November/December 1997): 145.

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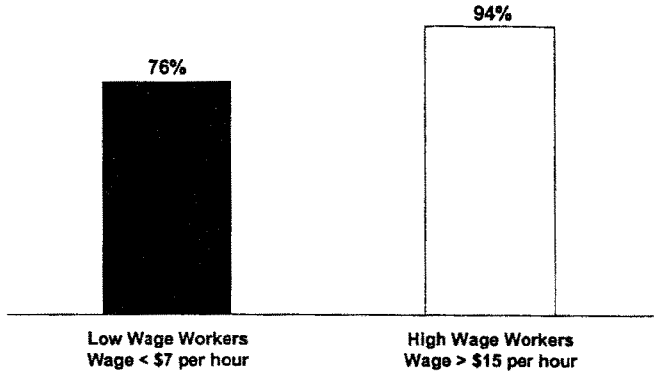
Figure 7

Family Take-Up Rates*

Low Wage and High Wage Workers, 1996



* Percent of workers who participate in any job-based health insurance available to them -- through their own employer or that of a family member.
SOURCE: Cooper and Schone, 1997

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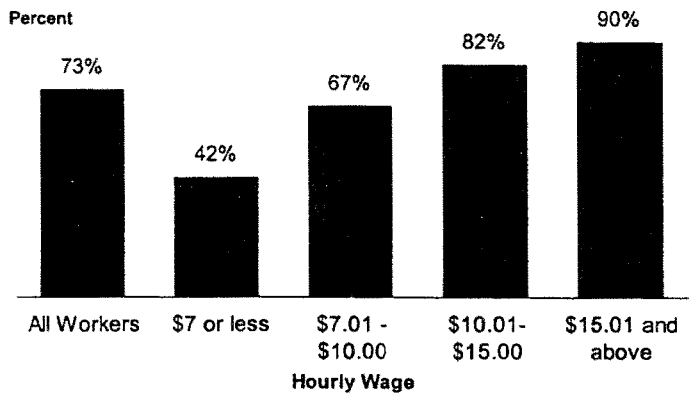
Figure 8

Workers With Employer Coverage, by Wage, 1996



SOURCE: Calculations based on Cooper and Schone, 1997.

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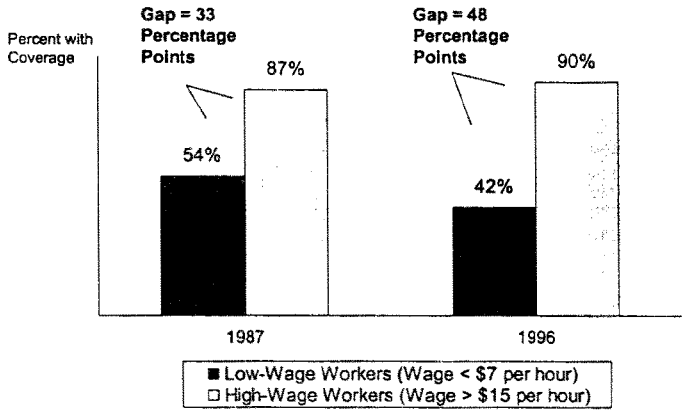
Figure 9

Gap in Employer-Sponsored Health Insurance Coverage High-Wage vs. Low-Wage Workers, 1987-1996



SOURCE: Calculations based on Cooper and Schone, 1997.

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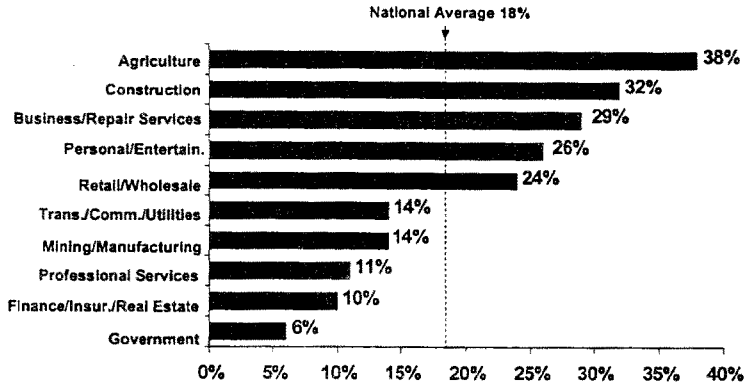
Figure 10

Percent of Uninsured Among Workers Age 18-64

By Type of Business, 1997



SOURCE: The Kaiser Commission on Medicaid and the Uninsured (analysis of the March 1998 Current Population Survey).

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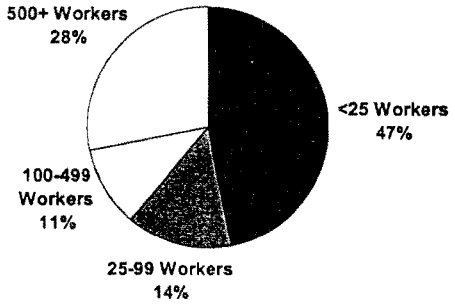
Figure 11

Profile of Uninsured Workers Age 18-64

By Size of Business, 1997



Total = 25 Million Uninsured Workers

SOURCE: The Kaiser Commission on Medicaid and the Uninsured (analysis of the March 1998 Current Population Survey).

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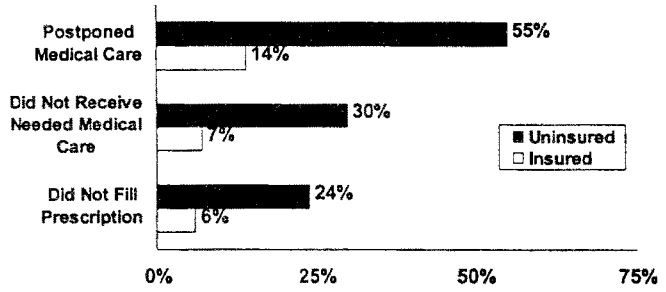
Figure 12

Percent of Adults Who Postponed or Did Not Obtain Needed Care in Past Year



SOURCE: Kaiser/Commonwealth 1997 National Survey of Health Insurance.

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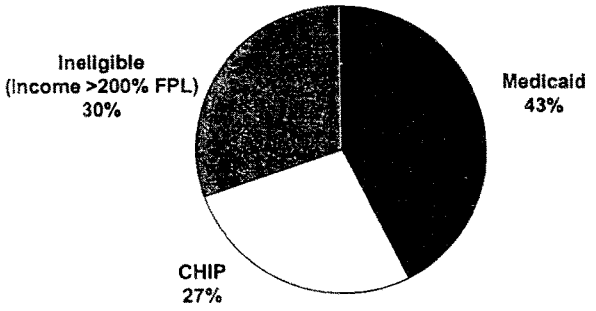
Figure 13

Uninsured Children Eligible for Medicaid or CHIP, 1994-1995



Total = 10.6 million uninsured children

SOURCE: Urban Institute estimates, 1998.

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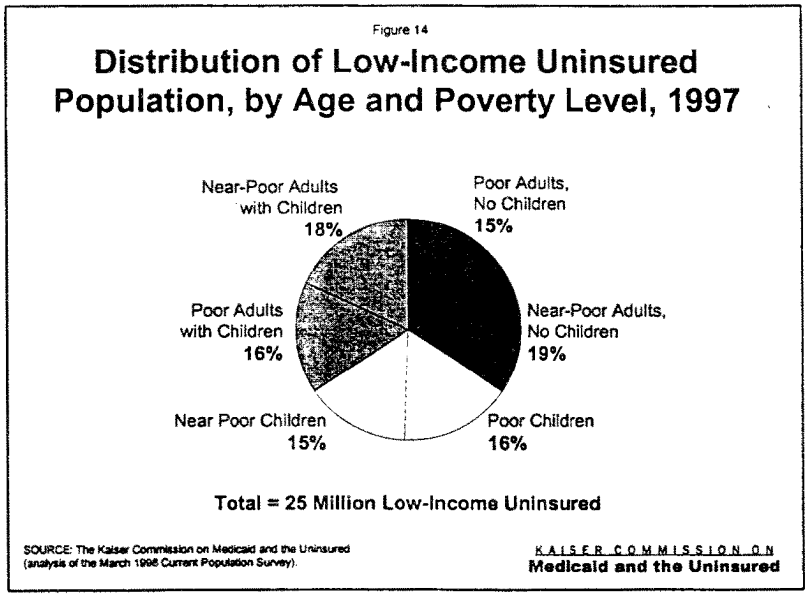

Mr. BILIRAKIS. Thank you, Ms. Rowland.

The Chair yields to Dr. Ganske to start the inquiries.

Mr. GANSKE. I thank the panel. I appreciate the comments of all of you, but particularly Ms. Rowland your comments on Medicaid and CHIP because it ties in with my comments at the beginning. And yours Mr. Garcia de Posada. I would add another reason why I think that there are a large number of people who qualify for Medicaid that are not in it and that is bureaucratic government red tape. For example, in California, you have to fill out a 25-page application for Medicaid. That is for people who can barely read many times. In fact, frequently English is their second language. So, look, why can we not simplify that?

In Texas, you have to apply in person at the Department of Health and Human Services, which is usually not very easily accessible. It is usually well off the beaten track, and if you show up you don't have all of your papers, you have to come back another day.

Just to show that I can be fair, as I mentioned in my statements in Iowa, my own State, to add insult to injury, the application isn't only long, but it is difficult to understand, and you have to report your income each month. I think those are all things, Mr. Chairman, that we ought to be looking at, in addition to I think we ought to hold a hearing—a hearing in conjunction with oversight with Mr. Upton and look at why isn't CHIP being implemented better? Why do we have such a large percentage of the poor who qualify for Medicaid not getting the message? Why are they out there without it?

I would like to work with you and Mr. Upton in organizing that. Maybe sometime we could also look at why insurance companies haven't pushed medical savings accounts as well.

But I have to go back to some comments that I made originally and that has to do with the factor of risk selection and ideas such as association health plans and multiple employer working associations.

The American Academy of Actuaries had this to say about MEWAs. In a letter to Congress June 1997 they wrote: While the intent of the bill is to promote health association plans as a mechanism for improving small employers' access to affordable health care, it may only succeed in doing so for employees with certain favorable risk characteristics. Furthermore, this bill—in reference to the Republican bill—contains features which may actually lead to higher insurance costs.

And just to expand on this, you know, in any year about 10 percent of any large population group accounts for about 70 percent of the medical expenses of that group. If you oversimplify, that means that if an insurer that is contemplating insuring 100 people can avoid covering just one of the 10 people that will be the sickest, the insurer can save approximately 7 percent in total medical claims. If the insurer can identify and exclude half of the people who will be sick, that is 5, the insurer can further reduce claims cost by 35 percent.

That is the easiest way insurers have to keep their premiums down to attract new business to make profits. And any small groups with below-average risk have then strong incentives to seek out an insurer that will group them with other below-risk groups and charge them a lower premium.

The problem is that when those healthier people leave that larger insurance pool, the rates remaining for those in the pool will rise. And although those remaining in the pool will have higher risks, there will still be differences in those with lower risk. You are going to end up, in my opinion, with a potential to do harm rather than good.

Mr. Chairman, I just have to use my time to make this comment, and that is that there is an old saying: Those who don't know history are bound to repeat it. Now look at what happened. Under court interpretations of ERISA in 1974——

Mr. BILIRAKIS. Please finish your point.

Mr. GANSKE. State insurance officials can't regulate health coverage provided by self-insured employers. That regulatory loophole created a lot of problems with association health plans. In the 1970's and 1980's, hundreds of thousands of people, Mr. Chairman, were stranded without coverage and providers with unpaid fees, because of unscrupulous entrepreneurs whose only incentive was to make a quick buck. If you don't believe it, read Carl Polser's article, "Preempting state Authority to Regulate State Association Plans." It is in National Health Policy Forum, 1997.

And, Mr. Chairman, those rash of failures led in 1983 to an amendment to ERISA which gave states authority to regulate those self-insured MEWAs. That has helped prevent some of the problems. I am afraid that we are looking at legislation that is going to go back to the problems that we saw in the 1970's and 1980's with those association health plans. I don't know if anyone on the panel has any comment on that or not.

Mr. BILIRAKIS. The gentleman's time has expired, and I would rather yield now to Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. Ms. Arnett, I apologize. I have never heard of the Galen Institute. Can you tell me who funds you?

Ms. ARNETT. We have a number of donors. We have individual contributors; we have some foundation funding, and some company support. It is very diverse. We are a new think tank.

Mr. BROWN. What is your annual budget?

Ms. ARNETT. About $178,000.

Mr. BROWN. Do you get more than $50,000 from any one think tank or individual or company?

Ms. ARNETT. We have a large grant from the Robert Wood Johnson Foundation to produce a book. So, yes, we do. We produced a book called Empowering Health Care Consumers Through Tax Reform. It is a publication composed of articles and chapters by members of the Consensus Group, which is a free-market think tank community comprised of members all the way from the Heritage Foundation to the Progressive Policy Institute and the Urban Institute.

Mr. BROWN. Could you give to this committee, or at least to me, your funding sources?

Ms. ARNETT. Of course.

Mr. BROWN. Ms. Arnett, in the absence of regulation you seem to think that the cost of health insurance, the overwhelming part of the increase, is because of mandates and regulations. In the absence of regulations, if there was object regulations that prevented insurers from dropping individuals when they became especially ill, do you think insurers would voluntarily keep those individuals on the roll?

Ms. ARNETT. I think we need to rethink the whole system of how people get health insurance. If people think in terms of being insured for periods of months, then I think the likelihood of this game plan——

Mr. BROWN. Wait, wait, wait. I only have 5 minutes. If there were not regulations saying that insurance companies could not drop people when they were sick, if we could get all of these burdensome onerous regulations off the backs of the American people that you suggest, do you think those insurance companies could act that way?

Ms. ARNETT. I think that the insurance companies should have to abide by contract enforcement, and I believe that individuals should have the opportunity to contract with their insurers for coverage that would not be dropped when they are sick——

Mr. BROWN. So the insurance companies with very expensive lawyers and individuals buying insurance that don't read contracts quite as well and probably can't afford to hire lawyers quite as good as the big insurance company have and that is still an even match? You still want to put that in the marketplace with no government involvement?

Ms. ARNETT. Contract enforcement or government rules and regulations, those are two choices. Right now we see what happens with Medicare when we have 111,000 pages of regulation governing the Medicare system in order to get people to do the right thing.

If we had contract enforcement that was much more effective and people had health insurance that they owned and kept over a long period of time that they owned themselves, I believe that there would be more market discipline on those companies to provide continuity of care and not to lose the public relations war that they would have if they saw that. If insurance companies dropped people when they got sick, they would not get any more business.

Mr. BROWN. Ms. Rowland, do you want to comment on that?

Ms. ROWLAND. The problem with insurance is that it is not a permanent thing that you can own like an automobile or something else. It is something that is offered on an annual basis by a company. And as my own small business, the Kaiser Family Foundation, experiences every year we have different companies pulling in and out of the market. And so we have some regulation of insurance in California. But we have no guarantee that our policy in any given year will cover the same benefits for the same premiums.

So I think, clearly, you need some protections for consumers in any market in which the insurer has the ability to pull out. And just as Mr. Ganske talked about, if you can pull out when there is a high-risk person in the pool or you can change the premiums there, then we really have a system in which instead of insuring people for illness, we take the sick out of our insurance market.

Mr. BROWN. I would contend it is not really insurance then. Ms. Arnett, you mentioned government regulation over and over, that that is the problem. No mention of insurance company executives' salaries. No mention of the drug company profits, the hugest profits of any industry in America, I believe. Again, it is all government regulation.

Yet one of the most unregulated industries in America, unregulated in terms of price, is the drug companies; $22 billion in profits last year. That is what is driving a big part of health care inflation. What am I missing? With no government regulation, can you blame huge drug company profits, huge drug company price increases? Can you blame that on government regulation?

Ms. ARNETT. No. This hearing is not about drug company prices. I am not an expert on this issue. It is a very large industry. I do think that there is an awful lot of invisibility of cost in the system and a lot of undisciplined costs. Because the market is so disconnected, because consumers are isolated from the full cost of the purchases, because it is such a shell game with costs being passed from one person to another, from employers to insurance companies to the taxpayer to uncompensated care.

Mr. BROWN. Sorry to interrupt and I know that the time has run out—except ironically in the place with consumers are most connected with the industry without any insurance company between them or any place else, is drug pricing. And the consumers in the free market have no real ability to say no to this drug, I will get something else, unless it is a generic drug, and that is where prices have gotten so out of control.

Ms. ARNETT. I would hope that that would be a subject for a hearing of another day.

Mr. BROWN. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Mr. Bryant will inquire.

Mr. BRYANT. Thank you, Mr. Chairman. I want to thank the panel and especially Ms. Horsley for your testimony. Let me just ask a couple of questions, Mr. Garcia de Posada. It has been discussed that the Hispanic segment of our population is uninsured for a number of reasons. I think there are other people out there that are uninsured for the reasons that you highlighted in addition to Hispanic people, and that is low income people and small employers.

I know that it has been suggested that we change the tax laws and give complete 100 percent deductibility to self-employed individuals. And I know Mr. Shadegg has a provision in his bill that he suggests a tax credit to individuals for their health insurance coverage. Would that be beneficial?

Mr. GARCIA DE POSADA. Absolutely, because part of the problem, aside from the issue of understanding and public information and outreach to this community, you cannot ask—and I am a big supporter of tax credits—but you cannot ask an individual making $12,000 to wait until the end of the year to then collect the money to be able to pay because you have to pay it as time goes on. And I think whether it is a refundable tax credit or whether you allow the individual or self-employed people who are buying insurance outside of the market to be able to deduct it 100 percent you are going to be giving an incentive for them to actually get in the process.

In preparation for this testimony, I talked to a lot of our members who have small businesses, and many of them do provide insurance, but they have a hard time providing it. And they are trying to identify ways their employees can get access to it in an affordable way. So I think definitely Mr. Shadegg's bill would be very helpful.

Mr. BRYANT. Let me ask the panel in general, comments on this argument about HealthMarts and risk segmentation occurring. Anyone have a response to that as a problem to HealthMarts? No one wants to jump in on that one?

Ms. ARNETT. It is my understanding that the next panel is going to be talking about that more. I think we were more prepared to talk about access and the uninsured.

Mr. COBURN. Will the gentleman yield?

Mr. BRYANT. Certainly I will yield.

Mr. COBURN. A statement was made a minute ago, and I can't just let it go to say that the Federal Government hadn't created an inducement for high-priced drugs is ludicrous. It costs $400 million to get through the bureaucracy and testing on average for a drug in this country, about twice what it should cost, because of the FDA. In spite of the FDA, we still have the best drugs. And I am not defending the profits. Don't get me wrong. I think there is tremendous greed in the drug industry. But to not recognize that we have created a false nonmarket through FDA rules and regulations is ludicrous.

Mr. BROWN. Would the gentleman yield on that?

Mr. COBURN. It is not my time to yield. I would like to finish my point. The fact is that we do have great drugs, and we do have safe drugs; but we could have more of them and we could have them less costly. There is a drug out there right now, a Premarin sub-

stitute, that the FDA will not allow approval. Not on any good scientific basis, but on some type of political favor basis. And, therefore, we have women paying two and three and four times for what they should be for estrogen supplementation simply because of some bureaucratic decision to do a power play and a favor for someone. Don't tell me that drugs don't cost more because of bureaucracy in this country. It is not true. I yield back, and I thank the gentleman for the time.

Mr. BRYANT. I would yield to the gentleman.

Mr. BROWN. Thank you. I appreciate that very much. I would not dispute that totally that the cost of—that the FDA in protecting the public tends to keep for a while, keep the drug company's drug off the market for some period while the research is done to protect the public. But I would also remind the gentleman that some of us went to NIH last week, and you can see the kind of research that government does with our tax dollars; and we all support a doubling of the NIH budget. The chairman has shown great leadership on that in the last 3 or 4 years. And a good bit of the research that is done for those drug companies is done by taxpayers.

So the subsidy there works both ways that we clearly as a Congress have decided as a tax policy that we should spend taxpayer dollars to do a lot of basic research that these drug companies can then turn around to use to help the public and to make profits. And I think we have made that decision, but let's not let the drug companies off the hook is saying that we are not helping them in that way too. And I know that the gentleman from Oklahoma has worked on this.

Mr. COBURN. I would be happy to work with you to make sure that some of those dollars come back to the taxpayers.

Mr. BILIRAKIS. Mr. Dingell to inquire?

Mr. DINGELL. Thank you, Mr. Chairman. These questions first for Ms. Rowland. Ms. Rowland, the study with regard to the—that was referenced here by the Galen Institute, isn't it fair to say that some of the States they used could be significantly affected by other events like a large employer pulling out of the market?

Ms. ROWLAND. In general, in reviewing the study that was done by Heritage and the Galen Institute, one would have to look at the fact that in these studies we typically do what we call multivaried analysis where we control for a variety of factors. This is just looking really at one variable, rather, State regulation.

And you are exactly right, there could be a number of other factors that explain the deficiency between the States and a study should really take into account all of those factors.

I could make an association between the number of Republican versus Democratically controlled legislatures and the number of uninsured and that would be an equally flawed study.

Mr. DINGELL. I would think you could also, for example, deal with weather too.

Ms. ROWLAND. You could.

Mr. DINGELL. Am I fair?

Ms. ROWLAND. The other thing I think that should be pointed out is that the rate of uninsurance in the states with regulation was somewhat lower than in the states without reforms, although they experienced a somewhat greater increase over the time, and I think

it really points out how complex what shapes any State's uninsurance rate is. It depends at any given time on the economy, on the nature of the jobs in the economy. Motorola, as you said, can pull out of one state and take with it a large part of the insured base.

Mr. DINGELL. Now, let's go to another thing. Would it be fair to inquire, did the study examine the effect of specific reform on the populations when those—and what those reforms were intended to address? Did the study examine specific reforms compared to coverage rates in the larger market which include markets that these insurance reforms did not affect?

Ms. ROWLAND. Well, my understanding of the study—and I am not the author of the study—was that it really looked at the changes in the rate of uninsurance in the State in contrast to the implementation of a number of legislative reforms, some of which may have had little to do with the insurance changes.

Some of them may very well have been directed almost exclusively at giving people coverage for existing prior conditions through insurance pools, and you would not have picked up those kind of changes in the broad aggregate statistics being used in the study.

Mr. DINGELL. Was there any effort to relate the questions to the events that were studied?

Ms. ROWLAND. In my reading of the study, it was looking at it State by State, but it was not looking at some of these other events or really categorizing the nature of some of the legislative changes.

Mr. DINGELL. Now, I gather that the study then considered data on covered populations which state reforms cannot and do not reach; is that correct?

Ms. ROWLAND. Well, it would be on the broad—it included both those in ERISA plans as well as those in general plans and obviously state regulation at this point doesn't reach people with ERISA——

Mr. DINGELL. I was going to come to the question of ERISA plans as well as the large group market. Would you want to comment on that?

Ms. ROWLAND. I think my major comment would be that I think there are more intensive ways of examining the questions that the study proposed and that future work should really look at a wide variety of the variables that influence whether or not a State has an increase or a decrease in the number of uninsured.

Mr. DINGELL. Would you want to define your opinion of the study? Would you rely on this study as a piece of accurate academic research?

Ms. ROWLAND. I would say it needs a lot more work to be a piece of academic research.

Mr. DINGELL. So in your estimation, what kind of effects have market reforms had on coverage?

Ms. ROWLAND. I think the effects of market reforms on coverage have been extremely mixed. I think in many places they have helped to increase the number of people with preexisting conditions who have access to an insurance pool. And I think in other places we have seen, in New York and other places, community rating has

caused some increase in premiums. So I think you really need to look at really very carefully the effects in individual States.

Overall, market reforms have helped to protect people from some of the abuses identified especially in the individual insurance market. But they have also come with some costs associated.

Mr. DINGELL. I think my time has expired. Thank you very much.

Mr. BILIRAKIS. Thank you. Ms. Arnett, would you care to follow up on the ranking member's questioning regarding your study which you did not have an opportunity to speak to?

Ms. ARNETT. Thank you, Mr. Chairman. We looked at the six variables, identified by the General Accounting Office in two different studies, as the most common insurance regulations that were being enacted by the States, including community rating, guaranteed issue, guaranteed renewable, portability, et cetera, to look at the impact of those six provisions that were so generally accepted as being able to help people access affordable health insurance.

So we looked at the States that had done the majority of those provisions. Every State was different; every state implemented them differently, we looked in aggregate to begin to see what was the overall effect.

And when we saw that in the first year after all of those provisions were in effect in the 16 States doing the analysis, perhaps the majority of them, we found their uninsured rates were increasing eight times faster than other States.

That told us that perhaps there is evidence that we need to look further at the impact of those reforms. Absolutely, we should look further at the impact of those regulations whether or not they really are, in fact, helping people as they were designed to do.

Mr. BILIRAKIS. Thank you, Ms. Arnett. Mr. Garcia de Posada, among Hispanics there is a disproportionate share of the uninsured. There are a lot of reasons for that, I suppose. One of the reasons that has been suggested—and I would like to get your comments on that—is because of the reluctance of many to seek out government assistance programs which they may be eligible for. You have heard that mentioned by members up here and witnesses on your panel. Any comment on that?

Mr. GARCIA DE POSADA. Well, I think that you are dealing with—particularly with the very poor, you are dealing with possibly a foreign-born immigrant population that does not understand the concept of health insurance or the concept of government helping you in these areas. You are starting from there, and that is why Mr. Ganske's comments about trying to reach out are so critical and I think that is one of the reasons that that the community-based associations could be very helpful in trying to reach out because they have much closer ties to these communities.

Aside from that, I think the whole debate last year over legal, illegal, et cetera, scared a lot of people. They do not understand what they can apply for and what they cannot apply for. And it is sad to say that the whole issue of immigration was demagogued beyond belief in a way that legals do not understand that they do have access to a lot of these programs.

Once again, whether you use language, whether you use how hard it is to reach out to these programs, I think those are things that need to be addressed because they are critical factors.

Mr. BILIRAKIS. There is only so much that government can do. Don't you think that much of that can be done and should be done, with some assistance from us, through your Hispanic coalitions or organizations.

Mr. GARCIA DE POSADA. Absolutely.

Mr. BILIRAKIS. For instance, years ago—God rest his soul, our former Florida Governor who was then a United States Senator—and I worked together on the infant mortality problem. We came to the conclusion that it was terrible in the United States. No question about it. We came to the conclusion we had the resources, but we could not get the resources to the people who needed them, that they were just not making themselves available.

And so, we came up with mobile vans and ways to bring the resources there.

Mr. GARCIA DE POSADA. I completely agree with you. I think that the onus should be placed on organizations or groups like mine to be able to go to these communities and to promote this effort. It shouldn't be government. However, I think government has a role maybe in starting to provide that first assistance or that little push so that associations and groups do go out there and start promoting this.

Mr. BILIRAKIS. Will you communicate with us, this committee, ideas that you may have? Because whatever we might be able to do along with you—and it can't be done without your help—is also going to be available to other minority groups. And I know what you are saying about the language problem. I am Greek American, and we have experienced the same problems.

Mr. GARCIA DE POSADA. And the institutions are in place. We don't have to reinvent the wheel. The community-based organizations are there.

Mr. BILIRAKIS. Any ideas that you have, please communicate them with us so that we may take those into consideration. Ms. DeGette.

Ms. DEGETTE. Thank you. Ms. Horsley, I especially appreciate you coming to talk to us today about your family situation. I know it is always hard for individuals. I have relatives myself who have had these struggles with health insurance, so I appreciate it.

I don't mean to pry, but if I could ask you just one more question. You said that you and your husband made about $13,000 last year. Do you recall how much you paid in Federal income tax?

Mrs. HORSLEY. Actually, every year changes a little bit as far as our income. Every year it changes according to what we are making too. Last year we may have earned just a little bit more. This year we may not earn that much. Last year I was working say 6 weeks in the summer. Also we had a brief separation, and I worked 2 months in Richmond. So——

Ms. DEGETTE. Do you have an idea, roughly?

Mrs. HORSLEY. We don't pay much tax. We get pretty much all of our tax refund back. We have the earned income credit.

Ms. DEGETTE. So you really are not paying any Federal taxes. You get it back.

Mrs. HORSLEY. Not really. I think we are getting most of our taxes back.

Ms. DEGETTE. Mr. Garcia de Posada, in your testimony you said that what would help low-income working Latinos and others like Ms. Horsley would be tax incentives for individuals, either tax credits or vouchers. And I certainly think that is a tool we could use.

But the concern I have is for people who are working with low incomes, they just don't pay that much tax. Therefore, there is not that much you could give back to them. I am wondering for someone like Ms. Horsley, who would have to pay $5,000 a year in insurance premiums, how is that tax voucher system going to work exactly?

Mr. GARCIA DE POSADA. Well, I mean, from her check there is money being taken in the withholding.

Ms. DEGETTE. But she gets that back at the end of the year because her income is not high enough. What is the added benefit to her for the $5,000 in premiums that she is going to have to pay to get private insurance.

Mr. GARCIA DE POSADA. Maybe government should look at people like her, and there should be that extra incentive.

Ms. DEGETTE. What would it be.

Mr. SHADEGG. Would the gentlewoman yield?

Ms. DEGETTE. Not right now. Let me finish.

Mr. GARCIA DE POSADA. Well, there should be—whether it is a voucher program——

Ms. DEGETTE. But she is not losing that money to the government now. She gets all that back.

Mr. GARCIA DE POSADA. Maybe she should get the money.

Ms. DEGETTE. She does. She doesn't pay taxes.

Mr. SHADEGG. Will the gentlelady yield?

Ms. DEGETTE. Just a minute, please. Now, I have been struggling with this for a long time, particularly with uninsured kids. I think we should eliminate government red tape, and I think we should do tax credits if they work, for someone who makes $13,000 a year and would have to pay $5,000 in insurance premiums, I just don't see how this would work.

Mr. GARCIA DE POSADA. Well, I am sure you could not pay at all because of the level which she is at. I think if we start instituting some kind of assistance whether—I mean, specific programs where they can get some additional benefit or some additional source of income to do that, through the government tax system it is worth looking at.

Ms. DEGETTE. Let me make one more comment to you, sir, which is, I am always saddened and dismayed when a witness or another Member of Congress makes a purely partisan comment as you did in this hearing today, because many us do not believe that providing insurance benefits for lower-income Americans is a partisan issue. And, in fact, I have got a bill, H.R. 827, which I would ask Dr. Ganske to look at, because of his concerns about CHIP and Medicaid. This is the bill I introduced on a bipartisan basis. We have Democrats and Republicans on the bill.

The goal of the bill is to get the States to look at more streamlined administration of the CHIP bill and Medicaid program so we

could get the 9 million uninsured kids in this country into some kind of insurance program. All of us on this committee, while we might think of different approaches, believe that low-income Latinos, of which I represent many, low-income African Americans, Anglos, everyone in this country regardless of race or ethnic background ought to have health insurance.

Mr. GARCIA DE POSADA. But it is a problem that is disproportionately affecting my community. And I think it is—people like Mr. Green and yourself who have very large community constituency within your district, this is something that should be highlighted.

Ms. DEGETTE. Sir, believe me, we do. And it is not helpful to make partisan remarks.

Mr. SHADEGG. Mr. Chairman, I would like unanimous——

Mr. BILIRAKIS. You are up next.

Mr. SHADEGG. I would first like to ask unanimous consent to extend the lady 1 additional moment.

Mr. BILIRAKIS. I would rather not do that because unfortunately we have a large panel coming up. But you'll have an opportunity. We do have votes on the floor too as a matter of fact. But the Chair will yield to you now for your time, John.

Mr. SHADEGG. Thank you, Mr. Chairman. I just would begin by pointing out to my colleague from Colorado that under a refundable tax credit, as in my legislation which is currently being looked at by the committee as perhaps a committee mark, a refundable tax credit means the taxpayer would get cash back even if they owed no tax.

So, for example, in Miss Horsley's case, if she had no income tax liability, she and her family would nonetheless get dollars from the government, affirmative dollars, out of the government to go buy a health insurance policy.

Ms. DEGETTE. Will the gentleman yield?

Mr. SHADEGG. No, I will not, because you didn't yield to me, and I have got a lot points I would like to make. I would like to begin with Mrs. Horsley and talk about her particular situation. Mrs. Horsley with her husband and one child is right at the Federal poverty level with a three-person family. The Federal poverty level is 13,650 for a family of three.

She indicates in her testimony that her health care coverage she was quoted would cost her about $400 a month. I simply want to point out some aspects of the legislation we are considering which would be a value to you. The first one is it provides tax equity and that is it is a refundable tax credit which would mean dollars in your pocket to go buy health insurance coverage. We think you should have that.

We think it is very important that it is unjust that the government today subsidizes someone who does the same job as your husband, but whose employer offers him health care coverage. We subsidize that by allowing the employer to deduct the cost of the coverage and to say to the employee that it is not income. But for you, we force you to go out and use after-tax dollars, which you obviously do not have, to buy your own health care.

So a refundable tax credit like is in our legislation I think would give money in your pocket to go buy health insurance.

I would like to point out that the alternative was discussed on the other side of aisle. For example, expanding Medicare clearly will not help you. There is no one in your family eligible for Medicare. And while expanding Medicaid might help because your income level is such that if it were to rise to simply 1.2 times the Federal poverty level you would not be eligible for Medicaid assistance either so that wouldn't do you a lot of good.

So I do believe that we can help you by, for example, getting you some coverage through this refundable tax credit by association health plans, HealthMarts, or individual membership associations. For example, right now you can't join a health insurance plan sponsored by your church or by some other organization you belong to. When you don't get employer coverage, you don't have the chance to do that.

As the testimony indicated from the gentleman from the Hispanic Business Roundtable, we ought to make it possible for your church to sponsor a plan for you or for any other voluntary association that you belong to.

I would also like to point out that the legislation the committee is looking at and that the committee chairman is considering at least as he looks at his mark, would include high-risk pools. That would put you in a position where your husband, even if you were excluded as a result of a prior condition, would be able to participate.

But I do want to tell you that last night after looking at your testimony we went on the Internet and went out to look for some policies that might be available to you. We found two categories of policies on an Internet Web site set up by Dr. Koop, the former surgeon general.

Looking at high-deductible policies, we found 16 different policies that would cover you and your family and would have been able for you to get coverage at prices as low as $78 a month, which would have meant the refundable tax credit in our legislation would have fully covered the cost of your health care other than the high deductible and the copayments which you might have to pay.

We also looked at lower deductible in the range of $1,000 to $1,500 deductible and we found 48 different policies in a range of $76 to $180. You would not be able to afford the higher end of those, but when I listened to the testimony with regard to question of your husband's preexisting condition, we looked back at those policies and we found, for example, in the high-deductible policies there was one available from, I believe it is Fidelity Security Life Insurance Company, currently available with a premium of $88 a month. And while they do exclude preexisting conditions—they specifically exclude cancer. However, they specifically do not exclude a preexisting condition of skin cancer.

So that would be a policy that you may want to look at, and you might want to talk to my staff about when we finish this hearing.

Mr. Garcia de Posada, I want to thank you for your testimony. In Arizona I have a significant Hispanic proportion throughout the State, and I am very concerned about them being able to get coverage. I certainly agree with the points in your testimony and want to just point out that our legislation, the legislation the chairman

is looking at, first of all we do do equality and equity between employer-based health care insurance and consumer-based health care coverage. We create the tax incentives so that employer-sponsored coverage doesn't have the only subsidy. And I think we can work that into the system.

I also appreciate your support of HealthMarts. I think HealthMarts would help Mrs. Horsley quite extensively.

Mr. Chairman, obviously I have a series of other questions and points to make which, perhaps, I will get a chance to in the second round.

Mr. BILIRAKIS. Well, I am not sure we are going to have a second round or not. We will play that by ear. But we do have a vote on the floor. So we will break for half an hour, maybe give us a chance to grab a fast sandwich on the run. The panel is unfortunately not discharged, though. We appreciate your patience. But there will be people returning who I know will want to ask you questions. Thank you.

[Brief recess.]

Mr. BILIRAKIS. Okay. We will come to order. Our apologies to the panel and to the audience. We appreciate your patience. Let's see. We finished up just before the break with Mr. Shadegg. So Mr. Barrett. You are on, sir.

Mr. BARRETT. Thank you, Mr. Chairman. I thank you for allowing the panel to return and apologize to the panel also for put putting you to the inconvenience of having to sit through that vote.

I want to sort follow up on some the questions pertaining to the tax credit notion to make sure that I have an understanding where we are on it, because it is certainly an intriguing proposition.

Again, Mrs. Horsley, my understanding is that your family income is in the $13,000 to $14,000 range. You do benefit from the earned-income tax credit. So I am frankly assuming that you might have, in essence, a negative income tax that you might, in fact, be receiving money from the Federal Government. Is that correct? Do you recall?

Ms. HORSLEY. I think we have some income taxes just, you know, what is taken out in the income credit is above that. So we do get a pretty good refund. We usually get—I think we got $1,100 back this spring.

Mr. BARRETT. And Mr. Garcia de Posada, if I am pronouncing your name correctly, your testimony or some of your questions and answers to Ms. DeGette's questions indicated to me that you support a refundable tax credit; is that correct?

Mr. GARCIA DE POSADA. Correct.

Mr. BARRETT. At what level? In other words, we have a situation here where Mrs. Horsley pays little, if any, in Federal income tax. She might have a negative income tax in terms of getting a refund under the income tax credit. Would you tack this directly on top of that?

Mr. GARCIA DE POSADA. Absolutely. I think we need to figure this out. I couldn't come here and tell you specifically what level or what amount, but I think this is something that is worth looking at because it is something that is very much needed. And it is something that if we are going to look at a cost effectiveness from the government investment this is definitely an area worth doing.

Mr. BARRETT. And Ms. Rowland, I think that you have some misgivings about that approach. Can you share those with us?

Ms. ROWLAND. Well, I think a tax credit approach works the best for those that are able to pay out for the purchase of the insurance policy and then get assistance at the end of the year or through the withholding system. My concern is for the lowest income part of the population, those like Mrs. Horsley, they may not have the cash on hand to purchase the insurance policy in the first place; and, therefore, the tax credit would have to be very, very substantial for them to be able to afford $5,000. So a $1,000 tax credit against a $5,000 insurance policy would not provide the level of assistance that she would need to be able to purchase that kind of coverage.

Mr. BARRETT. So your opposition, if I can use that phrase or that word, is not philosophical as much as it is logistic?

Ms. ROWLAND. My concern is that it is not as workable an approach for people with lower incomes as it is for people with higher incomes.

Mr. BARRETT. What would you propose instead?

Ms. ROWLAND. Well, I currently think the Medicaid program can be improved, especially for children at the low income of the economic spectrum. We need to make the program more affordable and more workable, we need to reach more children through that approach. And I think for some of their parents like Mrs. Horsley it may make more sense to extend coverage through that vehicle than through a tax credit where she would have to go purchase insurance in the individual market.

Mr. BARRETT. So you would build off the CHIP program?

Ms. ROWLAND. The CHIP and Medicaid program.

Mr. BARRETT. What are your comments?

Ms. ARNETT. Thank you, Mr. Barrett. The chart over here is a depiction of exactly this problem. Where, if you look at the vertical axis—it is on page 8 of my testimony—the taxpayer subsidies for health coverage, and the horizontal access is income, it really does show the two choices we have.

If somebody makes enough—is poor enough, the likelihood of being on some sort of Federal aid——

Mr. BARRETT. I understand the graph. What is your point then?

Ms. ARNETT. Either we can move toward expanding that, filling that gap of 43 million uninsured disproportionately $20,000 to $40,000 income, by expanding more government programs or we can look at the right side of that chart to where so many people that have job-based health insurance get very generous tax breaks.

Mr. BARRETT. So what is your proposal?

Ms. ARNETT. So my proposal is let's look at it in providing direct tax assistance to those who completely are shut out of the equation right now. They make too much to qualify for public programs, and they make too little to get good job benefits.

Mr. BARRETT. How do you respond to Ms. Rowland who says it is a logistic problem?

Ms. ARNETT. The National Health Underwriters Association has done a lot of work—they have been studying this problem for about 10 years—to figure out how you actually deliver assistance to people so that they can purchase the health insurance in real time. And they have done some excellent work on that issue. The dif-

ficulty lies in the refundability of the tax credit and getting it to people in time in order to be able to purchase health insurance and to make it generous enough so that it really does provide a big enough part of the premium.

Mr. BARRETT. But you are still not saying how we deal with the logistic problem of a person who has a very low income. Giving them $5,000 in April or May of the year 2000 doesn't help them with their health care needs in 1999.

Ms. ARNETT. But it doesn't have to be done annually. It could be either advanced so the premium could be paid all at once; or it could be done monthly. There are a lot of different ways. It is complicated to deliver it, but it is no more complicated than Medicaid.

And the National Association of Health Underwriters has done a lot of really good work about the delivery mechanism so it doesn't have to be refunded at the end of the year, but it could be provided in real time.

Mr. BILIRAKIS. The gentleman's time has expired, but it is a point that has been made by others; and I think it is a very meritorious point. And my understanding is that, as Ms. Arnett says, refundable tax credit doesn't necessarily mean lump sum the following year; that it can be done in incremental basis. And Mr. Shadegg may or may not be returning, but I believe that that is his intent.

Mr. BARRETT. Thank you.

Mr. BILIRAKIS. Mr. Greenwood. I believe you were here first.

Mr. GREEN. Do you have a time problem?

Mr. COBURN. No.

Mr. GREEN. Thank you, Mr. Chairman. Everybody up here wants to solve the Horsley family problem. And it is a real problem. We want to solve it. And what we don't want to do is pass the law that we pass most often which is the law of unintended consequences and make matters worse for other folks.

And I think that the hardest part of this—and I hope some of the panelists would have some suggestions—is no matter how we—the only way to get her family, Mrs. Horsley's family insurance is for—somebody has got to pay for it. Because they don't have the income to pay for it.

And you can deregulate it as much as you want; it still isn't going to be a free—it still isn't going to be affordable. So somebody has to pay for it.

Now, if the taxpayers pay for it, whether they pay for it with, as Mr. Shadegg would, with a refundable tax credit or whether we pay for it by raising the level of Medicaid, the unintended consequence that we haven't figured out how to deal with is somewhere down the road. There is another shop employing other people at the same wages who is paying health care benefits.

And the guy down the street who isn't—who is paying health benefits is going to say to himself, when we take care of the Horsley family, well they ought to take that burden off of my shoulders then. Because if the taxpayers will pay for it, one way or another through a tax credit or Medicaid, why am I doing it? And I will just dump that.

So it becomes a slippery slope. And I think we are sort of afraid to pull that brick out for fear of the consequences.

So do any of you have any comments about how we fill the gap without creating more of an incentive for employers to drop coverage or disincentive, if you will, to provide coverage, thereby making the burden suddenly double or triple or quadruple? And if you can answer that question, you win.

Ms. ROWLAND. Well, in the world of mandates, one of the ways you prevent that from happening is you impose an employer mandate where employers are required to provide coverage to certain individuals or to maintain coverage. But that is in the world of mandates.

Mr. GREEN. It is convenient that the woman from the center is not here because she probably would disagree with that.

Mr. GARCIA DE POSADA. Well, I do too. Imposing more mandates on small businesses is not the way to do it. But I think that you do have some incentives in the tax system for an employer who can afford to provide health insurance. In some cases, taxwise, it is convenient for that employer to provide. And I don't think that employer will automatically drop somebody because it is also partly a tax benefit for him.

So, you know, that could happen in some instances, but it is not overwhelmingly the pattern that is going to continue. However, I think that ultimately if we are looking at the mobility that we have in the work force, that the idea of allowing self-employed or individuals who buy outside of the work to be considered the same, you know, to be able to fully deduct their wages, that is going to be also a——

Mr. GANSKE. Would the gentleman yield?

Mr. GREEN. Briefly.

Mr. GANSKE. I think another situation frequently occurs and that is that an employer will offer insurance but for the employees who are at the lower income scale in terms of his or her business, the employee then makes a choice that I am not going to take that benefit because I don't want to pay my share, cost share of it.

I think that Mr. Shadegg if he were here would probably make the argument that his tax credit could actually be considered a help to that individual to help them then manage their cost share of that individual insurance.

Mr. GREEN. Yes. Our other two witnesses.

Ms. HORSLEY. Well, something I just—I think I got on the e-mail through Families USA, I think, somewhere on the Internet, but is there a program that just came about in California where they have raised the minimum wage to $7 or $8 an hour and then enabled them to help pay for a State program in order for the individual to help?

You know, if my husband's wage was raised—and I know down in Newport News where they have been striking for like—you know, they want to be paid like $20 an hour, at the shipyards; and I think, my gosh, $20 an hour and he makes $5 something an hour or $6, somewhere around that, you know, just even the raise to $7 or $8 an hour would give him that much extra to be able to pay some on health insurance.

Mr. GREEN. Okay. Thank you.

Ms. ARNETT. It really is a cost issue. If people have money, some percentage of them—I think it depends on how much money it is,

we would have to do the demographics—will purchase health insurance. And one of the most important things about health insurance is pooling risk and having large pools.

And if the tax credits were directly targeted to individuals, then a large percentage of them are going to use that to purchase health insurance. So they are buying insurance rather than gaming the system as many do when they don't have subsidies, and they just wait until they get sick and purchase health insurance. And then the premiums go up. So getting people the money so they buy it is the critical factor.

Mr. BILIRAKIS. I thank the gentleman.

Dr. Coburn.

Mr. COBURN. I am reminded of President Clinton's statement talking about taxes. We can't give it back to you because you may not spend it right. And the philosophy is we can't give you a tax credit for your health because you may not make the right choice that we think you should make with your money. Isn't that ironic.

Dr. Rowland, what is the Kaiser Commission on the Future of Medicaid? And what is its mission statement?

Ms. ROWLAND. The Kaiser Commission on the Future of Medicaid was established in 1991 to do research and analysis on the Medicaid program and coverage to the low-income population. And in 1996 the commission was reestablished as the Kaiser Commission on Medicaid and the Uninsured.

It is a 15-member national commission chaired by James Hallon of New York. And the commission membership meets, reviews, and discusses the analyses prepared by the commission staff. And then they are policed.

Mr. COBURN. What is its mission statement?

Ms. ROWLAND. Its mission is really to look at health care coverage for the low-income population, the role Medicaid plays in covering the low-income population, and the extent to which Medicaid is meeting health needs and long-term care needs for low-income families, the elderly, and the disabled. So it really is a policy institute, and its mission statement is to look at how adequately low-income populations are covered today.

Mr. COBURN. It is not a federally funded commission.

Ms. ROWLAND. It is not federally funded, no.

Mr. COBURN. So part of it is to make sure Medicaid is meeting the needs that are out there for those that do not have health care and cannot get health care.

Ms. ROWLAND. Correct. It is to analyze the way in which the Medicaid program is operating in the 50 States and jurisdictions.

Mr. COBURN. In your history, you heard me make my statement about HCFA, which I make at every opportunity I get. You having been employed at HCFA, what is your thought of HCFA?

Ms. ROWLAND. I was employed at HCFA at its creation. At the time, I thought that the Health Care Financing Administration had an important role to play in trying to set standards for the provision of services under Medicare as it was charged by Federal legislation to try to implement the Medicaid program.

I think today it is struggling under a lot of different charges and different burdens, and it could do a lot of things better, and it could do a lot of things worse.

Mr. COBURN. And you also worked for this committee?

Ms. ROWLAND. I worked for this committee until 1991.

Mr. COBURN. What years did you work for the committee.

Ms. ROWLAND. I believe it was 1987 or 1986 to 1991.

Mr. COBURN. All right. I am sorry that Terry Neese isn't here and had to leave. She should have been the Lieutenant Governor of the State of Oklahoma and lost in a very close primary. But she has done great work for women business owners in terms of raising their issues.

But as the gentleman from Puerto Rico has stated, it is not just women business owners; it is small business. We are innately unfair in how we treat them, especially if they are unincorporated because we say you don't have any tax benefit that is equal to what we are going to give somebody who is incorporated.

I wonder if any of you all would offer any suggestions on things that—we have asked a lot of questions about what the studies have shown, and I tend to agree with most of what I have heard, especially from Ms. Arnett having known—with the knowledge that I continue to practice in a small community that has a ton of small businesses who cannot afford insurance for their employees. What else could we be doing? What else could we be doing? Yes, ma'am.

Ms. HORSLEY. Well, I did want to say that so much of what we have a problem with is trying to get coverage for hospital and specialized care. I do want to point out that the care we have on the Eastern Shore as far as basic care and going to the doctor for a checkup, we have the Eastern Shore Rural Health System, which I am very pleased with as far as what it provides my family. We can go to the doctor and get a basic checkup on a sliding scale. Now, I don't know how and what the State and Federal——

Mr. COBURN. It reminds me of a question I was going to ask you. So basically you are getting preventative care if you need; is that correct?

Ms. HORSLEY. Yeah.

Mr. COBURN. When you delivered your baby, did you have title 19 or Medicaid to assist with your delivery?

Ms. HORSLEY. At that time, I did have some insurance with Nationwide.

Mr. COBURN. Well, I guess I will yield back. I thank the chairman.

Mr. BILIRAKIS. Mr. Burr. I know you are on a roll, there, Tom. I was interested in some of the responses, but we have a panel of seven people coming up.

Go ahead, Richard.

Mr. BURR. Let me thank all of you, and I am going to be very brief because I think there is one thing that I do understand from today. Even if you—even if you drop health insurance and you capped drug cost, health care is not free. I mean, that is a reality and that in American society, businesses strive every day for new devices.

Pharmaceutical companies along with the help of NIH and many research teaching hospitals around the country strive to try to find the breakthrough for terminal and chronic illness toward which we have made a tremendous amount of progress. And somebody has

to pay the cost of that. And the American people want the best. They want the absolute best.

I watched a show last night that talked about a new 30-second CAT Scan—I think General Electric is the manufacturer—and it was used in trauma cases. And when that trauma victim comes in, in 30 seconds they have scanned the entire body, have a three-dimensional view. They know exactly where to go for what the problem is.

Dr. Coburn told me that in some cases it is eliminating angioplasty—or, excuse me, catheterization because of the option that exists. This is a good thing. But it costs something. It will make the cost of health care increase, but it also makes the quality increase.

And I think the reason that we hear about this is that a lot of members feel there is a disconnect between the cost and quality. I think, in fact, it is something that we should question. It is something we should look at. We should strive for new efficiencies if, in fact, they are available and, yes, we should get the Federal Government out of the way if, in fact, it is a hurdle or a contributor to that cost increase.

I was looking—Mr. Garcia, is he still here? I was looking at North Carolina. The Hispanic population of uninsured since 1998, 1999, has gone from 23.8 percent to 52.7 percent at a time when coverage by most definitions has doubled if not tripled for the population. And I think one of the questions that we should ask of you how much of it is a communication breakdown.

Mr. GARCIA DE POSADA. I think a good chunk of it is—and I think that a good part of it is a communications breakdown in the fact that a lot of these people, first, don't know about are not familiar with the process of buying health insurance.

I think a lot of people could not comprehend the government giving them some services when you are very poor, and they do not understand the concept of health insurance when you are a low-income worker.

I think we need to begin the process of communicating to them. That is why we are such strong supporters of the idea of equalizing the employer based on the individual purchase because that way we will start putting a lot more responsibility on the individual.

And if we start working in some of the community-based organizations and some of the associations to start participating and be responsible, I don't think that the government should be providing this all by itself.

I think there has to be a strong component into this program that has to be personal responsibility. And the individual working poor or middle income should be paying part of the cost because it is to their benefit. But I think the communication part is critical.

Mr. BURR. Ms. Rowland, how much of the cost of health care is the threat of litigation today? Have you looked at that?

Ms. ROWLAND. We haven't looked specifically at that. It is a share of the cost. But a lot of the cost of health care is, as you pointed out, are advances in technology and drugs and devices today—are the two largest contributors to most of the cost increases facing hospitals and a lot of the physicians' offices.

Mr. COBURN. There is an interesting study done by the University of Indiana—if I could just take a second, I think this is very insightful for everybody to know. They compared doctors who said I don't do any tests based on the threat of litigation to those who say, man, I am scared to death. But what they found is there is no difference.

They all do a bunch of tests because they are afraid they are going to get sued. The cost in 1989 in 1989 dollars was $33 billion just in unneeded tests on the basis of trying to document something that they knew they couldn't document. So you can extrapolate that is about $100 billion right now in terms of 1989 dollars. So it is significant.

Mr. BURR. One last question, Mr. Chairman, to Ms. Horsley. And if I don't state your position right, correct me. You don't want something for free. You just like to have a choice of something that fills the need at a price that is affordable. Is that an accurate statement?

Ms. HORSLEY. I would like to be able to afford something, yeah. But right now, I mean, we are in a situation that the only chance there is is this SLH. But we—in order to get by, we depend on my little bit that I bring in; and if I bring in any more, we won't get SLH again in July. I mean, that is how it is. I have to reapply in July.

Mr. BURR. You see your position as SLH; and I see it as SOL and I won't define it for you.

Ms. HORSLEY. That is the other thing in Virginia.

Mr. BILIRAKIS. Ms. Horsley you mentioned Rural Health Care. Was that a community health center?

Ms. HORSLEY. It is Eastern Shore Rural Health System Incorporated. And it is a series of clinics up and down in Northampton and Accomack Counties. In each little area on the Shore in those two counties there is a clinic. Now, I know—I think they do have one X-ray machine in only—although my doctor sent me to Shore Memorial which means it costs $223 for an X-ray.

Mr. BILIRAKIS. Did you have to pay that?

Ms. HORSLEY. I do. Out of my pocket. And I believe from their Web site, they are looking for a dentist currently so that they can include a dentist in their system. But as far as basic care though, you know, they do really well. Maybe not enough doctors. They provide a place for doctors to work at after they come out of medical school. So that some of their, you know——

Mr. BILIRAKIS. So you get the basic care there. Did you want to respond?

Ms. ARNETT. One last point and also to answer Dr. Coburn's question, all health care is local. And there are so many opportunities at the local level to provide access to care that are unique to those communities.

But the Federal Government by providing tax credits to the uninsured, refundable tax credits and also perhaps allowing some of the kid-care money to be able to—that is not being used now to be able to be targeted through vouchers and through tax credits that supplement at the State level would provide many more resources for people to be able to get access to the system and then allow the communities to supplement as well.

Mr. BILIRAKIS. All right. Well, we——

Mr. BROWN. I am not going to ask questions. I have a unanimous consent request.

Mr. BILIRAKIS. Okay.

Mr. BROWN. I have two letters that I would like to submit, one was to Congressman Norwood from the CBO about the issue of health insurance private premiums going up, is there any impact on the amount of coverage. And there seems to be no real evidence there according to these two things—I would like to enter into the record.

Mr. BILIRAKIS. Without objection.

Mr. BROWN. Third is a couple of people on the panel cited the Commonwealth Fund study, and I would like to point out one page that I would like to enter into the record and that is that Medicare beneficiaries of all of the providers of health care, the employer, Medicaid, and uninsured for that matter, the question of the number of people satisfied with health care services Medicare had the highest percentage of satisfaction. I think that is significant in light of sort of the tilt of this subcommittee hearing today.

Mr. BILIRAKIS. Without objection.

[The information referred to follows:]

Working Families at Risk: Coverage, Access, Costs, and Worries

The Kaiser/Commonwealth
1997 National Survey of Health Insurance

April 1998

The Henry J. Kaiser Family Foundation, based in Menlo Park, California, is an independent national health philanthropy and is not associated with Kaiser Permanente or Kaiser Industries. Established in 1948 by industrialist Henry J. Kaiser and his wife Bess, the Foundation focuses its work on four main areas: health reform/health policy, reproductive health, HIV, and health and development in South Africa. The Foundation also maintains a special interest in health care in its home state of California.

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MEDICARE: EXPERIENCES OF ADULTS AGE 65 AND OLDER COMPARED WITH WORKING-AGE ADULTS

Once adults reach age 65 or older they are almost all eligible for Medicare. As a result, a negligible proportion of the 65-and-older population are uninsured or experience gaps in coverage. In contrast to private health insurance or Medicaid, Medicare offers a standardized benefit with few changes over time that might trigger confusion over benefits or coverage.

The survey findings indicate that Medicare coverage contributes to improved health care and health insurance experiences. The access, cost and satisfaction experiences of adults age 65 and older were more positive than experiences of adults under age 65 or adults with other types of health insurance coverage. Medicare beneficiaries were less likely to report access or medical bill problems, more likely to rate their care and insurance experiences positively, and less likely to worry about their health care future.

Medicare's continuous health insurance helped support longer term relationship with physicians and reduce access barriers.

The contrast between the experiences of working-age adults and those age 65 or older—most of whom were covered by Medicare—underscores the importance of continuous health insurance coverage. More than half the elderly had the same doctor for five years or longer, compared with 41 percent of non-elderly insured adults and only one-quarter of uninsured adults or those with a recent gap in coverage.

Adults age 65 and older were less likely to report problems getting needed care or paying bills than working-age adults.

Twenty percent of all adults under age 65 had problems getting health care in the past year—primarily because of gaps in coverage—while only 7 percent of the elderly reported such problems. Likewise, only 7 percent of the elderly had problems paying their medical bills, compared with 18 percent of working-age adults.

Medicare beneficiaries were the most satisfied with their health care services, health plans and choice of physicians.

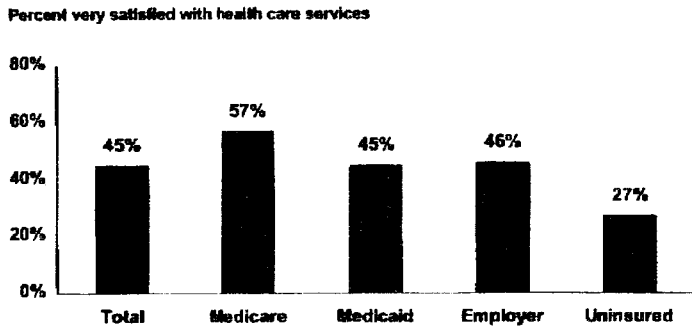
Overall, Medicare outscored other types of coverage of the under-65 population in terms of overall satisfaction. The majority of Medicare beneficiaries (57 percent) said they were "very satisfied"[1] with their health

[1] Possible responses included: very satisfied, somewhat satisfied, somewhat dissatisfied and very dissatisfied.

services, compared with only a quarter of the uninsured. An even higher proportion of Medicare beneficiaries rated their insurance and choice of physicians highly: two-thirds (64 percent) were very satisfied with their health insurance and three in four (74 percent) were very satisfied with their choice of doctors. Compared with those with Medicare, adults with job-based health coverage[1] and adults with Medicaid were far less likely to give top ratings to the care they received, their insurance or their choice of doctors.

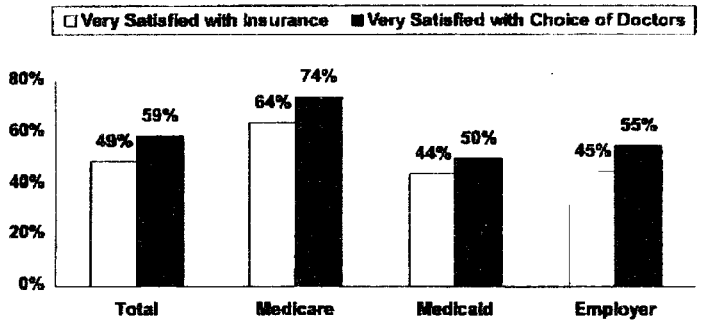
[1] Some adults surveyed had more than one type of insurance coverage. Adults with multiple types of insurance were assigned to one group. All adults age 65 and older with Medicare were assigned to Medicare. If under age 65, adults with Medicaid were assigned to Medicaid and adults with job-based coverage (and not Medicaid) were assigned to job-based coverage, although these adults might also have had Medicare. Adults under age 65 with Medicare were assigned to Medicare only if they had neither Medicaid nor job-based coverage.

Medicare Beneficiaries Were the Most Satisfied with Health Care Services



Adults age 18 and older

Medicare Beneficiaries Were the Most Satisfied with Insurance and Plan Choice of Doctors



Adults age 18 and older

Congressional Budget Office

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FAX TRANSMISSION COVER SHEET

Date:	*October 30, 1997*
To:	*Matt Keast*
Fax:	*5-0279*
Re:	*Increases in insurance premiums and extent of coverage*
Sender:	*Joseph R. Antos*

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A statement attributed to CBO that 200,000 Americans lose health insurance coverage for every 1 percent increase in premium cost appears to be a misinterpretation of work we did on the original mental health parity amendment (which was not passed). The 1996 analysis is attached. The first sentence of that paper states that the subject amendment would impose direct costs on the private sector equivalent to 4 percent of private insurance premiums. The paper goes on to explain the numerous ways in which those mandate costs might be absorbed, including increases in premium payments, reductions in the generosity of health insurance benefits, and reduced premium payments for mental health benefits for people losing or dropping their employment-based coverage. A paragraph on p. 4 indicates our imprecise estimate of 800,000 workers and dependents who might lose, or decide to decline, coverage. Our analysis is confined to the particular provision, however, and does not constitute a general statement on the relationship between cost and coverage. Other insurance mandates would affect costs and coverage differently than the provision in question. Only by analyzing a specific legislative proposal could anyone determine the potential coverage losses associated with a different mandate.

- Inpatient hospital days would be unlimited (compared with a typical limit of 30 days a year for mental health services).
- Coinsurance for inpatient hospital services would be 20 percent (representing no change from typical mental health coverage).
- Coinsurance for outpatient services would be 20 percent (compared with a typical coinsurance rate of 50 percent for mental health services).
- There would be no lifetime limits on covered benefits (compared with a typical lifetime limit for mental health services of $50,000).
- Out-of-pocket payments for mental health services would count towards the overall out-of-pocket limit.

The estimate defines parity in terms of service and spending limits, rather than in how care is provided. CRS assumed that insurers would continue to use current management techniques, including "carve-outs", to control utilization of mental health services.

Increase in Private Sector Costs

Under these assumptions, CRS estimated that the premium increase for an indemnity plan that incorporated mental health parity would be 5.3 percent. Because the CRS estimate was confined to the impact of parity on indemnity plans, CBO lowered the increase to 4.0 percent to reflect the prevalence of managed care plans in the employer-sponsored health insurance market and the significant savings in mental health spending that managed care plans can produce relative to indemnity plans. Thus, in aggregate, CBO estimated that the parity amendment would impose direct costs on the private sector of 4 percent of private health insurance premiums.

Responses by Employers

Most employers offering health insurance coverage to their workers could face additional costs as a result of the mental health parity amendment. Data on employment-based plans from the Bureau of Labor Statistics (cited by Coopers and Lybrand, L.L.P, in a study of the effects of the parity amendment) indicate that almost all employment-based plans offered some mental health benefits in 1991, but less than 2 percent of them had parity for outpatient coverage of mental health services.

Employers could respond to those additional costs in a variety of ways. They could lessen the impact on health insurance premiums by reducing the overall generosity of their health insurance benefits or by dropping mental health coverage. Some employers might cease to offer health insurance to their workers altogether. Any remaining increase in premiums would most likely be passed on to workers in the form of lower wages or reductions in other fringe benefits.

Projections of the relative magnitude of the possible responses are, inevitably, speculative. The best studies of the effects of mandates on health insurance coverage have large margins of error associated with their estimates. Some empirical questions, such as the degree to which other components of health benefits would be dropped in response to a mandate about a specific component of coverage, have simply not been addressed by academic studies. Nonetheless, we can provide estimates of the plausible magnitudes of various responses, albeit with a high degree of uncertainty.

For calendar year 1998, CBO estimates that the parity amendment would impose direct costs of $11.6 billion on the employment-based insurance market—costs that we assume would ultimately be borne by workers. Based on our assumptions, we estimate that the additional costs would be allocated in the following ways:

- $6.7 billion in additional premium payments for people who continued to have employment-based coverage;
- $4.8 billion in reductions in health insurance premiums attributable to less generous health benefits; and
- $80 million in reduced premium payments for mental health benefits for people losing or dropping their employment-based coverage.

Most of the $6.7 billion in additional premium payments would come from increased contributions by employers, with the remainder being employees' contributions. Employers would shift their additional costs onto workers in the form of lower non-health compensation (cash wages and other fringe benefits.) Non-health compensation for workers who continued to have employment-based coverage would be reduced by almost $6 billion, or by about 0.15 percent of what they otherwise would have received.

Employers would also reduce the generosity of their health insurance benefits by about $4.8 billion in 1998. Reductions in coverage generosity could encompass moving toward more restrictive forms of managed care, increasing cost-sharing requirements, restricting or dropping other benefits, or dropping mental health coverage entirely (if permitted under applicable state laws).

If employers took no action to reduce the generosity of benefits, annual premium would rise, on average, by approximately $190 per policy or $95 per covered person. The reductions in benefit generosity would offset those increases, however, so that the net increase in premiums would average about $110 per policy or about $55 per covered person.

CBO estimates that the parity requirement could result in 400,000 fewer workers (800,000 fewer workers and dependents) having employment-based coverage than otherwise. But those estimates are highly uncertain because of the large margins of error in the study on which they are based. (Indeed, the possibility that the parity amendment would have no effects at all on the number of covered workers is within the margin of error.) Had those workers continued to have coverage, their premiums would have risen by $80 million, reflecting the additional costs attributable to mental health parity. By dropping coverage, the $80 million in mental health parity costs would be saved. CBO assumes that the affected workers would receive the equivalent of the premium contributions formerly made by their employers as additional non-health compensation.

Effects of Existing State Benefit Mandates

Many states currently have mandates requiring insurers to provide or offer mental health coverage. According to the most recent data from GAO, 15 states require insurers to cover mental health benefits, 23 require insurers to cover alcoholism treatment, and 13 require insurers to cover drug abuse treatment. In addition, 16 states require insurers to offer at least one plan with mental health coverage, 16 require insurers to offer alcoholism treatment, and 10 require insurers to offer substance abuse treatment. Specific requirements under those mandates vary considerably from state to state. Thus, the effects of mental health parity on insurers and employers could vary significantly by state.

In general, employers with fully-insured plans could not drop mental health, alcoholism, or substance-abuse treatment in states where the corresponding mandates apply. These employers would have fewer options open to them than self-insured plans, which are not covered by state benefit mandates, and employers in states with no mental-health-related mandates. Employers not affected by state mandates could choose to drop all mental health coverage in order to avoid the parity requirements, although it seems unlikely that many employers, other than small firms, would choose that option.

In states that require insurers to offer a plan that provides mental health (or alcoholism or substance abuse) coverage, insurers may already be experiencing adverse-selection problems between plans that do and do not have mental health

coverage. That is, people who believe that they will need to use mental health services are more likely to purchase policies offering mental health coverage, thereby pushing up the premiums for such plans. If more employers sought policies without mental health coverage to avoid premium increases induced by the parity requirement, the result could be somewhat greater adverse selection among health plans in the future.

The behavioral response of employers, regardless of whether they were affected by state benefit mandates, would depend critically on whether use of managed care "carve-outs" and other managed care techniques could continue and expand under the parity requirement. If those options were precluded by legislation, CBO's cost estimates would be substantially higher.

Severe Mental Illness

Information is limited on the differences in the costs of coverage for the severely mentally ill as compared to those with less serious mental health conditions. Research conducted by Richard Frank at Harvard University suggests that patients with severe mental illness, defined as schizophrenia, manic-depressive disorder, and depression with a history of hospitalization, may account for 40-60 percent of all mental health care costs. The high end of that range reflects experience in Medicaid programs, whereas the low end of the range may be more likely among the privately insured population.

To our knowledge, the only estimates of the costs of the mental health parity provision that attempt to distinguish between different levels of severity are those conducted by Milliman and Robertson, Inc. Using a somewhat broader definition of severe mental illness than did Professor Frank, that firm concluded that premiums would increase by an average of 3.9 percent if the parity amendment covered all mental health conditions, compared with 2.5 percent if severe mental illness only were covered. We are unable to evaluate those estimates because the Milliman and Robertson report provides little information about its data sources or estimation techniques. We do, however, have concerns about the effectiveness of a policy to limit the parity provisions to treatment of certain specified diagnoses, because of the incentives providers would face to "upcode" less serious diagnoses to meet the parity provisions.

Mr. BILIRAKIS. It is interesting that Medicare even had a higher degree of satisfaction than Medicaid; and Medicaid is considered to be a higher quality program in terms of the benefits.

Thank you so much. I think you can see how much help you have been. You have been very patient. There will be questions from the panel to you in writing. I know Dr. Coburn and others didn't get an opportunity to go into it deeper. So we would appreciate your responding to those in a very quick time because we are on a quick path here. Thank you very much.

I would ask panel two to come forward. Dr. Daniel H. Johnson, president of the World Medical Association; Mr. Raymond Arth, Phoenix Products, Inc., on behalf of the Council of Smaller Enterprises; Mr. Robert M. Morehead, area president of Gallagher Byerly, Inc., of Englewood, Colorado; Mr. Richard Carlson, the executive director of the Illinois Comprehensive Health Insurance Program from Springfield, Illinois; Ms. Christine Baumgardner, executive director for the Alcona Health Center, Lincoln, Michigan; Mr. Len Nichols, principal reserach associate of the Urban Institute; and Mr. Jack Meyer, president of the Economic and Social Research Institute based here in Washington, DC.

Ms. Baumgardner and gentlemen, welcome. We again appreciate your patience sitting there for what is 3-plus hours. Your written statements, which have already been turned in to us, are a part of the record. And the Chair will give you 5 minutes to supplement them or read them if you wish, whatever the case might be.

We will kick it off with Dr. Johnson, president of the World Medical Association.

STATEMENTS OF DANIEL H. JOHNSON, JR., PRESIDENT, WORLD MEDICAL ASSOCIATION; RAYMOND ARTH, PHOENIX PRODUCTS, INC., ON BEHALF OF COUNCIL OF SMALLER ENTERPRISES; ROBERT N. MOREHEAD, CEBS, AREA PRESIDENT, GALLAGHER BYERLY, INC.; JACK A. MEYER, PRESIDENT, ECONOMIC AND SOCIAL RESEARCH INSTITUTE; CHRISTINE BAUMGARDNER, EXECUTIVE DIRECTOR, ALCONA HEALTH CENTER; RICHARD W. CARLSON, EXECUTIVE DIRECTOR, ILLINOIS COMPREHENSIVE HEALTH INSURANCE PROGRAM; AND LEN M. NICHOLS, PRINCIPAL RESEARCH ASSOCIATE, URBAN INSTITUTE

Mr. JOHNSON. Thank you, Mr. Chairman. My name is Daniel H. Johnson, Jr., M.D. I am a practicing diagnostic radiologist from Metairie, Louisiana; and I would like to express my appreciation for the opportunity to testify.

I would like to summarize the written testimony that I have submitted as follows. We have three things: a significant problem, a need for change, and, in my view, a remarkable opportunity. I would like to emphasize, Mr. Chairman, that I am testifying as an individual, not representing any organization, despite the current and previous activities that are listed.

Mr. BILIRAKIS. So you are not testifying on behalf the World Medical Association.

Mr. JOHNSON. No, I am not. I am here as an individual testifying from the perspective of a practicing physician and from the per-

spective of a small business person with 12 full-time employees in my medical practice.

With respect to the significant problem, nearly everyone is miserable. The patients are angry and/or terrified, business is worried about the return of double digit escalation of cost, insurance companies are complaining about the loss of profit in the provision of their products, and physicians—I list them last because no one seems to care about us—but physicians are angry about the disruption of the patient-physician relationship which has occurred over the years as we seek to solve a cost problem.

And we are now in an era of unprecedented prosperity. We have an ever increasing number of uninsured. If that system is not broken, Mr. Chairman, I don't know what is. The need for change is clear. And as a physician, in my view, I would like to see all patients be able to get the appropriate care and the appropriate setting at the appropriate time in their illness or injury. And I believe every individual ought to have some mechanism of financing his or her health care to get that appropriate care.

As a small business person, I want my employees to be able to choose their own doctors, whichever doctors they feel are desirable for them to see, to be able to choose their own insurance plan, and to be able to change if they don't like the choice that they made. I want my employees to own and control their own insurance.

And I would like to continue to provide the benefit for them, but it is very important to me to know how much it is going to cost next year and in the years ahead for providing that benefit.

And those things don't necessarily exist in the environment that we have today. And the result is that those patients who have insurance are insulated from the cost of their care by third-party payments. So we have a disconnect that doesn't occur anywhere else in our economy.

As one of my colleagues from St. Louis pointed out, employees in this country have become commodities to be auctioned off to the lowest bidder. This is not a desirable situation for them, in my judgment. And the costs of insurance, nevertheless, are again beginning to increase at unacceptable rates. And what is more, the number of uninsured is increasing.

Now, Mr. Chairman, I spoke earlier about having a remarkable opportunity for solution. I believe that opportunity is there and it is real. It has been my experience that there is widespread understanding of the potential of expanding choice, creating a better marketplace by having a competition between imperfect financing mechanisms, by taking advantage of individual selection and ownership of insurance with a periodic right to change if dissatisfied, and with the notion of defined contribution, having the employer put up the same amount of money no matter which plan the individual picks.

And the same thing is true in the government programs. The government should provide that individual with a defined contribution no matter which plan the person takes.

Now, the discussion about how to accomplish those things is the result of a variety of subjects one of which has been discussed at some length earlier in the first panel, the notion of tax credits. I support tax credits. It is not the subject of this panel. I will answer

questions about it, but I am not going to go there unless you ask me to.

What I do want to emphasize is the notion of voluntary choice cooperatives. I would like to explain that term a little. Voluntary means for those employers or others who want to use it, that they would be able to. No one would be forced to. Choice, the name is implicit there, some mechanism of giving people the opportunity to choose between these different kinds of plans.

And the cooperative term refers to pooling people together so they can take advantage of the large numbers. The pooling concept has been addressed in the earlier panel, and it is very important.

I make the distinction in my own thinking about this between voluntary choice cooperatives and voluntary purchasing cooperatives. To me a purchasing cooperative entails micromanagement by the employers who come together to put that together.

A choice cooperative would function simply as a clearing house, qualifying the plans much as is described in Congressman Shadegg's plan, as I understand it, for HealthMarts. And it certainly is my opinion, Mr. Chairman, that HealthMarts should be adopted but they should look more like voluntary choice cooperatives than voluntary purchasing cooperatives.

Mr. BILIRAKIS. Well, finish your point.

Mr. JOHNSON. Simply the only other point I want to make, Mr. Chairman, was a personal plea to you. I have had the opportunity in my experience in organized medicine to see you and your colleagues on the committee at work, and I am aware of your interests in these issues; and I am also aware that there are unbelievable conversations going on in these halls between very diverse members without respect to partisanship toward crafting solutions. And my plea to all of you is to take advantage of that opportunity and to realize that. Thank you.

[The prepared statement of Daniel H. Johnson, Jr. follows:]

PREPARED STATEMENT OF DANIEL H. JOHNSON, JR., PRESIDENT, WORLD MEDICAL ASSOCIATION

Mr. Chairman and Members of the Subcommittee: My name is Daniel H. Johnson, Jr., M. D. Although I have been privileged to serve my physician colleagues in a variety of capacities, I appear before the Subcommittee this morning as an individual practicing physician. I would like to express my appreciation for the opportunity to testify. As a Diagnostic Radiologist owning and operating a small outpatient diagnostic imaging facility in Metairie, Louisiana, a suburb of New Orleans, I wish to provide the perspective of one who is both a practicing physician and a small business person.

At Clearview Medical Imaging, we have twelve full-time employees. I have long considered my practice an ongoing opportunity to study what's wrong with American medicine as well as what's right. My remarks today will address significant problems that I believe can easily be corrected and I propose to offer you some suggestions for making those corrections.

The Current Situation

In out health system today, nearly everyone is miserable. Employers are faced with a return to double-digit escalation of premium costs for insurance for their employees. Employees have suffered through ever reducing choice of both physicians and health plans. One colleague put it beautifully, "Employees in this country have become commodities to be auctioned off to the lowest bidder." Physicians are frustrated because of the ever-increasing intrusion into the patient physician relationship resulting from an understandable desire to control the cost of health care. Widespread dissatisfaction with the system has lead to a clamor for greater regulation of the system. Think about it. The idea that employers chose to get a handle

on increasing cost is such a wonderful idea, we have to pass laws to protect the patients from the idea! Yet, in an era of unprecedented prosperity, the number of uninsured is escalating significantly.

What's the Problem?

Of the three issues of cost, access and quality, the issue that I believe is driving the change in the country and has provoked so much anxiety is cost. Patients are interested in quality of care and physicians are desirous of providing quality care. However, inability to control cost has threatened the quality of care. The most important single facet of the access problem is cost. Therefore, when attempting to solve the problem of the increasing number of uninsured, doesn't it make sense to more thoroughly examine the cost problem?

Why Do We Have a Cost Problem?

It is true that the aging population, rapidly emerging new technologies and the ongoing professional liability insurance crisis contribute significantly to escalating costs. But, it is my view that the single most important (and most easily corrected) factor is that the person consuming the services, which is to say the patient, is insulated from the cost of those services because someone else is paying for them.

Food For Thought

Several questions come to mind. Is it better to link the individual to the cost or insulate the person from the cost? If one wishes to link the person to the cost, is it better to reward the individual for using our health care system in a cost-effective way or punish the individual for not doing so? Is it better to motivate or to regulate? Is it better to entice or coerce? Can market solutions work if you limit choice?

What could we do to change the current situation?

A substantial, broad-spectrum consensus seems to be developing around the following four points: 1. Expanding the choices. 2. Individual selection and ownership of insurance. 3. Defined contribution. 4. Some way to accomplish the above three points. Let's examine those in greater detail.

Expand the Choices

There is no perfect way of financing the delivery of care and there is no perfect delivery mechanism. Financing mechanisms include HMOs, PPOs, Point of Service Plans, Traditional Insurance, Benefit Payment Schedules and Medical Savings Accounts. Each of these has advantages and disadvantages. The way to bring out the strong points and suppress the weak points is through an improved marketplace. Instead of government or employers dictating to beneficiaries which one of these mechanisms is best, the beneficiary should have access to an expanded array of choices. Each should operate without discrimination from employers or government. For example, Medical Savings Accounts are one way to directly reward individuals for using the system in a cost-effective way. Every beneficiary should have an equal opportunity, without prejudice, to choose a Medical Savings Account or an HMO or whatever plan seems to make the most sense to that person. Having these various imperfect mechanisms competing with one another in a better marketplace will have the same result that competition has in other marketplaces for goods and services: increased quality and decreased cost.

Individual Selection and Ownership

The individual should be given both the opportunity and the responsibility to choose and own his or her insurance, but with the periodic right to change if dissatisfied with the previous choice. The ability to change if dissatisfied represents a safety valve for the beneficiary and causes the accountability in the system to flow to the beneficiary.

Defined Contribution

Whether the employer, in the private sector, or the government, in the public sector funds the benefit, the employer/government should put up the same amount of money no matter which choice the individual makes. If the individual wants more or different coverage, he or she can supplement that defined contribution as desired. This gives the employer and/or government predictability as to cost next year or even over the next several years. It also offers an opportunity for the individual to be rewarded for selecting wisely.

Some Way to Make It All Happen

Two significant problems exist with the above three proposals, tax inequity and disadvantage to the individual purchasing health insurance. Current tax law discriminates against someone who buys health insurance as an individual and that

needs to be changed. However, that is not the subject of this hearing and, other than offering strong support for tax equity, I have no further comment to make on that subject at this time. The other issue is very relevant and the Committee on Commerce has shown great leadership in this area.

To put the issue in perspective, how can I as an employer offer my twelve employees a choice of multiple different kinds of insurance and how can each of them purchase insurance at group rates rather than individual rates? Some mechanism needs to be developed to facilitate that process. Two methods of doing this have been proposed, voluntary purchasing cooperatives and voluntary choice cooperatives.

The distinction between purchasing cooperative and choice cooperative is an important one. In a purchasing cooperative, employers band together to micro-manage the insurance benefits. Typically, the employers determine what the plans should look like and even engage in negotiation over the price. The result is a distorted marketplace that may continue to limit the choice through a cookie cutter mechanism so that the individual chooses between a variety of similar plans rather than a variety of different plans. Negotiating the price between the cooperative and the insurance plans means that the individual is still insulated from variations in cost from one delivery setting to another. Using an automotive metaphor, we'll provide you the car. You can have any color you want as long as it's black. You can have however many doors you want, as long as it's two. You can have whatever transmission you want, as long as it's three-speed manual, etc.

On the other hand, a voluntary choice cooperative would function simply as a clearing-house. It would qualify the plans to make certain that they are solvent and that they adhere to truth in advertising, covering what they say they will cover and living up to the contract they make with each individual who picks the plan. Rather than becoming immersed in the micro-management of the process, the employer is entirely out of the health insurance management loop. The term "voluntary choice cooperative" is significant, in that employers should have a choice, as well. They should not be forced to participate in a voluntary choice cooperative but should have the option to do so if they like the idea better than the way they are currently providing the benefit. "Choice" implies the beneficiary being able to select from among a variety of different plans. The term "cooperative" implies a pooling of individual employees in order to take advantage of the rule of large numbers to spread the risk. In my view, the Health Mart concept developed by the Commerce Committee should take on the characteristics of a voluntary choice cooperative rather than those of a voluntary purchasing cooperative. As the committee develops the concept, attention should be paid to fairness. If I am going to send my twelve employees down to the local voluntary choice cooperative, with multiple different plans offering themselves, the plan should have to take whoever signs up with that plan, without respect to considerations such as pre-existing conditions. But, to be fair to the plans, shouldn't I have to send all twelve of my employees and not just the sick ones?

Conclusion:

As a practicing Physician offering high tech services, I want to be able to compete in a marketplace that recognizes my commitment to cost-effectiveness. A marketplace that allows a physician to send a patient to me to take advantage of some subspecialty expertise I might have in a particular situation, without requiring the patient or my staff to jump through all kinds of hoops. As an employer, I want to provide a benefit to my valued employees that will give them adequate protection. But, I want them stop and think about how to take better care of themselves and how to use the system in the most cost-effective way possible when they become ill or injured. I want my employees to be rewarded for using the system well. I want them to be motivated to do the right thing. I want them to be enticed to do the right thing. I don't want any kind of price controls that insulate them from the cost of any services they need. I value my employees and want them to have the benefit. I want system accountability to flow to them, not to me. Yet, at the same time, like any other businessperson, I am continually concerned about the cost of that benefit. I want to be shielded from significant escalation in cost and want to know how much the benefit I am providing my employees is going to cost me next year. In my judgment, the points I have outlined accomplish all of that and more by putting the patient in the driver's seat.

Every person in this country should have health insurance. We have two long running experiments in this country for providing universal coverage. One is a defined benefit plan and one is a defined contribution plan. One has tens of thousands of pages of regulations, the other around a hundred pages. One threatens to bankrupt the country and the other has outperformed the private sector over the last fifteen years or so. One is called Medicare and the other is the Federal Employees Health Benefit Plan and both are run by the same government. We don't have to

reinvent the wheel to solve the problem of the uninsured. We are spending more than enough money today to provide the coverage. We just have to spend it more wisely.

Thank you again for the opportunity for input.

Mr. BILIRAKIS. Thank you so much, Doctor.

Mr. Arth.

STATEMENT OF RAYMOND ARTH

Mr. ARTH. Thank you, Mr. Chairman and members of the committee. I am glad to be here today. I am Raymond Arth. I am the president of Phoenix Products, located in Congressman Brown's district in Ohio. We are a manufacturer of plumbing faucets and employ about 100 people.

As a volunteer, I serve as the chairman of Group Services, Inc., which manages the benefit plans offered by the Council of Smaller Enterprises, or COSE, in the greater Cleveland area. I also serve as a member of the board of National Small Business United, the country's oldest small business advocacy organization.

We are pleased that you are trying to review options to expand coverage for the uninsured. And, quite frankly, I am pleased to be able to talk about a model that really works.

We think that the HealthMarts might be a good solution if they are done right and looked more like our plan, but we are presently concerned about the Federal regulation composition of the boards and some other things.

And before I describe COSE's plans, let me make two points. What we have accomplished in Cleveland did not require any Federal legislation. And one of the things that makes our organization unique is that the board members who govern our plans are actually the consumers, small business owners who get their own health insurance through the COSE plans.

Let me tell you about the COSE success story. Today we have 16,000 members in the seven-county area that we serve near greater Cleveland. This is a tribute to our 25 years of hard work to deliver small business insurance. As evidence of that success, 13,000 of our members and over 200,000 lives are covered under the COSE health plans. And I should mention that 2,500 of those companies did not offer insurance to their employees before they joined COSE.

We also manage health benefit plans for several other chambers in northern Ohio, and all told we have over 15,000 companies and almost 250,000 covered lives in northern Ohio.

The COSE plan provides up to 18 plan options, everything from fee for service to PPO's, triple option plans, HMO's, and MSA. Any individual employer could offer more than one option to their employees. And we focus on companies typically with 150 employees down to and including one. Sole proprietors would be covered.

What makes GSI, Group Services, Inc., and the COSE plan different is that GSI is actually the customer. We negotiate on behalf of our members. We manage the administration. We buy the insurance from our providers. We are not a multiple-employer trust, a Taft-Hartley Trust, a VEBA or MEWA. We are basically a not-for-profit purchasing co-op and we are negotiating on behalf of ourselves for the product we are buying and using.

We believe our program works because first of all we know our customers. We are them. And we also poll them regularly. We track the utilization and costs of services that are used by our members. We have centralized the administration function. We do the billing. We remit payment to carriers. Our administrative costs are about 13.5 percent in an industry where rates as high at 30 percent are common.

Our members get one bill regardless of how many benefit plans they offer. They pay us with one check. We have standardized paperwork and forms across our carriers to try to take out inefficiencies and unnecessary costs.

We have also taken a long-term look at our objectives, have long-term commitments with our carriers, and this has produced more stable and predictable rates for all of our members, that get better prices than they can get on their own. And we have had a history of providing very stable pricing and rate increase that is typically about half what the industry averages are.

As you consider the HealthMarts, I would like to identify six factors that have made us successful. Today, we have the benefit of size, which is the result of 13,000 companies and all those lives. And we leverage that size in the purchasing power where we sit down and negotiate with our carriers.

We have two primary health insurance carriers. We are the largest customer for both. So when we sit down and negotiate, we have got a lot of clout. We have made long-term commitments with these carriers. We have a proactive management approach. We have a very active board of volunteers and consumers who are very aware of the problems that may exist and opportunities to improve our product.

In addition to that long-term commitment to our carriers, we also try to maintain a decent and working relationship with them. When we sit down to negotiate, we know what the numbers are. They need to make money. We need to pay as little as possible. It has worked well in the long term.

Finally, I want to emphasize again the importance of a board that is comprised solely of the consumers and the interested parties at the buying end and not every stakeholder who has a say in the proposition.

It has been said before that health care is a local issue. We have addressed it in Cleveland as a local issue. We have brought health care in the Cleveland area down across the board, and we have built a very successful plan that serves the small business community, in particular.

I should mention in closing that our average member employs 6-1/2 employees. So this is a product that is really targeted at those smaller companies where we have identified a large proportion of the uninsured population being employed.

Thank you very much.

[The prepared statement of Raymond Arth follows:]

PREPARED STATEMENT OF RAYMOND ARTH, PRESIDENT, PHOENIX PRODUCTS, CHAIRMAN, GROUP SERVICES, INC. COUNCIL OF SMALLER ENTERPRISES (COSE)

Thank you Mr. Chairman and members of the sub-committee, I am Raymond Arth, President, Phoenix Products a 100 employee manufacturer of faucets for the manufactured housing and recreational vehicle industries located in Avon Lake,

Ohio. I am also, Chairman, Group Services, Inc. Council of Smaller Enterprises (COSE) in Cleveland, Ohio. COSE is the small business division of the Greater Cleveland Growth Association, which is Cleveland's Chamber of Commerce. I also serve on the Board of Directors of National Small Business United. Based here in Washington, NSBU is the nation's oldest small business advocacy group. I am pleased to present the views of COSE on expanding health insurance coverage among employees of small businesses.

COSE is a success story. We represent over 16,000 small businesses in the greater Cleveland area. Our health insurance program was adopted 25 years ago and gives small business owners a chance to provide high quality, affordable health care benefits to their employees and families. Our efforts follow two simple principles, increase the access and the affordability of health insurance as an employee benefit for small business owners and their employees. Over the years, COSE has become a national model for group purchasing alliances. Today, in the Cleveland area, over 13,000 businesses and over 200,000 individuals receive their benefits through a COSE plan. Our research tells us that nearly 2,500 of these businesses did not offer health insurance as an employee benefit before joining our program. Additionally, we manage the health insurance programs of the Toledo Area Chamber of Commerce, The Mansfield/Richland Area Chamber and a consortium of smaller chambers in the Findlay, Lima and Tiffin area of our state. Collectively, we have increased the access and affordability of health insurance to over 15,300 companies and nearly 250,000 individuals in the northern half of Ohio. The average size company enrolled in the COSE program has 6.5 employees. Our plans are available to companies with as few as 1 employee.

For years, COSE has advocated on the local, state and national level on issues of particular concern to small businesses. We are pleased that Congress is reviewing ways to address the problem of uninsured workers and we hope that any solution will be built on a stable health insurance market. We believe that HealthMarts are intended to be modeled after COSE's health program, and as such are a good concept that if done right will have the effect of increasing access to affordable health insurance coverage for small business. However, we still have some concerns because HealthMarts are federally controlled and the make up of their Board differs from our model.

In my remarks, I will highlight several key points to our success: 1. A general overview of our program; 2. The power of: information, centralized administration and acting like a customer; and 3. Our long-term commitment.

As I begin, I would like you to consider two points: First, COSE is completely a creature of the marketplace, we required no legislation to get started. Unfortunately, many people and institutions—including some with a tremendous impact on our society—still think and act as if our success is so unusual and our goal so impossible that it cannot be replicated. Our philosophy, objectives and achievements are based on sound principles. COSE is not unique; it does not exist in a strange or perfect vacuum. We have proven that the private sector can address the problem of small business health insurance in a creative and practical way.

Second, in addition to being a volunteer for the organization, I have enrolled my company and my family in the COSE program and that is true of everyone one of my fellow Board members and our staff. We all live with our creation. This provides us with a very good reality check on the decisions we must make.

The COSE Health Insurance Program

We offer 18 choices of group health insurance plans, which are available through Medical Mutual of Ohio and Kaiser Permanente. Our plans are representative of the type of plans in our community and range from traditional fee-for-service products through PPO's, Triple Option, HMO and Medical Savings Accounts. Our plans are managed to be flexible—one company can offer several different choices to their employees—and affordable. In addition to health insurance plans, we offer our members the ability to add group life and disability, dental, vision and Section 125 programs. COSE also offers small business education and training programs, workers' compensation, retirement and soon will offer an energy program to our members.

How We Manage

In 1983, we created an independent entity called Group Services, Inc. This entity is the one centralized customer to which our insurance carriers would ultimately be accountable. We have found that our program is quite different from the programs offered by many other associations and chambers of commerce. We do not simply hand our logo over to an insurance carrier or broker and let them sell to our members. Often we must define ourselves by explaining what we are not. We are not a multiple employer trust, a Taft-Hartley Trust, a voluntary employee benefit asso-

ciation or a Multiple Employee Welfare Arrangement. Group Services, Inc. is a not-for-profit purchasing group or co-op. Our structure is that simple. On behalf of our members, Group Services negotiates the contractual terms of the insurance products made available to our members. Additionally, we negotiate both the medical and non-medical underwriting regulations, prices and we coordinate the billing, enrollment, communications and customer service aspects of the program. In a nutshell, we are the employee benefits division for our members. They look to us to keep their program affordable and up to date with the latest trends in health insurance.

Why Our Program Works

As in any business, the more you know about your customers, your products and where and why the two meet, the better chance you have to be successful. What do we know about our members? Almost everything. Through regular surveying and close attention to their buying patterns we know what our members want from their insurance program. They want access to affordable and stable, high quality programs. Next, we pay very close attention to the costs. Through monthly, quarterly and annual reports, we monitor both how much a procedure costs and how often a procedure is used. We believe that it is our job to know as much, if not more than our carriers about our book of business so that when it comes time to negotiate we negotiate from a base of knowledge. We are a very educated customer.

In order to maintain this information and establish a solid base we have centralizing key components of our administration. This includes billing and reimbursement to our carriers. Our members pay us and we pay our carriers. This is also a key component of our ability to save our members money and time. In a world where total administration costs can reach 30% or more, the administrative cost to our members averages about 13.5%. Regardless of how many products our members buy from us, they receive one bill once a month and pay by one check. Additionally, all carriers accept a common employer and employee addition, change and termination form that we have developed. We have also discovered, through random audits, that many of our members have problems meeting eligibility rules. In roughly half of the problem cases, people are enrolled who do not qualify—we want them off the plan. In the other half, we find full-time eligible (usually young and healthy people) who are not insured. We want them on the plan. Our products are group insurance and we demand the right mix of risk.

Our management approach contains a long-term commitment to our members and our carriers. When we manage our programs we do not attempt to make the best deal for one year or the best deal for everybody for all time. What we do attempt to do is maximize the benefit for the most people for the most time. We seek stability and predictability. Our rates of increase have averaged roughly one-half the regional rate of inflation to health insurance costs over the last several years.

As we think about additional ways to increase the number of small business owners who offer health insurance as an employee benefit, we urge you consider the benefits and costs to all health care legislation. We do not believe that increased benefits through patients' rights to be the best answers for health care reform. We urge Congress to keep health insurance affordable by:

- Enacting legislation to provide immediate 100% deductibility of health insurance premiums for all businesses or individuals who do not benefit from employer sponsored coverage.
- Granting tax credits for low wage workers in small firms.
- Not increasing costs by imposing liability on managed care organizations or businesses for denial of experimental treatment when the insurer acted within contractual provisions.
- Support a well defined and binding internal and external review process, direct access to ob/gyn, pediatricians and prudent layperson definition for emergency treatment.
- Oppose "medical necessity" language in current legislation that would turn back the clock on managed care by elimination the system of checks and balances that have developed between providers and payers.
- Oppose mandated benefits that only tend to raise the cost of insurance and add to the numbers of the uninsured.
- Support employee and consumer health care education efforts aimed at maintaining wellness and proper use of our health care system.
- Support a drive for a common definition of terms and language used in insurance materials, and encourage the use of common claims forms for all payers.
- Support the measurement of quality for insurance plans, hospitals and physicians, which can be used by customers to make better decisions.

In summary, as you consider HealthMarts, Association Health Plans or any other efforts to bring small employers together please remember that COSE's success is built on six key factors:

- We have the advantage of tremendous size.
- Our size has in turn enabled us to exert maximum leverage.
- We have built long-term commitments into our contracts.
- We have taken a strong, proactive approach to management.
- We have a good working relationship with our carriers.
- We have small business owners—health care purchasers—on our board of directors.

As a result of these factors, COSE has produced an innovative program that produces a wide variety of options to our members at costs that are lower, year-in and year-out than what our members can obtain on their own. Please also remember that health care is primarily a local issue and that attempts to raise the governance to a national level should be done with careful consideration of who will regulate and who will manage the program on a daily basis, how the program will be funded (Fully insured vs. self-insured), who is eligible to enroll and who is keeping an eye on the integrity of the program.

Our experience over a 25-year period, in a competitive environment, has convinced us that it is indeed possible for small business owners to provide good health care benefits at affordable and stable prices.

Thank you for the opportunity to speak with you on this important topic. COSE looks forward to working with Congress as it continues to address the access and affordability needs of small businesses.

Mr. BILIRAKIS. Thank you very much, sir. I am glad that there are at least five us of us here to have heard your testimony.

Mr. Morehead.

STATEMENT OF ROBERT N. MOREHEAD

Mr. MOREHEAD. I wish to thank the committee for this opportunity to present testimony on HealthMarts. I am the area president of Gallagher Byerly Incorporated, and I am also a small businessman. Gallagher Byerly is an employee benefits consulting firm, actively involved in multiple small-employer health plans for more than 20 years all across the country.

We currently administer consumer choice health care purchasing cooperatives in four States: Washington, Oregon, Colorado, and Montana. In total, these cooperatives include 2,150 employers and over 23,000 employees. And I might mention that the oldest of these, the Colorado Purchasing Cooperative, is 3 years old. So they are fairly recent developments.

And the purchasing cooperatives we administer include both large and small employers. But the primary focus is aimed at giving small employers and their employees additional clout and choice in obtaining health care or health insurance coverage. With this concept employers are able to make more choices of plans and coverage available to their employees, and they are relieved of the burden of having to administer the coverage. You might think of this as a 401(k) health plan.

In addition, the employer is not placed in the bind of having to seek out new health insurance carriers, often every year, in order to cope with sharply rising premiums. Cooperatives handle that problem, and the availability of a number of plans help to mitigate premium increases on the part of any one plan.

Does the purchasing cooperative concept expand access to health insurance coverage? While we don't have figures for all of the States that we cover, we do know that in the State of Washington, 17 percent of the sales are with companies that didn't previously

offer health insurance coverage. In Colorado, that figure is over 30 percent. The information from Oregon indicates that it is 20 percent in Oregon.

Equally important, we are in most cases able to tailor plans to meet the coverage needs of the employee. These cooperatives have telephonic customer service that is available to all employees to assist them in selecting the proper benefit plan and also to determine the health plan that contracts with their own family doctors.

In Washington, 90 percent of Washington physicians are participating in one or more of the plans offered to consumers through the cooperative. Because of that 90 percent figure, employees are virtually assured of the opportunity of retaining their family physicians when enrolling in the cooperative.

Do purchasing cooperatives reduce the cost of insurance coverage? We think they have a positive impact on overall costs and coverage, even if actual premium costs in a number of cases may stay the same. We are finding out that the availability of a much wider range of choices is viewed as a positive factor. With the employee having the ability to participate in plans where their family physicians are participating providers, the employees' out-of-pocket claim costs are reduced even if the premiums are not.

It should also be noted that the coverage we administer is still subject to state benefit mandates. We estimate that dropping the State benefit mandate requirements as is provided for in at least one of the plans under HealthMarts could save 15 to 20 percent.

The administrator of the purchasing cooperative such as Gallagher Byerly can help to limit costs in several ways with large numbers of participants. We have more clout in dealing with insurance carriers than does the individual small employer. In administering the daily activities of the cooperative, we have the benefit of experience, volume, and sophisticated computer systems that the employer does not have, thus allowing us to operate more efficiently and provide a more efficient expense component.

We also act as a patient advocate and help the patient navigate through complex health care issues. It is important that this service be provided by experienced, impartial persons that are not affiliated with the health plans. That is another benefit of HealthMarts.

Based on our experience, we think that the purchasing cooperative concept represents an important way to expand access and choice. Establishing broad national standards, as the HealthMart proposal would do, would make it easier to expand the concept nationwide. Often these programs have been blocked by State laws passed for other purposes that have unintended consequences.

In establishing national standards, however, it is important to allow reasonable flexibility in order to permit innovation and the adaptation of purchasing cooperatives to meet local needs. We believe that purchasing cooperatives have a potentially bright future, but they are still in their infancy and need the flexibility to experiment in order to fully determine what works best. Legislation that provides too many specific requirements at the outset will make this experimentation more difficult.

Mr. BILIRAKIS. Please summarize.

Mr. MOREHEAD. I have just a couple of points on the design of the bill itself.

The revised version of the HealthMart proposal requires at least four plans be offered including a nonnetwork plan and two of those plans providing State-mandated benefits. We think this goes too far. It will tie the hands of those who may be interested in organizing a HealthMart.

Frequently the number of plans that a carrier can offer may differ based on a lot of factors, further requiring the same level of benefits statewide, not allowing for adaptation within the State, such as in counties where there may not be a hospital or a doctor or any networks that we can work with. So we have to provide the best coverage which we can in each geographic location, but it may not be identical to the coverage that is available in the urban areas.

So we think purchasing cooperatives or HealthMarts are a viable program. We think they should be subject to the competitive pressures of the marketplace, and we think the competitive marketplace allows the ideas to grow and we think is a proposal worthy of adoption by the committee with a few changes.

[The prepared statement of Robert N. Morehead follows:]

PREPARED STATEMENT OF ROBERT MOREHEAD, PRESIDENT, GALLAGHER BYERLY, INC.

I wish to thank the committee for this opportunity to present testimony on health insurance purchasing cooperatives, or HealthMarts as they are referred to in the legislation before the Committee.

Gallagher Byerly is an employee benefits consulting firm that has been actively involved in multiple employer health plans for more than 20 years, from California to South Carolina. In recent years, we have been active in the creation, operation, and administration of what we call Consumer Choice Healthcare Purchasing Cooperatives. We currently administer such cooperatives in four states: Washington, Oregon, Colorado, and Montana. In total, these cooperatives include over 1800 employers and nearly 22,000 employees. With this experience, I think we are in a good position to advise you as to how the consumer choice purchasing cooperative concept is working out in actual practice.

While the purchasing cooperatives we administer include both large and small employers, the primary focus of the cooperative is aimed at giving small employers and their employees additional clout and choice in obtaining health insurance coverage.

Employers are able to make more choices of plans and coverage available to their employees, and they are relieved of the burden of having to administer the coverage. You might think of this as 401k medical. The employer remains an integral part of the plan, offering quality benefits and paying a portion of the premium, yet allowing each employee a wide variety of flexibility based on their individual and family needs.

In addition, the employer is not placed in the bind of having to seek out new insurance carriers, often as much as annually, in order to cope with sharply rising premiums. The cooperative handles that problem, and the availability of a number of plans helps to mitigate premium increases on the part of any one plan.

Does the purchasing cooperative concept expand access to health insurance coverage? While we do not have figures for all of the states we cover, we do know that in Washington State some 17% of the program sales are coming from companies that did not previously offer health insurance of any kind to their employees. In Colorado, of the first 1271 groups entering the plan that we had records of previous coverage, 398 had not offered coverage previously—31%!

Equally important, we are in most cases able to tailor plans to meet the coverage needs of the employee. In Washington, for instance, we have a telephonic customer service that is available to all employees to assist them in selecting the proper benefit plan, and also determine the health plan that contracts with their own family doctors. With over 90% of Washington physicians participating in one or more of the health plans, employees are virtually assured of the opportunity to retain their family physicians when enrolling in the cooperative. In addition, they are not faced with

the burden of having to change family doctors, sometimes annually, because the employer has had to change health plans in order to reduce costs. A stability is provided that otherwise did not exist.

Do purchasing cooperatives reduce the cost of insurance coverage? We are not necessarily finding that is the case, but what we are finding is that the availability of a much wider range of choices is viewed as a positive factor, even if the premium costs are not less. With the employee having the ability to participate in plans where their family physicians are participating providers, the employee's out-of-pocket claim costs are reduced, even if the premiums are not. It should also be noted that coverage we administer is basically still subject to state benefit mandates. We estimate that dropping state benefit mandate requirements, as is provided for in at least one of the plans under HealthMarts, could save some 15-20%. We would suggest each plan in the HealthMart be required to offer at least one plan with all state mandates and one without any mandated benefits. This would allow consumers that cannot afford a full range of benefits to still have basic coverage, without lowering benefits on the other employees.

For small employers, participation in the purchasing cooperative helps to stabilize the health care component of their business. They can determine the level of coverage they want to pay for, and then the employees can decide from a number of options as to what extent they want to contribute their own funds. The employees can get coverage that best suits their individual situation, and where they get the best service.

The administrator of the purchasing cooperative, such as Gallagher Byerly, can also help to limit costs in several ways. With large numbers of participants, we have more clout in dealing with insurance carriers than does an individual small employer. In administering the daily activities of the cooperative, we have the benefit of experience and volume that the employer does not have, thus allowing us to operate more efficiently and provide a more efficient expense component. We also act as a "patient advocate" to help the patient navigate through complex health-care issues. It is important that this service be provided by experienced persons that are not affiliated with the health plans.

Based on our experience, we think that the purchasing cooperative concept represents an important way to expand access and choice. Establishing broad *national* standards, as the HealthMart proposal would do, will make it easier to expand the concept nationwide. Often, these programs have been blocked by state laws passed for other purposes that have unintended consequences. It is important in doing so, however, to allow reasonable flexibility, in order to permit innovation and the adaptation of purchasing cooperatives to meet local needs.

It is essential to keep in mind that while we believe purchasing cooperatives have a potentially bright future, they are basically still in their infancy as far as their development is concerned. We need the flexibility to experiment in order to fully determine what works best and to experiment with different approaches in order to work out the kinks. Legislation that provides too many specific requirements at the outset will make this experimentation more difficult.

For instance, the revised version of the HealthMart proposal requires that at least four plans be offered, including a non-network indemnity plan and two providing state mandated benefits. Those requirements may very well tie the hands of those who may be interested in organizing a HealthMart as the number of plans a carrier can offer differ, based on several factors. Requiring the same level of benefits statewide will not allow for adaptation within the state, such as in counties where there may not be a hospital or available networks to offer identical coverage to urban areas. Using the word "comparable" in defining benefits would allow needed flexibility.

Regarding the non-network plan, if this definition of "non-network" is interpreted as representing an indemnity plan, that could prevent a HealthMart from forming, because it is very hard to find carriers that would be willing to offer indemnity coverage in the HealthMart environment. If "non-Network" coverage is intended to include PPO and Point-of-Service options, the law should say so.

Purchasing cooperatives, or HealthMarts, are only going to be effectively developed if they are subject to the competitive pressures of the market place. The original Clinton health alliance concept was rejected in part at least because the alliances were to be government entities. The competitive market place allows ideas to grow, and the HealthMart proposal basically fosters that concept. With a few changes, we think it is a proposal worthy of adoption by the committee.

Thanks for your attention, and I look forward to answering any questions you may have.

Mr. BILIRAKIS. Thanks so much. Mr. Morehead.

Mr. Meyer.

STATEMENT OF JACK A. MEYER

Mr. MEYER. Thank you, Mr. Chairman. I will just summarize my remarks, and I have submitted for the record a longer study on HealthMarts and association plans that my colleague Elliot Wicks and I have done.

Imagine that this pitcher were filled with water and that the water in this pitcher was all the 43 million uninsured. As background for what I want to say about these HealthMarts and association plans I want to point out that what complicates the problem is that every day more water is going into that pitcher. And it is coming from the employer sector where people, particularly employees, are turning down employer's offer because they can't afford the premium, people with incomes like the woman on the previous income of $13,000 cannot afford a $2,300 premium contribution, which I note in my testimony is the average for people in small business. So they say no thank you.

In addition, only 49 percent of small firms under 10 employees offer health insurance. So more people are coming into this pitcher, and they are also coming from Medicaid because of welfare reform which has done a lot of good things. The welfare rolls are down by 4 million, but a lot of people come off welfare are diverted; and they cannot get Medicaid any more after a period, and they do not qualify for private health insurance so they are all coming into this pitcher; and we haven't seen anything yet because most people haven't hit their time limits.

Proposals like the ones we are here to discuss today in my view are likely to maybe drain 5 to 10 percent of the water out of this pitcher. I saw that there are some estimates that show there is likely to be no effect. There is some estimates as high as 15 to 20 percent, but I think the bulk of the range would be fair to say in the 5 to 10 percent range as a result of getting rid of mandates.

I am not a fan of mandates. I don't think the government should load up the insurance package with a lot of requirements, but I am realistic and I believe that eliminating those mandates which would have some hardship for some of those people when the mandates cover mental health and substance abuse and so on, the likely effect is to maybe offset the new water coming in with the 5 to 10 percent reduction of water drained out so that we will be meeting in this room 2 years from now, and we will still have a water pitcher that is full.

So I don't come up to ridicule or severely criticize these proposals, but to be realistic about what they are likely to be able to achieve and also to point out a few side effects that could be troublesome.

I have to say that, in fact, to really drain half or most or all of the water out of this pitcher, we are going to have to revisit the terribly difficult and controversial options that have been considered by this Congress in the past. Those include whether to take that family with $13,000 of income and, as the gentleman from Arizona pointed out, really help them, not just waive their Federal taxes but to really help her and her husband buy health insurance. And that costs money, and whether to require an employer to at

least make an insurance vehicle available, perhaps to contribute to it. That is controversial. It could lead to some layoffs, perhaps require people to accept that offer and certainly it has more insurance market reforms so we don't get all the risk selection. Those are the options we need to consider.

Now, let me just comment very briefly on these two proposals, HealthMarts and association plans, and I want to underscore the point made by Mr. Arth about the HealthMarts. It is nice to have everybody in the same room from the point of view of cooperation. I don't believe in confrontation but the real progress—we have been studying business coalitions for 15 years—the real progress comes when buyers are on one side of the table and sellers are on the other side of the table. Yes, they work cooperatively; but the buyers establish standards and they hold the sellers accountable for cost and quality, so I am concerned about having all the stakeholders as he said under the same umbrella. As I indicated, I also think that the ability of the mandate waiver to decrease the number of uninsured is quite limited.

I want to say a few words about association plans. I will be happy to comment further in the question period if you want. What concerns me with the association plans is that unlike HealthMarts which do require entities to offer to all employers, in association plans some employers can be offered, some can be excluded and you can bet that the ones that are going to be attractive to the insurers out there are ones that have aerobics instructors who can bench press 300 pounds. That is going to be a very attractive risk group; and a group of older, sicker workers is not going to be attractive.

My concern about that proposal is it will undermine some of the reforms that have been passed by the States and the Federal Government to try to broaden the risk pool. We ought to be putting more people in groups like COSE and business coalitions and not enticing them like the 16 million people that are already in the individual market into that market.

And so I would just close—I see my time is up—by one comment on the tax subsidy. It is $125 billion in foregone revenue. There is a lot of money there if you wanted to help these families like this one that could be retargeted and my concern about some of the tax proposals on the table is that they are either insufficient to allow people to buy coverage or they would further undermine the employer group market. Thank you.

[The prepared statement of Jack A. Meyer follows:]

PREPARED STATEMENT OF JACK A. MEYER, PRESIDENT, ECONOMIC AND SOCIAL RESEARCH INSTITUTE

There are several reasons why more than 43 million Americans are uninsured. First, a substantial number of employers do not offer health coverage; second, an increasing number of workers are declining employer-sponsored coverage, usually because they believe that they cannot afford it. Third, the transition from welfare to work often leaves people without health coverage.

Employees of small firms are especially likely to be uninsured. Only 49 percent of firms with fewer than 3 to 9 workers were offered health benefits in 1998, compared to 95 percent of firms with 50 to 199 workers.[1] The average monthly employee

[1] The Kaiser Family Foundation, *Changes in Employee Health Coverage by Small Businesses,* February 1999.

premium contribution for all workers was $141 in 1998; for workers in firms with fewer than 200 employees, however, the average monthly contribution was $194, or more than $2,300 a year.[2] Particularly among low-income workers, the employee contribution toward health coverage can be unaffordable. According to one study, the "take-up" rate by workers who are offered employer-based health insurance fell by 8.2 percentage points between 1987 and 1996.[3]

In total, 44.9 million workers, or 36.5 percent of all workers in 1997, were employed by firms that did not offer insurance or were ineligible for their employer-sponsored coverage (often related to insufficient number of hours or weeks they work). While many of these workers obtain coverage through a family member, another employment source, or individually purchased insurance, more than 40 percent of those in firms without health benefits and 37 percent of ineligible workers were uninsured.[4]

Finally, about 16 million people buy coverage on their own in the individual market.[5] They generally pay significantly more for it than those enrolled in group plans, and they enjoy fewer protections regarding the ability to get coverage initially, to renew coverage, and to avoid large increases in premiums related to a change in health status.

Welfare reform is helping many Americans make the transition from dependency to work, but it is also beginning to exacerbate health coverage problems. "Front-end" policies to reduce cash assistance, such as diversion and lump-sum payments, coupled with "de-linking" TANF and Medicaid and "back-end" benefit exhaustions, will place many people in the gap between Medicaid and employer-sponsored coverage.

A number of proposals are now under consideration in Congress to address these problems. In this testimony, I will briefly address three sets of proposals—those involving Health Marts, Association Plans, and extensions of health-related tax benefits to people who are not a part of employer group health plans or public programs such as Medicare and Medicaid.

HEALTH MARTS AND ASSOCIATION PLANS

As noted, workers employed by small employers make up a disproportionate share of the uninsured. And small firms have had an especially difficult time buying reasonably priced health insurance. They have thus been a focus of numerous health insurance reforms. The proposals for Health Marts and Association Plans have been offered as one further step in this reform process.

Let me say at the outset that I believe collective purchasing arrangements—such as the health purchasing cooperatives that have been initiated in many states—offer important advantages. They can help small employers to buy reasonably priced coverage and to offer employees a degree of choice among plans that would not otherwise be practical. But it would be a mistake to see Health Marts, Association Plans, or any other small-group purchasing arrangement as a major tool for reducing the number of uninsured. The reason is that these arrangements, by themselves, are unlikely to reduce the cost of coverage sufficiently to bring most small firms *not now offering coverage* under the insurance umbrella.

In judging these proposals, it is also essential to determine whether they jeopardize hard-won state and federal legislative reforms that have already improved the equity and efficiency of the workings of the small-group insurance market. These reforms require health plans to sell coverage to all small employers seeking it. They guarantee portability of coverage as people move from employer to employer. And they limit variation of premium rates. Most people agree that these represent minimum conditions to make coverage accessible for higher-risk groups. If not very carefully crafted, there is a danger that Health Marts and Association Plans could undercut these efforts.

Health Marts

Health Marts, as outlined in the bill passed by the House in the last Congress, bear many similarities to purchasing cooperatives. They would offer multiple health plans (at least two), would conform to state rating laws, and must accept all small employers. But unlike cooperatives, they would be free of state mandates that re-

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[2] The Kaiser Family Foundation, *Health Benefits of Small Employers in 1998,* February 1999.

[3] Philip F. Cooper and Barbara Steinberg Schone, *More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996 Health Affairs,* Vol. 16, No.6.

[4] Thorpe, Kenneth E., and Curtis S. Florence, *Why are Workers Uninsured?* Datawatch, *Health Affairs,* March/April 1999.

[5] Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1998 Current Population Survey,—EBRI Issue Brief N. 204, Employee Benefit Research Institute, December 1998.

quire coverage of certain benefits and certain providers. Thus they might be able to offer a less costly benefit package. They would also not be required to offer a set of *standardized* benefits. And they would be governed by boards of employers, employees, health plans and insurers, and health care providers. Thus, they would not be agents of the purchasers of health care but would represent all the interested stakeholders.

On balance, it is not clear that Health Marts would do much to entice small groups *not now covered* into the insurance market. Although organized small business has long objected to mandates, eliminating the requirement may not cause the price of coverage to fall sufficiently to induce many uninsured small employers to buy coverage. Many uninsured small firms are marginal operations that could not afford even a stripped-down plan. Even the most optimistic estimates of the impact of eliminating mandated benefits or implementing Association Plans suggest that perhaps 10 percent to 20 percent of uninsured people would become covered, leaving unaffected 80 or 90 percent of the currently 43 million uninsured. Moreover, lean benefit packages that have been available in many states subsequent to small-group reform have not sold well. Such limited-benefit plans do not seem to have broad appeal, and they still may too costly to be affordable to many small employers.

There is also reason to be concerned that, because they can operate in non-contiguous counties, Health Marts could engage in "red-lining," choosing to operate only where they can avoid high-risk groups. In addition, if they do not offer standardized benefit packages and leave the decision about benefits up to insurers, health plans will be tempted to craft benefits packages to attract primarily low-risk employees. Such risk segmentation endangers the reforms that have encouraged broader risk pooling.

Finally, it is apparent that requiring that the governing board include providers and health plans builds in a severe conflict of interest: providers and insurers could not aggressively represent the interests of the people buying and paying for coverage—that is, employers and employees.

Association Plans

Association Plans would not have to conform to state laws mandating coverage of certain benefits and providers. In addition, they would be able, under certain circumstances, to offer a *self-insured* health plan. They would thus generally not be subject to state insurance regulation. The expectation is that health coverage could be less expensive, for four reasons: no mandated benefits; no charge to cover premiums taxes; fewer costs of complying with state insurance regulation; and savings associated with not having to pay an insurer to take on risk.

The feature of Association Plans that is unique is also the most serious cause for concern: they can self-insure and are not required to sell coverage to any small employer seeking it but only to members of the sponsoring association. That features poses a serious potential threat to the preservation of a broad risk pool. Association Plans could offer relatively low premiums if they provide coverage primarily to employers with below-average risk—for example, to firms employing younger, healthier workers. But this would raise the price of insurance for all those remaining in the "outside" risk pool and jeopardize small-group market reform.

Even many *existing* associations will not represent a cross section of risk. If a high proportion of those with members who are relatively healthy decide to offer Association Plans—perhaps with the help of an enterprising consultant—that alone could cause a significant dilution of the small-group risk pool. And unless the law precludes doing so, lower-risk groups will have a strong incentive to join some existing or newly formed association for the purpose of getting less expensive health coverage for themselves by excluding from membership groups that exhibit higher-risk profiles. If there were no restrictions on who could form an association for purposes of getting health coverage, we would surely see a proliferation of associations that bring together just lower-risk employers who then self-insure.

Those who wrote the proposal for Association Plans are mindful of the dangers of risk selection. They include several important provisions to limit the potential for excluding higher-risk groups and individuals. But the rewards for being able to risk-select and self-insure are so great that there is still a danger that some insurers and entrepreneurs will find creative ways to skirt the intention of the legislation.

On balance, it seems likely that implementation of Health Marts and Association Plans would not initially produce a massive shift from other kinds of coverage. But over the long run, there may be greater cause for concern that they will cause a dilution in the small-group risk pool and threaten access for firms with above-average risk. (For a more detailed analysis of the advantages and disadvantages of Health Marts and Association Plans, see *Small Employer Health Insurance Pur-*

chasing Arrangements: Can They Expand Coverage? which my colleague Elliot K. Wicks and I prepared for the National Coalition on Health Care.)

EXTENDING TAX SUBSIDIES AS A MECHANISM TO REDUCE THE NUMBER OF UNINSURED

There are significant health-related tax subsidies under current law, primarily benefiting the nearly two-thirds of non-elderly people insured under employment-sponsored health coverage.[6] The subsidies take the form of income tax exclusions and deductions. The total value of these subsidies was nearly $125 billion in 1998. The bulk of this loss in tax revenue, $111.2 billion, was incurred by the federal government. The remainder, $13.6 billion, was foregone state income taxes.[7]

The largest health-related subsidy under current law is the "tax exclusion." Health insurance contributions by employers are excluded from employee gross income when determining income tax liability. This exclusion applies to coverage in firms that self-insure as well as to conventional insurance premiums, and resulted in foregone federal revenues of $65.9 billion in 1998.[8] Employer health insurance contributions are also excluded from employment taxes (both the employee's and the employer's share of Social Security, Medicare, and unemployment taxes).[9] The value of this tax loss to the federal government was approximately $36 billion in 1998.[10]

Other health-related tax subsidies include 1) the medical expense deduction for households, which is geared only toward individuals or families who itemize their deductions; they may deduct unreimbursed medical expenses that exceed 7.5 percent of adjusted gross income; 2) a deduction for the self-employed; 3) health benefits provided through cafeteria plans and flexible spending accounts; and 4) certain medical savings account contributions.

The tax exclusion fails tests of both "horizontal" and "vertical" equity. The exclusion does not treat people with equal incomes equally (only people obtaining health coverage through employment benefit from the exclusion) and it is regressive—the subsidy rises as income increases.

People in the highest marginal tax brackets—those most able to afford coverage and thus with the least need for subsidies—receive the largest tax subsidies. Those individuals without any tax liability—often the working poor and near-poor—typically receive little or no subsidy. In 1998, the average tax subsidy was $1,031 per family; yet, families with incomes of $100,000 or more received subsidies averaging $2,357; families with income under $15,000 received only $71 on average. Nearly 70 percent of health-related tax subsidies went to the 36 percent of the population with incomes of $50,000 or more.[11]

The tax exclusion also leads to the overpurchase of health insurance and the overuse of health services.

Congressional Proposals

Numerous federal tax reform bills have been proposed in both the last legislative session and the current one, and more are expected to be introduced by both Republicans and Democrats.[12] The details and mechanisms in these proposals vary, but they generally share common goals. Their primary objective is to encourage more uninsured people to purchase individual insurance by reducing the net cost of the coverage. The reforms are also designed to improve equity by providing tax benefits to those outside of employer-based coverage that are similar to those already enjoyed by people inside this system. They tend to target individuals who do not have access to employment-based insurance. Some proposals also would assist those with employer-subsidized coverage to pay for the employee's share of the premium.

While making insurance more affordable to some individuals, the overall scope of most of these tax reform proposals is limited. They represent incremental steps toward expanding health coverage. They leave intact the current tax exclusion, with

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[6] Lyke, Bob. *Tax Benefits for Health Insurance: Current Legislation,* CRS Issue Brief, Congressional Research Service, The Library of Congress, Updated April 5, 1999.

[7] Sheils, John and Paul Hogan, *Cost of Tax-Exempt Health Benefits in 1998,* Datawatch, *Health Affairs,* March/April 1999.

[8] Exception: benefits received by "highly compensated employees under discriminatory self-insured plans" are partly taxable. (Lyke, 1999, p.2); Sheils and Hogan, 1999.

[9] In addition, benefits paid under accident and health insurance policies purchased by individuals and under public insurance programs such as Medicare and Medicaid are excluded from gross income, with some exceptions (Lyke, 1999)

[10] Sheils and Hogan, 1999.

[11] Sheils and Hogan, 1999.

[12] See, for example, HR 1136 (Norwood); HR 1819 (McDermott); HR 448 (Bilirakis) and HR 614 (Archer). These and other bills are analyzed in a forthcoming paper that Sharon Silow-Carroll and I have prepared for the Kaiser Family Foundation.

its inherent inequities and inefficiencies, and they do not address the serious problems in the individual market.

A longer term, more fundamental concern involves the potential of these proposals to erode the employer-based health coverage system. While the objective is to induce only the uninsured to enter the individual market, an unintended side effect could be to induce some of the people currently in the group market to switch to individual coverage. Those who could find it advantageous to make this switch are healthier, lower-risk people who might find it less costly to buy subsidized individual coverage than to pay their portion of their employer's group premium. Group plans would be left with the less healthy, higher-risk, and thus higher-cost enrollees.

Simply extending partial tax credits to people outside the employer-based system while leaving the inequities and inefficiencies of the current tax exclusion intact is not likely to contribute to a significant reduction in the number of uninsured. Congressional proposals use either dollar caps set well below the cost of coverage, or cover only a portion of the premium (e.g. 30 percent). They are not likely to lower the cost of coverage enough to bring large numbers of the uninsured into the individual coverage market.

Instead of putting more people into the individual market—with all of its risk selection and the danger of drawing people *out of* the employer-group market—we should find bolder ways to move people *into* employer group coverage or other comparable large risk pools. In this way, costs can be widely shared. To achieve a significant reduction in the number of uninsured, we should cap, and eventually eliminate the current tax exclusion and use a portion of this money to provide well-targeted and fully adequate subsidies to people based on financial need. Some elements of this idea have been recommended by Eugene Steuerle at the Urban Institute and Gordon Mermin at the University of Michigan.

Finally, to substantially reduce the number of uninsured, we may have to consider a requirement that employers offer at least an insurance vehicle to their workers, and perhaps require some limited employer contributions. This could be coupled with requirements that individuals obtain coverage (as long as those who cannot afford it are assisted). Such requirements, of course, could generate certain adverse side effects (e.g. some job loss associated with any requirements on employers).

As health care spending accelerates and the number of uninsured continues to rise, we need to debate bold reforms that can substantially improve access to affordable health care. The proposals reviewed here are relatively low-risk, but the potential gains are also small.

Mr. BILIRAKIS. Thank you Mr. Meyer.

Ms. Baumgardner.

STATEMENT OF CHRISTINE BAUMGARDNER

Ms. BAUMGARDNER. Thank you, Chairman Bilirakis, ranking member Brown, members of the subcommittee. I want to thank you for the opportunity to testify today on legislation to improve the ability of community health centers to provide our brand of high-quality cost-effective care to greater numbers of privately insured Americans.

My name is Chris Baumgardner, and for the last 15 years I have been the executive director of Alcona Health Center in Lincoln, Michigan. It is located in northeastern Michigan in the lower peninsula, a rural area, and our service delivery area is roughly the size of the State of Rhode Island. In the center of that service area is Alcona county, about 700 square miles. And in that county we are the sole provider of health care.

I am also a member of the board of directors of Community Choice Michigan, which is a licensed not-for-profit HMO that is owned and was developed by 17 federally qualified health centers in the State of Michigan.

Before I begin my testimony, I would like to thank Chairman Bilirakis, ranking member Brown, and the other members of the subcommittee for their leadership in the efforts to secure sufficient

funding to help health centers continue their mission for the uninsured.

Believe me when I say that without your leadership, health centers would not be able to fulfill our safety net role.

In addition, I would like to thank Representatives Burr and Towns for their upcoming efforts to secure health centers a prospective payment system from Medicaid. In Michigan for a brief period of time in 1 year, in 1998, community health centers actually operated on something very similar to this proposed prospective payment system and it was quite effective.

Again, this kind of a commitment is what we need to keep our safety net strong in community health centers.

But today what I want to do is I want to give you the perspective of a health center managed-care plan that has already successfully entered the managed-care market and argue that the efforts in the creation of community responsive managed-care entities will yield real benefits to patients and employers.

We developed Community Choice Michigan because the State was rapidly moving to mandated Medicaid managed care. It was our best opportunity to use the power of collaboration to facilitate information sharing and develop best practices.

CCM also gives health centers the opportunity to build vertical health system relationships and clinical networks to support and enhance the centers' positions in their communities. It has allowed Medicaid and other patients in underserved areas to continue receiving care in health centers. And perhaps most importantly, it has allowed Michigan health care centers to become successful in the managed-care market, thereby ensuring that we will be able to continue our core mission, and that is to make health care affordable and accessible to everyone, regardless of the ability to pay.

Efforts to expand private insurance into medically underserved areas can build on the expertise of health centers in serving underserved communities. Health centers can do this by bringing together different providers to form a comprehensive coordinated care plan that is uniquely tailored to the needs of the community.

I believe that a plan organized by a health center can attract a different kind of customer than would a traditional insurance plan. Small employers such as grocers and coffee shops, restaurants et cetera in medically underserved areas that are looking for a product that is cost efficient and is oriented toward primary preventive care.

As entry points into the health care system for the uninsured as well as cost-effective managers of primary care services, health centers are the natural access points for a different type of coverage. In our efforts to create Community Choice Michigan, we encountered financial and bureaucratic hurdles that seemed to be overwhelming. In our case, the State's financial requirements were exceedingly burdensome, the solvency requirements that you have to have cash on hand for health centers to meet. And if it had not been for some extraordinary action and assistance we would not have been able to form CCM.

This is because by and large health centers do not have excess resources to attempt such an endeavor. Resources that are earned from the health center are reinvested back into the communities

they serve either through expanded services or expanded delivery sites. Even if we are in the black, we still may not have the cash on hand for these efforts.

Strong financial standards are needed to protect enrollees but should take into account the financial realities of medically underserved communities.

The community health organization legislation would have been very helpful to the efforts of the health centers to create an HMO in Michigan. Had we been able to waive the State HMO requirements issue, we would have avoided excessive delays in the processing of the license, discrimination against health plans, and inappropriate financial requirements.

Mr. BILIRAKIS. Please summarize if you would.

Ms. BAUMGARDNER. I guess what I want to say finally is that we feel that this waiver of these requirements is an excellent beginning and is an excellent idea. It is not the cure all. We do not believe it will solve the problems in delivering health care to the uninsured, but it certainly is a start.

We would hope that we can continue to have support for community health centers to help us remedy our problems with the Balanced Budget Act Medicaid issues and hopefully get some support for additional Federal funds to serve the uninsured. Those are topics that I would happily entertain questions on. Thank you very much.

[The prepared statement of Christine Baumgardner follows:]

PREPARED STATEMENT OF CHRISTINE BAUMGARDNER, EXECUTIVE DIRECTOR, ALCONA HEALTH CENTER

Chairman Bilirakis, Ranking Member Brown, Mr. Dingell, Mr. Stupak, Mr. Upton, members of the subcommittee; thank you for the opportunity to testify today on legislation to improve the ability of community health centers to provide our brand of high quality, cost effective care to greater numbers of privately insured Americans.

My name is Christine Baumgardner and I am the executive director of Alcona Health Center in Lincoln, Michigan. I am also a member of the Board of Directors of Community Choice Michigan (CCM), a licensed, not-for-profit health maintenance organization (HMO) owned by 16 Federally-qualified health centers (FQHCs) across Michigan.

Before I begin my testimony, I would like to thank Chairman Bilirakis, Ranking Member Brown, and the other members of the subcommittee for your leadership in efforts to secure sufficient funding to help health centers continue their mission to care for the uninsured. Without your leadership, health centers would not be able to fulfill the vital safety net role that we perform today.

In the time that I have today, I hope to give you the perspective of a health center managed care plan that has already successfully entered into the managed care market and is competing for Medicaid patients. I would also like to argue that the social benefits of having community-responsive managed care entities in place will produce real benefits in enhancing the trust of the American people in today's health care system.

The establishment of Community Choice Michigan reflected a strategic response by FQHCs in anticipation of the State moving to mandated Medicaid managed care. It also reflects the best opportunity for FQHCs to control their own destiny in the growing managed care market and to use the power of collaboration to facilitate information sharing and develop best practices. In addition, CCM gives health centers the opportunity to build relationships and clinical networks to support and enhance the centers' position in their communities. It has allowed Medicaid and other patients in medically underserved areas to continue receiving care at health centers. Perhaps most importantly, it has allowed health centers to become successful in the managed care market, thereby ensuring that health centers will be able to continue with their core mission—to make health care affordable and accessible to everyone, regardless of the ability to pay.

As of today, CCM has 56,000 enrolled members and is currently serving members in nearly half of Michigan's counties. As of December 31, 1998, CCM's net worth was $4.5 million and cash and short-term investments are $13.9 million.

It is my hope that my testimony today will give you some insight into the unique difficulties that health centers have in creating managed care plans and the importance of the Community Health Organization provisions that you are discussing.

Legislation making it easier for community health centers to become involved in the managed care market is essential to ensuring that health centers survive and thrive in today's health care system.

Why?

Today, over 85% of all individuals in the privately insured market are in some form of managed care plan. It is unlikely, given efforts to control the cost of health care on the part of public and private purchasers, that fee-for-service medicine will return.

Efforts to expand private insurance into medically underserved areas in which it has been traditionally difficult to provide both coverage and care can build on the expertise of health centers in serving underserved communities. Health centers can do this by bringing together different providers in a community to form a comprehensive coordinated care plan that is uniquely tailored to the needs of the community.

However, health centers' participation in the managed care market as owners of managed care plans is qualitatively different than their participation as subcontracting providers to a managed care plan. Health centers face unique problems as subcontractors. In many cases, reimbursement rates under most managed care contracts do not come close to covering the cost of providing care to health center managed care patients. Underpayments from managed care plans reduce amounts that can be spent on the uninsured—threatening their statutory mission to make care accessible to everyone, regardless of their ability to pay. When health centers decide to establish a community based managed care organization, they can adapt the services and rate structure of the plan to the unique needs of medically underserved communities.

In addition, health centers believe that the way to control costs in the health care market is to do what we do best—providing comprehensive primary and preventive care services. Keeping people healthy should be the first goal of the health care system. Health centers take that as a core principle of our work.

I believe a plan organized by a health center can attract a different type of customer than would a traditional insurance plan—individuals and small employers, such as groceries and coffee shops, in medically underserved areas that are looking for a product that is cost-efficient yet oriented towards preventive care. As entry points into the health care system for the uninsured, as well as cost-effective managers of primary care services, health centers are natural access points for a different type of coverage.

As a member of a managed care plan owned by health centers, I believe that community health organizations can become entities that meet a special niche in today's health care system. CHOs will ensure that coordinated care plans are operated by providers that understand the health care needs of their communities. These plans will be operated by local community based providers, whose primary mission is to meet the health care needs of the communities they serve and tailor their products toward the employers of that community.

CHOs will enhance competition among commercial managed care plans *for the better*. If CHOs are successful, they will provide strong competition for commercial plans because they will deliver care that is responsive to the needs of their communities. The owners and operators of the plans will be people from the communities. Competition will drive quality up while driving costs down.

The Community Health Organization legislation would have been very helpful in the efforts of health centers in Michigan to create an HMO. Repeatedly, we encountered hurdles that disincentivized us from pursuing this course of action. If the CHO provisions had been in place and provided the options for waiving State HMO requirements, including excessive delays, discrimination against health center plans, or inappropriate financial requirements, this would have benefited our efforts.

Before I discuss some of the barriers we overcame, I would like to state unequivocally that we believe that there needs to be strong financial standards in place to protect member health centers and the patients we serve. These protections should ensure that financial problems will not disrupt the delivery of health care services. I support strong financial standards for these reasons.

However, I also believe that financial standards that fail to take into account the difficulty of setting up plans to care for unique health populations in medically underserved communities, and even institutional biases against non-insurance based

plans, create inappropriate barriers for patients to benefit from services that could be provided by a health center-operated plan. That is why allowing a community-based plan, organized by a health center, to apply for a waiver of State licensure requirements is important in giving health centers the option to overcome hurdles to entering into the market.

In our case, the State's financial requirements were exceedingly burdensome for health centers to meet, and if it were not some extraordinary action and assistance, we never would have been able to form CCM. This is because, by and large, health centers do not have excess resources to attempt such an endeavor. Resources earned from the health center are reinvested back into the communities they serve—by maintaining or expanding health care services or service delivery sites. If health centers are in the black, they may not have the cash on hand to invest in such efforts. Financial standards, while retaining the need to protect enrollees, should be developed to take into account the financial realities of the medically underserved communities served by health centers.

To meet the State financial standards for managed care plans, the health centers involved in CCM had to assemble funds in three ways. Each health center contributed $22,000 in non-grant revenues. We entered into a complicated loan arrangement with the management services organization that provides administrative services for CCM. We worked with the State to have supplemental Medicaid payments to the health center withheld to help satisfy the solvency requirements.

Additionally, CCM member centers wanted to ensure that CCM remained a not-for-profit entity, despite the fact that its created additional hardships because we didn't have financing from other outside sources. However, we felt this was a better move for a number of reasons. First, as a not-for-profit entity, CCM would enable health centers to continue with their mission to care for the uninsured. Second, we were concerned that, if we were forced to go to outside investors, health centers would not have been able to take full advantage of the financial benefits associated with creating the HMO in order to reinvest funds to care for the communities. Finally, we also wanted to retain control over patients and medical policies that we may have been forced to relinquish if outside entities with a financial interest in the profitability of the HMO been involved.

In addition to the financial hurdles, we also confronted bureaucratic entanglements that slowed and delayed the process of approving our license. At the request of the State, we submitted reams of information in our HMO application, only to have those reams returned to us because of bureaucratic hassles. Each time this occurs, it costs health centers additional, already scarce resources to rework and refile the application or the information requested. I do not mean to imply that these actions were taken to prevent Michigan health centers from obtaining an HMO license, but such things have happened to other providers seeking to create HMOs. The ability of health centers to waive State requirements and fall under Federal standards because of excessive delays in action on a license or discrimination against the health center plan would ensure that States respond to a CHO application in a fair and timely manner.

Each of these things created hurdles to the creation of a socially responsive, community-based managed care organization. Congress has historically supported health centers because they are responsive to their communities. The CHO provisions would continue that commitment and bring the community-based nature of health center care to the managed care world.

Health centers are well acquainted with issues of the uninsured—forty percent of health center patients nationwide lack health insurance coverage. Most of these people are the working poor who do not qualify for Medicaid, but neither they nor their employers lack the resources to purchase insurance for themselves and their families. We believe that Congress should do everything within its power to expand access to health care for all Americans.

The Community Health Organization provisions should not be viewed as a panacea to cure all that ails America=s struggling safety net, but as a tool to expand access to care in appropriate circumstances. Nationwide, health centers have *seen over a million new uninsured patients in the last three years.* That pressure, combined with the pending elimination of the payment system that ensures that Medicaid pays health centers what it costs them to provide care to Medicaid patients, are two issues that must be addressed. If these pressures force health centers to cut services or close their doors, health centers will not be able to participate in the formation of community health organizations.

Whatever the approach, however, no effort to expand coverage will be successful without the proper health care infrastructure in place to serve the newly uninsured. America=s community, migrant, and homeless health centers provide the foundation and the framework for any more comprehensive efforts to expand health care cov-

erage for the uninsured. Therefore, protecting and preserving health centers as essential community providers should be the top priority and the first step in any effort to expand health care coverage to the tens of millions of uninsured Americans today.

Conclusion

In conclusion, I would ask the members of the Subcommittee to look at a holistic approach to dealing with the problems of the uninsured. Congress cannot make health insurance more affordable or increase coverage without simultaneously ensuring that the safety net providers that form the backbone of America=s health care system in medically underserved areas remain effective and strong.

Protecting community health centers and ensuring that health centers can maximize their unique role in the health care system, while also fostering the historic role of health centers to make health care affordable to everyone, should be a top priority of this Congress.

Thank you for the opportunity to testify. I look forward to answering any questions you may have.

Mr. BILIRAKIS. Mr. Carlson, you are on, sir.

STATEMENT OF RICHARD W. CARLSON

Mr. CARLSON. Thank you very much, Mr. Chairman and members of the committee. My name is Richard Carlson. I am the executive director of the Illinois Comprehensive Health Insurance Plan. On behalf of the board of directors of our Illinois CHIP program and the more than 7200 Illinois residents who are currently participating in this state program, I want to thank you for the opportunity to testify before your committee.

My testimony today will focus on how Illinois has used its highly successful state risk pool, commonly known as CHIP, to comply with the individual requirements of the Health Insurance Portability and Accountability Act of 1996, or HIPAA. While other states have reported serious disruptions and large premium increases resulting from guaranteed issue in their individual health insurance markets, Illinois has not experienced any such problems.

CHIP has been designated as Illinois' alternative mechanism for implementing these individual portability requirements, and thousands of eligible Illinois residents who have exhausted their rights to continue prior group coverage and have run out of options for securing their own individual policy are now obtaining comprehensive medical coverage with CHIP with no exclusions for preexisting conditions.

Deficits for the coverage afforded to these federally eligible individuals are covered by a broad-based assessment levied against all health insurers and health maintenance organizations doing business in Illinois.

For the first 2 years of this program, assessments for this new HIPAA CHIP pool have been $7.5 million and $6.7 million, respectively. These assessments have been levied against a nearly $10 billion premium base in Illinois that is collected by all health insurers and HMOs doing business in Illinois and has amounted to less than .08 of 1 percent of total direct Illinois premiums.

As of the end of May of this year, 23 months into this new program, we have a total of 2,685 federally eligible individuals who have enrolled in one of two alternative health benefit plans that are offered by this program. Total enrollment for these two plans as of the end of May is 2,099.

And I think it is important to point out that of the 586 people who have enrolled in the program and subsequently terminated, many of them have written us and advised us that they have been able to obtain other coverage in the private market, but were very grateful for having the opportunity to access CHIP in the interim.

The use of CHIP to comply with these individual requirements of HIPAA has clearly been the right decision for Illinois. By using a broad-based assessment, it has been possible to spread the cost of insurance for these high-risk individuals across the entire health insurance industry in our state. As a result, the individual health insurance market in Illinois, which is very price sensitive and amounts to approximately $800 million in annual premiums, has not been forced to fully absorb and subsidize these costs.

This has allowed the individual health insurance market in Illinois to remain stable and not experience the significant increases in premiums that have occurred in many of the Federal fall-back States that have chosen to implement the guarantee issue requirements in HIPAA. With few exceptions the same insurers continue to offer individual health insurance policies in Illinois without significant increases in premiums which are being charged for those policies.

The broad-based assessment feature of our alternative mechanism has resulted in considerable cost sharing and risk spread for the new HIPAA CHIP pool without being disruptive to Illinois' viable health insurance market. Based on other states' experiences, Illinois residents whom this Federal law was designed to serve are also being provided coverage at a cost that, in all likelihood, is lower than it would be if the individual health insurance market had been accessed directly.

Illinois' original CHIP program is now 10 years old and continues to be funded by an annual appropriation which the CHIP board receives from the State's general revenue fund each year. Since its first policy was issued in 1989, CHIP has served more than 17,000 Illinois residents from all 102 counties who have qualified for this coverage.

We have paid out $330 million in benefits on behalf of these CHIP participants. The average annualized premium paid by participants in our program is currently about $3,800. And these premiums cover only approximately 45 percent of the total cost of CHIP providing coverage to these participants.

A State health benefits risk pool like CHIP would do relatively little to increase access to health insurance for the medically uninsurable if premiums for this program were priced according to each individual's actual risk, based on his or her health status. Premiums in that case would have to be approximately twice their current level; and, therefore, the premiums have to be subsidized by the state or an industry assessment.

CHIP's story, in conclusion, is one of people and of a classic public-private partnership that directly improves the lives of the individual itself that it provides coverage for. And the impact of this program has gone well beyond those that it has directly served.

Mr. Chairman, I would offer to the committee if you would like, for the record, our State has produced an educational video about our program and about HIPAA that is mentioned in a GAO report

that was just released. And I would offer that for the record, as well as historical report.

Mr. BILIRAKIS. Without objection, that will be offered for the record. I am not sure how we handle it from the standpoint of publishing it. Thank you very much, Mr. Carlson.

[The prepared statement of Richard W. Carlson follows:]

PREPARED STATEMENT OF RICHARD W. CARLSON, EXECUTIVE DIRECTOR, ILLINOIS COMPREHENSIVE HEALTH INSURANCE PLAN

Good Morning, Mr. Chairman, and members of the Committee. My name is Richard W. Carlson, and I am the Executive Director of the Illinois Comprehensive Health Insurance Plan (CHIP).

On behalf of the Board of Directors of the Illinois CHIP program, which is chaired by the Director of Insurance for the State of Illinois, Nat Shapo, and the more than 7,200 Illinois residents who are currently participating in this state program, I want to thank you for the opportunity to testify today before your Committee.

Illinois' CHIP program is a state health benefits risk pool which has been established and maintained by the State of Illinois since 1989 to provide health insurance coverage for thousands of eligible Illinois residents who can afford, but are unable to purchase, adequate coverage in the private market due to the existence or history of a chronic illness, disability or other high risk medical condition.

My testimony today will focus on how Illinois has used its highly successful state health benefits risk pool, commonly known as CHIP, to comply with the individual requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). While other states have reported serious disruptions and large premium increases resulting from guaranteed issue in their individual health insurance markets, Illinois has not experienced any such problems.

CHIP has been designated as Illinois' alternative mechanism for implementing these individual portability requirements in HIPAA. Thousands of eligible Illinois residents who have exhausted their right to continue prior group coverage and have run out of options for securing their own individual policy are now obtaining comprehensive medical coverage with CHIP with no exclusions for pre-existing conditions.

Deficits for the coverage afforded to these federally eligible individuals are covered by a broad-based assessment levied against all health insurers and health maintenance organizations doing business in Illinois. For the first two years, fiscal 1998 and 1999, assessments for this new HIPAA-CHIP pool have been $7.5 million and $6.7 million respectively. These assessments have been levied against the nearly $10 billion in premiums collected by all health insurers and HMO's in Illinois, and have amounted to less than 8/100th of 1% of total direct Illinois premiums.

As of May 28, 1999, or 23 months into this new program, 3,662 applications had been received for HIPAA-CHIP, and a total of 2,685 federally eligible individuals had enrolled in one of two alternative health benefit plans. Total in force enrollment for these two plans as of May 28, 1999, was 2,099. Many of the 586 individuals who have enrolled and subsequently terminated have written and advised us that they had been able to obtain other coverage in the private market, but were very grateful for the opportunity to access CHIP in the interim.

The use of CHIP to comply with the individual requirements of HIPAA clearly has been the right decision for Illinois. By using a broad-based assessment, it has been possible to spread the cost of insurance for these high-risk individuals across the entire health insurance industry in our state. As a result, the Illinois individual health insurance market, which is very price sensitive and amounts to approximately $800 million in annual premiums, has not been forced to fully absorb and subsidize these costs.

This has allowed the individual health insurance market in Illinois to remain stable and not experience the significant increases in premiums that have occurred in many of the "federal fall-back" states that chose to implement the guarantee issue requirements in HIPAA. With few exceptions, the same insurers continue to offer individual health insurance policies in Illinois without significant increases in the premiums which are being charged for those policies.

The broad-based assessment feature of our alternative mechanism has resulted in considerable cost sharing and risk spreading for the new HIPAA-CHIP pool without being disruptive to Illinois' viable individual health insurance market. Based on other states' experiences, Illinois residents whom this federal law was designed to serve are also being provided coverage at a cost that, in all likelihood, is lower than it would be if the individual health insurance market were accessed directly.

Building on the Success of Original CHIP Program

When the Comprehensive Health Insurance Plan (CHIP) Act was approved on February 9, 1987, Illinois became the 15th state to establish a health insurance plan for those residents whose access to medical coverage is denied due to ill health or disability. Illinois was also the first state to pledge the use of state revenues to cover anticipated deficits between premiums and claims.

Illinois' original CHIP program is now ten years old and continues to be funded in part by an annual appropriation which the CHIP Board receives from the State's General Revenue Fund. Since its first policies were issued in 1989, CHIP has served more than 17,000 Illinois residents from all 102 counties in our state who qualified for this coverage. It has paid more than $330 million in benefits on behalf of these CHIP participants. At the same time, this state provided health care program has remained financially stable and secure while not increasing in recent years the amount of the annual appropriation which our Governor and General Assembly have so generously approved each year.

The Illinois Comprehensive Health Insurance Plan is one that has definitely worked well to serve those who have found it necessary to access this program. In fact, it has been recognized as one of the premier programs nationwide. In its 1995 monograph, State High Risk Pools: The Most Promising Way to Insure the Uninsurable, the Council for Affordable Health Insurance (CAHI) provides a case study on the Illinois risk pool and identified it as "one of the more successful programs" among those that are currently operated by 27 states throughout the country.

This monograph noted that state high risk pools (classified as state health benefit pools in HIPAA) are mechanisms through which people with existing medical conditions can purchase comprehensive health insurance at a price that is not commensurate with the individuals health status. Premiums are subsidized in this manner for such individuals because the price otherwise would be prohibitively expensive. In this 1995 monograph, CAHI also suggested that "state risk pools are the most promising mechanism available for ensuring that high risk individuals will be able to obtain coverage without disrupting the insurance market for the other 99 percent of Americans."

Program Funding

CHIP is funded partly by premiums paid by participants and, to the extent that premiums do not meet anticipated expenses for our original CHIP program, by an appropriation from the state's General Revenue Fund. A separate industry assessment supports the newer HIPAA-CHIP program. The premiums charged by CHIP are currently set at 135% of the average rates charged individuals for comparable coverage by five or more of the largest insurance companies in the individual health insurance market in Illinois.

The average annualized premium paid by participants in the CHIP program is currently about $3,800. These premiums cover approximately 45% of the total cost for CHIP providing this coverage to all of its participants. Premiums for an optional hospital PPO plan, introduced in 1995, are approximately 20% less than those for the standard indemnity plan.

The CHIP Board of Directors is sensitive to the fact that cost continues to be the number one barrier to individuals obtaining health insurance today, whether from CHIP or from the private market. A state health benefits risk pool like CHIP would do relatively little to increase access to health insurance for the medically uninsurable if premiums for this program were priced according to each individual's actual risk based on his or her health status. Premiums in that case would have to be approximately twice their current level. Premiums must, therefore, be subsidized by the state or an industry assessment.

These subsidies allow the cost of insuring the uninsurable in Illinois to be spread across a broad segment of our population and it helps keep everyone's insurance rates down by pooling the cost of treating these high-risk individuals.

As in previous years, an appropriation from the state's General Assembly was once again needed to fund the anticipated deficit for the original state-funded pool. This appropriation for CHIP has been able to remain relatively level for the past eight years, and is once again $17.3 million for Fiscal Year 2000.

CHIP Today

CHIP's story is one of people and of a classic public/private partnership that directly improves the lives of the individuals it provides coverage for. The impact of this program has gone well beyond those whom it has directly served.

Total CHIP enrollment today is approximately 7,200.

- The lifetime maximum in benefits for each individual covered by CHIP was increased from $500,000 to $1 million as of July 1, 1997.

- Heart disease and cancer remain the two costliest conditions for which CHIP participants receive benefits.
- Forty-five percent of CHIP participants believe that having CHIP improved their employment opportunities.
- CHIP has helped Illinois residents avoid having to access Public Aid's Medical Assistance No Grant Program.
- One-third of CHIP participants believe that having CHIP kept them from filing for bankruptcy.

The existence of CHIP has given these individuals and their families "freedom from fear" and allowed them to concentrate on fighting their illnesses, rather than having to worry about how they are going to pay for their medical care.

While many, unfortunately, have died after long, painful and expensive illnesses, there are also many other inspiring personal success stories where CHIP has been able to help provide access to lifesaving medical care.

Its overwhelming success demonstrates that state government can be sensitive and responsive to the needs of some of its more vulnerable citizens while also controlling costs and restraining the rate of growth of a health care program.

Health Insurance Portability and Accountability Act (HIPAA)

Of major significance for CHIP and its now more than 7,200 participants was the approval and implementation in 1997 of a major new program for CHIP in response to the enactment of new federal portability legislation, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Among the many important provisions of this major legislation was that it gave the individual states, like Illinois, several options for ensuring that "eligible individuals" have access to individual health insurance coverage on a guaranteed-issue basis, with no pre-existing condition exclusions.

After months of study and debate concerning the implications for CHIP and its participants, the CHIP Board voted unanimously in December, 1996 to recommend to the Governor and General Assembly that the existing CHIP program be expanded for this purpose. This recommendation was conditioned on the insurance industry agreeing to pay a broad-based assessment for funding the anticipated deficits resulting from CHIP providing coverage to all of these federally eligible individuals.

A threshold issue concerning the use of CHIP as an acceptable "alternative mechanism" had to do with the fact that if it were not used, the cost to insurance consumers in Illinois—and to those whom HIPAA would seek to protect—would be higher. Our Department of Insurance actuaries believed it was almost certain that guaranteed issue of individual policies with no pre-existing condition exclusions to all eligible individuals in Illinois would result in a higher cost.

In the private individual health insurance market, there is no mechanism to subsidize increased costs. Therefore, when costs go up, all individual policyholders will end up having to pay higher premiums. Since these policies are very price sensitive, this in turn will likely result in many healthier individuals choosing to drop their insurance. This could then very well be the beginning of a "death spiral" in premium rates for these policies. Only individuals with significant medical problems will be willing to pay these ever increasing rates which the insurer must charge to cover its increased costs for a diminishing group of policyholders.

In contrast, our CHIP Act places a ceiling on the premium rates which persons who are eligible for CHIP are required to pay, and provides for subsidization of the resulting deficit from the state's General Revenue fund. By using CHIP as an "alternative mechanism" to offer federally eligible individuals coverage that is guaranteed issue with no pre-existing condition exclusions, there is also by statute an upper limit on the premium rates which federally eligible individuals have to pay, and a means for paying the deficit.

It should also be noted that CHIP rates are themselves a function of the private individual market rates. Therefore, if we did not use CHIP as an "alternative mechanism" and premium rates for individual policyholders in general went up because of the guarantee issue requirement, the premium rates for all of our current CHIP participants would also automatically increase. As a result, everyone has to pay more, there is no means for subsidizing or spreading the risk for individuals with significant medical expenses, and the total number of uninsured individuals in our state would undoubtedly increase as the healthier individuals choose to drop any insurance coverage rather than pay the increased premiums.

Acting on this recommendation, our Governor then submitted a formal request to the Secretary of the U.S. Department of Health and Human Services in March of 1997 to use CHIP as an alternative mechanism for meeting the requirements for access to individual health insurance coverage as set forth in Section 111 of HIPAA.

The Illinois General Assembly also overwhelming approved Senate Bill 802 to make the necessary changes in state law to implement the federal HIPAA. It also amended the CHIP Act to qualify CHIP as an "acceptable alternative mechanism" for ensuring "federally eligible individuals" can obtain individual health insurance coverage through CHIP with no exclusions for pre-existing conditions. This legislation also provided that this new HIPAA-CHIP program was to be funded by an assessment of all health insurers, health maintenance organizations and voluntary health service plans, and that there be no limitation on enrollment or exclusion for pre-existing conditions for these federally eligible individuals.

This legislation was signed by the Governor on June 26, 1997, and with the hard work and diligent planning of the existing CHIP Board, its staff and Administrator, we then were able to begin enrolling federally eligible individuals on July 1, 1997, a full six months before the date required by federal law. As of May 28, 1999, approximately 2,700 eligible individuals had taken advantage of this new program and enrolled in either of the new plans 4 or 5 pursuant to a new Section 15 which was added to the CHIP Act by Senate Bill 802.

Using CHIP to Comply with HIPAA was Right Decision for Illinois

Illinois has received national recognition for its use of CHIP as an alternative mechanism for implementing the individual access requirements in HIPAA because it has helped maintain and preserve a stable individual health insurance market in Illinois. By contrast, in a report to Congress on HIPAA in February of last year, the General Accounting Office reported that premiums for individual policies had increased from 140% to 600% in a number of the "federal fallback" states that had chosen to implement and enforce the guarantee issue requirements in this federal legislation. We are pleased that problems of this nature have not been reported in Illinois, and that the use of CHIP to meet this new federal mandate has clearly been the right decision for Illinois.

Illinois continues to enjoy a stable individual health insurance market because the additional costs of providing this type of guaranteed coverage for high-risk individuals is being spread over the entire health insurance industry in Illinois with annual premiums of almost $10 billion rather than having to be absorbed by the individual market with a premium base of approximately $800 million.

The success of the Illinois HIPAA-CHIP program, which has been able to maintain its premiums at 135% of the rate charged by the five or more of the largest carriers in Illinois providing similar individual coverage, is largely attributable to its ability, by statute, to assess a broad base of all health insurance companies and health maintenance organizations doing business in Illinois. The direct Illinois premium base for this purpose, for both the Fiscal Year 1998 and 1999 assessments, amounted to nearly $10 billion. This then allowed the assessments for each of these two fiscal years of $7.5 million and $6.8 million, respectively, to be less than 8/100ths of 1% of this large premium base.

As a result, the individual health insurance market in this state, which is very price sensitive and amounts to approximately $800 million in annual premiums, has not been forced to absorb and fully subsidize the costs of these higher cost individuals. This has allowed the individual health insurance market in our state to remain stable and not experience the significant increases in premiums that the GAO has previously reported occurred in several of the "federal fall-back" states that chose to implement the guarantee issue requirements in HIPAA.

The other important impact that the new HIPAA-CHIP pool has had on those enrolled in the traditional CHIP pool concerns the premiums which we are required by state law to charge. Since our premiums are a function of those charged by the largest insurers in Illinois, our participants are also directly benefiting from premiums in the private individual market here having remained relatively stable.Summary and Close

Having CHIP to turn to is one of the State of Illinois' real success stories that benefits everyone. It helps keep everybody's insurance rates down by pooling the cost of treating high risk individuals. It's an important stopgap measure for early retirees until Medicare becomes available to them, or for those who are between jobs or no longer able to work. It allows people to stay self-employed, to avoid bankruptcy and to stay off of medical assistance. Without CHIP, these devastating medical expenses would be cost-shifted, making both medical care and health insurance more expensive for everybody, even causing more people to become uninsured as a result of being priced out of the market.

The existence of CHIP has also meant a "freedom from fear" for many Illinois residents. It has meant that individuals with serious medical conditions are able to purchase health insurance and secure needed medical treatment without worrying whether or not the bills will be paid.

With the implementation of the new HIPAA-CHIP program, CHIP is now more than ever allowing these individuals to lead productive lives without the fear that a sudden medical crisis might result in personal bankruptcy for them or cause them to end up on Medical Assistance. Accessing CHIP coverage allows these individuals to gain and maintain employment which they previously might not have been able to because of health insurance concerns. There is no doubt that the existence of our program has allowed some of the individuals whom we have been able to cover to establish their own business or move into a more productive type of job for which they have been trained. We also have undoubtedly kept many of these people off Medicaid. We have helped to preserve and maintain a stable and affordable private individual health insurance market in Illinois.

We look forward to continuing to help meet the health care needs of this very special segment of our population. We are delighted and honored that the proven track record of this important and successful State program has been recognized by our lawmakers at both the state and federal level. We very much appreciate our legislator's confidence in CHIP by deciding to use our program as an alternative mechanism for meeting the individual portability requirements of the federal Health Insurance Portability and Accountability Act of 1996.

Mr. BILIRAKIS. Mr. Nichols.

STATEMENT OF LEN M. NICHOLS

Mr. NICHOLS. Thank you, Mr. Chairman. My name is Len Nichols. I am a health economist and a principal research associate at the Urban Institute. Everything I will say today is my opinion alone, which is not necessarily shared by the Urban Institute, its trustees, sponsors, or any known person, living or dead.

Much of the research I will describe is coauthored with my colleague, Linda Blumberg, who is with us in case I falter later in the question period.

As you have heard today, it is true that health insurance market reforms have disappointed some of their advocates. As luck would have it, I just completed an extensive review of that literature for a conference I attended last week in Holland; and I think it is fair to conclude that there has been precious little, if any, coverage expansion as a result of those reforms.

Now, this does not mean I would offer that reforms were necessarily a failure. They may have increased access for the sick while decreasing coverage for the low risk. This is a hypothesis and tradeoff that needs careful testing in the future. But it is clear that coverage was not expanded, and that is what led to the kinds of reforms that we are discussing today; and I applaud your committee for taking on this issue in such a serious way.

HealthMarts and association health plans, I think, would take a step back from regulation and allow more market freedom and market segmentation among risk pools in different ways than current market rules allow. And while appealing in some ways, these new proposals do raise the recurrent question, and in my view the fundamental question of health insurance policy: What kind of risk pools do we really want?

There are two polar answers to this question: Homogeneous and purely volunteer versus heterogeneous and partially coerced. Homogeneous pools have the virtue of not forcing anyone to pay for someone else's expected cost. They serve the healthy well with low premiums. But they also leave the unhealthy uninsured.

Heterogeneous pools subsidize access to care for the unhealthy, but they discourage care by the healthy who may prefer the risk of being uninsured to the burden of that implicit tax. Now, all

health insurance market reforms essentially force more risk pooling than the market would achieve on its own. So the hard question before us today is would introducing AHPs and HealthMarts into the current mix of forced risk pooling lead to increased coverage; and if so, who would gain and who would lose the most from such policy change?

My colleagues and I have built an empirical model to address these questions by focusing on the issues faced by employers making these choices. Our findings at this point must be characterized as preliminary, for they are not yet published; but we would be glad to discuss the details of the models and the assumptions with your staff, if you would find that useful, as we have with other researchers around town.

The overarching lesson of our simulation results is that the composition of the risk pool is much more important than the marginal effects of benefit mandates, premium taxes, and administrative loads. Premium differences associated with different risk pools are much greater than the variance in benefit packages in the real world. We find that small firms do appear to prefer more risk pooling than insuring alone and self-insurance mechanisms would allow. Thus AHPs and HealthMarts are attractive because they offer those employers a way to achieve an intermediate degree of pooling between none and self-insurance and that that is sometimes required by state regulations.

However, there is a cost to this freedom to select into AHPs and HealthMarts and that is, as Jack pointed out, the risk pool of commercial products and of existing MEWAs could deteriorate since AHPs and HealthMarts are likely to be most attractive to the lowest-risk groups.

On net, our model suggests that there is going to be very little net overall change in offered rates; and thus we tentatively conclude that there will be little effect on net coverage. This is because those few who are enticed to offer as a result of the new plans are almost exactly offset by those who find their premiums go up when their particular risk pool deteriorates, both in commercial and in MEWAs.

We also find that HealthMarts are likely to be less attractive to most firms than are AHPs because AHPs have lower premiums, they are exempt from premium taxes, they have lower solvency requirements, and they also, we think, would have lower administrative loads. But the real-world price responsiveness which we built into our model led us to believe that there is not likely to be a wholesale land rush to AHPs. Rather, we think that after 4 years AHPs would cover at most 10 percent of workers who are currently offered health insurance.

Furthermore, we predict that those who would choose AHPs would come mostly from self-insured arrangements; and most of the workers would actually come from medium and large firms, those with more than 100 workers, as opposed to the specific target group of small employer workers.

We intend to continue this line of research to test the results against alternative assumptions and to adapt this model to address the implications of the tax credits that are being discussed. We expect to have results on this new model by September.

I would like to devote the last seconds of my oral testimony to a comment on high-risk pools because some of the empirical work that I have reviewed and some that I have done has found a very interesting finding which supports almost everything that Mr. Carlson just said and that is that those States with high-risk pools without enrollment caps do appear to have higher rates of private coverage.

Now, we don't think the household surveys that we use to do these surveys are picking up the 300 people that actually are in them. We think that the insurance industry behaves in different way when the high-risk valve is there. The high-risk valve fundamentally says to the insurers: You don't have to worry as much about adverse selection. The truly, truly sick are already taken care of. When they are out, we think the evidence suggests it is clear they are offering lower premiums and therefore the private market works better.

So a well structured high-risk pool could be a nice complement to any other coverage expansion policy. Thank you very much.

[The prepared statement of Len M. Nichols follows:]

PREPARED STATEMENT OF LEN M. NICHOLS, PRINCIPAL RESEARCH ASSOCIATE, THE URBAN INSTITUTE

As a health economist and as an American citizen I am very pleased to be here before you today. My remarks, both written and oral, reflect my opinions alone and do not represent those of my employer, the Urban Institute, nor of its trustees or sponsors. Most of the papers emanating from the research work that is reported upon were co-authored with my esteemed colleague, Linda J. Blumberg, who is here today and can answer any questions should I falter.

Four facts have brought us to this policy crossroads: 1) most Americans get their health insurance through some employment relation; 2) most of the uninsured are either workers or dependents of workers; 3) despite all the policy attention in the last few years, small employers are still much less likely than large firms to offer health insurance to their workers; and 4) workers in small firms are the most likely to be uninsured. These facts suggest that focusing on ways to get coverage to workers in small firms is the most important incremental reform strategy we could undertake in this country at this time. I applaud the committee for recognizing these facts and addressing this issue in a thoughtful and serious way.

At the same time I want to impart just a few words of caution, because I've learned the hard way that we all need to maintain modesty and think through the complicated interactions among the many parts of our health care system before proposing specific policies that will most likely help some people but hurt others. Real world health policy is almost always about choosing among alternative positions along some kind of tradeoff function. "First Do No Harm," was the title of one my first published papers on health insurance reform, and I think the admonition is a wise one for all policy discussions.

Most of my research effort is devoted to studying the theory and actual consequences of health insurance reform legislation as introduced by state, federal, and increasingly, by foreign governments around the world. Pursuant to that research interest, with the help of my colleagues at Urban and elsewhere, I have built an elaborate model that can simulate the choices different kinds employers make about offering health insurance to their workers. If our firms decide to offer coverage, the model then simulates their preferences among possible insurance vehicles, which of course in our country are many: commercial insurance, self-insurance, as a participant in a MEWA, or perhaps in a new AHP or a Health Mart, where these new options were modeled as described in the legislation that was proposed last year in the House.

Our results at this point are best characterized as preliminary, but since our ongoing work is so relevant to the topics you are discussing today, it seemed useful to share with you our as yet unpublished research findings.

Our simulated employers' choices among their many alternatives depend upon the factors we and others believe are most important to them in the real world: the relative premiums of the options, which in turn depend upon the presence or absence

of benefit mandates, premium taxes, solvency requirements, different administrative loads, and state insurance market regulations.

All microsimulation models depend upon a long list of technical assumptions, which we try very hard to make consistent with what we can observe about the real world. These unavoidable assumptions do make all our conclusions contingent upon them. Different assumptions would produce different results, and Linda and I would be glad to discuss the details of our model with you or your staffs at your leisure. Still, the overarching lesson that can be distilled from our modeling exercise is, I think, quite intuitive: by far the most important element of health insurance choices is the risk pool to which groups or individuals have access.

By stressing the importance of the risk pool, I hope to remind you all of the principle that all insurance is about pooling risk. Indeed, the fundamental health insurance policy debate can be boiled down to a question of what kind of risk pools we really want: homogeneous and purely voluntary, vs. heterogeneous and partially coerced. Homogeneous and voluntary pools have the virtue of forcing no one to pay for someone else's expected costs, and they serve the healthy with low premiums, but they also often leave the unhealthy uninsured. Heterogeneous and community pools have the virtue of subsidizing access to care for the unhealthy, but they can discourage coverage of the healthy who may prefer the risk of being uninsured to the burden of this implicit tax. Policy making is about choosing among these desirable yet imperfect alternatives, and wise policy making is about trying to balance our competing objectives along the feasible paths which good analysts try to describe for you.

All health insurance market reforms—guaranteed issue, guaranteed renewal, portability, limits on pre-existing condition restrictions, restrictions on the variance of premiums—all of these reforms force more risk pooling than the market alone would achieve. What our research shows is that the nature of the resulting risk pools to which different firms have access is more important to employer choices about health insurance than the presence or absence of benefit mandates, premium taxes, and solvency requirements.

Some firms clearly prefer to go it alone: they have low risk workers and dependents and can do quite well through self-insurance, especially if they're large enough to enjoy administrative economies of scale.

But most small firms appear to prefer more risk pooling than self-insurance allows, hence the relative popularity of commercial insurance, and the potential popularity of AHPs and Health Marts, if carefully structured.

One reason these options are appealing is because they exempt participants from benefit mandates. And while benefit mandates, as the research literature suggests, may add little to costs on average, they can surely add considerably to the cost of some benefit packages, especially those preferred by some small firms. At the same time, more mandates make the packages more attractive to workers, and probably increase worker take-up, so once again we have a tradeoff.

Again, our research simulations suggest that by far the most important factor determining the attractiveness of various health insurance options is the pool with whom the firm's workers will be joined for premium rating purposes. AHPs and Health Marts, to the extent they are exempted from state premium rating rules, will be more attractive to the good risks and less attractive to high risks in search of more heterogeneous pools.

MEWAs are attractive to firms of all sizes in some industries, but they are not a very large part of the overall private health insurance market today, and our simulations do not suggest that they're likely to grow a lot in the future. The interesting policy question is, which types of firms would want to join AHPs or Health Marts, and what would happen to the commercial, self-insured, and MEWA markets if these options came into existence next year?

Our simulations, based on our detailed assumptions, predict that Health Marts are not likely to be very popular, for the simple reason that their only real advantage over commercial products is exemption from benefit mandates, and that is simply not enough of a price advantage on average to entice many firms to choose to purchase health insurance through one, at least not when AHPs are also an option.

AHPs then appear to be the most popular new option that federal legislation might create, and our model suggests that they will be more popular after 4 years than MEWAs are now. Still, our results suggest that AHPs are not likely to capture huge shares of the market, with a little more than 6% of all workers. Somewhat surprisingly to us, almost 4/5 of the workers in our model who work for firms that will choose AHPs are currently in large firms (with more than 100 workers) as opposed to small firms (with fewer than 100 workers).

Perhaps even more interestingly, most new AHP enrollment appears to come from the currently self-insured, not from the commercial insurance market. This finding

suggests to us that at least medium sized firms also want a bit more pooling than self-insurance affords, but not as much as commercial insurance would impose, even without extensive regulation.

This result also implies suggests that much of the opposition to AHPs may have been a bit shrill, since the commercial risk pool does not appear to be destroyed by this new option. This opposition was based on the likelihood that AHPs are most likely to appeal to the healthiest risks. AHPs will appeal to good risks since they can practice more segmented premium rating practices than the commercial insurance industry is expected to, whether that commercial sector is regulated or not (we simulated both scenarios).

This segmentation increases the chances that firms will be pooled only with firms with similar cost structures. Thus AHPs represent a step toward homogeneous pools from a moderately heterogeneous status quo. And as such, they do represent a threat to established heterogeneous risk pools. But the real-world-based price responsiveness that we built into our model suggests that this threat is not likely to be destroy the commercial market, though some firms may stop offering as low risk groups leave and commercial premiums rise, as I discuss below.

At the same time, in our simulations, extremely few new firms are enticed to offer health insurance which did not offer before the reform options were made available. Some firms do drop coverage, and the average firm size of those which do offer declines. These findings translate into the result that introducing the new options—AHPs and Health Marts—may actually reduce overall offer rates on net, though by such a small amount—less than 1% of all workers—that it probably should be considered as no net effect on employer offerings. Net coverage is reduced because the commercial and MEWA pools lose some of their best risks to the AHPs, and thus their pools deteriorate. Because of this risk pool deterioration, some firms drop coverage rather than pay the new higher prices that go with this deteriorating risk pool.

These firms do not join AHPs, however, because that risk pool is too segmented for their taste and risk profiles. Most of the firms that drop coverage after AHPs are made available, by the way, were initially insured through MEWAs, not through commercial insurance. Our preliminary results also suggest that about half of all employment-based insurance policyholders experience a premium change of more than 5%, with winners slightly outnumbering losers. So we predict rather a lot of premium churning for relatively little coverage impact.

We intend to continue this line of research, to test the results against alternative assumptions, and to refine this model and to adapt it to address the implications of switching to an individual tax credit system rather than the current exemption for employer contributions to employee premiums. We expect to have results to report on this new model by September of this year.

High Risk Pools

I'd like to devote the remainder of my testimony to reporting on one empirical result that was found in a couple of different studies, including one of my own with other Urban Institute colleagues. The studies tested for the effects of a number of state policies, including high risk pools, on private insurance coverage. While the results are not definitive, they are strongly suggestive that the existence of certain kinds of high risk pools leads to more non-group coverage than would otherwise be the case.

Now you all know that most high risk pools are very, very small, and I don't think the household surveys that underlie the best empirical work in this area are picking up many people who are actually enrolled in them. But the results DO suggest that when high risk pools provide reasonably comprehensive coverage, are reasonably subsidized, and are not limited by enrollment caps, the individual insurance market seems to work better. I think this is most likely to be because when insurers are confident the truly hard to insure are safely cordoned off in reasonable high risk pools, then they are less fearful of adverse selection and thus offer lower prices, which in turn entice more, and especially more low risk individuals, to purchase non-group health insurance. This suggests that adequately funded high risk pools, without enrollment caps and with statutory definitions of high risk, can be useful components of a coverage-enhancing policy mix. Not to mention the fact that they provide immense financial relief to the unfortunate families involved, and thus could serve a major equity role in our free society.

It is worthwhile to remember that in the absence of high risk pools, these individuals still get care, but it is often uncompensated. We all share in that risk, in that we collectively subsidize their care, either with tax dollars going directly to the public facilities that provide the care, or through implicit surcharges that are added by providers to privately financed services and thus to private health insurance pre-

miums. An appropriate high risk pool strategy, which preserves family dignity and enables needed, comprehensive care to be delivered at a time in the patient's illness episode when it is most likely to be effective care, can be a much more efficient risk sharing mechanism than those "backdoor" channels we otherwise use.

I would now be glad to answer any questions you may have.

Mr. BILIRAKIS. Thank you very much, Mr. Nichols.

Well, if we have gotten anything at all out of this hearing, it is that it is a tough question. It is something that I think everybody wants to accomplish. It is amazing to me that there are two or three members of this subcommittee who think you can just wave a magic wand and solve the problem. But you experts out there, you and the prior panel, don't see it quite that easily done.

We have heard that some of the solution is expanding Medicare down to the age 55. And yet the administration itself only forecasts that about 300,000 people would be covered there, and in over 10 years CBO says maybe you might reach 700,000. That is far from a solution.

We have heard that with HealthMarts, anywhere from 5 to 10 to 20 percent might be covered. That is pretty good, but it is still a fairly low percentage insofar as the overall uninsured are concerned.

Tax credits, we have all heard most people agree that they are going to be helpful. We don't know how many that would help. It certainly would help with the young lady who was in here telling us the sad story of her family. But would that be enough? Probably not.

And so, I think back to a few years ago. It might have been before Mr. Brown was here. I think it was certainly before Mr. Barrett was here—when we proposed a bipartisan health reform plan. It was truly a bipartisan plan where we spent hours and hours starting about 4 o'clock in the afternoon to all hours of the night, practically every day in the week trying to develop a plan, and we came up with some pretty good ideas to expand coverage to the uninsured.

Would that have covered all 43 million? I am not sure, but certainly a large portion of them. But politics entered the picture, and that unfortunately didn't go anywhere.

In an ideal world, should everyone in a country such as ours have insurance? I would say yes. I don't hesitate to say that. But it is not an ideal world. And I guess my biggest concern is should everyone in a country such as ours at least have adequate access to health care, whether it be covered by insurance or not? And I feel very, very strongly, about that. I think that should be our immediate goal.

Some would say if that is your immediate goal, and you feel like you have solved that, then you are not going to be concerned about the insurance aspect. Well, maybe we should or shouldn't be. We can also talk about the role of community health centers in expanding access to care.

But they only go, of course, so far because they don't cover specialized care. But they go pretty far in terms of basics.

So I guess I would raise a question, Ms. Baumgardner, I suppose all of your patients, clients, whatever the proper term would be, are uninsured?

Ms. BAUMGARDNER. All of ours are?

Mr. BILIRAKIS. Are they?

Ms. BAUMGARDNER. No, sir, not all of ours are uninsured. We have a large Medicaid population in our patient base. We also have——

Mr. BILIRAKIS. Would those Medicaid populations be a part of this 43 million, they don't have insurance but they are covered?

Ms. BAUMGARDNER. They are covered by Medicaid and are not considered part of the 43 million. We have a lot of people just like Mrs. Horsley who, by the way, is getting her primary care from a community health center. We have an awful lot of people who we call the working-class poor who simply are just working as hard as they possibly can for very, very little wages and just don't have access to care.

Mr. BILIRAKIS. But they are uninsured.

Ms. BAUMGARDNER. They are uninsured, that is correct, and they come to the community health center and they are able to get reduced-cost health care. And since we have developed our Medicaid HMO, we have developed stronger ties and relationships to specialty practices and to hospitals. And we have been able to work out a number of arrangements with those larger facilities, those more expensive levels of care, where they are also offering reduced-rate care for our uninsured patients.

Mr. BILIRAKIS. Can you—and I suppose in a way you are responding to this—can health centers retain their mission to make health care services available to everyone and still actively compete in the managed-care market?

Ms. BAUMGARDNER. I think we are doing it. I think actually if you look back at the legislation that enables community health centers, what you will see is that we really are managed-care organizations. We attack health care issues at the front end at the least expensive end where problems can be fixed much more easily.

If you heard what Mrs. Horsley said, they let her husband's second bout of cancer go too long which happens frequently with uninsured people. They think it is something minor and that it is going to go away, and they come in much later and the problem is much worse than it would have been had they sought care early on.

But we are successful in our Medicaid HMO. In the State of Michigan, we are ranked as one of the top 4 out of the 26 participating plans in Michigan. So we are able—we understand management of health care services and——

Mr. BILIRAKIS. Let me ask you just very quickly as I finish up, approximately what percentage of the uninsured do you feel are covered by rural and community health centers? Rural and community health centers?

Ms. BAUMGARDNER. I believe that the national data is about 1 out of 10 persons.

Mr. BILIRAKIS. Ten percent of the uninsured are covered?

Ms. BAUMGARDNER. I believe that is correct. Am I accurate, friends? Yes, that is about 1 in 10.

Mr. BILIRAKIS. And that can be improved?

Ms. BAUMGARDNER. Oh, yes it can be. Right now we are using our Federal grant dollars to cover our uninsured population; and to give you some idea of how much money that is, we are a $3 million project with four delivery sites and of that we receive—of that

$3 million budget annually we receive $400,000, just a little under $400,000 in Federal funds; and that is what we use to help cover our uninsured, and it is not entirely adequate, certainly.

Mr. BILIRAKIS. Thank you. Mr. Barrett.

Mr. BARRETT. Thank you, Mr. Chairman. When I first got involved in this debate as a Member of Congress several years ago, the figure that was bandied about at that time was that there were 36 million in this country without health insurance. And then the next time it came up—the next bill that came up the figure was, I think, 39 million. Following that it was 41 million and now I think the figure we hear is——

Mr. BILIRAKIS. Forty-three.

Mr. BARRETT. [continuing] 43 million. So clearly, either the figures are incorrect or the approach that we have taken thus far has not addressed the problem. And I just want to touch on a couple of different little approaches that have been used to address it to see where the problem is.

And we heard testimony earlier today, for example, that the big problem is we have got out of these state-imposed mandates and because we have all of these mandates, employers will not purchase the plans so the states respond and the States pass bills that provide for a bare-bones policies.

Mr. Meyer, I think you have done some work in this area. What has been your experience or what have your studies shown you in terms of how successful these bare-bones policies have been at the state level?

Mr. MEYER. Bare-bones policies have been very unsuccessful for two reasons. First, people have difficulty affording even bare-bones policies. Small employers are living on the edge or even when the cost comes down they have difficulty affording their contribution which might be half or 80 percent. Employees have a lot of trouble affording their share. And in the small employer market that share might be 50 percent.

And finally, people like comprehensive health coverage in this country. They do not like bare-bones. It is a tough sell. And a colleague of mine, Professor Mark Hall at Wake Forest University, has done a lot of work on this with my colleague, Elliot Wicks. They have been around the country, State after State performing interviews, and they have found very low numbers of people that have taken these up for those reasons.

Mr. BARRETT. So clearly you don't think making these more widespread is going to lower the number of uninsured.

Mr. MEYER. I think it would lower it a little. I think it would take a little bit of water out of this pitcher, and I am not against experimentation with some marginal changes in mandates or giving something relief to small business. I just think it would be a mistake, given the magnitude of the problem and the upward march in the numbers that you cited, to think that would make a major dent in the problem. It would be a small positive contribution.

And remember, when you don't have the unmandated benefits, as unpleasant as mandates are, somebody is not getting something that they would otherwise get such as mental health coverage, substance abuse coverage, or other services, some of which may be

viewed on the margin by the society at large, but if you are the one that needs them, there would be some give-up there.

Mr. BARRETT. Mr. Nichols, you, I think, have done some work on HealthMarts and association health plans. Again, these are devices that have been introduced to lower the number of uninsured. How effective have those been?

Mr. NICHOLS. Well, we don't have association health plans and HealthMarts as proposed in the legislation. We do have a number of examples around the country, some of which you have heard of today of different features that are like them; and some of them have been very successful.

What we tried to model in our work was what would happen to the small employer market that exists today, the commercial sector, the self-insured sector, and the existing MEWAs and how attractive would these new vehicles be; and what we found fundamentally was that they would offer an appealing product to a certain group of small and, surprisingly to us, medium to large firms who are looking for a little more pooling than they can get alone in the self-insurance market. They don't like it going it alone but they don't want as much pooling as some State regulations do indeed force today.

We are Americans. We always go too far one way or the other way. We probably went too far in some of the state regulations. We could probably scale that back. But I would echo the comments of Jack, it doesn't follow that you repeal the entire thing and go back. I would point out before we had State insurance regulations, we had some uninsured in this country, I think the number of 37 million that you were starting with in your sojourn there. And the number was rising then at least as rapidly as it is rising now without the benefit of health insurance regulation.

So I think it is important to go back to the pitcher. These kinds of reforms on the margin are not going to get at the core of it. It is going to have effects on the margin. And I would certainly submit that we think about health insurance regulations as affecting the mix of the pool more than the size of the pool. Because it determines who does have access to it and who does not.

Mr. BARRETT. I am going to do right down the line quickly, but we have seen this increase, 7 to 8 million increase, if I can go for another minutes.

Mr. COBURN [presiding]. Without objection.

Mr. BARRETT. I am going to ask each of you to give me one factor or two factors in about 10 seconds as to why we have seen this continual increase. Dr. Johnson?

Mr. JOHNSON. The dilemma is one of cost, and I think we made the wrong diagnosis with respect to cost and why we have an increase in cost. I suggested in both my written and oral testimony that there is a disconnect between the person consuming the services and the price of those services.

Mr. BARRETT. Mr. Arth.

Mr. ARTH. I would agree with cost, and sometimes it is just access. The products aren't out there and available.

Mr. BARRETT. Mr. Morehead?

Mr. MOREHEAD. The main is cost. And people can't afford it. A lot of the health care reform has made it easier for people to wait

and not sign up until they actually needed the coverage. The deterrent is cost.

Mr. MEYER. I would cite two factors. First the erosion of employer-based coverage, particularly because people are turning down the employer's offer because they can't afford it and second, the changing labor force away from the good jobs with benefits toward part-time temp and contract work.

Ms. BAUMGARDNER. I would agree that cost is one of the first factors. And the second factor is that the infrastructure, the health care infrastructure, the accessibility is not there. You can bring a low-cost plan out, but if you don't have providers to provide the care, the services for where the people are, you are not going to have any use of it.

Mr. BARRETT. Mr. Carlson?

Mr. CARLSON. I would echo everyone else that it is cost. The No. 1 reason for people being uninsured is—or dropping out is that they can't afford the premium. And if you want to talk about Mr. Greenwood's law of unintended consequences, some of these reforms are well intended and in fact they are directed at the population I serve. But one of the side effects of that is they raise costs premiums for the other 99 percent of the population. The young healthies drop out.

Mr. NICHOLS. Cost is No. 1. I think it is driven largely by technology, not so much the cost sharing. We get a very good health care product. We like it. It is the best health care system in the world. That cost is now too expensive for an increasing fraction of our population.

Mr. BARRETT. Thank you, Mr. Chairman.

Mr. COBURN. You are welcome. I will recognize Mr. Burr because he has another meeting, for 5 minutes.

Mr. BURR. Thank you, Mr. Chairman. The answer is you are all right. Mr. Nichols, I want to compliment you on your presentation. It was one of the best I have ever heard. I didn't understand much of it, but it was one of the best I have ever heard.

Mr. NICHOLS. I appreciate the compliment.

Mr. BURR. I look forward to reading it so I will understand it just a little bit better.

Dr. Johnson, let me just ask you—and I have I feeling the answer is going to be the same—you said that patients have become a commodity. Why?

Mr. JOHNSON. The colleague of mine from St. Louis who came up with that sound bite I think was right on point because employers in an effort to get a handle on cost have gone out and negotiated the best insurance they could for the amount of money they could afford, and the employees don't have a choice; and sometimes the employer has shifted from one insurance plan to another for 25 cents per member per month in order to save the money.

It comes back again to cost, with wholesale disruption of the patient-physician relationships that are intrinsic to that kind of shift.

Mr. BURR. So cost has driven us into a commodity market to some degree?

Mr. JOHNSON. That is my view, yes.

Mr. BURR. Cost has increased the number of uninsured, as Mr. Barrett asked. Would anybody disagree with Dr. Coburn's state-

ment that half of the uninsured today choose to be uninsured? Anybody disagree with it.

Mr. NICHOLS. I am not sure it is so much a disagreement, but I would like to question the interpretation a little bit because I would think what you are citing are reports that people turn it down when they are offered. We agree with that. The question is are they choosing to be uninsured or are they choosing to be uninsured at that price. There is a price at which they would pay for health insurance. It is lower than what they are being offered so we should not infer——

Mr. COBURN. If the gentleman would yield.

Mr. BURR. I would be happy to.

Mr. COBURN. We had a great example here. We have somebody who makes $12,000 a year and has Internet access in her home. She chooses to have that but not to have health care coverage. So the question is what are the priorities and do we not essentially move in a direction that says we are going to subsidize you to make priorities that are not for your health by some of our programs? I will yield back and get my chance to go around with you.

Mr. BURR. I think if we looked at statistics, wouldn't we find that the majority of those individuals would be in the 19- to 30-year age group? I mean, you can look at it with an age group and see a large block that probably are employed but uninsured by definition.

Mr. CARLSON. I would like to support what Dr. Nichols has talked about—and I don't know what the percentage is that you talk about in terms of 50 percent declining—but insurance is a transfer of risk and people making judgments about whether the premium they pay for it is going to be less than what their medical expenses. And there is a lot of people that you are talking about, what I call the young healthies, that believe that they are just not vulnerable and are not going to have any medical expenses, and they believe it is cheaper for them to go uninsured than it is to pay the premium.

Mr. BURR. Until the Harley Davidson hits the tree.

Mr. MEYER. I would just like to comment that it is not anywhere near half the people that turn down an employer's offer of insurance. It is about 20 percent. That is much higher than it was. The proportion of people that were offered an employer plan, according to a study by the Agency for Health Care Policy Research, and accepted it fell, from 88 percent 10 years ago to 80 percent today. So that is disturbing, but that still means four out of five that are offered employer plans take it.

Mr. BURR. Would you agree that there are a large number of self-employed individuals who choose not to be covered because of age? They are employed, they make a good income, they don't get picked up in that group you just talked about?

Mr. MEYER. Yes, I agree with that, but they are a minority of uninsured, and the majority of uninsured have incomes under 200 percent of poverty.

Mr. JOHNSON. Those employees who turned down the insurance might not do so if there was an expanded array of choices and they had a defined contribution from the employer that they could use toward the purchase of different models, not the ones that we currently think of today.

Mr. BURR. Thank you, because that is where I was heading. And I think I want to go to Mr. Nichols because that was the part that I did understand about what you said. Nobody knows today how many people get covered when you expand the choices. You have some methodologies that you follow, but I think that where this committee falls short is if we don't allow the creation of as many new choices out there, if we don't explore ways that might bring 1 percent here or 3 percent there, it is almost customizing a product for a population that has chosen either not to be insured or could not afford it.

Let me ask just the last question of Ms. Baumgardner. What is unique about the health centers that enable you to succeed in a managed-care market?

Ms. BAUMGARDNER. Well, sir, as I said, I think, in one of the other questions that I had answered, if you look at the legislation that enables community health centers, we are designed to manage care. Our whole focus is to go in at the front end of health care services to deal with prevention and education and primary health care services. And what we have learned in the last 2 years now that we have been operating in Medicaid HMO is that, in fact, we are pretty good at it in the State of Michigan.

We manage our patients' health care problems at the lowest possible cost level. We keep them out of emergency rooms. We keep them out of the very expensive levels of care, unless it is absolutely essential; and as a result, our front-end costs may look a little high, or capitations, our prevention services are a little high, but relative to the expenses that you run into in terms of hospitalizations and other high-cost health care issues, we are very good at that. It is our mission, it is our specialty, if you will, and that is what we do best.

Mr. BURR. I thank this panel and thank the Chair for his indulgence and I yield back.

Mr. COBURN. If Dr. Ganske doesn't mind, I think I will recognize myself since we are going to be here a little bit.

Mr. GANSKE. Mr. Chairman, you have got the gavel.

Mr. COBURN. That is right. And I am going to give you something to add to yours. Dr. Meyer, you talked about a changing workforce, temping, people turning down employer policies simply because the cost differential. Doesn't that suggest trying something new in the market? From the testimony that we have heard and what I have read, is if people are making that choice now either because they are not employed or they are in a temporary work and wouldn't that suggest that something like an IMA or something similar, a new product, let the market work and let them try it.

By the way, nobody says this is going to work. Nobody is claiming that it is going to work. They are just claiming let's give it a chance to see what the market will do with it.

Mr. MEYER. Well, I am certainly in favor of market innovation. In fact, we study it all the time. But I think realistically, you mentioned individual medical accounts, the story has been the same. Congress put a cap on them—in this experiment a couple of years ago. We are nowhere near the cap.

Mr. COBURN. Let me interrupt you for a minute. Having tried to get the medical savings accounts for every one of my employees,

what Congress did was a disaster because you cannot get through the loops to get one. And so what they did was very cleverly make the regulations so difficult that you are just very fortunate and lucky if you happen to get one. And I tried. And I tried with all three people in the United States that offer it. All right?

So we limited it so that nobody would come in and offer it; and so, therefore, nobody is offering it so they don't have a variety of a product. So that is not a good excuse. We are not giving it a fair trial or an open shot in the market and saying let's try medical savings accounts, let's lower the bar, and let's let people try it. That doesn't hold water in terms of the facts of what is happening out there in the market on medical savings accounts.

Mr. MEYER. I understand that. I think you will find that, given that the majority, over 60 percent of the people that are uninsured have incomes under 200 percent of poverty, very limited means, that unless you really enable them to buy in with significant amounts of money on a sliding scale basis that you probably won't make a major dent in the problem. It doesn't mean that you won't improve the lives of some.

HealthMarts, individual savings accounts, association plans might help some. The only thing I would point out is they might help some—and Len mentioned this too—at the expense of others. And that is——

Mr. COBURN. So you would support then a sliding scale voucher system for our poorest people?

Mr. MEYER. Yes, I would.

Mr. COBURN. So that we can allow them to go purchase private health insurance and not mandate that they have to go anywhere. They can go anywhere they want.

Mr. MEYER. One way to do that—and some proposals are on the table—would be to have a refundable income tax credit that you get money back if you are very low income that would help you buy into a health insurance program.

Mr. COBURN. Kind of like what Congressman Shadegg has proposed.

Mr. MEYER. Yes, like what he was talking about. We might find that the proposals under consideration that add $1,000 to a family is not enough and maybe you need $2,000, but I think he is moving in the right direction. I am all for this innovation, but I think it will be difficult to purchase it on the margin or on the cheap. I think we will have to put real money into it.

Mr. COBURN. Is there anybody on the panel who disagrees that we ought to try every market innovation that we can to see if we can use market forces to help allocate the scarce resources? Do you disagree with that? Is the demand/supply curve so inelastic that we cannot trust market forces to work in this area? Does anybody disagree with that?

Mr. NICHOLS. I don't disagree, Congressman. I certainly think, though, that you want to be careful about the innovations that you set out.

Mr. COBURN. So that you don't harm something that is existing.

Mr. NICHOLS. Exactly. As you stated about the medical savings account example, it did turn out to have features that people found

unattractive and the fact that only three insurers are willing to offer it is the telling one.

Mr. COBURN. It is not the concept of medical savings account that they find unattractive; it is the rules, regulations, and bureaucracy that has been applied to it.

Mr. NICHOLS. And what I am suggesting is that we think carefully about the rules that go into place for the association health plans, for the HealthMarts, et cetera. Because one of the things I was going to say, when we talked about the purchasing cooperatives before, is that I think some of the more successful ones in the country today have found it useful to have the same rules about guaranteed issue and rules about rating restrictions inside the pool as is the case outside the pool. You set up different rules in a state, you set yourself up for adverse selection. That is what I am talking about with being careful.

Mr. COBURN. I will reserve the balance of my time at this time and recognize Congressman Ganske for 5 minutes.

Mr. GANSKE. It is my opinion that association plans raise two general categories of problems, and I will seek your comments on this. No. 1, if they bring together people who have below-average risk and exclude others and are not subject to State small-group rating rules, they draw off people from the larger insurance pool; and thereby they raise premiums for those who remain in the larger pool.

Would anyone disagree with that? So let it be recorded that even this panel agreed with that statement.

Mr. COBURN. Will the gentleman yield?

Mr. GANSKE. Let me finish.

Mr. COBURN. All right. Then I will take the time.

Mr. GANSKE. Second point——

Mr. CARLSON. I might just say I don't hold myself out to be an expert on the subject, so I will be happy to respond to questions about high-risk pools. But I suspect your statement is true and then the question, the follow-up needs to be: Is that bad?

Mr. JOHNSON. I would offer the same disclaimer.

Mr. GANSKE. Second general category of problems. If they are not subject to appropriate insurance regulation to prevent fraud and to ensure solvency and long-run financial viability—I think many of you were here when I talked about the experience we had in the 1970's, early 1980's that resulted in Congress coming back and reestablishing insurance regulation because of problems that we had on that. So if they are not subject to appropriate insurance regulation to prevent fraud and ensure solvency and long-run financial viability, they may leave enrollees with unpaid claims and no funds for future medical expenses.

Mr. CARLSON. On that point I am with you 100 percent because I was assistant commissioner of insurance during that period and worked with our Congressman Erlenborn at the time. The solvency problems that developed with the MEWAs—the problem was that even though you had a lot of very good well-run MEWAs, the law as it was written allowed for the good entrepreneurs but fast-buck artists to come in and skim off—what they would do is they worried about the fees they were getting paid, and a year later the claims started rolling in and couldn't get paid and they just

walked. And then the insurance departments around the country were left to clean up the mess.

And that is the No. 1 underlying—that absolutely supports what you are saying. You have to be concerned about that.

Mr. GANSKE. Now, this is not to say, I am not saying that all association health plans had that problem. I mean, by all reports COSE, for example, is a well-run plan and is doing pretty well.

Mr. ARTH. But we do not self-insure.

Mr. GANSKE. I understand. But I want to get to another point that has to deal with COSE. Basically, my understanding—and I don't know exactly if you would characterize COSE as an AHP or whether you would characterize it as a health purchases coalition or co-op; but it is somewhere in that range.

But basically health purchases co-ops are collective purchasing efforts where the only written criteria for eligibility to participate is in some cases being below a certain firm size and that people are willing to pay the premium. So pretty open enrollment.

Mr. ARTH. And you need to join our association.

Mr. GANSKE. Right. Now, correct me if I am wrong, but when that was set up, weren't there concerns that unless you had some type of modified community rating that if you were required to accept anyone that then the private insurers could skim off the healthy and the—healthy and then leave the larger insurance pool with a sicker group? Wasn't that a concern?

Mr. ARTH. Yes we have always been concerned about adverse selection and being the insurer of last resort, if you will.

Mr. GANSKE. So my concern on this is extending ERISA protection, getting those groups out of those State insurance pools, not necessarily whether you have pooling like you have got with COSE. So I would finish with one question, just because you are for association health plans that doesn't necessarily mean that you would be—or that some of them have worked okay, that doesn't necessarily mean that we would want to exempt them from State oversight, would it? Mr. Meyer?

Mr. MEYER. I agree with you. No I don't think we would. And I think you can compare them to the many purchasing co-ops that we have around the country such as in California, where the co-op is required to take all employers that want to join. The fundamental feature of concern about the AHPS is that unlike the HealthMarts they can pick and choose, meaning employers. Framers of these proposals have been careful to build in certain protections against fraud and against some of the concerns like, for example, the 3-year waiting period, and you can't just form an association for health insurance. It must have some other purpose.

So they have put a lot of thought into mitigating those problems, but the ingenuity of this industry to cherry-pick and find the good risks is very great. And it isn't that you have not had well-meaning legislators trying to build in, but once you drop that kind of requirement that all comers can participate, they are going to find those aerobic instructors.

Mr. GANSKE. Mr. Chairman, I ask unanimous consent for one additional moment.

Mr. BILIRAKIS. I am going to deny the unanimous consent request because I was not yielded time. And if we have time, I will be happy to——

Mr. GANSKE. Mr. Chairman, I was kind enough to yield to you so you could go first before me.

Mr. COBURN. That is the prerogative of the Chair. I want to make a couple of points. No. 1, the assumption that AHP patients are going to take patients from plans, the goal with the AHP are to take people that are not insured, not necessarily draw—and there is no assumption in anybody's study that I know of that all AHP patients are going to come from previously insured products.

So that the assumption of the gentleman's statement is erroneous. As a matter of fact, the greatest estimate I have seen is maybe 20, 22 percent. So it is not the thing that we are going to see.

The other thing is, Dr. Meyer, can you not write into things to offer the protections in the AHPS that are necessary out there? Can this legislation that has been proposed not be improved to address your concerns?

Mr. MEYER. Yes, it can, and I think I made it clear that a lot of thought has already been put into that. But I still think that one feature that I highlighted is a pretty big loophole, but I don't mean to say that these problems cannot be fixed.

Mr. COBURN. Mr. Arth, have you really experienced adverse selection?

Mr. ARTH. Mr. Chairman, I do get the yes from my sidekicks here, but I can't give you examples. I will say with respect to the ERISA exemption our position on that is either give it to everybody or don't give it to everybody, but let us all compete on a level playing field.

Mr. COBURN. I would agree with that. Dr. Ganske. If the panel would not mind staying for a few additional. Dr. Ganske, you are recognized.

Mr. GANSKE. Thank you, Mr. Chairman. Dr. Johnson, are you testifying in favor of your voluntary purchasing co-ops being exempted from State regulation? Is that your position?

Mr. JOHNSON. No. And I hasten to emphasize that what I am testifying in favor of is the concept of voluntary choice cooperatives, the clearinghouse as opposed to the micromanagement negotiation function. And I don't think they should be exempted from State oversight. As a matter of fact, the typical insurance commissioner type of role of the determination of the solvency of the plan, the determination of the truth in advertising, whether or not the plan is providing the benefits that it says it is going to provide are all very important functions.

Also the notion of dealing with adverse selection within the plans that elect to participate. And the opportunity of a voluntarily choice cooperative is a very significant one.

I want to comment, Mr. Meyer said that buyers hold sellers accountable. He was referring to employers buying the insurance. I suggest the same statement could be made with respect to individuals buying insurance. And my testimony was with respect to having a marketplace for individuals to buy insurance to take advantage of pooling risk, but for buyers to hold sellers accountable, have

the accountability flow to the person who is using the plan, i.e., the patient. The way I have said it, Dr. Ganske as a physician is put the patient in the driver's seat.

Mr. GANSKE. Thank you. I thank you, Mr. Chairman.

Mr. COBURN. Mr. Barrett.

Mr. BARRETT. Thank you, Mr. Chairman. My last question to each of you pertains to what the major factor was and most of you said cost. I bring that up because I just want to respond to a statement that Mr. Coburn said with respect to the young woman who was here this morning.

I didn't hear her say that she owned a computer and was online at home. She may have been in a library. But even if she did have it at home, I think it is important to point out—I don't know exactly how much it costs, but if America Online is $12 a month, if she made that choice rather than going to a movie once a month with her husband, I don't know that that makes her a bad person.

Mr. COBURN. Would the gentleman yield? I wasn't criticizing the individual. What I was doing was making a point as we all have discretion with the money that we have that some discretion is used to buy certain things, others have the discretion to buy health care.

Mr. BARRETT. I totally agree with that. I am someone when I am in the grocery store and I am looking at someone ahead of me who has food stamps, I am wondering why they are buying Cheerios and I am buying generic cereal.

But my point is if you have an individual who is looking at maybe spending $150 a year on America Online versus $5,000 a year on health care, she might feel overwhelmed. And this is assuming that she has it at home.

What we heard from this panel is that cost is a real issue. That is the issue. And I just want to make sure that the record reflects that.

The other issue that again I think we have talked a lot about today that is important is the whole issue of notion of a refundable credit. And, Mr. Meyer, you showed your support for it, and I think even on the first panel the Democratic witness was not philosophically opposed to them. At what point is it going to work?

In other words, if you have got an individual who makes $13,000 a year is it going to have to be $1,000, $2,000, $3,000, $9,000? Where do we make sure that the person will buy the policy and that it will be a policy that will offer, for example, OB/GYN care? Where do you see that?

Mr. MEYER. I hate to say this, but I think for very low income people living below poverty and half of them are uninsured, you will have probably to pick up most of that $5,000 cost. If their income is $8- or $10- or $12,000, they just can't afford it. Their contribution should then rise in steps as you get up to the $12,000, $15,000. I don't think $1,000 would be nearly enough for a family with $8,000 or $10,000 of income. Remember, they may have some child care; and they have to pay rent.

A person like this witness this morning out of that $13,000 if she has a young child, she is working to make that $13,000, she may need some child care that is $5,000 a year if she gets bare-bones child care.

So I think you have to be realistic and pick up most or all of the costs for the very poor and then graduate it down. Now where would that money come from? We give away—the Federal Government excuses $125 billion in taxes. Well, let me amend that, the Federal and State together.

But the Federal Government is the overwhelming majority over 110 billion. Because you and I don't have to count as income when our employer contributes to our health care. If they give us wages, we pay taxes on it; if they give us health care, we don't. If a portion of that money, and I mentioned in my testimony that the value of that tax subsidy for people over $100,000 a year is $2,537, the value of that tax subsidy for people under $15,000, target we are talking about is $71 a person instead of $2,500. So that is really a big subsidy going to upper-middle and upper-class people.

If we could redirect some of that—it is very difficult to do politically—that could pay for the kind of thing I am talking about.

Mr. BARRETT. One final question—and I am shifting gears here a little bit—the vouchers, if we have a voucher system where individuals can choose and leave their group plan—let's say I am a young guy who works for an employer. I see everybody else who works for this employer has kids, or they are sick, I am out of there.

So then the next person sees well, wait a minute, everybody else has that family plan, I am out of here. So all the single people leave. And then somebody notices that someone has a serious health problem. So the healthy people leave.

Are we creating a program with such adverse selection that employers are going to be left with the people who are basically—I don't want to say uninsurable, but the ones that make the insurance pool work because of the higher risk?

Mr. MEYER. That is why I would not limit the subsidy only to people that would leave or do not qualify for employer coverage. There are a lot of people that have employer coverage that need a lot of help with their third or half of the premium. So I think you could limit it by making it available to people who are financially burdened whether they leave the plan or not. But that is a concern.

Mr. COBURN. I would just make one comment. If you really let the market work, you can't make any assumptions that it would be $5,000, if you truly had a market force working. We don't have health insurance in this country today. We have prepaid expense. And we pay 18 percent of that for somebody to manage it for us.

So, you know, it is a farce to say we have health insurance in this country. We don't. And it is a cherry pick, and you all know it is a cherry pick. And what you are saying is the status quo of letting the insurance industry continue to cherry pick is better than letting the market allocate the cost to those people who are truly going to consume it. You can't have it both ways.

So we need to do something. And we do know that if we allow market forces—and I am not married to any one of these plans—but if we don't reconnect as Dr. Johnson said the patient and the provider, you realize how much we are losing because there is no accountability felt by the physician back to the patient when they spend their money? And how much overutilization that creates?

That doesn't have anything to do with liability scare. That has to do with human, natural human tendencies that are not checked by an obligation of the doctor-patient relationship because the patient isn't paying me anymore.

And if we don't reconnect that doctor-patient relationship, we are never going to do anything here. And we are also going to lose the quality of care that our country has been known for.

And so I want to make a couple of statements. We are going to leave the record open for questions. I also would like Ms. Baumgardner if you would supply the records of your community health center for the last year in terms of financial records so—you seem to really have demonstrated a lot of efficiency. I would like to use that to compare on some of the others if you wouldn't mind doing that.

And the record will remain open until such time, what, 48 hours, to submit questions if we have no objection.

Mr. BARRETT. No objection.

Mr. COBURN. I want to thank the panel.

Mr. CARLSON. Mr. Chairman, I might make one follow-up comment to Mr. Brown's question because I was going to comment for Mr. Ganske. Had Mrs. Horsley lived in Illinois—and I don't represent myself as an expert on our public aid system—but my best understanding is that we have a program through public aid called Medical Assistance No Grant. And I was surprised when she said she didn't qualify for medical assistance as an adult. If her husband came to our program, we would refer them to our department of public aid. They would be subject to a spin-down and would probably have to pay about $100 a month. But the rest of his medical expenses would get paid through our medical assistance program and the no grant means that they are not eligible for subsistence, and they are not on welfare. Public aid doesn't like me to call it, but we tend to in our office refer to it as medical assistance for the middle class.

And our program is set up so that somebody like her husband, who now has a serious medical problem, if their income goes up and they transition off, they can come into our program and afford the premiums. And it is working very well for us.

Mr. COBURN. He obviously has a disability now surgically secondary, but that is a classic case with HIV patients. They become disabled, become full blown AIDS, and they die before they can get their disability because they haven't been sick long enough.

Mr. CARLSON. That is now changing.

Mr. COBURN. I know it is, but that is exactly the same kind of problem we are talking about.

Dr. Ganske, did you have a comment?

Mr. GANSKE. Mr. Chairman, I know that Kaiser Family Foundation is doing a study right now of people who are uninsured and doing focus groups and other things on why they are uninsured, both. And maybe the committee can make a request for some preliminary data from them on that. It sounds like it is kind of interesting material.

Mr. COBURN. Are there any objections to the request?

Mr. BARRETT. No.

Mr. COBURN. And we thank you again. The committee is adjourned.

[Whereupon, at 2:40 p.m., the subcommittee was adjourned.]

[Additional material submitted fore the record follows:]

PREPARED STATEMENT OF MARINA L. WEISS ON BEHALF OF THE MARCH OF DIMES BIRTH DEFECTS FOUNDATION

On behalf of the March of Dimes Birth Defects Foundation, I am pleased to submit the following statement regarding access to health coverage for the uninsured. Expanding health insurance to pregnant women, infants and children is one of the highest legislative priorities for the March of Dimes this Congress. Foundation volunteers and staff are eager to work with Members, Committees and staff to enact and implement improvements in Medicaid and the new State Children's Health Insurance Program (SCHIP).

The March of Dimes is a national voluntary health agency founded in 1938 by President Franklin Delano Roosevelt to address public health issues. The Foundation's more than 3 million volunteers and 1,600 staff members work with the 92 chapters that are located in every state, the District of Columbia and Puerto Rico. A unique partnership of scientists, clinicians, parents, business leaders and other volunteers, the Foundation works to improve the health of infants and children by preventing birth defects and infant mortality. In order to accomplish its mission, the March of Dimes funds community services, research, education and advocacy.

Given the Foundation's mission to improve the health of America's children, we are especially concerned about the approximately 11 million children currently without health insurance. Volunteers and staff have been deeply involved in efforts to secure health insurance for mothers, infants and children, most recently the creation of SCHIP. In 1997, the Foundation worked closely with Members of the Commerce and Senate Finance Committees as well as the Administration to enact SCHIP. We were especially engaged in the policy and legislative deliberations relating to infant and maternal care, in particular the provisions relating to coverage of preventive services (e.g. immunization, well-baby and well-child care) and access to specialty services for medically compromised children.

Since the enactment of the federal SCHIP legislation, March of Dimes volunteers and staff have worked with health officials and legislators in more than 30 states to design and implement individual state programs. In December 1997, the Foundation issued a report written and produced jointly with the Healthcare Leadership Council entitled *Insuring America's Children: New Opportunities for States.* The report is a state by state "snapshot" of the insured status of children at the time the program was enacted and includes information about coverage for mothers and children. The report was written to assist state policymakers in designing their SCHIP programs. Today, the Foundation is supporting SCHIP outreach in all 50 states and has joined with Kmart and other corporate partners to promote the "Insure Kids Now" campaign and national toll-free hotline.

The March of Dimes supports many of the steps states are taking to implement and expand their programs and we are gratified by many of the early successes of SCHIP; but we are also concerned about the lower than anticipated enrollment in the start up years of the program. Specifically, in our judgment the program could be strengthened by adapting the following modifications that are designed to improve enrollment and provide better health coverage for infants and children.

1) Increase Outreach Activities

Experience with the Medicaid program has shown that aggressive outreach is critical to ensure that children who are eligible receive necessary services. SCHIP outreach may be even more challenging because the families of eligible children are typically from families with higher-incomes who have little, if any, experience with publicly-funded programs. As you may recall, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) authorized $500 million through fiscal year 2000 to support state Medicaid outreach activities. The March of Dimes supports the provision in the Administration's FY 2000 budget that would extend the availability of these funds and allow states to use the funds for Medicaid and SCHIP outreach.

2) Expand SCHIP Coverage to Pregnant Women Over Age 18

Lack of health insurance IS a significant barrier to prenatal care, and women who receive no prenatal care are far more likely to have low birth weight babies and babies with other medical complications. While most pregnant women have health insurance, gaps in coverage remain. According to a recent study commissioned by the

March of Dimes, an estimated 13.7 percent of women who gave birth in 1997 (465,000 women) were uninsured.[1]

More aggressive Medicaid outreach coupled with expanded SCHIP coverage could improve these figures significantly. In 1997, an estimated 77 percent of uninsured pregnant women met Medicaid income eligibility requirements but were not enrolled. Moreover, under current law, 40,000 uninsured pregnant teens could be covered if states were able to take maximum advantage of SCHIP by extending eligibility for the program to all income-eligible adolescents. With a change in the law to allow women over age 18 to qualify for maternity coverage an additional 45,000 uninsured pregnant women could be insured. A recent study conducted by Kenneth Thorpe, Ph.D. for the Foundation found that, together these simple steps could increase the rate of insured pregnancies in the country to approximately 95 percent.[2] Moreover, since women who enroll in SCHIP are likely to also enroll their children, opening SCHIP to income eligible pregnant women age 19 and older could raise the number of children enrolled in the program. For these reasons, the March of Dimes strongly supports allowing states to enroll all income-eligible pregnant women in SCHIP.

3) Expanding Coverage

Finally, the March of Dimes has a long history of supporting efforts to ensure that all pregnant women and children in the United States, including immigrants, have access to medical care. Therefore, the Foundation supports the provisions in the Administration's FY 2000 budget that extend SCHIP and Medicaid coverage to legal immigrants who lost coverage with enactment and implementation of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193).

On behalf of the Foundation, thank you for the opportunity to submit this statement regarding access to health coverage for the uninsured.

GALEN INSTITUTE
June 21, 1999

The Honorable JOHN D. DINGELL
U.S. House of Representatives
2328 Rayburn House Office Building
Washington, D.C. 20515

DEAR CONGRESSMAN DINGELL: I appreciated the opportunity to testify before last week's hearing of the Health and Environment Subcommittee of the Commerce Committee, and appreciated your attending the hearing. I would like to take a moment of your time to respond to your comments regarding our study, "Uninsured Rates Rise Dramatically in States with Strictest Health Insurance Regulations."

The states have been very active in recent years in passing legislation designed to improve portability, access, and rating practices for the small-employer health insurance market and, to a lesser extent, for the individual health insurance market.

The General Accounting Office has conducted studies to assess the impact of these reforms. It identified 45 states that enacted reform regulating the small-employer health insurance market and 25 states that passed individual market reforms prior to 1995.

Our study focused on the 16 states that had implemented both small employer market reforms between 1990 and 1994 and individual market reforms prior to 1995. States implementing small employer market reforms between 1990 and 1994 were identified in the U.S. GAO report, *Health Insurance Regulation; Variation in Recent State Small Employer Health Insurance Reforms* (GAO/HEHS-95-l61FS, June 12, 1995). States implementing individual market reforms prior to 1995 were identified in the U.S. GAO report, *Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs* (GAO/HEHS-97-8, November 25, 1996).

To be included in our study, a state must have been included in both reports and have passed a majority of the reforms studied by the GAO. As we point out in our study, the GAO provided considerable detail in variations of the reforms, and researchers are invited to analyze those differences, as did we.

To determine the impact on uninsured rates, we analyzed U.S. Bureau of the Census Current Population Survey (CPS) survey data from 1989 to 1996 with a detailed study of a select sample of 16 states. CPS data from 1989 to 1996 were used to iden-

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[1] Thorpe, Kenneth. "The Distribution of Health Insurance coverage Among Pregnant Women 1990-1997," March 1999. Paper prepared for the March of Dimes.

[2] Thorpe, Kenneth. "The Distribution of Health Insurance coverage Among Pregnant Women 1990-1997," March 1999. Paper prepared for the March of Dimes.

tify the number and percentage of non-elderly individuals with: (1) private insurance coverage, (2) employment-based insurance coverage, (3) Medicaid coverage, (4) Medicare coverage, and (5) no coverage for each year between 1989 and 1996.

A separate study conducted by the Urban Institute attempted to quantify the impact of each of the state insurance reforms individually. ("Variations in the Uninsured: State and County Level Analyses," Jill A. Marstellar, et al. Washington, D.C., June, 1998.) Although the report indicated that guaranteed issue itself may decrease the number of uninsured, it showed that other policies, particularly community rating (or premium rate restrictions generally); offset any gains from guaranteed issue itself. The Urban Institute study points out that most states implement insurance reforms as a "package" of reform. In fact only five states did not implement premium rate restrictions along with the other small employer insurance reforms, and all of the states that implemented individual insurance market reforms included some form of premium rate restrictions.

Unfortunately, citizens wishing to purchase health insurance in these states do not have the choice of selecting from among the laws with which they wish to comply. When someone in one of these states is buying an insurance policy, the policy they buy is governed by state laws which may include community rating, guaranteed issue and renewability, mandates on coverage, pre-existing condition exclusions, etc. Therefore, we felt it was quite legitimate to look at the impact of the regulations as a package rather than individually.

As a result of insurance market regulations, affordability and access to insurance coverage may improve for some specific populations, such as those with special needs or chronic illnesses, based on community rating and guaranteed issue. However, such regulation also is likely to impose an offsetting increase in cost and decrease in access to insurance for other populations, such as young families and the healthy. The net effect of such regulatory policies on relative cost will depend upon the success with which citizens are able to obtain coverage.

You also questioned whether specific economic conditions in any given state, such as loss of a major employer, could influence uninsured rates. Certainly, it could. But there is no reason to believe that this would have been any more or less likely in our 16 focus states than in the other 34 states.

As our study points out, the 16 states vary substantially in the size and urban/rural distribution of their populations, the size of their individual insurance markets, and the degree and type of other forms of insurance regulation. In general, they are representative of the range and variation of circumstances and regulation across all of the states. Collectively, these states are very similar to the nation on measures of employment, earnings, and health care system characteristics. In addition, there were states with high rates and low rates of uninsured in our 16-state study.

I would be more than happy to discuss with you further our research and methods and hope to continue to work with you in advancing understanding of the reason for the growing number of uninsured and in developing effective policy solutions.

Sincerely,

GRACE-MARIE ARNETT
President

THE COMMONWEALTH FUND *Task Force on the Future of Health Insurance for Working Americans* APPLAUDS SUBCOMMITTEE HEARING

PANEL'S FIVE-YEAR EFFORT TO FOCUS ON PUTTING HEALTH COVERAGE BACK ON NATIONAL AGENDA AND REDUCING THE NUMBER OF UNINSURED AMERICANS THROUGH INCREMENTAL 'WORKABLE SOLUTIONS'

Washington, DC, June 16, 1999—An expert panel created by The Commonwealth Fund today strongly supported the House Commerce Subcommittee on Health and Environment for holding the latest hearing of the 106th Congress on the issue of health coverage for Uninsured Americans. In a letter released today, The Commonwealth Fund's *Task Force on the Future of Health Insurance for Working Americans* applauded Subcommittee Chair Mike Bilirakis and Ranking Member Sherrod Brown for bringing the critical issue of the uninsured to the attention of Congress and the American public.

The *Task Force* will carry out and fund cutting-edge research on solutions to the problem of working Americans who lack health insurance coverage, the New York-based foundation recently announced. It will be chaired by James J. Mongan, M.D., President of Massachusetts General Hospital. The non-partisan expert panel—made up of individuals who are nationally recognized for their contributions to business,

government, public policy, economics and/or medicine—will seek to accomplish the following two goals:

1) Put the debate over expanding health insurance coverage back on the national policy agenda, and
2) Make significant progress toward reducing the number of uninsured Americans and improving the quality of health insurance for working families.

The *Task Force* will provide constructive analyses on a wide range of incremental "workable solutions" that have the potential for broad-based, bipartisan political support. To address the current problems with the job-based health insurance system, the *Task Force* will consider workable solutions including: refundable tax credits or other tax subsidies for the purchase of health coverage; expansion to working families of subsidized health coverage programs including Medicaid and the state Children's Health Insurance Program (CHIP); programs to allow the working uninsured to buy-in to existing state and federal employee health plans; and creation of a Medicare buy-in for older, uninsured workers. The *Task Force* will also be reviewing, performing and commissioning research on a variety of other workable solutions.

THE COMMONWEALTH FUND
June 16, 1999

The HONORABLE MICHAEL BILIRAKIS
Chair
Commerce Subcommittee on Health and Environment
U.S. House of Representatives
Washington, DC 20515

The HONORABLE SHERROD BROWN
Ranking Member
Commerce Subcommittee on Health and Environment
U.S. House of Representatives
Washington, DC 20515

DEAR CONGRESSMEN: The Commonwealth Fund's *Task Force on the Future of Health Insurance for Working Americans* applauds you and the Subcommittee for holding today's hearing on Access to Affordable Health Coverage for the Uninsured. It is critical that the issue of health insurance for the uninsured is again brought to the attention of Congress and the American public. The Task Force looks forward to working with you and other members of the subcommittee as this issue moves ahead in the coming months and years.

The Task Force is a new national expert panel created by The Commonwealth Fund, a New York-based foundation. The Task Force will carry out and fund cutting-edge research on solutions to the problem of working Americans who lack health insurance coverage. The 15-member panel will be chaired by James J. Mongan, M.D., President of Massachusetts General Hospital.

The non-partisan expert task force—made up of individuals who are nationally recognized for their contributions to business, government, public policy, economics and/or medicine—will not advocate for specific solutions to the growing problem of working Americans who lack health care coverage. Instead, the panel will seek to accomplish the following two goals:

1) Put the debate over expanding health insurance coverage back on the national policy agenda, and
2) Make significant progress toward reducing the number of uninsured Americans and improving the quality of health insurance for working families.

The Task Force will provide constructive analyses on a wide range of incremental "workable solutions" that have the potential for broad-based, bipartisan political support. Panel members and staff will endeavor to assist public policy makers working on the issue of health coverage for working Americans through the dissemination of thoughtful, fact-based analysis of policy proposals and costs.

As you well know, federal legislative proposals to address problems with the employer-based health insurance system are needed, in part because:

- **43.1 million** non-elderly Americans lacked health insurance in 1997
- **4 of 5 uninsured Americans** in 1995 came from a family with at least one full time worker
- Working poor adults are **twice as likely** to be uninsured as are unemployed adults

To address the current problems with the job-based health insurance system, the Task Force will consider workable solutions including: refundable tax credits or

other tax subsides for the purchase of health coverage; expansion to working families of subsidized health coverage programs including Medicaid and the state Children's Health Insurance Program (CHIP); programs to allow the working uninsured to buy-in to existing state and federal employee health plans; and creation of a Medicare buy-in for older, insured workers. The Task Force will also be reviewing, performing and commissioning research on a variety of other workable solutions.

The Commonwealth Fund is a philanthropic foundation established in 1918 with the mission of enhancing the common good. The Fund currently carries out this charge through its efforts to help Americans live healthy and productive lives and to assist specific groups with serious and neglected problems. The Fund's four national program areas are improving health care services, bettering the health of minority Americans, advancing the well-being of elderly people, and developing the capacities of children and young people.

For more information please contact me, or John Budetti from the Task Force staff at (301) 913-0500. Or send information to 4800 Montgomery Lane, Suite 400, Bethesda, MD, 20814.

Sincerely,

JANET SHIKLES, *Executive Director*
Task Force on the Future of Health Insurance for Working Americans

AMERICA'S HEALTH: PROTECTING PATIENTS WITH A STRONG APPEALS PROCESS

WEDNESDAY, JUNE 23, 1999

HOUSE OF REPRESENTATIVES,
COMMITTEE ON COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 2 p.m., in room 2123, Rayburn House Office Building, Hon. Michael Bilirakis, (chairman), presiding.

Members present: Representatives Bilirakis, Upton, Burr, Bilbray, Whitfield, Ganske, Norwood, Coburn, Shadegg, Bryant, Brown, Pallone, Stupak, Green, DeGette, Barrett, Capps, Hall, Eshoo, and Dingell (ex officio).

Staff present: Patrick Morrisey, majority counsel; Jason Lee, majority counsel; Bridget Taylor, minority professional staff member; Amy Droskoski, minority professional staff member, and Karen Falk, minority professional staff member.

Mr. BILIRAKIS. The hearing will come to order.

As you can hear from the buzzer, we call them the "bells,"—not so fondly sometimes—we have a couple of votes on the floor.

Now I would rather try to go through at least a couple of opening statements before we have to break. We are going to ask the apologies of the panel while we do that. The Chair will recognize himself for an opening statement.

This is the third in our latest series of hearings focusing on the state of America's health care system and proposals for reform. Last week this subcommittee focused on the problems of the 43 million Americans who lack of any form of health insurance. As many of our witnesses testified, patient protections mean little to individuals without health coverage.

Of course, coverage alone does not guarantee access to quality health care. About 160 million Americans have some form of health insurance, and many of them are enrolled in managed care plans. With the growth of managed care in recent years, we have all heard from constituents who question whether their health plans provide the best possible care or whether they focus too much attention on cutting costs.

Many proposals have been advanced to address these concerns. One key element, of course, is the process for appeals. Patients who are denied medical services should know why the services were denied. They must be able to appeal coverage decisions and have their appeals heard in time—again, I repeat, in time—to make a difference. The process must be fair and independent.

Today our witnesses will discuss ways to structure an appeals process that will ensure patients receive the care they were promised in a timely manner. A common theme in their testimony is the need for a fair, independent, and strong external review as the basis for any patient protection legislation. To guarantee patients' access to care when they need it, I believe we must focus particularly on the timetable for review.

I remain hopeful that this subcommittee and the full Commerce Committee will act on a bipartisan basis to approve health reform legislation this year. I am pleased to report that, since our hearing last week, when I first announced that our committees will be working on a bipartisan basis, the committee staff for the majority and the minority have had several productive meetings to discuss principles for legislation.

I recognize the challenging task before us. However, if we can resolve the difficult issues involved in the appeals process—and, I might add parenthetically, put politics aside, which we have a tough time doing up here—I believe we can address other patient concerns related to the quality of managed care in America.

I would like to thank all of our witnesses for taking the time to join us today. I look forward to hearing their testimony and learning more about this very critical subject. I would yield to the gentleman? All right, the Chair will then yield to Mr. Pallone for an opening statement.

Mr. PALLONE. Thank you. I would like to thank the chairman for holding this hearing. I do think it is unfortunate that it is only a hearing. The individual issues that make up the managed care debate have been examined in great detail over the last 1½ years. This subcommittee could be serving the American people in a far better fashion by considering legislation such as the Patient's Bill of Rights, which is a comprehensive approach to managed care reform.

Mr. Chairman, I am sorry to say that, when it comes to managed care reform, in my opinion the Commerce Committee so far has been all talk and no action. That is why it was necessary for Democrats this morning to begin the discharge petition process on the Patient's Bill of Rights, just as we did last year to get the Patient's Bill of Rights considered on the floor of the House.

The Republican leadership is using every trick and excuse it can to forestall a full, fair, and open debate on the Patient's Bill of Rights. Last week's markup in the Education and Workforce Committee's Employee-Employer Relations Subcommittee, where Democrats were denied the opportunity to consider the Patient's Bill of Rights, was an unambiguous statement to that effect. Unfortunately, I think today's hearing is more of the same.

Having said that, Mr. Chairman, it is important to note that, although it is only hearing today, it is at least on a key aspect of the patient protection debate. Along with giving the patients the right to sue, the appeals process cuts right to the core of the managed care reform debate. Democrats believe that in order for an appeals process to be effective, a definition of medical necessity based on generally accepted principles of professional medical practice must be written into law. Writing that definition into law will ensure that medical decisions are made by doctors and patients, not by in-

surance company bureaucrats. It is for this reason that the Patient's Bill of Rights defines medical necessity as I have just described.

Republicans, on the other hand, have proven themselves to be champions of the status quo and defenders of the insurance industry. Last year when managed care reform legislation came to the House floor, the Republicans approved legislation that would have allowed managed care companies to define medical necessity. H.R. 4250, the so-called "Patient Protection Act," would have limited external appeals to the question of whether the plan followed its own definition of medical necessity when denying a patient care, as does the sham legislation the GOP approved in the Employer/Employee Relations Subcommittee last week.

The appeals process approved by the Republicans—for the second time now—would, if implemented, be worse than current law. Instead of helping individuals, it would create another layer of bureaucracy for patients to contend with when trying to force plans to provide the care they are obligated—but do not want—to provide.

Make no mistake about it, any similar proposal that allows the managed care industry to police itself will be just as bad. It is the industry's very inability to police itself that has turned managed care reform into the rallying cry it has become today. Codifying the problem into the law, and then claiming to have to come up with a solution—as the Republicans are again trying to do—is as backward as it gets, in my opinion.

Throughout the managed care debate, Democrats made it more than abundantly clear that we will support a good managed care reform bill or no bill whatsoever. If the Republicans are interested in working with us to get the bill the American people have overwhelmingly shown that they want, they are going to have to recognize the solutions that are promoting are not solutions at all.

I am hopeful today's hearing will help our colleagues on the other side realize that if they are serious about managed care reform, they need not look far in their search for a markup vehicle that includes an appeals process that truly protects patients. The answer is the Patient's Bill of Rights. It is staring them right in the face.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman. The Chair will now recess for 25 minutes. We have two votes coming up.

[Brief recess.]

Mr. BILIRAKIS. The hearing will come to order. Again, our apologies for the break.

The Chair will yield 5 minutes for an opening statement to Dr. Ganske.

Mr. GANSKE. Thank you, Mr. Chairman. I hope this hearing moves the process along. It seems like we have been working on this for along time.

I have been going to the floor every week to give a 1-hour special order. I think this week I will probably talk about what happened in the Workforce Committee last week, which was pretty much a sham and a fig leaf, in my opinion.

The problem with fig leaves, Mr. Chairman, is that sometimes those fig leaves are poison ivy. It can cause acute discomfort. It

would be my hope that, as my fellow Republicans look at an issue of passing a patient protection legislation, rather than just something to give political cover, they will remember the debacle of last week on the gun debate.

Today we are going to be talking primarily about medical necessity and about liability. Some time ago, Mr. Chairman, I wrote a "dear colleague" on medical necessity, and also sent around an editorial piece from the Hartford Current by John McDonald. I would ask unanimous permission to have them entered into the record, and also to pass them to our fellow panel members.

Mr. BILIRAKIS. Without objection.

[The information referred to follows:]

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES

Dear Colleague: On May 30, 1996, a small, nervous woman testified before the House Commerce Committee. Her testimony was buried in the fourth panel at the end of a long day about the abuses of managed health care. The reporters were gone, the television cameras had packed up, most of the original crowd had dispersed.

She should have been the first witness that day, not one of the last. She told about the "choices" that managed care companies and self-insured plans are making everyday when they determine "medical necessity." Linda Peeno had been a claims reviewer for several HMOs. Here's her story:

"...I wish to begin by making a public confession. In the spring of 1987, as a physician, I caused the death of a man.

"Although this was known to many people, I have not been taken before any court of law or called to account for this in any professional or public forum. In fact, just the opposite occurred: I was 'rewarded' for this. It brought me an improved reputation in my job, and contributed to my advancement afterwards. Not only did I demonstrate I could do what was expected of me, I exemplified the "good" company doctor: I saved a half million dollars!"

As she spoke, a hush came over the room. The representatives of the trade associations who were still there averted their eyes. The audience shifted uncomfortably in their seats, both gripped and alarmed by her story. Her voice became husky and I could see tears in her eyes. Her anguish over harming patients as a managed care reviewer had caused this woman to come forth and bare her soul.

She continued, *"...Since that day I have lived with this act, and many others, eating into my heart and soul. For me, a physician is a professional charged with the care, or healing, of his or her fellow human beings. The primary ethical norm is: do no harm. I did worse: I caused death. Instead of using a clumsy, bloody weapon, I used the simplest, cleanest of tools—my words. This man died because I denied him a necessary operation to save his heart. I felt little pain or remorse at the time. The man's faceless distance soothed my conscience. Like a skilled soldier, I was trained for this moment. When any moral qualms arose, I was to remember: I am not denying care; I am only denying payment."*

By this time, trade association representatives were staring at the floor. The Congressmen who had spoken on behalf of the HMO's were distinctly uncomfortable, and the staff, several of whom subsequently became representatives of HMO trade associations, were thanking God that this witness came at the end of the day.

Dr. Peeno's testimony continued, *"...at the time, this helped me avoid any sense of responsibility for my decision. Now I am no longer willing to accept the escapist reasoning that allowed me to rationalize this action. I accept my responsibility now for this man's death, as well as for the immeasurable pain and suffering many other decisions of mine caused."*

She then listed the many ways managed health plans deny care to patients. But she emphasized one particular issue—the right to decide what care is medically necessary. *"There is one last activity that I think deserves a special place on this list, and this is what I call the smart bomb of cost containment, and that is medical necessities denials...Even when medical criteria is used, it is rarely developed in any kind of standard, traditional, clinical process. It is rarely standardized across the field. The criteria is rarely available for prior review by the physicians or members of the plan..."*

"We have enough experience from history to demonstrate the consequences of secretive, unregulated systems that go awry..." After exposing her own transgressions,

she closed by urging everyone in the room to examine their own conscience. *"... One can only wonder: how much pain, suffering, and death will we have before we have the courage to change our course? Personally, I have decided even one death is too much for me."*

The room was stone-cold quiet. The Chairman mumbled: "Thank you, Doctor."

Linda Peeno could have rationalized her decisions as so many do: "I was just working within guidelines" or "I was just following orders" or "we have to save resources" or "this isn't about treatment, it's really just about benefits." Dr. Peeno refused to continue this denial and will do penance for her sins the rest of her life by exposing the dirty little secret of HMO's determining "medical necessity."

My friend, if there is only one thing you read before voting on patient protection legislation, I beg you to read the following. Before voting on any patient protection legislation, please keep in mind the fact that **no amount of procedural protection or schemes of external review can help patients if insurers are legislatively given broad powers to determine what standards will be used to make decisions about coverage.**

As Dr. Peeno so poignantly observed, insurers now routinely make treatment decisions by determining what goods and services they will pay for. The difference between clinical decisions about medically necessary care and decisions about insurance coverage are especially bluffed. Because all but the wealthy rely on insurance, the power of insurers to determine coverage gives them the power to dictate professional standards of care.

Make no mistake, along with the question of health plan liability, **the determination of who should decide when health care is medically necessary is the key issue in patient protection legislation.**

Contrary to the claims of HMOs that this is some new concept, for over two hundred years most private insurers and third-party payers have viewed as medically necessary those products or services provided in accordance with the "prevailing standards of medical practice." This is the definition used in many managed care reform bills, including my own—the Managed Care Reform Act of 1999. The courts have been sensitive to the fact that insurers have a conflict of interest because they stand to gain financially from denying care and have used "clinically derived professional standards of care" to reverse insurers' attempts to deviate from these standards.

This is why it is so important that managed care reform legislation include an independent appeals panel with no financial interest in the outcome. A fair review process utilizing **clinical standards of care** guarantees that the decision of the review board is made without regard to the financial interests of either the HMO or the doctor. On the other hand, if the review board has to use the health plan's definition of "medically necessary," there is no such guarantee.

In response to the growing body of case law and their own need to demonstrate profitability to shareholders, insurers are now writing contracts that threaten even this minimal level of consumer protection. They are writing contracts in which standards of medical necessity are not only separated from standards of good practice but are also essentially not subject to review. Here is one example, of many, of a health plan's definition of "medically necessary services."

> "Medical necessity means the **shortest, least expensive, or least intense level** of treatment, care or service rendered, or supply provided, as determined by us (the health plan), to the extent required to diagnose or treat an injury or sickness. The service or supply must be consistent with the insured person's medical condition at the time the service is rendered, and is not provided primarily for the convenience of the injured person or doctor." (emphasis added)

Contracts like this demonstrate that some health plans are manipulating the definition of medical necessity to deny appropriate patient care by arbitrarily linking it to saving money, not the patient's medical needs.

On the surface, some may say, "So what's wrong with the 'least expensive treatment'?"

Here's just one example out of the thousands I could cite: as a reconstructive surgeon, I treated children with cleft palates. "Clinical standards of care" would determine that the best treatment is surgical correction, but under this HMO's definition, the plan could limit coverage to a piece of plastic to fill the hole instead. After all, this plastic obturator would be cheaper. However, instead of condemning children to a lifetime of using a messy prosthesis, the proper treatment—reconstruction using the child's own tissue—would give that child the best chance at nominal speech and a normal life.

Paradoxically, insurers stand to benefit from misguided legislative changes that displace case law! Last year, legislation that passed the House and the GOP bill in the Senate would have granted insurers the explicit power to define medical neces-

sity, without regard to current standards of medical practice. This would have been accomplished by allowing them to classify as medically unnecessary any procedures not specifically found to be "necessary" by the insurer's own technical review panel. The Senate bill would have even given insurers the power to determine what evidence would be relevant in evaluating claims for coverage and would have permitted insurers to classify some coverage decisions as exempt from administrative review.

I know that many of our colleagues who supported those bills last year had no idea of the implications of the medical necessity provisions in them.

Specifically, insurers now want to move away from clinical standards of care applied to particular patients to standards linking medical necessity to "population studies." On the surface this may seem "scientific" and rational. However, as a former medical reviewer myself who worked with many insurers large and small, let me explain why I think it is critical that we stick with medical necessity as defined by clinical standards of care:

- First, sole reliance on broad standards from generalized evidence isn't good medical practice;
- Second, there are practical limits to designing studies that can answer all clinical questions; and
- Third, most studies aren't of sufficient scientific quality to justify overruling clinical judgment. Let me explain these points further (I also recommend the article on these shortcomings by Rosenbaum, et al, in the January 21, 1999 edition of the *New England Journal of Medicine*).

First, while it may sound counter-intuitive, it isn't good medicine to solely use "outcome-based" studies of medical necessity, even when the science is rigorous. Why? Because the choice of the outcome is inherently value-laden. The medical reviewer for the HMO is likely, as shown by the above mentioned contract, to consider cost the essential value. But what about quality?

As a surgeon I treated many patients with broken fingers simply by reducing the fracture and splinting the part. For most patients this would restore adequate function. But for the musician who needs a better range of motion, surgery might be necessary. Which outcome should be the basis for the decision about insurance coverage: playing the piano or routine functioning? My point is this—taking care of patients involves much variation.

Definitions of medical necessity must be flexible enough to take into account the needs of each patient. "One size fits all" outcomes make irrelevant the doctor's knowledge of the individual patient and is bad medicine, period.

Second, there are practical limitations on basing medical necessity on "generalized evidence," particularly as applied to HMO's. Much of medicine is the result of collective experience, and many basic medical treatments haven't been studied rigorously. Furthermore, aside from a handful of procedures that are not explicitly covered, most care is not specifically defined in health plans because the number of procedures and the circumstances of their application are limitless.

In addition, by their very nature many controlled clinical trials study treatments in isolation, whereas physicians need to know the benefits of one type of treatment over another. Prospective, randomized comparison studies on the other hand are expensive. Given the enormous number of procedures and individual circumstances, if coverage is limited to only those that have scientifically sound generalized outcomes, care could be denied for almost all conditions. Come to think of it, maybe that is why HMO's are so keen to get away from prevailing standards of care!

Third, the validity of HMO guidelines and how they are used is open to question. Medical directors of HMOs were asked to rank the sources of information they use to make medical decisions. Industry guidelines generated by the trade associations representing health plans ranked ahead of information from national experts, government documents, and NIH consensus conferences. The most highly ranked respected source—medical journals—was used less than 60% of the time!

Industry guidelines are frequently done by Milliman and Robertson, a strategy shop for the HMO industry. This is the same firm that championed "drive through deliveries" and outpatient mastectomies. Many times, these practice guidelines aren't grounded in science but are cookbook recipes derived by actuaries to reduce health care costs. Here are two examples of the errors of their guidelines:

- A National Cancer Institute Study released in June found that women receiving outpatient mastectomies face "significantly higher" risks of being re-hospitalized and have a higher risk of surgery-related complications like infections and embolisms.
- A 1997 study published in the Journal of the American Medical Association showed that babies discharged within a day of birth faced increased risk of developing jaundice, dehydration, and dangerous infections.

Objectivity of medical decision making requires that the results of studies be open to peer review. Yet much of the decision-making by HMO's is based on unpublished, "proprietary," and unexamined methods and data. Such secret and potentially biased guidelines simply can't be called scientific.

This is not to say that outcomes-based studies don't make up a part of how clinical standards of care are determined. They do. But we are all familiar with the ephemeral nature of new "scientific" studies such as those on the supposed dangers of alar!

Clinical standards of care do take into account valid and replicable studies in the peer-reviewed literature, as well as the results of professional consensus conferences, practice guidelines based on government funded studies, and guidelines prepared by insurers that have been determined to be free of any conflict of interest. But most importantly, they also include the patient's individual health and medical information and the clinical judgment of the treating physician.

Congress should pass legislation defining this standard of medical necessity because: 1) ERISA shields plans from the consequences of most decisions about medical necessity, 2) under ERISA, patients generally can only recover the value of benefits denied, and 3) even this limited remedy is being eroded by insurance contracts that give insurers the authority to make decisions about medical necessity based on questionable evidence. And to ensure these protections, Congress must provide patients with a speedy, external review of all coverage decisions, not merely those that insurers decide are subject to review.

It is time for Congress to defuse the "smart bomb" of HMO's.

Sincerely,

GREG GANSKE
Member of Congress

[Saturday, March 27, 1999—THE HARTFORD COURANT]

A COMMON-SENSE COMPROMISE ON HEALTH CARE

By John MacDonald

U.S. Rep. Greg Ganske is a common-sense lawmaker who believes patients should have more rights in dealing with their health plans. He has credibility because he is a doctor who has seen the runaround patients sometimes experience when they need care. And he's an Iowa Republican, not someone likely to throw in with Congress' liberal left wing.

For all those reasons, Ganske deserves to be heard when he says he has found a way to give patients more rights without exposing health plans to a flood of lawsuits that would drive up costs.

Ganske's proposal is included in a patients' bill of rights he has introduced in the House. Like several other bills awaiting action on Capitol Hill, Ganske's legislation would set up a review panel outside each health plan where patients could appeal if they were denied care. Patients could also take their appeals to court if they did not agree with the review panel.

But Ganske added a key provision designed to appeal to those concerned about an explosion of lawsuits. If a health plan followed the review panel's recommendation, it would be immune from punitive damage awards in disputes over a denial of care. The health plan also could appeal to the review panel if it thought a doctor was insisting on an untested or exotic treatment. Again, health plans that followed the review panel's decision would be shielded from punitive damage awards.

This seems like a reasonable compromise. Patients would have the protection of an independent third party review and would maintain their right to go to court if that became necessary. Health plans that followed well-established standards of care—and they all insist they do—would be protected from cases such as the one that recently resulted in a $120.5 million verdict against an Aetna plan in California. Ganske, incidentally, calls that award "outrageous."

What is also outrageous is the reaction of the Health Benefits Coalition, a group of business organizations and health insurers that is lobbying against patients' rights in Congress. No sooner had Ganske put out his thoughtful proposal than the coalition issued a press release with the headline: Ganske Managed Care Reform Act—A Kennedy-Dingell Clone?

The headline referred to Sen. Edward M. Kennedy, D-Mass., and Rep. John D. Dingell, D-Mich., authors of a much tougher patients' rights proposal that contains no punitive damage protection for health plans.

The press release said: "Ganske describes his new bill as an affordable, common sense approach to health care. In fact, it is neither. It increases health care costs

at a time when families and businesses are facing the biggest hike in health care costs in seven years."

There is no support in the press release for the claim of higher costs. What's more, the charge is undercut by a press release from the Business Roundtable, a key coalition member, that reveals that the Congressional Budget office has not estimated the cost of Ganske's proposal. The budget office is the independent reviewer in disputes over the impact of legislative proposals.

So what's going on? Take a look at the coalition's record. Earlier this year, it said it was disappointed when Rep. Michael Bilirakis, R-Fla., introduced a modest patients' rights proposal. It said Sen. John H. Chafee, R-R.I., and several co-sponsors had introduced a "far left" proposal that contained many extreme measures. John Chafee, leftist? And, of course, it thinks the Kennedy-Dingell bill would be the end of health care as we know it.

The coalition is right to be concerned about costs. But the persistent No-No-No chorus coming from the group indicates it wants to pretend there is no problem when doctor-legislators and others know better.

This week, Ganske received an endorsement for his bill from the 88,000-member American Academy of Family Physicians. "These are the doctors who have the most contact with managed care," Ganske said. "They know intimately what needs to be done and what should not be done in legislation."

Coalition members ought to take a second look. Ganske's proposal may be the best deal they see in a long time.

Mr. GANSKE. Thank you, Mr. Chairman. I remember, very well, a prior hearing that we had, Mr. Chairman. We had testimony from a claims reviewer named Linda Pino. I think it would be very informative for the people in the audience and for the members of this committee to go back over her testimonies. So let me quote from her story.

She said, "I wish to begin by making a public confession. In the spring of 1987, I caused the death of a man. Although this was known to many people, I have not been taken to any court of law or called to account for this in any professional or public forum. In fact, just the opposite occurred. I was rewarded for this. It brought me an improved reputation in my job, and it contributed to my advancement afterwards. Not only did I demonstrate I could do what was expected of me, I exemplified the good company doctor. I saved a half million dollars."

She continued, "Since that day I have lived with this act, and many others, eating into my heart and soul. For me a physician is a professional charged with the care or healing of his or her fellow human beings. The primary ethical norm is 'do no harm.' I did worse. I caused death. Instead of using a clumsy, bloody weapon, I used the simplest, cleanest of tools: my words. This man died because I denied him a necessary operation to save his heart. I felt little pain or remorse at the time. The man's faceless distance soothed my conscience. Like a skilled soldier, I was trained for this moment. When any qualms arise, I was to remember I am not denying care; I am only denying payment."

She continued, "At the time that helped me avoid any sense of responsibility for my decision. Now I am no longer willing to accept the escapist reasoning that allowed me to rationalize that action. I accept my responsibility now for that man's death, as well as the immeasurable pain and suffering many other decisions of mine caused."

She then listed the many ways that managed care plans denied care to patients. She emphasized one particular issue: the right to decide what care is medically necessary.

She continued, "There is one last activity that I think deserves a special place on this list. This is what I call the 'smart balm of cost containment.' That is medical necessities denials. Even when medical criteria is used, it is rarely developed in any kind of standard, traditional clinical process. It is rarely standardized across the field. The criteria is rarely available for prior review by physicians or members of the plan. We have enough experience from history to demonstrate the consequence of secretive, unregulated systems that go awry."

Mr. Chairman, after exposing her own transgressions, she closed by urging everyone in the room to examine their own conscience.

She went on, "One may only wonder how much pain, suffering, and death will we have before we have the courage to change our course. Personally, I have decided even one death is too much for me."

Mr. BILIRAKIS. The gentleman's time has expired. I do remember that.

Mr. GANSKE. Mr. Chairman, it was very powerful testimony.

Mr. BILIRAKIS. Very powerful.

Mr. GANSKE. We ought to remember that. Thank you.

Mr. BILIRAKIS. Ms. Capps, I believe, was here prior to our break? You are recognized.

Ms. CAPPS. Thank you, Mr. Chairman. I want to commend you, Mr. Bilirakis, for holding a hearing on this most important topic: protecting patients with a strong appeals process. I want to add to that strong equaling, as you have mentioned yourself, a timely and also external process.

It is a privilege to follow our colleagues, Dr. Ganske, and his poignant opening statements. We all know as our country's health care system has changed from fee-for-service to managed care, many patients have been denied health coverage for medical treatments that are truly necessary.

As the bottom line has become the major focus for many of these companies, the quality of care for millions of patients across the country has suffered. As a nurse, I can remember many times where very sick patients, that I knew personally and worked with, were denied coverage for conditions that clearly should have been covered.

I am thinking right now of a young couple giving birth to twins. They had another toddler at home. One of the twins had multiple congenital difficulties requiring round-the-clock, skilled nursing care—that being denied by the managed care company. In the time that they were able to finally successfully appeal, so much damage was done this young child. When I see them now, they are a really strong example to me. They have persevered. They are a very strong example in my mind of the need for timely external reviews.

In these sad cases, lives literally hang in the balance. A strong appeals process acts as a check on health plans' authority to control the treatments that are provided to patients. An appropriate appeals entity must be independent to ensure credibility. The appeals must be handled by individuals who have appropriate professional medical expertise related to the specific cases and appeals. It also must be handled, as I said, in a timely manner.

Patients need a well-designed external appeals process. Without one, there is a grave danger that health care will wither. Patients will simply not receive the care they need when they need it. This is very costly to families, and also, I believe, to our society.

As we grapple with the appeals issue today, Mr. Chairman, I think it will become clear that we need to mark up managed care reform legislation in this committee, and do it now. Only through bills like the Patient's Bill of Rights or the Norwood-Coburn bill can we begin to effectively navigate the problems of an effective appeal process. I have said this before. By delaying action managed care reform, I believe we are losing our opportunity to make quality health care a reality for millions of people every day.

I urge the majority to bring managed care reform legislation before the committee for markup immediately. The American people should not have to wait any longer.

Thank you. I yield back my time.

Mr. BILIRAKIS. I thank the gentlelady. Mr. Whitfield, for an opening statement.

Mr. WHITFIELD. Mr. Chairman, the hearing today is going to focus on the key issue for patient protection. One thing is certain: Every member of this committee wants to provide better patient protections. Many of us realize, also, that HMO's are a valuable component of our health care system. The way that we can improve that system is working jointly together, moving forward to make sure that the changes we make improve the system, rather than create additional regulatory burdens.

I, for one, become quite concerned when we talk about amending ERISA. The last thing we want to do is make it more difficult to provide health care to employees. I think we need a patient protection bill. But I also believe that today our health system is in chaos. HCFA is totally micro-managing the health care in our country today.

I, for one, am glad that this committee and the Congress have moved slowly on this issue. The last thing that we need is reacting in an emotional way, without any regard to what the final consequences of our legislation will be. I think we have a duty and responsibility to be very careful about what we do, and to recognize the impact that it will have down the road on health care.

We have a distinguished panel of witnesses today who will provide valuable information. I look forward to their testimony.

I yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman. Mr. Dingell, for an opening statement.

Mr. DINGELL. Mr. Chairman, I wish consent to insert my entire statement into the record.

Mr. BILIRAKIS. Without objection. The opening statement of all members of the subcommittee have been made a part of the record.

Mr. DINGELL. Mr. Chairman, I would like to just summarize briefly and observe that today we start on something of great importance that is a cornerstone for patient protection: the Patient's Bill of Rights. It is important we recognize two things are absolutely essential to this. One is an internal and external appeals process which works to ensure there is a mechanism to protect the rights of the patient. Second of all, a real definition and require-

ment for the doctor to be able to address the question on the basis of medical necessity.

Now having said that, I am delighted to see us holding this hearing. I would observe that it comes to me as—what I hope is—a good sign that something will be moving on this important matter, which has unfortunately languished overlong.

I would like to welcome Dr. Conway from the Henry Ford Health System, a great institution; and a great lady, Connie Barron, who has earned my respect by the very capable way that she processes her business and that of the Nation. I welcome you both. I welcome the other panelists, also. Thank you for being here.

Thank you, Mr. Chairman.

[The prepared statement of Hon. John D. Dingell follows:]

PREPARED STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Today the Health and Environment Subcommittee will discuss the cornerstone of any patient protection legislation, the external appeals process. I would like to thank Chairman Bliley and Subcommittee Chairman Bilirakis for holding a hearing on a topic that is so fundamental to managed care reform.

A timely, independent, and enforceable internal and external appeals process would help to restore faith in the health care system on behalf of all parties. People would know that if their doctors' treatment recommendations were denied, they would be entitled to an impartial opinion from medical experts. A fair external appeals process would reinforce the behavior of health plans that made good medical decisions rather than insurance decisions. Most importantly, an external appeals process would help patients get the health care they need, when they need it.

As part of this debate we must discuss medical necessity, the key component of any appeals process. If this process is to settle disputes between a health plan and your doctor on what treatment you get, then we want the decision to be based on the doctor's best medical judgment, not the health plan's. We do not want these independent experts to be bound by the way the plan defines "medical necessity," which in some cases is whatever the plan says it is. A review conducted in this narrow bureaucratic fashion would be a sham.

These reviewers should determine if the treatment is appropriate based on the "professional standard of care" at the time and taking into consideration the individual circumstances of the patient. The professional standard is not a static concept, but instead is a way of assessing a provider's conduct toward individual patients in light of the current state of knowledge of medical care within the profession. We don't want anyone to get "cookbook" medicine, particularly if the cookbook is written by bureaucrats.

An external appeals process that fails to meet this standard will not do the job. A weak or biased system would actually make life worse for patients by creating another layer between a plan's internal review process and a patient's last resort, the legal system.

Finally, a strong external appeals process is no good without enforcement. A good external appeals process should help to reduce the number of court cases by ensuring that more patients receive the care they need, but it can do nothing to help patients for whom further treatment would be futile. For those patients who have died or have been permanently harmed, we must see that health plans, just like any other organization, are held accountable for their actions.

Chairman Bliley and Subcommittee Chairman Bilirakis, thank you again for holding this hearing. I hope that this Committee will soon mark up managed care reform legislation that includes a strong external appeals process, as well as other protections patients want and deserve.

Mr. BILIRAKIS. I thank the gentleman. Mr. Bryant, for an opening statement.

Mr. BRYANT. Thank you, Mr. Chairman, for holding this hearing today on grievance and appeals processes of managed care health plans. I look forward to exploring this issue, particularly to the benefits of a strong, binding, independent external review process. This concept is a good one because it would give patients the com-

fort of knowing an independent panel of physicians will be reviewing determinations made by their health plan, should they choose to appeal a decision.

An independent external review would provide a mechanism by which patients can get the care they need, which is what the patients want when they are sick. When you get sick, you want the best and most appropriate care—no more, no less. You want it with the least amount of hassle. I look forward to learning more about this review as we hear from the two panels before us today.

I do believe, however, that Congress should proceed carefully. There are three components of health care that must be taken into account when we consider legislative action: access, affordability, and quality. These three components are undeniably linked. Congress cannot simply focus on one of these components without assessing the harm it might do one of the other components. We must be very careful to abide by the same creed doctors do when they take the Hippocratic Oath that we must first do no harm. Today as we are examining external review and other aspects of the grievance and appeals processes of managed care, I say the issue goes to the quality of these health care plans.

I want to commend the chairman for holding a hearing last week on America's No. 1 health care problem: the 43 million people without health insurance. Last week's hearing explored ways to expand access and affordability of health care for these Americans. In that hearing, we looked at proposals to provide tax credits to individuals for health insurance; to provide greater opportunities for small businesses to purchase insurance for their employees, and to provide other innovative ways for people to get coverage.

As we in Congress tackle these very complex issues, we must perform a delicate balancing act, balancing the interest of each of these factors: access, affordability, and quality. I know I speak for all members here when I say that we all want to do what is right. We want to get it right the first time. We don't want to have to deal with it later down the road with unintended consequences of legislation passed this year.

I might also say—as I read some of the statements of the panel, and heard some of the comments that have already been advanced today—on the issue of liability, we don't want to litigate our way to better health, if we can avoid it. There is a better way here. I believe it is this external review process. We all know that you cannot sue your way to better health. If we can resolve patient disputes by creating a strong, independent, timely, and binding external appeals process, we avoid an awful lot of trouble. I think the consumers aren't looking to resolve their medical problems in court. I think they want to receive the care they deserve through an independent appeals process. If we do this external appeals process the right way, we ought to be able to get around this discussion of liability. What we are doing is proposing to have independent physicians look at this medical coverage decision denied by the plans, and do it in a timely, expeditious, and fair fashion.

Coming from the legal community and being a lawyer who was involved in malpractice lawsuits, I can tell you that expanded liability means more courts, more costs, higher premiums, and more Americans added to the rolls of the uninsured. I might say, also,

that participants can already sue for their benefits in the Federal courts, and can sue negligent providers for malpractice in their State courts.

With that said, I hope that we can move on to the issue of the day, which is the external review process—not liability. I thank the chairman and yield back my time.

Mr. BILIRAKIS. I thank the gentlemen. Mr. Barrett, for an opening statement.

Mr. BARRETT. Thank you, Mr. Chairman. This certainly is an issue that deserves our immediate attention. I just want to relay to the committee two incidents that were brought to my attention by constituents that deal with this issue.

The first one deals directly to the issue of external review, to make sure as we talk about this issue we remain mindful of the nuances. The constituent was denied care, and asked for a review of the decision. He was sent before a panel. He was a layman, and was sitting there in a room with five or six individuals who were the review panel. It was quite intimidating. As he looked up, he saw there was a representative on that review commission that was labeled the "consumer representative." He felt confident that she would be the person that would be on his side, or sympathetic to his case.

As the appeal occurred, he realize the person who was labeled the consumer representative was by far the most aggressive person on the panel against him. She was asking the most difficult questions. When they were done, he was perplexed. He went up and said, "Well, I understand that you are the consumer representative. How did you get that position?" She said, "Oh, I work for the company." He said, "But I thought you were the consumer representative." She said, "I am. I am a consumer of the product. I also work for the HMO. So I got to be on this panel."

I tell this story because I think as we craft legislation here, we have to be very careful. If we are going to have an external review, it has to truly be an objective review.

The second thing, and this follows up on Mr. Bryant's comments, I think, about trying to avoid confrontational decisionmaking. There was another constituent who had been told that he had a condition. Cancer was not ruled out. Although the doctor didn't think it was cancer, there was a 10 percent chance that it was. He should come back in 3 months. Needless to say, if you think that you have a 10 percent chance that you have cancer, you are not all that comfortable sitting around for 3 months to see whether or not you do.

So he said, "Well, I would like to see another physician to do this." The physician said, "No, we are not going to do that." He simply said, "That is fine. Would you put that decision in writing, please?" The physician became very defensive and said, "There is no way that I am going to put that refusal in writing." The constituent said, "Well, that is fine. I will just write you a letter saying that I have asked you to refer me to another physician, and you have refused to do so." He got the permission at that point, obviously, to see the other physician.

I bring that to the committee's attention because I think we have to be mindful that we don't create an even more confrontational

system here. It is important as we try to craft solutions to remember that the physician is there to help the patient. I am confident that if we can move this legislation and the legislation that is on the floor right now, we can address a lot of these concerns.

I remain optimistic. I have publicly said that this is the piece of legislation that can break the logjam that has occurred in this Congress. I think we can move this legislation forward. I am pleased that Mr. Pallone and others have worked so aggressively to get the issue to the floor. It is my hope that we can really pass a true Patient's Bill of Rights bill.

I would yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman. Mr. Burr, for an opening statement.

Mr. BURR. Thank you, Mr. Chairman. I would like to thank our panelists today for their willingness to come in and share their knowledge and talents. Hopefully, they will move us to the next step.

I think that good policy is a process of patience. It is a process of learning. It is a process of talking to experts, of which we have some on our committee.

There is one that I know to be sure: Health care is not perfect today. Health care will not be perfect when we write legislation. I think we can all agree to that. Can it be better than it is today? That is certainly the objective of this subcommittee. I will continue, despite those who would like to move faster than other members can possibly move in good conscience, to stay engaged in the process.

I remember when I started FDA reform 2½ years ago. There were some that wanted to do it the day before we introduced it. There were some that didn't want to ever do it at all. The fact was, as we went through the process, as more people understood the problems, the challenges on both sides of every issue, we were able to craft legislation that addressed the needs of that human face that sat out there waiting for the drugs. At the same time, we created the incentive for a tremendous investment by the industry that was so much affected by that legislation. By the way, even by FDA standards, we did protect the safety and efficacy process—that gold standard we hold so high at the Food and Drug Administration.

Personally, Mr. Chairman, I make a commitment today to you and all of my colleagues to continue to stay engaged, and continue to work and strive for legislation that meets the right policy.

I do have to say that I resent Dr. Ganske's broad-brush remarks about Republicans. I am included in that. As a member that has been very diligent about my willingness to spend time in hearings—whether it is one or whether it is ten—to sit and listen to him to determine what part of his great education I don't understand, or have not had an opportunity for it to be shared with me, but it upsets me greatly when any individual can suggest that to perfect policy on my part is to neglect the quality of care for patients. It is absurd. I cannot speak for the other 434 Members of the Congress, but I think it is time for all Members—Republican and Republican, Republican and Democrat, Democrat and Democrat—to start talking about the right policy, and stop talking about

the petty issues: Who does what when; who is right; who is wrong; who is an expert; who is not?

Mr. Chairman, I look forward to the process as we head forward. I diligently commit to work with you and all the members to see that this is a successful end where the patients win. I yield back.

Mr. BILIRAKIS. Thank you so much for that opening statement, Richard. Mr. Brown, for an opening statement.

Mr. BROWN. Thank you, Mr. Chairman. One of the ironies of the managed care reform debate is the consensus around external appeals. Everyone, even the insurance industry, agrees that an external appeals process makes sense.

The irony is that if you believe enrollees need and deserve not just internal, but an external appeals mechanism, you must believe that patients have rights, and that from time to time health plans violate these rights. Working backward from the need for external appeals, the logic behind enacting the package of reforms in the Patient's Bill of Rights is simply difficult to refute.

How do health plans let down their enrollees? By collecting premiums for coverage that shrinks in proportion to the amount that is needed. Health plans let down their enrollees by withholding coverage for specialists, for out-of-network emergency visits, for clinical trials, for services, that by any other standard other than the one the health plan itself uses, would be considered medically necessary. In short, they withhold payment for the kind of care that makes coverage, coverage.

Enrollees who are assured upfront of a fair medical necessity standard protection in the case of emergencies, and access to the right provider, would be less dependent on external at the back end. If health plans know they are truly accountable in State and Federal court for arbitrary and bottom-line-oriented decisions that harm a patient, I think they will think twice before shortchanging their enrollees.

External review is, in fact, a piece of the puzzle. Comprehensive reform, including external review, is the solution. This hearing is about external review. There are some fundamentals that distinguish a true external review mechanism from a false one. Obviously, the external review panel must be impartial, must have relevant expertise, and must look at the evidence fresh, without the fingerprints of the health plan on it. It is equally obvious that the health plan should not be the one to determine what is, in fact, appealable. The process should be available to any enrollee whose health is in jeopardy.

Finally, we must dispense with any manipulation of the term, "medical necessity." An external review panel must have the authority to override a health plan's medical necessity determination regardless of what is alluded to in the enrollee's benefit booklet or plan contract. The fact that medical necessity determinations are vulnerable to gaming is the crux of the problem. When you think about it, giving the enrollee the protection of a second opinion on questionable medical necessity decisions is really the whole point.

I look forward to hearing from our witnesses, Mr. Chairman. I hope after today's hearing, we will waste no time in marking up and discharging a comprehensive managed care reform bill. Thank you.

Mr. BILIRAKIS. I thank the gentleman. Mr. Shadegg, for an opening statement.

Mr. SHADEGG. Thank you, Mr. Chairman. I would like to begin by complimenting you for scheduling this extremely important hearing. There is no doubt that the issue of external appeals is critical as a key to important debate.

I think that it is very important that we begin with an understanding of where this problem came from. The overall topic of HMO reform is one that has been discussed here at great length. I want to make it clear at the outset that I am one of those who believe that HMO's have performed a valuable service in holding down costs, but holding down costs at what price? I think, quite frankly, we have reached a point where HMO's have achieved some level of cost savings, but they are now beginning to achieve any further cost savings by denying care.

Why is that occurring, and what is the cause of it? My colleague referred to the fact that under ERISA, which has been discussed and the topic of damages, patients can currently sue to recover the actual costs of any care that they should have received. With all due respect, I would to disagree with that. ERISA has changed the law in this area. I think it is important to note—and I am very pleased the committee memo points out—that until 1974, when this Congress passed ERISA, States had a traditional role of regulating insurance companies. They regulated both quality and cost issues. They looked even at the financial underpinnings of insurance companies which provide health care coverage.

In 1974 when Congress passed ERISA, it blocked that traditional role that States provide in giving patients protection. It specifically precluded State regulatory laws from governing ERISA plans. As a result of that, today in America 48 million Americans—as the committee memo points out—are covered by ERISA-governed plans. Those ERISA-governed plans are exempt from State protection laws, and immune from any meaningful damages. Yes, the law says you can recover the actual cost of any care that wasn't provided. The reality is, if you can't recover a dime more than that, you can't afford to bring suit. So the reality is that, as a result of this Congress changing the law in ERISA, patients now lack vital protections which they need.

I don't suggest that we go back to a tort-law-driven system, or that we open the door to unlimited lawsuits. I do believe that we can improve, as my colleague pointed out, on the current system. We can do better than the current system. We do not have to have incentives which encourage HMO's to deny care, which is what we have with the current system.

My colleagues, Mr. Coburn and Mr. Norwood, and I have worked for the last several months on this issue. We have drafted legislation which contains both a carefully thought out internal and external appeals process. The external process in that legislation, I suggest, is more carefully thought out than anything that has yet been presented to Congress. It does not open the doors to unlimited litigation. It does, however, provide meaningful review by an external panel which will look carefully at what coverage should have been, or should not have been, provided. But, most importantly, it goes

beyond that and says that, if the HMO refuses to comply with that, there is liability beyond that point.

I suggest that is a careful balance. In the absence of any ultimate penalty as we have put in the legislation we have crafted; that is, in the absence of any extension of liability where an HMO does not comply with the external review procedure, then you have no meaningful legislation at all.

I want to add that I began this Congress not favoring HMO legislation at all. I am not fond of the idea of extending the regulatory arm of the Federal Government. I think, however, that we need this legislation now. Having looked at this legislation, we need to go beyond that and look at the cause of the problem. There is a cause behind all of this. That cause is that, as a result of the tax code, we have divorced the person consuming health care in America—the individual employee—from the entity paying for health care in America—the employer. As a result of that change in the tax code, the vast majority of Americans get their health care through their employer, but they have no ability to pick the plan they want. They have no ability to fight when they don't get the coverage they want.

I think that is a serious flaw in the current system. The legislation which I have crafted, and which Mr. Coburn and Mr. Norwood have joined me on, is legislation that would say we need to change that. I urge this committee to move the legislation as quickly as possible.

We need to empower individuals to select the health care that meets their needs. We need to empower them to be able to shop with their feet. We need to let a market work in this place. I believe we can allow a market to work in the health care arena with those kinds of changes.

We have to do a temporary fix with regard to HMO reform. I believe we can. The legislation which is before this committee is thoughtful, I think. It moves in that direction. We then have to look at the long-term cause. I suggest that the solution to the long-term cause is to empower individuals to shop with their feet, to give them the right of choice, and increase the access they have to plans that suit their needs.

With that, I yield back the balance of my time.

Mr. BILIRAKIS. Thank you, sir. Ms. DeGette.

Ms. DEGETTE. Mr. Chairman, Ms. Eshoo had to leave. I would ask unanimous consent to insert her statement for the record.

Mr. BILIRAKIS. Without objection.

[The prepared statement of Hon. Anna G. Eshoo follows:]

PREPARED STATEMENT OF HON. ANNA G. ESHOO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Thank you, Mr. Chairman, for holding this hearing—the second this Congress on managed care reform.

I'm pleased that the Subcommittee is tackling the issues surrounding managed care reform. Last year, I lived and breathed this issue as co-chair of the Health Care Task Force.

We worked daily writing the Democratic Patients Bill of Rights because we knew that the American people want and need consumer health protections.

- Over half of the 143 million Americans enrolled in managed care plans say they are worried that if they become ill their health plan would be more interested in saving money than in providing the best medical treatment,

- Nearly 40% of physicians in HMOs report decreased ability to make the best medical decisions for their patients.

There are several guarantees Americans need to ensure that they're getting quality, reliable health care. We addressed a few of them in our last hearing on managed care reform.

- Access to specialists.
- Emergency care when and where it is needed.
- Health plan information that is available and easily understood.
- An ombudsman to help navigate the system.

While critically important, none of these rights will guarantee any real health protection's without the ability to hold health plans accountable for their medical decisions.

One of the critical ways we can hold health plans accountable is through a meaningful external appeals process.

If appropriately designed, this process would allow a patient to appeal disputes over medical care to an independent entity with appropriate expertise to hear cases.

As we all know too well, the devil is always the details. It is not enough to simply require health plans to institute an external appeals process. We must ensure that the process is meaningful.

- It must be independent and timely.
- It must allow appeal of a broad range of medical decisions.
- It must be based on a medical necessity standard that incorporates generally accepted principles of medical practice.

As the health care system has changed from fee for service to managed care, the incentives to provide care have also changed. A meaningful external appeals process will help to shift the balance back in favor of quality health care.

Mr. Chairman, I'm grateful we're moving toward by holding hearings on needed protections. I'm hopeful that we also will have an opportunity to consider legislative proposals, like the Patients Bill of Rights, that provide these protections.

I look forward to the day we send a meaningful patient protection bill to the House Floor that includes guarantees like independent review of medical decisions that have real affects on people's health.

Thank you, Mr. Chairman. I look forward to hearing from the witnesses.

Mr. BILIRAKIS. Please extend my apologies to her. If we had known that she had to leave, I am sure Mr. Brown would have been happy to yield his time to her.

Ms. DEGETTE. I didn't realize it until she was just getting up.

Mr. Chairman, I am very pleased that we are having this hearing, and all of these hearings. I think that many of us feel that a strong appeals process must be a part of comprehensive reform. That is why many of us have today signed a discharge petition on the Patient's Bill of Rights.

We have all heard horror stories of patients denied critical health care services by a health plan, only then to find that they have no recourse to appeal the decision. If properly designed, effective external appeals process can provide the necessary checks on health plans' authority to control the treatments that are provided to patients. Without those external appeals processes, any managed care reforms that we enact will fail to protect patients. It is that simple.

I hope that today's hearing will shed some light on some of the critical issues surrounding development of an effective external appeals process. How do we assure independence? What is a reasonable timeframe for appeals? Who are the reviewers? How do they comply with the verdict? I am especially interested in how we do an adequate and timely external appeals process in emergency care situations, for example. I think that we have to address these issues on medical necessity and how it is defined. Without a clear definition, it is hard to determine when a case should be reviewed. It is hard to ensure that plans will provide medically appropriate care.

With that, Mr. Chairman, I think Mr. Ganske was saying some very important things when his time ran out. So if he has any more to say, I am happy to yield him the rest of the time I have remaining.

Mr. GANSKE. If the gentlelady would yield?

Ms. DEGETTE. I would be happy to.

Mr. GANSKE. I did want to commend my colleague from Arizona for his comments on liability.

Not too long ago I had a conversation with the CEO of my own Iowa Blue Cross-Blue Shield Welmark Organization. He said, "You know, Greg, we are in the process of implementing your Patient's Bill of Rights Managed Care Reform Act of 1999. It is costing our plant almost nothing. We expect to see no premium increases from that. It is a matter of tightening up our own protocols."

Part of that may be the fact that Blue Cross plans frequently sell to the individual market as well. They are under State regulation for those policies. But he said, "You know, on the liability issue, I could see where after an internal review, if there is still a dispute on a denial of care, we could go to a independent peer panel. I would agree with that panel determining medical necessity as long as they can't overrule specific exclusions of coverage." He said, "I could agree with that being binding on my plan. But if it is binding on my plan, and we have to follow this other group's recommendation, then we should be free of punitive damages liability. We didn't make the decision. We just have to follow it. Punitive is for punishing malicious behavior." I said, "That sounds very reasonable, John. I will put that into my bill, The Managed Care Reform Act of 1999."

I am happy that I have been able to work with Congressmen Coburn and Norwood. That is, essentially, the provision in the consensus draft that was given to the chairman of this committee and to the chairman of the full committee. I think that is a reasonable compromise.

What it accomplishes is this: It does reestablish responsibility back where it should be for a medical decision, but it creates an incentive to avoid the lawsuit. For the patient, you have an opportunity to get an independent second opinion.

Let's say a patient wants Laetrile from Mexico. They know they have an unhappy customer. The plan under this bill could take it to an independent panel for a confirmatory decision. In so getting a confirmatory decision, it would be shielding itself from any punitive damages.

I think it is a very reasonable compromise. I would encourage my colleague from North Carolina to keep an open mind on that type of compromise. I would point out to my colleagues that it is already June 23. It is not earlier in the year. We were burning the midnight oil. This issue has been before Congress for several years. It is has been before this committee for a long time. I think it is time to move to a full markup. It is time to get it to the floor, and do it in a fair and reasonable way with an open rule, something where we don't end up with a sham process.

Mr. BILIRAKIS. The gentlelady's time has expired. Dr. Coburn.

Mr. COBURN. Thank you, Mr. Chairman. You know, I really don't care who gets credit for getting patients better care. But you can

tell from both sides of the panel that there are a lot of people interested in reforming managed care. It is going to happen.

The things that are going to slow it down are turf battles for credit and politics. The politics of it stink. The politics on the Democrat side stink, and the politics on the Republican side stink. If we really want to do something, we will put external review that has teeth in it that allows people to get the care that was bought and paid for.

We are going to do that. No matter which committee it comes through, right is going to win on this process in this Congress. It is going to cross party lines. It is going to cross political lines. It is going to cross thought lines. Patients are going to be the winners.

My colleague from Arizona makes great points. I, too, have supported a lot of what managed care has done. They have made better doctors out of a lot of doctors. They have kept us from wasting a lot of money that we should not waste.

There are two points that we need to realize. No. 1 is that when ERISA was put in it was for those self-funded plans. It was not for independent HMO's out marketing. That is No. 1. It has been expanded to include that.

No. 2 is that we now have a profit center in between the patient and the purchaser of their health care. That can't be a good thing for patient care. Regardless of its motivation of saving money, the real motivation is to make money. That is at the risk of patients not getting the care that was bought and paid for.

I will challenge anybody. In the last 4 weeks I have run into five episodes of denial of care from managed care companies in my own practice on either a Friday or a Monday. It is out there. The way that the money is being made is care not being delivered to the patients for whom it was bought and paid for by their employers.

We can deny that. We can say that it doesn't happen, but it does. We are going to change it. The best way for us to change it is to not make it a political issue, to not try to gain political points, to not spar between ourselves, but to get together and do it. If we will do that, we will fix health care in terms of this aspect for the American public. If we make it political, then we may get a poor result. It will be the Members' of Congress fault, not any of the patients, and not any of the managed care companies. It will be our fault.

Mr. Chairman, I thank you for having the hearing. I also would say that I would exert any pressure I could on you to reclaim the authority of this committee over health care in this Congress. We do have authority over that. We should reclaim that. We should get into the fight with the parliamentarian on whether or not we do have that. I would tell you that the Subcommittee on Health of the Committee on Commerce—no committee has more jurisdiction over the health in the country than this committee. We ought to exert that right.

With that, I yield back.

Mr. BILIRAKIS. Mr. Hall, for an opening statement.

Mr. HALL. Mr. Chairman, thank you. I am, of course, pleased to be here today. In a way, I am pleased to be here, and in a way, I am very saddened to be here. I had hoped that the entities that

were involved would get together and work this out. I had, I guess, every insurance company, hospital administrator, and many of the physicians that are in my area in my office in Rockwall, Texas earlier in the session. I suggested to them that they get together and work it out, and give us a business decision, rather than getting a congressional decision. No one is going to like the congressional decision. You could have brought us something. I think you should have. I think you let a lot of people down when you didn't do that.

Actually, the blue dogs, a group of conservative Democrats, got together and asked trial lawyers, insurance companies, hospital administrators, physicians, and others interested, like the NFIB and chambers of commerce, to sit in and try—one last time—to get together and work this out. Come bring us a decision that you all can work out yourselves. I don't think there is anyone on this committee, or in this Congress, who wouldn't like that.

We had the same problems when we wrote the Clean Air Act, earlier in the 1980's. As a result, we still have some requirements for technology to clean the way that Congress wanted to clean the air that is not even in existence. I think you are not going to like it. If you don't get together and bring us something, I am going to be very disappointed.

I think, certainly, that I don't take a back seat to anyone for voting for all of the entities that I have enumerated here. I am a lawyer who voted to cap damages. I have put my amendment on everything that has been through here to punish the lawyer and the client if they file a frivolous lawsuit. I think that solved much of the problem that we are facing today.

So I just don't understand why the entities can't get together and see that this is really ridiculous to say that this is going to spawn lawsuits if we erase ERISA. Mr. Chairman, I think numerous hearings by this committee that we have held over the past few years have shown, indeed, that a lot of patients have been denied care by their health insurer, without the rights of due process guaranteed by our Constitution, and denied by the sleight-of-hand use of ERISA. It was never meant to be used as a shield, but it is being used as a shield.

I believe our witnesses today are going to bring us some very valuable insight into various appeal processes available today, and make suggestions and recommendations that we can use in crafting a strong internal and external appeals process that would be guaranteed to every employee, whether they are in managed care plans, or fee-for-service, or other health insurance plans, regardless of the employer's participating or not in ERISA.

I would be remiss if I did not, again, tip my hat to our in-house medical experts, Dr. Ganske, Dr. Norwood, Dr. Coburn, who give us advice and don't charge us for it. Their common-sense approach to this is something that has been really very thrilling to me. I would remiss if I didn't suggest to Dr. Ganske that his opening statement ought to go to every Member of Congress, and every Member of the House and Senate.

Mr. Chairman, I also note your wisdom in having two Texans on the panel today. Mr. Dingell has already tipped his hat to Ms. Barron, who is Associate Director of Legislative Affairs at the Texas Medical Association. She has been very helpful to our office. I

didn't know if Connie was on the first or second panel. I see her at the table. I assure you that they are well qualified to speak on our topic today. They have given Texas and the Texas legislature their good advice. We have good, strong patient protection laws in place down there that are working.

So I, once again, urge all the entities to get together and work out a bill that you can live with that is fair and can be passed by this committee. We still have time. This year is not over.

I yield back my time.

Mr. BILIRAKIS. I thank the gentleman. I trust the gentleman knows that the staffs have been working very diligently—the majority and the minority—towards that end.

I would now recognize Dr. Norwood, for an opening statement.

Mr. NORWOOD. Thank you very much, Mr. Chairman, for holding this hearing. Thank you for holding all the many hearings you have held on this subject over the last 4 years. I thank you in advance to not hold any more.

I want to thank you for a markup that, surely, the health care committee of Congress should have, and have soon—certainly in July. It is something that we have talked out. I am almost out of something to say. I have said it so many different times, so many different ways: We need to do battle. We need to have a markup, so both sides of the aisle can have their points made.

This will never work if it is not bipartisan. It is not about Democrats. It is not about Republicans. It is about patients. I promise you that the Democrats have patients in their constituents just like we have patients in our districts in our constituents. For us to win, for America to win—for the patients of this country to win—we need and can have an absolutely bipartisan bill.

Today we are focused specifically, I think, on one of the most important aspects of any type of managed care reform that we do. At the end of the day, I cannot think of anything in the entire bill that is going be more important than internal and external review, and how that structure works. It is delicate. It is complicated. Dr. Coburn and Dr. Shadegg have it, in my opinion, just exactly right in the consensus bill. It will work. It will ensure that patients really do get the care that they paid for when they need it.

Former Congresses are responsible, in my opinion, for the problems that we are dealing with today in health care. Mr. Shadegg alluded to this. Congress created the laws that are forcing the conflicts that we are here trying to solve. They created them in 1973 and 1974. My good friend from North Carolina, Mr. Burr, knows that I don't have any patience. I have been waiting 25 years. I think that is fairly patient.

We have been working on this problem since 1995. This is about, as he said, us passing legislation that really affects an industry. That is exactly what Congress did in 1973, when it used the taxpayers' dollars to subsidize a new form of medical delivery, then called "managed care." That is exactly what Congress did in 1974, when it preempted State laws and then wrapped their arms with a shield of immunity around those that would be involved in it. They passed legislation that affected an industry. That industry was sick patients and people willing to treat those sick patients. So I think patience has been exhibited greatly, after 25 years. We are

now trying to straighten out the problems that we have watched occur over the last 25 years in this Congress. It is high time that we did that.

Once upon a time, there really was a market in health care. There really was. It was a market between a sick patient and a willing doctor. The market is very much skewed today. It doesn't work that way. Today, we have willing doctors that are very able and competent to try to provide the appropriate care. We have patients who want all the possible care they can get, since oftentimes someone else is paying for it. We have insurers who simply want to keep the costs down. This is just another profit center.

You know, when these forces come into conflict—which they do every day—we have the problems that we are all trying desperately to deal with. In these bills, whether it be John Dingell's bill, or whether it be Greg Ganske's bill, or whether it be Drs. Coburn and Shadegg's bill does not have anything to do with it. We are all trying to face the problems.

Under current law, the insurer is always right. No matter what happens, they win. You have nowhere to go. You have nobody to turn to. The treating physician has no one to go to. The patient has no one to go to. Unlike in the early 1970's, when it actually helped to be able to occasionally call the insurance commissioner, at least you got somebody to listen. You didn't always win. But the frustrations are today that some clerk says, "no," and you are out of business.

Mr. Chairman, I see the light. I will just ask your permission to put the rest of my statement in the record. Again, I thank you. I know you have been through a lot, personally, with this. I appreciate all the hearings you have held for us, and all the times you have really done everything you could with these conflicting forces, which are on both sides of you. It is just as bad over here as it is on the other side. I know you have been beat up. I thank you, sir, for what you have tried to do for the patients in your district.

Mr. BILIRAKIS. Thank you, so much, Dr. Norwood. Mr. Green, do you have an opening statement?

Mr. GREEN. Thank you, Mr. Chairman. I would like unanimous consent to place my opening statement in the record.

Mr. BILIRAKIS. Without objection.

Mr. GREEN. I would like to just briefly say that like my colleague, Ralph Hall, I want to welcome Ms. Barron. I appreciate the friendship over the years with the Medical Association.

What I have is an ad that has been running in publications up here that says, "The Kennedy-Dingell bill will change health care. It will make it more expensive." I would hope each of you would address it, particularly Ms. Barron, because of her Texas experience. It said we are talking about an outside appeals process. I know the numbers that I remember seeing were that actually half of the appeals were found in favor of the patient. If you could talk about the cost of that appeals process in Texas, and maybe some of the other things. I don't know if anybody on the panel represents the health benefits coalition. But with all the money they are spending on ads, at least in DC, it might would be better if they would pay for better insurance for their businesses. If you could ad-

dress some of the cost in not only the appeals process, but other cost items.

I am glad to follow my colleague from Georgia, Mr. Norwood. We do have both Democrat and Republican patients. I know the patience on your side is wearing thin, just like the patience on our side. Hopefully, we will be able to move a comprehensive bill. Thank you, Mr. Chairman.

[The prepared statement of Hon. Gene Green follows:]

PREPARED STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Thank you Mr. Chairman for scheduling this important hearing. The issue of external appeals is so complex, it is critical that we consider every issue to insure that the provision is crafted to adequately protect patients.

External appeals is yet another issue that, on the surface, is very easy to agree on. Every comprehensive managed care reform bill that has been introduced over the past year has included an external appeals provision.

However, how these appeal processes work varies widely from bill to bill. In some cases, the framework falls well short of what is required to protect patients.

The key elements that an external appeals process must include are:

- It must be binding—There has to be an adequate accountability provision to punish plans who delay or deny care even after an appeals process has ruled in favor of the patient, especially on the issue of medical necessity. If the treating physician AND the physicians on the external review board agree that a particular treatment is medically necessary, than the plan should have to pay for that treatment.
- It must be timely—Patients with life threatening conditions must have access to a timely appeals process. There is no time more stressful for a family than when a loved one is sick. It is hard enough dealing with the anxiety and uncertainty of the illness without having to negotiate the bureaucracy of a drawn out appeals process. Moreover, many diseases like cancer, progress so quickly that by the time the patient wins their appeal, it is already too late for the treatment they were appealing.
- It must be independent—Any external appeals board must be fully and completely independent of the health plan. Under some proposals, the plan would be allowed to set up the external appeal board, but under this scenario, there would be a direct conflict of interest between meeting the needs of the patient and serving the best financial interest of their employer.
- There have to be specialists involved—The bottom line is I don't want a heart surgeon making the medical decision about a child's cancer treatment. There are medical specialties for a reason and decisions effecting each disease or part of the body needs to be made by people who are trained to do so. If a doctor wouldn't treat a particular disease in their office, they shouldn't make decisions about them in an appeals process.

As always, Mr. Chairman, the devil is in the details. I look forward to working with you and other Members of the subcommittee to ensure that patients are protected, and a strong external appeals process is one of the key elements to achieving this goal.

Mr. BILIRAKIS. Thank you.

I know we are all very anxious to hear from the panelists. They have been very patient listening to us. They are really here for us to listen to them.

However, Mr. Upton has come into the hearing. Do you have an opening statement, Fred?

Mr. UPTON. I will make it as part of the record.

Mr. BILIRAKIS. We do appreciate that, without objection.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. Chairman, thank you for convening today's hearing on protecting patients with a strong appeals process. *I am convinced that ensuring patients have access to strong, independent external appeals process conducted by medical experts is the single most effective step we can take to ensure they will receive medically necessary, appropriate, high-quality and timely care.*

That such an appeals process, not lawsuits, is the best way to ensure access to high quality, timely care was brought home to me in an unfortunately tragic way by the recent death of my school roommate and long-time friend and groomsman at my wedding. When he became quite ill, he did not receive the specialized care he needed, and his condition went undiagnosed until it was too late. His colon burst, and he died. His wife is suing their health plan, but I know that she would much rather have her husband and father to her three children.

Independent, external appeals systems put questions regarding medical necessity and appropriateness in the hands of qualified physicians and other health professionals, rather than in the hands of judges and juries with no medical training. While lawsuits can drag on for years, internal and external appeals systems would provide very timely decisions. And while there may be some modest additional costs to plans and employers associated with the internal and external appeal provisions of this legislation, exposing insurers and employers to open-ended liability would be far more costly. I am convinced that exposing employers who self-insure and may be legally construed as a result to be involved in benefit decisions to open-ended liability could well translate into a significant increase in the number of uninsured in this nation.

In order to be effective in ensuring access to medically necessary and appropriate care, the decisions of the independent, external appeals bodies must be binding. There must be severe penalties for plans that fail to provide care that an independent, external, expert review process has found to be appropriate. There should also be severe penalties for patterns or practices of repeated refusal to authorize coverage for services that external appeals panels have found to be appropriate.

I am looking forward to hearing today's witnesses describe their experience with external review systems and their recommendations to use as we prepare to craft legislation that will ensure all patients that their insurance will be there when they most need it.

PREPARED STATEMENT OF HON. CLIFF STEARNS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. Chairman. I want to thank you for holding this important hearing today.

Last year in the Rules Committee I offered an amendment to H.R. 4250, the Patient Protection Act. While I recognize that that bill did provide for an external review process, I thought its review process could have been stronger.

The purpose of the amendment I offered was to provide for patients and their physicians an independent remedy for denial of medical care, treatment or services by managed care health providers. The amendment also sought to provide an independent third party physician review process by a panel of physicians (not fewer than three) not associated with the provider and appointed by the State or local Medical Society board for this purpose. The panel would have the authority to order the plan to provide the care, treatment, or services denied and assess penalties where appropriate, such order shall be enforceable by federal courts. In circumstances where the panel determines that the denial of health services was a dilatory tactic employed by the plan or caused harm to the patient in disregard for the patient's welfare or where the panel deems appropriate, the panel has the authority to award monetary penalties on a daily basis until the services are performed and/or three times the value of the services denied to the patient. Such potential penalties are to provide an incentive to insure that health care contracted for under the plan is actually obtained by the patient and to keep down the costs of the managed care plan in delivering services.

I am pleased that we are having this hearing today because this is an extremely important issue that must be resolved as we work toward improving managed care plans' accountability to patients.

I look forward to hear from our expert panel of witnesses.

PREPARED STATEMENT OF HON. TOM BLILEY, CHAIRMAN, COMMITTEE ON COMMERCE

Thank you, Mr. Chairman for holding this important hearing on improving patient protections. I want to especially commend the Gentleman for focusing our attention on how we can construct a strong, binding and independent external appeals process.

In the ongoing conversations that this Subcommittee is having on America's health, there are fewer issues more important than increasing accountability to patients and ensuring that Americans receive the medical coverage they are entitled to under their health policies. Development of a strong appeals process will accomplish both of these goals.

Everyone here in this room knows that a contract is only as good as your ability to enforce it. Today, I'm pleased to report that our Committee is working in a bipartisan manner to craft an external appeals process that is fair to patients. This process will provide plans with strong incentives to adhere to an external reviewer's decision.

I hope that this hearing moves us away from destructive rhetoric. Instead, we should roll up our sleeves and address the real problems in managed care.

Let me be clear. While I am committed to enacting a strong external appeals process, I am no less committed to opposing any initiative that significantly drives up the costs of health care premiums and adds to the rolls of the uninsured.

I firmly believe that if we set up the right type of external appeals process, decisions affecting Americans' medical care can be decided by physicians and *not* courts. A strong, external appeals process is far better, and far less costly, to consumers than a system that encourages litigation and creates a new treasure trove for trial lawyers. Patients need care, not courts, and we intend to provide them better access to care.

I believe our first principle in considering legislation is: *do no harm.* I've said it before, and I'll say it again. We simply cannot pass legislation that increases the numbers of the uninsured.

I would like to thank all of the witnesses for coming today and discussing this important topic. With that, I thank the Chair and yield back the balance of my time.

Mr. UPTON. A late one.

Mr. BILIRAKIS. But a good one, I am sure.

Mr. UPTON. Very good.

Mr. BILIRAKIS. All right. That being the case, we will go right into the panelists now. Dr. William A. Conway is the Vice Chair of the Henry Ford Health System. He is speaking here today on behalf of the American Medical Group Association. Ms. Connie Barron is Associate Director of Legislative Affairs for the Texas Medical Association. Dr. Bruce A. Weiss is the Group Vice President of Medical Operations for AvMed, out of Gainesville, Florida—Go Gators. Dr. Stanley E. Grogg is Associate Professor of Pediatrics at Oklahoma State University College of Osteopathic Medicine.

Doctors, and Ms. Barron, thank you so very much, again, for your patience and for being here. I know that we can learn an awful lot from you. Your written statements are part of the record. I hope that you could complement those if you would. I will turn the 5-minute light on. If you could stay as close to that as you possibly can, I would appreciate it.

We will kick it off with Dr. Conway. Please proceed, sir.

STATEMENTS OF WILLIAM A. CONWAY, VICE CHAIR, HENRY FORD HEALTH SYSTEM, ON BEHALF OF THE AMERICAN MEDICAL GROUP ASSOCIATION; CONNIE BARRON, ASSOCIATE DIRECTOR, LEGISLATIVE AFFAIRS, TEXAS MEDICAL ASSOCIATION; BRUCE A. WEISS, GROUP VICE PRESIDENT, MEDICAL OPERATIONS, AVMED; AND STANLEY E. GROGG, ASSOCIATE PROFESSOR OF PEDIATRICS, OKLAHOMA STATE UNIVERSITY COLLEGE OF OSTEOPATHIC MEDICINE, ON BEHALF OF THE AMERICAN OSTEOPATHIC ASSOCIATION

Mr. CONWAY. Chairman Bilirakis, Congressman Brown, and members of the subcommittee, it is obvious from your opening statements that you have some pretty significant issues to resolve. I just want to thank you for the opportunity to talk to you today about our views regarding the appeals process and liability of health plans.

I am a physician and the Vice Chair of the Henry Ford Medical Group in Detroit. Our group is 800 salaried, multi-specialty physicians in southeastern Michigan. We provide care for half of the managed care patients enrolled with the Henry Ford Health Alliance Plan, Michigan's largest HMO. We also provide care under various types of contracted arrangements with many other managed care plans in southeastern Michigan.

I am here today on behalf of the American Medical Group Association. This association represents 50,000 physicians practicing in our Nation's largest multi-specialty group practices. Our members include the Mayo Clinic, Cleveland Clinic, Palo Alto Clinic, and the Permanente Federation—to name just a few.

We would like to make some comments on liability. From a consumer perspective, the intent of extending liability to health plans may appear beneficial. I don't think that anybody would argue with the right of injured patients to seek redress. We believe there are several problems with extending liability to health plans.

The first is the current medical liability system does not work well. It is broken. There are three well-respected studies looking at this. Injured patients aren't the ones that really receive benefit from that system. We think it is unlikely that using the liability system to resolve differences with health plans is going to do any better than that.

Second, making litigation a major concern of health plans as well as patients we are taking care of, instead of improving the patient/physician relationship, is actually going to add another barrier to that.

Third is the troubling consequence of extending liability to health plans. It reinforces the faulty notion that HMO's are legitimately engaged in the practice of medicine. Some plans think they are in the practice of medicine. Only physicians are trained and licensed to render clinical decisions. We don't want insurance companies and plans making clinical decisions. We have worked very hard over the years to make sure that the roles of clinicians and health plans are clearly delineated. The role of the health plan is to simply organize care, and interpret benefits and coverage. Clinical decisions should be left to physicians.

Fourth, we believe this would add costs involved in this new area of litigation, and wick even more funds away from patient care dol-

lars. This is going to become yet another administrative cost that the dollars in the health care system are going to have to go to cover. It will take those away from bedside care.

I would like to turn to the positive and talk about grievance procedures and things that can work to resolve the issues before us. These are processes designed to assure that the right care is received at the right time that is most beneficial to our patients. Timely medicine is a powerful tool to improve care and prevent bad outcomes that result in litigation. A number of you have commented on the importance of timeliness. Appropriate and fairly structured grievance procedures will provide special value in assuring timely care, particularly in managed care environments. These are effective ways to settle disputes. They can do so expeditiously. They can do so at a time when the patient truly needs that decision made and help facilitate our medical care of the patients.

I would like to share with you an example of our experience on how an effective internal and external grievance procedure can work to the patient's benefit. We have had a structured process at our Health Alliance Plan for a number of years. Our members may seek resolution to situations when they are dissatisfied or feel aggrieved over the services, the benefits, or any of the policies or procedures of the plan, its hospitals, or its medical staff.

This policy is published. It is distributed annually to each member. The process has three levels of decisionmaking. The final internal level involves the board of the Health Alliance Plan, its member services committee. The board of the Health Alliance Plan is composed largely of independent individuals. Half of them are elected by the membership. No committee member is an employee of the organization.

This process is used by about 1 percent of patients a year—590 appeals. Sixty percent of the time the patient's request is supported. In the State of Michigan there is an external review process that is required by Michigan law that is available. Out of these 590 cases, in the past year only three patients went on to access the external review process, because the internal procedures, we believe, were so effective. In all three cases, the State process upheld the plan's decision. We believe you can have effective appeals processes.

In summary, we think the debate on health plan liability has actually been a blessing. It has helped crystallize the need to structure and protect the rights of patients under managed care plans. It has forced us all to focus on ways to prevent litigation through grievance and appeals processes that result in what we all want: better care and better clinical decisions for patients, when it matters and at the time care is needed.

We commend the committee, and our especially our Congressman from Michigan, John Dingell, for leadership in this debate. We would urge you to go forward to establish a grievance and appeal process for health plans. We thank you for the opportunity to come before you today. We will be happy to work with you on this issue going forward. I am available to answer questions.

[The prepared statement of William A. Conway follows:]

PREPARED STATEMENT OF WILLIAM CONWAY, VICE-CHAIRMAN OF THE HENRY FORD MEDICAL GROUP ON BEHALF OF THE AMERICAN MEDICAL GROUP ASSOCIATION

Chairman Bilirakis, Congressman Brown, and members of the subcommittee, thank you for this opportunity to speak before you today on our views on the internal and external appeals process and expanding liability to health plans. My name is William Conway and I am the Vice-Chairman of the Henry Ford Medical Group in Detroit, Michigan. I have spent 31 years in medicine, including 26 years with Henry Ford Hospital.

The Henry Ford Medical Group (HFMG) consists of more than 800 multi-specialty salaried physicians in Southeast Michigan. HFMG has provided medical care to patients of the Henry Ford Health System (HFHS) since 1915. Our physicians provide care to approximately one-half of all managed care patients enrolled with the Henry Ford Health Alliance Plan (HAP), Michigan's largest HMO. We work in collaboration with another 1,200 private practice doctors who make up the HAP network. We also provide care under various types of contracted arrangements with many of the other managed care plans in Southeast Michigan.

I am here today on behalf of the American Medical Group Association. AMGA is the leading advocacy group on behalf of the nation's larger multi-specialty group practices. It represents over 250 medical groups across 40 states, representing over 45,000 physicians. Other members include the Mayo Foundation, the Cleveland Clinic, the Palo Alto Clinic, and the Permanente Federation, Inc. AMGA's mission is to shape the health care environment by advancing high quality, cost-effective, patient-centered, and physician-directed health care.

Liability

From a consumer perspective, the intent of extending liability may appear beneficial. No one would argue with the right of injured patients to seek redress: but there are two main problems with extending liability to health plans. First, the current medical liability system is broken. It makes no sense to expand liability under the current unreformed system. Secondly, making litigation the first concern of health plans and the first concern of a patient upon entering a doctor's office erodes year's of trust and works against successful health outcomes for the patient.

Cost increase is one of the most troubling consequences of extending liability to health plans in our current environment. Removing the ERISA barrier would result in revenue being shifted away from patient care into the legal arena. This comes at the worst time. Costs for administrative and regulatory burdens are exploding and directly competing with patient care in most group coverage (including Medicare and Medicaid), taking anywhere from 10% to 25% of group insurance payments. At the same time, purchasers have held the line against increased premiums overall. This means that any action that increases litigation costs for health plans will have to come at the expense of patient care.

Another consequence of extending liability to health plans is that it reinforces the faulty notion that HMOs are legitimately engaged in the "practice of medicine." Only physicians are trained and licensed to render clinical decisions. If liability were extended to health plans, we worry that health plans would feel compelled to practice "defensive medicine" and tell physicians what type of tests, procedures, and treatments to use to reduce the plan's exposure to liability. We do not want insurance companies and health plans making clinical decisions. We have worked very hard over the years to make sure that the roles of clinicians and health plans are clearly delineated. The role of the health plans is to organize and interpret benefits and coverage—but actual clinical decisions must be left to physicians.

It is important to note that under the current tort system lawsuits have little to no beneficial effect on quality. In addition, it has been shown that lawsuits do not help injured patients who need and deserve the most assistance.

According to a 1991 Harvard study, most victims of malpractice never collect a dime. The research indicates that patients who sue are rarely the actual victims of malpractice, and jury awards are erratic and capricious. The Harvard study found that only 1 in 8 victims of actual malpractice ever sue. Only six out of every 100 patients who experience adverse outcomes as a result of negligent care receive compensation. Most of those never collect anything by way of compensation. Among *similarly* injured patients, 25 percent were awarded 10 times more than others. Two-thirds of the people who sued had meritless claims. Patients who were awarded compensation received only 43 cents of every dollar. The rest was spent on attorneys' fees, litigation expenses and insurance administration costs. Finally, on average, it takes more than two years from the date of filing a claim for the injured patient to resolve a medical liability case.

We believe the current system does not work for patients. Consequently, we believe that the first order of business for Congress is to adopt tort reform. Medical liability reform is an indispensable part of improving overall health care delivery. Reform will increase access to care, save vital health dollars, and make the civil justice system more equitable for patients and physicians. We believe it is self-defeating to shift the emphasis in matters of dispute to an unpredictable and unscientific final authority.

Grievance procedures

Turning to what does work, processes designed to assure that the right care is received at the right time are most beneficial for patients. Timely medicine is a powerful tool to improve care and prevent the bad outcomes that result in litigation. Appropriately and fairly structured grievance procedures have special value in assuring timely medicine, particularly in managed care environments. Not only are they an effective way to settle disputes, but they do it expeditiously and at a time when a patient truly needs the care—which is what patients and physicians want in the first place. Laws that make litigation the first thing a patient thinks of upon entering a doctor's office erode trust and work against successful health outcomes for the patients. Litigation signals failure and doesn't address the problems, whereas a grievance process can identify and resolve the problems quickly.

Henry Ford's Health Alliance Plan Grievance Policy

The Henry Ford internal grievance policy is structured so that any Health Alliance Plan (HAP) member may seek resolution to situations where the member is dissatisfied or feels aggrieved by the services, benefits, and/or policies and procedures of the plan or its hospitals and doctors. This policy is published and distributed annually to each member. The grievance process is a three level decision-making process. A final determination is rendered within ninety days following the initial patient request or within a 72 hour expedited review process for urgent issues. The third level of review and decision-making consists of the Member Services Committee of the HAP Board of Directors. This board is composed of independent individuals half of whom are subscriber-elected. No board member is an employee or member of the plan. If the patient is not happy with the decision, there is a strong external review process outlined in Michigan law.

In 1998, the HAP grievance rate per 1000 members was less than one percent. 527 members initiated a first level grievance. Of those, 51% of the first level grievances found in favor of the patient. 56 patients pursued the second level grievance process. Of those, 46% of the grievances found in favor of the patient. 11 members pursued the third level grievance. Of those 11, 35% of the grievances found in favor of the patient. In 1997, only three individuals further pursued his/her grievance to the independent Michigan State Task Force authorized to resolve disputes with HMOs under Michigan law. Of these three grievances, the Task Force upheld the decision that had been reached through the internal grievance process. According to a 1996 patient satisfaction survey, 60 percent of patients were either very satisfied or satisfied with the grievance process. Since then, we have implemented a number of the members' recommendations to improve the process and make it more customer-friendly.

This process works. We believe it reduces the number of issues that result in litigation. As physicians, we were initially skeptical about this grievance requirement because it seemed to mean that someone would be second-guessing our clinical decisions as doctors. Today, we would not give it up for anything. We value it highly as part of how we practice medicine.

Strong Appeals Process

The AMGA favors a strong appeals process. Standards that force quicker review of medical decisions benefit both the patient and the health plan. The AMGA believes that strong external and internal appeals processes also strengthen the physician-patient relationship.

A strong appeals process should allow reviewers to consider all relevant medical evidence. It should take into consideration all appropriate and available information, including any evidence-based decision-making or clinical practice guidelines used by the group or HMO. In addition, it should include timely evidence or information submitted by the plan, issuer, patient, or patient's physician; the patient's medical record; expert consensus; and all available medical literature. The Agency for Health Care Policy and Research has served as the lightning rod to promote the creation and better use of such scientific-based information for medical decision-making. AMGA believes that Congress should increase funding to AHCPR to promote more rapid development of evidence-based medical processes.

Expedited review of medical decisions is the responsible approach to ensuring that patients receive the care they need, while holding the health plan and physician accountable for ensuring that the proper level of high quality care is administered. Our experience demonstrates that a strong appeals process will improve patient satisfaction with managed care and alleviate patient's need to resort to litigation.

Alternative Dispute Resolution

We also believe there is a role for the appropriate use of alternative dispute resolution (ADR) in the private health plan and managed care environment. We recognize that there will always be situations where an injured patient needs access to the legal system. Hospitals, doctors and health plans make mistakes. There will be situations where things just go wrong. Some 123 million American's receive health insurance through their employer. Consequently, the use of ADR as a middle step prior to litigation has real value for managed care. When parties have legitimate issues in dispute, ADR can create a level-playing field without resorting to litigation.

The Importance of Quality and Accountability

Litigation is a flawed tool for improving the quality of patient care. It comes too late in the clinical decision-making process to help the patient much, and enforcement is sporadic. True quality health care systems address three components: appropriateness of care, technical quality, and outcomes measurement with research, or what is more commonly known as "evidence-based medicine."

As group practice physicians, we are committed to working collectively to avoid preventable errors. This means actively identifying and openly acknowledging mistakes when they do occur, with commensurate reparations to injured parties, identifying root cause of problems and taking whatever steps necessary to see that similar errors are avoided in the future.

In its recent annual report to Congress, MedPAC made several recommendations solely aimed at decreasing preventable errors. One such recommendation is that Medicare should establish patient safety as a quality improvement priority and take steps to reduce errors in beneficiaries' care. Second, the Department of Health and Human Services (HHS) should consider opportunities for minimizing preventable errors through coverage and payment policies, quality measurement initiatives, and quality improvement programs. Third, HHS should support and use ongoing public and private error-reduction initiatives, such as the National Patient Safety Foundation, which is an independent not-for-profit organization founded by the American Medical Association. Fourth, Congress should enact legislation to protect the confidentiality of individually identifiable information relating to errors in health care delivery to address providers' fears that information reported for quality improvement purposes may not be used against them. AMGA agrees with MedPAC's recommendations, and we continue to work toward reaching these goals.

Conclusion

The debate on health plan liability is a blessing in disguise. It has helped crystallize the need to structure and protect the rights of patients under managed care plans and has forced us to focus on ways to prevent litigation through grievance and appeals processes that result in what we all want—better care and better clinical decisions for patients when it matters—at the time care is needed. We commend the committee and especially our Congressman John Dingell for leadership in this debate. We urge you to go forward to establish a grievance and appeals process in health plans.

Thank you for the opportunity to come before you today. We look forward to working with you on this important issue. I'll be happy to answer any questions you might have.

Mr. BILIRAKIS. Thank you very much, Doctor.

If you could summarize, please—I would hope that with all of the questioning you can get all of your points across. By all means, if there is something really significant that you want to tell us, feel free to do so. Ms. Barron, you are on.

STATEMENT OF CONNIE BARRON

Ms. BARRON. Mr. Chairman, Mr. Brown and members——

Mr. BILIRAKIS. Why don't you pull that closer, please, so that we can hear.

Ms. BARRON. That better?

Mr. BILIRAKIS. Much better.

Ms. BARRON. Mr. Chairman, Mr. Brown, and members, thank you for your attention to a very important issue: who decides what is medically necessary, and what happens were there is a dispute?

I am the Associate Director for Legislative Affairs of the Texas Medical Association, where I represent 35,000 physicians in issues pertaining to managed care.

Mr. BILIRAKIS. If you will just hold on a minute, I want to make sure we have order.

[Mr. Bilirakis uses gavel.]

Mr. BILIRAKIS. Thank you, please proceed.

Ms. BARRON. Thank you. I appreciate having a chance to be here. Knowing that people from Texas are prone to understatement and humility, it will probably surprise when I say that we are proud to have been at the forefront for a number of years in patient protection legislation in the State of Texas.

We started it early in 1991, when we had a law passed that dealt with how utilization review entities make their decisions. That established the criteria that said that medical necessity had to be clinically sound, scientifically based, consistent with generally accepted principles of good medical practice, fully disclosed, and there had to be a mechanism for appeal. We have strengthened those requirements in every session since that time. We went so far in the last legislative session in 1997, when we dealt with more patient protections, to tighten those appeals processes, and added an external review procedure that is binding. We also said that if a managed care plan in the course of doing its business negligently makes a medical treatment decision that is the proximate cause of injury to the patient, they should be held accountable in the State courts. That was our statement.

The law was challenged. I know that surprises you, but it was. At this point, it is in appeal in the fifth circuit. Much to our disappointment, what we found was that in the Federal district court the judge overruled our external review, saying that the State could not have an external review because ERISA preempted it.

So I am here today to say, first of all, please make sure that we get a good, strong, binding external review. I would say that at every step of the way, the members of the Texas Legislature were warned that this would raise premiums. Costs would skyrocket. Plans would leave Texas. There would be an end to managed care in Texas. I have to tell you none of those things have happened.

Our premiums now, with the strongest patient protections in place for a number of years, even with the liability provision in place, are not higher than any other section of the United States. They are consistent with increases we would expect to see any place else. We have gone from having about 30 HMO's to having in excess of 50 HMO's. I would even say that the CEO of Aetna, if not the largest—pretty doggone close to the largest—managed care company in the country, recently referred to Texas as the "filet mignon of marketplaces for managed care."

I think that what we have been able to do is to say we can put responsible patient protections in place, including binding external reviews that base scientific information. We take medical decision-

making out of the black box. We make sure everyone understands what criteria are being used. Physicians with appropriate expertise are involved in an appeals process. We have gone so far as to say that, if that external review is not followed, if the information isn't turned over in a timely manner, if the plan doesn't participate in an external review, if they don't do what the law says—I will tell you that we have only had one lawsuit filed to date. This was a case where the health plan did not obey the law. They did not provide an expedited external review. They sent someone home from the hospital that was suicidal. Had that person received the expedited review, very likely that patient would be alive today. This case is moving through the process. We will see what the jury says. This is exactly what the idea of liability was designed for. If somebody doesn't abide by a strong external review, what is the price that they pay?

Again, we did not set in place a malpractice standard. We are not holding health plans accountable at the same level a physician would be held accountable. We are holding managed care plans accountable for what a prudent and reasonable managed care entity would do. Did you provide all of the appropriate information? Did you base decisions upon sound clinical evidence? Did you use appropriately trained specialists to review that case? Did you do everything that a reasonable health plan should do? If you did, you shouldn't have to worry under our law. If you didn't, you should be accountable like any other entity out there conducting a for-profit business that provides the services in a negligent manner you are being compensated for.

We believe that the accountability for the quality of health care provided to consumers rests with the State. That was the premise of the Texas legislature. We are here again to ask your support on making sure that we get to keep our strong external appeals process, and that other States that are doing their will also. We have not had blood in the streets, women and children cast out, loss of health care, loss of coverage, or skyrocketing costs. We think responsible public policy can coexist with a thriving market. That is what we look forward to having be available for citizens of other States as well.

[The prepared statement of Connie Barron follows:]

PREPARED STATEMENT OF CONNIE BARRON, ASSOCIATE DIRECTOR OF LEGISLATIVE AFFAIRS, TEXAS MEDICAL ASSOCIATION

Chairman Bilirakis and members, my name is Connie Barron. For the last five and a half years I have been the Associate Director of Legislative Affairs for the Texas Medical Association. In that capacity I represent approximately 35,000 physicians, residents and medical students. My primary focus is in areas of public policy affecting the quality and access to care for patients in managed care systems. On behalf of these Texas physicians and their patients, I want to thank you for holding these hearings to explore the important issues of access to a timely and fair appeal when a patient is denied care deemed necessary and appropriate by a treating physician. Texas has had the honor of being at the forefront of patient protection legislation, and I appreciate the chance to share our experiences with you.

"MEDICALLY NECESSARY"—WHO DECIDES?

The first attempt to deal with the issue of medical necessity arose in Texas in 1991. At that time, a utilization review law was passed that established standards by which utilization review agents conduct business in Texas. Physicians believed then as they do now that *decisions regarding "medical necessity" should be based*

upon criteria that are scientifically and clinically sound and flexible enough to meet the individually unique circumstances of a particular patient. These criteria should be fully disclosed and available for discussion. In other words, everyone—physicians, patients, health plan representatives—should know and understand how these decisions are made. We chose not to define "medical necessity," but rather to set out standards such as those referenced above. In 1995 regulations regarding these reviews were strengthened to include *disclosure of the criteria to the treating physicians and the patient.* In addition, *any decision to deny care must be appealable to a physician of the same or similar specialty who is most likely to provide the kind of care being requested, and any special circumstances of the patient must be taken into consideration.* In 1997, an independent review provision was added. If the treating physician disagrees with the plan's specialist or the criteria used, *an independent third party may be requested to review the case.* Additionally, *Texas chose to clarify that if a managed care plan makes a negligent decision to withhold payment for care in spite of the recommendations of the treating physician, the managed care plan can be held legally accountable in Texas courts.*

INDUSTRY CLAIMS REGARDING MEDICAL NECESSITY DETERMINATIONS

You will hear claims that without full authority to define medical necessity, managed care plans would be unable to set quality standards for their participating physicians. Managed care plans would be unable to educate physicians regarding appropriate care and physicians would have free reign to order anything they want simply by claiming that it is medically necessary. Costs would skyrocket and the number of uninsured would increase. Members, *none of these things have happened in Texas.*

Prior to enacting our appeals provisions, physicians frequently were sent letters stating simply, "*...the care you have requested does not meet our standards of medical necessity...*" and is therefore denied. No explanation was given. When the plan was called, a clerk would tell the doctor that the criteria were confidential and the patient could write and ask the plan to reconsider its decision. All appeals were internal and final. This kind of process is not educational for physicians. It certainly does not set standards for quality, and clearly, it does nothing to improve patient care.

You will frequently hear managed care plans refer to "evidence based medicine." Nothing in the Texas standards for medical necessity decision-making conflicts with this concept. Based on their code of medical ethics and their training as scientists, physicians are morally and intellectually bound to ground recommendations for their patients' treatment in the best available science. Because double-blind, controlled studies are not available for all treatment regimens, physicians tend to use the following algorithm for making these decisions:

1)Decision rests upon valid and reliable evidence, when it exists, (evidence-based medicine) that is appropriate given the patient's individual circumstances.
2) Peer reviewed evidence—meets professionally recognized standards of validity and replicability
3) Generally accepted standards of medical practice (these criteria are being used in courts today for many cases in which no clinical evidence exists)

Physicians welcome updated scientific information. They are accustomed to discussing cases with colleagues in an attempt to achieve the best outcome for their patients. These guidelines should be at the heart of any standards established for medical necessity decision making.

It is imperative that there be an independent review entity that will evaluate all available information, consider the individual circumstances of the patient, and render an expert, unbiased decision regarding any dispute over the medical necessity or appropriateness of care.

Finally, we believe there must be legal accountability when managed care plans make medical decisions that harm patients. Without this "hammer" there is no true mechanism for enforcement. The Texas law protects good managed care plans by requiring an external review prior to litigation, except in such cases where harm has already occurred. Other states may choose to provide other enforcement mechanisms such as administrative or licensure models. Regardless of their approach, the states have long had the duty to ensure quality medical care is provided to their citizens. Decisions about a specific treatment for a specific patient is in our judgement, the practice of medicine and belongs under the purview of the states.

THE TEXAS EXPERIENCE—APPEALS, INDEPENDENT REVIEW AND LIABILITY

There have been many warnings about the negative impact that managed care reforms will have on access to health insurance coverage. When the Texas Legisla-

ture strengthened the appeals process of managed care plans and added an independent review and liability provision to the law, health plans predicted dire consequences. They said litigation would run rampant, costs would skyrocket and the managed care market would shrink. *None of these predictions have come true.*

Two years after the passage of our managed care liability act, to my knowledge, only one lawsuit has been filed. *Plocica v. NYLCare* is a case in which the managed care plan did not obey the law and a man died. This case exemplifies the need for accountability at the end of the review process. Mr. Plocica was discharged from the hospital suffering from severe clinical depression. His treating psychiatrist informed the plan that he was suicidal and required continued hospitalization until he could be stabilized. Texas law required an expedited review by an independent review organization prior to discharge. Such a review was not offered to the patient's family. Mr. Plocica wife took him home. During the night he went into his garage, drank antifreeze, and subsequently died. Without the threat of legal accountability, these kinds of abuses will go unchecked.

External reviews continue to demonstrate their value by *overturning plan denials approximately 50 percent of the time.* Having this independent entity available has improved communications between physicians and plans. These improved communications ensure that the best care is available for the patient most of the time. When there is a dispute over appropriate care, patients have the benefit of an unbiased expert's review of the case. The independent review process has promoted confidence in the managed care systems operating in Texas. The independent review program has been a success for patients and managed care plans alike; however, *it was recently ruled to be pre-empted by ERISA.* A federal district judge concluded that such a review involved the determination of employee plan benefits and could not be imposed by the state. Unless Congress acts to establish an independent review process, the excellent program in Texas (as well as the independent review process in 25 other states) is in jeopardy.

Just as there has not been a vast increase in litigation, neither has there been skyrocketing insurance premiums. The national average for overall health care costs increased by 3.7 percent in 1998 while *Dallas and Houston markets were well below average* at 2.8 percent and 2.4 percent respectively. *Other national surveys show Texas premium increases to be consistent with those of other states that do not have the extensive patient protections passed by the Texas legislature.*

Nor has the managed care market in Texas withered. In 1994, the year prior to the first set of managed care reforms, there were 30 licensed HMOs in Texas. Today, there are 51. In a recent newspaper article, Aetna CEO, Richard L. Huber, referred to Texas as the "...filet mignon" when asked about Aetna's plans to acquire Prudential. This does not support the accusations that Texas laws would have a negative impact on the ability and the desire of managed care plans to do business in our state.

SUMMARY

Texas has passed one of the most comprehensive packages of managed care reforms in the country. At every step members of the Legislature were told of the terrible consequences of requiring managed care plans to abide by certain standards in determining medical necessity, provide a fair and timely appeals process, require an independent review of medical care denials and more. When the Legislature spoke on the issue of managed care liability by holding managed care plans legally accountable if their negligent decisions cause harm to enrollees, managed care plans said it would be the end of managed care in Texas.

Most of the managed care reforms have been in place for more than four years. The external review and liability provisions have been law for almost two years. We have yet to see the threatened consequences materialize. On the contrary, the managed care market in Texas is thriving. Physicians report that it is now easier to have meaningful discussions with managed care plans regarding patient care. Access to an independent external review organization ensures that care is provided when it is medically appropriate based upon scientific information. There has not been a plethora of litigation, but one enrollee will have appropriate redress for the negligence of a managed care plan that resulted in the death of her husband. Hopefully this will send a message to other managed care plans that they, too, are accountable for their actions, and will prevent any more such tragedies.

With no unexpected increases in premiums and a growth of managed care plans entering the market, Texas has proven that responsible public policy protecting patients from irresponsible managed care plans is possible.

Mr. BILIRAKIS. Perfect.

Dr. Weiss.

STATEMENT OF BRUCE A. WEISS

Mr. WEISS. Good afternoon. Mr. Chairman and members of the subcommittee, I am Dr. Bruce Weiss. I am Group Vice President, Medical Operations, for AvMed Health Plan, Florida's oldest and largest not-for-profit health maintenance organization. It serves 400,000 members, including nearly 80,000 Medicare members throughout the State. AvMed is federally qualified and is accredited by the National Committee for Quality Assurance, as well as the Joint Commission on Accreditation of Health Care Organizations.

Health plans provide a vehicle for systematic quality improvement that is not available under the old fee-for-service health care systems. Health plans combine a number of interrelated features that foster a comprehensive approach to quality, including a section of defined, fully credentialed network of providers who can work together on care and quality issues; provision of comprehensive services across the spectrum of inpatient and outpatient settings, allowing a full range of quality improvement interventions; clinical and fiscal accountability for health care of a defined population, allowing population-based data collection, analysis, intervention and monitoring, and ensuring accountability for performance.

These unique characteristics enable network-based plans to deliver quality care and to be accountable for the care provided. The organizations and individuals who purchase health care, including consumers, employers, and the Federal and State governments, now demand this accountability.

I appreciate the opportunity to testify today about the important role of appeals, grievances, and remedies, and ensuring the consumers' needs and concerns are addressed in a timely fashion by health plans. All health care delivery systems offered to all subscribers, including provider-sponsored networks, should be required to meet comparable standards governing quality of care, access, grievance procedures, and solvency. Subscribers should have confidence that all options meet standards of accountability that ensure they will have access to all benefits and rights, regardless of choice of plan they select. My comments today will focus on the State grievance procedures.

I would like to first address the internal grievance procedures which our plan has, like most plans. In addition, the State of Florida does require all health plans to have internal grievance procedures. They also have a requirement to have an expedited process.

What I would like to highlight this afternoon, in trying to hold the testimony, is the external review, which we found to be fairly effective. The key things to look at in Florida law is that they do require grievance procedures by all plans. They do discriminate between complaints and grievance. I have outlined the definitions by the Florida statutes between complaints and grievances. Basically, the main part is, when the member has exhausted the right to internal process, be it the expedited or the standard review, they always have the right to then appeal to an external body which basically has been established by Florida law.

The members can appeal to the statewide subscriber and provider assistance panel after they have exhausted the internal grievance procedures. In addition, health plans must report annually to the Agency for Health Care Administration all grievances and their final dispositions. Plans must respond to an initial complaint within a reasonable amount of time. The organization must also inform the member that they can submit a written grievance at any time.

The grievance procedures in the State of Florida have minimal standards. It must explain how to pursue the redress of the grievance. It names the appropriate employees of the department that are responsible. It lists an address and the toll-free number of the grievance department in the Agency for Health Care Administration, as well as the statewide provider and assistance panel. Every physician who is doing managed care in the State of Florida posts this toll-free number. There must be an expedited review, and a notice when the determination is final that the member can contact the statewide subscriber provider assistance panel.

I would like to address the external process in Florida. Some States have legislated processes for external independent review of adverse decisions made by plans. There are three States—Arizona, Connecticut, and Texas—as Connie has mentioned, that have enacted laws with external provisions. Two States, New Jersey and New Mexico, have issued regulations with such provisions. These States join California, Florida, and Rhode Island, all of which have had some type of independent review since 1997.

In addition to the statewide provider and subscriber assistance panel, which the Agency for Health Care Administration and the Department of Insurance in Florida have, there are other external reviews that health plans in Florida and throughout the country have to deal with. As you are aware, HCFA has an external review policy for all Medicare members. The Office of Personnel Management also has a similar external review clause for all members who are under Federal employee health benefits.

In summary, in my view, any consideration of an external review process should be guided by several principles. Foremost, an external review should not be initiated unless and until an enrollee has exhausted the internal appeals process, including the internal expedited review process, if applicable. Additionally, the scope of the review for an external review process should be limited and clearly defined. More generally, an external review process should be fair to all parties, administratively simple, non-adversarial, objective, credible, accessible, cost efficient, time limited, and subject to quality standards.

Grievances and appeals processes are in a state of evolution with changes being initiated by health plans, the States and HCFA. The common purpose is adequate protection for consumers while contributing to quality. Subscriber grievance and appeal processes are evolving as health plans, consumer groups, and regulators seek to find a suitable balance between consumer protection and high-quality, cost-efficient care.

AvMed and other AAHP health plans have demonstrated they are listening and responding to consumer needs. We are committed to upholding high standards of patient care. AvMed is prepared to be held accountable for our actions, and we believe that all health

care organizations and providers should likewise be held accountable. I will be happy to answer any questions.

[The prepared statement of Bruce A. Weiss follows:]

PREPARED STATEMENT OF BRUCE A. WEISS, GROUP VICE PRESIDENT, MEDICAL OPERATIONS, AVMED HEALTH PLAN

Mr. Chairman and members of the Subcommittee, I am Bruce A. Weiss, M.D., M.P.H., Group Vice President, Medical Operations of AvMed Health Plan which is Florida's oldest and largest not-for-profit health maintenance organization, serving some 400,000 members, including nearly 80,000 Medicare members, throughout the state. AvMed is Federally qualified and is accredited by the National Committee for Quality Assurance and the Joint Commission on Accreditation of Healthcare Organizations. Health plans provide a vehicle for systematic quality improvement that is not available under the old-style fee-for-service health care system. Health plans combine a number of interrelated features that foster a comprehensive approach to quality, including:

- selection of a defined, fully-credentialed network of providers who can work together on care and quality issues;
- provision of comprehensive services across the spectrum of inpatient and outpatient settings, allowing a full range of quality improvement interventions; and
- clinical and fiscal accountability for the health care of a defined population—allowing population-based data collection, analysis, intervention, and monitoring—and ensuring accountability for performance.

These unique characteristics enable network-based plans to deliver quality care, and to be accountable for the care provided. The organizations and individuals who purchase health care, including consumers, employers, and the federal and state governments, demand this accountability. It is the accountability that provides the mechanism for marketplace competition based on quality.

I appreciate the opportunity to testify today about the important role appeals, grievances and remedies play today in ensuring that consumers' needs and concerns are addressed in a timely fashion by health plans. All health care delivery systems, including provider-sponsored networks, offered to all subscribers should be required to meet comparable standards governing quality of care, access, grievance procedures and solvency. Subscribers should have confidence that all options meet standards of accountability that ensure that they will have access to all benefits and rights regardless of the choice of plan they select. My comments today will focus on state grievance procedure requirements.

STATE GRIEVANCE PROCEDURE REQUIREMENTS

Internal Grievance Procedures

Grievance and appeals procedures are required of health plans by the states, and by the federal government for federally qualified HMOs and other health plans contracting with Medicare as well as contractors for federal employees' health benefits. Using my state as an example, Florida requires that each health plan have a written grievance procedure available to its subscribers for the purpose of addressing complaints and grievances, an expedited grievance procedure, and external review by the state through the Statewide Subscriber and Provider Assistance Panel which will be described more fully below.

Definitions—Florida law distinguishes between a "complaint" which is "any expression of dissatisfaction by a subscriber, including dissatisfaction with the adminis-tration, claims practices, or provision of services, which relates to the quality of care provided by a provider pursuant to the organization's contract and which is submitted to the organization or to a state agency", and a "grievance". A complaint is part of the informal steps of a grievance procedure and is not part of the formal steps of a grievance procedure unless it is a "grievance". A "grievance" "means a written complaint submitted by or on behalf of a subscriber to an organization or a state agency regarding the:

(a) Availability, coverage for the delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) Claims payment, handling, or reimbursement for health care services; or

(c) Matters pertaining to the contractual relationship submitted by or on behalf of a subscriber eligible for a grievance and appeals procedure provided by an organization pursuant to contract with the Federal Government under Title XVIII of the Social Security Act.

An "adverse determination" means a coverage determination by a plan that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and coverage for the requested service is therefore denied, reduced, or terminated. An "urgent grievance" means an adverse determination when the standard time frame of the grievance procedure would seriously jeopardize the life or health of a subscriber or would jeopardize the subscriber's ability to regain maximum function.

Every health plan is required by Florida law to have a grievance procedure. Plans, as part of their procedure, must inform subscribers that they have one year from the date of the occurrence to initiate the grievance and that the member can appeal to the Statewide Subscriber and Provider Assistance Panel after the final disposition of the grievance through the plan's grievance process. Health plans must report annually to the Agency for Health Care Administration all grievances and their final dispositions. Plans must respond to an initial complaint within a reasonable time. The organization must also inform the member that the member can submit a written grievance at any time. The plan in addition must inform the member that the plan will assist the member in preparing the written grievance.

The grievance procedure must at a minimum contain the following:

1. An explanation of how to pursue redress of a grievance.
2. The names of appropriate employees or departments that are responsible for implementing the grievance procedure.
3. A list of the addresses and toll free numbers of the grievance department, the Agency for Health Care Administration and the Statewide Subscriber and Provider Assistance Panel.
4. The description of the process through which a subscriber may contact the toll free hot line of the Agency for Health Care Administration.
5. An expedited review process. Notice that the member can use binding arbitration, if provided in the contract, instead of the Statewide Subscriber and Provider Assistance Panel.
7. A procedure giving access to the grievance procedure to members who cannot submit a written grievance.

With respect to a grievance regarding an adverse determination, a plan must make available to the subscriber a review of the grievance by an internal review panel; such review must be requested with 30 days after the plan's transmittal of the final determination notice of the adverse determination. A majority of the panel must be persons who previously were not involved in the initial adverse determination. A plan must establish written procedures for a review of an adverse determination and the procedures must be available to the subscriber. In any case when the review process does not resolve a difference of opinion between the organization and the subscriber, the subscriber may submit a written grievance to the Statewide Provider and Subscriber Assistance Panel.

Expedited Internal Grievance Procedure—A health plan in Florida must have a written procedure for an expedited appeal of an urgent grievance. In an expedited review, all necessary information, including the plan's decision must be transmitted between the plan and the subscriber by telephone, facsimile, or the most expeditious method available. In an expedited review, an organization shall make a decision and notify the subscriber as expeditiously as the subscriber's medical condition requires, but in no event more than 72 hours after receipt of the request for review. In any case when the expedited review process does not resolve a difference of opinion between the organization and the subscriber, the subscriber may submit a written grievance to the Statewide Provider and Subscriber Assistance program.

External Grievance Procedures

Statewide Provider and Subscriber Assistance Program (SPSAP)—Some states have legislated processes for external or independent review of adverse decisions made by health plans. For example, three states (Arizona, Connecticut, and Texas) have enacted laws with external review provisions, and two states (New Jersey and New Mexico) have issued regulations with such provisions. These states join California, Florida and Rhode Island, all of which had some form of independent review of disputes prior to 1997.

In Florida, the external review is accomplished by the Statewide Provider and Subscriber Assistance panel. This six-member panel was established by the Florida Legislature to provide assistance to subscribers by hearing the grievances they have against health maintenance organizations which have not been resolved to the subscriber's satisfaction. The panel recommends to the Agency for Health Care Administration any actions the Agency or the Department of Insurance should take con-

cerning both individual cases as well as the types of grievances. This program has three components: 1) responsibility to provide assistance with unresolved grievances to both subscribers and providers of HMOs; 2) review of quarterly unresolved grievance reports submitted by HMOs; and 3) the imposition of fines, after investigation, for failure to comply with quality of care standards.

How It Works

- HMOs and the agency notify subscribers of their right to appeal to panel at completion of plans' internal grievance processesSubscriber voluntarily completes and returns SPSAP form and medical release to the Agency for Health Care Administration
- Agency notifies HMO of subscriber's appeal and requests dataCase review initiated by Agency staff and case is discussed with panel members to determine if case meets criteria for hearing
- Hearings are generally open to the public but may be closed in whole or in part upon request of a party for confidentiality of medical record or other legitimate privacy purpose
- Case heard (not subject to the Administrative Procedures Act); panel prepares recommendations to Agency or Department of Insurance
- Agency or Department issues final determination based on panel recommendations.

The Statewide Subscriber and Provider Assistance Panel is chaired by the Florida Consumer Advocate and is composed of employees of the Florida Agency for Health Care Administration and the Florida Department of Insurance. The panel also contracts with a medical director of a health maintenance organization and a primary care physician. The panel reviews cases submitted to it by members who are not satisfied with the results of their HMO's grievance procedure. The panel then makes recommendations to the agency and the department on actions that the agency or department should take in a particular case.

External review is also utilized by HCFA and the Office of Personnel Management (OPM). HCFA requires HMOs to submit adverse or unresolved grievances to independent reviewers such as the Center for Health Dispute Resolution that are contracted with HCFA. The contracted reviewer makes the final decision in those grievances.

Similarly, OPM utilizes external review in its administration of the Federal Employee Health Benefit Plan (FEHBP). OPM contracts with HMOs to provide federal employees health coverage. As part of the contract, HMOs must have a grievance procedure. Federal employees who have a complaint about an HMO must use the HMO's full grievance procedure. However, if the federal employee is dissatisfied with the HMO's determination, the employee can appeal the HMO's decision to OPM.

In my view, any consideration of an external review process should be guided by several principles. Foremost, an external review process should not be initiated unless, and until, an enrollee has exhausted the internal appeals process, including the internal expedited review process, if applicable, established by the health plan. Additionally, the scope of review for an external review process should be limited and clearly defined. More generally, an external review process should be fair to all parties, administratively simple, non-adversarial, objective and credible, accessible, cost efficient, time limited, and subject to quality standards. Grievance and appeals processes are in a state of evolution with changes being initiated by health plans, the states and, as more fully appears below, the Health Care Financing Administration. The common purpose is to adequately protect the consumer while contributing to a quality health care delivery system.

Subscriber grievance and appeals processes are evolving as health plans, consumer groups and regulators seek to find a suitable balance between consumer protection and a high quality, cost efficient health care delivery system. AvMed and the other AAHP member plans have demonstrated that they are listening and responding to consumers' needs. We are committed to upholding high standards of patient care. AvMed is prepared to be held accountable for our actions, and we believe that all health care organizations and providers should likewise be held accountable.

AvMed Health Plan welcomes the Committee's interest in these issues, and I thank you for the opportunity to testify today.

Mr. BILIRAKIS. Thank you.

Dr. Grogg.

Mr. COBURN. I would beg the Chair's indulgence. I actually failed to recognize a colleague from Oklahoma who is a member of the panel.

Mr. BILIRAKIS. I beg your pardon, by all means.

Mr. COBURN. I just wanted to welcome you here. I would note for the people in the audience and our members that Dr. Grogg has had greater than 20 years' practice in the real world. He has just moved into academic medicine, which makes him extremely qualified to give us his testimony. Welcome, Dr. Grogg.

STATEMENT OF STANLEY E. GROGG

Mr. GROGG. Dr. Coburn, you are very elite in your presentation in what I would recommend, too. I commend you.

Mr. Chairman and members of the committee, I have been in practice, as Dr. Coburn has said, for greater than 20 years in osteopathic pediatric medicine. I am presently a faculty member at the Oklahoma State College of Osteopathic Medicine.

It gives me great pleasure to be present today. On behalf of the 43,000 osteopathic physicians in the United States, and as president-elect of the American College of Osteopathic Pediatricians, I appreciate the opportunity to testify on the issue of protecting patient's rights. That is what it is all about.

Osteopathic medicine is one of two distinct branches of medical practice in the United States. We have the allopathic group, which are the M.D.'s, and we have the osteopathic group, which are the D.O.'s. The osteopathic physician's past history is in primary care and in serving the rural population. The AOA has submitted their position on managed care. I would like to highlight some of these recommendations.

Medical decisions should be made by physicians, and must be reviewed by physicians of the license and specialty. The results of the reviews must be communicated to the patient as soon as possible, in a timely manner. An independent and fair standard for medical necessity, based on the best science and the best clinical practice should be used for reviews. Review decisions must be binding on the plan. The plan must be held accountable for the decisions that are made.

Review timeliness should be dependent upon the seriousness of the illness. If a child is in congestive heart failure, the review should be immediate, and not wait for the prolonged review process. This is where independent review would be great.

No longer is an individual physician spoken of as "my physician." The new buzzwords include the "primary care physician," or the "PCP." The PCP is the bottom rung of the health care ladder for a patient's health care needs in the eyes of insurance companies or the HMO's. Managed care organizations contract with chosen groups of physicians, or individual physicians, thereby making up a panel from which a patient must choose their PCP. The process of credentialing the PCP with an insurance company is a "take-it-or-leave-it" type of contract. The contract dictates the specialty physicians to which a PCP can refer a child, which laboratory and x-ray facilities must be used, and which hospitals must be used as the child is approved for the hospital care.

How can executives of an insurance company determine the most efficacious plan for a child? How can an insurance company possibly understand the dynamics of the individual child's family or medical needs? We are of the opinion that it cannot. The panels of physicians, laboratories, x-ray facilities, and hospitals are all chosen by their insurance company based on their lowest cost—economics, again. These decisions are made regardless of the needs of the child, and of the particular medical problem in question. In addition, the managed care company monitors the physicians to make certain they follow the rules of economics of care. If the rules are broken or bent, the offending physician's contract may not be renewed.

I recently had an infant referred to me by a family practice physician for respiratory problems. I am credentialed by some managed care companies as a PCP and as a specialist in other insurance companies. In this particular instance, however, the insuring managed care company would not allow me to see the patient as a specialist. I have approximately 100 referring family physicians and physicians' assistants and nurse practitioners from rural Oklahoma.

The parents' options were to accept a referral to an adult pulmonologist or go to an emergency room where they would be seen by an emergency room physician without the knowledge of some pediatric medicine. This child's primary care physician elected to send the infant to me and personally issued a blank check to the family to give to me for my services. What a travesty that is. Of course, I did not cash the check.

In another instance I cared for newborn quadruplets in a local hospital. Because the family lives in a rural community outside a metropolitan area, they were assigned several weeks after birth to a non-pediatric PCP and physician's assistant. Not only were the rural providers uncomfortable caring for these high-risk infants, but the quads were assigned to two different health care providers in separate locations, in two separate rural cities. The parents had to take two kids to one PCP, and the others to a physician's assistant.

This is managed care. This type of situation does not seem to be easily remedied by insurance companies. It is not uncommon to take 1 to 2 months to receive changes in the physician or PCP for their parents. This is a very long time in the medical care of a high-risk infant.

Many chronically ill children requiring multi-specialty care, such as cerebral palsy, have a difficult time trying to coordinate their needed specialty care. In one such instance, a child with a syndrome consisting of severe developmental delays, but who was able to socially interact with his parents, was devastated by the managed care company's decision. The medical director of the managed care company contacted me in order that I could describe the syndrome to him. This medical director was an adult internal medicine specialist. After discussions with me, he notified the family by letter—not in person—that because of the child's poor prognosis—the child would not be able to care for himself later in life—multi-specialty care would not be provided by the company. Only after 2 years of appeals were we able to remedy the situation. In the

meantime, the child suffered the consequences of severe loss of muscle tone.

An extreme example of abuses of managed care is an 8-month-old under my service. Because of the change of insurance by the parents, he was not able to get the corrective heart surgery. He died. If an appeals panel was present for this particular patient, the patient may be still alive today.

These cases are just the tip of the iceberg of problems in which I have personally been involved. Because of these frustrations and gross misuse of available medical care by managed care companies for financial gain, I have, after 25 years as a solo pediatrician, elected to move into academic medicines. I have joined the ranks of medical professors in the hope of providing graduating physicians with more knowledge about caring for the pediatric patient.

However, I would encourage each of you to carefully consider these issues. We in American have the potential for the best care, the best facilities, and the most dedicated physicians in the world. Yet, we are being shackled by managed care companies to benefit the bottom line, not our children's medical needs.

Again, thank you for the opportunity to allow me to share my experiences with you today. The AOA and the ACOP is ready to participate in a bipartisan effort to develop strong protectional legislation for all Americans. I am happy to answer questions. Thank you.

[The prepared statement of Stanley E. Grogg follows:]

PREPARED STATEMENT OF STANLEY E. GROGG, ON BEHALF OF THE AMERICAN OSTEOPATHIC ASSOCIATION

Introduction

Mr. Chairman and Members of the Committee, my name is Stanley E. Grogg, D.O. I am an Associate Professor of Pediatrics at the Oklahoma State University College of Osteopathic Medicine, and have practiced pediatric osteopathic medicine in America's heartland for more than 25 years. On behalf of the 43,000 osteopathic physicians represented by the American Osteopathic Association (AOA), and as President-Elect of the American College of Osteopathic Pediatricians, I appreciate the opportunity to testify on the issue of "Protecting Patients' Rights."

The AOA is the national professional organization for osteopathic physicians. In addition, the AOA is the recognized accrediting authority for colleges of osteopathic medicine, osteopathic postdoctoral training programs and osteopathic continuing medical education.

Osteopathic medicine is one of two distinct branches of medical practice in the United States. While allopathic physicians (M.D.s) comprise the majority of the nation's physician workforce, osteopathic physicians (D.O.s) comprise more than five percent of the physicians practicing in the United States. Significantly, D.O.s represent more than 15 percent of the physicians practicing in communities of less than 10,000 and 18 percent of physicians serving communities of 2,500 or less.

Patients' Access to Specialty Care

I would like to take this opportunity to address the difficult problems of access to appropriate treatments and facilities for children's medical needs. Instances of horrendous breaches of pediatric medical care are escalating as more and more managed care medical programs are utilized. It is all too evident that the driving force behind medical decision-making activities of many managed care organizations is not the well-being of the pediatric patient, but rather, economic outcomes which are favorable to the insurance company.

No longer are individual physicians in the medical community spoken of as "my physician." New buzzwords minimize us to the acronym of PCP—Primary Care Physician. A PCP is the bottom rung of the healthcare ladder for a patient's healthcare needs in the eyes of the insurance company/HMO. Managed care organizations contract with chosen groups of physicians or individual physicians thereby making up a "panel" from which a parent must choose their child's PCP. The process of credentialing a PCP with an insurance company is a "take-it-or-leave-it" contract

with the PCP. The contract dictates which specialty physicians to whom the PCP can refer a child for individual needs, which laboratory must be used, which x-ray facility must be used, and which hospital must be used if and when a child is approved for hospital care.

How can executives of an insurance company determine the most efficacious plan of care for a child? How can an insurance company possibly understand the dynamics of the individual child's family and medical needs? The answer is: **IT CAN NOT.** The decisions, panels of physicians, laboratories, x-ray facilities, and hospitals are all chosen by the insurance company based on the **lowest** cost. These decisions are made regardless of the needs of the child, and of the particular medical problem in question. In addition, the managed care company monitors the physicians to make certain they follow the rules of economy of care. If the rules are broken or bent, the "offending" physician's contract may not be renewed.

When a parent's employer chooses an insurance program for the company, the employee is forced to study the panel and select a PCP from that panel. It matters not that a child has multiple or chronic problems that have been treated by the same physician for a number of years. The child will have to change primary care physicians if his or her physician is not on the new panel. Continuity of care is a concept of the past when managed care "comes to town." If a parent changes jobs, or the employer changes insurance offerings, the innocent child is the one who suffers. As a result, the child may not receive continuity of care during the formative years.

I recently had an infant referred by a family physician for respiratory problems. I am credentialed by some managed care companies as a PCP, as well as a pediatric specialist for referrals from primary care physicians and nurse practitioners. In this particular instance, however, the insuring managed care company would not allow me to see the patient as a specialist. The parent's options were to accept a referral to an adult pulmonologist with no pediatric training or to go to an emergency department for care from a non-pediatric specific physician. This child's primary care physician elected to send the infant to me and personally issued a blank check to cover the charges incurred. What a travesty!

In another instance, a child with a bone fracture was unable to be evaluated in the urban area of Tulsa because of the lack of specialty coverage on the insurance panel. Instead, the child had to be transported 35 miles to a "bedroom" rural community hospital for treatment by an adult orthopedist who was on the panel. My office spent three continuous hours on the telephone with the insurance company as well as the Oklahoma HealthCare Authority to try to resolve this situation, but to no avail.

Due to difficult, confusing, and sometimes absent language of insurance contracts, as well as outdated provider booklets, some longstanding physician-child relationships can be strained or even broken when a parent arrives at the physician's office with a sick child only to find (after much time consuming research on the part of the office staff) that the child has been assigned by the insurance company to a different PCP.

It is not unusual for a child with a serious illness that requires diagnostic laboratory and radiological evaluations, to be forced to travel to various parts of the city for needed laboratory tests, back across town for x-rays, then back to my office for an evaluation and consultation regarding the findings. This is all being done with a sick child in tow even though there is a laboratory and x-ray facility within our building.

I recently cared for newborn quadruplets in a local hospital. Because the family lives in a suburban community, they were assigned, several weeks after birth, to a non-pediatric PCP and to a physician's assistant. Not only were the rural providers uncomfortable caring for these high-risk infants, but the quads were assigned to two different healthcare providers in separate locations in separate rural cities. This is managed care. This type of situation does not seem to be easily remedied by insurance companies. It is not uncommon to take one to two months to receive changes in PCPs. That is a very long time in the medical care of a high-risk infant.

Hospitalization of sick children is often difficult. Not all hospitals are staffed and equipped to care for infants and children in an emergent situation. Some managed care companies have contracted with hospitals with no Pediatric Intensive Care Units (PICU). I have had several patients who have required cardio-pulmonary resuscitation while hospitalized and, thereafter, required emergent transport to a non-participating facility that had a pediatric intensivist and PICU. If these children had been admitted to the facility of choice with a PICU, a more optimal situation would have been possible.

In yet another case, a pediatric patient was referred to me by a rural physician for evaluation of meningitis and was hospitalized in my "participating" hospital.

After 24 hours of observation and testing, the managed care company mandated that the patient be discharged back to the rural community late one weekend evening to be followed by a non-pediatric home health care nursing service. The laboratory tests were still pending and the child continued to have an elevated temperature. This recommendation was given by a utilization assurance nurse (an employee of the managed care company) who was unfamiliar with pediatric patients. Fortunately the child survived, but this was an egregious decision by the managed care plan based on financial considerations, with no thought to the well-being of a seriously ill child.

Many chronically ill children requiring multi-specialty care have a difficult time trying to coordinate needed specialty care. In one such instance, a child with a syndrome consisting of severe developmental delays, but who was able to interact with his parents, was devastated by the managed care company's decision. The medical director of the managed care company contacted me to describe the syndrome to him. This medical director, an adult internal medicine specialist, notified the family by letter that because of the child's poor prognosis, multi-specialty care would not be provided by the company. Only after 2 years of appeals were we able to remedy this situation. In the meantime, the child suffered the consequences of severe loss of muscle tone.

Each managed care company has a formulary which is a specific set of medications listed as "approved". These available medications are chosen by a managed care company committee and arranged based on efficacy, costs, and safety profiles. If a physician issues a non-formulary prescription, the patient must bear the cost. One of my recent patients required a specific antibiotic for her illness. After waiting two hours in the evening at a pharmacy with an ill, fussy child, the mother found that the managed care company would not pay for this needed medication. The sick child was taken home with no medication because of the inability to pay. The following morning, due to the progression of the illness, I had to admit the child to the hospital and give IV antibiotics to arrest the disease. Situations such as this are quite common. Pharmacists frequently will contact the physician's office to request a substitute drug which may not have equivalent efficacy for the treatment of a particular child's illness. In the meantime, the parent is left waiting with the ill child at the pharmacy window.

PCPs are being mandated by managed care companies to care for infants and children with special needs. I was recently asked to provide all services for an AIDS child. I did not feel qualified to manage this child's multiple medications and treatment protocols that are very multifaceted and constantly changing with new research being published. In Tulsa, there is a pediatric infectious disease specialist who was most assuredly qualified to be the caregiver for this child. However, he is not available for this special child's needs because he was not on her panel.

Another example is the care of an insulin-dependent diabetic child. For years I have used local pediatric endocrinologists for the management of these children. Now, however, I am asked by the managed care companies to assume all treatment. This puts the physician and patient at a higher risk for unnecessary complications, but the pediatric endocrinologist is not on the panel.

One nationwide managed care company is notorious for "downcoding" patient visits. This is a practice in which the insurance company computer has been programmed to "kick out" a level of care coding that requires a more intense level of services rendered by a physician. When this visit is "kicked out" of the system, it is then reimbursed at a lower level irregardless of the time and involvement of the care rendered. If a physician appeals this computer generated downcoded reimbursement, his or her contract with the managed care company is in jeopardy. My contract was not renewed with one company because I have always been, and will remain, a child advocate. I believe in the evaluation of the whole child, not just the acute illness.

Another issue of concern is the referral of children to local health departments for immunizations. Some insurance companies do not reimburse the physician even for the **actual cost** of the immunization medication, which in turn has forced many physicians to discontinue giving immunizations and, instead, refer children to the local health department. This ultimately results in decreased immunization compliance because of the increased difficulty in conveniently immunizing children.

Appeals for Denials of Claims

The appeal process for managed care is often tedious and cumbersome both for the patient and the PCP. Recently, a 7 year-old child broke her elbow and was left with significant restriction of the use of her arm. Her general orthopedist recommended that she be evaluated by a pediatric bone specialist due to the severity of the fracture and other complications. The local pediatric orthopedist rec-

ommended further evaluation by a pediatric elbow specialist in Little Rock, Arkansas or San Antonio, Texas. It has now been six months without a resolution of the request for further evaluation, and treatment has not been authorized by her managed care company despite numerous appeals.

Another patient developed a swelling of her face and neck. When her breathing became labored she went to the emergency department of a nearby hospital fearing that she was having an allergic reaction and would soon be unable to breathe. In fact, she was having an allergic reaction and was placed in the 24-hour observation unit of the hospital. She gave her insurance information to the hospital, but received a bill from the hospital about a month later. Her insurance plan had denied the emergency room visit because she did not go to the "network" hospital. As a layperson she felt she needed to seek immediate treatment, irregardless of the "network" hospital on her plan. The appeals process is still ongoing, a torturous four months later. Her account has since been flagged for collection proceedings by the hospital.

A relatively new medication is now available as a medicine to be administered to high-risk newborns to help prevent serious respiratory illness from the RSV virus. Guidelines for administration have been approved by the American Academy of Pediatrics. Because of the cost of the medication, many managed care companies have not approved reimbursements for the administration of the medication. This lack of approval for treatment, in spite of the managed care company being provided with medical facts and appeals, has resulted in at least one unnecessarily prolonged hospitalization of a child in my practice this past winter.

An 8 month-old male presented with a heart anomaly that could have been surgically corrected after stabilizing the child. The family was on managed care plan #1 during the first phase of stabilizing the child for surgery. This plan would not allow the number of skilled nursing hours the pediatrician felt was necessary for the care of the baby. At that same time, the father's employer changed insurance companies to managed care plan #2. Plan #2 also refused to authorize the skilled nursing care the pediatrician desired. The baby's condition became worse. He was taken to the emergency department and admitted to the hospital. The pediatrician involved was reluctant to appeal the decision because of financial repercussions his network group would incur. However, the pediatric home healthcare company involved chose to be the patient advocate and appealed the decision of the managed care company. The home healthcare agency was reprimanded. The child died of congestive heart failure within days and without the benefit of the corrective heart surgery. Subsequently, the contract between the managed care company and the pediatric home healthcare agency was terminated involuntarily by the managed care company.

AOA Positions

The AOA believes legislation which allows patients access to specialty care and institutes a fair process for appeals of treatment denials is necessary to ensure the best quality care for our patients. The AOA further believes:

- Medical decisions made by physicians must be reviewed by physicians of the same license and specialty. Cases involving the review of an osteopathic physician must be reviewed by other osteopathic physicians.
- The results of reviews must be communicated to the patient as soon as possible and plans should not be allowed to miss the deadlines for review without penalty.
- An independent and fair standard for "medical necessity," based on the best science and best clinical practice, should be used for reviews.
- Plans should not be given the right to charge patients for independent review.
- Patients should not be forced to waive all future legal rights to gain access to Alternative Dispute Resolution (A.D.R.).
- Reviews should be independent and *de novo*. The "rebuttable presumption" that the health plan was correct should not be used as the basis for review.
- Review decisions must be binding on the plan and plans must be held accountable for decisions which harm patients.
- There should be one "prudent layperson emergency" standard for both screening and treatment (not be a "prudent emergency professional" standard for treatment) which allows patients to go to the nearest emergency room without fear of extra charges.
- Any federal patient protection bill must allow state patient protection laws to remain in force.
- Patients should have access to specific information about their medical care including what doctors are in the plan, what drugs are in the formulary, and what procedures are excluded by contract, before enrolling.

- Plans should be required to offer a "Point of Service" option for employees in HMOs (paid for entirely by the employee) to allow patients to see the doctor of their choice.
- Any commission created to report to Congress on "the appropriateness and availability of particular medical treatments" should not have the authority to regulate the practice of medicine. The commission members must be allopathic and osteopathic physicians.
- Any prohibition against "Gag Practices" should also include due process for providers and a prohibition against financial incentives to deny care.
- Timelines for internal and external reviews should be shortened and should start when the review is requested, not following the filing completion date.

Conclusion

These cases are just the tip of the iceberg of problems in which I have personally been involved. Because of these frustrations and the gross misuse of available medical care by managed care companies for financial gain, I have, after 25 years as a solo pediatrician, elected to move into academic medicine. I join the ranks of medical professors in the hope of providing graduating physicians with more knowledge about caring for the pediatric patient.

I would encourage each of you to consider carefully these issues. We, in America, have the potential for the best care, the best facilities, and the most dedicated physicians in the world—yet we are being shackled by managed care companies to benefit the bottom line, not our children's medical care.

Thank you for the opportunity to share my experiences as a physician with you today. The AOA stands ready to participate in the bipartisan effort to develop strong patient protection legislation for all Americans.

Mr. BILIRAKIS. Thank you, Doctor.

All right, I will start the questioning.

I think that all of us in this room, participants, people out in the audience, and of course, you panelists—more so than the rest of us, I guess—understand your frustrations with many managed care plans' practices.

Sometimes it is tough because of politics, partisanship, demagoguery, and things of that nature. We are trying to work in a bipartisan manner to develop legislation that addresses many of these frustrations, but at the same time does not add to the rolls of the uninsured. I would like to think you all want us to always keep that in mind in everything that we do.

Dr. Grogg, you stated that medical decisions, panels of physicians, laboratories, x-rays facilities, and hospitals, and other providers are all chosen by the insurance company based on the lowest cost, in your testimony. You also went on further to add that the decisions, quite often, are made regardless of the needs—I am quoting you now—"regardless of the needs of the child, and of the particular medical problem in question." Of course, I think that, again, goes to the word "frustration," and what we are all here about.

Now, I think also along with these frustrations most of us in this room—all of us in this room—support very strong, very independent, very qualified appeal panelists who are of the same persuasion of the medical problem in the external appeals process.

Ms. Barron, you told us that in all of this time there has only been one case brought to court?

Ms. BARRON. To my knowledge.

Mr. BILIRAKIS. To your knowledge.

Ms. BARRON. I understand there may be a second.

Mr. BILIRAKIS. All right. That is why, because you have, in fact, put into place a good, strong, independent, binding external appeals process, right?

Ms. BARRON. Yes, sir. I believe that is right.

Mr. BILIRAKIS. Going back to Dr. Grogg, and the problems you have mentioned, if there is a strong, binding, independent external review process where independent clinical peers are reviewing the medical decisions of a plan, doesn't that address most of your concerns? Isn't that, for the most part I suppose, a large part of the reason why there haven't been any cases going to court which would render the liability portion of all of this—I am not going to say moot—but certainly not as significant as some would think it to be?

Ms. BARRON. Mr. Chairman, we believe in Texas that those two issues, the review and the accountability, are linked together. They were passed at the same time. In fact, in our law, they were linked. Our law required an external review prior to an individual being able to bring an action.

I don't remember—I apologize—which one of the members said that we don't believe individuals want to sue their way to better health. They don't. They want to get they care they believe they paid for. They want to feel they had it fair.

Mr. BILIRAKIS. What was the history before the legislature passed the liability portion? In other words, you indicated you had the external review process in place before that was done.

Ms. BARRON. No, sir. We did not have external review prior to the liability.

Mr. BILIRAKIS. You did not.

Ms. BARRON. We passed external review at the same time that we passed accountability. We linked them together in the single bill. We crafted the bill in a way to avoid frivolous litigation, but to have it out there, really, as an enforcement tool to be able to say, "If you comply with external review and you do everything it is intended, you shouldn't have to worry about a lawsuit. But just in case you decide you don't want to, or you slow walk, or you lose the paperwork, or you consistently miss timelines, then you should know that if this is going on, you may well be held legally accountable for any harm that occurs to someone because you didn't comply."

When the law was challenged, the judge upheld to some extent the liability portion and threw out the external review. The health plans had been voluntarily complying with the external review, because they do like it. Now, if the liability had been thrown out, would they have wanted to continue with the external review? We don't know, because we linked them together as a single package.

Mr. BILIRAKIS. Dr. Grogg.

Mr. GROGG. Yes, Mr. Chairman and the committee, the biggest problem in the pediatric care is not getting to a pediatrician. There is an adequate number of pediatricians. It is getting the child with special needs to a sub-specialists, or a specialty in a particular area. For instance, if a child has a seizure and there is not a pediatric neurologist on the physician panel, oftentimes they are seen by an adult neurologist.

Mr. BILIRAKIS. Why don't you back up now? The child has a seizure. Take us through that, if you will, very quickly, the process of how the internal review process would be held, then the external, and what-not.

My time really is already up. But I think it is important that we get an idea of how this works. Dr. Weiss and Dr. Conway, maybe, can get involved very briefly if you disagree in the scenario that Dr. Grogg is summarizing.

Mr. GROGG. If a 2-year-old has a seizure, and I as a pediatrician don't quite understand why this child has had the seizure, we would do specific tests, such as EEG's, which is checking the electrical activity of the brain, and MRI's to check the anatomy and make sure everything is intact in the child. This may take 2 to 3 days. If it is on Friday evening, it will not be until Monday or Tuesday before we can get permission to run these other tests.

On the other hand, if there is not a pediatric neurologist in the panel, which is frequently the case, they have adult neurologists instead of a pediatric neurologist. They may not understand why a child may have a seizure. We then have to wait 2 weeks—even 2 months—in order to get a neurological referral.

Mr. BILIRAKIS. Any comment to that, Dr. Conway? Dr. Weiss? I am sorry to interrupt you.

Mr. WEISS. Well, under the standard procedure, the patient really does need to see a neurologist. A pediatric neurologist or a neurologist who is familiar with children is what they need to see. That shouldn't be an issue. I think in most plans in most areas that may not be. As you get into areas where there is a limited number of pediatric neurologists, that may be an issue. I don't know if with the Henry Ford Center that is as much of a problem, either.

Mr. CONWAY. The example given is one of just having a referral authorized. It sounds like a pretty slow process. That isn't even an issue that has been denied that a patient would want to appeal. But in an appeals process, there should be a strong, as we stated, external review available with a couple of levels internal to the health plan for the patient to appeal to.

Mr. BILIRAKIS. Well, in the case that Dr. Grogg mentions to us, could an adequate, strong, external and internal review process be established that would still be helpful to that patient? We talk about liability. By the time you get into court—in the meantime, the patient doesn't get proper care. That is the question. That ought to be my last question because I have to go on to the others.

Mr. CONWAY. I would also say that it would need to be prompt. If an important health care need is taking 2 weeks to get settled by the health plan, I think we ought to be looking at that.

Mr. BILIRAKIS. That is not very prompt, is it?

Mr. CONWAY. Prompt is 2 hours.

Mr. BILIRAKIS. Yes.

Mr. WEISS. I think from the side of an appeals process, the only thing for an internal or external review would be whether or not a non-par pediatric neurologist was going to get paid. That is where its place would be. The child needs to be seen. If there is going to be a debate over reimbursement after the physician has seen him, and the plan denies payment because it is non-par physician, I think there is a place, then, for an internal or an external review. They would say that a par provider was not available, and it is reasonable that you pay for a non-par provider. That is where

the safeguards would be available through internal or external review.

Mr. BILIRAKIS. Well, I am concerned about timeliness. We are concerned about patients here. We are not concerned about patients after they have passed away or gotten to the point where they can't be cured. We are concerned about patients getting the proper care in a timely fashion. Quite frankly, I don't think we are as concerned about liability, although I realize the clout that it can possibly have.

Okay, I am going to yield to Mr. Brown because my time has expired. Thank you so much.

Mr. BROWN. Thank you, Mr. Chairman.

Ms. Barron, thank you for joining us, and all four of you. You explained well, I thought, what happened in Texas after your mid-1990's legislation. Opponents said that medical necessity would sort of end the world as we know it. People would get out of managed care into more expensive fee-for-service. That clearly didn't happen.

You said the number of plans went up. Costs would go through the roof. You showed that premiums are consistent with other states. There would be an increase in fraud and abuse. That did not happen.

Let us talk for a moment about the Texas situation prior to the passage of that legislation. You represent, I understand, about 35,000 physicians, right? Tell us, how were health plans making decisions about medical care? Were they basing their decisions on good medical practice prior to your new law?

Ms. BARRON. Prior to passing our law, we weren't sure how health plans were making their decisions. What would happen very often for physicians is that when a request was made to have a particular treatment provided, a response would come back saying that treatment is not consistent with our criteria for medical necessity. There was no disclosure of what those criteria are. The appeals process was very cumbersome. If there was one, it required that everything be done in writing. There were no specific timelines. There was a guarantee that a physician with the same or similar specialty would be in position to discuss the case with the treating physician. The third thing that did not exist until 1995 was clarification that there had to be flexibility to take into consideration unique circumstances of an individual patient.

It is fine to have general screening criteria and general guidelines. We support that. There is nothing better than evidence-based medicine when you have it. The problem is that is embryonic right now. There are very few treatments out there that have the level of what would be termed "evidenced-based."

Then you move to peer review. That is great. If you don't have either of those, you are looking at generally accepted standards. In the light of all of those things, you have to look at the individual situation of the patient and ask, "Does it make sense to apply these things to this patient? Are we looking are multiple conditions? Is the patient able to get to the care?"

The conversation has to take place. What we are finding now is that is what is happening. Physicians are being able to get the criteria that are being used to make those decisions. They are able

to have those discussions with their colleagues and peers. Patients are getting better care as a result of this.

Mr. BROWN. If I understand this, prior to the law, patients and doctors were not often notified of the reasons for the denial of that particular treatment.

Ms. BARRON. That is correct.

Mr. BROWN. And you mentioned evidence-based medicine. If a health plan refused to share information with physicians, with evidence-based medicine, how is a physician better able to continue the treatment for the next time?

Ms. BARRON. I think that is one of the big problems. There is no educational process involved. If the idea is that health plans believe they have access to information right now that is the best, and they can help make that available to their physicians, that is often true. It is a good thing. If you don't tell the doctors what the state-of-the-art is in treating something, then you can't educate them. You can't expect them to improve the quality of care they provide to their patients.

I know I look very young. You probably won't believe this, but I have one of those T-shirts that says, "Because I am the mom." The process used to be, "Because we are the health plan." That doesn't really help educate the physicians. We say "no" because we can.

The full disclosure, the scientific evidence, the ability to discuss specific patient conditions with another physician that has clinical expertise and understands the conditions being discussed are all components in our law that we believe are imperative in moving ahead to improve the quality of care provided, and make it available in timely fashion.

Mr. BROWN. So my understanding of the advantage of managed care over the years—to contain costs and to wring waste out of the system—the real positive aspects of managed care require educational processes back and forth between the plan, the patient and the physician, so that physicians in the future will know better how to treat—not just in the least expensive way, but most efficiently and effectively. That was missing prior to your law in Texas, because there was not the communication between doctor and health plan, correct?

Ms. BARRON. That is correct.

Mr. BROWN. So you would say that, prior to your legislation, that it was more of managing costs than managing care?

Ms. BARRON. I think that could be a very appropriate statement, yes, sir.

Mr. BROWN. Okay. Thank you.

Mr. BILIRAKIS. Dr. Ganske.

Mr. GANSKE. Thanks, Mr. Chairman.

There is a Federal court case called Jones v. Kodak. In relationship to ERISA, it basically says that a health plan under ERISA can define medical necessity in any way that it wants to.

So what some health plans have done is that they put into their contractual language this definition of medical necessity. Medical necessity means, "the shortest, least expensive, and least intense level of treatment, care, or service rendered, or supply provided as determined by us." Isn't that amazing?

I would like every member of this panel to describe whether they think that is an adequate definition of medical necessity.

Mr. GROGG. Dr. Ganske, I understand that situation and do not think that is appropriate. Medical necessity should be defined by physicians and based upon scientific knowledge, in particular for the disease process that is going on, and a particular patient. If a patient needed tubes in his ear for otitis media, it is more appropriate to get that patient in immediately if they have a cleft palate in addition to the problems that they have with the ear.

So you need to look at the specific patient, with peer review understanding the necessity and the types of challenges associated with medical necessity.

Mr. GANSKE. Dr. Weiss?

Mr. WEISS. I don't agree with the statement that it is defined by us. Sharing Connie Barron's view and TMA, it is that it should be supported by evidence-based data. The converse is, I think, that with that definition there needs to be some evidence suggesting the therapy that is being requested is going to be of benefit to the patient.

Mr. GANSKE. Ms. Barron?

Ms. BARRON. I would say that, clearly, we would not agree with that definition of medical necessity. Again, we look for evidence-based whenever it is there, and peer review standards. Sometimes there are treatments that are new. There are situations and conditions that what you have to go on is what is the generally accepted standards for caring for this patient in this situation. That is not unusual. But that definition is the most commonly offered definition in State laws today. It is understandable.

It is sort of like the old adage of pornography: I can't define it, but I know it if I see it. I think, as a physician, you know when you are talking with a colleague if you are understanding what is going on with that patient you will know what is medically appropriate for them in the absence of scientifically based, clinically proven evidence.

Mr. GANSKE. Dr. Conway?

Mr. CONWAY. I wouldn't accept that definition. I wouldn't sign that contract. That gets us into a subject area outside of the purview of what you are interested in today. One way to manage that is anti-trust relief for physicians so they can collectively bargain and tell an insurance plan that is unacceptable.

Mr. GANSKE. Let me, just for my own practice, expand on why I think we then need to change ERISA if it allows, in fact, that type of definition of medical necessity. As a reconstructive surgeon taking care of a lot of kids with cleft palates, yes, it would be possible to treat a child with a cleft palate with a plastic obturator. Would their speech be as good? No. If they lost their obturator, would they have food coming out of their nose? Yes. Would it be the cheapest treatment? Yes, it sure would. Under Federal law, ERISA, if unamended or changed, any health plan can do that.

Now let me get to something else. I want to make a statement. It may seem counter-intuitive, but I would like your comments on this. I would say that while it may sound counter-intuitive, it is not good medicine to solely use outcome-based studies of medical neces-

sity, even if the science is rigorous. I think, Ms. Barron, you have made that point. You have added some qualifications.

Let me explain why I think that is the case. You will frequently hear the health plan say, "Well, just use outcome-based, or experience-based studies." That is that the choice of the outcome is inherently value laden.

Mr. Chairman, if I could have 1 minute to follow up?

Mr. BILIRAKIS. I don't want to make a habit of that now because we have another panel to go. It is a quarter to 5 already. If there is no objection, I do have concerns, Greg, that we are setting a precedent here.

Mr. COBURN. Unanimous consent that the gentleman be given 1 additional minute.

Mr. BILIRAKIS. Without objection.

Mr. GANSKE. Thank you.

Let us say that I, as a hand surgeon, am taking care of a patient with a broken finger. Now the majority of those patients with broken fingers you can treat with splinting. I may be treating somebody who plays the piano or plays the guitar. They need to get motion back soon. They need to get 100 percent. The better treatment would be an open fixation, internal reduction.

Now which is the value that you use? Do you use the cheapest? Do you use the best result? That is why I think we need to be very careful in having a series of things that we use for the medical necessity. Certainly, a plan's guidelines can be part of that as long it is peer reviewed. I think it should be the medical literature. It should be NIH consensus statements. It should also be looking at the individual circumstances of that patient. Is he a construction worker or does he depend on playing the piano for his living? Would anyone disagree with that?

Mr. GROGG. No I wouldn't.

Mr. GANSKE. Let the record show that nobody disagrees with that. Thank you, Mr. Chairman.

Mr. GROGG. Mr. Chairman, if I may add to that conversation? You heard the statement that, if you see that in your contract, don't sign it. It would be good if we had the collective bargaining physician as physicians, but we do not.

Mr. BILIRAKIS. That is happening, though.

Mr. GROGG. I encourage that. It is a take-it-or-leave-it type of contract. If you don't want to sign a contract, then you are frequently without a large panel of patients.

Mr. BILIRAKIS. Yes, I have heard those stories.

Let us see, Mr. Pallone.

Mr. PALLONE. Thank you, Mr. Chairman. I was struck during the panel's testimony about the contrast, really, between what Ms. Barron said and what Dr. Conway said. It seemed like they were totally contradictory.

Just two examples: Dr. Conway, you talked about your fear of litigation; how litigation was so terrible. Yet she talked about how there had only been one suit filed since the Texas law came into place. You talked about how somehow HMO's are not engaged, or don't make decisions about the practice of medicine. She talked about how the Texas law had to be changed, or clarified, to say that if managed care plans make negligent decisions to withhold

payment for care in spite of the recommendations of the treating physician, the managed care plan can be legally accountable in Texas courts. That was only done, theoretically, because in fact managed care plans were overruling decisions and effectively making decisions about treatment.

My first question is, Dr. Conway, I assume you would have opposed the Texas law? You still oppose the Texas law, or you just disagree with the facts? What is you comment about Ms. Barron's testimony?

Mr. CONWAY. I think Connie and I would agree. Ninety percent of what we covered is in agreement, especially on appeals processes and how important and effective external appeals opportunities are for members. I can't disagree with her factual statement of Texas experience over the past year. This bill has not been around for very long. I don't think we can assume that we are not going to see a lot of lawsuits out of that bill. What is it, 18 months old?

Mr. PALLONE. Did you oppose the Texas bill? Do you still think it should not have been passed? Would you favor it being repealed?

Mr. CONWAY. Our position is we can get just as much by requiring aggressive external appeals processes being available to all members.

Mr. NORWOOD. Will the gentleman yield?

Mr. PALLONE. No. I would like to—I just want to ask a few questions. Please forgive me for not yielding.

You say that the HMO's are not legitimately engaged in the practice of medicine. In fact, if they overrule recommendations that physicians make with respect to specific treatment, why aren't they effectively in the practice of medicine? Why aren't they effectively practicing medicine by overruling what the physicians say should be done?

Mr. CONWAY. I think they are making payment decisions.

Mr. PALLONE. Why is that any different if the effect is that they overrule a physician and the patient can't get the treatment that their physician recommends?

Mr. CONWAY. This is the way we would want to see the kind of appeals processes that we make available to our plan patients required of everybody in the industry.

Mr. PALLONE. She said in her testimony that one of the problems with the independent review program in Texas is that it was recently ruled to be preempted by ERISA. A Federal district judge concluded that the review involved determination employee plan benefits that could not be imposed by the State. She says that Congress has to act to establish an independent review process; otherwise, the Texas program is in jeopardy. Would you be in favor of Congress enacting that?

Mr. CONWAY. I think our testimony asked you to take action on requiring external review of health plans. We would support that.

Mr. PALLONE. The type of independent review process that was overruled by the courts? You would be in favor of us implementing that on a Federal level?

Mr. CONWAY. Yes.

Mr. PALLONE. Okay. Let me just ask one more thing here. One of the things that I really don't understand is in many ways you suggest that you are so afraid of this litigation. I guess your an-

swer is that Texas law hasn't been around long enough. You think there is going to be a lot more litigation. Then you talk about medical malpractice reform being the first order of business.

But to be honest with you, Dr. Conway, most of the physicians I talk to consider HMO reform the first order of business. They don't really have a problem with HMO's being sued. As much as they might have problems with the medical malpractice system the way it is. I have heard their complaints about it. They don't have a problem with the fact that HMO's could be sued and come under the same system.

I guess I am just a little confused about why you are so concerned about the litigation aspect. I think you have answered it. If you want to go on a little more—it seems to me there isn't really a problem. Really, what it is is preventative. She has basically shown that what we do is create a preventative-type situation. People aren't suing. It is a means of prevention.

Mr. CONWAY. Beyond costs. I was pointing out very good studies at Harvard University, and confirmed in two additional studies, that the medical liability system doesn't really benefit the people who are injured. There isn't any reason to think that allowing health plans to be sued is really going to help the people that have a coverage need to be settled. An aggressive external review process will settle that promptly. We can impose short time limits, like 72 hours on that, and get this resolved and not have to rely on courts.

Mr. PALLONE. I know my time has expired. I just think: Think about the preventative aspect. I think that is the key. It means, ultimately, people are responsible. They get into prevention.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. The gentleman's time has expired. Mr. Whitfield.

Mr. WHITFIELD. Thank you, Mr. Chairman.

It is my understanding that Michigan, Texas and Florida—all three States—have a State law relating to external appeals process. Are there any caps on punitive damages or anything else in the three States?

Mr. WEISS. First off, Florida has mandated external review, but has not put in the liability. As far as the liability, basically, the reason why the health plans are doing the external reviews and why it is successful, Florida has taken half of the pie that Texas has done. I think it has had good results. I think it sort of goes to the point that the external review may be the solution. There may not be the need for additional liability. But liability without the external review probably would not yield the results that the committee would be looking for.

Mr. CONWAY. Michigan doesn't have a liability option like Texas. Texas is the only State, I think, that allows for suing health plans.

Ms. BARRON. Congressman, I will say I am not a lawyer. I will say that we have significant tort reform on the books in Texas. I think we do have caps on our punitive. I think we have formulas for non-economic damage recoveries. We have joint and several. We have many, many tort reforms.

It was interesting that the State senate sponsor of the managed care accountability act was the same sponsor of all of the tort reform packages that were passed this previous session. He felt this

act was very consistent with tort reform. It was designed in a way to avoid frivolous litigation. We believe it has been demonstrated by having that external review, but was also consistent with principles of joint and several of having the responsible party at the table.

If I could just comment from Mr. Pallone's question, I think that Dr. Conway is in a situation that is probably ideal in many ways for lots of physicians. He is in a group practice, a large group practice, where I suspect that many of his contracts are on a capitated basis. He is able to make, among those physicians in the group practice, all the decisions about what is appropriate for those patients. It is up to him to keep those costs in a budget.

In Texas, we have very few group practices. Because of the individual physicians, what we were finding very often was the health plan overruling the decision of the treating physician.

Mr. WHITFIELD. In Florida, you said your HMO provides coverage for 400,000 patients.

Mr. WEISS. Yes.

Mr. WHITFIELD. How many of those are under self-insured plans or subject to ERISA preemption?

Mr. WEISS. Of the members that we have, we don't administer plans. This is all fully insured versus being a third-party administrator and administering the self-funded. So all of our members are fully insured.

Mr. WHITFIELD. Okay, all of yours are fully insured. Does that mean self-insured?

Mr. WEISS. No. They are fully insured by the health plan. They are not self-funded plans where they would have the ERISA exemption.

Mr. WHITFIELD. So none of yours are under ERISA, then?

Mr. WEISS. Right. None of our plans. The closest to ERISA exemption would be the municipalities—governmental entities.

Ms. BARRON. If I could comment? This is something that is so confusing, but so important to understand. I think Dr. Coburn mentioned this earlier. Just because a plan is fully insured and licensed by the State does not mean that ERISA does not impact it.

In other words, I take an insurance product that is licensed by the State and I put it upon the shelf for somebody to purchase. If an individual walks in the door and buys that plan, or if a public sector employer walks in and buys that plan, they are fully covered by all State laws and ERISA has no jurisdiction over that plan.

If, however, I am a private sector employer, I walk into that store, reach up on that shelf, and I take that very same plan off the shelf, because I am a private sector employer, that plan is arguably subject to certain requirements of ERISA. Those are all of the cases that are constantly being disputed in the courts about whether the facts in a particular situation fall under the authority of the State, or under the authority of ERISA. It is very confusing. That is why crafting any legislation is important.

Mr. COBURN. Would the gentleman yield?

Mr. WHITFIELD. Yes.

Mr. COBURN. What actually happens is that, as soon as they get a lawsuit, they start running toward ERISA and changing the doc-

umentation—which we have proof of in several instances—so they can claim ERISA exemption.

I thank the gentleman.

Mr. WHITFIELD. I spent a number of years with CSX Corporation, which is in Jacksonville, Florida. Of course, they were self-insured and protected by ERISA. They had four or five plans available for their employees. They had a tremendous interest in making sure that the insurance carrier was not denying health care for these employees. So I know that there are exceptions to that rule. I know there are some problems out there.

My time has expired.

Mr. BILIRAKIS. Mr. Barrett.

Mr. BARRETT. Thank you, Mr. Chairman. I am hoping that by the end of this hearing I will have a better understanding of how these grievance procedures work so that as we move forward on legislation we can make sure that they are responsive.

Dr. Conway, maybe I will start with you and the Henry Ford grievance policy, if I can. Reading from your prepared testimony, "The grievance process is a three-level decisionmaking process. A final determination is rendered within 90 days following the initial patient request, or within a 72-hour expedited review process for urgent issues."

My first question for you is, who decides which process kicks in, whether it is the 72-hour expedited review or the 90 days?

Mr. CONWAY. The patient can ask for an expedited review.

Mr. BARRETT. If the patient asks for an expedited review, will the patient automatically receive that or not?

Mr. CONWAY. Sure.

Mr. BARRETT. Is that your understanding, Dr. Weiss?

Mr. WEISS. That is correct. If they request an expedited review, we will review it within 72 hours.

Mr. BARRETT. From a practical standpoint, how often does the person not ask for one? I would think that, as a layperson you would say, "I would like to have a quick decision."

Mr. WEISS. Well, if the patient is in the middle of care. If you are asking for coverage and are not in the middle of treatment, then the non-expedited review would be appropriate. If they ask for an expedited review, we can look at that. It requires getting information more quickly. Sometimes it is not as comprehensive to rush something along. We may need to contact several doctors and get the information.

Mr. BARRETT. So would each of you support in our legislation a provision that said that, if the patient asked for expedited review within 72 hours, the patient would be entitled to that? Dr. Conway?

Mr. CONWAY. Sure.

Mr. BARRETT. Ms. Barron?

Ms. BARRON. Yes.

Mr. WEISS. I think one of the problems with that is, as you said, if you are told that everything can be expedited, everybody wants an answer now. As you try to accumulate the information and get the answer, it sometimes makes it far more difficult, both for the plan, but also for the physicians we need to contact and ask them to provide documentation as to why a member may need that.

I think, in our plan, non-expedited reviews are completed within 28 days. Some are completed in just a few days, once we can get the information. Making everything expedited is probably going to back up the true expedited, and may interfere in actually trying to review cases for the patients who really need it reviewed today.

Mr. BARRETT. Now when you say for your plan that it will be completed within 28 days, is that the first level? How many levels are you speaking of there?

Mr. WEISS. That would be the third level. When someone asks for a review, it will be reviewed immediately. There may be a conversation with the physician who is requesting the services to try to get a clarification of the information. Based on that, the decision can be changed. If at that point there is no change—this is now the first level of reconsideration—then there would be the formal one. If a patient is in the hospital at that time, that would be appropriate for an expedited review. Or if there is a serious service that needs to be done where timing is of an issue, then it can be done as an expedited review. If it is for coverage of a service that is not time-related, then it wouldn't be an expedited review.

Mr. BARRETT. In my opening statement I made reference to a constituent who asked for additional treatment. When he was told he couldn't receive it, he asked the physician to put that in writing. The physician, obviously, was not happy with that and declined to do so. The constituent then pressed on and said, "Well, then, I will write to you and recount this conversation." At that point, things changed dramatically.

Do you support a requirement where, in the real world, there is any type of written documentation? Many times you are talking about a person who is not sophisticated, who just has this gut feeling there is something wrong.

Mr. WEISS. In that situation, the member would have been able to call the plan and be able to basically complain, or file a grievance saying they wanted that. It would be reviewed at that time. The other option, also in Florida, is there is the 800 number for the Agency for Health Care Administration. They can call that number and register a complaint, which would then be immediately forwarded to the plan.

Whether the physician wants to participate or not, the member should have—and in Florida does have—a vehicle to be able to register a concern that will be looked into by the health plan and/or the State.

Mr. BARRETT. Well, my question is, if I am on the phone and I am calling the physician and saying there is something wrong here, will I receive something in writing that will tell me why I am denied coverage?

Mr. WEISS. You would only receive something in writing from the health plan if something was denied. If the physician never requests it, we would not send out a denial letter. If a request is put in to the health plan, and it is denied, you would receive a letter explaining why it was denied.

Mr. BARRETT. But isn't there a financial incentive for the physician not to ask for it in the first place?

Mr. WEISS. With our contracts and our physicians, there is not. In some, there may be.

Mr. BARRETT. So what should we be doing to make sure, then, that there is at least some indication? In the real world, if the physician is never asking for it, then there is no documentation. So Joe Blow, who has been denied treatment, never existed in terms of bring the issue to the forefront.

Mr. BILIRAKIS. Brief answer, please.

Mr. WEISS. At that point, there should be a vehicle for the member to be able to register their complaint or concern. Telephonically would be the easiest for them, or being able to send a letter in registering their concern. Once the health plan is made aware of it, they need to address it in the formal process.

Mr. BILIRAKIS. The gentleman's time has expired. Mr. Burr.

Mr. BURR. Thank you, Mr. Chairman.

Ms. Barron, let me ask you one question. You said in the close of your statement, underlined, "With no unexpected increases in premiums and a growth of managed care plans."

Let me just ask you about the portion "unexpected increase in premiums." How much have premiums gone up, on average? I am not talking about specifically that you targeted for this legislation. But in the 18-month period, do you think this has been long enough that you would have experienced an increase?

Ms. BARRON. I would say that we should have seen any anticipated increase at this point, because the health plans told us early on that they were going to begin accruing and charging as if what they expected to happen was going to happen.

Mr. BURR. They expected how much, and you have seen how much?

Ms. BARRON. They said this would be a billion-dollar health care tax; premiums would soar 35 percent. We have seen a 3 percent increase in the Houston marketplace, about 6 percent increase in the Dallas marketplace; what you would see consistent around the country with HMO's having sustained long losses, and now having to recoup those losses. Nothing inconsistent with what we see in increases in any other State.

Mr. BURR. Let me ask all of you—Dr. Conway, do you agree that the external review is an important component of what we look at?

Mr. CONWAY. Absolutely.

Mr. BURR. Ms. Barron?

Ms. BARRON. Yes, absolutely.

Mr. BURR. Dr. Weiss?

Mr. WEISS. Yes, I do.

Mr. BURR. Dr. Grogg?

Mr. GROGG. Yes.

Mr. BURR. Great. We have agreement on a very important component, which is external review.

Now I will ask you to focus on three words as we talk. My question to you is: Where do we go from here? What is the next step that we need to accomplish the right balance? The three words are quality of care, access, and affordability, because that is what this committee should be challenged with. I am not sure every member is focused on those three things.

But with an agreement that there are 43 million uninsured in the country, Dr. Grogg, would you agree with me that a child that

is covered under an insurance policy is more likely to get care than one that is uninsured today?

Mr. GROGG. Yes.

Mr. BURR. We agree that insurance is an important component to the availability of health care?

Mr. GROGG. Yes.

Mr. BURR. Access. Let me ask you to dwell on these three things: access, affordability, and quality. Tell me, if you could design a change to protect patients, to assure access, and to assure affordability as best you can, what would you do? I will just start with Dr. Conway.

Mr. CONWAY. I would put into the patient protection legislation the requirement for an external review, related to the subject. That should cost little. Even the Texas experience would suggest that.

Mr. BURR. You laugh. I didn't tell you this would be easy.

Ms. BARRON. Well, that is right. How many years do I have to think about this? I would say that I do think that one of the most important things is that we look at what is driving the cost of health care. We should not move forward in looking at public policy solutions that aren't addressing the real problems.

If you look at what we are seeing, we are seeing consistently all of the articles that I read from the think-tank folks and the policy experts, and even employers, when surveyed will put the two three cost drivers as being rapid developments in technology, advancement with new pharmaceuticals coming out, especially in terms of genetic research and an aging population. They don't list government regulation. They don't list liability. They don't list mandated benefits as being the true cost drivers.

It is important to look to see if those assumptions are right. Is everybody looking at the right things? If so, do we have a reasonable way to address that affordability? How do we do that?

Mr. BURR. I wonder if we would get the same three at the top of the list if we asked physicians? It might be an interesting thing for us to do sometime.

Dr. Weiss?

Mr. WEISS. I think that if we are looking at trying to address all those issues, managed care offers the opportunity.

Mr. BURR. Let me stop you. It is not a question of if we tried. That is the challenge we are given right now.

Mr. WEISS. I understand. Managed care offers the opportunity versus unmanaged care. Now how can we make sure that managed care is done well so that we are being accountable for the costs, and—most importantly—the quality? I think an external review panel, which could be mandated to include review by similar-specialty physicians, offers the opportunity to make sure that we are able to control the cost, make health insurance affordable, and also, to make sure the quality is not negatively impacted.

Mr. BURR. Mr. Chairman, can I get the last panelist?

Mr. BILIRAKIS. By all means, go ahead.

Mr. BURR. Dr. Grogg?

Mr. GROGG. Both the American College of Osteopathic Pediatricians and the American Academy of Pediatrics would like to see universal health care for all children. If this were in place, external review as we have discussed today would certainly benefit, I think,

to make it accountable. But we would like to see that all children have access to specialty care, and have insurance available to them.

Mr. BURR. I thank our panelists. Certainly this committee tried, with the expansion of the CHIPS program, to help here.

Mr. BILIRAKIS. Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman. Let me follow up real quick on the increased costs as the result of the Texas HMO reform.

Ms. Barron, I understood that the 3 percent in Houston and 6 percent in Dallas, and the increase statewide was similar to what other States were experiencing. It had both urban and rural markets, for example, California, or some other place. So the last 18 months you could see no appreciable increase in premiums based on the reforms that were passed in 1997?

Ms. BARRON. That is correct. I think it is very important to know that, when our reforms went into place, the majority of the reforms went into place in 1995. The issue dealing with medical necessity criteria, and disclosure of those criteria started as early as 1991. They were strengthened in 1995. They allowed for flexibility to address the individual needs. Then we added the external review in 1997, along with the health plan accountability. So we have had some significant patient protections on the books for a lot of years.

Mr. GREEN. Let me go to the issue today. There is a linkage between all the issues on managed care reforms that were passed in 1997 in Texas and is being considered and passed by other States.

On the one concerning liability and the outside appeals process—correct me if I am wrong—in Texas, we had the outside appeals process. The success rate for patients is about 50 percent. In the patients that are being appealed, 50 percent are found to the HMO and 50 percent to the patient. If the patient is denied, the patient was wrong. The patient now does not have the right, under Texas law, to do to the courthouse. Is that correct?

Ms. BARRON. I am sorry?

Mr. GREEN. If those 50 percent of the patients that appeal and are denied whatever services, do they have the right, under the accountability provision, to go to the courthouse?

Ms. BARRON. They could if they chose to do that. But all of the information is discoverable, if you will. In other words, if you were going to file a lawsuit against a health plan, you would know that the health plan did everything right. Their decision was agreed to and supported by an independent external review entity. The chances of that case moving ahead are pretty slim. We have not seen that happen.

Mr. GREEN. So the accountability section, then, is linked to the success of the appeals process—a swift, outside appeals process.

Ms. BARRON. We believe that, based on our experience.

Mr. GREEN. Do you think, after watching the Texas experience, that is probably why we have only had one or two lawsuits filed?

Ms. BARRON. I do.

Mr. GREEN. One of the things that I talked about this morning, when we were lining up, was the 50 percent on the outside appeals. If I were a Houston Astro, for example, and batted 300, I would be a 30 percent success rate. I would make $8 million a year.

A health care provider, though, who is only 50 percent right worries me. I would like to have better than the chance of a flip of the coin when my physician calls for a certain treatment. So I think that 50 percent has made both HMO providers and physicians more comfortable with it. There is a linkage between the accountability you have to have and the appeals process. Do you feel like that is so?

Ms. BARRON. We do. We believe they work well together.

Mr. GREEN. Of the 50 percent who were provided, is that binding on the provider?

Ms. BARRON. It was originally binding in the law until the court ruled that we couldn't make it binding. So we had to go back this session and say, "We can't make it binding. We can't make you do it. It is voluntary. But if you opt as a health plan to participate in our external review process, you agree that you will be bound by the decision." But the health plans now must voluntarily participate because of the ruling. It is still being appealed.

I will say that Phil Dunne is here from the Texas Medical Foundation, our external review entity. He has the majority of the experience and can certainly more knowledgeably address the issues about how that has worked and the number of cases.

Mr. GREEN. Do you know of any of the appeals process that were successful, where the plan decided not to provide the service?

Ms. BARRON. Not to my knowledge.

Mr. GREEN. So there would be no appeal from the patient's standpoint. Let us say we are going to get the service. Again, that is linkage that we have to have: the appeals process with the accountability. If we are afraid of increasing the court system's lawsuits, it seems like the appeal process is not dissimilar to what talked about when I was in the legislature: going to mediation before you filed a lawsuit. In that way it saves the cost of the lawsuit. You don't have to have an attorney in the appeals process in Texas?

Ms. BARRON. You do not have to have an attorney. I would say that one of the things we did do that we believe is very important is we gave the physician standing. I am sorry to hear about the kind of situation that Congressman Barrett referenced.

What we found more frequently was the situation where the physician wanted to advocate for the patient, but was told, "Doctor, you are not the one that has the contract with us. You go have the patient call us. The patient must write us. The patient must provide all this information." This was ludicrous. It took the doctor out of the loop in terms of being the direct advocate to be able to provide the clinical information directly to the health plan to help expedite the review. It is important that the physician can be the advocate for the patient and can conduct that appeals process.

Mr. GREEN. Thank you. Mr. Chairman. I know I am out of time. Let me just give a quick example of an experience I had.

Mr. BILIRAKIS. Very quick.

Mr. GREEN. Last year I spoke to the Harris County Medical Society. I was surprised, being a Democrat, being asked to speak to the Harris County Medical Society. I talked about my daughter had only been in medical school 2 weeks, so she is not ready to do brain surgery. After my speech one of the physicians said, "Your daugh-

ter, after 2 weeks in medical school, has more knowledge than the people I call to treat my patients." I think that is what the frustration is about: the need for this legislation for more than just an appeals process.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. Thank you. Mr. Shadegg.

Mr. SHADEGG. Thank you, Mr. Chairman. Let me begin by just walking through some points that I think we have some agreement on.

First of all, it is my understanding that every single one of you believes—I think I might even be accurate in saying believes strongly—that there should be an internal appeals procedure, followed by an external appeals procedure. The external appeals procedure needs to be independent. It is a critical part of the process in determining what care should or should not be delivered. Is that correct, Dr. Conway?

Mr. CONWAY. Yes.

Mr. SHADEGG. You agree with that. Ms. Barron, you would agree with that?

Ms. BARRON. I would agree.

Mr. SHADEGG. Dr. Weiss, you would agree?

Mr. WEISS. I would agree with that.

Mr. SHADEGG. Okay, and Dr. Grogg?

Mr. GROGG. I would agree with that, with the addition of in a timely manner.

Mr. SHADEGG. Okay, I fully agree with that. Now, I want to go over a second point on which think there is some confusion.

Several of you have talked about the various appeals procedures—external and internal—existing in various State laws. Some discussion has been of my home State, Arizona. I want to make it very clear. Ms. Barron, the definitive law in this area is coming out of the State of Texas at this moment, is it not?

Ms. BARRON. It appears that, yes, it will come out of the fifth circuit.

Mr. SHADEGG. And as we sit here today, the law is that the State of Texas cannot legally enact a law compelling HMO's or other providers to agree to an internal and external appeal procedure and have that be binding upon those HMO's as a matter of law, correct?

Ms. BARRON. That is correct.

Mr. SHADEGG. So Arizona can act. Texas can act. Florida can act. Every State can act, but it is meaningless, at least as to the ERISA population. Is that right?

Ms. BARRON. That is my understanding.

Mr. SHADEGG. It is my understanding that roughly 70 percent of all Americans who are covered by plans are covered under an ERISA plan. Is that right?

Ms. BARRON. Yes.

Mr. SHADEGG. So 70 percent of all Americans—you all agree—should have access to a binding external appeal procedure, but as a result of ERISA today, they do not legally have that. Is that not correct?

Ms. BARRON. That is right.

Mr. SHADEGG. Does anybody disagree with that?

Mr. CONWAY. They don't have that in Texas.

Mr. SHADEGG. Pardon me?

Mr. CONWAY. We do have that in Michigan.

Mr. SHADEGG. No, you do not. It is fascinating to hear that even some people on this panel don't understand. As a matter of law, you can pass a State statute in Michigan which gives to people not governed by ERISA a binding appeals procedure. That will be binding as a matter of law in Michigan on everyone who is not covered under an ERISA plan. Your HMO may choose voluntarily to extend that binding appeals procedure to ERISA-governed patients. You may choose to do that. But if you choose not to do that, then those 70 percent—roughly—of people in Michigan who are governed by ERISA have no access to a binding appeals procedure. But you think they should, correct?

Mr. CONWAY. They should. I am sure you know more about the law than I do. But in practical day-to-day activity, our members who are under ERISA plans can appeal. Now we may have voluntarily decided.

Mr. SHADEGG. You may have voluntarily decided. Not all HMO's have done so, which is why we are here. I think it is very important to understand that every single one of you agrees that this Congress should act to deal with the right of ERISA-governed patients to a binding internal and external appeal procedure, correct?

[All witnesses nod their heads indicating, "yes."]

Mr. SHADEGG. Everybody would agree with that.

Now, let me go to the next step. Is there anyone here who believes that, since there should be a binding external appeal procedure, that after that appeal procedure the HMO should be able to thumb its nose at the decision and say, "We had an external appeal procedure, but we just don't like. We are not going to follow it."? Does anybody think that should be the rule?

[All witnesses shake their heads indicating, "no."]

Mr. SHADEGG. Dr. Conway, you don't believe that?

Mr. CONWAY. The external appeal should be binding.

Mr. SHADEGG. It should be binding. Now, you testified at length about your concerns about liability. You would agree that tort liability, some kind of legal liability, must extend following the binding external appeal to force an HMO to abide by that appeal if it doesn't choose to do so. You would agree with that?

Mr. CONWAY. I think we would prefer putting into a regulation that the external——

Mr. SHADEGG. But what happens if they don't abide by the regulations?

Mr. CONWAY. If we regulate the fact that the external decision is binding, how can you violate a Federal law?

Mr. SHADEGG. Well, I guess there is really two ways. You have civil liability or you have criminal liability. Are you proposing that, instead of a civil liability for an HMO that ignores the decision of a binding external appeal, we should have a criminal penalty? I would suggest that is not a very good remedy.

It seems to me that what you are saying, Dr. Conway, is you don't want to have the legal system to go around the binding internal/external appeal. Your comments about not favoring liability would be limited to circumstances before somebody went through internal and external appeal. If they go through internal and exter-

nal appeal, and they get a decision, they ought to be bound and they ought to be liable for not complying with the decision of the external appeal panel. Would you agree with that?

Mr. CONWAY. Yes.

Mr. SHADEGG. You would agree with that.

Mr. WEISS. That would be, I believe, different than saying they are responsible for malpractice in that they are responsible for liability for not following.

Mr. SHADEGG. I believe Ms. Barron testified eloquently to the fact that the Texas law, which does what I just tried to describe—but regrettably, has been held to violate ERISA—does precisely that. It does not hold plans to a malpractice standard. It, rather, holds them liable under the Texas appeals procedure. Is that correct, Ms. Barron?

Ms. BARRON. That is correct. What it says is that as long as you did not act negligently—that would mean that you abided by the appeals process, met the time lines, disclosed all of the information—you did everything that a reasonable managed care organization would do in attempting to make sure that the right decision was made for that patient; that is the standard.

Mr. SHADEGG. With the Chair's indulgence, I would like to ask one last question on a different topic. Several of you expressed concern about the doctor/patient relationship. I am deeply concerned about the doctor/patient relationship. I would like to know the answer to two questions from each of you. Do you believe the doctor/patient relationship has been enhanced by the growth of employer-based health insurance, as opposed to individually purchased health insurance? Do you believe that the doctor/patient relationship has been enhanced, or damaged, by the prevalence of HMO's?

Mr. COBURN [presiding]. If we could have "yes-or-no" answers. The gentleman's time has expired.

Ms. BARRON. I would say as far as the enhancement of managed care, it has damaged the doctor/patient relationship. As far as the basis of the funding for the care, I would say that there has been some effect from that as well.

Mr. SHADEGG. Thank you. Anyone?

Mr. WEISS. I think from the employer-based it may have been there is more availability for health care through employer-based. I think that enhances the doctor/patient relationship. Without coverage, there is a stress in that relationship.

Mr. GROGG. I would suggest that the doctor/patient relationship has lost considerable—I think it has damaged the situation.

Mr. CONWAY. I think our first preference would be for individual health insurance decisions that would strengthen the relationship between a patient and a physician, provided in that arrangement that we can ensure people in this country are insured. The first preference is for universal coverage for the population.

Mr. COBURN. The gentleman's time is up.

Mr. SHADEGG. I appreciate the indulgence of the Chair.

Mr. COBURN. The gentleman from Texas, my friend, Mr. Hall.

Mr. HALL. Thank you, Mr. Chairman. I want to start out by apologizing to Connie. When I looked down as I was going to allude to you a while ago, I saw Connie Dunne. I wondered if anything

had happened since you last visit up here. I know I have transferred Phil Dunne's name to the end of your name.

That brings me to Phil Dunne, Mr. Chairman. I want to thank him. He is going to be on the next panel. He is a Texas Medical Foundation, CEO. He is very knowledgeable. He has served a lot of good purposes in our State.

Connie, you have, too. You have helped us. You have helped the blue dogs as they set out their legislative plans. I thank you for that.

You mentioned in your testimony that Texas' external appeals system was recently ruled to be preempted by ERISA. Go back to basics. Could you elaborate on this a little bit? What does that exactly mean—for the record?

Ms. BARRON. What Judge Gilmore ruled was that a State could not require a health plan to have an external review that was binding on them. That was the administration of the plan. It was a coverage decision; therefore, it was preempted by ERISA. What that would mean is that our external review process in Texas, and possibly, depending on how the law progresses, every external review process everywhere that a State would impose, would apply only to individual coverages and coverages of public sector, government employees. It would not apply to private sector employer-offered programs, be they self-funded or fully insured. Health plans would have to volunteer to participate in the external review. The State could not make them do it.

Mr. HALL. This opinion just seems to establish that ERISA plans don't have to participate in the State-run external review programs. Are ERISA plans required to participate in any external review at all?

Ms. BARRON. They are not, to my knowledge.

Mr. HALL. None at all?

Ms. BARRON. No. Not now.

Mr. HALL. Let us talk about how beneficial this shield is for insurance companies, and the effect of it. Do you have an opinion whether or not removing ERISA as shield for insurers, or the employee, agent, or servant of an insurance company who says a doctor says they have to be iced—the insurance company agent says it isn't covered. The doctor even puts it in writing that this could be life-threatening. They don't do it. Death ensues. Litigation is going to take place, is it? But who is the one person that will not be in the courtroom?

Ms. BARRON. Currently, the managed care plan would be, or the insurer would be the empty chair, if you will, in the courthouse.

Mr. HALL. I am a lawyer. I have two sons that are lawyers. I have represented insurance companies, and sued almost all of them at one time or another. Lawyers are going to sue somebody, aren't they, if you have a death like that?

Ms. BARRON. That is my understanding.

Mr. HALL. Who is standing there for them to sue? The doctor. The hospital administrator. The anesthesiologist. The circling nurse. On down the line. With a death or serious injury, they are going to recover from someone, aren't they?

Ms. BARRON. Yes, sir.

Mr. HALL. But the person that spawned this, that catapulted them into that courtroom, is not there. Do you see any unfairness in that?

Ms. BARRON. I would, if I could, say that there was one case in Texas some time back, Hand v. Tavera. It was a situation where a decision was made. Mr. Hand had a stroke and came to the emergency room. The treating physician in the emergency room said that he should be admitted because his blood pressure couldn't be controlled. The representative of the health plan said "Don't think so. We aren't denying treatment. We are only denying payment. We aren't going to pay for it, Mr. Hand." Mr. Hand said, "How much is it going to cost." The doctor said, "I don't know, maybe a few thousand dollars." Mr. Hand said, "I can't afford that, so I better go on home."

Even though the doctor told him to worry about payment later, Mr. Hand said, "No, I am responsible. I am a responsible individual. I don't think that I can pay for that. I will go home and hope that the health plan representative was right." He went into the parking lot. He had a massive stroke. He has been disabled since.

On the one hand, if a health plan makes a negligent decision that is irresponsible and financially motivated, they have no liability, in essence. They aren't held accountable for their decisions. If an individual makes maybe what isn't the best decision for—what I would consider the right reason—responsibility, but it is financially motivated as well, he can pay for it with his life. It seems that is an imbalance.

Mr. HALL. I have just one final question. We are discussing here as if this situation came up with every patient/physician relationship. Of course, it does not. I doesn't come up in 100 percent of the situations. I doesn't come up in 90 percent, 80 percent, 70, 60, 50, 40, 30, 20, 10, 5 even, does it?

Ms. BARRON. No, sir.

Mr. HALL. So really what we are talking about is just a few cases a year, or a small percent of the cases. Why wouldn't whoever is advising the insurance companies advise them, for PR purposes, it would be better for them to step up and not hide behind ERISA just because they can? I don't believe all of them are doing it. I don't believe that everybody that runs an insurance company is thinking that way.

Ms. BARRON. We think there is some very good managed care plans in the market. We believe that our laws in Texas exemplify the best practices of good managed care plans. That is why they have been successful.

Mr. HALL. I am still hoping that there be something worked out on this. I am still hoping that the companies who continue to pursue using ERISA as a shield will not do so, but will see the sensibility in coming together and giving us bill that they can live. I don't know if that is going to happen. I hope it will. There is still plenty of time. I would hope that the insurance companies don't lead the other entities like the chamber of commerce, NFIB, and others down this road, because it is not a good road.

Mr. COBURN. The gentleman is still my friend, but his time has expired.

Mr. HALL. The chairman is still a great man, even though he has cut me short. I yield back my time.

Mr. COBURN. Thank you for those comments. I recognize myself for 5 minutes.

Dr. Conway, I have some real problems with some of the things that you said. I think we need to distinguish. The two gentlemen here are from non-profit HMO's. Is that correct?

Mr. CONWAY. That is correct.

Mr. WEISS. That is correct.

Mr. COBURN. There is a big difference between not-for-profit HMO's and for-profit HMO's. That has not been put into the record.

I want to tell you, where I practice medicine, health care plans do make medical decisions. They may say they are not, but they do it every day. I just wonder if you and Dr. Weiss have read the bill proposed by Dr. Norwood, Mr. Shadegg, and myself on our external appeals procedure, the timeliness of it, and also the very high hurdle that there is not a lawsuit unless somebody can show an injury. Are you familiar with what we have proposed?

Mr. CONWAY. Yes.

Mr. COBURN. And what do you think of that?

Mr. CONWAY. I think we support it.

Mr. COBURN. So you support what we have proposed in terms of a limited liability as a way to hold plans accountable for external appeals process on a timely basis?

Mr. CONWAY. I think that is it.

Mr. COBURN. Dr. Weiss?

Mr. WEISS. I haven't seen the bill. As long as the internal process is done first, and then the external process is used in holding the plans liable for the determination of the external process.

Mr. COBURN. Let me ask this question as well: Dr. Conway, your plan is run by physicians. Is that correct?

Mr. CONWAY. That is correct.

Mr. COBURN. Do you find that different?

Mr. CONWAY. Let me just reinforce what I said earlier. If we restructured the way doctors could relate to health plans in this country, you would not have to pass all this legislation. You could allow them and the community to get together a negotiate with the health plan and say what is unacceptable medical practice.

Mr. COBURN. Or we could have them all do what you have done, and form their own HMO's with no change in the law.

Mr. CONWAY. Right.

Mr. COBURN. So there is an option for physicians to do that if they so desire. The other thing is that you can be tough and say you are not going to sign it. That is what we have done in a lot of the areas where I practice. We have had minimal penetration into HMO's. We haven't colluded at all. We are saying our patients are more important than the profits with the HMO's.

Dr. Weiss, is your HMO run by physicians?

Mr. WEISS. No, it is not. It is a not-for-profit health plan that is run by a community board.

Mr. COBURN. Okay. I am going to put this into the record. I would like your response. I will send you, through the committee, if I can have unanimous consent, the proposed consensus managed

care bill, and have you comment back in writing on our external and internal appeals process, which—I also might add—has inpatient-stay expedited appeal, so that somebody doesn't go home from the hospital when they should not be going home.

I also would like to read for you a very short—just what medical necessity we put in this bill. I want to see if you all have any problems with it.

We set the bill up as the insurance or HMO has to say up front what they cover. Then the standard we use as admissible evidence is the following: "Additional personal health and medical information supplied with respect to an individual whose claims for benefits had been appealed. An opinion of the individual's treating physician, or health care professional. An external appeals entity may take into consideration, but not be limited to the following evidence: the result of studies that meet professionally recognized standards of validity; the results of professional consensus conferences; practice and treatment guidelines prepared or financed in whole or by the part by a government agency; government-issued coverage and treatment priorities and polices; community standard of care to the extent that the entity determines it to be free of any conflict of interest, the opinions of the individuals who are qualified as experts in one or more fields, or the results of peer reviews conducted by the plan or issuer involved."

We also say that there has to be practicing physicians that are in that peer review panel. Would any of you disagree with what I just read as far as the determination of what should or should not be in the make up of how we make a decision on medical necessity and the panel?

Mr. WEISS. I would have no problem with what you have read, with the exception of where you bring up the community standard. The question there is: What is the community standard? Is it different than all of the studies that you have presented? Does that mean that since the community standard doesn't follow what the scientific information or evidence studies show, you can do it because we just do it this way?

I would hate to see a community standard that would be poor. If the community standard doesn't follow that——

Mr. COBURN. We would be happy to drop that. The community standard, most often, is following behind the lead of the centers like Henry Ford Hospital and some of these others where we are seeing more advanced techniques. So the question is it still should be considered, because it is considered in all the liability cases.

Just to extend the opportunity to answer the question, Dr. Conway? Ms. Barron?

Mr. CONWAY. I would tend to agree with Bruce. What you ran through—studies, guidelines, professional consensus groups, suggestions released from the government—are all objective things that you can get your hand around. What the community standard is is pretty tough to incorporate into decisionmaking around medical necessity.

Mr. GANSKE. Would the gentleman yield?

Mr. COBURN. Let me get the answers finished here, first.

Ms. BARRON. I would say that I would agree—with two caveats. One is to add that it is flexible enough to take into account any

specific or individual needs. I don't see a problem with the community standard being part of it for two reasons. One, it is already, as you mentioned, something that is considered in medical malpractice cases everywhere. If I had all the resources available to me, then it would make sense.

For example, if normally you would get an MRI before doing a particular surgery and you have an MRI machine available, then you get one. If you are in Bodinky, Texas, and the closest MRI machine is 400 miles away, all the clinical symptoms say surgery is warranted, the patient's condition is such, then I may go ahead and do that surgery and not ship him off 400 miles to get the MRI. So it is the resources available to you that sets the community standard.

Mr. COBURN. Dr. Grogg?

Mr. GROGG. I agree with the statement. I like it.

Mr. COBURN. Dr. Ganske, I would like to let Dr. Norwood go. Then if we have a moment, let you follow up with a question.

Mr. GANSKE. I was not going to ask questions, just make a simple comment. It is that the operative words in that definition are "shall take into consider, but not be bound by." It doesn't give any preferential thing. Does that make you feel more comfortable with those?

Mr. WEISS. I just didn't want that statement to exempt everything else.

Mr. COBURN. Thank you very much. Dr. Norwood.

Mr. NORWOOD. I would like to ask the panel a question. I would like for you to listen to this first statement.

"No one would argue with the right of injured patients to seek redress." Would any of you argue with that?

Ms. BARRON. I would not.

Mr. CONWAY. No.

Mr. WEISS. No.

[Dr. Grogg is out of the room.]

Mr. NORWOOD. Everybody tends to agree?

Ms. Barron, probably the wild, wild west in Texas was at its height some 100 years ago. We solved a lot of problems out there with six-guns. We have sort of gotten away with that.

Now if you feel your child has been injured, we tend the best thing to do is not go get your six-gun, but perhaps use the judicial system. Does everybody still think that is an okay way to go in 1999?

Let me ask you a question about liability. Let us assume that when we pass this bill, Dr. Conway—and we are going to—we pass all of it but the liability part. Do you think the subject is over, then? Does that mean those of you who are against us having any redress in court if a patient has been harmed, if we don't get it in this bill, the subject is done?

Mr. CONWAY. I don't know what the subject——

Mr. NORWOOD. I am sorry. I must have not said it well. Do you believe that when we get through passing this bill, the liability part of the bill—not external review—the ability to go to court is over in this country?

Mr. CONWAY. Yes. I think we would get the same result they were talking about in Texas. I think the effective piece in what is

going on in Texas was the requirement for mandated external review.

Mr. NORWOOD. So this will all go away if we pass all of this except the liability? We will not hear about that again?

Mr. CONWAY. I would predict that is probably true.

Mr. NORWOOD. Well, I would predict to you that it may be in Congress. Then you are going to get some liability that you are going to love. The circuit courts are going to give it to you. We are going to let the lawyers hand it to you. I have a hunch—it is only a hunch; I can't prove it—that they are going to give it to you in ways you really will not like. Perhaps we ought to consider dealing with people who do love you. I think for you to keep this out of our legislation and everything is lovely and wonderful—it will not be for long. It will be a lot worse than any of you ever dreamed.

Those of you that looked at Dr. Coburn's consensus bill, which has external review language that is outstanding, do any of you believe that it will be anything but very, very difficult to be negligent if you use that program?

Mr. WEISS. I think that may, in fact, assist the plans in that if you go through that process, and in the external review by experts they agree with the health plan that something is not covered; that provides relief to the plans. They have gone outside it. Their denial of the services or the requested care has been upheld by outside people saying that is a reason.

Mr. NORWOOD. Yes. You can blame it on somebody else. I understand.

Mr. WEISS. Well, if someone else has said they agree with the plan, that is correct. If they came back and said they disagree, then, obviously, the plans need——

Mr. NORWOOD. Therefore, if and when we end up with this very narrow liability, we can't be talking about many people.

Dr. Grogg, did you carry malpractice insurance?

Mr. GROGG. I am sorry?

Mr. NORWOOD. Did you carry malpractice insurance?

Mr. GROGG. Yes.

Mr. NORWOOD. Did it cost you a lot of money?

Mr. GROGG. Yes.

Mr. NORWOOD. Why didn't you quit practicing medicine?

Mr. GROGG. I love to care for patients.

Mr. NORWOOD. I am sorry?

Mr. GROGG. I love to care for patients. As a pediatrician, I don't have to go to work. I just go play.

Mr. NORWOOD. I appreciate that. Still, it cost you a lot of money. You loved your patients so much that you were willing to pay out this goodles of money.

I will not get into all this, because I think a lot of studies you can make them be anything you want to make. But I find it pretty interesting that Milliman and Robinson, along with four other studies, is predicting that we may be actually talking about 34 cents per month per patient in order to allow those very narrow, few patients who really have been wronged to be able to use our justice system. I will make this available to you if you want. I think that is not unreasonable. I don't believe so at all.

Mr. Chairman, I just want to quickly finish up. Let me just mention about this Harvard study that was in 1991. Dr. Conway, please make available to us exactly what that Harvard study is, so that we can look. I have a pretty good idea that you are just finding there that, at the end of the day, the lawyers get the money, not the patients. I think that is probably what the Harvard study is.

I just want to say to you that you are right in some of things you say. Only physicians are trained and licensed to render clinical decisions, which would make me believe that you think the definition of "medical necessity" should stop with primary health care doctor. If they are the only ones who can do it, why don't they get simply the decision of what medical treatment is needed?

Mr. CONWAY. The primary care physician?

Mr. NORWOOD. Yes. We don't need all these reviews. Leave it up to the doctors. You said in your statement: Only physicians are trained and licensed to render clinical decisions. Fine. Let us simply say that they primary health care physician will do just that.

Mr. CONWAY. That is how we think it should be. Plans have to decide what is a covered benefit in some of the things that plans do.

Mr. NORWOOD. Yes, they do have to decide what is a covered benefit. But a lot of times you decide what is a covered benefit that is a covered benefit, and medically you say it is not needed. So that means the physician is not making the statement; a great accountant is. That is not the way to do it—according to you. Only physicians are trained and licensed.

Mr. COBURN. Would the gentleman like to make unanimous request to leave the record open to ask for further question in written form to our panel?

Mr. NORWOOD. I would indeed, Mr. Chairman. I know you are coming with that hammer.

Mr. COBURN. Without objection. I thank the gentleman. I thank the panel.

One other thing needs to be put into the record that has not with this one. I apologize for taking 30 seconds to say this. Binding external review lowers costs, increases quality, and makes physicians better. It does not raise costs. It will lower costs. If you think about a physician who is going to appeal and doesn't have his act together, he is only going to appeal once. They are not going to go up there and look foolish again.

Second point is, if a doctor appeals, or fails to appeal on something he should, he is liable. So we increase accountability on the physicians. We decrease costs. We improve quality care, both for the managed care company and for the physicians that are doing it.

I thank the panel. We will seat immediately the second panel. Thank you.

On behalf of the chairman, again, let me apologize for the lengthy course we took with the first panel. Welcome to our three panelists. Mr. Larry Atkins, President of Health Policy Analysts; Mr. Philip Dunne, with the Texas Medical Foundation, and Ms. Sara Rosenbaum, Director of the Center of Health Services Research and Policy. Welcome.

Mr. Atkins, you are recognized for 5 minutes.

STATEMENTS OF G. LAWRENCE ATKINS, PRESIDENT, HEALTH POLICY ANALYSTS, INC., ON BEHALF OF CORPORATE HEALTH CARE COALITION; SARA ROSENBAUM, DIRECTOR, CENTER FOR HEALTH SERVICES RESEARCH AND POLICY; AND PHILIP K. DUNNE, CHIEF EXECUTIVE OFFICER, TEXAS MEDICAL FOUNDATION

Mr. ATKINS. Thank you, Mr. Chairman. Mr. Chairman and members of the committee, my name is Larry Atkins. I am President of Health Policy Analysts, Incorporated, a Washington-based consulting firm. I am testifying today in my capacity as coordinator of the Corporate Health Care Coalition.

The Coalition is an alliance of 25 companies, formed in 1993 to reflect the views of large, multi-state, self-insured companies on national health care policy. Coalition members cover over 6 million lives, and provide over $12 billion in benefits annually. They have been in the forefront of health plan quality initiatives.

I appreciate having the opportunity today to appear and address the question of accountability for health care decisions, and the benefit of an external medical review process. Accountability at all levels of the health care system is what employer initiatives in quality measurement and purchasing are all about today.

Employers moved to managed care to increase the accountability of physicians and hospitals. They rely on the health plans to identify the best providers and practices, and wean the system of outdated, unnecessary and inappropriate medical care. Employers use purchasing standards, comparative measures of performance, plan accreditation, and a variety of other methods to hold health plans accountable for performance and patient outcomes.

ERISA, the Federal law much maligned in the last few minutes, governs our plans. It is an important part of the accountability picture. ERISA requirements for information disclosure, fiduciary duties, liability, claims procedures, and judicial remedies are substantial tools for participants to use in obtaining the benefits their employer plans provide.

With that in mind, ERISA's claims review requirements have not kept pace with the changes in claims determinations brought on by the growth of managed care. Coverage decisions are now often made before treatment is rendered. With comprehensive benefits, more decisions are made on the basis of medical necessity, than on the basis of overt plan coverage limitations. In response, employer plans and their claims administrations today process claims more rapidly than ERISA requires, and often provide independent external medical review of significant contested medical necessity denials.

Employers have found that independent medical review is an effective way to resolve significant coverage issues involving medical treatment questions. It can instill confidence in plan enrollees that the plan will cover the most effective treatment. It ensures that medical necessity decisions remain medical, using expert medical judgment and medical evidence. It is independent of the plan and its financial incentives. It renders the decision promptly, when the participant can still benefit from treatment.

An external review process and Federal law would provide universal procedures for resolving difference in medical opinion on medical necessity. Any Federal requirement for ERISA or other plans should provide a uniform Federal process that is consistent from State to State, and preempts State processes. It should be the last word on treatment. If the medical judgment is sound, there should be no value in second-guessing it in the courts before juries.

Some patient's rights bills include a statutory definition of medical necessity to serve as a touchstone for external review. A statutory standard for medical necessity is dangerous idea. The standard these bills would use—generally accepted medical practice—is borrowed from medical malpractice defense, as you have heard from the previous panel. It is the lowest common denominator of medical practice. You can't fault a physician who is only doing what everyone else does. External review decisions should rely on the best medical knowledge—the kind of review standard you have in your bill, Mr. Chairman.

A statutory standard is useless in external review anyway. The reviewer would still have to decide what generally accepted medical practice was. External review itself provides the objective standard for medical necessity. It is the process by which an expert with knowledge of the state of medical practice and knowledge selects the most appropriate treatment by referencing the best medical evidence.

State tort liability for coverage decisions is another very dangerous idea. Sending a patient into litigation for 3 years does little to get him the treatment he needs now. The only point of punitive damages is to create a hammer to scare plans. Recent punitive damage awards involving State employee plans—for example, the settlement recently against Aetna in California of $116 million—make it clear that liability for coverage decisions sends all the wrong signals to health plans. In these cases, juries disregarded external reviews, consensus guidelines, and clear medical evidence in punishing plans for denying what actually had been shown through external review to be ineffective and inappropriate treatment. The message liability is sending to the plans is to approve everything because only blanket approval can protect the plan from the wrath of a jury.

Some of the patient's rights bill try to exempt employers from liability. I just want to make the point quickly that we don't believe that is possible. I can explain in answers to questions.

I want to close by making a simple comment about the issue of cost of liability in Texas. I think there has been some misunderstanding about that. First of all, the Texas liability law, because of the way the district court interpreted it, did not actually change the way the Federal courts have been reviewing these cases anyway. So the case that came forward, which was a Medicare case, after the Texas liability law was passed was treated the same way as cases that came before the liability law was passed. So the fact is, there is no costs to the Texas liability law, because it didn't really change the situation. In fact, that Medicare case was decided on the basis of four previous Medicare cases, not on the basis of the Texas law, itself.

Ironically, health plan liability will lead to a reduction in the accountability of health plans to employers, because the employers will reduce their selection and plan comparison efforts because of the danger that they would be considered to be exercising discretion.

Mr. Chairman, that is all I really have to say. I appreciate the opportunity to testify. Thank you.

[The prepared statement of G. Lawrence Atkins follows:]

PREPARED STATEMENT OF G. LAWRENCE ATKINS, PRESIDENT, HEALTH POLICY ANALYSTS, INC. ON BEHALF OF THE CORPORATE HEALTH CARE COALITION

Mr. Chairman and Members of the Committee: My name is Larry Atkins. I am President of Health Policy Analysts, Inc., a Washington-based consulting firm. I also serve as the Coordinator of the Corporate Health Care Coalition (CHCC).

The Coalition is an alliance of 25 companies formed in 1993 to reflect the views of large, multi-state, self-insured companies on national health care policy. Coalition members operate health benefit plans for employees and their families as well as retirees, covering over 6 million lives and providing over $12 billion in benefits annually. They have been in the forefront of efforts to provide high quality and cost-effective benefits for employees. Coalition members have extensive experience in designing, administering and delivering employee health benefits, and are a major force today in ongoing efforts to improve the health care system.

I am here today to address the question of health plan and provider accountability and the role of external, independent medical review in improving accountability.

I. ACCOUNTABILITY OF PLANS AND PROVIDERS

From an employer perspective, health plan accountability is created through the purchasing and oversight activities of employers. Employers have expended considerable effort to increase accountability for the quality of medical decisions and patient outcomes at all levels of the health care system: health care professionals, health facilities, and health plans. CHCC companies have sought provider accountability through the managed care activities of health plans, and have sought plan accountability through the development of quality measures and the application of quality indicators as a factor in selecting health plans for employees.

The employer view of accountability is proactive. Quality needs to be built into health care from the front end: through clinical research to develop medical evidence on effective treatments, through development of guidelines and protocols, through selection and training of practitioners, through financial incentives that encourage quality, through monitoring and feedback on patient outcomes, through better comparative information for participants. Quality and accountability can not be built from the back end—through the threat of litigation and punitive damages for lapses in quality. We believe in incentives to discover what works and to apply the right treatment in the first place, rather than disincentives based on searching for the mistakes and seeking retribution for them after the fact.

A. Accountability through Managed Care

Organized health care delivery systems and managed care developed originally as part of an effort to bring accountability to medical practice. In fee-for-service medicine, solo practitioners were on their own to keep up with innovation and were specifically accountable to no one for the quality of their work. Managed care was intended to develop a system that routinely applied new knowledge to medical practice through the development of guidelines and protocols based on medical evidence in an effort to improve the quality of medical decisionmaking. The move toward "evidence-based medicine" has been the effort to subject medical treatment decisions to the test of what has been shown to work best.

Employers moved decisively to managed care plans in the mid 1980s to find efficiencies in health care that could lower costs and improve quality. The shift was a response to double digit medical inflation driven in part by excess capacity and increasing utilization; financial incentives in fee-for-service medicine that encouraged over-utilization; and research by the RAND Corporation showing that one-third of the health care in the U.S. was unnecessary and inappropriate. Employers believed that better patient outcomes and more cost-effective care would result from a change in the financial incentives to encourage management of care delivery.

The basic ideas behind the move to managed care are consistent with consumer protection initiatives at the state and federal level today. They include:

* *Creating a single point of accountability*—In an indemnity world, patients coordinate their own care, moving from provider to provider. In a managed care environment, a health plan can be accountable for the procedures and outcomes for its enrolled population. Purchasers can set targets for the health plan and expect the organization to manage its members to meet those targets. Patients can have a single primary physician coordinating their care. This single point of accountability has created a more intense focus on health care quality than existed in a purely indemnity/fee-for-service environment.
* *Shifting the focus from input to outcome*—Services in an indemnity system were evaluated on the basis of the input—the volume and type of service provided—without being able to know the ultimate impact on the patient's health. The service integration and improved patient record keeping of managed care makes it possible to manage and evaluate patient care on the basis of whether the patient's condition improves.
* *Shifting from static quality to dynamic quality*—Quality in an indemnity system was a state of practice that remained unchanged once attained—it was a function of the physician's training or the character of the health care facilities. The shift to organized service delivery with performance and outcome measures, has made quality a constantly evolving goal. Providers are encouraged to share information, learn from their collective experience, rethink their practices, and respond to new guidelines and protocols.
* *Reliance on "benchmarking" and "best practices"*—In the competitive world of managed care, no organization can assume that they are doing the best possible job. Plans can be compared to one another, and plans that have done the best job of treating a particular illness or attaining a particular health status for their population can be held out to others as an example. Purchasers can require visible progress on specific health problems as a condition for being awarded a contract. The whole concept of quality-based competition requires an organized system that can pursue strategies to achieve specified results.

Purchasers have seen in managed care the opportunity to improve the value they receive for their health care dollars. With a single point of accountability, employers and employees can compare the performance of plans, select plans that show evidence of meeting certain performance targets, choose the more effective plans and providers, and encourage ongoing improvements in quality and efficiency.

B. CHCC Companies Pursue Health Plan Accountability

CHCC member companies are in the forefront of efforts to purchase health benefits on the basis of quality. Given the diversity of industries and types of workers in CHCC companies, a "one-size-fits-all", "cookie-cutter" approach does not work. Member companies approach quality purchasing in a variety of ways that give testimony to the innovation that has developed among private purchasers. The following provides only a sample of the quality-based purchasing activities of CHCC member companies.

1. Plan Accreditation—Many companies require health plans to have National Committee for Quality Assurance (NCQA) accreditation or be in the process of pursuing accreditation as a condition for purchasing. Employers have worked closely with NCQA in developing accreditation standards for health plans. A number of companies also require or review Utilization Review Accreditation Commission (URAC) and the Joint Commission on Accreditation of Healthcare Organizations (JACHO) accreditation.

2. Purchasing Standards—Some companies set performance standards for health plans they offer. These standards may be extensive—covering such things as standard benefits, governance, financial solvency and fiscal operations, access, credentialing, network requirements, data monitoring and evaluation, UR and claims processing, grievance and appeals processes, quality assurance processes, and a number of other factors. Some companies require health plans to operate a program of continuing quality improvement or continuing targets for quality.

3. Employee education—plan comparisons—Employers in the CHCC offer choices to their employees and provide their employees substantial comparative information to select plans. Some companies provide a benchmarking process in which they compare each plan's results to results for a designated "preferred plan" on a number of dimensions, including: employee satisfaction, provider access, network coverage, and HEDIS (Health Plan Employer Data and Information Set) measures. Other companies provide an HMO fact sheet or simplified report card, with exceptional plans identified.

4. On-Going Quality Improvement Activities—Some companies work closely with their plans on efforts to identify best practices and modify plan practices to meet agreed upon performance targets. Others help their plans develop an action plan for

correcting problems identified in employee satisfaction surveys. One company provides incentives for health plans that meet their targets, works on improvement plans with the health plans that are mediocre, and eliminates poor plans from their group of suppliers.

5. Prevention and Disease Management Programs—Some companies require that plans adopt specific preventive services and disease management programs. Others develop preventive and disease management programs in conjunction with their plans. Disease management programs have been effective in dramatically improving health outcomes and reducing medical costs for chronically ill patients with specific medical problems.

6. External Review—Most companies provide for external review by qualified outside medical groups in cases where an employee contests a coverage decision with regard to significant medical treatment issues. The external review addresses medical treatment issues raised by the case and is advisory to the plan in making a final coverage decision.

7. Centers of Excellence and Specialized Providers—Most employers have contracts with treatment centers that have specialized in specific procedures and have a high volume of cases, evidence of high quality, and a willingness to contract for comprehensive treatment of particular illnesses. These centers can improve patient outcomes and manage overall costs of expensive medical care.

II. CLAIMS AND APPEALS PROCEDURES

The Employee Retirement Income Security Act of 1974 (ERISA) provides a structure of responsibilities, rights and remedies for the employer's sponsorship of employee benefits. The purpose of ERISA is to protect benefits that are promised by employers to participants. In the enactment of ERISA, Congress acknowledged that the employer's sponsorship of health benefits was voluntary and a matter between the employer and employee. The role of federal law was not to specify what was in that agreement—but to ensure that if there was an agreement, it had to be understandable to the parties and enforceable.

Employers, as voluntary sponsors of health plans, and their benefits administrators have the responsibility for designing the health plan, determining the benefits that will be provided under the plan, and determining that a claim is made for an item or service that is covered under the plan. ERISA was intended to provide a "toolkit" to employees to help them obtain their benefits: information and disclosure, fiduciary obligations of the sponsor, rights to benefits, and remedies for participants.

A. ERISA Requirements for Claims Processing and Appeals

ERISA imposes a number of the information and procedural requirements on plan sponsors to protect participants. CHCC member companies operate their claims processing and appeals procedures to meet the needs of their employees for prompt and fair decisions. Their procedures easily meet ERISA requirements. Several of the information and procedural requirements sought in the Patients' Rights legislation are further enhancements of requirements already imposed by ERISA. ERISA's statutory and regulatory requirements include:

- *Information to participants on their rights and the appeals process*—the ERISA statute requires that plan sponsors provide each participant with a summary plan description (SPD). The SPD must be "written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants of their rights and obligations under the plan." [ERISA § 102(a)(1)]. The plan description and SPD must include "... the procedures to be followed in presenting claims for benefits under the plan and the remedies available under the plan for the redress of claims that are denied in whole or in part." [ERISA § 102(b)].
- *Fiduciary Duties and Liability*—the ERISA statute requires that a plan fiduciary: "... discharge his duties with respect to a plan solely in the interest of plan participants and beneficiaries and—for the exclusive purpose of... providing benefits to participants and their beneficiaries." [ERISA § 404(a)(1)]. A fiduciary is personally liable for any breach of any duties imposed by ERISA. These duties include fair and consistent administration of the claims and appeals procedures required under ERISA. Courts can override decisions of a plan fiduciary or remove a fiduciary who fails to perform these duties.
- *Claims Procedures*—the ERISA statute requires that a plan:
  "(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

"(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." [ERISA § 503].

Department of Labor (DoL) Regulations [29 CFR Sec. 2560.503-1] provide a specific set of requirements for claims determinations and review procedures. The regulations require:

- A plan must have a reasonable claim filing procedure
- If a claim is wholly or partially denied, a notice must be furnished to the claimant with a reasonable period of time, but not more than 90 days after receipt of the claim (unless special circumstances warrant an extension of time for processing the claim).
- The written notice furnished to the claimant must include, in a manner calculated to be understood by the claimant:
  - the specific reason for the denial, a reference to pertinent plan provisions,
  - a description of additional material needed to perfect the claim, and
  - information on the steps to be taken if the participant wishes to submit the claim for review.
- A plan must establish and maintain a procedure by which a claimant or authorized representative has a reasonable opportunity to appeal a denied claim.
- The review procedure must include provisions allowing a claimant to:
  - Request a review in writing;
  - Review pertinent documents
  - Submit issues and comments in writing.
- The period within which the plan can require the participant to file the request cannot be shorter than 60 days after receipt of written notice of the denial.
- A named fiduciary must render a decision promptly, and in no case may respond later than 60 days, unless special circumstance require an extension of the review time).
- Notification of the decision on the review must be in writing and must include the specific reasons for the decision written in a manner to be understood by the average plan participant and include specific references to pertinent plan provisions.

- *Judicial Remedies*—Once the participant or beneficiary has exhausted the internal appeal process, ERISA statute [§ 502] enables the individual to bring a civil action in federal court against the health plan to:
  - Recover benefits due under the terms of the plan;
  - Enforce rights under the terms of the plan; or
  - Clarify rights to future benefits under the terms of the plan.

The time limits required by DoL for processing claims and appeals are outside time limits. With improved information systems and changes in claims processing techniques, health plans today typically process claims more rapidly than required by the Department. CHCC member companies typically require claims processing contractors to meet specific timeframes in processing claims and deciding appeals that are significantly faster than those specified in the regulations.

B. The Impact of Managed Care on Coverage Decisions

The emergence of managed care has brought significant changes in the nature of claims review and coverage decisionmaking. ERISA was enacted when indemnity plans were dominant, and patients typically submitted claims to the plan after receiving medical care and paying the physician and hospital themselves. Managed care has moved toward comprehensive benefits covering medical treatment for the whole patient, and has sought to improve care by eliminating inappropriate or ineffective treatment that was common in a fee-for-service environment. As a result, managed care has placed a greater reliance on determining the appropriateness or medical necessity of treatment at the point of care. The effort to remove inappropriate and unnecessary care has led to an increased the reliance on scientific evidence of effectiveness as a factor in coverage determinations.

By integrating the insurance and service delivery functions, managed care moved toward prospective decisionmaking on coverage and treatment and away from the retrospective claims adjustment that was characteristic of indemnity coverage. The shift to prospective review has necessitated a faster decision on coverage issues where treatment is urgently needed and prior approval is required for coverage.

The changes brought by the growth of managed care have raised a number of issues with current federal law requirements for claims review and appeals. One set of issues relate to the adequacy of current regulatory timeframes for review, given the shift to prior approval. The second set of issues relates to the need to ensure that medical necessity and appropriateness decisions are evidence-based.

Employers have invested in the effort to improve the accountability of providers and plans for the quality of medical care and ensure that decision making is based on the best medical evidence available. Changes in the process for resolving coverage questions should ensure that we continue to move in both coverage and treatment decisions toward a reliance on "evidence-based medicine."

III. MEDICAL NECESSITY DETERMINATION

All health plans provide access within limits to medical care. Plans have specific exclusions from coverage (e.g. cosmetic surgery) or coverage limitations for some services (e.g. one influenza vaccine annually for adults over age 65; up to twenty outpatient mental health visits per year). Plans will additionally exclude any covered item or service that is not medically necessary or appropriate. With the move to comprehensive benefits, there is increasing emphasis in coverage determinations on the decision about what is medically necessary and appropriate care.

All plans—including Medicare and Medicaid—rely on judgments about medically necessary and appropriate care to avoid paying for outdated procedures or for untested medical technologies while, at the same time, readily incorporating major innovations in health care treatment that are shown to work. Decisions on medical necessity are the means by which plans eliminate inefficiencies, lower costs, and improve quality of care.

Quality is a central focus of medical necessity decisionmaking. The Institute of Medicine National Roundtable on Health Care Quality[1] recently identified several areas of major quality problems in medical treatment in the U.S. where guidelines based on medical evidence and applied through medical necessity determinations could improve the quality of medical care. Medical necessity determinations are also important in the effort to correct some of the geographic variation in medical treatment. Medicare relies heavily on medical necessity determinations to reduce overutilization, unnecessary care, and fraud.

A number of the Patient Bill of Rights bills include a provision that would establish a statutory definition of "medically necessity or appropriateness." Generally this provision has two parts: 1) it states that a plan: "may not arbitrarily interfere with or alter the decision of the treating physician. . . if the services are medically necessary or appropriate for treatment or diagnosis . . ."; and 2) it defines define medical necessity or appropriateness as: "a service or benefit which is consistent with generally accepted principles of professional medical practice."

The intent of this provision is to ensure that: ". . . an insurer [can] set aside the recommendations of a treating physician only in restricted circumstances.[2]" Advocates of a medical necessity standard contend that the standard would: prevent plans from denying benefits based on "arbitrary" plan guidelines; provide a standard for external review decisions; and shift the burden of proof in external review or judicial action to the plan.

The statutory definitions of medical necessity offered in these bills would seriously jeopardize the efforts of employers and health plans to improve health care quality. Health plans would be limited in their ability to deny coverage for the recommendation of a treating physician as long as that recommendation was consistent with "generally accepted principles of professional medical practice," regardless of guidelines or protocols to the contrary.

With no arbiter of "generally accepted principles", any practice a treating physician contended was "generally accepted" would be medically necessary unless the plan could prove it was not. Where there were genuine differences of opinion among specialists about treatment (where each alternative could be considered "generally accepted") the choice of the treating physician would prevail, regardless of the medical evidence. The consequences for health care quality could be significant:

A statutory definition of medical necessity would have no real value in establishing a standard for external medical review. Any external review procedure enacted by Congress would create its own standard of review for the independent medical reviewers. By basing the decision of the independent reviewer on an assessment of plan guidelines, treating physician recommendations, external guidelines and protocols, and medical evidence, the conclusion of the medical reviewer would become the definition of medically necessary care.

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[1] MR Chassin, RW Galvin, and the National Roundtable on Health Care Quality. The Urgent Need to Improve Health Care Quality. Journal of the American Medical Association. 280:1000-1005; September 16, 1998.

[2] S. Rosenbaum, D. Frankford, B. Moore, P. Borzi. "Who Should Determine When Health Care is Medically Necessary," *New England Journal of Medicine.* 340:229-232. January 21, 1999.

Even with a statutory definition, the concept of "generally-accepted medical practice" would have to be defined in external review by the reviewer. The level of care suggested to the reviewer by a standard of general practice would be less advanced than the level of care identified through a review of the current medical literature and the consensus opinions of leading experts.

Concerns about who makes medical necessity decisions and about the basis for those decisions can be more effectively addressed through an independent, external, evidence-based review of the medical decision than through a rigid, statutory definition of medical necessity.

IV. INDEPENDENT, EXTERNAL REVIEW

Many health plans today will conduct an independent, external review of significant medical necessity, appropriateness, or experimental treatment decisions. External review, properly designed, is a more appropriate way to ensure timely accountability of health plans for coverage and medical necessity decisions than state tort liability and punitive damages. External review ensures that medical necessity decisions will be evaluated by medical experts on the basis of the best medical evidence. It is consistent with the employers' interest in paying for what works and not paying for what doesn't work in that it confirms plan decisions upheld by medical evidence and overturns those that are not.

External review, however, should be limited to medical treatment issues. It should not become a means to rewrite or expand a health plan's terms and conditions of coverage or bypass its provider networks. Plan administrators under ERISA are charged with the responsibility for consistent interpretation and application of the plan document. External interpretation of the terms of the plan could relieve the fiduciary of this obligation, and expose participants to wide variation in the application of plan benefits. Questions of eligibility for benefits, limitations on benefits, exclusions of specific items or services from coverage, in- or out-of-network use of providers, and other issues that do not involve medical judgement should not be subject to external review.

—External review should be a medical, evidence-based review that resolves tough medical necessity questions. It should not be used as a way to challenge a plan's explicit limitation in coverage or exclusion of a treatment.

—External review should be limited to treatment issues where there is substantial cost for the treatment or substantial risk to the participant's health. It should not be available to review denials of payment for small amounts where the cost of reviewing the denial exceeds the amount in dispute. Without a limitation to significant issues, external review merely becomes a weapon to force plans to pay for small claims for inappropriate treatment. If external review becomes impractical or expensive, it will force plans to explicitly limit coverage to avoid these issues.

—External review should uphold the plan's decision on medical necessity unless the reviewer determines on the basis of the medical evidence that the denied item or service would be of substantially greater benefit to the patient. In arriving at this judgment, the reviewer should take into account the full array of scientific evidence and practice experience that can be instructive.

—External review should be a uniform process available on a consistent basis nationwide. Any federal rules should clearly preempt state procedures to avoid confusion by participants, duplication of procedures, or conflict of jurisdictions.

—An independent, external review that is evidence-based should fully resolve the coverage and treatment questions. Access to judicial review (other than through existing ERISA remedies) would throw these evidence-based judgments before untrained parties in an adversarial environment and undercut the objectivity achieved through the external review process. If the best-informed judgment available is to be made by a qualified external panel, there should be no value in second-guessing this medical judgment in state courts before juries.

Employers have had a largely positive experience with voluntary external review to date. The responsibility for sending a case to review usually rests with the contracting health plan or insurer, although employers may request reviews of decisions made by a plan or insurer. Cases requiring external review are often sent to academic medical institutions or Centers of Excellence that specialize in treating the patients' condition. The cases frequently involve choices among alternative treatments where practice standards or best practices are not clear and where an opportunity for independent medical review by a well-qualified medical expert can be of value to health plans and enrollees alike. Medical reviews focus on the questions of efficacy and cost-effectiveness of the treatment, general acceptance of the treatment in the medical community, and suitability of the particular patient for the

treatment. The results of reviews tend to be fairly even handed, overturning plan decisions about as frequently as they uphold them.

State external review programs that apply to state regulated plans have begun to emerge in the last few years. Until recently, only Michigan and Florida had established external review programs. At the beginning of this year, however, 17 states had external review requirements on the books, with many of them just beginning to implement the first reviews. The results of state external reviews appear to mirror the employers' anecdotal experience—depending on the state, between 40 and 60 percent of reviews are decided in favor of the consumer.

While external review programs vary substantially from state to state, the general experience of the states suggests that external review is a quick and fair way to resolve significant medical treatment questions in involved in plan coverage decisions. These reviews work because, in most cases—including Medicare and private group plans—the decisions of the reviewers cannot be challenged in state court and undercut by a jury.

V. HEALTH PLAN LIABILITY FOR COVERAGE DECISIONS

Currently under ERISA, participant suits on benefit issues are tried in federal court and damages are not available. Similarly, Medicare and Medicaid beneficiaries, federal employees, and military personnel have remedies available under federal law, with access in certain circumstances to federal courts once internal appeals are exhausted. Participants cannot bring an action for benefits in state courts under state tort laws for denial of plan benefits.

Several Patient's Rights bills would waive ERISA preemption of state causes of action to permit participants in employer-provided health plans to sue the plan in state court for harm allegedly caused by an adverse benefit denial. The effect of these provisions would be to permit lawsuits for coverage decisions to go forward in state court, with access to jury trials and punitive damages. Some of these bills would also attempt to protect the plan sponsor (the employer) from liability for decisions made by the health plan.

The coverage decisions at issue are the most difficult decisions to make in health care. They relate to treatments that may have a very small chance of success for a critically ill patient with little hope of survival, at a very substantial cost to the plan. They relate to treatments where experts disagree and there is no consensus on a widely-accepted standard of care. They relate to emerging untested treatments where there is no evidence of success and questionable value for a patient.

Adding substantially to the liability for claims decisions and enabling patients to bring these questions before juries with large punitive damage awards is the wrong way to resolve these difficult questions. It is often after-the-fact—of little value to the patient. It is punishing the plan for what medical science cannot do.

Tort liability for health plan coverage decisions would enable physicians who resist plan guidelines and accountability to encourage retaliatory lawsuits for adverse coverage decisions. It would encourage physicians with a financial stake in untested new treatments to encourage suits to discourage plan denials of coverage. Indeed, any effort of a health plan to bring a more systematic and disciplined approach to medical decision making could conceivably be challenged.

* Patients could sue a health plan if they believe that a better outcome would have resulted from a different treatment, regardless of whether the treatment they received was the most effective known therapy for their condition.
* Patients could sue over the use of protocols or guidelines, no matter how well designed they were, if treating physicians could be found to disagree with them.
* Patients could sue to punish plans that followed the right process in making medically-based decisions, if the provider or patient disagree with the decision.

Creating new avenues for litigation would not begin to solve the immediate problem for the patient—the need to get the best treatment when it can still do some good. Litigation would only offer the patient or their survivors hope after-the-fact.

Creating health plan liability for coverage decisions in state court will set changes in motion that will have the reverse effect of what the advocates of liability seek:

—It will reduce health plan accountability by reducing or eliminating the quality assurance and plan selection activities of employers;
—It will encourage plans to approve all treatments, and create a disincentive for quality improvement and evidence-based decision making by health plans.
—It would discourage plan sponsorship by employers and lead to a reduction in the availability and quality of health benefits to employees.

Before the Congress sets forces in motion that will erode health care coverage further, we urge you to carefully weigh the consequences of creating liability for benefit decisions.

1. **Employers who sponsor health plans cannot be protected from health plan liability if ERISA preemption is waived**—Many of the bills pending in Congress and the Texas and Georgia laws include language intended to protect the employer from liability. In some cases this is intended to be a blanket protection, in others it would be limited to employers who exercise no discretion regarding plan benefits. I believe no effort to protect plan sponsors from liability would work. Employers could protect themselves from liability in only one of two ways:

—Terminate the health plan and no longer sponsor a plan; or

—Amend the plan to cover only specifically stated items and services, so that failure to provide a service that was not explicitly covered would not be actionable in the courts.

There are several reasons why plan sponsors cannot be protected from health plan liability[3]:

—These bills would waive ERISA and federal common law that have defined the duties of employers and plan administrators, leaving it to the States to define these duties. State laws would create a liability for the employers' failure to exercise the duties they define. Employers would be protected only for those activities the bill explicitly prohibits States from including as a duty.

—These bills would specifically permit States to create liability for employers who "exercised discretion." Many employers review the decisions of their third party administrators, and would be liable for this reason alone. Indeed, under federal law, any involvement of an employer's in-house benefits personnel in the actions of a third party administrator—even unauthorized—would subject the employer to liability for the acts of its employee. [*Cf. Crocco v. Xerox Corp.*, 956 F.Supp. 129 (D. Conn. 1997)].

—Even employers who do not exercise discretion are today sued (under ERISA) for actions of health plans or third-party administrators on the basis that they "negligently selected" or "negligently retained" plan administrators.

2. **Health plan liability will lead to a reduction in the accountability of health plans to employers.** Ironically, the logical response of employers who continue to sponsor plans will be to put the managed care organizations at greater arms length and reduce their own potential liability by:

—Ceasing activities to monitor or overturn the benefit denials of the health plans;

—Reducing their quality oversight and selection activities—providing a wider array of health plans for employees, with less effort to evaluate plans or guide employee selection toward higher quality plans;

—Reducing the comparative plan information they provide to employees that might be interpreted as guiding or influencing employee choice.

3. **Health plan liability will significantly raise health plan costs for employers.** The increase in costs will come in two ways:

—Large punitive damage awards—recent judgments against state employee plans have revealed a potential for substantial punitive damage awards in benefit denial cases: including a recent California court judgment of $116 million in an Aetna case involving a bone marrow transplant[4]; a $13 million Kentucky court award in a Humana case involving a hysterectomy[5].

—Defensive utilization review—an increase in the approval of unnecessary, inappropriate and expensive procedures to avoid liability.

Advocates of liability have championed the 1997 Texas liability law as an example of how liability can be passed with little effect on costs. Quite the opposite is true. Cases only now begun to appear in Texas, having waited until last October for a district court to uphold the law. Since then, two cases have cleared the federal appeals court and have been remanded to state courts for trial.

Even without litigation, the law has had an effect on plan behavior and premiums. A physician group health plan in Texas that announced a 15 percent premium increase for employers in 1999 determined that half of the increase was attributable to a rise in the utilization of services driven by the new liability law[6]. The plan found that their Medical Directors were unwilling to review or deny a request for benefits for fear of delaying the process or triggering a lawsuit. The plan also eliminated requirements for prior approval and provided automatic coverage for some costly diagnostic procedures to avoid delay—a factor in the Texas law that cre-

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[3] Memorandum on "employer's exposure to lawsuits for negligent claims reviews," prepared by Rosina Barker, Esq., Ivins, Phillips and Barker, February 26, 1999.

[4] Goodrich v. Aetna/USHEalthcare—January 20, 1999.

[5] Johnson v. Humana Health Plans, Ky. Cir. Ct., No. 96-CI-00462, 10/20/98.

[6] Internal memorandum, Scott & White Health Plan, Temple Texas, December 23, 1998.

ates considerable risk of liability for the plans. The plan considered that the cost of defending itself—even against unfounded cases—would average $100,000 a case[7].

4. **Health plan liability will send the wrong signals to health plans:** State juries have already shown their tendency to override plan decisions on medical necessity that are consistent with consensus guidelines or have been upheld in external review. Often the only questions jury considers are whether the plan denied the benefit and whether the denial could have caused harm. Evidence that the denial was consistent with best medical practice is often not considered.

—In the Humana case, a patient with pre-cancerous cells on her cervix was approved for conization and denied a hysterectomy by Humana. The patient had the hysterectomy anyway and sued Humana. Even though tissue samples introduced in court clearly indicated the hysterectomy was inappropriate, the court awarded $13 million in punitive damages, not on the basis of this case, but to represent all hysterectomies denied by Humana in Kentucky over 3 years.

—In the Aetna case, the patient was denied an autologous bone marrow transplant for a rare stomach cancer by Aetna. Aetna had referred the patient to an out-of-network cancer expert who determined the cancer had spread too much. Aetna had this decision reviewed by two outside experts who concurred. The patient, who had the procedure performed under his wife's health plan, died despite the treatment. The jury addressed only the question of whether the plan denied the treatment and whether the denial could have caused harm. Without reviewing the findings of the outside experts or addressing the question of the medical appropriateness of the plan decision, the jury awarded $116 million in punitive damages.

If the response we want from plans is to improve the quality of their coverage decisionmaking, how do plans get that message from these jury awards? In both cases, the message to the plan was "cover everything, and deny nothing." Indeed, these juries made it clear to plans that coverage decisions supported by sound medical judgment backed by medical evidence and the consensus of external reviewers can not protect the plan from liability.

If the Congress truly wants plans to make coverage decisions that are right for the patient, it should enact an effective external review requirement. It should only provide health plan liability for these decisions, if it intends to discourage plans from relying on consensus panel recommendations, national guidelines, and medical evidence in making coverage decisions.

As the 1st Circuit Court stated in its decision in the case of *Turner v. Fallon*:

> "...the real problem confronting the Turners was not one of judicial remedies but a larger and more intractable one. It is a society-wide problem of when and how to provide last-chance health care for a courageous patient faced with a mortal disease who may have a small chance at survival if provided an expensive cutting edge treatment that she cannot afford out of her own resources. This is not the kind of problem to which the courts can supply the solution.[8]"

Mr. COBURN. Again, thank you for sticking with us.

Ms. Rosenbaum.

STATEMENT OF SARA ROSENBAUM

Ms. ROSENBAUM. Thank you very much. I am going to be very brief, since you have heard a great deal this afternoon, and this is such a knowledgeable panel that you hardly need a lot more testimony.

I would like to spend my time on what I consider to be the key elements of the external appeals process. There are a lot of elements that are fundamentally important in your external appeals process. The first one is that it should follow the most rapid possible internal process. You shouldn't spend a lot of time on the issue on the conduct of the internal process itself, other than to make sure that the timelines are proper to the needs; that someone who did not have an interest in the case does the internal review;

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[7] Letter from Jim Rohack, MD, Scott & White Health Plan to the Honorable Dale VanVyven, Chair, Ohio House Health, Retirement & Aging Committee. March 3, 1999.

[8] Turner v. Fallon Community Health Plan (127 F.3d 196 (1st cir. 1997).

that there is a written decision, and the individual has notice of further appeals rights.

Second is the external process should follow an internal process unless the internal process fails to follow the rules. In which case, you should be able to jump over the internal process. Third, the external reviewer has to be somebody with absolutely no ties to the insurer or the health plan, who is selected through either an independent selection process, or through a State insurance department, depending on how you structure your law. Fourth, the external reviewer should possess relevant expertise in the field.

Fifth—and this is where I think the recommendation begins to substantially depart from the bills that I have seen to date—the external reviewer should have the power to review any decision that involves medical judgment. The process should not be limited to medical necessity decisions, or experimental decisions. In fact, it should involve a review of any decision involving medical judgment.

For example, if a decision is made to deny coverage, to exclude treatment because it is cosmetic, that is a medical judgment. It is a medical call as to whether the surgery that is needed is cosmetic or medical in nature. So the scope of the review should be any decision involving medical judgment. Only the external review should decide if that threshold scope was met. This should not be a decision by the plan. This should not be a decision by anybody retained by the plan.

Sixth, the external review process, obviously, should be calibrated to meet the exigencies of the cases. The job of the external reviewer to decide de novo whether in light of relevant and reliable evidence—those are two different issues: relevance and reliability—the insurer's decision was medically reasonable. If you put that in a statute and then list the evidence that is both relevant and reliable, you have the kind of procedure that essentially is what this whole legislative enterprises all about, because what it assures is that the external reviewer will be looking at the reasonableness of medical treatment judgments.

I do absolutely agree that what is going on here is medical treatment decisionmaking. That reviewer will do so in an impartial fashion, using relevant and reliable evidence. By "relevant and reliable," what I mean is evidence that has something to do with the case. If the issue on appeal is heart surgery, studies of heart surgery are not relevant to a case if the individual who needs the surgery also has diabetes. That is a co-morbidity. Any evidence that looks only at the issue of heart surgery is simply not relevant to the case.

Reliable evidence is evidence that is valid and scientific. It can be peer reviews. It can be impartial treatment guidelines. It can even be the opinion of the treating clinician, as a piece of evidence that comes in. It can be the plan's own guidelines to the extent that the guidelines were developed in a peer-controlled fashion.

The reviewer should be able to inspect any and all evidence; should have the full medical record before him or her, not only those pieces selected by the plan. The reviewer's decision should be based on the evidence. It should be in writing. It should be binding on the plan. Thank you, very much.

[The prepared statement of Sara Rosenbaum follows:]

PREPARED STATEMENT OF SARA ROSENBAUM, HAROLD AND JANE HIRSH PROFESSOR OF HEALTH LAW AND POLICY, THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER, SCHOOL OF PUBLIC HEALTH AND HEALTH SERVICES

Mr. Chairman and Members of the Sub-Committee: Thank you for inviting me to appear before this Sub-Committee today.

In my capacity as a professor of health law at the George Washington University, as well as in my earlier life as an attorney representing individuals who were adversely affected by insurers' treatment decisions, I have spent a good deal of time thinking about the minimum elements of a fair process of review for persons who are faced with an adverse treatment and coverage decision. I am the co-author of a health law textbook that extensively addresses this matter.[1] Understanding the importance of the debate now taking place in Congress, in January, 1999, I also published an article on the topic of medical necessity and review of insurer coverage and treatment decisions in the New England Journal of Medicine.[2] I am grateful for this opportunity to testify before your Sub-Committee on this matter.

Before reaching the central question for this hearing, I believe that it would be useful to provide you with a bit of background on two matters: the respective state and federal roles in the design of the external review system for insurer coverage and treatment decisions in both employer and non-employer settings; and the issue of medical necessity.

Review of insurer coverage and treatment decisions: historic state powers and the impact of ERISA: As part of their power under the McCarren Ferguson Act to regulate the business of insurance, states have the power to establish external review mechanisms to ensure impartial examination of the correctness of an insurer's coverage and treatment decisions. In a pre-managed care era, coverage and treatment were not one and the same. People tended to get health care first and then fight with their insurers over payment after the fact. No one really perceived the need for a rapid, concurrent review process for insurer denials, since the care had been furnished, and the fight over payment, while terribly important, was not a life or death matter. It also should be pointed out that until relatively recently—within the last 25 years or so—insurers did not seriously challenge physicians' health care decisions. This lack of insurer challenges to physicians' medical judgements also dimmed any interest in an external review process.

Two events then occurred simultaneously: a more active involvement by insurers in coverage decisions through the development of prospective review mechanisms; and the enactment of ERISA, which preempted state laws related to employee benefit plans other than laws that regulate insurance. The ERISA preemption clause rendered inapplicable to self-insured employer plans the body of state insurance law.[3] Moreover, many of the most important state laws that address insurer practices in fact are not "laws that regulate insurance." They may be laws of general applicability that are not confined to the insurance industry and that do not involve either the spreading of risk or the relationship between the insurer and the insured. Instead, they are consumer protection laws, administrative procedure laws, contract laws, and tort laws. Thus, despite some recent signs of judicial willingness to rethink ERISA preemption, the doctrine still has a powerful impact on the ability of states to reach the conduct of health plans offered by employers covered under ERISA (i.e., most of the American work force).

With respect to those insurance products that are governed by state law, most states today do not offer their citizens a rapid external review system for treatment denials like the one available to Medicare beneficiaries. About a dozen states have put external review systems into place (Texas' system was held to be inapplicable to ERISA plans in 1998).[4] Furthermore, state laws are uneven in their scope and impact. In some cases, the decisions of external reviewers are binding on insurers; in others they are not. The systems vary significantly in their structure and operations. The Texas decision is of course a clear signal that these systems, even where effective and binding, may be struck down if challenged by an ERISA plan. Thus, the question of fair process rests with Congress.

ERISA today provides no rapid, prospective external review process for plan beneficiaries adversely affected by insurer treatment decisions. ERISA plans must pro-

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[1] Rand Rosenblatt, Sylvia Law and Sara Rosenbaum, Law and the American Health Care System (Foundation Press, Old Westbury NY, 1997; 1999-2000 supplement).

[2] Sara Rosenbaum, David Frankford, Brad Moore and Phyllis Borzi, "Who Should Determine When Health Care is Medically Necessary?" 340 New England Journal of Medicine 3 (January 21, 1999) pp. 229-233.

[3] *Metropolitan Life v Massachusetts,* 421 U.S. 724 (1985).

[4] *Corporate Health Insurance Inc. v Texas Department of Insurance* 12 F. Supp. 2d. 597 (S.D. Tx., 1998).

vide an internal review, but under existing Department of Labor rules, these internal reviews are lengthy processes; more importantly, perhaps, in their very definition and nature, a review conducted by an employer plan of its own treatment decisions (or the decisions of its agents) cannot a disinterested and objective one, even when well done. ERISA permits claimants to pursue any claim for benefits in court, usually following exhaustion of their internal review rights. Except in the rare instance when a court steps in and grants injunctive relief, the judicial review process can take a very long time. Moreover, because of the limits on recovery that apply to ERISA claims, it may be very difficult for families—particularly those with modest means—to secure legal representation, a "must" when pursuing a claim against an employer in federal court.

Because the advent of managed care with its prospective treatment decision-making element has effectively blurred the line between coverage and care, access to a rapid and impartial review process has become a matter of extraordinary importance for American families. No issue is more central to the federal managed care quality debate than rapid access to a fair, objective and external review system that can measure the quality of health plans' treatment decisions in an unbiased manner. Because of ERISA preemption, this is an area in which states cannot act and Congress must.

Medical necessity: In many instances, an external reviewer (typically a court) is called upon to decide whether an insurer (or other entity acting on the insurer's behalf, such as an individual physician or a medical group) was correct in its decision regarding the medical necessity of care. However, the external review process plays a pivotal role in any situation in which the reasonableness of a medical judgement is the issue to be decided. ERISA court decisions reach all cases of medical judgement, not only those classified by insurers as medical necessity cases. A medical necessity decision is in essence a decision regarding whether a particular covered service is necessary in an individual's case. In fact, medical judgement is also at play in many decisions that involve questions of whether a particular benefit or procedure is covered at all. A good example of this is reconstructive surgery following a mastectomy. Until Congress acted to correct the widespread practice of treatment denials in these cases, requests for this procedure were routinely denied, not because they were not medically necessary, but because in insurers' view, the benefit was cosmetic and therefore excluded altogether from the coverage as an excluded benefit. In fact, in both reconstructive breast surgery following mastectomy, as well as other situations (e.g., dental surgery for a child with a cleft palate or other type of congenital anomaly) treatment may or may not be covered at all depending on how they its is viewed medically.

The concept of medical necessity is protean. As our vision of medicine changes, so does the body of medical evidence regarding what is necessary and what is not. Two hundred years ago, bleeding was considered medically necessary. Today, mercifully, it is not. As a result, impartial external reviewers—typically courts—devised a *framework* for making decisions regarding what was medically appropriate care. In the old days, this issue would arise typically in the context of a tort case involving a claim of negligence. Today it can arise in both a tort case and a benefit review case, where the issue is the same, but the remedy (i.e., the care itself rather than damages for negligent care) is the issue that is presented.

The judicial concept of medical necessity thus is a *framework concept* rather than a substantive definition. By *framework concept*, I mean a way of thinking about and framing the facts of a particular case, rather than a substantive rule of thumb for second guessing the content of medical care.

Beginning in the 18th century courts, in approaching medical quality cases, devised a theory known as the "professional standard of care." Under this theory, a court would examine the facts and circumstances in a particular case in order to determine whether the physician's actions were reasonable in light of relevant and reliable evidence. Because medical decisions were made by professionals, courts concluded that they could not be compared to those of the "reasonable man," the standard frame of reference in a tort case. Instead, courts compared the physician's judgement to the standard followed by other physicians in the "community" in which the physician practice. In the beginning, the concept of "community" was the locale in which the conduct occurred. As medical care advanced, the "community" against which the physician's conduct was compared ceased to be the physicians in the practitioner's locality and became the national community of similarly situated physicians.

Thus, the "professional standard" is a legal concept that has its roots in the English common law.[5] The professional standard is not a static concept, but instead

[5] *Slater v Baker and Stapleton* 95 Eng. Rep. 860 (King's Bench, 1767).

is a way of thinking about providers' conduct toward individual patients in light of the current state of knowledge of medical care within the profession. Indeed, the "professional standard" is embodied in many insurance contracts today, as reflected in *Lee v Blue Cross/Blue Shield of Alabama*;[6] in *Lee*, the insurance contract defined medically necessary care as treatment and services that "are appropriate and necessary for treatment of the insured's condition . . . in accordance with standards of good medical practice." For these reasons, incorporating the professional standard into an external review process would consistent with existing practice within much of the industry today.

As I have noted, in its earliest form, the professional standard considered the quality of a physician's care in the context of the locality in which he practiced.[7] As medical care advanced, however, the so-called locality rule has for the most part disappeared. Today, while access to resources remains a consideration for courts in determining a health provider's liability in a health care quality case,[8] the professional standard turns on evidence of the best practice within the profession as a whole nationally.[9]

As knowledge of quality grows, so do our expectations of hospitals, physicians and managed care organizations. An objective professional standard thus remains the proper means of measuring quality at the point at which an internal or external examination of a particular patient's case is at issue. In these situations, the issue under consideration is not whether the practice is good quality as a general matter (which is the task of internal quality reviewers), but whether the care that has been prescribed or allowed is appropriate for an individual patient. This focus certainly does not mean that all individuals get what they want, or even what they get what their personal physicians recommend for them.

There are actually very few reported decisions that involve challenges to medical decisions made by insurers and health plans in a non-tort context. This is because for most Americans, the standard clinical response followed by insurers and their medical decision-makers is the right response; otherwise medicine would be nearly impossible to practice. But the purpose of an insurance coverage review—and the reason probably why there are so few of them—is to consider the needs of those patients whose conditions may not fit neatly into a particular approach used by the insurer in certain types of cases. An external review process that relies on the professional standard for its decision framework is the means for preventing the problem of one-size-fits-all treatment decisions that can flow from the increased use of practice guidelines and that work most, but not all of the time.

An external review guided by the professional standard considers not only what the health care industry says is good overall technical clinical practice, but also whether, in the context of a patient's case, the practice is appropriate. This objective focus on individual patients rather than general norms is what distinguishes coverage decision-making from general quality improvement activities and it is this focus on the individual that is a key element of the professional standard.

A question that has been asked regarding the use of the professional standard is whether the standard holds back quality rather than advance it. I find this question quite puzzling, since the evidence of the past two centuries points to the opposite result. Had the professional standard had a retardant rather than advancing effect on health care quality, the extraordinary advances in medicine that have taken place over the past two centuries might never have occurred.

Indeed, from being static, the professional standard is dynamic: as knowledge and practice evolve, so does the concept of what is professionally acceptable. Rather than holding back progress, the professional standard is in fact one of the tools that has moved it forward. The professional standard is exactly the opposite of a rubber stamp for industry preferences. In fact, courts have found health care providers liable for poor quality care, even when they adhere to the standards of their own professional industry.[10] In doing so, courts have applied a fundamental common law principle that the standard of care should be governed by the best evidence of professional practice, not by an industry's self-serving practices at any particular moment in time.[11]

Even today, the use of the professional standard is common throughout the managed care industry in its own insurance contracts. Most health plan contracts in use

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[6] 10 F. 3rd 547 (11th Cir., 1994).

[7] *Small v Howard* 128 Mass. 131 (1880).

[8] *Shilkret v Annapolis Emergency Hospital,* 349 A. 2d 245 (Md., 1975).

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[10] *Washington v Washington Hospital Medical Center* 579 A. 2d 177 (D.C. App., 1990), *Helling v Carey* 519 P. 2d 981 (Washington, 1974)

[11] *The T.J. Hooper,* 60 F. 2d 737 (2d Cir., 1932).

today specify that, in determining whether care that is enumerated in a plan will be furnished in a specific case, the insurer will rely on "accepted standards of professional medical practice." We know this, because in cases challenging the denial of care by insurers, courts begin their review by setting out the terms of the contract. The exact words used to describe the professional standard may vary, but the concept remains the same.

The issue of medical necessity and coverage decision-making is shrouded in secrecy and typically comes to light only when a court publishes a decision that quotes from a contract and lays out evidence. For example, in *Bedrick v Traveler's Insurance Company*,[12] the company had grafted a whole new meaning of medical necessity that was not part of its original agreement onto its contract, and also lacked virtually any evidence on which to base its treatment denial. This fact was not known until a family with a very disabled baby appealed the company's decision to stop all therapy on the unwritten ground that where no recovery was possible, a child such as Ethan Bedrick, who had cerebral palsy and therefore could not recover from his condition, did not need treatment.

In considering whether a health care provider's treatment decisions are consistent with the professional standard, courts consider an array of evidence: the patient's medical record; evidence pertaining to the particular individual that is presented by the treating clinician; the results of rigorous and impartial peer review procedures; and findings from valid and reliable studies and reports relating to the treatment at issue. Practice guidelines, if grounded in scientific, valid evidence and developed by experts in the field, would be relevant to any consideration of what constitutes the professional standard. On the other hand, self—serving company "practice guidelines" that are developed without expertise and that are not calibrated to account for the variable situations that distinguish one medical case from another, would not be considered valid and reliable evidence of the professional standard.

There are some who say that an objective professional standard has no place in the legal framework that governs contractual employee health benefits, because in a market-driven health system, the parties must be free to agree to care of any standard. This of course assumes that a party to the contract—in this case the purchaser of the plan—would ever be in a position to understand that it is agreeing to substandard care. Yet many of the most basic concepts health coverage are obscure, and the convoluted language of insurance contracts generally is known only to highly skilled insurance lawyers. Moreover, even if purchasers' knowledge were to increase, many buyers, particularly small businesses, lack the market clout that would be needed to force insurers to alter their definitions or even disclose material facts relating to their standards during contract negotiations.

KEY ELEMENTS OF AN EXTERNAL REVIEW PROCESS

In fashioning an external review system that is objective and fair, Congress needs to address a range of matters.

1. What is appealable

Just as the courts are open to all ERISA plan and insurer claims involving benefits, the external review process should be available in the case of any treatment and coverage decision in which medical judgement was involved in reaching the decision. This certainly includes medical necessity cases. It also extends the process to any coverage decision in which the reviewer needed to use medical judgement in evaluating the claim. A claim for 20 mental health visits where only 10 are covered does not involve medical judgement. The service clearly is excluded, and any person can make this decision. But where, for example, the decision is to deny coverage on cosmetic grounds, someone with medical expertise must compare the individual facts to the standard of care in order to decide that the care sought is indeed cosmetic and not covered medical care.

2. Whose decision is appealable

We think of appealable decisions as decisions made by the medical director of an insurance company or a health plan. But increasingly, health plans and insurers delegate decisions involving coverage and care to the medical groups with whom they subcontract. Thus, any decision made by an individual working on behalf of the insurer or the plan or an agent or contractor to the plan should be appealable.

3. Application to various forms of coverage

As I noted, in some states there are external appeals rights. In most, however, there are not. It would indeed be ironic if employees covered by self-insured plans

[12] *Bedrick v Traveler's Insurance Co.* 93 F. 3d 149 (4th Cir., 1996).

had appeals rights that were not extended to persons employed by a firm that purchased insurance or individuals who buy insurance products individually.

4. The external review process

The external review process should consist of the following elements:

- It should follow a rapid internal review process that is calibrated to meet the exigencies of the case, that results in a written decision, and that is carried out by an individual other than the person who made the initial decision.
- It should be available to persons who have exhausted their internal appeals procedures or in cases in which the insurer has failed to act in a timely fashion.
- It should be conducted by an external reviewer who has no ties to the insurer or health plan and who is either selected by a state insurance department or in accordance with a federal process that ensures non-biased assignment of cases.
- An external reviewer should possess expertise in the relevant field covering the matter on appeal (i.e., a reviewer with expertise in mental health in a mental health case).
- The external reviewer should be the entity that decides whether the claim is one that involves medical judgement and thus is reviewable. This decision, which is akin to a jurisdictional decision by a court, should be the initial step in any external appeal and should not be decided by the insurer or the plan.
- The external review process should be calibrated timewise to the matter before the reviewer, so that a rapid time frame (e.g., 72 hours) is used for matters in which the medical record and claim indicate a need for an expedited review. This decision should be made by the external reviewer and should be based on the patient's record and the care that is sought.
- The reviewer's job should be to determine on a de novo basis whether, in light of relevant and reliable evidence, the insurer's decision (or that of the insurer's sub-contractor or agent) was medically reasonable. This is the essence of the framework that is embodied in the professional standard concept. By relevant and reliable evidence, I mean the patient's medical record, the opinion of the treating clinician, the results of peer reviews, the results of valid and scientific studies that have been published in the medical literature, and practice guidelines developed by impartial bodies.
- The reviewer should be able to inspect any and all relevant evidence, and the plan and the plan's agents and subcontractors should be obligated to provide the reviewer with any evidence deemed necessary.
- The reviewer's decision should be based on the evidence, should be in writing, and should be binding on the plan and insurer.

Mr. COBURN. Thank you.

Dr. Dunne.

STATEMENT OF PHILIP K. DUNNE

Mr. DUNNE. Thank you, Mr. Chairman, for the opportunity to share a few ideas with you and your colleagues on the subject of external review.

I am Phil Dunne, CEO of the Texas Medical Foundation, and Vice President of the National Quality Health Council. The Texas Medical Foundation is the organization in Texas that, for the first 14 months, was the sole external review certified entity. For the last 4 months we have shared that responsibility with another organization. So we are the group that Ms. Barron was referring to that has been doing the work in Texas.

I know our time is brief. I submitted my full statement for the record and the committee's review. Let me highlight a few thoughts that I hope will be of value, and perhaps stimulate a constructive dialog on the practical elements of truly independent external review. There is a difference between independent and external.

No. 1, external review works. It works if it is truly independent, and conducted by properly matched, licensed, practicing physicians or allied health professionals. It works when you have ready access

to all the relevant data in a timely manner. It works when it is binding on plans and conducted in a medical, fact-based manner.

In Texas we have reviewed nearly 450 cases. The split of upholding the plan's and payor's decisions versus reversing their adverse determination is approximately 50-50. In many of the cases which we reversed, we have learned from plan reviewers they would have concurred with our findings had they had complete data in a timely way. A more thorough review of these results is in my complete statement.

No. 2, when properly conducted, binding, unbiased, medical, fact-based external review findings can reduce, if not virtually eliminate, the need for liability suits against payors. In Texas in the 18 months since the Texas IRO statute has been in operation, with 477 referrals of requests for external review, only one lawsuit is identified as having been filed even though the Texas statute permits such suits.

Mr. Chairman, I am convinced that one of the reasons we have not had an explosion of lawsuits is that we have a mechanism in Texas which affords the enrollees and beneficiaries to address legitimate concerns about payor's practices which is demonstrated by our reviews.

Last, I note in my written statement we report our findings and decisions to the Texas Department of Insurance, or "TDI." When the TDI determines that the rate of reversal for any given plan or payor is at significant variation with the average, or if they find a particularly disturbing situation, they may order a standard examination of the plan's procedures and practices. The findings of this examination can be incorporated into a corrective action plan, which the plan or payor can implement to improve performance and avoid further regulatory intervention.

Mr. Chairman, I recognize that the authorities at the State level in Texas are for State-licensed plans. I further recognize that you and your colleagues are grappling with ways to enact appropriate measures for self-insured plans, or other ERISA-protected payors without further damaging ERISA protections. Let me only say that when the external review process is fair, independent and recognized to bias-free, it is not threatening to these payors. Most ERISA-protected plans in Texas have agreed to voluntarily participate in the Texas IRO process, and agree to be bound by their decisions.

Finally, I recognize that certain jurisdictional complexities complicate your task. I believe that these can be resolved with a constructive dialog with all parties. I pledge our cooperation and that of our colleagues to assist you in crafting an acceptable measure containing the elements I have described. The American people deserve nothing less. Thank you.

[The prepared statement of Phillip K. Dunne follows:]

PREPARED STATEMENT OF PHILLIP K. DUNNE, CHIEF EXECUTIVE OFFICER, TEXAS MEDICAL FOUNDATION AND VICE PRESIDENT, NATIONAL QUALITY HEALTH COUNCIL

Mr. Chairman, thank you for the opportunity to provide testimony to the Health and Environment Subcommittee of the United States House Committee on Commerce regarding Independent External Reviews of Health Plan decisions and the impact of these on the quality of health care. I am Phil Dunne, Chief Executive Officer of the Texas Medical Foundation (TMF). My testimony is respectfully submitted

as the views of both the National Quality Health Council (NQHC) and those of the TMF.

As the Vice President of the Board of Trustees of the NQHC, an affiliation of forward-looking health care quality improvement organizations, I would like to first commend the Subcommittee, and you Mr. Chairman, on your efforts in looking at independent external review as a mechanism to help ensure that American health care consumers have access to the highest quality health care to which they are entitled. We look forward to working with you, and the other members of this committee as you hopefully develop a legislative proposal that will assist health insurance plans, employers, physicians and patient consumers in reinstating confidence that our health care system has the necessary mechanisms in place to continue to provide the highest quality health care available anywhere in the world.

Mr. Chairman, the NQHC, with members in Ohio, Texas and Massachusetts has extensive experience in a number of states dealing with Medicare quality review, Medicaid quality review and private plan and ERISA quality review. Last year our organization provided technical assistance on this subject to a number of Members of Congress, including the so-called Hastert Task Force, whose preliminary external review provision was included in legislation later adopted by the House. Let me say that we share the Subcommittee's interest in continuing to work on developing a sound proposal, and are pleased to provide our views regarding our experience in assuring and improving health care quality for all Americans.

Specifically, NQHC notes the utmost importance of providing all recipients of health care with an external review process which is "independent" of all biases, including those of payor, plan, health care provider, or patient. We strongly urge that the Congress and this Subcommittee consider a legislative policy solution which will assure that both independence and clinical expertise exist in an external review process.

As the NQHC member from Texas, we have had extensive independent review experience under the state of Texas' relatively new "IRO" statute. In 1997, the 75th Texas legislature passed legislation which established an independent review organization (IRO) activity in Texas. The Texas Department of Insurance (TDI) was assigned the responsibility for implementing the legislation, developing regulatory requirements, and performing administrative program coordination activities. The 75th Texas legislature adjourned in late May 1997, proposed regulations for IRO were promulgated in September 1997, and the program activities became operational in November 1997 with certification of the first IRO. The Texas Medical Foundation (TMF) was the first organization to be certified by TDI as an IRO and maintained the designation as the only IRO in Texas from November 1997 until January 1999. A second organization is now certified by TDI as an IRO for Texas.

Operationally, the IRO process is initiated when a patient or a patient's representative submits a request for independent review to the payor organization (or a utilization review agent working under contract for the payor) following the issuance of a notice of adverse determination. There is not any charge to the patient or patient's representative for requesting the IRO review. Upon receipt of a request for IRO review, the payor organization, or its utilization review contractor, must forward the request for IRO review in a timely manner along with supporting documentation and medical records to TDI. TDI then screens the IRO request to ensure the issue is appropriate for IRO review and that the adverse determination is based on medical necessity, not benefit structure. Then, on a rotational basis, TDI forwards the IRO request to one of the certified organizations to perform the requested review.

The Texas IRO program utilizes single matched peer review rather than a panel approach. The single matched peer review individual must be in active practice and perform the type of service upon which IRO review is requested. The IRO selects an appropriately qualified physician/allied health professional to review the IRO request and may, as appropriate, request additional materials to reach a complete and comprehensive review decision. Following completion of the review, the IRO informs the patient/patient representative, provider of care, payor or payor's utilization review agent, and TDI of the review decision and includes the reviewer's rationale for either approving or disapproving the requested health care service.

The IRO submits an invoice directly to the payor or payor's utilization review agent as outlined in TDI regulations. The IRO review process is divided into two tiers of activity. Tier One relates to traditional medical/surgical review matters, and Tier Two pertains to allied health review, including podiatry, optometry, physical/occupational/speech therapy, etc. Current TDI regulations outline that Tier One reviews are to be invoiced at $650 per case and Tier Two cases are to be invoiced at $460.

Over the past eighteen months, the actual caseload is revealing. The Texas IRO process has identified that the most common health care service on which IRO review is requested pertains to psychiatric or mental health services. Adult, adolescent, and child psychiatry constitute the major reason for IRO review requests. This is followed by health services related to obstetrics and gynecology, oncology, pain management, plastic surgery, orthopaedic procedures, etc. As a certified IRO, TMF has received 477 cases for review. In the early days of the program, more cases were returned to TDI as inappropriate for IRO activity. Approximately 455 IRO reviews have been completed with 13 cases pending at this time.

IRO review requests are divided into three categories: preauthorization with life threatening potential; preauthorization not life threatening; and retrospective. Preauthorization with life threatening potential have constituted 12% of cases received. Preauthorization not life threatening have constituted 36%, and retrospective review requests have constituted 52%. Of the 455 cases upon which IRO review has been completed, 221, or 49% of the decisions by the payor or payor's utilization review agent have been upheld by TMF and in the remaining 234, or 51%, TMF has disagreed with the original decision of the payor or payor's utilization review agent. Of the overturned decisions, reviews pertaining to psychiatry (including adult, adolescent, and child) along with obstetrics and gynecology have the higher percentage of reversal.

Through its review of the 455 IRO cases, TMF has recognized that approximately one-half of the plan determinations are overturned and approximately one-half are upheld. Additionally, TMF has recognized a wide variance among the payor organizations or the payor's utilization review agents as to upholding and/or reversing decisions. Documentation made available to TMF as a certified IRO has identified that in some cases it appears that the payor or the payor's utilization review agent did not have access to or consider all available relevant information in prior decisions. Also, it has been identified that the payor or the payor's utilization review agent did not use a matched peer reviewer in previous decisions.

In summary, the Texas IRO program utilizes a certified IRO agent approach, includes administrative and operational oversight and screening by the Texas Department of Insurance, a single matched peer reviewer approach, and provides for expedited IRO review when the potential for life threatening situations exists. The patient is not assessed any fee for requesting the IRO review.

Mr. Chairman, these experiences lead me to conclude that there are a few very important principles that should guide you and your colleagues as you grapple with crafting an effective and fair national independent external appeals process.

Chief among these principles is true "independence," in both function and appearance. Certifiable independence coupled with clinical expertise will produce sensible, understandable outcomes that plans and patients will accept and that the public and political leaders can trust.

In Texas this independence is achieved by requiring the Texas Department of Insurance to certify as to an IRO's competence and also by having the appeal request pass through TDI which then assigns it to the IRO after assuring that it is a medical review rather than a benefit structure issue.

We would urge that the committee consider utilizing an appropriate authority or authorities, to certify the competence of external review entities, and to assign the certified IRO entity to referred cases as a means of eliminating any presumption of bias, conflict of interest or close relationship with any payor.

Secondly, and as important, is to require a suitable level of clinical experience and expertise. Only licensed, practicing physicians should be used to conduct external reviews. As "matched peers", they should be assigned to the case under review by virtue of their expertise in the subject or specialty area to be reviewed. Further, we believe single matched peers are an effective means of controlling costs

Third, the results of the review must be binding on the plans, thus providing an evidence-based record for use by any appropriate controlling authority.

Fourth, there should be no threshold or financial barrier to a patient requesting the external review. As I mentioned earlier, the flood of appeals anticipated in Texas did not materialize. Our costs for Tier I and Tier II reviews have remained reasonable and are not a burden on the payor or the system.

Finally Mr. Chairman, in addition to providing for a workable and strong independent external process, we would commend to the Subcommittee an additional concept embodied in the Texas Statute. Under the Texas law, Mr. Chairman, the Texas Department of Insurance may order a "standard examination" of a health plan that has experienced exceedingly high reversal rates or an egregious health care quality failure. This allows an examination of such "outlier" plan's internal review and clinical decision making processes and the development of recommendations for improvement. We would propose that the Subcommittee likewise consider

an appropriate means of dealing with plans with high reversal rates or with an egregious failure. This would provide authority to order an independent quality improvement organization to examine these plans' utilization management and review policies and to structure a corrective action plan which, when implemented, can reduce or avoid further sanctions and can assure a more effective consistent quality of care to patients.

In the Texas' experience, a small number of plans constitute a high percentage of repeat review requests and of reversals by the IRO. It is common knowledge that high profile adverse determinations by payors fuel the anecdotal stories cited by interest groups to press for legislative remedies. By taking the independent review concept and methodology to another level, with a similar approach, the Committee could both reduce the need for individual patient review, and provide a preventative and corrective mechanism for dealing with plans that are experiencing quality difficulties.

Mr. Chairman, through our combined 75+ years of experience in this quality review and improvement field, we at the Texas Medical Foundation and the NQHC, have learned that external independent review can make a significant difference to both individual patients and the health care bottom line for which consumers and taxpayers ultimately foot the bill. We urge the Subcommittee to approve an individual patient independent external review process that is evidentiary-based, and a mechanism for insuring the improvement of health care practices by plans which are repeatedly reversed by an independent reviewer. As always, Mr. Chairman, we stand ready to provide technical and other assistance to the Subcommittee through our resources which include epidemiologists and biostatisticians and other specialized physicians and nurses and allied professionals.

Once again, Mr. Chairman, on behalf of NQHC, let me thank you for the opportunity to provide this testimony. We look forward to working with you and the other Members of this Committee as legislation on this subject is developed and to answering any questions you may have.

Mr. COBURN. Thank you.

The Chair recognizes himself, first, for 5 minutes. Then we will go down.

Mr. Atkins, you represent this Corporate Health Care Coalition, some of the best companies we have. My experience with those companies in caring for some of their employees is you aren't the problem. Unfortunately, you are covered by a law that has allowed people who are the problem to hide behind the law.

I want to make sure I understood what you said. You are familiar with the consensus health care bill that Congressmen Shadegg, Norwood and I have put out?

Mr. ATKINS. Yes.

Mr. COBURN. Do you have objections to what we have in there in terms of internal review, external review, expedited internal and external review, and the liability portions of that bill?

Mr. ATKINS. Yes, I have a very substantial problem with the liability portion of the bill. I recognize that you don't create an opportunity in the bill for punitive damages, or at least you attempt to close it off.

But the biggest problem with the way the liability provision works is that under ERISA you have a set of relationships now under Federal law. You have a fiduciary obligation. You have a history, and you have 25 years of Federal case law, that defines those relationships and the liability—and there is liability—that relates to the performance of fiduciary duties. What your bill does as a first step is to waive all of that Federal law.

Mr. COBURN. I would take exception to that. Let me just say so the record shows, what we say is that nobody gets to court unless they have injury. That is the first thing. That is determined by an independent panel. Unless you can show injury by an independent

set of physicians who say there is an injury associated with the absence of this care that was denied, you can't ever get there.

First of all, we are talking about a minimal of a minimal of a minimal of 1 percent. In terms of that, you have something that you have to jump across that is higher than any standard that we have ever had in this country in terms of liability.

The second thing that you said is that people do have action. They only have action if they have a whole lot of money. I would remind you of Corcoran v. United Healthcare, and several other cases where the judges have written specifically that Congress never intended for this to happen when they wrote this law.

Corcoran v. United Healthcare is a case in which care was denied that caused the death of an infant. The company said, "We are not doing what our external reviewer has said we should do." The couple had no recourse—none. The Federal judge in commenting on that said that this could not have been what Congress meant. So we are here to address that. It is not to go after a company, like the companies you represent, who have demonstrated goodwill in terms of trying to provide a service for their employees. Bear in mind, not everybody is as you are.

Mr. ATKINS. Mr. Chairman, can I respond to that?

Mr. COBURN. Sure.

Mr. ATKINS. The real impact on our companies is not that anybody necessarily will be suing either us directly, or even the health plans, but the whole ability to go to court, and raise issues of treatment in court. You say only 1 percent will be able to go forward——

Mr. COBURN. No, I said it doesn't ever approach a millionth of 1 percent.

Mr. ATKINS. Right. But you are saying that they have to have exhausted the external review process before they can go to court.

Mr. COBURN. No, they have to have shown injury from the lack of treatment. That is a totally different thing than an exhausted remedy. If there is no injury, there is no lawsuit.

Mr. ATKINS. Right. But all of these cases that have gone forward, all of the ones that are now going forward against State plans, under State law, first established there was harm caused, and relate that harm proximately back to the plan's actions.

Mr. COBURN. I would disagree with you. There is no State in the United States today that has a bar that says you have to pass a mustard test of injury by independent panel determining injury before you can ever get in. It doesn't exist. If it does, please correct me. My staff says that doesn't exist anywhere in the United States. Do you know of a State that it does?

Mr. ATKINS. Where you can go to court?

Mr. COBURN. No, no. What I specifically said——

Mr. ATKINS. Alleged harm?

Mr. COBURN. No. Where there has to be a predetermined fact finding of harm proximately related to the lack of care not given. So that doesn't exist.

Mr. ATKINS. You say you are requiring that in your bill?

Mr. COBURN. That is in the bill. That is what I am saying.

Mr. ATKINS. The fact-finding is done by the external review panel?

Mr. COBURN. No, it is done by a totally separate panel who could not be connected to the external, so we don't have any bias from external appeal panels to the panel that is determining the injury. You can't cover what might have been a mistake in external appeals to prevent a lawsuit—or to encourage one.

Mr. ATKINS. Let me just say that, as far as the Coalition is concerned, we have no problem with saying that we want a strong external review process that is enforceable.

Mr. COBURN. Could I ask you what that means? "Enforceable," does that mean absolutely binding?

Mr. ATKINS. It means binding.

Mr. COBURN. Does it mean up to the cost of what the treatment was? If something is going to cost $3 million for somebody to have treatment——

Mr. ATKINS. If the external review panel comes back says that treatment should have been approved, then that is a binding decision. That is under Federal law a binding decision, in which case a participant can go to court and get injunctive relief and get that decision enforced.

Mr. COBURN. You would support a bill that would say that, if the external appeals panel says that we should do this, then we are bound to do it. The minimum fine, before you ever get to court, is the cost of the coverage. You would agree to that?

Mr. ATKINS. I am not talking about the minimum fine. I am talking about the benefit as paid.

Mr. COBURN. Okay, the benefit as paid. What happens if you decide not to do that?

Mr. ATKINS. Then you have injunctive relief. The court can order the benefit to be paid. The Department of Labor can remove the fiduciary. There are a lot of penalties now under law that are available if you have Federal law that says it is binding.

Mr. COBURN. And if that happened after the patient died?

Mr. ATKINS. That can happen in minutes.

Mr. COBURN. No, no. I am just saying that, if that happens after the fact, if an independent insurer provider decides not to following binding—it is okay to have binding, as long as we have a method to make binding binds.

Mr. SHADEGG. Will the gentleman yield?

Mr. COBURN. I will be happy to yield.

Mr. SHADEGG. I just want to make a point that what you have just said is circular. What you said is, if we had injunctive relief following the binding appeal that Dr. Coburn is talking about, and the company refused to do it, the problem would be taken care of because the patient who needed the care could go to court and get an injunction. That is exactly a parallel to what ERISA does right now. ERISA says you can get consequential damages; you can't get a dime more.

In Corcoran v. United Healthcare, they said, "Well, we are terribly sorry Mr. and Mrs. Corcoran. Your baby is dead. Your baby is dead as a result of the negligence of United Healthcare. So if you had gone ahead and gone to the hospital and your baby hadn't died, we would have given you the cost of the health care bill. But you couldn't afford to do that. You can't afford to hire a lawyer now to do any more about this."

Under what you have just proposed, you give injunctive relief. The rich—the very, very wealthy—who went through and got a binding decision could go to court. The insurance company could sit there and thumb their nose, and say, "Well, yes, you have a binding decision. You can go get injunctive relief, but that is all you can get. You can't get attorneys' fees. You can't get any recovery on top of that."

Mr. ATKINS. You can get attorneys' fees now, Congressman, under ERISA.

Mr. SHADEGG. Only for the cost of the denied care. What good did that do Mr. and Mrs. Corcoran? In this case you would go to get injunctive relief if you had the money to front the cost of a lawyer. You could only get the cost of that lawyer, plus attorneys' fees at a rate set by the court.

Mr. ATKINS. If I could——

Mr. SHADEGG. You are providing no disincentive.

Mr. ATKINS. Can I respond to that?

Mr. COBURN. Give the gentleman an opportunity to answer.

Mr. ATKINS. I thought we were talking about a process in which there was an expeditious external review. That did not exist with Corcoran. If there had been an opportunity for that to be reviewed quickly, then it is possible that the baby would not have died. You are also talking about a real world situation where some of these medical conditions move along very quickly.

Mr. SHADEGG. So you agree that Corcoran v. United Healthcare ought to be reversed?

Mr. ATKINS. I didn't say reversed. If you have external review——

Mr. SHADEGG. We don't have it now.

Mr. ATKINS. What?

Mr. SHADEGG. We don't have it now.

Mr. ATKINS. We are advocating for that, okay?

Mr. SHADEGG. So you are advocating external review——

Mr. ATKINS. Yes.

Mr. SHADEGG. [continuing] to reverse Corcoran v. United Healthcare?

Mr. ATKINS. I am saying external review. That case, had it gone to external review, would have been reversed. There would not have been a need for damages. If a plan follows the law expeditiously, and moves the claims through the process to eternal review, the external review decision comes down and is binding. The plan follows along in compliance with that and executes that promptly. There should be no damages or penalties. Because then what you are saying to people is, "Don't ever deny a case. Don't ever take the chance that you don't give the patient or the treating physician exactly what they want, because you will then create huge amounts of liability."

I think if you look at the Medicare Program, which is a parallel to what our program looks like, you will have huge cost problems for the Federal Government, if you create that set of incentives in the law.

Mr. SHADEGG. Just one quick comment: I believe you have just endorsed what is in our legislation. What you are saying is that, once an external plan has made its decision, if it loses and is told

to do what the external panel says it should do, it will do that. If that happens, then there is no liability under our bill.

Mr. ATKINS. That is right. If it doesn't happen, there should be a penalty available. There should be a route for the participant to get the benefit paid. There should be penalties available which are available now under Federal law. It would be contempt of court if you went to get an injunction. There would be penalties available.

I do not advocate economic or other damages if you have complied with the process. I don't see any reason to award damages.

Mr. COBURN. Thank you. The gentleman from Ohio.

Mr. BROWN. Ms. Rosenbaum, comment on that exchange between Mr. Atkins and Mr. Shadegg.

Ms. ROSENBAUM. I think, actually, there are two different issues on the table. They got a little crossed. What I understand Mr. Atkins to be talking about is the process for enforcing the results of an external review.

I go. I need a benefit. I go through an external review. I win at the external review level. Then I need to have—and I think Mr. Atkins is absolutely right—a rapid system for getting an enforcement of the order. What is at stake in a prospective internal review is still my treatment. I still have a chance to get the treatment.

What I understand the consensus document to have in it is, in addition to prospective relief, to avoid exactly the tragedy of Corcoran, a provision to allow for some recovery for injury in those cases where you couldn't get the prospective relief. What I understand Mr. Atkins to be saying is that he doesn't object to judicial intervention to enforce a prospective judgment, but he does object to the ability, or adding a right to Federal law to allow me to recover damages for injuries that I sustained.

It is really two different places that a court can intervene: prospectively and after the fact. I think you, very appropriately, in your bill deal with the two types of legal intervention: prospective and after the fact.

Mr. BROWN. Ms. Rosenbaum—shifting gears—tell us why reviewing a case de novo is so important?

Ms. ROSENBAUM. Reviewing a case de novo is important because right now in ERISA all that happens when a case reaches a court in a medical coverage decision of the kind that we are talking about here is that the court is limited to what is known as an arbitrary and capricious standard. It can only look to see whether the plan acted arbitrarily and capriciously, which is a very difficult standard to overcome for a claimant.

Often what happens is if a plan—and there have actually been cases—either deliberately, or through its own negligence, did such a poor job developing the medical record in the case that we have had decision where the court says, "Had evidence X, Y, or Z been in the record, we would have found for the claimant. But because we are limited to an arbitrary and capricious standard, we cannot find for the claimant. We are bound by the record that the plan created."

By substituting a de novo review, you essentially make the appeal itself the reviewable action. If I am still unhappy with the result of the external review and I go to court, the court is going to be looking at the record created by a much more impartial external

review process. If you don't make it de novo, then there is a danger that when I finally do appeal to court, the court is still going to go back to the original plan decision and look at the record created by the plan.

So for purposes of protecting people all the way up the line, you have to make this a de novo review. Also, for the integrity of the review, it has to be de novo.

Mr. BROWN. You insist in your testimony that we shouldn't limit the scope of appeal to questions only of medical necessity and experimental treatment. You have touched on something. Give us an example, if you will. In Senator Jefford's bill, it is my understanding that he limits his bill to the question of medical necessity. That is not good enough, I understand? Give us an example.

Ms. ROSENBAUM. An example of a decision that involves medical judgment, but that is not a medical necessity decision is a case, for example, of a child who is terribly burned, or a child who is born with a congenital anomaly, like a cleft palate. A benefit plan or an insurance contract has a standard clause in it saying, "We exclude coverage for cosmetic surgery."

An exclusion is not a medical necessity holding. An exclusion is saying that no matter how necessary you think this care is, it is simply uncovered. It is outside the contract. Yet, if you stop and think about it, the same process of medical judgment that one needs to make a medical necessity decision is what you need to bring to bear on a burn case, or a cleft palate case. Somebody is looking at the facts and deciding if the child's condition falls on this side of the line or that side of the line. Therefore, any case in which there is a medical judgment is exactly the kind of case that you are setting up the external review system for.

If you don't cover all medical judgment, you leave insurers essentially free to write all of their denials as simply "not covered."

Mr. BROWN. Mr. Atkins?

Mr. ATKINS. Can I comment on that, quickly? I agree with Ms. Rosenbaum. I want to make one clarification.

If a plan says that it doesn't cover plastic surgery, which is a procedure, then when a case comes forward that involves plastic surgery, there really is no question. The plan does not cover it. That may be cruel that the plan doesn't cover it, but it is just not covered by the plan. It is not available, no matter what decision-making was involved. What the patient needed is not available.

However, cosmetic surgery involves a medical interpretation to determine whether the plastic surgery is cosmetic or not. So what I think she is defining is a situation where you have terms that are used that have implicit medical judgment involved. The participant should have the opportunity to raise that issue with the external review and say, "I think there really is medical judgment involved in coming to this conclusion"; then let the review entity make that determination about whether it should go forward to review or not.

Mr. COBURN. Would the gentlemen yield? Does that fit into the flexibility requirements that we heard earlier, in terms of external review? It has to be flexible enough so that you can encounter something like this?

Ms. ROSENBAUM. It is certainly part and parcel, part of the external review process. You want the process to be flexible enough to

be able to consider and pass on any decision in which medical judgment is involved. As Mr. Atkins points out, there may be cases where on the face of the contract you see the exclusion.

I don't know enough about plastic surgery to know how this fits, but if the contract says, "We don't cover acupuncture," and somebody wants acupuncture, under my proposal, the external reviewer would not accept the appeal. The external reviewer would say, "There is no medical judgment here. This is simply wanting something that is outside the contract." If the issue is the cosmetic surgery issue that I gave before, then the external reviewer would say, "Yes, somebody had to exercise some medical judgment to make this call. I am going to accept the case." Then he would go on to decide it.

Mr. COBURN. Dr. Ganske, 5 minutes.

Mr. GANSKE. Thank you, Mr. Chairman. I guess I am not the last one. I bet this panel wishes that I were. I want to thank the panel for being very patient all day long. I could see several of you reacting emotionally during prior testimony.

Mr. Atkins, are you an attorney?

Mr. ATKINS. No, I am not.

Mr. GANSKE. Ms. Rosenbaum?

Ms. ROSENBAUM. I am.

Mr. GANSKE. Mr. Dunne?

Mr. DUNNE. No, I am not.

Mr. GANSKE. Okay, so we have one attorney on there. Mr. Coburn, and I, and Mr. Norwood agree on a lot. But there is one provision in this bill that has to do with the certificates of medical eligibility. I want to raise a question to Ms. Rosenbaum.

By the way, I appreciate the advice you have given my staff in the past who has talked to you. I think you do have a point on medical judgments. We, in my bill, decided not to go that route because we wanted to use a form that basically had been used before, which was prevailing standards of medical care where you could get a handle on that.

Maybe I will get a reaction from the other members on this. Those certificates of medical eligibility basically set up a panel to determine fact finding. The Supreme Court has rejected removing fact finding from America's juries. In Granfinacierra v. Norberg, the court rejected Federal law that authorized certain claims that would be transferred from article III courts to article I bankruptcy tribunals. Chief Justice Rehnquist, writing for the court concluded the Federal law was unconstitutional because it eliminated the party's right to trial by jury.

In this legislation, in this one very limited section, I would have to disagree with some of my colleagues on this. I think that it would take factual issues, place them in the hands of a private entity, and that would, in fact, violate prior Supreme Court determinations on this. Ms. Rosenbaum, do you have any comment on that?

Ms. ROSENBAUM. It has been awhile for me since I have seen the proposal. I have talked extensively with your staff, and appreciate the opportunity to have input. As I understand the proposal, you are not creating an administrative process that precludes judicial relief. In fact, as I understand it, nobody is suggesting opening up

the judicial review provisions of ERISA and foreclosing remedies that already exist.

Mr. GANSKE. In the last draft that was given to the committee chairman, there was a provision that basically said that an independent panel of medical professionals would determine, in fact, whether an injury had taken place.

Ms. ROSENBAUM. This is on the liability provision?

Mr. GANSKE. Yes.

Ms. ROSENBAUM. The liability provision, as I was listening to the discussion, I was, in fact, not at all sure that this would be constitutional.

Mr. GANSKE. This was the problem that I have with this. I am concerned this will open up a big can of worms. For instance, I think the existence of personal injury can involve some important policy matters that are traditionally left to the courts and the States.

For example, until relatively recently, an unborn child was not deemed a person for purposes of tort actions or injuries before birth. State courts evolved differing approaches to prebirth, or even preconception torts, although a majority of States allow recovery for prebirth injuries. Those sensitive policy decisions were made by the Judicial Branch, or in some cases, with the State legislatures. I think they should not be left with private bodies who are not accountable to anyone. There is nothing that would prevent an external appeal entity from reverting to the notion that a fetus is not a person; and therefore, there was not personal injury for birth defects, or for other harm occurring before birth.

This, in my opinion, is a section that needs to be more fully vetted. Would you tend to agree with that?

Ms. ROSENBAUM. I certainly think it would be wise in any provision dealing with redress for injuries to get the advice of outside lawyers on the question of whether you could have a situation where an external panel makes a binding decision on causation.

Mr. GANSKE. I appreciate that. Thank you.

Mr. COBURN. The gentleman from Texas is recognized.

Mr. HALL. Ms. Rosenbaum, I want to talk you a little more about external appeals. I don't think that has been mentioned today.

Ms. ROSENBAUM. Just a little.

Mr. HALL. About over a thousand times. You know, they can't solve all of our problems. I want to go beyond that a little bit.

There are times when getting care doesn't do any good because the damage is already done. For that reason, many people think we need the liability provision in there. The whole point of external review is to make sure patients have a rapid way to get the care they need when they need it. It is to prevent delays in treatment that could be potential harmful for patients. There are cases though, are there not, where an external appeals entity because the plan has improperly denied care, and the harm is already done?

Ms. ROSENBAUM. Certainly.

Mr. HALL. So what can you do in these cases? Mr. Atkins, from his testimony, indicates that he seems to think that the remedies that ERISA currently provides are sufficient to compensate people when a benefit was denied. But the harm was already done, and external reviews or external appeals are futile. What rights would

a patient have under the current ERISA law as I have set out here?

Ms. ROSENBAUM. If the injury arises out of a benefit decision, under the current ERISA law a patient has no remedy other than payment of the benefit. So in the case of Mrs. Corcoran, had she won her case on the merits, she could have gotten recovery, of course, for the value of the hospitalization for the pre-term labor. So you are quite right to note there is no recovery now, other than the payment of the benefit if you are injured and it involved a benefit determination.

Mr. HALL. Then, Mr. Atkins, do you disagree with that?

Mr. ATKINS. No, I agree with that assessment of how it works.

Mr. HALL. Then, Ms. Rosenbaum, in an external appeal decision discuss whether or not you think the decision ought to be binding on the patient.

Once again, Mr. Atkins has agreed to the contrary as to what I set out a moment ago. I am glad he did. I appreciate him doing that. But he says on page 15 of his testimony that external review programs work, because in most cases decisions of reviews can't be challenged in State court or undercut by a jury.

I think that where the review process is successful is because it helps patients get care quickly. It has nothing to do with limiting an individual's legal rights. I would ask you to comment on that. Would we want an external review process that limited a person's further legal rights?

Ms. ROSENBAUM. My answer would be no. I think that with an external review process the number of appeals to court would actually be infinitesimal at that point. You would have gone through a fact finding on your case. A de novo fact finding on the case is better than a court review under an arbitrary and capricious standard.

If you try to make the decision binding on individuals at this point, you are going to have to open up the judicial review provisions of ERISA. You are going to have to start dealing with changing the jurisdiction of the courts under ERISA.

Mr. HALL. You have a lot of things to address, like efforts to compromise are not admissible. You have to ride around that, haven't you?

Ms. ROSENBAUM. I think that you already have such a complicated bill on your hands that to add to that list a revision of the provisions of ERISA regarding access to courts in health benefit cases would probably be a serious error, at this point.

Mr. HALL. You might even have to redefine "hearsay evidence."

Ms. ROSENBAUM. You would have to redefine a lot of things, including an historic obligation of courts and right of courts to review the decisions of administrative agencies.

Mr. COBURN. Will the gentleman yield on this?

Mr. HALL. I do yield, sir.

Mr. COBURN. I just would make a comment that patients are worth that. If that is what it costs for us to have the right treatment, even if it means we may have to work a little harder. There is nothing wrong with saying that you ought to have to have an injury before you get to sue somebody, rather than just suing because you don't have an injury. If we have a binding external ap-

peals, we won't see any lawsuits if they are truly binding. The whole key is that the liability portion of it is there as a hammer in case it doesn't work. That is what we are seeing in Texas.

Nobody wants to generate lawsuits. We also don't want to limit people's rights. You testimony just then is that we dare not should get into that area because we have so much work to do before us. I just wanted to challenge that. I will grant the gentleman the time that I took.

Ms. ROSENBAUM. I meant in the context of appeal from an external decision.

Mr. HALL. But there is a difference in the plan. Discuss that, if you would.

Ms. ROSENBAUM. Finding on the plan?

Mr. HALL. Yes. Finding on the plan.

Ms. ROSENBAUM. Currently, in today's fabric of life, plans don't appeal. If, in the current scheme of things the internal review process for an ERISA plan finds in favor of the claimant, that is the end.

Mr. HALL. Can the plan be bound?

Ms. ROSENBAUM. The plan's fiduciaries have to honor the decision that becomes the position of the fiduciary. You are not taking away the appeals rights of plans. It is just not an issue here.

Mr. HALL. Is my time up, Mr. Chairman?

Mr. COBURN. I believe it is.

Mr. HALL. Will we get another shot at them in a minute? You cut me off a while ago. You recognized two Republicans in a row.

Mr. COBURN. Well, I will be sure and make that error again in the future, Mr. Hall. I recognize the gentleman from Arizona, or is the gentleman from Tennessee? Who has privilege? The gentleman from Tennessee.

Mr. BRYANT. I thank the Chair. I thank my colleague from Arizona.

I apologize to the panel, and to the previous panel. I had to leave. I have been working very diligently on a TVA matter regarding the energy bill, which is very important to my district. I did want to come back and catch up a little bit.

I apologize to you, because if I am repeating what has already been discussed, just ignore me—or tell me. I sort of jumped in my opening statement about this liability issue. I know there has been some discussion. I hope it has been minimal. I know there has been some reference to that.

While I am at it I would to ask unanimous consent to attach to the record of this hearing, the documents—a Scott and White letter to some senators, our colleague Mr. Edwards, and its attachments.

In that letter, the liability issue in Texas, tells me that it is not the panacea that seems to be floating around. There are problems in Texas. Particularly being a lawyer, having practiced law on the defense side, defending doctors, dentists, and other people when they are sued, I know when you get involved in litigation it takes a lot of time; it takes a lot of money. There are lots of other problems there.

That is why I am somewhat reluctant to advocate litigation and liability as the end all to this situation. I understand from the Scott and White letter that I have attached that costs have, in fact,

gone up out of fear. Any time you face potential litigation, and in a medical environment I think any doctor will tell you that when you face the possibility of going to trial and putting your whole financial stake in the hands of a judge and jury, it is kind of scary. Sometimes you over-treat. I think that is one of the criticism that I have heard from my doctors when we talk about medical malpractices: "I get sued every time I don't do this test and cover myself." I think maybe we are seeing that, a little bit, in Texas.

I wanted to ask Mr. Atkins, are you familiar with the Texas situation?

Mr. ATKINS. Somewhat, because we worked on that bill in Texas—or tried to work on it.

Mr. BRYANT. Can you tell me where I am right or wrong on my testimony here?

Mr. ATKINS. The situation in Texas is very complicated. The legislature passed that law, and then it was challenged in court. For the period of time during which the challenge was ongoing, it didn't actually get implemented. So although there was liability, there were no cases that went forward until October of last year.

Then when the court actually ruled on it, they voided the external review part of the law. It is important to note that there are 18 States that have external review. Employers now comply with the external review. It is only in Texas that it has actually be challenged. But the external review part of it was voided. Then the plans have subsequently decided, as has been testified earlier, to voluntarily comply with that part. But, no, I don't think anybody is really worried about the expense of that part of the law.

The liability part of the law, the ruling that came down from the District Court was that the law could only stand—it could not be preempted—as long as the law was consistent with prior Federal Court decisions on what kinds of cases can go forward under State law. So in other words, under the previous interpretation on ERISA's preemption, the courts had said if you are suing on a matter of how you are practicing medicine, your actual practice technique, or things you have done wrong in the practice of medicine, you can sue the health plan, because of its supervisory responsibility. That is not preempted by ERISA. So the court said that if that is all this Texas law is doing, it is not preempted, but it cannot start to create liability for the coverage decision.

So the net effect of the liability law in reality, in terms of the number of cases coming forward, hasn't changed anything. In fact, the kind of case that did come forward was actually reviewed on the same basis as previous cases before the Texas law was passed. That hasn't changed anything.

What has happened with Scott and White—and I think Scott and White raised their premiums by 15 percent to employers in the wake of that law—they went back and tried to figure out where the cost was coming from. About half of that cost, they felt, came from all the HMO legislation that the State had passed in prior years. I think Ms. Barron referred to it earlier, the 1995 law. About half of it was that. After talking to the medical directors, the attributed the other half to the fact that their medical directors had decided that they would create personal liability for themselves, if they delayed or denied treatment. They did not know what "delay" was

under the law. So if it looked like they were going to cause delay, they would just go ahead and approve. They were basically making the decision to go ahead and approve anything where they didn't think it was going to harm the patient to provide the care. That was causing costs for the Scott and White plan—fairly substantial costs.

Now how general that is for other plans in the State of Texas, I can't argue. I am not sure that is a hard figure, but I think it is a fair reflection of what would happen.

Mr. BRYANT. Mr. Chairman, can I have 2 extra minutes?

Mr. COBURN. Without objection.

Mr. BRYANT. I think Ms. Barron back there was shaking her head in disagreement to some of that. Perhaps Mr. Dunne can speak? Do you have a comment or anything?

Mr. DUNNE. Did I understand you to say that the program was not in place? Because the law was enacted on September 1. The program began November 1997. The judge's ruling in the court case did not occur until September 1998. All during the period of November through September, the program was in operation. We have seen no decrease in the number of cases coming through the system, because the plans have continued to voluntarily comply. So I would like to say that is a correction to your statement.

Mr. ATKINS. Okay. Then I am sorry. I understood that it was voluntary compliance when the case went forward from that point.

Mr. DUNNE. Which would be September 1998. But from November 1997 to September 1998, we received cases.

Mr. ATKINS. I stand corrected. I stand corrected.

Mr. BRYANT. In terms of the balance of the testimony, as far as Mr. Atkins is concerned, does that change your testimony, Mr. Atkins?

Mr. ATKINS. I stand corrected that they were actually under the Texas law. I knew that they were processing external review cases. I believed it was voluntary once the action filed, because I thought that the court enjoined it. But I guess it was not until September that they actually overturned it.

Mr. DUNNE. I think Ms. Barron could perhaps comment to the committee on that.

Mr. COBURN. Well, we will ask her to do that, since she is not at the table now. I will also ask staff to inquire of Scott and White. We have had testimony that the inference was that this law caused them to raise rates 15 percent. We need an inquiry to them if that, in fact, is the case for their increase in premiums.

The gentleman from Arizona is recognized for 5 minutes.

Mr. SHADEGG. I thank the gentleman. I think Mr. Hall wanted to be recognized as the next Democrat.

Mr. COBURN. Well, we were having some discussion about who is Democrat and who is Republican. Go ahead, gentleman from Arizona.

Mr. SHADEGG. I appreciate that very much.

Mr. Dunne, let me see if I can clarify this—at least for myself. What you have told us is that the law was in effect for a period of a year. Is that correct—roughly a year?

Mr. DUNNE. Yes, sir. The actual program activity began in November 1997. The court ruling on this particular case did not occur until September 1998.

Mr. SHADEGG. So the requirement that plans go through an external appeal and abide by an it stood, as a matter of law, for that time period.

Mr. DUNNE. I would believe so. Yes, sir.

Mr. SHADEGG. Okay. As I understand it from the dialog that has gone on between you and Mr. Atkins, since then it has been a voluntary program—is that right?

Mr. DUNNE. For the ERISA plans. Yes, sir.

Mr. SHADEGG. Because they can't be bound by State law—correct?

Mr. DUNNE. Correct.

Mr. SHADEGG. Mr. Atkins, you would agree with that?

Mr. ATKINS. That is right.

Mr. SHADEGG. You made some reference to the fact that only in Texas has that been challenged. You weren't trying to imply that if a law in Arizona commanding such an external review was enacted and was not challenged, that it would in fact be binding on a plan, were you?

Mr. ATKINS. What I was saying was that in States that have enacted external review, where those programs are in place and running now, employers who are using plans that are required under State law to go through those processes, have not challenged those laws. There are not a lot States in the category: Michigan, Florida, Connecticut. There are a number of States that are doing it. They are just generally complying with those.

They could challenge those laws. If they did challenge those laws, I believe most courts would find the way the Texas court found. But the only that ever has been challenged to my knowledge was the one in Texas.

Mr. SHADEGG. So you are not arguing that States can pass laws which impose upon ERISA plans a binding external appeal procedure.

Mr. ATKINS. That is right. That is correct.

Mr. SHADEGG. So if this Congress wants a binding external appeal procedure, as every single witness on the last panel thought we ought to have, then that much of the law needs to be changed. You agree with that?

Mr. ATKINS. I believe that a Federal law needs to be passed and applied across the board to all plans. Yes.

Mr. SHADEGG. Okay. Let me go back for a moment. In our earlier exchange you said attorneys' fees aren't available now. That is, within the discretion of the court that is not mandatory—correct?

Mr. ATKINS. Correct.

Mr. SHADEGG. And in point of fact, the Corcorans didn't get attorneys' fees, did they?

Mr. ATKINS. I don't believe they did.

Mr. SHADEGG. Let us go through this issue of how we enforce a decision following an external appeal. As I understand it, you discussed this issue with Dr. Coburn. He explained to you that the legislation we have drafted erects a barrier which has never been erected before in any other draft legislation.

You have one external panel that makes a decision, finding in favor of the patient or finding in favor of the plan. If a plan does not abide by that decision and provide the care, there is a subsequent review to determine actual injury. If there is actual injury and the plan still has not provided the care, a suit may be brought. That suit would require that there have been a finding of a medical panel that there was actual injury. Do you now understand that aspect of the draft legislation?

Mr. ATKINS. Yes.

Mr. SHADEGG. Okay. You don't think that is sufficient? What I want to go through is, are there other things that you think we ought to erect as additional barriers, or bars, or intermediary steps before such litigation can be brought?

Mr. ATKINS. Well, yes. I think that the important differentiation to make here is between harm that can be caused by a decision to render one treatment as opposed to another treatment, and harm that can get caused by delaying or interfering with the proper conduct of the process that is required under Federal law.

My feeling is that, where there are process violations, ERISA now provides remedies for process violations. I think if you wanted impose penalties under ERISA for process violations, there is a precedent for doing that. ERISA currently has a similar kind of structure.

That is different from going to arbitrate the question of whether or not a decision about treatment caused harm. Because that is where I think we get into very difficult and dangerous territory. I don't know how you would differentiate between legitimate differences of opinion between equally qualified medical professional, one being in a plan who says, "We don't think this is the appropriate treatment," and another one——

Mr. COBURN. Would the gentleman yield?

Mr. SHADEGG. I would be happy to yield.

Mr. COBURN. Under our plan it wouldn't be a difference of opinion. It is a three-doctor panel versus the plan's doctor. The three-doctor panel, who are actually practicing physicians who are state-of-the-art, if they side with the plan, the plan has an affirmative defense—even if there is injury. If they side against the plan, then there has to be injury. It is not a difference of opinion of just two doctors.

Mr. ATKINS. Well, I understand. You know this better than I do. I am not even qualified to practice. A lot medicine is questions of treatment which are not definitive. Very often they are judgment calls. A lot of the practice of medicine is an art. You are going to get into decisions about treatment where reasonable, well-trained physicians will disagree.

Mr. COBURN. If the gentleman will continue to yield—the point about what you are saying is if our plan doctor doesn't think so even though three, highly qualified, peer-equivalent doctors think so, we ought to side with the plan, because it can't be determined. What we have written is of an injury because of the absence of that care specifically related to that external appeals panel. So the paper tiger that you put up there is not available under our bill.

Mr. ATKINS. But, Congressman, I am not saying that. I am saying that if you have a good external review process, that process'

decision is binding on the plan. It doesn't matter what the plan doctor or the plan medical director thought. That decision is binding.

The further question, then, is, what do you do when you go to court? Was harm caused by the treatment decision? The plan denied it, in the first instance. Then there was a time delay while this being adjudicated, and this caused harm.

Mr. COBURN. You would never get to court under our plan unless there is a predetermination that the absence of that care caused that harm.

Mr. ATKINS. I don't doubt for a minute that you can establish was caused by the choice of one treatment versus the other, because courts do it all the time.

Mr. COBURN. No, the absence of treatment. The absence of treatment. We are very careful on how we have written this. It is the absence—the withdrawal, not application—of a specific treatment that was appealed on external appeal. You are talking about a very specific thing.

Say I want this woman to have an ultrasound at 38 weeks because I am worried about her baby. "You can't have it, Doctor." I am appealing it. The appeals panel agrees with me that we can. The company says, "No, you can't." There is injury to the baby. If there is injury related to the absence of that care being applied, that is what we are talking about.

Mr. ATKINS. I understand that. I really don't have any confidence that we have a judicial system that can deliberate questions of whether harm was caused by choice of one treatment or another—or the absence of one treatment or another.

Mr. SHADEGG. Reclaiming my time——

Mr. ATKINS. I understand we do it, but I don't believe we should discipline the medical system that way. That covers the decision-making level. I think it has huge implications for Medicare and for us.

Mr. SHADEGG. Reclaiming my time, let me try to make sure, at least in my own words, that you understand the standard that we laid out in the legislation. If you don't agree with it, that is fine. We can have a legitimate disagreement on whether it ought to be the standard. I just want to explain, in my own words as an attorney—not a doctor, how I think the legislation is designed.

The way the legislation is crafted, it is not a different opinion. What has to happen is you go through the first external appeal. I am a little troubled with your position. Because you say that if the external appeal concludes that the care ought to be provided, it is your position that the care will be provided. And that is really the end of the discussion.

However, under our legislation, if at that point in time the care is not provided, there is a separate external appeal panel, also made up of medical professionals, also completely independent. They make a separate decision. That is not simply a second guess. Was this the best care or the right care? Would I have done that treatment, or not done that treatment?

There really are two steps at that point. A majority of the doctors on the separate external appeal panel have to say the plan violated the standard of care for the treatment of this illness. There might

have been two or three treatments that were available. The plan didn't give any one of those treatments. That constituted a violation of the standard of care. That is finding No. 1.

But that alone is not sufficient. Dr. Coburn can correct me if he has a different understanding about that language. They have to show first they violated the standard of care.

Second, that same external panel has to certify that that specific violation of the standard of care resulted in actual injury. That is the second piece of the hurdle that doesn't exist in any other system. That is where we believe we have gone above and beyond. We are really not asking the judicial system to make that decision. We are saying that with that subsequent decision, were they both a violation of the standard of care? Did this doctor, operating for this plan, screw up and fall below the standard of care?

We are going beyond that. We are saying that we are not going to let a lawyer, at that moment, get to a jury to make an emotional case. We are going to say, "Before you get to a jury to make the emotional case just based on that breach of the standard of care, there also has to be a proximately caused, actual injury."

Mr. ATKINS. If I could comment on that.

Mr. SHADEGG. I would like a comment. Then I just want to go over three other pieces that I think could be erected as barriers. I want to find out if you are going to be opposed to all three of them.

Mr. ATKINS. Well, that is probably the case. I mean, I think what you have defined is a respectable process. It has a lot of merit, all right? I think that the bigger question of creating Federal tort liability at all, as a way to discipline this process, is a huge question. I recognize all the controls you are putting in it. But I am very concerned that those controls are not going to be adequate. I think it is far better if we have a good process and we make it work effectively. We won't have these problems. If we do, if there are people who are guilty of misconduct in the process, I think penalties are in order. But I think the penalties should be those kinds of penalties that can be imposed within the existing structure without creating a whole new area of Federal tort liability.

Mr. SHADEGG. With all due respect, we are not creating anything. There was no immunity until ERISA passed. So ERISA created immunity. What we are doing is talking about repealing back—ratcheting back very, very slightly—the immunity that ERISA created.

Second, I would point out that sovereign immunity, which existed when this country was created, was a doctrine which this Nation rejected a long time ago. It rejected it on the notion that sending the message to anyone that you are not responsible for the consequences of your conduct is wrong. Long ago in this Nation we said the English rule of sovereign immunity—the king can do no wrong—is irrational and unfounded.

Yet, when we passed ERISA in 1974, we created that again. We said that health plans can do no wrong. They are immune for the consequential damages of their negligence, or their intentional conduct. So I suggest that we are not creating anything. What we are doing is repealing—I think—the overly broad extension of immunity in ERISA.

Let me ask you, quickly: Would you be comfortable, as a further extension of our legislation, if there were a cap on punitive damages?

Mr. ATKINS. Well, you are laying out that there are punitive damages to begin with.

Mr. SHADEGG. Under our legislation, if a plan is told by a binding panel, "Yes, you must provide this care," and then they don't, because they have gone against the decision of the binding appeal, we make punitive damages available.

Mr. ATKINS. I honestly believe that, if there is injunctive relief, you know I have the punitive damages.

Mr. SHADEGG. But we provide for punitive damages. I am asking you if you would be comfortable if we added on top of that——

Mr. ATKINS. Would I be more comfortable with punitive damages if they were capped than if they were not capped? To the extent that I am not comfortable with punitive damages at all, I would be probably somewhat less uncomfortable with punitive damages capped. I would have to agree to that.

Mr. SHADEGG. I presume you would make the same statement with regard to a cap on pain and suffering?

Mr. ATKINS. Yes. I am not going to walk down the line saying, "If it is capped, it is okay." Under either scenario, we are not happy with it.

Mr. SHADEGG. I understand. I hear you. You would say it is less bad.

Let me ask you another one. We have not put into our legislation a provision that in any litigation following a decision by a binding appeal that you would have "loser pays." But I guess I want to ask you—I am personally of the believe that loser pays is an additional disincentive to unnecessary litigation.

I think you have said all along, if an external panel says that you must provide the care it is your belief that that plan will provide the care. If that were true, I take it you would be more comfortable, for example, with a version that says, "loser pays." So if they don't provide the care, they must mandatorily pay the attorneys' fees. The same, by the way, would be true of an appeal by a patient, were the panel to go against them.

Mr. ATKINS. Hypothesizing on a legal process which I really don't want to see, the answer is I guess I would be less unhappy, yes.

Mr. SHADEGG. If there were a loser pays provision to discourage frivolous litigation?

Mr. COBURN. The gentleman's time is up.

Mr. ATKINS. I can't imagine there is going to be much frivolous litigation here. Once you have done external review, the standards get kind of hardened up.

Mr. SHADEGG. Then we are in agreement. There is not going to be much frivolous litigation.

Mr. COBURN. The gentleman from Texas is recognized for a final 5 minutes.

Mr. HALL. Mr. Chairman, thank you.

As a matter of fact, if you removed the ERISA shield, Mr. Atkins, the State law would come into effect, wouldn't it?

Mr. ATKINS. Yes.

Mr. HALL. I doubt seriously if the legislature would check with you as to your comfort degree in that instance.

Mr. ATKINS. I haven't met a legislature that would, yet.

Mr. HALL. Let me ask you a question. You represent some wonderful companies here. You are president of Health Policies Analysis, Inc., in behalf of Corporate Health Care Coalition. I think there are 24 of them. I either personally know, or am familiar with, about 17 of the CEO's of those companies. Are most of them self-insured?

Mr. ATKINS. I think they are all self-insured, in one form or another, although they also all buy insured arrangements.

Mr. HALL. And their greatest asset is their employees?

Mr. ATKINS. Absolutely.

Mr. HALL. They believe that and want care for them don't they?

Mr. ATKINS. That is right.

Mr. HALL. Do you understand that under this legislation here that the companies are not liable unless they are the ones that make the decision that causes the damage?

Mr. ATKINS. Well, almost every one of my companies would probably do something that would be interpreted by the courts as exercise of discretion. If you look at the Xerox case as a definition of what that would be, almost all of my companies would be found guilty of exercise of discretion.

Mr. HALL. That is probably right. If this Congress should decide, and the President sign the bill to remove the ERISA shield, do you have an opinion as to whether or not we would have more litigation, or less litigation?

Mr. ATKINS. I think you would have very significant litigation.

Mr. HALL. Do you think you would have more or less?

Mr. ATKINS. More, much more. The reason is because there huge rationing issues that are going on every day in this country about who should get care, and how should that care be delivered, that Medicare is dealing with and everybody else who provides health care. Those issues would move to the courts, many of them. If you look at what the court decisions have been on, like autologous bone marrow transplants, which the National Cancer Institute says you shouldn't be doing. Plans, when they have denied them, have been taken to court and sued. They lose the cases. That is the kind of change in the environment that would go on.

Mr. HALL. Ms. Rosenbaum, would you like to comment on that?

Ms. ROSENBAUM. Yes. Actually, I don't agree that there would be a lot more litigation if we simply repealed Pilot Life and went back to law prior to 1986. That is because a good lawyer today can characterize any case, just about, as a quality of care case. If you characterize the case as a quality of care case, you can get yourself out from under ERISA preemption. All State and common law remedies are available to you since ERISA does not preempt quality of care cases.

I was very interested in Congressman Norwood's point earlier. What ultimately is going to happen, I believe, is that the courts will understand completely that a treatment decision in the guise of a benefit determination is a quality of care case. Once the courts understand that, then the shield will be down. So I don't think that

opening up the door, either through a limited roll-back or through a full roll-back, would significantly alter the outcome of events.

Mr. HALL. Mr. Dunne, as you know the law passed by the Texas Legislature includes the ability of individuals to sue their plans for damages if the plan doesn't abide by the decision of the IRO. That is correct, isn't it?

Mr. DUNNE. Yes, sir.

Mr. HALL. In your opinion, what impact does evidence-based medical record of the independent external review by matched peer experts have on these cases?

Mr. DUNNE. It would appear that the experience in Texas is that the evidentiary medical record, or the medical fact-based record coming from the review may reduce the number of cases that are brought to court after the IRO review is complete, for several reasons.

Mr. HALL. Tell us why you believe that.

Mr. DUNNE. The record itself, and the so-called work paper documents that are developed by the IRO demonstrate the complete rationale for our decision as an IRO. That decision is made available to everyone: the plan, the State agency, the patient, and the provider of care. Rationale is very clearly documented. Everyone has access to that information.

No. 2, it is my understanding that evidentiary-based record would be admissible in any legal action. Finally, this process—in my mind—brings more confidence, both to the patient and the to plan because it is open and independent. I think when you take all of those factors together, as Ms. Barron and other have said, if you have a well-documented, clearly explained, timely performed record, and it says that this is the decision, the parties—why would they feel like they are in a very good position to go forward?

Mr. HALL. Mr. Chairman, may I have just 30 more seconds to ask Ms. Rosenbaum if she agrees with that?

Mr. COBURN. Yes, sir.

Ms. ROSENBAUM. Yes, I do.

Mr. HALL. And do you, Mr. Atkins?

Mr. ATKINS. Yes.

Mr. HALL. I yield back my time.

Mr. COBURN. I would like to make one comment. I think Dr. Dunne had testified that 50 percent of the cases agreed with the plans; 50 percent didn't. I want to make the same point that I made at the end of the last panel: Binding external review increases quality of care, improves education of doctors, improves education of plan management. The fact that it is open will accomplish that.

What we have heard today is some worry about the liability question. I will tell you, the last thing I want to do is create another lawsuit in this country. I want to tell you also, my patients who aren't getting care in Oklahoma today because of managed care bought through by some of these companies deserve better. If that what it takes to get it, I am for getting it.

Mr. HALL. Will the Chair yield?

Mr. COBURN. Yes, sir.

Mr. HALL. You mean that to be binding on both the patient and the plan?

Mr. COBURN. Absolutely. What I will tell you is that I am willing to move any way we can to make sure that plans deliver the care that they tell the employer/purchaser that they are doing. If binding will do it, and binding with a fine up to the level of the cost of treatment within a short period of time, I am happy to back off of litigation.

But don't think we are going to get that. I think the people you represent don't want any crack in ERISA. They see it as a negative. If we can't move to something like Mr. Hall said, let us work it out before we get to the floor of the House, we are not ever going to accomplish it.

Mr. ATKINS. I just want to say that we are willing to support you in getting a tough, binding external review provision that is enforced through penalties. It does not create liability. I think if we can start there and watch the process work, you will see that is happening in Texas. We are finding a lot out about what plans are making bad decision and which ones aren't. It equips our purchasers, our employers, to go after those plans. So I think you will see a huge sea change in the way decisions get made, once you put in a good external review provision and get this all out in the light of day. I don't think liability is necessary—as a first step, anyway.

Mr. COBURN. The real way is what Mr. Shadegg suggested earlier: Let the market work. Let patients own their health care. Then they will decide what they want to do with it.

I want to thank this panel. I apologize for the lengthy delay. I appreciate your testimony.

The record will remain open for 3 days for additional questions, if no objections.

We are dismissed.

[Whereupon, at 7 p.m., the subcommittee was adjourned.]