



PATIENTS' BILL OF RIGHTS

Over the past seven years, Congress has wrestled with the contentious issue of patient protection legislation. Proponents of the legislation have argued that managed care plans have imposed stringent cost control measures on the health care system at the expense of quality. They maintain that individuals have been harmed and the current remedies available under the Employee Retirement Income Security Act of 1974 (ERISA) are inadequate. Opponents of the Patients' Bill of Rights (PBOR) measures have countered that the PBOR proposals would greatly encumber the employer-sponsored health care system largely because of the efforts of the plaintiffs' trial bar to expose employers and health plans to unlimited liability.

During the 107th Congress, the House and Senate approved separate versions of the Patients' Bill of Rights. The most pronounced differences in the legislative proposals concern how broadly the House and Senate bills would expand the legal remedies available to individuals who believe they were harmed as a result of an erroneous health care coverage decision.

The return of double-digit health care inflation, the weakening U.S. economy, the increasing numbers of Americans facing lay-offs and the fact that PBOR has not ranked high on the list of Americans' health care concerns may move this issue lower on the list of health care priorities facing Congress and the Administration.

ACTIONS RECOMMENDED:

- At a time when employers and employees are struggling with significant increases in health care costs, the Council urges Congress to resist expanded financial liability for health coverage decisions – especially under differing state law standards.
- Rather than enacting numerous new mandates on employer-sponsored health plans or exposing employers and health plans to a major expansion in liability, the Council believes that strong, enforceable patient protections will be achieved by the implementation of comprehensive regulatory standards for the fair and timely review of all health care claims. The U.S. Department of Labor has already issued far-reaching standards aimed at ensuring better decision-making on health care claims for all participants in employer-sponsored health plans and these new standards should address the core concerns that gave rise to Patients' Bill of Rights legislation over the past several years.



EXPANDING HEALTH COVERAGE FOR UNINSURED AMERICANS

Over 41 million Americans are uninsured and that number is rising. Double digit health care inflation has returned and President Bush is expected to address the issue in his State of the Union speech. Last year, in his fiscal year 2003 budget, President Bush proposed \$89 billion over ten years in new refundable health credits for means-tested individuals (\$1,000) and families (\$3,000) that would be used to purchase health insurance in the private market or, starting in 2004, through state-sponsored purchasing pools. The health tax credits could be "advanced" by individuals who qualify for the new federal assistance to an insurance company, which would then redeem the value of the advanced credit from the U.S. Treasury. Only those without access to employer-sponsored health coverage would qualify for the new tax credit.

In addition, the President's budget message last year proposed to loosen the restrictions on Medical Savings Accounts (MSAs) to make them permanent and available to all employers. Flexible Spending Account (FSA) rollovers of up to \$500 would be permitted and individuals would also have the option to move the unspent funds into their 401(k) plan.

The President is likely to propose similar initiatives and possibly additional ones this year as part of his proposed fiscal year 2004 budget.

ACTIONS RECOMMENDED:

- The Council recommends that Congress consider supporting legislation to expand health coverage on an incremental basis, starting with those most in need, such as the millions of Americans, including retirees, who may have no connection to employer-sponsored health coverage or who are low-income and are unable to afford health care coverage that is available to them.
- The Council urges that any changes in existing tax policy for health coverage -- including new health tax credits likely to soon be considered by the 108th Congress -- must be carefully designed so they do not undermine the current employer-based system that serves over 100 million Americans.
- The Council supports legislation to allow individuals to rollover up to \$500 in unexpended funds from a flexible spending account (FSA) to meet their future health care needs. The Council also worked closely on the far-reaching guidance issued by the U.S. Department of Treasury and the Internal Revenue Service in 2002 which allows employers to establish consumer-driven health plan designs that are expected to provide more affordable and innovate health plan choices to millions of Americans over the next several years.
- The Council also urges Congress to allow insurers to offer health coverage free of state mandated benefits so that more affordable health coverage options may enter the marketplace. At the same time, the Council believes that Congress should firmly resist further efforts to impose mandated health benefits at the federal level.



MEDICARE REFORM AND PRESCRIPTION DRUG COVERAGE

Immediately following the 2002 mid-term elections, President Bush and GOP leaders of Congress said enactment of a prescription drug benefit for seniors and reform of the Medicare program would be top domestic priorities in 2003. U.S. Health and Human Services (HHS) Secretary Tommy Thompson is urging the President to outline his prescription drug plan in his State of the Union address. In June 2002, the House of Representatives passed a GOP plan to offer drug coverage through the private insurance market at an estimated cost of \$320 billion over ten years. Democrats called the plan inadequate and proposed their own \$600 billion alternative. In July, the Senate debated the issue but failed to approve a prescription drug bill.

It is unclear how comprehensive the plan proposed by the Bush Administration will be. Recently, Secretary Thompson discussed a plan in which seniors would be eligible for prescription drug coverage if they left Medicare's fee-for-service plan. Other news reports emphasize a focus on providing drugs to low-income seniors first and later expanding the program. Cost will be a key factor during this debate.

ACTIONS RECOMMENDED:

- The Council supports efforts to modernize Medicare, making it more competitive and more reflective of innovative employers' value-based purchasing practices designed to encourage health care providers to more consistently deliver efficient, high quality health services. Similarly, the Council urges Congress to provide more adequate and stable funding for Medicare+Choice plans so that more Medicare beneficiaries will have the option of electing their coverage through competing private health plans without concern about these plans remaining available to them in the future.
- Expanded prescription drug coverage for Medicare beneficiaries should go hand-in-hand with much-needed program reforms based on proven market principles and expanded consumer choice in coverage. In addition, any prescription drug coverage made available to Medicare beneficiaries should rely on private sector entities to apply pharmaceutical management practices based on those already widely in place in the private marketplace. For example, these practices include encouraging efficient mail-order purchasing, the use of therapeutically equivalent generic products, and the use of disease management programs to help determine the most effective approach to the treatment of a disease or serious medical condition.
- The Council also urges that any proposals to expand prescription drug coverage to Medicare beneficiaries must not include mandates on employers that now provide retiree health coverage, including for prescription drugs. Rather, employers should have the choice of either voluntarily accepting a financial incentive to continue the prescription drug coverage provided to their retirees or to redesign their plans to supplement any coverage made available by Medicare.

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- The Council recommends that a combination of broad-based financing and appropriate cost-sharing by beneficiaries should be used to finance Medicare reforms and any expanded prescription drug coverage. Additional increases in the payroll tax should be the last alternative considered by Congress.
- Finally, the Council recommends that Medicare's current eligibility age be maintained. Since many employers provide early retirees with valuable health benefits until they reach eligibility for Medicare, expansions in the eligibility age would force these employers to pay for additional years of benefits which they did not intend to pay for when the original commitment was made. In addition, there can be no guarantee that health benefits will be extended in all cases to fill the expanded gap between early retirement and any increase in the Medicare eligibility age, leaving more Americans without health coverage during this period.



MENTAL HEALTH PARITY

The current mental health parity law (P.L. 104-204) prohibits employer-sponsored health plans from having a lower annual or lifetime dollar limit on mental health benefits than the plan may have for other non-mental health benefits but does not require cost-sharing and treatment limits to be the same for the two categories of services. It expires on December 31, 2003.

During the 107th Congress, Senator Pete Domenici (R-NM) and the late Senator Paul Wellstone (D-MN) proposed legislation to significantly expand current law requirements and Senator Domenici is expected to press for consideration of his bill during the 108th Congress. The measure will likely continue to attract the bipartisan support it experienced over the past two years. In addition, President Bush has said he would work to pass legislation to "prevent (health) plans from applying less generous treatment or financial limitations on mental health benefits than are imposed on medical and surgical benefits." As Governor of Texas, President Bush signed a bill mandating parity for severe mental health illnesses.

Despite the widespread Congressional support for the expanded mental health parity mandate, there are some in Congress who continue to caution against passage of health benefit mandates – no matter how well-intentioned – particularly in light of the return of double digit health care inflation.

ACTIONS RECOMMENDED:

- The Council recommends extending current federal mental health parity standards – now set to expire on December 31, 2003 – rather than expanding current law by imposing numerous detailed restrictions on employer-sponsored health plans that provide coverage for mental health care services. Under current law if a health plan has an annual or lifetime maximum dollar limit for covered medical and surgical benefits, the total dollar limits for any mental health services covered by the plan may be no less.
- The Council believes that current federal parity law strikes an appropriate balance between the need to ensure basic fairness in the health plans that provide coverage for vitally important mental health care services without overly restricting the ability to carefully manage the coverage for these services so that they will remain as comprehensive and affordable as possible for all plan participants.



RETIREE HEALTH COVERAGE

Retiree health care has been a subject of intense interest to policymakers and one that is likely to generate strong interest in the next session of Congress. Many employers are concerned that negative judicial activity and ill-advised legislative proposals will severely undercut employer-sponsored retiree health benefit programs at a time when these benefits are already rapidly eroding.

Rapidly rising retiree health care costs are prompting many employers to increase retiree health insurance premiums and co-payments and consider eliminating coverage for future retirees altogether.

ACTIONS RECOMMENDED:

- The Council recommends legislation be enacted to clarify that it is not a violation of the Age Discrimination in Employment Act (ADEA) to provide a higher level of health care coverage to early retirees than is provided after an individual reaches eligibility for Medicare, which then becomes their primary source of health coverage. Such a clarification is needed because of a federal appeals court decision known as the *Erie County* case which reached a contrary conclusion and would cause nearly all retiree health plans to be found in violation federal law if this court's reasoning were applied more broadly.
- The Council urges Congress to resist any proposals that would mandate employers that currently provide retiree health coverage to continue these plans in perpetuity. Such mandates would impose an unfair burden on employers who have worked hard to voluntarily continue health coverage for their retirees compared to others who have discontinued similar plans or never offered this benefit at all. Moreover, any such mandates would have an immediate chilling effect on the willingness of any other employers to establish retiree health plans for future retirees.
- The Council encourages Congress to support legislation aimed at encouraging employers to establish more flexibility in the use of defined benefit and defined contribution retirement plans to meet retiree health care needs, such as allowing these plans to make tax and penalty free distributions directly to a retiree health plan on behalf of a plan participant or to pay for their share of their employer-sponsored retiree health plan.
- The Council also recommends that further changes in tax policy be considered to provide incentives for individuals to fund their future retiree health care needs through contributions to tax preferred savings and investment plans throughout their working careers.



MEDICAL MALPRACTICE/TORT REFORM

Sharply increased medical malpractice premiums have forced physicians and hospitals in some parts of the country to either limit their case loads or close their doors altogether. Physicians and insurers blame rising court awards for the current crisis in the medical malpractice system. The American Medical Association (AMA) says jury awards in medical malpractice cases increased by 43 percent between 1999 and 2000 alone, from an average of \$700,000 to about \$1 million. The impact of the crisis on already rising health care costs is a key concern to employers and employees, along with the impact on access to health care services for patients in high-risk practice areas such as obstetrics and trauma surgery in some states.

The House of Representatives passed a bill in September 2002 (H.R. 4600) that would have established a \$250,000 cap on non-economic damages or twice the amount of economic damages awarded and limit attorneys' contingency fees on a sliding scale basis. In addition, the bill would have limited the number of years a plaintiff can wait before filing a health care liability action and allocate damages in proportion to a party's degree of fault. The Senate considered, but failed to approve, a similar bill (S. 1370) during the Medicare prescription drug debate. This issue will be a key health care priority for House and Senate Republicans in the 108th Congress and will continue to face stiff opposition from the plaintiffs' trial bar and their allies in Congress.

President Bush supports federal medical malpractice reform saying a Health and Human Services (HHS) study shows that a federal standard for liability in medical malpractice cases could alone lower federal government costs by \$30 billion or more per year and save Americans \$60 billion on health care premium costs.

ACTIONS RECOMMENDED:

- The Council supports legislation akin to the House-passed bill from the 107th Congress to limit medical malpractice awards and make other important tort reforms in cases including health care services.
- The Council also believes any federal medical malpractice/tort reform legislation should apply equally to health plan actions determined by the courts to be subject to a state law that might also be applicable to the actions of a health care provider.