

PATIENT PROTECTIONS IN MANAGED CARE

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES
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PATIENT PROTECTIONS IN MANAGED CARE

TUESDAY, APRIL 24, 2001

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:08 p.m., in room 1100 Longworth House Office Building, Hon. Nancy Johnson (Chairwoman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
April 17, 2001
HL-5

CONTACT: (202) 225-3943

Johnson Announces Hearing on Patient Protections in Managed Care

Congresswoman Nancy L. Johnson (R-CT), Chairwoman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on managed care and how to ensure quality, affordable care is available to America's patients. **The hearing will take place on Tuesday, April 24, 2001, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 2 p.m.**

Oral testimony at this hearing will be from invited witnesses only. Witnesses will include experts on health plan liability, financing health benefits for employees and delivering timely and appropriate health services. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

In response to rising health care costs and more limited benefits through a fee-for-service system, many employers have turned to health maintenance organizations (HMO's) and other managed care arrangements. While managed care has been helpful in moderating costs, and may have helped reduce the number of uninsured, many believe the pressure to constrain costs has squeezed health providers and has inserted insurance managers into the doctor-patient relationship.

In 1998 and again in 1999, the House passed the Patient Protection Act and the Bipartisan Consensus Managed Care Improvement Act respectively to protect patients enrolled in managed care plans and to ensure timely access to covered benefits. However, both pieces of legislation failed to become law.

Earlier this year, President Bush issued principles to guide legislators as Congress crafts a patients' bill of rights. Those principles state that new protections should apply to all Americans, patients should be allowed to go to Federal court after an independent medical review, and should include appropriate employer protection with caps on damages.

In announcing the hearing, Chairwoman Johnson stated: "The time to enact a real patients' bill of rights is long past due. I am encouraged by the principles President Bush issued, which strike the right balance between appropriate accountability and costs. I think there is significant agreement on both sides of the aisle on the underlying patient protections, such as access to OB/GYNs, access to specialists, prudent layperson standard for emergency rooms, and disclosure of plan information. This hearing will enable Members to assess whether consensus has emerged on these issues and how we might best resolve the more vexing issue of accountability for health plans."

FOCUS OF THE HEARING:

The hearing begins the Subcommittee's consideration of Patients' Bill of Rights legislation. Witnesses on the panel will explore patient protection provisions including allowing access to specialty care, internal and external review and various proposals to expand health plan liability. Witnesses will explore the adequacy of current plan review procedures and whether new external review processes should be established and exhausted prior to any new liability.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should *submit six (6) single-spaced copies of their statement, along with an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, with their name, address, and hearing date noted on a label*, by the close of business, Tuesday, May 8, 2001, to Allison Giles, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136, Longworth House Office Building, by close of business the day before the hearing.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be submitted on an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, typed in single space and may not exceed a total of 10 pages including attachments. **Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.**

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers where the witness or the designated representative may be reached. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press, and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at "http://www.house.gov/ways_means/".

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairwoman JOHNSON. Good afternoon everyone. Today's hearing begins the Subcommittee's examination of issues related to the Patients' Bill of Rights. When we started exploring legislative solutions to protect patients from bad actors in the health insurance market, there was much disagreement regarding what the Federal legislation should look like. There was even a large degree of uncertainty as to whether Congress should enact any Federal protections.

I am happy to say that after 8 years of examining managed care reform legislation, there is now a great deal of consensus as to what a Federal patient protection bill should encompass. There is also strong bipartisan agreement that Congress should act quickly to extend patient protections to all Americans.

I hope we can achieve this goal this year, and promptly, but time to enact a real Patients' Bill of Rights is long overdue. In response to rising health care costs and the desire to provide more preventive care, many employers have turned to health insurance maintenance organizations and other managed care arrangements.

While managed care has been helpful in moderating costs and may have helped reduce the number of uninsured, many believe the pressure to constrain costs has squeezed health providers and inserted insurance managers into the doctor-patient relationship.

In 1998 and 1999, the House passed legislation to protect patients enrolled in managed care plans and to ensure timely access to covered benefits; however, both pieces of legislation failed to become law. Earlier this year, President Bush issued principles to guide legislators as Congress crafted a Patients' Bill of Rights.

Those principles stated that new protections should apply to all Americans. Patients should be allowed to go to Federal Court after exhausting an independent external medical appeals process, and there should be appropriate employer protection with caps on damages.

I am encouraged by President Bush's principles which I think strike the right balance between accountability and costs. I think there is significant agreement on both sides of the aisle on the underlying patient protections, such as access to OB/GYNs, access to pediatricians for children, access to specialists, the prudent standards for emergency room care, and disclosure of plan information.

However, I am concerned about some proposals that would do real damage to employer-provided health care and could increase the number of the uninsured.

Some are advocating additional unlimited lawsuits as a panacea to better quality health care. We have seen the effect of unlimited lawsuits on health care providers with malpractice insurance premiums increasing dramatically. Just yesterday, the Philadelphia Inquirer reported that hundreds of doctors will shut down their offices today and go to Harrisburg to lobby their State representatives to grant them relief from soaring malpractice insurance premiums. The problem has gotten so serious, 11 percent of doctors have left the State to escape high premiums.

I don't believe we can sue our way to better care. Ultimately and foremost, we should be trying to ensure that patients get the med-

ical care they need, when they need it. A strong, independent, external appeals process conducted by doctors will ensure patients get that care.

Health plan enrollees should also be required to exhaust the medical review process prior to pursuing court remedies. Why establish an external review process which utilizes medical experts if that process can be circumvented?

In an attempt to develop a consensus on the issue, today we will hear from the major interest groups on their protections in managed care reform.

The Patient Access Coalition, which collectively represents more than 300,000 physicians, will stress the underlying patient protections that Congress has been debating for a number of years.

The American Medical Association, which also represents about 300,000 physicians, and the Association of Trial Lawyers of America will emphasize their belief that an ERISA plan should be exposed to unlimited liability.

Finally, we will hear a consumer perspective; and from an employee representing the National Association of Manufacturers, providing the viewpoint from someone paying for health care and trying to do what is right for their employees.

But the time is ripe for Congress to act. We spent too much time stressing our differences, rather than trying to build on common ground. The President has indicated his willingness to sign a real Patients' Bill of Rights. It is up to us to deliver legislation to his desk. It is also up to us to be coldly realistic, not only about what our intended consequences might be of legislation, but what the likely unintended consequences of legislation will be as well; because day by day, it is becoming ever clearer, if you listen carefully, that if we manage this situation wrong, if we solve this problem wrong, we will push the current employer-provided insurance system from a defined benefit system to a defined contribution system.

That would be a terrible disservice to every working person in America who has employer-provided insurance, because over time it would steeply erode that benefit.

So what we do in solving this very real problem of patients' rights will determine access to insurance and the quality of coverage American workers enjoy in future decades.

I believe that the issue of unintended consequences is far more evident now than it was 2 years ago when this first hit the floor of the House, and every day it is more serious as the costs of drugs and the costs of other procedures push premiums up on their own.

So I look forward to the testimony of our witnesses, and thank you for your preparation and for your attendance.

[The opening statement of Chairwoman Johnson follows:]

**Opening Statement of Hon. Nancy L. Johnson, M.C., Connecticut, and
Chairwoman, Subcommittee on Health**

Today's hearing begins the Subcommittee's examination of issues related to a Patient's Bill of Rights. When we started exploring legislative solutions to protect patients from bad actors in the health insurance market, there was much disagreement regarding what the federal legislation should look like. There was even a large degree of uncertainty as to whether Congress should enact any federal protections.

I am happy to say that after eight years of examining managed care reform legislation, there is now a great deal of consensus as to what a federal patient protection bill should encompass. There is also strong, bipartisan agreement that Congress

should act quickly to extend patient protection to all Americans. I hope we can achieve that goal this year. The time to enact a real patients' bill of rights is long past due.

In response to rising health care costs and the desire to provide more preventative care, many employers have turned to health maintenance organizations (HMO's) and other managed care arrangements. While managed care has been helpful in moderating costs, and may have helped reduce the number of uninsured, many believe the pressure to constrain costs has squeezed health providers and has inserted insurance managers into the doctor-patient relationship.

In 1998 and again in 1999, the House passed legislation to protect patients enrolled in managed care plans and to ensure timely access to covered benefits. However, both pieces of legislation failed to become law.

Earlier this year, President Bush issued principles to guide legislators as Congress crafts a patients' bill of rights. Those principles state that new protections should apply to all Americans, patients should be allowed to go to Federal court after exhausting an independent, external medical appeals process and there should be appropriate employer protection with caps on damages.

I am encouraged by President Bush's principles, which I think strike the right balance between appropriate accountability and costs. I think there is significant agreement on both sides of the aisle on the underlying patient protections, such as access to OB/GYNs, access to specialists, prudent layperson standard for emergency rooms, and disclosure of plan information.

However, I remain concerned about some proposals, which would do real damage to employer provided health care and could increase the number of uninsured. Some are advocating additional, unlimited lawsuits as a panacea to better quality health care. We have seen the effect of unlimited lawsuits on health care providers, with malpractice insurance premiums increasing dramatically. Just yesterday, the Philadelphia Inquirer reported that hundreds of doctors will shut down their offices today and got to Harrisburg to lobby their state representatives to grant them relief from soaring malpractice insurance premiums. The problem has gotten so bad, 11 percent of doctors have left the state to escape high premiums.

I don't believe we can sue our way to better care. Ultimately and foremost, we should be trying to ensure that patients get the right medical care when they need it. A strong, independent external appeals process conducted by doctors, not lawyers or laymen, will ensure patients get that care. Health plan enrollees should also be required to exhaust the medical review process prior to pursuing court remedies. Why establish an external review process which utilizes medical experts, if that process can be circumvented by lawyers?

In an attempt to develop consensus on the issue, today we will hear from the major interest groups on their perspectives on managed care reform. The Patient Access Coalition, which collectively represents more than 300,000 physicians will stress the underlying patient protections that Congress has been debating for a number of years. The American Medical Association, which also represents about 300,000 physicians, and the Association of Trial Lawyers of America will emphasize their belief that ERISA plans should be exposed to unlimited liability. Finally, we will hear a consumer perspective and from an employer representing the National Association of Manufacturers, providing the view from someone paying for health care and trying to do what's right for its employees.

The time is ripe for Congress to act. We have spent too much time stressing our differences rather than trying to build common ground. The President has indicated his willingness to sign a real patient bill of rights. It is up to us to deliver legislation to his desk.

Chairwoman JOHNSON. Mr. Stark.

Mr. STARK. Thank you, Madam Chair, for holding this hearing on the question of patient protections in managed care. I only regret that we are having a hearing instead of sitting in the Rose Garden, signing the bill which has passed the House. And my sentiment is that when you have got Dr. Corlin and Ms. Arkin sitting as close together as they are here and agreeing, we better drop the gavel and say that we have got a pretty good bill.

My theory on legislation in this town is that if you got anybody in the room smiling, somebody is getting away with something and

you ought not to; but when everyone is looking a little grumpy, like our witnesses, that means that everyone has to contribute a little and we have got the right mix.

There isn't much disagreement. We had, I think, 60 Republicans, and I am sure that you have beaten up on some and knocked a few off the bill since we passed it, but it is strictly over the issue of liability.

The CBO came out today and said that it is going to cost one-tenth of a percent more, due to the liability portions of the right to sue. The doctors understand that if they are negligent in malpractice in—in a negligent fashion, they are apt to be sued—and rightfully—why should a health plan escape having those same penalties?

I cannot understand for a moment the rationale of letting health plans off free. We find that in the State of Texas, where a famous politician comes from, that they indeed have not had a decrease but an increase in the number of employer-sponsored insureds after their Patients' Bill of Rights has been in effect, I guess, now several years.

So I would say let us get on with it. Let us hear everybody's complaints about the egregiousness of the trial lawyers, and let us have the AMA tell us that they ain't so bad, or if they've got to suffer, so should everybody else, and let us get this bill signed.

The American public wants it, 60 Republicans joined with the Democrats—Senator Nickles stalled it in the Senate, I think as long as he reasonably can—and let us get this bill passed, get it to the President's desk and see if he chooses not to sign it. I can't believe he won't.

We will have protected an awful lot of Americans from capricious actions by the few irresponsible managed care plans who do negligently and wantonly withhold or deny needed coverage.

Thank you.

[The opening statement of Mr. Stark follows:]

Opening Statement of Hon. Fortney Pete Stark, M.C., California

Madame Chairwoman, thank you for holding a hearing on the important topic of patient protections in managed care. I only regret that this is a hearing rather than a signing ceremony. I fear we are "hearing" this issue to death. In the last Congress the House overwhelmingly passed the Patients' Bill of Rights only to be stymied during the conference with the Senate. We don't need more hearings on this topic, what we need is to get meaningful patient protection legislation signed into law.

At this point in the game, there is broad agreement on the patient protection provisions of a real, effective patients' bill of rights.

There is also widespread agreement in the House that the set of protections need to apply to each and every person in private health insurance. That has been a point of contention with certain colleagues in the Senate, but here in the House there is agreement that a patients' bill of rights needs to afford a basic set of protections that act as a floor in each and every state and for each and every person in private insurance.

There is also vast agreement that we must have a strong, independent appeals process in order to assure that patients get the care they need and have paid for with their premiums and that are guaranteed under the new law.

However, at this point we come to the giant chasm in philosophy that has stymied ultimate agreement for too long. I hope some of our witnesses here today have a solution.

That chasm is the issue of liability. Why shouldn't plans be accountable—i.e. held liable—if their negligence harms or kills a patient? If someone suffers personal injury or death as a result of a decision made by their health plan, shouldn't that health plan be held liable in the same way his/her doctor would be? If a doctor com-

mits medical malpractice, there is no question that you can sue that doctor under personal injury law. The same is true of a hospital. However, under today's laws, a health plan is often protected from any liability even if it was the direct action of the plan that caused the patient's harm or death.

I don't want courts deciding what is appropriate medicine any more than my colleagues on the other side of the aisle. I want health plans providing the appropriate care up front so that patients are not forced to go through the appeals process or to court. But, if a health plan inappropriately withholds or delays needed care, I want a patient to have access to an independent appeals process that will work.

The only way that an appeals process will be an effective means of resolving disputes with health plans is if there are REAL consequences—which means real *financial* consequences—for health plans not going along with the determination of the independent appeals entity.

Without a strong, effective liability component in the legislation, health plans will continue to deny appropriate care, delay treatment, and continue many of today's abusive practices that result in substandard care for patients because it will continue to be in their financial interest to do so.

Including effective liability provisions in the legislation isn't just about enforcement. It is also about providing people with real remedies when they are injured or killed by a plan's bad decision. The liability system must be one to which consumers will have adequate access. That is why maintaining liability at the state court level is so important. The federal courts are overloaded, they lack the expertise in tort cases, and they are difficult for consumers to access. The state courts have always been the venue for medical malpractice and personal injury cases and they are the appropriate venue for the vast majority of managed care cases as well.

So, that is the rub. We agree we need a bill, but we absolutely disagree on what is the best venue for people to enforce their rights and get remedies if they are injured or killed by a plan's action or inaction. I am tired of passing legislation at the federal level and sending out press releases saying we've solved the problem—when our solutions haven't worked. We passed CHIP, but still have more than 10 million uninsured children. We passed HIPAA and people are still denied health insurance coverage through the use of exorbitant premiums that price people out of the coverage. We have an opportunity here to pass a bill that will really assure patients of better quality care—and redress if they don't get the quality care they deserve and have paid for with their premiums. I urge my colleagues to join with me in seizing that opportunity.

Of course, we have a strong bipartisan bill that has been introduced this year, H.R. 526, the Bipartisan Patient Protection Act of 2001. In the last Congress, the House overwhelmingly passed a patients' bill of rights with broader liability protections. We've modified the liability section of the new bill in order to address concerns that have been raised. This new legislation has the support of a majority of the U.S. Senate—where our actions were stymied last year. And just yesterday the CBO confirmed yet again that we can afford to guarantee strong patient protections and accountability. The bottom line is that providing the all of protections in the Bipartisan Patient Protection Act, including accountability, will cost employees less than \$1.25—less than a gallon of gas or a loaf of bread—per person per month.

During this debate, independent surveys have shown repeatedly that a strong majority of both patients and employers are willing and able to cover these costs. This legislation is a strong model for reform and I urge my colleagues to take a close look at it.

I look forward to hearing from the distinguished panel of witnesses before us today and expect that the question and answer session will be quite lively. Thank you again, Madame Chairwoman, for addressing this important issue. I hope our next meeting on this topic will be to take long overdue action on the problem.

Chairwoman JOHNSON. It is a pleasure, before the panel begins, to welcome the Chairman of the Ways and Means Committee, Chairman Thomas, former chairman of this Subcommittee, really remarkable mind on this subject. And I am very glad, Bill, that you have been able to join us for at least part of this hearing. I hope you will be able to hear the whole panel.

Ms. Arkin.

**STATEMENT OF SHARON J. ARKIN, PARTNER, ROBINSON,
CALCAGNIE & ROBINSON, NEWPORT BEACH, CALIFORNIA,
AND MEMBER, ASSOCIATION OF TRIAL LAWYERS OF AMERICA**

Ms. ARKIN. Thank you. My name is Sharon Arkin. I am a partner with the law firm of Robinson, Calcagnie & Robinson, and I am a Member of the Association of Trial Lawyers of America. First, I greatly appreciate being invited to speak here today and that we have been permitted to express our views on these incredibly important issues.

When ERISA was originally passed, it had a very positive intent: Congress was trying to protect employees and their benefits. Over the intervening years, because of interpretation by the Supreme Court, because of the change in the medical care delivery system in this country, ERISA now actually hurts employees because it provides an unwarranted immunity to the managed care health system and allows that system to operate without control, without recourse. If they act negligently, if they act unreasonably, and even more frightening, if they act deliberately to ration and withhold care, they can hurt people and not be affected by it.

If injuries are caused by the wrongful conduct of a person, the damages for those injuries should be borne by the person who acted improperly. Those damages should not be borne by society. They should not be borne by the taxpayers, and they should not be borne by the person who was victimized, the person who got injured.

We are not talking unlimited liability here. We are not talking caps, I will get to that later. But liability of a wrongdoer in the civil justice system is always limited by the amount of harm they actually cause to people. And punitive damages are always limited by the jury's sense of what is appropriate and what is right, and by the trial court's sense of what is appropriate and right and by the appeal court's sense of what is appropriate and right. They are always limited to what is appropriate for the case. It is never unlimited.

It is a fact of human nature that people who can profit by doing wrong will continue to do wrong. We need to deter the managed care industry from putting profits over people. They accept premiums, they promise services, and they should be held to their bargain.

Speaking of unintended consequences, the tragedy is that that is what we are dealing—that is what we are trying to fix now. When Congress passed ERISA, the result was unintended consequences and giving immunity to an industry that has people's lives in their hands, literally.

I want to emphasize that I do support a fair, prompt, unbiased, external review system. I think that that is very important. I think it can help people enormously, but it can't cure the problem that ERISA has created by itself. It will get more people more care faster, and frankly, that is what we are after here. We are not after more lawsuits. If there was never another lawsuit in the HMO industry because HMOs were doing what they were supposed to do, believe me, I wouldn't starve, I would be happy. I would find something else to do with my time. But until that happens, we have to deal with this problem. We have to deal with this issue.

ERISA limits the liability of a managed care company to providing benefits and possibly having to pay attorney's fees. The external review process does exactly the same. It doesn't compensate people who are injured before they get to the external review process, or even after the external review process.

The written testimony that has been submitted by several different people demonstrates that there will not be a limitation on access to care. There will not be an increase in costs that is untoward or unable to be absorbed by employers or employees. And that is no reason—given the limitation on the costs, it is no reason to strip people of their right to obtain damages when they have been hurt.

The industry is not really afraid of frivolous lawsuits. They like to say that frivolous lawsuits will result, but the reality is they are afraid of meritorious lawsuits. That is what the industry is worried about, and that is why they are fighting so hard. If frivolous lawsuits are a problem, then let us deal with frivolous lawsuits, but don't take away the rights of people who have legitimate claims to get their damages.

The States have traditionally been the areas to supervise regulation of medical care and insurance and that should remain. I see I am out of time.

Chairwoman JOHNSON. You are out of time, and I did not—I did neglect to lay that out clearly for the panel at the beginning. We do have a 5-minute rule. You have lights in front of you. You can see them from your side, can't you? Yes. Green, yellow, and red. And we would appreciate it if you could stay within that time limit so we have more time for questions.

But since I didn't tell you, Ms. Arkin, if you have a closing sentence, you're welcome to make it.

Ms. ARKIN. Thank you. I just wanted to close by saying that damage caps actually hurt the civil justice system and they hurt the people who have the most egregious cases. The people who are hurt the worst are then victimized again by damaged caps, and that should not be permitted. Thank you.

Chairwoman JOHNSON. Thank you, Ms. Arkin.

[The prepared statement of Ms. Arkin follows:]

Statement of Sharon J. Arkin, Partner, Robinson, Calcagnie & Robinson, Newport Beach, California, and Member, Association of Trial Lawyers of America

TO THE HONORABLE MEMBERS OF THE COMMITTEE:

A. Introduction and Case Histories

My name is Sharon Arkin. I am a partner in the law firm of Robinson, Calcagnie & Robinson, and I am a member of the Association of Trial Lawyers of America. I thank you both personally and on behalf of ATLA for inviting us to testify for you here today. I was chosen to represent ATLA in this hearing because I have extensive experience in litigating actions against health maintenance organizations and managed care entities. Additionally, I was co-litigation counsel in the case of *Goodrich v. Aetna US Healthcare of California*, in which a San Bernardino County, California jury awarded \$116 million in punitive damages (that is punishment for egregious misbehavior) against an HMO for its failure to provide adequate care to its patient. Because of my experience in litigating HMO cases, I am personally acquainted with the devastation and tragedy that have resulted from the fact that HMOs are not legally accountable to their members when they breach their contractual agreement to provide care, when they substitute their judgment in place of a patient's physician, and when they violate their members' trust.

Examining the facts from cases that I have personally been involved in will help you understand why the issue of managed care accountability is so important and compelling:

- Mrs. B., a 42-year-old mother of three, was diagnosed with colon cancer. After treatment, she was forced to enroll in a large HMO because of the decision by her husband's employer to change benefit plans. A few months later, the cancer indicators in Mrs. B.'s blood tests signaled a recurrence of her cancer. Without even bothering to find out where the metastasis was—or whether it was treatable—her health plan oncologist told her nothing could be done except to make her “comfortable.” In reality, there were several options, but the oncologist—who was also the head of the utilization review committee for the medical group—threw roadblocks up at every turn and considerably delayed her treatment. Ultimately, the cancer metastasized to her liver and her lungs and then her brain. Mrs. B. underwent several rounds of experimental chemotherapy in a desperate effort to live long enough to see her children grown. She did not succeed and died in July 1997.
- Mrs. A enrolled in a senior care health plan. Because she lived in an isolated, mountainous area with only very rudimentary health care services available, she specifically questioned the health care plan's sales representative about the availability of air-lift transport in case of a serious illness or injury that the local hospital could not handle. Mrs. A was assured that such transport would be provided whenever needed. When Mrs. A had a mild heart attack, however, and the emergency room doctor in the local hospital—which had no critical care or cardiac care unit—repeatedly requested airlift transport to the nearest medical center, it was denied. Mrs. A died of cardiac arrest several hours later, in the small, unequipped rural hospital.
- Mrs. S., an elderly lady, enrolled in a large managed care plan. She went to the primary care physician assigned to her by the HMO, complaining of joint pain. The doctor told her she had degenerative arthritis and referred her for physical therapy. Despite the physical therapy, her pain worsened and her health steadily deteriorated. She returned to the doctor time and time again. Each time, the doctor shrugged off her complaints. Finally, a year and a half after her first visit, and after incessant demands by her family to know what was going on, the doctor admitted that Mrs. S. had metastatic cancer—which, the records show, he had known all along. Mrs. S. died a week later. Her cancer had never been treated.
- Mrs. R. also enrolled in a large managed care plan. She began having bladder discomfort and went to her primary care physician. The doctor referred her to a urologist, but the first available appointment was nearly three weeks away. In the meantime, Mrs. R. began bleeding from her urinary tract. She went to the emergency room. The ER doctors wanted to admit her to the hospital and called for authorization from the HMO. Authorization was denied. Mrs. R. went home. She returned to the ER the following day, bleeding even more heavily. Again, the ER doctors requested authorization to admit her. Again, it was denied. Mrs. R. went home. The following day, when Mrs. R. went to the emergency room, she was bleeding so heavily that she had to walk with bath towels between her legs. **Again** the HMO refused authorization to admit her to the hospital. Finally, in desperation, Mrs. R.'s son took her to another hospital. The doctors there discovered a tumor the size of a grapefruit in Mrs. R.'s bladder, admitted her on an emergency basis and rushed her to surgery. Because of the loss of blood over the preceding days, Mrs. R. suffered a heart attack during the surgery. Although she survived, her health has been seriously compromised.
- David was a highly-respected and well-liked career deputy district attorney enrolled in the health care plan purchased by the county. After he collapsed one day in court and was transported to the hospital, he was diagnosed with a rare form of stomach cancer. The plan oncologist admitted that the type of cancer was beyond his scope of experience and ability and requested referral to UCLA—an out-of-plan facility. After battling with the plan and its administrative review organization, the out-of-plan referral for consultation was finally approved, but by the time approval for the actual treatment was obtained, the cancer had metastasized. Then, when another therapy was recommended by another out-of-plan treatment center—and was specifically requested by and approved by the primary care physician and the plan oncologist—the treatment was denied. The HMO denied the treatment despite the fact that the head of the HMO's technology assessment department **actually recommended that David receive the treatment**. David's death left his wife bereft—and nearly \$750,000 in debt.

- Mr. L. was diagnosed with lung cancer. His plan oncologist told him that the tumor was too close to his heart and that he could, therefore, only be treated with radiation therapy. After the health plan refused Mr. L.'s request for an outside consultation with a surgical oncologist and because the plan did not have a surgical oncologist available, Mr. L. paid for his own consultation with a USC specialist. The USC specialist told Mr. L. that the tumor was, in fact, operable, although it would be a very delicate and tricky operation. The surgeon also told Mr. L. that the surgery was his *only* chance for survival because radiation therapy simply could not eradicate the tumor and, in addition, was likely to damage his heart. Even more frightening, the surgeon also informed Mr. L. that the tumor was growing very fast and could double in size within 30 days. As such, it was imperative that the surgery occur as soon as possible. Mr. L. then had to start the referral and review process within the HMO to get approval. He had to go back to his primary care physician for a referral to the in-plan oncologist and then had to go to a consultation with the in-plan oncologist. The in-plan oncologist concurred that surgery was the best possible treatment and that it had to be done immediately, but that the plan had no surgeons qualified to perform the surgery. Thus, the oncologist recommended, the plan should authorize the out-of-plan treatment. *The plan denied the treatment.* That process, alone, took one week. Mr. L. simply did not have the luxury of waiting for the plan's internal grievance process to review the issue and he certainly did not have the time to have an external review process deal with the issue. He had to have the surgery *immediately*. He disenrolled from the health plan the next day and the day after that had the surgery—which was paid for by Medicare. He is still alive and well, four years later.

The horror stories coming out of the managed care industry are legion. The truly horrible part is that they are not the tortured imaginings of a fevered plaintiffs' bar. They are real. They are about real people. And there are thousands of them.

B. Why Legal Accountability is Necessary for Managed Care Insurers

The civil justice system in this country is predicated on two guiding principles: (1) For every wrong there is a remedy; and, (2) When the wrongful misconduct of one person causes injuries to another, the wrongdoer must be legally accountable to the injured person and must compensate for the injuries their misconduct has caused. There are, in fact, two underlying public policy purposes for these principles. The first, of course, is to assure that injuries are compensated by the person who caused the injuries so that neither society nor taxpayers through their government is forced to bear that financial burden. The second underlying purpose is akin to one of the goals of the criminal justice system: Deterrence. If wrongdoers, whether criminal or civil, know that they will face no consequences, they have no reason to stop their wrongdoing—especially if their conduct is financially rewarding. Forcing civil wrongdoers to compensate their injured victims for the harm they cause removes any financial incentive that might exist for engaging in that wrongdoing.

ERISA, as it is presently structured and as it has been interpreted by the Supreme Court in *Pilot Life v. Dedeaux*, lacks this deterrent effect. Under ERISA, an HMO can deliberately and purposely deny a claim which it knows is covered under the plan. The most that can happen to the HMO if the member sues is that the HMO will have to pay for the wrongfully-denied benefit and may possibly have to pay some attorneys' fees to the patient. That's it. If the denial is for life-saving treatment and the patient dies without obtaining that treatment, the HMO is completely free of **any** potential liability: It will never have to pay for even the treatment because the treatment was never received and the family cannot sue for wrongful death. That, of course, builds in an incentive to the HMO to deny care and take the chance that the patient will never sue and, tragically, may not be alive to do so.

1. Market Forces Cannot Correct the Problem

Some would say that employers and employees would never choose an HMO that wrongfully denied claims and that market forces would put those companies out of business. That is simply not the case. First, remember that in the majority of private sector employment situations, most employees do not have a choice—their employer selects one plan and the employee must take it or leave it. Second, even when more than one plan is provided as a choice, the consumer/employee and even the employer often have little or no information on which to base a selection, at least with respect to these issues. That is because HMOs are “graded” on the way they handle routine care rather than the way they handle more serious care requests. When accrediting organizations, like National Committee for Quality Assurance (“NCQA”) or URAC, assess HMOs, they generally do it on the basis of how well the

HMOs meet standards regarding processes and structure, not whether the HMO determines individual claims fairly and properly. And while both entities rely on customer service surveys in formulating their accreditation criteria, those surveys generally focus, again, on routine services—which most HMOs perform well. Since, fortunately, many HMO patients do not require more than routine services, they are unaware of the problems they may encounter when a health care plan decides that its own financial well-being takes priority over a patient’s medical well-being.

Additionally, NCQA’s own survey shows that, traditionally, patients rely on family and friends when choosing a health care plan. (See www.ncqa.org/Pages/Programs/QSG/reportcards.htm.) Obviously, this information source has the least likelihood of providing accurate information about how HMOs respond when care beyond the normal routine care is needed.

Perhaps the most telling statement on the distinction between the standard of care an HMO provides with respect to routine care and that provided with respect to other types of care comes from the primary care physician who treated David Goodrich in the *Goodrich* case. Dr. Wang encountered David’s wife in the hospital waiting room while David was receiving an MRI that had been denied by his HMO. When Mrs. Goodrich asked Dr. Wang—who had requested the MRI—how Aetna could deny that test, Dr. Wang’s response tells the whole story: “HMOs are good if you don’t get sick.”

Thus, neither employers nor patients/employees have a good means of determining whether a particular HMO’s decision making is going to become problematic once significant or expensive care is needed. Because of that, “market forces” cannot function well to control or limit the abuses.

2. Case Law Evolution Cannot Correct the Whole of the Problem

Further evidence that market forces cannot—or, at least, do not—factor into this problem is the fact that the federal judiciary has become a catalyst in an attempt to ameliorate the harshness of the ERISA rule. As a whole, federal judges are not activists and are unwilling to step on Congressional prerogatives. But the problems created by ERISA’s liability limitations have driven even the most conservative judges to frustration and dismay. For example, J. Spencer Letts, a very conservative judge of the United States District Court, Central District of California, has undergone an epiphany regarding the risks and dangers to insureds where an insurance company decides and administers benefits under its own policy where that policy is part of an ERISA plan. (*Dishman v. UNUM*), 21 Empl. Bene. Cas. 2941 (C.D. CA 1997). Judge Letts’ commentary provides a compelling and insightful demonstration of the type of insurer conduct that occurs because ERISA provides a disincentive for insurers and HMOs to provide promised benefits:

“This Court has always strongly believed in preserving the remarkably successful balance of competing interests struck by Congress when it enacted ERISA. . . .

“However, the facts of this case are so disturbing that they call into question the merit of the expansive scope of ERISA preemption. UNUM’s unscrupulous conduct in this case may be closer to the norm of insurance company practice than the Court has previously suspected. This case reveals that for benefit plans funded and administered by insurance companies, there is no practical or legal deterrent to unscrupulous claims practices. Absent such deterrents, the bad faith denial of large claims, as a strategy for settling them for substantially less than the amount owed, may well become a common practice of insurance companies.

* * *

“Insurance companies do not have the same practical incentives as employers to administer benefit plans in good faith. For self-administered and even self-insured plans, employers are motivated to act in good faith not only in order to comply with the law, but by the practical considerations of maintaining employee loyalty and morale. . . . For many employers, trying to hold down the costs of employee plans through unscrupulous practices may undermine employee morale and loyalty even more than not having an employee plan at all.

* * *

“Without these practical incentives, there is no counter-balance to insurance companies’ interests in minimizing ERISA claims.

* * *

“The fact that most people in the Dishmans’ situation would have had to capitulate is the most troubling aspect of this case. The need to deter insurance companies from behaving in this manner is why bad faith liability exists under almost all state laws. ERISA preempts all such laws. Under ERISA, no matter how unfounded the denial of a claim may be, the only recovery permitted to the claimant is the amount of the benefit.

“As this case demonstrates, the reform of shifting the attorney’s fees to the insurer is not enough to deter this type of conduct. UNUM’s bad faith acts placed pressure on the Dishmans because they were deprived of monthly income which they needed to live. A lump sum benefit after a lawsuit, even with interest and free from legal expense, did nothing to alleviate the pressure upon them at the time the claim was denied and during the course of the litigation. UNUM was not deterred by the prospect of paying the Dishmans’ attorneys’ fees, because it had every reason to believe that the economic straits in which it had placed the Dishmans would force a favorable settlement long before any substantial fees had been accumulated.

* * *

“[W]ithout any statutory or other legal deterrent it is entirely predictable that insurers will go overboard to minimize claims.” (Emphasis added.)

A similar, though far more lengthy and scholarly, analysis was conducted by District Court Judge William Young of the United States District Court, District of Massachusetts. Writing in a health care case, *Andrews-Clarke v. Travelers Insurance Co.*, 984 F.Supp. 49 (1997), Judge Young issued a stinging indictment of ERISA’s preemptive effect. After summarizing the tragic facts of the case and the prior procedural history of the action, Judge Young explained:

“Travelers and Greenspring promptly removed [the widow’s] case to this Court and then, just as promptly, asked this Court to throw her out without hearing the merits of her claim [on the basis that the wrongful death claim was preempted by ERISA].

“This, of course, is ridiculous. The tragic events set forth in Diane Andrews-Clarke’s Complaint cry out for relief.

* * *

“Under traditional notions of justice, the harms alleged—if true—should entitle Diane Andrews-Clarke to some legal remedy on behalf of herself and her children against Travelers and Greenspring. Consider just one of her claims—breach of contract. This cause of action—that contractual promises can be enforced in the courts—pre-dates the Magna Carta. It is the very bedrock of our notion of individual autonomy and property rights. It was among the first precepts of the common law to be recognized in the courts of the Commonwealth and has been zealously guarded by the state judiciary from that day to this. Our entire capitalist structure depends on it.

“Nevertheless, this Court had no choice but to pluck Diane Andrews-Clarke’s case out of the state court in which she sought redress (and where relief to other litigants is available) and then, at the behest of Travelers and Greenspring, to slam the courthouse doors in her face and leave her without any remedy.

“This case, thus, becomes yet another illustration of the glaring need for Congress to amend ERISA to account for the changing realities of the modern health care system. Enacted to safeguard the interests of employees and their beneficiaries, ERISA has evolved into a shield of immunity that protects health insurers, utilization review providers, and other managed care entities from potential liability for the consequences of their wrongful denial of health benefits.” (*Andrews-Clarke*, 984 F.Supp. at 52–53.)

The judiciary has not only vocally expressed its dissatisfaction with ERISA’s effect on the rights of private sector employees to obtain compensation for their damages, they have begun to chip away at its application. Although it is generally held—in the context of a health care plan subject to ERISA preemption—that contract and tort claims arising from an HMO’s refusal to provide approval for referrals, tests and/or treatments (i.e., a denial of *benefits*) are preempted, the courts have carved out an exception and have held that *malpractice* claims against an HMO are not preempted by ERISA.

The lead case on this issue is *Dukes v. U.S. Healthcare*, 57 F.3d 350 (3rd Cir. 1995) in which the court determined that the HMO should properly be subject to vicarious liability for the medical negligence of the medical providers arranged for by the HMO under the plan and that such medical negligence is not preempted by ERISA. Essentially, the *Dukes* court's analysis turns on a distinction between the existence of coverage for the treatment and the quality of the treatment itself. In other words, if the HMO denies requested care because the treatment is not covered, e.g., the treatment falls under the plan's experimental exclusion, the claim is subject to ERISA preemption because it deals with coverage for benefits. If, on the other hand, the treatment is covered under the terms of the plan, but the doctor or the HMO want to provide a less effective treatment (usually for reasons of cost) and that injures the patient, it is not preempted because, in fact, benefits were provided, but the benefits were simply of poor quality. The *Dukes* court pointed out that ERISA was only designed and intended to assure that the promised benefits are, in fact, provided and was never intended to operate beyond that threshold or go into the realm of examining the **quality** of the benefit provided. Thus, the court concluded, state law acts in that context.

One of the most telling examples of the shift in the courts towards easing the impact of ERISA's remedy preemption is that of the Fifth Circuit. In *Corcoran v. United Health Care, Inc.*, 965 F.2d 1321 (5th Cir. 1992), *cert. denied* 113 S.Ct. 812, 121 L.Ed.2d 684 (1992), the Fifth Circuit held that a wrongful death action based on claims of malpractice brought against the HMO was preempted by ERISA. Seven years later, in *Giles v. NYLCare Health Plans*, 172 F.3d 331 (5th Cir. 1999), the Fifth Circuit upheld the district court's order remanding the action to the state court on the grounds that the malpractice action raised a state-law claim not completely preempted by ERISA.

The Fifth Circuit, however, never addressed the merits of the *Corcoran* issue at all—i.e., does ERISA preempt the malpractice claims. Rather, the court fashioned its analysis around the procedural question of jurisdiction, and dodged the *Corcoran* issue by expressly stating that “restraint and comity indicate we should reserve the issue [of whether ERISA does, in fact, preempt the state law claims of malpractice] for resolution in the first instance by the state court.”

That the Fifth Circuit would utilize a procedural vehicle to avoid a conflict with its *Corcoran* decision on the merits of the substantive issue of preemption of malpractice claims provides a telling demonstration of how far the courts will now go to avoid sacrificing victims' remedies on the altar of ERISA preemption.

Even the United States Supreme Court has expressed a growing dissatisfaction with the consequences resulting from the breadth of ERISA preemption and has retrenched to some degree on that issue. In a series of decisions, the Court began to narrow and limit ERISA's preemptive effect: *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995); *De Buono v. NYSA-ILA Med. and Clinical Servs.*, 520 U.S. 806, 117 S.Ct. 1747, 138 L.Ed.2d 21 (1997); *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 117 S.Ct. 832, 136 L.Ed.2d 791 (1997).

More importantly, in the specific context of insurance and managed care benefits, the Supreme Court has indicated that ERISA preemption should not be so broadly applied. In *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358 (1999), the Court held that a state law claim which might otherwise relate to an ERISA plan is saved from ERISA preemption where the relevant state law regulates the business of insurance. And, even more recently, the Court held in *Pegram v. Herdrich*, 530 U.S. 211, 120 S.Ct. 2143 (2000) that “mixed” decisions by a managed care doctor that implicated both medical judgment and administrative concerns do not constitute fiduciary actions subject to control under ERISA.

The “sticking point,” however, with these judicial efforts to chip away at the devastating effect of ERISA preemption in the insurance or health care context is the second half of the Court's opinion in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549 (1987). In the first half of the opinion, the Court held that state tort law of general application was not saved from ERISA preemption. Further, the Court noted, the tort law at issue in that case, Mississippi's bad faith law, was a tort law of general application and was not restricted in its application to the insurance industry. It was not, therefore, saved from ERISA preemption.

In the second half of its opinion, however, the Court went on to express reservations about whether a state law which did, in fact, regulate insurance would still be saved from ERISA preemption. The Court's concern centered around the issue of whether any state law which provided **remedies** other than those set forth in the ERISA statute should be permitted in light of Congress's apparent intent that all such plans be given similar administrative regulation and protection, even if that

state law would otherwise be exempted from ERISA preemption. It is that portion of the *Pilot Life* case which remains intact and which has not been readdressed by the Court since that decision. And it is that portion of the decision which necessarily hampers any other court from imposing damages against an HMO or health insurance company, no matter how outrageous or egregious the misconduct. It is that portion of the decision which must be addressed—and fixed—by Congress.

C. Accountability Will Not Increase Either Costs or the Number of Lawsuits

Opponents of permitting liability lawsuits against irresponsible HMOs or health insurers raise two common objections. First that liability provisions will increase costs and that in turn, will require an increase in premiums and a resulting decrease in the number of people who can or will be insured. Second, that public outcry for legislation that would give patients the legal right to hold the HMO industry accountable is somehow nothing more than an attempt by trial lawyers to have another basis for bringing “frivolous” lawsuits. Neither of these criticisms has any merit.

1. Fear of Increased Costs is Unfounded

The first thing to keep in mind, of course, is that ERISA has granted the managed care industry an extraordinary immunity—absolute immunity from legal accountability for the injuries and deaths their decisions may cause. No other industry has that. Indeed, even the Federal government has not given itself such broad immunity. And there is simply no justification for this immunity. HMOs and insurers are in business just like every other industry. They have been making profits just like every other industry. Despite some massive losses for not-for-profit HMOs, the managed care industry expects profits of more than \$3 billion in 2000, a 60 percent increase over 1999 profits, according to a study by the Corporate Research Group Inc., New Rochelle, New York, as reported in the May 2000 edition of *Healthcare Finance Management*. Revenues are expected to increase about \$14 billion to \$176 billion this year. Because HMO enrollment will rise only about 1 percent in 2000, most of the increase in industry revenues is expected to come from higher rates, according to the study.

More importantly, the claim that costs would increase, that premiums would increase and that the number of uninsured Americans would increase are simply not supportable, either logically or empirically.

First, premiums are already increasing, in part, because premiums during the last decade have been artificially depressed. In addition, huge increases in the cost of prescription drugs are driving medical inflation according to a September 2000 survey by Kaiser Family Foundation and Health Research & Educational Trust.

Second, costs should not increase at all as the result of HMO accountability legislation. If an HMO is providing the care it is contractually required to provide—and is acting in good faith—it will not be sued. Indeed, the best way to avoid litigation is to provide quality services and products that do not endanger the health and safety of consumers. Texas is a good example. In 1997, when the Texas Legislature passed an HMO accountability law, 24.5 percent of Texans had no health insurance. By 1999, the percentage of Texans without health insurance decreased to 23.3 percent according to the U.S. Census Bureau. (Data available online at: <http://www.census.gov/hhes/hlthins/hlthin99/hi99te.html>.) Clearly, in Texas, fears of increasing the number of uninsured were unfounded.

Third, if medical costs increase, it will only be because HMOs start paying for services they were contractually obligated to provide, but for which they were unreasonably denying claims. That means that they were receiving a windfall—getting premiums for benefits they previously were not providing. The fact that they will now be providing the benefits for which they have been receiving premiums should not increase costs—since, in fact, they were receiving premiums for those benefits all along. If the cost of providing those promised benefits does drive up premiums, that could only be the result of the fact that the HMOs were deliberately deflating the premiums in order to obtain market share—a very common occurrence during the mid-to-late '90's. None of that economic theory, however, justifies immunizing this particular industry from its own wrongdoing when the health and the lives of Americans are at stake.

That premium costs should not be impacted as the result of the advent of liability provisions is confirmed by empirical analysis as well. In a study conducted by the Kaiser Family Foundation prior to the enactment of California's new HMO liability law, patterned on the Texas legislation, it was estimated that additional liability exposure should have an extremely minimal impact on premiums—on the order of approximately 17 cents per member per month or \$2 a year.

2. *The Contingency Fee System Deters “Frivolous” Lawsuits*

ATLA and the plaintiffs’ bar do not support the inclusion of accountability provisions in order to generate lawsuits for their own sake. We support it, and patients and their families support it, because they want people to receive the care they have been promised and be *protected* from, not exposed to, serious illness, injury, or death. Our society does not make bank robbery illegal because we want to fill up the jails with prisoners. We make bank robbery illegal because we want people to stop robbing banks. The same is true here. We do not want liability provisions because we want to fill the courts with law suits. We want to make HMOs accountable because we want HMOs to fulfill their contractual promises to provide quality care to the patients who are paying premiums.

Most plaintiffs’ attorneys are in reality small business people. No lawyer—especially a contingency fee lawyer, who is paid and reimbursed for expenses only if he or she wins for the client—will take a case that has little merit or a case where it is a “close call” as to whether the HMO’s denial of care was unreasonable. It simply does not make financial sense for the lawyer to do so. Thus, if the HMOs provide the benefits they are supposed to provide, costs will not increase as the result of damages imposed in litigation—because there will be no litigation. And if the HMOs do **not** provide the care they are supposed to provide, what justification is there for protecting them—unlike anyone else—from the consequences of that misconduct? Again, Texas is a good example. Although no government entity in Texas officially tracks the number of lawsuits brought under the HMO statute, only 10 lawsuits have been brought against managed care entities even though 4 million Texans are covered by managed care plans.

If frivolous lawsuits are a concern, then that is the concern that should be addressed. The rational approach is to punish lawyers who file frivolous claims. State court and state bar associations already have mechanisms in place to punish such lawyers. It is never a wise public policy to deal with frivolous lawsuits by taking away the legal rights of people who have been injured through no fault of their own.

D. External Review Cannot Solve the Problem

The industry asserts that the problems of abuse by the industry can be rectified by the use of the external, or independent, review process. I have several comments with regard to that proposal.

First, in a perfect world, an external review system that is truly fair and prompt could eliminate many—though not all—of the problems engendered by the health care benefits industry’s pattern and history of misconduct. And to the extent that even an imperfect system may help, I whole-heartedly support it. But it cannot be embraced as the cure-all for the problems faced by managed care patients. And there are several reasons why:

- Because any exhaustion of remedies requirement is necessarily a limitation on access to justice, it should be as narrow as possible. This issue is of particular concern with respect to the suggestion that an external review process be **binding**. *Essentially, such a provision would deny patients their 7th Amendment right to a jury trial in cases where an HMO has made an incorrect medical decision that results in injury or death.* That is contrary to 225 years’ of jurisprudence in America. The American jury is a uniquely democratic institution. The more than five million Americans called for jury duty each year still serve as the conscience of the community. And it is the only governmental body that is truly neutral, unswayed by electoral pressure, financial self-interest, and blind ambition.

There is no proof that an external review process would not be biased, complicated, or otherwise impose a hardship on a sick patient or a family that has already suffered a loss. I also fear that there would be unfairness at the internal review stage of the process. At both stages, most patients likely would not have counsel to assist them in preparing their case for review or in presenting their case. The HMOs, of course, would have counsel on staff for just that purpose. Thus, many patients would be placed at an immediate disadvantage. Similarly, most patients at that stage do not have either the access to, or the funds necessary to obtain, expert medical opinions in support of their claims. Again, the HMOs would and do have those resources. The system is thus skewed in favor of the HMO going in. These problems, of course, raising serious due process concerns for patients.

A major concern would be the issue of who conducts the reviews. In my experience as a litigator dealing with purportedly “experimental” procedures, and denials of care based on that exclusion, I have observed a distinct disparity in the opinions of equally-qualified experts, depending on the nature of their practices. The clinicians—the doctors who actually treat patients as opposed to merely studying them—

tend to be on the cutting edge of medical practice. They are aware of the alternative treatments, what their likelihood of success may be and what the downside risks of the treatment are. More importantly, they are willing to let their patients decide whether they are willing to undergo that treatment in the hope of obtaining relief from illness or disease. These doctors see, up close and personally, on a daily basis what works and what does not.

On the other hand, academics, who may have virtually no hands on experience with real live patients with real health problems, tend to be far more cautious and conservative. They are more tied to the scientific method than they are to the practice of medicine as a healing art. They require stringent standards of scientific proof that may not be realistic when dealing with a particular patient's illness.

This disparity in the way that clinicians versus academics view cutting edge treatments can have a significant impact on the outcome of an external review evaluation process. And the question is, who should resolve that dispute? If the external reviewer deciding the case is a clinician, the HMO may claim the process is not fair. If the reviewer is an academic, the patient may claim the process is not fair. If the process is binding, without recourse to a jury to resolve that dispute, there is no way to assure fairness at all.

These due process and fairness concerns, in fact, led California to provide that its external review process not be binding. Thus, a patient can proceed through the external review process and, even if the reviewer decides that the care need not be provided, the patient still retains his or her Constitutional right to a jury trial to correct the injustice of the HMO's denial of benefits.

- *For many people, an external review process simply cannot help.* In the case history examples provided at the beginning of this testimony, for example, external review could achieve nothing. For Mrs. A, the lady who died of a heart attack in a rural hospital because the HMO would not authorize an air lift for her to a medical center, external review could not bring her back to life or restore her to the bosom of her family. In that context, then, if the only remedy were external review, it would continue to give HMOs the incentive to deny necessary, life-saving emergency care because there would be no consequences resulting from that denial. Similarly, in the case of Mrs. R—who had the tumor in her bladder and needed immediate surgery—external review alone could not help her get the care in time. Moreover, it could do nothing to compensate her for the heart attack she suffered as the result of the HMO's delay in care. And what about Mrs. S—who was diagnosed with cancer, but never told about that diagnosis until shortly before she died? What good would external review do her? Or her family?

External review without legal accountability is a sham. As these examples illustrate, the fundamental problem with external review is that it leaves the same loophole as ERISA itself. Where death or injury has already occurred, where damage is imminent or has already happened, external review provides no remedies. All it can do is what ERISA does now—tell the HMO to provide the care it should have provided to begin with. How will that give HMOs the incentive to provide the care **willingly**, and without forcing patients to go through yet another process? It cannot.

Thus, while external review may be an important adjunct to the liability provisions, it cannot, by itself, solve the problems that have resulted from the HMOs' abuse of ERISA immunity.

E. State Law Should Apply to Control HMO Misconduct

1. Insurance Law has Historically been Regulated by the States

Once it is decided that adequate remedies should be included in ERISA, the question becomes whether those remedies should be federally mandated or controlled by state law. The history of insurance regulation and the regulation of health and safety mandate that this issue be controlled by state law.

Many of the courts which have followed the *Dukes* line of cases have reasoned that malpractice-type claims or "quality of care" claims against HMOs should be governed by state law and not preempted by ERISA on the basis of the standard "police powers" analysis. In other words, the Constitution, and the cases interpreting and applying it, have been very clear that states can and should regulate and control issues relating to the health and safety of their citizens. Thus, where an HMO makes a determination that impacts the health or safety of a state's citizens, principles of federalism mandate that the state controls the remedies that are to be afforded those citizens.

In addition, the McCarran-Ferguson Act leads irrevocably to the same conclusion. When anti-trust legislation was being passed by Congress in the 1940's, the insur-

ance industry lobbied for and obtained an exemption from that regulation for itself. In the McCarran-Ferguson Act, Congress expressly declared “that the continued regulation and taxation by the several States of the business of insurance is in the public interest.” (15 U.S.C. section 1011.) As such, under that Act, no federal legislation of general application is permitted to preempt state regulation of the business of insurance.

And that HMOs are, in fact, in the business of insurance cannot seriously be challenged. The Ninth Circuit, the Wisconsin Supreme Court, the California Supreme Court and the California Legislature have all made express findings to that effect. (See *Washington Physicians Service Ass’n v. Gregoire* (9th Cir. 1998) 147 F.3d 1039, 1045–1046; *Sarchett v. Blue Shield of California* (1987) 43 Cal.3d 1, 3, fn. 1; *McEvoy v. Group Health Cooperative of Eau Claire* (1997) 213 Wis. 2d 507, 570 N.W.2d 397; California Civil Code section 3428, 1999 ch. 536, section 1.)

Since HMOs are in the business of insurance, and since the McCarran-Ferguson Act—obtained through the insurance industry’s own efforts—mandates that state regulation of insurance is in the public interest, state regulation of HMO conduct is demanded.

State regulation of HMO conduct also makes sense on other levels. Each state already regulates HMOs and even nationwide HMOs, like Aetna, incorporate separately in each state. Additionally, state-based regulation of HMOs allows local community standards regarding appropriateness of damages—both as to type and extent—to prevail. State regulation also puts government employees and private sector employees living in the same community on precisely the same footing. As it now stands, the rights and remedies of employees of local and state governmental agencies are regulated by state law while a next-door-neighbor who is a private sector employee is subject to ERISA’s limitations. A teacher at a public school who suffers precisely the same injury as a result of an HMO’s decision as a private school teacher has a remedy under state law. But the private school teacher has no remedy. If state control of ERISA-based remedies is permitted, both citizens are afforded equal treatment.

2. Federalizing HMO Claims Wastes Limited Judicial Resources

There is nothing magical about federal court. Federalizing managed care liability denigrates legitimate states’ rights. Throughout American history, state courts have always been the arbiter of medical malpractice claims and related lawsuits. Federalization duplicates the work of state courts and wastes limited judicial resources. Since the mid-1990s, the federal civil dockets have been severely backlogged as the result of unprecedented number of judicial vacancies and the increasing federalization of state and local criminal drug laws. Chief Justice Rehnquist has repeatedly asked Congress not to expand the jurisdiction of the federal judiciary. Federalizing HMO suits only ensures that such cases will go to the back of the line of the federal docket, creating unreasonable delays for injured patients. In contrast, state courts’ civil dockets move with much greater speed due to a smaller caseload and greater experience with state-law based injury claims.

Managed care insurers often prefer the federal court system because they have found that it allows them to delay the resolution of claims—and thereby earn investment income on even the most meritorious compensation—and blame the “empty chair”—the doctor or the hospital—for the patient’s injuries. Since only managed care insurers, and no other potential defendants, would be under the jurisdiction of federal court, successfully blaming the empty chair lets HMOs off the hook.

In addition, federal court can be extremely expensive, time consuming and inconvenient for patients, who may live hundreds of miles from the nearest federal courthouse. In some of the larger, western states, for example, injured patients often live hundreds of miles from the nearest federal courthouse while the local state court is likely just across town.

Proponents of federal jurisdiction argue that federal regulation of ERISA remedies is necessary in order to assure administrative consistency and efficiency of ERISA plan administration. The reality is that—even under ERISA as it is presently structured—every HMO already operates under both state and federal regulation simultaneously. This is because the vast majority of commercial HMOs offer plans to both private sector employers and government employers. Any time a government or church employee is covered, the entire panoply of state-based regulations—and state remedies—is automatically triggered. That necessarily requires the HMO to be attuned to and prepared for that state regulation. Indeed, state regulation of HMO remedies under ERISA will ease HMO compliance requirements because each HMO in each state will be required to comply only with that state’s regulatory scheme and will not be burdened with a continuing dual system of both state and federal regulation.

Thus, for both historical, constitutional reasons and for practical, procedural reasons, state regulation of HMO liability simply makes the most sense.

3. Caps on Damages are Unnecessary and Unfair

Congress should not federally mandate limitations on damages. A federal mandate would again abrogate and violate the state's interests and the principles underlying the McCarran-Ferguson Act. The issue of limiting damages and whether, in a particular state, such limits are warranted should be left to each state and its legislature, consistent, of course, with state and federal constitutions. A Washington-knows-best philosophy in an area of the law that has historically been left to the states has no place in our system of government.

Non-economic damages compensate injured patients for very real injuries—such as the loss of a limb or sight, the loss of mobility, the loss of fertility, excruciating pain, and permanent and severe disfigurement. They also compensate for the loss of a child or a spouse. Caps on non-economic damages discriminate against those patients who are not in the workforce—children, seniors, homemakers—and who cannot show substantial economic loss, such as lost wages or salary. There is no reason why the injuries of a stay-at-home mom should be valued less than the same injuries of a corporate executive.

Experience at the state level shows that damage caps have virtually no impact on health care costs. An arbitrary and inflexible cap is inconsistent with the completely unpredictable nature and extent of injuries caused by a managed care insurer's negligence. Fairly compensating victims is not a "one-size-fits-all" proposition. Rather jurors, who are sitting in the courtroom, are in a better position than Congress to determine what damages are justified in cases involving differing injuries and circumstances.

Caps on non-economic damages punish those with the most severe, devastating injuries and do nothing to address concerns regarding frivolous claims. (As I have stated previously in my testimony, if frivolous lawsuits are a concern, then that is the concern that should be addressed—but not by penalizing someone who has been injured.) Caps on damages reward the person or company which caused the injury by limiting liability, while further harming the injured patient by denying full compensation determined by a citizen jury.

I understand there is some confusion over Texas' law on non-economic damages. Texas does not cap non-economic damages in personal injury cases. The only non-economic damage cap in Texas applies in statutorily created medical malpractice actions for wrongful death. That cap is adjusted for inflation and the 2000 cap amount is \$1,410,000. *This cap does not apply to a cause of action against a managed care insurer.*

While non-economic damages are designed to compensate injured patients for very real injuries, punitive damages are *very rare* and are designed to punish wrongdoers for egregious misconduct. While some states limit or do not recognize punitive damages, that is not the case in California. Indeed, as the California Supreme Court noted, one of the most important factors in determining whether an award of punitive damages is excessive is the wealth of the company: Too small an award will not have the effect of deterring the misconduct while too large an award may risk permanent damage to the company's operations. (*Adams v. Murikami* (1991) 54 Cal.3d 105.) Clearly, a rote formula of three times compensatory damages or an overall cap cannot fulfill either the ameliorative deterrent purposes of punitive damages or the protective effect of assuring that the award will not cause excessive harm to the defendant. States which have reached this conclusion—and which have done so on the basis of reasoned logic—should not be hamstrung by a federal mandate limiting the effectiveness of the state's regulation of its businesses.

F. Employers Need Not Fear Accountability Provisions Aimed at HMO or Insurer Activity

Employers and employer groups are necessarily concerned about potential imposition of liability provisions on them. It is not intended that the current ERISA protections be abrogated with respect to them—***so long as they are not the entities making the health care benefit decisions.*** The practical reality is that once an employer or employer group purchases an HMO or health insurance policy for its employees, the employer is literally "out-of-the-picture" with respect to the benefit determinations. There is simply no reason to impose liability on an employer or employer group when it has fulfilled its ERISA obligation to provide benefits through the purchase of an independent plan or policy. Legislative language limiting employer liability unless there is direct participation in a benefit decision effectively addresses employers concerns.

Opponents of managed care reform seem to forget that employers can be held liable under the current ERISA statute for breach of fiduciary duty. The mere handful of cases in this area occur in situations where the employer deducts a portion of the employee's pay for insurance premiums, but fails to turn that premium over to the insurer, effectively rendering the employee uninsured. In these sorts of situations, employers should continue to be held accountable.

One note of warning must be sounded here. I have been involved in litigation in which the employer purportedly provided the benefits directly with the assistance of a "third party administrator" which was, in fact, an HMO. Under the operative contract, the employer maintained a checking account which the administrator could draw on in order to pay benefits and the contract provided—at least nominally—that the employer had the final right to determine claims. Under normal circumstances, this situation would not impose additional liability on either the employer or the administrator under current ERISA reform proposals. But the reality in the case I litigated was vastly different from the appearances and creates a potential loophole that could be abused by HMOs or health insurers if ERISA is amended to protect patients.

The reality of this case was that, although final coverage decisions were "reserved" to the employer, that was a subterfuge. The employees were issued plan booklets by the HMO that were identical to those issued by the HMO to employees of plans that had been purchased by employers; the exact same health care provider network was established and used by the "third-party administrator;" the claims were administered in precisely the same way as in all the other plans and the net effect of the operation was that the HMO, as the "third-party administrator," in fact, made all the claim determinations and the employer had no actual input into that process, even though the final decision was "reserved" to the employer under the administration contract.

It can be expected that, if HMO liability provisions are amended into ERISA, that this type of subterfuge will be attempted, and it should be made clear that even where the HMO is purportedly operating only as a third-party administrator, it may still be liable for unfair claim decisions. This will protect both the patient and the employer.

G. What Standard of Conduct Should Be Applied?

Once Congress agrees that patients and their families can be protected only if HMOs are—like every other industry and even the government—held accountable for their misconduct, the next concern is the standard of conduct to be applied.

Some may suggest that HMO decisions which implicate medical considerations should be measured against a medical malpractice standard, i.e., the standard of care in the medical community. I would vigorously disagree with that proposal, and I will give you an example provided by a gynecologist to explain why.

I was attending an ERISA seminar in which a gynecologist spoke regarding her experience with the HMO system. She had been practicing for several years in Phoenix, which has a very high HMO penetration. She had, however, just moved to Boise, Idaho, which has very little HMO activity, for the express purpose of escaping HMOs and the problems they bring to the practice of medicine. She explained this situation as one example of why she moved.

The doctor's patient was a woman in her late 30's who had been diagnosed with non-invasive cervical cancer. This type of cancer is very treatable and usually curable. The first treatment of choice is a cryosurgery, in which the cervix is frozen with liquid nitrogen. The freezing destroys the cancer cells and does not impair the woman's fertility. The treatment was provided to this patient without incident. Approximately two years later, however, tests showed a recurrence of the cervical cancer. The cancer was still non-invasive, but a recurrence was, of course, worrisome. The *medical* standard of care at that point offered two alternatives: Either another cryosurgery or a hysterectomy. The woman was now in her early 40's, had three children and was not interested in having any more. She elected to have the hysterectomy. Her health plan, however, refused to authorize a hysterectomy and forced her to accept the less expensive cryosurgery. Two years later, she was diagnosed with *invasive* cervical cancer, requiring a complete hysterectomy and other follow-up treatment, long-term care and monitoring and engendering the risk of metastatic cancer. All because the HMO wanted to save money.

The point here is that the *medical* standard of care permitted either procedure. But the HMO's obligations go beyond what the medical standard of care provides. The HMO contractually obligated itself to provide *any* medically necessary care needed by the patient. When marketing themselves to employers or employees, HMOs never disclose to those potential purchasers that they intend to provide the *minimal* care needed, or the *least expensive* care needed and that they reserve

to themselves the exclusive right to make these life-and-death decisions. To the contrary, HMOs market themselves as providing **comprehensive** care of the highest quality.

When a patient has the choice between two accepted and medically appropriate treatment options, it should be left to the *patient* to choose what treatment he or she will undergo. That is not a choice that should ever be made by an HMO, let alone a choice made by an HMO solely on the basis of cost.

So, it is not the medical malpractice standard of care that should be applied to an HMO's benefit decisions. Rather, a simple test of reasonableness—the standard test for negligence—should apply. Was the HMO's denial of benefits reasonable under the circumstances? If an HMO's decision is based on monetary self-interest, that should, by definition, be considered unreasonable.

This standard has the further benefit of being a common standard for liability in every state and involves a well-developed body of law which can be applied in this context.

H. Conclusion

The ERISA “experiment” of total tort immunity is a dismal failure. People have suffered and died as a direct result. It is time to call a halt to this unwarranted and unprecedented immunity and to restore balance to the system.

Something must be done about ERISA's remedy limitations. And the need is not just the “superficial” one of fulfilling the fundamental principle of equity that “for every wrong there is a remedy.” The need runs much deeper. As noted by Judge Young:

“A further cost of this near absolute immunity is its pernicious effect on our democratic system. Whenever Congress extinguishes a right which heretofore has been vindicated in the courts through citizen juries, there is a cost. It is not a monetary cost. It is a cost paid in rarer coin—the treasure of democracy self.” (*Andrews-Clarke*, at p. 63, fn. 73.)

Chairwoman JOHNSON. Dr. Corlin.

STATEMENT OF RICHARD F. CORLIN, M.D., PRESIDENT-ELECT, AMERICAN MEDICAL ASSOCIATION

Dr. CORLIN. Thank you, Mrs. Johnson. My name is Richard Corlin. I am the President-Elect of the American Medical Association and a practicing gastroenterologist from Santa Monica, California.

As Chairman Johnson has observed, virtually everyone now agrees that patient protection legislation must include certain basic patient rights. We are strongly encouraged by this and by President Bush's principles for a bipartisan Patients' Bill of Rights which include these protections.

A core issue remains: How can patients hold health plans accountable for their decisions? It is about the patient. This is a crucial point for everyone to understand. If a managed care organization makes a negligent medical decision that harms or kills a patient, it must take the responsibility. Is it fair to grant a shield of immunity to managed care organizations, a shield which is not given to any other private business entity? We don't think so. Neither do a vast majority of Americans.

But why is this even an issue? ERISA was never intended to apply to managed care. There is no sound policy reason why this law should leave patients who are injured by negligent health plans with no real remedy.

The judiciary agrees with this point. Numerous Federal judges have called on Congress to amend ERISA. In one instance, a Federal judge had to throw out a case, and he complained that, quote,

the tragic events set forth in this woman's complaint cry out for relief; nevertheless, this court has no choice but to slam the courthouse doors in her face and leave her without any remedy. This is truly an issue of fundamental fairness.

I think many of us here would agree that health plans need to be held accountable. So what is the best solution for this problem? The best solution must reflect the relative strengths of the different courts and levels of government.

Under principles of federalism, the States retain powers not delegated to the Federal Government. Historically, the States have retained jurisdiction to govern the practice of medicine and the delivery of health care.

We support a split cause of action. If a patient is injured by a negligent health plan, the patient must have a legal remedy in either the State or the Federal court, but not both. Because States retain jurisdiction to govern the practice of medicine, if the case involves medical judgment, the case should go to State court.

Federal courts should hear cases that have traditionally been decided under ERISA, the eligibility of benefits claims. An acceptable patient protection bill should in a targeted fashion remove certain ERISA preemptions allowing State laws to continue to govern the delivery of health care.

The bill should also provide an adequate Federal remedy for patients injured when a plan makes a negligent nonmedical decision.

Our proposal is in no way arbitrary. The Judicial Conference of the United States, headed by Chief Justice Rehnquist, has expressed support for this view by stating, quote, the State courts have significant experience with personal injury claims and would be an appropriate forum to consider personal injury actions pertaining to health care treatment.

He also urged Congress, and again I quote, to provide that in any managed care legislation, the State courts be the primary forum for the resolution of personal injury claims arising from the denial of health care benefits.

This solution would also protect the rights of States and their citizens. Every State legislature has passed laws governing the delivery of health care services. In addition to existing common law rights, States have passed laws granting their citizens a cause of action against negative health plans.

We urge Congress, therefore, not to pass a "Federal-only" cause of action that would destroy these State laws. The insurance industry continues to claim that making health plans accountable in this targeted way will open a Pandora's box. The gloom and doom predictions by the insurance industry have not come about.

President Bush has repeatedly stated that the patient protection laws in Texas are working well. Despite the insurance industry's claims, accountability has not caused health care costs to skyrocket. Employers have not suddenly dropped health benefits and the courts have not been overrun by participants filing frivolous lawsuits.

In closing, the patient protections we support, including accountability, closely reflect President Bush's principles. A Federal Patients' Bill of Rights must ensure that every person enrolled in a

health plan enjoys strong patient protections, with deference given to State laws.

Madam Chairman, and the entire Committee, thank you for inviting me to participate today, and we look forward to any further discussions.

Chairwoman JOHNSON. Thank you, Dr. Corlin.
[The prepared statement of Dr. Corlin follows:]

Statement of Richard F. Corlin, M.D., President-Elect, American Medical Association

Madam Chairman and members of the Subcommittee, my name is Richard F. Corlin, MD. I am the President-Elect of the American Medical Association (AMA), and formerly served as the Speaker of the AMA's House of Delegates. I am a practicing gastroenterologist from Santa Monica, California. On behalf of the three hundred thousand physician and medical student members of the AMA, I appreciate the opportunity to comment on patient protections in managed care.

Close to Agreement

The AMA firmly believes that virtually all patient protections are interrelated. Ensuring that patients have information about accessible grievance and appeals procedures, for instance, would 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.

The good news is that, as Chairman Johnson has said, there truly is "significant agreement on both sides of the aisle on the underlying patient protections, such as access to OB/GYNs, access to specialists, prudent layperson standard for emergency rooms, and disclosure of plan information." Virtually everyone now agrees that any patient protection legislation considered by Congress should include certain basic rights which all patients deserve and want. Even the details of those rights in most of the various competing bills are extraordinarily similar. We are strongly encouraged by this progress and by President Bush's Principles for a Bipartisan Patients' Bill of Rights, which include these protections.

Allow us to focus, therefore, on what—as Chairman Johnson has called—the "more vexing issue": how to ensure that health plans can be held accountable for their decisions.

An Issue of Fundamental Fairness

The Employee Retirement Income Security Act of 1974 (ERISA) established an elaborate regulatory system intended to ensure that employees receive the pension benefits which their employers have promised them. The statute was enacted in response to widespread allegations of pension fund mismanagement and fraud. In addition to preventing these abuses, the statute sought to create uniform regulatory requirements that would govern the administration of pension and benefit plans, thereby encouraging employers to offer employees these benefits. The intention of the bill's sponsors therefore was to ensure that employers doing business in more than one state could design financial benefits plans that could operate nationwide and would not face conflicting state requirements. To override then current state laws that sought to regulate pension plans, Congress incorporated broad preemption language into ERISA.

Most of the remedies included in ERISA were also geared toward protecting plan assets. ERISA's appeals procedures and civil enforcement mechanisms were all directed at ensuring that plan fiduciaries handled plan *funds* properly and prudently for the plan participants' benefit. **The drafters of ERISA never anticipated or intended the bill to protect plan participants who sought to access services, such as medical care, as part of a health care benefits package.**

The drafters of ERISA also could not have anticipated the eventual effects of ERISA and its preemption provision because of the dramatic changes the health care market itself has undergone. In 1974, the health care delivery system was entirely different from today's market. Over the last several decades, we have seen a transformation in employer-sponsored health care plans

from traditionally insured or “fee-for-service” to managed care. This transformation has given rise to new types of arrangements and relationships for financing and delivering health care that were not foreseen by the framers of ERISA in 1974.

A Matter of Fundamental Fairness

In the era of managed care, health plans increasingly make decisions that directly affect the care that patients receive. Illustrations of these practices include: inappropriately limiting access to physicians through restricted networks (blocking patient access to specialists); refusing to cover or delaying needed medical services (transplants, transfusions, therapies); drawing treatment protocols too narrowly (patients discharged from a hospital prematurely); offering payment incentives or creating deterrents to care (disciplining physicians who refer patients for necessary medical care); and discouraging physicians from fully discussing health plan treatment options (gag rules and gag practices).

These non-financial functions were never intended to be covered or regulated by ERISA. Instead, **the states typically have regulated the practice of medicine and, more generally, the delivery of health care.** Even the federal courts have repeatedly noted that the regulation of quality of care has traditionally been a matter of state law, and that quality of care standards should be enforced in state courts.

Nevertheless, under many circumstances, ERISA currently preempts state-based causes of action, thereby preventing injured patients from recovering against health plans that have acted wrongfully. As a result, ERISA’s federal preemption of state liability actions leads to harsh consequences for many patients harmed by their health plans. **The federal judiciary has also observed the incongruity and inherent unfairness resulting from ERISA preemption, with several federal judges calling on Congress to amend ERISA.** One case involved a 41-year-old father of four who went on a drinking binge and committed suicide. After his death, his widow said that the health plan had refused to approve a detoxification program after an earlier suicide attempt. Unable even to look at the merits of the case, the U.S. District Judge threw it out of court, saying that ERISA gave the health plan a “shield of immunity.” The judge went on to say that “the tragic events set forth in Diane Andrews-Clarke’s complaint cry out for relief. . . . Nevertheless, this court has no choice but to . . . *slam* the courthouse doors in her face and leave her without any remedy.”¹ According to Judge Young, “the shield of near absolute immunity now provided by ERISA simply cannot be justified. . . . Even more disturbing to this Court is the failure of Congress to amend a statute that, due to the changing realities of the modern health care system, has gone conspicuously awry from its original intent.”²

Allowing plans to continue to escape liability for negligent decision-making through this statutory loophole leaves patients in serious jeopardy. If ERISA plans know they can avoid liability due to ERISA preemption of state law, they have no incentive to act responsibly and provide needed and contracted for medical care.

Consider, for example, some evidence presented in a lawsuit against one of the nation’s largest insurance companies last year. The case involved a deputy district attorney, Mr. Goodrich, who died of stomach cancer after trying for 2½ years to get his insurance company to approve the cancer treatment that the insurance company’s own physicians had recommended. During the trial, a training video of the insurance company was admitted into evidence. The training film showed one of the company’s attorneys instructing claims handlers, and telling them “[a]s a practical matter, you really may have to do more on a non-ERISA plan to protect against some of the legal exposure we’re talking about.”³

The bottom line is that patients who receive health benefits through ERISA plans are currently denied the same rights and remedies as patients in non-ERISA plan. This is a simple question of fairness. It is also a matter of the public’s will and desire. A vast majority of Americans believe that health plans should be legally accountable for negligent decisions that injure or kill patients.⁴ We strongly agree.

¹ *Andrews-Clarke v. Travelers Insurance Co.*, 984 F. Supp. 49, 64–5 (D. Mass. 1997).

² *Id.*

³ January 27, 1999, Los Angeles Times, B. 7.

⁴ A national public opinion poll conducted by Penn, Schoen & Berland showed that seventy-seven percent (77%) of Americans support changing federal law to allow patients to sue a managed care company when they are injured by negligent decisions or cost containment actions. May 7, 1998, APA News Release. Henry J. Kaiser Family Foundation, Harvard School of Public

While some courts continue to view ERISA as preempting all state-based causes of action against health plans, many courts have allowed injured patients' complaints against health plans to survive ERISA preemption scrutiny. In fact, most ERISA experts acknowledge a definite trend in federal courts whereby the courts are deciding that causes of action against health plans based on medical decisions or "mixed" medical-eligibility decisions are not preempted by ERISA. In other words, injured patients or the estates of deceased patients may increasingly pursue legal remedies in state courts under state law. Legislative ERISA reform, however, is necessary to *ensure* that *all* patients are protected.

A Developing Trend

Because of the existing "preemption" provision of ERISA, patients enrolled in ERISA plans lack the remedies currently available to patients participating in non-ERISA plans. Many courts have recognized this problem. In *Corcoran v. United Healthcare*,⁵ for instance, a patient who had a high-risk pregnancy was advised by her physician to be hospitalized as she approached her due date. The plan, however, denied the request and instead authorized nursing home care. When the patient was at the nursing home and the nurse was off-duty, the fetus went into distress and died. The woman sued the plan alleging that the plan was negligent in not hospitalizing her. The federal court, however, decided that because the woman's claim involved a decision about the availability of hospitalization it was actually a "benefits" decision, and consequently preempted by ERISA. As a result, the woman could only proceed under ERISA, which provides as the woman's *sole* remedy the benefits sought—in this case pre-delivery hospitalization. The woman therefore could obtain no real legal remedy under either ERISA or state law.

Several other federal courts, however, have taken the position that ERISA was never intended to preempt injured patients from suing managed care plans for negligence simply because the plans contract with private employers or unions. These courts have looked to the preemption doctrine as articulated in the *Pilot Life Insurance Co. v. Dedeaux*⁶ and *Metropolitan Life Insurance Co. v. Taylor*⁷ cases, and then focused on the *Dukes v. U.S. Healthcare, Inc.*⁸ case. In *Dukes*, the Third U.S. Circuit Court of Appeals acknowledged a previously identified distinction between "quality of care" decisions and "quantity of benefits" claims, and found that state law claims addressing the quality of care that the enrollees received were outside the scope of ERISA remedies and were not preempted.

After the *Dukes* case, a federal court in Connecticut found in *Moscovitch v. Danbury Hospital*⁹ that a claim against an ERISA plan in which the enrollee challenged the medical and psychiatric decisions of the plan administrator was *not* preempted by ERISA, despite the plan's allegations to the contrary. The enrollee had on two occasions attempted suicide and was hospitalized both times. Determined to be suicidal on a third occasion, the patient was again hospitalized. Deciding that hospitalization was no longer medically necessary, the plan administrator on this occasion transferred the enrollee from the hospital to a treatment center, where he committed suicide.

Similarly, federal and state courts in Pennsylvania, Missouri, and Illinois, in the *Tiemann v. U.S. Healthcare, Inc.*¹⁰ and *Pappas v. Asbel*,¹¹ *Harris v. Deaconess Health Services Corp.*,¹² and *Crum v. Health Alliance-Midwest, Inc.*,¹³ respectively, all found that plan participants and beneficiaries could bring their negligence claims against the health plans in state court—ERISA did not preempt them. In *Harris*,

Health survey conducted on January 25, 2001, found that seventy-five percent (75%) of Americans support patient protection legislation, including the right to sue health plans. Fifty-three percent (53%) of Americans favor legislation making it easier to sue managed care plans that make negligent decisions which cause injury or harm to patients. Harris Poll #56, September 29, 1999.

⁵ 965 F.2d 1321 (5th Cir. 1992).

⁶ 481 U.S. 41 (1987).

⁷ 481 U.S. 58 (1987).

⁸ 57 F.3d 350 (3^d Cir. 1995), rev'g *Visconti v. U.S. Healthcare*, 857 F. Supp. 1097 (E.D. Pa. 1994), and *Dukes v. United States Healthcare Sys. of Pennsylvania, Inc.*, 848 F. Supp. 39 (E.D. Pa. 1994), cert. denied, 116 S. Ct. 564 (1995).

⁹ 25 F. Supp. 2d 74 (D. Conn. 1998).

¹⁰ 93 F. Supp. 2d 585 (E.D. Pa. 2000).

¹¹ 2001 Pa. LEXIS 687. See also, *Lazorco v. Pennsylvania Hospital*, 2000 U.S. App. LEXIS 33792 (3^d Cir.) (finding that a managed care plan physician's decision not to rehospitalize an enrollee for treatment of depression and schizophrenia constituted a "mixed eligibility decision" which implicates the quality of care the patient could receive, and the patient's claim must therefore be decided in state court).

¹² 61 F. Supp. 2d 889 (E.D. Mo. 1999).

¹³ 47 F. Supp. 2d 1013 (C.D. Ill. 1999).

a plan participant had sought authorization for hospitalization, for what he thought was appendicitis. The plan denied him admission and his appendix ruptured. The participant suffered permanent physical injury as a result. In the recent Pappas case, a managed care plan physician denied one of the plan enrollees permission for admission to a spinal cord trauma center. The patient now suffers from permanent quadriplegia resulting from an abscess compressing his spine. The Pennsylvania Supreme Court found that the plan's decision which determined where and when the patient's epidural abscess would be treated, constituted a "mixed eligibility and treatment decision" and was not preempted by ERISA. In Crum, a plan participant believed that he may be suffering a heart attack and sought admission to an emergency room. The plan's advisory nurses twice denied him permission for emergency room services, and he died of a heart attack.

As we have stated, however, this trend remains in its nascent stage and without clear leadership from Congress, the court rulings will remain inconsistent and unpredictable. Many patients will continue to have no legal remedies when their health plans act negligently and cause them injury or death.

A Complementary Solution

Under the principle of federalism, the federal and state governments maintain a complementary relationship; the states retain all powers not delegated to the federal government. The Tenth Amendment of our U.S. Constitution reiterates this principle by assuring that "the powers not delegated to the United States" nor prohibited to the states "are reserved to the states respectively, or to the people."

The political theory underlying this judicial philosophy was that the local or state governments were best equipped to address the needs of their citizens. The Founders were also generally concerned about an excessively powerful, excessively centralized national government. As a result, many of the Founders sought to ensure that the national government would be empowered to legislate only in those areas in which the separate states were incompetent.

Historically, the states have retained jurisdiction to govern the practice of medicine and, more generally, the delivery of health care for their citizens. The states, for instance, retain virtually sole authority to license and regulate health care professionals and institutions, as well as to provide remedies to citizens who are harmed by the negligent acts of those practicing medicine. When health plans, insurance companies, or even employers, make medical treatment decisions—and in essence, practice medicine—they should therefore be held accountable under state law, in state courts.

Recent statements by the Judicial Conference of the United States, which is headed by Chief Justice Rehnquist, prove instructive on this issue. In a March 2000 letter to the Chairman of the conference committee on managed care legislation passed in the 106th Congress, the Judicial Conference stated that: **"Personal injury claims arising from the provision or denial of medical treatment have historically been governed by state tort law, and suits on such claims have traditionally and satisfactorily been resolved primarily in the state court system. . . . The state courts have significant experience with personal injury claims and would be an appropriate forum to consider personal injury actions pertaining to health care treatment."** (Emphasis added).

The Judicial Conference urged Congress "to provide that, in any managed care legislation agreed upon, **the state courts be the primary forum for the resolution of personal injury claims arising from the denial of health care benefits.**" (Emphasis added).

Recent federal case law reflects the Judicial Conference's policy favoring state court jurisdiction over cases regarding medical judgments. The Supreme Court in last year's *Pegram v. Herdrich*¹⁴ case stated that health plan coverage decisions often involve medical and administrative components which are "inextricably mixed," and the "eligibility decisions cannot be untangled from physicians' judgments about reasonable medical treatment." The Court expressly declined to find a "fiduciary malpractice claim" under ERISA, and noted that permitting such a cause of action would create the unattractive possibility of ERISA preemption of state medical malpractice laws. **The Supreme Court's reasoning therefore supports the contention that state courts remain the appropriate forum for holding health plans accountable.** Many lower federal courts have made similar state-

¹⁴530 U.S. 211.

ments, acknowledging that states retain “their traditional police powers in regulating the quality of health care.”¹⁵

Not only does the federal judicial branch—including the U.S. Supreme Court—recognize the importance of states retaining jurisdiction over the practice of medicine, the states also are trying to exercise their authority over the regulation of medical care. *Every state legislature* has passed laws governing the delivery of health care services to its citizens, whether pertaining to external appeal rights, utilization review, access to emergency services, or some other patient protection. Eight states have passed laws expressly authorizing statutory causes of action against health plans, in addition to the state “common law” actions already recognized by their courts.

Texas, for instance, in 1997 passed a statute that creates a new state cause of action against health insurance carriers, HMOs, and other managed care entities who breach their duty to exercise ordinary care when making health care treatment decisions, and the breach causes harm to the patient. An additional seven (7) states—Arizona, California, Georgia, Louisiana, Maine, Oklahoma, and Washington—have passed similar health plan accountability statutes.

We strongly urge Congress therefore to recognize the legitimate authority of states and incorporate a bifurcated cause of action into a bipartisan patient protection bill. Such a bill would need to remove ERISA preemption in a targeted fashion, permitting states to pass or retain their own legislation which would protect the legitimate interests of their citizens. Additionally, removing ERISA preemption in this manner would preserve prior federal court decisions that have recognized state common law causes of action.

The “split” between the federal and state causes of action must be made according to whether the plan exercised medical judgment when making its decision. The judiciary has repeatedly relied on that criteria, and so should Congress. When a health plan intervenes in the medical decision-making process, and imposes its medical judgment on the patient, the plan is engaging in the practice of medicine and should be held accountable under state law. If the plan has not made a medical judgment and has made simply an eligibility decision, the claim should be brought in federal court.

Because of the gross inadequacy of ERISA remedies, an acceptable patients’ bill of rights must modify ERISA to also permit a meaningful federal cause of action when an enrollee has been injured by a health plan’s decision that did not involve medical judgment. As we mentioned above, ERISA was enacted to protect pension plan and other employee benefit financial assets. ERISA needs to be updated to reflect the current managed care market and protect plan participants and beneficiaries when their group health plans act negligently and cause them harm.

Some advocates of plan accountability have suggested that patient protection legislation should provide only a federal cause of action. **A federal cause of action alone however would wipe out those state statutes as well as state common law rights which have provided citizens with state law remedies against health plans for negligent medical decision-making.** Additionally it would prevent forty-two (42) other state legislatures from passing similar patient protection legislation in the future. The AMA firmly believes that Congress should not override the will of the states by passing a federal-only cause of action.

Creating solely a federal remedy for health plan and employer misconduct would also violate the most basic principles of federalism. Chief Justice Rehnquist has warned that **“Congress should commit itself to conserving the federal courts as a distinctive judicial forum of limited jurisdiction in our system of federalism. . . . [M]atters that can be adequately handled by states should be left to them. . . .”**¹⁶ (Emphasis added).

To provide all patients with adequate remedies, Congress must enact federal legislation permitting patients to seek legal recourse against managed care plans under state law when the plans’ negligent medical decisions result in death or injury.

Controlling Litigation

A bifurcated cause of action would grant all Americans who receive employer-based health benefits an extremely important patient protection, which they both need and desire. This protection could, and should, be coupled with other critical

¹⁵ (Corporate Health Insurance Inc. v. Texas Department of Insurance, 5th Cir., June 20, 2000, No. 98–20940, 215 F.3d 526; 2000 U.S. App. LEXIS 14215).

¹⁶ Remarks of Chief Justice William H. Rehnquist at the American Law Institute Annual Meeting, May 11, 1998.

patient rights that would directly benefit patients while both directly and indirectly benefiting health plans.

As we have noted, many federal courts have begun to allow injured patients to bring causes of action against health plans in state courts. The pleadings and legal theories for these cases will increasingly mimic the pleadings and theories of those cases that have successfully withstood ERISA preemption scrutiny. As a result, managed care organizations will most likely become increasingly subject to liability—despite ERISA—for improper claims decisions that result in patient injury or death.

When patients have been successful in bringing legal actions against ERISA plans, current law provides few protections for the plans. In many jurisdictions, patients would be able to proceed directly to court without appealing internally or externally, and theoretically, could proceed against their employers, as well. **Critical to any acceptable patient protection bill, therefore, are provisions granting employers protection against unwarranted liability and independent external appeals provisions that would eliminate unnecessary litigation.** With these provisions, health plans and employers would also certainly benefit from the bill.

Restricting Negligence Actions

Crucial to an acceptable patients' bill of rights are a grievance system and an internal and independent external appeals provision. Without a grievance system, disgruntled patients with legitimate, though perhaps minor, complaints against their health plans would be required to go to court to resolve their disputes. And patients who are seeking medical care and have serious coverage disputes with their health plans, need and want timely coverage determinations and medical treatment, not lengthy and expensive litigation.

We therefore consider it essential that a patient protection bill provide patients with access to a grievance system and an internal and independent external appeals process, which would effectively eliminate any need for litigation.

An acceptable bill, for instance, could require patients first to appeal coverage denials directly to reviewers selected by their plans. The plans could control whether an internal review would be conducted, but their decision would have to be timely and account for the medical exigencies of the specific case. If the plan chose not to waive this requirement, the patient would be obligated to complete the internal review before proceeding to an external appeal.

External appeals should be independent, binding on the plan, timely and conducted by qualified physicians (MDs/DOs) of the appropriate specialty. To ensure that their decisions are truly independent, plan definitions of “medically necessary” and “investigational and experimental treatment” must not be binding on the external reviewers. An effective independent appeals process would resolve virtually all of the egregious cases—like Corcoran—without the need for litigation. **We firmly believe that with access to efficient, effective, and truly independent external appeals entities, patients will rarely need to go to court.**

Employer Liability

The insurance industry and some other opponents of patient protection legislation have alleged that a patient protection bill would place employers in jeopardy. They claim that by holding *health plans* accountable for their own negligence, the legislation would somehow expand employers' liability. These concerns, though understandable, can easily be addressed and remedied in a bipartisan patients' bill of rights.

A patient protection bill can offer real and meaningful protection to employers and other plan sponsors. The bill for example could expressly state that it does *not* authorize a cause of action against an employer or other plan sponsor, and only an employer or plan sponsor that directly participates in making an incorrect medical determination for an individual claim decision could be held accountable. Consequently, only if an employer or plan sponsor *directly participated* in making an incorrect medical decision for an individual claim decision under its group health plan, and that decision resulted in injury or wrongful death, could it be exposed to a state law claim. Even then, to recover, the injured patient would have to prove: (1) that the employer directly participated in making an incorrect medical determination on that particular claim for benefits, (2) that individual decision caused the patient's injury or death, and then (3) that the employer's conduct also met *all* elements of an applicable state law cause of action.

Some opponents of patient protection legislation have spuriously alleged that employers will be held liable for simply selecting the plans, under this scenario. We

therefore believe that the bill should explicitly state that employers and other plan sponsors cannot be held liable for fulfilling their traditional roles as employers and plan sponsors. The bill should provide “**safe harbors**,” for instance, for the following activities: (I) *any* participation by the employer or other plan sponsor in the selection of the group health plan or health insurance coverage involved or the third party administrator or other agent; (II) *any* engagement by the employer or other plan sponsor in any cost-benefit analysis undertaken in connection with the selection of, or continued maintenance of, the plan or coverage involved; (III) *any* participation by the employer or other plan sponsor in the process of creating, continuing, modifying, or terminating the plan or any benefit under the plan, if such process was not substantially focused solely on the particular situation of the participant or beneficiary; and (IV) *any* participation by the employer or other plan sponsor in the design of any benefit under the plan.

Additionally, because many employers and other plan sponsors seek to advocate for their employees during the review and appeals processes, **an acceptable patient protection bill should explicitly protect employers and plan sponsors functioning as patient advocates as well.**

Some advocates of patient protection legislation have suggested that a federal bill should mirror the Texas “accountability” statute. In fact, the provisions we have identified would provide employers the same if not greater protection than what is offered in the Texas law. Both our principles and the Texas statute protect employers, but neither specifically excludes from liability employers who “play doctor” and improperly intervene in medical decisions. We note, though, that our proposed principles also expressly protect employers functioning as employers.

We anticipate that some employer advocacy groups will continue to allege nevertheless that employers would, despite these employer protections, still be exposed to liability under such a bill. Interestingly, in our many discussions with many of these organizations, we and the sponsors of several patients’ rights bills have explicitly requested alternative language that the employer groups believe would adequately address their concerns. In every instance, these organizations have failed even to propose such language. After our repeated and diligent efforts to arrive at an agreement, we have begun to think that some of the organizations are not genuinely interested in solving what they claim is a potential problem.

We acknowledge that if an employer “plays doctor” and directly participates in making an incorrect medical determination on a particular claim for benefits, the employer could potentially be held liable in state court. In such an extraordinarily rare situation of an employer directly interfering in a specific medical treatment decision and injuring a patient, should it not be exposed to liability? **President Bush apparently thinks so, since he stated in his Principles for a Bipartisan Patients’ Bill of Rights that he would hold those employers accountable “who retain responsibility for and make final medical decisions.”**

Exhaustion of Remedies

In order to ensure that the external appeals process can effectively reduce litigation while encouraging timely coverage decisions, patients must be required to utilize the appeals process. **Patients should therefore have to exhaust all appropriate administrative remedies before going to court.**

The purpose of the appeals process is to ensure that coverage disputes may be resolved in a timely fashion, so that patients may obtain the medical treatment to which they are entitled before they unnecessarily suffer harm. If, because of the health plan’s conduct, they suffer serious and irreparable harm or die, they or their estates should not be required to exhaust all administrative appeals. At that point, the patient is no longer seeking the medical treatment, but instead desires and needs court protection. Consequently, the patient or the patient’s estate should not be required to spend additional time and money unnecessarily in an appeals process. To complete the external appeals process under those circumstances would be futile. The patient should at that time be allowed access to the court system.

Texas law includes a very similar exception in its appeals process. Under Texas law, a person is permitted to bypass the independent review if harm has already occurred.

The AMA recognizes the current controversy regarding the extent to which exceptions to an exhaustion of administrative remedies requirement are appropriate. As with various other specific provisions of patient protection legislation, the AMA is willing to work with this Subcommittee to find new ways to address the various parties’ concerns with an exhaustion requirement and any applicable exceptions.

Cost

In the past, many opponents of health plan accountability have alleged that federal patient protection legislation would cause health care premiums to skyrocket. **Although no cost reports are presently available for pending federal patients' rights legislation, the fact remains that if plans were forced to accept responsibility for their decisions, costs would not be significantly affected.**

We are aware for instance that in Texas, the first state to adopt managed care accountability legislation, this issue was hotly debated. Milliman and Robertson completed an actuarial determination of the cost of the Texas liability legislation to a Texas-based HMO and set the cost at only 34 cents per member per month. A study prepared by William M. Mercer, Inc. and the AMA demonstrates that managed care accountability legislation would only increase premiums between .5% and 1.8%.

In fact, the American Association of Health Plans (AAHP) and the Health Insurance Association of America (HIAA) surveyed their HMO members in Texas and "could not find one example" where the Texas patient protection law forced Texas HMOs to raise their premiums or provide unneeded and expensive medical services.¹⁷

Other representatives of the insurance industry have also publicly admitted that holding plans accountable will not significantly drive up health care premiums. Jeff Emerson, the former CEO of NYLCare, stated in a July 11, 1999, Washington Post article that he is "... not going to make the argument that it's going to be a lot of money." Aetna/USHealthcare spokesman, Walter Cherniak, stated in the same Washington Post article that "we would charge the same premium to a customer with the ability to sue as we do those who do not have the ability to sue." Why? "Those judgments to date have been a very small component of overall health care costs," according to Cherniak.

In fact, the four-year-old Texas law that allows HMOs to be sued for their negligent medical decisions has prompted little litigation—approximately ten lawsuits out of the 4 million Texans in HMOs. Texas State Senator David Sibley, a Republican, stated two years after this bill was enacted, that "those horror stories" raised by the HMO industry "just did not transpire." President George W. Bush, who was then the Texas Governor, has repeatedly affirmed that he thinks this law has worked well in Texas.

Some opponents of HMO accountability have alleged that employers would drop their health benefits if ERISA preemption is removed. In many industries, however, companies provide additional incentives to attract and keep quality employees or else lose them to competitors, and one of the basic corporate benefits is full or partial health care coverage. It is therefore very unlikely that companies will eliminate health benefits simply because health plans are held accountable for the coverage and medical decisions they make.

Tort Reform

The issue of liability caps has been raised frequently in recent discussions of health plan accountability in patient protection legislation. Within the context of medical malpractice, the AMA has long supported tort reforms, including reasonable caps on damages. In recent years, we sought the passage of tort reform legislation, which passed the House of Representatives but has consistently failed in the Senate. A number of Senators from both parties have opposed reasonable limits on non-economic damages.

When discussing caps in a patients' bill of rights, several issues must be addressed. What would be considered "reasonable" caps for damages? What type of damages would be capped? Would a federal bill permit state tort reform laws to remain intact? Would the caps apply only to federal causes of action? Would a disparity between state and federal caps create undesirable and unnecessary forum-shopping? Would caps applicable to health plans also apply to all other health care providers?

The AMA fully recognizes the complexity of these and various other issues associated with tort reform, and we believe that tort reform must be addressed. With that said, we question whether adequate support exists in the Senate to pass meaningful tort reform in the context of patient protection legislation. If sufficient votes are not present, we would urge Congress to pass an acceptable patient protection bill at this time and then continue to push for meaningful tort reform. **The AMA remains**

¹⁷September 28, 1999, Washington Post.

fully committed to both issues, but recognizes that coupling them together, could kill both.

Conclusion

We appreciate the Committee's interest in addressing the issue of health plan accountability and the respective state and federal roles. As we have indicated, the AMA strongly believes that ERISA must be reformed to permit injured patients or their estates to recover against negligent health plans. The most sensible solution to this problem parallels the traditional roles of the state and federal governments, allowing states and their courts to continue to govern the practice of medicine while the federal courts adjudicate strictly benefits decisions under ERISA. Without this type of ERISA reform, any patient protection or health care quality legislation would not fully ensure fairness for all patients.

The AMA understands that several patient protection bills will be or are being considered, and we are committed to working with both Congress and the President to reach agreement on a bipartisan patient protection bill that can be enacted into law this year. We thank the Chairman and this entire Subcommittee for the opportunity to discuss this critical issue.

Chairwoman JOHNSON. Ms. Lichtman.

STATEMENT OF JUDITH L. LICHTMAN, PRESIDENT, NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES

Ms. LICHTMAN. I am Judith Lichtman, President of the National Partnership for Women and Families. The national partnership is a nonprofit, nonpartisan organization that has worked for over 30 years on issues critical to the success and health of America's women and our families.

We are also leading a coalition of more than 300 health care and consumer organizations supporting passage of a strong patient protection legislation. I appreciate this opportunity and would appreciate my longer testimony being inserted into the record.

Over the past decade, our health care system has changed considerably, especially in the movement toward managed care. Managed care has great potential. It can save money and provide better quality care through better coordination of services and a strong emphasis on preventive and primary care.

As the primary consumers of health care and the primary health care decisionmakers for their families, women have much at stake and much to gain from managed care done right.

While managed care holds much promise, its potential has been overshadowed by fear that concerns about costs will compromise quality. It is for this reason that meaningful patient protections are needed to restore a sense of trust in our system.

Congress has come a long way in its understanding of America's need for patient protections. We are encouraged by the view that there is now general agreement on many of the patient protections that must be included in a bill. But there are still key issues that must be resolved.

My written testimony highlights a number of those concerns regarding the scope of the bill and the patient protections that have to be included. Central among these is the issue of accountability. What rights would consumers have to ensure that health plans can be held accountable? Issues of trust and accountability lie at the very heart of this debate, and for that reason, we believe that meaningful patient protection legislation must include access to a

speedy and genuinely independent external review and must also include expanded legal responsibility.

Access to timely and independent reviews by a neutral third party are critical to assure consumers that there is a fair process for resolving disputes with their plan. True independence from the plan means that the managed care plan cannot select the external review entity.

It also must ensure that the reviewer has no financial or business relationship with the plan, and the external reviewer must be free to make its own determinations regarding medical necessity and should not be bound by the plan's definitions.

The process should not contain unnecessary barriers like short time frames to bring an appeal, or financial thresholds that would keep consumers from exercising their right to appeal.

Finally, the external appeals process should not be used to diminish the right to seek judicial recourse. Consumers who have already been injured should not be required to complete the external review process before seeking review in court. An external review's decision should not foreclose a consumer's right to judicial remedy.

The second criteria to achieve real patient protection is expanded legal authority. Because of an anomaly in ERISA, health plans offered by private employers, unlike any other business, are often immune from accountability for their actions, even if individuals are hurt as a result.

If we agree that companies that make tires for our cars or toys for our kids should be accountable when people are hurt, then why should we treat those who are entrusted with our health any differently?

In the recent case of the Firestone Tire recall, none of us challenged the rights of consumers to seek remedy when they learned that the cars they were driving were unsafe. In fact, central to American sense of fair play is the belief that when a company causes injury, they should take responsibility for the consequences. Yet, there are far too many examples of patients who are left without redress with the tragic results of health plans' decisions to delay or deny care.

As Congress continues to debate these issues on the—in the coming months, we will be evaluating new proposals to measure whether they meet the needs of women and families.

We strongly encourage Members of Congress to consider these principles and to pass a strong Patients' Bill of Rights without delay. The health of women and families hang in the balance.

Thank you. I am happy to answer any questions you may have. [The prepared statement of Ms. Lichtman follows:]

Statement of Judith L. Lichtman, President, National Partnership for Women & Families

Good afternoon, Chairwoman Johnson, Congressman Stark, and other distinguished members of the Subcommittee. I am Judith L. Lichtman, President of the National Partnership for Women and Families. Thank you for convening this important hearing and for the opportunity to testify today about patient protections in managed care. The National Partnership is a nonprofit, nonpartisan organization that uses public education and advocacy to promote fairness in the workplace, quality health care, and policies that help women and men meet the dual demands of work and family. Founded in 1971 as the Women's Legal Defense Fund, the National Partnership has grown from a small group of volunteers into one of the na-

tion's leading advocates for women and families. We are also a leading member of a coalition of more than 300 health care and consumer organizations supporting passage of strong patient protection legislation. One of the Partnership's key priorities is ensuring that American women and their families enrolled in health insurance plans, particularly "managed" health plans, receive the highest quality health care.

Over the past decade, our health care system has undergone unprecedented changes, most notably in the movement towards managed care. These changes affect every one of us, and women in particular have a tremendous stake in the outcome. Women are the primary consumers of health care services in this country, as well as the majority of managed care enrollees. They make up the majority of those on Medicare and the overwhelming majority of adults on Medicaid—programs that are also increasingly turning to managed care. Women are also the primary health care decisionmakers for their families—from choosing the family health plan to weighing different treatment options, women are the primary payers of our health care dollars. As both consumers of care and guardians of their families health needs, women's lives are dramatically affected by the rise of managed care.

Women have a real stake in how health care services are delivered for other reasons as well. They have unique health care needs that include, but are not limited to, their reproductive capacity. Some diseases (such as osteoporosis and eating disorders) are more prevalent in women, and others (such as heart disease) are too often ignored, misdiagnosed, or mistreated. Moreover, women and men with the same underlying disease do not always have the same symptoms, nor do they have the same risk factors. Cutting-edge research continues to shed more light on these gender differences. And finally, differences in social roles and behaviors can have significant implications for women's health. For example, women, much more than men, are victims of domestic violence in our society. To appropriately diagnose and treat women, health care professionals—and the health plans that increasingly determine the care they provide—need to understand the substantial impacts of gender and be specifically trained to provide health care to women.

Managed care has great potential. Its promise is to save money and provide better quality care through better coordination of services and a strong emphasis on preventive and primary care. Managed care plans are also uniquely positioned to educate millions of women and men about how to get and stay healthy. Women, especially, stand to benefit from managed care done right. A quality managed care plan can make it easier for women to learn about and obtain services, such as mammograms, Pap smears, and prenatal care, and take advantage of health-promoting benefits, from smoking-cessation classes to discounted health club memberships. In addition, a good relationship with a well-trained primary care provider can give women a chance to get answers to health questions that might otherwise go unasked. But providing quality health care is about much more than just delivering preventive services.

Over the past few years, managed care's potential has been eclipsed by concerns that for some it may do more harm than good. The American people, including American women, have become increasingly worried that the legitimate interest in controlling costs could compromise the quality of care managed care plans provide. Concerns about emergency treatment not being covered, restrictions on direct access to Ob/Gyns or pediatricians, and limits on participation in clinical trials on breast cancer or other life-threatening illnesses that could save women's lives have marred women's experiences of managed care. These and other concerns have helped to fuel the groundswell of public support for improved patient protections aimed at righting managed care's balance between quality and cost. Meaningful patient protections must ensure high quality, affordable health care and restore a sense of trust and accountability to our system.

Congress has come a long way in its understanding of Americans' need for patient protections in the nearly seven years that these issues have been debated. While we are heartened to hear the Chairwoman's view that there is now general agreement on many of the patient protections that must be included in a bill, there are still key unresolved issues that must be addressed to ensure that the bill will really help women and families. Central among these issues is the issue of accountability: what new rights will consumers have to ensure that health plans can be held accountable?

Issues of trust and accountability lie at the heart of this debate. Many consumers have lost trust in their health plan because they fear that their health plan will deny them the care they need when they need it most. A recent Kaiser Family Foundation survey of managed care consumers suggests this concern is grounded in real experiences. Of those surveyed, half reported having some problem with their managed care plan, a third of which involved either a delay or denial of needed

care—one in five with problems reported that their difficulties resulted in declining health.¹ As managed care has increasingly blurred the distinction between medical and insurance decisions, consumers worry that the current system gives too much power over medical treatment decisions to those who now have a financial incentive to deny care. This sense of mistrust is only deepened by consumers' growing awareness that there are few protections in place to hold plans accountable for their decisions. This absence of true accountability is unacceptable—a parent whose child has been injured by an HMO insurance company's decision deserves the same access to remedies as a parent whose child has been injured by a defective toy. These are critical issues of concern to women and families, and issues that must be addressed in any patient protection legislation being considered by Congress.

My testimony today will highlight key considerations relating to the need for greater accountability, focusing on external review and expanded legal responsibility. I will also briefly discuss two other main areas of concern: the scope of the bill and the key patient protections that are needed to ensure a strong and enforceable patients' rights bill.

External Review

Independent, external review procedures are an essential component to restoring consumers' trust in the health care system. Although internal review protections that allow the plan to conduct its own timely review of the dispute are also important, a timely independent review by a neutral third party outside of the plan is critical to assure that an individual will get a fair decision that is based on their specific medical needs. External review is now required in thirty-five states, making it a firmly established principle of business for many health plans and insurers. Experience in the states also shows that consumers are not abusing these rights by overusing the system. Despite its prevalence in the states, a federal law is still needed to ensure that all consumers have access to these important protections.

Strong patient protection legislation must ensure that patients have access to a speedy and genuinely independent external review. True independence from the plan means that the managed care plan cannot select the external review entity. It also means there must be ample standards to ensure the reviewer has no financial or business relationship with the plan or other parties involved in the appeal that could bias the decision. In addition, the external reviewer must be free to make its own determinations regarding medical necessity and should not be bound by the plan's definitions.

With respect to the process of bringing an appeal, the external review process should be fair and open, without unnecessary barriers like short time frames to bring an appeal or financial thresholds that could keep consumers from exercising their rights to appeal. Some important aspects of the external appeal process deal with the relationship between the right of appeal and the right to judicial review. While individuals should be required to complete the internal and external appeal process before they may seek judicial review, consumers who have already been injured should not be required to complete the external review process before seeking review in court. This is the model that applies for Medicare beneficiaries and is consistent with general principles of administrative law, which do not require an individual to exhaust administrative remedies when it would be futile. In this context, the patient is no longer seeking the benefit she was denied, but is seeking redress for her injury, which cannot be given through the external review process. Finally, the external reviewer's decision should not be given the same weight as a judge's opinion, and should not foreclose a consumer's right to a full and fair review in court that includes all of the evidentiary rules and discovery protections.

The external review scheme should also build on, not replace, states' expertise in this area and allow states flexibility to provide a stronger appeal process where they choose. Any federal rights that are created should establish a floor, not a ceiling, of protections for consumers.

While these protections are essential to ensuring a fair process for resolving benefit disputes with the managed care plan, they do not replace the need for additional legal responsibility.

Expanded Legal Responsibility

Health plans are protected against liability for many of their decisions today because of an anomaly in the law that was created by the Employee Retirement Income Security Act of 1974 (ERISA). Some background on ERISA and its interpreta-

¹ Kaiser Family Foundation National Survey of Consumer Experiences with Health Plans, June 2000.

tion by the courts is important to understand the current legal baseline that Congress will affect with any new patient protection legislation.

When ERISA was passed, it included a provision that preempted state laws that “relate to” private job-based benefit plans, including health plans. In 1987, the Supreme Court issued a landmark decision in *Pilot Life Insurance Co. v. Dedeaux* in which it held that ERISA’s preemption of state law meant that state law suits that relate to private job-based health plans’ benefit decisions are barred. Individuals seeking redress for a plan’s decision could only bring an action under ERISA for the benefit that should have been provided—no compensation for injuries would be available. Since the mid-1990s, a trend in federal caselaw has developed that has carved out an area from ERISA’s general preemption—cases involving medical malpractice have been found *not* to be preempted by ERISA. These cases established a distinction between suits involving the quality of medical care and those involving a benefit decision—cases involving medical quality issues could now be brought in state court; but those involving a benefit decision were still preempted by ERISA.

Many believe that state law liability has been expanded even further under a unanimous decision issued by the Supreme Court last year in *Pegram v. Herdrich*. In their opinion in *Pegram*, the Supreme Court suggested that cases involving a benefit decision that also involved a medical treatment issue should be pursued under state law, not under ERISA. Under the Court’s rationale, only cases that involved what the Court referred to as “pure eligibility” decisions—decisions that involve coverage issues like whether an individual was a member of the plan or whether a waiting period under the plan had elapsed—were still subject to ERISA’s preemption of state suits. This is a major shift in the courts’ view regarding ERISA preemption and one that could greatly expand the types of cases that can now be brought in state court. The new legal baseline after the *Pegram* case allows individuals to hold most health plans accountable in state court for decisions involving medical treatment issues.

Although Congress is considering legislation at a time when remedies may be greatly expanding, there is still a need for action to expand legal accountability. First, it is unclear how federal courts will interpret the Court’s suggestion in the *Pegram* decision—settling this issue could take many years, depriving individuals of greater certainty. Second, it is important to remember that the Court’s decision did little to address the need for greater remedies for cases involving what the Court called a “pure eligibility decision”—a case that only involves the plan’s interpretation of its own coverage policies. Without addressing this area, individuals will not be able to have any redress when their plan makes a mistake regarding enrollment or determining whether a benefits is covered, or wrongly interprets a waiting period requirements. However, the recent expansion of liability also creates a new baseline that Congress must consider in establishing new rights. The courts have already established a precedent that allows individuals greater access to meaningful remedies—whatever new accountability Congress creates should not curtail these rights.

ERISA’s preemption of much state law liability has created a situation in which health plans offered by private employers have become outliers in our legal system—unlike almost every other business entity, they are often immune from accountability for their actions, even if individuals are hurt by their actions. Other businesses in the health care and other industries are legally accountable for their actions as a generally accepted principle of public policy. If we agree that companies that make tires for our cars or toys for our kids should be accountable when people are hurt, then why should we treat those who are entrusted with our health, our most precious commodity, any differently? This immunity from suit also further perpetuates an imbalance of power between patients and their plans—a real patients’ bill of rights will tip the balance back to empower patients.

Real people are hurt by the absence of meaningful accountability. Health plan denials can jeopardize the quality of patients’ care as well as their financial security. In a Kaiser Family Foundation survey of consumers’ experiences with managed care, those who had experienced delays or denials of care suffered tangible harms including a quarter reporting physical injuries or lost school or work time, and forty percent reporting financial losses. There are also too many examples of those who are left without redress after the tragic results of a health plan’s decision to delay or deny care. The parents who lost their baby after their health plan refused to authorize round-the-clock hospital monitoring during the mother’s high-risk pregnancy despite two doctor’s recommendations. The man who committed suicide after his health plan denied him admission to a health plan’s alcohol rehabilitation program, despite his desperate need for help and the plan’s stated coverage of the services. These are the real faces behind the need for health plans to be accountable for these

decisions, not only to address the inequity of these tragic losses, but to deter bad decisions that can lead to them.

The costs of expanding accountability are low. According to estimates prepared by the Congressional Budget Office evaluating the effect of the Bipartisan Consensus Managed Care Improvement Act (H.R. 2990), the cost of expanding liability to allow all suits to go to state court is minimal—a total increase of one percent of premium for job-based health plans per member per month, approximately \$2.50 per month for the average individual. And practical experience in the states where there is now expanded liability shows that there will not be a flood of litigation—in Texas, where a bill expanding HMO liability was passed four years ago, only nine suits have been brought. Even if there is some additional cost, public opinion surveys gauging Americans' support for patient protections have consistently shown that a majority of Americans are willing to spend a little more to ensure they have these strong protections.²

In response to charges that this increased cost will cause employers to drop coverage, it should be noted that health care costs increased last year at a rate from two to three times the estimated cost of the entire Bipartisan Consensus Managed Care Improvement Act, and census data shows that employer coverage actually increased. In a recent survey of employers, when asked what they would do in the face of projected increases of up to 12% or more in the coming year, almost half said they would either absorb the costs themselves or do nothing—the other half said they would pass some costs on to consumers.³ No one responded that they would drop coverage. Another survey of smaller employers showed a vast majority of small employers support patient protection legislation and a majority would maintain coverage if patient protection legislation passed, even if their share of premiums rose by as much as \$20 per month.⁴

Expanding accountability for managed care consumers is a practical, common sense answer that will neither break the bank nor disrupt our health care system—the majority of Congress has supported these rights in the past and the overwhelming majority of Americans support them as well. The time has come for them to be enacted.

Scope

Any patient protection bill must apply to all Americans with private health insurance. This includes those covered by private-sector group health plans, individual health plans, and fully-insured state or local government plans. Proposals that only cover those in private job-based plans, or only those that are in self-insured job-based plans do not meet the mark—all Americans need and deserve the same protections. Some versions of these bills would apply key protections to only those in self-insured job-based plans, leaving out as many as seven in ten Americans with private health insurance coverage who need and deserve the same rights.

Patient protections should apply a uniform federal floor of protection of everyone, regardless of what type of plan covers them. The certification of state laws that meet or exceed the Federal minimum standard should be determined and enforced by a federal body. States should not be provided with loopholes, such as having limited penetration of managed care in their state or allegations of premium increases, which allow them to easily opt out of the Federal minimum standard.

Patient Protections

In addition to these other components, a strong patient protection bill must guarantee a variety of other comprehensive patient protections that are essential to women and families. These include access to emergency rooms, Ob/Gyns, prescription drugs, clinical trials, pediatricians and other medical specialists including those outside of the network if the network providers are not adequate. Patient protection legislation must also assure that medical judgments are made by medical experts, patients with a special medical condition receive continuity of care, patients have a choice of a full range of health providers, and patients are provided with full and understandable information about their health plan. Health care professionals must be protected against retaliation when they advocate on behalf of patients' needs or to improve health care quality. And "gag clauses" that prevent medical professionals from providing patients with full information about their treatment should also be barred.

² Kaiser Family Foundation Public Opinion Update, February 2000.

³ Actual cost increases for the year 2000 were 8.1%; estimated cost increases for the year 2001 are 10–12%—these are respectively two and three times the amount of CBO's 4.1% estimated cost increase associated with the Bipartisan Consensus Managed Care Improvement Act. Mercer/FosterHiggins National Survey of Employer-Sponsored Health Plans 2000, April 2001.

⁴ Kaiser-Harvard National Survey of Small Business Executives on Health Care, June 1998.

As Congress continues to debate these issues in the coming months, we will be evaluating new proposals to measure whether they meet the needs of women and families. We strongly encourage members of Congress to consider these principles and to pass a strong patients bill of rights without delay—the health of women and families hang in the balance. Thank you—I am happy to answer any questions you might have.

Chairwoman JOHNSON. Mr. Toohey.

STATEMENT OF MICHAEL J. TOOHEY, DIRECTOR, GOVERNMENT RELATIONS, ASHLAND, INC., ON BEHALF OF THE NATIONAL ASSOCIATION OF MANUFACTURERS

Mr. TOOHEY. Good afternoon, Madam Chairman, and Members of the Committee. My name is Michael Toohey and I am director of government relations for Ashland, Incorporated. I am pleased to appear on behalf of the National Association of Manufacturers. Though I usually wear a government relations cap, I am here also to tell you that I am a perfect example of the great success of employer-provided health care.

In 1994, I was diagnosed with leukemia. My employer said go wherever you need to go, do whatever you need to do, don't worry about anything. And I am here to tell you Ashland stood by me when I didn't have many people standing with me. I never had to worry about one thing, not about the costs.

Bone marrow transplantation was not totally accepted at that time as a treatment for leukemia, and Ashland didn't even have a problem with qualifying me, or any of our other employees.

The good news is it worked. My trial lawyer sister was my donor, and I have been symptom free ever since, but I have been in the hospital five times for pneumonia. I had two cataract procedures as a consequence of chemotherapy treatment. Ashland has stood up and every time been there for me.

I am very concerned that we may lose this benefit if we open up employer-provided insurance to litigation costs, and I would urge you to tread lightly as you consider new legislation. Above all else, please don't make it more difficult for employers to continue to provide the excellent health care that they do to so many Americans.

A good managed care reform bill will provide the additional protections and ensure procedural fairness that are needed, but don't add to the costs of employers in trying to solve the problem of a Patients' Bill of Rights.

We believe that H.R. 526, the Bipartisan Patient Protection Act, does not achieve, even closely, our tenet of what a good managed care reform bill is. Indeed, by exposing employers directly to Federal and State health care liability, and indirectly to the downstream costs of Federal and State HMO and insurer liability, the Ganske-Dingell bill and similar legislative initiatives will greatly increase health coverage costs and inflate the roles of uninsured Americans because people like me will not be able to obtain insurance, except through my employer. And if the costs go up significantly to defend themselves, they simply will not continue to provide this voluntary benefit.

Expanded health care liability helps no one. Not one of the bills, in our view, shields the health care purchaser, whether employer or individual, from the increased costs of coverage due to HMO or insurer liability. And in NAM's view, there is no good or acceptable expanded health care liability.

We, too, would like to see this issue go off Congress' agenda, Mr. Stark. However, the NAM is unwilling to gamble the future of an employer-based health care system which provides coverage for 172 million Americans. We hope you will join us in first protecting what works well today, employer-sponsored health care.

Chairwoman JOHNSON. Thank you, very much, Mr. Toohey.
[The prepared statement of Mr. Toohey follows:]

Statement of Michael J. Toohey, Director, Government Relations, Ashland, Inc., on behalf of the National Association of Manufacturers

Madam Chairwoman, my name is Michael J. Toohey and I am director of government relations for Ashland, Inc. I am pleased to appear before you today on behalf of our more than 14,000 fellow members of the National Association of Manufacturers. I would like to commend you for beginning the subcommittee's consideration of patients' rights legislation with a focus on our existing health care system, both in terms of what works and what needs improvement.

Though I usually wear a governmental affairs cap, I am here to testify as a beneficiary of Ashland's health plan, without which, I might not be alive today. Let me tell you a little of my story.

In April of 1994, I went to the doctor to check on a persistent cough. I was diagnosed with CML, which is a chronic form of leukemia. My life expectancy at that point was six years.

Fortunately for me, I work for Ashland, which voluntarily sponsors a health plan. With their support, I entered the Fred Hutchinson Center in Seattle, one of the top leukemia research facilities in the country. I underwent a bone marrow transplant and have been symptom-free ever since. I owe my life to Ashland's health plan.

I would be in big trouble if that health plan ever disappears. Given my history, I probably could not afford coverage in the individual health insurance marketplace, even if I were to find someone willing to offer it to me. The coverage that Ashland provides me is irreplaceable, just as it is for the 172 million Americans who receive their health coverage through the workplace. I hope you will tread lightly as you consider new legislation and, above all else, don't make it more difficult for Ashland to provide my coverage. It is already hard enough.

The cost of health coverage for the NAM's 14,000 members (including 10,000 small and mid-sized manufacturers) is once again increasing at a double-digit rate (12-13% on average). In light of this renewed health care inflation, the NAM urges Congress to be wary of adding additional costs to health coverage costs. We can't afford to price both employers and employees out of health coverage.

A good managed-care reform bill will provide additional protections and ensure procedural fairness to beneficiaries without adding much in the way of additional costs. H.R. 526, the so-called "Bipartisan Patient Protection Act" introduced in the House by Reps. Ganske and Dingell does not come even remotely close to meeting this definition. Indeed, by exposing employers directly to federal and state health care liability and indirectly to the downstream costs of federal and state HMO and insurer liability, the Ganske-Dingell bill (and similar bills) will greatly increase health coverage costs and, consequently, will inflate the rolls of uninsured Americans.

Expanded health care liability helps no one but the trial bar. Ganske-Dingell and similar bills purport to shield employers from liability, but, in fact, they all still ensnare employers in potential health care liability through clever drafting (*e.g.*, "discretionary authority" and the definition of "direct participation"). Employers will be forced to bear the time and expense of litigating over the extent of their participation and authority exercised over the disputed benefit determination.

Further, not one of these bills shields the health care purchaser—whether employer or individual—from the increased cost of coverage due to HMO or insurer liability. Even the Texas Health Care Liability Act—which clearly and unambiguously says one may not sue an employer-sponsor of a health plan—fails to protect employers from the downstream cost of HMO and insurer liability. In the NAM's view, there is no good or acceptable expanded health care liability.

We, too, would like to see this issue off Congress' agenda. However, the NAM is unwilling to gamble the future of the employer-based health care system—which provides coverage to more than 172 million Americans. We hope you will join us in first protecting what works best in health care today: employer-sponsored health coverage.

Health Plan Accountability

A persistent myth in this debate holds that HMOs and other health insurers can only be held accountable by the threat of health care liability. The NAM strongly disputes this unfounded conclusion. The best means to health care accountability, in our view, lies in a well-structured independent external review procedure that binds both the plan and the beneficiary. A quick, timely review—first internally by the plan and then by independent physicians in the external review procedure—will help ensure that patients receive what they desire most: good quality health care on a timely basis.

Health care liability punishes both good and bad actors—almost without distinction—and will threaten coverage for the 172 million Americans who receive their coverage through the workplace. Manufacturers and workers alike will bear the aggregate cost of expanded health care liability—a cost we believe has been greatly underestimated in the past—which is of great concern in an environment of double-digit health care inflation.

The greater concern is that employers will be forced to defend themselves from direct health care liability, an expensive and time-consuming proposition, at a minimum, and potentially a business-killing prospect. Any possible positive effects of health care liability are by far outweighed by its negative consequences, which are unnecessary given the availability of binding external review to hold health plans accountable. The NAM remains strongly opposed to expanded health care liability.

Employer Liability

Another persistent and insidious myth in this debate has been that the Ganske-Dingell, the old Dingell-Norwood and other patients' rights bills do not expose employers to direct liability. This is simply not the case.

As noted earlier, the Ganske-Dingell bill relies on clever drafting to ensnare employers.¹ The very term “direct participation”—upon which the sponsors rely in arguing that, unless an employer “directly participates” in the decision to deny benefits, he or she won't be liable—is defined as including the “actual exercise of control” over the decision. Like the earlier “discretionary authority” standard, the “direct participation” standard implicates ERISA's fiduciary responsibility duty. At the very least, employers will be forced to litigate the extent of their “direct participation” or “actual exercise of control.” The Ganske-Dingell bill, like the Dingell-Norwood bill before it, exposes employers directly to liability.

Employers and Health Care Liability

Some have sought to downplay the risk of employer liability, citing the lack of employers willing to state publicly their intention to drop coverage rather than face expanded health care liability. The danger of these proposals isn't only in the number of employers who would drop coverage; there is also a real risk that expanded liabil-

¹**Sec. 302 Availability of Civil Remedies**

Sec. 302(a) creates a new federal cause of action under new subsection (n) of Section 502 of ERISA.

Paragraph (4) of the new subsection (n) is entitled Exclusion of Employers and Other Plan Sponsors.

Paragraph 4(A) Causes of Action Against Employers and Plan Sponsors Precluded.— Subject to subparagraph (B), paragraph (1)(A) does not authorize a cause of action against an employer or other plan sponsor maintaining the plan . . .

But,

Paragraph 4(B) Certain Causes of Action Permitted.—

Notwithstanding subparagraph (A), a cause of action may arise against an employer or other plan sponsor . . .

(i) . . . to the extent there was direct participation by the employer or other plan sponsor (or employee) in the decision of the plan under section 102 of the Bipartisan Patient Protection Act of 2001 upon consideration of a claim for benefits or under section 103 of such Act upon review of a denial of a claim for benefits, or

(ii) . . . to the extent there was direct participation by the employer or other plan sponsor (or employee) in the failure described in such clause.

And

Paragraph 4(C) Definition of Direct Participation—

(i) Direct Participation in Decisions—. . . the term “direct participation” means . . . the actual making of such decision or the actual exercise of control in making such decision or in the conduct constituting the failure.

ity would force many employers to reduce benefits or increase employees' share of coverage costs—strategies already well under consideration due to the present double-digit health care inflation. A worker who cannot afford the coverage his employer offers is just as uninsured as a worker whose employer no longer offers coverage.

It is no surprise to us that most companies are reluctant to publicly state that they will drop coverage. Both employees and investors are likely to react adversely to a premature declaration, making polls and surveys a valid and safer way to gauge employer concern. In our most recent poll of small manufacturers, nearly 60 percent said they would seriously consider dropping coverage in response to expanded liability.² In our view, we can neither afford to increase the number of uninsured Americans (43 million) nor reduce the number of Americans with employer-sponsored coverage (172 million).

Additional Patient Protections

Although there is broad consensus on the subject matter to be covered (*e.g.*, external review, pediatricians as primary care physicians, direct access to OB/GYNs, emergency room treatment), there remains considerable disagreement on the specifics of these proposals. Last Congress's conference committee on managed care reform discovered this, much to its ultimate frustration. For our part, the NAM urges Congress to proceed carefully and with an awareness of the high and increasing cost of coverage. The most trivial of mandates becomes important if it becomes the straw that breaks the camel's back and prices the worker and his family out of coverage.

We urge your particular attention to the question of what standard will govern the external review panel's examination of a disputed benefit determination. It makes sense to us that the health plan's terms—particularly its definition of medical necessity—should govern. After all, the plan's terms are what we design or purchase. Many patient protection proposals have taken the position that the review should be made *de novo*, without regard to the plan's terms and definitions. In our view, this approach will create as great a potential for increased costs as would expanded health care liability. The better approach would allow the plan's enumeration of covered benefits to govern and would give substantial deference to the plan's definition of medical necessity.

Conclusion

The NAM strongly opposes the Ganske-Dingell bill and similar bills that will expand health care liability for employers, HMOs and other health insurers. We urge Congress to adopt a more limited patient protection bill that relies on binding independent external review to resolve disputes over benefit determinations, instead of costly and wasteful litigation. President Bush also has indicated he favors a more limited approach.

It is more important than ever that we build on the strength of our employer-based health care system to expand coverage, rather than expand the rolls of uninsured Americans. I thank the Subcommittee and will welcome your questions.

Chairwoman JOHNSON. Dr. Zipes.

STATEMENT OF DOUGLAS P. ZIPES, M.D., PRESIDENT, AMERICAN COLLEGE OF CARDIOLOGY, AND PROFESSOR OF MEDICINE, INDIANA UNIVERSITY SCHOOL OF MEDICINE, ON BEHALF OF THE PATIENT ACCESS COALITION

Dr. ZIPES. Madam Chairman and distinguished Members of the Subcommittee, I am here today on behalf of the Patient Access Coalition, a national organization representing nearly 70 organizations. Collectively, the Coalition's Member organizations represent more than 1 million patients, 300,000 doctors, and 300,000 non-physician providers across the country.

²NAM Survey of Small Manufacturers, February 2001. 58.82 percent of respondents said they would "seriously consider dropping coverage."

I am a practicing cardiovascular specialist and Distinguished Professor of Medicine at Indiana University School of Medicine, and I also serve as president of the American College of Cardiology.

The Coalition was formed in 1993 in the context of congressional debate over comprehensive health system reform to ensure that any resulting legislation would contain the guarantee that every patient would be able to choose the kind of medical treatments and services they needed.

The Coalition was the first national organization of patient and provider groups to call for Federal patient protection legislation, and for nearly 8 years we have stood united in our concern that the focus of health care in this country must be on patients and quality of their medical care.

Throughout the years, the Coalition has not deviated from its strongly held belief that all patients in managed care plans must have health care choice and access and that health plans must be held accountable. That is why we believe that all patients should be guaranteed basic protections from health plan practices that could negatively affect medical outcomes.

Two of the Coalition's chief principles are patient access to a point-of-service option and timely access to specialty care. Patients must be allowed treatment by their health care provider of their choice.

A point-of-service option at the time of enrollment is the ultimate patient protection against poorly managed health care plans. This choice could be offered with no additional cost to the employer.

Direct access to specialty care is essential for patients in both emergency and nonemergency situations for patients with chronic and temporary conditions, as well as those with unexpected acute care episodes. Specialty care must be available for the full duration of the occurrence and must not be limited by the number of visits.

Furthermore, any routine costs incurred for items and services furnished in connection with participation in clinical trials must be covered by the health plan.

In addition to ensuring choice and access, barriers that impede access and put patients at risk must be eliminated. Any legislation must include a ban on health plan financial incentives and gag clauses and require full disclosure of health plan information to patients.

The patient protections of access and choice that I have outlined have limited value unless the managed care plan is held accountable for its actions.

One of the most consistent complaints against managed care plans is that when the providers or patients appeal a decision, health plans are slow to act. Because decisions about patients' care can be a matter of life and death, managed care plan foot dragging can have profound consequences.

To protect patients and give them a meaningful right to appeal, sound and timely internal and external appeal processes are critical. In the case of external appeals, the review must be de novo and genuinely independent, and the review panel's decision must be binding on the health plan.

The external reviewers must have clinical expertise in the area in which the review is being conducted, and the findings of the ex-

ternal reviewers must not be constrained by the health plan's definition of medical necessity.

Decisions on urgent or emergency cases must be made within the expedited time period. These enhanced internal and external review processes will assist consumers in obtaining access to appropriate services in a timely fashion, thus maximizing the likelihood of positive health outcomes.

These principles, if incorporated into Federal legislation in a meaningful way, will go a long way toward protecting patients in managed care plans and ensuring that patients get the care they pay for and deserve.

Most importantly, and without exception, these protections must be guaranteed to all patients in managed care plans to the extent that they are not already enforced through stronger State laws. Medicare and Medicaid beneficiaries, as well as Federal employees, already have many of these protections.

We are aware that the debate on the issue of accountability has centered on the patient's ability to bring suit against health plans. This debate has been complicated by the many variables associated with liability. Because of the divisiveness of this issue and the various positions held by individual organizations within the Coalition, we have not taken a position on liability. However, we strongly believe it is time for Congress to finish its work and pass legislation this year to make patient protections apply to all managed care enrollees.

Madam Chairwoman, the Patient Access Coalition firmly believes that enactment of its patient protection principles will ensure that patients will have real choice and timely access to quality health care. Our approach is straightforward and comprehensive, and places nonintrusive reasonable requirements on the health insurance industry.

We look forward to your leadership and want to work with you to see that enactment of these patient protections occurs this year.

I thank you for allowing me the opportunity to speak before you and your Subcommittee.

Chairwoman JOHNSON. I thank you, and thank you, Dr. Zipes.

[The prepared statement of Dr. Zipes follows:]

Statement of Douglas P. Zipes, M.D., President, American College of Cardiology, and Professor of Medicine, Indiana University School of Medicine, on behalf of the Patient Access Coalition

Madam Chairwoman and members of the subcommittee: I am here today on behalf of the Patient Access Coalition—a national organization representing nearly 70 organizations dedicated to fighting for the enactment of comprehensive and meaningful patient protection legislation. Collectively, the Coalition's member organizations represent more than one million patients, 300,000 doctors, and 300,000 non-physician providers across the country. I am a practicing cardiovascular specialist and Distinguished Professor of Medicine at Indiana University School of Medicine. I also serve as president of the American College of Cardiology.

The Coalition was formed in 1993 in the context of congressional debate over comprehensive health system reform to ensure that any resulting legislation would contain the guarantee that every patient would be able to choose the kind of medical treatments and services they needed. The Coalition was the first national organization of patient and provider groups to call for federal patient protection legislation. And for nearly eight years, we have stood united in our concern that the focus of health care in this country must be on patients and the quality of their medical care.

Throughout the years, the Coalition has not deviated from its strongly held belief that all patients in managed care plans must have health care choice and access, and that health plans must be held accountable. This is why we believe that all patients should be guaranteed basic protections from health plan practices that could negatively affect medical outcomes.

Choice

Two of the Coalition's chief principles are patient access to a point-of-service option and timely access to specialty care. Patients must be allowed treatment by the health care provider of their choice. A point-of-service option at the time of enrollment is the ultimate patient protection against poorly managed health care plans. This choice could be offered with no additional cost to the employer.

Direct access to specialty care is essential for patients in both emergency and non-emergency situations, for patients with chronic and temporary conditions, as well as those with unexpected acute care episodes. Specialty care must be available for the full duration of the occurrence and must not be limited by the number of visits. Furthermore, any routine costs incurred for items and services furnished in connection with participation in clinical trials must be covered by the health plan.

Access

In addition to ensuring choice and access, barriers that impede access and put patients at risk must be eliminated. Any legislation must include a ban on health plan financial incentives and gag clauses, as well as full disclosure of health plan information to patients.

I want to take a moment to elaborate on what we mean by prohibiting financial incentives. Financial incentives should not interfere with medical judgement. For instance, health plans must be prohibited from establishing arrangements where the gatekeeper has a financial incentive not to refer patients. We need to protect patients from under-referral for financial gain.

Accountability

The patient protections of access and choice that I have outlined have limited value unless the managed care plan is held accountable for its actions. One of the most consistent complaints against managed care plans is that, when the providers or patients appeal a decision, health plans are slow to act. Because decisions about patients' care can be a matter of life and death, managed care plan foot-dragging can have profound consequences.

To protect patients and give them a meaningful right to appeal, sound and timely internal and external appeals processes are critical. In the case of external appeals, the review must be de novo and genuinely independent, and the review panel's decision must be binding on the health plan. The external reviewers must have clinical expertise in the area in which the review is being conducted, and the findings of the external reviewers must not be constrained by the health plan's definition of medical necessity. Decisions on urgent/emergency cases must be made within an expedited time period. These enhanced internal and external review processes will assist consumers in obtaining access to appropriate services in a timely fashion, thus maximizing the likelihood of positive health outcomes.

These principles, if incorporated into federal legislation in a meaningful way, will go a long way toward protecting patients in managed care plans and ensuring that patients get the care they pay for and deserve.

Most importantly and without exception, these protections must be guaranteed to *all* patients in managed care plans to the extent that they are not already enforced through stronger state laws.

In 1996, the Coalition's efforts, working with this committee, led to the only set of federal patient protections ever to be signed into law. Those patient protections were enacted as part of the Balanced Budget Act of 1997 and apply to Medicare and Medicaid beneficiaries enrolled in managed care plans. It has been four years since Medicare and Medicaid beneficiaries were guaranteed these basic and fundamental protections.

We are aware that the debate on the issue of accountability has centered on the patient's ability to bring suit against health plans. This debate has been complicated by the many variables associated with liability. Because of the divisiveness of this issue, and the various positions held by individual organizations within the Coalition, we have not taken a position on liability. However, we strongly believe it is time for Congress to finish its work and pass legislation this year to make basic patient protections apply to all managed care enrollees.

Madam Chairwoman, the Patient Access Coalition firmly believes that enactment of its patient protection principles will ensure that patients have real choice and timely access to quality health care. Our approach is straightforward and com-

prehensive and places nonintrusive, reasonable requirements on the health insurance industry. We look forward to your leadership and want to work with you to see that enactment of these patient protections occurs this year.

Madam Chairwoman, I thank you for allowing me the opportunity to speak before you and your subcommittee.

[Attachments Are Being Retained In The Committee Files.]

Chairwoman JOHNSON. As one who believes that the goal of this legislation should be to return control of health care to physicians, I absolutely agree with you that the board must be independent and the decision must be binding. And I appreciate your comments about the definition of medical necessity.

The benefits that are laid out, the rights that are laid out in this bill, access to an obstetrician, a pediatrician, to a specialist, access to a point-of-service plan, so no American can be in a plan that didn't offer them some choice of physician, those things are extremely important in my mind, as is a consistent national appeals process that can turn around appeals promptly, rapidly, actually reducing the need to go to court. Most of the examples Ms. Arkin gave in her written testimony were cases that never would have become malpractice cases or cases against the plans if we had had a timely appeals process in place.

If we were able—if we are not able to get agreement on the issues of suit because of the complex impact on employer participation, as well as costs, would it be worth it to pass the patient protections and the national appeals right with a mandatory binding decision by the physician panel?

Dr. ZIPES. That is addressed to me?

Chairwoman JOHNSON. Yes.

Dr. ZIPES. The Coalition, as I said, has taken no stance on liability. We feel that the patient protection items are of the utmost and extreme importance. We have in the past supported these items in the bills that had and did not have liability clauses, and conceivably that could happen again. But most importantly to us, the patient protection provisions must come forward and be approved.

Chairwoman JOHNSON. Yes.

Mr. Toohey, it is a special pleasure to welcome you here. For my colleagues and the Subcommittee, I would tell you that Mr. Toohey was the staff director to the House Public Works and Transportation Committee when I was a freshman Member of Congress, and taught me a lot I know about the legislative process.

And I bring that up because he has long experience in legislating and in watching the impact of laws that we pass.

You now have had a lot of experience in the private sector. And I wonder what your judgment is—would be as to the impact of a Patients' Bill of Rights that included a right to sue, recognizing that there is no way to fully protect employers from exposure to suit under ERISA, no matter how carefully we try.

Mr. TOOHEY. I think it would be devastating. And the reason it would be devastating is because publicly held companies like mine would face the dilemma of rising costs to defend themselves in litigation. And shareholders are saying why are you providing a voluntary benefit that costs so much?

We, at Ashland, for example, last year spent \$80 million for 52,000 people's health care. That is \$1.10 a share. We made \$4 a share. And so when you promise the shareholders a return, you have got to control your costs.

Chairwoman JOHNSON. So you're reducing the—

Mr. TOOHEY. Litigation doesn't add one dime to medical treatment.

Chairwoman JOHNSON. It is—I do want to correct the record, as I understand it, Mr. Stark, that CBO has now said that the liability provisions will increase costs 8 percent, not 1 percent, and the Barrett's Group also has come to that conclusion.

Mr. STARK. .8.

Chairwoman JOHNSON. .8 percent as opposed to 1 percent.

Mr. STARK. So it is less?

Chairwoman JOHNSON. But it is a lot more than their original estimate which was 1.1 percent. We are talking about 1 percent versus 8 percent. I was right to begin with.

Mr. STARK. No; .8, Madam Chair. It is less.

Chairwoman JOHNSON. Sorry, .8. But it is—

Mr. STARK. It is a 10th of a percent less, down.

Chairwoman JOHNSON. The Barrett's Group has under their studies found that it would increase costs anywhere from 2.7 to 8.6 percent, which would increase the number of uninsured, without question at all. A survey by the Chamber of Commerce indicates that 65 percent of employers would terminate their health plans if liability expansion is enacted.

In that regard, Dr. Corlin, I just want to ask you whether or not you would support a change in the language from the suit—the exposure to suit by someone who directly participates in employee's health care, to limiting that exposure to suit to a “dedicated decisionmaker,” because the language “directly participates” can be far more inclusive than a dedicated decisionmaker.

If we are going to try to narrow the liability and control the costs, we believe and many Members believe that we can achieve this goal in part by narrowing the right to sue to the right to sue the dedicated decisionmaker, and that that would in some degree insulate the employer.

Dr. CORLIN. Mrs. Johnson, it has never been our intention to hold accountable and make eligible to be sued an employer whose total involvement is to pay the premium and provide the plan. The only circumstances—and these are virtually unheard of—where employers would be liable would be in cases where the employer was directly involved in making the decision that denied or affected the medical care.

Our concern is the decisions that are made—affecting care, which are made virtually every—in every circumstance by the health plan.

If there is some specific language that we can participate with you to develop to make that point more clear, we are absolutely willing to do so. It is not our intent that employers who just pay the premium should be accountable.

And if I may, I am thrilled with Mr. Toohey's description of the excellent results of his medical care. It rings a particular ring with me, since in that same year, 1994, one of my partner's wives also

developed acute leukemia, and she had a bone marrow transplant, and she is today cured and doing well.

But I think he makes the case better than I could, the issue—he made the statement that in 1994, bone marrow transplant was not fully accepted, yet his employer said go anywhere and get it. Imagine the circumstance of where would we be and where would he be, if instead a health plan had said, that still is experimental, we are not going to approve it, and held it up for 12 or 18 months. I don't think we would have the same hearing with the same participants. And that is the circumstance which is all too real that we are concerned about.

Chairwoman JOHNSON. I appreciate that. It is also true that if we had a timely appeals process and the panel of physicians ruled that it was medically necessary, they would have gotten the right that Mr. Toohey got, and that is I think what is important to remember. We are talking about patients' rights and physician control.

And a strong appeals process guarantees physician control of a medical process, whereas if you don't have exhaustion you do end up having lawyer control of what should be a medical process.

So let me yield—because my time is expired, and I also am controlled by the clock, let me recognize Mr. Stark. I have no time.

Mr. STARK. Thank you, Madam Chair. Mr. Toohey, I am going to ask you some questions because you seem to be the only witness who is against this bill. And the—I want to find a little about Ashland here.

You said that you spent 80 million bucks last year to provide insurance to 52,000 people. You got about 25- or 26,000 employees, so I assume you are adding in there families and—

Mr. TOOHEY. Retirees and families.

Mr. STARK. That would have meant that it would have cost you \$12 a year, according to the CBO estimate of your costs going up to eight-tenths of a percent, to cover the added costs of this liability portion of the bill which is at issue.

Mr. TOOHEY. I wish I could foresee the future as well as they do.

Mr. STARK. I am just telling you that is their estimate. I just want to get it into focus here, because it is interesting that you mention \$80 million.

Now, that is the same amount that Ashland has been charged with in the Lockheed litigation where there were five trials involving 130 plaintiffs, and these were verdicts against Ashland, including 75 million of that 80 was punitive damages for personal injuries resulting from chemicals sold to Lockheed and inadequately labeled by Ashland.

Now, it is interesting also that you got insurance—44 insurance companies who are going to pick up that 80 million bucks. So that ain't going to put Ashland out of business, is it, paying \$80 million for hurting 130 people? You are going to survive that one, aren't you?

Mr. TOOHEY. We are not the only defendant in that case. And that case is on appeal. And—

Mr. STARK. You are going to survive it, aren't you?

Mr. TOOHEY. I don't know, sir. You are asking me to speculate.

Mr. STARK. Your report to the SEC says it is not going to cost you anything. I hope you are not telling the straight skinny to the SEC. That is not considered good taste. Also in 1998—

Chairwoman JOHNSON. If they appeal it and win it, however, it is evidence of frivolous suits pushing up costs.

Mr. STARK. The U.S. Department of Justice and the EPA announced that Ashland had agreed to spend more than \$32.5 million to settle allegations of illegal discharge of pollutants and various violations at your refineries in Kentucky, Minnesota and Ohio. Now, that \$32 million would cost—in 1 year, I guess, it would cost about \$1,200 per employee. That isn't going to force Ashland to quit paying for health insurance or close up shop, is it?

Mr. TOOHEY. It hasn't yet.

Mr. STARK. And one would think that a company like Ashland that takes that good care of its employees wouldn't really miss 12 bucks a person per year. Do you think? If they can spend \$32 million for environmental infractions, and if they can spend \$80 million for improperly labeling chemicals that only hurt 130 people, wouldn't you think that a company that has the interests of all mankind at heart, as Ashland obviously does, would be able to find that 12 bucks a year to take care of their employees?

Mr. TOOHEY. Congressman, your premise is built around a CBO gaze into the future, but in one of the testimonies presented today in the written record, there is discussion of one case in California where the award was \$126 million. That is more than we spent on health care.

Mr. STARK. That is chump change to guys who are polluting and mislabeling chemicals. That wouldn't even—if that were right, Ashland could swallow that one, could they?

Mr. TOOHEY. That is an unfair characterization—

Mr. STARK. Look, I am just—it is not my characterization. These are SEC reports, Ashland's own statements about what is going to happen, and I presume that if you can insure yourself against the loss because of environmental infractions or because of improper labeling and the liability thereto, you could also insure yourself against any—if I am wrong, and if the CBO is wrong—the CBO is run by the Republicans now, I want to point out, not me, and if they are saying that it is only going to cost you 8/10 of a percent increase in your premium—let's say they are wrong by an order of 10. Let's say it is going to cost you—

Mr. TOOHEY. I don't think it is fair to risk 127 million people's employer-provided health care on a CBO report which may say this or may say that when we don't even know what—

Mr. STARK. What kind of a risk do you take when you mislabel chemicals or dump stuff into the water? Is that a fair risk?

Mr. TOOHEY. Those events occurred during World War II—

Mr. STARK. Those events occurred during 1998.

Mr. TOOHEY. I understand.

Chairwoman JOHNSON. Mr. McCrery.

Mr. MCCRERY. Thank you.

I am tempted to get into a discussion with my good friend from California about the tort system, but I won't. We will do that privately maybe, but suffice it to say that the goal of the tort system shouldn't be to put companies out of business. Companies do com-

mit errors, and we have a judicial system that is designed to compensate victims, but the goal should not be to force companies out of business.

Mr. Toohey, is Ashland self-insured?

Mr. TOOHEY. Yes, it is.

Mr. MCCRERY. For health insurance?

Mr. TOOHEY. Yes, sir.

Mr. MCCRERY. So you don't have any insurance companies involved?

Mr. TOOHEY. No. What we do is we have a contract with Blue Cross/Blue Shield to manage our program, and then we have an employee review panel that handles the few reviews and appeals that we get under this plan. So we are involved, in other words.

Mr. MCCRERY. The employer exemption, then, that Dr. Corlin speaks about would not apply to Ashland.

Mr. TOOHEY. Or most other employers—

Mr. MCCRERY. There are a great many large companies that are self-insured, at least to some extent, and therefore are directly involved in the decisions. So I think the employer exemption really is not much cover for very many employers, and when good lawyers get ahold of it, I suspect it won't be much good to anybody. So we really ought to talk about the cost to the employer community, whether it is .8 percent or 8 percent. There is going to be some cost increase, and employers will bear that cost, either directly or indirectly.

Dr. Corlin, last year when we were debating the Patient's Bill of Rights, the AMA was adamant in opposing attaching medical malpractice reform to the Patients' Bill of Rights, because it was said by the AMA President Clinton would veto the bill if medical malpractice were attached, and that you all were interested in making law, not making a point. This year we have a President who I suspect would sign a bill with medical malpractice reform attached to it. What is the AMA's position this year on medical malpractice reform?

Dr. CORLIN. Thank you. If I may—thank you, Mr. McCrery. If I may, I will give a bit of an expanded answer first.

Mr. MCCRERY. Sure.

Dr. CORLIN. I have spent most of my time as an officer of a medical association and got my start in 1975 fighting the good lady to my right on tort reform issues. I was instrumental in dealing with MICRA and, in almost every year since then, in defending MICRA. It is an issue that is close to my heart.

It has been our belief, and, at the moment, the analysis continues to be our belief, that no matter how much we want tort reform at the Federal level, which we sincerely do, that the act to both get this bill to the President's desk and get it signed as a combined two-step process, it was our opinion last year that that would not be possible if tort reform were attached to it.

It is our opinion this year that that would be the same circumstance. I would love very much to give you a different answer.

I find the whole issue ironic, not in your question, which is very valid and sincere, but in this issue being raised in this context, and the reason is we now have the health plans coming forth and saying, oh, we can't do this, that or the other thing because we don't

have tort reform. Yet 5 years ago when the medical association was here before this very body seeking Federal tort reform, which we got passed through this House, and we are approximately four votes short of getting passed through the Senate, we turned to the American Association of Health Plans and to their executive director and said, please help us get tort reform. It will help us all. They ignored us. She refused, didn't even bring the issue to her board, and no help was coming, and we lost the opportunity to get tort reform, which, had we had it, would have taken that .8 percent probably down to .3 percent.

So the short answer to your question is we would maintain our present position. We are always open to reevaluating it in discussions. We want still to get this bill through two Houses of Congress and get it signed by the President. We would love to have tort reform. If putting tort reform in—

Mr. MCCRERY. So if I might—

Dr. CORLIN. Excuse me?

Mr. MCCRERY. I think I get your point. And my time has expired, but I sure do want to ask you a few more questions when we get the second round.

Chairwoman JOHNSON. Mr. Johnson?

Mr. JOHNSON OF TEXAS. Thank you, Madam Chairman.

Dr. Corlin, you state that patients should exhaust administrative remedies before going to court, and then state, if patients alleged irreparable harm, or if the patient dies, their estate should be able to go straight to court. Under this standard a patient, under my view, must only allege harm and then could circumvent the entire appeals process, which is based on medical experts making medical decisions. If a patient has already died, what harm does it do to require independent medical experts to examine a case and the medical circumstances that surround it before you throw it into court, you know, when you have people that have no medical training at all? Can you answer that?

Dr. CORLIN. Yes. Thank you for raising that issue, and I think this issue, probably more than any other, is the one that we would very much value some private discussion to get this issue clarified. I think that there is some confusion about it. I think it can be readily clarified to both our satisfactions.

The concern if a patient has died obviously has to do with urgent needs that the family may have, given the circumstances. I think that if we were able to assure a very significantly expedited appeals process, that might resolve that problem. We need to recognize that proof of a claim has to start with allegation of a claim. We also need to recognize the opposite side, that every damage that is alleged is not real. We fully recognize that.

But that damage can be—can occur on more than one occasion. There can be consequences to the remaining family after a death, and in all probability, I think of all of the points of difference, at least from our perspective, this is the one that probably could be most readily resolved with some language change.

Mr. JOHNSON OF TEXAS. OK. Also, you say that approximately—in about 20 of your 22-page testimony, you focused on liability for health plans. Can you explain why the premiere physician group, which you represent, would focus nearly all your atten-

tion on litigation and none on appropriate patient care, the primary intended result, I would think, of a Patients' Bill of Rights? And could you also tell me how many Members of AMA there were 10 years ago, and what is your Membership today?

Dr. CORLIN. OK. Our membership now is down somewhat from 10 years ago. We are 290 something thousand now. To be honest with you, Mr. Johnson, I don't know the exact number of what it was 10 years ago.

With regard to the issue of the emphasis placed in the testimony on health plan liability as opposed to quality of care issues, health plan liability is, in our view at least, one of the major items, if not the major item, on which we have to have some closure for legislation to move. So we concentrated on that as representing the major open issue. Nobody wants to hold health plans accountable for things that they are not responsible for; but similarly, I don't want to see physicians or hospitals or other people in the health care delivery system be held accountable for things that they are not responsible for. I believe that people should be held accountable and responsible for the decisions that they make, and we have an anomaly in that our health care delivery system has changed to the point that the insurers are no longer simply premium collectors and claims processors, but they are involved in the decision-making stream of health care, and they are the only people involved in that entire stream who are immune from liability for the consequences of their actions.

Mr. JOHNSON OF TEXAS. OK. In your proposal, Expanding Health Care Insurance, you endorse the concept of health marts, I believe.

Dr. CORLIN. I am sorry, sir. I didn't hear you.

Mr. JOHNSON OF TEXAS. In your proposal, Expanding Health Care Insurance, the AMA proposal for reform, you endorse health marts, I believe. Health marts create an alternative in insurance plans and exempt those plans from State regulations; is that true?

Dr. CORLIN. Well, we do endorse voluntary health marts as buying cooperatives. With regard to—my understanding and view of that is that they would not be the health plans themselves, but would be an organization similar to the FEHBP whereby Federal employees are given a choice of being able to select what plan they wish, and within the choices offered by the health mart would be each and every one of the plans that were approved by a mechanism at least broadly similar to that whereby plans get approved for the FEHBP.

Mr. JOHNSON OF TEXAS. Yeah. But under those conditions, you allow them to have Federal patient protection standards, and yet, on the one hand, you ask for State jurisdiction. On the other hand, you are saying you like Federal jurisdiction. I mean, I am a little confused, but our time is up.

Dr. CORLIN. May I respond, Madam Chairman?

Chairwoman JOHNSON. Very briefly.

Dr. CORLIN. OK. Yes. We recognize that there are two types of decisions to be made. One are medical necessity-type decisions, which we believe should remain in State courts. The other are coverage-type decisions under ERISA so that we are separating out the two types of decisions, one which we would wish to have han-

dled in State court, one which we would wish to have handled in Federal court, but it would not be a circumstance that for any given type they would have a choice of one or the other. One type goes one place; one type goes the other place.

Mr. JOHNSON OF TEXAS. Thank you.

Dr. CORLIN. Thank you.

Chairwoman JOHNSON. Ms. Thurman.

Mrs. THURMAN. Thank you, Madam Chairman, and thank you all for joining us today and discussing the different views here. It has been somewhat enlightening, and I appreciate that.

Mr. Toohey, let me ask you just a question. Are you familiar with the article that was written on April 12th, 2001, in the Washington Post that had done some interviews with some of the signatories on who was in favor of or against the Patients' Bill of Rights and the way that you have expressed it for the employer-based part of it?

Mr. TOOHEY. No, I am not aware of that article.

Mrs. THURMAN. Well, just so you will know, basically what they have said is that they have not found any of those companies who have said that they would actually drop those plans, I mean, basically is the gist of the article. So, I mean, I don't want to use scare tactics, because I think all of us are really trying. Just the idea of the Patients' Bill of Rights in itself is such a good piece of legislation in helping the health care in this country, so to say that, I think, is misleading at best.

Second, you know, I also find it interesting, and I don't know where your company or what has happened, but, you know, you talked about the CBO and what could happen in the future, but, yet, you know, we are sitting here passing tax packages based on CBO numbers in the next 10 years, too. So, you know, if we are not right here, then we may not be right in the other. So maybe we ought to slow down on all of it.

So I don't know where you all were on that, but I would just suggest we need to be careful how we flip numbers out here on both sides of the aisle, because if it is not good for one, it shouldn't be good for the other. So I would just caution.

Let me ask you a question, because we have heard of, Mr. Toohey, and we have understood—or Dr. Corlin or Dr. Zipes. Tell me, can you give me examples where we needed this law to have a hammer behind it? Because if you can't, I will.

Ms. ARKIN. Well, included in my written testimony are several cases that I actually litigated. Because they were either private insurance, government employees or Medicare insurance, they weren't subjected to ERISA limitations. These people could get relief. The problem is that other cases—and I see dozens of them in a month. Other people are just as severely hurt, just as badly damaged, and they don't have recourse. The types of cases are the same, whether it is the government employee or not a government employee, and the circumstances often—several of the cases I have disclosed in my testimony: Mr. Levy, who needed a tumor removed from his lung, and it was too close to his heart, he had to have that surgery immediately. He couldn't even wait for a review process any longer. He went through the internal review process of the plan, and that took over a week, and the doctor told him his tumor

was going to double in size in 30 days. He couldn't wait any longer. He had to go ahead. He had to—he had to save his own life, and he couldn't wait for the plan or an external review process or a court to make that happen for him. He had to take care of the problem, and then he had to go and try and get the financial aspect of it fixed. He had to sue later because he was forced to take care of his own life.

The same thing with the lady I have identified as Mrs. R. She had a bleeding tumor in her bladder that the health plan refused to deal with. She had to go get it fixed. She had to save her own life. The external review process couldn't help her. The external review process is designed to get people their care. If that is its goal—and that is a spectacular goal—it can't help people who can't wait that long. It can't help people who die in the meantime, like Mrs. A. She needed—she—she had 3 hours to get to the right kind of care, and no review process is fast enough for that, and she died. Going through review process after she died wasn't going to help her, wasn't going to help her family. It wasn't going to get her the care she needed, and it wasn't going to compensate her family for the damages that you wanted.

Mrs. THURMAN. And, Dr. Corlin, what happens to doctors who are in these networks where—where, in fact, they have been denied—you have recommended or somebody has recommended care, they have been denied, and they die because they didn't get it? Do you become responsible for that? Who becomes responsible for that?

Dr. CORLIN. The existing tort process winds up with everybody else getting sued except for the insurance plan.

Mrs. THURMAN. Who might have been the person making the decision?

Dr. CORLIN. That is correct. And there were—there have been cases that have been—the Pappas case in Philadelphia is one such case. A gentleman who had an abscess near his spinal cord and needed specifically to go to one hospital in Philadelphia where they had this particular service and this particular neurosurgical expertise available, and the plan had to contract with another hospital a couple of miles away. Now, the couple miles is not the point, but the point is that the care was denied, and the gentleman was rendered a quadriplegic, when, had he gotten timely service, he might have—might well have avoided that.

And the most significant part of that, in addition to the individual tragedy to one family, is that there can't be a specific time-frame put on an expedited review. In some cases, an expedited review taking 60 days would be fine. In some cases, an expedited review would have to be done in 7 days. In some cases, an expedited review has to be done in minutes, depending on the specifics of the medical indication involved, and those are the concerns that we have.

Mrs. THURMAN. Thank you.

Chairwoman JOHNSON. Dr. Corlin, are you aware that our bill requires—allows only 72 hours for an expedited review? That would have solved most of the problems that all three of you have pointed to.

One of the things that has to be remembered as we consider this bill is that an expedited review is fast and free, maybe \$25. Going

to court is expensive and long. Now, when you say there will be very few cases, do you think about that every—the fact that every State, at least Connecticut does and I believe most States, have panels that malpractice cases have to go to—go through in order to be allowed to go forward? There is no such provision in the Patients' Bill of Rights. So every case that wanted to be brought could be brought, and that is why I bring you back briefly to clarify your answer to Mr. Johnson.

This issue of exhaustion of the appeals process is extremely important, because if you don't exhaust it, you don't get four physicians' opinion on the record. Now, if you want—if you are a trial lawyer, you probably don't want those three physicians on the panel, their position on the record. But if you want physicians to regain control of our health care system, you want the physician's opinion, the caring physician, the physician for the patient. You want his physician to be—excuse me, his recommendation for care to be reviewed by physicians, and you want the physician opinion on the record, and you want it binding. If you can have a binding position, a binding decision in 72 hours by physicians reviewing a physician, aren't you better off, and isn't the fact that that will serve everyone, not just those who can find themselves in a position to go to court, isn't that good?

Dr. CORLIN. Ms. Johnson, I thought I said earlier—I meant to say in response to Mr. Johnson's question to me, yes, I think this is something that with discussion we can resolve the concerns about exhaustion of remedies, probably more easily than anything else. And—

Chairwoman JOHNSON. Specifically, though, to my question, you did mention some aspects of this, but this issue of the patient alleging, you know, alleging is not a high standard, and that would stop the appeals process and eliminate the requirement to exhaust. Don't you think that is not in physicians' interests or patients' interests?

Dr. CORLIN. I think we can come to agreement on that. I am not prepared to read the specific language today, but—

Chairwoman JOHNSON. Appreciate that, and I don't expect you to.

Dr. CORLIN. But with recognition of some concerns, I agree with you, usually 72 hours is enough. We could probably fashion language we are both comfortable with to cover those circumstances, and there are few where medically 72 hours would be too long. We can deal with that very easily, I am sure.

But I would like, if I may, Madam Chair, to put it in one bit of perspective. In Texas where this law has been in effect for 3 or 3½ years, there have only been a total to—what we have been able to find—10 lawsuits filed in that entire time. Now, one—

Chairwoman JOHNSON. I have another question for you, sir. I don't want to go into—

Dr. CORLIN. One may be too many, but 10 lawsuits in 3½ years in a jurisdiction the size of Texas is not a, if you will pardon—

Chairwoman JOHNSON. I know that the new law takes a while to get the regulations on the books and that the Texas law schools now have pages and pages of courses in how to sue health plans. When that law was first passed, there was no educating of lawyers

in how to do this. So you will, without question, see an increase in the number of suits.

But let me bring you back to the Ganske-Dingell bill which will permit an agent of a health plan to be sued—the agent to be sued for failing to exercise ordinary care.

Now, who is the agent? The agent is anyone who is making a claims decision or is performing a duty under the terms and contract of the plan. Physicians are performing a duty under the terms and contracts of the plans. They are not only performing a duty toward the patient, but they are carrying out typical contract-related administrative duties. So physicians will be liable as well as others under the very broad language of the Ganske-Dingell bill, and I hope this is also something that you would be willing to discuss with us, as our language about who can be sued is very much narrower, only the dedicated decisionmaker, so that the plan is held accountable, but not for administrative issues or for carrying out typical responsibilities under a plan. But there is very broad language about agent, that the agent can be sued for failing to exercise ordinary care, and that an agent is anyone who makes a claims-related decision—a claims decision related to eligibility, coverage or cost-sharing, or in performing a duty under the terms and contracts of the plan.

So it is very broad, and don't believe for a minute that physicians aren't going to be defined as being someone who is performing duties under the terms and contracts—terms of the duties of the—conditions of the contract.

So my time is expired, but I did want to get that on the record, because this is the nature of my concern. This is what gets back to Mr. Toohey's concern. Any small employer in their right mind cannot expose themselves to being an agent. And if you look at employers' concerns about liability in general, small employers can't run the risk. They just need to know it would be possible, and they are out of there.

Ms. ARKIN. Madam Chair, would it be possible for me to address that issue?

Chairwoman JOHNSON. Sorry.

Mr. Camp. I am sorry.

Mr. CAMP. Thank you, Madam Chairman, and my first question was going to be along the lines of the comment you made that I do think if we can agree on a final decisionmaker exposure as opposed to just a—someone who—an employer who just participates in their employees' health care should be liable might be a direction we can go. But my question is for you, Doctor.

Last year there was a significant push on the antitrust legislation, even though there was no Senate bill introduced. There was virtually no chance of any legislation passing the Senate or even going to the President for signature, and so even—and so even there there was a significant push by the AMA on behalf of that legislation, and I am having trouble reconciling your view that because tort reform is unlikely to be enacted, that there shouldn't be an effort made here in the House on that legislation. Can you help me with that paradox?

Dr. CORLIN. The difference between the two, at least in our view, is that with regard to antitrust reform, that was an issue in and

of itself, and we either could or couldn't get it. We obviously were able to get it through one House of Congress. We could not achieve any measure of success at all in the other House of Congress. The assessment with regard to issues of tort reform were not just could or couldn't we get it by itself, but what was the assessment as to attempting to get it as part of the Patients' Bill of Rights, and how would it affect the ability to get that Patients' Bill of Rights. It was the collateral effect on the other legislation.

You know, if you were to ask me, do you want PBR, I would say, absolutely. If you were to say, do you want tort reform, absolutely; and if we were of the belief that we could get them together, we would attempt to do that. The best information we have been given to this point is that trying to link the two of them would hurt the more achievable one at the present time. I don't like that answer any more, I suspect, than you do, but we have been told that that is the reality of the—of the issues as we find them.

Mr. CAMP. All right. Ms. Arkin, under the bifurcated Federal-State liability approach in H.R. 526, what would prevent a plaintiff from suing simultaneously in State and Federal court alleging the same denial, alleging, you know, failure on both the medical and nonmedical areas?

Ms. ARKIN. Theoretically when a health plan denies a claim, the health—the health plan actually bets to control which end of the spectrum the patient is going to go. If the health plan denies a claim because it is not medically necessary, because it is experimental, under the statute's own definitions it has to go to State court. The problem is health plans often give several grounds for denial, and they may include administrative reasons for denying the plan. You have put the patient on the horns of a dilemma when the health plan does that. So the health plan—or the patient is then forced to try to decide, do I go to State court because they have denied on experimental grounds, and do I also have to go to Federal court because they have denied on administrative grounds? The control of that issue is not in the hands of the patient. It is in the hands of the health plan and the way the health plan frames the denial.

If a patient gets a denial based only on experimental or medical necessity grounds and sues in Federal court, their very first motion that is going to be made by the health plan is a dismissal, because it is not appropriately a Federal case, and the plaintiff—the patient will then have to go back to State court. The patient doesn't control that.

Mr. CAMP. All right. I have one other quick question for Mr. Toohey. First of all, thank you for testifying and representing the employer and employees that you represent. And I know that it has been brought up by another member of this panel the number of unrelated cases against your employer, and I think those are topics for another hearing in another committee.

But my question to you is, do you believe employers should be held liable for providing health benefits to employees?

Mr. TOOHEY. No, I do not.

Mr. CAMP. And why not?

Mr. TOOHEY. That is a voluntary benefit. We are not required to provide it.

Mr. CAMP. All right. Thank you.

Thank you, Madam Chairman.

Chairwoman JOHNSON. Thank you.

I had started a second round of questioning, and then Mr. Camp arrived for his first round, and before the Chairman leaves, he would like to ask a few questions. Mr. Thomas.

Chairman THOMAS. Thank you very much, Madam Chairman.

I just want to clarify a couple of points so that I can understand the positions that are currently being advocated. Dr. Corlin, you earlier, in response to a question, indicated that you had at one time been urging health plans, I believe, to support the idea of med mal, and they weren't willing to do it. Now, it was noted that you are sitting next to the trial lawyers, and you are very comfortable with the trial lawyers' position.

Dr. CORLIN. That, sir, is an alphabetical coincidence.

Chairman THOMAS. I understand that, but the health plans are consistent, and the trial lawyers are consistent. So I just think it underscoring the fact that politics sometime make strange bed-fellows, because you are the only ones that have shifted in terms of the position. And I understand your argument about wanting med mal, but not being interested in trying to figure out a way to bring it about.

In response to a question about the size of your membership—and I have got two physician groups here, so I do want to clarify who is speaking for whom—you indicated that the current membership of AMA is somewhere below 300,000?

Dr. CORLIN. 290-something thousand.

Chairman THOMAS. Yeah. And you didn't know for sure how much it was 10 years ago?

Dr. CORLIN. No. It was slightly larger. I don't know what the number was.

Chairman THOMAS. So it has gone down over the last decade, but you are somewhere under 300,000.

Dr. Zipes, no one has asked you a question, so I will ask you a question. You represent the Patient Access Coalition. Is that all physicians, or is it made up of other groups?

Dr. ZIPES. It is made up of multiple groups, and the list is part of my submission.

Chairman THOMAS. Thank you. I will double-check that.

How many physicians are in the group?

Dr. ZIPES. Approximately 300,000.

Chairman THOMAS. So you are approximately larger than the American Medical Association in terms of the number of doctors you represent?

Dr. ZIPES. I don't know how many they have, but we have approximately 300,000.

Chairman THOMAS. They are south of 300,000.

Dr. ZIPES. And we are larger.

Chairman THOMAS. The point I want to make is that I read your testimony, and I saw all of the usual concerns about patients and getting coverage. The point was made—I examined the AMA's testimony, and it was 20 of 22 pages on an unfettered attempt to garner unlimited liability against a particular group, which I find somewhat interesting in terms of the thrust of the testimony.

I guess I would tell you, Dr. Corlin, that you might think about the idea that unlimited liability on employers is probably as unacceptable to some people as malpractice is to others, and that if you will examine how far we came in the conference last year on very timely internal and very meaningful external appeal, that if, in fact, that structure was supported, ultimately leaving a court remedy, but with all of the particulars that have been discussed, we wouldn't have to turn to Texas as an example of how few cases got to court. We would have, in fact, a Federal program with limited liability in defined circumstances for employers who choose to be participants.

The difficulty is, if you read legislation that has been proffered, most recently on the Senate side, the McCain-Kennedy language, it has all kinds of loopholes in which employers will still be held liable.

So in terms of additional discussions that we need to have, what you need to do is to go back to whoever informed you that med mal didn't have a chance to go into this product, because from my perspective, the obvious political solution that would be a winner would be limited liability on health plans and employers under a review procedure, which is pretty close to what we have got, including limited liability in terms of the medical professionals as well. That would be a coalition that would move legislation fairly rapidly. The AMA is currently standing in the doorway opposed to it on record in terms of malpractice reform.

My time is running out. Ms. Lichtman, I would like to ask you a question about your testimony. Let me ask her first, and then you can respond. I have noticed you have consumed a lot of Members' clocks, so you can answer as soon as I ask Ms. Lichtman.

On page 4 of your testimony, top paragraph, quote, consumers who have already been injured should not be required to complete the external review process before seeking review in court. This is the model that applies for Medicare beneficiaries.

Ms. LICHTMAN. That is right. I am not sure I understand what your question is. The model of already injured persons not having to exhaust a remedy which at that point is totally meaningless is a system that is already in place.

Chairman THOMAS. So you are not saying Medicare beneficiaries have a right to go to court?

Ms. LICHTMAN. No. I am saying that they don't have to exhaust remedies that for them at that point are meaningless if they have already been injured.

Chairman THOMAS. Well, that agent—but you are not saying, then, that they have a right to go to court? You are not saying that.

Ms. LICHTMAN. I actually wasn't speaking to that in that sentence, and so I was not saying that there.

Chairman THOMAS. Okay. But they don't have a right—

Ms. LICHTMAN. I wasn't—

Chairman THOMAS. To go to court.

Ms. LICHTMAN. Asserting that they do.

Chairman THOMAS. And that would be a question, as the Chairman indicated, the timeliness of review under extreme circumstances and a panel of doctors on the external review. We are not looking at a particular bill. There is no bill in front of us, but

there is a matrix to the solution, and, Doctor, I would ask you to go back to whoever it is that told you that med mal is an absolute no-go in resolving the concern, because if you are looking for some additional political bedfellows to support you on limited liability, they are going to be available if you folks are interested in moving a package which includes med mal and the limited liability. But if you are seeking the liability in your testimony, that increases the chances of not making the law this year. That is my personal observation. So do you want to respond?

Dr. CORLIN. Yes, if I may.

The AMA has been consistent in its positions with regard to tort reform. Trying to characterize what we are doing now as affiliating with the trial lawyers on this issue is incorrect. We are not attempting to hold the employer community liable, and indeed, the language in the bill would make——

Chairman THOMAS. Which bill? You keep saying the bill. There is no bill.

Dr. CORLIN. Language which we have proffered would indicate that employers who simply pay the premium and choose a plan and are not involved in the decision-making process regarding health plans are not liable and are not to be held liable.

What we object to is the people who are not here today who actually have surrogate defenders, which is the health plans. Health plans are both good and bad, as are doctors, hospitals, Congressmen, businesses and everybody else. The good health plans are wonderful. Bad health plans make decisions that hurt patients, and they do it with impunity. We want them to not be able to do that. That is what we are here for.

Chairman THOMAS. I understand that, and what I am doing is telling you there is an area for compromise in which we have limited liability in that regard with a very good internal/external review and that we can include med mal. Do you want to participate in that endeavor?

Dr. CORLIN. We certainly will participate in that discussion, absolutely.

Chairman THOMAS. Endeavor and discussion are two different things.

Dr. CORLIN. We will——

Chairman THOMAS. I understand. I understand what you are saying. You want to discuss. We want to make law.

Dr. CORLIN. We want to see law made, too.

Chairman THOMAS. OK.

Dr. CORLIN. I am not here today with the total authority, number one, to make the decision.

Chairman THOMAS. I understand that.

Dr. CORLIN. Nor am I here with the background and experience that our staff in Washington have. I would like nothing better than to be able to be told after I go back to 1101 Vermont and said, yes, we absolutely agree that everything that Chairman Thomas said is the way it will go, and if we adopt that position, we can get a bill, I will be back here waving the flag for that tomorrow, but I have got to go back to the people who have done the analysis for us, as I am sure you understand.

Chairman THOMAS. Dr. Corlin, let me suggest that one of the reasons the AMA has gone down in membership may very well be the fact that you never mentioned going to your rank and file, but rather you decided to go to the professionals who have made a history of not necessarily representing the rank and file. Because I have got a fellow over here who has got more members than you do who has said liability is not that great a concern, focusing on patient protections ought to be the primary goal. So perhaps you might want to go beyond that Vermont address and take a look at your rank and file in terms of where they are for med mal and where they are for moving a resolution of this sooner rather than later.

Thank you, Madam Chair.

Dr. CORLIN. We go to our rank and file twice a year on this topic, Mr. Thomas.

Chairwoman JOHNSON. Thank you, Mr. Chairman.

Mr. Stark.

Mr. STARK. Well, I am under the impression that at least this Member has been referring to the Ganske-Dingell or Dingell-Ganske bill, which is a reintroduced iteration of the Norwood bill, and the current one has maybe 110 to 150 cosponsors or whatever they have got, and that is the bill.

Chairman THOMAS. Do you want, briefly—do you know how many Republicans or cosponsors of that bill?

Mr. STARK. I guess a half a dozen. How many?

Mrs. THURMAN. In the Senate?

Chairman THOMAS. No, no. The House.

Mrs. THURMAN. In the Senate, for your information, there are five.

Chairman THOMAS. And I think there are two over here, Ganske being one of them.

Mr. STARK. My guess would be half a dozen, but I am not aware. In any event, it is a bill that is similar in many respects, although it has been compromised to move toward the Republican position that got 60 Republicans or thereabouts to vote when it passed the House.

Now, be that as it may, it is a bill that has passed here and has been in the conference meetings a bill of discussion.

It was my understanding that the witnesses were advised that we wanted to talk about the liability issues today. Is that correct?

Ms. LICHTMAN. Yes.

Mr. STARK. Is there any witness who had any other—that was the thrust of the testimony today; was it not? So for those of you who have been—suggested that you are not doing your duty by not talking about liability, that is why I thought I was here, and I would presume that that is why the witnesses were here, which is a good topic.

Now, I want to apologize to Mr. Toohey for—Mr. Toohey actually is here representing the National Association of Manufacturers, and Ashland Inc. probably would have given him the week off if they thought I was going to bring up all this past history about him.

But you do mention, Mr. Toohey, and I don't know the numbers, but I have a hunch when you talk about the fact that health insur-

ance ought to be voluntary, I think as a practical matter—and I am going to just guess, and you may know better than I do, or somebody else may have the numbers, but I am going to bet that half of the people who have—who have employee insurance or get it from their employers get it as a result of bargain plans through their union. Does that sound about right to you? I don't know. Maybe it is only a third, but it is a large percentage of those—

Mr. TOOHEY. I honestly think it is less, but I don't know the answer.

Mr. STARK. Okay. And is it also standard reason that where a union has negotiated or contractually gets health insurance, that it would be the rare company that would not provide it to its non-union employees? That would make good sense from labor relations, bargaining and just from good human resources; would it not?

Mr. TOOHEY. Well, sure.

Mr. STARK. So that the voluntariness of health insurance, absent a short supply of employees, as we have today—right now probably every business in the country is—wouldn't think about cutting back on their health insurance, just because it is hard to find good employees, but in a—

Mr. TOOHEY. If I could answer?

Mr. STARK. Sure.

Mr. TOOHEY. The question I was answering over here, I thought, was that should employers be sued for providing health care, but why would you want to sue somebody for providing a voluntary benefit?

Mr. STARK. Mr. Toohy, you are getting right to the point. If you could—if you were assured by your company's attorney that the company could not be sued, would you have objection then to the liability provisions in this bill?

Mr. TOOHEY. Yes, I would.

Mr. STARK. Why?

Mr. TOOHEY. Because you have to realize—

Mr. STARK. Wait a minute. If the company could not be sued, if you could be guaranteed that, why would you then object to the idea of your—of the liability provisions?

Mr. TOOHEY. Well, at the end of the day, it is the corporation that is going to pay the costs, and so if the plan is sued—

Mr. STARK. Under any circumstances, if the company weren't liable, you would still oppose the bill?

Mr. TOOHEY. We are opposed to employer liability, and when you provide this voluntary benefit and you get sued for it, no matter who is the manager of it, whether it is—

Mr. STARK. Whoa, whoa, whoa. Let's talk about this perfect world. I am just saying that if you could be assured that your company could not be sued, then would you object to the bill?

Mr. TOOHEY. Yes, in its current form.

Mr. STARK. That is what I thought. Thank you.

Chairwoman JOHNSON. Mr. McCrery.

Mr. MCCREERY. Well, Mr. Stark, if I were the CEO of Ashland Inc. or some company, any company, and my lawyer came to me and said, you can't be sued, I would fire the lawyer.

Mr. STARK. That is probably why you are not a CEO of a large company.

Mr. MCCRERY. Well, but I am a lawyer, and I have a confession to make. I was with a plaintiffs' firm. I practiced plaintiffs' law, and I was also on the other law practicing on the defense side. So I have been on both sides, so I know a little bit about the practical nature of our judicial system. And the fact is that if you write a law that says you can't be sued, you can still be sued. Somebody can name you in a lawsuit, a lawyer—a good lawyer will name you in the lawsuit, even though he may know eventually you are going to get thrown out of the lawsuit. That means you are going to have to hire a lawyer, and you are going to have to go to court to get thrown out of court. That is going to cost you money.

Mr. STARK. That is where we are now.

Mr. MCCRERY. That is where we are now.

Mr. STARK. So what is new?

Mr. MCCRERY. Nothing yet. That is what we are talking about, what might be new. What might be new is that you won't get thrown out of court, but you will not only be faced with the cost of going to court, but you will be faced with damages. And it is a legitimate discussion.

Look, I am proud of being at one time a plaintiffs' attorney. I defend plaintiffs' attorneys with some of my friends occasionally in the medical profession and in the business world. Plaintiffs' attorneys, by and large, like doctors by and large, are honorable people doing a good job for their patients or clients, and they play an important role in this Nation and in our judicial system and in getting compensation for people who are damaged because of somebody else's negligence or wrongful actions.

So I happen to think that ERISA is in need of reform. I think ERISA is not—does not provide sufficient remedies. There. I have said it. But the very reason that the AMA has steadfastly been for medical malpractice reform, and they still are, even though I am disappointed that they are not out front pushing for medical malpractice reform to be attached to this bill so that we can have uniform liability across the health care system, and I am very disappointed in that, and I think you are wrong, and I think you should be, but you have steadfastly been for medical malpractice reform. And before I give my opinion as to why you are, let me ask you, Dr. Corlin, why is the AMA for medical malpractice reform?

Dr. CORLIN. We are for medical malpractice reform because we have seen the consequences of what happens when it gets enacted and what happens when it doesn't get enacted, and we are in a circumstance where in the absence of medical malpractice reform, the circumstance amounts to an unfunded mandate. Premiums drive people out of practice. They do not provide anything in the way of added patient safety. Well, we are here today, Mr. McCrery—and I—

Mr. MCCRERY. No, no, no, no. I don't want to get you—

Dr. CORLIN. All right.

Mr. MCCRERY. I want you to answer my question. Are you through answering my question about why you are for medical malpractice reform?

Dr. CORLIN. Yes.

Mr. MCCRERY. So you are—if I can restate, you are for medical malpractice reform because you have seen systems which have it and systems which don't, and in those systems which don't have reform, doctors are worried about the costs that are imposed upon them, and it drives some of them out of practice. Is that—

Dr. CORLIN. Well, it is not just physicians. The costs go up inordinately, and they are passed along to everyone.

Mr. MCCRERY. Right.

Dr. CORLIN. Not just doctors, but they are passed along in fees by physicians, hospitals—

Mr. MCCRERY. Right.

Dr. CORLIN. And everyone else in the health care delivery system.

Mr. MCCRERY. Right. So what?

Dr. CORLIN. It is a cost that is—

Mr. MCCRERY. Why is that bad? Because you have injured patients who deserve compensation, unlimited compensation, so why is that bad?

Dr. CORLIN. OK. The costs go up out of proportion in benefit, number one, and number two, patients are not denied compensation in the presence of tort reform. We have never advocated a system that would not deny patients—

Mr. MCCRERY. I didn't say compensation. I said unlimited compensation.

Dr. CORLIN. I made a mistake when I said—we have never advocated a system that would deny injured patients compensation for their injuries. I never said that.

Mr. MCCRERY. But you are for a system which denies unlimited compensation for patients who are injured.

Dr. CORLIN. Under circumstances, yes, particularly in the non-economic damages area, which are very, very subjective.

Mr. MCCRERY. Right. And why is that, in your opinion, necessary in the medical—field of medical practice to have those caps on damages and other tort reforms for medical malpractice?

Dr. CORLIN. Because in our opinion, the circumstances were getting to be so subjective and so irrational that they could no longer be sustained, that the cost of maintaining the insurance, which is a legal requirement—it is not an option. The cost of maintaining the insurance, which is a legal requirement, has driven people out of practice and reduced access to care in certain areas and increased the costs as those costs are passed along to the end users, as are the costs of everything that all of us in this panel do.

Mr. MCCRERY. Madam Chair, I have further questions, but I will give the other Members a chance to ask.

Chairwoman JOHNSON. Congresswoman Thurman.

Mrs. THURMAN. Thank you, Madam Chairman.

Dr. Zipes, we need to clear up some stuff here, because I actually looked at your testimony and all the people who are actually a member of your coalition, and I have to say to you, maybe as a group they have taken this step where they have said that they support this year's based on principles. Last year it was my understanding—and correct me if I am wrong—but that this group also endorsed the bill last year, the Dingell-Norwood, Norwood-Dingell, whoever, bill. And second, as individual groups, there are many,

many on this list that have come out in support of Dingell-Norwood or whatever it is this year. Is that correct?

Dr. ZIPES. As I indicated in my response to the very first question that I got from the Madam Chairwoman Johnson, the Coalition has supported the provisions of the bills that advocate those things that we feel are so important for patient protection, whether or not they included issues about liability, and we continue to do so.

Mrs. THURMAN. Well, but you could tell me, too, when I look at this list that individually there are groups on this list who have, in fact, supported, outside of the Patient Access Coalition, the Norwood-Dingell bill with the liability standard in it?

Dr. ZIPES. Yes, ma'am. As I also testified, there was not unanimity among all the members; and, therefore, we felt it best to not take a position on liability, but to strongly support the patient protection issues.

Mrs. THURMAN. Thank you. I just needed to clear that up, because it seemed to get kind of foggy out there for a minute, and I think this Committee wants the best information available.

You know, Mr. McCrery, one of the things that I find interesting is that I, quite frankly, on the liability issue would like to see the States do what they have been doing, because I think Dr. Corlin would tell you that we probably had more success—Dr. Zipes would probably tell you that we have had more success in dealing with medical malpractice at the State level, is that correct, over the years?

I mean, Ms. Arkin, you could tell me. You have to say yes, because we have to get you on the record. For some reason, it doesn't do that. Is that—

Ms. ARKIN. That is true. In various States in response to specific insurance crises within those States, individual State legislators have dealt with it on a State basis, and that is the appropriate way to deal with those—

Mrs. THURMAN. As they have, quite frankly, with the Patients' Bill of Rights.

Ms. ARKIN. In large respect they have—the States have attempted to deal with the ERISA problem through State legislation, and it is still an open question if that is going to be successful.

Mrs. THURMAN. And that is where we come in as to why we have to do that.

Ms. ARKIN. Correct.

Mrs. THURMAN. So what we don't need to be doing up here is setting up whole new review panels, doing that. But let me ask you all, you know, I have been trying to listen to this conversation going on up here, and quite frankly, I was really taken back by—a little bit by our Chairman Mr. Thomas, that it is this way or no way. Quite frankly, I don't consider that to be compromised, and I certainly don't see that as kind of—I take offense of somebody trying to cram something down my throat, and I wish he was here to hear me say that, but I was somewhat taken back when, in fact, last year this was passed—or in 1999 this was passed on the floor of the House with a majority of both Democrats and Republicans, sent over to the Senate, sat in conference, many times motions to the Committee to get this bill out. So to say that this is only the

way something can happen I think is a little misleading to the public.

And the other thing I would say is, who have we forgotten in this? What is this all about? This is about patients who are all only asking for access to their health care, and if, in fact, they go through an internal and an external process, that they have some remedy. I would say to my colleagues, in every bill that has been introduced into this Legislature over the last several years, there has been some remedy or some tried to get to a remedy. Some have imposed civil fines. I mean, there has been a multitude of ways to do this, but the bottom line is—so I don't know what we are stuck on—that this liability issue, no matter what we look at, or if you like it or don't like it or are just opposed to it, the fact of the matter is there is a remedy in every bill to hold them accountable.

Now, why, I ask the question, would we back off from a system that every other person has the opportunity to—I think Mrs. Lichtman said that. If you have a toy that is broken, you go to the manufacturer, and you have liability. If you are responsible, why would you abrogate that responsibility? And my time is up.

Chairwoman JOHNSON. I think it is significant that the system that States have adopted for malpractice liability is really quite different, and very few States have adopted liability in the Patients' Bill of Rights situation because of the complexity of setting up that and the fine line between malpractice and suing of the employer. So we do want to be sure that people have appropriate rights, and particularly that patients have rights to medical care, and physicians are in charge of that decision.

Mr. MCCRERY. Excuse me. Dave had—

Mr. CAMP. Thank you, Madam Chairman.

I would just say to my colleague from Florida one of the problems that we have had is the exposure of employers to lawsuits simply because they have a health plan, and I think that is one of the real troubling aspects of this. We have a system—and Mr. McCrery touched on this—where everybody can sue anybody about anything. That is our legal system. And so it is the exposure, and in the business world the employers—and small business and large—cannot take the risk.

And last, multistate employers, particularly looking at 50 different standards in 50 States, they are looking for uniformity, something that will be ultimately administered. But my question is this for Ms. Arkin: The Rand Corporation study that happened—and their studies said that between half and two-thirds of medical malpractice claims are brought with no apparent indication of negligence, and, in other words, the current medical malpractice system demonstrates that just because the correct decision was made, it doesn't mean you are going to avoid a lawsuit. So given that statistic, I would ask your comment on the expansion of liability and whether that would serve as an effective deterrent for alleged wrongful behavior or negligent behavior, and would that promote better decisionmaking?

Ms. ARKIN. Well, first, obviously, I take issue with the Rand study. I don't believe it is correct, and the Institute—

Mr. CAMP. Do you have any reason why you don't believe it is correct?

Ms. ARKIN. The Institute of Medicine study has determined that medical malpractice does result in massive injuries, massive deaths, and that something needs to be done about the system.

And if you look at the Institute of Medicine study, they are very adamant that there are systems corrections that can be made that will eliminate malpractice, and they actually advocate liability as one of the tools to help control malpractice.

Additionally, I want this Committee to understand that the trial lawyers do not want to impose liability on employers, where the employer simply goes out and buys a plan, small employers, large employers. An employer that doesn't involve itself in the decision-making process should not be liable.

If they just go and buy a plan for their employees, and the plan is making the medical decisions, it is the plan that should be held liable, not the employer.

Mr. CAMP. Right. I saw Dr. Corlin shaking his head at part of your answer. I don't want to cut you off, but I think the point also is—on that broad principle, we probably have consensus—the issue is in the real world, that won't necessarily mean that there is protection. But I wanted to get Dr. Corlin's comment as well before my time ran out.

Dr. CORLIN. The Institute of Medicine study dealt with the issue of medical errors. And I would characterize them as medical errors, not malpractice. There has been a great deal of data, a lot of it carried in several articles of the New England Journal, that indicates even those cases where there are settlements and/or judgments on retrospective review, only between 1 in 4 or 1 in 5 involve negligence as opposed to other items. So that is that particular issue.

Mr. Camp, with regard to the second thing that you asked, it is nobody's attempt, and, you know, if we have the trial lawyers and the AMA agreeing with each other, well, we both are going to have to live with that, but neither one of us is interested in creating one penny of liability to the employer who buys and selects and pays for a plan, even if it is through a TPA and they are—in effect they are self-insured and they are not involved in the decisionmaking process with regard to medical decisions.

We ask, please, for the Committee's help in coming up with some language that will achieve that goal, because that is our decision. What we are concerned about are the actions of the health plans, not the actions of the employers who in good faith provide money to pay for health insurance for their employees. They are not our target. We want to exempt them as much as they want to be exempted.

Mr. CAMP. I appreciate that, and I appreciate the sincerity of your comment there. I am not taking issue with that. I think beyond the people in this room, the system is such that the lawsuits would occur whether they are successful or not; but just the cost of defending, and the risk, the exposure of those lawsuits, to test that legal principle that we might all agree on and we might put in an iron-clad way in a bill, in fact just putting the language there, I think as others have committed, would invite the litigation.

It is not just whether you would prevail in the litigation, it is whether you would be subjected to the litigation that is a problem.

And, again, you know, I think there have been some instances where certainly wrongs have been righted in our legal system.

But the idea that expanding the circle of lawsuits would bring a higher level of patient care I think is an issue. Obviously, the way that we have tried to work on this is to try to find a way for immediate and internal and external independent review and fines in civil matters.

Ultimately, if those remedies are exhausted, where we are at is, is there going to be an ability to go to court and how would that occur? So I appreciate both of your comments. And I realize my time is expired. Thank you.

Ms. ARKIN. Well, Madam Chair, I would like to finish my response to that question. I never had a chance to give the other half of my response.

Chairwoman JOHNSON. You may proceed.

Ms. ARKIN. Thank you. I don't believe that any responsible attorney is going to sue an employer where it is clear that the employer is free from liability. That is not to say that there aren't some irresponsible attorneys out there, and Mr. McCrery obviously has experience with those.

But the point is there are facilities, there are remedies within our judicial system to take care of those irresponsible attorneys, both through State bar disciplinary proceedings, malicious prosecution actions, sanctions for a frivolous case; but the fear of frivolous actions should not strip people with legitimate claims of their right to reap compensation when they have been harmed. That is not a good public policy to engage in.

The reality is there aren't going to be a lot of frivolous lawsuits. There very well may be meritorious lawsuits until the industry comes to realize they can't continue this conduct and they have to change their behavior, and that is what lawsuits do.

Mr. CAMP. Thank you. Thank you, Madam Chairman.

Chairwoman JOHNSON. Would you like—do you have any further questions?

Mr. Stark.

Mr. STARK. No.

Chairwoman JOHNSON. Mr. McCrery.

Mr. MCCRERY. Ms. Thurman, my good friend from Florida, I don't disagree with anything that you said.

Mrs. THURMAN. I like that.

Mr. MCCRERY. So you don't need to talk again. I thought you made some excellent points, and I thought I made some of the same points. But I was on the conference committee last year, and I can tell you that we could have passed a bill and sent it to the President real quickly if some had been willing to compromise on the issue of liability.

We certainly could have gotten one on the President's desk if some in the Senate would have agreed to the patient—the patients' rights section of the bill without liability.

Mrs. THURMAN. Will the gentleman yield?

Mr. MCCRERY. Sure.

Mrs. THURMAN. I think we had a lot of those kinds of bills last year.

Mr. MCCREERY. I know we were on that conference, and I know we offered and the offer was rejected. Just so you will know, we could have had these patient protections in law.

Ms. Arkin, you are right, there are some irresponsible attorneys out there practicing law, as there are probably irresponsible doctors practicing medicine. But there are also good attorneys out there who, in good conscience and to avoid maybe malpractice suit against them, would name employers if there is any question that that employer exercises any control over the decision. And particularly with TPA or third-party administrators, there is going to be a question. And even if you wall off the employer as best as you can, and then you are going—I think you are going to have a hard time finding a third-party administrator to administer that plan for a small employer. They are going to be scared to death of being sued because they do exercise control.

So you know, even with that, I am still willing to establish a cause of action under ERISA. I think ERISA, as I said, provides an insufficient remedy to patients who are injured as a result of decisions, wrongful decisions of health plans. That is not at issue.

But getting back to Dr. Corlin's explanation of why the AMA is for medical malpractice reform, the sum and substance of your argument, Dr. Corlin, is that unlimited damages in the field of medical malpractice is bad for the health care system. It inhibits the ability of people to get health care, because it discourages physicians from practicing, it runs them out of practice. It drives up costs for everybody.

There is a higher national purpose, which is to make sure that the greatest number of people get the best quality of health care we can give our society. Therefore, it is necessary, even though as a Republican, philosophically I am opposed to damages—to caps on damages, limiting lawsuits, I do think there is in the field of health care particularly, a higher purpose to be served than individual rights to sue for unlimited damages.

You have made the point. The point, Dr. Corlin, and others, though, is the same for health plans. If you allow unlimited damages against health plans, you will have the same problem. You will drive up costs in the health care system. You will inhibit employers and health plans and certainly third-party administrators from engaging in the delivery of health benefits, and it will be bad for our society.

So why don't we compromise, Ms. Arkin; create a Federal cause of action under ERISA, which you want and which the AMA wants and Dr. Zipes group probably wants, and put caps on damages and other reasonable tort reforms in place for health plans—liability of health plans. And then, if we could, also for physicians. Yes.

Mr. STARK. Will you yield for a question, the gentleman from Louisiana?

Mr. MCCREERY. Sure.

Mr. STARK. Would it not be possible if this—if it was the Ganske-Dingell bill, or some iteration of this liability plan in the other bills, and it passed, for the States still to impose tort limits on a State-by-State basis?

Mr. MCCRERY. That is unclear, but certainly if it is a Federal cause of action that we create, it is possible that States could not limit the damages under that Federal cause of action.

Mr. STARK. But under any State action, they could?

Mr. MCCRERY. Yes, sir. And, in fact, if we don't do—create a Federal cause of action, my guess is the courts are going to continue to expand access to the justice system for these types of cases, and then obviously State tort reforms would affect those cases.

But that should not relieve—even if we knew that States could do that, it shouldn't relieve us of our responsibility as policymakers to impose the best liability regime we could, in the best interests of all of the people, to receive not only their individual rights and cause of actions when they are injured, but also to receive the highest quality of health care for the most people in our society.

And if we do that, I think there is a balance here that we could reach, and I would urge those of you who have seen that for years and years to be out front and urge us to do the right thing, not the expedient thing, not the thing that you think we can do just to get you what you—part of what you want, but be for the right thing across the board, and that would be medical malpractice reform and liability for health plans under the same regime.

Mrs. THURMAN. Madam Chairman—

Chairwoman JOHNSON. Mrs. Thurman.

Mrs. THURMAN. I am going to do something very quickly. I would just suggest, because it seems like we tried to put the doctors and the lawyers altogether in one, I think it is unfair to the public and to this record not to recognize that there are hundreds of groups out there that in fact are supporting the Patients' Bill of Rights. And it is not just doctors and lawyers. It is also people like Families USA, it is League of Women Voters, Mental Health. I mean, there are a series of groups in this country that are supporting this with the liability. Thank you.

Chairwoman JOHNSON. There are certainly many groups out there supporting it. There are also many groups opposing. And I will have to say, I have been meeting with the doctors throughout my district in small groups. I have been meeting with small businessmen. I have not met a small business group that isn't literally panicked at the idea of the liability provisions in the Dingell-Norwood bill.

I have gone through with them the liability provisions in the Shadegg bill, which is at least drawn more narrowly. At least you have to exhaust the appeals process, so you have the virtue of four physician opinions on the record, and you can only sue if you have been harmed. They are still panicked.

The law doesn't have to make them liable. It only has to make them think they are liable, and then you will see action.

Now, I am concerned with what has—the statements of both Ms. Arkin and Dr. Corlin that you don't want to see employers held liable, not a penny of liability. I have sat for a whole year, hours and hours and hours of discussion of the bill that passed the House. There is no way you can protect employers from liability.

It is only a question of whether we can sort of contain it, so that the insurance the company has to buy for the directly responsible party can at least be limited. Because under ERISA, I as an em-

ployer have a fiduciary responsibility, so that means that any plaintiff could argue that the discretionary acts of the insurance company or the third-party administrator could be imputed to me, the employer, as acts of an agent.

This contention would have solid common law basis and is commonplace in personal injury litigation. What we do here is not in isolation. So what I say to my small employers is, it is true, I can't totally protect you.

I have never heard, and I have sat for many hours with lawyers on both sides of this issue, not one of them when you really get down to it will claim that under the fiduciary rules of ERISA, you can totally protect the employer. That is why we came up with the designated decisionmaker. Because as I read to you, the language in the bills allows even the physicians to be an agent.

The language in the bills allows even just an allegation to stop the exhaustion of the appeals process. The physicians will not have control of this system, not if a mere allegation turns control over to the lawyers.

So really, folks, if you don't want to hold lawyers liable, you have got to be much more serious about the language of this bill. And, in fact, if you want to provide physician-control of health care, you have to guarantee physician decisions on the record.

Let me just say, 40 cents, remember 40 cents of every dollar paid to litigate is paid to victims, 40 cents. The rest goes to the costs of the process, the lawyers, the courts, and everybody else.

Second, 80 percent of all medical malpractice suits—and remember, we are talking medical malpractice, we are not talking exactly the same, but it is very similar and that is what employers are afraid of, they will be held accountable for medical decisions over which they not only have no control, but no knowledge.

Eighty percent of all medical malpractice claims did not involve a negligent adverse event.

So if we narrow this bill to those patients that are harmed, we help—we eliminate all of those suits that are not about medical harm. That is a good thing. That will reduce costs. That will prevent an explosion of litigation, the costs of which we have seen drive up health care premiums through the physician sector.

The average costs to defend a provider—and remember, you see, you don't have to be liable under this bill. The suit can be brought anyway. The suit can be brought against the employer, and then he has to prove that he was not directly involved.

The costs of that kind of suit is roughly \$20,000. A suit was just heard in Texas on March 1st, and not only did it cost \$20,000 to defend, but it was so outrageous—I am not a lawyer so I have to hustle around here for the wording—it was dismissed with prejudice. In other words, it was such an outrageous suit, it was so clear that the plan did not provide the benefit, that the judge dismissed it without any right to ever bring it again in any venue.

Now, to maintain that there won't be suits under this bill, that they won't be frivolous, that they won't be without medical harm or without medical costs, is simply to fly in the absolute face of experience. Now—

Ms. ARKIN. That is not what I said, Madam Chairman.

Chairwoman JOHNSON. Because I believe in this so passionately, does that mean that I don't think patients ought to have a right to sue? No. I think that patients who are harmed by a negligent decision by an insurer that denies them medically necessary care ought to be held accountable.

And under every example you have given in your testimony, Ms. Arkin, our 72-hour appeals process would have gotten them the care they needed and they would have been whole medically, without any one expenditure for a trial lawyer.

Ms. ARKIN. Well, that is not true, Your Honor.

Chairwoman JOHNSON. We will talk about that afterward, because you must not understand our appeals process, but I am shocked at your insensitivity to the breadth of the language in these bills. What it will do—

Ms. ARKIN. Ms. Artery had to have transport to a medical center within 3 hours or she would have died and did die from her heart attack. External review couldn't help her.

Chairwoman JOHNSON. No, the emergency room provisions under the patients' rights would have.

Ms. ARKIN. No, she was already dead. It wasn't going to help her.

Chairwoman JOHNSON. The minute she came into the emergency room, that would have been taken care of. She would have had to have all stabilizing care and so on and so forth. They could not have ignored her and they could not have not treated her.

Ms. ARKIN. That is not true, ma'am.

Mr. MCCRERY. Will the Chairlady yield?

Chairwoman JOHNSON. I would be happy to yield.

Mr. MCCRERY. I think both of you are right. I think for the few cases in which someone is injured prior to availing themselves of the review, we could create a liability for that. That is not a problem.

I think it is a reasonable thing to do. So I think—I don't think there is a problem there.

Mrs. THURMAN. Madam Chairman, could I ask a question? In the case that you were citing, was it the judge said that the benefit was not covered, so it was over a benefit or a procedure?

Chairwoman JOHNSON. It was so clearly not covered by the plan—

Mrs. THURMAN. So it was actually on the benefit part of it, not necessarily whether there was any problem with the service delivery?

Chairwoman JOHNSON. That is right. But you see, under—one of the things that is hardest about writing this legislation is to prevent suit over—

Mrs. THURMAN. That is if you were harmed. That is if you were harmed, not necessarily because of what is in the benefit plan.

Chairwoman JOHNSON. No. There are two different issues, though. One is how do you prevent suit over things that are clearly not covered, and that is harder to do in legal language than you might think.

And the second thing is that if it is covered, then you still should be able to sue if you suffered medical—you should be able to sue if you suffered medical harm.

Mrs. THURMAN. Just to take that, if that could be—Mr. Toohey there says his plan had decided, or the company—because I understood you to say that Ashland, because I guess they are self-insured, actually, made that determination, but if they had said no—

Mr. TOOHEY. It was already a covered benefit under our plan.

Mrs. THURMAN. If it had not been a covered benefit.

Mr. TOOHEY. Then our employee review panel could have covered it, yeah.

Mrs. THURMAN. Could have covered it?

Dr. CORLIN. Madam Chairman—

Chairwoman JOHNSON. I'm sorry, we do have to wind this up. We've got a lot of healthy differences of opinion, and those are the kinds of things that have to be worked out.

But I did really want to get on the record that these statements that are flying—because this happens in the House, too—about protecting employers, and I have many colleagues of mine stand up and say, I don't want to have employers sued.

Let me tell you, there is not a bill that is going to open ERISA that will protect all employers, you cannot do it under the fiduciary concept. But you can control it. You can—there are things you can do to reduce the liability—the vulnerability to suit and make it responsible.

There are broad differences in language between the Dingell-Norwood bill or the Dingell-Ganske bill and the Goss-Shadegg bill on these specific issues about employer liability and about who has the right to sue. If we could narrow those down, we have some hope of passing the whole bill and some hope of controlling costs.

Health care costs are rising at 8 to 10 percent a year. Employers are going to be struggling with those costs. If we are not careful about what we do here, we will move our health insurance system the same direction we have already moved the pension system, from a defined benefit plan to a defined contribution plan.

If you talk to retirees, this is not a happy circumstance. If you talk to health people who in the future will have the \$5,000 to buy a plan, but won't be able to—the employer won't provide it, which you would see he has no liability, it is a no-brainer. So that is the relevant fear is that we will hurt employees who currently have coverage.

Now, I want to get—to return the system to the control of doctors; that is why exhaustion is essential, no matter what the circumstances. It doesn't mean that you can't get the care earlier, but still you need the panel's decision on the record.

These are the kinds of things we will have to talk about in more detail, and I thank the panel for their tolerance and the Members for their interest, it is rare that we have.

Ms. LICHTMAN. May I—one point of personal privilege? In my answer to Chairman Thomas, I wanted to make clear that indeed in a ninth circuit case called Artery versus Aetna, I have been advised that indeed Medicare recipients do have a right for a judicial remedy. And I didn't want to leave the incorrect impression, even though my testimony was not talking about that, I didn't want to leave the suggestion that there wasn't.

Chairwoman JOHNSON. I appreciate that on the record.

I thank the panel. The hearing is adjourned.
 [Whereupon, at 4:21 p.m., the hearing was adjourned.]
 [Submissions for the record follow:]

Statement of American Psychological Association

Madame Chairwoman and members of the subcommittee, the American Psychological Association (APA) writes to clarify our understanding of the position of the Patient Access Coalition on the subject of legal accountability. The APA alone represents within the Coalition more than half of the individuals who are non-physician providers, and we have served on the Coalition's steering committee for many years. In this capacity, we feel it necessary to clarify that the Coalition has never taken any position on the issue of legal accountability other than neutrality.

We believe that the Coalition's testimony will be misinterpreted as the Coalition is critical of liability and could live without it. This is not the position of the Coalition. The position of the Coalition is, and has always been, neutral on the subject of legal accountability due to the differing opinions of our member organizations and their different priorities.

In fact, many individual members of the Coalition—including the APA—do indeed strongly support the inclusion of liability protection in the Patients' Bill of Rights. We believe that reform must embody both internal and external appeals rights to ensure that patients are able to obtain quality and timely health care. The vast majority of disputes between managed health plans and patients should be resolved without the need for judicial intervention through a strong, independent external appeals process.

Although a strong and independent appeals process is essential, it will not always suffice. Even under an expedited appeals process, such as a 72-hour deadline, patients can sustain injuries that warrant appropriate compensation. Consider the following scenarios where an appeals process alone would not prevent the negligent denial or delivery of treatment:

A patient is admitted to a community hospital complaining of paralysis and numbness in his extremities. The hospital concludes that the gravity of the patient's neurological condition is beyond the scope of the hospital's expertise, necessitating his immediate transfer to an academic hospital, which the hospital promptly arranges. The health plan, however, denies authorization for transfer to the selected hospital and instead recommends three others that are part of the health plan's network. By the time one of the health plan's hospitals accepts the patient *three hours later*, the patient has sustained permanent quadriplegia.

A patient with major depression is actively threatening suicide. Her treating psychologist recommends immediate hospitalization, which the managed care plan denies and continues to deny after an internal appeal. The psychologist immediately requests expedited external review of the managed care plan's denial. While the review is pending, the patient kills herself, leaving behind a surviving spouse and two children.

The incidents described above can and do occur in real life. Consequently, we believe that reform must include the ability of a patient injured as a result of negligence by a health plan to seek redress for his or her injuries in a court of law. We also believe that the deterrent effect of health plan legal accountability will lead to better, more appropriate care up front, thus reducing the possibility of lawsuits.

NATIONAL COUNCIL ON DISABILITY
 Washington, DC 20004-1107
April 25, 2001

The Honorable Nancy L. Johnson
 Chairwoman, Subcommittee On Health, House Ways and Means Committee
 U.S. House Of Representatives
 Washington, DC 20515

Dear Madam Chairwoman:

On behalf of the National Council on Disability (NCD), I want to thank you for your leadership in issues related to care-giving and health care reform and for the April 24, 2001 hearing on these issues. Your work to ensure an equitable system

of health care in this nation is essential for many of our nation's citizens, particularly people with disabilities who need either short or long-term care.

NCD is an independent federal agency mandated to make recommendations to the President and Congress on issues affecting 54 million Americans with disabilities. In keeping with our mission to advise the President and Congress on public policy that affects people with disabilities, NCD has taken an interest in the ability of Americans with disabilities to fully participate in and equally benefit from a comprehensive health care bill, including one that address patients' rights. I want to inform you of our activities and to offer our expertise to you and your staff as you move forward with your work on this all-important issue.

NCD requests that the attached statement be entered into the Committee record of testimony. It outlines ten key principles on equitable health care and background information from our studies and reports over the past eight years, as evidence of consumers' and advocates' support for the enactment of comprehensive and enforceable legislation that also protects patients' rights. We hope that the information will be useful to you and your colleagues on the Health Subcommittee. Further, we would offer the expertise of the members of NCD and would welcome the opportunity to meet with you and your staff at some time in the near future to further explore ways that our leadership can be of assistance to you as you move forward with legislative inquiry and proposals that impact all Americans, including people with disabilities.

Sincerely,

MARCA BRISTO
Chairperson

Enclosure

Patients' Rights Principles

Scope: A patients' bill of rights should cover all 161 million Americans with private insurance.

Access to Specialists: All patients, especially patients with disabilities and chronic conditions, should have timely access to specialty physicians, providers, and facilities.

Point-of-Service Option: Health plans that only cover services if they are obtained through a closed network of providers should be required to offer enrollees a "point-of-service option" at the time of enrollment which includes reasonable cost sharing.

Continuity of Care for Patients with Ongoing, Chronic Conditions: In order to minimize disruption in service, consumers should have the right to an appropriate transitional period (such as 90 days) from the date of a provider's termination from a network plan, with limited exceptions. This transitional period should be further extended to include enrollees with terminal illnesses, pregnancies, or those who are receiving institutional or inpatient care at the time of the change in providers.

Timely and Accurate Comparative Information: All patients, particularly persons with disabilities, should have access to accurate, easily understandable information to assist them in making informed decisions about their health plans, professionals, and facilities.

Right to Participate in Treatment Decisions and to Refuse Treatment: Patients should be fully informed about treatment options, told about risks and benefits, and participate to the maximum extent possible in decisions that impact their mental and physical health care. Patients should have the right to refuse treatment.

Elimination of "Gag Clauses": Physicians and other health care professionals must not be restricted from advising a patient on his or her health care options, regardless of whether the patients' health plan covers such treatment or the treatment is expensive. Financial incentives designed to limit communication between the patient and provider should also be prohibited.

Access to Clinical Trials: Patients with disabilities and chronic illnesses should have access to the full range, and all phases of, federally approved clinical trials. Any routine patient costs incurred for items and services furnished in connection with participation in a clinical trial should be covered by the health plan.

Strong Grievance Procedures: All consumers, including persons with disabilities, should have access to a fair, unbiased, and timely internal appeals process as well as an independent external appeals mechanism to address health plan grievances and to help govern decisions about medically necessary treatments. Health plan liability provisions should strike a balance between holding plans accountable for the medical decisions they make and not creating significant increases in insurance premiums.

Emergency Room Protections: Patients should have a right to visit the closest emergency room in an emergency situation, according to the “prudent layperson” standard, without prior plan authorization.

Drug Formularies: Health plans should be required to disclose to providers and beneficiaries formulary restrictions and provide exceptions when a non-formulary drug alternative is medically indicated. In addition, plans should include physicians and pharmacists in the development of drug formularies.

Position Paper on Patients’ Bill of Rights Legislation

March 30, 2001

Introduction

The National Council on Disability (“NCD”) is an independent federal agency that advises the President and Congress on issues affecting 54 million Americans with mental and physical disabilities. NCD’s overall purpose is to promote policies, programs, practices, and procedures that guarantee equal opportunity for all individuals with disabilities, regardless of the nature or severity of the disability; and to empower individuals with disabilities to achieve economic self-sufficiency, independent living, inclusion, and integration into all aspects of society.

NCD has been engaged in the issue of improving access to and the quality of health care for people with disabilities for many years. NCD has prepared several reports in the past that address these important issues. These reports include:

- **Sharing the Risk and Ensuring Independence: A Disability Perspective on Access to Health Insurance and Health-Related Services. March 4, 1993.** This report identifies the major issues of access to health insurance and health-related services for people with disabilities.
- **Making Health Care Reform Work for Americans with Disabilities. July 26, 1994.** This report summarizes the identified health care priorities of over 130 witnesses and hundreds of participants in five “town meetings” held by NCD during March and April of 1994.
- **Achieving Independence: The Challenge for the 21st Century. July 26, 1996.** Achieving Independence is the follow-up report to NCD’s 1986 report *Toward Independence*. It offers an assessment of the nation’s progress in achieving equal opportunity and empowerment for people with disabilities in the last decade.
- **From Privilege to Rights: People Labeled with Psychiatric Disabilities Speak for Themselves. January 20, 2000.** In this report, NCD develops ten core recommendations for improving the care of people with psychiatric disabilities.
- **National Disability Policy: A Progress Report. May 15, 2000.** This report is a series of public policy recommendations designed to advance the inclusion, empowerment, and independence of people with disabilities.

As part of its health care agenda, NCD has long supported the enactment of a comprehensive and enforceable patients’ bill of rights. As far back as 1996, NCD argued that “all managed care plans, including those that service only privately insured persons, should be required to meet federal standards to ensure access to specialty care, adequate grievance and appeals procedures . . . and equitable utilization review criteria.” *Achieving Independence* (July 1996). People with disabilities and chronic illnesses are often high users of health care services and devices and, as such, are a litmus test for assessing the effectiveness of patient rights legislation. In other words, if a patient’s bill of rights protects people with disabilities, it is bound to adequately protect the rights of all health care consumers.

NCD has identified the aspects of a patients’ bill of rights that are most important to people with disabilities and chronic illnesses. NCD does not endorse any specific legislation. Rather, NCD supports any approach that meets the principles that are identified and described in this document. It is our hope that members of Congress and their staff, other federal and state policymakers, and people with disabilities view this position paper as a valuable tool as Congress continues to debate this important issue.

NCD Managed Care Reform Principles

Scope of Application of the Law

People with disabilities and chronic conditions have historically faced major hurdles in obtaining and maintaining private health insurance. However, NCD’s 1993 report *Perspectives on Access to Health Insurance and Health-Related Services*, found that while private health insurance is difficult to obtain and keep for many

in the disability community, particularly in the individual insurance market, it is still the major source of coverage for people with disabilities.

A patients' bill of rights, therefore, should cover all 161 million individuals with private health insurance in order to ensure that its protections apply to all people with disabilities. Application of the patients' bill of rights to all privately insured persons will have the added benefit of establishing a uniform set of protections on which all privately insured Americans can rely, regardless of their employer or the state laws in which they reside. This includes the 48 million Americans who receive group health coverage from their employers who self-insure as well as the additional 113 million Americans whose group or individual health coverage is subject to state law.

Timely Access to Specialty Care

The health care needs of people with disabilities and chronic conditions are best met when the focus is on maintenance of function, rather than on acute or post-episodic care. People with disabilities often require ongoing access to specialist physicians, specialty facilities, and other specialty health care providers to maintain the functional ability required to be independent, participating members of society. In addition, the debilitating impact of many primary and secondary disabilities could be reduced or even avoided if specialty services and supports were available to people with disabilities on a routine basis.

NCD recognized in its 1996 report *Achieving Independence: The Challenge for the 21st Century* the importance of federal standards to ensure access to specialty care for people with disabilities in managed care health plans. In fact, improving access to specialty care is the highest priority for the disability community in the patients' bill of rights. NCD reiterates its belief that all patients, especially individuals with disabilities, should have timely access to specialized medical services if they need them. Health plans should ensure that the specialist is appropriate to the specific condition of the patient. If an appropriate specialist is not available within a plan's network of providers, the plan should be required to refer the patient to an appropriate specialist outside the provider network for no additional cost to the patient.

Point-of-Service Option

NCD's 1994 report "Making Health Care Reform Work for Americans with Disabilities" detailed the challenge people with disabilities face when seeking appropriate medical care. Many adults with disabilities and parents of children with disabilities have testified that it takes them years to locate medical professionals who are competent in treating a particular disability. Any "closed panel" managed care plan should be required to offer a "point-of service option" to all enrollees, thereby permitting a person with a disability or chronic condition to access the patient's specialist of choice with reasonable cost sharing. The availability of a point-of-service option is especially important to people with disabilities and chronic illnesses, since the specialized medical care they require is often not available within the existing network of a plan's providers.

Continuity of Care

All health plans should be required to ensure the continuity of care for patients with ongoing, chronic conditions. This can be achieved by permitting an enrollee to continue to visit his or her network of providers for a reasonable period of time after a health plan discontinues operations in a particular geographic region or disrupts its provider network in other ways. In order to minimize the impact of these disruptions, consumers should have a right to an appropriate transitional period (such as 90 days) from the date of a provider's termination from a network plan, except in cases where a provider is placing patients in harm's way through poor quality care. This transitional period should be further extended for enrollees with terminal illnesses, pregnancies, or those who are receiving institutional or inpatient care, through death, birth and discharge respectively.

Standing Referrals

Finally, consumers with complex or chronic conditions who require frequent specialty care should have the right to "standing referrals" without having to continually return to their primary care physician to secure approval. Standing referrals can be made as part of a treatment plan developed by the specialist, primary care provider and patient, and approved by the health plan. Timely, and in some cases, direct access to specialty care will help foster higher quality, more efficient, and cost-effective health care of people with disabilities and chronic conditions.

Timely and Accurate Comparative Information

In a market-based health care system, reliable and useful information is critical to effective decision-making. NCD strongly believes that all health care consumers, particularly people with disabilities, must have access to accurate, easily understood information to assist them in making informed decisions about their health plans, professionals, and facilities. All consumer-directed information should be available in alternative formats that meet the accessibility and communication needs of people with disabilities so that they are able to fully participate in this decision-making process. Health plans and providers should be required to disclose whether their facilities and operations are in compliance with the Americans with Disabilities Act of 1990.

Health plans and providers should be required to provide certain information upon enrollment and additional information upon request of the plan enrollee. Plans should provide information such as covered benefits and exclusions, lifetime and annual limitations in benefits and cost sharing requirements. Health care providers and facilities should provide information including experience rates in treating specific illnesses or injuries and accreditation status. Health care professionals should provide information including education and board-certification status. Health plans should also be required to disclose to providers and consumers drug formulary restrictions as well as exceptions when a non-formulary drug alternative is medically indicated. In addition, plans should include physicians and pharmacists in the development of drug formularies.

Right to Participate in Treatment Decisions and to Refuse Treatment

NCD believes that all patients should be respected and afforded the opportunity to fully participate in decisions related to their health care or the care of a person under their legal guardianship. Patients should be provided with easily understood information on all appropriate treatment options and should be told about the risks and benefits of each treatment, including mental health services. All patients should also have the right to refuse treatment. Finally, health plans should establish specific policies assisting people with sensory, mental and other disabilities in order to maximize the degree to which they are active participants in the decisions related to their health care, including training health care providers to be aware of how to communicate with people with developmental, psychiatric and sensory disabilities.

Elimination of "Gag Clauses": NCD believes that health plans should be explicitly prohibited from restricting patient-provider communications in any manner. Providers should be allowed to inform patients of all medical options, not just the least expensive, without retribution from the plan. In addition, financial incentives designed to restrict patient-provider communications should be prohibited. Providers should also be permitted to advocate on behalf of their patients, without retribution from the health plan.

Emergency Room Protections

Like all health care consumers, people with disabilities and chronic illnesses are in need of emergency room services on occasion. NCD supports a patients' bill of rights that gives patients the right to visit the closest emergency room in an emergency situation, according to the "prudent layperson" standard. In other words, if a "prudent layperson" without medical training believes that he or she is experiencing an emergency medical condition and visits an emergency room, the health plan should be required to pay for this care. Prior authorization for emergency room care under the prudent layperson standard should be prohibited and the patient should pay no more for an out-of-network emergency room visit than if the emergency provider were in the plan's network. Emergency room patient protections should extend to crisis intervention and emergency mental health services provided to people with acute mental illness.

Access to Clinical Trials

The Medicare program recently announced that it would pay for the routine costs associated with a beneficiary's participation in a clinical trial. "Routine" costs include items and services that Medicare would normally pay for, such as room and board during a hospital stay and health care services to treat the side effects and complications of the clinical trial regimen.

NCD believes that this benefit should be extended to all patients who are covered by private insurance. Patients with chronic illnesses must have access to the full range, and all phases of, federally approved clinical trials. Therefore, individuals with life-threatening or serious illnesses for which no standard treatment is available should be allowed to participate in clinical trials. Any routine patient care costs

incurred in connection with participation in the clinical trial should be covered by the health plan.

Strong Grievance Procedures

All patients, including people with disabilities, should have access to a fair and timely internal appeals process as well as an independent, unbiased external appeals mechanism to address health plan grievances and to help govern decisions about medically necessary treatments. Health plans should be held responsible for providing patients with timely, understandable notice of decisions to deny, reduce, or terminate treatment and the reasons for these decisions. All information about the grievance process should also be made available in alternative formats so that effective communication with enrollees with disabilities is ensured. NCD also believes that patients should have access to a binding independent external review process after they have exhausted the plan's internal appeals processes, except in cases of urgently needed care.

Health Plan Liability

NCD is aware that the health plan liability issue has confounded Congress for several years and has led to an unacceptable delay in enacting a comprehensive and enforceable patients' bill of rights. On the other hand, as stated in its recent Progress Reports, NCD believes that without adequate remedies, there will be no meaningful patient rights. Health plans should be held accountable for the medical decisions they make, especially when those decisions harm patients or lead to the patient's death. However, the remedies within the patients' bill of rights should instill accountability in the system without leading to sharp spikes in the cost of health insurance, thereby increasing the number of uninsured Americans. Therefore, NCD will support any thoughtful, balanced approach to health plan liability that holds plans accountable for medical decisions without excessively driving up plan costs.

Patient Rights that Require Additional Attention

There are a number of issues that impact the disability community significantly but have not been included in the patient rights debate to date for a variety of reasons. While NCD is very interested in seeing a patients' bill of rights signed into law at the earliest possible opportunity, the following issues are of such great importance to the disability community that NCD will continue to work for their inclusion in the short and long term:

Benefits/Medical Necessity Definition

One of the greatest threats to the quality of health care of people with disabilities is the restrictive trend in the breadth of most health plans' benefit packages. This trend can be seen in two primary ways: The imposition of limitations and exclusions in benefits and the way in which the term "medical necessity" is defined by the health plan. All of the major patients' rights bills completely omit this important issue. NCD believes that any definition of "medical necessity" should include the concept of not only improving, but maintaining the functional capacity of the patient, taking into account consumer choice, consumer lifestyle, and the long-term effectiveness of the intervention, service, or device under consideration.

In addition, Medicare and Medicaid provide for in-home services critical for people with disabilities, such as physical, occupational, and speech/language therapy, as well as home health aides. Such coverage is often absent or inadequate in private health insurance. Also, most private health plans do not provide coverage for assistive technologies, which are crucial in helping people with disabilities return to work, improve their functional abilities, and live more active and independent lives. Finally, private health plans should be no more restrictive of mental health benefits than they are for physical health benefits. Private health plans should include these kinds of benefits for them to be truly responsive to the needs of all people with disabilities.

Privacy and Confidentiality of Medical Records

NCD believes that patients should be able to communicate with their health care providers in confidence and should have the confidentiality of their individually identifiable health care information protected. Patients should have unfettered access to their own medical records and be able to request amendments to their records to correct mistakes.

ADA Application to Health Plans

NCD believes that health plans and providers with rare exception are subject to Title III of the Americans with Disabilities Act ("ADA"), including the requirement

to provide reasonable modifications to their policies, practices, and procedures under Title III of the ADA. In addition, private health plans and providers that receive Medicare and Medicaid funds for the treatment of these beneficiaries are required to meet the nondiscrimination provisions of the Rehabilitation Act of 1973, which apply to federal contractors and recipients of federal funds. Full implementation of these laws by health plans and providers could significantly improve access to and quality of health care for people with disabilities and chronic illnesses.

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Statement of Thomas W. Self, San Diego, California; Linda P. Self, San Diego, California; Miles J. Zaremski, Chicago, Illinois

Dear Members of the Subcommittee on Health of the Committee on Ways and Means:

We hope that our remarks will be able to be part of your record of the hearing that will occur on patient protections in managed care, scheduled for April 24, 2001. While we have endeavored to communicate with several of you, either by letter, phone or by in person conferences with you or your staff over the last several months, we feel our individual, yet collective, wisdom on the underpinnings of this area before you is critical and important. Two of us have a unique experience not shared by other health care providers in our country. The other has considerable expertise based on experience and writings on managed care liability, what our courts have done with ERISA preemption, and what is likely to be done in the future by our judicial system. [One final introductory remark: while this letter comes from the three of us, we refer to each of us in the third person.]

Our plea is not as Democrats, Republicans or members of other political parties. Our plea comes to you as a physician, a nurse and a lawyer. Our plea comes to you as people who are deeply and passionately concerned about the quality and delivery of health care for our patients, all patients, and the legal and legislative efforts to do the right thing—insure fairness and accountability for patients by those delivering health care.

To quote a famous line from a motion picture of some years back, the battle cry of patients is, **“We are mad as hell and we are not going to take it anymore!”** Patients and providers alike should not be subject to the grave inequities foisted upon them by what managed care has done to the delivery of health care. Linda and Tom Self are fitting, and perhaps, unfortunately, unique examples of what has to occur before managed care moguls will listen.

As a doctor who ran afoul of managed care and was actually fired for spending “too much time” with his patients, Dr. Self is unique in that he fought back against the medical group that fired him and won a three month court battle. This jury victory is the first of its kind in the nation, and was profiled by ABC’s “20/20” on August 6, 1999.

Dr. Self’s experience, where managed care profit motives infiltrated and contaminated the professional ethics of his medical group, shows clearly the murky and often brutal influences wielded by HMOs which have only profit, not quality of care, as their goal. In this scenario, patients become “cost units” and doctor is pitted against doctor, undermining the very foundation of medicine and throwing to the winds the Hippocratic axiom, “first of all do no harm.”

With the art and science of medicine controlled by managed care forces, it is not surprising that the number of patient casualties continues to soar. The ability of a clerk with no medical training, in the employ of a payor thousands of miles away, to overrule the medical decisions of a trained physician is allowed in no other profession, but is the standard of practice under managed care! Furthermore, this type of employee and also the managed care entity which acts as the puppeteer behind the clerk are completely immune from any accountability when their faulty medical decisions cause patient harm. Amazingly, that this situation is allowed to continue is also unique to the medical profession. *This is unfair and inequitable!*

As an experienced diagnostician with a reputation of being thorough and careful, Dr. Self was criticized and ultimately fired under managed care as a physician who ordered “too many costly tests” and as a “provider” who “does not understand how managed care works.” Sadly, this situation continues nationwide as more and more experienced doctors are unjustly censored, dropped from managed care plans or fired from medical groups anxious to conform to managed care dictates, leaving their needy patients feeling confused, frightened and abandoned.

This pillage and waste of medical resources (under the yoke of managed care which destroys the very quality and continuity so necessary for a positive outcome

from medical treatment) is running rampant in America. Dr. Self and his wife have put their lives and their careers on the line to combat the wrongs caused by the health care delivery system called managed care. Now, representing, in microcosm, all health care providers, they turn to you as lawmakers, representing all past, present and future patients, to stop the horror and carnage by the HMOs by voting for S. 283 (McCain-Kennedy Bill) and restoring quality, decency and humanity to health care for the American people.

Linda Self, a registered nurse, is, like her husband, a healer. Always active in charitable activities, Linda returned to nursing full time 4 years ago to work with her husband when he was fired. After being away from nursing for many years, she realized that her compassion and love for the art of healing was now even stronger, especially after raising two children, one of whom had a serious illness. Devoted to caring for children with chronic diseases and giving support to their families, she was shocked and unprepared for the massive de-emphasis on patient care that had been fostered by the health plans. Linda realized that her commitment to people had not changed nor had the needs of sick children—what had changed, and changed for the worse, was the indifference to patient suffering held by the managed care system. Linda realized that in order to care for sick patients and their families in the 90's, there is, and was going to be, a constant battle with the managed care bureaucracy involving patient referrals, treatment authorizations and, above all, the daily need to appeal treatment plans denied patients by their health plans.

As if in microcosm to what other private medical practitioners face, this office “busy work,” in addition to the requirements of providing necessary medical support to sick patients, has created enormous frustrations among health care providers as well as increasing the costs of running a practice. Conversely, the reimbursements from the health plans have steadily diminished, regardless of the severity of the patient's illness or the increased amount of physician and nursing time expended.

Also, in her dual role as nurse and office administrator, Linda works daily to insure that patients receive the appropriate medical care they need and deserve without suffering the indignity and humiliation of having their health plans ignore, delay, or deny health care that is not only medically necessary, but for which the patient has already paid insurance premiums. This endless paper shuffle mandated by managed care with its cost cutting mentality further decreases the amount of time that a nurse can devote to patient care. This dilemma has driven competent and caring paraprofessionals from the medical field in droves, thereby further weakening the overall quality of medical care needed by patients nationwide. The resulting upswing in poorly trained, undedicated office personnel hired to replace the nursing flight has created a hemorrhage in medical care delivery which, if not stopped, will hasten the demise of American medicine as far as any vestige of quality of care which still remains.

Meanwhile, Linda has continued to fight side by side with her husband, not only during their lengthy legal battle and during a three month trial, but to preserve the quality of their practice against the current tide of managed care. Her recent experiences with managed care atrocities have been etched in her memory and will be forever carried as emotional scars. Linda fervently believes that no physician or nurse should ever be faced with the ordeal that she and her husband have had to endure to insure quality of care for patients.

Patients must not be considered as commodities to be bartered by HMOs; payors must be held fully and judicially accountable wherever their pressures on physicians to curtail tests, delay or deny treatment plans, or by clogging the wheels of medicine with mountains of paperwork cause patient harm. Therefore, Linda Self, speaking as a mother, a patient, and a nurse brings her experiences to your Subcommittee (through this Statement) and adds her plea to those of Dr. Self and Mr. Zaremski to bring dignity and salvation to the practice of medicine. Those in your Subcommittee, listen, as we have done for years, to the voices of the grass roots populace when they cry out for help and relief from a medical system that harms, not heals.

Additionally, the three of us have seen and heard the disingenuous of opponents of what patients really need and which is embodied in the McCain-Kennedy bill as introduced earlier this year. We have heard that lifting the ERISA preemption will cause employers to terminate health plans for their employees, that lifting this so-called shield will cause premiums to increase and that trial lawyer will gain an avenue to sue. To all of this, and with all the passion we can muster, we bellow, “absolutely *not!*”

First, the ERISA law that was enacted in 1974 had nothing to do with shielding managed care plans from accountability for their medical decision-making process. There has never been anything in the legislative history on ERISA having to do

with this subject. Further, the ERISA preemption was court created, and those same courts are peeling away at an ever rapidly pace, on a case-by-case basis, what was never intended in the first place by the ERISA law.

Next, allowing for accountability by health plans to patients, as contained in S. 283, provides for real equity in distributing responsibility to all those persons and entities involved in the medical decision-making process.

As for increased litigation, the status quo of what plans know their exposure to be now will not change in any significant way. Please know that our courts are continually eroding the ability of health plans to escape exposure by finding valid legal theories known as agency, breach of fiduciary duties, even using the Americans With Disability Act.

Also, realize that S. 283 provides for accountability and responsibility of health plans in state court according to *state* laws. This jurisdiction is where this area of responsibility and accountability for health plans should reside. For example, if your state has caps on the amount of money that an injured person could receive, such as in California, then those caps would equally apply to exposures faced by health plans.

And if the Texas state statute on holding HMOs responsible is any example, fears of increased litigation are totally without any basis in fact. In three plus years, there have been a handful of cases filed against health plans in that state. Also, nine states have now passed legislation recently, providing that HMOs can be held accountable for their medical decision-making. Moreover, the U.S. Supreme Court, with its *Travelers Insurance Company* and *Herdrich* cases, opines the proposition that medical professional liability cases, like ones plans are involved in, belong in state court.

In conclusion, we implore each and every one of you to do the right thing. Consider your conscience and critically think about each and every American who has been, or will be, a patient in our health care delivery system. Remember that a person's health is unlike anything that can be bought, traded, negotiated or sold. Don't hold hostage human sickness and injury to a "bottom line" mentality. Or, as a colleague in medicine wrote Dr. Self after his jury verdict, "The rewards of being a doctor are largely measured in identifying what is best for the patient and then having to do what one believes is correct and best for the patient." Finally, recall a quotation by Margaret Mead; "Never doubt that a small group of dedicated people can change the world. Indeed, it is the only thing that ever has." *In supporting a bill like S. 283, each one of you will heed this message, and, conversely, insure that the tendrils of greed in managed care will not be able to find fertile soil in which to take root and grow.*

Thank you for allowing this statement to be presented to your Subcommittee.

Highland Park, Illinois 60035
April 23, 2001

The Honorable Nancy L. Johnson (R-Ct.)
Chairwoman, Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

Attn.: Allison Giles

Re: April 24, 2001 hearing on Patient Protections in Managed Care

Dear Chairwoman Johnson:

Please take that which follows as a written statement I would like to be included for the printed record of the hearing. Thank you.

On your website's *ADVISORY* page, Chairwoman Johnson is quoted as being encouraged by the principles President Bush put forth to guide legislators in order to enact a real patients bill of rights. One of the those principles was to have patients go to federal court after an independent medical review, and should include appropriate employer protection with caps on damages.

While not an attorney who represents injured patients, I am someone who has tolled for 28 years in the health care law field. I also am an author, lecturer, law school teacher, and leader/participant within medicolegal organizations. I have also studied and researched issues within patient rights legislation for a couple of years

now, particularly the liability features; consequently, I believe I come to you with sufficient credentials to say what I am about to state.

With all due respect to our President, his “principle” of having disputes involving health plans resolved in a federal forum is fanciful thinking, a waste of millions of taxpayer dollars, and not in touch with judicial reality at all. Let me articulate.

Cases in which health plans would be involved are of one of three types: those strictly involving a plan benefit, i.e. whether the contract that an enrollee has covers a procedure or treatment or not; (2) whether the issue is “mixed,” that is, whether there are questions of eligibility and medical treatment decisions; and (3) whether the issue involves solely medical decision making in which the plan participated. The first of these three options is easy to resolve: its adjudication remains in federal court, as it has since the ERISA law was enacted back in 1974. The other two types of accountability belong in state court according to state law. Why? Because the United States Supreme Court has provided nearly explicit statements to this effect. In both the *Travelers Insurance Co.* and *Herdrich* decisions, the high court has stated, respectively, that ERISA does not preempt state law that regulates the provision of adequate medical treatment, and that an HMO’s mixed eligibility and treatment decision implicates a state law for medical malpractice, not an ERISA cause of action for fiduciary breach.

And, on April 2, 2001, the Pennsylvania Supreme Court came down with its decision in *Pappas v. Asbel*, 2001 Pa. Lexis 687. This is the first state supreme court that has decided health plan liability in light of the *Herdrich* and *Travelers* decisions. The Pennsylvania court held that a “mixed” case as presented by the facts there was not preempted by ERISA.

Next, how could any person in Congress condone litigating a noncoverage matter against a health plan in federal court, knowing that such cases belong in state court (per what the Supreme Court has already stated), but also realizing that everyone else involved in the very same medical decision-making process as the plan, like the hospital, doctor and nurse, for example, remains culpable in state court according to state law. Do you really want to “tie up” precious federal judicial resources when state courts have been adjudicating these type matters for at least a couple of centuries and when state courts will still be needed to adjudicate claims against the doctors, hospitals, nurses, and so forth. The “principle” that President Bush has announced about a federal forum would also mean that for every occurrence involving a health plan and medical decision-making, there would have to be two suits, not just one!

Finally, from what I have read in the press about employer liability, the thought of the “boy crying wolf” comes to mind. If anyone reads the language in the pending bill in the Senate, the employer group is cloaked with almost absolute immunity—the only exception is when that employer makes medical decisions just like a plan would . . . or even a physician. Moreover, from my review of the legal literature/cases, there is not one reported legal case in which an employer has been held liable for medical malpractice.

Thank you for listening. I trust the Subcommittee will find that which is contained herein informative and useful to what it ultimately decides to do.

Sincerely,

MILES J. ZAREMSKI

