104TH CONGRESS
2d Session

HOUSE OF REPRESENTATIVES

REPT. 104–865
Part 1

PATIENT RIGHT TO KNOW ACT OF 1996

SEPTEMBER 28, 1996.—Ordered to be printed

Mr. BLILEY, from the Committee on Commerce,
submitted the following

REPORT

together with

ADDITIONAL VIEWS

[To accompany H.R. 2976]

[Including cost estimate of the Congressional Budget Office]

The Committee on Commerce, to whom was referred the bill (H.R. 2976) to prohibit health plans from interfering with health care provider communications with their patients, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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29–006

AMENDMENT

The amendment is as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE; FINDINGS.

(a) SHORT TITLE.—This Act may be cited as the "Patient Right To Know Act of 1996".

(b) FINDINGS.—Congress finds the following:

(1) Patients cannot make appropriate health care decisions without access to all relevant information relating to those decisions.

(2) Restrictions on the ability of physicians and other health care providers to provide full disclosure of all relevant information to patients making health care decisions violate the principles of informed consent and the ethical standards of the health care professions. Contractual clauses and other policies that interfere with communications between health care providers and patients can impact the quality of care received by those patients.

(3) The offering and operation of health plans affects commerce among the States, health care providers located in one State serve patients who reside in other States as well as that State, and, in order to provide for uniform treatment of health care providers and patients among the States, it is necessary to cover health plans operating in one State as well as those operating among the several States.

SEC. 2. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

(a) IN GENERAL.—

(1) PROHIBITION OF CERTAIN PROVISIONS.—Subject to subsection (f), an entity offering a health plan (as defined in subsection (d)(2)) may not include any provision that prohibits or restricts any medical communication (as defined in subsection (b)) as part of—

(A) a written contract or agreement with a health care provider,

(B) a written statement to such a provider, or

(C) an oral communication to such a provider.

(2) NULLIFICATION.—Any provision described in paragraph (1) is null and void.

(b) MEDICAL COMMUNICATION DEFINED.—In this section, the term "medical communication" means a communication made by a health care provider with a patient of the provider (or the guardian or legal representative of such patient) with respect to the patient's physical or mental condition or treatment options.

(c) ENFORCEMENT THROUGH IMPOSITION OF CIVIL MONEY PENALTY.—

(1) IN GENERAL.—Any entity that violates paragraph (1) of subsection (a) shall be subject to a civil money penalty of up to $25,000 for each violation. No such penalty shall be imposed solely on the basis of an oral communication unless the communication is part of a pattern of such communications or the violation is demonstrated by a preponderance of the evidence.

(2) PROCEDURES.—The provisions of subsections (c) through (l) of section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) shall apply to civil money penalties under paragraph (1) in the same manner as they apply to a penalty or proceeding under section 1128A(a) of such Act.

(d) DEFINITIONS.—For purposes of this section:

(1) HEALTH CARE PROVIDER.—The term "health care provider" means anyone licensed under State law to provide health care services.

(2) HEALTH PLAN.—The term "health plan" means any public or private health plan or arrangement (including an employee welfare benefit plan) which provides, or pays the cost of, health benefits, and includes an organization of health care providers that furnishes health services under a contract or agreement with such a plan.

(3) COVERAGE OF THIRD PARTY ADMINISTRATORS.—In the case of a health plan that is an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974), any third party administrator or other person with responsibility for contracts with health care providers under the plan shall be considered, for purposes of this section, to be an entity offering such health plan.

(e) NON-PREEMPTION OF STATE LAW.—A State may establish or enforce requirements with respect to the subject matter of this section, but only if such requirements are more protective of medical communications than the requirements established under this section.

(f) CONSTRUCTION.—Nothing in this section shall be construed as preventing an entity from—

(1) acting on information relating to the provision of (or failure to provide) treatment to a patient; or

(2) restricting a medical communication that recommends one health plan over another health plan if the the sole purpose of the communication is to secure financial gain for the health care provider.

(g) EFFECTIVE DATE.—Subsection (a) shall take effect 90 days after the date of the enactment of this Act and shall apply to medical communications made on or after such date.

PURPOSE AND SUMMARY

The purpose of H.R. 2976, the Patient Right to Know Act of 1996, is to prevent health plans from interfering in medical communications between patients and their health care providers. The bill provides that a health plan may not include in a written contract with a provider, a written statement to a provider, or an oral communication with a provider, a provision that prohibits or restricts any medical communication. The bill declares such provisions null and void.

BACKGROUND AND NEED FOR LEGISLATION

As health care costs have risen and the need for more cost-conscious health care has grown, health insurers and employers have increasingly adopted principles of managed care. Currently, approximately 135 million Americans are enrolled in some form of managed care. This represents approximately 50.7 percent of the insured population. Managed care has been defined as any type of intervention in the provision of health care services or reimbursement of health care providers that is intended to provide health care services in the most efficient manner. Managed care is a broad concept that encompasses several different types of entities, such as: (1) Health Maintenance Organizations (HMOs); (2) Independent Practice Associations (IPAs); (3) Point of Service plans (POSs); and (4) Preferred Provider Networks (PPNs). Fee-for-service plans are also employing many of the same cost-saving mechanisms. Managed care represents an important component of the market and in many cases promotes good health and results in lower overall health care expenditures.

Recently, a number of reports from both patients and providers have expressed concern that some health plans may have pursued too vigorously cost-saving mechanisms by taking steps to limit doctor-patient communications. This is troubling because open communications are critical to quality care. Patients need all relevant information about their physical and mental conditions and their treatment options to make intelligent choices about their care. Any effort to constrain patients from receiving the necessary facts makes it very difficult for them to give informed consent.

During the Subcommittee on Health and Environment hearing, the Subcommittee heard from several witnesses who outlined ways in which some health plans have attempted to interfere in medical communications between patients and their health care providers. Testimony came from doctors who were threatened with retaliatory action for providing their patients with certain treatment information. The Subcommittee also heard from two widowers who alleged that plan interference led to delays in receiving critical information

which led to their wives' deaths. These physicians and patients whole-heartedly supported H.R. 2976.

The Subcommittee also heard from several managed care plans which all stated that they expect free and open communication between physicians and patients. They also pointed out that managed care requires accountability, coordination, and communication. While these witnesses were supportive of the goals of H.R. 2976, they expressed several concerns about the specifics of the legislation.

The bill, as reported by the Committee, represents an attempt to find a compromise that addresses the concerns of consumers and providers without imposing unacceptable burdens on health insurers.

HEARINGS

The Subcommittee on Health and Environment held a hearing on Contract Issues and Quality Standards for Managed Care on May 30, 1996. Testimony was received from the following witnesses: Dr. Michael Haugh, Tulsa, Oklahoma; Dr. Steve Buie, Kansas City, Missouri; Dr. John M. Ludden, Senior Vice President for Medical Affairs, Harvard Pilgrim Health Care; Dr. William J. Osheroff, Medical Director, Western Region, PacifiCare of California; Dr. Robert E. McAfee, Immediate Past President, American Medical Association; Ms. Karen Ignagni, President and CEO, American Association of Health Plans; Mr. David Ching, Fremont, California; Ms. Diane Martello, North Tarrytown, New York; Mr. Alan Charles deMeurers, Keizer, Oregon; Mr. Alfred Couture, Worcester, Massachusetts; Dr. Raymond Scalettar, Consultant, Joint Commission on Accreditation of Health Care Organizations; Dr. Spencer Falcon, Senior Vice President, National Services and Managed Care, Blue Cross and Blue Shield of Michigan; Dr. William S. Ten Pas, President, American Dental Association; Ms. Lauren Hirsch, Wantagh, New York; Dr. Linda Peeno, founder, The CARE Foundation; Mr. Mark Cloutier, MPH, MPP, Vice President, Bioethics Consultation Group; Ms. Heather Fraser, representing the Cystic Fibrosis Foundation; and Mr. Val D. Bias, representing the Patient Access to Specialty Care Coalition.

Although the hearing addressed many issues, the focus of the hearing was the issue of "gag rules" in managed care plans and whether legislation was necessary to address the issue.

COMMITTEE CONSIDERATION

On June 27, 1996, the Subcommittee on Health and Environment met in open markup session and approved H.R. 2976, the Patient Right to Know Act of 1996, for Full Committee consideration, as amended, by a rollcall vote of 22 yeas to 0 nays.

On July 24, 1996, the Full Committee met in open markup session and ordered H.R. 2976 reported to the House, as amended, by a voice vote.

ROLLCALL VOTES

Clause 2(l)(2)(B) of rule XI of the Rules of the House of Representatives requires the Committee to list the recorded votes on

the motion to report legislation and amendments thereto. There were no recorded votes taken in connection with ordering H.R. 2976 reported. A motion by Mr. Bilirakis to order H.R. 2976 reported to the House, as amended, was agreed to by a voice vote, a quorum being present.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 2(l)(3)(A) of rule XI of the Rules of the House of Representatives, the Committee held an oversight hearing and made findings that are reflected in this report.

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

Pursuant to clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Reform and Oversight.

NEW BUDGET AUTHORITY AND TAX EXPENDITURES

In compliance with clause 2(l)(3)(B) of rule XI of the Rules of the House of Representatives, the Committee states that H.R. 2976 would result in no new or increased budget authority or tax expenditures or revenues.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 403 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 2(l)(3)(C) of rule XI of the Rules of the House of Representatives, the following is the cost estimate provided by the Congressional Budget Office pursuant to section 403 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, August 1, 1996.

Hon. THOMAS J. BLILEY, Jr.,
Chairman, Committee on Commerce,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office (CBO) has reviewed H.R. 2976, the Patient Right to Know Act of 1996, as ordered reported by the House Committee on Commerce on July 24, 1996. Enclosed are CBO's federal cost estimate and estimates of the costs of intergovernmental and private-sector mandates.

Enactment of the bill would direct spending and thus would be subject to pay-as-you-go procedures under Section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985.

If you wish further details on these estimates, we will be pleased to provide them. The CBO staff contacts are identified in the separate estimates.

Sincerely,

JUNE E. O'NEILL, *Director.*

CONGRESSIONAL BUDGET OFFICE FEDERAL COST ESTIMATE

1. Bill number: H.R. 2976

2. Bill title: Patient Right to Know Act of 1996

3. Bill status: As ordered reported by the House Committee on Commerce on July 24, 1996.

4. Bill purpose: H.R. 2976 would require health plans to refrain from any activity that restricted or prohibited providers' communications with patients concerning their health conditions or treatment options.

5. Estimated cost to the Federal Government: CBO and the Joint Committee on Taxation (JCT) estimate that H.R. 2976 would increase the federal deficit by about $90 million between 1997 and 2002 (see attached table). As a result of increases in employer-paid health premiums, federal income and payroll tax revenues would fall by about $70 million over that period. Federal outlays for Medicaid would increase by $13 million, and mandatory outlays for federal employees' health benefits would increase by $8 million over the period. Discretionary spending for benefits of active federal workers would rise by another $8 million, and the Secretary of Health and Human Services would be required to undertake enforcement actions that would imply additional costs, assuming appropriation of the necessary amounts.

6. Basis of the estimate:

Gag rules.—H.R. 2976 would prohibit certain types of so-called gag rules, under which health plans restrict providers from discussing certain, presumably expensive, treatments with patients. The elimination of such restrictions could enable some health care providers to discuss treatment options with their patients more freely than at present, thereby allowing those patients to make more informed choices. By limiting one of the mechanisms by which health plans may control expenditures, H.R. 2976 would raise the cost of some of those plans. Their costs would rise if, as a result of more open communications between providers and patients about treatment options, the providers in their network performed more high-cost procedures or referrals.

For several reasons, however, the cost increases incurred by plans from the elimination of gag rules would be small:

CBO assumes that rules restricting communications about medical treatment options are not commonly used by health plans.

Some states have enacted anti-gag-rule legislation and others have such legislation under consideration. (Self-insured plans, however, would not be covered by state laws but would be covered under H.R. 2976.)

H.R. 2976 would not require health plans to provide more services than they do now.

The financial incentives for physicians and other providers in health plans would be unchanged.

Protocols, guidelines, and quality control.—Although the bill would not explicitly impose new restrictions on utilization review procedures or on other actions that plans could take to limit the use of high cost procedures, the prohibition on the restriction of medical communications is sufficiently broad that the bill might

prevent health plans from imposing any requirements on medical communications. Depending on how courts interpreted the bill and on the level of enforcement performed by the Secretary of Health and Human Services, this limitation could be more important—and costly—than the prohibition of gag rules alone.

Although H.R. 2976 does not directly address protocols and treatment guidelines, CBO assumes that the bill would make plans more cautions about implementing them. Such protocols would be seen as indirectly restricting provider-patient communications concerning treatment options by recommending certain treatments to the exclusion of others. The Blue Cross and Blues Shield Association has argued that H.R. 2976 could disrupt some standard quality control functions of plans, including, for example, the ability of plans to restrict certain providers from making referrals or to enforce limitations on the scope of practice of certain providers.

Effect on Federal revenues.—Any law that imposes additional requirements on health plans will tend to increase the costs of those plans. Because H.R. 2976 could potentially disrupt some quality control efforts and inhibit the development of treatment protocols. CBO assumes that enactment of the bill would initially result in a slight increase in private health insurance premiums—about 0.025 percent. This figure is highly uncertain; the actual increase would depend on the method and intensity of the Secretary's enforcement efforts and on the interpretations of the law in the courts. Because the bill is broadly worded, it has the potential to affect plans' ability to control their costs in unintended and unforeseen ways.

Employers and employees would offset part of the premium increase by reducing coverage, or by dropping benefits for other services. Because of these reactions, we assume that employer contributions for health insurance would rise by only 0.01 percent. Most of that increase would be passed back to employees in lower wages. The lower wages, in turn, would reduce federal income and payroll tax revenues, JCT estimates that revenues would fall by about $70 million between 1997 and 2002.

Effect on Federal outlays.—CBO estimates that the federal share of increased Medicaid costs implied by H.R. 2976 would total about $13 million over the period. Although the bill's requirements would not necessarily apply to Medicaid as a direct payer, plans contracting to provide care to Medicaid recipients would be affected.

Federal costs for federal employees' health benefits would also increase slightly. Direct spending for annuitants' benefits would rise by about $8 million over the period, and discretionary spending for active workers would rise by another $8 million, assuming the necessary amounts were appropriated.

Several federal agencies—including the Departments of Health and Human Services, Labor, and Justice—would incur the costs of enforcing this bill. CBO cannot estimate the magnitude of these costs.

7. Pay-as-you-go considerations: The Balanced Budget and Emergency Deficit Control Act of 1985 sets up pay-as-you go procedures for legislation affecting direct spending or receipts through 1998. The bill would have the following pay-as-you-go impact:

[By fiscal year, in millions of dollars]

	1996	1997	1998
Change in Outlays	0	2	3
Change in Revenues	0	−7	−11

8. Estimated impact on State, local, and tribal governments:

Intergovernmental mandates.—H.R. 2976 would impose an intergovernmental mandate, as defined in the Unfunded Mandates Reform Act of 1995 (Public Law 104–4), because state and local governments, as sponsors of health plans for their employees, would be prohibited from using a particular mechanism to control costs. CBO estimates that the bill would increase the cost of health insurance for employees of state and local government by $10 million annually, a 0.025 percent increase.

The cost would be borne primarily by the employees themselves and not by state and local taxpayers. Economists generally believe, and CBO's cost estimates have long assumed, that workers as a group bear most of the cost of employers' health insurance premiums. The primary reason for this conclusion is that the supply of labor is relatively insensitive to changes in take-home wages. Because most workers continue to work even if their take-home pay declines, employers have little trouble shifting most the cost of additional health insurance to workers' wages or other fringe benefits. The amount of total compensation paid by state and local governments would thus remain unchanged in the long run. However, during a transition period of about two years, state and local governments would have to spend between $1 million and $2 million annually because about 40 percent of their employees are covered by collective bargaining agreements that, on average, last for two years. Such agreements would prevent state and local governments from changing other elements of these employees' compensation packages until the collective bargaining agreements expire.

Other impacts.—The bill would also increase state Medicaid costs by $1 million to $2 million annually. Even though the bill's requirements would not necessarily apply to Medicaid as a direct payer, plans contracting to provide care to Medicaid recipients would be affected. The increase in cutting back on optional services and beneficiaries. Under Public Law 104–4, an increase in program costs for a large entitlement, such as Medicaid, is not a mandate if states have such flexibility to reduce their own financial or programmatic costs.

9. Estimated impact on the private sector: H.R. 2976 would impose a mandate on health plans in the private sector by prohibiting them from restraining certain types of communications between providers and patients. Under the bill, plans could not restrict providers' communications with patients concerning their physical or mental conditions or their treatment options. Health plans that violated this requirement would face civil money penalties.

By limiting one of the mechanisms through which managed care plans may control expenditures, H.R. 2976 would raise the costs of some of those plans. Their costs would rise if, as a result of more open communications between providers and patients about treatment options, the providers in their network performed more high-cost procedures or made more referrals. For reasons given above,

however, CBO assumes that the direct costs on the private sector would be small and would not exceed the $100 million annual threshold.

10. Previous CBO estimate: None.

11. Estimate prepared by: Jeff Lemieux (private insurance and federal employees' health benefits) and Jean Hearne (Medicaid); Linda Bilheimer (private sector) and John Patterson (state and local government).

12. Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

H.R. 2976, THE PATIENT RIGHT TO KNOW ACT OF 1996

[By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002	1997–2002
DIRECT SPENDING AND RECEIPTS							
Outlays:							
Medicaid	2	2	2	2	2	3	13
Federal Employees Health Benefits	0	1	1	2	2	2	8
Total, Outlays	2	3	3	4	4	5	21
Revenues:							
Income and Payroll Taxes	−7	−11	−11	−12	−14	−15	−70
Deficit	9	14	14	16	18	20	91
SPENDING SUBJECT TO APPROPRIATION							
Federal Employees Health Benefits:							
Budget Authority	0	1	1	2	2	2	8
Outlays	0	1	1	2	2	2	8
Enforcement by Department of Health and Human Services and other Agencies:							
Budget Authority	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Outlays	(1)	(1)	(1)	(1)	(1)	(1)	(1)

[1] Not estimated.

Sources: Congressional Budget Office, Joint Committee on Taxation.

INFLATIONARY IMPACT STATEMENT

Pursuant to clause 2(l)(4) of rule XI of the Rules of the House of Representatives, the Committee finds that H.R. 2976 would have no inflationary impact.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act are created by this legislation.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Short title; findings

Section 1 contains the short title which is the Patient Right to Know Act of 1996. The section also contains findings regarding the importance of communications between providers and their patients.

Section 2. Prohibition of interference with certain medical communications

Section 2 provides that an entity offering a health plan may not prohibit or restrict any medical communication as part of: (a) a written contract or agreement with a health care provider; (b) a

written statement to such provider; or (c) an oral communication to the provider. Section 2 provides that such provisions are null and void. The section defines the term "medical communication" to mean a communication by a health care provider with his or her patient with respect to the patient's physical or mental condition or treatment options.

Section 2 also provides for an enforcement mechanism for a violation of this section. The bill provides for civil money penalties of up to $25,000 for violations. In addition, it provides that no penalty shall be imposed solely on the basis of an oral communication unless it is a part of a pattern of such communications or the violation is demonstrated by a preponderance of the evidence. This is intended to establish a complaint-based system of enforcement, not one based on mandatory prior review of provider contracts, Federal participation in the contracting process, or ongoing monitoring of plan operations and communications. Civil money penalties are the only remedy provided by the bill.

A State is permitted to establish requirements regarding the interference with medical communications that are more protective of these communications. The bill also clarifies that nothing shall be construed as preventing a plan from (a) acting on information relating to the provision of (or failure to provide) treatment or (b) restricting medical communications that recommend one plan over another solely for the provider's financial gain.

Nothing in this Act is intended to modify, alter, or amend Section 514 of the Employee Retirement Income Security Act of 1974 (ERISA).

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

This legislation does not amend any existing Federal statute.

ADDITIONAL VIEWS

During a lengthy hearing on May 30, 1996, we heard from several witnesses who outlined the ways in which some health plans have attempted to interfere in medical communications between patients and their health care providers. Testimony came from doctors who were threatened with retaliatory actions for telling their patients information that the health plan did not want them to know. We also heard from two widowers who learned too late critical information about their wives' health care.

We have grave concerns that some—but certainly not all—health plans are attempting to interfere in the doctor-patient relationship. The trust between a patient and his or her health care provider is at the core of the medical profession and is central to the notion of informed consent. To make intelligent decisions about their health care, consumers must be informed of all of their treatment options—not just those that plan wants them to know about or is willing to pay for.

At the same time, we recognize that the health care market is undergoing rapid and often unpredictable changes. Managed care represents an important component of the market and its advocates believe that active case management can help promote good health and thereby result in lower overall health care expenditures. Such networks cannot thrive, however, if they are unable to monitor and prevent unnecessary utilization of services and to engage in active management of the care of enrollees.

Based on the testimony at the hearing as well as other reports, we agree that legislation is needed to prevent outside interference in communications between patients and their health care providers. At the same time, there was some disagreement as to whether the original text of H.R. 2976 would pose unacceptable burdens on health insurers.

In an effort to find a compromise that would address the very real concerns of consumer groups and health care providers without undermining the health care markets, we worked diligently to find a compromise that would meet these two important, but somewhat conflicting goals.

Shortly before the Health and Environment Subcommittee met to consider the legislation, we drafted a substitute that made a number of important changes to the base text. While we do not believe the substitute is perfect (some of us would like to see a stronger bill, others think it may unduly restrict legitimate activities of health insurers), it represents a true compromise which is a delicate balance of competing ideas and philosophies.

The substitute was ordered reported to the Full Committee by a 22–0 vote and was approved by voice vote by the Full Commerce Committee a month later.

We think it is appropriate to discuss the major changes to H.R. 2976 made by the substitute and the reasons for them:

1. First and foremost, the substitute is more narrowly focussed on protecting provider-patient communications. The base bill would have also placed restrictions on the ability of health plans to regulate communications between providers and the plan and between providers and state and federal regulators. Significant questions were raised about possible unintended consequences of these provisions, and the substitute deletes them and focusses on protecting the ability of patients to freely communicate with their health care providers.

2. The original bill contained a long definition of what is included as a protected medical communication. While we agree on what this should mean, there was some concern about the wisdom of placing that definition in legislative language. Instead, the substitute expressly states that a "'medical communication' means a communication made by a health care provider with a patient of the provider (or the guardian or legal representative of such patient) with respect to the patient's physical or mental condition or treatment options."

During the Subcommittee mark-up, Congressman Burr and Congressman Ganske had an exchange in which they discussed how broadly this term should be interpreted. The key elements of that discussion are as follows:

> Mr. Ganske: * * * it is my intention that the substitute would cover any tests, consultations, and treatment options; any risks or benefits associated with them; and any variation in quality among health care providers and any institutions providing such services. Medical communications also covers general descriptions of the standard used by plans to decide whether to authorize health care services; the process used by the plan to make those decisions; and a general description of financial incentives or disincentives provided by such an entity that may be based on service utilization.
>
> Mr. Burr: I am concerned about the ability of plans to safeguard proprietary data. While I do understand the desire to provide patients with access to information on utilization review procedures and financial incentives, I would not support a provision that forced plans to permit the disclosure of specific fee schedules.
>
> Mr. Ganske: A patient has a right to know the general way his policy works [and I] would be pleased to work with you and with Chairman Bliley to craft report language consistent with that need and also with the ability of plans to compete in the marketplace.

We believe that this reading of the substitute is appropriate. We met with several experts who were concerned that the original bill would result in the disclosure of confidential information and other trade secrets of health plans. We recognize that the health care market is very competitive and that plans have a legitimate interest in protecting proprietary data such as payment schedules.

But that does not mean that plans should be able to prevent providers from discussing the general nature of plan operations with their patients. The subject of provider compensation most squarely presents this issue. Health plans are paying their providers in new and innovative ways. Some pay a straight salary. Others pay a form of fee schedule, which pays providers for each service delivered. Some plans capitate their providers, meaning that they are paid a flat fee per patient but may be personally financially liable for a certain amount of care provided. Many plans use other, more innovative, payment systems which tie a provider's pay to some performance measurements—generally in the form of bonuses and withholds.

We do believe that patients ought to have access to descriptive information about the way in which their provider is paid. The testimony from David Ching demonstrates the importance of this information. His wife complained of severe abdominal pain and rectal bleeding. Her doctor repeatedly refused her requests for additional tests and referrals to specialists. After a delay of several months, she was finally referred to a specialists who diagnosed her with the colon cancer that had recently perforated her bowel wall and resulted in her early death.

What Joyce and David Ching did not know is that her doctor had a financial interest in providing her with less health care. He was paid $27 per month to care for her, and was personally responsible for the first $10,000 of care provided. After her first visit and a barium enema, Joyce Ching had cost her doctor his entire annual capitation. Further tests and referrals would effectively come out of his pocket. David Ching testified that had he known about that compensation arrangement, he definitely would have sought a second opinion for his wife out of his own pocket.

It is important to note that the compromise approved by the Committee would not require plans to allow discussions of the specific dollar amounts of financial arrangements. But Joyce Ching's case points out the very real dangers created when patients do not have complete access to information about their health care needs.

While we believe that providers should be able to fully inform patients as to their physical or mental condition and treatment options, the utilization review procedures established by health plans, and the general manner in which providers are compensated, we also believe that health plans should be able to establish utilization review procedures as well as quality guidelines, and that plans are not required to allow discussions of the specific dollar amounts of financial arrangements.

While we believe that patients can make informed decisions without knowing the specific dollar amounts involved in these payment arrangements, knowing the general manner in which their provider is compensated could be important. Accordingly, we do not believe health plans should be able to prevent providers from describing the general nature of these arrangements and how they could create incentives or disincentives for the delivery of additional care. For example, a provider could tell a patient, "I receive a flat fee per month from the plan and I can also qualify for certain bonuses if the amount of care I provide during the year falls below a certain level" or "Because of my compensation arrangement with

the plan, my salary decreases if I refer patients to too many specialists." Plans wishing to restrict the disclosure of specific dollar amounts in these arrangements should be able to do so, but the type of general information described above should not be considered to be proprietary data or a trade secret.

3. The original bill listed a series of "adverse actions" that health plans would be prohibited from taking. This placed the focus on whether the plan took any action against the provider, not whether patients had access to all the information they need. To keep the focus on preventing restrictions on medical communications, the substitute deleted the list of "adverse actions." Plans that attempt to prohibit or restrict free communications between providers and patients—whether in written policies or expressed orally—would be in violation of the law, even if they have taken no retaliatory actions.

For example, a plan could not tell providers not to discuss the possibility of bone marrow transplants with patients and threaten to terminate the contracts of those who disobey. The action of making the attempt to restrict the medical communication would be a violation of law, regardless of whether the plan actually took any action against non-complying providers. The substitute keeps the focus on whether the health plan is trying to place a prohibition or restriction on medical communications, not how the plan attempts to enforce those restrictions.

4. The substitute limited the civil money penalties that can be levied against health plans found in violation of the plan. The substitute retained the fine of up to $25,000 per violation but deleted a provision to create a $100,000 fine for repeated violations. Both the base text and the substitute declare restrictions on medical communications to be "null and void."

5. The substitute includes a provision that makes clear that providers may not use the protections in this bill solely for the purpose of steering patients into a competing health plan which pays them better. During the Subcommittee hearing, some witnesses expressed the concern that health care providers will use this legislation as a shield to encourage patients to join health plans which provide them a higher reimbursement. To prevent this, the substitute allows health plans to restrict a medical communication that "recommends one health plan over another plan if the sole purpose of the communication is to secure financial gain for the health care provider."

6. The substitute moves the bill's effective date back from 30 days to 90 days after enactment. This was done in response to concerns that 30 days was not enough time for health plans to amend hundreds of contracts and policy bulletins.

The amended effective date provision also makes clear that the enforcement provisions do not apply to medical communications made before that date. The base text could have been interpreted to create liability for restrictions on medical communications made before the date of enactment. The substitute clarifies this point.

7. We recognize that restrictions on medical communications could take several forms. While public attention has focussed on "gag rules" in plan contracts, restrictions also appear in health

plan policy bulletins and letters and have been orally conveyed to providers.

We are concerned that the standard of proof be high enough to ensure that health plans are not subjected to numerous claims of oral gags that degenerate into "he said-she said" arguments. The standard of proof for oral communications should be high enough to provide health plans with some degree of assurance that they will not be found to have violated the bill every time a provider makes an unsupported claim without any support or corroboration.

To address this issue, the substitute requires that allegations of a single instance of an oral restriction on communications be proved by a "preponderance of the evidence." This is a higher standard than the "substantial evidence" test and is designed to permit the Secretary of Health and Human Services to more easily weed out baseless allegations.

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ADDITIONAL VIEWS OF THE HONORABLE CHARLIE NORWOOD

As a cosponsor of H.R. 2976, the "Patient Right to Know Act," I want to applaud Messrs. Ganske and Markey for their work on ensuring that health plan enrollees are protected in this age of managed care.

As a former health care provider, I had an interest in doing what was best for the patients with whose health I was entrusted. I believe all health providers have that interest and that mandate. That mandate includes guaranteeing that their patients have access to all relevant information they need to make informed medical decisions. That includes information regarding treatment options and diagnoses and whether or not they have access to that treatment. Patients also have a right to know whether a provider has a financial incentive to limit or deny care to their patients. No health provider who has taken an oath to protect those they serve should be prevented from giving their patients the most information available about their medical condition or treatment options. To that extent, I am pleased that the House Commerce Committee passed H.R. 2976.

At the same time, there are other, equally severe problems that patients must confront when dealing with managed care organizations. Part of what makes managed care so effective is their use of contractual provisions to limit utilization of health care. In the case of overutilization of unnecessary health services, utilization reviews can be good. However, when someone needs emergency health care or care from a specialist, utilization reviews can be counterproductive. Even more, it endangers those who rely on complete and adequate health care from their plans.

It is my strong belief that Congress has an obligation to ensure that those who rely on their health plans for needed and adequate care should be protected from those companies with a profit motive to limit access to needed health care treatments. Controlling health care costs is necessary—controlling or otherwise limiting needed care in unacceptable. That is why I have introduced H.R. 2400, the Family Health Care Fairness Act, to ensure that patients are guaranteed adequate health care from their health plans.

Many states, including my own, have passed legislation to ensure that the health and well being of patients in managed care plans are protected. If this problem did not exist, we would not see the proliferation of these and other measures at the state and Federal level. Even more, the Commerce Health and Environment Subcommittee would not have heard testimony regarding the devastation that "gag rules" have wreaked on families. Given that, I fully support measures insuring that patients have access to the information they need to make informed decisions. H.R. 2976 and H.R. 2400 move to that end.

CHARLIE NORWOOD.

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