United States
Office of Personnel Management
Retirement and Insurance Service

Benefits Administration Letter

Number: 98-203 Date: June 2,1998

Subject: Implementing the Consumer Bill of Rights and Responsibilities (Patient's Bill of Rights) in The Federal Employee Health Benefit Program

What is The Patient's Bill of Rights?

On March 26, 1997, President Clinton appointed the Advisory Commission on Consumer Protection and Quality in the Health Care Industry (Quality Commission) to recommend measures necessary to promote and assure health care quality and value and protect consumers. As part of its work, the President asked the Quality Commission to draft a "Consumer Bill of Rights."

The Quality Commission presented the President with the Consumer Bill of Rights and Responsibilities (the Patient's Bill of Rights) in November of 1997. The President immediately directed all Federal agencies with authority over health care programs to:

- determine the extent of each agency's current compliance
- use the agencies' administrative authorities to initiate appropriate actions consistent with the recommendations contained in the November report, and
- identify any statutory impediments to compliance with the recommendations of the Quality Commission

This BAL provides you a copy of our letter to the President and Vice President communicating the results of our analysis. Our assessment of the FEHB Program's compliance with the Patient's Bill of Rights concluded that the Program is in substantial compliance with its eight broad principles. We do not believe there are any legislative impediments to full implementation.

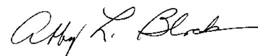
On February 20, 1998, the President signed an Executive Memorandum directing the Office of Personnel Management to take the necessary steps to bring the FEHB Program into full compliance with the Patient's Bill of Rights by the end of the year 1999.

How Will We Begin Implementing The Patient's Bill of Rights?

We will communicate our expectations to the carriers and develop a collaborative process for achieving the desired goals within the President's timeframe. We also will publish a regulation prohibiting so-called "gag clauses" that prevent full disclosure of treatment options in any contract between an FEHB carrier and its participating providers who serve patients covered under the FEHB Program.

We anticipate that certain requirements will be met at the beginning of the 1999 contract term for FEHB plans. For example, we will ensure that all participating carriers use the "prudent layperson" criterion for determining coverage for emergency care. Most of our plans already do. We also will ask carriers to give our enrollees direct access to women's health care providers for at least one routine visit a year, and to reduce the burden of getting referrals to a specialist when a patient has a condition for which multiple visits would be appropriate. During the year, we expect that carriers will be able to meet many of the informational requirements through cooperative industry efforts, and we will ask that information be shared with the public at the earliest time feasible. Finally, by the end of the year, we expect carriers to have made any needed modifications to their provider contracts, including those required by our "gag clause" regulation, so that we can be in full compliance in contract year 2000.

To begin the process of educating Federal enrollees, we will feature information about the Patient's Bill of Rights on our web site at http://www.opm.gov/insure, with a link to the full text and background information. This will quickly communicate the provisions of the Bill to FEHB participants so that they become aware of their responsibilities and know what information they can expect to receive in the future. Please let your employees know that this information is available.



Abby L. Block, Chief
Insurance Policy
and Information Division

Attachments: Letter to President and Vice President
Analysis and Implementation Action Plan for the Patient's Bill of Rights

ATTACHMENT

United States
Office of Personnel Management
Washington, DC 20415-0001

OFFICE OF THE DIRECTOR

February 19, 1998

The President
The White House
Washington, DC 20500

The Vice President
The White House
Washington, DC 20500

Dear Mr. President and Mr. Vice President:

When you endorsed the Health Care Consumer Bill of Rights and Responsibilities, you instructed the Office of Personnel Management (OPM), together with four other agencies, to report on their current and future compliance with its provisions. OPM's report accompanies this letter.

As you know, OPM administers the largest employer-sponsored health benefits program in the nation, the Federal Employees Health Benefits (FEHB) Program. Given a total membership of 9 million Americans and with 350 participating health benefits carriers, the FEHB Program is well positioned to influence the health care marketplace for the benefit of all consumers.

We are pleased to point out that the accompanying report reveals that the FEHB Program is currently in substantial compliance with the rights enumerated for health care consumers and that complete compliance is within reach with no legislative impediments. The Program is frequently cited as a model in which managed competition has produced both quality and cost effective health benefits. Unparalleled consumer choice is a hallmark of this Program, which rests on comprehensive consumer information and equitable treatment across participating plans. The Program has incorporated an independent third party review of grievances and appeals for over 20 years. All of these features are fundamental to the rights you have endorsed for all consumers.

In order to achieve full compliance with the Health Care Consumer Bill of Rights and

Responsibilities, several actions are needed. First, we should communicate our expectations that FEHB carriers will work with us to become fully compliant with the consumer rights. Second, regulations will be necessary in order to prohibit "gag orders" and similar mechanisms from inhibiting a provider's ability to advise patients. Third, OPM should undertake a communications campaign to assure that FEHB enrollees become aware of their rights and responsibilities, and what they can expect from OPM and their FEHB carriers in the future. Finally, the FEHB Program could be strengthened by adopting a more broadly accepted survey instrument–the Consumer Assessment of Health Plans Survey. Use of this survey can give Federal participants a better set of comparative data about health plan performance.

We look forward to completing the implementation of the Health Care Consumer Bill of Rights throughout the FEHB Program and hope that our leadership serves all our nation's health care consumers.

Sincerely,

Janice R. Lachance
Director

Enclosure

ATTACHMENT

Implementing the Health Care Consumer Bill of Rights and Responsibilities in the Federal Employees Health Benefits Program

Executive Summary

Introduction

The Federal Employees Health Benefits (FEHB) Program is, by far, the largest employer sponsored health benefits program in the United States with 4.1 million enrollees and 9 million covered lives. The FEHB Program encompasses 350 carriers and is cited as a model health care program where managed competition has produced cost effective results. Consumer choice is the hallmark of the Program. The typical FEHB enrollee has a dozen plans from which to choose including Managed Fee-for-Service Plans, Preferred Provider Organizations (PPO), Point of Service (POS) products, and Health Maintenance Organizations (HMO).

The FEHB Program is currently in substantial compliance with the eight broad principles of the Consumer Bill of Rights. Comprehensive consumer information and equitable treatment across participating plans are fundamental to the Program's hallmark, consumer choice. Current adherence to the Consumer Bill of Rights is a matter of consistency and degree, with all, or a majority of plans meeting some provisions.

The Office of Personnel Management (OPM) will communicate its policy and benefit expectations for the 1999 contract year in a letter sent to carriers in March. This letter will include our expectation that carriers work with OPM to achieve contractual compliance with the Consumer Bill of Rights by the end of 1999, with full implementation projected for the year 2000. The letter will ask carriers to assess their current compliance with the Consumer Bill of Rights and how they propose to achieve full compliance within our required time frames. Actions required on the part of carriers will vary, as will the time frames necessary to achieve full compliance. For example, some carriers already have much of the required information about plan characteristics and performance while others will need to collect and summarize information. OPM will facilitate and encourage the process by providing leadership, identifying and publicizing best practices, and developing frameworks and standards.

To kick the process off, OPM will feature information about the Consumer Bill of Rights on our Web page with a link to its full text and background information. This will quickly communicate the Consumer Bill of Rights to FEHB participants so that they become aware of their responsibilities and the information they can expect in the future. Literature provided to consumers in the 1999 and 2000 contract years will clearly delineate what consumers can expect from individual plans.

I. Information Disclosure

Consumers have the right to receive accurate, easily understood information and some require assistance in making informed health care decisions about their health plans, professionals and facilities.

OPM and its carriers currently publish health benefit brochures, provider directories, and comparison charts in multi-media formats that contain information on available plan types, benefits, limitations, maximums, exclusions, referral procedures, provider types and geographic location, quality assurance indicators, customer satisfaction survey results, and internal and external dispute resolution procedures.

Other information required by the Consumer Bill of Rights will be relatively easy to collect from health plans and providers such as license, certification, disenrollment rates, accreditation status, corporate form, years in existence, and compliance with state and federal requirements. Aggregate provider (physician and facility) network information will be more difficult for PPO plans to develop than for HMO and POS plans due to the size of their networks, limited contractual control of providers, and the fact that this level of network detail has not previously been required.

The technical information contained in the Consumer Bill of Rights will require development, compilation and refinement into consumer friendly formats. This information includes formulary development and experimental/investigational determination procedures, potential conflicts of interest, provider experience with and volume of procedures, provider compliant procedures, care management protocols, provider service and clinical quality indicators, and provider and health plan compensation arrangements.

OPM's letter to carriers in March will set forth our expectation that carriers begin collecting and summarizing information not yet available, and propose formats for presentation of currently available information to consumers in 1999.

II. Choice of Providers and Plans

Consumers have the right to a choice of health care providers that is sufficient to ensure access to appropriate high-quality health care.

OPM currently offers consumers a wide choice of health care deliver systems that can provide coverage for, and access to, any licensed or certified provider. OPM's 350 carriers provide a choice of approximately one dozen health plans in any one geographic location. Continuity of coverage is assured through temporary continuation of coverage and conversion opportunities when enrollments terminate, and hospitalized members have up to 92 days, or until discharge, to continue coverage under their current plan or option in the event of a change in plan or option. Network adequacy is assured during the FEHB Program carrier application process.

OPM will work with carriers to assure that there is reasonable access to specialty care, for the purpose of care continuity, where it makes sense taking into consideration clinical efficacy, plan design characteristics, and cost. OPM will establish guidelines to create consistency within the program in its letter to carriers in March.

III. Access to Emergency Services

Consumers have the right to access emergency health care services when and where the need arises. Health plans should provide payment when a consumer presents to an emergency department with acute symptoms of sufficient severity—including severe pain—such that a "prudent layperson" could reasonably expect the absence of medical attention to result in placing that consumer's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

All health plans under the FEHB Program cover members for emergency services whenever and wherever needed. The Emergency Benefits section of plan brochures explains procedures for accessing services, the availability of urgent care centers, and lists applicable cost sharing.

Our March letter will provide direction to carriers to utilize the "prudent layperson" standard when reviewing emergency care visits for coverage eligibility. We will also express our expectation that carriers fully educate consumers regarding the availability, location, and use of emergency care facilities, as well as our expectation that contracting emergency room personnel contact health plans as quickly as possible in order to coordinate follow-up-care.

IV. Participation in Treatment Decisions

Consumers have the right and responsibility to fully participate in all decisions related to their health care. Consumers who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members, or other conservators.

OPM encourages consumers to take an active role in the decisions that affect their health and welfare. To aid in the decision making process, OPM provides multi-media detailed information on individual plan provisions, customer satisfaction, NCQA accreditation, benefit and rate comparisons, and resolves claims disputes between carriers and consumers.

OPM's March letter will communicate to carriers our expectation that contracting providers fully discuss treatment options, consequences of non-treatment, ensure adequate communication with disabled and non-English speaking persons, discuss advanced directives, and abide by patients or designated representatives decisions consistent with the informed consent process. We also will inform carriers that we will eliminate "gag" clauses under the FEHB Program by working with them to publish an FEHB Regulation effectuating this change.

V. Respect and Nondiscrimination

- **Consumers have the right to considerate, respectful care from all members of the health care system at all times and under all circumstances. An environment of mutual respect is essential to maintain a quality health care system.**
- **Consumers must not be discriminated against in the delivery of health care services consistent with the benefits covered in their policy or as required by law based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.**
- **Consumers who are eligible for coverage under the terms and conditions of a health plan or program or as required by law must not be discriminated against in marketing and enrollment practices based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.**

The FEHB Program has a longstanding tradition of respect for its customers and prohibits discriminatory practices through a variety of legal provisions throughout its authorizing legislation.

Our March letter will require carriers and contracting providers to assure that FEHB

participants:

- receive respectful treatment
- have access to copies of laws prohibiting disrespectful or discriminatory treatment when requested
- are assured appropriate time during visits to address concerns
- are provided with timely notice of changes in billing practices
- are helped to overcome cultural, physical, or language barriers
- are not unnecessarily delayed and apologized to when delays are unavoidable

VI. Confidentiality of Health Information

Consumers have the right to communicate with health care providers in confidence and to have the confidentiality of their individually identifiable health care information protected. Consumers also have the right to review and copy their own medical records and request amendments to their records.

FEHB Program benefit brochures currently guarantee confidentiality of health care information for Federal members.

OPM's March letter will not address the confidentially issue since the FEHB Program is currently fully in compliance.

VII. Complaints and Appeals

All consumers have the right to a fair and efficient process for resolving differences with their health plans, health care providers, and the institutions that serve them, including a rigorous system of internal review and an independent system of external review.

In accordance with longstanding legislation, all health plans in the FEHB Program have internal appeal processes and OPM provides the extra protection of an external appeal process. OPM's external appeal process begins after a consumer requests their carrier to reconsider a benefit denial and the carrier affirms the denial. Consumers than have up to 90 days to appeal the denial to OPM from he date the carrier affirmed its original denial or 30 days after the consumer requested the carrier to reconsider a denial, and the carrier has not responded. By virtue of OPM's contract with carriers as well as FEHB law, OPM has final decision making authority to settle an appeal.

OPM's March letter will request that carriers review their internal procedures to assure

that they are in compliance with the detailed requirements of the Consumer Bill of Rights.

VIII. Consumer Responsibilities

In a health care system that protects consumers' rights, it is reasonable to expect and encourage consumers to assume reasonable responsibilities. Greater individual involvement by consumers in their care increases the likelihood of achieving the best outcomes and helps support a quality improvement, cost-conscious environment.

In the FEHB Program, our benefit brochures emphasize the member's responsibility to be informed about health benefits and indicate where information can be accessed regarding enrollment procedures, eligibility, and benefits.

OPM will immediately initiate the necessary communication plan to assure that consumers are advised of their responsibilities. We have a number of communication vehicles available such as plan brochures, comparison charts and an Internet Website.

Implementation Action Plan

I. Information Disclosure

Consumers have the right to receive accurate, easily understood information and some require assistance in making informed health care decisions about their health plans, professionals and facilities.

OPM currently publishes health benefit brochures that contain information on benefits, limitations, exclusions, referral procedures, and dispute resolution procedures. Our Guide to Employee Health Benefit Plans contains information on available plan types, quality assurance indicators, and customer satisfaction survey results. Plan provider directories contain information on various provider types and geographic location. Most of this information is presented in multi-media formats, which include Internet access.

The Bill indicates that Consumer Assistance Programs should be created to inspire consumer confidence, provide a safety valve, and foster collaboration between the different players of the health care system. OPM serves this function for Federal employees.

Information Disclosure	*Implementation Strategy*
Benefits, Cost Sharing, and Dispute Resolution (Prior to Enrollment)	
Benefits, premiums, dispute resolution, and general limits on coverage e.g., lifetime or annual max, cost sharing, exclusions, or preventive care.	Currently in compliance. Plan brochures and Web site contain the required information.
Formulary drug inclusion and exception process. Experimental/investagational determination process.	Call Letter will require that necessary information is in plan brochures.
Health Plan Characteristics and Performance Information (Prior to Enrollment)	
License, certification, disenrollment rates and accreditation status.	OPM currently requires most of this information in the carrier application process. We will work with carriers to make it available to consumers in 1999.
Service, clinical quality, and customer satisfaction performance measures.	Customer satisfaction data currently in place Service measures will be perfected in 1999 for implementation in year 2000 OPM is actively encouraging testing of clinical quality measures and will implement as they become available and are validated

Information Disclosure **Health Plan Characteristics and Performance Information (Upon Request)**	*Implementation Strategy*
• Number of years existence and corporate form. • Meets State, Federal, and accreditation requirements for fiscal solvency, confidentiality, and transfer of medical records.	OPM currently requires most of this information in the carrier application process. We will work with carriers to make it available to consumers in 1999.
Network Characteristics	
• Aggregate information on the numbers, types, board certification status, and geographic distribution of primary care providers and specialists. • Names, board certification status, and geographic location of PCPs; whether accepting new patients; language(s) spoken, availability of interpreter, and whether facilities are accessible to disabled people. • Provider compensation methods and additional financial incentives (bonus, withhold ect).	• OPM currently requires most of this information in the carrier application process for HMO and POS plans. We will work with carriers to make it available to consumers. PPOs will need more time to compile and disseminating this type of information. Work with the carriers to achieve compliance will begin immediately • Directories for HMO and POS products already communicate provider geographic distribution, specialty, and panel availability.
• Rules regarding coverage of out-of-network services, and applicable rates of cost sharing. • Information about circumstances under which primary care referral is required to access specialty care. • Information about what options exist for 24-hour coverage and whether enrollees have access to urgent care centers.	Currently in compliance. Plan brochures and Web site currently communicate this information.
Network Characteristics (Upon Request)	
• Names, board certification status, and geographic location of specialists and specialty care centers; whether accepting new patients; language(s) spoken, availability of interpreter; and whether facilities are accessible to disabled people. • Names, accreditation status, and geographic location of hospitals, home health agencies, rehabilitation and long-term care facilities; whether accepting new patients; language(s) spoken, availability of interpreter services; and whether accessible to disabled people.	OPM currently requires most of this information in the carrier application process for HMO and POS plans. We will work with carriers to make it available to consumers in 1999. PPOs will need more time to compile and disseminate this type of information. Action will be initiated immediately to achieve compliance in 2000.

Information Disclosure	*Implementation Strategy*
Care Management Information (Upon Request)	
• Preauthorization and utilization review procedures followed. • Use of clinical protocols, practice guidelines, and utilization review standards pertinent to patient's clinical circumstances. • Whether plan has special disease management programs or programs for persons with disabilities. • Whether a specific prescription drug is included in a formulary and procedures for considering requests for patient-specific waivers. • Qualifications of reviewers at the primary and appeals levels.	Call Letter will initiate process of compiling and summarizing technical information in consumer friendly formats and making it available to enrollees.
Health Professional Information	
• Whether ownership or affiliation arrangement with provider group or institution would make it likely that a consumer would be referred to particular specialists or facility or receive service. • How the provider is compensated, including base payment method and additional financial incentives.	OPM currently requires most of this information in the carrier application process for HMO and POS products. We will work with carriers to make it available to consumers.
Health Professional Information (Upon Request)	
• Education, board certification, and recertification status. • Names of hospitals where physicians have admitting privileges. • Years of practice as a physician or specialist. • Accreditation status. • Corporate form of the practice. • Availability of translation or interpretation services for non-English speakers and people with communication disabilities. • Cancellation, suspension, sanctions or exclusion from participation in Federal programs. • Suspension or revocation of medical licensure, Federal controlled substance license, or hospital privileges.	For information already available through the POS and HMO application process, OPM will work with carriers to compile, summarize, and disseminate it in 1999. We will require carriers to collect the remaining information and make it available in 2000.
• Experience with performing certain medical or surgical procedures (e.g., volume of care/services delivered), adjusted for case mix and severity. • Consumer satisfaction, clinical quality and service performance measures.	OPM will encourage carriers to make this provider level information available to consumers when comparative criteria are defined and data collection becomes feasible.

Information Disclosure **Health Care Facility Information**	***Implementation Strategy***
• Corporate form of the facility. • Accreditation status. • Whether specialty programs meet guidelines established by specialty societies or other bodies. • Complaint procedures. • Availability of translation or interpretation services for non-English speakers and people with communication disabilities. • Whether facility has been excluded from any Federal health programs (i.e., Medicare or Medicaid). • Volume of certain procedures performed at facility. • Consumer satisfaction, clinical quality and service performance measures. • Numbers and credentials of providers of direct patient care (e.g., registered nurses, other licensed providers) • Whether the facility's affiliation with a provider network would make it more likely that consumer would be referred to health professionals or other organizations in network.	Call Letter will initiate action by carriers to identify data currently available and data not historically required of facilities. Available data will be formatted for consumers in 1999. Carriers will be required to begin collection of data not currently available, with 2000 target compliance projected .
Consumer Assistance Program	
OPM serves this function.	Currently in compliance.

II. Choice of Providers and Plans

Consumers have the right to a choice of health care providers that is sufficient to ensure access to appropriate high-quality health care.

OPM currently offers a choice of Managed Fee-for-Service, PPO, HMO, and POS delivery systems that can provide coverage for, and access to, any licensed or certified provider across the nation to over 9 million people. OPM contracts with over 350 health plans and the FEHB Program offers a choice of approximately one dozen health plans in any one geographic location.

The FEHB Program provides continuity through temporary continuation of coverage and conversion opportunities when enrollments terminate. In addition, hospitalized members have up to 92 days, or until discharge, to continue coverage under their current plan or option in the event of a change in plan or option.

Carriers' networks are reviewed for adequacy when they apply to participate in the FEHB Program.

Choice of Providers and Plans	*Implementation Strategy*
• Offer consumers a choice of high-quality health insurance products. • All health plan networks should provide access to sufficient numbers and types of providers to assure covered services will be accessible without unreasonable delay—including access to emergency services 24 hours a day and seven days a week. • Plans also should establish and maintain adequate arrangements to ensure reasonable proximity of providers to the business or personal residence of their members.	Currently in compliance. These are minimum requirements of the FEHB Program that are verified in the carrier application process.
• Women should have access to plan gynecologists, certified nurse midwives, and other qualified providers for routine and preventative women's health care services. • If health plan has insufficient number or type of providers to provide covered benefits with the appropriate degree of specialization, plan should ensure consumer obtains benefit outside network at no greater cost than if obtained from in-network providers. • Authorizations when required should be for an adequate number of direct access visits under approved treatment plan.	OPM will work with carriers to assure reasonable access to specialty care. We will establish guidelines in the Call Letter to create consistency within the Program.
• Consumers with complex or serious medical conditions who require frequent specialty care should have direct access to qualified specialist of choice within plan's network of providers.	OPM will work with carriers to assure that there is reasonable access to specialty care, for the purpose of care continuity, where it makes sense taking into consideration clinical efficacy, plan design characteristics, and cost.
• Consumers, undergoing treatment for chronic or disabling conditions (or in second or third trimester of pregnancy) at time they involuntarily change health plans or at time when provider is terminated by plan for other than cause, should continue seeing specialty providers for up to 90 days (or through completion of postpartum care) to allow transition of care. During transition period, patients will continue to have information and medical records available and will not incur greater costs for services.	OPM will work with carriers to achieve full compliance in the year 2000.

III. Access to Emergency Services

Consumers have the right to access emergency health care services when and where the need arises. Health plans should provide payment when a consumer presents to an emergency department with acute symptoms of sufficient severity—including severe pain—such that a "prudent layperson" could reasonably expect the absence of medical attention to result in placing that consumer's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

All health plans under the FEHB Program cover members for emergency services whenever, and wherever, they are needed. The Emergency Benefits section of plan brochures explains procedures for accessing services, the availability of urgent care centers, and lists applicable cost sharing.

Access To Emergency Services	***Implementation Strategy***
• Plans should educate members about availability, location, and appropriate use of emergency and other medical services; cost sharing for emergency services; and availability of care outside emergency department. • Plans using defined networks should cover emergency department screening and stabilization services both in-network and out-of-network without prior authorization consistent with the "prudent layperson" standard. Patients should not be charged in excess of plan's routine payment arrangements. • Emergency department personnel should contact patient's primary care provider or plan, as appropriate, as quickly as possible to discuss follow-up and post-stabilization care and promote continuity of care.	OPM is in substantial compliance. However, to ensure consistency through out the program we will direct carriers to use the "prudent layperson" standard when reviewing emergency care visits for coverage eligibility and reflect the benefit in the 1999 brochures.

IV. Participation in Treatment Decisions

Consumers have the right and responsibility to fully participate in all decisions related to their health care. Consumers who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members, or other conservators.

OPM encourages members to take an active roll in the decisions that affect their health and well-being. To aid in the decision making process, OPM provides multi-media detailed information on individual plan provisions, customer satisfaction, NCQA accreditation, and benefit and rate comparison charts, and resolves claims disputes between carriers and members.

Participation In Treatment Decisions	*Implementation Strategy*

Health care professionals should:
• Provide patients with easily understood information and opportunity to decide among treatment options consistent with informed consent process. Specifically:
    • Discuss all treatment options with patient in culturally competent manner, including option of no treatment
    • Ensure persons with disabilities and non-English speaking persons have effective communications with members of health system in making decisions
    • Discuss current treatments, including self-administered alternative treatments
• Discuss risks, benefits, and consequences to treatment or non-treatment.
• Give patients opportunity to refuse treatment and to express preferences about future treatment.
• Discuss use of advance directives—both living wills and durable powers of attorney for health care.
• Abide by decisions made by patients and/or designated representatives consistent with informed consent process.
	We believe that FEHB plan participating providers are in substantial compliance. We will work with carriers to standardize practices throughout the Program by 2000.

Health plans should: • Disclose to consumers methods of compensation, ownership of or interest in health care facilities, or matters of conscience that could influence advice or treatment decisions.	Call Letter will require carriers to develop ways to make this information available to consumers.
Health plans should: • Ensure that provider contracts do not contain any "gag clauses" or other contractual mechanisms that restrict providers' ability to communicate with and advise patients about medically necessary treatment options. • Be prohibited from penalizing or seeking retribution against health care professionals or workers for advocating on behalf of patients.	Most carriers already comply. OPM will publish a Notice of Proposed Rule Making prohibiting carriers from having “gag clauses” in their contracts with providers serving FEHB enrollees. The NPRM will invite comments from the carriers and the public on how best to effectuate any necessary changes.

V. Respect and Nondiscrimination

- **Consumers have the right to considerate, respectful care from all members of the health care system at all times and under all circumstances. An environment of mutual respect is essential to maintain a quality health care system.**
- **Consumers must not be discriminated against in the delivery of health care services consistent with the benefits covered in their policy or as required by law based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.**
- **Consumers who are eligible for coverage under the terms and conditions of a health plan or program or as required by law must not be discriminated against in marketing and enrollment practices based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.**

The FEHB Program has a longstanding tradition of respect for its customers and prohibits discriminatory practices through a variety of legal provisions throughout its authorizing legislation.

Respect and Nondiscrimination	*Implementation Strategy*
Consumers should be assured: • Considerate, respectful care from the health care system at all times and under all circumstances. • Delivery of health care services consistent with benefits policy or as required by law regardless of race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment. • Nondiscriminatory plan marketing and enrollment practices based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.	Currently in compliance with Federal law.
Members of the health care industry should strive to: • Provide consumers with assurances that disrespect or discrimination is intolerable. • Provide consumers with information regarding existing laws prohibiting disrespectful or discriminatory treatment. • Provide consumers with an appropriate amount of time to fully discuss their concerns and questions. • Provide consumers with reasonable assistance to overcome language (including limited English proficiency), cultural, physical or communication barriers. • Provide consumers with timely notice and explanation of changes in fees or billing practices. • Avoid lengthy delays in seeing a patient; when delays occur, explain why they occurred and, if appropriate, apologize for such delays.	We believe that FEHB participating plans and providers are in substantial compliance. We will work with carriers to achieve program wide compliance by 2000.

VI. Confidentiality of Health Information

Consumers have the right to communicate with health care providers in confidence and to have the confidentiality of their individually identifiable health care information protected. Consumers also have the right to review and copy their own medical records and request amendments to their records.

FEHB Program benefit brochures currently guarantee confidentiality of health care information for Federal members.

Confidentiality of Health Information	***Implementation Strategy***

• Consumers have right to communicate with providers in confidence and to have confidentiality of individually identifiable information protected.
• Consumers also have right to review and copy own medical records and request amendments.
• Disclosure of individually identifiable health care information without written consent should be permitted for:
    • Provision of healthcare
    • Payment for services
    • Peer review
    • Health promotion
    • Disease management
    • Quality assurance
or only when there is a clear legal basis for doing so, such as:
    • Medical or health care research for which an institutional review board has determined anonymous records will not suffice
    • Investigation of health care fraud
    • Public health reporting
• Non-identifiable health care information should be used unless the individual has consented to disclosure of individually identifiable information.
• When disclosure required, no greater information should be disclosed than necessary to achieve specific purpose of disclosure.
	Currently in compliance. The confidentially provisions contained in our plan brochures and on our Web site are even more stringent then the Bill requires.

VII. *Complaints and Appeals*

All consumers have the right to a fair and efficient process for resolving differences with their health plans, health care providers, and the institutions that serve them, including a rigorous system of internal review and an independent system of external review.

All health plans in the FEHB Program have internal appeal processes and OPM provides the extra protection of an external appeal process.

Complaints and Appeals	*Implementation Strategy*

Internal appeals systems should include:
• Timely written notification of decision to deny, reduce, terminate services or deny payment for services. Notification include explanation for decisions and procedures for appeal.
• Resolve appeals in timely manner with expedited consideration for emergency or urgent care decisions consistent with time frames required by Medicare (i.e., 72 hours).
• Claim review process by health care professionals credentialed with respect to treatment involved.
• Reviews conducted by individuals not involved in initial decision.
• Written notification of final determination by plan that includes:
    • Reason for determination and how to appeal decision to external entity
    • Reasonable processes for resolving consumer complaints about issues e.g., waiting times, operating hours, demeanor of health care personnel, and adequacy of facilities
	Substantially in compliance. OPM currently requires carriers to maintain an appeal process. Call Letter will require that carriers review their internal procedures to assure full compliance by all plans in 1999.

External appeals systems should:
• Be available only after consumers have exhausted internal processes (except in cases of urgently needed care).
• Apply to any decision by health plan to deny, reduce, or terminate coverage or deny payment for services based on determination that treatment is
    • Experimental or investigational in nature
    • Not medically necessary and amount exceeds threshold
    • Patient's life or health is jeopardized
• Be conducted by health care professionals who are appropriately credentialed with respect to treatment involved and subject to conflict-of-interest prohibitions.
• Be conducted by individuals who were not involved in initial decision.
• Follow standard of review that promotes evidence-based decision making and relies on objective evidence.
• Resolve appeals in timely manner with expedited consideration for decisions involving emergency or urgent care consistent with time frames required by Medicare (i.e., 72 hours).
	Currently in compliance. Our third party appeal process is in place and available to consumers through our brochures and Web site. OPM's external appeal process begins after a consumer requests their carrier to reconsider a benefit denial and the carrier affirms the denial. Consumers than have up to 90 days to appeal the denial to OPM from he date the carrier affirmed its original denial or 30 days after the consumer requested the carrier to reconsider a denial, and the carrier has not responded. By virtue of OPM's contract with carriers as well as FEHB law, OPM has final decision making authority to settle an appeal.

VIII. Consumer Responsibilities

In a health care system that protects consumers' rights, it is reasonable to expect and encourage consumers to assume reasonable responsibilities. Greater individual involvement by consumers in their care increases the likelihood of achieving the best outcomes and helps support a quality improvement, cost-conscious environment.

In the FEHB Program, our benefit brochures emphasize the member's responsibility to be informed about health benefits and indicate where information can be accessed regarding enrollment procedures, eligibility, and benefits.

Consumer Responsibilities	***Implementation Strategy***
Greater individual involvement by consumers in care increases likelihood of achieving best outcomes and helps support a quality improvement, cost-conscious environment. Therefore members should be informed of their responsibility to: • Maximize healthy habits e.g., exercising, not smoking, and eating healthy diet. • Become involved in care decisions. • Work collaboratively with providers in developing and carrying out agreed-upon treatment plans. • Disclose relevant information and clearly communicate wants and needs. • Use health plan's internal complaint and appeal processes to address concerns that may arise. • Avoid knowingly spreading disease. • Recognize reality of risks and limits of the science of medical care and human fallibility of health care professionals. • Be aware of health care provider's obligation to be efficient and equitable in providing care to others • Become knowledgeable about coverage and health plan options (when available) including covered benefits, limitations, and exclusions, rules regarding use of network providers, coverage and referral rules, appropriate processes to secure additional information, and process to appeal coverage decisions. • Show respect for other patients and health workers. • Make a good-faith effort to meet financial obligations. • Abide by administrative and operational procedures of health plans, providers, and Government health programs. • Report wrongdoing and fraud to appropriate resources or legal authorities.	OPM will initiate the necessary communication plan to assure that consumers are advised of their responsibilities. We will use communication vehicles such as plan brochures and enrollment guides and our Web page.

Consumer Responsibilities	***Implementation Strategy***
Consumers should educate themselves with respect to specifics of benefit coverage and to learn how to access health care and services by: • Reading and understanding written information that explains benefit coverage, health plan processes, and procedures to follow when seeking care from physician, hospital, or other providers. • Seeking information or clarification of information from health plan as necessary. • Using health plan's processes for addressing complaints or grievances when disputes with providers or health plan procedures arise.	OPM will use communication vehicles such as plan brochures and enrollment guides and provide extensive information on our Web page.