Patients’ Bill of Rights

What is the Patients' Bill of Rights?

In March of 1997, President Clinton appointed the Advisory Commission on Consumer Protection and Quality in the Health Care Industry (Commission) to advise him on changes occurring in the health care system. He asked the Commission to recommend measures necessary to promote and assure health care quality and value, and protect consumers and workers in the health care system.

The Commission was comprised of 34 members, selected from the private sector. Members included representatives of consumers, institutional health care providers, health care professionals, other health care workers, health care insurers, health care purchasers, State and local government representatives, and experts in health care quality, financing, and administration.

The President asked the Commission to develop a "Consumer Bill of Rights" in health care and to provide him with recommendations to enforce those rights at the Federal, State, and local level. The Commission gave the President a report entitled the Consumer Bill of Rights (Patients' Bill of Rights) in November of 1997.

The President then asked the Office of Personnel Management (OPM), the Department of Labor, the Department of Health and Human Services, the Department of Veterans Affairs, and the Department of Defense to assess the level to which their health care programs were in compliance with the Patients' Bill of Rights (PBR). After this compliance assessment, the President directed these agencies by Executive Memorandum to adopt any measures necessary to come into full compliance with the PBR. This Executive Memorandum required the FEHB Program to be in full contractual compliance with the PBR by the end of 1999. OPM worked with health carriers throughout 1998 and 1999 to fully implement the PBR. The FEHB Program is now in full compliance with the President's Patients' Bill of Rights.

Objectives of the Patients' Bill of Rights and Responsibilities

The Patients' Bill of Rights and Responsibilities has three major objectives:

First, to strengthen consumer confidence by assuring the health care system is fair and responsive to consumers' needs, provides consumers with credible and effective mechanisms to address their concerns, and encourages consumers to take an active role in improving and assuring their health.

Second, to reaffirm the importance of a strong relationship between patients and their health care professionals.

Third, to reaffirm the critical role consumers play in safeguarding their own health by establishing both rights and responsibilities for all participants in improving health status.

Eight Principle Areas of Rights and Responsibilities

I. Information Disclosure

Patients have the right to receive accurate, easily understood information to help them make informed decisions about their health plans, professionals and facilities. The FEHB Program provides extensive information about benefits, customer satisfaction, delivery systems, health plan operating procedures and review rights through enrollment guides, plan brochures, and on the OPM website. Your FEHB plans make even more information available to you through their websites, provider directories, telephone numbers, or information sheets. Your plan may also refer you to plan providers or facilities for some information. However, if you are unable to get the information, the plan will assist you.

So that you can make informed health care decisions, your plan will make available to you, or aid you in obtaining, the following information:

About the Plan and Care Management:

- Accreditation status
- Compliance with State or Federal licensing, certification, or fiscal solvency requirements, if applicable, including the date the requirements were met.
- Disenrollment rate (FEHB Open Season losses / Dec 31 enrollment = %)
- Years in existence (corporate)
- Corporate form (profit/non-profit, private/public)
- Compliance with standards (State, Federal, and private accreditation) that assure confidentiality of medical records and orderly transfer to caregivers
- Methods of compensation, ownership or interest in health care facilities.
- Disclosure of the credentials of the person, or persons, involved in reviewing the patient's appeal.
- Experimental/investigational determination process
- Customer satisfaction measures
- Preauthorization and utilization review procedures used to approve care
- Clinical protocols, practice guidelines and utilization review standards being used to direct a patient's care
- Mandatory or voluntary disease management programs or programs for persons with disabilities and significant benefit differentials if any
- Formulary drug inclusion and exception process
- Whether a patient's medication is included in the plan's formulary, and if not, how the patient can request a waiver to allow coverage for the particular medication at preferred cost-sharing levels

About Networks and Providers:

- Number of primary care and specialty providers
- Name, education, board certification status and geographic location of all contracting primary and specialty care providers; whether they are accepting new patients; language(s) spoken and availability of interpreters (for non-English speaking and those with communication disabilities); and whether their facilities are accessible to the disabled
- Provider compensation, including base payment method (e.g., capitation, salary, fee schedule) and additional financial incentives (e.g., bonus, withhold, etc.)

About All Professional Providers:

- Corporate form of provider practice
- Names of hospitals where physicians have admitting privileges
- Years in practice as a physician and as a specialist if so identified
- Accreditation status
- Cancellation, suspension, or exclusion from participation in Federal programs or sanctions from Federal agencies; any suspension or revocation of medical licensure, Federal controlled substance license, or hospital privileges
- 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

About Facilities:

- Names, accreditation status, and geographic location of hospitals, home health agencies, rehabilitation and long-term care facilities; whether they are accepting new patients; language(s) spoken, and availability of interpreters (for non-English speaking and those with communication disabilities), and whether they are accessible to the disabled
- Corporate form
- Consumer satisfaction, clinical quality and service performance measures
- Whether facility specialty programs meet guidelines established by specialty societies or other bodies
- Complaint procedures
- Whether facility has been excluded from any Federal health programs
- Volume of certain procedures performed
- Numbers and credentials of providers of direct patient care
- Whether the facility's affiliation with a provider network would make it more likely that a consumer would be referred to health professionals or other organizations in that network.

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.

With almost 300 plans with delivery systems that include managed fee-for-service, preferred provider organizations, health maintenance organizations and point-of-service products, FEHB enrollees can choose among a broad range of health plans and providers. In implementing the Bill of Rights, we have assured that all participating carriers have the appropriate procedures in place to ensure access to high-quality health care.

For example, all plans in the FEHB Program provide:

- Direct access to women's health care providers for routine and preventative health care services.
- Direct access to a qualified specialist within your network of providers if you have complex or serious medical conditions that need frequent specialty care. Authorizations, when required by a plan, will be for an adequate number of direct access visits under an approved treatment plan.
- *Transitional care.* If you have a chronic or disabling condition and your health plan terminates your provider's contract (unless the termination is for cause), you may be able to continue seeing your provider for up to 90 days after the notice of termination. If you are in the second or third trimester of pregnancy, you may continue seeing your OB/GYN until the end of your postpartum care.

If you have a chronic or disabling condition or are in your second or third trimester of pregnancy and your health plan drops out of the FEHB Program, you may be able to continue seeing your provider if you enroll in a new FEHB plan. You may continue to see your current specialist after your old enrollment ends, even if he or she is not associated with your new plan, for up to 90 days after you receive the termination notice or through the end of postpartum care, and pay no greater cost than if your old enrollment had not ended.

III. Access to Emergency Services

Consumers have the right to access emergency health care services when and where the need arises. Health plans use a "prudent layperson" standard in determining eligibility for coverage of emergency services. Coverage of emergency department services are available without authorization if you have reason to believe your life is in danger or you would be seriously injured or disabled without immediate 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.

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.

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.

FEHB statute and regulations prohibit discriminatory practices in the FEHB Program.

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.

The privacy provisions already in place ensure that patient confidentiality is protected under the FEHB Program. We have ensured that carriers arrange with all their contracting providers so that you can review, copy, and request amendment to your medical records.

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.

The FEHB Program has had an external review process in place for the last 20 years. Our disputed claims process ensures an independent review of disputes between participating carriers and our enrollees.

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.

You as a consumer can make a significant contribution in these key areas:

- 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 the FEHB Program disputed claims process when there is a disagreement between you and your health plan. The process is described in your plan brochure.
- Become knowledgeable about coverage and health plan options, 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. This information is in your plan brochure.
- Show respect for other patients and health workers.
- Make a good-faith effort to meet financial obligations.
- Report wrongdoing and fraud to appropriate resources or legal authorities. The OPM Fraud Hot Line number is 202/418-3300.

FEHB enrollees should educate themselves with respect to specifics of benefit coverage and to learn how to access health care and services by using the information provided in FEHB enrollment information, plan brochures, and on the OPM website.