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Patient Protection During the 107th Congress: Side-by-Side Comparison of House and Senate Bills

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Summary

This report compares the major provisions of the Senate- and House-passed patient protection bills of the 107th Congress. S. 1052 and H.R. 2563 offer various approaches to regulate employment-based health plans and insurance issuers relating to access to providers, disclosure of plan information, grievances and appeals, confidentiality, and health care lawsuit reform among other provisions.

On June 29, the Senate passed S. 1052, the "Bipartisan Patient Protection Act." The bill had originally been introduced in slightly modified forms by Senators McCain, Kennedy and Edwards as S. 283 and later as S. 872. S. 1052 was amended on the Senate floor. In the House, a similar bill was originally introduced by Representatives Ganske and Dingell as H.R. 526 and a modified version, H.R. 2563 was introduced on July 19, to incorporate many of the amendments included in the Senate passed bill. On August 2nd the House passed H.R. 2563, adding two amendments on the floor before passage. The most significant differences between the House- and Senate-passed bills are in the provisions expanding patients' legal remedies against their health plan providers when medical care is unjustly denied and the denial results in harm. Other differences found in the bills include provisions applying the protections to federal health programs, prohibiting discrimination on the basis of genetic information, and encouraging health insurance coverage expansions.

Each of the bills would apply to group health plans and health insurance issuers offering health insurance coverage in both the group and individual markets for insurance. Both bills define a process for allowing states that have already passed patient protections at the state level to apply those laws in lieu of the federal laws although the House version is more limited than the Senate version.

At the heart of the debate on patient protection are different approaches to increasing access to legal remedies for persons denied access to medical care when the denial causes substantial harm or death. Under current law, enrollees in employer-sponsored plans can only sue their HMOs for benefits due under the Employee Retirement Income Security Act (ERISA). State law causes of action, which include consequential and punitive damages, are not available and ERISA does not provide for such damages. S. 1052 would expand the damages allowed under federal claims for benefits that arise from contract disputes and questions of coverage and would amend ERISA so that disputes at the state level over the medical necessity of covered benefits are not pre-empted. H.R. 2563 would amend ERISA to create a federal cause of action under certain conditions when a designated decision maker failed to exercise ordinary care in making a determination on a claim. State courts would have concurrent jurisdiction over claims under this new federal cause of action, which means that state courts could hear those claims, the federal law would apply, but the state courts' procedural rules could be used to process those claims.

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Introduction

The 107th Congress has resumed the debate, begun almost five years ago, over bills offering patients in managed care plans protection from certain practices that have sometimes resulted in untimely or denied medical care. The current debate is centered on two bills: S. 1052 as passed by the Senate on June 29, 2001 and H.R. 2563 as passed by the House on August 2, 2001. S. 1052, the "Bipartisan Patient Protection Act," was first introduced in early February by a bipartisan group led by Senators McCain, Kennedy and Edwards as S. 283 and then later as S. 872. The same group introduced a companion bill (S. 284) which includes tax provisions intended to increase access to health insurance. On the Senate floor, a number of amendments were appended to S. 1052 before passage. Representatives Ganske and Dingell introduced a House version of S. 283 in early February as H.R. 526. A modified version of H.R. 526 was introduced as H.R. 2563 on July 19, 2001, which includes many of the Senate amendments as well as tax provisions intended to increase access to health insurance similar to those found in S. 284.[1] H.R. 2563 was further modified before passage to include two new amendments. The two major amendments, and thus the major differences between the House- and Senate-passed bills are found in the sections on liability and expansions of health insurance coverage options (Association Health Plans and Medical Savings Accounts).

The two bills are largely alike in most of the other provisions. They both include provisions assuring timely access to specialists, direct access to pediatric, obstetrical and gynecological providers, emergency room services, clinical trials, and off-formulary drugs. The bills would establish procedures as well as timelines for plans conducting initial review of claims, and internal and external review of denied claims. Among other provisions appearing in both bills are those prohibiting gag rules and requiring plans to provide information on plan characteristics to enrollees.

President Bush developed principles for a bill that he would sign. Those principles are outlined in the "Principles for a Bipartisan Patients' Bill of Rights," issued by the White House, Office of the Press Secretary on February 7, 2001. The basic principles are: 1) patient protections should be comprehensive, 2) patients should have a rapid medical

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[1]This side-by side does not include a description of the tax provisions included in the patient protection bills. For a discussion of tax provisions, see CRS IB98037, *Tax Benefits for Health Insurance: Current Legislation*, by Bob Lyke.

review process for denials of care, and 3) federal remedies should be expanded to hold health plans accountable. H..R. 2563, as amended before passage, reflects an agreement reached between President Bush and Representative Norwood for expanding federal remedies. The President has also indicated that he would veto S. 1052.

The reader may find the following definitions helpful. The "health" definitions are based on terms used in the Health Insurance Portability and Accountability Act (HIPAA, P.L. 104-191); many have been incorporated into the patient protection bills under consideration here.

Health insurance coverage

Benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization (HMO) contract offered by a health insurance issuer.

Health insurance issuer

An insurance company, insurance service, or insurance organization (including a HMO) which is licensed to engage in the business of insurance in a state and which is subject to state law which regulates insurance.

Group health plan

An employee welfare benefit plan to the extent that the plan provides medical care to employees or their dependents directly or through insurance, reimbursement, or otherwise.

Self-insured group health plan

A plan in which the employer takes some or all of the risk of paying for the plan's covered items and services. Many self-insured plans assume risk for some amount of claims and then buy stop-loss coverage from a third party to cover losses over a preset amount or percentage of claims.

Insured group health plans

A plan in which the employer pays the insurer a premium in exchange for the insurer assuming the risk of the plan's covered items and services.

Other definitions that may be useful**:**

Cause of Action

A specific legal claim for which a party seeks compensation.

Damages

For lawsuits, money awarded to one party, based on injury or loss caused by another party.

Economic damages – damages intended to restore the injured party to the position they were in prior to the injury. Typically includes medical expenses and lost wages.

Noneconomic damages – damages intended to cover injuries for which an exact dollar amount cannot be calculated, such as pain and suffering and compensation for a shortened life expectancy.

Punitive or exemplary damages – damages awarded over and above other damages, intended to punish a losing party's willful or malicious misconduct.

Side-by-Side Comparison of S. 1052 and H.R. 2563

Provisions	S. 1052 Bipartisan Patient Protection Act	H.R. 2563 Bipartisan Patient Protection Act
Bill status	Introduced on June 14, 2001. Passed by the Senate on June 29, 2001.	Introduced on July 19, 2001. Passed by the House on August 2, 2001.

Scope

Applicability

Provisions	S. 1052	H.R. 2563
General	Group health plans and health insurance issuers offering both group health insurance coverage and individual health insurance coverage. Applies to state and local government sponsored plans, federal programs, including FEHBP, Medicare, Medicaid, SCHIP, Tricare, Indian Health Service, and VA health care.	Similar to S. 1052 but does not apply to federal programs (although OPM indicates that just as HIPAA requirements apply to FEHBP, these protections would also apply to FEHBP). Instead, expresses the sense of Congress that the President should require, by Executive Order, that federal officials with authority over each federal health insurance program, to the extent feasible, take steps to implement patient rights. Within 1 year after enactment of this act, GAO shall submit a report to Congress on statutory changes required to implement such rights.
Interaction with state patient protection laws	In states that provide certification to the Secretary that state laws *substantially comply* with protections created under Title I (includes access to care, internal and external review, access to information and protecting the doctor-patient relationship), state laws would apply to insured plans and state and local government plans instead of the federal protections. "Substantially complies" with respect to state law means that the state law has the same or similar features as patient protections requirements and has a similar effect. In any case in which the federal law applies to insurers, the application of state laws within the same subject	Similar to S. 1052 except would not allow state laws defining and requiring internal and/or external review processes to apply in lieu of the provisions in this bill.

Provisions	S. 1052	H.R. 2563
	matter are preempted.	
Exceptions	The following provisions would not apply to fee-for-service coverage or limited scope plans: requirements for consumer choice option, choice of health care professional, access to emergency care, specialists, OB/GYN and pediatric care, and continuity of care. The requirement for a consumer choice option does not apply to individual health insurance plans.	Similar to S. 1052, but adds that rights under this act may be waived if there is an agreement providing for arbitration or participation in any other non-judicial procedure to resolve a dispute. The agreement must: 1) be entered into knowingly and voluntarily by the parties involved after the dispute has arisen or, 2) be pursuant to the terms of a collective bargaining agreement. This exception does not permit the waiver of internal and external review requirements.
Impact of patient protections	No more than 24 months after the effective date and for each of 4 succeeding fiscal years, the Institute of Medicine (IOM) will submit a report concerning the impact of patients' rights legislation on the number of individuals without insurance. If the Secretary of HHS determines that more than 1 million people lose their coverage as a result of the legislation, then the act would be repealed.	Same as S. 1052.

Access

Access to Obstetric and Gynecologic Care and Pediatric Care

Provisions	S. 1052	H.R. 2563
Ob/Gyn care	Prohibits group health plans or issuers from requiring authorization or referral from the primary health care professional or otherwise for coverage of ob/gyn care provided by a *participating health care professional, including a physician* who specializes in obstetrics and gynecology. Requires that the ordering of other ob/gyn care be treated as authorized by the primary care professional. Does not preclude the plan or issuer from requiring that the ob/gyn provider notify the primary care health care professional, plan, or issuer of treatment decisions.	Same as S. 1052.

Provisions	S. 1052	H.R. 2563
Pediatric care	Allows a participant to designate a physician who specializes in pediatrics as a primary care provider for a child of the participant.	Same as S. 1052.

Access to Specialists

Provisions	S. 1052	H.R. 2563
General	Requires plans or issuers to make or provide for timely access to an available and accessible specialist with adequate expertise (including pediatric expertise) for persons with a condition or disease of sufficient seriousness and complexity to require treatment by a specialist. A "specialist" means a practitioner, facility or center. If conditions merit the use of a non-participating specialist, services must be provided at no additional cost to the patient (beyond the costs for a participating specialist). Persons with an ongoing special condition (which is life-threatening, degenerative, or disabling AND requires specialized medical care over a prolonged period of time) may have their care coordinated and provided by a specialist for such a condition. Referrals can be for an appropriate duration of time or number of referrals, including standing referrals, where appropriate. A plan or issuer may require that care be pursuant to a treatment plan developed by the specialist and approved by the plan or issuer, in consultation with the designated primary care provider or specialist, case manager, and the individual.	Same as S. 1052.

Emergency Services

Provisions	S. 1052	H.R. 2563
General	Requires plans that cover emergency medical services to cover "emergency services," without prior authorization and without regard to network limitations, if a prudent layperson could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the individual's health. If a plan covers emergency ambulance service, then those services must be provided subject to the same terms and conditions as other emergency services.	Same as S. 1052.
Maintenance and post-stabilization care	Requires reimbursement for maintenance care and post-stabilization care.	Same as S. 1052.
Definition	Defines "emergency services" as a medical screening examination and ancillary services to evaluate an emergency medical condition and such further medical examination and treatment as required to stabilize the patient. Defines "emergency medical condition" as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), as determined by a prudent layperson that could, without medical attention, reasonably expect to place their health in serious jeopardy or cause serious impairment or dysfunction.	Same as S. 1052.
Compensation	Prohibits plans or issuers from charging patients more for using a non-network provider than would have been charged if the services were provided in-network.	Same as S. 1052.

Continuity of Care

Provisions	S. 1052	H.R. 2563
General	For enrollees who are undergoing a course of treatment with a provider at the time of the provider's contract or a benefit termination, plans or issuers must continue to cover treatment for: (1) pregnancy, (2) acute illness requiring specialized medical treatment to avoid the reasonable possibility of death or permanent harm, or (3) chronic illness for ongoing special conditions (those that are life-threatening, degenerative, or disabling AND require special medical care over a prolonged period of time). Plans must notify individuals undergoing an active course of treatment for a serious and complex condition when their providers are to be terminated and allow beneficiaries to elect to continue treatment with the terminated provider. Coverage must be continued for up to 90 days, in general, except for enrollees who are pregnant at the time of contract termination (coverage through the provision of postpartum care), terminally ill (coverage for the remainder of the individual's life that is directly related to the illness or its medical manifestations), receiving institutional or inpatient care (until the earlier of the completion of reasonable follow-up care after discharge, or 90 days), and awaiting surgery (until the date of completion of the surgery and post-surgical follow-up care, within 90 days after surgery). Plans may condition such continued coverage by the provider agreeing to accept the payment rates and cost sharing amounts established under the prior agreement and adhering to the plans' quality standards, policies and procedures.	Same as S. 1052.

Prescription Drugs

Provisions	S. 1052	H.R. 2563
General	Requires plans and issuers that offer prescription drug coverage and limit benefits to those included in a formulary to provide exceptions from the formulary limitation when a non-formulary alternative is medically necessary and appropriate. Also requires the plan or issuer to ensure participation of physicians and pharmacists in the development of the formulary and to disclose the use of the formulary to providers and beneficiaries. Requires that if non-formulary drug is provided, the cost-sharing requirements are the same as they would be for formulary drugs. Also does not allow plan or issuer to deny coverage of prescription drugs or medical devices on basis that their use is investigational, as long as the use is included in the labeling required under federal law.	Same as S. 1052.

Clinical Trials

Provisions	S. 1052	H.R. 2563
General	Prohibits plans and issuers from denying, limiting, or imposing additional conditions on the participation in and coverage of routine patient costs (but not including the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved) incurred through participation in an approved and funded clinical trial for "qualified individuals." Allows the plan or issuer to require the use of a participating provider, if the provider is participating in the trial and will accept the individual as a participant. A qualified individual is a person: (1) who has a life-threatening or serious illness for which no standard treatment is effective; (2) who is eligible to participate in an approved clinical trial according to the trial protocol;	Same as S. 1052.

Provisions	S. 1052	H.R. 2563
	(3) whose participation in the trial offers meaningful potential for significant clinical benefits for the individual; and (4) a participating physician concludes, or the individual establishes, that the individual's participation in the trial is appropriate (based on meeting conditions (1)-(3)). Approved clinical trials are those approved and funded by the National Institutes of Health (NIH), and/or a cooperative group or center of the NIH, a peer reviewed study or investigation of the Department of Veteran's Affairs or the Department of Defense, or those approved by the Food and Drug Administration.	

Choice of Plans and Providers

Provisions	S. 1052	H.R. 2563
Access to point-of-service (POS) option	Requires group health plans or health insurance issuers (providing coverage in connection with a group health plan) that offer a restricted provider network, to make a non-network option available for enrollees to purchase during an annual open enrollment period. Does not require a non-network option if an individual is given a choice of non- network coverage through another group health plan or through another insurance issuer in the group market.	Same as S. 1052.
Choice of providers	Requires group health plans and issuers to allow enrollees to designate as their primary care provider any primary care provider who participates in the plan and is available. Pursuant to appropriate referral procedures, requires group health plans and issuers to allow enrollees to receive medically necessary specialty care from any participating specialty provider who is available. (Does not pre-empt plans from imposing limitations on the choice of participating health care providers for such specialty care, as long as enrollees are clearly informed.)	Same as S. 1052.

Breast Cancer Treatment

Provisions	S. 1052	H.R. 2563
General	Requires plans or issuers to ensure inpatient coverage for the surgical treatment of breast cancer (including a mastectomy, lumpectomy, or lymph node dissections) for a period of time as determined to be medically appropriate by the attending physician, in consultation with the patient. Prohibits the use of specified incentives to avoid compliance with mandate. A group health plan or issuer that provides coverage for medical and surgical services in relation to the diagnosis and treatment of cancer shall ensure that full coverage is provided for secondary consultations by specialists in appropriate medical fields to confirm or refute a diagnosis. This must be provided outside of the network if the attending physician certifies that necessary services for the second opinion are not sufficiently available within the plan.	Same as S. 1052.

Genetic Information and Services

Provisions	S. 1052	H.R. 2563
Nondiscrimination based on predictive genetic information	Prohibits health plans or health insurance issuers, in both group and individual markets, from: 1) establishing rules for eligibility (including continued eligibility) for any individual based on genetic information of that individual or their dependent, 2) denying eligibility or adjusting premium or contribution rates on the basis of predictive genetic information for an individual or their family member, and 3) requesting or requiring that an individual or their family members provide predictive genetic information. Allows plans or issuers to request (but not require) that an individual or their dependent disclose or authorize the collection or disclosure of predictive genetic information for diagnosis, treatment, or payment relating to health care services provided for that person. Requires plans to provide notice of confidentiality safeguards when requesting such information, to post or provide notice of confidentiality practices and to have safeguards in place with respect to predictive genetic information. Would not supersede state laws that more completely protect the privacy of an individual or family member with respect to genetic information.	No provision.

Disclosure

Information Disclosure

Provisions	S. 1052	H.R. 2563
Who provides information? How often? To whom?	Requires group health plans and health insurance issuers to provide information in an accessible medium and understandable format to participants and beneficiaries (jointly for those residing together or separately for those not residing together): (1) at the time of initial enrollment and at least annually thereafter; and (2) 30 days before any material reduction in benefits or information. Recipients retain the ongoing right to receive disclosure in printed form and the information may be provided through the Internet only if the recipient has affirmatively consented to the disclosure in this form and is capable of accessing the information on the Internet at work or home, and the plan administrator ensures the recipient is receiving the information.	Same as S. 1052.
Information required to be disclosed	C Benefits including any specific preventive services; C Any in-and out-of-network benefits; C Any specific exclusions or express limitation of benefits in the case of denial of referral under independent external appeals procedures; C Any other benefit limitations/exclusions; including annual or lifetime limits, monetary limits or limits on the number of visits, days, or services; C Any definition of medical necessity used in coverage determinations; C Any cost-sharing, including for out-of-network services received from nonparticipating providers or without prior authorization or pre-certification; maximum liability of participant, beneficiary, or enrollee for out-of-pocket expense. C Service area and any out-of-area coverage; C Information relating to disenrollment; C Directory of participating providers with name, address, and telephone numbers and how to inquire	Same as S. 1052.

Provisions	S. 1052	H.R. 2563
	whether provider is currently accepting new patients; C Requirements and procedures to be used by participants, beneficiaries, and enrollees in selecting, accessing or changing their primary care provider and any right to select a pediatrician as a primary care provider; C Any requirements and procedures for preauthorization of health services; C Process for determining experimental or investigational coverage and circumstances under which treatments are covered; C Requirements and procedures for accessing specialty care and obtaining referrals to participating and nonparticipating specialists; any limitations on choice of professionals and right to timely access to specialists if applicable; C Circumstances and conditions under which clinical trials are covered and the right of "qualified individuals" to obtain coverage for approved clinical trials; C Any formulary limitations on prescription drugs; provisions for obtaining on-and off-formulary medications and any cost-sharing; any rights to investigational prescription drugs; C Summary of rules, procedures, and right to obtain emergency services under the prudent layperson standard if applicable, and any educational information the plan or issuer may provide regarding appropriate use; C Plan or issuer's rules and procedures pertaining to claims and appeals; rights to claims and appeals under this legislation and any additional rights under ERISA or state law; C Any procedures for advance directives and organ donation decisions; C Name, address, and telephone numbers of the plan administrator and issuer to be used by participants, beneficiaries, and enrollees seeking information or authorization for services and treatment;	

Provisions	S. 1052	H.R. 2563
	C Whether benefits are provided under a contract or policy of insurance issued by an issuer, or directly by the plan sponsor who bears the risk; C Summary of any translation or interpretation services for non-English speakers and persons with communication disabilities and how to access these services; C Any public accreditation information or quality indicators made available to participants, beneficiaries, and enrollees by the plan or issuer; C Description of any applicable rights under this legislation including the right to information as specified in this section; C Name and address of designated decision makers who have assumed liability under ERISA; and C Instructions for obtaining additional information upon request.	
Information to be disclosed upon request	C State licensure status and, if available, the education, training, specialty qualifications or certifications of participating health care professionals and facilities; C Summary description of methods for compensating health care professionals and facilities; C Information about inclusion of specific prescription medication in any formulary; C Information about utilization review activities; and C Aggregate information on the number and outcomes of external medical reviews.	Same as S. 1052.
Civil penalties	No provision.	Same as S. 1052.

Medical Communications (Gag Rule)

Provisions	S. 1052	H.R. 2563
General	Requires that a plan or issuer not prohibit or restrict a health care professional from advising a patient about their health status or medical care or treatment for their condition or disease, regardless of whether such treatments are covered under the plan, if the professional is acting within the lawful scope of practice. Contract provisions or agreements restricting or prohibiting medical communication would be considered null and void.	Same as S. 1052.

Other Protections

Provider Provisions

Provisions	S. 1052	H.R. 2563
Provider incentive plans	Prohibits any provider incentive plans (as defined in the Social Security Act under Medicare-1876(i)(8)) that may directly or indirectly have the effect of reducing or limiting services provided.	Same as S. 1052, except refers to Medicare section – 1852(j)(4) relating to Medicare+Choice plans.
Discrimination	Prohibits discrimination with respect to participation or indemnification against any provider who is acting according to license or certification under state law, on the basis of such license or certification. Does not require coverage of particular benefits or the inclusion of every willing provider. Allows plans to include only those providers that are necessary to meet the needs of plan or issuer.	Same as S. 1052.

Provisions	S. 1052	H.R. 2563
Prompt payment of claims	Requires plans and issuers offering group health insurance to provide for prompt payment of claims with respect to covered benefits.	Same as S. 1052.

Protections for Patient Advocacy

Provisions	S. 1052	H.R. 2563
No retaliation	Protects enrollees, beneficiaries, participants and providers from retaliation by a plan or issuer for using appeals and grievance processes.	Same as S. 1052.
Quality advocacy	Prohibits a plan or issuer from retaliating against a protected health care professional (licensed or certified health care professional who is an employee or has a contract with the plan or issuer) who acts in good faith to participate in an investigation. Specifies requirements for internal procedures and exceptions and defines terms.	Same as S. 1052.
Health Care Consumer Assistance Fund	The Secretary shall establish the Health Care Consumer Assistance Fund to be used to award grants to eligible states to carry out consumer assistance activities designed to provide information, assistance, and referrals to consumers of health insurance products.	Same as S. 1052.

Appeals Processes

Initial Coverage Determinations and Utilization Review

Provisions	S. 1052	H.R. 2563
Initial claims and utilization review	Requires plans and issuers to conduct utilization review activities that: 1. are consistent with written policies and procedures using written clinical review criteria based on clinical evidence and developed with input from a range of appropriate health care professionals;	Same as S. 1052.

Provisions	S. 1052	H.R. 2563
	2. are administered by qualified health care professionals who are not compensated in a way that would encourage denials of claims for benefits nor have a conflict of interest; 3. make utilization reviewers reasonably accessible via toll free telephone; and 4. are not more frequent than reasonably required to determine whether services are medically necessary and appropriate.	
Definition	"Utilization review activities" are procedures used to monitor or evaluate the use, coverage, clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings. Utilization review includes prospective, concurrent, and retrospective review, as well as second opinions, case management and discharge planning.	Same as S. 1052.
Prior authorization determination	Requires plans or issuers to make a determination as soon as possible in accordance with the medical exigencies of the case, or within 14 days after receiving necessary information to make a determination, but in no case later than 28 days after receiving the initial request for prior authorization.	Same as S. 1052.
Expedited cases	(Cases where delay could seriously jeopardize the life or health of the participant, beneficiary, or enrollee or such an individual's ability to regain maximum function.) Requires plans or issuers to make a determination within 72 hours after the request for prior authorization is made. Specifies that at any time during the process, a request may be made to expedite the review.	Same as S. 1052.
Ongoing care	Requires plans or issuers to make a determination as soon as possible with sufficient time prior to the termination or reduction of care to allow for an appeal.	Same as S. 1052.
Previously provided services	A determination must be made within 30 days of receiving	Same as S. 1052.

Provisions	S. 1052	H.R. 2563
	the information reasonably necessary to make a decision, but in no case later than 60 days after the receipt of the claim for benefits.	

Appeals Process — Internal Review

Provisions	S. 1052	H.R. 2563
Requests for review	A participant, beneficiary, or enrollee has at least 180 days to request and obtain review.	Same as S. 1052.
Decisions that may proceed to internal review	A participant, beneficiary, or enrollee may request an internal review if denied a claim. The failure of the plan or issuer to issue a determination within the applicable timelines shall be treated as a denial for the purposes of proceeding to external review.	Same as S. 1052.
Who conducts review?	Review is conducted by (1) an individual with appropriate expertise who was not involved in the initial determination, and (2) a physician, with appropriate expertise (including, in the case of a child, appropriate pediatric expertise) if the appeal is based on the denial of a claim for a lack of medical necessity and appropriateness, an experimental or investigational treatment, or if the case requires evaluating medical facts, or (3) at least one non-physician health care professional for a claim for benefits provided by a non-physician health care professional.	Similar to S. 1052, except does not include a specific requirement for non-physician health care professionals.
Timing of review – generally	Review must be completed *in accordance with the medical exigencies of the case, or* within 14 days after the receipt of necessary information but not later than *28* days after the request for appeal.	Same as S. 1052.
Expedited cases	Review must be completed within 72 hours of receiving a request for review, and specifies that at any time during the process, a request may be made to expedite the review.	Same as S. 1052.

Provisions	S. 1052	H.R. 2563
Ongoing care	Review must be completed with sufficient time prior to termination or reduction of services to allow for external appeal before termination or reduction of services takes effect.	Same as S. 1052.
Previously provided services	A determination must be made within 30 days of receiving information that is reasonably necessary to make a decision, but in no case later than 60 days after the request for an appeal.	Same as S. 1052.
Interaction with state internal review laws	Allows substantially similar state laws defining and requiring internal review to apply in lieu of provisions in this bill.	State laws defining and requiring internal review would be pre-empted by the internal review provisions in this bill.

Appeals Process — External Review

Provisions	S. 1052	H.R. 2563
Requests for review	A request for an independent external review shall be filed with the plan or issuer no later than *180 days* after the date on which the participant, beneficiary, or enrollee receives notice of the denial under the internal review procedures, waiver of internal review by the plan or issuer, or notification that it has failed to make a timely decision. A plan or issuer may require a filing fee of up to $25, unless the individual certifies that he or she is indigent, or plan or issuer waives internal review. The filing fee shall be refunded if the recommendation of the external appeal entity is to reverse or modify the denial of a claim for benefits.	Same as S. 1052.
Criteria for external appeals	A denial for a claim for benefits is eligible for independent medical review if the denial: (1) is based on a decision that the item or service is not medically necessary or appropriate or is investigational or experimental; or	Same as S. 1052.

Provisions	S. 1052	H.R. 2563
	(2) requires a medical judgment to determine whether a benefit is covered. Use of external review may be conditioned on a final decision in an internal appeal, if decision is made on a timely basis within specified timelines. External review is not available for denials involving: (1) decisions that do not involve a medical judgment, (2) a decision regarding whether or not the individual is covered under the plan, (3) the application of cost-sharing requirements for a denial of a claim for benefits, or (4) the applied or specific exclusion or express limitation on the amount, duration, or scope of coverage.	
Referral to a Qualified External Review Entity	Once request is filed, the plan or issuer shall immediately refer such request to a qualified external review entity.	Same as S. 1052.
Who selects reviewer?	The applicable authority (depending on the plan type, the applicable authority is the state or the Departments of Labor and Health and Human Services) will implement procedures to assure that the selection process among external appeal entities will not create incentives to make biased decisions and will also audit a sample of claims. *Participants, beneficiaries, enrollees and plan may not determine or influence* the selection of the external appeal entity. For health insurance issuers offering health insurance coverage in a state, the state may provide for external review activities to be conducted by a qualified external appeal entity that it designates or selects.	Same as S. 1052.
Qualifications of external appeal entities	"Qualified external review entities": 1) must have sufficient medical, legal, and other expertise and sufficient staffing; 2) may not be a plan or issuer, 3) may not be an affiliate, subsidiary or trade association of plans, issuers or health	Same as S. 1052.

Provisions	S. 1052	H.R. 2563
	care providers; 4) must conduct external review consistent with requirements under the law; 5) must agree to provide information in a timely manner; and 6) must meet other requirements imposed by the appropriate Secretary .	
Certification of entities or private standard-setting organizations	Certification and recertification shall be made under a process recognized or approved by the appropriate Secretary, or by a qualified private standard-setting organization. The appropriate Secretary may only approve or recognize those entities that follow review procedures specified in the law, meet fiscal standards, maintain confidentiality requirements, and meet standards for recertification.	Same as S. 1052.
Qualification of reviewers	Review is conducted by a qualified external review entity that shall ensure that each independent medical reviewer is a physician or health care professional who is appropriately credentialed or licensed in 1 or more states to deliver health care services; and typically treats the condition, makes the diagnosis, or provides the type of treatment under review. In a case involving treatment, or the provision of items or service by a physician, a reviewer shall be a practicing physician of the same or similar specialty as a physician who typically treats the condition, makes the diagnosis, or provides the type of treatment under review. In a case involving a health care professional (other than a physician), a reviewer shall include at least one practicing health care professional, of the same or similar specialty as the health care professional who typically treats the condition, makes the diagnosis, or provides the type of treatment under review. In the case of an external review relating to a child, a reviewer shall have expertise in pediatrics.	Similar to S. 1052., except: 1) specifies that the external review panel shall consist of three individuals, and 2) specifies that in the case involving a physician, each member of the external review panel shall be a physician.

Provisions	S. 1052	H.R. 2563
Independence requirements	Each independent medical reviewer shall: (1) not be a related party, and (2) not have a conflict of interest or a material familial, financial, or professional relationship with a related party.	Same as S. 1052.
Standard of review	The reviewer shall consider the following evidence: (1) the medical condition of the beneficiary, including the medical records; (2) valid relevant scientific evidence and clinical evidence, including peer-reviewed medical literature or findings and expert consensus; (3) the internal review decision and any evidence, guidelines or rationale used to reach the decision; (4) recommendation of treating health care professional and evidence, guidelines, and rationale used in reaching such recommendation; (5) additional evidence or information submitted; and (6) the plan or coverage document. The reviewer shall consider, but is not bound by, any language in the plan or coverage document relating to the definitions of the terms medically necessary and appropriate, or experimental and investigational, or related terms. The review process shall provide for a fair, de novo determination.	Same as S. 1052.
Timing of review — generally	The independent medical reviewer shall make a determination on a denial of a claim for benefits that is referred to the reviewer in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 14 days after the date of receipt of information necessary to complete the review if the review involves a prior authorization of items or services and in	Same as S. 1052.

Provisions	S. 1052	H.R. 2563
	no case later than 21 days after the date the request for external review is received.	
Expedited cases	A determination must be made within 72 hours *after receiving the request for external review* and specifies that at any time during the process, a request may be made to expedite the review.	Same as S. 1052.
Ongoing care	Determinations must be completed within 24 hours *after receiving the request for external review* and before the end of the approved period of care.	Same as S. 1052.
Previously provided services	A determination must be made within 30 days of receiving all of the information reasonably necessary to make a decision, but in no case later than 60 days after the receipt of the claim for benefits.	Same as S. 1052.

Provisions	S. 1052	H.R. 2563
Binding decisions	The decision of the external appeal entity is binding on the plan and issuer involved in the determination.	Same as S. 1052.
Civil penalties/enforcement	A court of competent jurisdiction may order a civil penalty of up to $1,000 a day from the date on which a determination was transmitted to the plan or issuer, if the determination is not followed. In any case in which treatment was not commenced by the plan in accordance with the determination of an independent external reviewer, the Secretary shall assess a civil penalty of $10,000 against the plan and the plan shall pay such penalty to the participant, beneficiary, or enrollee involved. The court shall also issue an order requiring the person responsible for authorizing the benefit to cease and desist from failing to act in accordance with the determination. This order shall also compel the payment of attorney's fees. The appropriate Secretary may also assess a civil penalty for any pattern or practice of repeated refusals to authorize benefits after external review, or any pattern or practice of repeated violations of the requirements of the external review process. The penalty shall be payable only upon proof of clear and convincing evidence of such pattern or practice and shall not exceed the lesser of (1) 25% of the aggregate value of the benefits that have not been provided or have been unlawfully delayed; or (2) $500,000. The appropriate Secretary may petition for the removal of any person with the capacity to authorize benefits who has engaged in such pattern or practice.	Same as S. 1052.

Provisions	S. 1052	H.R. 2563
Termination of review process	No provision.	Same as S. 1052.
Interaction with state external review laws	Allows substantially similar state laws defining and requiring external review to apply in lieu of provisions in this bill.	State laws defining and requiring external review would be pre-empted by the internal review provisions in this bill.
Study	Twelve months after the effective date of this act the General Accounting Office shall submit a report to Congress containing a summary of information provided by external appeals entities, the number of denials upheld and reversed, and the extent to which independent review required coverage for benefits specifically excluded.	Same as S. 1052.

Medical Necessity Determinations

Provisions	S. 1052	H.R. 2563
General	External appeal entity shall consider, but is not bound by any language in the plan or coverage document relating to the definitions of the terms medical necessity, medically necessary or appropriate, or experimental, investigational, or related terms.	Same as S. 1052.

ERISA Preemption and Access to State Law

Provisions	S. 1052	H.R. 2563
Jurisdiction	Amends ERISA to allow state law causes of action and to expand federal law causes of action for denials of benefits, depending on the claim. State law causes of action would involve medically reviewable decisions and federal law causes of action would involve denials of claims, not based upon medically reviewable decisions.	Amends ERISA to expand federal law causes of action. Allows state courts to have concurrent jurisdiction over these claims, which means that state courts could hear those claims, the federal law would apply, but the state courts' procedural rules could be used to process those claims.
Federal law claims	Amends ERISA to create a cause of action in a case in which a person who is a fiduciary of a group health plan, a health insurance issuer offering health insurance coverage in connection with the plan, or an agent of the	Amends ERISA to create a cause of action in cases where a group health plan's designated decision maker fails to exercise ordinary care

Provisions	S. 1052	H.R. 2563
	plan, issuer, or plan sponsor, upon consideration of a claim for benefits of a participant or beneficiary or upon review of a denial of such a claim, fails to exercise ordinary care: 1) in making a decision regarding whether an item or service is covered under the terms and conditions of the plan or coverage, 2) regarding whether an individual is a participant or beneficiary who is enrolled under the terms and conditions of the plan or coverage, or 3) as to the application of cost-sharing requirements or the application of a specific exclusion or express limitation on the amount, duration, or scope of coverage of items or services under the terms and conditions of the plan or coverage, and such failure is a proximate cause of personal injury to, or the death of, the participant or beneficiary. The cause of action must not involve a medically reviewable decision.	1) in making a determination denying the initial claim for benefits, 2) in making a determination denying the claim for benefits during the internal review process, or 3) in failing to authorize coverage in compliance with the written determination of an independent medical reviewer that reverses a determination denying the claim for benefits, and the delay in receiving, or failure to receive, benefits attributable to the failure to exercise ordinary care is the proximate cause of personal injury to, or death of, the participant or beneficiary.
"Medically reviewable" decisions	Defines medically reviewable decisions are those related to denials for an item or service that would be a covered benefit under the terms and conditions of the plan but is found to: (a) not be medically necessary and appropriate, (b) be experimental or investigational, or (c) require an evaluation of the medical facts by a health care professional in the specific case involved to determine the coverage and extent of coverage of the item or service or condition.	Same as S. 1052.
Damages – federal law claims	Under the federal claim, the defendant shall be liable to the participant or beneficiary for economic and noneconomic damages (but not exemplary or punitive damages) in	The designated decision maker shall be liable to the participant or beneficiary for economic and noneconomic damages. Noneconomic damages may not exceed

Provisions	S. 1052	H.R. 2563
	connection with such personal injury or death. In addition, a civil assessment, in an amount not to exceed $5,000,000, payable to the claimant may be awarded in any action if the claimant establishes by clear and convincing evidence that the alleged conduct carried out by the defendant demonstrated bad faith and flagrant disregard for the rights of the participant or beneficiary under the plan and was a proximate cause of the personal injury or death that is the subject of the claim.	$1,500,000. Punitive damages not to exceed $1,500,000 may be awarded if the denial of a claim for benefits was reversed by an independent medical reviewer and there has been a failure to authorize coverage in compliance with such determination.
State law claims	Permits causes of action under state law relating to benefit determinations: a cause of action under state law by a participant or beneficiary under a group health plan to recover damages resulting from personal injury or for wrongful death against any person would not be preempted if such a cause of action arises by reason of a medically reviewable decision. Nothing in this bill would affect causes of action under state law related to the practice of medicine or the provision of or the failure to provide medical care.	Does not allow state law claims based on benefits denials. Nothing in this bill would affect causes of action under state law related to delivery medical care. State courts would have concurrent jurisdiction over claims under this new federal cause of action, which means that state courts could hear those claims, the federal law would apply, but the state courts' procedural rules could be used to process those claims.
Damages – state law claims	State law is superseded insofar as it provides any punitive, exemplary, or similar damages if, as of the time of the personal injury or death, all of the requirements relating to procedures for initial claims for benefits and prior authorization determinations, internal appeals of claims denials, and independent external appeals were met. However, state law is not superseded with respect to an action for wrongful death if the applicable state law provides for damages in such an action which are only punitive or exemplary in nature, or where in any action the plaintiff establishes by clear and convincing evidence that conduct carried out by the defendant with willful or wanton disregard for the rights or safety of others was the proximate cause of the personal injury or wrongful death that is the subject of the action.	For federal law claims heard in state courts, a state may limit damages for noneconomic loss or punitive, exemplary, or similar damages to amounts less than the amounts permitted by the legislation.

Provisions	S. 1052	H.R. 2563
Liability of employers and plans sponsors	Does not authorize a cause of action against an employer or plan sponsor (or against an employee of such an employer or sponsor acting within the scope of employment) unless there was direct participation by the employer or plan sponsor in the decision of the plan upon consideration of a claim for benefits or upon review of a denial of a claim for benefits, or there was direct participation by the employer or plan sponsor in the failure to exercise ordinary care. In any case in which there is a designated decision maker, all liability of such employer or plan sponsor would be transferred to, and assumed by, the designated decision maker. Prohibits any federal cause of action against a group health plan that is self-insured and self-administered by either 1) an employer or 2) a multi-employer plan, for the performance of, or the failure to perform, any non-medically reviewable duty under the plan.	Provides for the appointment of a designated decision maker for liability purposes.

Provisions	S. 1052	H.R. 2563
Exhaustion of internal and external review	A cause of action may not be brought in connection with any denial of a claim for benefits of any individual until all administrative processes have been exhausted. A participant or beneficiary may seek injunctive relief prior to the exhaustion of administrative remedies if it is demonstrated to the court that the exhaustion of such remedies would cause irreparable harm to the health of the participant or beneficiary. A state-law cause of action can be brought prior to the exhaustion of administrative remedies if the external review entity fails to make a determination within the specified timeline.	A cause of action may only be brought if a final determination denying a claim for benefits has been referred for independent medical review and a written determination by an independent medical reviewer has been issued with respect to such review, or the qualified external review entity has determined that a referral to an independent medical reviewer is not required. A participant or beneficiary may seek injunctive relief prior to the exhaustion of administrative remedies if it is demonstrated to the court, by a preponderance of the evidence, that exhaustion of such remedies would cause irreparable harm to the health of the participant or beneficiary.
Limitations on class actions	For federal law claims, class action lawsuits may be maintained only if the class is limited to the participants or beneficiaries of a group health plan established by only one plan sponsor.	No class action lawsuits allowed for the new federal law claims.
Physician Liability	No treating physician or other treating health care professional of the participant or beneficiary, and no person acting under the direction of such a physician or health care professional, shall be liable for the performance of, or the failure to perform, any non-medically reviewable duty of the plan, the plan sponsor, or any health insurance issuer offering health insurance coverage in connection with the plan. Additionally, a treating physician who directly delivered the care or treatment, or provided the patient service, that is the subject of a cause of action by a participant or beneficiary may not be designated as designated decision maker for liability purposes.	A treating physician who directly delivered the care, treatment, or provided the patient service that is the subject of a cause of action by a participant or beneficiary may not be designated as designated decision maker for liability purposes.
Limitation on Attorneys' Fees	The amount of an attorney's contingency fee allowable shall not exceed 1/3 of the total amount of the plaintiff's recovery, not including the reimbursement of actual out-of-pocket expenses of the attorney.[a]	No provision.

Market Reform And Insurance Affordability

Association Health Plans

Provisions	S. 1052	H.R. 2563
Eligibility requirements	No provision.	Establishes that an association health plan (AHP) is a group health plan offered by an association that has been in existence for at least 3 years, operates for substantial purposes other than that of providing health insurance or coverage, and is operated by a board of trustees with complete fiscal control and responsibility for all operations. AHPs may include a collectively bargained multi-employer plan or a group health plan established and maintained by a franchiser for its franchisees. A church plan is also eligible to elect AHP status if it complies with fiduciary, reporting, and actuarial standards. To be certified, a s*elf-insured* AHP must have at least 1,000 participants and beneficiaries. The self-insured AHP must have also offered coverage on the date of enactment or represent a broad cross-section of trades or represent one or more trades (as listed in the bill) that have average or above health insurance risk.
Participation and coverage	No provision.	Requires that all employers participating in the AHP be members or affiliated members of the sponsor. All individuals under the plan must be active or retired employees, owners, officers, directors, partners, or their beneficiaries. This applies to partnerships and self-employed individuals. For plans which were in existence on the date of enactment, no unaffiliated employer may participate unless they were affiliated on the date of certification or did not maintain or contribute to a group health plan for the previous 12-month period.

Provisions	S. 1052	H.R. 2563
		Prohibits discrimination by requiring that all employers who are association members be eligible for participation, all geographically available coverage options are made available upon request to eligible employers, and eligible individuals not be excluded from enrolling because of health status. Premium contribution rates for any particular small employer cannot be based on the health status or claims experience of plan participants or beneficiaries or on the type of business or industry in which the employer is engaged. Both health insurance coverage and any self-insured benefit options must be distributed by state-licensed health insurance agents.
Reserve requirements and provisions for solvency	No provision.	Reserves for AHPs which offer benefit options that are not fully-insured must be sufficient for unearned contributions, benefit liabilities, expected administrative costs, any other obligations and a margin for error recommended by the plan's qualified actuary. AHPs must also obtain aggregate and specific stop-loss insurance; indemnification insurance for any claims the plan is unable to satisfy if the plan is terminated; and must also make annual payments to an Association Health Plan Fund to guarantee that indemnification insurance is always available. The plan must maintain minimum surplus of at least $500,000 or an larger amount as set for in regulations. If an AHP is unable to provide benefits when due or is otherwise in a financially hazardous condition, the Secretary of Labor is required to act as a trustee to administer the plan for the duration of the insolvency. A certified AHP may terminate only if the trustees provide 60 days advance written notice to participants and beneficiaries and submit a plan for timely payment of all benefit obligations. A Solvency Standards Working Group is to be established within 90 days after enactment to

Provisions	S. 1052	H.R. 2563
		recommend initial regulations. Establishes an "Association Health Plan Fund"from which the Secretary of Labor (or applicable authority) would make (or authorize to the Secretary of Labor) payments to ensure continues benefits on behalf of AHPs in distress. Would be funded by annual payments made by AHPs.
ERISA preemption	No provision.	Establishes that certified AHPs are exempt from state benefit mandates, except that AHPs must comply with any federal or state laws that require coverage of specific diseases, maternal and newborn hospitalization, and mental health. Clarifies that states may regulate self-insured multiple employer welfare arrangements providing medical care which do not elect to meet the certification requirements for AHPs.
Enforcement	No provision.	Requires states to certify and enforce the provisions applicable to AHPs; failing to enter into an agreement to do so, the applicable authority is the Department of Labor. Provides for criminal penalties for willful misrepresentation as an exempt AHP or collectively bargained status; provides for cease activity orders; and establishes the responsibility of the board of trustees for meeting required claims procedures. The Secretary of Labor is required to report to Congress no later than January 1, 2006 on the effect of AHPs on reducing the number of uninsured individuals.

[a] The limitations on attorneys' fees shall not apply with respect to a cause of action brought under state law in a state that has a law or framework of laws with respect to the amount of an attorney's contingency fee that may be incurred for the representation of a participant or beneficiary who brings such a cause of action.