May 2000

THE HENRY J. KAISER FAMILY FOUNDATION

A Brief Overview of Major Features of Pending Patient Protection Legislation: House and Senate Versions of H.R. 2990

Prepared for the Kaiser Family Foundation by:

Phyllis C. Borzi, J.D., M.A.
Research Professor
Health Services Management and Policy

and

Sara Rosenbaum, J.D.
Harold and Jane Hirsh Professor of Health Law and Policy

Center for Health Services Research and Policy
School of Public Health and Health Services
The George Washington University Medical Center

The Kaiser Family Foundation, based in Menlo Park, California, is a non-profit, independent national health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries.

A Brief Overview of Major Features of Pending Patient Protection Legislation: House and Senate Versions of H.R. 2990

Prepared for the Kaiser Family Foundation by:

Phyllis C. Borzi, J.D., M.A.
Research Professor
Health Services Management and Policy

and

Sara Rosenbaum, J.D.
Harold and Jane Hirsh Professor of Health Law and Policy

Center for Health Services Research and Policy
School of Public Health and Health Services
The George Washington University Medical Center

May 2000

TABLE OF CONTENTS

OVERVIEW OF LEGISLATIVE PROPOSALS FOR PATIENT PROTECTION

Background

During the 1999 legislative year, both the U.S. House of Representatives and the U.S. Senate passed legislation addressing patient protections under health care plans.[1]

The Conference Committee is currently meeting to reconcile the bills. Although the bills take widely divergent approaches to many issues, several core themes have emerged. The purpose of this brief overview is to highlight in very broad terms the key similarities and differences between the bills in four general areas: (1) scope of coverage; (2) patient protections, (3) benefit claims and appeals procedures, and (4) ERISA preemption of state laws and health plan liability (including expanded patients' rights to sue and remedies). The details with respect to each of these subjects need to be carefully examined, since they vary considerably and could have fairly dramatic differences in effect. This points up both the strengths and weaknesses of a document like this providing only a brief overview of both bills. On the one hand, this report will provide the reader with a quick way to zero in on the major substantive differences between the two bills. On the other hand, the fact that both bills address a particular subject does not necessarily mean that patients will receive the same degree of protection under both bills.

This brief comparison does not address certain other provisions contained in the bills (including those relating to HealthMarts and Association Health Plans found only in the House bill) or their various revenue-related proposals.

Readers can find a more detailed analysis of the House and Senate versions of H.R. 2990 (*Pending Patient Protection Legislation: A Comparative Analysis of Key Provisions of the House and Senate Versions of H.R. 2990*), including a comprehensive side-by-side comparison of the bills and a special section on "Definitions and Acronyms," on the Kaiser Family Foundation website at http://www.kff.org. A side-by-side comparison of the tax provisions contained in H.R. 2990 and other tax subsidy proposals can also

[1] On July 15, 1999, the Senate passed the Patients' Bill of Rights Plus Act, S. 1344, as amended by the Lott/Nickles Amendment No. 1254. On October 6, 1999, the House passed H.R. 2990, which incorporated both the provisions of the original H.R. 2990, the Quality Care for the Uninsured Act of 1999 (the Talent/Shadegg bill), and H.R. 2723, the Bipartisan Consensus Managed Care Improvement Act of 1999 (the Norwood/Dingell bill). The Senate substituted the text of S. 1344 for the House-passed bill on October 14, 1999 and subsequently appointed conferees. House conferees were appointed on November 3, 1999. Both bills are now designated as H.R. 2990 and can be downloaded from Congress' website: http://thomas.loc.gov. Finding the correct text can be somewhat confusing. The House-passed bill is the H.R.2990.RDS version, and the Senate-passed bill is the H.R. 2990.EAS version. Another source of confusion is the fact that the House combined two very different bills into a single piece of legislation. The Quality Care for the Uninsured Act of 1999 is called "Division A" of H.R. 2990, and the Bipartisan Consensus Managed Care Improvement Act of 1999 is labeled "Division B." As noted later in this document, the Senate version of the bill contains no corresponding provisions to Division A of the House bill.

be found on the Foundation's website (*Recent Tax Proposals To Increase Health Insurance Coverage*, prepared by Randall Weiss and Mark Garay of Deloitte & Touche LLP, January 2000) or by calling the Foundation's Publication Request Line at 1-800-656-4533 (Pub. #1536).

Substantive Overview of Both House and Senate Versions of H.R. 2990

In broad terms, the two most significant differences between the House and Senate versions of H.R. 2990 are the number of people that would be covered by the reforms (and the corresponding laws that are amended to achieve that coverage) and the approach to the question of expanded health plan liability for coverage decisions that result in injury or death. The former is often referred to as "scope" and the latter as "liability."

1. Scope of Coverage

Probably the most significant difference between the House and Senate versions of H.R. 2990 is the number of people that would be covered by the reforms (and the corresponding laws that are amended to achieve that coverage). This is often referred to as the issue of "scope" or "scope of coverage."

Senate Bill

As a threshold coverage matter, the Senate version of H.R. 2990 is more limited in scope than the House version because most of its protections apply only to the 48 million people in "self-insured" employer-sponsored group health plans subject to ERISA (the Employee Retirement Income Security Act of 1974). According to its sponsors, the Senate bill focuses on these plans because they are outside of the reach of state insurance regulation since benefits are not provided through state-regulated issuers. But by limiting its scope of the patient protection reforms to this narrow group of plans and excluding fully insured ERISA plans, non-ERISA group health plans (including governmental and church plans), and health insurance issuers providing coverage in the group and/or individual insurance markets, the Senate bill's provisions only reach about a third of the number of Americans protected by the House bill. In imposing these new patient protections, the Senate bill amends Title I of ERISA, with some conforming amendments to the Internal Revenue Code, but excludes fully insured ERISA plans from the new requirements.

In addition, through amendments to Title I of ERISA, the benefit claims and appeals procedures in the Senate bill apply to all ERISA group health plans, both insured and self-insured.

Certain other provisions (such as the provisions regarding breast cancer treatment and genetic information and services) are applicable to (1) all group health plans (including insured and self-insured ERISA plans), (2) non-ERISA plans such as governmental plans and church plans) and (3) health insurance issuers offering coverage in connection with group health plans. Thus these provisions amend Title I of ERISA (with conforming amendments to the Internal Revenue Code) and the Public Health Service Act (to impose the requirements directly on health insurance issuers). Although the reach of the breast cancer treatment and genetic information and services provisions is closer in scope to the House bill, they still do not apply to individual health insurance policies.

In a few rare instances, the provisions of the Senate bill also apply to health insurance issuers in the individual marketplace (for example, the mandates associated with breast cancer treatment are applicable to individual insurance contracts as well as to benefits provided under group health plans).

To avoid confusing the reader, the scope of coverage is briefly described in the opening box of the table in this report labeled "Scope of Coverage," and is indicated on a provision-by-provision basis in the more comprehensive version of this analysis on the Kaiser website.

House Bill

The provisions in the House bill are generally applicable to all group health plans (including insured and self-insured ERISA plans and non-ERISA group plans such as governmental plans and church plans), and to health insurance issuers offering coverage in connection with group health plans or individual coverage. The rules also apply to health insurance issuers offering individual coverage. Thus, the total number of people protected by the House bill is approximately 161 million people. To apply the rules across the board to all entities providing health insurance, the House bill is drafted as a series of freestanding requirements that are ultimately incorporated into Title I of ERISA (with certain conforming amendments to the Internal Revenue Code) and the Public Health Service Act through a single amendment to each law incorporating by reference all of the new protections, rather than a series of individual amendments to each law.

2. Patient Protections – House and Senate Bills

The substantive areas of patient protection addressed by both versions of the bills are similar: for example, improving access to emergency room treatment under a prudent layperson standard, assuring access to specialty care (including pediatric, obstretrical and gynecological care), providing continuity of care for enrollees undergoing treatment when their treating providers are dropped from the health plan's network, precluding so-called "gag clauses," and improving patient access to information.

3. *Benefit Claims and Appeals – House and Senate Bills*

Both bills provide for a revamped internal plan review system for disputed benefit claims and establish a new right to independent external review of plan decisions. In each case, the new internal and external review systems establish shorter time-frames than current ERISA for responding to requests for preauthorization as well as special expedited procedures for responding to urgent treatment requests.

However, the appeals rights under the proposed claims and appeal structure in both bills are not the same as the rights participants now have under ERISA. Current ERISA law permits any "claim for benefits" (broadly defined to include virtually any type of complaint raised by a participant or beneficiary) to be appealable under the plan's internal appeals process. However, both versions of H.R. 2990 limit the types of disputes eligible for internal review to those involving coverage decisions and requests for payment.

Other claims (not involving coverage or payment) are termed "grievances" under both bills. Each bill requires that a separate procedure must be established for handling grievances. The design of this procedure is left, for the most part, to the discretion of the group health plan or health insurance issuer. One significant difference between the bills, however, is whether a participant who has followed the plan's separate grievance procedure and is dissatisfied with the result can appeal the plan's resolution of the complaint. Under the Senate bill, grievances are not appealable.

After a participant has exhausted his or her internal review rights, both bills establish a right to external review for claims eligible for internal review. However, the Senate version provides a more limited right to external review than does the House bill. Under the Senate bill, external review is available only for adverse coverage decisions involving medical necessity, experimental and investigational treatment. In contrast, the House version is broader, permitting external review for any other coverage question involving medical judgment, in addition to the types of disputes covered by the Senate external review provisions.

4. *ERISA Preemption of State Law and Health Plan Liability – House and Senate Bills*

Another significant difference between the House and Senate bills is the approach to the question of expanded health plan liability for coverage decisions that result in injury or death. This issue is often called health plan "liability" or "accountability."

The House bill amends Title I of ERISA to expand the current right to sue and the remedies available for participants in ERISA-covered plans (both fully insured and self-insured) by permitting injured participants to recover damages under state personal injury or wrongful death laws in certain circumstances after all applicable administrative appeals, both internal and external, have been

exhausted. Punitive damages would be available under state law only if the group health plan or health insurance issuer had not complied with the decision of the external reviewer.

Under current ERISA law, although participants have the right to sue group health plans, employers, other plan sponsors and plan fiduciaries for improper coverage decisions, the remedies they may claim are quite limited. Successful plaintiffs may receive only the benefit to which they are entitled under the plan. The courts have interpreted ERISA as precluding awarding compensation for injuries plaintiffs or their families suffer as a result of the improper coverage decision, even if the plan has acted in a knowing, willful or grossly negligent fashion in denying the claim.

Although the House bill would expand the type of remedies to which an injured participant would be entitled in certain circumstances, it also contains protective language to shield group health plans, employers, and other plan sponsors from this additional liability. Liability may only be imposed on those entities if the entity "exercises discretionary authority" over the coverage decision and if the patient can prove that the coverage decision caused the injury. According to its sponsors, this provision is designed to permit patients to hold managed care organizations accountable for their coverage decisions, while insulating employers (particularly small employers) who have no control over these coverage decisions from expanded liability. In addition, the House bill clarifies that certain acts (such as the decision to (1) include or exclude any specific benefit from a health plan, (2) provide extra-contractual benefits, or (3) not provide a benefit while internal or external review is being conducted) are not to be considered "exercise of discretionary authority," and thus these actions would not expose employers and other plan sponsors to additional liability.

In contrast, the Senate bill does not provide for any expansions of the right to sue or additional remedies available to injured participants.

BRIEF COMPARISON OF MAJOR FEATURES OF THE HOUSE AND SENATE VERSIONS OF H.R. 2990

PROVISIONS	HOUSE VERSION	SENATE VERSION
I. SCOPE OF COVERAGE *(i.e., entities to which the new rules apply)*	• All ERISA group health plans (insured and self-insured) • All non-ERISA group health plans (i.e., governmental plans, church plans) • Health insurance issuers providing individual health insurance coverage • Health insurance issuers providing group health coverage	• ERISA self-insured group health plans only (for purposes of new patient protections) • All ERISA group health plans (insured and self-insured) (for purposes of internal and external appeals provisions) • Same as House bill for provisions relating to (1) minimum hospital stays for mastectomies, and (2) prohibitions relating to genetic information
II. PATIENT PROTECTIONS		
A. Point-of-Service (POS) Requirement	Yes	Yes, but self-insured ERISA plan exempt from requirement if (1) POS coverage is unavailable or inaccessible, or (2) if plan is sponsored by small employer (i.e., one averaging 2-50 employees)
B. Access to Providers		
1. Patient chooses primary care provider (PCP) or specialist	Yes	No
2. Specialists may be used as gatekeepers for "ongoing special conditions"	Yes	No
3. Standing referrals for certain ongoing care required	Yes	No; but enrollee may obtain a single referral for several specialty care visits, provided that the referral is for an "adequate number" of future visits

PROVISIONS	HOUSE VERSION	SENATE VERSION
C. Access to Emergency Care		
1. Prior authorization prohibited if emergency	Yes	Yes
2. Prudent layperson definition of an emergency required	Yes	Yes
3. Emergency services may only be obtained in the emergency room	Yes	No, emergency services may be obtained on an inpatient or outpatient basis
4. Enrollee may use out-of-network providers for emergency services	Yes	Yes, but only if preauthorization obtained
5. Enrollee cannot be charged more for using out-of-network providers for emergency services	Yes	Yes, but only if preauthorization obtained
D. Self-Referral for OB/GYN Services	Yes	Yes
E. Child has Right to Use Pediatrician as PCP	Yes	No, but if the PCP is not a pediatrician, child must be permitted to self-refer to a pediatric specialist for routine pediatric services
F. Continuity of Care		
1. Enrollee has right to continue coverage with treating provider under certain circumstances	Yes	Yes
2. Nature of condition(s) triggering right to continuation	(1) "Ongoing special conditions" (i.e., a life-threatening, degenerative or disabling condition that requires specialized medical treatment over time), and (2) pregnancy	(1) Institutional care, (2) 2nd trimester of pregnancy or later, and (3) terminal illness (as defined under Medicare's eligibility rules for hospice benefit)
3. Length of continuation period	(1) For ongoing special conditions, 90 days, (2) for pregnancy, through post-partum period	(1) If institutionalized, to date of discharge, (2) if pregnancy, through post-partum period, (3) if terminal illness, for remainder of enrollee's life

PROVISIONS	HOUSE VERSION	SENATE VERSION
G. Access to Prescription Drugs		
1. Physicians must be involved in development of formulary	Yes	Yes
2. Formulary restrictions must be communicated to physicians	Yes	No
3. Formulary restrictions must be disclosed to enrollees upon request	Yes	No
4. Physicians and enrollees can get copy of formulary	Yes	No
H. Clinical Trials		
1. Discrimination against enrollees participating in clinical trials prohibited	Yes	Yes, but only for clinical trials for cancer
2. Payment of "routine medical costs" required	Yes	Yes, but only for clinical trial for cancer
I. Physician "Gag Clauses" Prohibited	Yes	Yes
J. Improper Physician Incentive Plans Prohibited	Yes	No
K. "Whistleblower" Protections for Health Care Providers	Yes	No
L. Minimum Hospital Stays for Mastectomies Mandated	No	Yes; but no specific number of days mandated, instead timing of discharge may only be based on determination of treating physician (in consultation with patient)
III. BENEFIT CLAIMS AND APPEALS PROCEDURES		
A. Utilization Review (UR)		
1. UR decision must be based on written clinical review criteria based on valid clinical evidence	Yes	No, but plans/issuers must have procedures to make UR decisions

PROVISIONS	HOUSE VERSION	SENATE VERSION
2. Maximum plan response time for routine requests	14 days	30 days
3. Maximum plan response time for expedited requests (request must be expedited when use of routine time frames would jeopardize the life or health of patient)	72 hours	72 hours
4. Maximum plan response time if services have already been provided	30 days	30 working days
5. Written notice of denial required which includes clinical rational for denial	Yes, notice must be understandable to individual patient	Yes, notice must be understandable to average enrollee
B. Internal Plan Appeals Procedures		
1. Disputes eligible for internal plan appeal	Denied "claim for benefits," i.e., "any request for coverage (including authorization of coverage), for eligibility, or for payment in whole or in part, for an item or service under a group health plan or health insurance coverage" that has been denied in whole or in part	"Adverse coverage determination," i.e., determinations that items or services are not covered or reimbursable under the terms of the contract
2. Qualifications of reviewers		
a. Reviewer must be a physician	Yes	Generally no, but individual must have "appropriate expertise"; physician required only if denial based on lack of medical necessity, investigational or experimental treatment
b. Reviewer can be same as one involved in original decision	No	No
3. Maximum period for plan's decision	14 days (72 hours for expedited case)	30 working days (72 hours for expedited case; burden on provider to demonstrate that expedited treatment is appropriate through submission of written evidence

PROVISIONS	HOUSE VERSION	SENATE VERSION
		satisfactory to plan)
4. Written notice of denial required	Yes, including the specific reasons for denial and description of rights and procedures for further appeal; notice must be understandable to individual patient	Yes, including the specific reasons for denial and description of right and procedures for appeal; notice must be understandable to average enrollee
C. Grievances		
1. Definition of a grievance	Any question, complaint, or concern raised by a (1) participant, beneficiary or enrollee, or (2) provider, that is not a "claim for benefits"	Any complaint by a participant or beneficiary that does not involve a "coverage determination"
2. Separate grievance procedure must be established	Yes; procedures must include mechanisms for resolving and following-up on grievances	Yes
3. Is grievance appealable under separate grievance procedure	Yes; at the discretion of the plan/issuer	No
D. Independent External Review of Plan's Decision		
1. Exhaustion of plan's internal review process required	Yes; if plan/insurer so requires	Yes
2. Disputes eligible for external review	"Externally appealable decision" - this means denial of a claim for benefits based on (1) lack of medical necessity, or classification of treatment as experimental or investigational, or (2) coverage decision involving medical judgment; also appealable if plan failed to make a timely decision on claim for benefits under the plan's internal review process	"Adverse coverage decision" - this means a decision that meets (1) and (2) below: (1) service would have been a covered benefit if medically necessary, or if not experimental or investigational (or plan failed to make timely coverage decision under the plan's internal review process), and (2) (A) the amount of each item or service exceeds a significant financial threshold (not defined in bill), or (B) there is a significant risk of

PROVISIONS	HOUSE VERSION	SENATE VERSION
		placing the life or health of patient in jeopardy
3. *Challenges to plan exclusions or limitations eligible for external review*	Yes, if they involve questions of medical judgment	No
4. *Who decides whether dispute eligible for external review*	External reviewer	Group health plan
5. *Who selects reviewer*	Plan selects review entity; review entity selects individual reviewer	Same as House bill
6. *Review entity/reviewer must be independent*	Yes	Yes
7. *External reviewer must defer to plan's definition of medical necessity*	No; reviewer makes "de novo" determination of whether decision "is in accordance with the medical needs of the patient involved"	Most likely yes; reviewer must make "independent determination" of medical necessity, but decision for external reviewer is whether or not the patient is entitled to coverage or reimbursement "under the contract"
8. *Evidence that may be considered*	• Internal appeals decision and guidelines or standards used in making decision • Patient's personal and medical information • Opinion of treating physician • Studies meeting recognized standards of professionalism appearing in peer-reviewed journals • Results of professional consensus conferences conducted/financed by government • Practice/treatment guidelines prepared/financed by government • Government-issued coverage/treatment	• Valid, relevant, scientific and clinical evidence • Appropriate and available information, including: o evidence-based decision-making or clinical practice guidelines used by group health plan or issuer o timely evidence or information submitted by plan, issuer, patient, or treating physician o patient's medical record o expert consensus, including generally accepted medical practice and best practices

PROVISIONS	HOUSE VERSION	SENATE VERSION
	policies • Community standard of care/generally accepted principles of professional medical practice • Expert opinions directly related to matter of appeal, if individuals free of conflict of interest • Results of peer review by plan or issuer involved, if free of conflict of interest	o medical literature as defined in Federal Food, Drug, and Cosmetic Act o certain standard reference compendia o findings, studies or research conducted/funded by federal government or certain federal research agencies
9. Maximum time for decision	21 days after request for review (72 hours for expedited review)	30 working days after later of (1) date reviewer designated, or (2) date all information necessary to complete the review is received (72 hours after the later of the above for expedited review)
10. Decision binding on plan and issuer	Yes	Yes, but only if external reviewer complied with procedures under bill
11. Penalty for failure to comply with external review decision	Yes, civil penalties	Yes, civil penalties plus enrollee has right to secure services and be fully reimbursed , even if services provided by non-network providers
IV. ERISA PREEMPTION AND HEALTH PLAN LIABILITY		
A. Applicability of State Patient Protections Laws	Current law retained: states retain ability to regulate issuers, but still cannot directly regulate ERISA plans (insured or self-insured)	Same as House bill

PROVISIONS	HOUSE VERSION	SENATE VERSION
B. Health Plan Liability		
1. State personal injury and wrongful death laws apply (i.e., are not preempted) in connection with providing insurance, administrative services, or medical services to ERISA-covered group health plans	Yes	No
2. Punitive damages available only if plan/issuer fails to follow decision of external reviewer	Yes	No
3. Group health plans, employers, and plan sponsors are exempt from state personal injury or wrongful death actions unless they exercise "discretionary control" over coverage decision and that exercise of control resulted in patient's injury or death	Yes	No
C. Limitations on Lawsuits		
1. Class actions prohibited for violations of new patient protection provisions	Yes	No
2. Relief available to individuals in suits involving new patient protections limited to providing denied benefits, plus attorneys' fees and costs	Yes	No

The Henry J. Kaiser Family Foundation
2400 Sand Hill Road
Menlo Park, CA 94025

650-854-9400 Facsimile: 650-854-4800

Washington Office:
1450 G Street N.W., Suite 250
Washington, DC 20005

202-347-5270 Facsimile: 202-347-5274

http://www.kff.org

Additional free copies of this publication (#3012) are available on the Foundation's website at www.kff.org or by calling the Kaiser Family Foundation's Publication Request Line at 1-800-656-4533.