<table>
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<th>ISSUE</th>
<th>H.R. 2990 – Senate Passed Amendment Patients Bill of Rights Plus Act, 10/14/99 (originally S. 1344)</th>
<th>H.R. 2990 – House Passed Version Division B—Bipartisan Consensus Managed Care Improvement Act of 1999, 10/14/99</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td>Health Plan Liability</td>
<td>No provision</td>
<td>Permits a plan participant/beneficiary (or the estate of either) to bring a cause of action in state court to recover damages resulting from personal injury or wrongful death against any person in connection with the provision of insurance, administrative services or medical services, or that arises out of the arrangement of such services, to or for a group health plan. Personal injury is defined as a “physical injury and includes injury arising out of the treatment (or failure to treat) a mental illness or disease.” §1302(a)/ ERISA §514(f)</td>
<td>In General: The House bill provisions will discourage plan sponsors – employers and unions – from voluntarily providing health benefits to employees. This is because the bill inappropriately expands state tort liability to all “group health plans” and treats health plan administration as if it were the same as medical practice. Any activity by any person that involves the provision or arrangement of insurance, administrative services, or medical services may give rise to a medical liability lawsuit.</td>
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<td>No person is liable for punitive, exemplary, or similar damages if cause of action under state law relates to an external appeal decision and the plan/issuer complied with external appeal requirements and the determination of the external appeal entity in a timely fashion. §1302(a)/ ERISA §514(f)</td>
<td>Meaningless Employer Exception: The House bill, for the first time in federal law, explicitly imposes tort liability directly on any “employer” that exercises discretion (i.e., makes a choice or decision regarding a health benefit plan) on a claim for benefits. This meaningless exception would not bar a lawsuit against an employer. In the separate role as a plan sponsor, an employer is always a “fiduciary” (defined by law as a person who exercises discretion). This exception merely offers a defense, and an employer would have to expend time and costs to prove in court that discretion was not exercised. Only by relinquishing control of employer-provided benefits would an employer be able to raise successful defenses to liability.</td>
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<td>Subjects group health plan, employers, or other plan sponsors maintaining a group health plan, or employees of such employer acting within scope of employment, to liability if they exercise “discretionary authority to make a decision on a claim for benefits covered under the plan or health insurance coverage in the case at issue; and the exercise . . . of such authority resulted in personal injury or death.” §1302(a)/ ERISA §514(f)</td>
<td>Illusory Punitive Damages Limit: The House bill includes a meaningless “safe harbor” and preempts state law punitive damages in very limited circumstances. Such a “safe harbor” would apply only where the group health plan approves coverage in accordance with the determination of an independent external review entity. In fact, plans would provide the care ordered by such a review without the “safe harbor” language, and so the provision has no real impact. This will, ironically, discourage plaintiffs from seeking external review – a means to a quicker, more direct solution – because if they do not, they can then go directly to court. The trial bar, preferring actions where punitive damages are available, will encourage this approach.</td>
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<td>Exercise of discretionary authority not construed to include: a decision to include/exclude any specific benefit from the plan; any decision to provide extra-contractual benefits; or any decision not to consider the provision of a benefit while internal or external review is being conducted. §302(a)/ ERISA §514(e)</td>
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<td>Individuals are not required to exhaust administrative remedies (internal or external appeals) when injury or death has occurred before completion of such processes. §1302(a)/ ERISA §514(f)</td>
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Act of 1999, 10/14/99 | COMMENTS |
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<td>Medical Necessity</td>
<td>No provision</td>
<td>Provisions do not contain a specific definition for medical necessity, but do provide that a qualified external appeal entity (QEAE) shall determine whether the decision of the plan/issuer is in accordance with the medical needs of the patient, based upon specified evidence at the time of the external review entity’s decision. The QEAE would not be bound by plan’s definition of medical necessity. Among the evidence that a QEAE could take into consideration in evaluating denials of claims involving “medical judgment,” questions of medical necessity or appropriateness, or the investigational or experimental nature of a course of treatment are “[c]ommunity standard of care and generally accepted principles of professional medical practice” and “government-issued coverage and treatment policies.” §1103/ ERISA §514(f)</td>
<td>In General: The House bill permits an independent external review panel of providers to substitute fundamental provisions in an insurance or health plan contract for standards manufactured in the appeals process by the provider panel. This could render a private contract negotiated between health plans and plan sponsors meaningless, and the obligations of the health plan would become uncertain, and this uncertainty would result in higher premiums. Sanctity of Contracts: A plan could become obligated to pay for items and services based upon standards outside the contract. This would have the effect of destroying the ability of the parties to negotiate terms and conditions of contractual agreements. The “reasonableness” of the plan’s determination would be replaced by the external provider panel’s own standard, which would vary with each panel that reviews each case, and the obligation of the health plan would become uncertain, leaving the plan and plan sponsor open to being sued for inequitable treatment of similar claims. Quality and Solvency: As a result of such concerns, plans may decide to pay many claims that they otherwise would not, regardless of their “medical necessity” and the outcome for the patient, in order to avoid abrogation of the contract by the external review panel. The use of ad hoc standards imposes costs for unanticipated treatments not reflected in the actuarial data used to price the health plan’s premium. This could well lead to health plan insolvency or, at a minimum, would introduce pricing factors that will increase the cost of coverage.</td>
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<td>Patients Bill of Rights Plus Act, 10/14/99</td>
<td>Division B—Bipartisan Consensus Managed Care Improvement</td>
<td>Act of 1999, 10/14/99</td>
<td>In General: These bills do not assure national uniformity in the application of plan standards. Both bills assure dual regulation of group health plans.</td>
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**Scope:**

**Amendment:** application of federal and state laws:

Grievance/Appeals/Disclosure: provisions apply to all ERISA group health plans; states may not enact provisions that “relate to” ERISA plan.

Breast Cancer Treatment: provisions apply to all group health and individual health plans; states may not enact provisions that prevent application of federal law with respect to insured plans (HIPAA model) or that “relate to” ERISA plan.

**Version:** application of federal and state laws:

Grievance/Appeals/Disclosure/ Liability: provisions apply to all group health and individual plans; states may not enact provisions that “relate to” ERISA plans; provides for non-preemption of “actions” under state law to recover damages for personal injury or wrongful death in connection with, or arising from, provision of insurance, administrative, or medical services; includes “actions” based on group health plan, employer/plan sponsor exercise of discretion. Grants states the ability to select external appeal entities for issuers.

**COMMENTS**

**Scope:**

Inter-relationship of federal and state laws:

Application of federal and state laws:

Grievance/Appeals/Disclosure: provisions apply to all ERISA group health plans; states may not enact provisions that “relate to” ERISA plan.

Breast Cancer Treatment: provisions apply to all group health and individual health plans; states may not enact provisions that prevent application of federal law with respect to insured plans (HIPAA model) or that “relate to” ERISA plan.

**Utilization Review**

Requires every employee benefit plan conducting utilization review (UR) to provide adequate written notice of denial to plan participants/beneficiaries and to provide for a fair and fair review. UR is defined as “a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.” §121(a)/ERISA §503(a),(b),(g)

Requires group health plan or health insurance issuer conducting UR to make eligibility, copayment determinations; notify plan participants/beneficiaries and treating health care professionals; and respond to oral/ written requests from the plan participant/beneficiary or treating health care professional (with consent of plan participant/beneficiary).

Requires group health plans (plans) and group and individual health insurance issuers (issuers) providing health insurance coverage and any outside agents to conduct utilization review (UR) only in accordance with specified requirements. UR defined as “procedures used to monitor or evaluate the use or coverage, clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings, and includes prospective review, concurrent review, second opinions, case management, discharge planning, or retrospective review.” §1101(a)/ ERISA §714

Requires UR to be conducted consistent with written policies and procedures, utilizing clinical review criteria developed with input from a range of health care professionals (directed to meet needs of at-risk populations and individuals with severe illnesses/chronic conditions using gender-specific and pediatric-specific criteria where available). §1101(b)/ ERISA §714

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Requires UR personnel be “reasonably accessible by toll-free telephone during normal business hours” with appropriate provision for prompt response during other hours. UR shall not be furnished more frequently than reasonably required to assess medical necessity. §1101(c)/ERISA §714

In General: Both bills define “utilization review” as involving a “clinical” decision making process, thus wrongly transforming an administrative procedure for coverage and payment decisions into a medical procedure. This overturns consistent federal court decisions determining “utilization review” to be an administrative procedure and could subject coverage and payment determinations to state tort liability as “medical” decisions.

**Overly Broad Definition:** Both bills cast a wide net over the types of “techniques” that would be classified as “utilization review.” For example, by including second opinions in the definition, many fee-for-service arrangements would become subject to full UR standards. Another effect would be to eliminate plan/issuer flexibility by “freezing” current techniques in statute, preventing the evolutionary development of new quality enhancing tools.

**Micromanagement Concerns:** The House bill imposes over 70 new requirements for “utilization review” procedures that would micromanage health plans. The bill would impose shortened and ambiguous time deadline standards for “group health plans” to meet in making claims determinations.

**Timeframes:** These are overly rigid, ambiguous, and much shorter than reasonable requirements that are defined on a case-by-case basis. Timelines do not distinguish between preauthorization of a service and claim payment for an already delivered medical service. This would create opportunities for mistakes due to hurried
### Utilization Review (continued)

| Time limits: | Sets prior authorization review decision time periods (non-emergency services, 30 days; expedited, 72 hrs). Plan participant/beneficiary may request that plan determine need for "expedited" review. Permits treating health care professional to document need for "expedited" review. |
| Time limits: | Requires UR determination be made w/in 14 days. Can be extended for 14 days if a request for necessary information is provided no later than 5 business days after receipt. Requires medical exigency (not defined) consideration. Expedited decision w/in 72 hours. Concurrent determination as soon as possible as needed, w/ sufficient time for appeal. Requires retrospective review of previously provided services w/in 30 days of receipt of information, and in no case later than 60 days. Reference to special rules for emergency services, maintenance of care, post-stabilization care in §1113(a), (b). Treats failure to meet deadline as a denial of the claim. §1101(d)/ERISA §503(b) |

### Claim Definition And Payment

| Definition: A coverage determination is defined as, with respect to items and services for which coverage may be provided under a health plan, a determination of whether or not such items and services are covered or reimbursable under the coverage and terms of the contract. §121(a)/ERISA §503(g) |
| Definition: A claim for benefits is defined as "any request for coverage (including authorization), for eligibility, or for payment in whole or in part, for an item or service under a group health plan or health insurance coverage." A denial is defined as "a denial, or a failure to act on a timely basis upon, in whole or in part, the claim for benefits and includes a failure to provide benefits (including items and services) required to be provided under this title." §1101(ERISA §714 |

### Appeals and Grievance Procedures

| Requires group health plan or health insurance issuer to have written grievance procedures to deal with complaints by participant/beneficiary that do not involve a coverage determination; determinations to be nonappealable. §121(a)/ERISA §503(c) |
| Requires group health plan and health insurance issuer in connection w/ health insurance coverage to establish/maintain a system to provide for presentation or resolution of oral/written grievances (not a claim for benefits). § 1104(a)/ERISA §714 |

| Requires review of an adversed coverage determination be conducted by an individual with appropriate expertise not directly involved in initial determination. Requires review related to medical necessity and appropriateness, or based on experimental or investigational treatment, be conducted by physician with appropriate expertise, including age-appropriate expertise, who was not involved in initial decision. §121(a)/ERISA §503(d) |
| Requires group health plans and health insurance issuers offering health insurance coverage to provide adequate notice in writing to plan participants/beneficiaries whose claim has been denied reasons for denial/rights to appeal, in manner to be understood by participant, beneficiary, enrollee, or representative. Requires full and fair review w/in 180 days. Request for review may be made orally (must be followed up in writing, no time specified). §1102(a)/ERISA §714 |

### Internal Review

| Requires prior authorization review decision time periods (non-emergency services, 30 days; expedited, 72 hrs). Plan participant/beneficiary may request that plan determine need for "expedited" review. Permits treating health care professional to document need for "expedited" review. |
| Requires UR determination be made w/in 14 days. Can be extended for 14 days if a request for necessary information is provided no later than 5 business days after receipt. Requires medical exigency (not defined) consideration. Expedited decision w/in 72 hours. Concurrent determination as soon as possible as needed, w/ sufficient time for appeal. Requires retrospective review of previously provided services w/in 30 days of receipt of information, and in no case later than 60 days. Reference to special rules for emergency services, maintenance of care, post-stabilization care in §1113(a), (b). Treats failure to meet deadline as a denial of the claim. §1101(d)/ERISA §503(b) |

### Comments

| In General: The bills do not clearly distinguish between coverage determinations and payment decisions. They would apply the standards established for coverage determinations to claim payment decisions. This is particularly inappropriate for payment decisions because the provider has already delivered the treatment or service. |
| In General: The use of the phrase “grievance” is easily confused with appeals for coverage denials. The types of issues under the “grievance” provisions are more clearly “complaints.” |
| In General: These bills would impose over 100 new requirements in relation to appeals for coverage denials. The types of issues under the “grievance” provisions are more clearly “complaints.” |
| Both bills would condition timelines on “medical exigency.” The actual timelines imposing duties and penalties for failure to meet the deadlines would be defined on an ad hoc basis by individual circumstances in each case. The meaning of “medical exigency” is not clear; but, a provider could shorten the “standard” deadline of 14 days to 1 day or 1 hour for any “sudden”/”urgent” medical problem. Industry compliance would be difficult and costly. |

### Prompt Payment:

| Requires group health plan or health insurance issuer to have written grievance procedures to deal with complaints by participant/beneficiary that do not involve a coverage determination; determinations to be nonappealable. §121(a)/ERISA §503(g) |
| Requires group health plan and health insurance issuer in connection w/ health insurance coverage to establish/maintain a system to provide for presentation or resolution of oral/written grievances (not a claim for benefits). § 1104(a)/ERISA §714 |

| Requires group health plan or health insurance issuer conducting UR to permit requirements in on participants or beneficiaries to appeal an adverse coverage determination for up to 180 days of date of denial. §121(a) ERISA §503(d) |
| Requires group health plans and health insurance issuers offering health insurance coverage to provide adequate notice in writing to plan participants/beneficiaries whose claim has been denied reasons for denial/rights to appeal, in manner to be understood by participant, beneficiary, enrollee, or representative. Requires full and fair review w/in 180 days. Request for review may be made orally (must be followed up in writing, no time specified). §1102(a)/ERISA §714 |

| Both bills would inappropriately broaden the scope of matters that are subject to review due to the definition of “claims.” As previously noted, payment decisions may be subject to these rules. The provision of 180 days in which to request an appeal in both bills is unreasonable long. The current 60 day rule under ERISA has worked well and is consistent with state law and the NAIC model. |

| Transfer of funds with respect to benefits covered by the plan/issuer in a manner consistent with the Social Security Act. §§1134/ERISA §714 |
| Prompt payment: Requires prompt payment of claims for health care services or supplies with respect to benefits covered by the plan/issuer in a manner consistent with the Social Security Act. §1134/ERISA §714 |

### Summary:

| H.R. 2900 – Senate Passed Amendment to Fix Patients Bill of Rights Plus Act, 10/14/99 (originally S. 1344) |
| H.R. 2900 – House Passed Version of Bipartisan Consensus Managed Care Improvement Act of 1999, 10/14/99 |

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<td>decision-making. In effect, all claims payment determinations would have to be made within 5 days of claim receipt in order to determine whether any additional information would be needed to pay a claim. This would apply the 5 day rule to literally billions of claims reviewed annually and currently paid within a 36 day period. Pressure to comply with this requirement would harm consumers by forcing needless claims denials for insufficient information.</td>
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| Medical Exigency: Both bills condition timelines on “medical exigency.” The actual timelines imposing duties and penalties for failure to meet the deadlines would be defined on an ad hoc basis by individual circumstances in each case. The meaning of “medical exigency” is not clear; but, a provider could shorten the “standard” deadline of 14 days to 1 day or 1 hour for any “sudden”/”urgent” medical problem. Industry compliance would be difficult and costly. |

| Fraud: These standards would make health plan/issuer detection of fraud/abuse more difficult as claims payment decisions would be made not on the basis of the facts of a claim, but on the basis of meeting artificial time deadlines. |
Internal Review (continued)

Time limits: Sets same timelines as for initial determination for initial appeal. Sets notice of determination to the plan participant/beneficiary and treating health care professional (routine: written notice within 2 working days of completion of review; expedited: within the 72 hr. review period). §112(a)/ERISA §503(d)

Failure to respond within guidelines shall be treated as an adverse determination.

Notice: must include reasons for determination, including clinical or scientific evidence based rationale, procedures for obtaining additional information and notice of right to independent external review. Plans must maintain appeal records for 6 yrs. §121(a)/ERISA §503(d)

Appeals and Grievance Procedures

External Review

Requires group health plan/health insurance issuer in connection w a group health plan to have external appeals process for adverse coverage determinations regarding (1) medically necessary and appropriate services if (a) service exceeds a significant financial threshold or (b) patient's life/health is in jeopardy; OR (2) services are experimental or investigational; AND (3) plan participant/beneficiary has completed internal appeals process.

Requires group health plan/health insurance issuer to permit plan participants to file written request for independent external review of adverse determination within up to 30 days of denial date. §121(a)/ERISA §503(e)

Failure of group health plan/health insurance issuer to meet timeline requirements would be treated as adverse determination.

Timeframes for selection of a qualified external appeals entity (QEAE), and for submission of information to QEAE: Routine: 5 working days or less; for parties (plan, participant/beneficiary, or physician) to forward necessary information to QEAE: 5 working days or less after notice by plan or issuer. Requires follow-up written notice to plan participant/beneficiary and plan administrator from plan or issuer. §121(a)/ERISA §503(e)

Qualifications for QEAE: Must be licensed or credentialed by a state; state agency established to conduct independent external reviews; an entity under contract with the federal government to provide such services; an entity accredited as such by an accrediting body recognized by the Secretary; or an entity recognized as meeting criteria established by the Secretary. Requires QEAE to designate one or more independent external reviewers (IERs) within 30 days or less of notification by plan or issuer. §121(a)/ERISA §503(e)

Qualifications for IER: Must be appropriately licensed/credentialed in a state; have no material, professional, familial, or financial affiliation with case under review or parties to it; have appropriate expertise (including age-appropriate) in diagnosis, treatment under review; be of the same specialty as treating health care professional; compensation not tied to decision rendered. IER would only be liable for arbitrary and capricious medical determinations. §121(a)/ERISA §503(e)

Requires review of denial of claim involving medical judgment by physician, or by an appropriate specialist in the case of limited scope coverage, who did not make initial determination. §1102(b)/ERISA §714. Defines limited scope coverage as coverage of only dental or vision benefits (or other coverage defined in regulation). (Does not include long-term care in definition of limited scope benefits.) §1102(b)/ERISA §714

Time limits: Review to be completed w/in 14 days (in accordance with the medical exigencies). Failure to make determination in timeframe treated as claim denial. If request for additional information is sent w/in 5 business days of receipt of request review, period extended for 14 days. §1102(b)/ERISA §714

Expeditied review: (1) w/in 72 hrs or before the end of approved period of care for on-going care, (2) when normal timeframe could seriously jeopardize life or health or ability to regain maximum function or continuation of coverage.

Notice: Requires plan/issuer to provide basis for decision/appeal rights in notice of denial. Permits information to be transmitted by telephone, fax, or other similarly expeditious method. §1102(c)/ERISA §714

Requires plan/issuer to provide written notice of requirement for internal review and proceed directly to external appeals process. §1102(d)/ERISA §714 Requires system to record/document appeals for at least 3 years §1104(b)/ERISA §714

In General: The House bill inappropriately references “medical judgment” decisions of a plan, this wrongly characterizes coverage and payment decisions as medical decisions. Also, use of a plan’s “failure to timely act” on a review request must be applied only when a plan has all of the information needed to make a decision. The concerns cited above about the timeframes required for the plan also apply, particularly with respect to the use of “medical exigency.” This would establish a case-by-case standard that would be impossible to meet and would only create opportunities for the trial bar.

Qualifications of Reviewers: The bills establish requirements that may be impossible to meet and could needlessly disqualify some of the nation’s most qualified expert medical reviewers. The independence requirements establish conflict-of-interest standards that are so overly broad that no one may be able to qualify as a reviewer. Certain professional relationships (e.g., reviewer affiliation w/ a hospital that participates in the health plan’s network) would be appropriately characterized as a conflict under this broad standard.
Standard of IER review: Requires IER to (1) make an independent determination based on valid, relevant, scientific and clinical evidence to determine the medical necessity, appropriateness, experimental or investigational nature of the proposed treatment; (2) take into consideration appropriate, available information including (a) any evidenced-based decision making or clinical practice guidelines used by the group health plan or health insurance issuer; (b) timely evidence or information submitted by the plan, issuer, patient or patient's physician; (c) the patient's medical records; (d) expert consensus including: (i) literature as defined in section 556(5) of the Federal Food, Drug, and Cosmetic Act; (ii) the following standard reference compendia: The American Hospital Formulary Service Drug Information, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information; and (iii) findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the Agency for Healthcare Research and Quality, National Institutes of Health, National Academy of Sciences, Health Care Financing Administration, and any national board recognized by the National Institutes of Health for the purposes of evaluating the medical value of health services. §121(a)/ERISA §503(e)

Notice: Requires plan or issuer to ensure that participant/beneficiary receives notice within 30 days of determination by IER.

Timeframes for IER review: Determined by medical exigencies of the case: expedited: no longer than 72 hrs; routine: 30 working days/less after later of: date assigned or date when all necessary information received. §121(a)/ERISA §503(e)

Other: Requires GAO to study completed independent external reviews and report to Congress within 2 yrs. §121(a)/ERISA §503(e)

Nothing in this section shall be construed as modifying section 514 of ERISA (preemption) with respect to a group health plan. §121(a)/ERISA §503(f)

Binding determination/reimbursement: Proper decision of IER is binding on plan or issuer. Requires IER to set timeframe in which plan or issuer must provide coverage. If plan/issuer does not comply, participant/beneficiary may obtain items or services from any provider, and plan/issuer must reimburse for the total costs regardless of plan limitations as long as the services would have been covered and are provided consistent with the IER’s determination. Plan/issuer can be sued for unpaid costs and any necessary legal expenses. §121(a)/ERISA §503(e)

Rule of construction: Nothing shall prohibit a plan administrator, plan fiduciary, or health plan medical director from requesting an independent external review by an IER without first completing the internal review process. §121(a)/ERISA §503(f)

Enforcement: Civil Penalties: $10,000 assessment on the plan by the Secretary if no conflict of interest exists under regulations of Secretary. QEAE/Peer Reviewer Protection

The concept that an external review determination is binding on all parties contractually agree to be bound by such a decision.
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<td><strong>Information Disclosure</strong></td>
<td>Requires a group health plan and a health insurance issuer that provides coverage in connection with a group health plan to provide comparative plan information on: covered items and services, in-network/out-of-network features, limits on cost-sharing, optional supplemental benefits, PCP selection, definition of “medical necessity”, appeals and grievances, access to OB/GYN or pediatricians, formularies/requests for off-formulary medications, continuity of care, access to medical records, compensation information and UR procedures. Requires Secretary of HHS to conduct a study relating to provider competencies. §112/ERISA §714</td>
<td>Requires that plans/issuers provide in printed form, at the time of initial coverage, and at least annually thereafter, information on: service area, covered benefits (limits/exclusions), cost-sharing (deductibles/coinsurance/stability limitations), nonparticipating providers, experimental coverage, drug formularies, providers, POS options, referrals, accommodations for non-English speakers, emergency coverage, cost ratios, prior authorization rules, appeals, QA, information on issuer. §§1121(a), (b) &amp; (c)/ ERISA §714</td>
<td>In General: Much of the information requiring disclosure should already be provided under current ERISA Summary Plan Description requirements. The provisions assume that inundating individuals with more information is better for consumers, without an assessment of its actual value to individuals. Some of the proposed requirements may unintentionally cause compulsory disclosure of otherwise proprietary information to ease the discovery process for the trial bar. This provision would impose over 70 new requirements on health benefit plans and would increase administrative costs, which will have to be reflected in premiums.</td>
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<td><strong>Emergency Medical Services</strong></td>
<td>Requires a group health plan, “other than a fully insured group health plan,” to use a “prudent layperson” standard for medical evaluation, necessary emergency care services, “emergency ambulance services” including additional emergency care to stabilize an emergency medical condition following an emergency medical screening. §101/ERISA §721</td>
<td>Requires plan/issuer providing any benefits for services “in an emergency department of a hospital” to provide coverage w/out prior authorization, whether or not furnished by a participating provider; a plan participant/beneficiary would be liable only for copayments incurred as if services were provided in-network, without regard to any other term or condition of coverage (other than an exclusion, coordination of benefits, affiliation, waiting period, or applicable cost-sharing). §§1113/ ERISA §714</td>
<td>In General: The mandates for payment of all emergency medical services provided to a patient by a non-network provider must be limited to ensure that the covered medical services are directly related to the emergency medical condition for which the patient has sought care. Balance Billing: These provisions would limit the patient’s copayments to the level that would have been required if care had been received in-network, but they do not provide any comparable capping mechanism for health plan payments to non-network providers.</td>
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<td><strong>Medical Communications (&quot;gag clauses&quot;)</strong></td>
<td>Prohibits a group health plan, “other than a fully insured group health plan,” from restricting or prohibiting providers in communications with patients regarding health status of the participant or medical care/treatment for the condition/disease. §101/ERISA §727</td>
<td>Prohibits the provisions of any contract or agreement or the operation of any contract or agreement from restricting the ability of a health care professional to advise his/her patient regarding health status, medical care, or treatment regardless of whether such benefits are covered under the plan, if the professional is acting within the lawful scope of practice. § 1131/ ERISA §714</td>
<td>In General: The GAO has been unable to find any evidence of the existence of gag clauses in health plan provider contracts. But both bills, as drafted, would require review of every sentence in each network agreement, involving hundreds of complex clauses. For example, these provisions would establish a very subjective standard under which a provider might assert that a phrase or clause has the effect of prohibiting or restricting the provider’s ability to give desired advice. This ambiguous standard favors providers and will be used to challenge many contract provisions, such as those relating to quality of care, and render otherwise valid terms and conditions null and void. This approach would be used by the trial bar to bring frivolous lawsuits.</td>
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Access to Specialty Services

Requires a group health plan "other than a fully insured group health plan" to allow female participants whose PCP is not an OB/GYN direct access to OB/GYNs for
pregnancy, routine and preventive women's health care services. Requires plans to treat the ordering of other routine care by an OB/GYN as if the patient's PCP
authorized it. §101/ERISA §723

Requires group health plans "other than a fully insured group health plan" to allow child participants whose PCP is not a pediatrician direct access to pediatricians for
routine care. Requires plans to treat the ordering of other routine care by a pediatrician as if authorized by patient's PCP. §101/ERISA §724

Requires a group health plan, "other than a fully insured group health plan" to ensure participants have timely access to primary and specialty health care
professionals as needed for covered services. Coverage may be provided through
network providers or, if necessary, contractual arrangements with out-of-network providers.

Does not prohibit a plan from including providers only to the extent necessary to meet the needs of the participant. Plan may require that specialty care be
provided pursuant to a treatment plan developed by specialist in consultation with the
PCP or case manager and the participant, approved by the plan, and in accordance with plan QA and UR standards. §101/ERISA §725

Prohibits plan from requiring authorization or referral for coverage of gynecological care
and pregnancy related services of participating OB/GYNs. Provides care ordered by
participating professional as authorized by PCP. §1115/ERISA §714 Permits designation of pediatric specialist as a child's PCP. §1116/ERISA §714

Requires plans/issuers that provide for designation of primary care provider (PCP) to
permit each participant, beneficiary and enrollee to designate any participating PCP
who is available. §1112(a)/ERISA §714

Requires plans/issuers to provide medically necessary or appropriate specialty care
for enrollee suffering from a condition or disease of sufficient seriousness and complexity;
limits of choice of professionals w/ respect to such care. §1112(d)/ERISA §714

Requires plans/issuers to make available or provide for referral to a specialist for an
individual with a 1) condition or disease of sufficient seriousness and complexity; and 2) where benefits for such treatment are provided under the plan or coverage. A specialist
may be a health care practitioner, facility, or center that has adequate expertise through
training/experience. Plan/issuer may require that care be provided pursuant to a
treatment plan established by the specialist, approved by plan in accordance with
applicable QA and UR standards). Plan not required to provide for referral to
nonparticipating specialist, unless no participating specialist with appropriate
expertise is available. §1114(a)/ERISA §714

Continuity of Care—Transitional Care

Requires a group health plan, "other than a fully insured group health plan," to
notify plan participants on a timely basis of coverage termination/changes, provide
notice of termination, or through: post-partum care for enrollees in 2
weeks post-term of pregnancy, end of a period of institutionalization for persons so
confined, or end of life for terminally ill persons. Requires provider to accept plan
payment, adhere to plan standards, policies and procedures. §101/ERISA §726

Requires MedPAC to prepare and submit a report on costs, patterns of care for
persons with serious, complex conditions and possibilities of improving upon that
Continuity of care provisions should focus on
ensure participants have timely access to primary and specialty health care
professionals as needed for covered services. Coverage may be provided through
network providers or, if necessary, contractual arrangements with out-of-network providers.

The term "ongoing special condition" includes a condition that is life threatening,
and pregnancy related services of participating OB/GYNs. Provides care ordered by
participating professional as authorized by PCP. §1115/ERISA §714

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nonparticipating specialist, unless no participating specialist with appropriate
expertise is available. §1114(a)/ERISA §714

If plan refers individual to a nonparticipating provider, costs shall not exceed in-network
amounts. Requires plan to maintain procedures to coordinate care for individuals with
ongoing special conditions" (disease that is life threatening, degenerative or disabling
and requires care over a long period) to request/receive referrals to specialists.
Specialists above shall be permitted to treat w/out a referral from PCP. Requires
procedure for individuals who require ongoing specialty care to receive standing referral. §1114(b)/ERISA §714

Prohibits plan from requiring authorization or referral for coverage of gynecological care
and pregnancy related services of participating OB/GYNs. Provides care ordered by
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Permits designation of pediatric specialist as a child's PCP. §1116/ERISA §714 If plan
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Permits designation of pediatric specialist as a child's PCP. §1116/ERISA §714

In General:
The bills would allow individuals to seek
specialty care from non-participating providers. Application of an
ambiguously "medical exigency" standard will require a
case-by-case review of each of these requirements. Current law imposes strict duties upon plan fiduciaries to
decisions about the expenditure of limited plan assets in the best interests of each individual covered; however,
plan fiduciaries also are required to balance individual
needs against the needs of all plan participants. Fiduciaries can be held liable for inappropriately spending plan assets
on a few individuals when reviewed in the context of the
group's needs.

Effect on Plans Requiring PCPs: Particularly in health plans requiring the designation of a PCP, this provision will
undermine the ability of health plans to coordinate care for
the majority of health plan enrollees.

Impracticable language: The vagueness of the term
"appropriate specialist" will invariably lead to extensive legal
challenges to – and external appeals of – health plan
participating provider requirements.

This requirement would have a negative impact on health
care costs and, therefore, on the numbers of people without
health care coverage. More importantly, it would have a
negative effect on attempts by health plans to implement
managed care mechanisms designed to coordinate and
improve the quality for care for plan participants.

In General: Continuity of care provisions should focus on
the continuity and quality of care provided to the individual
in transition, not on the continuity of care delivered by the
provider. The granting of an independent right of transition
to plan participants would not encourage them to work with
their health plans during the transitional period to select
another provider when and as appropriate. The "notice
requirements of the proposals would create a tremendous
administrative burden that would result in attendant
significant cost increases. Depending on the type of
coverage plan involved, health plans are in many cases not

Summary prepared by the Policy & Information Department, Updated March 2000

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**CONTINUITY OF CARE/TRANSITIONAL CARE (continued)**

Requires posting a notice of this information. §1135(b)/ ERISA §714

**PROHIBITS RETALIATION/DISCRIMINATION AGAINST PROTECTED HEALTH CARE PROFESSIONALS**

Prohibits plans/issuers from retaliating against an individual or health care provider based on their participation in an UR/grievance process. §1135(a)/ ERISA §714

Enrollees responsible for additional premiums and cost sharing unless paid by sponsor through arrangement with issuer. §1111/ERISA §714

**POINT-OF-SERVICE (POS) OPTION**

Requires a group health plan, "other than a fully insured group health plan," providing coverage through a defined set of participating health care professionals to offer participants the option to purchase POS coverage at the time of enrollment/other terms the plan offers participants a choice of coverage options. §101/ERISA §722

Does not apply to plans which a POS coverage option is not available or accessible within reasonable promptness. Exempts self-insured small employers (at least 2, but not more than 50 employees).

Does not include coverage of providers that the plan excludes because of fraud or quality of care.

Allows plans to impose higher premiums/cost sharing, but does not require an employer to pay additional costs or to make additional contributions with respect to POS option. §101/ERISA §722

**PROVIDER NONDISCRIMINATION/RETALIATION**

Requires a health insurance issuer who offers enrollees health insurance coverage in connection with a group health plan that only provides for coverage of in-network services to also offer enrollees, at the time of enrollment and annually (during open season) thereafter, the option of non-network coverage through another group health plan or other health insurance issuer in the group market. §1111/ERISA §714

Enrollees responsible for additional premiums and cost sharing unless paid by sponsor through arrangement with issuer. §1111/ERISA §714

Prohibits plans/issuers from discriminating with respect to participation or indemnification of providers, solely on the basis of a provider’s license or certification. §1132/ ERISA §714

Does not require coverage of particular benefits/services; does not prohibit plans from establishing quality measures; does not prohibit inclusion of providers only to the extent necessary to meet needs of participants, enrollees, or beneficiaries. Does not override state licensure, scope-of-practice law, or require plan/issuer to include every willing provider who meets conditions of the plan. §1132/ ERISA §714

Prohibits plans/issuers from retaliating against an individual or health care provider based on their participation in an UR/grievance process. §1135(a)/ ERISA §714

Prohibits retaliation/discrimination against a protected health care professional because the professional: disclosed health care information to public regulatory agency, private accreditation body, or management personnel of the plan/issuer; or cooperated in an agency investigation. §1135(b)/ ERISA §714

**NOTICE**

Requires posting a notice of this information. §1135(b)/ ERISA §714

**ISSUE**

**H.R. 2900 – Senate Passed Amendment Patients Bill of Rights Plus Act, 10/14/99 (originally S. 1344)**

**H.R. 2900 – House Passed Version Division B—Bipartisan Consensus Managed Care Improvement Act of 1999, 10/14/99**

**COMMENTS**

**moved to code of 1999**

**A**

Summary prepared by the Policy & Information Department, Updated March 2000
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<td>Access to Clinical Trials</td>
<td>Requires a group health plan, &quot;other than a fully insured group health plan,&quot; to pay for the routine costs of approved cancer clinical trials. Routine payment costs do not include the cost of tests or measurements conducted primarily for the purpose of the clinical trial involved. §101/ERISA §730(a) Establishes a committee to develop standards for “routine costs.” §101/ERISA §730(a)</td>
<td>Prohibits plans from denying qualified individuals from participation in clinical trials; imposing additional conditions; failing to pay for routine patient costs; discriminating on basis of participation in such trial. Plan may require use of participating provider who is participating in the clinical trial. §1119(a)/ ERISA §714 Qualified individuals are those covered under the plan with life-threatening/serious illness, no effective standard treatment, and meaningful potential for significant benefit. §1119(b)/ ERISA §714 Requires payment of routine patient costs, but not those reasonably expected to be borne by sponsors. Approved clinical trials: clinical research study/investigation funded by one or more federal agencies (NIH, DVA, DOD). §§119(c) and (d)/ ERISA §714</td>
<td>In General: This mandate broadly includes certain procedures that have not been proven to be effective in cancer treatment, and which are more characteristic of basic research (Phases I and II). The requirement is open-ended and will prove to be costly. These provisions and those dealing with the requirements for external review of experimental or investigational treatment are redundant. If both were to be enacted, which one of these requirements would prevail? In addition, the mandate lacks appropriate patient safety standards and, as drafted, could expose patients to harm and plans to liability if a patient were to die as a result of a problematic trial. This mandate would raise the same concerns regarding plan fiduciary responsibility as cited above.</td>
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<td>Prescription Drugs</td>
<td>Requires a group health plan, &quot;other than a fully insured group health plan,&quot; that provides coverage for prescription drug benefits and limits the coverage to drugs in formularies, to ensure that physicians, pharmacists participate in formulary development, review. §101/ERISA §728 Requires plan coverage for non-formulary alternatives considered medically necessary and appropriate. §101/ERISA §728</td>
<td>Requires plan/issuers that limit drugs to those in formulary to ensure: 1) participation of participating physicians/pharmacists in development of the formulary; 2) disclose the nature of formulary restrictions to individuals and providers; and 3) provide for exceptions from formulary when non-formulary is medically indicated. §1118/ ERISA §714</td>
<td>In General: This mandate would broadly apply to plan benefit designs beyond a closed formulary. Prescription drug coverage can be more affordable under benefit designs that include variations in copayment structure. The proposed mandate would prohibit such “tiered” copays; this would increase premiums or require a reduction in benefits for consumers because plans would have to cover non-formulary drugs as preferred drugs. This provision would also limit the effectiveness of PBMs to control costs that have on average increased 10 percent to 20 percent annually in recent years.</td>
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<td>Mental Health</td>
<td>Prohibits a group health plan, &quot;other than a fully insured group health plan,&quot; from discouraging or prohibiting participants from self-paying for behavioral health care services, once the plan has denied coverage of such services. §101/ERISA §729(a)</td>
<td>No provision</td>
<td>In general: The provisions with respect to self-pay will complicate the administration of privacy protections. While individuals should have the discretion to spend their own money on personal health care as they choose to, allowing mental health providers to simply charge individuals for treatment that the health plan does not consider medically necessary or appropriate would effectively undercut one of the tools that health plans use to influence providers to use “best practices.”</td>
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<td>No provision</td>
<td>Prohibits any physician incentive plan unless requirements under the Social Security Act are met; applies requirements of the Social Security Act (relating to incentive plans) as if the appropriate Secretary imposes requirements. §§1133 (a), (b)/ ERISA §714</td>
<td>In general: The imposition of Medicare rules on the private health plan market would seriously impair the ability of plans to encourage quality care delivery. It is critical when, in light of the recently released Institute of Medicine study, up to 98,000 individuals have died because of medical mistakes, that health care quality incentives be applied appropriately. The provision assumes that “improper” provider incentives only exist in managed care, ignoring various arrangements that exist between providers that create incentives to over treat patients regardless of medical need. Providers are not required to even disclose such financial relationships with each other (i.e., physician hospital privileges, purchase of practices, joint ventures, provision of management services) or malpractice and disciplinary histories.</td>
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<td><strong>Services related to Mastectomies</strong></td>
<td>Requires group health plans/health insurance issuers that provide coverage in connection with a group health plan that provides medical and surgical benefits to ensure inpatient coverage for treatment of breast cancer determined by attending physician to be medically necessary, in consultation with the patient following a mastectomy, a lumpectomy, or a lymph node dissection. §201/ERISA §715</td>
<td>No provision</td>
<td>In General: These provisions would grant providers complete freedom from any utilization review requirements for the specific aspects of breast cancer treatment outlined and would attempt to obligate plans to reimburse providers for any treatment that they chose regardless of the merits of the course of treatment. Most importantly, it would prevent health plans from implementing managed care mechanisms designed to coordinate and improve the quality for care for consumers/plan participants. It continues the practice of mandating coverage by “body part.”</td>
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