

## Patient Protection Legislation in the 107<sup>th</sup> Congress

### Comparison of Key Issues in S. 889 Frist-Breaux-Jeffords and S. 1052 McCain-Edwards-Kennedy

	S. 889 Frist-Breaux-Jeffords	S. 1052 McCain-Edwards-Kennedy
<i>Comprehensive Patient Protections</i>		
<b>Emergency and Post-Stabilization Care</b>	<p>Requires group health plans and health insurance issuers that provide coverage for emergency medical care (screening and stabilization) and emergency ambulance services to provide coverage (1) without prior authorization based on a prudent layperson standard and (2) provided by participating and non-participating providers.</p> <p>Requires plans to provide coverage for medically necessary and appropriate services related to the emergency medical condition after the patient is stabilized if: (1) the plan fails to respond to a request for coverage within 1 hour of being contacted and (2) coverage for the services is available under the plan. The plan's responsibility for coverage of these services ends when the plan arranges for the transfer or discharge of the patient or other arrangements are made between the plan and non-participating provider. [§101]</p>	<p>Requires plans that provide or cover any benefits with respect to services in an emergency department of a hospital to provide coverage (1) without prior authorization, for emergency care (screening and stabilization) and emergency ambulance services based on a prudent layperson standard and (2) provided by participating and non-participating providers.</p> <p>Requires plans to cover post-stabilization care without prior authorization provided by non-participating providers until the plan arranges for transfer or discharge if: (1) the plan fails to respond to a request for prior authorization within 1 hour of being contacted by the provider or (2) the plan could not be contacted. [§113]</p>
<b>Point of Service (POS)</b>	<p>Requires group health plans that offer only a closed-panel plan to offer enrollees a coverage option with an out-of-network component. This requirement does not apply to small employers (those employing between 2-25 employees). The plan must make the POS option available at the time of enrollment and during any other times the plan offers enrollees a choice of coverage options. Plans are not prevented from imposing higher premiums or cost-sharing for the POS option. Requirements under this section specifically apply to limited scope dental benefits. [§102]</p>	<p>Requires health insurance issuers and group health plans that offer a closed-panel plan to offer (or arrange to offer) enrollees, participants and beneficiaries a coverage option with an out-of-network component, unless such enrollees, participants and beneficiaries are offered out-of-network coverage through another plan or issuer in the group market. The issuer or plan must make the POS option available at the time of enrollment and during an annual open season. The amount of any additional premium charged by the issuer and the amount of any additional cost sharing shall be borne by the enrollee unless paid for by the plan sponsor. [§111]</p>
<b>Choice of Provider</b>	No similar provision.	Requires plans that require or provide for the designation of a PCP to permit enrollees to designate any participating PCP available to accept them. Requires plans to permit enrollees to receive medically necessary and appropriate specialty care, pursuant to appropriate referral

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		procedures, from any qualified participating health care professional available to accept them, unless the plan clearly informs enrollees of limitations with respect to choosing a specialist. [§112]
<b>Access to Ob-Gyn Care</b>	Requires group health plans and health insurance issuers that (a) cover OB/GYN care and (b) require the designation of a primary care provider (PCP) who is not an OB/GYN, to provide direct access to a physician who specializes in OB/GYN care for obstetrical and gynecological care and the ordering of related obstetrical and gynecological items and services. Does not preclude plans from requiring an OB/GYN to seek authorization for services for which the primary care provider would be required to obtain authorization. [§103]	Requires group health plans and health insurance issuers that (a) cover OB/GYN care and (b) require the designation of a primary care provider (PCP) who is not an OB/GYN, to provide direct access to a health care professional who specializes in OB/GYN care for obstetrical and gynecological care and the ordering of related obstetrical and gynecological items and services. [§115]
<b>Access to Pediatric Care</b>	Group health plans and health insurance issuers that require or provide for the designation of a PCP must allow enrollees to designate a participating physician specializing in pediatrics to serve as their child’s PCP. [§104]	Group health plans and health insurance issuers that require or provide for the designation of a PCP must allow participants, beneficiaries, and enrollees to designate a participating provider specializing in pediatrics to serve as their child’s PCP. [§116]
<b>Access to Specialists</b>	Requires group health plans and health insurance issuers to ensure that enrollees have timely access to appropriate specialists when such care is covered by the plan. If no participating specialist is available to provide necessary care, the plan is required to provide coverage for such care by a non-participating specialist at no additional cost to the enrollee beyond what the enrollee would have paid for a participating specialist. Requires plans to allow enrollees with “ongoing special conditions” to receive a referral to a specialist for the treatment of that condition, and allow the specialist to authorize referrals or other procedures subject to a treatment plan. [§105]	Requires group health plans and health insurance issuers to ensure that participants, beneficiaries, and enrollees have timely access to appropriate specialists when such care is covered by the plan. If no participating specialist is available to provide necessary care to a participant, beneficiary, or enrollee, the plan or issuer is required to provide coverage for such care by a non-participating specialist at no additional cost to the participant, beneficiary, or enrollee beyond what the participant, beneficiary, and enrollee would have paid for a participating specialist. Requires plans to allow a participant, beneficiary, and enrollee with an “ongoing special condition” to receive a referral to a specialist for the treatment of that condition, and allow the specialist to authorize referrals or other procedures subject to a treatment plan. [§114]
<b>Continuity of Care</b>	Requires group health plans and health insurance issuers to cover up to 90 days of care from a terminated provider for enrollees undergoing an active course of treatment from the provider for a “serious and complex condition”, for institutional care, or for scheduled surgery. Requirement also applies when coverage options offered by an employer change and a provider is no longer a participating provider under the new coverage option. Special timeframes apply to pregnant women who have entered their second trimester of pregnancy, and terminally ill patients.  Requires plans to notify such individuals of the termination (or arrange to have the individual notified by the provider) and permit the individual to	Requires group health plans and health insurance issuers to cover up to 90 days of care from a terminated provider for enrollees undergoing a course of treatment from the provider for a “serious and complex condition”, for institutional care, or for scheduled surgery. Requirement also applies when coverage options offered by an employer change and a provider is no longer a participating provider under the new coverage option. Special timeframes apply to pregnant women who are undergoing a course of treatment for the pregnancy, and terminally ill patients.  Requires plans to notify such individuals of the termination (or arrange to have the individual notified by the provider) and permit the individual to

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	<p>elect to continue coverage during a transitional period. Plans may require a terminated provider to provide the plan with the name of each enrollee whom the provider believes is eligible for transitional care.</p> <p>Plans may condition coverage of transitional care on the provider’s agreeing to the terms and conditions of the plan. [§106]</p>	<p>elect to continue coverage during a transitional period. Plans may require a terminated provider to provide the plan with the name of each enrollee whom the provider believes is a continuing care patient.</p> <p>Plans may condition coverage of transitional care on the provider’s agreeing to the terms and conditions of the plan. [§117]</p>
<b>Prohibition on Gag Rules</b>	<p>Prohibits group health plans and health insurance issuers from “prohibiting or otherwise restricting” communications about health status, medical care, or treatment between health care professionals and their patients, as long as the professional is acting within the lawful scope of practice. [§107]</p>	<p>Prohibits group health plans or health insurance issuers from “prohibiting or otherwise restricting” communications about health status, medical care, or treatment between health care professionals and their patients, as long as the professional is acting within the lawful scope of practice. [§131]</p>
<b>Access to Prescription Drugs</b>	<p>Requires group health plans and health insurance issuers that use a formulary to: (1) involve physicians and pharmacists in developing and reviewing the formulary and (2) in accordance with the applicable quality assurance and utilization review standards for the plan, provide for exceptions to the formulary when a non-formulary alternative is medically necessary and appropriate. Plans are not prohibited from excluding coverage for a specific drug or class of drugs if such drug or class of drugs are expressly excluded under the terms and conditions of the plan or coverage. [§108]</p>	<p>Requires group health plans and health insurance issuers that use a formulary to: (1) involve physicians and pharmacists in developing and reviewing the formulary; (2) provide for disclosure of the formulary to providers; and (3) in accordance with the applicable quality assurance and utilization review standards for the plan, provide for exceptions to the formulary when a non-formulary alternative is medically necessary and appropriate, applying the same cost-sharing requirements that would apply to a formulary drug.</p> <p>Prohibits plans and issuers from denying coverage of a drug or device on the basis that the use is investigational if the use is included in the drug and device’s authorized labeling under the FDCA or PHSA. [§118]</p>
<b>Access to Clinical Trials</b>	<p>Requires group health plans and health insurance issuers to cover the routine patient care costs associated with participation in NIH, VA, and DOD-approved and funded clinical trials. Plans may require enrollees to use in-network providers if such a provider is participating in the trial. Routine patient care costs “do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial.” Health plans are not required “to pay for the costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial.” [§109]</p> <p>Requires the Secretary of HHS to develop standards through negotiated rule making relating to the coverage of routine patient costs that plans and issuers must meet. [§109]</p>	<p>Requires group health plans and health insurance issuers to cover the routine patient care costs associated with participation in NIH, VA, FDA, and DOD-approved and funded clinical trials. Plans may require enrollees to use in-network providers if such a provider is participating in the trial. Routine patient care costs “do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial.” Health plans are not required “to pay for the costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial.” [§119]</p>

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<b>Breast Cancer Treatment</b>	Requires group health plans and health insurance issuers that provide medical and surgical benefits to provide coverage for an inpatient hospital stay “for a period of time as is determined by the attending physician, in consultation with the patient, to be medically necessary” following a mastectomy, lumpectomy, or lymph node dissection for the treatment of breast cancer. [§110]	Requires group health plans and health insurance issuers that provide medical and surgical benefits to provide coverage for an inpatient hospital stay “for a period of time as is determined by the attending physician, in consultation with the patient, to be medically necessary” following a mastectomy, lumpectomy, or lymph node dissection for the treatment of breast cancer. [§120]
<b>Cancer Diagnoses (Second Opinions)</b>	Requires group health plans and health insurance issuers that provide medical and surgical benefits related to the diagnosis and treatment of cancer to provide coverage for second opinions from “specialists in the appropriate medical field.” Plans are required to provide coverage for second opinions by non-participating physicians if the attending physician certifies that there are no suitable participating physicians. [§110]	Requires group health plans and health insurance issuers that provide medical and surgical benefits related to the diagnosis and treatment of cancer to provide coverage for second opinions from “specialists in the appropriate medical field.” Plans are required to provide coverage for second opinions by non-participating physicians if the attending physician certifies that there are no suitable participating physicians. [§120]
<b>Information</b>	<p>Requires group health plans and issuers to provide information to enrollees regarding: covered benefits; cost-sharing requirements; procedures to access physicians; preauthorization procedures; service areas; emergency care; clinical trials; grievance and appeals procedures; and provider compensation methods. Also requires plans to provide information upon request regarding: qualifications of providers and facilities; external appeals and drugs included in the formulary. [§121]</p> <p>Requires the Secretary of HHS to enter into a contract with the Institute of Medicine (IOM) to conduct a study, and submit a report, that includes (1) an analysis of information concerning health care professionals currently available to patients; (2) an evaluation of barriers to the sharing of information concerning health care professionals; and (3) recommendations for the disclosure of information on health care professionals. [§122]</p>	Requires group health plans and issuers to provide information to enrollees regarding: covered benefits; cost-sharing requirements; procedures to access physicians; preauthorization procedures; service areas; emergency care; clinical trials; and grievance and appeals procedures. Also requires plans to provide information upon request regarding: qualifications of providers and facilities; provider compensation methods; and external appeals and drugs included in the formulary. [§121]

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<i>Provider Protections</i>		
<b>Provider Participation/ Indemnification</b>	Prohibits group health plans and health insurance issuers from discriminating against providers with respect to participation or indemnification based solely on licensure or certification. Explicitly allows plans to include providers only to the extent necessary to meet the needs of enrollees and to establish measures to maintain quality and control costs consistent with the responsibilities of the plan or issuer. [§111]	Prohibits group health plans and health insurance issuers from discriminating against providers with respect to participation or indemnification based solely on licensure or certification. Explicitly allows plans to include providers only to the extent necessary to meet the needs of enrollees and to maintain quality and control costs consistent with the responsibilities of the plan or issuer. [§132].
<b>Prohibition on Provider Financial Incentives</b>	Requires the Secretary of HHS to enter into an contract with the Institute of Medicine (IOM) to conduct a study (1) including a survey, if necessary, of physician compensation arrangements that are utilized in employer-sponsored group health plans and commercial health insurance products and (2) an analysis of the effect of differing arrangements on physician behavior with respect to the provision of medical care to patients, including whether and how such arrangements affect the quality of patient care the ability of physicians to provide care that is medically necessary and appropriate. [§123]	Requires group health plans and health insurance issuers to adhere to Medicare/Medicaid physician incentive requirements. [§133]
<b>Prompt Payment of Provider Claims</b>	No similar provision.	Requires group health plans and health insurance issuers to provide for prompt payment of claims consistent with Medicare standards. [§134]
<b>Whistleblower Protections for Providers</b>	No similar provision.	Prohibits group health plans and health insurance issuers from “retaliating” against an enrollee or provider based on that person’s use of a UR process or grievance and appeals process or because a health care professional: (1) discloses information to a regulatory agency, accreditation body, or management personnel of the plan or (2) initiates, cooperates, or participates in an investigation by such an agency. Places burden on the plan to show that any adverse action it takes against a provider would still have been taken in the absence of whistleblower activities. [§135]

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<p><b>Utilization Review (UR)</b></p>	<p>No similar provision.</p>	<p>Requires plan UR programs to: utilize written clinical review criteria developed with the input from a range of “appropriate actively practicing health care professionals,” as determined by the plan; provide for an evaluation of the clinical appropriateness of at least a sample of denials; be administered by a “qualified health care professional;” and to conduct UR activities only through qualified, trained personnel.</p> <p>Prohibits plans from: upon retrospective review, revising or modifying standards, criteria, or procedures for pre-authorized services; providing compensation to employees (or agents) to encourage denials. Prohibits health care professionals providing services to an individual from performing UR in connection with that service. Requires UR personnel to be accessible by toll-free telephone during business hours, and prohibits the performance of UR “more frequently than is reasonably necessary to assess” whether the services are medically necessary or appropriate. [§101]</p>

*Appeals and Liability***Initial Coverage Determinations and Internal Appeals****Establishes timeframes for initial coverage determinations:**

- for expedited prior authorization, 72 hours
- for routine prior authorizations, 14 business days after receipt of all necessary information, but no later than 28 business days
- for concurrent determinations, 24 hours
- for retrospective determinations, 30 business days after receipt of all necessary information, but no later than 60 business days.

**Information Requirements:** Requires the enrollee and the treating professional to provide the plan or issuer with access to information that is necessary to making an initial coverage determination within 5 business days of making a claim for appeal. Requires providers to substantiate the need for expedited initial coverage determinations.

**Establishes timeframes for internal appeals:**

- for expedited prior authorization, 72 hours
- for routine prior authorization, 14 business days after receipt of all necessary information, but no later than 28 business days
- for concurrent determinations, 24 hours
- for retrospective determinations, 30 business days after receipt of all necessary information, but no later than 60 business days.

**Establishes timeframes for initial coverage determinations:**

- for expedited prior authorization, as soon as possible in accordance with the “medical exigencies” of the case, but in no case later than 72 hours
- for routine prior authorizations, as soon as possible in accordance with the medical exigencies of the case, but in no case later than 14 days after receipt of all necessary information and 28 days after receipt of the claim
- for concurrent review, as soon as possible in accordance with the medical exigencies of the case, “with sufficient time...to allow for an appeal before the termination or reduction [of coverage] takes effect”
- for retrospective determinations, as soon as possible in accordance with the medical exigencies of the case, but no later than 30 days after receipt of all necessary information or, if earlier, 60 days after receipt of the claim. [§102]

**Information Requirements:** Requires the enrollee and treating health care professional to provide the plan with access to information necessary to making an initial coverage determination within 5 days of receipt of information request. [§102]

**Establishes timeframes for internal appeals:**

- for expedited prior authorization, as soon as possible in accordance with the medical exigencies of the case, but in no case later than 72 hours
- for routine prior authorizations, as soon as possible in accordance with the medical exigencies of the case, but in no case later than 14 days after receipt of all necessary information and 28 days after receipt of the appeal request
- for concurrent review, as soon as possible in accordance with the medical exigencies of the case, “with sufficient time...to allow for an external appeal before the termination or reduction [of coverage] takes effect”
- for retrospective determinations, 30 days after receipt of all necessary information, but no later than 60 days after receipt of the claim. [§103]

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<p><b>Initial Coverage Determinations and Internal Appeals (cont.)</b></p>	<p>Requires the participant or beneficiary and the treating provider to provide the plan with information necessary to making an appeal determination within 5 business days of making a claim for appeal. Requires providers to substantiate need for expedited appeals determinations.</p> <p>Establishes timeframes for providing notice of coverage determinations. [§131/503A]</p>	<p>Requires the treating health care professional and participant, beneficiary or enrollee to provide the plan with access to information necessary to making an appeals determination within 5 days of receipt of information request. [§103]</p> <p>Establishes timeframes for providing notice of coverage determinations. [§102 and §103]</p>
<p><b>External Review</b></p>	<p><b>Appealable Decisions:</b> Requires plans to permit participants and beneficiaries access to independent medical review for denials for which the item or service would be a covered benefit under the terms and conditions of the plan but for one of the following determinations: (1) the denial is based on the fact that the item or service is not medically necessary and appropriate; (2) the denial is based on the fact that the item or service is experimental or investigational; (3) the denial that the item or service is not covered requires an evaluation of medical facts by a health care professional; or (4) the plan fails to meet the applicable internal appeal deadlines. In addition, the total amount payable under the plan or coverage for the item or service that was the subject of such denial must exceed \$100. Eligibility determinations, cost-sharing decisions, decisions concerning exclusions/limitations and decisions that do not involve medically reviewable decisions are not eligible for external review. Allows plans to require participant or beneficiary to exhaust internal appeals process and gives the participant or beneficiary 60 days to file request for review.</p> <p><b>Reviewer Independence:</b> Requires external reviewers to give no deference to the plan’s determination or to the treating provider’s recommendation. Requires independent medical reviewers to make a new independent determination to uphold or reverse the plan denial based on the medical condition of the patient and the valid, relevant scientific evidence and clinical evidence, including peer-reviewed medical literature or findings and including expert consensus.</p> <p>Reviewers are to take into consideration “but not be bound by” the plan’s definitions of medically necessary and appropriate or experimental and investigational, or other equivalent terms.</p> <p>Requires reviewers to consider:</p>	<p><b>Appealable Decisions:</b> Requires plans to permit participant, beneficiary, and enrollee access to independent medical review for denials for which the item or service would be a covered benefit under the terms and conditions of the plan but for one of the following determinations: (1) the denial is based on the fact that the item or service is not medically necessary and appropriate; (2) the denial is based on the fact that the item or service is experimental or investigational; (3) the denial that the item or service is not covered requires an evaluation of medical facts by a health care professional; or (4) the plan fails to meet the applicable internal appeal deadlines. Eligibility determinations, cost-sharing decisions, decisions concerning exclusions/limitations and decisions that do not involve medically reviewable decisions are not eligible for external review. Allows plans to require participant, beneficiary, or enrollee to exhaust internal appeals process and gives the participant, beneficiary, or enrollee 180 days to file request for review-- exceptions to exhaustion of the appeals process for claims of late manifestation of injury or if immediate and irreparable harm or death would occur if the appeals process were completed.</p> <p><b>Reviewer Independence:</b> Requires external reviewers to give no deference to the plan’s determination or to the treating provider’s recommendation. Requires independent medical reviewers to make a new independent determination to uphold, reverse or modify the plan denial based on the medical condition of the patient and the valid, relevant scientific evidence and clinical evidence, including peer-reviewed medical literature or findings and including expert opinion.</p> <p>Reviewers are to take into consideration “but not be bound by” the plan’s definitions of medically necessary and appropriate, or experimental and investigational, or other substantially equivalent terms.</p>

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<p><b>External Review (cont.)</b></p>	<ul style="list-style-type: none"> <li>the plan determination and any evidence or guidelines used by the plan to make such determination</li> <li>the recommendation of the treating provider and the evidence, guidelines, and rationale used by the provider in making such recommendation</li> <li>the plan or coverage document</li> <li>any additional evidence obtained by the reviewer or submitted by the related parties.</li> </ul> <p><b>Civil Actions:</b> The participant or beneficiary or provider may commence civil action against the plan to recover the amount of the unpaid reimbursement if the plan fails to reimburse the participant or beneficiary or any applicable providers for the services if the independent medical reviewers find in favor of the enrollee. Allows the Secretary to assess a penalty of \$10,000 against a plan that fails to comply with any applicable timeframe in this section and may assess an additional \$10,000 penalty against the plan, payable to the participant or beneficiary, if the plan ultimately fails to comply with the decision. [§131/503B]</p>	<p>Requires reviewers to consider:</p> <ul style="list-style-type: none"> <li>the plan determination and any evidence or guidelines used by the plan to make such determination</li> <li>the recommendation of the treating provider and the evidence, guidelines, and rationale used by the provider in making such recommendation</li> <li>the plan or coverage document</li> <li>any additional evidence obtained by the reviewer or submitted by the related parties.</li> </ul> <p><b>Civil Actions:</b> The enrollee or provider may commence civil action against the plan to recover the amount of the unpaid reimbursement if the plan fails to reimburse the enrollee or any applicable providers for the services if the independent medical reviewers find in favor of the enrollee. Includes civil penalties on plan (up to \$1,000 per day) for failure to abide by review decision, and additional penalties for patterns or practice of repeated violations (not to exceed the lesser of 25% of the aggregate value of benefits to have not been provided or \$500,000). [§104]</p>
<p><b>Expanded Liability to Hold Health Plans Accountable</b></p>	<p>Establishes remedies for two new federal causes of action involving “medically reviewable decisions” (i.e., those eligible for independent medical review) under ERISA. The first is for a plan’s failure to exercise ordinary care in complying with an external review decision for prior authorization that is the proximate cause of substantial harm to a participant or beneficiary; and the second is for a plan’s failure to exercise ordinary care in making an initial claims or internal appeals decision for prior authorization that is reversed by an external review organization, results in delay, and is the proximate cause of substantial harm. Federal courts are granted exclusive jurisdiction over these claims.</p> <p>Economic damages are uncapped and noneconomic damages are capped at \$500,000 and are indexed to inflation. Defendants are liable for non-economic damages in direct proportion to their share of fault or responsibility for the injury suffered.</p> <p>Identifies three affirmative defenses against the new causes of action: (1) the plan did not receive information necessary to make a final determination</p>	<p>Establishes remedies for two new federal causes of action under ERISA. The first is for a plan’s failure to exercise ordinary care in making a decision that is not medically reviewable (e.g., eligibility decisions, cost-sharing decisions and decisions concerning contract exclusions/limitations); and the second is for a plan’s failure to exercise ordinary care in the performance of a duty under the terms and conditions of a plan (includes, but is not limited to, most of the requirements imposed under this Act, HIPAA, COBRA, mental health parity law, maternity length of stay law, and reconstructive surgery for mastectomies law), with respect to a participant or beneficiary. For both causes of action, such failure must be the proximate of personal injury or death. Federal courts are granted exclusive jurisdiction over these claims.</p> <p>Economic and noneconomic damages are available for these federal claims and are uncapped. Punitive damages (labeled “civil assessments”) are capped at \$5 million.</p> <p>Additionally, amends ERISA to permit state causes of action to recover damages resulting from personal injury or for wrongful death against any person if such cause of action arises by reason of a “medically</p>

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<p><b>Liability (cont.)</b></p>	<p>(2) the participant or beneficiary possessed facts sufficient to enable him or her to know that an expedited review would have prevented harm, but failed to notify the plan of the need for an expedited review</p> <p>(3) the external review entity failed to meet its time deadlines.</p> <p>Does not preclude any action under State law against a person or entity for liability or vicarious liability with respect to the delivery of medical care. Claims that relate to a group health plan’s administration or coverage determination are not the delivery of medical care and are maintained exclusively under section 502 of ERISA.</p> <p>Internal (unless the group health plan waives the internal appeals process) and external review must be exhausted. A participant or beneficiary may seek injunctive relief prior to the exhaustion of administrative remedies if it is demonstrated to the court that exhaustion would cause irreparable harm.</p> <p>“Designated decisionmaker,” as defined in the bill, assumes liability.</p> <p>New claims under ERISA can only be brought as class actions if the group of claimants are participants or beneficiaries of a group health plan established by only one plan sponsor. No action maintained by such class may be joined in the same proceeding with any action maintained by another class. Also, no action may be brought under RICO, where the action seeks relief concerning the manner in which any person has marketed, provided information concerning, established, administered, or otherwise operated a group health plan, or health insurance coverage in connection with a group health plan. These limitations apply to pending cases that have not been finally determined by judgement or settlement as well as civil actions filed on or after the date of the bill’s enactment.</p> <p>A court may assess a civil penalty up to \$100,000 against a plan if the plan fails to exercise ordinary care in denying a benefit to which a participant or</p>	<p>reviewable decision.” Defines “medically reviewable decisions” as denials of claims for benefits under the plan that are eligible for independent medical review (denials based on whether an item or service is medically necessary and appropriate, is experimental or investigational, or requires an evaluation of medical facts).</p> <p>With respect to state claims, does not permit causes of action for the failure to provide an excluded benefit, except to the extent that the application involves a “medically reviewable decision” or the provision of the benefit is required by law. Does not affect any state laws relating to the practice of medicine or the provision of medical care. Does not affect state laws in connection with the provision or arrangement of certain excepted benefits. Economic, noneconomic, and punitive damages are available and uncapped (to the extent provided by state law).</p> <p><b>** CHANGED in S.1052</b>– Attempts to avoid situation in which defendant would be simultaneously defending himself in both federal and state courts based on the same incident. This new language simply reiterates another provision in the bill that requires medically reviewable decisions go to state court.</p> <p>Completion of internal (and external review for state claims) is not required if (1) the personal injury is first known (or first reasonably should have been known) to the individual after the deadline for requesting external review or (2) the individual alleges that irreparable harm occurred or would occur prior to completion of the administrative processes. (Under current law, a participant or beneficiary may seek injunctive relief prior to the exhaustion of administrative remedies if it is demonstrated to the court that exhaustion would cause irreparable harm.)</p> <p><b>** CHANGED in S.1052</b>– Deleted the word “allegation,” so exhaustion of the appeals process would not be required “in any case of immediate and irreparable harm or death...” Not clear as to standard of proof needed to show there would be immediate and irreparable harm or death. Also unclear as to whom a showing of irreparable harm would be made.</p> <p>Employers or other plan sponsors may be held liable, to the extent there was “direct participation” by the employer or other plan sponsor. Exposes physicians to new federal liability as “agents” of health plans for non-medically reviewable decisions/duties of the plan.</p>

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	<p>beneficiary is entitled under the plan at the internal appeals level, the participant or beneficiary has appealed the decision, but such decision is not eligible for independent medical review, and that denial is the proximate cause of substantial harm. [§§141, 142 &amp; 143]</p>	<p><b>CHANGED in S.1052</b>– Attempts to carve out the “treating physician” (and any person acting under that treating physician’s direction) as well as the treating hospital from liability as “agents” of the plan.</p> <p>Very limited bar to class actions for claims brought by a participant or beneficiary seeking relief based on the application of provisions relating to access to care. No bar on class actions brought under other sections of ERISA (including newly created liability claims) or under RICO. [§302]</p>

	S. 889 Frist-Breaux-Jeffords	S. 1052 McCain-Edwards-Kennedy
<i>Scope and Enforcement</i>		
<b>Applicability &amp; Scope</b>	<p>Requirements generally apply to group health plans, including insured and self-insured plans. Requirements also apply to health insurance issuers offering coverage in both the group and individual markets.</p> <p>Does not affect or change ERISA preemption for group health plans. Claims processes follow federal rules. Other state laws that are certified as imposing requirements that are “consistent with” the patient protection requirements in the bill and do not prevent the application of the bill’s requirements are not preempted and apply to issuers in place of the federal requirements [§151]</p>	<p>Requirements generally apply to group health plans, including insured and self-insured plans. Requirements also apply to health insurance issuers offering coverage in both the group and individual markets.</p> <p>Does not affect or change ERISA preemption for group health plans, except with respect to the bill’s liability provisions. State laws that are certified as imposing requirements that are “substantially equivalent” and do not prevent the application of the Act’s requirements are not preempted and apply to issuers in place of the federal requirements. [§152]</p>
<b>Enforcement</b>	Generally follows the enforcement scheme established in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).	Generally follows the enforcement scheme established in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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