House
REPUBLICAN
Conference

FloorPrep

Legislative Digest

Thursday, October 7, 1999

J.C. Watts, Jr.
Chairman
4th District, Oklahoma

House Meets at 10:00 a.m. for Legislative Business

Anticipated Floor Action:
H.R. 2723—Bipartisan Consensus Managed Care Improvement Act

H.R. 2723—Bipartisan Consensus Managed Care Improvement Act

Floor Situation: The House will complete consideration of H.R. 2723 as its only order of business today. Yesterday, the House completed general debate on the measure and will now begin considering substitute amendments under a structured rule. The rule waives all points of order against the bill and its consideration. It self-executed two manager's amendments into the base text of the bill (see below). In addition, the rule makes in order three substitute amendments to H.R. 2723—each debatable in the order listed and for the amount of time specified below—and waives points of order against their consideration. The rule states that adoption of any substitute by the Committee of the Whole will conclude consideration of the bill for amendment. The rule provides one motion to recommit, with or without instructions. Finally, the rule requires that, upon passage of H.R. 2723, the measure be incorporated into the text of H.R. 2990.

Summary: H.R. 2723 amends current law to establish new patient protections, set nationwide standards for health insurance, and expand medical liability. The measure establishes basic standards for utilization review (*i.e.*, establishing guidelines for how a plan reviews the medical decisions of its practitioner). In instances where the insurer and practitioner disagree about a patient's treatment, the insurer must disclose the reason for the coverage denial and inform the patient of his right to appeal. The bill establishes basic standards for the internal appeal process. If the internal appeal upholds the coverage denial, the patient may request an external review. The bill allows a patient to appeal any decision involving medical judgment; however, a decision may not be appealed if a benefit is specifically excluded from a health plan contract.

The measure expands health plan tort liability by permitting state causes of action under the 1974 Employment Retirement Income Security Act (ERISA; *P.L. 93-406*) to recover damages resulting from personal injury or for wrongful death for any action "in connection with the provision of insurance, administrative services, or medical services" by a group health plan. The bill prohibits insurers from retaliating against a

patient or provider based on that individual's use of the review or appeals process and establishes other whistleblower protections.

In addition, the measure:

* lifts so-called "gag rules" to allow free and open communications between patients and doctors in order for the patient to make fully-informed decisions about the best course of treatment;

* requires insurers to provide coverage, without prior authorization, for emergency care if a "prudent layperson" would consider the situation an emergency (resulting in serious injury or death);

* requires health plans and insurers to allow patients to choose their own primary care professional from the plan or insurer's network;

* requires HMOs to provide direct access to a participating physician that specializes in obstetrics and gynecology (OB-GYN) and allows parents to designate a pediatrician as a child's primary care provider;

* allows patients who have an ongoing special condition to have continued access to their treating specialist for up to 90 days in cases where the provider is terminated from the plan or if the plan is terminated;

* requires HMOs to provide a referral to specialists for patients with conditions that require ongoing treatment; and

* requires health plans to disclose information in order for patients to learn what their plan specifically covers, including benefits, doctors, and facilities, in addition to information on premiums and claims procedures.

Manager's Amendments. As stated above, the rule self-executes two manager's amendments to (1) make a number of technical corrections to the bill; and (2) clarify that employers may not be held liable unless they made medical decisions.

A CBO cost estimate was unavailable at press time. The bill was introduced by Messrs. Norwood and Dingell *et al.* and was not reported by a House committee.

Amendments: As stated above, the rule makes in order the following three substitutes, each debatable in the order listed and for the amount of time specified below:

— Boehner Substitute —

The Boehner Substitute, debatable for 60 minutes, includes measures designed to make health insurance more accessible and affordable. The measure *does not* include medical liability provisions enhancing an individual's "right to sue" HMOs. Details of the substitute are outlined below.

Access to Care. The substitute includes similar "access to care" provisions outlined in H.R. 2723, with some changes. Specifically, the substitute:

* lifts so-called "gag rules" to prohibit health plans from restricting physicians from giving advice to a patient about his or her health status, or the medical care or treatment for the condition or disease of that patient;

* requires insurers to provide coverage, without prior authorization, for emergency care if a "prudent layperson" would consider the situation an emergency (resulting in serious injury or death). The prudent layperson standard also applies to emergency ambulance services (which is not included in H.R. 2723);

* requires health plans to allow women to proceed directly to an OB/GYN provider without first going through a pre-authorization process;

* allows parents to designate a pediatrician as their child's primary care provider;

* requires plans to allow certain patients to continue their course of care for up to 90 days with a provider who leaves the plan for reasons other than fraud or inferior quality under certain circumstances. The provision applies to patients who are pregnant, terminally ill, or are preparing for surgery. Coverage may be extended past 90 days (1) until the date of release following surgery; (2) until birth for pregnancies; and (3) until death for those with a terminal illness. The provider must agree to the plan's payment schedule, quality assurance measures, review procedures, and other conditions of the previous contract for this period; and

* requires health plans to disclose information in order for patients to learn what their health plan specifically covers, including benefits, doctors, and facilities, in addition to information on premiums and claims procedures. All plan descriptions must be made available upon written request—via the Internet or some other electronic format.

Group Health Plan Review Standards. The substitute establishes standards for internal and external review of health plan decisions. Routine review requests must be completed as soon as possible and within 30 days after a patient applies (expedited cases must be completed within 72 hours). The substitute includes a rule for specialty care, requiring an initial coverage decision within three days if a patient requests an advance determination.

If an internal review upholds a coverage denial, the patient may request a review by an independent medical expert (IME) if the denial was (1) based on a determination of medical necessity or appropriateness; or (2) based on the fact that the procedure was experimental or investigative. The denial may not be appealed if the health plan does not cover the benefit in question. If there is a dispute over whether the denial was based on medical necessity or excluded from the plan contract, an independent contract expert (ICE) will determine if the denial required evaluation of medical facts. If it does, the denial may be reviewed by an IME; if not, the denial stands. After the review, the IME will issue an order affirming, modifying, or reversing the plan's final decision based on the medical condition of the patient and the recommendation of the treating physician and the plan's medical director.

If the plan refuses to comply with the IME decision, the plan may be held liable for up to $1,000 per day in civil penalties, or up to $5,000 per day if the plan acts in "bad faith." In addition, a patient may be reimbursed for the full cost of the medical care necessary to comply with the IME order under certain circumstances.

Association Health Plans. The substitute allows bona fide associations to sponsor an ERISA health plan for the employees of their members. The plan must offer at least two options for health coverage and must be marketed to all employers and employees regardless of health status. The measure also requires strict maintenance of reserves and solvency requirements.

Medical Malpractice Reform. The substitute reforms the guidelines governing health care lawsuits by (1) limiting non-economic damages to $250,000 but allowing states to enact higher or lower limits; (2) stipulating that juries may be informed about multiple recoveries paid to plaintiffs; (3) permitting periodic rather than immediate payment of damages; (4) requiring lawsuits to be filed within two years of discovery and within five years from the date of inquiry; (5) prohibiting plaintiffs from recovering 100 percent of damages from one party where multiple parties are involved; and (6) stipulating that punitive damages may not be awarded unless there is "clear and convincing evidence" of reckless disregard for the victim.

Patient Choice of Medical Provider. Subject to certain exceptions, the substitute requires closed-panel HMOs to offer a point-of-service option to employers in conjunction with certain plans. Employers may accept or decline the expanded choice option at the time of enrollment. If employers decline, the insurance company must offer a point-of-service option as supplemental coverage to employees through the individual market.

Medical Savings Accounts (MSA). The substitute expands medical savings accounts (MSAs) to increase access to health care services and give patients greater control over their health care expenditures. Specifically, the measure (1) allows both employers and employees to make contributions to MSAs; (2) makes MSAs a permanent health care choice under the law; (3) eliminates the cap on the number of taxpayers (currently 750,000) that may benefit annually from MSA contributions; (4) reduces the minimum deductible to $1,000 for individual coverage and $2,000 for families; and (5) allows MSA contributions equal to 100 percent of the deductible.

Flexible Spending Account (FSA) Roll-Overs. The measure allows up to $500 remaining in a FSA to be carried through the next year (current law generally requires that all remaining funds be forfeited). FSAs are tax-advantaged spending accounts used to pay for out-of-pocket health and/or dependent care expenses.

Refundable Tax Credit for Health Insurance Costs. The substitute creates a new $1,000 individual tax credit to purchase private health insurance, effective January 1, 2000 (the credit will be $500 for dependents, with a maximum of $3,000 for a family). The credit will be available to uninsured Americans (specifically, all persons who do not participate in a tax-subsidized employer health plan or Medicaid; do not receive VA or Indian health benefits; are not eligible for Medicare; are not in prison; and who live in the U.S. at least half the year). The credit may be used to buy any health-insurance policy that will be eligible for the existing health-care deduction.

Above-The-Line Deduction for Health Insurance Costs. The measure provides an above-the-line deduction for individuals who buy their own health care insurance and who are not covered by employer-provided plans. Current law provides a similar deduction for self-employed individuals, but those who

take advantage of this deduction must itemize their return. Under the substitute, individuals may deduct 25 percent of applicable health insurance costs in 2001, 40 percent in 2002, 50 percent from 2003 through 2006, 75 percent in 2007, and 100 percent in 2008.

HealthMarts. The substitute creates "HealthMarts," to offer health benefits within a defined geographic area. HealthMarts will be established and governed by small businesses and their employees, health care providers, and entities—such as insurance companies or HMOs—that underwrite or administer health benefit coverage. The measure stipulates that these underwriters must be licensed or regulated under state law and must meet state standards of consumer protection; however, the applicable authority may waive these requirements.

Community Health Organizations (CHOs). The measure permits CHOs to offer health insurance coverage in a state in which it is not licensed if the organization applies to the Department of Health & Human Services for a waiver of the licensure requirement.

Cancer Clinical Trials. The measure requires health plans to pay "routine patient costs" for cancer clinical trials sponsored by the National Institutes of Health (NIH), Department of Veterans' Affairs, the Department of Defense or other trials that pass stringent federal review (including FDA trials).

Health Care Commission. The measure establishes a commission comprised of physicians, employees, employers, third-party administrators, health researchers, and economists to review issues that impact employer-provided health care and develop model guidelines for ERISA plans. ***Staff Contact: Ben Peltier, x5-6205***

— Goss/Coburn/Shadegg/Greenwood/Thomas et al. Substitute —

The substitute, debatable for 60 minutes, establishes new patient protection standards for private health insurance and employer-sponsored plans, except those in state-regulated fee-for-service plans. The measure includes many of the same provisions outlined in H.R. 2723, but takes a different approach to medical liability, requires more expeditious decisions in the grievance and appeals process, provides greater access to ambulance and emergency services, *does not* include any whistleblower provisions, and establishes an independent panel on network adequacy.

Grievances and Appeals

Utilization Review/Coverage Determinations. The substitute establishes basic standards for utilization review and establishes timeframes for initial coverage determinations. Routine review requests must be completed as soon as possible and within 14 days of a patient's request. Expedited cases must be completed within 48 hours (as opposed to 72 hours in H.R. 2723). Requests to approve continued hospitalizations or ongoing care must be completed before the end of the approved in-patient hospitalization period.

Internal Appeals. The measure establishes an internal appeal process for instances where the insurer and physician disagree about a patient's treatment. An appeal must be reviewed by a health care professional who was not involved in the original decision. Generally, reviews must be completed within 14 days; however, plans must establish procedures to expedite appeals in 48 hours (as opposed to 72 hours in H.R. 2723) in cases where the normal process may be detrimental to the patient.

External Appeals. The substitute establishes an external appeals process and requires plans to permit patient access to this process if (1) the health plan covers the benefit for which coverage was denied; (2) the amount involved exceeds $100 (indexed to inflation); (3) the denial is based on medical necessity or involves medical judgment; or (4) the plan fails to meet the internal appeal deadlines (most of these provisions differ from H.R. 2723). Specific limitations outlined in the plan or eligibility determinations may not be externally reviewed. Plans may require patients to complete the internal appeals process before accessing the external review, unless the plan fails to complete an internal review. The substitute also outlines a process to certify independent reviewers.

The external review must be conducted without regard to the way in which the plan defines "medical necessity." The external reviewer must render its decision within 21 days, unless a 48-hour time frame is necessary for urgent matters. The reviewer's decision is binding on the health plan or insurer. If a plan does not comply with the decision, the court may award reasonable attorneys' fees (in addition to ordering the plan to provide the medical benefit) and may assess a penalty of $1,000 per day until the plan complies. The HHS Secretary also may ask the court to assess additional civil penalties if the insurer continues to ignore a benefit decision made by an external reviewer as a pattern of practice.

Access to Care

The substitute includes many of the same "access to care" provisions outlined in H.R. 2723, with some changes. Specifically, the substitute:

* lifts so-called "gag rules" to allow free and open communications between patients and doctors in order for the patient to make fully-informed decisions about the best course of treatment;

* requires insurers to provide coverage, without prior authorization, for emergency care if a "prudent layperson" would consider the situation an emergency (resulting in serious injury or death). The substitute also requires insurers to provide coverage for ambulance emergency services (which is not included in H.R. 2723);

* requires health plans and insurers to allow patients to choose their own primary care professional from the plan or insurer's network;

* requires HMOs to provide direct access to a participating physician that specializes in obstetrics and gynecology;

* allows parents to designate a pediatrician as the child's primary care provider;

* allows patients who have an ongoing special condition to have continued access to their treating specialist for up to 90 days in cases where the provider is terminated from the plan or if the plan is terminated;

* requires HMOs to provide a referral to a specialist for patients with conditions that require ongoing treatment by a specialist;

* requires health plans to disclose information in order for patients to learn what their health plan specifically covers, including benefits, doctors, and facilities, in addition to information on premiums and claims procedures. The substitute also requires a plan to list benefits that it does not cover;

* requires all health insurance issuers to offer a point-of-service (POS) option to participants that cover services delivered by non-network providers, if they agree to a higher premium or co-payment requirements; and

* prohibits prescription drugs and medical devices from being considered experimental or investigative by a health plan if they are approved by the Food and Drug Administration.

Medical Liability

The substitute establishes new remedies under ERISA to allow patients to file lawsuits in federal court (as opposed to state courts in H.R. 2723) against an employer, plan sponsor, or group health plan (1) that is authorized to make the final coverage decision; (2) that fails to exercise "ordinary care" in making an "incorrect determination" that a benefit is excluded from the plan's coverage; and (3) when the failure is the proximate cause of personal injury or wrongful death. The measure requires that an individual complete the external review process before bringing suit. In addition, plaintiffs who seek to overturn an external review finding in court and seek damages must pay all court costs for the defendant if they do not prevail.

The measure allows plans to use an external review entity to determine whether personal injury has been sustained and whether the plan's failure to exercise ordinary care was the proximate cause of the injury. If the review panel determines that the injury has not been sustained or was not caused by the plan's failure, this serves as an affirmative defense and precludes all liability in any suit based on the alleged injury. In all cases, the external review's decision on whether treatment should have been provided will receive significant deference in court (given the weight of a "rebuttable presumption").

A plan, third-party administrator, or insurer may be held liable only if they are found to have directly participated in the plan's final decision. The substitute specifies several employer or plan sponsor actions that do not constitute "direct participation." The court must dismiss a complaint if a plaintiff does not allege direct participation or does not demonstrate that it occurred.

The substitute does not limit economic damages but caps non-economic damages at the greater of $500,000 (indexed for inflation) or two times the amount of economic damages. The measure authorizes punitive damages only in cases where the plaintiff establishes by clear and convincing evidence that the plan's conduct (1) was carried out with "conscious, flagrant indifference to the rights or safety of others;" (2) was the proximate cause of harm; and (3) was contrary to the recommendation of the external review entity. Punitive damages may not exceed the greater of two times the amount of economic damages or $250,000. For small employers and individuals with a net worth of less than $500,000, punitive damages may not exceed $250,000.

However, a court may assess punitive damages beyond the limits outlined above in cases of egregious conduct if it considers specified factors, such as the extent to which the plan acted with malice. An individual may not sue in federal court if an action has already commenced in state court; also, a plaintiff may not bring suit in state court once a federal court action has commenced. Finally, the substitute does not preempt any action under state law (*i.e.*, it does not affect or change the ERISA preemption for group health plans).

Binding Arbitration. The substitute allows patients and plans to resolve disputes via binding arbitration at the election of the plaintiff.

Miscellaneous Provisions

Network Adequacy. The substitute establishes a panel to develop standards to ensure that plans have an adequate number and variety of providers to treat patients on a timely basis. The panel will be comprised of representatives of health insurers, state insurance commissioners, and state medical and specialty societies (these provisions are not included in H.R. 2723).

Other Provisions. Health plans may not prohibit providers from participating based solely on licensure or certification. In addition, the bill requires plans to adhere to Medicare/Medicaid physician incentive requirements and prohibits them from offering incentives to withhold medically necessary care. The measure requires plans to promptly pay claims consistent with Medicare standards. The substitute also (1) establishes a panel to develop a standard benefits form for providers to use in filing claims; and (2) makes the patient protection provisions effective on January 1, 2000. ***Staff Contact: Darren Wilcox (Goss), x5-2536; Roland Foster (Coburn), x5-2701; Alan Eisenberg (Shadegg), x5-3361***

— Houghton/Graham/Hilleary/Gibbons Substitute —

The substitute, debatable for 60 minutes, includes all of the provisions in the Norwood/Dingell base bill except for those regarding medical liability (which are similar to the Goss/Coburn/Shadegg substitute) and one provision relating to external review. The substitute allows patients up to 180 days to request an external review if the internal panel upholds a coverage denial (the Norwood/Dingell bill does not specify a time limit).

Medical Liability

The substitute allows patients to file lawsuits in federal court (as opposed to state courts in H.R. 2723) against an employer, plan sponsor, or group health plan (1) that is authorized to make the sole final coverage decision; (2) that fails to exercise "ordinary care" in making an "incorrect determination" that an item or service is excluded from the plan's coverage; and (3) when the failure is the proximate cause of personal injury or wrongful death. The measure requires patients to exhaust the external review process before bringing suit. Patients who need immediate treatment may receive it while the review process continues. In all cases, the external review's decision on whether treatment should have been provided will receive "significant weight" in court along with the consideration of other evidence.

A plan, third-party administrator, or insurer may be held liable only if they are found to have directly participated in the sole final decision of the plan. The substitute specifies several employer or plan sponsor actions that do not constitute "direct participation." The court must dismiss a complaint if a plaintiff does not allege direct participation or does not demonstrate that it occurred.

The substitute does not limit economic damages but caps non-economic damages at $250,000 or two times the amount of economic damages up to $500,000. The measure *does not* authorize punitive damages. Finally, the substitute allows patients and plans to resolve disputes via binding arbitration at the election of the plaintiff. ***Staff Contact: Cathy Rafferty (Houghton), x5-3161; Kevin Bishop (Graham), x5-5301***

Additional Information: See *Legislative Digest*, Vol. XXVIII, #28, Pt. III, October 4, 1999.