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Patient Protection During the 106th Congress: Side-by-Side Comparison of House- and Senate-Passed Bills

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Summary

This report compares the major provisions of two patient protection bills considered during the 106th Congress; H.R. 2990 as passed by the House and the Senate Amendment. These bills offered various ways to regulate employment-based health plans and insurance issuers relating to access, disclosure, grievances and appeals, market reforms, insurance affordability, confidentiality, and health care lawsuit reform among other provisions. They also would have expanded tax benefits for health insurance and long-term care. The Conference Committee appointed to negotiate an agreement was not able to resolve the differences between the two bills and the 106th Congress adjourned without sending a bill to the President. In the event that the 107th Congress turns again to such issues, the provisions of the two bills may provide background and could serve as a starting point for a renewed debate.

There were a number of substantive differences between the House-passed bill and the Senate amendment. The largest differences were in the scope of their application to private health insurance plans, the expansion of patients' legal remedies, and the provisions intended to increase access to health insurance coverage.

With one exception, the provisions in the House-passed bill would have applied to group health plans and health insurance issuers offering health insurance coverage in both the group and individual market. The Senate amendment was more restrictive in its scope of coverage for many provisions. Certain provisions would have only applied to self-insured group health plans (plans where the employers maintain the risk rather than transferring the risk to an insurance company) while others would have been applicable to group health plans and health insurance issuers in the group market and individual market.

On access to legal remedies, H.R. 2990 would have amended ERISA (§514) to prevent its preemption provision from interfering with any state law allowing the recovery of damages for personal injury or wrongful death. The Senate amendment, on the other hand, would not have changed current law allowing only for a civil action to recover the cost of benefits and some legal costs if a health plan fails to provide reimbursement for a medical item or service that external reviewers have determined a beneficiary is entitled to receive.

Finally, the House bill would have created two new legal entities; Association Health Plans (AHPs) and HealthMarts (HMs). Both AHPs and HMs are intended to increase incentives for employers to band together to purchase insurance coverage for their employees.

This side-by-side comparison does not discuss the provisions regarding retirement accounts or revenue offsets.

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Introduction

At the start of the 106th Congress several leadership bills from the 105th Congress were reintroduced with relatively minor modifications. After debate in the House and the Senate, both chambers passed patient protection bills. H.R. 2990 combines two House-passed bills. On October 6th 1999, the House passed the "Quality Care for the Uninsured Act of 1999" (H.R. 2990, introduced by Representatives Talent and Shadegg). This bill would increase access to health insurance and expand tax benefits. On October 7th, the House passed the "Bipartisan Consensus Managed Care Improvement Act of 1999" (H.R. 2723, introduced by Representative Norwood and Dingell). This bill would provide patient protections for consumers in managed care plans and with other forms of health care coverage. Pursuant H. Res. 323, which passed on October 6th, H.R. 2723 was then added as new matter to H.R. 2990. The House has appointed its conferees.

The Senate passed a Patients' Bill of Rights Plus Act (S. 1344, introduced by Senator Lott) on July 15, 1999. The Senate bill also includes provisions intended to increase access to health insurance, protect consumers in managed care plans, and expand tax benefits. On October 14th, the Senate amended H.R. 2990 as passed by the House, striking all language after the enacting clause and substituting the language in S. 1344. The Senate has appointed it conferees and has requested a conference.

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

Health insurance coverage

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

Health insurance issuer

An insurance company, insurance service, or insurance organization (including a HMO) which is licensed to engage in the business of insurance in a state and which is subject to state law which regulates insurance. This term does not include a group health plan.

Group health plan

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

Self-insured group health plan

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

Insured group health plans

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

Side-by-Side Comparison of H.R. 2990 and the Senate Amendment for Patient Protections

Provisions	House passed (H.R. 2990)	Senate Amendment
Bill status	Division A — Quality care for the Uninsured Act of 1999, passed by the House on October 6, 1999. Division B—Bipartisan Consensus Managed Care Improvement Act of 1999, passed by the House on October 7, 1999.	Passed by the Senate on October 14, 1999.
Applicability	Group health plans and health insurance issuers offering both group health insurance coverage and individual health insurance coverage except that the requirement for access to a Point of Service (POS) option does not apply to individual health insurance plans. See Note for further exceptions.	Group health plans, except that access provisions (emergency care; POS option; obstetric and gynecological car, pediatrics and specialty care; continuity of care; medical communications; and behavioral health care) apply to self-insured group health plans only.

Access

Access to Obstetric and Gynecologic Care and Pediatric Care

Provisions	House passed (H.R. 2990)	Senate Amendment
Ob/Gyn care	Prohibits group health plans or issuers from requiring authorization or referral from the primary health care professional or otherwise for coverage of ob/gyn care provided by a participating health care professional, including a physician who specializes in obstetrics and gynecology. Requires that the ordering of other ob/gyn care be treated as authorized by the primary care professional.	For self-insured plans only, requires group health plans to wave referral requirements for female participants or beneficiaries who seek coverage for obstetrical care and related follow-up obstetrical care or routine gynecological care. Requires that the ordering of other related routine care by a physician specializing in ob/gyn be treated as authorized by the primary care provider.
Pediatric care	Allows a participant to designate a physician who specializes in pediatrics as a primary care provider for a child of the participant.	For self-insured plans only, prohibits plans from requiring authorization or referral by a primary care provider in order for a participant or beneficiary to obtain coverage for routine pediatric care. Requires that the ordering of other routine care by a physician specializing in pediatrics be treated as authorized by the primary care provider.

Access to Specialists

Provisions	House passed (H.R. 2990)	Senate Amendment
General	Requires plans or issuers to make or provide for referral to an available and accessible specialist with adequate expertise (including pediatric expertise) for persons with a condition or disease of sufficient seriousness and complexity to require treatment by a specialist. A "specialist" means a practitioner, facility or center. If conditions merit the use of a non-participating specialist, services must be provided at no additional cost to the patient (beyond the costs for a participating specialist). Persons with an ongoing special condition (which is life-threatening, degenerative, or disabling AND requires specialized medical care over a prolonged period of time) may have their primary and specialty care coordinated and provided by a specialist for such a condition. Allows standing referrals to a specialist if a person has a condition that requires ongoing specialty care, as determined by the plan or issuer, or to a primary care provider in consultation with the medical director and the specialist (if any). A plan or issuer may require that care be pursuant to a treatment plan developed by the specialist and approved by the plan or issuer, in consultation with the designated primary care provider or specialist and the individual.	For self-insured plans only, requires group health plans to ensure timely access to specialty care when covered under the plan in accordance with the medical exigencies of the case. Specialty care means with respect to a condition, care and treatment provided by a health care practitioner, facility, or center that has adequate expertise through appropriate training and experience. A plan or issuer may require that care be pursuant to a treatment plan developed by the specialist and in consultation with a case manager or primary care provider or participant, and approved by the plan in a timely manner (in accordance with the medical exigencies of the case).

Emergency Services

Provisions	House passed (H.R. 2990)	Senate Amendment
General	Requires plans that cover emergency medical services to cover "emergency services" without prior authorization and without regard to network limitations, if a prudent layperson could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the individual's health. Requires plans that cover maintenance and post stabilization services to charge beneficiaries, who receive those services from non-participating providers, amounts that *do not* exceed what would have been incurred	For self-insured plans only, requires plans that cover emergency medical care to cover "emergency screening exams" and "emergency ambulance services" without prior authorization and without regard to network limitations, to the extent that a prudent layperson, who possesses an average knowledge of health and medicine, would determine such "emergency medical care" to be necessary. Requires that benefits be provided for "additional emergency

Provisions	House passed (H.R. 2990)	Senate Amendment
	if the services were authorized and provided by an network provider.	medical services" in an emergency department to the extent that they are necessary to stabilize an emergency medical condition following an emergency medical screening exam. In the case of emergency care provided at a non-participating facility, requires plans to cover "additional services to maintain stability" if the non-participating provider sought approval from the plan.
Definition	Defines "emergency" services as a medical screening examination and ancillary services to evaluate an emergency medical condition and such further medical examination and treatment as required to stabilize the patient. Defines "emergency medical condition" as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), as determined by a prudent layperson could, without treatment, reasonably expect to place their health in serious jeopardy or cause serious impairment or dysfunction.	Defines "emergency medical care"as covered inpatient and outpatient services that are furnished by participating and non-participating providers that are needed to evaluate or stabilize an emergency medical condition. Defines "emergency medical condition"as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain), as determined by a prudent layperson could, without treatment, reasonably expect to place their health in serious jeopardy or cause serious impairment or dysfunction.
Compensation	Prohibits plans or issuers from charging patients more for using a non-network provider than would have been charged if the services were provided in-network.	Same as House-passed bill H.R. 2990 and also allows cost-sharing to be imposed on patients for emergency medical care if any such charges are uniformly applied to "similarly situated" participants.

Continuity of Care

Provisions	House passed (H.R. 2990)	Senate Amendment
General	Requires plans or issuers to continue to cover treatment for pregnancy and ongoing special conditions (which is life-threatening, degenerative, or disabling AND requires special medical care over a prolonged period of time) with a terminated provider for enrollees who are undergoing a course of treatment with such a provider at the time of contract or benefit termination. Coverage shall be continued for "up to 90 days," in general, except for enrollees who are pregnant at the time of contract termination (coverage through the provision of postpartum care), terminal illness (coverage for the remainder of the individual's life), and for patients awaiting surgery or organ transplantation (coverage until the date of	Similar to House-passed bill H.R. 2990, except: (1) applies only to self-insured plans; (2) continuity of care for pregnant women is limited to those who have entered into the second trimester of pregnancy at the time of contract termination; (3) does not include exception for patients awaiting surgery or organ transplantation; (4) for institutional or inpatient care, continuity of care is extended until date of discharge or termination of the period of institutionalization; and (5) does not limit continuity of care to women who are pregnant and individuals with ongoing special conditions.

Provisions	House passed (H.R. 2990)	Senate Amendment
	discharge following surgery or transplant). Plans may condition such continued coverage by the provider agreeing to accept the payment rates and cost sharing amounts established under the prior agreement and adhering to the plans' quality standards, policies and procedures.	Requires a comprehensive study of the cost, quality, and coordination of coverage for patients at the end of their lives.

Prescription Drugs

Provisions	House passed (H.R. 2990)	Senate Amendment
General	Requires plans and issuers that limit prescription drug benefits to those included in a formulary to provide exceptions from the formulary limitation when a non-formulary alternative is medically indicated. Also requires the plan or issuer to ensure participation of participating physicians and pharmacists in the development of the formulary and to disclose the use of the formulary to providers and beneficiaries.	Same as House-passed bill H.R. 2990, except: 1) applies only to self-insured group health plans; and 2) does not require disclosure on the use of the formulary to providers and beneficiaries.

Clinical Trials

Provisions	House passed (H.R. 2990)	Senate Amendment
General	Prohibits plans and issuers which cover "qualified individuals" from denying, limiting, or imposing additional conditions on the coverage of routine patient costs (but not including the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved) incurred through participation in an approved and funded clinical trial. The plan or issuer may require the use of a participating provider, if the provider is participating in the trial and will accept the individual as a participant. A qualified individual is a person: (1) who has a life-threatening or serious illness for which no standard treatment is effective; (2) who is eligible to participate in an approved clinical trial according to the trial protocol; (3) whose participation in the trial offers meaningful potential for significant clinical benefits for the individual; and	Similar to House-passed bill H..R. 2990, except: (1) applies only to self-insured plans, and (2) applies only to *cancer* clinical trials. Also requires the Secretary to: (1) set up a process to establish standards relating to the coverage of routine patient cost for individuals in cancer clinical trials; and (2) conduct a study and report to Congress on the impact on group health plans of covering the costs under this section.

Provisions	House passed (H.R. 2990)	Senate Amendment
	(4) a participating physician concludes, or the individual establishes, that the individual's participation in the trial is appropriate (based on meeting conditions (1)-(3)). Approved clinical trails are those approved and funded by the National Institutes of Health (NIH), and/or a cooperative group or center of the NIH, or a peer reviewed study or investigation of the Department of Veteran's Affairs or the Department of Defense.	

Choice of Plans and Providers

Provisions	House passed (H.R. 2990)	Senate Amendment
Access to point-of-service (POS) option	Requires group health insurance issuers (in connection with group health plans) offering a restricted provider network, to make a POS option available for enrollees to purchase. (Referred to as a "consumer choice option".) Does not require a POS option if an individual is given a choice of health insurance coverage through another group health plan or through another insurance issuer in the group market.	Similar to House-passed bill H.R. 2990, except: (1) applies only to self-insured group health plans; and (2) small employers (2-50 employees) are exempt from POS requirements. Does not require a POS option if such coverage would not be available and accessible with reasonable promptness.
Choice of providers	Requires group health plans and issuers to allow enrollees to receive primary care from any primary care provider who participates in the plan and is available. Pursuant to appropriate referral procedures, requires group health plans and issuers to allow enrollees to receive medically necessary specialty care from any participating provider who is available. (Does not pre-empt plans from imposing limitations on the choice of participating health care providers, for such specialty care, as long as enrollees are clearly informed.)	No provision.

Behavioral Health

Provisions	House passed (H.R. 2990)	Senate Amendment
General	No provision.	For self-insured plans, prohibits plans from discouraging or prohibiting enrollees from self-paying for behavioral health care once the plan has denied coverage for such care or from terminating providers that accept self-payment for such services.

Breast Cancer Treatment

Provisions	House passed (H.R. 2990)	Senate Amendment
General	No provision.	Requires plans and issuers (not limited to self-insured plans) to ensure inpatient coverage for the surgical treatment of breast cancer (including a mastectomy, lumpectomy, or lymph node dissection) for a period of time as determined to be medically appropriate by the attending physician, in consultation with the patient. The determination should be consistent with generally accepted medical standards. Prohibits the use of specified incentives to avoid compliance with mandate. Requirements do not apply in states with more stringent laws.

Disclosure

Information Disclosure

Provisions	House passed (H.R. 2990)	Senate Amendment
Who provides information? How often? To whom?	Requires group health plans and health insurance issuers to provide information in printed form to participants and beneficiaries: (1) at the time of enrollment and at least annually thereafter; (2) when there is a significant change in the required information; and (3) when specified information is requested by participants, an applicable authority, and prospective participants and beneficiaries.	Requires group health plans or health insurance issuers to provide for the disclosure of information at least annually to enrollees, or upon request to a potential enrollee. Information must be in an accessible format that is understandable to an average plan participant or beneficiary. The Secretary of Labor is required to issue regulations coordinating these requirements to reduce duplication.
What information is disclosed?	Required: C Service area; C Benefits/exclusions; C Network characteristics; C Cost sharing; C Extent to which benefits may be obtained from nonparticipating providers and maximum out of pocket costs for these services; C Types, numbers, mix and distribution of providers participating in plan or network and extent to which participant, beneficiary, or enrollee may select from among them; C Name, address, and telephone numbers for these providers and	Required: C Description of covered items, services and any exclusions; C In-and out-of-network features; C Cost sharing; C Annual or lifetime limits on benefits; C Terms and premiums or cost-sharing for any optional supplemental benefits; C Restrictions on payments for services by a non-participating professional and liability of participant for additional payment for these services; C Plan service area, any out-of-area coverage;

Provisions	House passed (H.R. 2990)	Senate Amendment
	whether available to accept new patients; C Procedures and any limits for enrollees in selecting, accessing, or changing participating primary and specialty providers; C Rights and procedures for obtaining referrals to participating and nonparticipating providers; C Process for determining experimental coverage; C Use of prescription drug formulary; C Any out-of-network coverage; C Any point-of-service option, including any additional costs to enrollee; C Assistance for those who do not speak English or have special communications needs in accessing providers under the plan or coverage; C Out-of-area coverage; C Process, procedures for obtaining emergency services, explanation of appropriate use, and locations where emergency services and post-stabilization care are provided; C Percentage of premiums used for benefits (loss-ratios); C Prior authorization rules with mailing address and telephone number for enrollees seeking information or treatment authorization; C Appeal and grievance rights and procedures; C Any public accreditation information and any quality indicators the plan or issuer makes available; C Notice of these disclosure requirements and that the following information is available upon request.	C Extent to which enrollee may select primary care provider from in and outside of network; C Any procedures for advance directives and organ donations; C Requirements and procedures for obtaining preauthorization, including telephone numbers and mailing addresses; C Requirements and procedures for referrals for specialty care; C Definition of medical necessity used in making coverage decisions; C Rules and methods for appealing coverage decisions and filing grievances; C Provisions for obtaining off-formulary medications; C Rules for access to emergency room care and any available education materials on proper use of emergency services; C Coverage of experimental treatments or clinical trials and circumstances under which access is available; C Any preventative services; C Manner of access to obstetrician, gynecologist, pediatrician; C Manner in which continuity of care may be obtained; C A statement regarding the availability of the following information upon request.
What information is disclosed?	Upon Request: C Procedures and requirements under any utilization review program; C Procedures used, any requirements, and the nature of restrictions under any drug formulary program; C Number and total disposition of grievances and appeals; C General description of compensation of health care professionals; C Credentials of specific participating providers; and C List of current participating health care providers.	Upon Request: C Names, addresses, telephone numbers of participating health care professionals and facilities; C State licensure status and, if available, education, training, specialty qualifications or certifications of professionals; C Summary of compensation method for health care professionals and facilities; C Summary of utilization review procedures; C List of specific medications in formulary; C Specific coverage exclusions; C Availability of translation/interpretation services for non-English speakers and persons with communication disabilities; and

Provisions	House passed (H.R. 2990)	Senate Amendment
		C Any public information on accreditation or quality indicators made available by the plan.
Uniform Explanation of Benefits	Establishes a panel to devise a single form for use by third-party health care payers for the remittance of claims to providers.	No provision.

Medical Communications (Gag Rule)

Provisions	House passed (H.R. 2990)	Senate Amendment
General	Requires that a plan or issuer not prohibit or restrict a health care professional from advising a patient about their health status or medical care or treatment for their condition or disease, regardless of whether such treatments are covered under the plan, if the professional is acting within the lawful scope of practice. Any contract provision or agreement that restricts or prohibits medical communication shall be null and void.	Similar to House-passed bill H.R. 2990, except: (1) applies only to self-insured plans, and (2) does not address contract provisions.

Other Patient Protections

Quality Measurement

Provisions	House passed (H.R. 2990)	Senate Amendment
General	No provision.	No provision (but see related provisions in section on "Agency for Healthcare Quality Research", below).
Quality research and advice	No provision.	Requires the Secretary and the Institute of Medicine to study and report on information on health care professionals currently available, legal barriers to sharing formation, and make recommendations on disclosure of this information.

Provider Provisions

Provisions	House passed (H.R. 2990)	Senate Amendment
Provider incentive plans	Prohibits any provider incentive plans as defined by Section XVIII of the Social Security Act as any compensation arrangement between an eligible organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided.	No provision.
Discrimination	Prohibits discrimination with respect to participation or indemnification	Similar to House-passed bill H.R. 2990, except applies only to

Provisions	House passed (H.R. 2990)	Senate Amendment
	any provider who is acting according to license or certification under state law, on the basis of such license or certification. Does not require coverage of particular benefits or the inclusion of every willing provider. Does not prohibit including providers only as necessary to meet the needs of plan or issuer.	self-insured plans.
Prompt payment of claims	Requires plans and issuers offering group health insurance to provide for prompt payment of claims with respect to covered benefits.	No provision.

Protections for Patient Advocacy

Provisions	House passed (H.R. 2990)	Senate Amendment
No retaliation	Protects enrollees, beneficiaries, participants and providers from retaliation by a plan or issuer for using appeals and grievance processes.	No provision.
Quality advocacy	Prohibits a plan or issuer from retaliating against a protected health care professional (licensed or certified health care professional who is an employee or has a contract with the plan or issuer) who acts in good faith to participate in an investigation. Specifies requirements for internal procedures and exceptions and defines terms.	No provision.

Grievance and Appeals Processes

Grievances (Complaints about issues other than coverage determinations or benefit payments)

Provisions	House passed (H.R. 2990)	Senate Amendment
Generally	Requires group health plans and health insurance issuers to maintain a system that addresses oral and written grievances. Grievances may involve any question, complaint, or concern brought by a participant, beneficiary, or enrollee that is not a claim for benefits. Decisions are not appealable.	Requires group health plans and health insurance issuers to have written procedures for addressing grievances. Decisions are not appealable.

Initial Coverage Determinations and Utilization Review

Provisions	House passed (H.R. 2990)	Senate Amendment
Timing of Review—generally	Prior Authorization Services: Requires plans or issuers to make a determination as soon as possible in accordance with the medical exigencies of the case, but not later than 14 days after receiving the	Routine Determinations: Requires plans and issuers to issue initial coverage decisions within 30 days after the date on which the request for review is submitted. Notice of the decision must

Provisions	House passed (H.R. 2990)	Senate Amendment
	request for prior authorization, except if additional information is required to make a determination, the deadline may be extended to 14 days after receiving the additional information, but in no case later than 28 days after receiving the initial request for prior authorization.	be issued not later than 2 working days after the decision is made.
Expedited cases	Expedited Cases (Cases where delay could seriously jeopardize the life or health of the participant, beneficiary, or enrollee or such an individual's ability to regain maximum function): Requires plans or issuers to make a determination within 72 hours after the request for prior authorization is made.	Expedited Determinations (Cases where the failure to provide immediate care could seriously jeopardize the life or health of the participant or beneficiary): A decision must be made within 72 hours after a request for review is submitted. Notice of the decision must be issued within that 72 hour period. To receive expedited review, documentation is needed from the treating health care professional.
Ongoing Care	Ongoing Care (e.g., hospitalization): Requires plans or issuers to make a determination as soon as possible with sufficient time prior to the termination or reduction of care to allow for an appeal.	A plan or issuer shall maintain procedures to certify or deny coverage of an extended stay or additional services. Notice of the decision must be issued within 1 working day of the determination.
Previously provided services	Previously Provided Services: A determination must be made within 30 days of receiving all of the information reasonably necessary to make a decision, but in no case later than 60 days after the receipt of the claim for benefits.	Retrospective Determinations: A decision must be made within 30 working days after the date on which the plan or issuer receives all necessary information. Notice of the decision must be issued within 5 working days after the date on which the determination is made.
Failure to meet deadlines	Failure to follow these deadlines shall be treated as a denial of the claim.	Failure to follow these deadlines shall be treated as an adverse coverage determination for purposes of proceeding to internal review.

Appeals Process — Internal Review

Provisions	House passed (H.R. 2990)	Senate Amendment
Requests for review	A participant, beneficiary, or enrollee has at least 180 days to request and obtain review.	A participant or beneficiary has at least 180 days after the date of the adverse coverage determination to make an appeal.
Decisions that may proceed to internal review	No provision.	Decisions regarding payment, coverage, and cost-sharing can proceed to internal review.
Who conducts review?	Review is conducted by (1) a named fiduciary if the dispute involves a claim for benefits under the plans, (2) a named appropriate individual if the dispute involves denied coverage, (3) a physician in a case of medical judgment, or in certain	Review is conducted by (1) an individual with appropriate expertise who was not directly involved in the initial determination, or (2) a physician with appropriate expertise in a case involving issues of medical necessity or appropriateness, or experimental and investigational treatment.

Provisions	House passed (H.R. 2990)	Senate Amendment
	circumstances a specialist; and (4) an individual who has been selected by the plan or issuer; and did not make the initial denial.	
Timing of review-generally	Routine Cases: Review must be completed in accordance with the medical exigencies of the case, but not later than 14 days after receiving the request for internal review. The deadline may be extended to 28 days if additional information is needed.	Routine Determinations: Review must be conducted within 30 working days after the date on which a request for review is received. Notice of the decision must be issued not later than 2 working days after the completion of review.
Expedited cases	Expedited Cases: Review must be completed within 72 hours of receiving a request for review.	Expedited Determinations: Review must be conducted in accordance with the medical exigencies of the case, but not later than 72 hours after the request for review is received. Such a request must include documentation of medical exigency by the treating health care professional. Notice of the decision must be issued within the 72-hour period.

Appeals Process — External Review

Provisions	House passed (H.R. 2990)	Senate Amendment
Requests for review	Appeals must be "timely." The appropriate Secretary shall establish additional standards to carry out review. A plan or issuer may require a filing fee of up to $25, unless the individual certifies that he or she is indigent. The filing fee shall be refunded if the recommendation of the external appeal entity is to reverse or modify the denial of a claim for benefits.	Establishes that a written request for review must be submitted within 30 working days after receiving the initial review decision.
When external review is available	External review is available for benefit denials that: (1) are based on a decision that the item or service is not medically necessary; (2) involve an investigational or experimental treatment; or (3) involve a decision requiring medical judgment to determine whether a benefit is covered. External review is also available when the deadline for internal review has not been met.	External review is available for benefit denials that: (1) are based on decisions of medical necessity and that exceed a significant financial threshold; (2) are based on decisions of medical necessity and there is a significant risk of placing the life or health of the participant in jeopardy; or (3) involve an experimental or investigational treatment External review is also available when the deadline for internal review has not been met.
Who conducts review?	Review is conducted by a qualified external appeal entity in accordance with the following: (1) For group health plans, the entity must be certified either by the	The plan or issuer must select an external appeals entity that will designate an independent external reviewer.

Provisions	House passed (H.R. 2990)	Senate Amendment
	Secretary of Labor, under a process recognized or approved by the Secretary of Labor, or by a qualified private standard-setting organization; (2) For health insurance issuers operating in a state, the entity must be certified by the applicable state authority or under a process recognized or approved by such authority. If the state has not established a certification process, the entity must be certified either by the Secretary of HHS, under a process recognized or approved by such Secretary, or by a qualified private standard-setting organization. With respect to health insurance issuers in a state, the state may provide for external review to be conducted by a qualified external appeal entity that is designated by the state or that is selected by the state in a manner determined by the state to assure an unbiased determination. The external appeal entity must conduct its activities through a panel of not fewer than 3 clinical peers, and have sufficient medical, legal, and other expertise and sufficient staffing to conduct its activities in a timely manner. The external appeal entity (and its clinical peer members) must: (1) not have a familial, financial, or professional relationship with any related party; (2) receive only reasonable compensation that is not contingent on any decision rendered; (3) be free from recourse by the plan or issuer; and (4) not otherwise have a conflict of interest with a related party as determined under any regulations prescribed by the Secretary.	The following may be selected as the external appeals entity: (1) an independent external review entity licensed or credentialed by a state; (2) a state agency established to conduct independent external reviews; (3) any entity under contract with the federal government to provide independent external review services; (4) any entity accredited as an independent external review entity; or (5) any entity meeting criteria established by the Secretary of Labor. An independent external reviewer shall: (1) be appropriately credentialed or licensed to deliver health care services; (2) not have any material, professional, familial, or financial affiliation with the case under review, the participant or beneficiary, the treating health care professional, the treating institution, or the manufacturer or any drug, device, or procedure proposed for the participant or beneficiary; (3) have expertise in the diagnosis or treatment under review and be a physician of the same specialty, when reasonably available; (4) receive only reasonable and customary compensation from the plan or issuer that is not contingent on the decision rendered; and (5) not be held liable for decisions regarding medical determinations.
Standard of review	The external appeal entity shall consider the following evidence: (1) the internal review decision and any guidelines or standards used to reach the decision; (2) any personal health and medical information supplied with respect to the individual; and (3) the opinion of the participant's treating physician or health care professional. They external appeal entity may also consider: (1) the results of studies that meet professionally recognized standards	An independent external reviewer (IER) shall consider all valid, relevant, scientific, and clinical evidence to determine the medical necessity, appropriateness, or experimental nature of the proposed treatment. The IER shall also consider all appropriate and available information, including any clinical practice guidelines used by the plan or issuer, the patient's medical record, expert consensus, and medical literature.

Provisions	House passed (H.R. 2990)	Senate Amendment
	or that have been published in peer-reviewed journals; (2) the results of professional consensus conferences conducted or financed in whole or in part by one or more government agencies; (3) government treatment guidelines; (4) a community standard of care; (5) expert testimony; and (6) the results of peer reviews conducted by the plan or issuer involved. The review process shall provide for a fair, de novo determination.	
Timing of review — generally	A determination shall be made in accordance with the medical exigencies of the case, but not later than 21 days after receiving the request for external review.	Routine Determinations: Timeframes for selecting an external review entity, selecting an independent external reviewer, and conducting the review are as follows, (or earlier in accordance with the medical exigencies of the case): (1) The plan or issuer has up to 5 working days to select an external appeals entity and notify the participant or beneficiary of the entity; (2) Once the entity is designated, it has up to 30 days to designate an independent external reviewer; and (3) The review must be conducted no later than 30 working days after either the date on which a reviewer is designated or all necessary information is received, whichever is later.
Expedited cases	Expedited Appeals: A determination must be made within 72 hours after receiving the request for external review.	Expedited Determinations: The initial timeframe of 5 days for the plan to select an entity and 30 days for the entity to select an independent reviewer, or earlier in accordance with the medical exigencies of the case would still apply. However, the review must be conducted withing 72 hours after the date on which a reviewer is designated or all necessary information is received, whichever is later.
Binding decisions	The decision of the external appeal entity is binding on the plan and issuer involved in the determination.	Same as House-passed bill H.R. 2990.
Civil penalties/enforcement	A court of competent jurisdiction may order a civil penalty of up to $1,000 a day from the date on which a determination was transmitted to the plan or issuer if the determination is not followed. The court shall also issue an order requiring the person responsible for authorizing the benefit to cease and desist from failing to act in accordance with the determination. This order shall also compel the payment of attorney's fees.	The Secretary of Labor may assess a civil penalty against any plan of up to $10,000 for the plan's failure or refusal to comply with any deadlines. The Secretary shall assess a civil penalty of $10,000 against a plan if treatment is not commenced in accordance with a determination of an independent external reviewer. The penalty

Provisions	House passed (H.R. 2990)	Senate Amendment
	The appropriate Secretary may also assess a civil penalty for any pattern or practice of repeated refusals to authorize benefits after external review, or any pattern or practice of repeated violations of the requirements of the external review process. The penalty shall be payable only upon proof of clear and convincing evidence of such pattern or practice and shall not exceed the lesser of (1) 25% of the aggregate value of the benefits that have not been provided or have been unlawfully delayed; or (2) $500,000. The appropriate Secretary may petition for the removal of any person with the capacity to authorize benefits who has engaged in such pattern or practice.	will be paid to the participant or beneficiary involved. Where a plan or issuer fails to provide reimbursement in accordance with a determination by the external reviewers, the beneficiary commence a civil action to recover only the amount of unpaid reimbursement and any necessary legal costs incurred in recovering such reimbursement.
Study	No provision.	The General Accounting Office (GAO) shall conduct and submit a study to Congress that includes an assessment of the process involved during an independent external review and the basis of decision-making by the independent external reviewer.

Medical Necessity Determinations

Provisions	House passed (H.R. 2990)	Senate Amendment
General	Not specifically defined. External appeal entity shall consider, but is not bound by any language in the plan or coverage document relating to the definitions of the terms medical necessity, medically necessary or appropriate, or experimental, investigational, or related terms.	Not specifically defined. Directs external reviewers to independently determine the medical necessity or appropriateness of care under appeal. See “standards of review” section above.

ERISA Preemption and Access to State Law

Provisions	House passed (H.R. 2990)	Senate Amendment
General	The bill would amend Section 514 of ERISA to allow a participant or beneficiary to bring a cause of action under state law to recover damages for personal injury or wrongful death resulting from acts connected to or arising out of an arrangement regarding "the provision of insurance, administrative services, or medical services" to or for a group health plan. It bars from review those decisions denying coverage for items specifically excluded from the plan.	Does not change current ERISA Section 514 preemption of state laws. (Maintains current law remedies for equitable relief in state or federal court.) Determination of external reviewer is binding upon the plan or issuer. If plan or issuer fails to comply with external review decision, participant or beneficiary may obtain item or service from any provider, and then seek reimbursement from the plan or issuer.
Damages	Generally, the bill does not have a provision regarding damages. The amount of damages a participant or beneficiary would recover would be determined by state law. However, the bill would prevent the award of punitive damages if: (1) the decision was subject to external review as defined in the bill; (2) an external review was conducted; and (3) the plan promptly followed the recommendation issued by the external review entity. A participant or beneficiary must exhaust internal and external review, unless death or injury has occurred. If the participant or beneficiary files an action before external review has taken place, the plan or issuer may still avoid punitive damages if it requests external review within 30 days after the date the externally appealable decision was made, and the remaining requirements are met. This provision would not apply to a state cause of action for wrongful death, if the state law only allows for punitive damages.	Does not alter current law, which allows the participant or beneficiary to recover the costs of the benefit, reasonable attorney's fees, and court costs.
Employer Protections	The bill expressly states that it does not authorize a cause of action against a group health plan, employer or plan sponsor (or its employees). Further, the bill does not permit a cause of action under state law for failing to provide a benefit or service that is not covered by the plan. This provision also expressly prohibits a person from seeking recovery, indemnification, or contribution from the group health plan, employer or plan sponsor (or its employees) for damages awarded under the Act. However, the bill also includes an exception to these provisions where the group health plan, employer or plan sponsor (or its employees) exercised its discretionary authority to make a benefits decision and the decision resulted in harm. The exercise of	No provision.

Provisions	House passed (H.R. 2990)	Senate Amendment
	discretionary authority does not include the decision to include or exclude certain benefits from the plan, to provide extra-contractual benefits, or a decision not to provide a benefit while internal or external review is being conducted.	
Exhaustion of Internal & External Review	Internal and external review must be exhausted , unless injury or death has occurred before completion of such processes. In the case where injury or death has occurred and the patient files a court action without review, the plan may initiate and complete internal and external review. Punitive damages would not be available where the plan has complied with the external review process and decision.	No provision.
Weight Given to External Review Decision in Legal Proceedings	No provision, state law would apply.	Determination of external reviewer is binding upon the plan or issuer.
Impact on State Causes of Action	The bill would amend ERISA's preemption clause to allow a cause of action under state law to recover damages for personal injury or wrongful death resulting from acts connected to or arising out of an arrangement regarding "the provision of insurance, administrative services, or medical services" to or for a group health plan.	Does not change current ERISA § 514 preemption of state laws. (Maintains current law remedies for equitable relief.)
Jurisdiction	The bill would amend ERISA's preemption clause to allow a cause of action under state law to recover damages for personal injury or wrongful death resulting from acts connected to or arising out of an arrangement regarding "the provision of insurance, administrative services, or medical services" to or for a group health plan.	This bill would amend ERISA § 502 to create a federal cause of action for reimbursement of a claim when the plan or issuer fails to comply with external review.
Limitation of Actions	The bill prohibits a cause of action by a participant or beneficiary for damages under Section 1101 of the Act which covers utilization review activities. A participant or beneficiary may seek relief based on the individual circumstances of the participant/beneficiary under sections of the bill covering access to emergency care, specialty care, obstetrical or gynecological care, pediatric care, continuity of care and coverage for participation in clinical trials. Relief is limited to recovery of the benefit, item or service and attorney's fees and costs at the discretion of the court. The bill states that such actions may not be brought as a class action.	No provision.

Market Reform and Insurance Affordability

Association Health Plans

Provisions	House passed (H.R. 2990)	Senate Amendment
Eligibility requirements	Establishes that an association health plan (AHP) is a group health plan that offers at least one fully-insured health insurance coverage option (unless it is not available), has been certified, and is operated by a board of trustees with complete fiscal control and responsibility for all operations. The association sponsoring the plan must have been in existence for at least 3 years for substantial purposes other than providing health insurance coverage. AHPs may include a collectively bargained multi-employer plan or a group health plan established and maintained by a franchiser for its franchisees. A church plan is also eligible to elect AHP status if it complies with fiduciary, reporting, and actuarial standards. To be certified, a "self-insured" AHP must have at least 1,000 participants and beneficiaries. The self-insured AHP must have also offered coverage on the date of enactment or represent a broad cross-section of trades or represent one or more trades with average or above health insurance risk.	No provision (i.e., does not preempt state laws that govern AHPs).
Participation and coverage	Requires that all employers participating in the AHP be members or affiliated members of the sponsor. All individuals under the plan must be active or retired employees, owners, officers, directors, partners, or their beneficiaries. This applies to partnerships and self-employed individuals. For plans which were in existence on the date of enactment, no unaffiliated employer may participate unless they were affiliated on the date of certification or did not maintain or contribute to a group health plan for the previous 12-month period. Prohibits discrimination by requiring that all employers who are association members be eligible for participation, all geographically available coverage options are made available upon request to eligible employers, and eligible individuals not be excluded from enrolling because of health status. Premium contribution rates for any particular small employer cannot be based on the health status or claims experience of plan participants or beneficiaries or on the type of	No provision.

Provisions	House passed (H.R. 2990)	Senate Amendment
	business or industry in which the employer is engaged. Both health insurance coverage and any self-insured benefit options must be distributed by state-licensed health insurance agents.	
Reserve requirements and provisions for solvency	Reserves for AHPs which offer benefit options that are not fully-insured must be sufficient for unearned contributions, benefit liabilities, expected administrative costs, any other obligations and a margin for error recommended by the plan's qualified actuary. AHPs must also obtain aggregate and specific stop-loss insurance; indemnification insurance for any claims the plan is unable to satisfy if the plan is terminated; and must also make annual payments to an Association Health Plan Fund to guarantee that indemnification insurance is always available. The plan must maintain minimum surplus of at least $500,000. If an AHP is unable to provide benefits when due or is otherwise in a financially hazardous condition, the Secretary of Labor is required to act as a trustee to administer the plan for the duration of the insolvency. A certified AHP may terminate only if the trustees provide 60 days advance written notice to participants and beneficiaries and submit a plan for timely payment of all benefit obligations. A Solvency Standards Working Group is to be established within 90 days after enactment to recommend initial regulations.	No provision.
ERISA preemption	Establishes that certified AHPs are exempt from state benefit mandates, except that AHPs must comply with any federal or state laws that require coverage of specific diseases, maternal and newborn hospitalization, and mental health. Clarifies that states may regulate self-insured multiple employer welfare arrangements providing medical care which do not elect to meet the certification requirements for AHPs.	No provision.
Enforcement	Requires states to certify and enforce the provisions applicable to AHPs; failing to enter into an agreement to do so, the applicable authority is the Department of Labor. Provides for criminal penalties for willful misrepresentation as an exempt AHP or collectively bargained status; provides for cease activity orders; and establishes the responsibility of the board of trustees for meeting required claims procedures. The Secretary of Labor is required to report to Congress no later than January 1, 2004 on the effect of AHPs on reducing the number of uninsured individuals.	No provision.

HealthMarts

Provisions	House passed (H.R. 2990)	Senate Amendment
General	Defines a HealthMart (HM) as a legal nonprofit entity that makes health benefits coverage available to all small employers, and eligible employees. The HM is operated under the direction of a board that includes at least two representatives each of small employers, their employees, health care providers, and entities that underwrite or administer health benefits coverage. The HM assumes no insurance risk, but provides health benefits coverage through contracts with health insurance issuers. The HM is considered a group health plan for purposes of ERISA fiduciary and disclosure requirements. The HM also provides administrative services for purchasers. An HM must specify the geographic area in which it makes coverage available. Geographic areas must encompass at least one entire county or equivalent area. HMs can serve more than one state or portions of two or more contiguous states. Multiple HMs can be established in a single geographic area. HMs can serve more than one state or portions of two or more contiguous states. Geographic areas must encompass at least one entire county or equivalent area. (Does not require health insurance issuers to provide coverage outside their service area or to cover the entire geographic area served by a HM.) By end of first year of operation and thereafter, HMs must maintain at least 10 small employers and 100 employees/dependents. An HM cannot require a purchaser to sign a contract for more than 1 year, but a purchaser can elect to sign for a longer period. Creates the Health Care Marketplace Division under the authority of the Secretary of HHS to administer the HM provisions. The Secretary of HHS is required to submit a report to Congress every 30 months (for 10 years) on the effectiveness of HMs in promoting coverage of uninsured individuals.	No provision.
Benefits and premium rate requirements	A HM must offer (through one or more issuers) at least two coverage options. Benefits must be underwritten by issuers licensed and/or regulated under state law unless offered through a Community Health Insuring Organization, meet state standards relating to consumer	

Provisions	House passed (H.R. 2990)	Senate Amendment
	protection, and be approved or allowed under state law. (In certain cases of discrimination or delay, an issuer may have grounds to request that an applicable federal authority waive state approval requirements.) In accordance with existing federal law, any health benefits coverage offered through a HM must provide full portability for employees who remain members of the same HM if both employers are purchasers in the HM. Premium rates are established by the health insurance issuer on a policy or product specific basis and may vary only as permissible under State law. Rates may not vary among similarly situated individuals on the basis of health status. Health insurance issuers may establish premium discounts or rebates for HM members in return for adherence to wellness programs.	
Enrollment	Requires HMs to offer health benefits coverage to all eligible employees in small businesses (2 to 50 employees) in any geographic area in which it operates. A HM cannot deny enrollment or renewal of coverage on the basis of health status-related factors. Requires a 30-day annual open enrollment period during which members can change coverage options. If a contract between the HM and an issuer is terminated and the HM continues to offer coverage, the HM is required to make coverage available from among remaining issuers. An HM purchaser must agree not to obtain or sponsor health benefits coverage through any source other than the HM (with exceptions for persons living out of the HM coverage area).	No provision.
Information disclosure	Requires HMs to collect and disseminate consumer-oriented information (as defined by the HM) on the scope and cost of, and enrollee satisfaction with, coverage options. To the extent practicable, such information should include provider performance, locations and hours	No provision.

Provisions	House passed (H.R. 2990)	Senate Amendment
	of operation of providers and outcomes.	
State law application	Does "not preempt" state laws relating to: (1) the regulation of underwriters, including licensure and solvency requirements, (2) application of premium taxes, guaranty funds, and contributions to high-risk pools, (3) fair marketing requirements and other consumer protections, (4) requirements relating to the adjustment of rates for health insurance coverage, and (5) disease-specific state benefit mandates and state laws enacted to implement federal benefit mandates. Preempts state laws related to: (1) benefit mandates (other than those described above (2) grouping requirements (which bar employers from joining together for the sole purpose of purchasing health insurance), and (3) any other requirement that directly or indirectly impedes offering coverage through a HM.	No provision.

Community Health Organizations

Provisions	House passed (H.R. 2990)	Senate Amendment
General	Allows for waivers of state licensing requirements for certain community health organizations (CHO) that offer health insurance coverage. The Secretary shall establish solvency standards for such CHOs. CHOs are defined as a federally-qualified health center or an organization controlled by one or more federally-qualified health center.	No provision.

Other Provisions Relating To Health And Health Insurance

Medical Savings Accounts (MSAs)

Provisions	House passed (H.R. 2990)	Senate Amendment
Expanded Availability	Removes the current law provision restricting MSAs to employees of small employers and self-employed individuals, making them generally available to individuals with qualifying high deductible health plans. Allows MSAs to be offered under cafeteria plans. Eliminates limitations on the number of taxpayers who can have MSAs. Monthly contributions to accounts could be made up to one-twelfth of the annual insurance deductible. Contributions no longer would be limited by compensation (if employed) or net earnings (if self-employed). Contributions to an account could be made by both an employer and an employee. Reduces minimum insurance deductibles (prior to applying the cost-of-living adjustment) from $1,500 to $1,000 in the case of single coverage and $3,000 to $2,000 in the case of family coverage. Amendments would apply to taxable years beginning after December 31,2000.	Similar to House-passed bill H.R. 2990 except as noted. MSAs would continue to be disallowed under cafeteria plans. (Rollovers from cafeteria plans and flexible spending accounts to MSAs would be allowed.) Provides that notwithstanding any other provision of law, health insurance issuers may offer and eligible individuals may purchase high deductible plans as defined in section 220(c)(2)(A). For four years after enactment, high deductible health plans could not be required to provide payment for items or services that are exempt from the plan's deductible. Contributions to an account could continue to be made by either an employer or an employee, but not both. The penalty for distributions not used for qualified medical expenses would not apply to distributions that do not reduce the account balance to less than the annual insurance deductible. Clarifies that network-based managed care plans shall not fail to be considered high deductible plans if services are rendered by out-of-network providers, so long as the annual deductible and limit on out-of-pocket expenses for those services are not lower than those applicable to network providers. Amendments would apply to taxable years beginning after December 31, 1999.
MSAs and FEHBP	No provision.	Authorizes government contributions to an MSA of an employee or annuitant who is enrolled in a catastrophic health plan under the Federal Employees Health Benefits Program (FEHBP). The MSA contribution would equal the amount by which the maximum contribution allowed under Section 8906(b)(1) of Title 5 U.S.C. exceeds the government contribution for the

Provisions	House passed (H.R. 2990)	Senate Amendment
		catastrophic coverage of the individual. The latter contribution may not exceed 100% of the premium of the catastrophic plan (or, as under current law, 72% of the weighted average premium, whichever is less). Requires the Office of Personnel Management to contract for a catastrophic plan with any carrier that offers such plan and, as of the date of enactment, offers a FEHBP plan. The Office may contract for catastrophic plans with other qualified carriers. Provides that catastrophic plans are service benefit, indemnity benefit, or employee organization plans that provide benefits named under subsection 8904(a)(1) or (2) of title 5 U.S.C. except that annual deductible and out-of-pocket limits specified in subsection 220(c)(2) of the Internal Revenue Code shall apply. (Annual deductible limits would be lowered by this legislation.) Provides that the Office of Personnel Management (OPM) shall prescribe regulations under which various requirements of FEHBP shall apply to catastrophic plans. Amendments would apply to contract terms beginning on or after January 1, 2000.

Cafeteria Plans and Flexible Spending Accounts

Provisions	House passed (H.R. 2990)	Senate Amendment
Carryovers and Rollovers	No provision.	Provides that a plan would not fail to be treated as a cafeteria plan or flexible spending account (FSA) solely because unused nontaxable benefits may be carried forward to succeeding taxable years; in addition, no amount would be included in gross income because a carryover is allowed. These figures would not apply to annual amounts carried forward that exceed $500 (subject to a cost-of-living adjustment). In the case of unused health or dependent care FSAs, participants must be allowed to elect to receive such amounts as distributions in lieu of a carryover.

Provisions	House passed (H.R. 2990)	Senate Amendment
		Distributions would not be included in gross income to the extent they are rolled over (by a trustee-to-trustee transfer or a contribution within 60 days) to (1) a Section 401(k) plan, (2) a Section 403(b) annuity plan, (3) a Section 457 deferred compensation plan, or (4) a medical savings account (MSA). A rollover would be treated as an eligible rollover under these sections and not taken into account in applying any limitation or participation requirement on employer or employee contributions for the taxable year of the rollover. Amendments would apply to taxable years beginning after December 31, 1999.

Self-Employed Health Insurance Deduction

Provisions	House passed (H.R. 2990)	Senate Amendment
Deduction for health insurance	Allows self-employed taxpayers a 100% deduction for health insurance costs, effective for taxable years beginning after December 31, 2000. Allows the deduction even if taxpayer is eligible to participate (but does not) in employer-subsidized health plan.	Similar, but effective for taxable years beginning after December 31, 1999. Retains current law restriction that taxpayer cannot be eligible to participate in employer-subsidized plan.

Expanded Health Insurance Deduction

Provisions	House passed (H.R. 2990)	Senate Amendment
Deduction for health insurance.	Allows individual taxpayers a deduction (not limited to itemizers) for amount paid for health insurance, limited to 25% in 2002 through 2004, 35% in 2005, 65% in 2006, and 100% in 2007 and thereafter. Deduction does not apply to ancillary coverage for accidents, disability, dental care, vision care, or a specified illness, nor for fixed amount per day (or any other period) for hospitalization. Deduction also does not apply if taxpayer participates in health plan maintained by employer or employer of the spouse if 50% or more of its cost is paid or incurred by employer. Deduction also does not apply if taxpayer is covered by Medicare, Medicaid, State Children's Health Insurance Programs, or by armed forces or veterans health care, or by Indian Health Care Improvement Act program or FEHBP (aside from continuation coverage for the latter).	No provision.

Provisions	House passed (H.R. 2990)	Senate Amendment
	Amendments would be affective for taxable years beginning after December 31, 2001.	

Long-Term Care

Provisions	House passed (H.R. 2990)	Senate Amendment
Long-term care included in cafeteria plans and flexible spending accounts	Allows qualified long-term care insurance contracts to be included in cafeteria plans (subject to age-related limitations of Section 213(d)(10)). Allows long-term care benefits to be provided through flexible spending accounts. Amendments would be effective taxable years beginning after December 31, 2001.	Allows qualified long-term care insurance contracts to be included in cafeteria plans (not subject to age-related limitations). Does not delete restriction in section 106(c) against providing benefits through flexible spending accounts. Amendments would be effective taxable years beginning after December 31, 1999.
Deduction for long-term care insurance	Allows individual taxpayers a deduction (not limited to itemizers) for amount paid for long-term care insurance (plans with coverage for qualified long-term care services or which are qualified long-term care insurance contracts), limited to 25% in 2002 through 2004, 35% in 2005, 65% in 2006, and 100% in 2007 and thereafter. Qualified long-term care insurance contracts are subject to age limitations of current law. Deduction does not apply if taxpayer participates in long-term care plan maintained by employer or employer of the spouse if 50% or more of its cost is paid or incurred by employer. Amendments would be effective for taxable years beginning after December 31, 2001.	Similar, except: (1) deduction is not limited during a phase-in period, (2) deduction does not apply if taxpayer is eligible to participate in subsidized plan maintained by any employer or former employer of taxpayer or spouse, and (3) deduction shall not be taken into account in determining individual's net earnings from self-employment. Amendments would be effective for taxable years beginning after December 31, 1999.
Additional personal exemption	Allows individual taxpayers an additional personal exemption for qualified family members who need long-term care. Defines qualified family member as one who: (1) is an ancestor of the taxpayer or of the taxpayer's spouse (or who is the spouse of the ancestor), (2) is a member for the entire year of a household maintained by the taxpayer, and (3) has been certified by a physician as needing long-term care for a period that is at least 180 consecutive days (a portion of which is in the taxable year).	No provision.

Provisions	House passed (H.R. 2990)	Senate Amendment
	Individuals with long-term care needs are (1) unable to perform at least two activities of daily living (ADLs, as defined in Section 7702B(c)(2)(B)) due to a loss of functional capacity, or (2) require substantial supervision to be protected from threats to health and safety due to severe cognitive impairment and are unable to perform without substantial reminding or cuing at least one ADL or are unable to engage in age appropriate activities. The certification must be within the previous 39 ½ month period. Amendments would be effective for taxable years beginning after December 31, 2000.	
Study of long-term care needs	No provision.	Requires the Secretary of Health and Human Services (HHS)to provide for a study to determine the future demand for long-term care services and options to finance those services. Provides that the study shall address: (1) relevant demographic characteristics affecting long-term care, (2) viability and capacity of community-based and other long-term health services, (3) how to improve the quality of services, (4) the integration of services between providers and federal programs, (5) the possibility of expanding private sector initiatives including long-term care insurance, (6) the effect of the Health Insurance Portability and Ac countability Act (HIPAA) on the provision and financing of long-term care services and insurance, and (7) the financial impact of the provision of long-term health care services on caregivers and other family members. Requires the Secretary to arrange for the study to be conducted by the Institute of Medicine (or, if this cannot be arranged, by another qualified non-governmental entity) and in consultation with experts from a wide range of public and private groups. Requires the Secretary to report on the study not later than one year after enactment, including findings and recommendations and cost estimates.

Orphan Drug Tax Credit

Provisions	House passed (H.R. 2990)	Senate Amendment
Qualifying expenses	Expands qualifying expenses to include human clinical testing expenses incurred after date on which taxpayer files application under Section 526 of the Federal Food, Drug, and Cosmetic Act. Amendments would apply to amounts paid or incurred after December 31, 2000.	No provision.

Taxable Vaccines

Provisions	House passed (H.R. 2990)	Senate Amendment
Inclusion of certain vaccines	Includes any conjugate vaccine against streptococcus pneumoniae in the list of taxable vaccines. Amendment would apply to vaccine sales beginning the day after the Centers for Disease Control makes a final recommendation for routine administration to children of this vaccine, but only if amendments to Vaccine Injury Compensation Trust Fund take effect.	Similar to House-passed bill H.R. 2990, except not contingent on Trust Fund amendments.
Tax rate	Reduces the tax rate applicable to all taxable vaccines from 75 cents to 50 cents for sales after December 31, 2004. Amendment would apply to vaccine sales after December 31, 2004, but only if amendments to Vaccine Injury Compensation Trust Fund take effect.	No provision.
Vaccine Injury Compensation Trust Fund	Repeals provisions of the Vaccine Injury Compensation Program Modification Act to remove duplicative and contradictory provisions concerning payments from the Trust Fund. Changes effective date to incorporate vaccine added by P.L. 105-277.	No provisions.
Report on Vaccine Injury Compensation Trust Fund	Directs the General Accounting Office to report on the operation of the Trust Fund and its adequacy to meet future claims.	No provision.

Tax Credit for Clinical Testing Research

Provisions	House passed (H.R. 2990)	Senate Amendment
Tax credit for clinical testing research expenses	Authorizes a tax credit (as part of the general business credit) for increasing clinical testing research activities at educational institutions,	No provision.

Provisions	House passed (H.R. 2990)	Senate Amendment
	teaching hospitals, foundations, and hospitals designated as cancer centers by the National Cancer Institute. Credit would equal 40 percent of the excess of qualified medical innovation expenses for the taxable year over a medical innovation base period amount. Amendments would apply to taxable years beginning after December 31, 2000.	

Genetic Information and Services

Provisions	House passed (H.R. 2990)	Senate Amendment
General	No provision.	Amends the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act (PHS), and the Internal Revenue Code of 1986, respectively to prohibit health plans or health insurance issuers, both in group and individual markets, from using predictive genetic information to set premiums. Health plans or issuers may request, but not require, that individuals or their family members authorize the collection of predictive genetic information for diagnosis, treatment, or payment purposes related to health care. Requires plans to provide notice of confidentiality safeguards when requesting such information. Requires plans to post or provide notice of confidentiality practices and to have safeguards in place with respect to predictive genetic information. Requires the Secretary to develop a model notice. In the individual market, predictive genetic information cannot be used as a condition of eligibility for enrollment.

Agency for Healthcare Quality and Research

Provisions	House passed (H.R. 2990)	Senate Amendment
General	No provision.	Renames the Agency for Health Care Policy and Research (AHCPR) as the Agency for Healthcare Research and Quality. The mission of the Agency will be to enhance the quality, appropriateness, and effectiveness of healthcare services, and access to these services. Requires the Agency to conduct and support research related to all aspects of healthcare; produce and disseminate scientific data for use by patients, practitioners, consumers, and others; and foster private and public efforts to improve healthcare quality. In doing this, the Director must undertake and support research, demonstration projects and evaluations to deliver health services to populations in rural areas and for low-income groups and minority groups, among other things. The Agency must identify and disseminate methods or systems used to assess health care research results, in particular to judge the strength of the scientific evidence behind healthcare practice, recommendations in the research literature, and technology assessments. In addition, the agency will be required to use research methods and processes that link research directly with clinical practice in geographically diverse locations throughout the United States. Requires the Director of the Agency to conduct and support specific assessments of healthcare technologies through grants, cooperative agreements, or contracts with entities, including research institutions, professional organizations, and third party payers. Requires the Secretary of HHS to enter into a contract with the Institute of Medicine to describe and evaluate current quality improvement research and monitoring processes, identify options and make recommendations to improve the efficiency and effectiveness of quality improvement programs. Requires the Secretary to report to the Senate Committees on Finance and Health, Education, Labor and Pensions and House Committees

Provisions	House passed (H.R. 2990)	Senate Amendment
		on Ways and Means and Commerce, on the quality improvement programs of HHS for Medicare, Medicaid, and CHIP programs under Titles XVIII, XIX, and XXI of the Social Security Act. Establishes an Advisory Council for Healthcare Research and Quality to advise the Secretary and Director on activities related to the mission of the Agency for Health care Research and Quality. The Council would make recommendations related to: priorities of health care research; the field of health care and related disciplines; and the appropriate role of the Agency in each of these areas.

Note: Re applicability of House-passed bill H.R. 2990 for specified provisions (access to choice of providers, emergency care, specialists, continued treatment, clinical trials, non-formulary drugs, and payment of claims) a group health plan that provides health benefits through a health insurance issuer, can be deemed as meeting the requirements even if the insurer fails to meet the requirements as long as the plan sponsor did not cause the failure.

For other specified provision (information disclosure, internal and external grievance and appeals, and prohibitions relating to medical communications, discrimination, improper incentive arrangements, and protections for patient advocacy), the Secretary is provided with authority to relieve a group health plan from requirements, if an issuer which contracts with the group health plan also is obligated to meet the requirements or for other reasons.