S 1052

Bipartisan Patient Protection Act

Congress: 107 (2001–2003, Ended)
Chamber: Senate
Policy Area: Health
Introduced: Jun 14, 2001
Current Status: Held at the desk.
Latest Action: Held at the desk. (Nov 19, 2002)
Official Text: https://www.congress.gov/bill/107th-congress/senate-bill/1052

Sponsor

Name: Sen. McCain, John [R-AZ]
Party: Republican • **State:** AZ • **Chamber:** Senate

Cosponsors (3 total)

Cosponsor	Party / State	Role	Date Joined
Sen. Edwards, John [D-NC]	D · NC		Jun 14, 2001
Sen. Kennedy, Edward M. [D-MA]	D · MA		Jun 14, 2001
Sen. Murray, Patty [D-WA]	D · WA		Jul 17, 2001

Committee Activity

No committee referrals or activity are recorded for this bill.

Subjects & Policy Tags

Policy Area:

Health

Related Bills

Bill	Relationship	Last Action
107 HR 2563	Related bill	**Sep 6, 2001:** Read the second time. Placed on Senate Legislative Calendar under General Orders. Calendar No. 150.
107 S 872	Related bill	**May 15, 2001:** Read the second time. Placed on Senate Legislative Calendar under General Orders. Calendar No. 42.

Summary (as of Jun 29, 2001)

Bipartisan Patient Protection Act - **Title I: Improving Managed Care** - **Subtitle A: Utilization Review; Claims; and Internal and External Appeals** - Requires a group health plan, and a health insurance issuer (plan and issuer) providing health insurance coverage, to conduct utilization review activities in connection with the provision of benefits under such plan or coverage only in accordance with an approved utilization review program. Defines "utilization review" and "utilization review activities" to mean procedures used to monitor or evaluate the use or coverage, clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings, and includes prospective review, concurrent review, second opinions, case management, discharge planning, or retrospective review. Requires a utilization review program to, among other things, be: (1) administered by qualified health care professionals; and (2) conducted consistent with written policies and procedures that govern all aspects of the program.

(Sec. 102) Sets forth procedures concerning initial claims and notice for benefits, including setting forth a timeline for making benefit determinations and expedited determinations any time there is a serious threat to an individual's health or life.

(Sec. 103) Provides an appeals procedure and appeals timeline.

(Sec. 104) Requires a plan and issuer offering health insurance coverage, to provide beneficiaries, and enrollees (or authorized representatives), upon request, with access to an independent external review for any denial of a claim for benefits. Sets forth penalties for noncompliance. Sets forth standards for reviewers.

(Sec. 105) Directs the Secretary of Health and Human Services to establish the Health Care Consumer Assistance Fund to be used to award grants to eligible States to carry out consumer assistance activities designed to provide information, assistance, and referrals to consumers of health insurance products. Authorizes appropriations.

Subtitle B: Access to Care - Requires a plan and issuer providing coverage to provide for coverage of services only if the services are furnished through health care professionals and providers who are members of a network of health care professionals and providers who have entered into a contract with the plan or issuer to provide such services to offer (at the time of enrollment and during an annual open season) the option of health insurance coverage or health benefits which provide for coverage of such services which are not furnished through health care professionals and providers who are members of such a network unless there is also offered non-network coverage through another plan or issuer in the group market.

(Sec. 112) Requires a plan or issuer providing for the designation of a participating primary care provider to permit each participant, beneficiary, and enrollee to designate any participating primary care provider or specialist who is available to accept such individual.

(Sec. 113) Requires a plan or issuer offering emergency health services to cover emergency health services without prior authorization and by either a participating or nonparticipating health care provider.

(Sec. 114) Requires the timely provision of access to specialists.

(Sec. 115) Requires direct patient access for obstetrical and gynecological services.

(Sec. 116) Requires a plan or issuer providing for the designation of a participating primary care provider for a child to permit the designation of pediatrician as a child's primary care provider.

(Sec. 117) Sets forth provisions concerning continuation of care when a provider is terminated.

(Sec. 118) Requires a plan or issuer, to the extent that there is coverage for benefits with respect to prescription drugs and such coverage is limited to drugs included in a formulary to: (1) ensure the participation of physicians and pharmacists in developing and reviewing such formulary; (2) provide for disclosure of the formulary to providers; and (3) in accordance with the applicable quality assurance and utilization review standards of the plan or issuer, provide for exceptions from the formulary limitation when a non-formulary alternative is medically necessary and appropriate and, in the case of such an exception, apply the same cost-sharing requirements that would have applied in the case of a drug covered under the formulary.

Prohibits a group health plan (or health insurance offered in connection with such a plan) covering drugs or medical devices from denying of coverage of a drug or device on the basis that the use is investigational, if the use: (1) in the case of a prescription drug, is included in the labeling authorized by the application in effect for the drug pursuant to specified provisions of the Federal Food, Drug, and Cosmetic Act or the Public Health Service Act, without regard to any postmarketing requirements that may apply under either such Act; or (2) in the case of a medical device, is included in the labeling authorized by a regulation or approved application under specified provisions of the Federal Food, Drug, and Cosmetic Act, without regard to any postmarketing requirements that may apply under such Act. States that coverage of prescription drugs or medical devices shall not be required by a group health plan (or health insurance coverage offered in connection with such a plan).

(Sec. 119) Prohibits denying a "qualified individual" (an individual who, among other specifications, has a life threatening or serious illness for which there is no effective standard treatment) participation in an approved clinical trial.

(Sec. 120) Requires a plan or issuer providing medical and surgical benefits to ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time as is determined by the attending physician, in consultation with the patient, to be medically necessary and appropriate following a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer.

Subtitle C: Access to Information - Requires specific covered benefit, cost sharing, disrenrollment, service area, provider, preauthorization requirement, experimental and investigational treatment, specialty care, clinical trial, prescription drug coverage, emergency services, claims and appeals, advance directives and organ donation, and other information to be provided upon initial enrollment and annually. Requires information relating to benefits reduction to be provided at least 30 days before the reduction is effective.

(Sec. 122) Prohibits a plan or issuer establishing rules for eligibility (including continued eligibility) of any individual to enroll based on genetic information (or information about a request for or the receipt of genetic services by such individual or a family member of such individual) in relation to an individual or a dependent of such individual.

Prohibits requesting or requiring predictive genetic information concerning an individual or a family member of the individual (including information about a request for or the receipt of genetic services by such individual or a family member of such individual), except as necessary for diagnosis, treatment, or payment.

Requires notice of confidentiality practices, the establishment and maintenance of confidentiality safeguards, and the compliance with specified standards with respect to genetic information.

Subtitle D: Protecting the Doctor-Patient Relationship - Prohibits restricting a health care professional from advising a plan or issuer participant, beneficiary, or enrollee about the health status of the individual or medical care or treatment for

the individual's condition or disease based on the coverage provided (or not provided) by the plan or issuer, if the professional is acting within the lawful scope of practice.

(Sec. 132) Prohibits a plan from discriminating against a provider, with respect to participation or indemnification, as long as the provider is acting within the scope the provider's license.

(Sec. 133) Prohibits a plan or issuer from operating any physician incentive system.

(Sec. 134) Requires a plan or issuer to provide for prompt payment of claims.

(Sec. 135) Prohibits a plan or issuer from retaliating against a participant or provider due to the utilization of any grievance or utilization review process by a participant or provider.

Subtitle E: Definitions - Sets forth definitions.

(Sec. 152) Sets forth provisions concerning preemption of State laws.

(Sec. 153) Prohibits anything in this title from being construed to require a plan or issuer to offer specific items or services, other than those provided by the plan or issuer, except that the provisions of sections 111 through 117 shall not apply to a plan when the only coverage offered is fee-for-service coverage.

Title II: Application of Quality Care Standards to Group Health Plans and Health Insurance Coverage Under the Public Health Service Act - Amends the Public Health Service Act to require plans and issuers to adhere to the patient protection requirements of the Bipartisan Patient Protection Act and provides for cooperation between Federal and State authorities.

(Sec. 204) Eliminates the option of non-Federal governmental plans to be excepted from requirements concerning genetic information.

Title III: Application of Patient Protection Standards to Federal Health Care Programs - Requires the application of patient protection standards to Federal health care programs.

Title IV: Amendments to the Employee Retirement Income Security Act of 1974 - Amends the Employee Retirement Income Security Act of 1974 to require compliance with the patient protection requirements of the Bipartisan Patient Protection Act.

(Sec. 402) Sets forth provisions concerning the availability of Federal civil remedies in cases not involving medically reviewable decisions to provide, as a general rule, for liability to a participant or beneficiary (or the estate of such participant or beneficiary) for economic and noneconomic damages (but not exemplary or punitive damages) in connection with the personal injury or death of a participant or beneficiary if a plan or issuer fails to exercise ordinary care in making a decision with respect to the denial of a claim for benefits and such failure to provide benefits is a proximate cause of personal injury to, or the death of, the participant or beneficiary.

(Sec. 403) Sets forth provisions concerning: (1) certain limitations on class actions; (2) cooperation between Federal and State authorities; and (3) expressing the sense of the Senate that a court should consider the loss of a nonwage earning spouse or parent as an economic loss.

Title V: Effective Dates; Coordination in Implementation - Sets forth provisions concerning: (1) effective dates; (2) coordination in implementation; (3) severability; and (4) the treatment of religious nonmedical providers.

Title VI: Miscellaneous Provisions - States that: (1) nothing in this Act shall be construed to alter the Social Security Act; and (2) if the Secretary of the Treasury estimates that the enactment of this Act has a negative impact on the income and balances of the Social Security trust funds, the Secretary shall transfer from the general revenues of the Federal Government an amount sufficient so as to ensure that the income and balances of such trust funds are not reduced as a result of the enactment of such Act.

(Sec. 602) Amends the Consolidated Omnibus Budget Reconciliation Act of 1985 to extend the fees for certain customs services from September 30, 2003, to September 30, 2011, and March 31, 2006.

(Sec. 603) Requires any letter of credit under part B (Supplementary Medical Insurance Benefits for Aged and Disabled) of title XVIII (Medicare) of the Social Security Act that would otherwise be sent to the Treasury or the Federal Reserve Board on September 30, 2002, by a carrier with a contract under such part to be sent on October 1, 2002.

(Sec. 604) Expresses the sense of the Senate with respect to: (1) participation in clinical trials and access to specialty care; and (2) fair review process.

(Sec. 606) Requires the Secretary of Health and Human Services to annually request that the Institute of Medicine of the National Academy of Sciences prepare and submit to the appropriate committees of Congress a report concerning the impact of this Act on the number of individuals in the United States with health insurance coverage.

Provides for the repeal of section 402 of this Act if the Secretary, in any report submitted, determines that more than one million individuals in the United States have lost their health insurance coverage as a result of the enactment of this Act, as compared to the number of individuals with health insurance coverage in the 12-month period preceding the date of enactment of this Act.

(Sec. 607) Amends general provisions of Federal law to state that the terms "person," "human being," and "individual" include a born-alive infant.

Actions Timeline

- **Nov 19, 2002:** Message on Senate action sent to the House.
- **Nov 19, 2002:** Received in the House.
- **Nov 19, 2002:** Held at the desk.
- **Jun 29, 2001:** Considered by Senate. (consideration: CR S7127-7185)
- **Jun 29, 2001:** Motion by Senator Smith, of OR to commit to Senate Committee on Finance, with instructions to report H.R. 3 back to the Senate with an amendment, made in Senate. (text: CR S7136; text as modified: CR S7138)
- **Jun 29, 2001:** Point of order that the Smith (OR) Motion To Commit violates the U.S. Constitution raised in the Senate.
- **Jun 29, 2001:** By a decision of the Senate the point of order against the Smith (OR) Motion To Commit was sustained by Yea-Nay Vote. 57 - 41. Record Vote Number: 214.
- **Jun 29, 2001:** Passed/agreed to in Senate: Passed Senate with amendments by Yea-Nay Vote. 59 - 36. Record Vote Number: 220.(text: CR 7/09/2001 S7338-7361)
- **Jun 29, 2001:** Passed Senate with amendments by Yea-Nay Vote. 59 - 36. Record Vote Number: 220. (text: CR 7/09/2001 S7338-7361)
- **Jun 29, 2001:** Measure amended in Senate by unanimous consent after passage.
- **Jun 29, 2001:** Senate ordered measure printed as passed.
- **Jun 28, 2001:** Considered by Senate. (consideration: CR S7011-7076)
- **Jun 27, 2001:** Considered by Senate. (consideration: CR S6937-6983)
- **Jun 26, 2001:** Considered by Senate. (consideration: CR S6870-6885, S6887-6913)
- **Jun 26, 2001:** Motion by Senator Frist for Senator Grassley to commit considered by Senate. (text as modified: CR S6870)
- **Jun 26, 2001:** Motion by Senator Frist to commit to Senate Committee on Finance; Health, Education, Labor, and Pensions; the Judiciary rejected in Senate by Yea-Nay Vote. 39 - 61. Record Vote Number: 196.
- **Jun 25, 2001:** Considered by Senate. (consideration: CR S6835-6844, S6845-6860)
- **Jun 25, 2001:** Motion by Senator Frist for Senator Grassley to commit considered by Senate. (text: CR S6835)
- **Jun 22, 2001:** Considered by Senate. (consideration: CR S6627-6657)
- **Jun 22, 2001:** Motion by Senator Frist to commit to Senate Committees on Finance; Health, Education, Labor, and Pensions; the Judiciary,with instructions to report the same back not later than 14 days after adoption of the motion, made in Senate. (consideration: CR S6634; text: CR S6634)
- **Jun 21, 2001:** Motion to proceed to measure considered in Senate.
- **Jun 21, 2001:** Motion to proceed to consideration of measure agreed to in Senate by Yea-Nay Vote. 98 - 0. Record Vote Number: 193.
- **Jun 21, 2001:** Measure laid before Senate by motion. (consideration: CR S6535-6594)
- **Jun 21, 2001:** Motion to proceed to measure considered in Senate.
- **Jun 20, 2001:** Motion to proceed to measure considered in Senate. (consideration: CR S6463-6506)
- **Jun 19, 2001:** Motion to proceed to consideration of measure made in Senate. (consideration: CR S6403-6440)
- **Jun 18, 2001:** Read the second time. Placed on Senate Legislative Calendar under General Orders. Calendar No. 75.
- **Jun 14, 2001:** Introduced in Senate
- **Jun 14, 2001:** Introduced in the Senate. Read the first time. Placed on Senate Legislative Calendar under Read the First Time.