COMPARISON OF PATIENT PROTECTION BILLS

ISSUE	H.R. 358 (DINGELL)	H.R. 216 (NORWOOD)	H.R. 719 (GANSKE)
Emergency care			
	Access to emergency care without prior authorization.	YES.	YES.
	Access to emergency care out of network at no extra cost.	YES.	YES.
	Coverage of maintenance and post-stabilization care (according to the Secretary's guidelines for Medicare).	YES.	YES.
	Adopts "prudent layperson" standard of emergency medical condition.	YES.	YES.
Enrollee choice of plans			
	All health plans must offer POS option unless a person has a choice of two or more plans.	Every issuer must offer a POS option to a person unless that person has a POS option available in that market.	All health plans must offer POS option unless a person has a choice of plans that includes a POS option which does not pay non-participating providers less than participating providers.
	Does not apply to the individual market.	Applies to both group health plans (employer plans) and insurance plans in the individual market.	Does not apply to the individual market
	Enrollee liable for any extra cost of POS plan.	Enrollee liable for any extra cost of POS plan; however, limits on premiums based on NAIC recommendations.	Enrollee liable for any extra cost of POS plan.

COMPARISON OF PATIENT PROTECTION BILLS

ISSUE	H.R. 358 (DINGELL)	H.R. 216 (NORWOOD)	H.R. 719 (GANSKE)
Enrollee choice of plans (continued)	NO.	Establishes minimum payment for non-participating providers.	Establishes minimum payment for non-participating providers.
Enrollee choice of provider			
	Enrollee may choose among any primary care provider available in plan.	Patient may change their primary care provider every 4 months or in the event of a disciplinary action against the provider.	Enrollee may choose among any primary care provider available in plan
	OB/GYN as primary care provider.	NO.	NO.
	Routine OB/GYN care without prior authorization or referral	YES.	YES.
	Pediatrician as primary care provider.	YES.	YES.
Adequacy of provider network			
	Plan must include a sufficient number, distribution, and variety of qualified participating providers.	YES. Congress must vote on Secretary's regulations before implementation.	YES.
Enrollee access to specialist			
	Enrollee may select any available specialist in the plan, unless the plan informs the enrollee in advance of limits on choice (i.e., a specific panel).	YES, when medically or clinically indicated by treating physician.	YES.

COMPARISON OF PATIENT PROTECTION BILLS

ISSUE	H.R. 358 (DINGELL)	H.R. 216 (NORWOOD)	H.R. 719 (GANSKE)
Enrollee access to specialist (continued)	Plan must provide direct access to specialty care for covered benefits for individuals with serious and complex conditions.	Plan can't create an undue burden to access care as defined in state law.	YES.
	Access to out-of-network specialist when none is available within network at no additional cost to enrollee.	NO.	YES.
	Specialist may serve as primary care provider to coordinate care for enrollee's ongoing special condition.	YES.	Specialist may serve as gatekeeper to coordinate care for the enrollee's particular ongoing special condition.
	Enrollees may get a standing referral to specialist if they have an ongoing special condition.	Plan can't create an undue burden to access care as defined in state law.	YES.
Continuity of care			
	Continuity of care with provider for enrollees undergoing a course of treatment for up to 90 days when provider is no longer in network or enrollee's plan is terminated. Special protections for enrollees who are pregnant, institutionalized, or terminally ill. Provider must agree to terms and conditions (including payment rates) of the plan and must not have fraud/quality problems.	Plan must provide for continued coverage of items and services furnished by a provider for a reasonable period.	YES.

COMPARISON OF PATIENT PROTECTION BILLS

ISSUE	H.R. 358 (DINGELL)	H.R. 216 (NORWOOD)	H.R. 719 (GANSKE)
Clinical trials			
	Access to approved clinical trials for qualified individuals with serious or life-threatening illnesses that have no known effective treatment. Insurer must cover costs of routine care furnished in connection with approved clinical trial.	NO.	YES.
Drug formularies			
	Participation of physicians and pharmacists in development of formulary. Disclosure of use of formulary and advance notice of changes to the formulary to beneficiaries. Exceptions from formulary when medically indicated.	Disclosure of formularies and advance notice of changes to the formulary to beneficiaries.	YES.
	Plan may not deny coverage of FDA-approved drug or device on basis that it is investigational.	NO.	YES.
	Plan must have program to monitor proper prescribing and use of drugs and to protect enrollees against adverse drug reactions.	NO.	NO.

COMPARISON OF PATIENT PROTECTION BILLS

ISSUE	H.R. 358 (DINGELL)	H.R. 216 (NORWOOD)	H.R. 719 (GANSKE)
Non-discrimination			
	Protection for enrollees against age, race, religion, disability, etc. discrimination in delivery of services.	NO.	NO.
Quality assurance			
	Plan must have internal quality assurance program.	YES.	NO.
	Plan must collect and report standardized data on quality and outcomes.	NO.	NO.
Health Care Quality Advisory Board			
	Establishes a Health Care Quality Advisory Board to provide information to Congress and the Administration relating to quality monitoring and improvement and to identify and disseminate measures of health care quality.	NO.	NO.
Utilization review			
	Plan must have a utilization review program.	YES.	YES.

COMPARISON OF PATIENT PROTECTION BILLS

ISSUE	H.R. 358 (DINGELL)	H.R. 216 (NORWOOD)	H.R. 719 (GANSKE)
Utilization review (continued)	Utilization review administered by appropriately qualified health care professionals. Plan must have a sample of adverse decisions peer reviewed for appropriateness of decisions.	Physician must review initial coverage decision unless denied on the grounds that the item or service is not covered under the plan.	YES.
	Prior authorization determinations must be completed within 3 business days.	7 days (or longer as prescribed by the Secretary).	YES. Within 3 business days.
	Review of continued care must be completed within 1 business day.	Not addressed.	YES. Within 1 business day.
	Review of previously provided services must be completed within 30 calendar days. Notice of determinations in writing.	7 days (or longer as prescribed by the Secretary). Notice of determinations in writing.	YES. Within 30 calendar days. Notice of determinations in writing.
Expedited review			
	Enrollee may have expedited initial review which must be decided as soon as possible in accordance with medical exigencies of the case. No deadline for enrollee to appeal plan's decision.	YES. Within 2 days. Beneficiary must file appeal within 180 days of initial decision.	YES. As soon as possible in accordance with medical exigencies of the case. No deadline for enrollee to appeal plan's decision

COMPARISON OF PATIENT PROTECTION BILLS

ISSUE	H.R. 358 (DINGELL)	H.R. 216 (NORWOOD)	H.R. 719 (GANSKE)
Patient access to information			
	Plan must disclose information to all beneficiaries and enrollees as specified (either up-front or upon request) in a standard format. Potential enrollees may access this information upon request.	Plan must disclose information to all beneficiaries and enrollees as specified (either up-front or upon request). Plan must provide information at least annually and may charge beneficiary for any request for information beyond that.	YES.
Confidentiality			
	Plan must have procedures in place for the protection of individually identifiable information, maintain the records in a timely manner and assure access by individuals to their records.	Plan must have policies and procedures the comply with federal and state laws regarding confidentiality.	YES.
Ombudsmen			
	Health insurance ombudsmen to assist consumers in choosing plans and assist and counsel enrollees with respect to grievances and appeals.	NO.	YES.

COMPARISON OF PATIENT PROTECTION BILLS

ISSUE	H.R. 358 (DINGELL)	H.R. 216 (NORWOOD)	H.R. 719 (GANSKE)
Internal appeals			
	Plan must establish an internal appeals process which includes review of the appeal by a health care professional who was not involved in initial determination. Appeal must be decided within 30 calendar days (with a 10 business day extension in limited circumstances). Expedited review of a determination that could jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, must be decided according to the medical exigencies of the case but no later than 72 hours. No deadline for filing internal appeal. Failure to meet time frame results in case being eligible for external review.	Plan must provide for internal review process. Decisions must be rendered within 14 days or 2 days in the case of urgent care. Failure to meet the time frames results in case being eligible for external review. Beneficiary has 180 days from receiving initial determination to file an internal appeal.	Plan must establish an internal appeals process which includes review of the appeal by a health care professional who was not involved in initial determination. Appeal must be decided within 30 calendar days (with a 3 business day extension in limited circumstances). For expedited review of determination that could jeopardize the life or health of enrollee or enrollee's ability to regain maximum function, according to the medical exigencies of the case but no later than 72 hours. No deadline for filing internal appeal. Failure to meet time frame results in case being eligible for external review.
External appeals			
	Enrollee may file an appeal with an external entity if the case involves a claim which meets a significant financial threshold or if the enrollee's life or health is jeopardized. Enrollee may go directly to external review if plan fails to comply with internal appeal deadlines.	Plan must provide for an external review process if the time frame for the initial decision was not met and the decision was not based on an item or service that is not covered under the plan.	Enrollee may file an appeal with an external entity if the cost of the claim exceeds $100 or if the enrollee's life or health is jeopardized as a consequence of the decision.

COMPARISON OF PATIENT PROTECTION BILLS

ISSUE	H.R. 358 (DINGELL)	H.R. 216 (NORWOOD)	H.R. 719 (GANSKE)
External appeals (continued)	The State (for issuers) or the Secretary of Labor (for group health plans) must provide a process for the creation and selection of external review entities. Review must use clinical peers who are independent from plan in review of external appeal. (An entity could be a panel of reviewers.) Entities must be certified and periodically recertified and meet standards relating to conflict of interest.	Plan provides for the selection of appropriately credentialed independent person to review. Appeal must be filed within 30 days of review of internal appeal.	YES.
	The review is conducted de novo, independent of the plan's previous decision.	The review entity only provides a reconsideration of the plan's internal review decision and does not hear the case de novo. Decision is predicated on whether or not the plan complied with their own terms and conditions.	The review is conducted de novo, independent of the plan's previous decision. The external entity must not consider the plan's definitions of medical necessity in the process.
	Appeal must be completed within 60 days, or in the case of expedited appeal, in accordance with the medical exigencies of the case but no later than 72 hours.	Within 14 days, or in the case of expedited appeal, 2 days.	Appeal must be completed within 60 days, or in the case of expedited appeal, 72 hours, or within 24 hours for urgent care.

COMPARISON OF PATIENT PROTECTION BILLS

ISSUE	H.R. 358 (DINGELL)	H.R. 216 (NORWOOD)	H.R. 719 (GANSKE)
External appeals (continued)	Denials of coverage for services that are specifically listed in plan documents as excluded from coverage are not reviewable, but external appeal entity decides whether appeal is reviewable in external appeal process. Appeal is binding on the plan.	External review not available for cases involving the coverage of a specific benefit. Limitation on liability of reviewers.	Denials of coverage for services that are specifically listed in plan documents as excluded from coverage are not reviewable, but external appeal entity decides whether appeal is reviewable in external appeal process. Appeal is binding on the plan. Limitation on liability of reviewers. Decision may be vacated or modified by court in cases of fraud.
	N/A	If the plan denies the beneficiary external review, the beneficiary can go to court to get civil monetary penalties (CMPs) assessed against the plan of up to $750 a day but not more than $250,000 total. Court can also require plan to pay plaintiff's attorney's fees. Secretary can also assess CMPs (25% of the value of the denied benefit up to $500,000) against a plan if she finds clear and convincing evidence for a pattern or practice of denials of external review or other violations of this law.	N/A

COMPARISON OF PATIENT PROTECTION BILLS

ISSUE	H.R. 358 (DINGELL)	H.R. 216 (NORWOOD)	H.R. 719 (GANSKE)
Liability			
	Enrollee may access courts directly without exhausting administrative remedies at any time.	YES.	Enrollee may access courts at any time. If case goes through external review and plan abides by the external entity's decision, plan is not liable for punitive damages. Plan or enrollee may request that a case to proceed to external review.
	Allows the injured party (or their estate) to hold an insurance company liable in state court for personal injury or wrongful death resulting from the insurance company's action.	YES.	ERISA preemption is lifted to allow for cause of action in state court against an insurance company that has caused personal injury or wrongful death.
	Employers and plans sponsors not liable unless the employer exercised discretionary authority to make a decision regarding the claim that results in injury or wrongful death.	YES.	YES.
	State law would apply regarding liability damages. No federal limitation on punitive damages.	YES.	YES. Plan not liable for punitive damages if plan follows recommendation of external appeals entity.
Protections for the doctor-patient relationship			
	Protection against gag clauses.	YES.	YES.

COMPARISON OF PATIENT PROTECTION BILLS

ISSUE	H.R. 358 (DINGELL)	H.R. 216 (NORWOOD)	H.R. 719 (GANSKE)
Protections for the doctor-patient relationship (continued)	Protection against improper physician incentive plans and transferred risk.	YES	YES.
	Procedure for provider due process.	YES.	YES.
	Protection for providers who advocate on behalf of their patients or who report quality of care problems.	NO.	YES. Also provides protection against retaliation for those who serve on external review panels.
	Protection to assure treatment decisions are made according to good medical practice, and not based on financial interests or accounting standards.	NO.	YES, but prohibits Secretary from issuing regulations to implement this section.
Standards for breast cancer treatment			
• Protection for women undergoing mastectomy, lumpectomy, or lymph node dissection.	Plan may not restrict inpatient benefits to less than 48 hours following a mastectomy or 24 hours following a lymph node dissection, or require prior authorization for such hospitalization unless the attending physician and the patient agree otherwise.	NO.	Inpatient benefits following mastectomy, lumpectomy, or lymph node dissection shall be for a period of time as determined by the attending physician, consistent with generally accepted medical standards.