

Comparison of House and Senate Patient Protection Legislation - 106th Congress *

PROVISION	HR 2723 Norwood-Dingell as passed House	S 1344 Senate Republican Leadership as passed Senate
1. Entities Regulated	<p>All group health plans and health insurance issuers (including the individual market) and limited scope dental and vision plans. (§154)</p> <p>Fee-for-service coverage is excluded from access requirements in Subtitle B. (§153)</p>	<p>Group health plans and health insurance issuers providing coverage in connection with a group health plan. All ERISA plans for information disclosure and appeals; self-insured plans only for most other consumer protection provisions.</p> <p>For mastectomy length-of-stay, second opinions, and genetic information: all group health plans and health insurance issuers (including the individual market).</p>
2. Utilization Review (UR) Standards	<p>A UR program must be based on written clinical review criteria developed with the input of appropriate health care professionals. The program must be administered by qualified health care professionals, provide for a review of a denials of claims and ensure that UR personnel are reasonably accessible to discuss patient care and receive and respond promptly to calls. Compensation arrangements must not encourage denials of claims. (§101)</p>	Not addressed
3. Coverage (Utilization Review) Decisions <i>Timeframes</i>	<p>Prior authorization decisions (and notification of decisions) must be made no later than 14 days (or 72 hours for expedited review) after the receipt of the request for authorization.</p> <p>An extension is permitted if the plan notifies the requester no later than 5 business days after receiving the request of the need for specific additional</p>	<p>Routine prior authorization determinations must be made within 30 days (or 72 hours for expedited determinations) from the request for authorization.</p> <p>An extension is permitted where certain circumstances exist that are beyond control of the plan or issuer (as determined by the Secretary).</p>

* *The House bill, HR 2723, was combined with HR 2990, the Quality Care for the Uninsured Act of 1999, and sent to the Senate for Conference. This chart does not include the health care “access” provisions of HR 2990.*

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	<p>information. In no case shall the decision be made later than 28 days after the receipt of request for authorization.</p> <p>Concurrent reviews of ongoing care must be made with sufficient time to allow for an internal appeal before a termination or reduction of care takes effect.</p> <p>Retrospective review determinations and notification required within 30 days after the receipt of reasonably necessary information, but in no case later than 60 days after the receipt of the claim for benefits.</p> <p>Decisions made in accordance with the medical exigencies of the case. (§101)</p>	<p>No time frame for making concurrent determinations.</p> <p>Retrospective determinations must be made within 30 days of the receipt of necessary information.</p> <p>Expedited determinations are available if the plan or issuer determines or if the treating health care professional has documented, based on the medical exigencies of the case, that the normal time frame could seriously jeopardize the life or health of the enrollee.</p> <p>Decisions made based on the medical exigencies of the case only for expedited reviews. (§121)</p>
<i>Notice</i>	<p>See above. Notice of denial of claim must be in writing and include the reasons for the denial (including the clinical rationale) and instructions for initiating an appeal.</p>	<p>Notice of adverse coverage determinations must be in writing and include the reasons for the determination (including the clinical rationale), notification of the right to appeal, and information on how to initiate an appeal.</p> <p>Notice of routine determinations must be made no later than 2 working days after the plan makes the determination. For expedited determinations, notice within 72 hours (from the request); for concurrent reviews, notice within 1 working day (from the determination); for retrospective determinations, notice within 5 working days (from the determination).</p>
<p>4. Internal Appeals Procedures</p> <p><i>What is internally appealable?</i></p>	<p>For a denial, in whole or in part, of a claim for benefits, including a failure to act in a timely basis upon a claim. Plan or issuer must give enrollee a reasonable opportunity (not less than</p>	<p>For adverse coverage determinations, defined as a coverage determination under the plan which results in a denial of coverage or reimbursement. A failure to issue a timely UR</p>

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	<p>180 days) to request and obtain a full and fair review.</p> <p>Denial of a claim for benefits also includes a failure to provide benefits, items, or services required under Title I of the bill.</p> <p>Appeal may be filed by enrollee, provider, or other individual acting on the enrollee's behalf. Appeal may be filed orally but must be followed by a request in writing. (§102)</p>	<p>determination is considered an adverse coverage determination. Plan must give enrollee not less than 180 days beginning on the date of the adverse coverage determination to appeal.</p> <p>Appeal may be filed by enrollee, provider, or other individual acting on the enrollee's behalf. No specification of whether appeal may be made orally or in writing. (§121)</p>
<i>Expedited Internal Appeal</i>	<p>Expedited review available in situations where normal time frame could jeopardize life or health, as determined by the plan or issuer or certified in writing by a treating health care professional.</p>	<p>Expedited review available in situations where normal time frame could jeopardize life or health, as determined by the plan or issuer documented by the treating health care professional.</p>
<i>Standard of Internal Review</i>	<p>Review of denial must be made by an individual who did not make the initial denial. In cases involving medical judgement, the review must be made by a physician (or an appropriate specialist in the case of limited scope coverage).</p>	<p>Review of denial must be conducted by an individual with appropriate expertise who did not make the initial determination. For denials of coverage based on a lack of medical necessity or appropriateness, or an experimental or investigational treatment, the review must be made by a physician with the appropriate expertise.</p>
<i>Timeframes</i>	<p>Time line for decision begins upon receipt of request for review. Decision must be made within 14 days (from the receipt of request for review).</p> <p>An extension is permitted if the plan or issuer notifies the requester within 5 business days of the need for additional information, but in no case may the extension be more than 28 days after the receipt of request for review.</p> <p>For expedited appeals, no later than 72</p>	<p>Decision must be made within 30 working days of the receipt of request for an internal appeal. For expedited appeals no later than 72 hours after the request for appeal.</p> <p>If plan fails to meet internal appeal timeframes, enrollee may proceed to the next level of review.</p> <p>Only expedited decisions must be made according to the medical exigencies of the case.</p>

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	<p>hours after the request for review.</p> <p>If plan fails to meet the timeframes, the enrollee may proceed to the next level of review.</p> <p>Decision must be made according to the medical exigencies of the case.</p>	
<p>5. External Appeals Procedures</p> <p><i>What is externally appealable?</i></p>	<p>Externally appealable decisions are any denials of claims for benefits that involve medical judgement, including decisions that the item or service is not medically necessary or is experimental or investigational. Contract exclusions and decisions regarding whether an individual is a participant, beneficiary, or enrollee are not externally appealable. (§103)</p>	<p>Externally appealable decisions are adverse coverage determinations in which the covered benefit has been determined: 1) not to be medically necessary or appropriate or 2) experimental or investigational. (§121)</p>
<p><i>Who decides if a case is appealable?</i></p>	<p>The external appeal entity determines whether a decision is an externally appealable decision.</p>	<p>The plan; no authority is given to the review entity to do so.</p>
<p><i>Who decides if an appeal should be expedited?</i></p>	<p>The external appeal entity decides if an appeal should be expedited.</p>	<p>The plan; no authority is given to the review entity to do so.</p>
<p><i>Who may initiate an appeal?</i></p>	<p>Appeal may be requested by enrollee, enrollee’s representative, or by the plan.</p>	<p>Appeal may be requested by enrollee or enrollee’s representative. A written request must be filed not later than 30 days after the receipt of a denial of an internal appeal. Plan may also request external review without first completing the internal appeal process.</p>
<p><i>What are the limitations on appeals?</i></p>	<p>Plan or issuer may condition the use of an external appeals process upon completion of the internal process. If the plan or issuer does not adhere to the time frames for an internal appeal (including expedited appeals according to the medical exigencies of the case), the enrollee may proceed directly to the external appeals process.</p>	<p>Enrollee must have completed internal appeal process. If the plan or issuer does not issue a determination within the timeframes for an internal appeal, enrollee may proceed directly to external appeals process.</p> <p>For external appeals of coverage determinations in which the service was</p>

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		determined to be not medically necessary or appropriate, the amount of the service must exceed a significant financial threshold or there must be significant risk of placing the life or health of the enrollee in jeopardy.
<i>Independent Review Entity Certification</i>	<p>External review agencies must be certified by the State (or HHS where a state opts out) for health insurance issuers and by DoL for ERISA plans. DoL and HHS may provide for a process for certifying qualified private standard-setting organizations which provide for the certification of external review entities.</p> <p>Entities must conduct external review activities through a panel of not fewer than 3 clinical peers and must meet independence, conflict of interest, and clinical/legal expertise requirements to be qualified.</p> <p>The applicable authority must assure that the selection process is unbiased and audit a sample of the decisions. Entities must be periodically recertified to ensure they continue to meet the standards for review organizations.</p>	<p>Qualified external review entities are: an independent entity licensed by the State, a State agency, any entity under contract with the Federal Government, any entity accredited by an accrediting body recognized for the Secretary, or any other entity meeting criteria established by the Secretary.</p> <p>The external review entity designates one or more individuals to serve as the independent medical experts who conduct the review. Reviewers must be independent of: the enrollee; treating provider; institution where the treatment would take place; and manufacturer of drug, device, or procedure proposed. (No requirement that reviewers be independent of plan, issuer, or employer.) These reviewers must be credentialed or licensed in any State to deliver health care services, be a physician with the appropriate expertise, and not receive compensation contingent upon the review decision.</p>
<i>Selection of External Review Entity</i>	Plan or issuer selects and contracts with review entity according to the guidelines of the State or applicable Secretary. For issuers offering health insurance coverage in a State, the State may designate an entity to conduct external review activities or select entities in a manner that assures an unbiased determination. The State or appropriate Secretary may determine how the external reviewers are chosen and must assure that there is no conflict	<p>Plan designates external review entity within 5 days of receiving request for external review, or earlier according to the medical exigencies of the case, and provides notice to enrollee of such selection.</p> <p>Not later than 30 days after the date on which the entity is designated (or earlier according to the medical exigencies of the case), the external review entity designates independent medical</p>

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	of interest and that the entity makes unbiased determinations.	reviewers.
<i>Cost of Review</i>	Plan or issuer must pay all costs of the review process, except those incurred by the enrollee in support of the appeal. A plan or issuer may condition the use of the external appeal process upon payment of a \$25 filing fee to plan or issuer. No fee may be required for enrollees who are indigent. The plan or issuer must refund the filing fee if the decision of the external review entity reverses or modifies the denial of the claim.	Not addressed
<i>External Appeal Process</i>	Each party may submit evidence related to the case. The review must be conducted by at least 3 clinical peers. The review entity must consider the decision of the plan or issuer, the enrollee’s personal health and medical information, and the opinion of the treating health care professional. The entity may also consider (but is not limited to) professional peer-review studies, consensus documents, government-issued treatment policies, community standards of care and generally accepted principles of medical practice, and expert opinions free of conflict of interest.	Not later than 5 days after the plan provides notice to the enrollee that an external appeals entity has been designated (or earlier in accordance with the medical exigencies of the case), the plan, enrollee, or provider shall forward necessary information to the external appeals entity. The independent medical reviewers shall take into consideration appropriate and available information, including the plan’s clinical practice guidelines; information submitted by the plan, enrollee, or provider; the enrollee’s medical record; consensus documents; medical literature; standard reference compendia; and finds, studies, or research conducted by Federal Government agencies or Federal research institutes.
<i>Standard of Review (Definition of Medical Necessity)</i>	Review is conducted de novo. Entity determines whether the plan or issuer’s decision is in accordance with the medical needs of the patient. The entity is not bound by the plan’s definition of medical necessity, experimental, investigational, or related terms.	Review is not de novo. Review is an “independent” determination based on valid, relevant, scientific, and clinical evidence of the medical necessity, appropriateness, experimental, or investigational nature of the proposed treatment. Reviewers are bound by what would be considered medically

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		necessary, appropriate, experimental, or investigational under the terms and conditions of the plan.
<i>Notification of Decision</i>	External appeal entity must notify (orally and in writing) both the issuer and the enrollee of its decision within the established timeframes. Notice must include the basis for the determination and inform enrollee of rights to further review.	Plan must notify enrollee within 30 days of the determination of the independent medical expert of the actions of the plan with respect to the determination.
<i>Binding vs. Advisory</i>	Decision is binding on the plan or issuer. Review entities may not be held liable, if they exercise due care without malice or gross misconduct.	Decision is binding on the plan or issuer if the external review provisions and procedures are complied with. If the independent external reviewers determine that the enrollee is entitled to coverage of the item or service, reviewers establish a time frame, in accordance with the medical exigencies of the case, during which the plan or issuer must comply with the decision. Reviewers are not liable for medical determinations but may be held liable for actions that are arbitrary and capricious.
<i>Timeframes for Decisions</i>	No later than 21 days (from the receipt of the request for review.) For expedited appeals, no later than 72 hours. Decisions made in accordance with the medical exigencies of the case.	Review must be completed not later than 30 days after the later of: 1) the date on which the reviewer was designated (reviewer may be designated as late as 35 days after the plan receives request for review) ; or 2) the date on which all necessary information is received. For expedited appeals, not later than 72 hours after the later of: 1) the date on which the reviewer is designated; or 2) the date on which all necessary information is received. For expedited appeals only , decisions made in accordance with the medical exigencies of the case.

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6. Consumer Choice Point-Of-Service (POS) Option	For all health insurance issuers offering coverage to employers. Does not apply to self-insured employer plans or to the individual market. (§111)	For all group health plans with the exception of self-insured group health plans.
<i>Coverage Offered</i>	If health insurance issuer offers coverage for services only through a closed panel of providers, the issuer shall also offer POS coverage.	If group health plan offer coverage for benefits only through a closed panel of providers, plan must offer POS coverage.
<i>Exceptions</i>	If enrollees are offered POS coverage through another health insurance issuer or another group health plan, the POS requirement does not apply.	Does not apply to fully-insured group health plans. Other exceptions for small employers with under 50 employees and for group health plans if care relating to POS coverage would not be promptly available and accessible to the enrollee.
<i>Cost-Sharing and Additional Requirements</i>	Enrollee is responsible for any additional premiums or balance billing by out-of-network providers under this option, unless it is paid by the health plan sponsor through agreement with the health insurance issuer.	Enrollee is responsible for any additional premiums or balance billing by out-of-network providers under this option. (§722)
7. Access to Care Choice of Provider	Plan or issuer must allow enrollee to designate any available participating primary care provider and receive care from any available participating specialist. (§112)	Not addressed
<i>Direct Access to:</i> ▶ <i>Specialists</i>	Provides for standing referrals to specialists. Enrollees with life-threatening, degenerative, or disabling conditions which require specialized medical care over a prolonged period of time may elect their specialist to serve as care coordinators for that condition. (§114)	Plan shall ensure that enrollees have timely (in accordance with the medical exigencies of the case) access to appropriate specialty health care professionals. No requirements as to how plans must ensure access. (§725)
▶ <i>Ob/Gyn</i>	Direct access to health care professionals specializing in obstetrics and gynecology, who may make also referrals for ob/gyn care. Plan not required to allow designation of Ob/Gyn	Direct access to Ob/Gyn physicians for obstetrical care, related follow-up obstetrical care, or routine gynecological care. Ob/Gyns may make referrals for related care. Plan not

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	as PCP. (§115)	required to allow designation of Ob/Gyn as PCP. (§723)
► <i>Pediatricians</i>	Requires plan or issuer to allow a pediatrician to be designated as a PCP. (§116)	Direct access to routine pediatric care. Specialist in pediatrics may make referrals for other routine care related to routine pediatric care. Plan not required to allow designation of pediatrician as PCP. (§724)
8. Out-of-Network Referrals	Yes, if no appropriate specialist available in-network, plan must provide access to out-of-network specialist at no additional cost to enrollees (beyond what they would have paid for a participating provider). (§114)	Not addressed
9. Continuity of Care/Transitional Care	Patients undergoing treatment for an ongoing special condition may continue to see their treating provider for a limited time when the provider is dropped from the network or an employer changes health plans. (§117)	Patients in specified populations may continue to see their treating provider for a limited time when the provider is dropped from the network or an employer changes health plans. (§726)
<i>Additional Protections for Specified Populations</i>	Patients who have scheduled surgery or are on a waiting list for organ transplants, pregnant women, and the terminally ill.	Protections only extend to: a) institutionalized patients, or patients who receive institutionalized care within a reasonable time of the date of termination, if care was scheduled beforehand or patient was on a waiting list of receive care; b) women in the 2nd trimester of pregnancy; and c) the terminally ill.
<i>Time Frame for Transition Period</i>	Up to 90 days from the date of notice of termination; through hospital discharge for scheduled surgery or organ transplants; through postpartum care for pregnancy; for remainder of person's life for terminally ill.	Generally up to 90 days from the date of termination; through discharge for institutional care; through postpartum care for pregnancy; for remainder of person's life for terminally ill.
<i>Limitations</i>	Provider must accept insurer's previous payment rate, quality assurance, and UR standards.	Provider must accept plans' previous payment rate, quality assurance, and UR standards.
10. Access to	Language follows requirements of	

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Emergency Care	Medicare, Medicaid, and FEHBP.	
<i>Bans prior authorization?</i>	Yes (§113)	Yes (§721)
<i>Bans in-network requirements?</i>	Yes	Yes
<i>Bans cost-sharing differentials for out-of-network ERs?</i>	Yes	Yes
<i>“Prudent layperson” standard for emergency screening?</i>	Yes	Yes
<i>“Prudent layperson” standard for stabilization care?</i>	Yes	No. Additional stabilization services must be covered if determined necessary in the screening exam.
<i>Emergency medical condition includes “severe pain?”</i>	Yes	Yes
<i>Maintenance and Post-stabilization Care</i>	Mandates process consistent with Medicare guidelines or such guidelines established by the Secretary of HHS.	Not specifically addressed. Plan only required to cover services needed to maintain the medical stability of a patient, if coverage for these services is furnished under the plan, the services were provided in an ER department and related to the emergency medical condition, and the ER provider contacted the plan for approval. If plan does not respond within 1 hour, plan is liable for services provided by ER to maintain stability.
11. Drug Formularies	Participating physicians and pharmacists must be involved. (§118)	Participating physicians and pharmacists must be involved. (§728)
<i>Formulary Development</i>		
<i>Disclosure of Formulary Restrictions</i>	Must disclose to providers and to enrollees upon request the nature of formulary restrictions.	Disclosure upon request (§1101)

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Exceptions to Formulary	Plan must provide for exceptions to the formulary when medically indicated.	Plan must provide for exceptions to the formulary when medically necessary and appropriate, in accordance with the plan's applicable quality assurance and UR standards. (§728)
12. Access to Clinical Trials	Yes; if enrollee has a life-threatening or serious illness for which no standard treatment is effective, the enrollee is eligible for participate in an approved clinical trials, and the trial offers the potential for significant benefit based on the opinion of the referring physician or medical information supplied by the enrollee. Plan or issuer must pay routine costs for items and services furnished in connection with the trial. (§119)	Only for cancer clinical trials. If enrollee has cancer for which no standard treatment is effective, the enrollee is eligible for an approved clinical trial, and the trial offers meaningful potential for significant clinical benefit. Plan or issuer must pay routine costs for items and services furnished in connection with the trial. (§730)
“Approved” Clinical Trials	Trials approved by and funded by NIH; a cooperative group or center of NIH; the Dept. of Veteran’s Affairs; or the Dept. of Defense (under certain conditions).	Trials approved by and funded by NIH; a cooperative group or center of NIH; the Dept. of Veteran’s Affairs; or the Dept. of Defense (under certain conditions).
13. Information Disclosure Mandatory Disclosure	Health insurance issuers and group health plans must provide the following information to enrollees: service area; covered benefits; cost sharing; network restrictions; list and types of providers; process for determining experimental coverage; use of drug formularies; number, mix, and distribution of providers; out-of-network coverage (if any); any POS option; procedures for selecting and changing providers and for obtaining referrals; participating provider availability and contact information; any limitations on the choice of providers; communication assistance for non-English speaking populations or other populations with special communications needs; out-of-area coverage; procedures for accessing emergency services; medical-loss ratios	Group health plans must provide the following information to enrollees: a description of covered items and services, cost-sharing, optional supplemental benefits, network restrictions, service area, any out-of-network coverage, procedures for selection of primary care provider, procedures for advance directives and organ donation, prior authorization rules, and definition of medical necessity. Plans must provide a summary of: rules for grievances and appeals, any provisions for obtaining off-formulary medications, rules for accessing ER care, any coverage for experimental or investigational treatments and clinical trials, and any preventive services. Must provide a statement of procedures for accessing

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	for coverage; prior authorization rules; grievance and appeal procedures; any quality data the plan makes available; and information on the issuer. (§121)	Ob/Gyn providers and pediatricians and for obtaining continuity of care. Plan must provide a statement of types of information available on request. (§111)
<i>Disclosure upon Request</i>	The following information must be disclosed upon request: utilization review procedures and requirements, information on the number and disposition of grievances and appeals, a general description of methods of physician compensation, credentials of participating providers, formulary restrictions, and a participating provider list. (§121)	The following information must be made available upon request: contact information for participating providers and facilities, summary of provider and facility compensation methods, UR procedures, list of drugs on formulary, specific coverage exclusions, any services for non-English speakers and other people with communication disabilities, and any information made public in the accrediting process or any quality data the plan makes available. Also directs HHS to contract with IoM for a study that analyzes available information about health care professionals and makes recommendations for the disclosure of such information to better facilitate patient choice, quality improvement, and market competition. (§112)
<i>Timeframes</i>	Mandatory information must be issued at time of enrollment and at least annually thereafter. Notice of significant changes must be provided to enrollees within a “reasonable” period before or after the changes, as specified by the Secretary.	Mandatory Information must be provided within 12 months of the date of enactment of the bill and at least annually thereafter. No advance notice required for changes in plan.
14. Provider Protections <i>Anti-Gag Rule</i>	Bans plan contracts from restricting or prohibiting health care professionals from advising a patient about health status or treatment, if the professional is acting within the “lawful scope of practice.” (§131)	Bans plans from restricting or prohibiting health care professionals from advising a patient about health status or treatment (but not utilization review or financial incentives), if the professional is acting within the “lawful scope of practice.” (§727)

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<i>Non-discrimination against Providers</i>	Plan or issuer may not discriminate against any provider acting within the scope of provider's license or certification under applicable State law, solely on the basis of such license or certification. (§132)	Plan or issuer may not discriminate against any provider acting within the scope of provider's license or certification under applicable State law, solely on the basis of such license or certification. (§730B)
<i>Prohibition of Improper Physician Incentive Arrangements</i>	Also protects against improper incentive plans as under Medicare. (§133)	Not addressed
<i>Prompt Payment of Providers</i>	Plan must pay providers according to the timeframes established for Medicare payment of claims. (§134)	Not addressed
<i>No Retaliation Against Providers and Protection for Quality and Patient Advocacy</i>	Protects providers who use or participate in the utilization review or grievance and appeal processes. Also protects providers who report quality problems to a regulatory agency, accreditation body, or management personnel; protects providers who cooperate or participate in an investigation. (§135)	Not addressed
15. Enforcement	HIPAA model: DoL for ERISA plans, States with federal fallback for issuers. For fully-insured arrangements, States (with federal fallback) enforce against the issuer and DoL against the ERISA plan. Department of Treasury may levy tax penalties as well.	Department of Labor
<i>Enhanced Authority or Civil Monetary Penalties beyond Current Law</i>	For external review: The Secretary may assess CMPs for a pattern or practice of repeated refusal to authorize a benefit determination by an external review entity or repeated violations of the external review provisions. Secretary must provide "clear and convincing evidence" of pattern or practice. Penalty may not exceed the lesser of 25% of the aggregate value of benefits denied or \$500,000. Secretary may	For external review: If a plan fails to comply with the time frame for provision of care established by the external review entity, the enrollee may obtain the items or services from any provider. Plan must reimburse provider or enrollee (if enrollee pays for items or services), as long as the items or services would have been covered under the terms of the plan or coverage and were provided in a manner consistent

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	<p>petition court to have repeat violator removed from his or her post. (§103)</p> <p>Enrollee may go to court if the decision of the external reviewer is not followed and receive a CMP from the plan or issuer of up to \$1000 a day from the date of transmittal of review decision to date of compliance. Court shall serve defendant a cease and desist order and require payment to plaintiff of reasonable attorney’s fees and other reasonable costs. (§103)</p>	<p>with the terms of the external reviewer.</p> <p>Enrollee may commence a civil action is plan or issuer fails to provide reimbursement. Enrollee may recover reimbursement and any necessary legal costs or expenses (including attorneys’ fees).</p> <p>The Secretary may assess a CMP of up to \$10,000 against any plan for failure or refusal to comply with the time lines under §503(e) or any determination under such section. In case where plan did not commence treatment in accordance with the determination of an external reviewer, the Secretary may assess a CMP of \$10,000 against the plan, payable to the enrollee. (§121)</p>
<p>16. Liability (under ERISA)</p> <p><i>Allowable Causes of Action</i></p>	<p>Amends ERISA (§ 514) to permit under State law a cause of action against a health plan for personal injury or wrongful death. Exempts employer and plan sponsor (and the employee of such authority) from liability as long as they did not exercise discretionary authority to make a decision on a claim. (§302)</p> <p>Specifically notes that “discretionary authority” does not include an employer’s decision to include or exclude from the plan any specific benefit, to provide extra-contractual benefits, or not to provide a benefit while appeal is pending.</p>	<p>No change; beneficiary may sue group health plan in federal court.</p>
<p><i>Relief</i></p>	<p>Beneficiary may be awarded such relief as court deems appropriate subject to applicable state law restrictions. Plan (or issuer) is not liable for punitive damages if the issuer promptly followed an external review decision. Plan (or</p>	<p>No change; beneficiary may only be awarded the value of the benefit denied (and reasonable attorneys’ fees and other related costs).</p>

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	issuer) may require individual to go through external review, unless the individual has already been harmed by plan's (or issuer's) denial of care.	
<i>Interaction with State Medical Malpractice Actions</i>	Explicit statement that title has no effect on any state law (or any action based on that law) which regulates the practice of medicine or the provision of medical care.	N/A
17. Paperwork Simplification Panel	HHS must create a federal panel to devise a single claims form for use for third party payers. Work must be completed within 2 years and form must be in use beginning on or after 5 years following the date of enactment of this Act. (§601)	Not addressed
18. Additional Protection for Breast Cancer Patients	Not addressed	For plans and issuers that provide medical and surgical benefits, length of stay following a mastectomy, lumpectomy, or lymph node dissection is determined by the attending physician, in consultation with the patient. (§201)
<i>Second Opinions for Cancer Patients</i>	Not addressed	Plan must provide secondary consultations by specialists in the appropriate medical fields to confirm or refute an initial positive or negative diagnosis of cancer. If the attending physician certifies in writing that services for a secondary consultation are not available within the plan network, the plan must provide coverage for out-of-network care at no additional cost to the enrollee.
19. Medicare Competitive Pricing	Not addressed	Forbids Secretary from implementing Medicare Competitive Pricing Demonstration Project in Kansas City and Arizona. No demonstration may be

<i>PROVISION</i>	HR 2723 Norwood-Dingell as passed House	S 1344 Senate Republican Leadership as passed Senate
		implemented in any area before 2001. Secretary required to conduct a study on voluntary implementation of demonstration. (§901)
20. MSAs and Other Health Insurance Related Provisions <i>MSAs and Tax Deductions</i>	Included in H.R. 2990	<p>Allows full deductibility of health insurance costs for self-employed. (§501)</p> <p>Increases eligibility for MSAs by allowing all employers to offer MSAs and eliminating the caps on the number sold. Reduces the minimum annual deductible allowed on the catastrophic plans, increases the annual contribution limit, and limits the additional tax on MSA payments not used for qualified medical expenses. (§502)</p> <p>Expands eligibility to MSAs for individuals to federal government employees or annuitants through FEHBP. (§503)</p> <p>Allows unused benefits from cafeteria plans, flexible spending arrangements, and health flexible spending accounts to be carried over to later taxable years. (§504)</p>
21. Other Provisions	N/A	IoM study on information Self-pay for behavioral health care Genetic information ACHPR reauthorization Medicare competitive pricing demonstration