ISSUE	PATIENTS' BILL OF RIGHTS OF 1998 (DEMOCRATIC PROPOSAL)	PRESIDENT'S QUALITY COMMISSION	HIP/ KAISER PERMANENTE/AARP/FAMILIES USA	AAHP'S PUTTING PATIENTS FIRST	NORWOOD H.R. 1415
Entities Regulated	Individual health insurance, group health insurance, group health plans (including ERISA plans).	Applies to all consumers and participants in the health system.	Legally enforceable national standards would apply to all plans including ERISA plans.	Voluntary compliance for plans that are members of AAHP. AAHP member plans will attest that their plan abides by PPF and will provide information to enable AAHP to report on compliance.	Individual health insurance, group health insurance, group health plans (including ERISA plans).
Plan Choice - Enrollment Protections	Plans must provide access to specialists outside of plan if the plan has no appropriately qualified health professional available to treat enrollee. Such out of plan referrals would be available at no extra cost to the enrollee. The plan and the primary care doctor would establish the terms for out of network referrals. If an individual is offered only one health plan by their employer and that plan is a closed panel HMO, that HMO would have to offer beneficiaries (upon enrollment) the option to enroll in a Point of Service (POS) plan instead. Plans would have the option of using higher cost sharing and premiums. There are no requirements on employers with regard to the POS option.	If a plan has insufficient number or type of providers to provide a covered benefit with appropriate degree of specialization, the plan should ensure the consumer obtains the benefit outside the network at no extra cost. Public and private group purchasers should, wherever feasible, offer consumers a choice of high quality health insurance products.	Health plans must provide out-of-network referrals at no cost to the member when the health plan does not have a network physician with the appropriate training or expertise or when the health plan does not have an affiliation with a recognized specialty care center to meet a member's covered medical needs. Individuals should be given a choice of health plans.	No provision for out-of-network referrals. No provision on choice of health plan.	Does not specifically state that beneficiaries may go outside of plan if there is no available specialist in plan. Must offer POS option at time of enrollment if a health insurance issuer (group health plan) is a closed panel HMO. Premiums for this option must be established by the state in consultation with NAIC and must be fair and reasonable. Reimbursement rates for non-participating providers may not be less than those offered to participating providers, but only for covered services.

Prepared by House Committee on Commerce Democratic Staff and Senator Daschle's Staff.

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Information Disclosure	*Up-front disclosure to include:* covered benefits; cost-sharing; procedures for resolving complaints; comparable measures of quality and consumer satisfaction (including outcomes of grievance and appeals decisions); procedures that govern access to specialists and emergency services; provider ability to accept new patients; coverage of experimental treatment; use of prescription drug formulary; plan loss ratios; and methods to assist non-English speaking enrollees. *Information provided upon request:* description of utilization review process and requirements; provider financial incentives and payment methods; confidentiality policies; provider credentials and current participation status; and formulary restrictions.	*Disclosure should include:* covered benefits; cost-sharing; procedures for resolving complaints; comparable measures of quality and consumer satisfaction; the procedures that govern access to specialists and emergency services; care management information; health professional/facility education and/or board (re)certification; licensure, certification and accreditation status; years of practice; experience performing certain procedures; provider network composition; and community benefits provided.	*Disclosure to include:* covered and excluded benefits; how to obtain services, select providers, and obtain referrals; cost-sharing requirements; names/credentials of plan physicians; physician compensation mechanisms; utilization management procedures; a description of drug formularies; procedures for receiving emergency care and out-of-network services; procedures for determining coverage for investigational or experimental treatments; how to appeal decisions, and file grievances; plan loss ratios. Should also include information on contacting consumer organizations, such as ombudsman programs or government agencies regulating the health plan.	*Disclosure to include:* information on plan's structure and provider network; covered and excluded benefits; out-of-area and emergency coverage; cost-sharing requirements; and policies for referrals to specialists. Plans should allow access to up-to-date information about physician availability to accept new members. *Disclosure upon request:* pre-certification and other utilization review procedures; the plan's basis for specific utilization review decisions; whether a specific prescription drug is included in a formulary; a summary of participating physician payment methods, including financial incentives; and the procedures and medically-based criteria a health plan uses to determine whether experimental treatments and technologies should become covered services.	*Disclosure to include* (does not specify if this is mandatory disclosure or upon request): covered and excluded benefits; enrollee financial obligations; list of health plan providers; description of prior authorization/utilization review processes and requirements; outcomes of utilization determinations and percentage reversed on appeal; quality indicators; grievance and appeals data; financial arrangements and incentives that may limit services or treatment options; plan loss ratios; and ratio of enrollees to providers in professional category. The Secretaries of Labor and HHS shall issue regulations establishing the format of this information publication and the placement and positioning of the information in health plan marketing materials.

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Non-Discrimination	*For enrollees*: prohibits discrimination in the delivery of services based on health status, genetic information and variety of other factors.* *For providers*: plans may not discriminate on the basis standard civil rights protections (age, race, sex, etc), on the basis of having a high risk patient base, or being located in area with residents of poorer health status. Prohibits discrimination in participation or indemnification based solely on license but does not require plans to contract with unneeded providers or cover benefits that are not covered under the plan*. Does not override state licensure or scope of practice laws.	*For enrollees:* prohibits discrimination in the delivery of health care services or marketing and enrollment practices based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.	*For enrollees:* plans shouldn't discriminate in the provision of health care based on age, gender, race, national origin, language, religion, socio-economic status, sexual orientation, disability, genetic make-up, health status, or source of payment. *For providers:* health plans should not discriminate against providers who treat a disproportionate number of patients with expensive or chronic medical conditions. Health insurance reform should address discriminatory practices that discourage enrollment of high-risk, high-cost or vulnerable populations in health plans.	No provision.	For enrollees: prohibits discrimination directly or through contractual arrangements in any activity that has the effect of discriminating against enrollees on the basis of race, national origin, gender, language, socio-economic status, age, disability, health status, or anticipated need for health services. For providers: health plans may not discriminate against providers on the basis of race, national origin, gender, age or disability or the professional's lack of affiliation with or admitting privileges at a hospital. In addition, plans may not discriminate in participation, reimbursement, or indemnification against a health professional that is acting within the scope of their license solely on the basis of such license or certification

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Consumer Ombudsman	States that receive a grant from the federal government shall establish an Ombudsman to assist enrollees in understanding health insurance options and in filing grievances and appeals. Federally established when States default. Federal appropriations are necessary for the establishment of these programs.	Does not specifically call for an ombudsman but notes that consumer assistance programs would be a benefit to consumers and other stake holders. Consumer assistence programs should inspire confidence, act as a resource to help individuals resolve problems and foster collaboration of resources to meet the needs of consumers, as some consumers may need assistance in the health system.	Consumers should have access to, and health plans should cooperate with, an independent, external non-profit ombudsman program that helps consumers understand plan marketing materials and coverage provisions, educates members about their rights within health plans, investigates members' complaints, helps members file grievances and appeals, and provides consumer education and information.	No provision.	No provision.
Access -- General	Plans must have a sufficient number, distribution and variety of qualified providers to ensure that all enrollees receive covered services, including specialty services, on a timely basis (including rural areas).* Plans should consider contracting with federally-qualified health centers (FQHCs) if necessary to meet access standard.	Plan networks should provide access to sufficient numbers and types of providers to ensure that all covered services will be accessible without unreasonable delay -- including emergency access 24 hours/day, 7 days/week. Plans should establish and maintain adequate arrangements to ensure reasonable proximity of providers to the business or personal residence of their members. Consumers should have a choice of provider sufficient to ensure access to appropriate health care.	Plans must have enough physician specialists and other providers to provide timely, appropriate care 24 hours a day, seven days a week. Health plans should develop culturally competent provider networks. Members should be allowed to choose their own PCP and change PCP at any time.	Plans should offer a choice among primary care physicians participating in the network who are available to accept new patients. Members should be allowed to switch among participating primary care physicians who are available to accept new patients.	Requires access to sufficient number, mix and distribution of providers in a variety of service sites with reasonable promptness. Telemedicine and other innovative means may be considered to meet these requirements in rural or medically underserved areas. Enrollees must be allowed to choose a health professional from among all participating professionals and change selection as appropriate.

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Access -- Emergency Care	Allows a beneficiary to go to the nearest emergency room in an emergency. Uses prudent layperson definition and conforms post-stabilization standards to those proscribed by the Secretary for Medicare.* Protects enrollees against excess charges by emergency facilities. Plans should inform members about proper use, etc of emergency rooms.	Allows beneficiary to go to the nearest emergency room in an emergency based on prudent layperson standard without prior authorization and in-network requirements. Non-network providers and facilities should not bill patients or plans for any charges in excess of health plans' routine payment arrangements. ER department should contact plan as quickly as possible to coordinate follow-up and post-stabilization care.	Plans should cover emergency services, based on prudent layperson definition. Emergency departments should inform the health plan within 30 minutes after stabilization to obtain authorization for any post-stabilization services; plan should respond to the request within 30 minutes and provide access to a participating physician if it intends to deny the request for authorization. Plans should educate their members about ER use availability, cost sharing, etc. Plans should cover unforseen emergency and urgent care services for members traveling outside of the plan's service area.	Health plans should cover emergency -room screening and stabilization as needed for conditions that reasonably appear to constitute an emergency, based on the patient's presenting symptoms. Emergency conditions are those that arise suddenly and require immediate treatment to avoid jeopardy to a patient's life or health. To promote continuity of care and optimal care by the treating physician, the emergency department should contact the patient's primary care physician as soon as possible.	Requires plans to provide access to emergency care 24 hours a day, 7 days a week, and cover and reimburse for and not require PA for emergency services, ancillary services to diagnose, treat and stabilize a condition, and urgent care services. Uses prudent layperson definition. Post-stabilization care is not addressed.

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Access -- Specialty Care	Plans must provide access to specialists or specialty centers affiliated with the plan, pursuant to treatment plans, including standing referrals to specialists, if appropriate. Plans may restrict choice to participating specialists unless no appropriate specialist available.	Consumers with complex or serious medical conditions who require frequent specialty care should have direct access to a qualified specialist of their choice within a plan's network.	Health plans must provide access to specialists and specialty care centers affiliated with the plan pursuant to treatment plans, including standing referrals to specialists if appropriate.	Health plans should have procedures to promote timely and appropriate access to specialty care. Plans should periodically evaluate these procedures with reference to selected medical conditions, focusing on appropriateness of care. Each health plan should offer members a choice, in coordination with their primary care physician, among specialty physicians who participate in the plan's network and are available to accept new patients.	Plans must demonstrate enrollees have access to specialized treatment when deemed necessary by treating health professional in consultation with enrollee.
Access -- Women's Services	Women must have direct access to routine and preventive women's health services through a provider that specializes in obstetrics or gynecology. Women may designate an OB/GYN as PCP. Also includes provisions on mastectomy length of stay and breast reconstruction.	Women should be able to choose a qualified provider (including a ob/gyn, certified nurse midwife or other qualified provider) to provide routine and preventive women's health care services.	Health plans must provide women members with direct access to obstetricians and gynecologists.	Health plans should not require outpatient mastectomies and mastectomy care decisions should be made by a physician, after consultation with the patient, based on the best scientific information and unique characteristics of the patient.	No provisions on direct access to or selection of OB/GYN as PCP.

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Access -- Chronic Care	Plans must have written process for issuing standing referrals and for selection of specialists as PCP for enrollees requiring ongoing care, pursuant to a treatment plan.	Authorizations for specialty care should be for an adequate number of direct visits under an approved treatment plan.	Access to specialists including standing referrals to specialists.	No provisions.	Coordination of care or cost controls must not create an undue burden for enrollees with special health conditions or chronic conditions. Plan in conjunction with enrollee and treating professional must determine in these cases whether specialist or care coordinator appropriate to ensure continuity of care.
Transitional Care	If an enrollee's provider leaves the plan or if the enrollee's plan is terminated (except for quality or fraud violations), the enrollee must be permitted to continue their course of treatment for up to 90 days, with additional protections for institutional care, pregnancy, and terminal illness. The provider must accept the payment rate prior to termination and may not charge the beneficiary cost-sharing beyond what the plan allows.	If an enrollee's provider leaves the plan or if the enrollee's plan is terminated (except for quality or fraud violations) and the enrollee is receiving care for a chronic or disabling condition (or is in the second or third trimester of pregnancy) must be permitted to continue their course of treatment for up to 90 days (or through completion of postpartum care). Providers must accept the plan's rates in full, provide all necessary information to the plan for quality purposes, and promptly transfer all medical records with patient authorization during the transition period.	Members who are being treated for a serious illness or who are in the second trimester of pregnancy should be allowed to receive treatment from their physician specialists for up to 60 days or through post-partum if their doctor's contract is terminated by a plan (for reasons other than quality of care), or if their former health plan is replaced and the patient's previous physicians specialist is not in the new plan.	Each health plan should have procedures to facilitate the transfer of care from one practitioner to another when a practitioner treating a patient during an episode of serious illness (or a patient in the second or third trimester of pregnancy) leaves a network for reasons other than cause. Procedures may include, but are not limited to, facilitating establishment of appointments with a qualified new practitioner, a period of coverage of the previous practitioner (if the provider is in good standing), and/or supporting the transfer of medical records (which depends on cooperation of patient's previous practicioner).	Plans must cover items and services provided by the health professional or provider that was treating the enrollee before the change in provider. This may be due to change in the membership of an issuer's health professional and provider network, changes in the health coverage made available by an employer, or other similar circumstances. Applies to enrolles with special health care needs and with chronic conditions. Also applies to inpatients and persons dependent on high-tech home medical equipment.

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Clinical Trials and Experimental Treatment	Plans must have an objective process for considering experimental treatments. Clinical trials must be covered in defined circumstances. The plan may not discriminate against the enrollee based on their participation in the trial. Plan not responsible for costs reasonably expected to be covered by trial sponsors but plan must provide for routine patient costs.	No specific provision relating to clinical trials. However, health plans should provide consumers with the procedures used to determine coverage for investigational or experimental treatments.	Plans should have an objective process for reviewing new drugs, devices, procedures, and therapies. Plans should also have an external, independent review process to examine the cases of seriously ill patients who are denied coverage for experimental treatments.	No provision. But in the event of a dispute of coverage over experimental treatments and technologies, the plan should tell the beneficiary, if they ask, the procedures and medically-based criteria used to make the coverage decision.	No provisions, except that issuer must disclose "information" about the benefits covered and excluded, including experimental treatments. No coverage mandate. Clinical Trials not addressed.

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Grievances -- Internal	Requires plans to have a system of internal review with timely written notice of decision to deny, reduce or terminate services, and reasons for the decision and procedures for appeal. Appeals must be resolved in a timely manner (not longer than 15 business days) with expedited consideration for emergency/urgent care (within 72 hours). The review must be conduced by appropriately credentialed staff uninvolved with the initial decision. Determinations may be communicated orally to expedite the process, however denials must be in writing and include the process for appeal and reasons for denial. Expedited appeal process (activated by physician request) available for emergency situations.	Requires plans to have a system of internal review with timely written notice of decision to deny, reduce or terminate services, and reasons for the decision and procedures available for appeal. Appeals must be resolved in a timely manner with expedited considerations for emergency or urgent care (within 72 hours). The review must be conducted by appropriately credentialed staff uninvolved in initial decision. Plans must also have a reasonable process for resolving consumer complaints about issues such as waiting times, operating hours, demeanor of personnel, and the adequacy of facilities.	Does not establish a grievance and appeals process. Health plans should provide information on appealing appeal decisions, filing grievances, and contacting consumer organizations, such as ombudsman programs or government agencies regulating the health plan.	Plans must explain in a timely notice the basis for a determination which a patient disagrees with along with a description of rights and time frames for appeal. Appeals should be resolved as rapidly as warranted by the patient's situation. An expedited appeals process should be available for situations in which the normal time frame could jeopardize a patient's life or health.	Internal grievance procedure by appropriate clinical peer required for adverse utilization determinations and for other enrollee complaints of inadequate access. Review in 1 hour for urgent services; 24 hours for other services.

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Grievances -- External	Requires enrollees to have access to an independent external appeal body. To qualify for review, the case must involve a denial of care for experimental treatment, a decision based on lack of medical necessity where cost exceed a significant threshold, or a denial of care where the patient's life or health is jeopardized. Individuals first must exhaust internal appeals process (unless time frames are not met). Qualified entities must conduct review activities using appropriately credentialed clinical peers. The cost of the appeal is borne by the plan and the determination is binding on the plan. The state and the appropriate Secretary shall conduct reviews of the certified organizations to ensure their integrity. Appeals must be resolved within 60 days, with expedited consideration for emergency/urgent care (72 hours).	Requires enrollees to have access to an independent external appeals body. To qualify for review, the case must involve a denial of care for experimental treatment, a decision based on lack of medical necessity where cost exceed a significant threshold, or a denial of care where the patient's life or health is jeopardized. Individuals first must exhaust the internal appeals process. Appeals must be conducted by professionals who are appropriately credentialed (w/o conflict of interest and independent) and follow a standard of review that promotes evidence-based decision making relying on objective evidence. Appeals must be resolved in a timely manner with expedited consideration for emergency/urgent care consistent with time frames required by Medicare (72 hours).	Plans should have an external, independent review process to examine the cases of seriously ill patients with less than two years to live who are denied coverage for experimental treatments.	No provision.	A health insurance issuer (group health plan) must maintain an accessible appeals process that reviews adverse prior authorization determinations for urgent and other care services and an initial determination on payment for claims...by an appropriate clinical peer professional...that is not involved in the operation of the plan or in making the determination or policy being appealed (sect. 2776 (b)(4). No time frames set forth. Does not specify if these decisions are binding.

Issue	Patients' Bill of Rights of 1998 (Democratic Proposal)	President's Quality Commission	HIP/ Kaiser Permanente/AARP/Families USA	AAHP's Putting Patients First	Norwood H.R. 1415
Utilization Review	Plans must have a utilization review process administered by appropriately trained, qualified health professionals. Physician input required for development of clinical review criteria. The utilization review program may not provide financial incentives for denials of care. Beneficiaries may have medical director (or other appropriate person with authority to reverse decision) review an adverse determination. Written notice to beneficiary for denial of care.	No provision.	Plans must have a utilization review process that uses appropriately licensed providers to evaluate the clinical appropriateness of adverse decisions. Health plans should make timely and, if necessary, expedited decisions, and give the principal reasons for adverse determinations and instructions for initiating an appeal. Health plans should be prohibited from providing incentives for making adverse utilization review decisions.	Plans must have a utilization review process that is based on scientific and medical evidence; be directed by an experienced physician; and involve participating physicians in reviewing utilization management criteria. An exceptions process, directed by an experienced physician, should be available for cases in which a participating physicians believes that a utilization management determination does not adequately account for the unique characteristics of a particular patient, based on relevant medical evidence offered by the participating physician for review. Utilization management decisions should be based on clinical information about the patient and the treating physician should have an opportunity to provide clinical information and a rationale for recommending a specific course of treatment prior to a utilization review decision.	Plans must have a utilization review process whose fondation is a uniform criteria based on sound medical evidence applied by appropriately licensed health professionals and must not compensate individuals for denials. Must notify promptly of determination and explain basis of determination and right to immediate appeal. The utilization review program (1) must be developed with the involvement of participating health professionals, (2) may not compensate individuals conducting UR for denials of payment or coverage.

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Quality Assurance Program	Plans must have a quality assurance program guided by a written plan which includes quality criteria directed at meeting needs of at-risk or chronically ill populations (including gender, age and pediatric-specific criteria where appropriate). Plans must have procedures for providers and enrollees to report quality concerns; systematic review of type of health services provided and patient outcomes; and drug utilization required to promote proper use of medicines. Standardized comparative information will be collected and reported across all plans. The plan may be deemed to meet the requirements of the bill if their quality assurance program is accredited by a Secretary-certified program with standards at least as stringent as those in the bill. Requires a Health Care Quality Council similar to that advocated by the President's Quality Commission.	Recommends an Advisory Council for Health Care Quality that would identify national aims for improvement, specific objectives for improvement, and track the nation's progress in meeting those objectives. Council would include representatives from the public and private sectors and report annually to the President and Congress on progress in improving health care quality. The private sector should work to establish core sets of quality measures applicable to each sector of the industry. Special attention should be paid to the health needs of vulnerable populations including children. Information systems need to be upgraded to accomplish these goals.	Health plans should meet national standards for measuring and reporting performance in a number of areas. National standards for quality assurance should be non-duplicative and should provide latitude in the specific methods and activities employed to meet the standards to reflect differences in health plan organization. Standards should provide for external review of the quality of care conducted by qualified health professionals who are independent of the plan and accountable to the appropriate regulatory agency. There should be a collaborative effort to develop a national core data set of outcome-oriented , scientifically-based measures. Health plans should disclose the results of performance assessments subject to independent audit.	Health plans should have quality assessment and improvement programs to monitor targeted areas of a patient care to detect whether patterns of under-service or over-service exist and act to assure the appropriate care is rendered. This program should be physician-directed; participating physicians should be involved in its design and implementation; and all participating physicians should be informed of the program. Practice guidelines should be based on current scientific and medical evidence; designed with the input of participating physicians used to augment the physician patient relationship. Guidelines should be regularly updated and available to participating physicians as appropriate to their specialty. Health plans should have an internal committee (including participating physicians and other appropriate professionals) available to consider requests from participating physicians that guidelines be modified based on relevant scientific medical evidence.	Issuer must have a quality assurance program that assesses and improves enrollee health status, patient outcomes, processes of care, and enrollee satisfaction associated with health care provided by the issuer. Thia also applies to administrative and funding capacity of issuer to fund preventive care, utilization, access and availability, cost effectiveness, acceptable treatment modalities, specialist referrals, peer review. Must report findings to purchasers, participating health professionals, and administrative personnel.

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Privacy -- Confidentiality	Plans must establish procedures to safeguard the privacy of enrollee information, maintain records in manner that is accurate and timely, and assure timely access to enrollees to such records and information.*	Individually- identifiable health care information should be protected and should not be disclosed without written consent except for health purposes or where there is a clear legal need. Consumers should be able to review, copy and request amendments to their medical records. Non-identifiable health care information should be used to the maximum extent feasible.	Individual-level information should not be disclosed except: a) if necessary for quality assurance, for purchasers of providers (e.g., to determine eligibility for coverage or to administer payments) or to conduct research (but these data should not contain patient identifiers which could lead to violation of individual privacy and harm to patients); b) if the individual provides consent; or, c) if required by law or court order.	Consistent with applicable federal and state law, confidentiality policies should include reasonable and appropriate administrative, technical and physical safeguards to provide for appropriate training of plan staff; and delineate mechanisms, including a clear disciplinary policy, to address improper use of patient-identifiable health information. Patient-identifiable health information should not be disclosed without the patient's consent except when necessary to provide care; perform essential plan functions (e.g., quality assurance and plan administration); conduct bona fide research; comply with law or court order; or comply with public health needs.	Must establish procedures for compliance with Federal and State laws.
Provider Protections -- Anti-Gag Protections	Provider contracts must not contain "gag-clauses" or other contractual mechanisms that restrict health care providers' communication with patients about medically necessary treatment options.	Provider contracts must not contain "gag-clauses" or other contractual mechanisms that restrict health care providers' communication with patients about medically necessary treatment options.	Plans should not limit the exchange between health care providers and patients regarding the patient's condition and treatment options.	Plan policies or contracts between health plans and physicians should be interpreted as prohibiting physicians from discussing treatment options with patients.	Plans must not limit medical communication including information on patient's health status, utilization provisions that may affect treatment options,and financial incentives that may affect treatment.

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Provider Protections - - Physician Incentive Plans	Prohibits physician incentive plans if used as inducement to restrict medically necessary services. If plan puts provider at substantial financial risk, plan must provide stop-loss protection and conduct periodic customer satisfaction/access surveys.*	No specific provision on provider incentive plans or stop-loss requirements. Plans should disclose factors - such as compensation - that could influence advice on treatment plans.	Prohibits health plans or provider groups payment methodologies that directly encourage provider to overtreat patients or to limit medically necessary care. Full-risk capitation should not be used for an individual provider. Provider capitation should only apply to services directly rendered by that provider. Reinsurance or stop-loss coverage should be used when individual providers or small groups of providers are capitated or when providers are placed at substantial financial risk.	No provision.	Prohibited if made as inducement to restrict medically necessary services; if plan puts provider at substantial risk, plan must provide stop-loss protection and conduct periodic customer satisfaction/access surveys; and plan must provide State or Secretary with sufficient information to determine whether plan is acceptable.

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Provider Protections - - Due Process	Reasonable notice to provider of adverse participation decision, opportunity to review reasons/ information behind termination, and a process for appeal.* Prohibits transfer of any liability to provider relating to acts or omissions of plan. Plans may not penalize providers who advocate on behalf of their patient in participation in the utilization review or grievance process.	Plans should be prohibited from penalizing or seeking retribution against health care professionals or other health workers for advocating on behalf of their patients.	Plans should not penalize providers who in good faith advocate for their patients, assist patients with claims appeals, or report quality concerns to government authorities or health plan managers.	Plans should use, where feasible, AAHP's standardized Physician Application Form to help reduce repetitive and duplicative paperwork requirements.	No termination of provider contracts without cause. Plan must provide reasonable notice of decision to terminate provider for cause, opportunity to review reasons/information behind termination, and opportunity to enter into corrective action plan before determination becomes subject to appeal. Must allow all providers to apply annually, provide reasonable notice of application period, provide for review of applications by appropriately credentialed committee for each type and category of provider, notify applicants of information indicating that they fail to meet the plan's standard and allow them to submit supplemental or corrected information. These providers are based on objective standards. When economic considerations are used in selection, they must be objectively applied and adjusted for case mix and disclose results.
Provider Protections - - Credentialing	Plans must have written standards for hiring and contracting with health providers and facilities, including verification of provider's license and a history of suspension and revocation.	No provision.	Health plans and provider groups should develop written standards similar to those used by the National Committee for Quality Assurance for hiring and contracting with physicians, other providers and health care facilities.	Participating physicians should be credentialed and periodically recredentialed.	No provisions.

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ISSUE	PATIENTS' BILL OF RIGHTS OF 1998 (DEMOCRATIC PROPOSAL)	PRESIDENT'S QUALITY COMMISSION	HIP/ KAISER PERMANENTE/AARP/FAMILIES USA	AAHP'S PUTTING PATIENTS FIRST	NORWOOD H.R. 1415
Drug Formularies	Plan physicians must participate in the development of the drug formulary. Plans must disclose the nature of formulary restrictions and make allowance for exceptions to the formulary when medical necessity dictates that a non-formulary alternative is needed.	Requires disclosure of use of formulary, whether a specific drug is included in the formulary, and procedures for considering requests for patient-specific waivers.	Plans should allow physicians to participate in the development of drug formularies, provide a description of the formulary to consumers, and provide for an exception process when non-formulary alternatives are medically necessary.	Plans should involve participating physicians in developing and reviewing formularies (based on current medical and pharmacoeconomical evidence). Formularies should be regularly reviewed and updated, if necessary on an expedited basis, to take into account new medical evidence and newly approved drugs. Selective formularies should include an exceptions process (directed by a clinical with appropriate expertise) through which a patient or participating physician may present science-based medical evidence to support coverage for a prescription drug not routinely included in the formulary.	No provision.

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Medical Necessity	Prohibits health insurance issuers from arbitrarily limiting or altering the manner or setting of service delivery of covered benefits when determined to be medically necessary and appropriate. Medically necessary and appropriate services or benefits are those provided consistent with generally accepted principles of professional medical practice. Utilization review should be conducted consistent with this standard.	No specific provision relating to medical necessity. Bill of Rights states that health care should be evidence based, however.	No provision.	No provision. However, utilization management decisions should be based on clinical information about the patient and the treating physician should have an opportunity to provide clinical information and the rationale for recommending a specific course of treatment prior to a utilization review determination. Plans physicians should use plan practice guidelines to in determining what medical care to provide their patient.	A health issuer offering network coverage shall demonstrate that enrollees have access to specialized treatment expertise when such treatment is medically or clinically indicated in the professional judgement of the treating health professional in consultation with the enrollee. Health plans must ensure direct access to relevant specialists for the continued care of such enrollees when medically or clinically indicated in the judgement of the treating health professional in consultation with the enrollee.
ERISA Liability	Removes ERISA preemption that currently prevents beneficiaries from holding health plans liable when they make medical decisions that cause harm. Plans would be subject to state law concerning liability for their actions. Protects employers from liability when they were not involved in the decision.	Calls for a national dialogue among policy makers and other stakeholders on the state of existing remedies for individuals in public and private health plans who are injured as a result of inappropriate health care decisions.	No provisions.	No provisions.	Permits state liability laws to apply to ERISA plans in cases of wrongful death or personal injury. Does not specifically exempt employers from being sued, however, Norwood has introduced a bill, H.R. 2960, that would clarify that employers are not to be sued in these instances unless they exercised discretionary authority that lead to death or wrongful injury. They are also shielded from plan insurers and administrator's claims for indemnification.

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Enforcement	The draft bill would apply to all plans, both ERISA and state regulated, using the HIPAA mechanism of enforcement. Sets national floor of protections, but states may do more.	Federal programs have come into compliance for most of the Bill of Rights, however, plans regulated by the Department of Labor or by States would need legislative action to bring them into compliance.	Asks for federally enforceable standards to be put in place.	Voluntary compliance for plans that are members of AAHP.	States may impose equivalent or more stringent requirements on plans.