

104TH CONGRESS
1ST SESSION

S. 609

To assure fairness and choice to patients and health care providers, and
for other purposes.

IN THE SENATE OF THE UNITED STATES

MARCH 23, 1995

Mr. WELLSTONE introduced the following bill; which was read twice and
referred to the Committee on Labor and Human Resources

A BILL

To assure fairness and choice to patients and health care
providers, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Health Care Quality and Fairness Act of 1995.”

6 (b) TABLE OF CONTENTS.—The table of contents for
7 this Act are as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Definitions.

TITLE I—PROTECTION OF CONSUMER CHOICE

Sec. 101. Protection of consumer choice.
Sec. 102. Enrollment.

TITLE II—OFFICE FOR CONSUMER INFORMATION, COUNSELING AND ASSISTANCE

Sec. 201. Establishment.

TITLE III—UTILIZATION MANAGEMENT

- Sec. 301. Definitions.
- Sec. 302. Requirement for utilization review program.
- Sec. 303. Standards for utilization review.

TITLE IV—HEALTH PLAN STANDARDS

- Sec. 401. Health plan standards.
- Sec. 402. Minimum solvency requirements.
- Sec. 403. Information on terms of plan.
- Sec. 404. Access.
- Sec. 405. Credentialing for health professionals.
- Sec. 406. Grievance procedures.
- Sec. 407. Confidentiality standards.
- Sec. 408. Discrimination.
- Sec. 409. Prohibition on selective marketing.

TITLE V—HEALTH INSURANCE MARKET REFORM

- Sec. 501. Guaranteed issue and renewability.
- Sec. 502. Nondiscrimination based on health status.
- Sec. 503. Adjustments based on age, geography and family size.
- Sec. 504. Risk adjustment.
- Sec. 505. Lifetime limits.
- Sec. 506. Patient’s right to self-determination.
- Sec. 507. Affect on State law.
- Sec. 508. Association plans.

TITLE VI—MISCELLANEOUS PROVISIONS

- Sec. 601. Enforcement.
- Sec. 602. Effective date.

1 **SEC. 2. DEFINITIONS.**

2 Unless specifically provided otherwise, as used in this
3 Act:

4 (1) CARRIER.—The term “carrier” means a li-
5 censed insurance company, a hospital or medical
6 service corporation (including an existing Blue Cross
7 or Blue Shield organization, within the meaning of
8 section 833(c)(2) of Internal Revenue Code of 1986
9 as in effect before the date of the enactment of this

1 Act), a health maintenance organization, or other
2 entity licensed or certified by the State to provide
3 health insurance or health benefits.

4 (2) COVERED INDIVIDUAL.—The term “covered
5 individual” means a member, enrollee, subscriber,
6 covered life, patient or other individual eligible to re-
7 ceive benefits under a health plan.

8 (3) DEPENDENT.—The term “dependent”
9 means a spouse or child (including an adopted child)
10 of an enrollee in a health plan who is financially de-
11 pendent upon the enrollee.

12 (4) EMERGENCY SERVICES.—The term “emer-
13 gency services” means those health care services
14 that are provided to a patient after the sudden onset
15 of a medical condition that manifests itself by symp-
16 toms of sufficient severity, including severe pain,
17 and the absence of such immediate medical attention
18 could reasonably be expected, to result in—

19 (A) placing the patient’s health in serious
20 jeopardy;

21 (B) serious impairment to bodily function;

22 or

23 (C) serious dysfunction of any bodily organ
24 or part.

1 (5) HEALTH PLAN.—The term “health plan”
2 includes any organization that seeks to arrange for,
3 or provide for the financing and coordinated delivery
4 of, health care services directly or through a con-
5 tracted health professional panel, and shall include
6 health maintenance organizations, preferred provider
7 organizations, single service health maintenance or-
8 ganizations, single service preferred provider organi-
9 zations, other entities such as physician-hospital or
10 hospital-physician organizations, employee welfare
11 benefit plans (as defined in section 3(1) of the Em-
12 ployee Retirement Income Security Act of 1974 (29
13 U.S.C. 1002(1)), and multiple employer welfare
14 plans or other association plans, as well as carriers.

15 (6) HEALTH PROFESSIONAL.—The term
16 “health professional” means individuals who are li-
17 censed, certified, accredited, or otherwise
18 credentialed to provide health care items and serv-
19 ices as authorized under State law.

20 (7) MANAGED CARE PLAN.—

21 (A) IN GENERAL.—The term “managed
22 care plan” means a plan operated by a man-
23 aged care entity (as defined in subparagraph
24 (B)), that provides for the financing and deliv-

1 ery of health care services to persons enrolled in
2 such plan through—

3 (i) arrangements with selected provid-
4 ers to furnish health care services;

5 (ii) explicit standards for the selection
6 of participating providers;

7 (iii) organizational arrangements for
8 ongoing quality assurance, utilization re-
9 view programs, and dispute resolution; and

10 (iv) financial incentives for persons
11 enrolled in the plan to use the participat-
12 ing providers and procedures provided for
13 by the plan.

14 (B) MANAGED CARE ENTITY.—The term
15 “managed care entity” includes a licensed in-
16 surance company, hospital or medical service
17 plan (including physician and physician-hospital
18 networks), health maintenance organization, an
19 employer or employee organization, or a man-
20 aged care contractor (as defined in subpara-
21 graph (C)), that operates a managed care plan.

22 (C) MANAGED CARE CONTRACTOR.—The
23 term “managed care contractor” means a per-
24 son that—

- 1 (i) establishes, operates, or maintains
2 a network of participating providers;
- 3 (ii) conducts or arranges for utiliza-
4 tion review activities; and
- 5 (iii) contracts with an insurance com-
6 pany, a hospital or medical service plan, an
7 employer, an employee organization, or any
8 other entity providing coverage for health
9 care services to operate a managed care
10 plan.

11 (8) PHYSICIAN.—The term “physician” means
12 a doctor of medicine, a doctor of osteopathy, or a
13 doctor of allopathy.

14 (9) PROVIDER.—The term “provider” means a
15 physician, an organized group of physicians, a facil-
16 ity or any other health care professional licensed or
17 certified by the State, where licensure or certifi-
18 cation is required.

19 (10) PROVIDER NETWORK.—The term “pro-
20 vider network” means, with respect to a health plan
21 that restricts access, those providers who have en-
22 tered into a contract or agreement with the plan
23 under which such providers are obligated to provide
24 items and services under the plan to eligible individ-

1 uals enrolled in the plan, or have an agreement to
2 provide services on a fee-for-service basis.

3 (11) POINT-OF-SERVICE PLAN.—The term
4 “point-of-service plan” means a plan that offers
5 services to enrollees through a provider network and
6 also offers additional services or access to care by
7 network or non-network providers.

8 (12) SECRETARY.—The term “Secretary”
9 means the Secretary of Health and Human Services.

10 (13) SMALL GROUP MARKET.—

11 (A) IN GENERAL.—The term “small group
12 market” means, with respect to a calendar year,
13 employers (including sole proprietorships, firms,
14 corporations, partnerships, or associations ac-
15 tively engaged in business) that, on at least 50
16 percent of its business days, employ at least one
17 but not more than 50 employees. In determin-
18 ing the number of employees for purposes of
19 this paragraph, entities that are affiliated, or
20 that are eligible to file a combined tax return,
21 shall be considered as a single employer.

22 (B) APPLICATION OF PROVISIONS.—Except
23 as specifically provided otherwise, the require-
24 ments of this Act that apply to an employer in
25 the small group market shall continue to apply

1 to such employer through the end of the rating
2 period in which the employer has failed to meet
3 the requirements of subparagraph (A).

4 (14) SPECIALIZED TREATMENT EXPERTISE.—
5 The term “specialized treatment expertise” means
6 expertise in diagnosing and treating unusual dis-
7 eases and condition, diagnosing and treating dis-
8 eases and conditions that are usually difficult to di-
9 agnose or treat, and providing other specialized
10 health care.

11 (15) SPONSOR.—The term “sponsor” means a
12 carrier or employer that provides a health plan.

13 (16) TRADITIONAL INSURANCE PLAN.—The
14 term “traditional insurance plan” includes plans
15 that offer a health benefits package and that pay for
16 medical services on a fee-for-service basis using a
17 usual, customary, or reasonable payment methodol-
18 ogy or a resource based relative value schedule, usu-
19 ally linked to an annual deductible and/or coinsur-
20 ance payment on each allowed amount.

21 (17) UTILIZATION REVIEW.—The term “utiliza-
22 tion review” means a set of formal techniques de-
23 signed to monitor and evaluate the clinical necessity,
24 appropriateness and efficiency of health care serv-
25 ices, procedures, providers and facilities. Techniques

1 may include ambulatory review, prospective review,
2 second opinion, certification, concurrent review, case
3 management, discharge planning and retrospective
4 review.

5 **TITLE I—PROTECTION OF**
6 **CONSUMER CHOICE**

7 **SEC. 101. PROTECTION OF CONSUMER CHOICE.**

8 (a) IN GENERAL.—Each employer, including a self-
9 insured employer, who offers, provides, or makes available
10 to employees a health plan must provide to each such em-
11 ployee a choice of health plans as required under sub-
12 section (b).

13 (b) OFFERING OF PLANS.—Each employer referred
14 to in subsection (a) shall include among its health plan
15 offerings at least one of each of the following types of
16 health plans, where available:

17 (1) A managed care plan, including a health
18 maintenance organization or preferred provider or-
19 ganization.

20 (2) A point-of-service plan.

21 (3) A traditional insurance plan (as defined in
22 section 2).

23 **SEC. 102. ENROLLMENT.**

24 Each employer including a self-insured employer, who
25 offers, provides, or makes available a health plan shall es-

1 tablish a process for enrollment in such plan which con-
2 sists of—

3 (1) a general annual open enrollment period of
4 at least 30 days; and

5 (2) special open enrollment periods for changes
6 in enrollment as required by the Secretary.

7 **TITLE II—OFFICE FOR CON-**
8 **SUMER INFORMATION, COUN-**
9 **SELING AND ASSISTANCE**

10 **SEC. 201. ESTABLISHMENT.**

11 (a) IN GENERAL.—The Secretary shall award a grant
12 to each State for the establishment of an Office for
13 Consumer Information, Counseling and Assistance (here-
14 after referred to in this section as the “Office”) in each
15 such State. Each such Office shall perform public out-
16 reach and provide education and assistance concerning
17 consumer rights with respect to health insurance as pro-
18 vided for in subsection (d).

19 (b) USE OF GRANT.—

20 (1) IN GENERAL.—A State shall use a grant
21 under this section—

22 (A) to administer the Office and carry out
23 the duties described in subsection (d);

24 (B) to solicit and award contracts to pri-
25 vate, nonprofit organizations applying to the

1 State to administer the Office and carry out the
2 duties described in subsection (d); or

3 (C) in the case of a State operating a
4 consumer information counseling and assistance
5 program on the date of enactment of this Act,
6 to expand and improve such program.

7 (2) CONTRACTS.—With respect to the contract
8 described in paragraph (1)(B), the contract period
9 shall be not less than 2 years and not more than 4
10 years.

11 (c) STAFF.—A State shall ensure that the Office has
12 sufficient staff (including volunteers) and local offices
13 throughout the State to carry out its duties under this
14 section and a demonstrated ability to represent and work
15 with a broad spectrum of consumers, including vulnerable
16 and underserved populations.

17 (d) DUTIES.—An Office established under this sec-
18 tion shall—

19 (1) establish a State-wide toll-free hotline to en-
20 able consumers to contact the Office;

21 (2) have the ability to provide appropriate as-
22 sistance under this subsection to individuals with
23 limited English language ability;

24 (3) develop outreach programs to provide health
25 insurance information, counseling, and assistance;

1 (4) provide outreach and education relating to
2 consumer rights and responsibilities under this Act,
3 including the rights and services available through
4 the Office;

5 (5) provide individuals with assistance in enroll-
6 ing in health plans (including providing plan com-
7 parisons) or in obtaining services or reimbursements
8 from health plans;

9 (6) provide individuals with assistance in filing
10 applications for appropriate State health plan pre-
11 mium assistance programs;

12 (7) provide individuals with information con-
13 cerning existing grievance procedures and institute
14 systems of referral to appropriate Federal or State
15 departments or agencies for assistance with prob-
16 lems related to insurance coverage (including legal
17 problems);

18 (8) ensure that regular and timely access is
19 provided to the services available through the Office;

20 (9) implement training programs for staff mem-
21 bers (including volunteer staff members) and collect
22 and disseminate timely and accurate health care in-
23 formation to staff members;

1 (10) not less than once each year, conduct pub-
2 lic hearings to identify and address community
3 health care needs;

4 (11) coordinate its activities with the staff of
5 the appropriate departments and agencies of the
6 State government and other appropriate entities
7 within the State; and

8 (12) carry out any other activities determined
9 appropriate by the Secretary.

10 (e) STATE DUTIES.—

11 (1) ACCESS TO INFORMATION.—The State shall
12 ensure that, for purposes of carrying out the duties
13 of the Office, the Office has appropriate access to
14 relevant information, subject to the application of
15 procedures to ensure confidentiality of enrollee and
16 proprietary health plan information.

17 (2) REPORTING AND EVALUATION REQUIRE-
18 MENTS.—

19 (A) REPORT.—The Office shall annually
20 prepare and submit to the State a report on the
21 nature and patterns of consumer complaints re-
22 ceived by the Office during the year for which
23 the report is prepared. Such report shall con-
24 tain any policy, regulatory, and legislative rec-
25 ommendations for improvements in the activi-

1 ties of the Office together with a record of the
2 activities of the Office.

3 (B) EVALUATION.—The State shall annu-
4 ally evaluate the quality and effectiveness of the
5 Office in carrying out the activities described in
6 subsection (d).

7 (3) CONFLICTS OF INTEREST.—The State shall
8 ensure that no individual involved in selecting the
9 entity with which to enter into a contract under sub-
10 section (b)(1)(B), or involved in the operation of the
11 Office, or any delegate of the Office, is subject to a
12 conflict of interest.

13 (f) AUTHORIZATION OF APPROPRIATIONS.—There
14 are authorized to be appropriated such sums as may be
15 necessary to carry out this section.

16 **TITLE III—UTILIZATION** 17 **MANAGEMENT**

18 **SEC. 301. DEFINITIONS.**

19 As used in this title:

20 (1) ADVERSE DETERMINATION.—The term “ad-
21 verse determination” means a determination that an
22 admission to or continued stay at a hospital or that
23 another health care service that is required has been
24 reviewed and, based upon the information provided,
25 does not meet the clinical requirements for medical

1 necessity, appropriateness, level of care, or effective-
2 ness.

3 (2) AMBULATORY REVIEW.—The term “ambu-
4 latory review” means utilization review of health
5 care services performed or provided in an outpatient
6 setting.

7 (3) APPEALS PROCEDURE.—The term “appeals
8 procedure” means a formal process under which a
9 covered individual (or an individual acting on behalf
10 of a covered individual), attending physician, facility
11 or applicable health care provider may appeal an ad-
12 verse utilization review decision rendered by the
13 health plan or its designee utilization review organi-
14 zation.

15 (4) CASE MANAGEMENT.—The term “case man-
16 agement” means a coordinated set of activities con-
17 ducted for the individual patient management of se-
18 rious, complicated, protracted or chronic health con-
19 ditions that provides cost-effective and benefit-maxi-
20 mizing treatments for extremely resource-intensive
21 conditions.

22 (5) CLINICAL REVIEW CRITERIA.—The term
23 “clinical review criteria” means the recorded (writ-
24 ten or otherwise) screening procedures, decision ab-
25 stracts, clinical protocols and practice guidelines

1 used by the health plan to determine necessity and
2 appropriateness of health care services.

3 (6) CONCURRENT REVIEW.—The term “concur-
4 rent review” means utilization review conducted dur-
5 ing a patient’s hospital stay or course of treatment.

6 (7) DISCHARGE PLANNING.—The term “dis-
7 charge planning” means the formal process for de-
8 termining, coordinating and managing the care a pa-
9 tient receives following the discharge of the patient
10 from a facility.

11 (8) FACILITY.—The term “facility” means an
12 institution or health care setting providing the pre-
13 scribed health care services under review. Such term
14 includes hospitals and other licensed inpatient facili-
15 ties, ambulatory surgical or treatment centers,
16 skilled nursing facilities, residential treatment cen-
17 ters, diagnostic, laboratory and imaging centers and
18 rehabilitation and other therapeutic health care set-
19 tings.

20 (9) PROSPECTIVE REVIEW.—The term “pro-
21 spective review” means utilization review conducted
22 prior to an admission or a course of treatment.

23 (10) RETROSPECTIVE REVIEW.—The term “ret-
24 rospective review” means utilization review con-
25 ducted after health care services have been provided

1 to a patient. Such term does not include the retro-
2 spective review of a claim that is limited to an eval-
3 uation of reimbursement levels, veracity of docu-
4 mentation, accuracy of coding and adjudication for
5 payment.

6 (11) SECOND OPINION.—The term “second
7 opinion” means an opportunity or requirement to
8 obtain a clinical evaluation by a provider other than
9 the provider originally making a recommendation for
10 a proposed health service to assess the clinical neces-
11 sity and appropriateness of the initial proposed
12 health service.

13 (12) UTILIZATION REVIEW ORGANIZATION.—
14 The term “utilization review organization” means an
15 entity that conducts utilization review.

16 **SEC. 302. REQUIREMENT FOR UTILIZATION REVIEW PRO-**
17 **GRAM.**

18 A health plan shall have in place a utilization review
19 program that meets the requirements of this title and that
20 is certified by the State.

21 **SEC. 303. STANDARDS FOR UTILIZATION REVIEW.**

22 (a) ESTABLISHMENT.—The Secretary shall establish
23 standards for the establishment, operation, and certifi-
24 cation and periodic recertification of health plan utiliza-
25 tion review programs.

1 (b) ALTERNATIVE STANDARDS.—

2 (1) IN GENERAL.—A State may certify a health
3 plan as meeting the standards established under
4 subsection (a) if the State determines that the
5 health plan has met the utilization standards re-
6 quired for accreditation as applied by a nationally
7 recognized, independent, nonprofit accreditation en-
8 tity.

9 (2) REVIEW BY STATE.—A State that makes a
10 determination under paragraph (1) shall periodically
11 review the standards used by the private accredita-
12 tion entity to ensure that such standards meet or ex-
13 ceed the standards established by the Secretary
14 under this title.

15 (c) UTILIZATION REVIEW PROGRAM REQUIRE-
16 MENTS.—The standards developed by the Secretary under
17 subsection (a) shall require that utilization review pro-
18 grams comply with the following:

19 (1) DOCUMENTATION.—A health plan shall pro-
20 vide a written description of the utilization review
21 program of the plan, including a description of—

22 (A) the delegated and nondelegated activi-
23 ties under the program;

24 (B) the policies and procedures used under
25 the program to evaluate medical necessity; and

1 (C) the clinical review criteria, information
2 sources, and the process used to review and ap-
3 prove the provision of medical services under
4 the program.

5 (2) PROHIBITION.—With respect to the admin-
6 istration of the utilization review program, a health
7 plan may not employ utilization reviewers or con-
8 tract with a utilization management organization if
9 the conditions of employment or the contract terms
10 include financial incentives to reduce or limit the
11 medically necessary or appropriate services provided
12 to covered individuals.

13 (3) REVIEW AND MODIFICATION.—A health
14 plan shall develop procedures for periodically review-
15 ing and modifying the utilization review of the plan.
16 Such procedures shall provide for the participation
17 of providers in the health plan in the development
18 and review of utilization review policies and proce-
19 dures.

20 (4) DECISION PROTOCOLS.—

21 (A) IN GENERAL.—A utilization review
22 program shall develop and apply recorded (writ-
23 ten or otherwise) utilization review decision pro-
24 tocols. Such protocols shall be based on sound
25 medical evidence.

1 (B) PROTOCOL CRITERIA.—The clinical re-
2 view criteria used under the utilization review
3 decision protocols to assess the appropriateness
4 of medical services shall be clearly documented
5 and available to participating health profes-
6 sionals upon request. Such protocols shall in-
7 clude a mechanism for assessing the consistency
8 of the application of the criteria used under the
9 protocols across reviewers, and a mechanism for
10 periodically updating such criteria.

11 (5) REVIEW AND DECISIONS.—

12 (A) REVIEW.—The procedures applied
13 under a utilization review program with respect
14 to the preauthorization and concurrent review
15 of the necessity and appropriateness of medical
16 items, services or procedures, shall require that
17 qualified medical professionals supervise review
18 decisions. With respect to a decision to deny the
19 provision of medical items, services or proce-
20 dures, a physician shall conduct a subsequent
21 review to determine the medical appropriateness
22 of such a denial. Board certified physicians
23 from the appropriate specialty areas of medicine
24 and surgery shall be utilized in the review pro-
25 cess as needed.

1 (B) DECISIONS.—All utilization review de-
2 cisions shall be made in a timely manner, as de-
3 termined appropriate when considering the ur-
4 gency of the situation.

5 (C) ADVERSE DETERMINATIONS.—With re-
6 spect to utilization review, an adverse deter-
7 mination or noncertification of an admission,
8 continued stay, or service shall be clearly docu-
9 mented, including the specific clinical or other
10 reason for the adverse determination or
11 noncertification, and be available to the covered
12 individual and the affected provider or facility.
13 A health plan may not deny or limit coverage
14 with respect to a service that the enrollee has
15 already received solely on the basis of lack of
16 prior authorization or second opinion, to the ex-
17 tent that the service would have otherwise been
18 covered by the plan had such prior authoriza-
19 tion or a second opinion been obtained.

20 (D) NOTIFICATION OF DENIAL.—A health
21 plan shall provide a covered individual with
22 timely notice of an adverse determination or
23 noncertification of an admission, continued
24 stay, or service. Such a notification shall in-

1 clude information concerning the utilization re-
2 view program appeals procedure.

3 (6) REQUESTS FOR AUTHORIZATION.—A health
4 plan utilization review program shall ensure that re-
5 quests by covered individuals or physicians for prior
6 authorization of a nonemergency service shall be an-
7 swered in a timely manner after such request is re-
8 ceived. If utilization review personnel are not avail-
9 able in a timely fashion, any medical services pro-
10 vided shall be considered approved.

11 (7) NEW TECHNOLOGIES.—A utilization review
12 program shall implement policies and procedures to
13 evaluate the appropriate use of new medical tech-
14 nologies or new applications of established tech-
15 nologies, including medical procedures, drugs, and
16 devices. The program shall ensure that appropriate
17 professionals participate in the development of tech-
18 nology evaluation criteria.

19 (8) SPECIAL RULE.—Where prior authorization
20 for a service or other covered item is obtained under
21 a program under this section, the service shall be
22 considered to be covered unless there was fraud or
23 incorrect information provided at the time such prior
24 authorization was obtained. If a provider supplied
25 the incorrect information that led to the authoriza-

1 tion of medically unnecessary care, the provider shall
2 be prohibited from collecting payment directly from
3 the enrollee, and shall reimburse the plan and sub-
4 scriber for any payments or copayments the provider
5 may have received.

6 (d) HEALTH PLAN REQUIREMENTS.—

7 (1) DISCLOSURE OF INFORMATION.—

8 (A) PROSPECTIVE COVERED INDIVID-
9 UALS.—A health plan shall, with respect to any
10 materials distributed to prospective covered in-
11 dividuals, include a summary of the utilization
12 review procedures of the plan.

13 (B) COVERED INDIVIDUALS.—A health
14 plan shall, with respect to any materials distrib-
15 uted to newly covered individuals, include a
16 clear and comprehensive description of utiliza-
17 tion review procedures of the plan and a state-
18 ment of patient rights and responsibilities with
19 respect to such procedures.

20 (C) STATE OFFICIALS.—

21 (i) IN GENERAL.—A health plan shall
22 disclose to the State insurance commis-
23 sioner, or other designated State official,
24 the health plan utilization review program

1 policies, procedures, and reports required
2 by the State for certification.

3 (ii) STREAMLINING OF PROCE-
4 DURES.—To the extent practicable, a State
5 shall implement procedures to streamline
6 the process by which a health plan docu-
7 ments compliance with the requirements of
8 this Act, including procedures to condense
9 the number of documents filed with the
10 State concerning such compliance.

11 (2) TOLL-FREE NUMBER.—A health plan shall
12 have a membership card which shall have printed on
13 the card the toll-free telephone number that a cov-
14 ered individual should call to receive precertification
15 utilization review decisions.

16 (3) EVALUATION.—A health plan shall establish
17 mechanisms to evaluate the effects of the utilization
18 review program of the plan through the use of mem-
19 ber satisfaction data or through other appropriate
20 means.

21 (e) EMERGENCY CARE.—

22 (1) IN GENERAL.—A health plan shall provide
23 coverage for emergency services provided to an en-
24 rollee without regard to whether the health profes-

1 sional or provider furnishing such services has a con-
2 tractual (or other arrangement) with the plan.

3 (2) PREAUTHORIZATION.—With respect to
4 emergency services furnished in a hospital emer-
5 gency department, a health plan shall not require
6 prior authorization for the provision of such services
7 if the enrollee arrived at the emergency department
8 with symptoms that reasonably suggested an emer-
9 gency medical condition, regardless of whether the
10 hospital was affiliated with the health plan. All pro-
11 cedures performed during the evaluation and treat-
12 ment of an emergency condition shall be covered
13 under the health plan.

14 **TITLE IV—HEALTH PLAN** 15 **STANDARDS**

16 **SEC. 401. HEALTH PLAN STANDARDS.**

17 (a) ESTABLISHMENT.—The Secretary shall establish
18 standards for the certification and periodic recertification
19 of health plans, including standards which require plans
20 to meet the requirements of this title.

21 (b) STATE CERTIFICATION.—

22 (1) IN GENERAL.—A State shall provide for the
23 certification of health plans if the certifying author-
24 ity designated by the State determines that the plan
25 meets the applicable requirements of this Act.

1 (2) REQUIREMENT.—Effective on January 1,
2 1997, a health plan sponsor may only offer a health
3 plan in a State if such plan is certified by the State
4 under paragraph (1).

5 (c) CONSTRUCTION.—Whenever in this title a re-
6 quirement or standard is imposed on a health plan, the
7 requirement or standard is deemed to have been imposed
8 on the sponsor of the plan in relation to that plan.

9 **SEC. 402. MINIMUM SOLVENCY REQUIREMENTS.**

10 (a) IN GENERAL.—Except as provided in subsection
11 (b), each State shall apply minimum solvency require-
12 ments to all health plans offered or operating with the
13 State. A health plan shall meet the financial reserve re-
14 quirements that are established by the State to assure
15 proper payment for health care services provided under
16 the plan.

17 (b) FEDERAL STANDARDS.—The Secretary shall es-
18 tablish minimum solvency standards that shall apply to
19 all self-insured health plans. Such standards shall at least
20 meet the solvency requirements established by the Na-
21 tional Association of Insurance Commissioners.

22 **SEC. 403. INFORMATION ON TERMS OF PLAN.**

23 (a) IN GENERAL.—A health plan shall provide pro-
24 spective covered individuals with written information con-
25 cerning the terms and conditions of the health plan to en-

1 able such individuals to make informed decisions with re-
2 spect to a certain system of health care delivery. Such in-
3 formation shall be standardized so that prospective cov-
4 ered individuals may compare the attributes of all such
5 plans offered within the coverage area.

6 (b) UNDERSTANDABILITY.—Information provided
7 under this section, whether written or oral shall be easily
8 understandable, truthful, linguistically appropriate and
9 objective with respect to the terms used. Descriptions pro-
10 vided in such information shall be consistent with stand-
11 ards developed for supplemental insurance coverage under
12 title XVIII of the Social Security Act.

13 (c) REQUIRED INFORMATION.—Information required
14 under this section shall include information concerning—

15 (1) coverage provisions, benefits, and any exclu-
16 sions by category of service or product;

17 (2) plan loss ratios with an explanation that
18 such ratios reflect the percentage of the premiums
19 expended for health services;

20 (3) prior authorization or other review require-
21 ments including preauthorization review, concurrent
22 review, post-service review, post-payment review and
23 procedures that may lead the patient to be denied
24 coverage for, or not be provided, a particular service
25 or product;

1 (4) an explanation of how plan design impacts
2 enrollees, including information on the financial re-
3 sponsibility of covered individuals for payment for
4 coinsurance or other out-of-plan services;

5 (5) covered individual satisfaction statistics, in-
6 cluding disenrollment statistics;

7 (6) advance directives and organ donation;

8 (7) the characteristics and availability of health
9 care professionals and institutions participating in
10 the plan, including descriptions of the financial ar-
11 rangements or contractual provisions with hospitals,
12 utilization review organizations, physicians, or any
13 other provider of health care services that would af-
14 fect the services offered, referral or treatment op-
15 tions, or physician's fiduciary responsibility to pa-
16 tients, including financial incentives regarding the
17 provision of medical or other services; and

18 (8) quality indicators for the plan and for par-
19 ticipating health professionals and providers under
20 the plan, including population-based statistics such
21 as immunization rates and performance measures
22 such as survival after surgery, adjusted for case mix.

23 **SEC. 404. ACCESS.**

24 (a) IN GENERAL.—A health plan shall demonstrate
25 that the plan has a sufficient number, distribution, and

1 variety of qualified health care providers to ensure that
2 all covered health care services will be available and acces-
3 sible in a timely manner to adults, infants, children, and
4 individuals with disabilities enrolled in the plan.

5 (b) AVAILABILITY OF SERVICES.—A health plan shall
6 ensure that services covered under the plan are available
7 in a timely manner that ensures a continuity of care, are
8 accessible within a reasonable proximity to the residences
9 of the enrollees, are available within reasonable hours of
10 operation, and include emergency and urgent care services
11 when medically necessary and available which shall be ac-
12 cessible within the service area 24-hours a day, seven days
13 a week.

14 (c) SPECIALIZED TREATMENT.—A health plan shall
15 demonstrate that plan enrollees have access, when medi-
16 cally or clinically indicated in the judgment of the treating
17 health professional, to specialized treatment expertise.

18 (d) CHRONIC CONDITIONS.—

19 (1) IN GENERAL.—Any process established by a
20 health plan to coordinate care and control costs may
21 not impose an undue burden on enrollees with
22 chronic health conditions. The plan shall ensure a
23 continuity of care and shall, when medically or clini-
24 cally indicated in the judgment of the treating health

1 professional, ensure direct access to relevant special-
2 ists for continued care.

3 (2) CARE COORDINATOR.—In the case of an en-
4 rollee who has a severe, complex, or chronic condi-
5 tion, the health plan shall determine, based on the
6 judgment of the treating health professional, wheth-
7 er it is medically or clinically necessary or appro-
8 priate to use a care coordinator from an inter-
9 disciplinary team or a specialist to ensure continuity
10 of care.

11 (e) REQUIREMENT.—

12 (1) IN GENERAL.—The requirements of this
13 section may not be waived and shall be met in all
14 areas where the health plan has enrollees, including
15 rural areas. With respect to children, such services
16 shall include pediatric services.

17 (2) OUT-OF-NETWORK SERVICES.—If a health
18 plan fails to meet the requirements of this section,
19 the plan shall arrange for the provision of out-of-
20 network services to enrollees in a manner that pro-
21 vides enrollees with access to services in accordance
22 with this section.

1 **SEC. 405. CREDENTIALING FOR HEALTH PROFESSIONALS.**

2 (a) IN GENERAL.—A health plan shall credential
3 health professionals furnishing health care services under
4 the plan.

5 (b) CREDENTIALING PROCESS.—

6 (1) IN GENERAL.—A health plan shall establish
7 a credentialing process. Such process shall ensure
8 that a health professional is credentialed prior to
9 that professional being listed as a health professional
10 in the health plan's marketing materials, in accord-
11 ance with recorded (written or otherwise) policies
12 and procedures.

13 (2) RESPONSIBILITY OF MEDICAL DIRECTOR.—
14 The medical director of the health plan, or another
15 designated health professional, shall have respon-
16 sibility for the credentialing of health professionals
17 under the plan.

18 (3) UNIFORM APPLICATIONS.—A State shall de-
19 velop a basic uniform application that shall be used
20 by all health plans in the State for credentialing
21 purposes.

22 (4) CREDENTIALING COMMITTEE.—

23 (A) ESTABLISHMENT.—The health plan
24 shall establish a credentialing committee that
25 shall be composed of licensed physicians and
26 other health professionals to review

1 credentiaing information and supporting docu-
2 ments.

3 (B) REQUIREMENT.—The credentiaing
4 process shall provide for the review of an appli-
5 cation for credentiaing by a credentiaing com-
6 mittee with appropriate representation of the
7 applicant’s medical specialty.

8 (5) STANDARDS.—

9 (A) IN GENERAL.—Credentiaing decisions
10 under a health plan shall be based on objective
11 standards with input from health professionals
12 credentiaed under the plan. Information con-
13 cerning all application and credentiaing policies
14 and procedures shall be made available for re-
15 view by the health professional involved upon
16 written request.

17 (B) REQUIREMENT.—The standards re-
18 ferred to in subparagraph (A) shall include de-
19 terminations as to—

20 (i) whether the health professional has
21 a current valid license to practice the par-
22 ticular health profession involved;

23 (ii) whether the health professional
24 has clinical privileges in good standing at
25 the hospital designated by the practitioner

1 and the primary admitting facility, as ap-
2 plicable;

3 (iii) whether the health professional
4 has a valid DEA or CDS certificate, as ap-
5 plicable;

6 (iv) whether the health professional
7 has graduated from medical school and
8 completed a residency, or received Board
9 certification, as applicable;

10 (v) the work history of the health pro-
11 fessional;

12 (vi) whether the health professional
13 has current, adequate malpractice insur-
14 ance in accordance with the policy of the
15 health plan; and

16 (vii) the professional liability claims
17 history of the health professional.

18 (C) RIGHT TO REVIEW INFORMATION.—A
19 health professional who undergoes the
20 credentialing process shall have the right to re-
21 view the basis information, including the
22 sources of that information, that was used to
23 meet the designated credentialing criteria.

1 **SEC. 406. GRIEVANCE PROCEDURES.**

2 (a) IN GENERAL.—A health plan shall adopt a timely
3 and organized system for resolving complaints and formal
4 grievances filed by covered individuals. Such system shall
5 include—

6 (1) recorded (written or otherwise) procedures
7 for registering and responding to complaints and
8 grievances in a timely manner;

9 (2) documentation concerning the substance of
10 complaints, grievances, and actions taken concerning
11 such complaints and grievances, which shall be in
12 writing, and be available upon request to the Office
13 for Consumer Information, Counseling and Assist-
14 ance;

15 (3) procedures to ensure a resolution of a com-
16 plaint or grievance;

17 (4) the compilation and analysis of complaint
18 and grievance data;

19 (5) procedures to expedite the complaint proc-
20 ess if the complaint involves a dispute about the cov-
21 erage of an immediately and urgently needed service;
22 and

23 (6) procedures to ensure that if an enrollee
24 orally notifies a health plan about a complaint, the
25 plan (if requested) must send the enrollee a com-
26 plaint form that includes the telephone numbers and

1 addresses of member services, a description of the
2 plan's grievance procedure, and the telephone num-
3 ber of the Officer for Consumer Information, Coun-
4 seling and Assistance where enrollees may register
5 complaints.

6 (b) APPEAL PROCESS.—A health plan shall adopt an
7 appeals process to enable covered individuals to appeal de-
8 cisions that are adverse to the individuals. Such a process
9 shall include—

10 (1) the right to a review by a grievance panel;

11 (2) the right to a second review with a different
12 panel, independent from the health plan, or to a re-
13 view through an impartial arbitration process which
14 shall be described in writing by the plan; and

15 (3) an expedited process for review in emer-
16 gency cases.

17 The Secretary shall develop guidelines for the structure
18 and requirements applicable to the independent review
19 panel and impartial arbitration process described in para-
20 graph (2).

21 (c) NOTIFICATION.—With respect to the complaint,
22 grievance, and appeals processes required under this sec-
23 tion, a health plan shall, upon the request of a covered
24 individual, provide the individual a written decision con-

1 cerning a complaint, grievance, or appeal in a timely fash-
2 ion.

3 (d) NON-IMPEDIMENT TO BENEFITS.—The com-
4 plaint, grievance, and appeals processes established in ac-
5 cordance with this section may not be used in any fashion
6 to discourage or prevent a covered individual from receiv-
7 ing medically necessary care in a timely manner.

8 (e) DUE PROCESS WITH RESPECT TO
9 CREDENTIALING.—

10 (1) RECEIPT OF INFORMATION.—A health pro-
11 fessional who is subject to credentialing under sec-
12 tion 405 shall, upon written request, receive from
13 the health plan any information obtained by the plan
14 during the credentialing process that, as determined
15 by the credentialing committee, does not meet the
16 credentialing standards of the plan, or that varies
17 substantially from the information provided to the
18 health plan by the health professional.

19 (2) SUBMISSION OF CORRECTIONS.—A health
20 plan shall have a formal, recorded (written or other-
21 wise) process by which a health professional may
22 submit supplemental information to the
23 credentialing committee if the health professional de-
24 termines that erroneous or misleading information
25 has been previously submitted. The health profes-

1 sional may request that such information be recon-
2 sidered in the evaluation for credentialing purposes.

3 (3) NO ENTITLEMENT.—

4 (A) IN GENERAL.—A health professional is
5 not entitled to be selected or retained by a
6 health plan as a participating or contracting
7 provider whether or not such professional meets
8 the credentialing standards established under
9 section 405.

10 (B) ECONOMIC CONSIDERATIONS.—If eco-
11 nomic considerations, including the health care
12 professional's patterns of expenditure per pa-
13 tient, are part of a selection decision, objective
14 criteria shall be used in examining such consid-
15 erations and a written description of such cri-
16 teria shall be provided to applicants, participat-
17 ing health professionals, and enrollees. Any eco-
18 nomic profiling of health professionals must be
19 adjusted to recognize case mix, severity of ill-
20 ness, and the age of patients of a health profes-
21 sional's practice that may account for higher or
22 lower than expected costs, to the extent appro-
23 priate data in this regard is available to the
24 health plan.

1 (4) TERMINATION, REDUCTION OR WITH-
2 DRAWAL.—

3 (A) PROCEDURES.—A health plan shall de-
4 velop and implement procedures for the report-
5 ing, to appropriate authorities, of serious qual-
6 ity deficiencies that result in the suspension or
7 termination of a contract with a health profes-
8 sional.

9 (B) REVIEW.—A health plan shall develop
10 and implement policies and procedures under
11 which the plan reviews the contract privileges of
12 health professionals who—

13 (i) have seriously violated policies and
14 procedures of the health plan;

15 (ii) have lost their privilege to practice
16 with a contracting institutional provider; or

17 (iii) otherwise pose a threat to the
18 quality of service and care provided to the
19 enrollees of the health plan.

20 At a minimum, the policies and procedures im-
21 plemented under this subparagraph shall meet
22 the requirements of the Health Care Quality
23 Improvement Act of 1986.

24 (C) DUE PROCESS.—The policies and pro-
25 cedures implemented under subparagraph (B)

1 shall include requirements for the timely notifi-
2 cation of the affected health professional of the
3 reasons for the reduction, withdrawal, or termi-
4 nation of privileges, and provide the health pro-
5 fessional with the right to appeal the deter-
6 mination of reduction, withdrawal, or termi-
7 nation.

8 (D) AVAILABILITY.—A written copy of the
9 policies and procedures implemented under this
10 paragraph shall be made available to a health
11 professional on request prior to the time at
12 which the health professional contracts to pro-
13 vide services under the plan.

14 **SEC. 407. CONFIDENTIALITY STANDARDS.**

15 (a) IN GENERAL.—A health plan shall ensure that
16 the confidentiality of specified enrollee patient information
17 and records is protected.

18 (b) POLICIES AND PROCEDURES.—A health plan
19 shall have written confidentiality policies and procedures.
20 Such policies and procedures shall, at a minimum—

21 (1) maintain the confidentiality of enrollee pa-
22 tient information within the administrative structure
23 of the health plan;

24 (2) protect medical record information;

25 (3) protect claim information;

1 (4) establish requirements for the release of in-
2 formation; and

3 (5) inform employees of the confidentiality poli-
4 cies and procedures.

5 (c) PATIENT CARE PROVIDERS AND FACILITIES.—

6 A health plan shall ensure that providers, offices and fa-
7 cilities responsible for providing covered items or services
8 to plan enrollees have implemented policies and procedures
9 to prevent the unauthorized or inadvertent disclosure of
10 confidential patient information to individuals who should
11 not have access to such information.

12 (d) RELEASE OF INFORMATION.—An enrollee in a
13 health plan shall have the opportunity to approve or dis-
14 approve the release of identifiable personal patient infor-
15 mation by the health plan, except where such release is
16 required under applicable law.

17 **SEC. 408. DISCRIMINATION.**

18 (a) ENROLLEES.—A health plan (network or non-net-
19 work) may not discriminate or engage (directly or through
20 contractual arrangements) in any activity, including the
21 selection of service area, that has the effect of discriminat-
22 ing against an individual on the basis of race, national
23 origin, gender, language, socio-economic status, age, dis-
24 ability, health status, or anticipated need for health serv-
25 ices.

1 (b) PROVIDERS.—A health plan may not discriminate
2 in the selection of members of the health professional or
3 provider network (and in establishing the terms and condi-
4 tions for membership in the network) of the plan based
5 on—

6 (1) the race, national origin, or disability of the
7 health professional;

8 (2) the socio-economic status, disability, health
9 status, or anticipated need for health services of the
10 patients of the health professional or provider; or

11 (3) the health professional or provider's lack of
12 affiliation with, or admitting privileges at, a hospital.

13 (c) LICENSE OR CERTIFICATION.—A health plan may
14 not discriminate in participation, reimbursement, or in-
15 demnification against a health professional who is acting
16 within the scope of the license or certification of the pro-
17 fessional under applicable State law solely on the basis of
18 the license or certification of the health professional. A
19 health plan may not discriminate in participation, reim-
20 bursement, or indemnification against a health provider
21 that is providing services within the scope of services that
22 it is authorized to perform under State law.

23 **SEC. 409. PROHIBITION ON SELECTIVE MARKETING.**

24 A health plan may not engage in marketing or other
25 practices intended to discourage or limit the issuance of

1 health plans to individuals on the basis of health condition,
2 geographic area, industry, or other risk factors.

3 **TITLE V—HEALTH INSURANCE**
4 **MARKET REFORM**

5 **SEC. 501. GUARANTEED ISSUE AND RENEWABILITY.**

6 (a) **GUARANTEED ISSUE.**—Except as otherwise pro-
7 vided in this section, a health plan sponsor offering a
8 health plan to a class of individuals shall offer such plan
9 to any individual within such class who applies for cov-
10 erage (either directly with the plan or through an em-
11 ployer) under such plan. A health plan may not engage
12 in any practice that has the effect of attracting or limiting
13 enrollees on the basis of personal characteristics, such as
14 occupation or affiliation with any person or entity.

15 (b) **RENEWABILITY.**—

16 (1) **IN GENERAL.**—Except as provided in para-
17 graphs (2) and (3), a health plan sponsor may not
18 refuse to renew, or may not terminate, coverage
19 under a health plan with respect to any individual
20 or family.

21 (2) **GROUND FOR REFUSAL TO RENEW OR**
22 **TERMINATE.**—Paragraph (1) shall not apply in the
23 case of—

24 (A) nonpayment of premiums;

1 (B) fraud on the part of the individual re-
2 relating to such plan;

3 (C) misrepresentation of material facts on
4 the part of the individual relating to an applica-
5 tion for coverage or claim for benefits; or

6 (D) the occurrence of other acts as pre-
7 scribed in standards developed by the National
8 Association of Insurance Commissioners.

9 (3) TERMINATION OF PLANS.—The Secretary,
10 in consultation with the National Association of In-
11 surance Commissioners, shall develop standards
12 under which a health plan sponsor may terminate a
13 health plan.

14 **SEC. 502. NONDISCRIMINATION BASED ON HEALTH**
15 **STATUS.**

16 (a) NO LIMITS ON COVERAGE; NO PRE-EXISTING
17 CONDITION LIMITS.—Except as provided in subsection

18 (b), a health plan may not—

19 (1) terminate, restrict, or limit coverage or es-
20 tablish premiums based on the health status, medi-
21 cal condition, claims experience, receipt of health
22 care, medical history, anticipated need for health
23 care services, disability, genetic predisposition to
24 medical conditions, or lack of evidence of insurability
25 of an individual;

1 (2) terminate, restrict, or limit coverage in any
2 portion of the plan's coverage area;

3 (3) except as provided in section 501(b)(2),
4 cancel coverage for any individual until that individ-
5 ual is enrolled in another applicable health plan;

6 (4) impose waiting periods before coverage be-
7 gins; or

8 (5) impose a rider that serves to exclude cov-
9 erage of particular individuals or particular health
10 conditions.

11 (b) TREATMENT OF PREEXISTING CONDITION EX-
12 CLUSIONS.—

13 (1) IN GENERAL.—A health plan may impose a
14 limitation or exclusion of benefits relating to treat-
15 ment of a condition based on the fact that the condi-
16 tion preexisted the effective date of the plan with re-
17 spect to an individual if—

18 (A) the condition was diagnosed or treated
19 during the 3-month period ending on the day
20 before the date of enrollment under the plan;

21 (B) the limitation or exclusion extends for
22 a period not more than 6 months after the date
23 of enrollment under the plan;

1 (C) the limitation or exclusion does not
2 apply to an individual who, as of the date of
3 birth, was covered under the plan; or

4 (D) the limitation or exclusion does not re-
5 late to pregnancy.

6 (2) CONTINUOUS COVERAGE.—A health plan
7 shall provide that if an individual under such plan
8 is in a period of continuous coverage with respect to
9 particular services as of the date of enrollment
10 under such plan, any period of exclusion of coverage
11 with respect to a preexisting condition as permitted
12 under paragraph (1) shall be reduced by 1 month
13 for each month in the period of continuous coverage.

14 (3) DEFINITIONS.—As used in this subsection:

15 (A) PERIOD OF CONTINUOUS COVERAGE.—
16 The term “period of continuous coverage”
17 means the period beginning on the date an indi-
18 vidual is enrolled under a health plan or health
19 care program which provides benefits equivalent
20 to those provided by the plan in which the indi-
21 vidual is seeking to enroll with respect to cov-
22 erage of a preexisting condition and ends on the
23 date the individual is not so enrolled for a con-
24 tinuous period of more than 3 months.

1 (B) PREEXISTING CONDITION.—The term
2 “preexisting condition” means, with respect to
3 coverage under a health plan, a condition which
4 was diagnosed, or which was treated, within the
5 3-month period ending on the day before the
6 first date of such coverage (without regard to
7 any waiting period).

8 **SEC. 503. ADJUSTMENTS BASED ON AGE, GEOGRAPHY AND**
9 **FAMILY SIZE.**

10 (a) IN GENERAL.—With respect to health plan pre-
11 miums, the Secretary, in consultation with the NAIC,
12 shall specify uniform age, geography, and family size cat-
13 egories and maximum rating increments for age, geog-
14 raphy, and family size adjustment factors that reflect the
15 relative actuarial costs of benefit packages among enroll-
16 ees.

17 (b) AGE FACTORS.—With respect to age adjustment
18 factors established under subsection (a), for individuals
19 who have attained age 18 but not age 65, the highest age
20 adjustment factor may not exceed twice the lowest age ad-
21 justment factor.

22 (c) PHASE-IN PERIOD.—The Secretary, in consulta-
23 tion with the NAIC, shall establish a schedule for the
24 phase-in of age-adjusted community rates so as to mini-
25 mize disruption of the insurance market.

1 (d) APPLICATION.—A health plan shall ensure that
2 the factors developed under this section are applied uni-
3 formly across each of the small group and individual mar-
4 kets.

5 **SEC. 504. RISK ADJUSTMENT.**

6 (a) IN GENERAL.—A health plan shall participate in
7 a risk adjustment program developed by the State involved
8 under standards established by the Secretary in consulta-
9 tion with the National Association of Insurance Commis-
10 sioners. Such a risk adjustment program shall—

11 (1) with respect to a plan offered within the
12 small group market; or

13 (2) with respect to a plan offered within the in-
14 dividual market,

15 provide for adjustments based on risk within the market
16 in which the plan is marketed.

17 (b) PROCESS.—A program developed under sub-
18 section (a) shall include a process designed to share the
19 risk associated with, or to equalize, high cost claims,
20 claims of high cost individuals, costs of variations among
21 carriers based on demographic factors associated with the
22 individuals insured which correlate with such cost vari-
23 ations, to protect health plans from the disproportionate
24 adverse risks of offering coverage to all applicants. Risk
25 adjustment mechanisms under the program shall, to the

1 maximum extent practicable, be prospective to minimize
2 the uncertainty associated with the setting of premiums
3 by health plans to maintain consumer choice from among
4 multiple health plans based on rates that reflect the rel-
5 ative medical and administrative efficiencies of health
6 plans.

7 **SEC. 505. LIFETIME LIMITS.**

8 A health plan may not impose a lifetime limitation
9 on the amount or provision of benefits under the plan.

10 **SEC. 506. PATIENT'S RIGHT TO SELF-DETERMINATION.**

11 A health plan shall be considered to be an eligible
12 organization under title XVIII of the Social Security Act
13 for purposes of applying the rules under section 1866(f)
14 of such Act (42 U.S.C. 1395cc(f)).

15 **SEC. 507. AFFECT ON STATE LAW.**

16 (a) PREEMPTION.—The requirements of this title do
17 not preempt any State law unless such State law directly
18 conflicts with such requirements. The provision of addi-
19 tional consumer protections under State law shall not be
20 considered to directly conflict with such requirements.
21 Such State consumer protection laws which are not pre-
22 empted under this title include—

23 (1) laws that limit the exclusions for preexisting
24 medical conditions to periods that are less than
25 those provided for in section 502;

1 (2) laws that limit variations in premium rates
2 beyond the variations permitted under section 503;
3 and

4 (3) laws that would expand the small group
5 market.

6 (b) STATE REFORM MEASURES.—Nothing in this
7 title shall be construed as prohibiting a State from enact-
8 ing health care reform measures that exceed the measures
9 established under this title, including reforms that expand
10 access to health care services, control health care costs,
11 and enhance the quality of care.

12 **SEC. 508. ASSOCIATION PLANS.**

13 With respect to health plans offered to small employ-
14 ers and individuals through associations or other
15 intermediaries, such plans shall meet the requirements of
16 this title.

17 **TITLE VI—MISCELLANEOUS**
18 **PROVISIONS**

19 **SEC. 601. ENFORCEMENT.**

20 (a) IN GENERAL.—A State shall prohibit the offering
21 or issuance of any health plan in such State if such plan
22 does not—

23 (1) have in place a utilization review program
24 that is certified by the State as meeting the require-
25 ments of title III;

1 (2) comply with the standards developed under
2 title IV;

3 (3) have in place a credentialing program that
4 meets the requirements of section 405;

5 (4) comply with the requirements of title V; and

6 (5) meet any other requirements determined ap-
7 propriate by the Secretary.

8 (b) SELF-INSURED PLANS.—The Secretary of Labor
9 shall develop health plan standards, consistent with this
10 Act, that are applicable to self-insured plans. The Sec-
11 retary of Labor may take corrective action to terminate
12 or disqualify a self-insured plan that does not meet the
13 standards developed under this subsection.

14 **SEC. 602. EFFECTIVE DATE.**

15 (a) IN GENERAL.—Except as otherwise provided in
16 this section, this Act shall take effect on the date of enact-
17 ment of this Act.

18 (b) STANDARDS.—The standards and programs re-
19 quired under this Act shall apply to health plans beginning
20 on January 1, 1997.

21 (c) OFFICE FOR CONSUMER INFORMATION, COUN-
22 SELING AND ASSISTANCE.—A State shall have in place the
23 Office required under section 201 on January 1, 1997.
24 The Secretary may award grants for the establishment of

1 such Offices beginning on the date of enactment of this
2 Act.

3 (d) OTHER REQUIREMENTS.—The requirements of
4 titles I and V shall apply to health plans beginning on
5 January 1, 1997.

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