

105TH CONGRESS
1ST SESSION

H. R. 3009

To amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to establish standards for managed care plans.

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 9, 1997

Mr. PALLONE (for himself, Mr. GILMAN, Mr. BROWN of Ohio, Mr. FOX of Pennsylvania, Ms. SANCHEZ, Mr. HORN, Ms. ESHOO, Mr. GREEN, Mr. FROST, Mr. ANDREWS, Mr. FILNER, Mr. ACKERMAN, Mr. WEXLER, Mr. BROWN of California, Mrs. MALONEY of New York, Mr. HASTINGS of Florida, Mr. PASCRELL, Mr. MASCARA, Mr. DAVIS of Illinois, Ms. MILLENDER-McDONALD, Ms. CARSON, Mrs. CLAYTON, Mr. LAMPSON, Mr. NADLER, Ms. JACKSON-LEE of Texas, Mr. ROTHMAN, Mr. ENGEL, Mr. PAYNE, Mr. McCOLLUM, Mr. SHERMAN, Mr. CRAMER, and Mrs. MORELLA) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Ways and Means, and Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to establish standards for managed care plans.

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

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

2 (a) **SHORT TITLE.**—This Act may be cited as the
3 “Health Care Consumer Protection Act of 1997”.

4 (b) **TABLE OF CONTENTS.**—The table of contents of
5 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—PATIENT CHOICE; ACCESS; QUALITY OF CARE

Sec. 101. Patient choice.

Sec. 102. Access to care.

Sec. 103. Quality of care.

Sec. 104. Patient confidentiality.

Sec. 105. Coverage under approved clinical trials.

Sec. 106. Access to needed prescription drugs; drug utilization program.

TITLE II—CONTRACTING AND TERMINATION RIGHTS

Sec. 201. Nondiscrimination against providers.

Sec. 202. Development of plan policies.

Sec. 203. Due process.

Sec. 204. Non-preemption of State law respecting liability of group health plans.

TITLE III—INFORMATION REPORTING

Sec. 301. Information reporting.

Sec. 302. Automatic exclusion from medicare and medicaid for health plans that lie about quality data.

TITLE IV—PATIENT-PROVIDER COMMUNICATION

Sec. 401. Short title; findings.

Sec. 402. Prohibition of interference with certain medical communications.

Sec. 403. Definitions.

Sec. 404. Effective date.

TITLE V—UTILIZATION REVIEW AND MANAGEMENT

Sec. 501. Utilization review due process for enrollees.

TITLE VI—ADDITIONAL AMENDMENTS; EFFECTIVE DATES.

Sec. 601. Application to group and individual health insurance coverage.

Sec. 602. Consumer protection standards under the Employee Retirement Income Security Act of 1974.

1 professionals and providers who have entered into a
2 contract with the issuer to provide such services, the
3 issuer shall also offer to such enrollees (at the time
4 of enrollment) the option of health insurance cov-
5 erage which provides for coverage of such services
6 which are not furnished through health professionals
7 and providers who are members of such a network.

8 “(2) FAIR PREMIUMS.—The amount of any ad-
9 ditional premium required for the option described
10 in paragraph (1) may not exceed an amount that is
11 fair and reasonable, as established by the applicable
12 State authority, in consultation with the National
13 Association of Insurance Commissioners, based on
14 the nature of the additional coverage provided.

15 “(3) COST-SHARING.—Under the option de-
16 scribed in paragraph (1)—

17 “(A) the health insurance coverage shall
18 provide for reimbursement rates for covered
19 services offered by health professionals and pro-
20 viders who are not participating health profes-
21 sionals or providers that are not less than the
22 reimbursement rates for covered services offered
23 by participating health professionals and pro-
24 viders; and

1 “(B) the issuer shall disclose to enrollees
2 their potential liability for cost-sharing and
3 other out-of-pocket expenses.

4 “(c) CONTINUITY OF CARE.—A health insurance is-
5 suer offering network coverage shall—

6 “(1) ensure that any process established by the
7 issuer to coordinate care and control costs does not
8 create an undue burden, as defined by the applicable
9 State authority, for enrollees with special health care
10 needs or chronic conditions;

11 “(2) ensure direct access to relevant specialists
12 for the continued care of such enrollees when medi-
13 cally or clinically indicated in the judgment of the
14 treating health professional, in consultation with the
15 enrollee;

16 “(3) in the case of an enrollee with special
17 health care needs or a chronic condition, determine
18 whether, based on the judgment of the treating
19 health professional, in consultation with the enrollee,
20 it is medically or clinically necessary to use a spe-
21 cialist or a care coordinator from an interdiscipli-
22 nary team to ensure continuity of care; and

23 “(4) in circumstances under which a change of
24 health professional or provider might disrupt the
25 continuity of care for an enrollee, such as—

1 “(A) hospitalization, or

2 “(B) dependency on high-technology home
3 medical equipment,

4 provide for continued coverage of items and services
5 furnished by the health professional or provider that
6 was treating the enrollee before such change for a
7 reasonable period of time.

8 For purposes of paragraph (4), a change of health profes-
9 sional or provider may be due to changes in the member-
10 ship of an issuer’s health professional and provider net-
11 work, changes in the health coverage made available by
12 an employer, or other similar circumstances.

13 “(d) NO REQUIREMENT FOR ANY WILLING PRO-
14 VIDER.—Nothing in this part shall be construed as requir-
15 ing a health insurance issuer that offers network coverage
16 to include for participation every willing provider or health
17 professional who meets the terms and conditions of the
18 plan or issuer.

19 “(e) DEFINITIONS.—For purposes of this part:

20 “(1) ENROLLEE.—The term ‘enrollee’ means,
21 with respect to health insurance coverage offered by
22 a health insurance issuer, an individual enrolled with
23 the issuer to receive such coverage.

24 “(2) HEALTH PROFESSIONAL.—The term
25 ‘health professional’ means a physician or other

1 health care practitioner licensed, accredited, or cer-
2 tified to perform specified health services consistent
3 with State law.

4 “(3) NETWORK.—The term ‘network’ means,
5 with respect to a health insurance issuer offering
6 health insurance coverage, the participating health
7 professionals and providers through whom the plan
8 or issuer provides health care items and services to
9 enrollees.

10 “(4) NETWORK COVERAGE.—The term ‘network
11 coverage’ means health insurance coverage offered
12 by a health insurance issuer that provides or ar-
13 ranges for the provision of health care items and
14 services to enrollees through participating health
15 professionals and providers.

16 “(5) PARTICIPATING.—The term ‘participating’
17 means, with respect to a health professional or pro-
18 vider, a health professional or provider that provides
19 health care items and services to enrollees under
20 network coverage under an agreement with the
21 health insurance issuer offering the coverage.

22 “(6) PRIOR AUTHORIZATION.—The term ‘prior
23 authorization’ means the process of obtaining prior
24 approval from a health insurance issuer as to the ne-
25 cessity or appropriateness of receiving medical or

1 clinical services for treatment of a medical or clinical
2 condition.

3 “(7) PROVIDER.—The term ‘provider’ means a
4 health organization, health facility, or health agency
5 that is licensed, accredited, or certified to provide
6 health care items and services under applicable State
7 law.

8 “(8) SERVICE AREA.—The term ‘service area’
9 means, with respect to a health insurance issuer
10 with respect to health insurance coverage, the geo-
11 graphic area served by the issuer with respect to the
12 coverage.

13 “(9) UTILIZATION REVIEW.—The term ‘utiliza-
14 tion review’ means prospective, concurrent, or retro-
15 spective review of health care items and services for
16 medical necessity, appropriateness, or quality of care
17 that includes prior authorization requirements for
18 coverage of such items and services.”.

19 (b) REQUIRING MEDICARE+CHOICE ORGANIZATIONS
20 TO OFFER COVERAGE FOR OUT-OF-NETWORK SERV-
21 ICES.—

22 (1) IN GENERAL.—Section 1852(a)(3) of the
23 Social Security Act (42 U.S.C. 1395w–22(a)(3)), as
24 added by section 4001 of the Balanced Budget Act
25 of 1997, is amended by redesignating subparagraph

1 (C) as subparagraph (D) and by inserting after sub-
2 paragraph (B) the following new subparagraph:

3 “(C) REQUIRING OUT-OF-NETWORK SERV-
4 ICE OPTION.—If a Medicare+Choice organiza-
5 tion offers to members enrolled under this part
6 a plan which provides for coverage of services
7 covered under parts A and B of this title only
8 if such services are furnished through providers
9 and other persons who are members of a net-
10 work of providers and other persons who have
11 entered into a contract with the organization to
12 provide such services, the contract with the or-
13 ganization under section 1857 shall provide
14 that the organization shall also offer to mem-
15 bers enrolled under this part (at the time of en-
16 rollment) a plan which provides for coverage of
17 such services which are not furnished through
18 providers and other persons who are members
19 of such a network.”.

20 (2) EFFECTIVE DATE.—The amendments made
21 by paragraph (1) shall apply to contracts for years
22 beginning with 1999.

1 **SEC. 102. ACCESS TO CARE.**

2 (a) IN GENERAL.—Part C of title XVIII of the Public
3 Health Service Act, as inserted by section 101, is amended
4 by adding at the end the following:

5 **“SEC. 2771. ACCESS TO CARE.**

6 “(a) GENERAL ACCESS.—

7 “(1) IN GENERAL.—Subject to paragraphs (2),
8 and (3), a health insurance issuer shall establish and
9 maintain adequate arrangements, as defined by the
10 applicable State authority, with a sufficient number,
11 mix, and distribution of health professionals and
12 providers to assure that covered items and services
13 are available and accessible to each enrollee under
14 health insurance coverage—

15 “(A) in the service area of the issuer;

16 “(B) in a variety of sites of service;

17 “(C) with reasonable promptness (includ-
18 ing reasonable hours of operation and after-
19 hours services);

20 “(D) with reasonable proximity to the resi-
21 dences and workplaces of enrollees; and

22 “(E) in a manner that—

23 “(i) takes into account the diverse
24 needs of enrollees, and

25 “(ii) reasonably assures continuity of
26 care.

1 For a health insurance issuer that serves a rural or
2 medically underserved area, the issuer shall be treat-
3 ed as meeting the requirement of this subsection if
4 the issuer has arrangements with a sufficient num-
5 ber, mix, and distribution of health professionals and
6 providers having a history of serving such areas. The
7 use of telemedicine and other innovative means to
8 provide covered items and services by a health insur-
9 ance issuer that serves a rural or medically under-
10 served area shall also be considered in determining
11 whether the requirement of this subsection is met.

12 “(2) RULE OF CONSTRUCTION.—Nothing in
13 this subsection shall be construed as requiring a
14 health insurance issuer to have arrangements that
15 conflict with its responsibilities to establish measures
16 designed to maintain quality and control costs.

17 “(3) DEFINITIONS.—For purposes of paragraph
18 (1):

19 “(A) MEDICALLY UNDERSERVED AREA.—
20 The term ‘medically underserved area’ means
21 an area that is designated as a health profes-
22 sional shortage area under section 332 of the
23 Public Health Service Act or as a medically un-
24 derserved area for purposes of section 330 or
25 1302(7) of such Act.

1 “(B) RURAL AREA.—The term ‘rural area’
2 means an area that is not within a Standard
3 Metropolitan Statistical Area or a New England
4 County Metropolitan Area (as defined by the
5 Office of Management and Budget).

6 “(b) EMERGENCY AND URGENT CARE.—

7 “(1) IN GENERAL.—A health insurance issuer
8 shall—

9 “(A) assure the availability and accessibil-
10 ity of medically or clinically necessary emer-
11 gency services and urgent care services within
12 the service area of the issuer 24 hours a day,
13 7 days a week;

14 “(B) require no prior authorization for
15 items and services furnished in a hospital emer-
16 gency department to an enrollee (without re-
17 gard to whether the health professional or hos-
18 pital has a contractual or other arrangement
19 with the issuer) with symptoms that would rea-
20 sonably suggest to a prudent layperson an
21 emergency medical condition (including items
22 and services described in subparagraph
23 (C)(iii));

24 “(C) cover (and make reasonable payments
25 for)—

1 “(i) emergency services,

2 “(ii) services that are not emergency
3 services but are described in subparagraph
4 (B),

5 “(iii) medical screening examinations
6 and other ancillary services necessary to
7 diagnose, treat, and stabilize an emergency
8 medical condition, and

9 “(iv) urgent care services, without re-
10 gard to whether the health professional or
11 provider furnishing such services has a
12 contractual (or other) arrangement with
13 the issuer; and

14 “(D) make prior authorization determina-
15 tions for—

16 “(i) services that are furnished in a
17 hospital emergency department (other than
18 services described in clauses (i) and (iii) of
19 subparagraph (C)), and

20 “(ii) urgent care services, within the
21 time periods specified in (or pursuant to)
22 section 2781(a)(8).

23 “(2) DEFINITIONS.—For purposes of this sub-
24 section:

1 “(A) EMERGENCY MEDICAL CONDITION.—
2 The term ‘emergency medical condition’ means
3 a medical condition (including emergency labor
4 and delivery) manifesting itself by acute symp-
5 toms of sufficient severity (including severe
6 pain) such that a prudent layperson, who pos-
7 sesses an average knowledge of health and med-
8 icine, could reasonably expect the absence of
9 immediate medical attention could reasonably
10 be expected to result in—

11 “(i) placing the patient’s health in se-
12 rious jeopardy,

13 “(ii) serious impairment to bodily
14 functions, or

15 “(iii) serious dysfunction of any bodily
16 organ or part.

17 “(B) EMERGENCY SERVICES.—The term
18 ‘emergency services’ means health care items
19 and services that are necessary for the diag-
20 nosis, treatment, and stabilization of an emer-
21 gency medical condition.

22 “(C) URGENT CARE SERVICES.—The term
23 ‘urgent care services’ means health care items
24 and services that are necessary for the treat-
25 ment of a condition that—

1 “(i) is not an emergency medical con-
2 dition,

3 “(ii) requires prompt medical or clini-
4 cal treatment, and

5 “(iii) poses a danger to the patient if
6 not treated in a timely manner, as defined
7 by the applicable State authority in con-
8 sultation with relevant treating health pro-
9 fessionals or providers.

10 “(c) OBSTETRICAL AND GYNECOLOGICAL CARE.—

11 “(1) IN GENERAL.—If a health insurance is-
12 suer, in connection with the provision of health in-
13 surance coverage, requires or provides for an en-
14 rollee to designate a participating primary care pro-
15 vider—

16 “(A) the issuer shall permit a female en-
17 rollee to designate a physician who specializes
18 in obstetrics and gynecology as the enrollee’s
19 primary care provider; and

20 “(B) if such an enrollee has not designated
21 such a provider as a primary care provider, the
22 issuer—

23 “(i) may not require prior authoriza-
24 tion by the enrollee’s primary care provider
25 or otherwise for coverage of routine gyne-

1 cological care (such as preventive women’s
2 health examinations) and pregnancy-relat-
3 ed services provided by a participating phy-
4 sician who specializes in obstetrics and
5 gynecology to the extent such care is other-
6 wise covered, and

7 “(ii) may treat the ordering of other
8 gynecological care by such a participating
9 physician as the prior authorization of the
10 primary care provider with respect to such
11 care under the coverage.

12 “(2) CONSTRUCTION.—Nothing in paragraph
13 (1)(B)(ii) shall waive any requirements of coverage
14 relating to medical necessity or appropriateness with
15 respect to coverage of gynecological care so ordered.

16 “(d) REFERRAL TO SPECIALTY CARE FOR ENROLL-
17 EES REQUIRING TREATMENT BY SPECIALISTS.—

18 “(1) IN GENERAL.—In the case of an enrollee
19 who is covered under health insurance coverage of-
20 fered by a health insurance issuer and who has a
21 condition or disease of sufficient seriousness and
22 complexity to require treatment by a specialist, the
23 issuer shall make or provide for a referral to a spe-
24 cialist who is available and accessible to provide the
25 treatment for such condition or disease.

1 “(2) SPECIALIST DEFINED.—For purposes of
2 this subsection, the term ‘specialist’ means, with re-
3 spect to a condition, a health care practitioner, facil-
4 ity, or center (such as a center of excellence) that
5 has adequate expertise through appropriate training
6 and experience (including, in the case of a child, ap-
7 propriate pediatric expertise) to provide high quality
8 care in treating the condition.

9 “(3) CARE UNDER REFERRAL.—Care provided
10 pursuant to such referral under paragraph (1) shall
11 be—

12 “(A) pursuant to a treatment plan (if any)
13 developed by the specialist and approved by the
14 issuer, in consultation with the designated pri-
15 mary care provider or specialist and the enrollee
16 (or the enrollee’s designee), and

17 “(B) in accordance with applicable quality
18 assurance and utilization review standards of
19 the issuer.

20 Nothing in this subsection shall be construed as pre-
21 venting such a treatment plan for an enrollee from
22 requiring a specialist to provide the primary care
23 provider with regular updates on the specialty care
24 provided, as well as all necessary medical informa-
25 tion.

1 “(4) REFERRALS TO PARTICIPATING PROVID-
2 ERS.—An issuer is not required under paragraph (1)
3 to provide for a referral to a specialist that is not
4 a participating provider, unless the issuer does not
5 have an appropriate specialist that is available and
6 accessible to treat the enrollee’s condition and that
7 is a participating provider with respect to such treat-
8 ment.

9 “(5) TREATMENT OF NONPARTICIPATING PRO-
10 VIDERS.—If an issuer refers an enrollee to a non-
11 participating specialist, services provided pursuant
12 to the approved treatment plan shall be provided at
13 no additional cost to the enrollee beyond what the
14 enrollee would otherwise pay for services received by
15 such a specialist that is a participating provider.

16 “(e) CONTINUITY OF CARE.—

17 “(1) IN GENERAL.—A health insurance issuer
18 offering network coverage shall—

19 “(A) ensure that any process established
20 by the issuer to coordinate care and control
21 costs does not create an undue burden, as de-
22 fined by the applicable State authority, for en-
23 rollees with special health care needs or chronic
24 conditions;

1 “(B) ensure direct access to relevant spe-
2 cialists for the continued care of such enrollees
3 when medically or clinically indicated in the
4 judgment of the treating health professional, in
5 consultation with the enrollee;

6 “(C) in the case of an enrollee with special
7 health care needs or a chronic condition, deter-
8 mine whether, based on the judgment of the
9 treating health professional, in consultation
10 with the enrollee, it is medically or clinically
11 necessary to use a specialist or a care coordina-
12 tor from an interdisciplinary team to ensure
13 continuity of care; and

14 “(D) in circumstances under which a
15 change of health professional or provider might
16 disrupt the continuity of care for an enrollee,
17 such as—

18 “(i) hospitalization, or

19 “(ii) dependency on high-technology
20 home medical equipment,

21 provide for continued coverage of items and
22 services furnished by the health professional or
23 provider that was treating the enrollee before
24 such change for a reasonable period of time.

1 For purposes of subparagraph (D), a change of
2 health professional or provider may be due to
3 changes in the membership of an issuer’s health pro-
4 fessional and provider network, changes in the
5 health coverage made available by an employer, or
6 other similar circumstances.

7 “(2) CONTINUED COURSE OF TREATMENT.—

8 “(A) IN GENERAL.—If a contract between
9 a health insurance issuer, in connection with
10 the provision of health insurance coverage, and
11 a health care provider is terminated (other than
12 by the issuer for failure to meet applicable qual-
13 ity standards or for fraud) and an enrollee is
14 described in subparagraph (B)(i), (B)(ii), or
15 (B)(iii) and is undergoing a course of treatment
16 from the provider at the time of such termi-
17 nation, the issuer shall—

18 “(i) notify the enrollee of such termi-
19 nation, and

20 “(ii) subject to subparagraph (C), per-
21 mit the enrollee to continue the course of
22 treatment with the provider during a tran-
23 sitional period (provided under subpara-
24 graph (B)).

25 “(B) TRANSITIONAL PERIODS.—

1 “(ii) TRANSITIONAL PERIOD FOR IN-
2 STITUTIONAL CARE.—The transitional pe-
3 riod under this clause for institutional or
4 inpatient care from a provider shall extend
5 until the discharge or termination of the
6 period of institutionalization and shall in-
7 clude reasonable follow-up care related to
8 the institutionalization and shall also in-
9 clude institutional care scheduled prior to
10 the date of termination of the provider sta-
11 tus.

12 “(iii) PREGNANCY.—If—

13 “(I) an enrollee has entered the
14 second trimester of pregnancy at the
15 time of a provider’s termination of
16 participation, and

17 “(II) the provider was treating
18 the pregnancy before date of the ter-
19 mination,

20 the transitional period under this clause
21 with respect to provider’s treatment of the
22 pregnancy shall extend through the provi-
23 sion of post-partum care directly related to
24 the delivery.

25 “(iv) TERMINAL ILLNESS.—If—

1 “(I) an enrollee was determined
2 to be terminally ill at the time of a
3 provider’s termination of participa-
4 tion, and

5 “(II) the provider was treating
6 the terminal illness before the date of
7 termination,

8 the transitional period under this clause
9 shall extend for the remainder of the en-
10 rollee’s life for care directly related to the
11 treatment of the terminal illness. In sub-
12 clause (I), an enrollee is considered to be
13 ‘terminally ill’ if the enrollee has a medical
14 prognosis that the enrollee’s life expectancy
15 is 6 months or less.

16 “(C) PERMISSIBLE TERMS AND CONDI-
17 TIONS.—An issuer may condition coverage of
18 continued treatment by a provider under sub-
19 paragraph (A)(ii) upon the provider agreeing to
20 the following terms and conditions:

21 “(i) The provider agrees to continue
22 to accept reimbursement from the issuer at
23 the rates applicable prior to the start of
24 the transitional period as payment in full.

1 “(ii) The provider agrees to adhere to
2 the issuer’s quality assurance standards
3 and to provide to the issuer necessary med-
4 ical information related to the care pro-
5 vided.

6 “(iii) The provider agrees otherwise to
7 adhere to the issuer’s policies and proce-
8 dures, including procedures regarding re-
9 ferrals and obtaining prior authorization
10 and providing services pursuant to a treat-
11 ment plan approved by the issuer.

12 “(e) NONDISCRIMINATION AGAINST ENROLLEES.—
13 No health insurance issuer may discriminate (directly or
14 through contractual arrangements) in any activity that
15 has the effect of discriminating against an individual on
16 the basis of race, national origin, genetic makeup, gender,
17 language, socioeconomic status, sexual orientation, age,
18 disability, health status, or anticipated need for health
19 services.

20 **SEC. 103. QUALITY OF CARE.**

21 (a) QUALITY IMPROVEMENT PROGRAM.—Such part
22 is further amended by adding at the end the following:

23 **“SEC. 2772. QUALITY IMPROVEMENT PROGRAM.**

24 “(a) IN GENERAL.—A health insurance issuer shall
25 establish a quality improvement program (consistent with

1 subsection (b)) that systematically and continuously as-
2 sses and improves—

3 “(1) enrollee health status, patient outcomes,
4 processes of care, and enrollee satisfaction associ-
5 ated with health care provided by the issuer; and

6 “(2) the administrative and funding capacity of
7 the issuer to support and emphasize preventive care,
8 utilization, access and availability, cost effectiveness,
9 acceptable treatment modalities, specialists referrals,
10 the peer review process, and the efficiency of the ad-
11 ministrative process.

12 “(b) FUNCTIONS.—A quality improvement program
13 established pursuant to subsection (a) shall—

14 “(1) assess the performance of the issuer and
15 its participating health professionals and providers
16 and report the results of such assessment to pur-
17 chasers, participating health professionals and pro-
18 viders, and administrative personnel;

19 “(2) demonstrate measurable improvements in
20 clinical outcomes and plan performance measured by
21 identified criteria, including those specified in sub-
22 section (a)(1); and

23 “(3) analyze quality assessment data to deter-
24 mine specific interactions in the delivery system
25 (both the design and funding of the health insurance

1 coverage and the clinical provision of care) that have
2 an adverse impact on the quality of care.”.

3 “(c) INCENTIVE PLANS.—

4 “(1) IN GENERAL.—In the case of a health in-
5 surance issuer that offers network coverage, any
6 health professional or provider incentive plan oper-
7 ated by the issuer with respect to such coverage
8 shall meet the following requirements:

9 “(A) No specific payment is made directly
10 or indirectly under the plan to a professional or
11 provider or group of professionals or providers
12 as an inducement to reduce or limit medically
13 necessary services provided with respect to a
14 specific enrollee.

15 “(B) If the plan places such a professional,
16 provider, or group at substantial financial risk
17 (as determined by the Secretary) for services
18 not provided by the professional, provider, or
19 group, the issuer—

20 “(i) provides stop-loss protection for
21 the professional, provider, or group that is
22 adequate and appropriate, based on stand-
23 ards developed by the Secretary that take
24 into account the number of professionals
25 or providers placed at such substantial fi-

1 nancial risk in the group or under the cov-
2 erage and the number of individuals en-
3 rolled with the issuer who receive services
4 from the professional, provider, or group,
5 and

6 “(ii) conducts periodic surveys of both
7 individuals enrolled and individuals pre-
8 viously enrolled with the issuer to deter-
9 mine the degree of access of such individ-
10 uals to services provided by the issuer and
11 satisfaction with the quality of such serv-
12 ices.

13 “(C) The issuer provides the Secretary
14 with descriptive information regarding the plan,
15 sufficient to permit the Secretary to determine
16 whether the plan is in compliance with the re-
17 quirements of this paragraph.

18 “(2) In this subsection, the term ‘health profes-
19 sional or provider incentive plan’ means any com-
20 pensation arrangement between a health insurance
21 issuer and a health professional or provider or pro-
22 fessional or provide group that may directly or indi-
23 rectly have the effect of reducing or limiting services
24 provided with respect to individuals enrolled with the
25 issuer.”.

1 (b) OFFICE OF MEDICARE ADVOCACY.—Title XVIII
2 of the Social Security Act is amended by inserting after
3 section 1804 the following new section:

4 “OFFICE OF MEDICARE ADVOCACY

5 “SEC. 1805. (a) ESTABLISHMENT.—The Secretary
6 shall establish, within the Health Care Financing Admin-
7 istration, an office of medicare advocacy (in this section
8 referred to as the ‘office’), to be headed by a director ap-
9 pointed by the Secretary.

10 “(b) PURPOSE.—The office shall provide, in accord-
11 ance with this section, independent review of problems and
12 concerns of medicare beneficiaries in relation to the pro-
13 grams under this title, including, but not limited to, com-
14 plaints concerning plans offered under part C or section
15 1876.

16 “(c) ACCESS.—In order to carry out its functions, the
17 office shall provide for a toll-free telephone number
18 through which medicare beneficiaries can obtain assist-
19 ance in the programs under this title, including providing
20 comparative information on plans offered under part C or
21 section 1876. The office also shall undertake such addi-
22 tional outreach activities, such as the use of town meetings
23 and development of an appropriate Internet site, as most
24 effectively and efficiently promotes dissemination of infor-
25 mation to medicare beneficiaries.

1 “(d) RECEIPT AND DISPOSITION OF COMPLAINTS.—

2 The office shall provide for a record of the types of com-
3 plaints and problems received and shall submit to the Sec-
4 retary and publish an annual report on the nature of such
5 complaints and problems, the disposition with respect to
6 such complaints and problems, and such other additional
7 information as the Secretary may specify.

8 “(e) EXPEDITED REVIEW PROCESS FOR COM-
9 PLAINTS UNDER EMERGENCY CIRCUMSTANCES.—

10 “(1) IN GENERAL.—Under regulations of the
11 Secretary, the office shall have authority to provide
12 for an expedited review and resolution of complaints
13 under emergency circumstances, including those de-
14 scribed in paragraph (2). Such reviews and resolu-
15 tions shall be conducted to the greatest extent prac-
16 ticable through regional and local agencies.

17 “(2) EMERGENCY CIRCUMSTANCES DE-
18 SCRIBED.—The emergency circumstances described
19 in this paragraph are cases in which—

20 “(A) a delay in treatment resulting from
21 application of the usual hearing and appeals
22 process may endanger the life of the bene-
23 ficiary, result in a loss of function or a signifi-
24 cant worsening of a condition, or render treat-
25 ment ineffective; or

1 “(B) an advanced directive (as defined in
2 section 1866(f)(3)) or other end-of-life pref-
3 erence is involved.”.

4 (c) STATE HEALTH INSURANCE OMBUDSMEN.—Part
5 C of title XVIII of the Public Health Service Act, as pre-
6 viously inserted and amended, is further amended by add-
7 ing at the end the following:

8 **“SEC. 2773. STATE HEALTH INSURANCE OMBUDSMEN.**

9 “(a) IN GENERAL.—Each State that obtains a grant
10 under subsection (c) shall establish and maintain a Health
11 Insurance Ombudsman. Such Ombudsman may be part of
12 a independent, nonprofit entity, and shall be responsible
13 for at least the following:

14 “(1) To assist consumers in the State in choos-
15 ing among health insurance coverage.

16 “(2) To provide counseling and assistance to
17 enrollees dissatisfied with their treatment by health
18 insurance issuers in regard to such coverage and in
19 the filing of complaints and appeals regarding deter-
20 minations under such coverage.

21 “(3) To investigate instances of poor quality or
22 improper treatment of enrollees by health insurance
23 issuers in regard to such coverage and to bring such
24 instances to the attention of the applicable State au-
25 thority.

1 “(b) FEDERAL ROLE.—In the case of any State that
2 does not establish and maintain such an Ombudsman
3 under subsection (a), the Secretary shall provide for the
4 establishment and maintenance of such an official as will
5 carry out with respect to that State the functions other-
6 wise provided under subsection (a) by a Health Insurance
7 Ombudsman.

8 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
9 are authorized to be appropriated to the Secretary such
10 amounts as may be necessary to provide for grants to
11 States to establish and operate Health Insurance Ombuds-
12 men under subsection (a) or for the operation of Ombuds-
13 men under subsection (b).”.

14 **SEC. 104. PATIENT CONFIDENTIALITY.**

15 Part C of title XVIII of the Public Health Service
16 Act, as previously inserted and amended, is further
17 amended by adding at the end the following:

18 **“SEC. 2774. PROTECTION OF PATIENT CONFIDENTIALITY.**

19 “(a) IN GENERAL.—A health insurance issuer that
20 offers health insurance coverage shall establish appro-
21 priate written policies and procedures to ensure that all
22 applicable State and Federal laws to protect the confiden-
23 tiality of individually identifiable medical information are
24 followed.

1 “(b) DETAILS.—Such policies and procedures shall
2 provide that individually identifiable medical information
3 should not be disclosed except under the following cir-
4 cumstances:

5 “(1) For purposes necessary to perform re-
6 quired quality assurance functions, to meet require-
7 ments of purchasers and providers (in order to de-
8 termine entitlement to coverage and to administer
9 payments), and to conduct approved, bona fide clini-
10 cal or health services research. The disclosure of in-
11 formation in such circumstances should not contain
12 patient identifiers which could lead to violation of in-
13 dividual privacy and harm patients.

14 “(2) Upon the express consent of the covered
15 person.

16 “(3) Pursuant to law or court order for the pro-
17 duction of evidence or the discovery thereof or other
18 legally mandated disclosure.

19 “(4) In the event of claim or litigation between
20 the covered person and the issuer.”.

21 **SEC. 105. COVERAGE UNDER APPROVED CLINICAL TRIALS.**

22 Such part is further amended by adding at the end
23 the following new section:

1 **“SEC. 2775. COVERAGE FOR INDIVIDUALS PARTICIPATING**
2 **IN APPROVED CLINICAL TRIALS.**

3 “(a) IN GENERAL.—If a health insurance issuer of-
4 fers health insurance coverage to a qualified enrollee (as
5 defined in subsection (b)), the issuer—

6 “(1) may not deny the enrollee participation in
7 the clinical trial referred to in subsection (b)(2);

8 “(2) subject to subsection (c), may not deny (or
9 limit or impose additional conditions on) the cov-
10 erage of routine patient costs for items and services
11 furnished in connection with participation in the
12 trial; and

13 “(3) may not discriminate against the enrollee
14 on the basis of the enrollee’s participation in such
15 trial.

16 “(b) QUALIFIED ENROLLEE DEFINED.—For pur-
17 poses of subsection (a), the term ‘qualified enrollee’ means
18 an enrollee under health insurance coverage who meets the
19 following conditions:

20 “(1) The enrollee has a life-threatening or seri-
21 ous illness for which no standard treatment is effec-
22 tive.

23 “(2) The enrollee is eligible to participate in an
24 approved clinical trial with respect to treatment of
25 such illness.

1 “(3) The enrollee and the referring physician
2 conclude that the enrollee’s participation in such
3 trial would be appropriate.

4 “(4) The enrollee’s participation in the trial of-
5 fers potential for significant clinical benefit for the
6 enrollee.

7 “(c) PAYMENT.—

8 “(1) IN GENERAL.—Under this section an is-
9 suer shall provide for payment for routine patient
10 costs described in subsection (a)(2) but is not re-
11 quired to pay for costs of items and services that are
12 reasonably expected (as determined by the Sec-
13 retary) to be paid for by the sponsors of an ap-
14 proved clinical trial.

15 “(2) PAYMENT RATE.—In the case of covered
16 items and services provided by—

17 “(A) a participating provider, the payment
18 rate shall be at the agreed upon rate, or

19 “(B) a nonparticipating provider, the pay-
20 ment rate shall be at the rate the issuer would
21 normally pay for comparable services under
22 subparagraph (A).

23 “(d) APPROVED CLINICAL TRIAL DEFINED.—In this
24 section, the term ‘approved clinical trial’ means a clinical

1 research study or clinical investigation approved and fund-
2 ed by one or more of the following:

3 “(1) The National Institutes of Health.

4 “(2) A cooperative group or center of the Na-
5 tional Institutes of Health.

6 “(3) The Department of Veterans Affairs.

7 “(4) The Department of Defense.”.

8 **SEC. 106. ACCESS TO NEEDED PRESCRIPTION DRUGS;**
9 **DRUG UTILIZATION PROGRAM.**

10 Such part is further amended by adding at the end
11 the following new section:

12 **“SEC. 2776. ACCESS TO NEEDED PRESCRIPTION DRUGS;**
13 **DRUG UTILIZATION PROGRAM.**

14 “(a) ACCESS.—If a health insurance issuer offers
15 health insurance coverage (whether directly or through
16 any agent) that provides benefits with respect to prescrip-
17 tion drugs but the coverage limits such benefits to drugs
18 included in a formulary, the issuer shall—

19 “(1) ensure participation of participating physi-
20 cians in the development of the formulary;

21 “(2) disclose the nature of the formulary re-
22 strictions; and

23 “(3) provide for exceptions from the formulary
24 limitation when medical necessity, as determined by
25 the enrollee’s physician subject to reasonable review

1 by the issuer, dictates that a non-formulary alter-
 2 native is indicated.

3 “(b) DRUG UTILIZATION PROGRAM.—A health insur-
 4 ance issuer that provides health insurance coverage that
 5 includes benefits for prescription drugs shall establish and
 6 maintain a drug utilization program which—

7 “(1) encourages appropriate use of prescription
 8 drugs by enrollees and providers,

9 “(2) monitors illnesses arising from improper
 10 drug use or from adverse drug reactions or inter-
 11 actions, and

12 “(3) takes appropriate action to reduce the inci-
 13 dence of improper drug use and adverse drug reac-
 14 tions and interactions.”.

15 **TITLE II—CONTRACTING AND** 16 **TERMINATION RIGHTS**

17 **SEC. 201. NONDISCRIMINATION AGAINST PROVIDERS.**

18 Part C of title XXVII of the Public Health Service
 19 Act is amended by adding at the end the following:

20 **“SEC. 2777. NONDISCRIMINATION IN THE SELECTION OF** 21 **HEALTH PROFESSIONALS; EQUITABLE AC-** 22 **CESS TO NETWORKS.**

23 “(a) NONDISCRIMINATION IN SELECTION OF NET-
 24 WORK HEALTH PROFESSIONALS.—A health insurance is-
 25 suer offering network coverage shall not discriminate in

1 selecting the members of its health professional network
2 (or in establishing the terms and conditions for member-
3 ship in such network) on the basis of the race, national
4 origin, genetic makeup, gender, sexual orientation, age,
5 place or institution in which received health professional
6 education, or disability (other than a disability that im-
7 pairs the ability of an individual to provide health care
8 services or that may threaten the health of enrollees) of
9 the health professional.

10 “(b) NONDISCRIMINATION IN ACCESS TO HEALTH
11 PLANS.—While nothing in this section shall be construed
12 as an ‘any willing provider’ requirement (as referred to
13 in section 2770(d)), a health insurance issuer shall not
14 discriminate in participation, reimbursement, or indem-
15 nification against a health professional, who is acting
16 within the scope of the health professional’s license or cer-
17 tification under applicable State law, solely on the basis
18 of such license or certification.”.

19 **SEC. 202. DEVELOPMENT OF PLAN POLICIES.**

20 Such part is further amended by adding at the end
21 the following:

22 **“SEC. 2778. DEVELOPMENT OF PLAN POLICIES.**

23 “A health insurance issuer that offers network cov-
24 erage shall establish mechanisms to consider the rec-
25 ommendations, suggestions, and views of enrollees and

1 participating health professionals and providers regard-
2 ing—

3 “(1) the medical policies of the issuer (including
4 policies relating to coverage of new technologies,
5 treatments, and procedures);

6 “(2) the utilization review criteria and proce-
7 dures of the issuer;

8 “(3) the quality and credentialing criteria of the
9 issuer; and

10 “(4) the medical management procedures of the
11 issuer.”.

12 **SEC. 203. DUE PROCESS.**

13 Such part is further amended by adding at the end
14 the following:

15 **“SEC. 2779. DUE PROCESS FOR HEALTH PROFESSIONALS
16 AND PROVIDERS.**

17 “(a) IN GENERAL.—A health insurance issuer with
18 respect to its offering of network coverage shall—

19 “(1) allow all health professionals and providers
20 in its service area to apply to become a participating
21 health professional or provider during at least one
22 period in each calendar year;

23 “(2) provide reasonable notice to such health
24 professionals and providers of the opportunity to

1 apply and of the period during which applications
2 are accepted;

3 “(3) provide for review of each application by a
4 credentialing committee with appropriate representa-
5 tion of the category or type of health professional or
6 provider;

7 “(4) select participating health professionals
8 and providers based on objective standards of qual-
9 ity developed with the suggestions and advice of pro-
10 fessional associations, health professionals, and pro-
11 viders;

12 “(5) make such selection standards available
13 to—

14 “(A) those applying to become a partici-
15 pating provider or health professional;

16 “(B) health plan purchasers, and

17 “(C) enrollees;

18 “(6) when economic considerations are taken
19 into account in selecting participating health profes-
20 sionals and providers, use objective criteria that are
21 available to those applying to become a participating
22 provider or health professional and enrollees;

23 “(7) adjust any economic profiling to take into
24 account patient characteristics (such as severity of

1 illness) that may result in atypical utilization of
2 services;

3 “(8) make the results of such profiling available
4 to insurance purchasers, enrollees, and the health
5 professional or provider involved;

6 “(9) notify any health professional or provider
7 being reviewed under the process referred to in para-
8 graph (3) of any information indicating that the
9 health professional or provider fails to meet the
10 standards of the issuer;

11 “(10) offer a health professional or provider re-
12 ceiving notice pursuant to the requirement of para-
13 graph (9) with an opportunity to—

14 “(A) review the information referred to in
15 such paragraph, and

16 “(B) submit supplemental or corrected in-
17 formation;

18 “(11) not include in its contracts with partici-
19 pating health professionals and providers a provision
20 permitting the issuer to terminate the contract
21 ‘without cause’;

22 “(12) provide a due process appeal that con-
23 forms to the process specified in section 412 of the
24 Health Care Quality Improvement Act of 1986 (42

1 U.S.C. 11112) for all determinations that are ad-
2 verse to a health professional or provider; and

3 “(13) unless a health professional or provider
4 poses an imminent harm to enrollees or an adverse
5 action by a governmental agency effectively impairs
6 the ability to provide health care items and services,
7 provide—

8 “(A) reasonable notice of any decision to
9 terminate a health professional or provider ‘for
10 cause’ (including an explanation of the reasons
11 for the determination),

12 “(B) an opportunity to review and discuss
13 all of the information on which the determina-
14 tion is based, and

15 “(C) an opportunity to enter into a correc-
16 tive action plan, before the determination be-
17 comes subject to appeal under the process re-
18 ferred to in paragraph (12).

19 “(b) RULE OF CONSTRUCTION.—The requirements of
20 subsection (a) shall not be construed as preempting or su-
21 perseding any other reviews and appeals a health insur-
22 ance issuer is required by law to make available.”.

1 **SEC. 204. NON-PREEMPTION OF STATE LAW RESPECTING**
2 **LIABILITY OF GROUP HEALTH PLANS.**

3 (a) IN GENERAL.—Section 514(b) of the Employee
4 Retirement Income Security Act of 1974 (29 U.S.C.
5 1144(b)) is amended by redesignating paragraph (9) as
6 paragraph (10) and inserting the following new para-
7 graph:

8 “(9) Subsection (a) of this section shall not be
9 construed to preclude any State cause of action to
10 recover damages for personal injury or wrongful
11 death against any person that provides insurance or
12 administrative services to or for an employee welfare
13 benefit plan maintained to provide health care bene-
14 fits.”.

15 (b) EFFECTIVE DATE.—The amendment made by
16 subsection (a) shall apply to causes of action arising on
17 or after the date of the enactment of this Act.

18 **TITLE III—INFORMATION**
19 **REPORTING**

20 **SEC. 301. INFORMATION REPORTING.**

21 Part C of title XXVII of the Public Health Service
22 Act is further amended by adding at the end the following:

23 **“SEC. 2780. INFORMATION REPORTING AND DISCLOSURE.**

24 “(a) IN GENERAL.—A health insurance issuer offer-
25 ing health insurance coverage shall provide enrollees and
26 prospective enrollees with information about—

1 “(1) coverage provisions, benefits, and any ex-
2 clusions—

3 “(A) by category of service,

4 “(B) by category or type of health profes-
5 sional or provider, and

6 “(C) if applicable, by specific service, in-
7 cluding experimental treatments;

8 “(2) the percentage of the premium charged by
9 the issuer that is set aside for administration and
10 marketing of the issuer;

11 “(3) the percentage of the premium charged by
12 the issuer that is expended directly for patient care;

13 “(4) the number, mix, and distribution of par-
14 ticipating health professionals and providers;

15 “(5) the ratio of enrollees to participating
16 health professionals and providers by category and
17 type of health professional and provider;

18 “(6) the expenditures and utilization per en-
19 rollee by category and type of health professional
20 and provider;

21 “(7) the financial obligations of the enrollee and
22 the issuer, including premiums, copayments,
23 deductibles, and established aggregate maximums on
24 out-of-pocket costs, for all items and services, includ-
25 ing—

1 “(A) those furnished by health profes-
2 sionals and providers that are not participating
3 health professionals and providers, and

4 “(B) those furnished to an enrollee who is
5 outside the service area of the coverage;

6 “(8) utilization review requirements of the is-
7 suer (including prior authorization review, concu-
8 rent review, post-service review, post-payment re-
9 view, and any other procedures that may lead to de-
10 nial of coverage or payment for a service);

11 “(9) financial arrangements and incentives that
12 may—

13 “(A) limit the items and services furnished
14 to an enrollee,

15 “(B) restrict referral or treatment options,
16 or

17 “(C) negatively affect the fiduciary respon-
18 sibility of a health professional or provider to
19 an enrollee;

20 “(10) other incentives for health professionals
21 and providers to deny or limit needed items or serv-
22 ices;

23 “(11) quality indicators for the issuer and par-
24 ticipating health professionals and providers, includ-
25 ing performance measures such as appropriate refer-

1 rals and prevention of secondary complications fol-
2 lowing treatment;

3 “(12) grievance procedures and appeals rights
4 under the coverage, and summary information about
5 the number and disposition of grievances and ap-
6 peals in the most recent period for which complete
7 and accurate information is available; and

8 “(13) the percentage of utilization review deter-
9 minations made by the issuer that disagree with the
10 judgment of the treating health professional or pro-
11 vider and the percentage of such determinations that
12 are reversed on appeal.

13 “(b) REGULATIONS.—The Secretary, in collaboration
14 with the Secretary of Labor, shall issue regulations to es-
15 tablish—

16 “(1) the styles and sizes of type to be used with
17 respect to the appearance of the publication of the
18 information required under subsection (a);

19 “(2) standards for the publication of informa-
20 tion to ensure that such publication is—

21 “(A) readily accessible, and

22 “(B) in common language easily under-
23 stood,

24 by individuals with little or no connection to or un-
25 derstanding of the language employed by health pro-

1 professionals and providers, health insurance issuers, or
2 other entities involved in the payment or delivery of
3 health care services, and

4 “(3) the placement and positioning of informa-
5 tion in health plan marketing materials.”.

6 **SEC. 302. AUTOMATIC EXCLUSION FROM MEDICARE AND**
7 **MEDICAID FOR HEALTH PLANS THAT LIE**
8 **ABOUT QUALITY DATA.**

9 Notwithstanding any other provision of law, in the
10 case of a Medicare+Choice organization, an eligible orga-
11 nization, health maintenance organizations, or other entity
12 that is receiving payment on a prepaid basis for items and
13 services provided under title XVIII or XIX of the Social
14 Security Act and that submits information relating to the
15 quality of such services provided that is material and false,
16 the Secretary of Health and Human Services shall take
17 such steps as may be necessary to assure the exclusion
18 of the entity from continuing to qualify for such payments
19 under such title and shall provide for the imposition of
20 any intermediate sanctions in lieu of such exclusion.

21 **TITLE IV—PATIENT-PROVIDER**
22 **COMMUNICATION**

23 **SEC. 401. SHORT TITLE; FINDINGS.**

24 (a) **SHORT TITLE.**—This title may be cited as the
25 “Patient Right to Know Act”.

1 (b) FINDINGS.—Congress finds the following:

2 (1) Patients need access to all relevant informa-
3 tion to make appropriate decisions about their
4 health care.

5 (2) Open medical communications between
6 health care providers and their patients is a key to
7 prevention and early diagnosis and treatment, as
8 well as to informed consent and quality, cost-effec-
9 tive care.

10 (3) Open medical communications are in the
11 best interests of patients.

12 (4) Open medical communications must meet
13 applicable legal and ethical standards of care.

14 (5) It is critical that health care providers con-
15 tinue to exercise their best medical, ethical, and
16 moral judgment in advising patients without inter-
17 ference from health plans.

18 (6) The offering and operation of health plans
19 affect commerce among the States.

20 (c) PURPOSE.—It is the purpose of this title to estab-
21 lish a Federal standard that protects medical communica-
22 tions between health care providers and patients.

23 **SEC. 402. PROHIBITION OF INTERFERENCE WITH CERTAIN**
24 **MEDICAL COMMUNICATIONS.**

25 (a) PROHIBITION.—

1 (1) GENERAL RULE.—The provisions of any
2 contract or agreement, or the operation of any con-
3 tract or agreement, between an entity operating a
4 health plan (including any partnership, association,
5 or other organization that enters into or administers
6 such a contract or agreement) and a health care
7 provider (or group of health care providers) shall not
8 prohibit or restrict the provider from engaging in
9 medical communications with his or her patient.

10 (2) NULLIFICATION.—Any contract provision or
11 agreement described in paragraph (1) shall be null
12 and void.

13 (3) PROHIBITION ON PROVISIONS.—Effective on
14 the date described in section 404, a contract or
15 agreement described in paragraph (1) shall not in-
16 clude a provision that violates paragraph (1).

17 (b) RULES OF CONSTRUCTION.—Nothing in this title
18 shall be construed—

19 (1) to prohibit the enforcement, as part of a
20 contract or agreement to which a health care pro-
21 vider is a party, of any mutually agreed upon terms
22 and conditions, including terms and conditions re-
23 quiring a health care provider to participate in, and
24 cooperate with, all programs, policies, and proce-
25 dures developed or operated by a health plan to as-

1 sure, review, or improve the quality and effective uti-
2 lization of health care services (if such utilization is
3 according to guidelines or protocols that are based
4 on clinical or scientific evidence and the professional
5 judgment of the provider) but only if the guidelines
6 or protocols under such utilization do not prohibit or
7 restrict medical communications between providers
8 and their patients; or

9 (2) to permit a health care provider to mis-
10 represent the scope of benefits covered under a
11 health plan or to otherwise require the plan to reim-
12 burse providers for benefits not covered under the
13 plan

14 (c) ENFORCEMENT.—

15 (1) STATE AUTHORITY.—Except as otherwise
16 provided in this subsection, each State shall enforce
17 the provisions of this title with respect to health in-
18 surance issuers that issue, sell, renew, or offer
19 health plans in the State.

20 (2) ENFORCEMENT BY SECRETARY.—

21 (A) IN GENERAL.—Effective on January 1,
22 1998, if the Secretary, after consultation with
23 the chief executive officer of a State and the in-
24 surance commissioner or chief insurance regu-
25 latory official of the State, determines that the

1 State has failed to substantially enforce the re-
2 quirements of this title with respect to health
3 insurance issuers in the State, the Secretary
4 shall enforce the requirements of this title with
5 respect to such State.

6 (B) ENFORCEMENT THROUGH IMPOSITION
7 OF CIVIL MONEY PENALTY.—

8 (i) IN GENERAL.—With respect to a
9 State in which the Secretary is enforcing
10 the requirements of this title, an entity op-
11 erating a health plan in that State that
12 violates subsection (a) shall be subject to a
13 civil money penalty of up to \$25,000 for
14 each such violation.

15 (ii) PROCEDURES.—For purposes of
16 imposing a civil money penalty under
17 clause (i), the provisions of subparagraphs
18 (C) through (G) of section 2722(b)(2) of
19 the Health Insurance Portability and Ac-
20 countability Act of 1996 (42 U.S.C.
21 300gg–22(b)(2)) shall apply except that
22 the provisions of clause (i) of subpara-
23 graph (C) of such section shall not apply.

24 (3) SELF-INSURED PLANS.—Effective on Janu-
25 ary 1, 1998, the Secretary of Labor shall enforce the

1 requirements of this section in the case of a health
2 plan not subject to State regulation by reason of sec-
3 tion 514(b) of the Employee Retirement Income Se-
4 curity Act of 1974 (29 U.S.C. 1144(b)).

5 (4) RULE OF CONSTRUCTION.—Nothing in this
6 title shall be construed to affect or modify the provi-
7 sions of section 514 of the Employee Retirement In-
8 come Security Act of 1974 (29 U.S.C. 1144).

9 (d) NO PREEMPTION OF MORE PROTECTIVE
10 LAWS.—A State may establish or enforce requirements
11 with respect to the protection of medical communications,
12 but only if such requirements are equal to or more protec-
13 tive of such communications than the requirements estab-
14 lished under this section.

15 **SEC. 403. DEFINITIONS.**

16 In this title:

17 (1) HEALTH CARE PROVIDER.—The term
18 “health care provider” means anyone licensed or cer-
19 tified under State law to provide health care services
20 who is operating within the scope of such license.

21 (2) HEALTH INSURANCE ISSUER.—The term
22 “health insurance issuer” has the meaning given
23 such term in section 2791(b)(2) of the Public Health
24 Service Act (as added by the Health Insurance Port-
25 ability and Accountability Act of 1996).

1 (3) HEALTH PLAN.—The term “health plan”
2 means a group health plan (as defined in section
3 2791(a) of the Public Health Service Act (as added
4 by the Health Insurance Portability and Account-
5 ability Act of 1996)) and any individual health in-
6 surance (as defined in section 2791(b)(5)) operated
7 by a health insurance issuer and includes any other
8 health care coverage provided through a private or
9 public entity. In the case of a health plan that is an
10 employee welfare benefit plan (as defined in section
11 3(1) of the Employee Retirement Income Security
12 Act of 1974), any third party administrator or other
13 person with responsibility for contracts with health
14 care providers under the plan shall be considered,
15 for purposes of enforcement under this section, to be
16 a health insurance issuer operating such health plan.

17 (4) MEDICAL COMMUNICATION.—

18 (A) IN GENERAL.—The term “medical
19 communication” means any communication
20 made by a health care provider with a patient
21 of the health care provider (or the guardian or
22 legal representative of such patient) with re-
23 spect to—

24 (i) the patient’s health status, medical
25 care, or treatment options;

1 (ii) any utilization review require-
2 ments that may affect treatment options
3 for the patient; or

4 (iii) any financial incentives that may
5 affect the treatment of the patient.

6 (B) MISREPRESENTATION.—The term
7 “medical communication” does not include a
8 communication by a health care provider with a
9 patient of the health care provider (or the
10 guardian or legal representative of such patient)
11 if the communication involves a knowing or will-
12 ful misrepresentation by such provider.

13 (5) SECRETARY.—The term “Secretary” means
14 the Secretary of Health and Human Services.

15 **SEC. 404. EFFECTIVE DATE.**

16 This title shall take effect on the date of enactment
17 of this Act, except that section 402(a)(3) shall take effect
18 180 days after such date of enactment.

19 **TITLE V—UTILIZATION REVIEW**
20 **AND MANAGEMENT**

21 **SEC. 501. UTILIZATION REVIEW DUE PROCESS FOR EN-**
22 **ROLLEES.**

23 Part C of title XXVII of the Public Health Service
24 Act, as previously inserted and amended, is further
25 amended by adding at the end the following new section:

1 **“SEC. 2781. DUE PROCESS FOR ENROLLEES.**

2 “(a) UTILIZATION REVIEW.—The utilization review
3 program of a health insurance issuer shall—

4 “(1) be developed (including any screening cri-
5 teria used by such program) with the involvement of
6 participating health professionals and providers;

7 “(2) to the extent consistent with the protection
8 of proprietary business information (as defined for
9 purposes of section 552 of title 5, United States
10 Code) release, upon request, to affected health pro-
11 fessionals, providers, and enrollees the screening cri-
12 teria, weighting elements, and computer algorithms
13 used in reviews and a description of the method by
14 which they were developed;

15 “(3) uniformly apply review criteria that are
16 based on sound scientific principles and the most re-
17 cent medical evidence;

18 “(4) use licensed, accredited, or certified health
19 professionals to make review determinations (and for
20 services requiring specialized training for their deliv-
21 ery, use a health professional who is qualified
22 through equivalent specialized training and experi-
23 ence);

24 “(5) subject to reasonable safeguards, disclose
25 to health professionals and providers, upon request,

1 the names and credentials of individuals conducting
2 utilization review;

3 “(6) not compensate individuals conducting uti-
4 lization review for denials of payment or coverage of
5 benefits;

6 “(7) comply with the requirement of section
7 2771 that prior authorization not be required for
8 emergency and related services furnished in a hos-
9 pital emergency department;

10 “(8) make prior authorization determinations—

11 “(A) in the case of services that are urgent
12 care services described in section
13 2771(b)(2)(C), within 30 minutes of a request
14 for such determination, and

15 “(B) in the case of other services, within
16 24 hours after the time of a request for deter-
17 mination;

18 “(9) include in any notice of such determination
19 an explanation of the basis of the determination and
20 the right to an immediate appeal;

21 “(10) treat a favorable prior authorization re-
22 view determination as a final determination for pur-
23 poses of making payment for a claim submitted for
24 the item or service involved unless such determina-

1 tion was based on false information knowingly sup-
2 plied by the person requesting the determination;

3 “(11) provide timely access, as defined by the
4 applicable State authority, to utilization review per-
5 sonnel and, if such personnel are not available,
6 waives any prior authorization that would otherwise
7 be required;

8 “(12) provide notice of an initial determination
9 on payment of a claim within 30 days after the date
10 the claim is submitted for such item or service, and
11 include in such notice an explanation of the reasons
12 for such determination and of the right to an imme-
13 diate appeal; and

14 “(13) take into consideration guidelines estab-
15 lished by the medical societies relating to necessary
16 health care.

17 “(b) RIGHT OF APPEAL.—

18 “(1) IN GENERAL.—An enrollee in health insur-
19 ance coverage offered by a health insurance issuer,
20 and any provider acting on behalf of the enrollee
21 with the enrollee’s consent, may appeal any appeal-
22 able decision (as defined in paragraph (2)) under the
23 procedures described in the succeeding subsections
24 in this section and (to the extent applicable) sub-
25 section (a). Such enrollees and providers shall be

1 provided with a written explanation of the appeal
2 process upon the conclusion of each stage in the ap-
3 peal process.

4 “(2) APPEALABLE DECISION DEFINED.—In this
5 section, the term ‘appealable decision’ means any of
6 the following:

7 “(A) An adverse determination under a
8 utilization review program under subsection (a).

9 “(B) A denial of patient choice of health
10 care professionals under section 2770.

11 “(C) A denial of access to care under sec-
12 tion 2771.

13 “(D) Denial of coverage of routine patient
14 costs in connection with an approved clinical
15 trial under section 2775.

16 “(E) Denial of access to needed drugs
17 under section 2776(a)(3).

18 “(F) Denial of payment for a benefit,

19 “(c) INFORMAL INTERNAL APPEAL PROCESS (STAGE
20 1).—

21 “(1) IN GENERAL.—Each issuer shall establish
22 and maintain an informal internal appeal process
23 (an appeal under such process in this section re-
24 ferred to as a ‘stage 1 appeal’) under which any en-
25 rollee or any provider acting on behalf of an enrollee

1 with the enrollee’s consent, who is dissatisfied with
2 any appealable decision has the opportunity to dis-
3 cuss and appeal that decision with the medical direc-
4 tor of the issuer or the health care professional who
5 made the decision.

6 “(2) TIMING.—All appeals under this para-
7 graph shall be concluded as soon as possible in ac-
8 cordance with the medical exigencies of the cases,
9 and in no event later than 72 hours in the case of
10 appeals from decisions regarding urgent care and 5
11 days in the case of all other appeals.

12 “(3) FURTHER REVIEW.—If the appeal is not
13 resolved to the satisfaction of the enrollee at this
14 level by the deadline under paragraph (2), the issuer
15 shall provide the enrollee and provider (if any) with
16 a written explanation of the decision and the right
17 to proceed to a stage 2 appeal under subsection (d).

18 “(d) FORMAL INTERNAL APPEAL PROCESS (STAGE
19 2).—

20 “(1) IN GENERAL.—Each issuer shall establish
21 and maintain a formal internal appeal process (an
22 appeal under such process in this section referred to
23 as a ‘stage 2 appeal’) under which any enrollee or
24 provider acting on behalf of an enrollee with the en-
25 rollee’s consent, who is dissatisfied with the results

1 of a stage 1 appeal has the opportunity to appeal
2 the results before a panel that includes a physician
3 or other health care professional (or professionals)
4 selected by the issuer who have not been involved in
5 the appealable decision at issue in the appeal.

6 “(2) AVAILABILITY OF CLINICAL PEERS.—The
7 panel under subparagraph (A) shall have available
8 either clinical peers who have not been involved in
9 the appealable decision at issue in the appeal or oth-
10 ers who are mutually agreed upon by the parties. If
11 requested by the enrollee or enrollee’s provider with
12 the enrollee’s consent, such a peer shall participate
13 in the panel’s review of the case. In this paragraph,
14 the term ‘clinical peer’ means, with respect to a re-
15 view, a physician or other health care professional
16 who holds a non-restricted license in a State and in
17 the same or similar specialty as typically manages
18 the medical condition, procedure, or treatment under
19 review.

20 “(3) TIMELY ACKNOWLEDGMENT.—The issuer
21 shall acknowledge the enrollee or provider involved
22 of the receipt of a stage 2 appeals upon receipt of
23 the appeal.

24 “(4) DEADLINE.—

1 “(A) IN GENERAL.—The issuer shall con-
2 clude each stage 2 appeal as soon as possible
3 after the date of the receipt of the appeal in ac-
4 cordance with medical exigencies of the case in-
5 volved, but in no event later than 72 hours in
6 the case of appeals from decisions regarding ur-
7 gent care and (except as provided in subpara-
8 graph (B)) 20 business days in the case of all
9 other appeals.

10 “(B) EXTENSION.—An issuer may extend
11 the deadline for an appeal that does not relate
12 to a decision regarding urgent or emergency
13 care up to an additional 20 business days where
14 it can demonstrate to the applicable State au-
15 thority reasonable cause for the delay beyond
16 its control and where it provides, within the
17 original deadline under subparagraph (A), a
18 written progress report and explanation for the
19 delay to such authority and to the enrollee and
20 provider involved.

21 “(5) NOTICE.—If an issuer denies a stage 2 ap-
22 peal, the issuer shall provide the enrollee and pro-
23 vider involved with written notification of the denial
24 and the reasons therefore, together with a written
25 notification of rights to any further appeal.

1 “(e) DIRECT USE OF FURTHER APPEALS.—In the
2 event that the issuer fails to comply with any of the dead-
3 lines for completion of appeals under this section or in
4 the event that the issuer for any reason expressly waives
5 its rights to an internal review of an appeal under sub-
6 section (c) or (d), the enrollee and provider involved shall
7 be relieved of any obligation to complete the appeal stage
8 involved and may, at the enrollee’s or provider’s option,
9 proceed directly to seek further appeal through any appli-
10 cable external appeals process.

11 “(f) EXTERNAL APPEAL PROCESS IN CASE OF USE
12 OF EXPERIMENTAL TREATMENT TO SAVE LIFE OF PA-
13 TIENT.—

14 “(1) IN GENERAL.—In the case of an enrollee
15 described in paragraph (2), the health insurance is-
16 suer shall provide for an external independent review
17 process respecting the issuer’s decision not to cover
18 the experimental therapy (described in paragraph
19 (2)(B)(ii)).

20 “(2) ENROLLEE DESCRIBED.—An enrollee de-
21 scribed in this paragraph is an enrollee who meets
22 the following requirements:

23 “(A) The enrollee has a terminal condition
24 that is highly likely to cause death within 2
25 years.

1 “(B) The enrollee’s physician certifies
2 that—

3 “(i) there is no standard, medically
4 appropriate therapy for successfully treat-
5 ing such terminal condition, but

6 “(ii) based on medical and scientific
7 evidence, there is a drug, device, proce-
8 dure, or therapy (in this section referred to
9 as the ‘experimental therapy’) that is more
10 beneficial than any available standard ther-
11 apy.

12 “(C) The issuer has denied coverage of the
13 experimental therapy on the basis that it is ex-
14 perimental or investigational.

15 “(3) DESCRIPTION OF PROCESS AND DECI-
16 SION.—The process under this subsection shall pro-
17 vide for a determination on a timely basis, by a
18 panel of independent, impartial physicians appointed
19 by a State authority or by an independent review or-
20 ganization certified by the State, of the medical ap-
21 propriateness of the experimental therapy. The deci-
22 sion of the panel shall be in writing and shall be ac-
23 companied by an explanation of the basis for the de-
24 cision. A decision of the panel that is favorable to
25 the enrollee may not be appealed by the issuer ex-

1 cept in the case of misrepresentation of a material
2 fact by the enrollee or a provider. A decision of the
3 panel that is not favorable to the enrollee may be
4 appealed by the enrollee.

5 “(4) ISSUER COVERING PROCESS COSTS.—Di-
6 rect costs of the process under this subsection shall
7 be borne by the issuer, and not by the enrollee.

8 “(g) OTHER INDEPENDENT OR EXTERNAL RE-
9 VIEW.—

10 “(1) IN GENERAL.—In the case of appealable
11 decision described in paragraph (2), the health in-
12 surance issuer shall provide for—

13 “(A) an external review process for such
14 decisions consistent with the requirements of
15 paragraph (3), or

16 “(B) an internal independent review proc-
17 ess for such decisions consistent with the re-
18 quirements of paragraph (4).

19 “(2) APPEALABLE DECISION DESCRIBED.—An
20 appealable decision described in this paragraph is a
21 decision that does not involve a decision a described
22 in subsection (f)(1) but involves—

23 “(A) a claim for benefits involving costs
24 over a significant threshold, or

1 “(B) assuring access to care for a serious
2 condition.

3 “(3) EXTERNAL REVIEW PROCESS.—The re-
4 quirements of this subsection for an external review
5 process are as follows:

6 “(A) The process is established under
7 State law and provides for review of decisions
8 on stage 2 appeals by an independent review or-
9 ganization certified by the State.

10 “(B) If the process provides that decisions
11 in such process are not binding on issuers, the
12 process must provide for public methods of dis-
13 closing frequency of noncompliance with such
14 decisions and for sanctioning issuers that con-
15 sistently refuse to take appropriate actions in
16 response to such decisions.

17 “(C) Results of all such reviews under the
18 process are disclosed to the public, along with
19 at least annual disclosure of information on is-
20 suer compliance.

21 “(D) All decisions under the process shall
22 be in writing and shall be accompanied by an
23 explanation of the basis for the decision.

24 “(E) Direct costs of the process shall be
25 borne by the issuer, and not by the enrollee.

1 “(F) The issuer shall provide for publica-
2 tion at least annually of information on the
3 numbers of appeals and decisions considered
4 under the process.

5 “(4) INTERNAL, INDEPENDENT REVIEW PROC-
6 ESS.—The requirements of this subsection for an in-
7 ternal, independent review process are as follows:

8 “(A)(i) The process must provide for the
9 participation of persons who are independent of
10 the issuer in conducting reviews and (ii) the
11 Secretary must have found (through reviews
12 conducted no less often than biannually) the
13 process to be fair and impartial.

14 “(B) If the process provides that decisions
15 in such process are not binding on issuers, the
16 process must provide for public methods of dis-
17 closing frequency of noncompliance with such
18 decisions and for sanctioning issuers that con-
19 sistently refuse to take appropriate actions in
20 response to such decisions.

21 “(C) Results of all such reviews under the
22 process are disclosed to the public, along with
23 at least annual disclosure of information on is-
24 suer compliance.

1 “(D) All decisions under the process shall
2 be in writing and shall be accompanied by an
3 explanation of the basis for the decision.

4 “(E) Direct costs of the process shall be
5 borne by the issuer, and not by the enrollee.

6 “(F) The issuer shall provide for publica-
7 tion at least annually of information on the
8 numbers of appeals and decisions considered
9 under the process.

10 The Secretary may delegate the authority under sub-
11 paragraph (A)(ii) to applicable State authorities.

12 “(5) OVERSIGHT.—The Secretary (and applica-
13 ble State authorities in the case of delegation of Sec-
14 retarial authority under paragraph (4)) shall con-
15 duct reviews not less often than biannually of the
16 fairness and impartiality issuers who desired to use
17 an internal, independent review process described in
18 paragraph (4) to satisfy the requirement of para-
19 graph (1).

20 “(6) REPORT.—The Secretary shall provide for
21 periodic reports on the effectiveness of this sub-
22 section in assuring fair and impartial reviews of
23 stage 2 appeals. Such reports shall include informa-
24 tion on the number of stage 2 appeals (and deci-
25 sions), for each of the types of review processes de-

1 scribed in paragraph (2), by health insurance cov-
2 erage.

3 “(h) CONSTRUCTION.—Nothing in this part shall be
4 construed as removing any legal rights of enrollees under
5 State or Federal law, including the right to file judicial
6 actions to enforce rights.”.

7 **TITLE VI—ADDITIONAL AMEND-**
8 **MENTS; EFFECTIVE DATES.**

9 **SEC. 601. APPLICATION TO GROUP AND INDIVIDUAL**
10 **HEALTH INSURANCE COVERAGE.**

11 (a) GROUP HEALTH INSURANCE COVERAGE.—(1)
12 Subpart 2 of part A of title XXVII of the Public Health
13 Service Act is amended by adding at the end the following
14 new section:

15 **“SEC. 2706. CONSUMER PROTECTION STANDARDS.**

16 “(a) IN GENERAL.—Each health insurance issuer
17 shall comply with consumer protection requirements under
18 part C with respect to group health insurance coverage
19 it offers.

20 “(b) ASSURING COORDINATION.—The Secretary of
21 Health and Human Services and the Secretary of Labor
22 shall ensure, through the execution of an interagency
23 memorandum of understanding between such Secretaries,
24 that—

1 “(1) regulations, rulings, and interpretations is-
2 sued by such Secretaries relating to the same matter
3 over which such Secretaries have responsibility
4 under part C (and this section) and section 713 of
5 the Employee Retirement Income Security Act of
6 1974 are administered so as to have the same effect
7 at all times; and

8 “(2) coordination of policies relating to enforce-
9 ing the same requirements through such Secretaries
10 in order to have a coordinated enforcement strategy
11 that avoids duplication of enforcement efforts and
12 assigns priorities in enforcement.”.

13 (2) Section 2792 of such Act (42 U.S.C.
14 300gg-92) is amended by inserting “and section
15 2706(b)” after “of 1996”.

16 (b) APPLICATION TO INDIVIDUAL HEALTH INSUR-
17 ANCE COVERAGE.—Part B of title XXVII of the Public
18 Health Service Act is amended by inserting after section
19 2751 the following new section:

20 **“SEC. 2752. CONSUMER PROTECTION STANDARDS.**

21 “Each health insurance issuer shall comply with
22 consumer protection requirements under part C with re-
23 spect to individual health insurance coverage it offers.”.

24 (c) APPLICATION UNDER MEDICARE AND MEDICAID
25 PROGRAMS.—

1 (1) MEDICARE PROGRAM.—Section 1852 of the
2 Social Security Act (42 U.S.C. 1395w–22), as in-
3 serted by section 4001 of the Balanced Budget Act
4 of 1997 (Public Law 105–33) is amended by adding
5 at the end the following new subsection:

6 “(1) ADDITIONAL BENEFICIARY PROTECTIONS.—

7 “(1) IN GENERAL.—Each Medicare+Choice
8 plan shall comply with consumer protection require-
9 ments under part C of title XXVII of the Public
10 Health Service Act.

11 “(2) CONSTRUCTION.—Paragraph (1) shall not
12 be construed as superseding any requirements of
13 this part to the extent such requirements are more
14 stringent than the requirements under part C of title
15 XXVII of the Public Health Service Act.”,

16 (2) MEDICAID PROGRAM.—Section 1932(b) of
17 the Social Security Act (42 U.S.C. 1396u–2(b)), as
18 added by section 4704(a) of the Balanced Budget
19 Act of 1997 (Public Law 105–33) is amended by
20 adding at the end the following new paragraph:

21 “(9) ADDITIONAL ENROLLEE PROTECTIONS.—

22 “(A) IN GENERAL.—A medicaid managed
23 care organization shall comply with consumer
24 protection requirements under part C of title
25 XXVII of the Public Health Service Act with

1 respect to individuals enrolled with the organi-
2 zation under a contract under section 1903(m)
3 or 1905(t)(3).

4 “(B) CONSTRUCTION.—Paragraph (1)
5 shall not be construed as superseding any re-
6 quirements of this title to the extent such re-
7 quirements are more stringent than the require-
8 ments under part C of title XXVII of the Pub-
9 lic Health Service Act.”,

10 (d) MODIFICATION OF PREEMPTION STANDARDS.—

11 (1) GROUP HEALTH INSURANCE COVERAGE.—
12 Section 2723 of such Act (42 U.S.C. 300gg–23) is
13 amended—

14 (A) in subsection (a)(1), by striking “sub-
15 section (b)” and inserting “subsections (b) and
16 (c)”;

17 (B) by redesignating subsections (e) and
18 (d) as subsections (d) and (e), respectively; and

19 (C) by inserting after subsection (b) the
20 following new subsection:

21 “(c) SPECIAL RULES IN CASE OF CONSUMER PRO-
22 TECTION REQUIREMENTS.—Subject to subsection (a)(2),
23 the provisions of section 2706 and part C, and part D
24 insofar as it applies to section 2706 or part C, shall not
25 be construed to preempt any State law, or the enactment

1 or implementation of such a State law, that provides pro-
2 tections for individuals that are equivalent to or stricter
3 than the protections provided under such provisions.”.

4 (2) INDIVIDUAL HEALTH INSURANCE COV-
5 ERAGE.—Section 2762 of such Act (42 U.S.C.
6 300gg-62), as added by section 605(b)(3)(B) of
7 Public Law 104-204, is amended—

8 (A) in subsection (a), by striking “sub-
9 section (b), nothing in this part” and inserting
10 “subsections (b) and (c)”, and

11 (B) by adding at the end the following new
12 subsection:

13 “(c) SPECIAL RULES IN CASE OF CONSUMER PRO-
14 TECTION REQUIREMENTS.—Subject to subsection (b), the
15 provisions of section 2752 and part C, and part D insofar
16 as it applies to section 2752 or part C, shall not be con-
17 strued to preempt any State law, or the enactment or im-
18 plementation of such a State law, that provides protections
19 for individuals that are equivalent to or stricter than the
20 protections provided under such provisions.”.

21 (e) ADDITIONAL CONFORMING AMENDMENTS.—

22 (1) Section 2723(a)(1) of such Act (42 U.S.C.
23 300gg-23(a)(1)) is amended by striking “part C”
24 and inserting “parts C and D”.

1 (2) Section 2762(b)(1) of such Act (42 U.S.C.
2 300gg-62(b)(1)) is amended by striking “part C”
3 and inserting “part D”.

4 (f) EFFECTIVE DATES.—(1)(A) Subject to subpara-
5 graph (B), the amendments made by this Act shall apply
6 with respect to group health insurance coverage for group
7 health plan years beginning on or after July 1, 1998 (in
8 this subsection referred to as the “general effective date”)
9 and also shall apply to portions of plan years occurring
10 on and after January 1, 1999.

11 (B) In the case of group health insurance coverage
12 provided pursuant to a group health plan maintained pur-
13 suant to 1 or more collective bargaining agreements be-
14 tween employee representatives and 1 or more employers
15 ratified before the date of enactment of this Act, the
16 amendments made by this Act shall not apply to plan
17 years beginning before the later of—

18 (i) the date on which the last collective bargain-
19 ing agreements relating to the plan terminates (de-
20 termined without regard to any extension thereof
21 agreed to after the date of enactment of this Act),
22 or

23 (ii) the general effective date.

24 For purposes of clause (i), any plan amendment made pur-
25 suant to a collective bargaining agreement relating to the

1 plan which amends the plan solely to conform to any re-
2 quirement added by this Act shall not be treated as a ter-
3 mination of such collective bargaining agreement.

4 (2) The amendments made by this Act shall apply
5 with respect to individual health insurance coverage of-
6 fered, sold, issued, renewed, in effect, or operated in the
7 individual market on or after the general effective date.

8 (3) The amendments made by this Act shall apply
9 under the medicare and medicaid programs under titles
10 XVIII and XIX of the Social Security Act on and after
11 the general effective date.

12 **SEC. 602. CONSUMER PROTECTION STANDARDS UNDER**
13 **THE EMPLOYEE RETIREMENT INCOME SECUR-**
14 **RITY ACT OF 1974.**

15 (a) IN GENERAL.—Subpart B of part 7 of subtitle
16 B of title I of the Employee Retirement Income Security
17 Act of 1974 is amended by adding at the end the following
18 new section:

19 **“SEC. 713. CONSUMER PROTECTION STANDARDS.**

20 “(a) IN GENERAL.—Subject to subsection (b), a
21 group health plan (and a health insurance issuer offering
22 group health insurance coverage in connection with such
23 a plan) shall comply with the requirements of part C of
24 title XXVII of the Public Health Service Act.

1 “(b) REFERENCES IN APPLICATION.—In applying
2 subsection (a) under this part, any reference in such part
3 C—

4 “(1) to a health insurance issuer and health in-
5 surance coverage offered by such an issuer is
6 deemed to include a reference to a group health plan
7 and coverage under such plan, respectively;

8 “(2) to the Secretary is deemed a reference to
9 the Secretary of Labor;

10 “(3) to an applicable State authority is deemed
11 a reference to the Secretary of Labor; and

12 “(4) to an enrollee with respect to health insur-
13 ance coverage is deemed to include a reference to a
14 participant or beneficiary with respect to a group
15 health plan.

16 “(c) ASSURING COORDINATION.—The Secretary of
17 Health and Human Services and the Secretary of Labor
18 shall ensure, through the execution of an interagency
19 memorandum of understanding between such Secretaries,
20 that—

21 “(1) regulations, rulings, and interpretations is-
22 sued by such Secretaries relating to the same matter
23 over which such Secretaries have responsibility
24 under such part C (and section 2706 of the Public

1 Health Service Act) and this section are adminis-
2 tered so as to have the same effect at all times; and

3 “(2) coordination of policies relating to enforc-
4 ing the same requirements through such Secretaries
5 in order to have a coordinated enforcement strategy
6 that avoids duplication of enforcement efforts and
7 assigns priorities in enforcement.”.

8 (b) MODIFICATION OF PREEMPTION STANDARDS.—
9 Section 731 of such Act (42 U.S.C. 1191) is amended—

10 (1) in subsection (a)(1), by striking “subsection
11 (b)” and inserting “subsections (b) and (c)”;

12 (2) by redesignating subsections (c) and (d) as
13 subsections (d) and (e), respectively; and

14 (3) by inserting after subsection (b) the follow-
15 ing new subsection:

16 “(c) SPECIAL RULES IN CASE OF CONSUMER PRO-
17 TECTION REQUIREMENTS.—Subject to subsection (a)(2),
18 the provisions of section 713 and part C of title XXVII
19 of the Public Health Service Act, and subpart C insofar
20 as it applies to section 713 or such part, shall not be con-
21 strued to preempt any State law, or the enactment or im-
22 plementation of such a State law, that provides protections
23 for individuals that are equivalent to or stricter than the
24 protections provided under such provisions.”.

1 (c) CONFORMING AMENDMENTS.—(1) Section 732(a)
2 of such Act (29 U.S.C. 1185(a)) is amended by striking
3 “section 711” and inserting “sections 711 and 713”.

4 (2) The table of contents in section 1 of such Act
5 is amended by inserting after the item relating to section
6 712 the following new item:

“Sec. 713. Consumer protection standards.”.

7 (3) Section 734 of such Act (29 U.S.C. 1187) is
8 amended by inserting “and section 713(d)” after “of
9 1996”.

10 (d) EFFECTIVE DATE.—(1) Subject to paragraph
11 (2), the amendments made by this section shall apply with
12 respect to group health plans for plan years beginning on
13 or after July 1, 1998 (in this subsection referred to as
14 the “general effective date”) and also shall apply to por-
15 tions of plan years occurring on and after January 1,
16 1999.

17 (2) In the case of a group health plan maintained
18 pursuant to 1 or more collective bargaining agreements
19 between employee representatives and 1 or more employ-
20 ers ratified before the date of enactment of this Act, the
21 amendments made by this section shall not apply to plan
22 years beginning before the later of—

23 (A) the date on which the last collective bar-
24 gaining agreements relating to the plan terminates
25 (determined without regard to any extension thereof

1 agreed to after the date of enactment of this Act),

2 or

3 (B) the general effective date.

4 For purposes of subparagraph (A), any plan amendment

5 made pursuant to a collective bargaining agreement relat-

6 ing to the plan which amends the plan solely to conform

7 to any requirement added by subsection (a) shall not be

8 treated as a termination of such collective bargaining

9 agreement.

○