

105<sup>TH</sup> CONGRESS  
2<sup>D</sup> SESSION

# H. R. 3547

To amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to assure patient choice and access to services for enrollees in group health plans and health insurance coverage.

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## IN THE HOUSE OF REPRESENTATIVES

MARCH 25, 1998

Mr. WELDON of Florida (for himself, Mr. BROWN of Ohio, Mr. COBURN, Mr. STRICKLAND, Mr. COOKSEY, and Mr. GREEN) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committee on 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

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## A BILL

To amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to assure patient choice and access to services for enrollees in group health plans and health insurance coverage.

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.**

4 This Act may be cited as the “Patient Choice and  
5 Access to Quality Health Care Act of 1998”.

1 **SEC. 2. FINDINGS.**

2 Congress finds the following:

3 (1) There should be no unreasonable barriers or  
4 impediments to the ability of individuals enrolled in  
5 health care plans to obtain appropriate specialized  
6 medical services.

7 (2) The patient's first point of contact in a  
8 health care plan must be encouraged to make all ap-  
9 propriate medical referrals and should not be con-  
10 strained financially from making such referrals.

11 (3) Some health care plans may impede timely  
12 access to specialty care.

13 (4) Some contracts between health care plans  
14 and health care professionals may contain provisions  
15 which impede the professional in informing the pa-  
16 tient of the full range of treatment options.

17 (5) Patients cannot make appropriate health  
18 care decisions without access to all relevant informa-  
19 tion relating to those decisions.

20 (6) Restrictions on the ability of health care  
21 professionals to provide full disclosure of all relevant  
22 information to patients making health care decisions  
23 violate the principles of informed consent and the  
24 ethical standards of the health care professions.  
25 Contractual clauses and other policies that interfere  
26 with communications between health care profes-

1 sionals and patients can impact the quality of care  
2 received by those patients.

3 (7) Patients should have the opportunity to ac-  
4 cess out-of-network items, treatment, and services at  
5 an additional cost to the patient, recognizing preva-  
6 lent market conditions, which is not so prohibitive  
7 that they are deterred from seeing the health care  
8 professional of their own choice.

9 (8) Specialty care must be available for the full  
10 duration of the patient's medical needs at the discre-  
11 tion of the attending health care professional in con-  
12 sultation with the patient.

13 (9) Access to specialty care is essential for pa-  
14 tients in emergency and non-emergency situations  
15 and for patients with chronic and temporary condi-  
16 tions.

17 **SEC. 3. PROTECTION FOR HEALTH PLAN ENROLLEES.**

18 (a) GROUP HEALTH PLANS.—

19 (1) PUBLIC HEALTH SERVICE ACT AMEND-  
20 MENTS.—

21 (A) IN GENERAL.—Subpart 2 of part A of  
22 title XXVII of the Public Health Service Act is  
23 amended by adding at the end the following  
24 new section:

1 **“SEC. 2706. ADDITIONAL ENROLLEE PROTECTIONS.**

2 “(a) ASSURING ADEQUATE IN-NETWORK ACCESS.—

3 “(1) TIMELY ACCESS.—A group health plan,  
4 and a health insurance issuer offering group health  
5 insurance coverage, that restricts the health care  
6 professionals from whom benefits may be obtained  
7 shall guarantee to enrollees timely access to primary  
8 and specialty health care professionals who are ap-  
9 propriate to the enrollee’s condition.

10 “(2) ACCESS TO SPECIALIZED CARE.—A group  
11 health plan, and a health insurance issuer offering  
12 group health insurance coverage, shall assure that  
13 enrollees have access to specialized treatment when  
14 medically necessary. This access may be satisfied  
15 through contractual arrangements with specialized  
16 providers outside of the network.

17 “(3) CONTINUITY OF CARE.—A group health  
18 plan, and a health insurance issuer offering group  
19 health insurance coverage, shall assure that the  
20 plan’s or issuer’s use of case management may not  
21 create an undue burden for enrollees under this sec-  
22 tion. The plan and issuer shall ensure direct access  
23 to specialists for ongoing care as so determined by  
24 the case manager in consultation with the specialty  
25 care professional. This continuity of care may be  
26 satisfied for enrollees with chronic conditions

1 through the use of a specialist serving as case man-  
2 ager.

3 “(b) GRIEVANCE PROCESS.—

4 “(1) IN GENERAL.—A group health plan, and a  
5 health insurance issuer offering group health insur-  
6 ance coverage, shall provide a meaningful and expe-  
7 dited procedure, which includes notice and hearing  
8 requirements, for resolving grievances between the  
9 plan or issuer (including any entity or individual  
10 through which the plan or issuer provides health  
11 care services) and enrollees. Under the procedure  
12 any such enrollee may at any time file a complaint  
13 to resolve grievances between the enrollee and the  
14 plan or issuer before a board of appeals established  
15 under paragraph (3).

16 “(2) NOTICE REQUIREMENTS.—

17 “(A) IN GENERAL.—Such a plan or issuer  
18 shall provide, in a timely manner, an enrollee a  
19 notice of any denial of services in-network or  
20 denial of payment for out-of-network care.

21 “(B) INFORMATION REQUIRED.—Such no-  
22 tice shall include the following:

23 “(i) A clear statement of the reason  
24 for the denial.

1           “(ii) An explanation of the complaint  
2 process under paragraph (3) which is  
3 available to the enrollee upon request.

4           “(iii) An explanation of all other ap-  
5 peal rights available to all enrollees.

6           “(iv) A description of how to obtain  
7 supporting evidence for the hearing de-  
8 scribed in paragraph (3), including the pa-  
9 tient’s medical records from the plan or  
10 issuer, as well as supporting affidavits  
11 from the attending health care profes-  
12 sionals.

13           “(3) HEARING BOARD.—

14           “(A) IN GENERAL.—Each group health  
15 plan, and each health insurance issuer offering  
16 group health insurance coverage, shall establish  
17 a board of appeals to hear and make determina-  
18 tions on complaints by enrollees concerning de-  
19 nials of coverage or payment for services  
20 (whether in-network or out-of-network) and the  
21 medical necessity and appropriateness of cov-  
22 ered items and services.

23           “(B) COMPOSITION.—A board of appeals  
24 of a plan or issuer shall consist of—

1 “(i) representatives of the plan or  
2 issuer, including physicians, nonphysicians,  
3 administrators, and enrollees;

4 “(ii) consumers who are not enrollees  
5 and who have no financial interest in the  
6 plan or issuer; and

7 “(iii) health care professionals who  
8 are not under contract with and have no fi-  
9 nancial interest in the plan or issuer and  
10 who are experts in the field of medicine  
11 which necessitates treatment.

12 “(C) DEADLINE FOR DECISION.—

13 “(i) IN GENERAL.—Except as pro-  
14 vided in clause (ii), a board of appeals  
15 shall hear and resolve complaints within 30  
16 days after the date the complaint is filed  
17 with the board.

18 “(ii) EXPEDITED PROCEDURE.—A  
19 board of appeals shall have an expedited  
20 procedure in order to hear and resolve  
21 complaints regarding urgent care.

22 “(c) NOTICE OF ENROLLEE RIGHTS AND ENROLLEE  
23 INFORMATION CHECKLIST.—

24 “(1) IN GENERAL.—Each group health plan,  
25 and each health insurance issuer offering group

1 health insurance coverage, shall provide each en-  
2 rollee, at the time of enrollment and not less fre-  
3 quently than annually thereafter, an explanation of  
4 the enrollee’s rights under this section and a copy of  
5 the most recent enrollee information checklist for the  
6 plan or issuer (as described in paragraph (3)).

7 “(2) RIGHTS DESCRIBED.—The explanation of  
8 rights under paragraph (1) shall include an expla-  
9 nation of—

10 “(A) the enrollee’s rights to benefits from  
11 the plan or issuer;

12 “(B) the restrictions on payments (if any)  
13 under the plan or coverage for services fur-  
14 nished other than by or through the plan or  
15 issuer;

16 “(C) out-of-area coverage provided under  
17 the plan or coverage;

18 “(D) the plan’s or issuer’s coverage of  
19 emergency services and urgently needed care;

20 “(E) the plan’s or issuer’s coverage of out-  
21 of-network services; and

22 “(F) appeal rights of enrollees.

23 “(3) ENROLLEE INFORMATION CHECKLIST.—

24 For purposes of paragraph (1), the term ‘enrollee in-  
25 formation checklist’ means, with respect to a plan or

1 issuer for a year, a list containing the following in-  
2 formation (provided in a manner that permits con-  
3 sumers to compare plans and issuers with respect to  
4 the information):

5 “(A) For each plan or coverage offered, in-  
6 formation on the following:

7 “(i) The premium for the plan or cov-  
8 erage.

9 “(ii) The benefits offered under the  
10 plan or coverage.

11 “(iii) the amount of any deductibles,  
12 coinsurance, or any monetary limits on  
13 benefits.

14 “(iv) The identity, location, qualifica-  
15 tions, and availability of health care pro-  
16 fessionals in any networks of the plan or  
17 issuer.

18 “(v) The procedures used by the plan  
19 or issuer to control utilization of services  
20 and expenditures, including any financial  
21 incentives.

22 “(vi) The procedures used by the plan  
23 or issuer to ensure quality of care.

24 “(vii) The rights and responsibilities  
25 of enrollees.

1           “(viii) The number of applications  
2           during the previous plan year requesting  
3           that the plan or issuer cover certain medi-  
4           cal services that were denied by the plan or  
5           issuer (and the number of such denials  
6           that were subsequently reversed by the  
7           plan or issuer), stated as a percentage of  
8           the total number of applications during  
9           such period requesting that the plan or  
10          issuer cover such services.

11          “(ix) The number of times during the  
12          previous plan year that a court of law  
13          upheld or reversed a denial of a request  
14          that the plan or issuer cover certain medi-  
15          cal services.

16          “(x) The restrictions (if any) on pay-  
17          ment for services provided outside the  
18          plan’s or issuer’s health care professional  
19          network.

20          “(xi) The process by which services  
21          may be obtained through the plan’s or  
22          issuer’s health care professional network.

23          “(xii) Coverage for out-of-area serv-  
24          ices.

1                   “(xiii) Any exclusions in the types of  
2                   health care professionals participating in  
3                   the plan’s or issuer’s health care profes-  
4                   sional network.

5           “(d) RESTRICTIONS ON HEALTH CARE PROFES-  
6           SIONAL INCENTIVE PLANS.—A group health plan, and a  
7           health insurance issuer offering group health insurance  
8           coverage, may not operate any health care professional in-  
9           centive plan under which a specific payment is made di-  
10          rectly or indirectly under the plan to a health care profes-  
11          sional or professional group as an inducement to reduce  
12          or limit medically necessary services provided with respect  
13          to enrollees.

14          “(e) PROHIBITION OF INTERFERENCE WITH CER-  
15          TAIN MEDICAL COMMUNICATIONS.—

16                 “(1) IN GENERAL.—

17                         “(A) PROHIBITION OF CERTAIN PROVI-  
18                         SIONS.—Subject to paragraph (3), a group  
19                         health plan, and a health insurance issuer offer-  
20                         ing group health insurance coverage, may not  
21                         include under the plan or coverage any provi-  
22                         sion that prohibits or restricts any medical com-  
23                         munication (as defined in paragraph (2)) as  
24                         part of—

1                   “(i) a written contract or agreement  
2                   with a health care professional,

3                   “(ii) a written statement to such a  
4                   professional, or

5                   “(iii) an oral communication to such a  
6                   professional.

7                   “(B) NULLIFICATION.—Any provision de-  
8                   scribed in clause (i) is null and void.

9                   “(2) MEDICAL COMMUNICATION DEFINED.—In  
10                  this paragraph, the term ‘medical communication’  
11                  means a communication made by a health care pro-  
12                  fessional with a patient of the professional (or the  
13                  guardian or legal representative of such patient)  
14                  with respect to any of the following:

15                  “(A) How participating physicians and  
16                  health care professionals are paid.

17                  “(B) Utilization review procedures.

18                  “(C) The basis for specific utilization re-  
19                  view decisions.

20                  “(D) Whether a specific prescription drug  
21                  or biological is included in the formulary.

22                  “(E) How the plan or organization decides  
23                  whether a treatment or procedure is experi-  
24                  mental.

1           “(F) The patient’s physical or mental con-  
2           dition or treatment options.

3           “(3) CONSTRUCTION.—Nothing in this sub-  
4           section shall be construed as preventing an entity  
5           from—

6           “(A) acting on information relating to the  
7           provision of (or failure to provide) treatment to  
8           a patient, or

9           “(B) restricting a medical communication  
10          that recommends one health plan over another  
11          if the sole purpose of the communication is to  
12          secure financial gain for the health care profes-  
13          sional.

14          “(f) OUT-OF-NETWORK ACCESS.—

15          “(1) IN GENERAL.—Subject to paragraph (2),  
16          if a group health plan, or a health insurance issuer  
17          offering group health insurance coverage, offers to  
18          enrollees coverage for benefits for services only if  
19          such services are furnished through professionals  
20          and other persons who are members of a network of  
21          professionals and other persons who have entered  
22          into a contract with the plan or issuer to provide  
23          such services, the plan or issuer shall also offer to  
24          such enrollees (at the time of enrollment) the option  
25          of coverage of such services which are not furnished

1 through professionals and other persons who are  
2 members of such a network.

3 “(2) EFFECTIVENESS.—Paragraph (1) shall  
4 apply only in accordance with section 3(b)(2) of the  
5 Patient Choice and Access to Quality Health Care  
6 Act of 1998 (relating to a finding by the Secretary  
7 that the other patient protections have not assured  
8 quality of care).

9 “(g) ADDITIONAL DEFINITIONS.—For purposes of  
10 this section:

11 “(1) HEALTH CARE PROFESSIONAL.—The term  
12 ‘health care professional’ means a physician or other  
13 health care practitioner licensed, accredited, or cer-  
14 tified to perform specified health services consistent  
15 with State law.

16 “(2) IN-NETWORK.—The term ‘in-network’  
17 means services provided by health care professionals  
18 who have entered into a contract or agreement with  
19 a group health plan, or health insurance issuer offer-  
20 ing group health insurance coverage in connection  
21 with such a plan, under which such professionals are  
22 obligated to provide items, treatment, and services  
23 under this section to individuals enrolled under the  
24 plan.

1           “(3) NETWORK.—The term ‘network’ means,  
2           with respect to a group health plan or a health in-  
3           surance issuer that offers group health insurance  
4           coverage in connection with such a plan, the health  
5           care professionals who have entered into a contract  
6           or agreement with the plan or issuer under which  
7           such professionals are obligated to provide items,  
8           treatment, and services under this section to individ-  
9           uals enrolled under the plan.

10           “(4) OUT-OF-NETWORK.—The term ‘out-of-net-  
11           work’ means services provided by health care profes-  
12           sionals who have not entered into a contract or  
13           agreement described in paragraph (2).

14           “(h) NOTICE.—A group health plan under this part  
15           shall comply with the notice requirement under section  
16           713(b) of the Employee Retirement Income Security Act  
17           of 1974 with respect to the requirements of this section  
18           as if such section applied to such plan.”.

19                   (B) REFERENCE TO NON-PREEMPTION  
20           PROVISION.—Pursuant to section 2723 of the  
21           Public Health Service Act, States may provide  
22           protections for individuals that are equivalent  
23           to or stricter than the protections provided  
24           under the amendment made by subparagraph  
25           (A).

1 (C) CONFORMING AMENDMENT.—Section  
2 2723(c) of such Act (42 U.S.C. 300gg–23(c)),  
3 as amended by section 604(b)(2) of Public Law  
4 104–204, is amended by striking “section  
5 2704” and inserting “sections 2704 and 2706”.

6 (2) ERISA AMENDMENTS.—

7 (A) IN GENERAL.—Subpart B of part 7 of  
8 subtitle B of title I of the Employee Retirement  
9 Income Security Act of 1974 is amended by  
10 adding at the end the following new section:

11 **“SEC. 713. ADDITIONAL ENROLLEE PROTECTIONS.**

12 “(a) IN GENERAL.—Subject to subsection (b), a  
13 group health plan (and a health insurance issuer offering  
14 group health insurance coverage in connection with such  
15 a plan) shall comply with the requirements of section 2706  
16 of the Public Health Service Act. For purposes of applying  
17 this subsection, any reference in such section 2706 to an  
18 enrollee with respect to health insurance coverage is  
19 deemed to include a reference to a participant or bene-  
20 ficiary with respect to a group health plan.

21 “(b) NOTICE UNDER GROUP HEALTH PLAN.—The  
22 imposition of the requirement of this section shall be treat-  
23 ed as a material modification in the terms of the plan de-  
24 scribed in section 102(a)(1), for purposes of assuring no-  
25 tice of such requirements under the plan; except that the

1 summary description required to be provided under the  
2 last sentence of section 104(b)(1) with respect to such  
3 modification shall be provided by not later than 60 days  
4 after the first day of the first plan year in which such  
5 requirement apply.”.

6 (B) REFERENCE TO NON-PREEMPTION  
7 PROVISION.—Pursuant to section 731 of the  
8 Employee Retirement Income Security Act of  
9 1974, States may provide protections for indi-  
10 viduals that are equivalent to or stricter than  
11 the protections provided under the amendment  
12 made by subparagraph (A).

13 (C) CONFORMING AMENDMENTS.—(i) Sec-  
14 tion 731(c) of such Act (29 U.S.C. 1191(c)) is  
15 amended by striking “section 711” and insert-  
16 ing “sections 711 and 713”.

17 (ii) Section 732(a) of such Act (29 U.S.C.  
18 1191a(a)) is amended by striking “section 711”  
19 and inserting “sections 711 and 713”.

20 (D) The table of contents in section 1 of  
21 such Act is amended by inserting after the item  
22 relating to section 712 the following new item:

“Sec. 713. Additional enrollee protections.”.

23 (b) INDIVIDUAL HEALTH INSURANCE.—

1           (1) IN GENERAL.—Part B of title XXVII of the  
2           Public Health Service Act is amended by inserting  
3           after section 2751 the following new section:

4           **“SEC. 2752. ADDITIONAL ENROLLEE PROTECTIONS.**

5           “(a) IN GENERAL.—The provisions of section 2706  
6           (other than subsection (i)) shall apply to health insurance  
7           coverage offered by a health insurance issuer in the indi-  
8           vidual market in the same manner as they apply to health  
9           insurance coverage offered by a health insurance issuer  
10          in connection with a group health plan in the small or  
11          large group market.

12          “(b) NOTICE.—A health insurance issuer under this  
13          part shall comply with the notice requirement under sec-  
14          tion 713(b) of the Employee Retirement Income Security  
15          Act of 1974 with respect to the requirements referred to  
16          in subsection (a) as if such section applied to such issuer  
17          and such issuer were a group health plan.”.

18          (2) REFERENCE TO NON-PREEMPTION PROVI-  
19          SION.—Pursuant to section 2762 of the Public  
20          Health Service Act, States may provide protections  
21          for individuals that are equivalent to or stricter than  
22          the protections provided under the amendment made  
23          by paragraph (1).

24          (3) CONFORMING AMENDMENT.—Section  
25          2762(b)(2) of such Act (42 U.S.C. 300gg–62(b)(2))

1 is amended by striking “section 2751” and inserting  
2 “sections 2751 and 2752”.

3 (c) EFFECTIVE DATES.—

4 (1) GROUP HEALTH PLANS.—

5 (A) IN GENERAL.—Subject to subpara-  
6 graph (B), the amendments made by subsection  
7 (a) shall apply with respect to group health  
8 plans for plan years beginning on or after Jan-  
9 uary 1, 1999.

10 (B) RULE FOR CERTAIN COLLECTIVE BARGAIN-  
11 ING AGREEMENTS.—In the case of a group health  
12 plan maintained pursuant to 1 or more collective  
13 bargaining agreements between employee representa-  
14 tives and 1 or more employers ratified before the  
15 date of enactment of this Act, the amendments made  
16 subsection (a) shall not apply to plan years begin-  
17 ning before the later of—

18 (i) the date on which the last collective  
19 bargaining agreements relating to the plan ter-  
20 minates (determined without regard to any ex-  
21 tension thereof agreed to after the date of en-  
22 actment of this Act), or

23 (ii) January 1, 1999.

24 For purposes of clause (i), any plan amendment  
25 made pursuant to a collective bargaining agreement

1 relating to the plan which amends the plan solely to  
2 conform to any requirement added by subsection (a)  
3 shall not be treated as a termination of such collec-  
4 tive bargaining agreement.

5 (2) INDIVIDUAL HEALTH INSURANCE COV-  
6 ERAGE.—The amendment made by subsection (b)  
7 shall apply with respect to health insurance coverage  
8 offered, sold, issued, renewed, in effect, or operated  
9 in the individual market on or after such date.

10 (d) COORDINATED REGULATIONS.—Section 104(1)  
11 of Health Insurance Portability and Accountability Act of  
12 1996 is amended by striking “this subtitle (and the  
13 amendments made by this subtitle and section 401)” and  
14 inserting “the provisions of part 7 of subtitle B of title  
15 I of the Employee Retirement Income Security Act of  
16 1974, the provisions of parts A and C of title XXVII of  
17 the Public Health Service Act, and chapter 100 of the In-  
18 ternal Revenue Code of 1986”.

19 **SEC. 4. REPORT ON EFFECTIVENESS OF PATIENT PROTEC-**  
20 **TIONS.**

21 (a) STUDY.—The Secretary of Health and Human  
22 Services shall provide for a study on the effectiveness of  
23 the amendments made by section 3 in assuring quality of  
24 care for patients. Such study shall also examine any addi-

1 tional costs imposed as a result of the enactment of such  
2 amendments.

3 (b) REPORT.—

4 (1) IN GENERAL.—The Secretary shall submit  
5 to Congress a report on such study not later than  
6 January 1, 2001.

7 (2) FINDING REGARDING QUALITY CARE.—The  
8 Secretary shall include in the report a specific find-  
9 ing as to whether, taking into account the patient  
10 protections provided under such amendments, indi-  
11 viduals covered under health plans are not being  
12 provided quality care. If the Secretary makes such  
13 a finding that individuals covered under health plans  
14 are not being provided quality care and if Congress  
15 concurs by joint resolution or Act with such a find-  
16 ing, then subsection (f)(1) of section 2706 of the  
17 Public Health Service Act shall become effective in  
18 the same manner as amendments made by sub-  
19 sections (a) and (b) of section 3 become effective  
20 under section 3(c), except that (for purposes of this  
21 paragraph) any reference in such section 3(c) to  
22 January 1, 1999, shall be deemed a reference to  
23 January 1, 2002.

○