

105TH CONGRESS
2D SESSION

H. R. 4202

To amend title XXVII of the Public Health Service Act to establish certain standards with respect to health plans.

IN THE HOUSE OF REPRESENTATIVES

JULY 14, 1998

Mr. ENSIGN introduced the following bill; which was referred to the Committee on Commerce

A BILL

To amend title XXVII of the Public Health Service Act to establish certain standards with respect to health plans.

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

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

4 (a) **SHORT TITLE.**—This Act may be cited as the
5 “Health Quality and Fairness Act of 1998”.

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

Sec. 1. Short title; table of contents.

Sec. 2. Patient protection standards under the Public Health Service Act.

“PART C—PATIENT PROTECTION STANDARDS

“Sec. 2770. Notice.

“Sec. 2771. Coverage of services.

“Sec. 2772. Access to emergency care.
 “Sec. 2773. Protecting the doctor-patient relationship.
 “Sec. 2774. Quality assurance.
 “Sec. 2775. Designation of primary care provider.
 “Sec. 2776. Grievance and appeals procedures.
 “Sec. 2777. Understandability of information.”.

1 **SEC. 2. PATIENT PROTECTION STANDARDS UNDER THE**
 2 **PUBLIC HEALTH SERVICE ACT.**

3 (a) PATIENT PROTECTION STANDARDS.—Title
 4 XXVII of the Public Health Service Act is amended—

5 (1) by redesignating part C as part D, and

6 (2) by inserting after part B the following new

7 part:

8 “PART C—PATIENT PROTECTION STANDARDS

9 **“SEC. 2770. NOTICE.**

10 “A health insurance issuer under this part shall com-
 11 ply with the notice requirement under section 711(d) of
 12 the Employee Retirement Income Security Act of 1974
 13 with respect to the requirements of this part as if such
 14 section applied to such issuer and such issuer were a
 15 group health plan.

16 **“SEC. 2771. COVERAGE OF SERVICES.**

17 “(a) IN GENERAL.—If a health insurance issuer of-
 18 fering health insurance coverage provides benefits with re-
 19 spect to a service, and a physician recommends such serv-
 20 ice for an enrollee, the issuer shall cover any service fur-
 21 nished under the coverage unless a physician who has re-
 22 viewed the notes of the attending physician and any medi-

1 cal records of the enrollee determines that such services
2 should not be covered.

3 “(b) WRITTEN DENIAL OF COVERAGE.—In a case in
4 which a health insurance issuer denies coverage of a serv-
5 ice to an enrollee, issuer shall provide, in writing, to the
6 enrollee, the physician who recommended such service, and
7 the primary physician of the enrollee—

8 “(1) the reasons for the denial of coverage;

9 “(2) the criteria used to determine whether to
10 authorize or deny coverage; and

11 “(3) the right of the enrollee to file a written
12 grievance.

13 **“SEC. 2772. ACCESS TO EMERGENCY CARE.**

14 “(a) COVERAGE OF EMERGENCY SERVICES.—

15 “(1) IN GENERAL.—If health insurance cov-
16 erage provides any benefits with respect to emer-
17 gency services (as defined in paragraph (2)(B)), the
18 plan or issuer shall cover emergency services fur-
19 nished under the plan or coverage—

20 “(A) without the need for any prior au-
21 thorization determination;

22 “(B) whether or not the physician or pro-
23 vider furnishing such services is a participating
24 physician or provider with respect to such serv-
25 ices; and

1 “(C) without regard to any other term or
2 condition of such coverage (other than exclusion
3 or coordination of benefits, or an affiliation or
4 waiting period, permitted under section 2701 of
5 the Public Health Service Act, section 701 of
6 the Employee Retirement Income Security Act
7 of 1974, or section 9801 of the Internal Reve-
8 nue Code of 1986, and other than applicable
9 cost sharing).

10 “(2) DEFINITIONS.—In this section:

11 “(A) EMERGENCY MEDICAL CONDITION
12 BASED ON PRUDENT LAYPERSON STANDARD.—
13 The term ‘emergency medical condition’ means
14 a medical condition manifesting itself by acute
15 symptoms of sufficient severity (including se-
16 vere pain) such that a prudent layperson, who
17 possesses an average knowledge of health and
18 medicine, could reasonably expect the absence
19 of immediate medical attention to result in a
20 condition described in clause (i), (ii), or (iii) of
21 section 1867(e)(1)(A) of the Social Security
22 Act.

23 “(B) EMERGENCY SERVICES.—The term
24 ‘emergency services’ means health care items
25 and services that are necessary for the diag-

1 nosis, treatment, and stabilization of an emer-
2 gency medical condition.

3 **“SEC. 2773. PROTECTING THE DOCTOR-PATIENT RELATION-**
4 **SHIP.**

5 “(a) PROHIBITION ON RESTRICTING COMMUNICA-
6 TION.—A health insurance issuer offering health insur-
7 ance coverage may not restrict or interfere with any com-
8 munication between a health care professional and an en-
9 rollee with respect to information that the health care pro-
10 fessional determines is relevant to the health care of the
11 enrollee.

12 “(b) PROHIBITION ON FINANCIAL INCENTIVES.—A
13 health insurance issuer offering health insurance coverage
14 may not offer or pay any financial incentive to a provider
15 of health care services to deny, reduce, withhold, limit, or
16 delay services to an enrollee.

17 “(c) PROHIBITION ON RETALIATION.—A health in-
18 surance issuer offering health insurance coverage may not
19 terminate a contract, demote, refuse to contract with, or
20 refuse to compensate a health care professional because
21 the professional—

22 “(1) advocates on behalf of an enrollee;

23 “(2) assists an enrollee in seeking reconsider-
24 ation of a decision by the issuer to deny coverage for
25 a service; or

1 “(3) reports a violation of law to an appropriate
2 authority.

3 **“SEC. 2774. QUALITY ASSURANCE.**

4 “(a) REQUIREMENT.—A health insurance issuer of-
5 fering health insurance coverage shall establish and main-
6 tain an ongoing quality assurance program that meets the
7 requirements of subsection (b).

8 “(b) PROGRAM REQUIREMENTS.—The requirements
9 of this subsection for a quality assurance program of an
10 issuer are as follows:

11 “(1) ADMINISTRATION.—The issuer has an
12 identifiable unit with responsibility for administra-
13 tion of the program.

14 “(2) WRITTEN PLAN.—The issuer has a written
15 plan, developed in consultation with health care pro-
16 fessionals, that is updated annually and that speci-
17 fies at least the following:

18 “(A) Criteria and procedures for the as-
19 sessment of quality.

20 “(B) Criteria and procedures for determin-
21 ing coverage of services.

22 “(3) REVIEW.—The program provides for sys-
23 tematic review of the following:

24 “(A) Outcomes of health care services;

25 “(B) Peer review;

1 “(C) A system to collect and maintain in-
2 formation related to the health care services
3 provided to enrollees;

4 “(D) Guidelines for action when problems
5 related to quality of care are identified.

6 **“SEC. 2775. DESIGNATION OF PRIMARY CARE PROVIDER.**

7 “If a health insurance issuer offering health insur-
8 ance coverage requires or provides for an enrollee to des-
9 ignate a participating primary care provider—

10 “(1) the issuer shall permit a female enrollee to
11 designate an obstetrician-gynecologist who has
12 agreed to be designated as such, as the enrollee’s
13 primary care provider; and

14 “(2) the issuer shall permit the enrollee to des-
15 ignate a physician who specializes in pediatrics as
16 the primary care provider for a child of such en-
17 rollee.

18 **“SEC. 2776. GRIEVANCE AND APPEALS PROCEDURES.**

19 “(a) ESTABLISHMENT OF GRIEVANCE SYSTEM.—A
20 health insurance issuer, in connection with the provision
21 of health insurance coverage, shall establish and maintain
22 a system to provide for the presentation and resolution
23 of oral and written grievances brought by enrollees. The
24 system shall include grievances regarding—

1 “(1) payment or reimbursement for covered
2 services;

3 “(2) availability, delivery, and quality of serv-
4 ices; and

5 “(3) terms and conditions of the plan or cov-
6 erage.

7 “(b) GENERAL ELEMENTS.—The system shall in-
8 clude—

9 “(1) the general components described in sub-
10 section (c); and

11 “(2) a process for appeals of adverse denials of
12 benefits—

13 “(A) through an internal appeal process;

14 “(B) through an external appeal process;

15 and

16 “(C) through a process for expediting re-
17 view of the internal appeals process.

18 “(c) COMPONENTS OF THE SYSTEM.—Such system
19 shall include the following components with respect indi-
20 viduals who are enrollees:

21 “(1) The availability of a services representative
22 to assist such individuals, as requested, with the
23 grievance procedures.

1 “(2) A system to record and document, over a
2 period of at least 3 years, all grievances made and
3 their status.

4 “(3) A process providing for timely processing
5 and resolution of grievances.

6 “(d) INTERNAL APPEALS PROCESS.—

7 “(1) IN GENERAL.—Each health insurance
8 issuer shall establish and maintain an internal ap-
9 peals process under which any enrollee, or provider
10 acting on behalf of such an individual with the indi-
11 vidual’s consent, who is dissatisfied with the results
12 of the issuer has the opportunity to appeal the re-
13 sults before a review panel.

14 “(2) DEADLINE.—

15 “(A) IN GENERAL.—The issuer shall con-
16 clude each appeal as soon as possible after the
17 time of the receipt of the appeal in accordance
18 with medical exigencies of the case involved, but
19 in no event later than—

20 “(i) 72 hours after the time of receipt
21 of the appeal in the case of appeals from
22 decisions regarding urgent care, and

23 “(ii) 30 business days after such time
24 in the case of all other appeals.

1 “(3) NOTICE.—If an issuer denies an appeal,
2 the issuer shall provide the enrollee and provider in-
3 volved with written notification of the denial and the
4 reasons therefor, together with a written notification
5 of rights to any further appeal.

6 “(e) EXTERNAL APPEALS PROCESS.—A health insur-
7 ance issuer offering group health insurance coverage, shall
8 provide for an external appeals process which may be used
9 upon completion of the internal review process under sub-
10 section (d). The process shall be conducted consistent with
11 standards established by the Secretary.

12 “(f) EXPEDITED REVIEW PROCESS.—A health insur-
13 ance issuer shall establish written procedures for the expe-
14 dited consideration of appeals in situations in which the
15 timeframe of a standard appeal under the respective sub-
16 section has reasonable potential to jeopardize seriously the
17 life or health of the participant, beneficiary, or enrollee
18 involved or has reasonable potential to jeopardize such an
19 individual’s ability to regain maximum function.

20 **“SEC. 2777. UNDERSTANDABILITY OF INFORMATION.**

21 “Information provided to or made available to enroll-
22 ees under this part, whether written or oral, shall be easily
23 understandable by an average layperson, with respect to
24 the terms used.”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 subsection (a) shall apply to causes of action arising on
3 or after the date of the enactment of this Act.

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