

105TH CONGRESS
2^D SESSION

S. 1712

To amend title XXVII of the Public Health Service Act and part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 to improve the quality of health plans and provide protections for consumers enrolled in such plans.

IN THE SENATE OF THE UNITED STATES

MARCH 5, 1998

Mr. JEFFORDS (for himself and Mr. LIEBERMAN) introduced the following bill; which was read twice and referred to the Committee on Labor and Human Resources

A BILL

To amend title XXVII of the Public Health Service Act and part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 to improve the quality of health plans and provide protections for consumers enrolled in such 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 Care Quality, Education, Security, and Trust
6 Act” or the “Health Care QUEST Act”.

1 (b) TABLE OF CONTENTS.—The table of contents of
 2 this Act is as follows:

- Sec. 1. Short title; table of contents.
- Sec. 2. Findings and purpose.
- Sec. 3. Definitions.
- Sec. 4. Effect on other laws.

TITLE I—HEALTH QUALITY OVERSIGHT

- Sec. 101. Health Quality Council.
- Sec. 102. Members of the Council.
- Sec. 103. Personnel matters.
- Sec. 104. Powers.
- Sec. 105. General duties.
- Sec. 106. National benchmarks of quality.
- Sec. 107. National report cards.
- Sec. 108. Evaluating provider quality in fee-for-service.
- Sec. 109. Studies.
- Sec. 110. Authorization of appropriations.

TITLE II—QUALITY IMPROVEMENT

- Sec. 201. Investment in quality measurement.
- “Sec. 915. National health care quality information.

TITLE III—HEALTH CARE INFORMATION

Subtitle A—Plan Sponsor Responsibilities

- Sec. 301. Employee Retirement Income Security Act of 1974.

Subtitle B—Health Plan Requirements And Consumer Protection

- Sec. 311. Amendment to Public Health Service Act.

“PART C—PROTECTION FOR CONSUMERS

- “Sec. 2770. Exemption.

“SUBPART 1—CONSUMER INFORMATION

- “Sec. 2771. Health plan comparative information.

“SUBPART 2—CONSUMER PROTECTION AND PLAN STANDARDS

- “Sec. 2775. Emergency services.
- “Sec. 2776. Advance directives and organ donation.
- “Sec. 2777. Coverage determination, grievances and appeals.
- “Sec. 2778. Confidentiality and accuracy of enrollees records.

“SUBPART 3—HEALTH CARE PROFESSIONAL PROTECTIONS

- “Sec. 2781. Health care professional communications.
- Sec. 312. Amendments to the Employee Retirement Income Security Act of 1974.

“SUBPART B—PROTECTION FOR CONSUMERS

“Sec. 720. Exemption.

“CHAPTER 1—CONSUMER INFORMATION

“Sec. 721. Health plan comparative information.

“CHAPTER 2—CONSUMER PROTECTION AND PLAN STANDARDS

“Sec. 725. Emergency services.

“Sec. 726. Advance directives and organ donation.

“Sec. 727. Coverage determination, grievances and appeals.

“Sec. 728. Confidentiality and accuracy of participants and beneficiaries records.

“CHAPTER 3—HEALTH CARE PROFESSIONAL PROTECTIONS

“Sec. 730. Health care professional communications.

1 **SEC. 2. FINDINGS AND PURPOSE.**

2 (a) FINDINGS.—Congress makes the following find-
3 ings:

4 (1) While the health care delivered in the
5 United States is of high quality, the variations in
6 quality are large.

7 (2) The problems arising from the delivery of
8 poor health care quality are serious and raise the
9 cost of health care for all Americans.

10 (3) Health care quality can be defined and
11 measured, but additional resources are needed to
12 fully develop and implement the necessary tools.

13 (4) Inadequate information currently exists in
14 the health care marketplace to guide and inform
15 purchasing decisions.

16 (5) Health care professionals should act as ad-
17 vocates for their patients.

1 (6) Coverage determinations should be made in
2 a timely manner.

3 (7) Procedures should be available to consumers
4 of health care for dispute resolution.

5 (8) Consumers of health care should be able to
6 access emergency services for those conditions when
7 a “prudent layperson” would be concerned that lack
8 of such services would result in serious con-
9 sequences.

10 (9) Currently, there is no unified strategy for
11 obtaining quality indicators for health care in the
12 fee-for-service market.

13 (b) PURPOSE.—It is the purpose of this Act to—

14 (1) provide for the continuous quality improve-
15 ment of the health care delivered in the United
16 States;

17 (2) provide for the development and implemen-
18 tation of the tools necessary to measure health care
19 quality;

20 (3) provide consumers with the information nec-
21 essary to guide and inform consumers regarding
22 health care purchasing decisions;

23 (4) ensure that health care professionals can
24 act as advocates for their patients;

1 (5) provide consumers with timely coverage de-
2 cisions and defined procedures for appealing adverse
3 determinations; and

4 (6) provide a “prudent layperson” standard for
5 emergency care throughout the United States.

6 **SEC. 3. DEFINITIONS.**

7 (a) APPLICATION OF CERTAIN DEFINITIONS.—Ex-
8 cept as otherwise provided in subsection (b), the defini-
9 tions in section 2791 of the Public Health Service Act (42
10 U.S.C. 300gg–91) shall apply to this Act.

11 (b) OTHER DEFINITIONS.—In this Act:

12 (1) COUNCIL.—The term “Council” means the
13 Health Quality Council established under section
14 101.

15 (2) PLAN ADMINISTRATOR.—The term “plan
16 administrator” has the meaning given the term “ad-
17 ministrator” by section 3(16)(A) of the Employee
18 Retirement Income Security Act of 1974 (42 U.S.C.
19 1002(16)(A)).

20 (3) PLAN FIDUCIARY.—The term “plan fidu-
21 ciary” means a person named as a fiduciary in ac-
22 cordance with section 402(a) of the Employee Re-
23 tirement Income Security Act of 1974 (42 U.S.C.
24 1102(a)).

1 (4) PLAN SPONSOR.—The term “plan sponsor”
 2 has the meaning given that term by section
 3 2791(d)(13) of the Public Health Service Act (42
 4 U.S.C. 300gg–91(d)(13)).

5 **SEC. 4. EFFECT ON OTHER LAWS.**

6 (a) ERISA.—Nothing in this Act (or an amendment
 7 made by this Act) shall be construed as affecting or modi-
 8 fying section 514 of the Employee Retirement Income Se-
 9 curity Act of 1974 (29 U.S.C. 1144) with respect to a
 10 group health plan.

11 (b) PHSA.—Nothing in this Act (or an amendment
 12 made by this Act) shall be construed to prohibit a State
 13 from establishing, implementing or continuing in effect re-
 14 quirements relating to the regulation of insurance as per-
 15 mitted under section 514(b)(2)(A) of the Employee In-
 16 come Security Act of 1974 (29 U.S.C. 1144(b)(2)(A)).

17 **TITLE I—HEALTH QUALITY**
 18 **OVERSIGHT**

19 **SEC. 101. HEALTH QUALITY COUNCIL.**

20 There is established a council to be known as the
 21 “Health Quality Council” to provide advice to the Presi-
 22 dent and the Congress concerning health care quality and
 23 to otherwise carry out the duties described in this title.

24 **SEC. 102. MEMBERS OF THE COUNCIL.**

25 (a) APPOINTMENT.—

1 (1) IN GENERAL.—The Council shall be com-
2 posed of 9 members to be appointed by the Comp-
3 troller General from among individuals having exper-
4 tise relating to—

5 (A) the measurement and improvement of
6 the quality of health care;

7 (B) the purchase of health care in the pri-
8 vate sector;

9 (C) the purchase of health care in the pub-
10 lic sector (Federal and State);

11 (D) the delivery and provision of health
12 care;

13 (E) health economics;

14 (F) medical ethics; and

15 (G) the needs of participants and bene-
16 ficiaries in health care plans (including children
17 and individuals with disabilities).

18 (2) TERMS AND VACANCIES.—

19 (A) TERMS.—A member of the Council
20 (other than the Chairperson) shall be appointed
21 for a term of 4 years, except that of the mem-
22 bers initially appointed to the Council—

23 (i) 3 members shall be appointed for
24 a term of 1 year;

1 (ii) 3 members shall be appointed for
2 a term of 2 years; and

3 (iii) 3 members shall be appointed for
4 a term of 3 years.

5 (B) LIMITATION.—At the expiration of the
6 term of office of a member of the Council ap-
7 pointed under subsection (a), that member shall
8 continue to hold office until a successor for
9 such member is appointed, except that such
10 member shall not continue to serve beyond the
11 expiration of the next session of Congress sub-
12 sequent to the expiration of the fixed term of
13 office.

14 (C) VACANCIES.—A vacancy in the mem-
15 bership of the Council shall not affect the pow-
16 ers of the Council and shall be filled in the
17 same manner as the original appointment, ex-
18 cept that any member appointed to fill a va-
19 cancy that occurs prior to the expiration of the
20 term for which the predecessor of the member
21 was appointed shall be appointed for the re-
22 mainder of such term.

23 (b) CHAIRPERSON.—The Comptroller General shall
24 select a Chairperson from among the members of the

1 Council appointed under section (a)(1). A member may
2 not serve as Chairperson for longer than 8 years.

3 (c) EXECUTIVE DIRECTOR.—The Chairperson of the
4 Council shall appoint an individual to serve as the Execu-
5 tive Director of the Council. The Executive Director shall
6 serve at the discretion of the Chairperson.

7 (d) MEETINGS.—

8 (1) INITIAL MEETING.—Not later than 90 days
9 after the date on which all members of the Council
10 have been appointed, the Council shall hold its first
11 meeting.

12 (2) MEETINGS.—The Council shall meet at the
13 call of the Chairperson but in no case less than
14 quarterly.

15 (3) QUORUM.—A majority of the members of
16 the Council shall constitute a quorum, but a lesser
17 number of members may hold hearings.

18 (e) COMPENSATION OF MEMBERS.—

19 (1) FULL-TIME MEMBERS.—The Chairperson
20 and Executive Director of the Council shall be com-
21 pensated as provided for in title 5, United States
22 Code.

23 (2) OTHER MEMBERS.—Each member of the
24 Council not described in paragraph (1) who is not
25 an officer or employee of the Federal Government

1 shall be compensated at a rate equal to the daily
2 equivalent of the annual rate of basic pay prescribed
3 for level IV of the Executive Schedule under section
4 5315 of title 5, United States Code, for each day
5 (including travel time) during which such member is
6 engaged in the performance of the duties of the
7 Council. All such members of the Council who are
8 officers or employees of the United States shall serve
9 without compensation in addition to that received for
10 their services as officers or employees of the United
11 States.

12 (3) TRAVEL EXPENSES.—The members of the
13 Council shall be allowed travel expenses, including
14 per diem in lieu of subsistence, at rates authorized
15 for employees of agencies under subchapter I of
16 chapter 57 of title 5, United States Code, while
17 away from their homes or regular places of business
18 in the performance of services for the Council.

19 (f) CONFLICT OF INTEREST.—The Chairperson and
20 the Executive Director of the Council shall not engage in
21 any other business, vocation, or employment than that of
22 serving as the Chairperson or Executive Director of the
23 Council.

1 **SEC. 103. PERSONNEL MATTERS.**

2 (a) GENERAL SUPPORT.—Administrative and sci-
3 entific support for the Council shall be provided by the
4 Agency for Health Care Policy and Research.

5 (b) STAFF.—If determined necessary by the Council,
6 the Council may appoint and fix the compensation of such
7 officers and other experts and employees as may be nec-
8 essary for carrying out the functions of the Council under
9 this title and shall fix the salaries of such officers, experts,
10 and employees in accordance with chapter 51 and sub-
11 chapter III of chapter 53 of title 5, United States Code.

12 (c) DETAIL OF GOVERNMENT EMPLOYEES.—Any
13 Federal Government employee may be detailed to the
14 Council without reimbursement (other than the regular
15 compensation of the employee), and such detail shall be
16 without interruption or loss of civil service status or privi-
17 lege.

18 (d) PROCUREMENT OF TEMPORARY AND INTERMIT-
19 TENT SERVICES.—The Chairperson of the Council may
20 procure temporary and intermittent services under section
21 3109(b) of title 5, United States Code, at rates for individ-
22 uals which do not exceed the daily equivalent of the annual
23 rate of basic pay prescribed for level V of the Executive
24 Schedule under section 5316 of such title.

25 (e) LEASING AUTHORITY.—Notwithstanding any
26 other provision of law, the Council may enter directly into

1 leases for real property for office, meeting, storage, and
2 such other space as may be necessary to carry out the
3 functions of the Council under this title, and shall be ex-
4 empt from any General Services Administration space
5 management regulations or directives.

6 (f) CONTRACTING AUTHORITY.—Notwithstanding
7 any other provision of law, the Council may enter directly
8 into contracts with entities as the Council determines nec-
9 essary to carry out the duties of the Council under this
10 title.

11 (g) ACCEPTANCE OF PAYMENTS.—

12 (1) IN GENERAL.—Notwithstanding any other
13 provision of law, in accordance with regulations
14 which the Council shall prescribe to prevent conflicts
15 of interest, the Council may accept payment and re-
16 imbursement, in cash or in kind, from non-Federal
17 agencies, organizations, and individuals for travel,
18 subsistence, and other necessary expenses incurred
19 by members of the Council in attending meetings
20 and conferences concerning the functions or activi-
21 ties of the Council.

22 (2) CREDIT OF ACCOUNT.—Any payment or re-
23 imbursement accepted shall be credited to the appro-
24 priated funds of the Council.

1 **SEC. 104. POWERS.**

2 (a) HEARINGS.—The Council may hold such hear-
3 ings, sit and act at such times and places, take such testi-
4 mony, and receive such evidence as the Council considers
5 advisable to carry out the purposes of this title.

6 (b) ADVISORY COMMITTEES.—The Council may es-
7 tablish such advisory committees as the Council deter-
8 mines necessary to carry out its duties under this title.

9 (c) INFORMATION FROM FEDERAL AGENCIES.—The
10 Council may secure directly from any Federal department
11 or agency such information as the Council considers nec-
12 essary to carry out the provisions of this title. Upon re-
13 quest of the Chairperson of the Council, the head of such
14 department or agency shall furnish such information to
15 the Council. Any information furnished to the Council
16 under this subsection shall, upon the request of the de-
17 partment or agency, be kept confidential and be used only
18 for the purpose for which such information was provided.

19 (d) POSTAL SERVICES.—The Council may use the
20 United States mails in the same manner and under the
21 same conditions as other departments and agencies of the
22 Federal Government.

23 (e) GIFTS.—The Council may accept, use, and dis-
24 pose of gifts or donations of services or property.

25 **SEC. 105. GENERAL DUTIES.**

26 The Council shall—

1 (1) serve as a resource for the appropriate com-
2 mittees of Congress and the President in providing
3 information and scientific evidence with respect to
4 health care quality and consumer protection legisla-
5 tion;

6 (2) at the request of the appropriate commit-
7 tees of Congress or the President, develop financial
8 and socioeconomic impact statements for health care
9 quality and consumer protection legislation;

10 (3) develop, using the process recommended by
11 the National Academy of Sciences (Institute of Med-
12 icine) and the studies carried out under section 109,
13 update, and disseminate population-based bench-
14 marks and indicators of health care quality;

15 (4) in accordance with section 107, provide the
16 appropriate committees of Congress and the Presi-
17 dent with an annual report on the State of the Na-
18 tion's health care quality or related topics;

19 (5) in accordance with section 108, develop rec-
20 ommendations for measuring and reporting quality
21 indicators for use in the fee-for-service market;

22 (6) develop, in consultation with the Agency for
23 Health Care Policy and Research and appropriate
24 experts, the data sampling methods to be used in
25 data reporting for monitoring quality indicators and

1 health outcomes measures as required under section
2 915(c) of the Public Health Service Act (as added
3 by this Act); and

4 (7) carry out such other activities as the Coun-
5 cil determines appropriate to carry out its duties
6 under this Act.

7 **SEC. 106. NATIONAL BENCHMARKS OF QUALITY.**

8 (a) DEVELOPMENT.—

9 (1) IN GENERAL.—The Council shall develop
10 population-based benchmarks of health care quality.

11 (2) REVISIONS AND DISSEMINATION.—The pop-
12 ulation-based benchmarks developed under para-
13 graph (1) shall be revised, updated and disseminated
14 biennially.

15 (3) PROCESS FOR DEVELOPMENT.—The devel-
16 opment of the population-based benchmarks under
17 paragraph (1) shall follow the process recommended
18 by the National Academy of Sciences (Institute of
19 Medicine) under section 109, be consistent with ad-
20 vice and testimony received under subsection (b).

21 (b) EXPERTS.—

22 (1) CONTRACTS.—The Council may enter into a
23 contract with such experts as the Council determines
24 are necessary to carry out its duties under this Act.

1 (2) EXPERTS.—Consistent with sections 103
2 and 104, the Council shall have the authority to con-
3 vene expert panels, conduct hearings, and contract
4 for services to obtain information as necessary to
5 carry out its duties under this Act.

6 (c) MODEL STANDARD FORMAT.—The Council, in
7 conjunction with the Agency for Health Care Policy and
8 Research, shall develop model standard formats for pro-
9 viding health plan information to consumers that may be
10 used by employers or health insurance issuers. In develop-
11 ing such model formats, the Council shall take into consid-
12 eration the recommendations of the National Academy of
13 Sciences (Institute of Medicine) following the study au-
14 thorized under paragraph (4) of section 109(a).

15 (d) QUALITY INDICATORS AND OUTCOMES MEAS-
16 URES.—

17 (1) IN GENERAL.—The Council shall rec-
18 ommend to the Secretary of Health and Human
19 Services and the Secretary of Labor, a set of quality
20 indicators (including health services delivery and
21 processes) and health outcomes measures to be used
22 for the reporting of information under this Act (or
23 an amendment made by this Act) by health care pro-
24 viders and health plans. Such measures shall take
25 into consideration the different populations served

1 (such as children and the disabled) and where ap-
2 propriate shall be consistent with requirements ap-
3 plicable to Medicare+Choice plans under title XVIII
4 of the Social Security Act (42 U.S.C. 1395 et seq.).

5 (2) DIFFERENT INDICATORS AND OUTCOMES
6 MEASURES.—The Secretary of Health and Human
7 Services and the Secretary of Labor may adopt qual-
8 ity indicators or health outcomes measures that are
9 in a different form than the indicators or outcomes
10 measures recommended by the Council under para-
11 graph (1) if—

12 (A) the Secretary of Health and Human
13 Services or the Secretary of Labor finds that
14 different indicators or outcomes measures will
15 substantially reduce administrative costs to
16 health care providers and health plans as com-
17 pared to the alternatives, or that such indica-
18 tors or measures are demonstrated or proven to
19 be more appropriate for the populations served;
20 and

21 (B) the indicators or outcomes measures
22 are adopted in accordance with the rulemaking
23 procedures of subchapter III of chapter 5 of
24 title 5, United States Code.

1 **SEC. 107. NATIONAL REPORT CARDS.**

2 (a) REPORT ON NATIONAL GOALS.—Not later than
3 18 months after the date of enactment of this Act, and
4 every 2 years thereafter, the Council shall prepare and
5 submit to the appropriate committees of Congress and the
6 President a report that—

7 (1) establishes national goals for the improve-
8 ment of the quality of health care; and

9 (2) contains the recommendations of the Coun-
10 cil for achieving the national goals.

11 (b) REPORT ON HEALTH RELATED TOPICS.—Not
12 later than 30 months after the date of enactment of this
13 Act and every 2 years thereafter, the Council shall prepare
14 and submit to the Congress and the President a report
15 that addresses at least 1 of the following (or a related mat-
16 ter):

17 (1) The availability, applicability and appro-
18 priateness of information to consumers regarding
19 the quality of their health care.

20 (2) The state of information systems and data
21 collecting capabilities for measuring and reporting
22 on quality indicators.

23 (3) The impact of quality measurement on ac-
24 cess to and the cost of medical care.

25 (4) Barriers to continuous quality improvement
26 in medical care.

1 (5) The state of health care quality measure-
2 ment research and development.

3 **SEC. 108. EVALUATING PROVIDER QUALITY IN FEE-FOR-**
4 **SERVICE.**

5 (a) DEVELOPMENT.—The Council shall develop rec-
6 ommendations for measuring and reporting provider
7 health care quality indicators in the fee-for-service market.

8 (b) REPORT.—Not later than 24 months after the
9 date of enactment of this Act, the Council shall prepare
10 and submit to the Congress and the President a report
11 concerning the strategy developed under this section.

12 **SEC. 109. STUDIES.**

13 (a) NATIONAL ACADEMY OF SCIENCE.—The Sec-
14 retary of Health and Human Services shall enter into a
15 contract with the Institute of Medicine of the National
16 Academy of Sciences to conduct studies to—

17 (1) determine what standards should be used in
18 the development of population-based benchmarks
19 against which health care quality can be compared
20 and measured;

21 (2) determine the optimal process for establish-
22 ing such population-based benchmarks;

23 (3) validate the process determined most appro-
24 priate under paragraph (2);

1 (4) assess the optimal application of population-
2 based benchmarks and how information concerning
3 health care quality should be presented to users, in-
4 cluding consumers, providers, and purchasers;

5 (5) analyze the next steps necessary for a na-
6 tional continuous health care quality improvement
7 process;

8 (6) develop recommendations for linking pay-
9 ment for health services to health outcomes meas-
10 ures in order to recognize and reimburse health
11 plans and health care providers that provide quality
12 health care, particularly with respect to individuals
13 with special needs or chronic health problems; and

14 (7) consider the relationship between the need
15 for public information to help consumers make in-
16 formed health care choices and the processes nec-
17 essary to create an environment that will promote
18 the use of continuous quality improvement tech-
19 niques.

20 (b) REPORT.—During the period beginning 24
21 months after the date of enactment of this Act, but not
22 later than 36 months after such date of enactment, the
23 Institute of Medicine shall prepare and submit to the Con-
24 gress and the President a report concerning each study
25 conducted under subsection (a).

1 (c) REVIEW BY GAO.—The General Accounting Of-
 2 fice shall conduct a periodic review of the conduct of the
 3 Council and report its findings to the appropriate commit-
 4 tees of Congress and the President.

5 **SEC. 110. AUTHORIZATION OF APPROPRIATIONS.**

6 (a) IN GENERAL.—There are authorized to be appro-
 7 priated to the Council such sums as may be necessary to
 8 carry out this title.

9 (b) AVAILABILITY.—Any amounts appropriated
 10 under subsection (a) shall remain available, without fiscal
 11 year limitation, until expended.

12 **TITLE II—QUALITY**
 13 **IMPROVEMENT**

14 **SEC. 201. INVESTMENT IN QUALITY MEASUREMENT.**

15 Part B of title IX of the Public Health Service Act
 16 (42 U.S.C. 299b et seq.) is amended by adding at the end
 17 the following:

18 **“SEC. 915. NATIONAL HEALTH CARE QUALITY INFORMA-**
 19 **TION.**

20 “(a) PURPOSE.—It is the purpose of this section to
 21 expand the duties and responsibilities of the Agency to in-
 22 clude the collection, analysis, and dissemination of health
 23 care quality information.

24 “(b) DUTIES.—In carrying out this section, the
 25 Agency shall—

1 “(1) provide administrative and scientific sup-
2 port to the Health Quality Council established under
3 section 101 of the Health Care Quality, Education,
4 Security and Trust Act;

5 “(2) develop risk and case mix adjustment
6 methodology for use in comparing health outcomes
7 data;

8 “(3) compile and publicly disseminate aggregate
9 data regarding health care quality indicators and
10 outcomes;

11 “(4) develop a model standard format that may
12 be used by health insurance issuers in reporting the
13 information required under part C of title XXVII;

14 “(5) provide assistance in the development of
15 improved information systems, including computer-
16 ized formats that may be used by health plans in
17 providing the information required under title
18 XXVII;

19 “(6) collect, maintain and publicly distribute
20 health care quality population-based benchmarks es-
21 tablished by the Health Quality Council;

22 “(7) coordinate its activities with respect to
23 health care quality with health plan accrediting bod-
24 ies, the National Committee on Vital and Health

1 Statistics, the National Center for Health Statistics,
2 and State and local governments.

3 “(8) develop survey tools to measure participant
4 and beneficiary satisfaction as required under sec-
5 tion 101(j)(4) of the Employee Retirement Income
6 Security Act of 1974.

7 “(c) SUBMISSION OF DATA.—

8 “(1) IN GENERAL.—Health insurance issuers,
9 group health plans, and health insurance issuers of
10 group health plans shall submit aggregate data,
11 without patient identifiers, obtained in the process of
12 reporting quality indicators and health outcomes
13 measures to the Agency for the purpose of the
14 Health Quality Council’s report as required in sec-
15 tion 107(a) of the Health Care Quality, Education,
16 Security and Trust Act.

17 “(2) DATA SAMPLING METHODS.—The Sec-
18 retary of Health and Human Services and the Sec-
19 retary of Labor shall develop data sampling methods
20 for the submission of aggregate data under this sec-
21 tion. Such methods shall be based on the rec-
22 ommendation of the Health Quality Council estab-
23 lished under section 101 of the Health Care Quality,
24 Education, Security, and Trust Act.

1 “(3) DIFFERENT METHODS.—The Secretary of
 2 Health and Human Services and the Secretary of
 3 Labor may adopt data sampling methods that are in
 4 a different form than the methods recommended by
 5 the Council under paragraph (2) if—

6 “(A) the Secretary of Health and Human
 7 Services or the Secretary of Labor finds that
 8 different methods will substantially reduce ad-
 9 ministrative costs to health care providers and
 10 health plans as compared to the alternatives, or
 11 that such methods are demonstrated or proven
 12 to be more appropriate; and

13 “(B) the methods are adopted in accord-
 14 ance with the rulemaking procedures of sub-
 15 chapter III of chapter 5 of title 5, United
 16 States Code.”.

17 **TITLE III—HEALTH CARE**
 18 **INFORMATION**
 19 **Subtitle A—Plan Sponsor**
 20 **Responsibilities**

21 **SEC. 301. EMPLOYEE RETIREMENT INCOME SECURITY ACT**
 22 **OF 1974.**

23 (a) IN GENERAL.—Section 101 of the Employee Re-
 24 tirement Income Security Act of 1974 (29 U.S.C. 1021)
 25 is amended—

1 (1) by redesignating the second subsection (h)
2 (relating to cross reference) as subsection (i); and

3 (2) by adding at the end the following:

4 “(j) GROUP HEALTH PLAN DISTRIBUTION OF IN-
5 FORMATION.—

6 “(1) SUMMARY PLAN DESCRIPTION.—

7 “(A) IN GENERAL.—Notwithstanding sec-
8 tion 102, or any other provision of this Act,
9 with respect to a group health plan (as defined
10 in section 733(a)(1)), the plan administrator of
11 such plan shall furnish to each participant
12 under the group health plan, a copy of the most
13 recent summary plan description for each plan
14 option under which the participant or bene-
15 ficiary may elect to receive benefits—

16 “(i) upon the employment of the par-
17 ticipant or at the time the group health
18 plan first becomes subject to this title,
19 whichever is later; and

20 “(ii) at the beginning of an open en-
21 rollment period, if the plan sponsor pro-
22 vides such a period.

23 Plan sponsors that provide such information in
24 an accessible centralized location and notify

1 participants of that location shall be deemed to
2 meet the requirements of clause (ii).

3 “(B) ADDITIONAL REQUIREMENTS.—

4 “(i) IN GENERAL.—The plan adminis-
5 trator shall ensure that the most recent
6 summary plan description for a group
7 health plan is provided to participants and
8 beneficiaries—

9 “(I) at least annually if the plan
10 has been materially modified or
11 amended; and

12 “(II) upon the request of a par-
13 ticipant or beneficiary.

14 “(ii) REQUIRED INFORMATION.—A
15 summary plan description shall inform par-
16 ticipants and beneficiaries of the availabil-
17 ity of technical support and information
18 concerning the rights of such participants
19 and beneficiaries under this Act from the
20 Department of Labor, including the phone
21 numbers and location of the Department’s
22 regional offices, and Internet access to in-
23 formation.

24 “(2) REQUIRED ANNUAL INFORMATION.—

1 “(A) IN GENERAL.—Notwithstanding any
2 other provision of this Act, with respect to a
3 group health plan (as defined in section
4 733(a)(1)), the plan administrator of such plan
5 shall ensure that the information described in
6 subparagraph (B) with respect to material
7 modifications, will be provided not later than 30
8 days after the date on which the change in-
9 volved becomes effective, to participants and
10 beneficiaries.

11 “(B) INFORMATION.—The information re-
12 quired under this subparagraph includes infor-
13 mation with respect to—

14 “(i) any material changes in benefit
15 coverage including any new exclusions from
16 coverage or new optional supplemental cov-
17 erage (including the associated premiums,
18 deductibles, coinsurance, copayments for
19 which the enrollee will be responsible, and
20 any annual or lifetime limits on benefits);

21 “(ii) any material changes in the
22 health insurance issuer’s service area, in-
23 cluding any changes in the number, mix,
24 and geographic distribution of participat-
25 ing providers, including specialists;

1 “(iii) any material changes in out-of-
2 area coverage or out-of-network services (if
3 previously provided) or changes in addi-
4 tional payments required for these services;

5 “(iv) any material changes in prior
6 authorization rules; and

7 “(v) any material changes in plan
8 grievance and appeals procedures.

9 “(C) PERMISSIBLE PROVISION OF INFOR-
10 MATION.—A group health plan shall be consid-
11 ered to have complied with the provisions of
12 subparagraph (B)(ii) if the plan administrator
13 distributes a directory or listing of participating
14 providers to participants and beneficiaries and
15 such directory of list is updated to reflect any
16 material changes in participating providers.

17 “(D) PARTICIPANT SATISFACTION.—

18 “(i) IN GENERAL.—With respect to a
19 plan sponsor described in clause (ii) that
20 provides a group health plan, the plan
21 sponsor shall annually provide to partici-
22 pants and beneficiaries a summary report
23 of participant satisfaction and
24 disenrollment rates (if applicable) regard-

1 ing each enrollment option offered to par-
2 ticipants and beneficiaries.

3 “(ii) PLAN SPONSOR DESCRIBED.—A
4 plan sponsor described in this clause is a
5 plan sponsor—

6 “(I) with 100 or more partici-
7 pants enrolled in a group health plan
8 during a plan year; and

9 “(II) with a contracting relation-
10 ship with the health insurance issuer
11 involved for at least 2 years.

12 “(3) NOTIFICATIONS BY PLAN ADMINIS-
13 TRATOR.—With respect to a group health plan, a
14 plan administrator shall notify participants and
15 beneficiaries under the plan that the plan sponsor
16 involved—

17 “(A) has stopped paying plan premiums or
18 has terminated reimbursement for services cov-
19 ered under the plan not later than 30 days
20 after the date of the first nonpayment by the
21 plan sponsor; or

22 “(B) in the case of a plan sponsor involved
23 in a sale or merger, has made changes in the
24 group health plan involved not later than the

1 date on which the assets of the plan sponsor
2 are transferred following such sale or merger.

3 “(4) USE OF CERTAIN INFORMATION.—In order
4 to meet the requirements of paragraph (2)(D), a
5 group health plan sponsor may use satisfaction sur-
6 vey measurement tools that have been developed and
7 made available by the Agency for Health Care Policy
8 and Research.

9 “(5) ESTABLISHMENT OF INTERNET SITE.—
10 The Secretary shall provide for the establishment of
11 a site on the Internet to provide technical support
12 and information concerning the rights of partici-
13 pants and beneficiaries under this Act.

14 “(6) NO LIMITATION.—Nothing in this sub-
15 section shall be construed to prohibit a plan sponsor
16 from distributing any additional information that
17 such plan sponsor considers important or necessary
18 in assisting participants and beneficiaries with
19 changes to the group health plan.

20 “(7) RULE OF CONSTRUCTION.—For purposes
21 of this subsection, a plan administrator, in reliance
22 on records maintained by the administrator, shall be
23 deemed to have met the requirements of this sub-
24 section if the administrator provides the information
25 requested under this subsection to participants and

1 beneficiaries at the address contained in such
2 records with respect to such participants and bene-
3 ficiaries.”.

4 **Subtitle B—Health Plan Require-** 5 **ments And Consumer Protection**

6 **SEC. 311. AMENDMENT TO PUBLIC HEALTH SERVICE ACT.**

7 (a) CONSUMER PROTECTION STANDARDS.—Title
8 XXVII of the Public Health Service Act is amended—
9 (1) by redesignating part C as part D, and
10 (2) by inserting after part B the following:

11 “PART C—PROTECTION FOR CONSUMERS

12 **“SEC. 2770. EXEMPTION.**

13 “(a) IN GENERAL.—Upon the application of a group
14 health plan or a health insurance issuer, the Secretary
15 may exempt such plan or issuer from compliance with 1
16 or more of the requirements of this part.

17 “(b) REQUIREMENTS.—The Secretary may grant an
18 exemption under this section if—

19 “(1) the Secretary—

20 “(A) publishes a notice of the pendency of
21 such exemption in the Federal Register; and

22 “(B) provides notice, and an opportunity
23 for comment, of the pendency of such exemp-
24 tion to interested individuals; and

1 “(2) the Secretary determines that the exemp-
2 tion—

3 “(A) is administratively feasible;

4 “(B) is in the interests of the group health
5 plan and the participants and beneficiaries
6 under such plan, or in the interests of the
7 health insurance issuer and the enrollees in-
8 volved; and

9 “(C) is protective of the rights of partici-
10 pants and beneficiaries or enrollees, as the case
11 may be.

12 “(c) SCOPE OF EXEMPTION.—An exemption provided
13 under this section—

14 “(1) shall apply only to those requirements
15 identified by the Secretary in approving the exemp-
16 tion;

17 “(2) may be conditional; and

18 “(3) may be provided to a class of plans or
19 issuers.

20 “(d) PROCEDURES.—The Secretary shall develop
21 procedures to provide exemptions under this section.

22 “SUBPART 1—CONSUMER INFORMATION

23 “**SEC. 2771. HEALTH PLAN COMPARATIVE INFORMATION.**

24 “(a) REQUIREMENT.—A health insurance issuer in
25 connection with the provision of health insurance coverage,

1 shall, not later than 12 months after the date of enact-
2 ment of this part, provide for the disclosure, in a clear
3 and accurate form to each plan sponsor, with which the
4 issuer has contracted, each enrollee, or upon request to
5 a potential enrollee or plan sponsor, of the information
6 described in subsection (b).

7 “(b) REQUIRED INFORMATION.—The informational
8 materials to be distributed under this section shall include
9 for each plan the following:

10 “(1) A description of the covered items and
11 services under each such plan and the in- and out-
12 of-network features of each such plan.

13 “(2) A description of any cost sharing, includ-
14 ing premiums, deductibles, coinsurance, and copay-
15 ment amounts, for which the enrollee will be respon-
16 sible, including any annual or lifetime limits on ben-
17 efits, for each such plan.

18 “(3) A description of any optional supplemental
19 benefits offered by each such plan and the terms
20 and conditions (including premiums or cost-sharing)
21 for such supplemental coverage.

22 “(4) A description of any restrictions on pay-
23 ments for services furnished to an enrollee by a
24 health care professional that is not a participating

1 professional and the liability of the enrollee for addi-
2 tional payments for these services.

3 “(5) A description of the service area of each
4 such plan, including the provision of any out-of-area
5 coverage.

6 “(6) A description of the extent to which enroll-
7 ees may select the primary care provider of their
8 choice, including providers both within the network
9 and outside the network of each such plan (if the
10 plan permits out-of-network services) as well as pro-
11 cedures for obtaining specialist referral.

12 “(7) A summary of data concerning enrollee
13 satisfaction with the plan, including disenrollment
14 rates for the previous 2 plan years (excluding
15 disenrollments due to the death of an enrollee or the
16 enrollee moving outside of the service area of the
17 plan), based on the health plan’s ‘book-of-business’.
18 Health plans may elect to provide specific informa-
19 tion regarding disenrollment rates.

20 “(8) A description of the procedures for ad-
21 vance directives and organ donation decisions.

22 “(9) A description of the requirements and pro-
23 cedures to be used to obtain preauthorization for
24 health services (including telephone numbers and

1 mailing addresses), including referrals for specialty
2 care.

3 “(10) A summary of the rules and methods for
4 appealing coverage decisions and filing grievances
5 (including telephone numbers and mailing address-
6 es), as well as other available remedies.

7 “(11) A summary of the rules for access to
8 emergency room care, including educational material
9 regarding proper use of emergency services.

10 “(12) A description of licensure, certification or
11 accreditation status of the health plan and the name
12 and address of the State or Federal regulatory agen-
13 cy with oversight responsibilities.

14 “(13) A description of whether or not access is
15 provided to experimental treatments, investigational
16 treatments, or clinical trials and the circumstances
17 under which access to such treatments or trials is
18 made available.

19 “(14) A description of whether or not access is
20 provided to specialists without referral and the cir-
21 cumstances under which access to such specialists is
22 provided.

23 “(15) A description of the quality indicators
24 and health outcomes measures of the plan in accord-
25 ance with subsection (c).

1 “(16) A statement that the following informa-
2 tion, and instructions on obtaining such information
3 (including telephone numbers and Internet
4 websites), shall be made available upon request:

5 “(A) Additional information on the quality
6 of care and health outcomes under the plan.

7 “(B) The names, credentials, addresses,
8 and telephone numbers and the availability
9 (such as whether professionals accept patients),
10 speciality focus, affiliation arrangements, num-
11 ber and mix of the health care professionals in
12 the network of the plan, and any measures of
13 consumer satisfaction if such satisfaction meas-
14 ures are available.

15 “(C) The names and locations of partici-
16 pating health care facilities, the accreditation
17 status, the for-profit or not-for-profit status of
18 such facilities, and any measures of consumer
19 satisfaction if such satisfaction measures are
20 available.

21 “(D) A summary description of the meth-
22 ods used for compensating participating health
23 care professionals (including capitation, finan-
24 cial incentives or bonuses, fee-for-service, group
25 practice, salary and withholdings), including the

1 proportions of participating health care profes-
2 sionals who are compensated under each type of
3 arrangement under the plan.

4 “(E) A summary description of the proce-
5 dures used for utilization review, including the
6 process by which specific determinations are
7 made.

8 “(F) The list of the specific prescription
9 medications included in the formulary of the
10 plan, if the plan uses a defined formulary.

11 “(G) A description of the specific exclu-
12 sions from coverage under the plan.

13 “(H) A description of the specific prevent-
14 ative services covered under the plan.

15 “(I) A description of the availability of
16 translation or interpretation services for non-
17 English speakers and people with communica-
18 tion disabilities, including the availability of
19 audio tapes or information in Braille.

20 “(J) A description of the number of exter-
21 nal review requests that have been filed with an
22 external review panel designated in accordance
23 with section 2777(e) and the outcome of such
24 requests by an external review panel in the pre-
25 ceding calendar year.

1 “(c) DETERMINATION OF INDICATORS AND MEAS-
2 URES.—

3 “(1) IN GENERAL.—The Secretary of Health
4 and Human Services, in consultation with the Sec-
5 retary of Labor, shall develop quality indicators and
6 health outcomes measures for use by health insur-
7 ance issuers in providing the information required
8 under section (b), taking into consideration the rec-
9 ommendations of the Health Quality Council. Such
10 quality indicators and health outcomes measures
11 shall, while taking into consideration the different
12 populations served (such as children and individuals
13 with disabilities), be consistent where appropriate
14 with requirements applicable to Medicare+Choice
15 health plans under title XVIII of the Social Security
16 Act (42 U.S.C. 1395 et seq.).

17 “(2) DIFFERENT INDICATORS AND OUTCOMES
18 MEASURES.—The Secretary of Health and Human
19 Services and the Secretary of Labor may adopt qual-
20 ity indicators or health outcomes measures that are
21 in a different form than the indicators or outcomes
22 measures recommended by the Council under para-
23 graph (1) if—

24 “(A) the Secretary of Health and Human
25 Services or the Secretary of Labor finds that

1 different indicators or outcomes measures will
2 substantially reduce administrative costs to
3 health care providers and health plans as com-
4 pared to the alternatives, or that such indica-
5 tors or measures are demonstrated or proven to
6 be more appropriate for the populations served;
7 and

8 “(B) the indicators or outcomes measures
9 are adopted in accordance with the rulemaking
10 procedures of subchapter III of chapter 5 of
11 title 5, United States Code.

12 “(d) MANNER OF DISTRIBUTION.—

13 “(1) IN GENERAL.—The information described
14 in this section shall—

15 “(A) be distributed in an accessible format
16 that is understandable to an average plan en-
17 rollee; and

18 “(B) with respect to populations of individ-
19 uals whose primary language is other than
20 English, be provided in the primary language of
21 such population if that population comprises
22 not less than 20 percent of the total population
23 of the geographic area served by the health plan
24 involved.

1 shall cover emergency services furnished under the plan
2 or coverage—

3 “(1) in a manner so that, if such services are
4 provided to an enrollee by a non-participating health
5 care provider—

6 “(A) the enrollee shall not be liable for
7 amounts paid for such services in excess of the
8 amount that would have been paid if the serv-
9 ices were provided by a participating health
10 care provider; and

11 “(B) the plan or issuer shall pay an
12 amount for such services that is not less than
13 the amount that would be paid to a participat-
14 ing health care provider for the same services;
15 and

16 “(2) without regard to any other term or condi-
17 tion of such plan or coverage (other than exclusion
18 or coordination of benefits, or an affiliation or wait-
19 ing period permitted under section 2701, and other
20 than applicable cost-sharing requirements).

21 “(c) PRIOR AUTHORIZATION.—A group health plan,
22 health insurance issuer offering group health insurance,
23 or a health insurance issuer described in subsection (a)
24 shall provide coverage for emergency services without re-

1 gard to prior authorization or the emergency care provid-
2 er’s contractual relationship with the plan involved.

3 “(d) GUIDELINES RESPECTING COORDINATION OF
4 POST-STABILIZATION CARE.—

5 “(1) IN GENERAL.—A group health plan, a
6 health insurance issuer offering group health insur-
7 ance, or a health insurance issuer shall comply with
8 guidelines established by the Secretary of Health
9 and Human Services (with respect to health insur-
10 ance issuers) and the Secretary of Labor (with re-
11 spect to group health plans) relating to promoting
12 efficient and timely coordination of appropriate
13 maintenance and post-stabilization care of an en-
14 rollee after the enrollee has been determined to be
15 stable (as defined for purposes of section 1867 of
16 the Social Security Act).

17 “(2) GUIDELINES.—The guidelines established
18 by the Secretary of Health and Human Services and
19 the Secretary of Labor under paragraph (1) shall be
20 the guidelines adopted with respect to appropriate
21 maintenance and post-stabilization care for
22 Medicare+Choice plans under part C of title XVIII
23 of the Social Security Act.

24 “(e) DEFINITIONS.—In this section:

1 “(1) EMERGENCY SERVICES.—The term ‘emer-
2 gency services’ means, with respect to an enrollee in
3 a health plan, covered inpatient and outpatient serv-
4 ices that are needed to evaluate or stabilize an emer-
5 gency medical condition (as defined in paragraph
6 (2)).

7 “(2) EMERGENCY MEDICAL CONDITION.—The
8 term ‘emergency medical condition’ means a medical
9 condition manifesting itself by acute symptoms of
10 sufficient severity (including severe pain) such that
11 a prudent layperson, who possesses an average
12 knowledge of health and medicine, could reasonably
13 expect the absence of immediate medical attention to
14 result in—

15 “(i) placing the health of the individ-
16 ual (or, with respect to a pregnant woman,
17 the health of the woman or her unborn
18 child) in serious jeopardy;

19 “(ii) serious impairment to bodily
20 functions; or

21 “(iii) serious dysfunction of any bodily
22 organ or part.

23 “(2) POST-STABILIZATION CARE.—The term
24 ‘post-stabilization care’ means, with respect to an in-
25 dividual who is determined to be stable under section

1 1867 of the Social Security Act pursuant to a medi-
2 cal screening examination or who is stabilized after
3 provision of emergency services, medically necessary
4 items and services (other than emergency services
5 and other than maintenance care) that are required
6 by the individual.

7 **“SEC. 2776. ADVANCE DIRECTIVES AND ORGAN DONATION.**

8 “A group health plan or health insurance issuer shall
9 maintain written policies and procedures with respect to
10 advance directives (as such term is defined in section
11 1866(f)(3) of the Social Security Act (42 U.S.C.
12 1395cc(f)(3))) and organ donation decisions on the part
13 of an enrollee. Nothing in the preceding sentence shall be
14 construed to require the provision of information regard-
15 ing assisted suicide, euthanasia, or mercy killing.

16 **“SEC. 2777. COVERAGE DETERMINATION, GRIEVANCES AND**
17 **APPEALS.**

18 “(a) COVERAGE DETERMINATIONS.—

19 “(1) IN GENERAL.—A group health plan or a
20 health insurance issuer shall ensure that procedures
21 are in place for—

22 “(A) making determinations regarding
23 whether an enrollee is eligible to receive a pay-
24 ment or coverage for health service under the
25 plan or coverage involved and the amount (if

1 any) that the enrollee is required to pay with
2 respect to such service;

3 “(B) notifying covered enrollees (or indi-
4 viduals acting on behalf of such enrollees) and
5 health care professionals providing the service
6 involved regarding determinations made by the
7 plan or issuer and any additional payments that
8 the enrollee may be required to make with re-
9 spect to such service; and

10 “(C) responding to either written or oral
11 requests for coverage determinations from an
12 enrollee (or an individual acting on behalf of an
13 enrollee) or a treating health care professional.

14 “(2) ROUTINE DETERMINATION.—

15 “(A) IN GENERAL.—A group health plan
16 or a health insurance issuer shall ensure that
17 prior authorization determinations concerning
18 the provision of non-emergency items or serv-
19 ices are made within 15 days of the date on
20 which the plan or issuer receives a request for
21 such a determination.

22 “(B) INCOMPLETE INFORMATION.—If a
23 determination cannot be made under subpara-
24 graph (A) within the 15 day period referred to
25 in such subparagraph, because of the incom-

1 plete nature of the medical or coverage informa-
2 tion involved, the plan or issuer shall provide a
3 written notification of such fact to the enrollee
4 (or individual acting on behalf of the enrollee)
5 and the treating health care professional.

6 “(C) SUBMISSION OF ADDITIONAL INFOR-
7 MATION.—Upon receipt of a notification under
8 subparagraph (B), an enrollee (or individual
9 acting on behalf of an enrollee) or the treating
10 health care professional shall submit the addi-
11 tional information required within the 30-day
12 period beginning on the date on which such no-
13 tification is received.

14 “(D) DETERMINATION.—A group health
15 plan or health insurance issuer shall make a de-
16 termination under this paragraph within 2
17 working days of the date on which complete in-
18 formation is obtained.

19 “(3) EXPEDITED DETERMINATION.—

20 “(A) IN GENERAL.—A prior authorization
21 determination under this subsection shall be
22 made within 72 hours after a request is re-
23 ceived by the plan or issuer if the request indi-
24 cates that the treating health care professional
25 (regardless of whether the professional is affili-

1 ated with the plan or issuer involved) certifies
2 that a determination under the procedures de-
3 scribed in paragraph (2) could seriously jeop-
4 ardize the life or health of the enrollee or the
5 ability of the enrollee to regain maximum func-
6 tion.

7 “(B) INFORMATION.—In an expedited re-
8 view under this paragraph, all necessary infor-
9 mation shall be transmitted between the plan or
10 issuer and the enrollee (or individual acting on
11 behalf of the enrollee) and the treating health
12 care professional by the most expeditious meth-
13 od available.

14 “(C) NOTICE.—Notice of a determination
15 under an expedited review shall be provided to
16 the enrollee (or individual acting on behalf of
17 the enrollee) and the treating health care pro-
18 fessional within the 72-hour period referred to
19 in subparagraph (A) by the most expedient
20 method available. Written confirmation of such
21 determination shall be provided to the enrollee
22 (or individual) or treating health care profes-
23 sional within 2 working days of the initial no-
24 tice.

25 “(4) NOTICE OF DETERMINATIONS.—

1 “(A) APPROVAL.—With respect to the rou-
2 tine determination of a plan or issuer under
3 paragraph (2) to certify an admission, proce-
4 dure or service, with respect to an enrollee, the
5 plan or issuer shall provide notice of such deter-
6 mination to the treating health care profes-
7 sional involved within 24 hours of making such
8 determination. A written or electronic confirma-
9 tion of such determination shall be made to
10 such professional and enrollee (or individual
11 acting on behalf of the enrollee) within 2 work-
12 ing days of the date on which the initial notice
13 was provided.

14 “(B) ADVERSE DETERMINATIONS.—With
15 respect to a routine adverse determination by a
16 plan or issuer under paragraph (2), the plan or
17 issuer shall provide notice of such determination
18 to the treating health care professional within
19 24 hours of making the determination. A writ-
20 ten or electronic confirmation of such deter-
21 mination shall be made to such professional,
22 and a written notice of such determination shall
23 be made to the enrollee involved (or individual
24 acting on behalf of an individual), within 1

1 working day of the date on which the initial no-
2 tice was provided.

3 “(C) CONCURRENT REVIEWS.—With re-
4 spect to the determination of a plan or issuer
5 under paragraph (1) to certify or deny an ex-
6 tended stay or additional services, the plan or
7 issuer shall provide notice of such determination
8 to the health care provider rendering the service
9 involved within 1 working day of making such
10 determination. A written or electronic confirma-
11 tion of such determination shall be made to
12 such professional and to the enrollee involved
13 (or individual acting on behalf of the enrollee)
14 within 1 working day of the date on which the
15 initial notice was provided.

16 “(D) RETROSPECTIVE REVIEWS.—With re-
17 spect to the retrospective review by a plan or
18 issuer of a determination made under para-
19 graph (1), a determination shall be made within
20 30 working days of the date on which the plan
21 or issuer receives all necessary information. The
22 plan or issuer shall provide written notice of an
23 approval or disapproval of a determination
24 under this subparagraph to the enrollee (or in-
25 dividual acting on behalf of the enrollee) and

1 health care provider involved within 5 working
2 days of the date on which such determination is
3 made.

4 “(E) REQUIREMENT OF NOTICE.—A writ-
5 ten or electronic notice of an adverse deter-
6 mination under subparagraph (B), (C) or (D),
7 or of an expedited adverse determination under
8 paragraph (3), shall be provided to the enrollee
9 (or individual acting on behalf of the enrollee)
10 and health care provider (if any) involved and
11 shall include—

12 “(i) the reasons for the determination
13 (including the clinical rationale) written in
14 a manner to be understandable (to the ex-
15 tent possible) to the average enrollee;

16 “(ii) the procedures for obtaining ad-
17 ditional information concerning the deter-
18 mination; and

19 “(iii) notification of the right to ap-
20 peal the determination and instructions on
21 how to initiate an appeal in accordance
22 with subsection (d)(2).

23 “(5) DEFINITION.—As used in this section, the
24 term ‘adverse determination’ with respect to a group
25 health plan or health insurance coverage means a

1 determination to deny, reduce or terminate services,
2 deny payment for services, or any decision to deny
3 coverage based on a lack of medical necessity, under
4 the terms and conditions of such plan or coverage.

5 “(b) NOTICE FOR OTHER DETERMINATIONS.—A
6 group health plan or a health insurance issuer shall pro-
7 vide written notice to an enrollee (or individual acting on
8 behalf of an enrollee) and a health care professional in-
9 volved of a determination by the plan or issuer to deny,
10 reduce or terminate services or deny payment for services.
11 Such notification shall include a brief explanation (written
12 in a manner to be understood by an average enrollee) of
13 the reasons for the determination, procedures for obtain-
14 ing additional information, and procedures for appealing
15 the determination.

16 “(c) GRIEVANCES.—A group health plan or a health
17 insurance issuer shall have written procedures for address-
18 ing grievances between the plan and enrollees, including
19 grievances relating to waiting periods, operating hours,
20 the demeanor of personnel, and the adequacy of facilities.
21 Determinations under such procedures shall be non-
22 appealable.

23 “(d) INTERNAL APPEAL OF COVERAGE DETERMINA-
24 TIONS.—

1 “(1) IN GENERAL.—An enrollee (or an individ-
2 ual acting on behalf of an enrollee) and the treating
3 health care professional with the consent of the en-
4 rollee (or an individual acting on behalf of the en-
5 rollee), may appeal (orally or in writing) any adverse
6 determination under subsection (a) or (b) under the
7 procedures described in this subsection.

8 “(2) APPEAL.—A group health plan and a
9 health insurance issuer shall establish and maintain
10 an internal appeal process under which any enrollee
11 (or an individual acting on behalf of an enrollee) or
12 the treating health care professional with the con-
13 sent of the enrollee (or an individual acting on be-
14 half of the enrollee), who is dissatisfied with any ad-
15 verse determination has the opportunity to discuss
16 and appeal (either orally or in writing) that decision.

17 “(3) RECORDS.—A group health plan and a
18 health insurance issuer shall maintain written
19 records with respect to any appeal under this sub-
20 section for purposes of internal quality assurance
21 and improvement.

22 “(4) WRITTEN REQUEST.—With respect to an
23 oral request under paragraph (1), a group health
24 plan or a health insurance issuer may require that
25 the requesting individual provide written evidence of

1 such request for record keeping purposes. A request
2 for written evidence under the preceding sentence
3 shall not be used by a group health plan or health
4 insurance issuer to delay the initiation of the appeals
5 process under this subsection pending the receipt of
6 such evidence.

7 “(5) ROUTINE DETERMINATIONS.—Except as
8 provided for in paragraph (6), a group health plan
9 or a health insurance issuer shall provide for the
10 consideration of an appeal of an adverse determina-
11 tion under this subsection not later than 30 days
12 after the date on which a request for such appeal is
13 received.

14 “(6) EXPEDITED DETERMINATION.—A deter-
15 mination with respect to an appeal under this sub-
16 section shall, upon the written or oral request of an
17 enrollee (or an individual acting on behalf of the en-
18 rollee) or the treating health care professional, be
19 made within 72 hours after the request for such ap-
20 peal is received by the plan or issuer if the request
21 indicates that the treating health care professional
22 (regardless of whether the professional is affiliated
23 with the plan or issuer involved) certifies that a de-
24 termination under the procedures described in para-
25 graph (5) could seriously jeopardize the life or

1 health of the enrollee or the ability of the enrollee
2 to regain maximum function.

3 “(7) CONDUCT OF REVIEW.—A review of a de-
4 termination under this subsection shall be conducted
5 by health care professionals who are knowledgeable
6 about the enrollee’s condition and the treatment or
7 service involved, including physicians and other
8 trained health care professionals. Such review shall
9 not be conducted by an individual who was involved
10 in the initial decision.

11 “(8) LACK OF MEDICAL NECESSITY.—An ap-
12 peal under this subsection relating to a determina-
13 tion to deny coverage based on a lack of medical ne-
14 cessity or appropriateness shall be made only by a
15 physician with appropriate expertise in the field of
16 medicine involved who is not involved in the initial
17 determination.

18 “(9) NOTICE.—

19 “(A) IN GENERAL.—Written notice—

20 “(i) of a determination made under
21 paragraph (6) shall be provided to the en-
22 rollee (or individual acting on behalf of the
23 enrollee) and the treating health care pro-
24 fessional within the 72-hour period re-

1 ferred to in such paragraph in the most ex-
2 peditious manner possible; and

3 “(ii) of a determination under para-
4 graph (5), shall be provided in writing to
5 the enrollee (or individual acting on behalf
6 of the enrollee) and the treating health
7 care professional within 2 working days
8 after the completion of the review referred
9 to in such paragraph.

10 “(B) ADVERSE DETERMINATIONS.—With
11 respect to an adverse determination made under
12 paragraph (5) or (6), the notice described in
13 subparagraph (A) shall include written informa-
14 tion on how the determination may be appealed
15 to an external entity under subsection (e).

16 “(e) EXTERNAL REVIEW.—

17 “(1) IN GENERAL.—A group health plan or a
18 health insurance issuer shall have written procedures
19 to permit an enrollee (or an individual acting on be-
20 half of an enrollee) or the treating health care pro-
21 fessional with the consent of the enrollee (or individ-
22 ual), the right to an external appeal of an adverse
23 determination if such determination involves treat-
24 ments or services covered by the terms and condition
25 of the plan that cost at least \$1,000.

1 “(2) ELIGIBILITY FOR DESIGNATION AS EXTER-
2 NAL REVIEW PANEL.—

3 “(A) DESIGNATION.—The appropriate
4 State agent shall designate individuals who are
5 eligible to serve on, or entities eligible to act as,
6 an external review panel to review external ap-
7 peals brought under this subsection.

8 “(B) REQUIREMENTS.—In designating in-
9 dividuals or entities under subparagraph (A),
10 the State agent shall ensure that the individual
11 or entity is licensed or certified to conduct ex-
12 ternal reviews by—

13 “(i) the State agent, in accordance
14 with licensing and certification procedures
15 to be developed by the State in consulta-
16 tion with the National Association of In-
17 surance Commissioners; or

18 “(ii) in the case of a State that—

19 “(I) has not established such li-
20 censing and certification procedures
21 within 24 months of the date of enact-
22 ment of this subpart, the State in ac-
23 cordance with procedures to be devel-
24 oped by the Secretary; or

1 “(II) refuses to designate such
2 panels, the Secretary.

3 “(C) LIABILITY.—An individual designated
4 to an external review panel under this sub-
5 section shall not be held liable for any decision
6 made by such panel.

7 “(3) INITIATION OF THE EXTERNAL REVIEW
8 PROCESS.—

9 “(A) FILING OF REQUEST.—An enrollee
10 (or individual acting on behalf of an enrollee) or
11 the treating health care professional with the
12 consent of the enrollee (or individual) who de-
13 sires to have an external review conducted
14 under this subsection shall file a written request
15 for such a review with the plan or issuer in-
16 volved and the appropriate State agent not later
17 than 30 days after the receipt of a final denial
18 of a claim under subsection (d). Any such re-
19 quest shall include the consent of the enrollee
20 (or individual) for the release of confidential
21 medical information regarding the enrollee (or
22 individual) if such information is necessary for
23 the proper conduct of the external review.

24 “(B) INFORMATION AND NOTICE.—Not
25 later than 5 working days after the receipt of

1 a request under subparagraph (A), the plan or
2 issuer involved shall—

3 “(i) forward all necessary information
4 (including medical records, any relevant re-
5 view criteria, the clinical rationale for the
6 denial, and evidence of the enrollee’s cov-
7 erage) to the appropriate State agent (or
8 the designee of such agent); and

9 “(ii) send a written notification to the
10 enrollee (or individual acting on behalf of
11 the enrollee), the treating health care pro-
12 fessional, and the plan administrator, indi-
13 cating that an external review has been ini-
14 tiated.

15 “(C) APPOINTMENT OF PANEL.—Not later
16 than 30 days after the information and notifica-
17 tion are provided under subsection (b)—

18 “(i) the State agent, in the case of a
19 plan or issuer involved that is fully in-
20 sured, shall appoint an external review
21 panel from among the individuals and enti-
22 ties eligible under paragraph (2);

23 “(ii) the plan fiduciary, in the case of
24 a plan or issuer involved that is self-in-
25 sured, shall appoint an external review

1 panel from among the individuals and enti-
2 ties eligible under paragraph (2); or

3 “(iii) the State agent, in the case of
4 a group health plan where the plan spon-
5 sor directly provided health care under
6 such plan.

7 “(D) REQUIREMENTS.—A review panel ap-
8 pointed under subparagraph (C) shall—

9 “(i) consist of at least 3 physicians or
10 other health care professionals who are ex-
11 perts in the treatment of the enrollee’s
12 condition and knowledgeable about the rec-
13 ommended treatment; or

14 “(ii) be an impartial review entity in-
15 cluding a medical peer review organization
16 or an independent utilization review com-
17 pany.

18 “(E) APPROVAL OF ENROLLEE.—Not later
19 than 15 days after the date on which an exter-
20 nal review panel is designated under this para-
21 graph, the enrollee involved shall, in writing—

22 “(i) approve such panel; or

23 “(ii) object to such panel and select
24 alternative individuals or entities who are

1 eligible under paragraph (2) to serve on
2 such panel.

3 Individuals or entities approved or selected
4 under this subparagraph shall serve as the ex-
5 ternal review panel under this subsection with
6 respect to the enrollee involved.

7 “(F) CONFLICT OF INTEREST.—An exter-
8 nal review panel designated under this para-
9 graph shall not have any material, professional,
10 familial, or financial affiliation with the health
11 plan, health insurance issuer or the enrollee in-
12 volved, or any officer, director, or management
13 employee of the plan, issuer, physician, medical
14 group, or association recommending the treat-
15 ment, the institution where the treatment would
16 take place, or the manufacturer of any drug,
17 device, procedure, or other therapy proposed for
18 the enrollee whose treatment is under review.

19 “(4) STANDARD OF REVIEW.—An external re-
20 view panel designated under paragraph (3) shall—

21 “(A) complete a review of an adverse de-
22 termination not later than 30 days after the
23 later of—

24 “(i) the date on which such panel is
25 approved under paragraph (4)(E); or

1 “(ii) the date on which all information
2 necessary to completing such review is re-
3 ceived;

4 “(B) take into consideration the benefits
5 and coverage provided under the terms and con-
6 ditions of the plan involved;

7 “(C) follow a standard of review that pro-
8 motes evidence-based decision making; and

9 “(D) submit a report on the final deter-
10 minations of the panel to—

11 “(i) the plan or issuer involved;

12 “(ii) the enrollee involved (or individ-
13 ual acting on behalf of the enrollee);

14 “(iii) the health care professional in-
15 volved; and

16 “(iv) the State agent responsible for
17 designating review panels under paragraph
18 (2).

19 “(5) FILING FEE.—A State may impose a filing
20 fee to be applied to an enrollee initiating an external
21 review under this subsection. If a State elects to im-
22 pose such a filing fee, the State must include a pro-
23 cedure to provide for a fee reduction if the enrollee
24 demonstrates financial hardship through status or

1 evidence of participation in a State or Federal cash
2 assistance program.

3 “(6) PAYMENT FOR EXTERNAL REVIEW.—A
4 health plan, or health insurance issuer shall be fi-
5 nancially responsible for any reasonable costs associ-
6 ated with the conduct of an external review under
7 this subsection.

8 “(7) ANNUAL REPORTING.—The appropriate
9 State agent shall conduct annual reviews of the
10 number of external reviews requested under this sub-
11 section and the outcomes of such reviews. A report
12 concerning such annual reviews shall be made public
13 and forwarded to the Secretary of Health and
14 Human Services (with respect to health insurance
15 issuers) and the Secretary of Labor (with respect to
16 reports on group health plans). Such reports shall
17 breakdown the results by relevance to group health
18 plans and health insurance issuers.

19 “(8) AUDITS.—Not later than 2 years after the
20 date of enactment of this subpart, the General Ac-
21 counting Office shall conduct a review of all licensed,
22 certified, or appointed review panels under para-
23 graph (3). Such review shall include an assessment
24 of the process involved during an external review

1 and the basis of decisionmaking by the board or
2 panel.

3 “(9) **RULE OF CONSTRUCTION.**—The deter-
4 mination of an external review panel shall be binding
5 on the plan or issuer involved, except that nothing
6 in this subsection shall be construed to preclude the
7 right of a group health plan, health insurance issuer,
8 or an enrollee from commencing a civil action based
9 on the plan or coverage involved.

10 “(f) **PRIOR AUTHORIZATION DETERMINATION.**—For
11 purposes of this section, the term ‘prior authorization de-
12 termination’ means, with respect to items and services for
13 which coverage may be provided under a health plan, a
14 determination (before the provision of the items and serv-
15 ices and as a condition of coverage of the items and serv-
16 ices under the coverage) of whether or not such items and
17 services will be covered under the coverage.

18 **“SEC. 2778. CONFIDENTIALITY AND ACCURACY OF ENROLL-**
19 **EES RECORDS.**

20 “A group health plan or a health insurance issuer
21 shall establish procedures with respect to medical records
22 or other health information maintained regarding enroll-
23 ees to safeguard the privacy of any individually identifiable
24 enrollee information.

1 sionals with the information described in paragraph
2 (1).

3 “(3) RULE OF CONSTRUCTION.—Nothing in
4 this subsection shall be construed to in any way ef-
5 fect a provision in a contract between a plan or
6 issuer and a health care professional that permits ei-
7 ther party to the contract to terminate the employ-
8 ment or participation of the professional under the
9 plan or issuer without cause.

10 “(b) COMMUNICATIONS.—

11 “(1) IN GENERAL.—An organization on behalf
12 of a group health plan (as described in subsection
13 (a)(2)) or a health insurance issuer shall not penal-
14 ize (financially or otherwise) a health care profes-
15 sional for advocating on behalf of his or her patient
16 or for providing information or referral for medical
17 care (as defined in section 2791(a)(2)) consistent
18 with the health care needs of the patient and with
19 the code of ethical conduct, professional responsibil-
20 ity, conscience, medical knowledge, and license of the
21 health care professional.

22 “(2) CONSTRUCTION.—Nothing in paragraph
23 (1) shall be construed as requiring a health insur-
24 ance issuer or a group health plan to pay for medi-
25 cal care not otherwise paid for or covered by the

1 plan provided by nonparticipating health care profes-
2 sionals, except in those instances and to the extent
3 that the issuer or plan would normally pay for such
4 medical care.

5 “(3) ASSISTANCE AND SUPPORT.—A group
6 health plan or a health insurance issuer shall not
7 prohibit or otherwise restrict a health care profes-
8 sional from providing letters of support to, or in any
9 way assisting, enrollees who are appealing a denial,
10 termination, or reduction of service in accordance
11 with the procedures under section 2777.”.

12 (b) APPLICATION TO GROUP HEALTH INSURANCE
13 COVERAGE.—

14 (1) IN GENERAL.—Subpart 2 of part A of title
15 XXVII of the Public Health Service Act is amended
16 by adding at the end the following new section:

17 **“SEC. 2706. PROTECTION FOR CONSUMERS.**

18 “(a) IN GENERAL.—Each health insurance issuer
19 shall comply with the protections and requirements under
20 part C with respect to group health insurance coverage
21 it offers.

22 “(b) ASSURING COORDINATION.—The Secretary of
23 Health and Human Services and the Secretary of Labor
24 shall ensure, through the execution of an interagency

1 memorandum of understanding between such Secretaries,
2 that—

3 “(1) regulations, rulings, and interpretations
4 issued by such Secretaries relating to the same mat-
5 ter over which such Secretaries have responsibility
6 under part C (and this section) and section 713 of
7 the Employee Retirement Income Security Act of
8 1974 are administered so as to have the same effect
9 at all times; and

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

15 (2) CONFORMING AMENDMENT.—Section 2792
16 of such Act (42 U.S.C. 300gg-92) is amended by in-
17 serting “and section 2706(b)” after “of 1996”.

18 (c) APPLICATION TO INDIVIDUAL HEALTH INSUR-
19 ANCE COVERAGE.—Part B of title XXVII of the Public
20 Health Service Act is amended by inserting after section
21 2751 the following new section:

22 **“SEC. 2752. PROTECTION FOR CONSUMERS.**

23 “Each health insurance issuer shall comply with the
24 protections and requirements under part C with respect
25 to individual health insurance coverage it offers.”.

1 (d) DEFINITIONS.—Section 2791(d) of the Public
2 Health Service Act (42 U.S.C. 300gg–91(d)) is amend-
3 ed—

4 (1) by redesignating paragraphs (9) through
5 (14) as paragraphs (10) through (15), respectively;
6 and

7 (2) by inserting after paragraph (8), the follow-
8 ing:

9 “(9) HEALTH CARE PROFESSIONAL.—The term
10 ‘health care professional’ means a physician (as de-
11 fined in section 1861(r) of the Social Security Act)
12 or other health care professional if coverage for the
13 professional’s services is provided under the health
14 plan involved for the services of the professional.
15 Such term includes a podiatrist, optometrist, chiro-
16 practor, psychologist, dentist, physician assistant,
17 physical or occupational therapist and therapy as-
18 sistant, speech-language pathologist, audiologist,
19 registered or licensed practical nurse (including
20 nurse practitioner, clinical nurse specialist, certified
21 registered nurse anesthetist, and certified nurse-mid-
22 wife), licensed certified social worker, registered res-
23 piratory therapist, and certified respiratory therapy
24 technician.”.

1 **SEC. 312. AMENDMENTS TO THE EMPLOYEE RETIREMENT**
2 **INCOME SECURITY ACT OF 1974.**

3 (a) IN GENERAL.—The Employee Retirement Income
4 Security Act of 1974 (29 U.S.C. 1001 et seq.) is amend-
5 ed—

6 (1) by redesignating subpart C as subpart D;

7 and

8 (2) by inserting after subpart B, the following:

9 “SUBPART B—PROTECTION FOR CONSUMERS

10 **“SEC. 720. EXEMPTION.**

11 “(a) IN GENERAL.—Upon the application of a group
12 health plan or a health insurance issuer offering health
13 insurance coverage, the Secretary may exempt such plan
14 or issuer from compliance with 1 or more of the require-
15 ments of this part.

16 “(b) REQUIREMENTS.—The Secretary may grant an
17 exemption under this section if—

18 “(1) the Secretary—

19 “(A) publishes a notice of the pendency of
20 such exemption in the Federal Register; and

21 “(B) provides notice, and an opportunity
22 for comment, of the pendency of such exemp-
23 tion to interested individuals; and

24 “(2) the Secretary determines that the exemp-
25 tion—

26 “(A) is administratively feasible;

1 “(B) is in the interests of the group health
 2 plan and the participants and beneficiaries
 3 under such plan, or in the interests of the
 4 health insurance issuer and the participants
 5 and beneficiaries involved; and

6 “(C) is protective of the rights of partici-
 7 pants and beneficiaries, as the case may be.

8 “(c) SCOPE OF EXEMPTION.—An exemption provided
 9 under this section—

10 “(1) shall apply only to those requirements
 11 identified by the Secretary in approving the exemp-
 12 tion;

13 “(2) may be conditional; and

14 “(3) may be provided to a class of plans or
 15 issuers.

16 “(d) PROCEDURES.—The Secretary shall develop
 17 procedures to provide exemptions under this section.

18 **“CHAPTER 1—CONSUMER INFORMATION**

19 **“SEC. 721. HEALTH PLAN COMPARATIVE INFORMATION.**

20 “(a) REQUIREMENT.—A health insurance issuer in
 21 connection with group health insurance coverage, shall,
 22 not later than 12 months after the date of enactment of
 23 this part, provide for the disclosure, in a clear and accu-
 24 rate form to each plan sponsor, with which the issuer has
 25 contracted, each participant or beneficiary, or upon re-

1 quest to a potential participant or beneficiary or plan
2 sponsor, of the information described in subsection (b).

3 “(b) REQUIRED INFORMATION.—The informational
4 materials to be distributed under this section shall include
5 for each plan the following:

6 “(1) A description of the covered items and
7 services under each such plan and the in- and out-
8 of-network features of each such plan.

9 “(2) A description of any cost sharing, includ-
10 ing premiums, deductibles, coinsurance, and copay-
11 ment amounts, for which the participant or bene-
12 ficiary will be responsible, including any annual or
13 lifetime limits on benefits, for each such plan.

14 “(3) A description of any optional supplemental
15 benefits offered by each such plan and the terms
16 and conditions (including premiums or cost-sharing)
17 for such supplemental coverage.

18 “(4) A description of any restrictions on pay-
19 ments for services furnished to a participant or ben-
20 eficiary by a health care professional that is not a
21 participating professional and the liability of the
22 participant or beneficiary for additional payments
23 for these services.

1 “(5) A description of the service area of each
2 such plan, including the provision of any out-of-area
3 coverage.

4 “(6) A description of the extent to which par-
5 ticipants or beneficiaries may select the primary care
6 provider of their choice, including providers both
7 within the network and outside the network of each
8 such plan (if the plan permits out-of-network serv-
9 ices) as well as procedures for obtaining specialist
10 referral.

11 “(7) A summary of data concerning participant
12 or beneficiary satisfaction with the plan, including
13 disenrollment rates for the previous 2 plan years
14 (excluding disenrollments due to the death of a par-
15 ticipant or beneficiary or the participant or bene-
16 ficiary moving outside of the service area of the
17 plan), based on the health plan’s ‘book-of-business’.
18 Health plans may elect to provide specific informa-
19 tion regarding disenrollment rates.

20 “(8) A description of the procedures for ad-
21 vance directives and organ donation decisions.

22 “(9) A description of the requirements and pro-
23 cedures to be used to obtain preauthorization for
24 health services (including telephone numbers and

1 mailing addresses), including referrals for specialty
2 care.

3 “(10) A summary of the rules and methods for
4 appealing coverage decisions and filing grievances
5 (including telephone numbers and mailing address-
6 es), as well as other available remedies.

7 “(11) A summary of the rules for access to
8 emergency room care, including educational material
9 regarding proper use of emergency services.

10 “(12) A description of licensure, certification or
11 accreditation status of the health plan and the name
12 and address of the State or Federal regulatory agen-
13 cy with oversight responsibilities.

14 “(13) A description of whether or not access is
15 provided to experimental treatments, investigational
16 treatments, or clinical trials and the circumstances
17 under which access to such treatments or trials is
18 made available.

19 “(14) A description of whether or not access is
20 provided to specialists without referral and the cir-
21 cumstances under which assess to such specialists is
22 provided.

23 “(15) A description of the quality indicators
24 and health outcomes measures of the plan in accord-
25 ance with subsection (c).

1 “(16) A statement that the following informa-
2 tion, and instructions on obtaining such information
3 (including telephone numbers and Internet
4 websites), shall be made available upon request:

5 “(A) Additional information on the quality
6 of care and health outcomes under the plan.

7 “(B) The names, credentials, addresses,
8 and telephone numbers and the availability
9 (such as whether professionals accept patients),
10 speciality focus, affiliation arrangements, num-
11 ber and mix of the health care professionals in
12 the network of the plan, and any measures of
13 consumer satisfaction if such satisfaction meas-
14 ures are available.

15 “(C) The names and locations of partici-
16 pating health care facilities, the accreditation
17 status, the for-profit or not-for-profit status of
18 such facilities, and any measures of consumer
19 satisfaction if such satisfaction measures are
20 available.

21 “(D) A summary description of the meth-
22 ods used for compensating participating health
23 care professionals (including capitation, finan-
24 cial incentives or bonuses, fee-for-service, group
25 practice, salary and withholdings), including the

1 proportions of participating health care profes-
2 sionals who are compensated under each type of
3 arrangement under the plan.

4 “(E) A summary description of the proce-
5 dures used for utilization review, including the
6 process by which specific determinations are
7 made.

8 “(F) The list of the specific prescription
9 medications included in the formulary of the
10 plan, if the plan uses a defined formulary.

11 “(G) A description of the specific exclu-
12 sions from coverage under the plan.

13 “(H) A description of the specific prevent-
14 ative services covered under the plan.

15 “(I) A description of the availability of
16 translation or interpretation services for non-
17 English speakers and people with communica-
18 tion disabilities, including the availability of
19 audio tapes or information in Braille.

20 “(J) A description of the number of exter-
21 nal review requests that have been filed with an
22 external review panel designated in accordance
23 with section 727(e) and the outcome of such re-
24 quests by an external review panel in the pre-
25 ceding calendar year.

1 “(c) DETERMINATION OF INDICATORS AND MEAS-
2 URES.—

3 “(1) IN GENERAL.—The Secretary, in consulta-
4 tion with the Secretary of Health and Human Serv-
5 ices, shall develop quality indicators and health out-
6 comes measures for use by health insurance issuers
7 offering group health insurance coverage in provid-
8 ing the information required under section (b), tak-
9 ing into consideration the recommendations of the
10 Health Quality Council established under section
11 101 of the Health Care Quality, Education, Secu-
12 rity, and Trust Act (referred to in this subpart as
13 the ‘Council’). Such quality indicators and health
14 outcomes measures shall, while taking into consider-
15 ation the different populations served (such as chil-
16 dren and individuals with disabilities), be consistent
17 where appropriate with requirements applicable to
18 Medicare+Choice health plans under title XVIII of
19 the Social Security Act (42 U.S.C. 1395 et seq.).

20 “(2) DIFFERENT INDICATORS AND OUTCOMES
21 MEASURES.—The Secretary of Health and Human
22 Services and the Secretary of Labor may adopt qual-
23 ity indicators or health outcomes measures that are
24 in a different form than the indicators or outcomes

1 measures recommended by the Council under para-
2 graph (1) if—

3 “(A) the Secretary of Health and Human
4 Services or the Secretary of Labor finds that
5 different indicators or outcomes measures will
6 substantially reduce administrative costs to
7 health care providers and health plans as com-
8 pared to the alternatives, or that such indica-
9 tors or measures are demonstrated or proven to
10 be more appropriate for the populations served;
11 and

12 “(B) the indicators or outcomes measures
13 are adopted in accordance with the rulemaking
14 procedures of subchapter III of chapter 5 of
15 title 5, United States Code.

16 “(d) MANNER OF DISTRIBUTION.—

17 “(1) IN GENERAL.—The information described
18 in this section shall—

19 “(A) be distributed in an accessible format
20 that is understandable to an average plan par-
21 ticipant or beneficiary; and

22 “(B) with respect to populations of individ-
23 uals whose primary language is other than
24 English, be provided in the primary language of
25 such population if that population comprises

1 not less than 20 percent of the total population
2 of the geographic area served by the health plan
3 involved.

4 “(2) RULE OF CONSTRUCTION.—For purposes
5 of this section, a health insurance issuer, in reliance
6 on records maintained by the issuer, shall be deemed
7 to have met the requirements of this section if the
8 issuer provides the information requested under this
9 section to enrollees at the address contained in such
10 records with respect to such enrollees.

11 “(e) RULE OF CONSTRUCTION.—Nothing in this sec-
12 tion may be construed to prohibit a health insurance
13 issuer offering group health insurance coverage from dis-
14 tributing any other information determined to be impor-
15 tant or necessary in assisting participants or beneficiaries
16 or upon request potential participants or beneficiaries in
17 the selection of a health plan.

18 **“CHAPTER 2—CONSUMER PROTECTION**

19 **AND PLAN STANDARDS**

20 **“SEC. 725. EMERGENCY SERVICES.**

21 “(a) ACCESS TO SERVICES.—A group health plan or
22 a health insurance issuer offering group health insurance
23 coverage who provides coverage for emergency service
24 shall ensure that emergency services are available and ac-
25 cessible 24 hours a day and 7 days a week.

1 “(b) PAYMENT FOR SERVICES.—A group health plan
2 or a health insurance issuer offering group health insur-
3 ance coverage described in subsection (a), shall cover
4 emergency services furnished under the plan or coverage—

5 “(1) in a manner so that, if such services are
6 provided to a participant or beneficiary by a non-
7 participating health care provider—

8 “(A) the participant or beneficiary shall
9 not be liable for amounts paid for such services
10 in excess of the amount that would have been
11 paid if the services were provided by a partici-
12 pating health care provider; and

13 “(B) the plan or issuer shall pay an
14 amount for such services that is not less than
15 the amount that would be paid to a participat-
16 ing health care provider for the same services;
17 and

18 “(2) without regard to any other term or condi-
19 tion of such plan or coverage (other than exclusion
20 or coordination of benefits, or an affiliation or wait-
21 ing period permitted under section 701, and other
22 than applicable cost-sharing requirements).

23 “(c) PRIOR AUTHORIZATION.—A group health plan
24 or a health insurance issuer offering group health insur-
25 ance coverage described in subsection (a) shall provide

1 coverage for emergency services without regard to prior
2 authorization or the emergency care provider’s contractual
3 relationship with the plan involved.

4 “(d) GUIDELINES RESPECTING COORDINATION OF
5 POST-STABILIZATION CARE.—

6 “(1) IN GENERAL.—A group health plan or a
7 health insurance issuer offering group health insur-
8 ance coverage shall comply with guidelines estab-
9 lished by the Secretary of Health and Human Serv-
10 ices (with respect to health insurance issuers) and
11 the Secretary of Labor (with respect to group health
12 plans) relating to promoting efficient and timely co-
13 ordination of appropriate maintenance and post-sta-
14 bilization care of a participant or beneficiary after
15 the participant or beneficiary has been determined
16 to be stable (as defined for purposes of section 1867
17 of the Social Security Act).

18 “(2) GUIDELINES.—The guidelines established
19 by the Secretary of Health and Human Services and
20 the Secretary of Labor under paragraph (1) shall be
21 the guidelines adopted with respect to appropriate
22 maintenance and post-stabilization care for
23 Medicare+Choice plans under part C of title XVIII
24 of the Social Security Act.

25 “(e) DEFINITIONS.—In this section:

1 “(1) EMERGENCY SERVICES.—The term ‘emer-
2 gency services’ means, with respect to a participant
3 or beneficiary in a health plan, covered inpatient and
4 outpatient services that are needed to evaluate or
5 stabilize an emergency medical condition (as defined
6 in paragraph (2)).

7 “(2) EMERGENCY MEDICAL CONDITION.—The
8 term ‘emergency medical condition’ means a medical
9 condition manifesting itself by acute symptoms of
10 sufficient severity (including severe pain) such that
11 a prudent layperson, who possesses an average
12 knowledge of health and medicine, could reasonably
13 expect the absence of immediate medical attention to
14 result in—

15 “(A) placing the health of the individual
16 (or, with respect to a pregnant woman, the
17 health of the woman or her unborn child) in se-
18 rious jeopardy;

19 “(B) serious impairment to bodily func-
20 tions; or

21 “(C) serious dysfunction of any bodily
22 organ or part.

23 “(2) POST-STABILIZATION CARE.—The term
24 ‘post-stabilization care’ means, with respect to an in-
25 dividual who is determined to be stable under section

1 1867 of the Social Security Act pursuant to a medi-
2 cal screening examination or who is stabilized after
3 provision of emergency services, medically necessary
4 items and services (other than emergency services
5 and other than maintenance care) that are required
6 by the individual.

7 **“SEC. 726. ADVANCE DIRECTIVES AND ORGAN DONATION.**

8 “A group health plan or health insurance issuer offer-
9 ing group health insurance coverage shall maintain written
10 policies and procedures with respect to advance directives
11 (as such term is defined in section 1866(f)(3) of the Social
12 Security Act (42 U.S.C. 1395cc(f)(3))) and organ dona-
13 tion decisions on the part of a participant or beneficiary.
14 Nothing in the preceding sentence shall be construed to
15 require the provision of information regarding assisted
16 suicide, euthanasia, or mercy killing.

17 **“SEC. 727. COVERAGE DETERMINATION, GRIEVANCES AND**
18 **APPEALS.**

19 “(a) COVERAGE DETERMINATIONS.—

20 “(1) IN GENERAL.—A group health plan or a
21 health insurance issuer offering group health insur-
22 ance coverage shall ensure that procedures are in
23 place for—

24 “(A) making determinations regarding
25 whether a participant or beneficiary is eligible

1 to receive a payment or coverage for health
2 service under the plan or coverage involved and
3 the amount (if any) that the participant or ben-
4 efiary is required to pay with respect to such
5 service;

6 “(B) notifying participant or beneficiary
7 (or individuals acting on behalf of such partici-
8 pants or beneficiaries) and health care profes-
9 sionals providing the service involved regarding
10 determinations made by the plan or issuer and
11 any additional payments that the participant or
12 beneficiary may be required to make with re-
13 spect to such service; and

14 “(C) responding to either written or oral
15 requests for coverage determinations from a
16 participant or beneficiary (or an individual act-
17 ing on behalf of a participant or beneficiary) or
18 a treating health care professional.

19 “(2) ROUTINE DETERMINATION.—

20 “(A) IN GENERAL.—A group health plan
21 or a health insurance issuer offering group
22 health insurance coverage shall ensure that
23 prior authorization determinations concerning
24 the provision of non-emergency items or serv-
25 ices are made within 15 days of the date on

1 which the plan or issuer receives a request for
2 such a determination.

3 “(B) INCOMPLETE INFORMATION.—If a
4 determination cannot be made under subpara-
5 graph (A) within the 15 day period referred to
6 in such subparagraph, because of the incom-
7 plete nature of the medical or coverage informa-
8 tion involved, the plan or issuer shall provide a
9 written notification of such fact to the partici-
10 pant or beneficiary (or individual acting on be-
11 half of the participant or beneficiary) and the
12 treating health care professional.

13 “(C) SUBMISSION OF ADDITIONAL INFOR-
14 MATION.—Upon receipt of a notification under
15 subparagraph (B), a participant or beneficiary
16 (or individual acting on behalf of a participant
17 or beneficiary) or the treating health care pro-
18 fessional shall submit the additional information
19 required within the 30-day period beginning on
20 the date on which such notification is received.

21 “(D) DETERMINATION.—A group health
22 plan or health insurance issuer offering group
23 health insurance coverage shall make a deter-
24 mination under this paragraph within 2 work-

1 ing days of the date on which complete informa-
2 tion is obtained.

3 “(3) EXPEDITED DETERMINATION.—

4 “(A) IN GENERAL.—A prior authorization
5 determination under this subsection shall be
6 made within 72 hours after a request is re-
7 ceived by the plan or issuer if the request indi-
8 cates that the treating health care professional
9 (regardless of whether the professional is affili-
10 ated with the plan or issuer involved) certifies
11 that a determination under the procedures de-
12 scribed in paragraph (2) could seriously jeop-
13 ardize the life or health of the participant or
14 beneficiary or the ability of the participant or
15 beneficiary to regain maximum function.

16 “(B) INFORMATION.—In an expedited re-
17 view under this paragraph, all necessary infor-
18 mation shall be transmitted between the plan or
19 issuer and the participant or beneficiary (or in-
20 dividual acting on behalf of the participant or
21 beneficiary) and the treating health care profes-
22 sional by the most expeditious method available.

23 “(C) NOTICE.—Notice of a determination
24 under an expedited review shall be provided to
25 the participant or beneficiary (or individual act-

1 ing on behalf of the participant or beneficiary)
2 and the treating health care professional within
3 the 72-hour period referred to in subparagraph
4 (A) by the most expedient method available.
5 Written confirmation of such determination
6 shall be provided to the participant or bene-
7 ficiary (or individual) or treating health care
8 professional within 2 working days of the initial
9 notice.

10 “(4) NOTICE OF DETERMINATIONS.—

11 “(A) APPROVAL.—With respect to the rou-
12 tine determination of a plan or issuer under
13 paragraph (2) to certify an admission, proce-
14 dure or service, with respect to a participant or
15 beneficiary, the plan or issuer shall provide no-
16 tice of such determination to the treating health
17 care professional involved within 24 hours of
18 making such determination. A written or elec-
19 tronic confirmation of such determination shall
20 be made to such professional and participant or
21 beneficiary (or individual acting on behalf of
22 the participant or beneficiary) within 2 working
23 days of the date on which the initial notice was
24 provided.

1 “(B) ADVERSE DETERMINATIONS.—With
2 respect to a routine adverse determination by a
3 plan or issuer under paragraph (2), the plan or
4 issuer shall provide notice of such determination
5 to the treating health care professional within
6 24 hours of making the determination. A writ-
7 ten or electronic confirmation of such deter-
8 mination shall be made to such professional,
9 and a written notice of such determination shall
10 be made to the participant or beneficiary in-
11 volved (or individual acting on behalf of an indi-
12 vidual), within 1 working day of the date on
13 which the initial notice was provided.

14 “(C) CONCURRENT REVIEWS.—With re-
15 spect to the determination of a plan or issuer
16 under paragraph (1) to certify or deny an ex-
17 tended stay or additional services, the plan or
18 issuer shall provide notice of such determination
19 to the health care provider rendering the service
20 involved within 1 working day of making such
21 determination. A written or electronic confirma-
22 tion of such determination shall be made to
23 such professional and to the participant or ben-
24 eficiary involved (or individual acting on behalf
25 of the participant or beneficiary) within 1 work-

1 ing day of the date on which the initial notice
2 was provided.

3 “(D) RETROSPECTIVE REVIEWS.—With re-
4 spect to the retrospective review by a plan or
5 issuer of a determination made under para-
6 graph (1), a determination shall be made within
7 30 working days of the date on which the plan
8 or issuer receives all necessary information. The
9 plan or issuer shall provide written notice of an
10 approval or disapproval of a determination
11 under this subparagraph to the participant or
12 beneficiary (or individual acting on behalf of
13 the participant or beneficiary) and health care
14 provider involved within 5 working days of the
15 date on which such determination is made.

16 “(E) REQUIREMENT OF NOTICE.—A writ-
17 ten or electronic notice of an adverse deter-
18 mination under subparagraph (B), (C) or (D),
19 or of an expedited adverse determination under
20 paragraph (3), shall be provided to the partici-
21 pant or beneficiary (or individual acting on be-
22 half of the participant or beneficiary) and
23 health care provider (if any) involved and shall
24 include—

1 “(i) the reasons for the determination
2 (including the clinical rationale) written in
3 a manner to be understandable (to the ex-
4 tent possible) to the average participant or
5 beneficiary;

6 “(ii) the procedures for obtaining ad-
7 ditional information concerning the deter-
8 mination; and

9 “(iii) notification of the right to ap-
10 peal the determination and instructions on
11 how to initiate an appeal in accordance
12 with subsection (d)(2).

13 “(5) DEFINITION.—As used in this section, the
14 term ‘adverse determination’ with respect to a group
15 health plan or health insurance coverage means a
16 determination to deny, reduce or terminate services,
17 deny payment for services, or any decision to deny
18 coverage based on a lack of medical necessity, under
19 the terms and conditions of such plan or coverage.

20 “(b) NOTICE FOR OTHER DETERMINATIONS.—A
21 group health plan or a health insurance issuer offering
22 group health insurance coverage shall provide written no-
23 tice to a participant or beneficiary (or individual acting
24 on behalf of a participant or beneficiary) and a health care
25 professional involved of a determination by the plan or

1 issuer to deny, reduce or terminate services or deny pay-
2 ment for services. Such notification shall include a brief
3 explanation (written in a manner to be understood by an
4 average participant or beneficiary) of the reasons for the
5 determination, procedures for obtaining additional infor-
6 mation, and procedures for appealing the determination.

7 “(c) GRIEVANCES.—A group health plan or a health
8 insurance issuer offering group health insurance coverage
9 shall have written procedures for addressing grievances
10 between the plan and participants or beneficiaries, includ-
11 ing grievances relating to waiting periods, operating hours,
12 the demeanor of personnel, and the adequacy of facilities.
13 Determinations under such procedures shall be non-ap-
14 pealable.

15 “(d) INTERNAL APPEAL OF COVERAGE DETERMINA-
16 TIONS.—

17 “(1) IN GENERAL.—A participant or beneficiary
18 (or an individual acting on behalf of a participant or
19 beneficiary) and the treating health care professional
20 with the consent of the participant or beneficiary (or
21 an individual acting on behalf of an individual or
22 beneficiary), may appeal (orally or in writing) any
23 adverse determination under subsection (a) or (b)
24 under the procedures described in this subsection.

1 “(2) APPEAL.—A group health plan and a
2 health insurance issuer offering group health insur-
3 ance coverage shall establish and maintain an inter-
4 nal appeal process under which any participant or
5 beneficiary (or an individual acting on behalf of any
6 participant or beneficiary) or the treating health
7 care professional with the consent of the participant
8 or beneficiary (or an individual acting on behalf of
9 the participant or beneficiary), who is dissatisfied
10 with any adverse determination has the opportunity
11 to discuss and appeal (either orally or in writing)
12 that decision.

13 “(3) RECORDS.—A group health plan and a
14 health insurance issuer offering group health insur-
15 ance coverage shall maintain written records with re-
16 spect to any appeal under this subsection for pur-
17 poses of internal quality assurance and improve-
18 ment.

19 “(4) WRITTEN REQUEST.—With respect to an
20 oral request under paragraph (1), a group health
21 plan or a health insurance issuer offering group
22 health insurance coverage may require that the re-
23 questing individual provide written evidence of such
24 request for record keeping purposes. A request for
25 written evidence under the preceding sentence shall

1 not be used by a group health plan or health insur-
2 ance issuer to delay the initiation of the appeals
3 process under this subsection pending the receipt of
4 such evidence.

5 “(5) ROUTINE DETERMINATIONS.—Except as
6 provided for in paragraph (6), a group health plan
7 or a health insurance issuer offering group health
8 insurance coverage shall provide for the consider-
9 ation of an appeal of an adverse determination
10 under this subsection not later than 30 days after
11 the date on which a request for such appeal is re-
12 ceived.

13 “(6) EXPEDITED DETERMINATION.—A deter-
14 mination with respect to an appeal under this sub-
15 section shall, upon the written or oral request of any
16 participant or beneficiary (or an individual acting on
17 behalf of the participant or beneficiary) or the treat-
18 ing health care professional, be made within 72
19 hours after the request for such appeal is received
20 by the plan or issuer if the request indicates that the
21 treating health care professional (regardless of
22 whether the professional is affiliated with the plan
23 or issuer involved) certifies that a determination
24 under the procedures described in paragraph (5)
25 could seriously jeopardize the life or health of the

1 participant or beneficiary or the ability of the partic-
2 ipant or beneficiary to regain maximum function.

3 “(7) CONDUCT OF REVIEW.—A review of a de-
4 termination under this subsection shall be conducted
5 by health care professionals who are knowledgeable
6 about the participant’s or beneficiary’s condition and
7 the treatment or service involved, including physi-
8 cians and other trained health care professionals.
9 Such review shall not be conducted by an individual
10 who was involved in the initial decision.

11 “(8) LACK OF MEDICAL NECESSITY.—An ap-
12 peal under this subsection relating to a determina-
13 tion to deny coverage based on a lack of medical ne-
14 cessity or appropriateness shall be made only by a
15 physician with appropriate expertise in the field of
16 medicine involved who is not involved in the initial
17 determination.

18 “(9) NOTICE.—

19 “(A) IN GENERAL.—Written notice—

20 “(i) of a determination made under
21 paragraph (6) shall be provided to the par-
22 ticipant or beneficiary (or individual acting
23 on behalf of the participant or beneficiary)
24 and the treating health care professional
25 within the 72-hour period referred to in

1 such paragraph in the most expeditious
2 manner possible; and

3 “(ii) of a determination under para-
4 graph (5), shall be provided to the partici-
5 pant or beneficiary (or individual acting on
6 behalf of the participant or beneficiary)
7 and the treating health care professional in
8 writing within 2 working days after the
9 completion of the review referred to in
10 such paragraph.

11 “(B) ADVERSE DETERMINATIONS.—With
12 respect to an adverse determination made under
13 paragraph (5) or (6), the notice described in
14 subparagraph (A) shall include written informa-
15 tion on how the determination may be appealed
16 to an external entity under subsection (e).

17 “(e) EXTERNAL REVIEW.—

18 “(1) IN GENERAL.—A group health plan or a
19 health insurance issuer offering group health insur-
20 ance coverage shall have written procedures to per-
21 mit a participant or beneficiary (or an individual
22 acting on behalf of a participant or beneficiary) or
23 the treating health care professional with the con-
24 sent of the participant or beneficiary (or individual),
25 the right to an external appeal of an adverse deter-

1 mination if such determination involves treatments
2 or services covered by the terms and condition of the
3 plan that cost at least \$1,000.

4 “(2) ELIGIBILITY FOR DESIGNATION AS EXTER-
5 NAL REVIEW PANEL.—

6 “(A) DESIGNATION.—The appropriate
7 State agent shall designate individuals who are
8 eligible to serve on, or entities eligible to act as,
9 an external review panel to review external ap-
10 peals brought under this subsection.

11 “(B) REQUIREMENTS.—In designating in-
12 dividuals or entities under subparagraph (A),
13 the State agent shall ensure that the individual
14 or entity is licensed or certified to conduct ex-
15 ternal reviews by—

16 “(i) the State agent, in accordance
17 with licensing and certification procedures
18 to be developed by the State in consulta-
19 tion with the National Association of In-
20 surance Commissioners; or

21 “(ii) in the case of a State that—

22 “(I) has not established such li-
23 censing and certification procedures
24 within 24 months of the date of enact-
25 ment of this subpart, the State in ac-

1 cordance with procedures to be devel-
2 oped by the Secretary; or

3 “(II) refuses to designate such
4 panels, the Secretary.

5 “(C) LIABILITY.—An individual designated
6 to an external review panel under this sub-
7 section shall not be held liable for any decision
8 made by such panel.

9 “(3) INITIATION OF THE EXTERNAL REVIEW
10 PROCESS.—

11 “(A) FILING OF REQUEST.—A participant
12 or beneficiary (or individual acting on behalf of
13 a participant or beneficiary) or the treating
14 health care professional with the consent of the
15 participant or beneficiary (or individual) who
16 desires to have an external review conducted
17 under this subsection shall file a written request
18 for such a review with the plan or issuer in-
19 volved and the appropriate State agent not later
20 than 30 days after the receipt of a final denial
21 of a claim under subsection (d). Any such re-
22 quest shall include the consent of the partici-
23 pant or beneficiary for the release of confiden-
24 tial medical information regarding the partici-
25 pant or beneficiary if such information is nec-

1 essary for the proper conduct of the external re-
2 view.

3 “(B) INFORMATION AND NOTICE.—Not
4 later than 5 working days after the receipt of
5 a request under subparagraph (A), the plan or
6 issuer involved shall—

7 “(i) forward all necessary information
8 (including medical records, any relevant re-
9 view criteria, the clinical rationale for the
10 denial, and evidence of the participant’s or
11 beneficiary’s coverage) to the appropriate
12 State agent (or the designee of such
13 agent); and

14 “(ii) send a written notification to the
15 participant or beneficiary (or individual
16 acting on behalf of the participant or bene-
17 ficiary), the treating health care profes-
18 sional, and the plan administrator, indicat-
19 ing that an external review has been initi-
20 ated.

21 “(C) APPOINTMENT OF PANEL.—Not later
22 than 30 days after the information and notifica-
23 tion are provided under subsection (b)—

24 “(i) the State agent, in the case of a
25 plan or issuer involved that is fully in-

1 sured, shall appoint an external review
2 panel from among the individuals and enti-
3 ties eligible under paragraph (2);

4 “(ii) the plan fiduciary, in the case of
5 a plan or issuer involved that is self-in-
6 sured, shall appoint an external review
7 panel from among the individuals and enti-
8 ties eligible under paragraph (2); or

9 “(iii) the State agent, in the case of
10 a group health plan where the plan spon-
11 sor directly provided health care under
12 such plan.

13 “(D) REQUIREMENTS.—A review panel ap-
14 pointed under subparagraph (C) shall—

15 “(i) consist of at least 3 physicians or
16 other health care professionals who are ex-
17 perts in the treatment of the participant’s
18 or beneficiary’s condition and knowledge-
19 able about the recommended treatment; or

20 “(ii) be an impartial review entity in-
21 cluding a medical peer review organization
22 or an independent utilization review com-
23 pany.

24 “(E) APPROVAL OF PARTICIPANT OR BEN-
25 EFICIARY.—Not later than 15 days after the

1 date on which an external review panel is des-
2 ignated under this paragraph, the participant
3 or beneficiary involved shall, in writing—

4 “(i) approve such panel; or

5 “(ii) object to such panel and select
6 alternative individuals or entities who are
7 eligible under paragraph (2) to serve on
8 such panel.

9 Individuals or entities approved or selected
10 under this subparagraph shall serve as the ex-
11 ternal review panel under this subsection with
12 respect to the participant or beneficiary in-
13 volved.

14 “(F) CONFLICT OF INTEREST.—An exter-
15 nal review panel designated under this para-
16 graph shall not have any material, professional,
17 familial, or financial affiliation with the health
18 plan, health insurance issuer or the participant
19 or beneficiary involved, or any officer, director,
20 or management employee of the plan, issuer,
21 physician, medical group, or association rec-
22 ommending the treatment, the institution where
23 the treatment would take place, or the manu-
24 facturer of any drug, device, procedure, or other

1 therapy proposed for the participant or bene-
2 ficiary whose treatment is under review.

3 “(4) STANDARD OF REVIEW.—An external re-
4 view panel designated under paragraph (3) shall—

5 “(A) complete a review of an adverse de-
6 termination not later than 30 days after the
7 later of—

8 “(i) the date on which such panel is
9 approved under paragraph (4)(E); or

10 “(ii) the date on which all information
11 necessary to completing such review is re-
12 ceived;

13 “(B) take into consideration the benefits
14 and coverage provided under the terms and con-
15 ditions of the plan involved;

16 “(C) follow a standard of review that pro-
17 motes evidence-based decision making; and

18 “(D) submit a report on the final deter-
19 minations of the panel to—

20 “(i) the plan or issuer involved;

21 “(ii) the participant or beneficiary in-
22 volved (or individual acting on behalf of
23 the participant or beneficiary);

24 “(iii) the health care professional in-
25 volved; and

1 “(iv) the State agent responsible for
2 designating review panels under paragraph
3 (2).

4 “(5) FILING FEE.—A State may impose a filing
5 fee to be applied to a participant or beneficiary initi-
6 ating an external review under this subsection. If a
7 State elects to impose such a filing fee, the State
8 must include a procedure to provide for a fee reduc-
9 tion if the participant or beneficiary demonstrates fi-
10 nancial hardship through status or evidence of par-
11 ticipation in a State or Federal cash assistance pro-
12 gram.

13 “(6) PAYMENT FOR EXTERNAL REVIEW.—A
14 group health plan or health insurance issuer offering
15 group health insurance coverage shall be financially
16 responsible for any reasonable costs associated with
17 the conduct of an external review under this sub-
18 section.

19 “(7) ANNUAL REPORTING.—The appropriate
20 State agent shall conduct annual reviews of the
21 number of external reviews requested under this sub-
22 section and the outcomes of such reviews. A report
23 concerning such annual reviews shall be made public
24 and forwarded to the Secretary of Health and
25 Human Services (with respect to health insurance

1 issuers) and the Secretary of Labor (with respect to
2 reports on group health plans). Such reports shall
3 breakdown the results by relevance to group health
4 plans and health insurance issuers.

5 “(8) AUDITS.—Not later than 2 years after the
6 date of enactment of this subpart, the General Ac-
7 counting Office shall conduct a review of all licensed,
8 certified, or appointed review panels under para-
9 graph (3). Such review shall include an assessment
10 of the process involved during an external review
11 and the basis of decisionmaking by the board or
12 panel.

13 “(9) RULE OF CONSTRUCTION.—The deter-
14 mination of an external review panel shall be binding
15 on the plan or issuer involved, except that nothing
16 in this subsection shall be construed to preclude the
17 right of a group health plan, health insurance issuer,
18 or a participant or beneficiary from commencing a
19 civil action based on the plan or coverage involved.

20 “(f) PRIOR AUTHORIZATION DETERMINATION.—For
21 purposes of this section. the term ‘prior authorization de-
22 termination’ means, with respect to items and services for
23 which coverage may be provided under a health plan, a
24 determination (before the provision of the items and serv-
25 ices and as a condition of coverage of the items and serv-

1 ices under the coverage) of whether or not such items and
 2 services will be covered under the coverage.

3 **“SEC. 728. CONFIDENTIALITY AND ACCURACY OF PARTICI-**
 4 **PANTS AND BENEFICIARIES RECORDS.**

5 “A group health plan or a health insurance issuer of-
 6 fering group health insurance coverage shall establish pro-
 7 cedures with respect to medical records or other health
 8 information maintained regarding participants or bene-
 9 ficiaries to safeguard the privacy of any individually iden-
 10 tifiable participant or beneficiary information.

11 **“CHAPTER 3—HEALTH CARE**
 12 **PROFESSIONAL PROTECTIONS**

13 **“SEC. 730. HEALTH CARE PROFESSIONAL COMMUNICA-**
 14 **TIONS.**

15 “(a) PROVISION OF INFORMATION TO PROFES-
 16 SIONALS.—

17 “(1) HEALTH INSURANCE ISSUERS.—A health
 18 insurance issuer offering group health insurance cov-
 19 erage shall establish procedures concerning the par-
 20 ticipation of health care professionals under coverage
 21 provided by the issuer under which such profes-
 22 sionals will be provided with written notice of—

23 “(A) the rules of the issuer concerning
 24 participation;

1 “(B) any participation decisions that are
2 adverse to health care professionals; and

3 “(C) the process of the issuer for appealing
4 such adverse decisions, including the presen-
5 tation of information and the views of the
6 health care professional regarding such deci-
7 sion.

8 “(2) GROUP HEALTH PLANS.—A group health
9 plan shall ensure that the organization that is re-
10 sponsible for maintaining the provider network in-
11 volved under the plan provides health care profes-
12 sionals with the information described in paragraph
13 (1).

14 “(3) RULE OF CONSTRUCTION.—Nothing in
15 this subsection shall be construed to in any way ef-
16 fect a provision in a contract between a plan or
17 issuer and a health care professional that permits ei-
18 ther party to the contract to terminate the employ-
19 ment or participation of the professional under the
20 plan or issuer without cause.

21 “(b) COMMUNICATIONS.—

22 “(1) IN GENERAL.—An organization on behalf
23 of a group health plan (as described in subsection
24 (a)(2)) or a health insurance issuer offering group
25 health insurance coverage shall not penalize (finan-

1 cially or otherwise) a health care professional for ad-
2 vocating on behalf of his or her patient or for pro-
3 viding information or referral for medical care (as
4 defined in section 733(a)(2)) consistent with the
5 health care needs of the patient and with the code
6 of ethical conduct, professional responsibility, con-
7 science, medical knowledge, and license of the health
8 care professional.

9 “(2) CONSTRUCTION.—Nothing in paragraph
10 (1) shall be construed as requiring a health insur-
11 ance issuer offering group health insurance coverage
12 or a group health plan to pay for medical care not
13 otherwise paid for or covered by the plan provided
14 by nonparticipating health care professionals, except
15 in those instances and to the extent that the issuer
16 or plan would normally pay for such medical care.

17 “(3) ASSISTANCE AND SUPPORT.—A group
18 health plan or a health insurance issuer offering
19 group health insurance coverage shall not prohibit or
20 otherwise restrict a health care professional from
21 providing letters of support to, or in any way assist-
22 ing, participants or beneficiaries who are appealing
23 a denial, termination, or reduction of service in ac-
24 cordance with the procedures under section 727.”.

25 (b) CONFORMING AMENDMENTS.—

1 (1) Section 732(a) of the Employee Retirement
 2 Income Security Act of 1974 (29 U.S.C. 1185(a)) is
 3 amended by striking “section 711, and inserting
 4 “section 711 and subpart C”.

5 (2) The table of contents in section 1 of the
 6 Employee Retirement Income Security Act of 1974
 7 (29 U.S.C. 1001) is amended—

8 (A) in the item relating to subpart C, by
 9 striking “Subpart C” and inserting “Subpart
 10 D”; and

11 (B) by inserting after the item relating to
 12 section 712, the following:

“SUBPART B—PROTECTION FOR CONSUMERS

“Sec. 720. Exemption.

“CHAPTER 1—CONSUMER INFORMATION

“Sec. 721. Health plan comparative information.

“CHAPTER 2—CONSUMER PROTECTION AND PLAN STANDARDS

“Sec. 725. Emergency services.

“Sec. 726. Advance directives and organ donation.

“Sec. 727. Coverage determination, grievances and appeals.

“Sec. 728. Confidentiality and accuracy of participants and beneficiaries
 records.

“CHAPTER 3—HEALTH CARE PROFESSIONAL PROTECTIONS

“Sec. 730. Health care professional communications.”.

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