

105TH CONGRESS  
1ST SESSION

# S. 644

To amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to establish standards for relationships between group health plans and health insurance issuers with enrollees, health professionals, and providers.

---

## IN THE SENATE OF THE UNITED STATES

APRIL 24, 1997

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

---

## A BILL

To amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to establish standards for relationships between group health plans and health insurance issuers with enrollees, health professionals, and providers.

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       “Patient Access to Responsible Care Act of 1997”.

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

- Sec. 1. Short title; table of contents.  
 Sec. 2. Patient protection standards under the Public Health Service Act.

“PART C—PATIENT PROTECTION STANDARDS

- “Sec. 2770. Notice; additional definitions; construction.  
 “Sec. 2771. Enrollee access to care.  
 “Sec. 2772. Enrollee choice of health professionals and providers.  
 “Sec. 2773. Nondiscrimination against enrollees and in the selection of health professionals; equitable access to networks.  
 “Sec. 2774. Prohibition of interference with certain medical communications.  
 “Sec. 2775. Development of plan policies.  
 “Sec. 2776. Due process for enrollees.  
 “Sec. 2777. Due process for health professionals and providers.  
 “Sec. 2778. Information reporting and disclosure.  
 “Sec. 2779. Confidentiality; adequate reserves.  
 “Sec. 2780. Quality improvement program.

Sec. 3. Patient protection standards under the Employee Retirement Income Security Act of 1974.

Sec. 4. Non-preemption of State law respecting liability of group health plans.

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

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

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

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

8 “PART C—PATIENT PROTECTION STANDARDS

9 **“SEC. 2770. NOTICE; ADDITIONAL DEFINITIONS; CONSTRUC-**  
 10 **TION.**

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

1       “(b) ADDITIONAL DEFINITIONS.—For purposes of  
2 this part:

3           “(1) ENROLLEE.—The term ‘enrollee’ means,  
4 with respect to health insurance coverage offered by  
5 a health insurance issuer, an individual enrolled with  
6 the issuer to receive such coverage.

7           “(2) HEALTH PROFESSIONAL.—The term  
8 ‘health professional’ means a physician or other  
9 health care practitioner licensed, accredited, or cer-  
10 tified to perform specified health services consistent  
11 with State law.

12           “(3) NETWORK.—The term ‘network’ means,  
13 with respect to a health insurance issuer offering  
14 health insurance coverage, the participating health  
15 professionals and providers through whom the plan  
16 or issuer provides health care items and services to  
17 enrollees.

18           “(4) NETWORK COVERAGE.—The term ‘network  
19 coverage’ means health insurance coverage offered  
20 by a health insurance issuer that provides or ar-  
21 ranges for the provision of health care items and  
22 services to enrollees through participating health  
23 professionals and providers.

24           “(5) PARTICIPATING.—The term ‘participating’  
25 means, with respect to a health professional or pro-

1 vider, a health professional or provider that provides  
2 health care items and services to enrollees under  
3 network coverage under an agreement with the  
4 health insurance issuer offering the coverage.

5 “(6) PRIOR AUTHORIZATION.—The term ‘prior  
6 authorization’ means the process of obtaining prior  
7 approval from a health insurance issuer as to the ne-  
8 cessity or appropriateness of receiving medical or  
9 clinical services for treatment of a medical or clinical  
10 condition.

11 “(7) PROVIDER.—The term ‘provider’ means a  
12 health organization, health facility, or health agency  
13 that is licensed, accredited, or certified to provide  
14 health care items and services under applicable State  
15 law.

16 “(8) SERVICE AREA.—The term ‘service area’  
17 means, with respect to a health insurance issuer  
18 with respect to health insurance coverage, the geo-  
19 graphic area served by the issuer with respect to the  
20 coverage.

21 “(9) UTILIZATION REVIEW.—The term ‘utiliza-  
22 tion review’ means prospective, concurrent, or retro-  
23 spective review of health care items and services for  
24 medical necessity, appropriateness, or quality of care

1 that includes prior authorization requirements for  
2 coverage of such items and services.

3 “(c) NO REQUIREMENT FOR ANY WILLING PRO-  
4 VIDER.—Nothing in this part shall be construed as requir-  
5 ing a health insurance issuer that offers network coverage  
6 to include for participation every willing provider or health  
7 professional who meets the terms and conditions of the  
8 plan or issuer.

9 **“SEC. 2771. ENROLLEE ACCESS TO CARE.**

10 “(a) GENERAL ACCESS.—

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

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

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

21 “(C) with reasonable promptness (includ-  
22 ing reasonable hours of operation and after-  
23 hours services);

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

1 “(E) in a manner that—

2 “(i) takes into account the diverse  
3 needs of enrollees, and

4 “(ii) reasonably assures continuity of  
5 care.

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

17 “(2) RULE OF CONSTRUCTION.—Nothing in  
18 this subsection shall be construed as requiring a  
19 health insurance issuer to have arrangements that  
20 conflict with its responsibilities to establish measures  
21 designed to maintain quality and control costs.

22 “(3) DEFINITIONS.—For purposes of paragraph  
23 (1):

24 “(A) MEDICALLY UNDERSERVED AREA.—

25 The term ‘medically underserved area’ means

1 an area that is designated as a health profes-  
2 sional shortage area under section 332 of the  
3 Public Health Service Act or as a medically un-  
4 derserved area for purposes of section 330 or  
5 1302(7) of such Act.

6 “(B) RURAL AREA.—The term ‘rural area’  
7 means an area that is not within a Standard  
8 Metropolitan Statistical Area or a New England  
9 County Metropolitan Area (as defined by the  
10 Office of Management and Budget).

11 “(b) EMERGENCY AND URGENT CARE.—

12 “(1) IN GENERAL.—A health insurance issuer  
13 shall—

14 “(A) assure the availability and accessibil-  
15 ity of medically or clinically necessary emer-  
16 gency services and urgent care services within  
17 the service area of the issuer 24 hours a day,  
18 7 days a week;

19 “(B) require no prior authorization for  
20 items and services furnished in a hospital emer-  
21 gency department to an enrollee (without re-  
22 gard to whether the health professional or hos-  
23 pital has a contractual or other arrangement  
24 with the issuer) with symptoms that would rea-  
25 sonably suggest to a prudent layperson an

1 emergency medical condition (including items  
2 and services described in subparagraph  
3 (C)(iii));

4 “(C) cover (and make reasonable payments  
5 for)—

6 “(i) emergency services,

7 “(ii) services that are not emergency  
8 services but are described in subparagraph  
9 (B),

10 “(iii) medical screening examinations  
11 and other ancillary services necessary to  
12 diagnose, treat, and stabilize an emergency  
13 medical condition, and

14 “(iv) urgent care services, without re-  
15 gard to whether the health professional or  
16 provider furnishing such services has a  
17 contractual (or other) arrangement with  
18 the issuer; and

19 “(D) make prior authorization determina-  
20 tions for—

21 “(i) services that are furnished in a  
22 hospital emergency department (other than  
23 services described in clauses (i) and (iii) of  
24 subparagraph (C)), and

1                   “(ii) urgent care services, within the  
2                   time periods specified in (or pursuant to)  
3                   section 2776(a)(8).

4                   “(2) DEFINITIONS.—For purposes of this sub-  
5                   section:

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

16                  “(i) placing the patient’s health in serious  
17                  jeopardy,

18                  “(ii) serious impairment to bodily func-  
19                  tions, or

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

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

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

3            “(C) URGENT CARE SERVICES.—The term  
4            ‘urgent care services’ means health care items  
5            and services that are necessary for the treat-  
6            ment of a condition that—

7            “(i) is not an emergency medical condition,

8            “(ii) requires prompt medical or clinical  
9            treatment, and

10           “(iii) poses a danger to the patient if not  
11           treated in a timely manner, as defined by the  
12           applicable State authority in consultation with  
13           relevant treating health professionals or provid-  
14           ers.

15           “(c) SPECIALIZED SERVICES.—

16           “(1) IN GENERAL.—A health insurance issuer  
17           offering network coverage shall demonstrate that en-  
18           rollees have access to specialized treatment expertise  
19           when such treatment is medically or clinically indi-  
20           cated in the professional judgment of the treating  
21           health professional, in consultation with the enrollee.

22           “(2) DEFINITION.—For purposes of paragraph  
23           (1), the term ‘specialized treatment expertise’ means  
24           expertise in diagnosing or treating—

25           “(A) unusual diseases or conditions, or

1           “(B) diseases and conditions that are unusually  
2 difficult to diagnose or treat.

3           “(d) INCENTIVE PLANS.—

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

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

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

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

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

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

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

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

1 **“SEC. 2772. ENROLLEE CHOICE OF HEALTH PROFES-**  
 2 **SIONALS AND PROVIDERS.**

3 “(a) CHOICE OF PERSONAL HEALTH PROFES-  
 4 SIONAL.—A health insurance issuer shall permit each en-  
 5 rollee under network coverage to—

6 “(1) select a personal health professional from  
 7 among the participating health professionals of the  
 8 issuer, and

9 “(2) change that selection as appropriate.

10 “(b) POINT-OF-SERVICE OPTION.—

11 “(1) IN GENERAL.—If a health insurance issuer  
 12 offers to enrollees health insurance coverage which  
 13 provides for coverage of services only if such services  
 14 are furnished through health professionals and pro-  
 15 viders who are members of a network of health pro-  
 16 fessionals and providers who have entered into a  
 17 contract with the issuer to provide such services, the  
 18 issuer shall also offer to such enrollees (at the time  
 19 of enrollment) the option of health insurance cov-  
 20 erage which provides for coverage of such services  
 21 which are not furnished through health professionals  
 22 and providers who are members of such a network.

23 “(2) FAIR PREMIUMS.—The amount of any ad-  
 24 ditional premium required for the option described  
 25 in paragraph (1) may not exceed an amount that is  
 26 fair and reasonable, as established by the applicable

1 State authority, in consultation with the National  
2 Association of Insurance Commissioners, based on  
3 the nature of the additional coverage provided.

4 “(3) COST-SHARING.—Under the option de-  
5 scribed in paragraph (1), the health insurance cov-  
6 erage shall provide for reimbursement rates for cov-  
7 ered services offered by health professionals and pro-  
8 viders who are not participating health professionals  
9 or providers that are not less than the reimburse-  
10 ment rates for covered services offered by participat-  
11 ing health professionals and providers. Nothing in  
12 this paragraph shall be construed as protecting an  
13 enrollee against balance billing by a health profes-  
14 sional or provider that is not a participating health  
15 professional or provider.

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

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

23 “(2) ensure direct access to relevant specialists  
24 for the continued care of such enrollees when medi-  
25 cally or clinically indicated in the judgment of the

1 treating health professional, in consultation with the  
2 enrollee;

3 “(3) in the case of an enrollee with special  
4 health care needs or a chronic condition, determine  
5 whether, based on the judgment of the treating  
6 health professional, in consultation with the enrollee,  
7 it is medically or clinically necessary to use a spe-  
8 cialist or a care coordinator from an interdiscipli-  
9 nary team to ensure continuity of care; and

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

13 “(A) hospitalization, or

14 “(B) dependency on high-technology home  
15 medical equipment,

16 provide for continued coverage of items and services  
17 furnished by the health professional or provider that  
18 was treating the enrollee before such change for a  
19 reasonable period of time.

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

1 **“SEC. 2773. NONDISCRIMINATION AGAINST ENROLLEES**  
2 **AND IN THE SELECTION OF HEALTH PROFES-**  
3 **SIONALS; EQUITABLE ACCESS TO NETWORKS.**

4 “(a) NONDISCRIMINATION AGAINST ENROLLEES.—  
5 No health insurance issuer may discriminate (directly or  
6 through contractual arrangements) in any activity that  
7 has the effect of discriminating against an individual on  
8 the basis of race, national origin, gender, language, socio-  
9 economic status, age, disability, health status, or antici-  
10 pated need for health services.

11 “(b) NONDISCRIMINATION IN SELECTION OF NET-  
12 WORK HEALTH PROFESSIONALS.—A health insurance is-  
13 suer offering network coverage shall not discriminate in  
14 selecting the members of its health professional network  
15 (or in establishing the terms and conditions for member-  
16 ship in such network) on the basis of—

17 “(1) the race, national origin, gender, age, or  
18 disability (other than a disability that impairs the  
19 ability of an individual to provide health care serv-  
20 ices or that may threaten the health of enrollees) of  
21 the health professional; or

22 “(2) the health professional’s lack of affiliation  
23 with, or admitting privileges at, a hospital (unless  
24 such lack of affiliation is a result of infractions of  
25 quality standards and is not due to a health profes-  
26 sional’s type of license).



1           “(1) the patient’s health status, medical care,  
2           or legal treatment options;

3           “(2) any utilization review requirements that  
4           may affect treatment options for the patient; or

5           “(3) any financial incentives that may affect  
6           the treatment of the patient.

7   **“SEC. 2775. DEVELOPMENT OF PLAN POLICIES.**

8           “A health insurance issuer that offers network cov-  
9           erage shall establish mechanisms to consider the rec-  
10          ommendations, suggestions, and views of enrollees and  
11          participating health professionals and providers regard-  
12          ing—

13           “(1) the medical policies of the issuer (including  
14           policies relating to coverage of new technologies,  
15           treatments, and procedures);

16           “(2) the utilization review criteria and proce-  
17           dures of the issuer;

18           “(3) the quality and credentialing criteria of the  
19           issuer; and

20           “(4) the medical management procedures of the  
21           issuer.

22   **“SEC. 2776. DUE PROCESS FOR ENROLLEES.**

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

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

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

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

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

21          “(5) subject to reasonable safeguards, disclose  
22          to health professionals and providers, upon request,  
23          the names and credentials of individuals conducting  
24          utilization review;

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

4           “(7) comply with the requirement of section  
5           2771 that prior authorization not be required for  
6           emergency and related services furnished in a hos-  
7           pital emergency department;

8           “(8) make prior authorization determinations—

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

13                   “(B) in the case of other services, within  
14           24 hours after the time of a request for deter-  
15           mination;

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

19           “(10) treat a favorable prior authorization re-  
20           view determination as a final determination for pur-  
21           poses of making payment for a claim submitted for  
22           the item or service involved unless such determina-  
23           tion was based on false information knowingly sup-  
24           plied by the person requesting the determination;

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

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

12          “(b) APPEALS PROCESS.—A health insurance issuer  
13          shall establish and maintain an accessible appeals process  
14          that—

15                 “(1) reviews an adverse prior authorization de-  
16                 termination—

17                         “(A) for urgent care services, described in  
18                         subsection (a)(8)(A), within 1 hour after the  
19                         time of a request for such review, and

20                         “(B) for other services, within 24 hours  
21                         after the time of a request for such review;

22                 “(2) reviews an initial determination on pay-  
23                 ment of claims described in subsection (a)(12) with-  
24                 in 30 days after the date of a request for such re-  
25                 view;

1           “(3) provides for review of determinations de-  
2           scribed in paragraphs (1) and (2) by an appropriate  
3           clinical peer professional who is in the same or simi-  
4           lar specialty as would typically provide the item or  
5           service involved (or another licensed, accredited, or  
6           certified health professional acceptable to the plan  
7           and the person requesting such review); and

8           “(4) provides for review of—

9                   “(A) the determinations described in para-  
10                  graphs (1), (2), and (3), and

11                   “(B) enrollee complaints about inadequate  
12                  access to any category or type of health profes-  
13                  sional or provider in the network of the issuer  
14                  or other matters specified by this part,

15           by an appropriate clinical peer professional who is in  
16           the same or similar specialty as would typically pro-  
17           vide the item or service involved (or another li-  
18           censed, accredited, or certified health professional  
19           acceptable to the issuer and the person requesting  
20           such review) that is not involved in the operation of  
21           the plan or in making the determination or policy  
22           being appealed.

23   The procedures specified in this subsection shall not be  
24   construed as preempting or superseding any other reviews  
25   or appeals an issuer is required by law to make available.

1 **“SEC. 2777. DUE PROCESS FOR HEALTH PROFESSIONALS**  
2 **AND PROVIDERS.**

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

5 “(1) allow all health professionals and providers  
6 in its service area to apply to become a participating  
7 health professional or provider during at least one  
8 period in each calendar year;

9 “(2) provide reasonable notice to such health  
10 professionals and providers of the opportunity to  
11 apply and of the period during which applications  
12 are accepted;

13 “(3) provide for review of each application by a  
14 credentialing committee with appropriate representa-  
15 tion of the category or type of health professional or  
16 provider;

17 “(4) select participating health professionals  
18 and providers based on objective standards of qual-  
19 ity developed with the suggestions and advice of pro-  
20 fessional associations, health professionals, and pro-  
21 viders;

22 “(5) make such selection standards available  
23 to—

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

26 “(B) health plan purchasers, and

1           “(C) enrollees;

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

7           “(7) adjust any economic profiling to take into  
8 account patient characteristics (such as severity of  
9 illness) that may result in atypical utilization of  
10 services;

11           “(8) make the results of such profiling available  
12 to insurance purchasers, enrollees, and the health  
13 professional or provider involved;

14           “(9) notify any health professional or provider  
15 being reviewed under the process referred to in para-  
16 graph (3) of any information indicating that the  
17 health professional or provider fails to meet the  
18 standards of the issuer;

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

22           “(A) review the information referred to in  
23 such paragraph, and

24           “(B) submit supplemental or corrected in-  
25 formation;

1           “(11) not include in its contracts with partici-  
2           pating health professionals and providers a provision  
3           permitting the issuer to terminate the contract  
4           ‘without cause’;

5           “(12) provide a due process appeal that con-  
6           forms to the process specified in section 412 of the  
7           Health Care Quality Improvement Act of 1986 (42  
8           U.S.C. 11112) for all determinations that are ad-  
9           verse to a health professional or provider; and

10           “(13) unless a health professional or provider  
11           poses an imminent harm to enrollees or an adverse  
12           action by a governmental agency effectively impairs  
13           the ability to provide health care items and services,  
14           provide—

15           “(A) reasonable notice of any decision to  
16           terminate a health professional or provider ‘for  
17           cause’ (including an explanation of the reasons  
18           for the determination),

19           “(B) an opportunity to review and discuss  
20           all of the information on which the determina-  
21           tion is based, and

22           “(C) an opportunity to enter into a correc-  
23           tive action plan, before the determination be-  
24           comes subject to appeal under the process re-  
25           ferred to in paragraph (12).

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

5       **“SEC. 2778. INFORMATION REPORTING AND DISCLOSURE.**

6       “(a) **IN GENERAL.**—A health insurance issuer offer-  
7 ing health insurance coverage shall provide enrollees and  
8 prospective enrollees with information about—

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

11                       “(A) by category of service,

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

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

16               “(2) the percentage of the premium charged by  
17 the issuer that is set aside for administration and  
18 marketing of the issuer;

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

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

23               “(5) the ratio of enrollees to participating  
24 health professionals and providers by category and  
25 type of health professional and provider;

1           “(6) the expenditures and utilization per en-  
2           rollee by category and type of health professional  
3           and provider;

4           “(7) the financial obligations of the enrollee and  
5           the issuer, including premiums, copayments,  
6           deductibles, and established aggregate maximums on  
7           out-of-pocket costs, for all items and services, includ-  
8           ing—

9                   “(A) those furnished by health profes-  
10                   sionals and providers that are not participating  
11                   health professionals and providers, and

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

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

19           “(9) financial arrangements and incentives that  
20           may—

21                   “(A) limit the items and services furnished  
22                   to an enrollee,

23                   “(B) restrict referral or treatment options,  
24                   or

1           “(C) negatively affect the fiduciary respon-  
2           sibility of a health professional or provider to  
3           an enrollee;

4           “(10) other incentives for health professionals  
5           and providers to deny or limit needed items or serv-  
6           ices;

7           “(11) quality indicators for the issuer and par-  
8           ticipating health professionals and providers, includ-  
9           ing performance measures such as appropriate refer-  
10          rals and prevention of secondary complications fol-  
11          lowing treatment;

12          “(12) grievance procedures and appeals rights  
13          under the coverage, and summary information about  
14          the number and disposition of grievances and ap-  
15          peals in the most recent period for which complete  
16          and accurate information is available; and

17          “(13) the percentage of utilization review deter-  
18          minations made by the issuer that disagree with the  
19          judgment of the treating health professional or pro-  
20          vider and the percentage of such determinations that  
21          are reversed on appeal.

22          “(b) REGULATIONS.—The Secretary, in collaboration  
23          with the Secretary of Labor, shall issue regulations to es-  
24          tablish—

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

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

6                   “(A) readily accessible, and

7                   “(B) in common language easily under-  
8           stood,

9           by individuals with little or no connection to or un-  
10          derstanding of the language employed by health pro-  
11          fessionals and providers, health insurance issuers, or  
12          other entities involved in the payment or delivery of  
13          health care services, and

14          “(3) the placement and positioning of informa-  
15          tion in health plan marketing materials.

16 **“SEC. 2779. CONFIDENTIALITY; ADEQUATE RESERVES.**

17          “(a) CONFIDENTIALITY.—

18               “(1) IN GENERAL.—A health insurance issuer  
19               shall establish mechanisms and procedures to ensure  
20               compliance with applicable Federal and State laws  
21               to protect the confidentiality of individually identifi-  
22               able information held by the issuer with respect to  
23               an enrollee, health professional, or provider.

24               “(2) DEFINITION.—For purposes of paragraph  
25               (1), the term ‘individually identifiable information’

1 means, with respect to an enrollee, a health profes-  
2 sional, or a provider, any information, whether oral  
3 or recorded in any medium or form, that identifies  
4 or can readily be associated with the identity of the  
5 enrollee, the health professional, or the provider.

6 “(b) **FINANCIAL RESERVES; SOLVENCY.**—A health  
7 insurance issuer shall—

8 “(1) meet such financial reserve or other sol-  
9 vency-related requirements as the applicable State  
10 authority may establish to assure the continued  
11 availability of (and appropriate payment for) covered  
12 items and services for enrollees; and

13 “(2) establish mechanisms specified by the ap-  
14 plicable State authority to protect enrollees, health  
15 professionals, and providers in the event of failure of  
16 the issuer.

17 Such requirements shall not unduly impede the establish-  
18 ment of health insurance issuers owned and operated by  
19 health care professionals or providers or by non-profit  
20 community-based organizations.

21 **“SEC. 2780. QUALITY IMPROVEMENT PROGRAM.**

22 “(a) **IN GENERAL.**—A health insurance issuer shall  
23 establish a quality improvement program (consistent with  
24 subsection (b)) that systematically and continuously as-  
25 sesses and improves—

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

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

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

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

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

21           “(3) analyze quality assessment data to deter-  
22           mine specific interactions in the delivery system  
23           (both the design and funding of the health insurance  
24           coverage and the clinical provision of care) that have  
25           an adverse impact on the quality of care.”.

1 (b) APPLICATION TO GROUP HEALTH INSURANCE  
2 COVERAGE.—

3 (1) Subpart 2 of part A of title XXVII of the  
4 Public Health Service Act is amended by adding at  
5 the end the following new section:

6 **“SEC. 2706. PATIENT PROTECTION STANDARDS.**

7 “(a) IN GENERAL.—Each health insurance issuer  
8 shall comply with patient protection requirements under  
9 part C with respect to group health insurance coverage  
10 it offers.

11 “(b) ASSURING COORDINATION.—The Secretary of  
12 Health and Human Services and the Secretary of Labor  
13 shall ensure, through the execution of an interagency  
14 memorandum of understanding between such Secretaries,  
15 that—

16 “(1) regulations, rulings, and interpretations is-  
17 sued by such Secretaries relating to the same matter  
18 over which such Secretaries have responsibility  
19 under part C (and this section) and section 713 of  
20 the Employee Retirement Income Security Act of  
21 1974 are administered so as to have the same effect  
22 at all times; and

23 “(2) coordination of policies relating to enfore-  
24 ing the same requirements through such Secretaries  
25 in order to have a coordinated enforcement strategy

1 that avoids duplication of enforcement efforts and  
2 assigns priorities in enforcement.”.

3 (2) Section 2792 of such Act (42 U.S.C.  
4 300gg-92) is amended by inserting “and section  
5 2706(b)” after “of 1996”.

6 (c) APPLICATION TO INDIVIDUAL HEALTH INSUR-  
7 ANCE COVERAGE.—Part B of title XXVII of the Public  
8 Health Service Act is amended by inserting after section  
9 2751 the following new section:

10 **“SEC. 2752. PATIENT PROTECTION STANDARDS.**

11 “Each health insurance issuer shall comply with pa-  
12 tient protection requirements under part C with respect  
13 to individual health insurance coverage it offers.”.

14 (d) MODIFICATION OF PREEMPTION STANDARDS.—

15 (1) GROUP HEALTH INSURANCE COVERAGE.—  
16 Section 2723 of such Act (42 U.S.C. 300gg-23) is  
17 amended—

18 (A) in subsection (a)(1), by striking “sub-  
19 section (b)” and inserting “subsections (b) and  
20 (c)”;

21 (B) by redesignating subsections (c) and  
22 (d) as subsections (d) and (e), respectively; and

23 (C) by inserting after subsection (b) the  
24 following new subsection:

1           “(c) SPECIAL RULES IN CASE OF PATIENT PROTEC-  
 2 TION REQUIREMENTS.—Subject to subsection (a)(2), the  
 3 provisions of section 2706 and part C, and part D insofar  
 4 as it applies to section 2706 or part C, shall not be con-  
 5 strued to preempt any State law, or the enactment or im-  
 6 plementation of such a State law, that provides protections  
 7 for individuals that are equivalent to or stricter than the  
 8 protections provided under such provisions.”.

9           (2) INDIVIDUAL HEALTH INSURANCE COV-  
 10 ERAGE.—Section 2762 of such Act (42 U.S.C.  
 11 300gg-62), as added by section 605(b)(3)(B) of  
 12 Public Law 104-204, is amended—

13                   (A) in subsection (a), by striking “sub-  
 14 section (b), nothing in this part” and inserting  
 15 “subsections (b) and (c)”, and

16                   (B) by adding at the end the following new  
 17 subsection:

18           “(c) SPECIAL RULES IN CASE OF PATIENT PROTEC-  
 19 TION REQUIREMENTS.—Subject to subsection (b), the  
 20 provisions of section 2752 and part C, and part D insofar  
 21 as it applies to section 2752 or part C, shall not be con-  
 22 strued to preempt any State law, or the enactment or im-  
 23 plementation of such a State law, that provides protections  
 24 for individuals that are equivalent to or stricter than the  
 25 protections provided under such provisions.”.

1 (e) ADDITIONAL CONFORMING AMENDMENTS.—

2 (1) Section 2723(a)(1) of such Act (42 U.S.C.  
3 300gg-23(a)(1)) is amended by striking “part C”  
4 and inserting “parts C and D”.

5 (2) Section 2762(b)(1) of such Act (42 U.S.C.  
6 300gg-62(b)(1)) is amended by striking “part C”  
7 and inserting “part D”.

8 (f) EFFECTIVE DATES.—(1)(A) Subject to subpara-  
9 graph (B), the amendments made by subsections (a), (b),  
10 (d)(1), and (e) shall apply with respect to group health  
11 insurance coverage for group health plan years beginning  
12 on or after July 1, 1998 (in this subsection referred to  
13 as the “general effective date”) and also shall apply to  
14 portions of plan years occurring on and after January 1,  
15 1999.

16 (B) In the case of group health insurance coverage  
17 provided pursuant to a group health plan maintained pur-  
18 suant to 1 or more collective bargaining agreements be-  
19 tween employee representatives and 1 or more employers  
20 ratified before the date of enactment of this Act, the  
21 amendments made by subsections (a), (b), (d)(1), and (e)  
22 shall not apply to plan years beginning before the later  
23 of—

24 (i) the date on which the last collective bargain-  
25 ing agreements relating to the plan terminates (de-

1       terminated without regard to any extension thereof  
 2       agreed to after the date of enactment of this Act),  
 3       or

4               (ii) the general effective date.

5 For purposes of clause (i), any plan amendment made pur-  
 6 suant to a collective bargaining agreement relating to the  
 7 plan which amends the plan solely to conform to any re-  
 8 quirement added by subsection (a) or (b) shall not be  
 9 treated as a termination of such collective bargaining  
 10 agreement.

11       (2) The amendments made by subsections (a), (c),  
 12 (d)(2), and (e) shall apply with respect to individual health  
 13 insurance coverage offered, sold, issued, renewed, in effect,  
 14 or operated in the individual market on or after the gen-  
 15 eral effective date.

16 **SEC. 3. PATIENT PROTECTION STANDARDS UNDER THE EM-**  
 17                       **PLOYEE RETIREMENT INCOME SECURITY**  
 18                       **ACT OF 1974.**

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

23 **“SEC. 713. PATIENT PROTECTION STANDARDS.**

24       “(a) IN GENERAL.—Subject to subsection (b), a  
 25 group health plan (and a health insurance issuer offering

1 group health insurance coverage in connection with such  
2 a plan) shall comply with the requirements of part C of  
3 title XXVII of the Public Health Service Act.

4 “(b) REFERENCES IN APPLICATION.—In applying  
5 subsection (a) under this part, any reference in such part  
6 C—

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

11 “(2) to the Secretary is deemed a reference to  
12 the Secretary of Labor;

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

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

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

24 “(1) regulations, rulings, and interpretations is-  
25 sued by such Secretaries relating to the same matter

1 over which such Secretaries have responsibility  
2 under such part C (and section 2706 of the Public  
3 Health Service Act) and this section are adminis-  
4 tered so as to have the same effect at all times; and

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

10 (b) MODIFICATION OF PREEMPTION STANDARDS.—

11 Section 731 of such Act (42 U.S.C. 1191) is amended—

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

14 (2) by redesignating subsections (c) and (d) as  
15 subsections (d) and (e), respectively; and

16 (3) by inserting after subsection (b) the follow-  
17 ing new subsection:

18 “(c) SPECIAL RULES IN CASE OF PATIENT PROTEC-  
19 TION REQUIREMENTS.—Subject to subsection (a)(2), the  
20 provisions of section 713 and part C of title XXVII of  
21 the Public Health Service Act, and subpart C insofar as  
22 it applies to section 713 or such part, shall not be con-  
23 strued to preempt any State law, or the enactment or im-  
24 plementation of such a State law, that provides protections

1 for individuals that are equivalent to or stricter than the  
2 protections provided under such provisions.”.

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

6 (2) The table of contents in section 1 of such Act  
7 is amended by inserting after the item relating to section  
8 712 the following new item:

“Sec. 713. Patient protection standards.”.

9 (3) Section 734 of such Act (29 U.S.C. 1187) is  
10 amended by inserting “and section 713(d)” after “of  
11 1996”.

12 (d) EFFECTIVE DATE.—(1) Subject to paragraph  
13 (2), the amendments made by this section shall apply with  
14 respect to group health plans for plan years beginning on  
15 or after July 1, 1998 (in this subsection referred to as  
16 the “general effective date”) and also shall apply to por-  
17 tions of plan years occurring on and after January 1,  
18 1999.

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

1           (A) the date on which the last collective bar-  
2           gaining agreements relating to the plan terminates  
3           (determined without regard to any extension thereof  
4           agreed to after the date of enactment of this Act),  
5           or

6           (B) the general effective date.

7 For purposes of subparagraph (A), any plan amendment  
8 made pursuant to a collective bargaining agreement relat-  
9 ing to the plan which amends the plan solely to conform  
10 to any requirement added by subsection (a) shall not be  
11 treated as a termination of such collective bargaining  
12 agreement.

13 **SEC. 4. NON-PREEMPTION OF STATE LAW RESPECTING LI-**  
14 **ABILITY OF GROUP HEALTH PLANS.**

15           (a) IN GENERAL.—Section 514(b) of the Employee  
16 Retirement Income Security Act of 1974 (29 U.S.C.  
17 1144(b)) is amended by redesignating paragraph (9) as  
18 paragraph (10) and inserting the following new para-  
19 graph:

20           “(9) Subsection (a) of this section shall not be  
21           construed to preclude any State cause of action to  
22           recover damages for personal injury or wrongful  
23           death against any person that provides insurance or  
24           administrative services to or for an employee welfare

1 benefit plan maintained to provide health care bene-  
2 fits.”.

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

○