

106TH CONGRESS
1ST SESSION

H. R. 2046

To amend title I of the Employee Retirement Income Security Act of 1974 to ensure access by participants and beneficiaries of group health plans to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.

IN THE HOUSE OF REPRESENTATIVES

JUNE 8, 1999

Mr. FLETCHER introduced the following bill; which was referred to the Committee on Education and the Workforce

A BILL

To amend title I of the Employee Retirement Income Security Act of 1974 to ensure access by participants and beneficiaries of group health plans to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Patient Access to In-
5 formation Act of 1999”.

1 **SEC. 2. PATIENT ACCESS TO INFORMATION REGARDING**
2 **PLAN COVERAGE, MANAGED CARE PROCE-**
3 **DURES, HEALTH CARE PROVIDERS, AND**
4 **QUALITY OF MEDICAL CARE.**

5 (a) IN GENERAL.—Part 1 of subtitle B of title I of
6 the Employee Retirement Income Security Act of 1974 is
7 amended—

8 (1) by redesignating section 111 as section 112;
9 and

10 (2) by inserting after section 110 the following
11 new section:

12 “DISCLOSURE BY GROUP HEALTH PLANS

13 “SEC. 111. (a) DISCLOSURE REQUIREMENT.—

14 “(1) GROUP HEALTH PLANS.—The adminis-
15 trator of each group health plan shall take such ac-
16 tions as are necessary to ensure that the summary
17 plan description of the plan required under section
18 102 (or each summary plan description in any case
19 in which different summary plan descriptions are ap-
20 propriate under part 1 for different options of cov-
21 erage) contains, among any information otherwise
22 required under this part, the information required
23 under subsections (b), (c), (d), and (e)(2)(A).

24 “(2) HEALTH INSURANCE ISSUERS.—Each
25 health insurance issuer offering health insurance
26 coverage in connection with a group health plan

1 shall provide the administrator on a timely basis
2 with the information necessary to enable the admin-
3 istrator to comply with the requirements of para-
4 graph (1). To the extent that any such issuer pro-
5 vides on a timely basis to plan participants and
6 beneficiaries information otherwise required under
7 this part to be included in the summary plan de-
8 scription, the requirements of sections 101(a)(1) and
9 104(b) shall be deemed satisfied in the case of such
10 plan with respect to such information.

11 “(b) PLAN BENEFITS.—The information required
12 under subsection (a) includes the following:

13 “(1) COVERED ITEMS AND SERVICES.—

14 “(A) CATEGORIZATION OF INCLUDED BEN-
15 EFITS.—A description of covered benefits, cat-
16 egorized by—

17 “(i) types of items and services (in-
18 cluding any special disease management
19 program); and

20 “(ii) types of health care professionals
21 providing such items and services.

22 “(B) EMERGENCY MEDICAL CARE.—A de-
23 scription of the extent to which the plan covers
24 emergency medical care (including the extent to
25 which the plan provides for access to urgent

1 care centers), and any definitions provided
2 under the plan for the relevant plan termi-
3 nology referring to such care.

4 “(C) PREVENTATIVE SERVICES.—A de-
5 scription of the extent to which the plan pro-
6 vides benefits for preventative services.

7 “(D) DRUG FORMULARIES.—A description
8 of the extent to which covered benefits are de-
9 termined by the use or application of a drug
10 formulary and a summary of the process for de-
11 termining what is included in such formulary.

12 “(E) COBRA CONTINUATION COV-
13 ERAGE.—A description of the benefits available
14 under the plan pursuant to part 6.

15 “(2) LIMITATIONS, EXCLUSIONS, AND RESTRIC-
16 TIONS ON COVERED BENEFITS.—

17 “(A) CATEGORIZATION OF EXCLUDED
18 BENEFITS.—A description of benefits specifi-
19 cally excluded from coverage, categorized by
20 types of items and services.

21 “(B) UTILIZATION REVIEW AND
22 PREAUTHORIZATION REQUIREMENTS.—Whether
23 coverage for medical care is limited or excluded
24 on the basis of utilization review or
25 preauthorization requirements.

1 “(C) LIFETIME, ANNUAL, OR OTHER PE-
2 RIOD LIMITATIONS.—A description of the cir-
3 cumstances under which, and the extent to
4 which, coverage is subject to lifetime, annual, or
5 other period limitations, categorized by types of
6 benefits.

7 “(D) CUSTODIAL CARE.—A description of
8 the circumstances under which, and the extent
9 to which, the coverage of benefits for custodial
10 care is limited or excluded, and a statement of
11 the definition used by the plan for custodial
12 care.

13 “(E) EXPERIMENTAL TREATMENTS.—
14 Whether coverage for any medical care is lim-
15 ited or excluded because it constitutes experi-
16 mental treatment or technology, and any defini-
17 tions provided under the plan for the relevant
18 plan terminology referring to such limited or
19 excluded care.

20 “(F) MEDICAL APPROPRIATENESS OR NE-
21 CESSITY.—Whether coverage for medical care
22 may be limited or excluded by reason of a fail-
23 ure to meet the plan’s requirements for medical
24 appropriateness or necessity, and any defini-
25 tions provided under the plan for the relevant

1 plan terminology referring to such limited or
2 excluded care.

3 “(G) SECOND OR SUBSEQUENT OPIN-
4 IONS.—A description of the circumstances
5 under which, and the extent to which, coverage
6 for second or subsequent opinions is limited or
7 excluded.

8 “(H) SPECIALTY CARE.—A description of
9 the circumstances under which, and the extent
10 to which, coverage of benefits for specialty care
11 is conditioned on referral from a primary care
12 provider.

13 “(I) CONTINUITY OF CARE.—A description
14 of the circumstances under which, and the ex-
15 tent to which, coverage of items and services
16 provided by any health care professional is lim-
17 ited or excluded by reason of the departure by
18 the professional from any defined set of pro-
19 viders.

20 “(J) RESTRICTIONS ON COVERAGE OF
21 EMERGENCY SERVICES.—A description of the
22 circumstances under which, and the extent to
23 which, the plan, in covering emergency medical
24 care furnished to a participant or beneficiary of
25 the plan imposes any financial responsibility de-

1 scribed in subsection (c) on participants or
2 beneficiaries or limits or conditions benefits for
3 such care subject to any other term or condition
4 of such plan.

5 “(c) PARTICIPANT’S FINANCIAL RESPONSIBIL-
6 ITIES.—The information required under subsection (a) in-
7 cludes an explanation of—

8 “(1) a participant’s financial responsibility for
9 payment of premiums, coinsurance, copayments,
10 deductibles, and any other charges; and

11 “(2) the circumstances under which, and the
12 extent to which, the participant’s financial responsi-
13 bility described in paragraph (1) may vary, including
14 any distinctions based on whether a health care pro-
15 vider from whom covered benefits are obtained is in-
16 cluded in a defined set of providers.

17 “(d) DISPUTE RESOLUTION PROCEDURES.—The in-
18 formation required under subsection (a) includes a de-
19 scription of the processes adopted by the plan pursuant
20 to section 503, including—

21 “(1) descriptions thereof relating specifically
22 to—

23 “(A) coverage decisions;

24 “(B) internal review of coverage decisions;

25 and

1 “(C) any external review of coverage deci-
2 sions; and

3 “(2) the procedures and time frames applicable
4 to each step of the processes referred to in subpara-
5 graphs (A), (B), and (C) of paragraph (1).

6 “(e) INFORMATION AVAILABLE ON REQUEST.—

7 “(1) ACCESS TO PLAN BENEFIT INFORMATION
8 IN ELECTRONIC FORM.—

9 “(A) IN GENERAL.—In addition to the in-
10 formation required to be provided under section
11 104(b)(4), a group health plan (and a health
12 insurance issuer offering health insurance cov-
13 erage in connection with a group health plan)
14 shall, upon written request (made not more fre-
15 quently than annually), make available to par-
16 ticipants and beneficiaries, in a generally recog-
17 nized electronic format—

18 “(i) the latest summary plan descrip-
19 tion, including the latest summary of ma-
20 terial modifications, and

21 “(ii) the actual plan provisions setting
22 forth the benefits available under the plan,
23 to the extent such information relates to the
24 coverage options under the plan available to the
25 participant or beneficiary. A reasonable charge

1 may be made to cover the cost of providing
2 such information in such generally recognized
3 electronic format. The Secretary may by regula-
4 tion prescribe a maximum amount which will
5 constitute a reasonable charge under the pre-
6 ceding sentence.

7 “(B) ALTERNATIVE ACCESS.—The require-
8 ments of this paragraph may be met by making
9 such information generally available (rather
10 than upon request) on the Internet or on a pro-
11 prietary computer network in a format which is
12 readily accessible to participants and bene-
13 ficiaries.

14 “(2) ADDITIONAL INFORMATION TO BE PRO-
15 VIDED ON REQUEST.—

16 “(A) INCLUSION IN SUMMARY PLAN DE-
17 SCRIPTION OF SUMMARY OF ADDITIONAL IN-
18 FORMATION.—The information required under
19 subsection (a) includes a summary description
20 of the types of information required by this
21 subsection to be made available to participants
22 and beneficiaries on request.

23 “(B) INFORMATION REQUIRED FROM
24 PLANS AND ISSUERS ON REQUEST.—In addition
25 to information required to be included in sum-

1 mary plan descriptions under this subsection, a
2 group health plan (and a health insurance
3 issuer offering health insurance coverage in
4 connection with a group health plan) shall pro-
5 vide the following information to a participant
6 or beneficiary on request:

7 “(i) NETWORK CHARACTERISTICS.—If
8 the plan (or issuer) utilizes a defined set of
9 providers under contract with the plan (or
10 issuer), a detailed list of the names of such
11 providers and their geographic location, set
12 forth separately with respect to primary
13 care providers and with respect to special-
14 ists.

15 “(ii) CARE MANAGEMENT INFORMA-
16 TION.—A description of the circumstances
17 under which, and the extent to which, the
18 plan has special disease management pro-
19 grams or programs for persons with dis-
20 abilities, indicating whether these pro-
21 grams are voluntary or mandatory and
22 whether a significant benefit differential
23 results from participation in such pro-
24 grams.

1 “(iii) INCLUSION OF DRUGS AND
2 BIOLOGICALS IN FORMULARIES.—A state-
3 ment of whether a specific drug or biologi-
4 cal is included in a formulary used to de-
5 termine benefits under the plan and a de-
6 scription of the procedures for considering
7 requests for any patient-specific waivers.

8 “(iv) PROCEDURES FOR DETERMINING
9 EXCLUSIONS BASED ON MEDICAL NECES-
10 SITY OR EXPERIMENTAL TREATMENTS.—
11 Upon receipt by the participant or bene-
12 ficiary of any notification of an adverse
13 coverage decision based on a determination
14 relating to medical necessity or an experi-
15 mental treatment or technology, a descrip-
16 tion of the procedures and medically-based
17 criteria used in such decision.

18 “(v) PREAUTHORIZATION AND UTILI-
19 ZATION REVIEW PROCEDURES.—Upon re-
20 ceipt by the participant or beneficiary of
21 any notification of an adverse coverage de-
22 cision, a description of the basis on which
23 any preauthorization requirement or any
24 utilization review requirement has resulted
25 in such decision.

1 “(vi) ACCREDITATION STATUS OF
2 HEALTH INSURANCE ISSUERS AND SERV-
3 ICE PROVIDERS.—A description of the ac-
4 creditation and licensing status (if any) of
5 each health insurance issuer offering
6 health insurance coverage in connection
7 with the plan and of any utilization review
8 organization utilized by the issuer or the
9 plan, together with the name and address
10 of the accrediting or licensing authority.

11 “(vii) MEASURES OF ENROLLEE SAT-
12 ISFACTION.—The latest information (if
13 any) maintained by the plan, or by any
14 health insurance issuer offering health in-
15 surance coverage in connection with the
16 plan, relating to enrollee satisfaction.

17 “(viii) QUALITY PERFORMANCE MEAS-
18 URES.—The latest information (if any)
19 maintained by the plan, or by any health
20 insurance issuer offering health insurance
21 coverage in connection with the plan, relat-
22 ing to quality of performance of the deliv-
23 ery of medical care with respect to cov-
24 erage options offered under the plan and

1 of health care professionals and facilities
2 providing medical care under the plan.

3 “(ix) INFORMATION RELATING TO EX-
4 TERNAL REVIEWS.—The number of any
5 external reviews under section 503 that
6 have been completed during the prior plan
7 year and the number of such reviews in
8 which a recommendation is made for modi-
9 fication or reversal of an internal review
10 decision under the plan.

11 “(C) INFORMATION REQUIRED FROM
12 HEALTH CARE PROFESSIONALS ON REQUEST.—
13 Any health care professional treating a partici-
14 pant or beneficiary under a group health plan
15 shall provide to the participant or beneficiary,
16 on request, a description of his or her profes-
17 sional qualifications (including board certifi-
18 cation status, licensing status, and accreditation
19 status, if any), privileges, and experience and a
20 general description by category (including sal-
21 ary, fee-for-service, capitation, and such other
22 categories as may be specified in regulations of
23 the Secretary) of the applicable method by
24 which such professional is compensated in con-
25 nection with the provision of such medical care.

1 “(D) INFORMATION REQUIRED FROM
2 HEALTH CARE FACILITIES ON REQUEST.—Any
3 health care facility from which a participant or
4 beneficiary has sought treatment under a group
5 health plan shall provide to the participant or
6 beneficiary, on request, a description of the fa-
7 cility’s corporate form or other organizational
8 form and all forms of licensing and accredita-
9 tion status (if any) assigned to the facility by
10 standard-setting organizations.

11 “(f) ACCESS TO INFORMATION RELEVANT TO THE
12 COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT
13 OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition
14 to information otherwise required to be made available
15 under this section, a group health plan (and a health in-
16 surance issuer offering health insurance coverage in con-
17 nection with a group health plan) shall, upon written re-
18 quest (made not more frequently than annually), make
19 available to a participant (and an employee who, under
20 the terms of the plan, is eligible for coverage but not en-
21 rolled) in connection with a period of enrollment the sum-
22 mary plan description for any coverage option under the
23 plan under which the participant is eligible to enroll and
24 any information described in clauses (i), (ii), (iii), (vi),
25 (vii), and (viii) of subsection (e)(2)(B).

1 “(g) ADVANCE NOTICE OF CHANGES IN DRUG
2 FORMULARIES.—Not later than 30 days before the effec-
3 tive of date of any exclusion of a specific drug or biological
4 from any drug formulary under the plan that is used in
5 the treatment of a chronic illness or disease, the plan shall
6 take such actions as are necessary to reasonably ensure
7 that plan participants are informed of such exclusion. The
8 requirements of this subsection may be satisfied—

9 “(1) by inclusion of information in publications
10 broadly distributed by plan sponsors, employers, or
11 employee organizations;

12 “(2) by electronic means of communication (in-
13 cluding the Internet or proprietary computer net-
14 works in a format which is readily accessible to par-
15 ticipants);

16 “(3) by timely informing participants who,
17 under an ongoing program maintained under the
18 plan, have submitted their names for such notifica-
19 tion; or

20 “(4) by any other reasonable means of timely
21 informing plan participants.

22 “(h) DEFINITIONS.—For purposes of this section—

23 “(1) GROUP HEALTH PLAN.—The term ‘group
24 health plan’ has the meaning provided such term
25 under section 733(a)(1).

1 “(2) MEDICAL CARE.—The term ‘medical care’
2 has the meaning provided such term under section
3 733(a)(2).

4 “(3) HEALTH INSURANCE COVERAGE.—The
5 term ‘health insurance coverage’ has the meaning
6 provided such term under section 733(b)(1).

7 “(4) HEALTH INSURANCE ISSUER.—The term
8 ‘health insurance issuer’ has the meaning provided
9 such term under section 733(b)(2).”.

10 (b) CONFORMING AMENDMENTS.—

11 (1) Section 102(b) of such Act (29 U.S.C.
12 1022(b)) is amended by inserting before the period
13 at the end the following: “; and, in the case of a
14 group health plan (as defined in section 111(h)(1)),
15 the information required to be included under sec-
16 tion 111(a)”.

17 (2) The table of contents in section 1 of such
18 Act is amended by striking the item relating to sec-
19 tion 111 and inserting the following new items:

“Sec. 111. Disclosure by group health plans.

“Sec. 112. Repeal and effective date.”.

20 **SEC. 3. EFFECTIVE DATE AND RELATED RULES.**

21 (a) IN GENERAL.—The amendments made by this
22 Act shall apply with respect to plan years beginning on
23 or after January 1 of the second calendar year following
24 the date of the enactment of this Act. The Secretary shall

1 first issue all regulations necessary to carry out the
2 amendments made by this subtitle before such date.

3 (b) LIMITATION ON ENFORCEMENT ACTIONS.—No
4 enforcement action shall be taken, pursuant to the amend-
5 ments made by this Act, against a group health plan or
6 health insurance issuer with respect to a violation of a re-
7 quirement imposed by such amendments before the date
8 of issuance of final regulations issued in connection with
9 such requirement, if the plan or issuer has sought to com-
10 ply in good faith with such requirement.

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