

105TH CONGRESS
1ST SESSION

H. R. 1415

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 HOUSE OF REPRESENTATIVES

APRIL 23, 1997

Mr. NORWOOD (for himself, Mr. BACHUS, Mr. BAKER, Mr. BARCIA, Mr. BARR of Georgia, Mr. BARRETT of Wisconsin, Mr. BISHOP, Mr. BROWN of Ohio, Mr. CANADY of Florida, Mr. CHAMBLISS, Mr. COBLE, Mr. COBURN, Mr. COMBEST, Mr. COOKSEY, Mr. CRAMER, Mr. DAVIS of Illinois, Mr. DAVIS of Virginia, Mr. DEAL of Georgia, Mr. DEFazio, Mr. DICKEY, Mr. DUNCAN, Mr. FILNER, Mr. FOLEY, Mr. FOX of Pennsylvania, Mr. FROST, Mr. GILMAN, Mr. GRAHAM, Mr. HALL of Ohio, Mr. HILLEARY, Mr. HILLIARD, Mr. HINCHEY, Mr. JENKINS, Mrs. KELLY, Mr. KENNEDY of Rhode Island, Mr. KIND, Mr. LAHOOD, Mr. LEWIS of Kentucky, Mr. LINDER, Mr. LIVINGSTON, Mrs. MALONEY of New York, Mr. McHALE, Mr. McHUGH, Mrs. MORELLA, Mrs. MYRICK, Mr. NETHERCUTT, Mr. PALLONE, Mr. PICKERING, Mr. RANGEL, Mr. RIGGS, Mrs. ROUKEMA, Mr. SANDERS, Mr. SCARBOROUGH, Mr. SENSENBRENNER, Mr. SHADEGG, Mr. SOLOMON, Mr. SPENCE, Mr. STRICKLAND, Mr. TOWNS, Mr. WALSH, Mr. WICKER, Mr. WISE, Ms. WOOLSEY, Mr. WEYGAND, Mr. CHRISTENSEN, Mr. COLLINS, and Mr. WAMP) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committee on Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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 communica-
 tions.

“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.

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

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

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

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

3 “PART C—PATIENT PROTECTION STANDARDS
4 **“SEC. 2770. NOTICE; ADDITIONAL DEFINITIONS; CONSTRUC-**
5 **TION.**

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

12 “(b) ADDITIONAL DEFINITIONS.—For purposes of
13 this part:

14 “(1) ENROLLEE.—The term ‘enrollee’ means,
15 with respect to health insurance coverage offered by
16 a health insurance issuer, an individual enrolled with
17 the issuer to receive such coverage.

18 “(2) HEALTH PROFESSIONAL.—The term
19 ‘health professional’ means a physician or other
20 health care practitioner licensed, accredited, or cer-
21 tified to perform specified health services consistent
22 with State law.

23 “(3) NETWORK.—The term ‘network’ means,
24 with respect to a health insurance issuer offering
25 health insurance coverage, the participating health

1 professionals and providers through whom the plan
2 or issuer provides health care items and services to
3 enrollees.

4 “(4) NETWORK COVERAGE.—The term ‘network
5 coverage’ means health insurance coverage offered
6 by a health insurance issuer that provides or ar-
7 ranges for the provision of health care items and
8 services to enrollees through participating health
9 professionals and providers.

10 “(5) PARTICIPATING.—The term ‘participating’
11 means, with respect to a health professional or pro-
12 vider, a health professional or provider that provides
13 health care items and services to enrollees under
14 network coverage under an agreement with the
15 health insurance issuer offering the coverage.

16 “(6) PRIOR AUTHORIZATION.—The term ‘prior
17 authorization’ means the process of obtaining prior
18 approval from a health insurance issuer as to the ne-
19 cessity or appropriateness of receiving medical or
20 clinical services for treatment of a medical or clinical
21 condition.

22 “(7) PROVIDER.—The term ‘provider’ means a
23 health organization, health facility, or health agency
24 that is licensed, accredited, or certified to provide

1 health care items and services under applicable State
2 law.

3 “(8) SERVICE AREA.—The term ‘service area’
4 means, with respect to a health insurance issuer
5 with respect to health insurance coverage, the geo-
6 graphic area served by the issuer with respect to the
7 coverage.

8 “(9) UTILIZATION REVIEW.—The term ‘utiliza-
9 tion review’ means prospective, concurrent, or retro-
10 spective review of health care items and services for
11 medical necessity, appropriateness, or quality of care
12 that includes prior authorization requirements for
13 coverage of such items and services.

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

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

21 “(a) GENERAL ACCESS.—

22 “(1) IN GENERAL.—Subject to paragraphs (2),
23 and (3), a health insurance issuer shall establish and
24 maintain adequate arrangements, as defined by the
25 applicable State authority, with a sufficient number,

1 mix, and distribution of health professionals and
2 providers to assure that covered items and services
3 are available and accessible to each enrollee under
4 health insurance coverage—

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

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

7 “(C) with reasonable promptness (includ-
8 ing reasonable hours of operation and after-
9 hours services);

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

12 “(E) in a manner that—

13 “(i) takes into account the diverse
14 needs of enrollees, and

15 “(ii) reasonably assures continuity of
16 care.

17 For a health insurance issuer that serves a rural or
18 medically underserved area, the issuer shall be treat-
19 ed as meeting the requirement of this subsection if
20 the issuer has arrangements with a sufficient num-
21 ber, mix, and distribution of health professionals and
22 providers having a history of serving such areas. The
23 use of telemedicine and other innovative means to
24 provide covered items and services by a health insur-
25 ance issuer that serves a rural or medically under-

1 served area shall also be considered in determining
2 whether the requirement of this subsection is met.

3 “(2) RULE OF CONSTRUCTION.—Nothing in
4 this subsection shall be construed as requiring a
5 health insurance issuer to have arrangements that
6 conflict with its responsibilities to establish measures
7 designed to maintain quality and control costs.

8 “(3) DEFINITIONS.—For purposes of paragraph
9 (1):

10 “(A) MEDICALLY UNDERSERVED AREA.—
11 The term ‘medically underserved area’ means
12 an area that is designated as a health profes-
13 sional shortage area under section 332 of the
14 Public Health Service Act or as a medically un-
15 derserved area for purposes of section 330 or
16 1302(7) of such Act.

17 “(B) RURAL AREA.—The term ‘rural area’
18 means an area that is not within a Standard
19 Metropolitan Statistical Area or a New England
20 County Metropolitan Area (as defined by the
21 Office of Management and Budget).

22 “(b) EMERGENCY AND URGENT CARE.—

23 “(1) IN GENERAL.—A health insurance issuer
24 shall—

1 “(A) assure the availability and accessibil-
2 ity of medically or clinically necessary emer-
3 gency services and urgent care services within
4 the service area of the issuer 24 hours a day,
5 7 days a week;

6 “(B) require no prior authorization for
7 items and services furnished in a hospital emer-
8 gency department to an enrollee (without re-
9 gard to whether the health professional or hos-
10 pital has a contractual or other arrangement
11 with the issuer) with symptoms that would rea-
12 sonably suggest to a prudent layperson an
13 emergency medical condition (including items
14 and services described in subparagraph
15 (C)(iii));

16 “(C) cover (and make reasonable payments
17 for)—

18 “(i) emergency services,

19 “(ii) services that are not emergency
20 services but are described in subparagraph
21 (B),

22 “(iii) medical screening examinations
23 and other ancillary services necessary to
24 diagnose, treat, and stabilize an emergency
25 medical condition, and

1 “(iv) urgent care services, without re-
2 gard to whether the health professional or
3 provider furnishing such services has a
4 contractual (or other) arrangement with
5 the issuer; and

6 “(D) make prior authorization determina-
7 tions for—

8 “(i) services that are furnished in a
9 hospital emergency department (other than
10 services described in clauses (i) and (iii) of
11 subparagraph (C)), and

12 “(ii) urgent care services, within the
13 time periods specified in (or pursuant to)
14 section 2776(a)(8).

15 “(2) DEFINITIONS.—For purposes of this sub-
16 section:

17 “(A) EMERGENCY MEDICAL CONDITION.—

18 The term ‘emergency medical condition’ means
19 a medical condition (including emergency labor
20 and delivery) manifesting itself by acute symp-
21 toms of sufficient severity (including severe
22 pain) such that a prudent layperson, who pos-
23 sesses an average knowledge of health and med-
24 icine, could reasonably expect the absence of

1 immediate medical attention could reasonably
2 be expected to result in—

3 “(i) placing the patient’s health in se-
4 rious jeopardy,

5 “(ii) serious impairment to bodily
6 functions, or

7 “(iii) serious dysfunction of any bodily
8 organ or part.

9 “(B) EMERGENCY SERVICES.—The term
10 ‘emergency services’ means health care items
11 and services that are necessary for the diag-
12 nosis, treatment, and stabilization of an emer-
13 gency medical condition.

14 “(C) URGENT CARE SERVICES.—The term
15 ‘urgent care services’ means health care items
16 and services that are necessary for the treat-
17 ment of a condition that—

18 “(i) is not an emergency medical con-
19 dition,

20 “(ii) requires prompt medical or clini-
21 cal treatment, and

22 “(iii) poses a danger to the patient if
23 not treated in a timely manner, as defined
24 by the applicable State authority in con-

1 sultation with relevant treating health pro-
2 fessionals or providers.

3 “(c) SPECIALIZED SERVICES.—

4 “(1) IN GENERAL.—A health insurance issuer
5 offering network coverage shall demonstrate that en-
6 rollees have access to specialized treatment expertise
7 when such treatment is medically or clinically indi-
8 cated in the professional judgment of the treating
9 health professional, in consultation with the enrollee.

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

13 “(A) unusual diseases or conditions, or

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

16 “(d) INCENTIVE PLANS.—

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

22 “(A) No specific payment is made directly
23 or indirectly under the plan to a professional or
24 provider or group of professionals or providers
25 as an inducement to reduce or limit medically

1 necessary services provided with respect to a
2 specific enrollee.

3 “(B) If the plan places such a professional,
4 provider, or group at substantial financial risk
5 (as determined by the Secretary) for services
6 not provided by the professional, provider, or
7 group, the issuer—

8 “(i) provides stop-loss protection for
9 the professional, provider, or group that is
10 adequate and appropriate, based on stand-
11 ards developed by the Secretary that take
12 into account the number of professionals
13 or providers placed at such substantial fi-
14 nancial risk in the group or under the cov-
15 erage and the number of individuals en-
16 rolled with the issuer who receive services
17 from the professional, provider, or group,
18 and

19 “(ii) conducts periodic surveys of both
20 individuals enrolled and individuals pre-
21 viously enrolled with the issuer to deter-
22 mine the degree of access of such individ-
23 uals to services provided by the issuer and
24 satisfaction with the quality of such serv-
25 ices.

1 “(C) The issuer provides the Secretary
 2 with descriptive information regarding the plan,
 3 sufficient to permit the Secretary to determine
 4 whether the plan is in compliance with the re-
 5 quirements of this paragraph.

6 “(2) In this subsection, the term ‘health profes-
 7 sional or provider incentive plan’ means any com-
 8 pensation arrangement between a health insurance
 9 issuer and a health professional or provider or pro-
 10 fessional or provide group that may directly or indi-
 11 rectly have the effect of reducing or limiting services
 12 provided with respect to individuals enrolled with the
 13 issuer.

14 **“SEC. 2772. ENROLLEE CHOICE OF HEALTH PROFES-**
 15 **SIONALS AND PROVIDERS.**

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

19 “(1) select a personal health professional from
 20 among the participating health professionals of the
 21 issuer, and

22 “(2) change that selection as appropriate.

23 “(b) POINT-OF-SERVICE OPTION.—

24 “(1) IN GENERAL.—If a health insurance issuer
 25 offers to enrollees health insurance coverage which

1 provides for coverage of services only if such services
2 are furnished through health professionals and pro-
3 viders who are members of a network of health pro-
4 fessionals and providers who have entered into a
5 contract with the issuer to provide such services, the
6 issuer shall also offer to such enrollees (at the time
7 of enrollment) the option of health insurance cov-
8 erage which provides for coverage of such services
9 which are not furnished through health professionals
10 and providers who are members of such a network.

11 “(2) FAIR PREMIUMS.—The amount of any ad-
12 ditional premium required for the option described
13 in paragraph (1) may not exceed an amount that is
14 fair and reasonable, as established by the applicable
15 State authority, in consultation with the National
16 Association of Insurance Commissioners, based on
17 the nature of the additional coverage provided.

18 “(3) COST-SHARING.—Under the option de-
19 scribed in paragraph (1), the health insurance cov-
20 erage shall provide for reimbursement rates for cov-
21 ered services offered by health professionals and pro-
22 viders who are not participating health professionals
23 or providers that are not less than the reimburse-
24 ment rates for covered services offered by participat-
25 ing health professionals and providers. Nothing in

1 this paragraph shall be construed as protecting an
2 enrollee against balance billing by a health profes-
3 sional or provider that is not a participating health
4 professional or provider.

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

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

12 “(2) ensure direct access to relevant specialists
13 for the continued care of such enrollees when medi-
14 cally or clinically indicated in the judgment of the
15 treating health professional, in consultation with the
16 enrollee;

17 “(3) in the case of an enrollee with special
18 health care needs or a chronic condition, determine
19 whether, based on the judgment of the treating
20 health professional, in consultation with the enrollee,
21 it is medically or clinically necessary to use a spe-
22 cialist or a care coordinator from an interdisciplinary
23 nary team to ensure continuity of care; and

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

4 “(A) hospitalization, or

5 “(B) dependency on high-technology home
 6 medical equipment,

7 provide for continued coverage of items and services
 8 furnished by the health professional or provider that
 9 was treating the enrollee before such change for a
 10 reasonable period of time.

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

16 **“SEC. 2773. NONDISCRIMINATION AGAINST ENROLLEES**
 17 **AND IN THE SELECTION OF HEALTH PROFES-**
 18 **SIONALS; EQUITABLE ACCESS TO NETWORKS.**

19 “(a) NONDISCRIMINATION AGAINST ENROLLEES.—
 20 No health insurance issuer may discriminate (directly or
 21 through contractual arrangements) in any activity that
 22 has the effect of discriminating against an individual on
 23 the basis of race, national origin, gender, language, socio-
 24 economic status, age, disability, health status, or antici-
 25 pated need for health services.

1 “(b) NONDISCRIMINATION IN SELECTION OF NET-
 2 WORK HEALTH PROFESSIONALS.—A health insurance is-
 3 suer offering network coverage shall not discriminate in
 4 selecting the members of its health professional network
 5 (or in establishing the terms and conditions for member-
 6 ship in such network) on the basis of—

7 “(1) the race, national origin, gender, age, or
 8 disability (other than a disability that impairs the
 9 ability of an individual to provide health care serv-
 10 ices or that may threaten the health of enrollees) of
 11 the health professional; or

12 “(2) the health professional’s lack of affiliation
 13 with, or admitting privileges at, a hospital (unless
 14 such lack of affiliation is a result of infractions of
 15 quality standards and is not due to a health profes-
 16 sional’s type of license).

17 “(c) NONDISCRIMINATION IN ACCESS TO HEALTH
 18 PLANS.—While nothing in this section shall be construed
 19 as an ‘any willing provider’ requirement (as referred to
 20 in section 2770(c)), a health insurance issuer shall not dis-
 21 criminate in participation, reimbursement, or indemnifica-
 22 tion against a health professional, who is acting within the
 23 scope of the health professional’s license or certification
 24 under applicable State law, solely on the basis of such li-
 25 cense or certification.

1 **“SEC. 2774. PROHIBITION OF INTERFERENCE WITH CER-**
2 **TAIN MEDICAL COMMUNICATIONS.**

3 “(a) IN GENERAL.—The provisions of any contract
4 or agreement, or the operation of any contract or agree-
5 ment, between a health insurance issuer and a health pro-
6 fessional shall not prohibit or restrict the health profes-
7 sional from engaging in medical communications with his
8 or her patient.

9 “(b) NULLIFICATION.—Any contract provision or
10 agreement described in subsection (a) shall be null and
11 void.

12 “(c) MEDICAL COMMUNICATION DEFINED.—For
13 purposes of this section, the term ‘medical communication’
14 means a communication made by a health professional
15 with a patient of the health professional (or the guardian
16 or legal representative of the patient) with respect to—

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

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

21 “(3) any financial incentives that may affect
22 the treatment of the patient.

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

24 “A health insurance issuer that offers network cov-
25 erage shall establish mechanisms to consider the rec-
26 ommendations, suggestions, and views of enrollees and

1 participating health professionals and providers regard-
2 ing—

3 “(1) the medical policies of the issuer (including
4 policies relating to coverage of new technologies,
5 treatments, and procedures);

6 “(2) the utilization review criteria and proce-
7 dures of the issuer;

8 “(3) the quality and credentialing criteria of the
9 issuer; and

10 “(4) the medical management procedures of the
11 issuer.

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

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

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

18 “(2) to the extent consistent with the protection
19 of proprietary business information (as defined for
20 purposes of section 552 of title 5, United States
21 Code) release, upon request, to affected health pro-
22 fessionals, providers, and enrollees the screening cri-
23 teria, weighting elements, and computer algorithms
24 used in reviews and a description of the method by
25 which they were developed;

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

4 “(4) use licensed, accredited, or certified health
5 professionals to make review determinations (and for
6 services requiring specialized training for their deliv-
7 ery, use a health professional who is qualified
8 through equivalent specialized training and experi-
9 ence);

10 “(5) subject to reasonable safeguards, disclose
11 to health professionals and providers, upon request,
12 the names and credentials of individuals conducting
13 utilization review;

14 “(6) not compensate individuals conducting uti-
15 lization review for denials of payment or coverage of
16 benefits;

17 “(7) comply with the requirement of section
18 2771 that prior authorization not be required for
19 emergency and related services furnished in a hos-
20 pital emergency department;

21 “(8) make prior authorization determinations—

22 “(A) in the case of services that are urgent
23 care services described in section
24 2771(b)(2)(C), within 30 minutes of a request
25 for such determination, and

1 “(B) in the case of other services, within
2 24 hours after the time of a request for deter-
3 mination;

4 “(9) include in any notice of such determination
5 an explanation of the basis of the determination and
6 the right to an immediate appeal;

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

13 “(11) provide timely access, as defined by the
14 applicable State authority, to utilization review per-
15 sonnel and, if such personnel are not available,
16 waives any prior authorization that would otherwise
17 be required; and

18 “(12) provide notice of an initial determination
19 on payment of a claim within 30 days after the date
20 the claim is submitted for such item or service, and
21 include in such notice an explanation of the reasons
22 for such determination and of the right to an imme-
23 diate appeal.

1 “(b) APPEALS PROCESS.—A health insurance issuer
2 shall establish and maintain an accessible appeals process
3 that—

4 “(1) reviews an adverse prior authorization de-
5 termination—

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

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

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

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

22 “(4) provides for review of—

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

1 “(B) enrollee complaints about inadequate
 2 access to any category or type of health profes-
 3 sional or provider in the network of the issuer
 4 or other matters specified by this part,
 5 by an appropriate clinical peer professional who is in
 6 the same or similar specialty as would typically pro-
 7 vide the item or service involved (or another li-
 8 censed, accredited, or certified health professional
 9 acceptable to the issuer and the person requesting
 10 such review) that is not involved in the operation of
 11 the plan or in making the determination or policy
 12 being appealed.

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

16 **“SEC. 2777. DUE PROCESS FOR HEALTH PROFESSIONALS**
 17 **AND PROVIDERS.**

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

20 “(1) allow all health professionals and providers
 21 in its service area to apply to become a participating
 22 health professional or provider during at least one
 23 period in each calendar year;

24 “(2) provide reasonable notice to such health
 25 professionals and providers of the opportunity to

1 apply and of the period during which applications
2 are accepted;

3 “(3) provide for review of each application by a
4 credentialing committee with appropriate representa-
5 tion of the category or type of health professional or
6 provider;

7 “(4) select participating health professionals
8 and providers based on objective standards of qual-
9 ity developed with the suggestions and advice of pro-
10 fessional associations, health professionals, and pro-
11 viders;

12 “(5) make such selection standards available
13 to—

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

16 “(B) health plan purchasers, and

17 “(C) enrollees;

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

23 “(7) adjust any economic profiling to take into
24 account patient characteristics (such as severity of

1 illness) that may result in atypical utilization of
2 services;

3 “(8) make the results of such profiling available
4 to insurance purchasers, enrollees, and the health
5 professional or provider involved;

6 “(9) notify any health professional or provider
7 being reviewed under the process referred to in para-
8 graph (3) of any information indicating that the
9 health professional or provider fails to meet the
10 standards of the issuer;

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

14 “(A) review the information referred to in
15 such paragraph, and

16 “(B) submit supplemental or corrected in-
17 formation;

18 “(11) not include in its contracts with partici-
19 pating health professionals and providers a provision
20 permitting the issuer to terminate the contract
21 ‘without cause’;

22 “(12) provide a due process appeal that con-
23 forms to the process specified in section 412 of the
24 Health Care Quality Improvement Act of 1986 (42

1 U.S.C. 11112) for all determinations that are ad-
2 verse to a health professional or provider; and

3 “(13) unless a health professional or provider
4 poses an imminent harm to enrollees or an adverse
5 action by a governmental agency effectively impairs
6 the ability to provide health care items and services,
7 provide—

8 “(A) reasonable notice of any decision to
9 terminate a health professional or provider ‘for
10 cause’ (including an explanation of the reasons
11 for the determination),

12 “(B) an opportunity to review and discuss
13 all of the information on which the determina-
14 tion is based, and

15 “(C) an opportunity to enter into a correc-
16 tive action plan, before the determination be-
17 comes subject to appeal under the process re-
18 ferred to in paragraph (12).

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

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

2 “(a) IN GENERAL.—A health insurance issuer offer-
3 ing health insurance coverage shall provide enrollees and
4 prospective enrollees with information about—

5 “(1) coverage provisions, benefits, and any ex-
6 clusions—

7 “(A) by category of service,

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

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

12 “(2) the percentage of the premium charged by
13 the issuer that is set aside for administration and
14 marketing of the issuer;

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

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

19 “(5) the ratio of enrollees to participating
20 health professionals and providers by category and
21 type of health professional and provider;

22 “(6) the expenditures and utilization per en-
23 rollee by category and type of health professional
24 and provider;

25 “(7) the financial obligations of the enrollee and
26 the issuer, including premiums, copayments,

1 deductibles, and established aggregate maximums on
2 out-of-pocket costs, for all items and services, includ-
3 ing—

4 “(A) those furnished by health profes-
5 sionals and providers that are not participating
6 health professionals and providers, and

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

9 “(8) utilization review requirements of the is-
10 suer (including prior authorization review, concur-
11 rent review, post-service review, post-payment re-
12 view, and any other procedures that may lead to de-
13 nial of coverage or payment for a service);

14 “(9) financial arrangements and incentives that
15 may—

16 “(A) limit the items and services furnished
17 to an enrollee,

18 “(B) restrict referral or treatment options,
19 or

20 “(C) negatively affect the fiduciary respon-
21 sibility of a health professional or provider to
22 an enrollee;

23 “(10) other incentives for health professionals
24 and providers to deny or limit needed items or serv-
25 ices;

1 “(11) quality indicators for the issuer and par-
2 ticipating health professionals and providers, includ-
3 ing performance measures such as appropriate refer-
4 rals and prevention of secondary complications fol-
5 lowing treatment;

6 “(12) grievance procedures and appeals rights
7 under the coverage, and summary information about
8 the number and disposition of grievances and ap-
9 peals in the most recent period for which complete
10 and accurate information is available; and

11 “(13) the percentage of utilization review deter-
12 minations made by the issuer that disagree with the
13 judgment of the treating health professional or pro-
14 vider and the percentage of such determinations that
15 are reversed on appeal.

16 “(b) REGULATIONS.—The Secretary, in collaboration
17 with the Secretary of Labor, shall issue regulations to es-
18 tablish—

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

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

24 “(A) readily accessible, and

1 “(B) in common language easily under-
2 stood,
3 by individuals with little or no connection to or un-
4 derstanding of the language employed by health pro-
5 fessionals and providers, health insurance issuers, or
6 other entities involved in the payment or delivery of
7 health care services, and
8 “(3) the placement and positioning of informa-
9 tion in health plan marketing materials.

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

11 “(a) CONFIDENTIALITY.—

12 “(1) IN GENERAL.—A health insurance issuer
13 shall establish mechanisms and procedures to ensure
14 compliance with applicable Federal and State laws
15 to protect the confidentiality of individually identifi-
16 able information held by the issuer with respect to
17 an enrollee, health professional, or provider.

18 “(2) DEFINITION.—For purposes of paragraph
19 (1), the term ‘individually identifiable information’
20 means, with respect to an enrollee, a health profes-
21 sional, or a provider, any information, whether oral
22 or recorded in any medium or form, that identifies
23 or can readily be associated with the identity of the
24 enrollee, the health professional, or the provider.

1 “(b) FINANCIAL RESERVES; SOLVENCY.—A health
2 insurance issuer shall—

3 “(1) meet such financial reserve or other sol-
4 vency-related requirements as the applicable State
5 authority may establish to assure the continued
6 availability of (and appropriate payment for) covered
7 items and services for enrollees; and

8 “(2) establish mechanisms specified by the ap-
9 plicable State authority to protect enrollees, health
10 professionals, and providers in the event of failure of
11 the issuer.

12 Such requirements shall not unduly impede the establish-
13 ment of health insurance issuers owned and operated by
14 health care professionals or providers or by non-profit
15 community-based organizations.

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

17 “(a) IN GENERAL.—A health insurance issuer shall
18 establish a quality improvement program (consistent with
19 subsection (b)) that systematically and continuously as-
20 sesses and improves—

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

24 “(2) the administrative and funding capacity of
25 the issuer to support and emphasize preventive care,

1 utilization, access and availability, cost effectiveness,
2 acceptable treatment modalities, specialists referrals,
3 the peer review process, and the efficiency of the ad-
4 ministrative process.

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

7 “(1) assess the performance of the issuer and
8 its participating health professionals and providers
9 and report the results of such assessment to pur-
10 chasers, participating health professionals and pro-
11 viders, and administrative personnel;

12 “(2) demonstrate measurable improvements in
13 clinical outcomes and plan performance measured by
14 identified criteria, including those specified in sub-
15 section (a)(1); and

16 “(3) analyze quality assessment data to deter-
17 mine specific interactions in the delivery system
18 (both the design and funding of the health insurance
19 coverage and the clinical provision of care) that have
20 an adverse impact on the quality of care.”.

21 (b) APPLICATION TO GROUP HEALTH INSURANCE
22 COVERAGE.—

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

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

2 “(a) IN GENERAL.—Each health insurance issuer
3 shall comply with patient protection requirements under
4 part C with respect to group health insurance coverage
5 it offers.

6 “(b) ASSURING COORDINATION.—The Secretary of
7 Health and Human Services and the Secretary of Labor
8 shall ensure, through the execution of an interagency
9 memorandum of understanding between such Secretaries,
10 that—

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

18 “(2) coordination of policies relating to enforce-
19 ing the same requirements through such Secretaries
20 in order to have a coordinated enforcement strategy
21 that avoids duplication of enforcement efforts and
22 assigns priorities in enforcement.”.

23 (2) Section 2792 of such Act (42 U.S.C.
24 300gg-92) is amended by inserting “and section
25 2706(b)” after “of 1996”.

1 (c) APPLICATION TO INDIVIDUAL HEALTH INSUR-
 2 ANCE COVERAGE.—Part B of title XXVII of the Public
 3 Health Service Act is amended by inserting after section
 4 2751 the following new section:

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

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

9 (d) MODIFICATION OF PREEMPTION STANDARDS.—

10 (1) GROUP HEALTH INSURANCE COVERAGE.—

11 Section 2723 of such Act (42 U.S.C. 300gg–23) is
 12 amended—

13 (A) in subsection (a)(1), by striking “sub-
 14 section (b)” and inserting “subsections (b) and
 15 (c)”;

16 (B) by redesignating subsections (c) and
 17 (d) as subsections (d) and (e), respectively; and

18 (C) by inserting after subsection (b) the
 19 following new subsection:

20 “(c) SPECIAL RULES IN CASE OF PATIENT PROTEC-
 21 TION REQUIREMENTS.—Subject to subsection (a)(2), the
 22 provisions of section 2706 and part C, and part D insofar
 23 as it applies to section 2706 or part C, shall not be con-
 24 strued to preempt any State law, or the enactment or im-
 25 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 (2) INDIVIDUAL HEALTH INSURANCE COV-
 4 ERAGE.—Section 2762 of such Act (42 U.S.C.
 5 300gg-62), as added by section 605(b)(3)(B) of
 6 Public Law 104-204, is amended—

7 (A) in subsection (a), by striking “sub-
 8 section (b), nothing in this part” and inserting
 9 “subsections (b) and (c)”, and

10 (B) by adding at the end the following new
 11 subsection:

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

20 (e) ADDITIONAL CONFORMING AMENDMENTS.—

21 (1) Section 2723(a)(1) of such Act (42 U.S.C.
 22 300gg-23(a)(1)) is amended by striking “part C”
 23 and inserting “parts C and D”.

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

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

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

20 (i) the date on which the last collective bargain-
21 ing agreements relating to the plan terminates (de-
22 termined without regard to any extension thereof
23 agreed to after the date of enactment of this Act),
24 or

25 (ii) the general effective date.

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

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

12 **SEC. 3. PATIENT PROTECTION STANDARDS UNDER THE EM-**
 13 **PLOYEE RETIREMENT INCOME SECURITY**
 14 **ACT OF 1974.**

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

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

20 “(a) IN GENERAL.—Subject to subsection (b), a
 21 group health plan (and a health insurance issuer offering
 22 group health insurance coverage in connection with such
 23 a plan) shall comply with the requirements of part C of
 24 title XXVII of the Public Health Service Act.

1 “(b) REFERENCES IN APPLICATION.—In applying
2 subsection (a) under this part, any reference in such part
3 C—

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

8 “(2) to the Secretary is deemed a reference to
9 the Secretary of Labor;

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

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

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

21 “(1) regulations, rulings, and interpretations is-
22 sued by such Secretaries relating to the same matter
23 over which such Secretaries have responsibility
24 under such part C (and section 2706 of the Public

1 Health Service Act) and this section are adminis-
2 tered so as to have the same effect at all times; and

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

8 (b) MODIFICATION OF PREEMPTION STANDARDS.—
9 Section 731 of such Act (42 U.S.C. 1191) is amended—

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

12 (2) by redesignating subsections (c) and (d) as
13 subsections (d) and (e), respectively; and

14 (3) by inserting after subsection (b) the follow-
15 ing new subsection:

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

1 (c) CONFORMING AMENDMENTS.— (1) Section
2 732(a) of such Act (29 U.S.C. 1185(a)) is amended by
3 striking “section 711” and inserting “sections 711 and
4 713”.

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

“Sec. 713. Patient protection standards.”.

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

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

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

24 (A) the date on which the last collective bar-
25 gaining agreements relating to the plan terminates

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

4 (B) the general effective date.

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

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

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

18 “(9) Subsection (a) of this section shall not be
19 construed to preclude any State cause of action to
20 recover damages for personal injury or wrongful
21 death against any person that provides insurance or
22 administrative services to or for an employee welfare
23 benefit plan maintained to provide health care bene-
24 fits.”.

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

○