

105TH CONGRESS
1ST SESSION

H. R. 1222

To amend the Employee Retirement Income Security Act of 1974 and the Public Health Service Act to require managed care group health plans and managed care health insurance coverage to meet certain consumer protection requirements.

IN THE HOUSE OF REPRESENTATIVES

MARCH 21, 1997

Mrs. ROUKEMA introduced the following bill; which was referred to the Committee on Education and the Workforce, and in addition to the Committee on Commerce, 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 Employee Retirement Income Security Act of 1974 and the Public Health Service Act to require managed care group health plans and managed care health insurance coverage to meet certain consumer protection requirements.

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 “Quality Health Care
5 and Consumer Protection Act”.

1 **SEC. 2. PURPOSE.**

2 The purpose of this Act is to ensure that enrollees
3 in managed care group health plans and managed care
4 health insurance coverage receive adequate health care
5 services by ensuring that—

6 (1) enrollees have full and timely access to clini-
7 cally appropriate health care personnel and facilities;

8 (2) enrollees have adequate choice among health
9 care professionals who are accessible and qualified;

10 (3) there is open communication between physi-
11 cians and enrollees;

12 (4) enrollees have access to comprehensive
13 pharmaceutical services;

14 (5) enrollees have access to information regard-
15 ing limits on coverage of experimental treatments;

16 (6) there is high quality care provided within
17 the plan or coverage;

18 (7) medical decisions are made by the appro-
19 priate medical personnel;

20 (8) participating health care professionals are
21 practitioners in good standing;

22 (9) data on the plan or coverage are available
23 as appropriate;

24 (10) there is full public access to information
25 regarding health care service delivery within the plan
26 or coverage;

1 (11) there is a fair vehicle for resolving enrollee
 2 complaints under the plan or coverage; and

3 (12) there is timely resolution of enrollee griev-
 4 ances and appeals.

5 **SEC. 3. QUALITY HEALTH CARE AND CONSUMER PROTEC-**
 6 **TION ACT UNDER GROUP HEALTH PLANS**
 7 **AND GROUP HEALTH INSURANCE COVERAGE.**

8 (a) ERISA AMENDMENTS.—(1) Subpart B of part
 9 7 of subtitle B of title I of the Employee Retirement In-
 10 come Security Act of 1974, as amended by section 702(a)
 11 of Public Law 104–204, is amended by adding at the end
 12 the following new section:

13 **“SEC. 713. QUALITY HEALTH CARE AND CONSUMER PRO-**
 14 **TECTION ACT.**

15 “(a) ACCESS TO PERSONNEL AND FACILITIES.—

16 “(1) IN GENERAL.—A managed care group
 17 health plan (and a health insurance issuer offering
 18 managed care group health insurance) shall—

19 “(A) include a sufficient number and type
 20 of primary care practitioners and specialists,
 21 throughout the service area, to meet the needs
 22 of enrollees and to provide meaningful choice;
 23 and

24 “(B) demonstrate that it offers the follow-
 25 ing:

1 “(i) An adequate number of accessible
2 acute care hospital services, within a rea-
3 sonable distance and travel time for enroll-
4 ees.

5 “(ii) An adequate number of acces-
6 sible primary care practitioners, within a
7 reasonable distance and travel time for en-
8 rollees.

9 “(iii) An adequate number of acces-
10 sible specialists and subspecialists, within a
11 reasonable distance and travel time for en-
12 rollees.

13 “(iv) The availability of specialty med-
14 ical services, including physical therapy,
15 occupational therapy, and rehabilitation
16 services.

17 “(v) The availability of specialists who
18 are not participating providers or profes-
19 sionals, when a patient’s unique medical
20 circumstances warrant it.

21 Clause (iii) shall be construed as requiring ac-
22 cess to nonparticipating health care profes-
23 sionals who are specialists for treatment of a
24 specific condition if and when there are not suf-

1 sufficient number of such specialists who are par-
2 ticipating health care professionals.

3 “(2) CONTINUITY OF CARE.—A managed care
4 group health plan (and a health insurance issuer of-
5 fering managed care group health insurance) shall—

6 “(A) provide for continuity of care with es-
7 tablished primary care practitioners, when the
8 health care professional’s contract is termi-
9 nated, and

10 “(B) allow enrollees, at no additional out-
11 of-pocket cost, to continue receiving services
12 from a primary care practitioner whose contract
13 with the plan or issuer is terminated without
14 cause for a period of at least 60 days if the en-
15 rollee requests such continuation.

16 “(3) TELEPHONE ACCESS.—A managed care
17 group health plan (and a health insurance issuer of-
18 fering managed care group health insurance) shall
19 provide telephone access to the plan or issuer for
20 sufficient time during business and evening hours to
21 ensure enrollee access for routine care, and 24 hour
22 telephone access to either the plan, issuer, or a par-
23 ticipating provider or professional, for emergency
24 care or authorization for such care.

1 “(4) STANDARDS FOR WAITING TIMES.—A
2 managed care group health plan (and a health insur-
3 ance issuer offering managed care group health in-
4 surance) shall establish reasonable standards for
5 waiting times for enrollees to obtain appointments,
6 subject to special rules for emergency services under
7 paragraph (5). Such standards shall include appoint-
8 ment scheduling guidelines based on the type of
9 health care service, including prenatal care appoint-
10 ments, well-child visits and immunizations, routine
11 physicals, follow-up appointments for chronic condi-
12 tions, and urgent care.

13 “(5) COVERAGE OF EMERGENCY SERVICES.—

14 “(A) IN GENERAL.—A managed care
15 group health plan (and a health insurance is-
16 suer offering managed care group health insur-
17 ance) shall cover and reimburse expenses for
18 treatment of an emergency medical condition if
19 the treatment is obtained, without prior author-
20 ization.

21 “(B) EMERGENCY MEDICAL CONDITION
22 DEFINED.—The term ‘emergency medical con-
23 dition’ means a medical condition, the onset of
24 which is sudden and unexpected, that manifests
25 itself by symptoms of sufficient severity, that a

1 prudent layperson, who possesses an average
2 knowledge of health and medicine, could reason-
3 ably assume that the condition requires imme-
4 diate medical treatment, and could expect the
5 absence of medical attention to result in serious
6 impairment to bodily functions or place the per-
7 son’s health in serious jeopardy.

8 “(C) PRUDENT LAYPERSON DEFINED.—In
9 this paragraph, the term ‘prudent layperson’
10 means a person without specific medical train-
11 ing for the illness or condition in question who
12 acts as a reasonable person would under similar
13 circumstances.

14 “(b) ASSURING ADEQUATE CHOICE OF HEALTH
15 CARE PROFESSIONALS.—

16 “(1) IN GENERAL.—A managed care group
17 health plan (and a health insurance issuer offering
18 managed care group health insurance) shall provide
19 that each enrollee shall have adequate choice among
20 participating health care professionals who are ac-
21 cessible and qualified.

22 “(2) CHOICE.—A managed care group health
23 plan (and a health insurance issuer offering man-
24 aged care group health insurance) shall permit en-
25 rollees to choose their own primary care practitioner

1 from a list of health care professionals within the
2 plan or coverage. Such list shall be updated as
3 health care professionals are added or removed and
4 shall include—

5 “(A) a sufficient number of primary care
6 practitioners who are accepting new enrollees;
7 and

8 “(B) a sufficient mix of primary care prac-
9 titioners that reflects a diversity that is ade-
10 quate to meet the needs of the enrollees’ varied
11 characteristics, including age, gender, race, and
12 health status.

13 “(3) MEDICAL SPECIALISTS.—A managed care
14 group health plan (and a health insurance issuer of-
15 fering managed care group health insurance) shall
16 develop a system to permit enrollees to use a medical
17 specialist primary care practitioner, when the enroll-
18 ee’s medical conditions (including suffering from a
19 chronic disease or medical condition) warrant it.

20 “(4) CONTINUITY OF CARE.—A managed care
21 group health plan (and a health insurance issuer of-
22 fering managed care group health insurance) shall
23 provide—

1 “(A) continuity of care and appropriate re-
2 ferral to specialists within the plan or coverage,
3 when specialty care is warranted,

4 “(B) enrollees with access to medical spe-
5 cialists on a timely basis, and

6 “(C) enrollees with a choice of specialists
7 when a referral is made.

8 “(5) REQUIREMENT FOR POINT OF SERVICE OP-
9 TION.—A managed care group health plan (and a
10 health insurance issuer offering managed care group
11 health insurance) shall offer each enrollee with an
12 enrollment option under which the enrollee may re-
13 ceive benefits for services provided by nonparticipat-
14 ing health care professional or provider. The plan or
15 issuer may require that the enrollee pay a reasonable
16 premium to reflect the cost of such option.

17 “(6) CONSULTATION FOR SECOND OPINIONS.—
18 A managed care group health plan (and a health in-
19 surance issuer offering managed care group health
20 insurance) shall provide enrollees with access to a
21 consultation for a second option.

22 “(c) PROHIBITION OF GAG RULES.—A managed care
23 group health plan (and a health insurance issuer offering
24 managed care group health insurance)—

1 “(1) shall not have any contract provision with
2 a health care professional that limits the health care
3 professional’s disclosure to an enrollee or on behalf
4 of an enrollee of any information relating to the en-
5 rollee’s medical condition or treatment options; and

6 “(2) shall not penalize (through contract termi-
7 nation or otherwise) a health care professional—

8 “(A) because the professional offers refer-
9 rals, or discusses any or all medically necessary
10 or appropriate care or treatment options (in-
11 cluding disclosing any information, determined
12 by the health care professional to be in the best
13 interest of the enrollee) with, or on behalf of,
14 an enrollee; or

15 “(B) for discussing financial incentives and
16 financial arrangements between the health care
17 professional and the plan or issuer.

18 “(d) COVERAGE OF DRUGS AND DEVICES.—

19 “(1) IN GENERAL.—A managed care group
20 health plan (and a health insurance issuer offering
21 managed care group health insurance) that provides
22 benefits with respect to drugs and medical devices
23 shall provide coverage for all drugs and medical de-
24 vices approved by the Food and Drug Administra-
25 tion, whether or not that drug or device has been

1 approved for the specific treatment or condition, so
2 long as the primary care practitioner or other medi-
3 cal specialist treating the enrollee determines the
4 drug or device is medically necessary and appro-
5 priate for the enrollee's condition.

6 “(2) OPERATION OF DRUG UTILIZATION RE-
7 VIEW PROGRAM.—A managed care group health plan
8 (and a health insurance issuer offering managed
9 care group health insurance) that provides benefits
10 with respect to prescription drugs shall establish and
11 operate a drug utilization review program that in-
12 cludes the following:

13 “(A) Retrospective review of prescription
14 drugs furnished to enrollees.

15 “(B) Education of physicians, enrollees,
16 and pharmacists regarding the appropriate use
17 of prescription drugs.

18 “(C) An ongoing periodic examination of
19 data on outpatient prescription drugs to ensure
20 quality therapeutic outcomes for enrollees.

21 “(D) A primary emphasis on enhancing
22 quality of care for enrollees by assuring appro-
23 priate drug therapy.

24 “(E) Clinically relevant criteria and stand-
25 ards for drug therapy.

1 “(F) Application of nonproprietary criteria
2 and standards, developed and revised through
3 an open, professional consensus process.

4 “(G) Interventions which focus on improv-
5 ing therapeutic outcomes.

6 “(H) An educational outreach program
7 that—

8 “(i) is directed to enrollees, phar-
9 macists, and other health care profes-
10 sionals, and

11 “(ii) emphasizes the appropriate use
12 of prescription drugs.

13 “(I) Denial of services under prospective
14 review of drug therapy only in cases of enrollee
15 ineligibility, coverage limitations, or fraud.

16 “(J) Determination of the appropriate
17 drug therapy for the enrollee by the prescribing
18 health care professional and prohibitions of sub-
19 stitutions without the direct approval of such
20 professional.

21 “(e) COVERAGE OF EXPERIMENTAL TREATMENTS.—

22 “(1) IN GENERAL.—A managed care group
23 health plan (and a health insurance issuer offering
24 managed care group health insurance) that limits
25 coverage for services shall define the limitation and

1 disclose the limits in any agreement or certificate of
2 coverage. Such disclosure shall include—

3 “(A) who is authorized to make such a de-
4 termination, and

5 “(B) the criteria the plan or issuer uses to
6 determine whether a service is experimental.

7 “(2) DENIALS.—A managed care group health
8 plan (and a health insurance issuer offering man-
9 aged care group health insurance) that denies cov-
10 erage for an experimental treatment, procedure,
11 drug, or device, for an enrollee who has a terminal
12 condition or illness shall provide the enrollee with a
13 denial letter within 20 working days of the submit-
14 ted request. The letter shall include—

15 “(A) the name and title of the individual
16 making the decision;

17 “(B) a statement setting forth the specific
18 medical and scientific reasons for denying cov-
19 erage;

20 “(C) a description of alternative treatment,
21 services, or supplies covered by the plan or
22 under the coverage, if any; and

23 “(D) a copy of the plan’s or issuer’s griev-
24 ance and appeal procedure.

1 “(3) EXPERIMENTAL TREATMENT DEFINED.—

2 In this subsection, the term ‘experimental treatment’
3 means treatment that, while not commonly used for
4 a particular condition or illness, nevertheless is rec-
5 ognized for treatment of the particular condition or
6 illness, and there is no clearly superior, nonexperi-
7 mental treatment alternative available to the en-
8 rollee.

9 “(f) QUALITY ASSURANCE PROGRAM.—

10 “(1) IN GENERAL.—A managed care group
11 health plan (and a health insurance issuer offering
12 managed care group health insurance) shall develop
13 comprehensive quality assurance standards, ade-
14 quate to identify, evaluate, and remedy problems re-
15 lating to access, continuity, and quality of care. The
16 standards shall include—

17 “(A) an ongoing, written, internal quality
18 assurance program;

19 “(B) specific written guidelines for quality
20 of care studies and monitoring, including atten-
21 tion to vulnerable populations;

22 “(C) performance and clinical outcomes-
23 based criteria;

1 “(D) a procedure for remedial action to
2 correct quality problems, including written pro-
3 cedures for taking appropriate corrective action;

4 “(E) a plan for data gathering and assess-
5 ment under subsection (g); and

6 “(F) a peer review process.

7 “(2) PROCESS FOR SELECTION OF PROFES-
8 SIONALS.—A managed care group health plan (and
9 a health insurance issuer offering managed care
10 group health insurance) shall have a process for se-
11 lection of health care professionals who will be par-
12 ticipating professionals, with written policies and
13 procedures for standards used by the plan or issuer.
14 Such process shall meet the following requirements:

15 “(A) The plan or issuer shall establish
16 minimum professional requirements.

17 “(B) The plan or issuer shall demonstrate
18 that it has consulted with appropriately quali-
19 fied health care professionals to establish the
20 requirements.

21 “(C) The process shall include verification
22 of the individual practitioner’s license, history
23 of suspension or revocation, and liability claims
24 history.

1 “(D) The plan or issuer shall establish a
2 formal, written, ongoing, process for the re-
3 evaluation of all participating health care pro-
4 fessionals within a specified number of years
5 after the initial acceptance. Such reevaluations
6 shall include updates of the previous review cri-
7 teria and an assessment of the performance
8 pattern based on criteria including enrollee clin-
9 ical outcomes, number of complaints, and mal-
10 practice actions.

11 “(3) LIMITATION ON USE OF PROFES-
12 SIONALS.—A managed care group health plan (and
13 a health insurance issuer offering managed care
14 group health insurance) shall not use a health care
15 professional beyond, or outside of, the professional’s
16 legally authorized scope of practice.

17 “(g) DATA SYSTEMS AND CONFIDENTIALITY.—

18 “(1) IN GENERAL.—A managed care group
19 health plan (and a health insurance issuer offering
20 managed care group health insurance) shall provide
21 information on the plan’s or issuer’s structure, deci-
22 sion making process, health care benefits and exclu-
23 sions, cost and cost-sharing requirements, list of
24 participating providers and health care professionals
25 as well as grievance and appeal procedures, to all

1 potential enrollees, all enrollees covered by the plan
2 or coverage, and, to the Secretary of Labor and to
3 the Secretary of Health and Human Services (or,
4 with respect to a health insurance issuer, to the
5 State oversight agency).

6 “(2) REPORTING OF DATA.—A managed care
7 group health plan (and a health insurance issuer of-
8 fering managed care group health insurance) shall
9 collect and report annually to the Secretary of Labor
10 and to the Secretary of Health and Human Services
11 (or, in the case of a health insurance issuer, State
12 oversight agency) specified data including—

13 “(A) gross outpatient and hospital utiliza-
14 tion data;

15 “(B) enrollee clinical outcome data;

16 “(C) the number and types of enrollee
17 grievances or complaints during the year, the
18 status of decisions, and the average time re-
19 quired to reach a decision; and

20 “(D) the number, amount, and disposition
21 of malpractice claims resolved during the year
22 by the plan or issuer and any of its participat-
23 ing health care providers and professionals.

24 “(3) REPORTING.—All data specified in para-
25 graphs (1) and (2) shall be reported to the Secretary

1 of Labor and to the Secretary of Health and Human
2 Services (or, in the case of a health insurance issuer,
3 the State oversight agency) and shall be available to
4 the public on a timely basis.

5 “(4) MEDICAL RECORDS AND CONFIDENTIAL-
6 ITY.—A managed care group health plan (and a
7 health insurance issuer offering managed care group
8 health insurance) shall—

9 “(A) establish written policies and proce-
10 dures for the handling of medical records and
11 enrollee communications to ensure enrollee con-
12 fidentiality;

13 “(B) ensure the confidentiality of specified
14 enrollee information, including, prior medical
15 history, medical record information and claims
16 information, except where disclosure of this in-
17 formation is required by law; and

18 “(C) not release any individual patient
19 record information, unless such a release is au-
20 thorized in writing by the enrollee or otherwise
21 required be law.

22 “(h) CLINICAL DECISION MAKING.—

23 “(1) APPOINTMENT OF MEDICAL DIRECTOR.—A
24 managed care group health plan (and a health insur-
25 ance issuer offering managed care group health in-

1 surance) shall appoint a medical director who is a li-
2 censed physician in the State in which the plan or
3 issuer operates, who shall be responsible for treat-
4 ment policies protocols, quality assurance activities,
5 and utilization management decisions of the plan or
6 issuer.

7 “(2) DISCLOSURE ABOUT FINANCIAL ARRANGE-
8 MENTS.—A managed care group health plan (and a
9 health insurance issuer offering managed care group
10 health insurance) shall inform enrollees of the finan-
11 cial arrangements between the plan or issuer and
12 participating providers and professionals (including
13 pharmacists), if those arrangements include incen-
14 tives or bonuses for restriction of services.

15 “(3) QUALITY ASSURANCE DEFINED.—In this
16 subsection, the term ‘quality assurance’ means the
17 ongoing evaluation of the quality of health care pro-
18 vided to enrollees.

19 “(4) OVERSIGHT.—The Secretary of Labor and
20 the Secretary of Health and Human Services are re-
21 sponsible for performance of annual audits of man-
22 aged care group health plans and, in the case of a
23 health insurance issuer, the State oversight agency
24 is responsible for performance of annual audits of
25 managed care health insurance coverage offered by

1 such issuers, in order to review enrollee clinical out-
2 come data, enrollee service data, and operational and
3 other financial data.

4 “(i) GRIEVANCE PROCEDURES, REVIEWS, AND AP-
5 PEALS.—

6 “(1) IN GENERAL.—A managed care group
7 health plan (and a health insurance issuer offering
8 managed care group health insurance) shall provide
9 written notification to enrollees, in a language en-
10 rollees understand, regarding the right to file a
11 grievance concerning denials or limitations of cov-
12 erage under the plan or coverage. At a minimum,
13 such notification shall be given—

14 “(A) prior to enrollment in the plan or
15 under the coverage; and

16 “(B) at the time care is denied or limited
17 under the plan or coverage.

18 “(2) NOTICE OF RIGHT TO FILE GRIEVANCE.—

19 At the time of such a denial, such a plan or issuer
20 shall notify the enrollee of the right to file a griev-
21 ance. Such notice shall be in writing and shall in-
22 clude the reason for denial, the name of the individ-
23 ual responsible for the decision, the criteria for de-
24 termination, and the enrollee’s right to file a griev-
25 ance.

1 “(3) GRIEVANCE PROCEDURES.—The grievance
2 procedures under the plan or coverage shall in-
3 clude—

4 “(A) identification of the reviewing body
5 and an explanation of the process of review;

6 “(B) an initial investigation and review;

7 “(C) notification within a reasonable
8 amount of time of the outcome of the grievance;
9 and

10 “(D) an appeal procedure.

11 “(4) TIME LIMITS.—

12 “(A) IN GENERAL.—Such a plan or issuer
13 shall set reasonable time limits for each part of
14 the review process, but in no case shall the re-
15 view extend beyond 30 days.

16 “(B) EXPEDITED REVIEW.—Such a plan
17 or issuer shall provide for expedited review for
18 cases involving an imminent, emergent, or seri-
19 ous threat to the health of an enrollee. In such
20 case the plan or issuer shall—

21 “(i) immediately inform the enrollee
22 of this right, and

23 “(ii) provide the enrollee with a writ-
24 ten statement of the disposition or pending

1 status of the grievance within 72 hours of
2 the commencement of the review process.

3 “(5) REPORTING.—Such a plan or issuer shall
4 report to the Secretary of Labor and to the Sec-
5 retary of Health and Human Services (or, in the
6 case of a health insurance issuer, the State oversight
7 agency), the number of grievances and appeals re-
8 ceived by the plan or issuer within a specified time
9 period, including if applicable, the outcomes or cur-
10 rent status of the grievance and appeals as well as
11 the average time taken to resolve both grievances
12 and appeals.

13 “(6) DEFINITIONS.—In this subsection:

14 “(A) APPEAL.—The term ‘appeal’ means a
15 formal process whereby an enrollee whose care
16 has been reduced, denied, or terminated, or
17 whereby the enrollee deems the care inappropri-
18 ate, can contest an adverse grievance decision
19 by the plan or issuer.

20 “(B) The term ‘expedited review’ means a
21 review process which takes no more than 72
22 hours after the review is commenced.

23 “(C) The term ‘grievance’ means a written
24 complaint submitted by or on behalf of the en-
25 rollee.

1 “(j) NOTICE UNDER GROUP HEALTH PLAN.—The
2 imposition of the requirements of this section shall be
3 treated as a material modification in the terms of the plan
4 described in section 102(a)(1), for purposes of assuring
5 notice of such requirements under the plan; except that
6 the summary description required to be provided under the
7 last sentence of section 104(b)(1) with respect to such
8 modification shall be provided by not later than 60 days
9 after the first day of the first plan year in which such
10 requirements apply.

11 “(k) GENERAL DEFINITIONS.—For purposes of this
12 section:

13 “(1) The term ‘enrollee’ means an individual
14 who is entitled to benefits under a managed care
15 group health plan or under managed care health in-
16 surance coverage offered in connection with such a
17 plan.

18 “(2) The term ‘health care provider’ means a
19 clinic, hospital physician organization, preferred pro-
20 vider organization, independent practice association,
21 or other appropriately licensed provider of health
22 care services or supplies.

23 “(3) The term ‘health care professional’ means
24 a physician or other health care practitioner provid-
25 ing health care services.

1 “(4) The term ‘managed care’ means, with re-
2 spect to a group health plan or health insurance cov-
3 erage, a plan or coverage that provides financial in-
4 centives for enrollees to obtain benefits through par-
5 ticipating health care providers or professionals.

6 “(5) The term ‘participating’ means, with re-
7 spect to a health care provider or professional and
8 a group health plan or health insurance coverage of-
9 fered by a health insurance issuer, such a provider
10 or professional that has entered into an agreement
11 with the plan or issuer with respect to the provision
12 of health care services to enrollees under the plan or
13 coverage.

14 “(6) The term ‘primary care practitioner’
15 means, with respect to a group health plan or health
16 insurance coverage offered by a health insurance is-
17 suer, a health care professional (who may be a fam-
18 ily practice physician, general practice physician, in-
19 ternist, obstetrician/gynecologist, or pediatrician)
20 designated by the plan or issuer to coordinate, su-
21 pervise, or provide ongoing care to enrollees.

22 “(7) The term ‘State oversight agency’ means,
23 with respect to a health insurance issuer, the State
24 agency responsible for the regulation of the issuer.”.

1 (B) Section 731(c) of such Act (29 U.S.C.
 2 1191(c)), as amended by section 603(b)(1) of Public
 3 Law 104–204, is amended by striking “section 711”
 4 and inserting “sections 711 and 713”.

5 (C) Section 732(a) of such Act (29 U.S.C.
 6 1191a(a)), as amended by section 603(b)(2) of Pub-
 7 lic Law 104–204, is amended by striking “section
 8 711” and inserting “sections 711 and 713”.

9 (D) The table of contents in section 1 of such
 10 Act is amended by inserting after the item relating
 11 to section 712 the following new item:

“Sec. 713. Managed care consumer protections.”.

12 (b) PHSA AMENDMENTS.—(1) Subpart 2 of part A
 13 of title XXVII of the Public Health Service Act, as amend-
 14 ed by section 703(a) of Public Law 104–204, is amended
 15 by adding at the end the following new section:

16 **“SEC. 2706. QUALITY HEALTH CARE AND CONSUMER PRO-**
 17 **TECTION ACT.**

18 “(a) ACCESS TO PERSONNEL AND FACILITIES.—

19 “(1) IN GENERAL.—A managed care group
 20 health plan (and a health insurance issuer offering
 21 managed care group health insurance) shall—

22 “(A) include a sufficient number and type
 23 of primary care practitioners and specialists,
 24 throughout the service area, to meet the needs

1 of enrollees and to provide meaningful choice;
2 and

3 “(B) demonstrate that it offers the follow-
4 ing:

5 “(i) An adequate number of accessible
6 acute care hospital services, within a rea-
7 sonable distance and travel time for enroll-
8 ees.

9 “(ii) An adequate number of acces-
10 sible primary care practitioners, within a
11 reasonable distance and travel time for en-
12 rollees.

13 “(iii) An adequate number of acces-
14 sible specialists and subspecialists, within a
15 reasonable distance and travel time for en-
16 rollees.

17 “(iv) The availability of specialty med-
18 ical services, including physical therapy,
19 occupational therapy, and rehabilitation
20 services.

21 “(v) The availability of specialists who
22 are not participating providers or profes-
23 sionals, when a patient’s unique medical
24 circumstances warrant it.

1 Clause (iii) shall be construed as requiring ac-
2 cess to nonparticipating health care profes-
3 sionals who are specialists for treatment of a
4 specific condition if and when there are not suf-
5 ficient number of such specialists who are par-
6 ticipating health care professionals.

7 “(2) CONTINUITY OF CARE.—A managed care
8 group health plan (and a health insurance issuer of-
9 fering managed care group health insurance) shall—

10 “(A) provide for continuity of care with es-
11 tablished primary care practitioners, when the
12 health care professional’s contract is termi-
13 nated, and

14 “(B) allow enrollees, at no additional out-
15 of-pocket cost, to continue receiving services
16 from a primary care practitioner whose contract
17 with the plan or issuer is terminated without
18 cause for a period of at least 60 days if the en-
19 rollee requests such continuation.

20 “(3) TELEPHONE ACCESS.—A managed care
21 group health plan (and a health insurance issuer of-
22 fering managed care group health insurance) shall
23 provide telephone access to the plan or issuer for
24 sufficient time during business and evening hours to
25 ensure enrollee access for routine care, and 24 hour

1 telephone access to either the plan, issuer, or a par-
2 ticipating provider or professional, for emergency
3 care or authorization for such care.

4 “(4) STANDARDS FOR WAITING TIMES.—A
5 managed care group health plan (and a health insur-
6 ance issuer offering managed care group health in-
7 surance) shall establish reasonable standards for
8 waiting times for enrollees to obtain appointments,
9 subject to special rules for emergency services under
10 paragraph (5). Such standards shall include appoint-
11 ment scheduling guidelines based on the type of
12 health care service, including prenatal care appoint-
13 ments, well-child visits and immunizations, routine
14 physicals, follow-up appointments for chronic condi-
15 tions, and urgent care.

16 “(5) COVERAGE OF EMERGENCY SERVICES.—

17 “(A) IN GENERAL.—A managed care
18 group health plan (and a health insurance is-
19 suer offering managed care group health insur-
20 ance) shall cover and reimburse expenses for
21 treatment of an emergency medical condition if
22 the treatment is obtained, without prior author-
23 ization.

24 “(B) EMERGENCY MEDICAL CONDITION
25 DEFINED.—The term ‘emergency medical con-

1 dition’ means a medical condition, the onset of
2 which is sudden and unexpected, that manifests
3 itself by symptoms of sufficient severity, that a
4 prudent layperson, who possesses an average
5 knowledge of health and medicine, could reason-
6 ably assume that the condition requires imme-
7 diate medical treatment, and could expect the
8 absence of medical attention to result in serious
9 impairment to bodily functions or place the per-
10 son’s health in serious jeopardy.

11 “(C) PRUDENT LAYPERSON DEFINED.—In
12 this paragraph, the term ‘prudent layperson’
13 means a person without specific medical train-
14 ing for the illness or condition in question who
15 acts as a reasonable person would under similar
16 circumstances.

17 “(b) ASSURING ADEQUATE CHOICE OF HEALTH
18 CARE PROFESSIONALS.—

19 “(1) IN GENERAL.—A managed care group
20 health plan (and a health insurance issuer offering
21 managed care group health insurance) shall provide
22 that each enrollee shall have adequate choice among
23 participating health care professionals who are ac-
24 cessible and qualified.

1 “(2) CHOICE.—A managed care group health
2 plan (and a health insurance issuer offering man-
3 aged care group health insurance) shall permit en-
4 rollees to choose their own primary care practitioner
5 from a list of health care professionals within the
6 plan or coverage. Such list shall be updated as
7 health care professionals are added or removed and
8 shall include—

9 “(A) a sufficient number of primary care
10 practitioners who are accepting new enrollees;
11 and

12 “(B) a sufficient mix of primary care prac-
13 titioners that reflects a diversity that is ade-
14 quate to meet the needs of the enrollees’ varied
15 characteristics, including age, gender, race, and
16 health status.

17 “(3) MEDICAL SPECIALISTS.—A managed care
18 group health plan (and a health insurance issuer of-
19 fering managed care group health insurance) shall
20 develop a system to permit enrollees to use a medical
21 specialist primary care practitioner, when the enroll-
22 ee’s medical conditions (including suffering from a
23 chronic disease or medical condition) warrant it.

24 “(4) CONTINUITY OF CARE.—A managed care
25 group health plan (and a health insurance issuer of-

1 fering managed care group health insurance) shall
2 provide—

3 “(A) continuity of care and appropriate re-
4 ferral to specialists within the plan or coverage,
5 when specialty care is warranted,

6 “(B) enrollees with access to medical spe-
7 cialists on a timely basis, and

8 “(C) enrollees with a choice of specialists
9 when a referral is made.

10 “(5) REQUIREMENT FOR POINT OF SERVICE OP-
11 TION.—A managed care group health plan (and a
12 health insurance issuer offering managed care group
13 health insurance) shall offer each enrollee with an
14 enrollment option under which the enrollee may re-
15 ceive benefits for services provided by nonparticipat-
16 ing health care professional or provider. The plan or
17 issuer may require that the enrollee pay a reasonable
18 premium to reflect the cost of such option.

19 “(6) CONSULTATION FOR SECOND OPINIONS.—
20 A managed care group health plan (and a health in-
21 surance issuer offering managed care group health
22 insurance) shall provide enrollees with access to a
23 consultation for a second option.

1 “(c) PROHIBITION OF GAG RULES.—A managed care
 2 group health plan (and a health insurance issuer offering
 3 managed care group health insurance)—

4 “(1) shall not have any contract provision with
 5 a health care professional that limits the health care
 6 professional’s disclosure to an enrollee or on behalf
 7 of an enrollee of any information relating to the en-
 8 rollee’s medical condition or treatment options; and

9 “(2) shall not penalize (through contract termi-
 10 nation or otherwise) a health care professional—

11 “(A) because the professional offers refer-
 12 rals, or discusses any or all medically necessary
 13 or appropriate care or treatment options (in-
 14 cluding disclosing any information, determined
 15 by the health care professional to be in the best
 16 interest of the enrollee) with, or on behalf of,
 17 an enrollee; or

18 “(B) for discussing financial incentives and
 19 financial arrangements between the health care
 20 professional and the plan or issuer.

21 “(d) COVERAGE OF DRUGS AND DEVICES.—

22 “(1) IN GENERAL.—A managed care group
 23 health plan (and a health insurance issuer offering
 24 managed care group health insurance) that provides
 25 benefits with respect to drugs and medical devices

1 shall provide coverage for all drugs and medical de-
2 vices approved by the Food and Drug Administra-
3 tion, whether or not that drug or device has been
4 approved for the specific treatment or condition, so
5 long as the primary care practitioner or other medi-
6 cal specialist treating the enrollee determines the
7 drug or device is medically necessary and appro-
8 priate for the enrollee's condition.

9 “(2) OPERATION OF DRUG UTILIZATION RE-
10 VIEW PROGRAM.—A managed care group health plan
11 (and a health insurance issuer offering managed
12 care group health insurance) that provides benefits
13 with respect to prescription drugs shall establish and
14 operate a drug utilization review program that in-
15 cludes the following:

16 “(A) Retrospective review of prescription
17 drugs furnished to enrollees.

18 “(B) Education of physicians, enrollees,
19 and pharmacists regarding the appropriate use
20 of prescription drugs.

21 “(C) An ongoing periodic examination of
22 data on outpatient prescription drugs to ensure
23 quality therapeutic outcomes for enrollees.

1 “(D) A primary emphasis on enhancing
2 quality of care for enrollees by assuring appro-
3 priate drug therapy.

4 “(E) Clinically relevant criteria and stand-
5 ards for drug therapy.

6 “(F) Application of nonproprietary criteria
7 and standards, developed and revised through
8 an open, professional consensus process.

9 “(G) Interventions which focus on improv-
10 ing therapeutic outcomes.

11 “(H) An educational outreach program
12 that—

13 “(i) is directed to enrollees, phar-
14 macists, and other health care profes-
15 sionals, and

16 “(ii) emphasizes the appropriate use
17 of prescription drugs.

18 “(I) Denial of services under prospective
19 review of drug therapy only in cases of enrollee
20 ineligibility, coverage limitations, or fraud.

21 “(J) Determination of the appropriate
22 drug therapy for the enrollee by the prescribing
23 health care professional and prohibitions of sub-
24 stitutions without the direct approval of such
25 professional.

1 “(e) COVERAGE OF EXPERIMENTAL TREATMENTS.—

2 “(1) IN GENERAL.—A managed care group
3 health plan (and a health insurance issuer offering
4 managed care group health insurance) that limits
5 coverage for services shall define the limitation and
6 disclose the limits in any agreement or certificate of
7 coverage. Such disclosure shall include—

8 “(A) who is authorized to make such a de-
9 termination, and

10 “(B) the criteria the plan or issuer uses to
11 determine whether a service is experimental.

12 “(2) DENIALS.—A managed care group health
13 plan (and a health insurance issuer offering man-
14 aged care group health insurance) that denies cov-
15 erage for an experimental treatment, procedure,
16 drug, or device, for an enrollee who has a terminal
17 condition or illness shall provide the enrollee with a
18 denial letter within 20 working days of the submit-
19 ted request. The letter shall include—

20 “(A) the name and title of the individual
21 making the decision;

22 “(B) a statement setting forth the specific
23 medical and scientific reasons for denying cov-
24 erage;

1 “(C) a description of alternative treatment,
2 services, or supplies covered by the plan or
3 under the coverage, if any; and

4 “(D) a copy of the plan’s or issuer’s grievance and appeal procedure.

6 “(3) EXPERIMENTAL TREATMENT DEFINED.—

7 In this subsection, the term ‘experimental treatment’
8 means treatment that, while not commonly used for
9 a particular condition or illness, nevertheless is recognized for treatment of the particular condition or
10 illness, and there is no clearly superior, nonexperimental treatment alternative available to the enrollee.

14 “(f) QUALITY ASSURANCE PROGRAM.—

15 “(1) IN GENERAL.—A managed care group
16 health plan (and a health insurance issuer offering
17 managed care group health insurance) shall develop
18 comprehensive quality assurance standards, adequate to identify, evaluate, and remedy problems relating to access, continuity, and quality of care. The
20 standards shall include—

22 “(A) an ongoing, written, internal quality
23 assurance program;

1 “(B) specific written guidelines for quality
2 of care studies and monitoring, including atten-
3 tion to vulnerable populations;

4 “(C) performance and clinical outcomes-
5 based criteria;

6 “(D) a procedure for remedial action to
7 correct quality problems, including written pro-
8 cedures for taking appropriate corrective action;

9 “(E) a plan for data gathering and assess-
10 ment under subsection (g); and

11 “(F) a peer review process.

12 “(2) PROCESS FOR SELECTION OF PROFES-
13 SIONALS.—A managed care group health plan (and
14 a health insurance issuer offering managed care
15 group health insurance) shall have a process for se-
16 lection of health care professionals who will be par-
17 ticipating professionals, with written policies and
18 procedures for standards used by the plan or issuer.
19 Such process shall meet the following requirements:

20 “(A) The plan or issuer shall establish
21 minimum professional requirements.

22 “(B) The plan or issuer shall demonstrate
23 that it has consulted with appropriately quali-
24 fied health care professionals to establish the
25 requirements.

1 “(C) The process shall include verification
2 of the individual practitioner’s license, history
3 of suspension or revocation, and liability claims
4 history.

5 “(D) The plan or issuer shall establish a
6 formal, written, ongoing, process for the re-
7 evaluation of all participating health care pro-
8 fessionals within a specified number of years
9 after the initial acceptance. Such reevaluations
10 shall include updates of the previous review cri-
11 teria and an assessment of the performance
12 pattern based on criteria including enrollee clin-
13 ical outcomes, number of complaints, and mal-
14 practice actions.

15 “(3) LIMITATION ON USE OF PROFES-
16 SIONALS.—A managed care group health plan (and
17 a health insurance issuer offering managed care
18 group health insurance) shall not use a health care
19 professional beyond, or outside of, the professional’s
20 legally authorized scope of practice.

21 “(g) DATA SYSTEMS AND CONFIDENTIALITY.—

22 “(1) IN GENERAL.—A managed care group
23 health plan (and a health insurance issuer offering
24 managed care group health insurance) shall provide
25 information on the plan’s or issuer’s structure, deci-

1 sion making process, health care benefits and exclu-
2 sions, cost and cost-sharing requirements, list of
3 participating providers and health care professionals
4 as well as grievance and appeal procedures, to all
5 potential enrollees, all enrollees covered by the plan
6 or coverage, and, to the Secretary (or, with respect
7 to a health insurance issuer, to the State oversight
8 agency).

9 “(2) REPORTING OF DATA.—A managed care
10 group health plan (and a health insurance issuer of-
11 fering managed care group health insurance) shall
12 collect and report annually to the Secretary (or, in
13 the case of a health insurance issuer, State oversight
14 agency) specified data including—

15 “(A) gross outpatient and hospital utiliza-
16 tion data;

17 “(B) enrollee clinical outcome data;

18 “(C) the number and types of enrollee
19 grievances or complaints during the year, the
20 status of decisions, and the average time re-
21 quired to reach a decision; and

22 “(D) the number, amount, and disposition
23 of malpractice claims resolved during the year
24 by the plan or issuer and any of its participat-
25 ing health care providers and professionals.

1 “(3) REPORTING.—All data specified in para-
2 graphs (1) and (2) shall be reported to the Secretary
3 or, in the case of a health insurance issuer, the
4 State oversight agency and shall be available to the
5 public on a timely basis.

6 “(4) MEDICAL RECORDS AND CONFIDENTIAL-
7 ITY.—A managed care group health plan (and a
8 health insurance issuer offering managed care group
9 health insurance) shall—

10 “(A) establish written policies and proce-
11 dures for the handling of medical records and
12 enrollee communications to ensure enrollee con-
13 fidentiality;

14 “(B) ensure the confidentiality of specified
15 enrollee information, including, prior medical
16 history, medical record information and claims
17 information, except where disclosure of this in-
18 formation is required by law; and

19 “(C) not release any individual patient
20 record information, unless such a release is au-
21 thorized in writing by the enrollee or otherwise
22 required by law.

23 “(h) CLINICAL DECISION MAKING.—

24 “(1) APPOINTMENT OF MEDICAL DIRECTOR.—A
25 managed care group health plan (and a health insur-

1 ance issuer offering managed care group health in-
2 surance) shall appoint a medical director who is a li-
3 censed physician in the State in which the plan or
4 issuer operates, who shall be responsible for treat-
5 ment policies protocols, quality assurance activities,
6 and utilization management decisions of the plan or
7 issuer.

8 “(2) DISCLOSURE ABOUT FINANCIAL ARRANGE-
9 MENTS.—A managed care group health plan (and a
10 health insurance issuer offering managed care group
11 health insurance) shall inform enrollees of the finan-
12 cial arrangements between the plan or issuer and
13 participating providers and professionals (including
14 pharmacists), if those arrangements include incen-
15 tives or bonuses for restriction of services.

16 “(3) QUALITY ASSURANCE DEFINED.—In this
17 subsection, the term ‘quality assurance’ means the
18 ongoing evaluation of the quality of health care pro-
19 vided to enrollees.

20 “(4) OVERSIGHT.—The Secretary is responsible
21 for performance of annual audits of managed care
22 group health plans and, in the case of a health in-
23 surance issuer, the State oversight agency is respon-
24 sible for performance of annual audits of managed
25 care health insurance coverage offered by such issu-

1 ers, in order to review enrollee clinical outcome data,
2 enrollee service data, and operational and other fi-
3 nancial data.

4 “(i) GRIEVANCE PROCEDURES, REVIEWS, AND AP-
5 PEALS.—

6 “(1) IN GENERAL.—A managed care group
7 health plan (and a health insurance issuer offering
8 managed care group health insurance) shall provide
9 written notification to enrollees, in a language en-
10 rollees understand, regarding the right to file a
11 grievance concerning denials or limitations of cov-
12 erage under the plan or coverage. At a minimum,
13 such notification shall be given—

14 “(A) prior to enrollment in the plan or
15 under the coverage; and

16 “(B) at the time care is denied or limited
17 under the plan or coverage.

18 “(2) NOTICE OF RIGHT TO FILE GRIEVANCE.—

19 At the time of such a denial, such a plan or issuer
20 shall notify the enrollee of the right to file a griev-
21 ance. Such notice shall be in writing and shall in-
22 clude the reason for denial, the name of the individ-
23 ual responsible for the decision, the criteria for de-
24 termination, and the enrollee’s right to file a griev-
25 ance.

1 “(3) GRIEVANCE PROCEDURES.—The grievance
2 procedures under the plan or coverage shall in-
3 clude—

4 “(A) identification of the reviewing body
5 and an explanation of the process of review;

6 “(B) an initial investigation and review;

7 “(C) notification within a reasonable
8 amount of time of the outcome of the grievance;
9 and

10 “(D) an appeal procedure.

11 “(4) TIME LIMITS.—

12 “(A) IN GENERAL.—Such a plan or issuer
13 shall set reasonable time limits for each part of
14 the review process, but in no case shall the re-
15 view extend beyond 30 days.

16 “(B) EXPEDITED REVIEW.—Such a plan
17 or issuer shall provide for expedited review for
18 cases involving an imminent, emergent, or seri-
19 ous threat to the health of an enrollee. In such
20 case the plan or issuer shall—

21 “(i) immediately inform the enrollee
22 of this right, and

23 “(ii) provide the enrollee with a writ-
24 ten statement of the disposition or pending

1 status of the grievance within 72 hours of
2 the commencement of the review process.

3 “(5) REPORTING.—Such a plan or issuer shall
4 report to the Secretary or, in the case of a health
5 insurance issuer, the State oversight agency, the
6 number of grievances and appeals received by the
7 plan or issuer within a specified time period, includ-
8 ing if applicable, the outcomes or current status of
9 the grievance and appeals as well as the average
10 time taken to resolve both grievances and appeals.

11 “(6) DEFINITIONS.—In this subsection:

12 “(A) APPEAL.—The term ‘appeal’ means a
13 formal process whereby an enrollee whose care
14 has been reduced, denied, or terminated, or
15 whereby the enrollee deems the care inappropriate,
16 can contest an adverse grievance decision
17 by the plan or issuer.

18 “(B) The term ‘expedited review’ means a
19 review process which takes no more than 72
20 hours after the review is commenced.

21 “(C) The term ‘grievance’ means a written
22 complaint submitted by or on behalf of the en-
23 rollee.

24 “(j) NOTICE.—A group health plan under this part
25 shall comply with the notice requirement under section

1 713(j) of the Employee Retirement Income Security Act
2 of 1974 with respect to the requirements of this section
3 as if such section applied to such plan.

4 “(k) GENERAL DEFINITIONS.—For purposes of this
5 section:

6 “(1) The term ‘enrollee’ means an individual
7 who is entitled to benefits under a managed care
8 group health plan or under managed care health in-
9 surance coverage offered in connection with such a
10 plan.

11 “(2) The term ‘health care provider’ means a
12 clinic, hospital physician organization, preferred pro-
13 vider organization, independent practice association,
14 or other appropriately licensed provider of health
15 care services or supplies.

16 “(3) The term ‘health care professional’ means
17 a physician or other health care practitioner provid-
18 ing health care services.

19 “(4) The term ‘managed care’ means, with re-
20 spect to a group health plan or health insurance cov-
21 erage, a plan or coverage that provides financial in-
22 centives for enrollees to obtain benefits through par-
23 ticipating health care providers or professionals.

24 “(5) The term ‘participating’ means, with re-
25 spect to a health care provider or professional and

1 a group health plan or health insurance coverage of-
 2 fered by a health insurance issuer, such a provider
 3 or professional that has entered into an agreement
 4 with the plan or issuer with respect to the provision
 5 of health care services to enrollees under the plan or
 6 coverage.

7 “(6) The term ‘primary care practitioner’
 8 means, with respect to a group health plan or health
 9 insurance coverage offered by a health insurance is-
 10 suer, a health care professional (who may be a fam-
 11 ily practice physician, general practice physician, in-
 12 ternist, obstetrician/gynecologist, or pediatrician)
 13 designated by the plan or issuer to coordinate, su-
 14 pervise, or provide ongoing care to enrollees.

15 “(7) The term ‘State oversight agency’ means,
 16 with respect to a health insurance issuer, the State
 17 agency responsible for the regulation of the issuer.”.

18 (2) Section 2723(c) of such Act (42 U.S.C. 300gg-
 19 23(c)), as amended by section 604(b)(2) of Public Law
 20 104–204, is amended by striking “section 2704” and in-
 21 serting “sections 2704 and 2706”.

22 **SEC. 4. MANAGED CARE CONSUMER PROTECTIONS UNDER**
 23 **INDIVIDUAL HEALTH INSURANCE COVERAGE.**

24 (a) IN GENERAL.—Part B of title XXVII of the Pub-
 25 lic Health Service Act, as amended by section 605(a) of

1 Public Law 104–204, is amended by inserting after sec-
2 tion 2751 the following new section:

3 **“SEC. 2752. MANAGED CARE CONSUMER PROTECTIONS.**

4 “(a) IN GENERAL.—The provisions of section 2706
5 (other than subsection (j)) shall apply to health insurance
6 coverage offered by a health insurance issuer in the indi-
7 vidual market in the same manner as it applies to health
8 insurance coverage offered by a health insurance issuer
9 in connection with a group health plan.

10 “(b) NOTICE.—A health insurance issuer under this
11 part shall comply with the notice requirement under sec-
12 tion 713(j) of the Employee Retirement Income Security
13 Act of 1974 with respect to the requirements referred to
14 in subsection (a) as if such section applied to such issuer
15 and such issuer were a group health plan.”.

16 (b) CONFORMING AMENDMENT.—Section 2762(b)(2)
17 of such Act (42 U.S.C. 300gg–62(b)(2)), as added by sec-
18 tion 605(b)(3)(B) of Public Law 104–204, is amended by
19 striking “section 2751” and inserting “sections 2751 and
20 2752”.

21 **SEC. 5. EFFECTIVE DATES.**

22 (a) GROUP HEALTH PLANS AND GROUP HEALTH IN-
23 SURANCE COVERAGE.—(1) Subject to paragraph (2), the
24 amendments made by section 3 shall apply with respect

1 to group health plans for plan years beginning on or after
2 January 1, 1998.

3 (2) In the case of a group health plan maintained
4 pursuant to 1 or more collective bargaining agreements
5 between employee representatives and 1 or more employ-
6 ers ratified before the date of enactment of this Act, the
7 amendments made by section 3 shall not apply to plan
8 years beginning before the later of—

9 (A) the date on which the last collective bar-
10 gaining agreements relating to the plan terminates
11 (determined without regard to any extension thereof
12 agreed to after the date of enactment of this Act),
13 or

14 (B) January 1, 1998.

15 For purposes of subparagraph (A), any plan amendment
16 made pursuant to a collective bargaining agreement relat-
17 ing to the plan which amends the plan solely to conform
18 to any requirement added by section 3 shall not be treated
19 as a termination of such collective bargaining agreement.

20 (b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—
21 The amendments made by section 4 shall apply with re-
22 spect to health insurance coverage offered, sold, issued,
23 renewed, in effect, or operated in the individual market
24 on or after January 1, 1998.

○