

105TH CONGRESS
1ST SESSION

H. R. 1749

To amend title I of the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code of 1986 to improve and clarify accountability for violations with respect to managed care group health plans.

IN THE HOUSE OF REPRESENTATIVES

MAY 22, 1997

Mr. STARK (for himself, Mr. KILDEE, Mrs. LOWEY, Mr. MILLER of California, Mr. FRANK of Massachusetts, Ms. PELOSI, Mr. SANDERS, Mr. TIERNEY, Mr. FROST, Mr. DELLUMS, Ms. CHRISTIAN-GREEN, Mr. LEWIS of Georgia, Mr. DEFazio, Mr. WAXMAN, Mr. RANGEL, Mr. KUCINICH, Mr. KLECZKA, Mr. KENNEDY of Rhode Island, Ms. RIVERS, Mr. MCGOVERN, Mr. BERMAN, and Mrs. TAUSCHER) introduced the following bill; which was referred to the Committee on Education and the Workforce, and in addition to the Committee on Ways and Means, 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 title I of the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code of 1986 to improve and clarify accountability for violations with respect to managed care group health plans.

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

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Managed Care Plan
3 Accountability Act of 1997”.

4 **SEC. 2. IMPROVEMENTS IN ERISA ENFORCEMENT WITH RE-**
5 **SPECT TO MANAGED CARE GROUP HEALTH**
6 **PLANS.**

7 (a) ADDITIONAL REMEDIES FOR COST-DRIVEN VIO-
8 LATIONS OF PLAN TERMS.—

9 (1) IN GENERAL.—Section 502(c) of the Em-
10 ployee Retirement Income Security Act of 1974 (29
11 U.S.C. 1132(c)) is amended—

12 (A) by redesignating paragraph (6) as
13 paragraph (7); and

14 (B) by inserting after paragraph (5) the
15 following new paragraph:

16 “(6)(A) In any case in which a group health plan,
17 or a health insurance issuer offering health insurance cov-
18 erage in connection with such plan, provides benefits
19 under such plan under managed care, and such plan or
20 issuer fails to provide any such benefit in accordance with
21 the terms of the plan or such coverage, insofar as such
22 failure occurs pursuant to a clinically or medically inap-
23 propriate decision or determination resulting from—

24 “(i) the application of any cost containment
25 technique,

1 “(ii) any utilization review directed at cost con-
2 tainment, or

3 “(iii) any other medical care delivery policy de-
4 cision which restricts the ability of providers of med-
5 ical care from utilizing their full discretion for treat-
6 ment of patients,

7 each specified defendant shall be jointly and severally lia-
8 ble to any participant or beneficiary aggrieved by such
9 failure for actual damages (including compensatory and
10 consequential damages) proximately caused by such fail-
11 ure, and may, in the court’s discretion, be liable to such
12 participant or beneficiary for punitive damages.

13 “(B) For purposes of this paragraph—

14 “(i) a group health plan, or a health insurance
15 issuer offering health insurance coverage in connec-
16 tion with the plan, provides benefits under ‘managed
17 care’ if the plan or the issuer—

18 “(I) provides or arranges for the provision
19 of the benefits to participants and beneficiaries
20 primarily through participating providers of
21 medical care, or

22 “(II) provides financial incentives (such as
23 variable copayments and deductibles) to induce
24 participants and beneficiaries to obtain the ben-

1 efits primarily through participating providers
2 of medical care,
3 or both.

4 “(ii) The term ‘specified defendant’ means, in
5 connection with any failure to provide any benefit, a
6 person who is—

7 “(I) the plan sponsor, or

8 “(II) a health insurance issuer offering
9 health insurance coverage in connection with
10 the plan,

11 insofar as an act or failure to act of such person
12 constitutes or contributes to the failure to so provide
13 such benefit.

14 “(iii) The term ‘participating’ means, with re-
15 spect to a provider of medical care in relation to a
16 group health plan or health insurance coverage of-
17 fered in connection with a group health plan, a pro-
18 vider that furnishes the items and services compris-
19 ing medical care to participants and beneficiaries
20 under the plan under an agreement with the plan or
21 with a health insurance issuer offering the coverage.

22 “(iv) The provisions of section 733 apply in the
23 same manner and to the same extent as they apply
24 for purposes of part 7.

1 “(C) Remedies under this paragraph are in addition
2 to remedies otherwise provided under this section.”.

3 (2) CONCURRENT JURISDICTION.—Section
4 502(e)(1) of such Act (29 U.S.C. 1132(e)(1)) is
5 amended—

6 (A) in the first sentence, by inserting “and
7 except for actions under subsection (a)(1)(A) of
8 this section for the relief provided in subsection
9 (c)(6) of this section,” after “this section,”; and

10 (B) in the last sentence, by inserting “and
11 under subsection (a)(1)(A) of this section for
12 the relief provided in subsection (c)(6) of this
13 section” after “this section”.

14 (b) INDEMNIFICATION FOR LIABILITY OF PROVIDERS
15 BOUND BY PLAN RESTRICTIONS ON MEDICAL COMMU-
16 NICATIONS.—Section 502 of such Act (29 U.S.C. 1132)
17 is amended further by adding at the end the following new
18 subsection:

19 “(n)(1) In any case in which a group health plan,
20 or a health insurance issuer offering health insurance cov-
21 erage in connection with such plan, provides benefits
22 under such plan under managed care, the plan shall pro-
23 vide for full indemnification of any participating provider
24 of medical care for any liability incurred by such provider
25 for any failure to provide any such benefit in accordance

1 with the terms of the plan or such coverage, if such failure
2 is the direct result of a plan restriction on medical commu-
3 nications under the plan.

4 “(2) For purposes of this subsection—

5 “(A) the term ‘plan restriction on medical com-
6 munications’ under a group health plan means a
7 provision of the plan, or of any health insurance cov-
8 erage offered in connection with the plan, which pro-
9 hibits, restricts, or interferes with any medical com-
10 munication as part of—

11 “(i) a written contract or agreement with
12 a participating provider of medical care,

13 “(ii) a written statement to a participating
14 provider of medical care, or

15 “(iii) an oral communication to a partici-
16 pating provider of medical care.

17 “(B) The term ‘medical communication’—

18 “(i) means any communication made by
19 the provider of medical care—

20 “(I) regarding the mental or physical
21 health care needs or treatment of a patient
22 and the provisions, terms, or requirements
23 of the group health plan or health insur-
24 ance coverage or another plan or coverage
25 relating to such needs or treatment, and

1 “(II) between the provider and a cur-
2 rent, former, or prospective patient (or the
3 guardian or legal representative of a pa-
4 tient), between the provider and any em-
5 ployee or representative of the plan or is-
6 suer, or between the provider and any em-
7 ployee or representative of any State or
8 Federal authority with responsibility for
9 the licensing or oversight with respect to
10 the plan or issuer; and

11 “(ii) includes communications concern-
12 ing—

13 “(I) any tests, consultations, and
14 treatment options,

15 “(II) any risks or benefits associated
16 with such tests, consultations, and options,

17 “(III) variation among any providers
18 of medical care and any institutions pro-
19 viding such services in experience, quality,
20 or outcomes,

21 “(IV) the basis or standard for the
22 decision of a managed care group health
23 plan, or a health insurance issuer offering
24 health insurance coverage in connection

1 with such a plan, to authorize or deny par-
 2 ticular benefits consisting of medical care,
 3 “(V) the process used by the plan or
 4 issuer to determine whether to authorize or
 5 deny particular benefits consisting of medi-
 6 cal care, and

7 “(VI) any financial incentives or dis-
 8 incentives provided by the plan or issuer to
 9 a provider of medical care that are based
 10 on service utilization.

11 “(C) For purposes of this paragraph, the provi-
 12 sions of subsection (c)(6)(B) apply in the same man-
 13 ner and to the same extent as they apply for pur-
 14 poses of subsection (c)(6), and the provisions of sec-
 15 tion 733 apply in the same manner and to the same
 16 extent as they apply for purposes of part 7.”.

17 **SEC. 3. EXCISE TAX FOR COST-DRIVEN VIOLATIONS OF**
 18 **PLAN TERMS.**

19 (a) IN GENERAL.—Chapter 100 of the Internal Reve-
 20 nue Code of 1986 is amended by adding at the end the
 21 following new subchapter:

22 **“Subchapter B—Failure To Provide Health**
 23 **Benefits Due to Improper Cost-Driven**
 24 **Delivery Policy Decisions**

“Sec. 9811. Failure to provide health benefits due to improper
 cost-driven delivery policy decisions.

1 **“SEC. 9811. FAILURE TO PROVIDE HEALTH BENEFITS DUE**
2 **TO IMPROPER COST-DRIVEN DELIVERY POL-**
3 **ICY DECISIONS.**

4 “(a) GENERAL RULE.—In the case of a group health
5 coverage to which this section applies, there is a failure
6 to meet the requirements of this chapter if—

7 “(1) the provider of such coverage fails to pro-
8 vide any benefit in accordance with the terms of the
9 coverage, and

10 “(2) such failure occurs pursuant to a clinically
11 or medically inappropriate decision or determination
12 resulting from the application of—

13 “(A) any cost containment technique,

14 “(B) any utilization review directed at cost
15 containment, or

16 “(C) any other medical care delivery policy
17 decision which restricts the ability of providers
18 of medical care from utilizing their full discre-
19 tion for treatment of patients.

20 “(b) HEALTH COVERAGE PROVIDERS TO WHICH
21 SECTION APPLIES.—This section shall apply to any group
22 health coverage which is provided under managed care.

23 “(c) DEFINITIONS.—For purposes of this section—

24 “(1) GROUP HEALTH COVERAGE.—The term
25 ‘group health coverage’ means—

1 “(A) coverage under any group health
2 plan, and

3 “(B) health insurance coverage provided by
4 a health insurance issuer.

5 “(2) MANAGED CARE.—Group health coverage
6 is provided under managed care if—

7 “(A) such coverage is provided primarily
8 through participating providers of medical care,
9 or

10 “(B) the provider of such coverage pro-
11 vides financial incentives (such as variable co-
12 payments and deductibles) to induce partici-
13 pants and beneficiaries to obtain the benefits
14 primarily through participating providers of
15 medical care,

16 or both.

17 “(3) PROVIDER.—The term ‘provider’ means—

18 “(A) the group health plan in the case of
19 coverage described in paragraph (2)(A), and

20 “(B) the health insurance issuer in the
21 case of coverage described in paragraph (2)(B).

22 “(4) OTHER DEFINITIONS.—The terms ‘group
23 health plan’, ‘health insurance coverage’, and ‘health
24 insurance issuer’ have the respective meanings given
25 such terms by section 9805.”.

1 (b) CONFORMING AMENDMENTS.—

2 (1) Subtitle K of such Code is amended by
 3 striking all that precedes section 9801 and inserting
 4 the following:

5 **“Subtitle K—Group Health Plan**
 6 **Requirements**

“Chapter 100. Group health plan requirements.

7 **“CHAPTER 100—GROUP HEALTH PLAN**
 8 **REQUIREMENTS**

“Subchapter A. Requirements relating to portability, access, and
 renewability.

“Subchapter B. Failure to provide health benefits due to improper
 cost-driven delivery policy decisions.”

9 (2) The table of subtitles for such Code is
 10 amended by striking the item relating to subtitle K
 11 and inserting the following new item:

“Subtitle K. Group health plan requirements.”

12 **SEC. 4. EFFECTIVE DATE.**

13 The amendments made by this Act shall apply with
 14 respect to plan years beginning after on or after January
 15 1, 1998.

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