

105TH CONGRESS
1ST SESSION

H. R. 2967

To amend the title XXVII of the Public Health Service Act and other laws to assure the rights of enrollees under managed care plans.

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 8, 1997

Mr. SCHUMER introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Education and the Workforce, Ways and Means, and Government Reform and Oversight, 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 title XXVII of the Public Health Service Act and other laws to assure the rights of enrollees under managed care plans.

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 “Health Insurance Consumer’s Bill of Rights Act of
6 1997”.

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

Sec. 1. Short title; table of contents.

TITLE I—HEALTH INSURANCE BILL OF RIGHTS

Sec. 101. Health insurance bill of rights.

“PART C—HEALTH INSURANCE BILL OF RIGHTS

“Sec. 2770. Notice; additional definitions.

“SUBPART 1—ACCESS TO PRIMARY CARE PHYSICIANS, SPECIALISTS, OUT OF NETWORK PROVIDERS, EMERGENCY ROOM SERVICES, PRESCRIPTION DRUGS

“Sec. 2771. Access to personnel and facilities; assuring adequate choice of health care professionals.

“Sec. 2772. Access to specialty care.

“Sec. 2773. Access to emergency care.

“Sec. 2774. Coverage for individuals participating in approved clinical trials.

“Sec. 2775. Continuity of care.

“Sec. 2776. Prohibition of interference with certain medical communications.

“Sec. 2777. Access to needed prescription drugs.

“SUBPART 2—UTILIZATION REVIEW, GRIEVANCE, APPEALS, AND QUALITY IMPROVEMENT

“Sec. 2779. Standards for utilization review activities, complaints, and appeals.

“Sec. 2780. Quality improvement program.

“SUBPART 3—NONDISCRIMINATION

“Sec. 2784. Nondiscrimination.

“SUBPART 4—CONFIDENTIALITY

“Sec. 2785. Medical records and confidentiality.

“SUBPART 5—DISCLOSURES

“Sec. 2786. Health prospectus; disclosure of information.

“SUBPART 6—PROMOTING GOOD MEDICAL PRACTICE AND PROTECTING THE DOCTOR-PATIENT RELATIONSHIP

“Sec. 2787. Promoting good medical practice.

TITLE II—APPLICATION OF BILL OF RIGHTS UNDER VARIOUS LAWS

Sec. 201. Amendments to the Public Health Service Act.

Sec. 202. Managed care requirements under the Employee Retirement Income Security Act of 1974.

Sec. 203. Managed care requirements under the Internal Revenue Code of 1986.

Sec. 204. Managed care requirements under medicare, medicaid, and the Federal employees health benefits program (FEHBP).

Sec. 205. Effective dates.

1 **TITLE I—HEALTH INSURANCE**
2 **BILL OF RIGHTS**

3 **SEC. 101. HEALTH INSURANCE BILL OF RIGHTS.**

4 Title XXVII of the Public Health Service Act is
5 amended—

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

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

9 “PART C—HEALTH INSURANCE BILL OF RIGHTS

10 **“SEC. 2770. NOTICE; ADDITIONAL DEFINITIONS.**

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

17 “(b) ADDITIONAL DEFINITIONS.—For purposes of
18 this part:

19 “(1) ENROLLEE.—The term ‘enrollee’ means
20 an individual who is entitled to benefits under a
21 group health plan or under health insurance cov-
22 erage.

23 “(2) HEALTH CARE PROFESSIONAL.—The term
24 ‘health care professional’ means a physician or other

1 health care practitioner providing health care serv-
2 ices.

3 “(3) HEALTH CARE PROVIDER.—The term
4 ‘health care provider’ means a clinic, hospital physi-
5 cian organization, preferred provider organization,
6 independent practice association, community service
7 provider, family planning clinic, or other appro-
8 priately licensed provider of health care services or
9 supplies.

10 “(4) MANAGED CARE.—The term ‘managed
11 care’ means, with respect to a group health plan or
12 health insurance coverage, such a plan or coverage
13 that provides financial incentives for enrollees to ob-
14 tain benefits through participating health care pro-
15 viders or professionals.

16 “(5) NONPARTICIPATING.—The term ‘non-
17 participating’ means, with respect to a health care
18 provider or professional and a group health plan or
19 health insurance coverage, such a provider or profes-
20 sional that is not a participating provider or profes-
21 sional with respect to such services.

22 “(6) PARTICIPATING.—The term ‘participating’
23 means, with respect to a health care provider or pro-
24 fessional and a group health plan or health insur-
25 ance coverage offered by a health insurance issuer,

1 such a provider or professional that has entered into
 2 an agreement or arrangement with the plan or is-
 3 suer with respect to the provision of health care
 4 services to enrollees under the plan or coverage.

5 “(7) PRIMARY CARE PRACTITIONER.—The term
 6 ‘primary care practitioner’ means, with respect to a
 7 group health plan or health insurance coverage of-
 8 fered by a health insurance issuer, a health care pro-
 9 fessional (who may be trained in family practice,
 10 general practice, internal medicine, obstetrics and
 11 gynecology, or pediatrics and who is practicing with-
 12 in the scope of practice authorized by State law)
 13 designated by the plan or issuer to coordinate, su-
 14 pervise, or provide ongoing care to enrollees.

15 “SUBPART 1—ACCESS TO PRIMARY CARE PHYSICIANS,
 16 SPECIALISTS, OUT OF NETWORK PROVIDERS,
 17 EMERGENCY ROOM SERVICES, PRESCRIPTION
 18 DRUGS

19 **“SEC. 2771. ACCESS TO PERSONNEL AND FACILITIES; AS-**
 20 **SURING ADEQUATE CHOICE OF HEALTH**
 21 **CARE PROFESSIONALS.**

22 “A managed care group health plan (and a health
 23 insurance issuer offering managed care group health in-
 24 surance coverage) shall comply with regulations promul-

1 gated by the Secretary that ensure that such plans and
 2 issuers—

3 “(1) have a sufficient number and type of pri-
 4 mary care practitioners and specialists, throughout
 5 the service area to meet the needs of enrollees and
 6 to provide meaningful choice;

7 “(2) maintain a mix of primary care practition-
 8 ers that is adequate to meet the needs of the enroll-
 9 ees’ varied characteristics, including age, gender,
 10 race, and health status; and

11 “(3) include, to the extent possible, a variety of
 12 primary care providers (including community health
 13 centers, rural health clinics, and family planning
 14 clinics).

15 **“SEC. 2772. ACCESS TO SPECIALTY CARE.**

16 “A managed care group health plan (and a health
 17 insurance issuer offering managed care group health in-
 18 surance coverage) shall comply with regulations promul-
 19 gated by the Secretary that ensure that such plans and
 20 issuers provide enrollees with—

21 “(1) access to specialty care;

22 “(2) standing referrals to specialists;

23 “(3) access to nonparticipating providers;

1 “(4) direct access (without the need for a refer-
2 ral) to health care professionals trained in obstetrics
3 and gynecology; and

4 “(5) a process that permits a health care pro-
5 fessional trained in obstetrics and gynecology or
6 other field appropriate to women’s health to be des-
7 ignated and treated as a primary care practitioner.

8 **“SEC. 2773. ACCESS TO EMERGENCY CARE.**

9 “(a) IN GENERAL.—If a group health plan or health
10 insurance coverage provides any benefits with respect to
11 emergency services (as defined in subsection (b)(1)), the
12 plan or the health insurance issuer offering such coverage
13 shall—

14 “(1) provide for emergency services without re-
15 gard to prior authorization or the emergency care
16 provider’s contractual relationship with the organiza-
17 tion; and

18 “(2) comply with such guidelines as the Sec-
19 retary of Health and Human Services may prescribe
20 relating to promoting efficient and timely coordina-
21 tion of appropriate maintenance and post-stabiliza-
22 tion care of an enrollee after the enrollee has been
23 determined to be stable under section 1867 of the
24 Social Security Act.

1 “(b) DEFINITION OF EMERGENCY SERVICES.—In
2 this subsection—

3 “(1) IN GENERAL.—The term ‘emergency serv-
4 ices’ means, with respect to an enrollee under a plan
5 or coverage, inpatient and outpatient services cov-
6 ered under the plan or coverage that—

7 “(A) are furnished by a provider that is
8 qualified to furnish such services under the plan
9 or coverage, and

10 “(B) are needed to evaluate or stabilize an
11 emergency medical condition (as defined in sub-
12 paragraph (B)).

13 “(2) EMERGENCY MEDICAL CONDITION BASED
14 ON PRUDENT LAYPERSON.—The term ‘emergency
15 medical condition’ means a medical condition mani-
16 festing itself by acute symptoms of sufficient sever-
17 ity (including severe pain) such that a prudent
18 layperson, who possesses an average knowledge of
19 health and medicine, could reasonably expect the ab-
20 sence of immediate medical attention to result in—

21 “(A) placing the health of the individual
22 (or, with respect to a pregnant woman, the
23 health of the woman or her unborn child) in se-
24 rious jeopardy,

1 “(B) serious impairment to bodily func-
2 tions, or

3 “(C) serious dysfunction of any bodily
4 organ or part.

5 **“SEC. 2774. COVERAGE FOR INDIVIDUALS PARTICIPATING**
6 **IN APPROVED CLINICAL TRIALS.**

7 “(a) IN GENERAL.—If a group health plan provides
8 benefits, or a health insurance issuer offers health insur-
9 ance coverage to, a qualified enrollee (as defined in sub-
10 section (b)), the plan or issuer—

11 “(1) may not deny the enrollee participation in
12 the clinical trial referred to in subsection (b)(2);

13 “(2) subject to subsection (c), may not deny (or
14 limit or impose additional conditions on) the cov-
15 erage of routine patient costs for items and services
16 furnished in connection with participation in the
17 trial; and

18 “(3) may not discriminate against the enrollee
19 on the basis of the enrollee’s participation in such
20 trial.

21 “(b) QUALIFIED ENROLLEE DEFINED.—For pur-
22 poses of subsection (a), the term ‘qualified enrollee’ means
23 an enrollee who meets the following conditions:

1 “(1) The enrollee has a life-threatening or seri-
2 ous illness for which no standard treatment is effec-
3 tive.

4 “(2) The enrollee is eligible to participate in an
5 approved clinical trial with respect to treatment of
6 such illness.

7 “(3) The enrollee and the referring physician
8 conclude that the enrollee’s participation in such
9 trial would be appropriate.

10 “(4) The enrollee’s participation in the trial of-
11 fers potential for significant clinical benefit for the
12 enrollee.

13 “(c) PAYMENT.—

14 “(1) IN GENERAL.—Under this section a plan
15 or issuer shall provide for payment for routine pa-
16 tient costs described in subsection (a)(2) but is not
17 required to pay for costs of items and services that
18 are reasonably expected (as determined by the Sec-
19 retary) to be paid for by the sponsors of an ap-
20 proved clinical trial.

21 “(2) PAYMENT RATE.—In the case of covered
22 items and services provided by—

23 “(A) a participating provider, the payment
24 rate shall be at the agreed upon rate, or

1 “(B) a nonparticipating provider, the pay-
2 ment rate shall be at the rate the plan or issuer
3 would normally pay for comparable services
4 under subparagraph (A).

5 “(d) APPROVED CLINICAL TRIAL DEFINED.—In this
6 section, the term ‘approved clinical trial’ means a clinical
7 research study or clinical investigation approved by the
8 Food and Drug Administration or approved and funded
9 by one or more of the following:

10 “(1) The National Institutes of Health.

11 “(2) A cooperative group or center of the Na-
12 tional Institutes of Health.

13 “(3) The Department of Veterans Affairs.

14 “(4) The Department of Defense.

15 **“SEC. 2775. CONTINUITY OF CARE.**

16 “A managed care group health plan (and a health
17 insurance issuer offering managed care group health in-
18 surance coverage) shall comply with regulations promul-
19 gated by the Secretary that ensure that such plans and
20 issuers provide continuity of coverage in the case of termi-
21 nated coverage where an enrollee is undergoing a course
22 of treatment with the provider at the time of such termi-
23 nation.

1 **“SEC. 2776. 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 group health plan or health insurance is-
6 suer (offering health insurance coverage in connection
7 with a group health plan) and a health professional shall
8 not prohibit or restrict the health professional from engag-
9 ing in medical communications with his or her patient.

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

13 “(c) MEDICAL COMMUNICATION DEFINED.—For
14 purposes of this section, the term ‘medical communication’
15 has the meaning given such term by the Secretary.

16 **“SEC. 2777. ACCESS TO NEEDED PRESCRIPTION DRUGS.**

17 “If a group health plan, or health insurance issuer
18 offers health insurance coverage that, provides benefits
19 with respect to prescription drugs but the coverage limits
20 such benefits to drugs included in a formulary, the plan
21 or issuer shall ensure in accordance with regulations of
22 the Secretary that—

23 “(1) the nature of the formulary restrictions is
24 fully disclosed to enrollees; and

1 “(2) exceptions from the formulary restriction
2 are provided when medically necessary or appro-
3 priate.

4 “SUBPART 2—UTILIZATION REVIEW, GRIEVANCE,
5 APPEALS, AND QUALITY IMPROVEMENT

6 **“SEC. 2779. STANDARDS FOR UTILIZATION REVIEW ACTIVI-**
7 **TIES, COMPLAINTS, AND APPEALS.**

8 “A group health plan and a health insurance issuer
9 offering health insurance coverage in connection with a
10 group health plan shall comply with standards established
11 by the Secretary relating to its conduct of utilization re-
12 view activities. Such standards shall include the following:

13 “(1) A requirement that a plan or issuer de-
14 velop written policies and criteria concerning utiliza-
15 tion review activities.

16 “(2) A requirement that a plan or issuer pro-
17 vide notice of such policies and criteria and the writ-
18 ten notice of adverse determinations.

19 “(3) A restriction on the use of contingent com-
20 pensation arrangements with providers.

21 “(4) A requirement establishing deadlines to
22 ensure timely utilization review determinations.

23 “(5) The establishment of an adequate process
24 for filing complaints, and appealing decisions, con-
25 cerning utilization review determinations, including

1 the mandatory use of an outside review panel to
2 make decisions on such appeals.

3 “(6) A requirement that a plan or issuer that
4 utilizes clinical practice guidelines uniform apply re-
5 view criteria that are based on sound scientific prin-
6 ciples and the most recent medical evidence.

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

8 “(a) IN GENERAL.—A group health plan and health
9 insurance issuer offering health insurance coverage shall
10 make arrangements for an ongoing quality improvement
11 program for health care services it provides to enrollees.
12 Such a program shall meet standards established by the
13 Secretary, including standards relating to—

14 “(1) the measurement of health outcomes rel-
15 evant to all populations, including women;

16 “(2) evaluation of high risk services;

17 “(3) monitoring utilization, underutilization,
18 and overutilization of services;

19 “(4) ensuring appropriate action to improve
20 quality of care; and

21 “(5) providing for an independent external re-
22 view of the program.

1 “SUBPART 3—NONDISCRIMINATION

2 **“SEC. 2784. NONDISCRIMINATION.**

3 “(a) ENROLLEES.—A group health plan or health in-
4 surance issuer offering health insurance coverage (whether
5 or not a managed care plan or coverage) may not discrimi-
6 nate or engage (directly or through contractual arrange-
7 ments) in any activity, including the selection of service
8 area, that has the effect of discriminating against an indi-
9 vidual on the basis of race, culture, national origin, gen-
10 der, sexual orientation, language, socio-economic status,
11 age, disability, genetic makeup, health status, anticipated
12 need for health care services, or payer source.

13 “(b) PROVIDERS.—Such a plan or issuer may not dis-
14 criminate in the selection of members of the health pro-
15 vider or provider network (and in establishing the terms
16 and conditions for membership in the network) of the plan
17 or coverage based on any of the factors described in sub-
18 section (a).

19 “(c) SERVICES.—Such a plan or issuer may not ex-
20 clude coverage (including procedures and drugs) if the ef-
21 fect is to discriminate in violation of subsection (a) or (b).

1 “SUBPART 4—CONFIDENTIALITY

2 **“SEC. 2785. MEDICAL RECORDS AND CONFIDENTIALITY.**

3 “A managed care group health plan (and a health
4 insurance issuer offering managed care group health in-
5 surance) shall—

6 “(1) establish written policies and procedures
7 for the handling of medical records and enrollee
8 communications to ensure enrollee confidentiality;

9 “(2) ensure the confidentiality of specified en-
10 rollee information, including, prior medical history,
11 medical record information and claims information,
12 except where disclosure of this information is re-
13 quired by law; and

14 “(3) not release any individual patient record
15 information, unless such a release is authorized in
16 writing by the enrollee or otherwise required by law.

17 “SUBPART 5—DISCLOSURES

18 **“SEC. 2786. HEALTH PROSPECTUS; DISCLOSURE OF INFOR-**
19 **MATION.**

20 “(a) DISCLOSURE.—Each group health plan, and
21 each health insurance issuer providing health insurance
22 coverage, shall provide to each enrollee at the time of en-
23 rollment and on an annual basis, and shall make available
24 to each prospective enrollee upon request—

1 “(1) a prospectus that relates to the plan or
2 coverage offered and that meets the requirements of
3 subsection (b); and

4 “(2) additional information described in sub-
5 section (c).

6 “(b) PROSPECTUS.—

7 “(1) IN GENERAL.—Each prospectus under this
8 subsection for a plan or coverage—

9 “(A) shall contain the information de-
10 scribed in paragraphs (2) through (4) concern-
11 ing the plan or coverage,

12 “(B) shall contain such additional informa-
13 tion as the Secretary deems appropriate, and

14 “(C) shall be no longer than 3 pages in
15 length and in a format specified by the Sec-
16 retary for purposes of comparison by prospec-
17 tive enrollees.

18 “(2) QUALITATIVE INFORMATION.—The infor-
19 mation described in this paragraph is a summary of
20 the quality assessment data on the plan or coverage.
21 The data shall—

22 “(A) be the similar to the types of data as
23 are collected for managed care plans under title
24 XVIII of the Social Security Act, as determined
25 by the Secretary and taking into account dif-

ferences between the populations covered under such title and the populations covered under this title;

“(B) be collected by independent, auditing agencies;

“(C) include—

“(i) a description of the types of methodologies (including capitation, financial incentive or bonuses, fee-for-service, salary, and withholds) used by the plan or issuer to reimburse physicians, including the proportions of physicians who have each of these types of arrangements; and

“(ii) cost-sharing requirements for enrollees.

The information under subparagraph (C) shall include, upon request, information on the reimbursement methodology used by the plan or issuer or medical groups for individual physicians, but do not require the disclosure of specific reimbursement rates.

“(3) QUANTITATIVE INFORMATION.—The information described in this paragraph is measures of performance of the plan or issuer (in relation to coverage offered) with respect to each of the following

1 and such other salient data as the Secretary may
2 specify:

3 “(A) The ratio of physicians to enrollees,
4 including the ratio of physicians who are obstetrician/gynecologists to adult, female enrollees.

6 “(B) The ratio of specialists to enrollees.

7 “(C) The incentive structure used for pay-
8 ment of primary care physicians and specialists.

9 “(D) Patient outcomes for procedures, in-
10 cluding procedures specific to female enrollees.

11 “(E) The number of grievances filed under
12 the plan or coverage.

13 “(F) The number of requests for proce-
14 dures for which utilization review board review
15 or approval is required and the number (and
16 percentage) of such requests that are denied.

17 “(G) The number of appeals filed from de-
18 nial of such requests and the number (and per-
19 centage) of such appeals that are approved,
20 such numbers and percentages broken down by
21 gender of the enrollee involved.

22 “(H) Disenrollment data.

23 “(4) DESCRIPTION OF BENEFITS.—The infor-
24 mation described in this paragraph is a description
25 of the benefits provided under the plan or coverage,

1 as well as explicit exclusions, including a description
2 of the following:

3 “(A) Coverage policy with respect to cov-
4 erage for female-specific benefits, including
5 screening mammography, hormone replacement
6 therapy, bone density testing, osteoporosis
7 screening, maternity care, and reconstructive
8 surgery following a mastectomy.

9 “(B) The costs of copayments for treat-
10 ments, including any exceptions.

11 “(c) ADDITIONAL INFORMATION.—The additional in-
12 formation described in this subsection is information
13 about each of the following:

14 “(1) The plan’s or issuer’s structure and pro-
15 vider network, including the names and credentials
16 of physicians in the network.

17 “(2) Coverage provided and excluded, including
18 out-of-area coverage.

19 “(3) Procedures for utilization management.

20 “(4) Procedures for determining coverage for
21 investigational or experimental treatments, as well
22 as definitions for coverage terms.

23 “(5) Any restrictive formularies or prior ap-
24 proval requirements for obtaining prescription drugs,

1 including, upon request, information on whether or
2 not specific drugs are covered.

3 “(6) Use of voluntary or mandatory arbitration.

4 “(7) Procedures for receiving emergency care
5 and out-of-network services when those services are
6 not available in the network and information on the
7 coverage of emergency services, including—

8 “(A) the appropriate use of emergency
9 services, including use of the 911 telephone sys-
10 tem or its local equivalent in emergency situa-
11 tions and an explanation of what constitutes an
12 emergency situation;

13 “(B) the process and procedures for ob-
14 taining emergency services; and

15 “(C) the locations of (i) emergency depart-
16 ments, and (ii) other settings, in which physi-
17 cians and hospitals provide emergency services
18 and post-stabilization care.

19 “(8) How to contact agencies that regulate the
20 plan or issuer.

21 “(9) How to contact consumer assistance agen-
22 cies, such as ombudsmen programs.

23 “(10) How to obtain covered services.

24 “(11) How to receive preventive health services
25 and health education.

1 “(12) How to select providers and obtain refer-
2 rals.

3 “(13) How to appeal health plan decisions and
4 file grievances.

5 “(d) STATE AUTHORITY TO REQUIRE ADDITIONAL
6 INFORMATION.—

7 “(1) IN GENERAL.—Subject to paragraph (2),
8 this section shall not be construed as preventing a
9 State from requiring health insurance issuers, in re-
10 lation to their offering of health insurance coverage,
11 to disclose separately information (including com-
12 parative ratings of health insurance coverage) in ad-
13 dition to the information required to be disclosed
14 under this section.

15 “(2) CONTINUED PREEMPTION WITH RESPECT
16 TO GROUP HEALTH PLANS.—Nothing in this part
17 shall be construed to affect or modify the provisions
18 of section 514 with respect to group health plans.

19 “SUBPART 6—PROMOTING GOOD MEDICAL PRACTICE
20 AND PROTECTING THE DOCTOR-PATIENT RELATIONSHIP
21 **“SEC. 2787. PROMOTING GOOD MEDICAL PRACTICE.**

22 “(a) PROHIBITING ARBITRARY LIMITATIONS OR
23 CONDITIONS FOR THE PROVISION OF SERVICES.—A
24 group health plan and a health insurance issuer, in con-
25 nection with the provision of health insurance coverage,

1 may not impose limits on the manner in which particular
 2 services are delivered if the services are medically nec-
 3 essary or appropriate to the extent that such procedure
 4 or treatment is otherwise a covered benefit.

5 “(b) CONSTRUCTION.—Subsection (a) shall not be
 6 construed as requiring coverage of particular services the
 7 coverage of which is otherwise not covered under the terms
 8 of the coverage.”.

9 **TITLE II—APPLICATION OF BILL** 10 **OF RIGHTS UNDER VARIOUS** 11 **LAWS**

12 **SEC. 201. AMENDMENTS TO THE PUBLIC HEALTH SERVICE** 13 **ACT.**

14 (a) APPLICATION TO GROUP HEALTH INSURANCE
 15 COVERAGE.—Subpart 2 of part A of title XXVII of the
 16 Public Health Service Act is amended by adding at the
 17 end the following new section:

18 **“SEC. 2706. MANAGED CARE REQUIREMENTS.**

19 “Each health insurance issuer shall comply with the
 20 applicable requirements under part C with respect to
 21 group health insurance coverage it offers.”.

22 (b) APPLICATION TO INDIVIDUAL HEALTH INSUR-
 23 ANCE COVERAGE.—Part B of title XXVII of the Public
 24 Health Service Act is amended by inserting after section
 25 2751 the following new section:

1 **“SEC. 2752. MANAGED CARE REQUIREMENTS.**

2 “Each health insurance issuer shall comply with the
3 applicable requirements under part C with respect to indi-
4 vidual health insurance coverage it offers, in the same
5 manner as such requirements apply to group health insur-
6 ance coverage.”.

7 (c) MODIFICATION OF PREEMPTION STANDARDS.—

8 (1) GROUP HEALTH INSURANCE COVERAGE.—

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

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

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

16 (C) by inserting after subsection (b) the
17 following new subsection:

18 “(c) SPECIAL RULES IN CASE OF MANAGED CARE
19 REQUIREMENTS.—Subject to subsection (a)(2), the provi-
20 sions of section 2706 and part C, and part D insofar as
21 it applies to section 2706 or part C, shall not prevent a
22 State from establishing requirements relating to the sub-
23 ject matter of such provisions so long as such require-
24 ments are at least as stringent on health insurance issuers
25 as the requirements imposed under such provisions.”.

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

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

8 (B) by adding at the end the following new
9 subsection:

10 “(c) SPECIAL RULES IN CASE OF MANAGED CARE
11 REQUIREMENTS.—Subject to subsection (b), the provi-
12 sions of section 2752 and part C, and part D insofar as
13 it applies to section 2752 or part C, shall not prevent a
14 State from establishing requirements relating to the sub-
15 ject matter of such provisions so long as such require-
16 ments are at least as stringent on health insurance issuers
17 as the requirements imposed under such section.”.

18 (d) ADDITIONAL CONFORMING AMENDMENTS.—

19 (1) Section 2723(a)(1) of such Act (42 U.S.C.
20 300gg-23(a)(1)) is amended by striking “part C”
21 and inserting “parts C and D”.

22 (2) Section 2762(b)(1) of such Act (42 U.S.C.
23 300gg-62(b)(1)) is amended by striking “part C”
24 and inserting “part D”.

1 (e) ASSURING COORDINATION.—Section 104(1) of
 2 the Health Insurance Portability and Accountability Act
 3 of 1996 (Public Law 104–191) is amended by striking
 4 “under this subtitle (and the amendments made by this
 5 subtitle and section 401)” and inserting “title XXVII of
 6 the Public Health Service Act, under part 7 of subtitle
 7 B of title I of the Employee Retirement Income Security
 8 Act of 1974, and chapter 100 of the Internal Revenue
 9 Code of 1986”.

10 **SEC. 202. MANAGED CARE REQUIREMENTS UNDER THE EM-**
 11 **PLOYEE RETIREMENT INCOME SECURITY**
 12 **ACT OF 1974.**

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

17 **“SEC. 713. MANAGED CARE REQUIREMENTS.**

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

23 “(b) REFERENCES IN APPLICATION.—In applying
 24 subsection (a) under this part, any reference in such part
 25 C—

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

5 “(2) to the Secretary is deemed a reference to
 6 the Secretary of Labor;

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

9 “(4) to an enrollee with respect to health insur-
 10 ance coverage is deemed to include a reference to a
 11 participant or beneficiary with respect to a group
 12 health plan.”.

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

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

17 (2) by redesignating subsections (c) and (d) as
 18 subsections (d) and (e), respectively; and

19 (3) by inserting after subsection (b) the follow-
 20 ing new subsection:

21 “(c) SPECIAL RULES IN CASE OF MANAGED CARE
 22 REQUIREMENTS.—Subject to subsection (a)(2), the provi-
 23 sions of section 713 and part C of title XXVII of the Pub-
 24 lic Health Service Act, and subpart C insofar as it applies
 25 to section 713 or such part, shall not be construed to pre-

1 empt any State law, or the enactment or implementation
 2 of such a State law, that provides protections for individ-
 3 uals that are equivalent to or stricter than the protections
 4 provided under such provisions.”.

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

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

“Sec. 713. Managed care requirements.”.

11 **SEC. 203. MANAGED CARE REQUIREMENTS UNDER THE IN-**
 12 **TERNAL REVENUE CODE OF 1986.**

13 (a) IN GENERAL.—Subchapter B of part B of part
 14 7 of subtitle B of title I of the Employee Retirement In-
 15 come Security Act of 1974 is amended by adding at the
 16 end the following new section:

17 **“SEC. 9813. MANAGED CARE REQUIREMENTS.**

18 “(a) IN GENERAL.—Subject to subsection (b), a
 19 group health plan shall comply with the applicable require-
 20 ments of part C of title XXVII of the Public Health Serv-
 21 ice Act.

22 “(b) REFERENCES IN APPLICATION.—In applying
 23 subsection (a) under this subchapter, any reference in
 24 such part C—

1 “(1) to the Secretary is deemed a reference to
2 the Secretary of the Treasury; and

3 “(2) to an applicable State authority is deemed
4 a reference to the Secretary.”.

5 (b) CLERICAL AMENDMENT.—The table of sections
6 in subchapter B of chapter 100 of such Code is amended
7 by inserting after the item relating to section 9812 the
8 following new item:

“Sec. 9813. Managed care requirements.”.

9 **SEC. 204. MANAGED CARE REQUIREMENTS UNDER MEDI-**
10 **CARE, MEDICAID, AND THE FEDERAL EM-**
11 **PLOYEES HEALTH BENEFITS PROGRAM**
12 **(FEHBP).**

13 (a) MEDICARE.—Section 1852 of the Social Security
14 Act (42 U.S.C. 1395w–22), as inserted by section 4001
15 of the Balanced Budget Act of 1997 (Public Law 101–
16 33), is amended by adding at the end the following new
17 subsection:

18 “(1) MANAGED CARE REQUIREMENTS.—Each
19 Medicare+Choice organization that offers a
20 Medicare+Choice plan described in section 1851(a)(1)(A)
21 shall comply with the applicable requirements of part C
22 of title XXVII of the Public Health Service Act in the
23 same manner as such requirements apply with respect to
24 health insurance coverage offered by a health insurance
25 issuer, except to the extent such requirements are less pro-

1 tective of enrollees than the requirements established
2 under this part.”.

3 (b) MEDICAID.—Section 1932(b)(8) of the Social Se-
4 curity Act, as added by section 4704(a) of the Balanced
5 Budget Act of 1997, is amended—

6 (1) by striking “AND MENTAL HEALTH” and in-
7 serting “, MENTAL HEALTH, AND MANAGED CARE”,

8 (2) by inserting “and of part C” after “of part
9 A”, and

10 (3) by inserting before the period at the end the
11 following: “, except to the extent such requirements
12 are less protective of enrollees than the requirements
13 established under this title”.

14 (c) FEDERAL EMPLOYEES’ HEALTH BENEFITS PRO-
15 GRAM (FEHBP).—Chapter 89 of title 5, United States
16 Code, is amended—

17 (1) by inserting after the item relating to sec-
18 tion 8905a the following new section:

19 **“§ 8905b. Application of managed care requirements**

20 “Each health benefit plan offered under this chapter
21 shall comply with the applicable requirements of part C
22 of title XXVII of the Public Health Service Act in the
23 same manner as such requirements apply with respect to
24 health insurance coverage offered by a health insurance
25 issuer, except to the extent such requirements are less pro-

1 tective of enrollees than the requirements established
 2 under this chapter.”; and

3 (2) in the table of sections, by inserting the fol-
 4 lowing item after the item relating to section 8905a:
 “8905b. Application of managed care requirements.”.

5 **SEC. 205. EFFECTIVE DATES.**

6 (a) GENERAL EFFECTIVE DATE FOR GROUP
 7 HEALTH PLANS.—

8 (1) IN GENERAL.—Subject to paragraph (2),
 9 the amendments made by section 101, subsections
 10 (a), (c)(1), and (d) of section 201, and sections 203
 11 and 204 shall apply with respect to group health in-
 12 surance coverage for group health plan years begin-
 13 ning on or after July 1, 1998 (in this section re-
 14 ferred to as the “general effective date”) and also
 15 shall apply to portions of plan years occurring on
 16 and after January 1, 1999.

17 (2) TREATMENT OF GROUP HEALTH PLANS
 18 MAINTAINED PURSUANT TO CERTAIN COLLECTIVE
 19 BARGAINING AGREEMENTS.—In the case of a group
 20 health plan, or group health insurance coverage pro-
 21 vided pursuant to a group health plan, maintained
 22 pursuant to 1 or more collective bargaining agree-
 23 ments between employee representatives and 1 or
 24 more employers ratified before the date of enactment
 25 of this Act, the amendments described in paragraph

1 (1) shall not apply to plan years beginning before
2 the later of—

3 (A) the date on which the last collective
4 bargaining agreements relating to the plan ter-
5 minates (determined without regard to any ex-
6 tension thereof agreed to after the date of en-
7 actment of this Act), or

8 (B) the general effective date.

9 For purposes of subparagraph (A), any plan amend-
10 ment made pursuant to a collective bargaining
11 agreement relating to the plan which amends the
12 plan solely to conform to any requirement added by
13 such amendments shall not be treated as a termi-
14 nation of such collective bargaining agreement.

15 (b) GENERAL EFFECTIVE DATE FOR HEALTH IN-
16 SURANCE COVERAGE.—The amendments made by section
17 101 and subsections (b), (c)(2), and (d) of section 201
18 shall apply with respect to individual health insurance cov-
19 erage offered, sold, issued, renewed, in effect, or operated
20 in the individual market on or after the general effective
21 date.

22 (c) EFFECTIVE DATE FOR COORDINATION.—The
23 amendment made by section 201(e) shall take effect on
24 the date of the enactment of this Act.

1 (d) FEDERAL PROGRAMS.—The amendments made
2 by section 204 shall take effect on January 1, 1999.

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