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105TH CONGRESS
2D SESSION

H. R. 4202

To amend title XXVII of the Public Health Service Act to establish certain standards with respect to health plans.

IN THE HOUSE OF REPRESENTATIVES

JULY 14, 1998

Mr. ENSIGN introduced the following bill; which was referred to the Committee on Commerce

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A BILL

To amend title XXVII of the Public Health Service Act to establish certain standards with respect to health plans.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Quality and Fairness Act of 1998''.

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

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

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

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

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

''PART C—PATIENT PROTECTION STANDARDS

''SEC. 2770. NOTICE.

''A health insurance issuer under this part shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of this part as if such section applied to such issuer and such issuer were a group health plan.

''SEC. 2771. COVERAGE OF SERVICES.

''(a) IN GENERAL.—If a health insurance issuer offering health insurance coverage provides benefits with respect to a service, and a physician recommends such service for an enrollee, the issuer shall cover any service furnished under the coverage unless a physician who has reviewed the notes of the attending physician and any medi-

cal records of the enrollee determines that such services should not be covered.

''(b) WRITTEN DENIAL OF COVERAGE.—In a case in which a health insurance issuer denies coverage of a service to an enrollee, issuer shall provide, in writing, to the enrollee, the physician who recommended such service, and the primary physician of the enrollee—

''(1) the reasons for the denial of coverage;

''(2) the criteria used to determine whether to authorize or deny coverage; and

''(3) the right of the enrollee to file a written grievance.

''SEC. 2772. ACCESS TO EMERGENCY CARE.

''(a) COVERAGE OF EMERGENCY SERVICES.—

''(1) IN GENERAL.—If health insurance coverage provides any benefits with respect to emergency services (as defined in paragraph (2)(B)), the plan or issuer shall cover emergency services furnished under the plan or coverage—

''(A) without the need for any prior authorization determination;

''(B) whether or not the physician or provider furnishing such services is a participating physician or provider with respect to such services; and

"(C) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of the Public Health Service Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost sharing).

"(2) DEFINITIONS.—In this section:

"(A) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON STANDARD.—The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

"(B) EMERGENCY SERVICES.—The term 'emergency services' means health care items and services that are necessary for the diag-

nosis, treatment, and stabilization of an emergency medical condition.

"SEC. 2773. PROTECTING THE DOCTOR-PATIENT RELATIONSHIP.

"(a) PROHIBITION ON RESTRICTING COMMUNICATION.—A health insurance issuer offering health insurance coverage may not restrict or interfere with any communication between a health care professional and an enrollee with respect to information that the health care professional determines is relevant to the health care of the enrollee.

"(b) PROHIBITION ON FINANCIAL INCENTIVES.—A health insurance issuer offering health insurance coverage may not offer or pay any financial incentive to a provider of health care services to deny, reduce, withhold, limit, or delay services to an enrollee.

"(c) PROHIBITION ON RETALIATION.—A health insurance issuer offering health insurance coverage may not terminate a contract, demote, refuse to contract with, or refuse to compensate a health care professional because the professional—

"(1) advocates on behalf of an enrollee;

"(2) assists an enrollee in seeking reconsideration of a decision by the issuer to deny coverage for a service; or

''(3) reports a violation of law to an appropriate authority.

''SEC. 2774. QUALITY ASSURANCE.

''(a) REQUIREMENT.—A health insurance issuer offering health insurance coverage shall establish and maintain an ongoing quality assurance program that meets the requirements of subsection (b).

''(b) PROGRAM REQUIREMENTS.—The requirements of this subsection for a quality assurance program of an issuer are as follows:

''(1) ADMINISTRATION.—The issuer has an identifiable unit with responsibility for administration of the program.

''(2) WRITTEN PLAN.—The issuer has a written plan, developed in consultation with health care professionals, that is updated annually and that specifies at least the following:

''(A) Criteria and procedures for the assessment of quality.

''(B) Criteria and procedures for determining coverage of services.

''(3) REVIEW.—The program provides for systematic review of the following:

''(A) Outcomes of health care services;

''(B) Peer review;

''(C) A system to collect and maintain information related to the health care services provided to enrollees;

''(D) Guidelines for action when problems related to quality of care are identified.

''SEC. 2775. DESIGNATION OF PRIMARY CARE PROVIDER.

''If a health insurance issuer offering health insurance coverage requires or provides for an enrollee to designate a participating primary care provider—

''(1) the issuer shall permit a female enrollee to designate an obstetrician-gynecologist who has agreed to be designated as such, as the enrollee's primary care provider; and

''(2) the issuer shall permit the enrollee to designate a physician who specializes in pediatrics as the primary care provider for a child of such enrollee.

''SEC. 2776. GRIEVANCE AND APPEALS PROCEDURES.

''(a) ESTABLISHMENT OF GRIEVANCE SYSTEM.—A health insurance issuer, in connection with the provision of health insurance coverage, shall establish and maintain a system to provide for the presentation and resolution of oral and written grievances brought by enrollees. The system shall include grievances regarding—

''(1) payment or reimbursement for covered services;

''(2) availability, delivery, and quality of services; and

''(3) terms and conditions of the plan or coverage.

''(b) GENERAL ELEMENTS.—The system shall include—

''(1) the general components described in subsection (c); and

''(2) a process for appeals of adverse denials of benefits—

''(A) through an internal appeal process;

''(B) through an external appeal process; and

''(C) through a process for expediting review of the internal appeals process.

''(c) COMPONENTS OF THE SYSTEM.—Such system shall include the following components with respect individuals who are enrollees:

''(1) The availability of a services representative to assist such individuals, as requested, with the grievance procedures.

''(2) A system to record and document, over a period of at least 3 years, all grievances made and their status.

''(3) A process providing for timely processing and resolution of grievances.

''(d) INTERNAL APPEALS PROCESS.—

''(1) IN GENERAL.—Each health insurance issuer shall establish and maintain an internal appeals process under which any enrollee, or provider acting on behalf of such an individual with the individual's consent, who is dissatisfied with the results of the issuer has the opportunity to appeal the results before a review panel.

''(2) DEADLINE.—

''(A) IN GENERAL.—The issuer shall conclude each appeal as soon as possible after the time of the receipt of the appeal in accordance with medical exigencies of the case involved, but in no event later than—

''(i) 72 hours after the time of receipt of the appeal in the case of appeals from decisions regarding urgent care, and

''(ii) 30 business days after such time in the case of all other appeals.

''(3) NOTICE.—If an issuer denies an appeal, the issuer shall provide the enrollee and provider involved with written notification of the denial and the reasons therefor, together with a written notification of rights to any further appeal.

''(e) EXTERNAL APPEALS PROCESS.—A health insurance issuer offering group health insurance coverage, shall provide for an external appeals process which may be used upon completion of the internal review process under subsection (d). The process shall be conducted consistent with standards established by the Secretary.

''(f) EXPEDITED REVIEW PROCESS.—A health insurance issuer shall establish written procedures for the expedited consideration of appeals in situations in which the timeframe of a standard appeal under the respective subsection has reasonable potential to jeopardize seriously the life or health of the participant, beneficiary, or enrollee involved or has reasonable potential to jeopardize such an individual's ability to regain maximum function.

''SEC. 2777. UNDERSTANDABILITY OF INFORMATION.

''Information provided to or made available to enrollees under this part, whether written or oral, shall be easily understandable by an average layperson, with respect to the terms used.''.

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

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