

105TH CONGRESS
1ST SESSION

S. 1499

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 9, 1997

Mrs. BOXER introduced the following bill; which was referred to the Committee on Labor and Human Resources

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 vider trained in obstetrics and gynecology to be des-
 6 ignated and treated as a primary care practitioner.

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

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

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

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

24 “(b) DEFINITION OF EMERGENCY SERVICES.—In
 25 this subsection—

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

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

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

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

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

23 “(B) serious impairment to bodily func-
 24 tions, or

1 “(C) serious dysfunction of any bodily
2 organ or part.

3 **“SEC. 2774. COVERAGE FOR INDIVIDUALS PARTICIPATING**
4 **IN APPROVED CLINICAL TRIALS.**

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

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

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

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

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

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

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

4 “(3) The enrollee and the referring physician
5 conclude that the enrollee’s participation in such
6 trial would be appropriate.

7 “(4) The enrollee’s participation in the trial of-
8 fers potential for significant clinical benefit for the
9 enrollee.

10 “(c) PAYMENT.—

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

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

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

22 “(B) a nonparticipating provider, the pay-
23 ment rate shall be at the rate the plan or issuer
24 would normally pay for comparable services
25 under subparagraph (A).

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

6 “(1) The National Institutes of Health.

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

9 “(3) The Department of Veterans Affairs.

10 “(4) The Department of Defense.

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

12 “A managed care group health plan (and a health
 13 insurance issuer offering managed care group health in-
 14 surance coverage) shall comply with regulations promul-
 15 gated by the Secretary that ensure that such plans and
 16 issuers provide continuity of coverage in the case of the
 17 terminated coverage where an enrollee is undergoing a
 18 course of treatment with the provider at the time of such
 19 termination.

20 **“SEC. 2776. PROHIBITION OF INTERFERENCE WITH CER-**
 21 **TAIN MEDICAL COMMUNICATIONS.**

22 “(a) IN GENERAL.—The provisions of any contract
 23 or agreement, or the operation of any contract or agree-
 24 ment, between a group health plan or health insurance is-
 25 suer (offering health insurance coverage in connection

1 with a group health plan) and a health professional shall
 2 not prohibit or restrict the health professional from engag-
 3 ing in medical communications with his or her patient.

4 “(b) NULLIFICATION.—Any contract provision or
 5 agreement described in subsection (a) shall be null and
 6 void.

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

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

11 “If a group health plan, or health insurance issuer
 12 offers health insurance coverage that, provides benefits
 13 with respect to prescription drugs but the coverage limits
 14 such benefits to drugs included in a formulary, the plan
 15 or issuer shall ensure in accordance with regulations of
 16 the Secretary that—

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

19 “(2) exceptions from the formulary restriction
 20 are provided when medically necessary or appro-
 21 priate.

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

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

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

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

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

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

18 “(4) A requirement establishing deadlines to
19 ensure timely utilization review determinations.

20 “(5) The establishment of an adequate process
21 for filing complaints, and appealing decisions, con-
22 cerning utilization review determinations, including
23 the mandatory use of an outside review panel to
24 make decisions on such appeals.

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

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

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

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

14 “(2) evaluation of high risk services;

15 “(3) monitoring utilization of services;

16 “(4) ensuring appropriate action to improve
 17 quality of care; and

18 “(5) providing for an independent external re-
 19 view of the program

20 “SUBPART 3—NONDISCRIMINATION

21 **“SEC. 2784. NONDISCRIMINATION.**

22 “(a) ENROLLEES.—A group health plan or health in-
 23 surance issuer offering health insurance coverage (whether
 24 or not a managed care plan or coverage) may not discrimi-
 25 nate or engage (directly or through contractual arrange-

1 ments) in any activity, including the selection of service
 2 area, that has the effect of discriminating against an indi-
 3 vidual on the basis of race, culture, national origin, gen-
 4 der, sexual orientation, language, socioeconomic status,
 5 age, disability, genetic makeup, health status, payer
 6 source, or anticipated need for healthcare services.

7 “(b) PROVIDERS.—Such a plan or issuer may not dis-
 8 criminate in the selection of members of the health pro-
 9 vider or provider network (and in establishing the terms
 10 and conditions for membership in the network) of the plan
 11 or coverage based on any of the factors described in sub-
 12 section (a).

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

16 “SUBPART 4—CONFIDENTIALITY

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

18 “A managed care group health plan (and a health
 19 insurance issuer offering managed care group health in-
 20 surance) shall—

21 “(1) establish written policies and procedures
 22 for the handling of medical records and enrollee
 23 communications to ensure enrollee confidentiality;

24 “(2) ensure the confidentiality of specified en-
 25 rollee information, including, prior medical history,

1 medical record information and claims information,
 2 except where disclosure of this information is re-
 3 quired by law; and

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

7 “SUBPART 5—DISCLOSURES

8 **“SEC. 2786. HEALTH PROSPECTUS; DISCLOSURE OF INFOR-**
 9 **MATION.**

10 “(a) DISCLOSURE.—Each group health plan, and
 11 each health insurance issuer providing health insurance
 12 coverage, shall provide to each enrollee at the time of en-
 13 rollment and on an annual basis, and shall make available
 14 to each prospective enrollee upon request—

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

18 “(2) additional information described in sub-
 19 section (c).

20 “(b) PROSPECTUS.—

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

23 “(A) shall contain the information de-
 24 scribed in paragraphs (2) through (4) concern-
 25 ing the plan or coverage,

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

3 “(C) shall be no longer than 3 pages in
 4 length and in a format specified by the Sec-
 5 retary, for purposes of comparison by prospec-
 6 tive enrollees.

7 “(2) QUALITATIVE INFORMATION.—The infor-
 8 mation described in this paragraph is a summary of
 9 the quality assessment data on the plan or coverage.
 10 The data shall—

11 “(A) be the similar to the types of data as
 12 are collected for managed care plans under title
 13 XVIII of the Social Security Act, as determined
 14 by the Secretary and taking into account dif-
 15 ferences between the populations covered under
 16 such title and the populations covered under
 17 this title;

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

20 “(C) include—

21 “(i) a description of the types of
 22 methodologies (including capitation, finan-
 23 cial incentive or bonuses, fee-for-service,
 24 salary, and withholds) used by the plan or
 25 issuer to reimburse physicians, including

1 the proportions of physicians who have
2 each of these types of arrangements; and
3 “(ii) cost-sharing requirements for en-
4 rollees.

5 The information under subparagraph (C) shall in-
6 clude, upon request, information on the reimburse-
7 ment methodology used by the plan or issuer or
8 medical groups for individual physicians, but do not
9 require the disclosure of specific reimbursement
10 rates.

11 “(3) QUANTITATIVE INFORMATION.—The infor-
12 mation described in this paragraph is measures of
13 performance of the plan or issuer (in relation to cov-
14 erage offered) with respect to each of the following
15 and such other salient data as the Secretary may
16 specify:

17 “(A) The ratio of physicians to enrollees,
18 including the ratio of physicians who are obste-
19 trician/gynecologists to adult, female enrollees.

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

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

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

1 “(E) The number of grievances filed under
2 the plan or coverage.

3 “(F) The number of requests for proce-
4 dures for which utilization review board review
5 or approval is required and the number (and
6 percentage) of such requests that are denied.

7 “(G) The number of appeals filed from de-
8 nial of such requests and the number (and per-
9 centage) of such appeals that are approved,
10 such numbers and percentages broken down by
11 gender of the enrollee involved.

12 “(H) Disenrollment data.

13 “(3) DESCRIPTION OF BENEFITS.—The infor-
14 mation described in this paragraph is a description
15 of the benefits provided under the plan or coverage,
16 as well as explicit exclusions, including a description
17 of the following:

18 “(A) Coverage policy with respect to cov-
19 erage for female-specific benefits, including
20 screening mammography, hormone replacement
21 therapy, bone density testing, osteoporosis
22 screening, maternity care, and reconstructive
23 surgery following a mastectomy.

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

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

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

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

9 “(3) Procedures for utilization management.

10 “(4) Procedures for determining coverage for
11 investigational or experimental treatments as well as
12 definitions for coverage terms.

13 “(5) Any restrictive formularies or prior ap-
14 proval requirements for obtaining prescription drugs,
15 including, upon request, information on whether or
16 not specific drugs are covered.

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

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

22 “(A) the appropriate use of emergency
23 services, including use of the 911 telephone sys-
24 tem or its local equivalent in emergency situa-

1 tions and an explanation of what constitutes an
2 emergency situation;

3 “(B) the process and procedures for ob-
4 taining emergency services; and

5 “(C) the locations of (i) emergency depart-
6 ments, and (ii) other settings, in which physi-
7 cians and hospitals provide emergency services
8 and post-stabilization care.

9 “(8) How to contact agencies that regulate the
10 plan or issuer.

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

13 “(10) How to obtain covered services.

14 “(11) How to receive preventive health services
15 and health education.

16 “(12) How to select providers and obtain refer-
17 rals.

18 “(13) How to appeal health plan decisions and
19 file grievances.

20 “(d) STATE AUTHORITY TO REQUIRE ADDITIONAL
21 INFORMATION.—

22 “(1) IN GENERAL.—Subject to paragraph (2),
23 this section shall not be construed as preventing a
24 State from requiring health insurance issuers, in re-
25 lation to their offering of health insurance coverage,

1 to disclose separately information (including com-
 2 parative ratings of health insurance coverage) in ad-
 3 dition to the information required to be disclosed
 4 under this section.

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

9 “SUBPART 6—PROMOTING GOOD MEDICAL PRACTICE
 10 AND PROTECTING THE DOCTOR-PATIENT RELATIONSHIP
 11 **“SEC. 2787. PROMOTING GOOD MEDICAL PRACTICE.**

12 “(a) PROHIBITING ARBITRARY LIMITATIONS OR
 13 CONDITIONS FOR THE PROVISION OF SERVICES.—A
 14 group health plan and a health insurance issuer, in con-
 15 nection with the provision of health insurance coverage,
 16 may not impose limits on the manner in which particular
 17 services are delivered if the services are medically nec-
 18 essary or appropriate to the extent that such procedure
 19 or treatment is otherwise a covered benefit.

20 “(b) CONSTRUCTION.—Subsection (a) shall not be
 21 construed as requiring coverage of particular services the
 22 coverage of which is otherwise not covered under the terms
 23 of the coverage.”.

1 **TITLE II—APPLICATION OF BILL**
 2 **OF RIGHTS UNDER VARIOUS**
 3 **LAWS**

4 **SEC. 201. AMENDMENTS TO THE PUBLIC HEALTH SERVICE**
 5 **ACT.**

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

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

11 “Each health insurance issuer shall comply with the
 12 applicable requirements under part C with respect to
 13 group health insurance coverage it offers.”.

14 (b) APPLICATION TO INDIVIDUAL HEALTH INSUR-
 15 ANCE COVERAGE.—Part B of title XXVII of the Public
 16 Health Service Act is amended by inserting after section
 17 2751 the following new section:

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

19 “Each health insurance issuer shall comply with the
 20 applicable requirements under part C with respect to indi-
 21 vidual health insurance coverage it offers, in the same
 22 manner as such requirements apply to group health insur-
 23 ance coverage.”.

24 (c) MODIFICATION OF PREEMPTION STANDARDS.—

1 (1) GROUP HEALTH INSURANCE COVERAGE.—
 2 Section 2723 of such Act (42 U.S.C. 300gg–23) is
 3 amended—

4 (A) in subsection (a)(1), by striking “sub-
 5 section (b)” and inserting “subsections (b) and
 6 (c)”;

7 (B) by redesignating subsections (c) and
 8 (d) as subsections (d) and (e), respectively; and

9 (C) by inserting after subsection (b) the
 10 following new subsection:

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

19 (2) INDIVIDUAL HEALTH INSURANCE COV-
 20 ERAGE.—Section 2762 of such Act (42 U.S.C.
 21 300gg–62), as added by section 605(b)(3)(B) of
 22 Public Law 104–204, is amended—

23 (A) in subsection (a), by striking “sub-
 24 section (b), nothing in this part” and inserting
 25 “subsections (b) and (c)”, and

1 (B) by adding at the end the following new
 2 subsection:

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

11 (d) ADDITIONAL CONFORMING AMENDMENTS.—

12 (1) Section 2723(a)(1) of such Act (42 U.S.C.
 13 300gg-23(a)(1)) is amended by striking “part C”
 14 and inserting “parts C and D”.

15 (2) Section 2762(b)(1) of such Act (42 U.S.C.
 16 300gg-62(b)(1)) is amended by striking “part C”
 17 and inserting “part D”.

18 (e) ASSURING COORDINATION.—Section 104(1) of
 19 the Health Insurance Portability and Accountability Act
 20 of 1996 (Public Law 104–191) is amended by striking
 21 “under this subtitle (and the amendments made by this
 22 subtitle and section 401)” and inserting “title XXVII of
 23 the Public Health Service Act, under part 7 of subtitle
 24 B of title I of the Employee Retirement Income Security

1 Act of 1974, and chapter 100 of the Internal Revenue
2 Code of 1986”.

3 **SEC. 202. MANAGED CARE REQUIREMENTS UNDER THE EM-**
4 **EMPLOYEE RETIREMENT INCOME SECURITY**
5 **ACT OF 1974.**

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

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

11 “(a) IN GENERAL.—Subject to subsection (b), a
12 group health plan (and a health insurance issuer offering
13 group health insurance coverage in connection with such
14 a plan) shall comply with the applicable requirements of
15 part C of title XXVII of the Public Health Service Act.

16 “(b) REFERENCES IN APPLICATION.—In applying
17 subsection (a) under this part, any reference in such part
18 C—

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

23 “(2) to the Secretary is deemed a reference to
24 the Secretary of Labor;

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

3 “(4) to an enrollee with respect to health insur-
4 ance coverage is deemed to include a reference to a
5 participant or beneficiary with respect to a group
6 health plan.”.

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

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

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

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

15 “(c) SPECIAL RULES IN CASE OF MANAGED CARE
16 REQUIREMENTS.—Subject to subsection (a)(2), the provi-
17 sions of section 713 and part C of title XXVII of the Pub-
18 lic Health Service Act, and subpart C insofar as it applies
19 to section 713 or such part, shall not be construed to pre-
20 empt any State law, or the enactment or implementation
21 of such a State law, that provides protections for individ-
22 uals that are equivalent to or stricter than the protections
23 provided under such provisions.”.

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

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

“Sec. 713. Managed care requirements.”.

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

9 (a) IN GENERAL.—Subchapter B of part B of part
 10 7 of subtitle B of title I of the Employee Retirement In-
 11 come Security Act of 1974 is amended by adding at the
 12 end the following new section:

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

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

18 “(b) REFERENCES IN APPLICATION.—In applying
 19 subsection (a) under this subchapter, any reference in
 20 such part C—

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

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

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

“Sec. 9813. Managed care requirements.”.

5 **SEC. 204. MANAGED CARE REQUIREMENTS UNDER MEDI-**
 6 **CARE, MEDICAID, AND THE FEDERAL EM-**
 7 **PLOYEES HEALTH BENEFITS PROGRAM**
 8 **(FEHBP).**

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

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

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

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

6 (2) by inserting “and of part C” after “of part
 7 A”, and

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

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

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

17 **“§ 8905b. Application of managed care requirements**

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

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

3 **SEC. 205. EFFECTIVE DATES.**

4 (a) GENERAL EFFECTIVE DATE FOR GROUP
 5 HEALTH PLANS.—

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

15 (2) TREATMENT OF GROUP HEALTH PLANS
 16 MAINTAINED PURSUANT TO CERTAIN COLLECTIVE
 17 BARGAINING AGREEMENTS.—In the case of a group
 18 health plan, or group health insurance coverage pro-
 19 vided pursuant to a group health plan, maintained
 20 pursuant to 1 or more collective bargaining agree-
 21 ments between employee representatives and 1 or
 22 more employers ratified before the date of enactment
 23 of this Act, the amendments described in paragraph
 24 (1) shall not apply to plan years beginning before
 25 the later of—

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

6 (B) the general effective date.

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

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

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

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

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