105TH CONGRESS
2D SESSION

S. 1808

To amend title XXVII of the Public Health Service Act and part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 to establish standards for the health quality improvement of children in managed care plans and other health plans.

IN THE SENATE OF THE UNITED STATES

MARCH 20, 1998

Mr. REED (for himself, Mr. KENNEDY, and Mrs. MURRAY) introduced the following bill; which was read twice and referred to the Committee on Labor and Human Resources

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A BILL

To amend title XXVII of the Public Health Service Act and part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 to establish standards for the health quality improvement of children in managed care plans and other 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.

This Act may be cited as the ''Children's Health Insurance Accountability Act of 1998''.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) Children have health and development needs that are markedly different than those for the adult population.

(2) Children experience complex and continuing changes during the continuum from birth to adulthood in which appropriate health care is essential for optimal development.

(3) The vast majority of work done on development methods to assess the effectiveness of health care services and the impact of medical care on patient outcomes and patient satisfaction has been focused on adults.

(4) Health outcome measures need to be age, gender, and developmentally appropriate to be useful to families and children.

(5) Costly disorders of adulthood often have their origins in childhood, making early access to effective health services in childhood essential.

(6) More than 200 chronic conditions, disabilities and diseases affect children, including asthma, diabetes, sickle cell anemia, spina bifida, epilepsy, autism, cerebral palsy, congenital heart disease, mental retardation, and cystic fibrosis. These children need the services of specialists who have in-depth knowledge about their particular condition.

(7) Children's patterns of illness, disability and injury differ dramatically from adults.

SEC. 2. AMENDMENTS TO 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—CHILDREN'S HEALTH PROTECTION STANDARDS

''SEC. 2770. ACCESS TO CARE.

''(a) ACCESS TO APPROPRIATE PRIMARY CARE PROVIDERS.—

''(1) IN GENERAL.—If a group health plan, or a health insurance issuer, in connection with the provision of health insurance coverage, requires or provides for an enrollee to designate a participating primary care provider for a child of such enrollee—

''(A) the plan or issuer shall permit the enrollee to designate a physician who specializes in pediatrics as the child's primary care provider; and

''(B) if such an enrollee has not designated such a provider for the child, the plan or issuer

shall consider appropriate pediatric expertise in mandatorily assigning such an enrollee to a primary care provider.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of services.

''(b) ACCESS TO PEDIATRIC SPECIALTY SERVICES.—

''(1) REFERRAL TO SPECIALITY CARE FOR CHILDREN REQUIRING TREATMENT BY SPECIALISTS.—

''(A) IN GENERAL.—In the case of a child who is covered under a group health plan, or health insurance coverage offered by a health insurance issuer and who has a mental or physical condition, disability, or disease of sufficient seriousness and complexity to require diagnosis, evaluation or treatment by a specialist, the plan or issuer shall make or provide for a referral to a specialist who has extensive experience or training, and is available and accessible to provide the treatment for such condition or disease, including the choice of a nonprimary care physician specialist participating in the plan or a referral to a nonparticipating provider as pro-

vided for under subparagraph (D) if such a provider is not available within the plan.

''(B) SPECIALIST DEFINED.—For purposes of this subsection, the term 'specialist' means, with respect to a condition, disability, or disease, a health care practitioner, facility, or center (such as a center of excellence) that has extensive pediatric expertise through appropriate training or experience to provide high quality care in treating the condition.

''(C) REFERRALS TO PARTICIPATING PROVIDERS.—A plan or issuer is not required under subparagraph (A) to provide for a referral to a specialist that is not a participating provider, unless the plan or issuer does not have an appropriate specialist that is available and accessible to treat the enrollee's condition and that is a participating provider with respect to such treatment.

''(D) TREATMENT OF NONPARTICIPATING PROVIDERS.—If a plan or issuer refers a child enrollee to a nonparticipating specialist, services provided pursuant to the referral shall be provided at no additional cost to the enrollee beyond what the enrollee would otherwise pay for

services received by such a specialist that is a participating provider.

''(E) SPECIALISTS AS PRIMARY CARE PROVIDERS.—A plan or issuer shall have in place a procedure under which a child who is covered under health insurance coverage provided by the plan or issuer who has a condition or disease that requires specialized medical care over a prolonged period of time shall receive a referral to a pediatric specialist affilated with the plan, or if not available within the plan, to a nonparticipating provider for such condition and such specialist may be responsible for and capable of providing and coordinating the child's primary and specialty care.

''(2) STANDING REFERRALS.—

''(A) IN GENERAL.—A group health plan, or health insurance issuer in connection with the provision of health insurance coverage of a child, shall have a procedure by which a child who has a condition, disability, or disease that requires ongoing care from a specialist may request and obtain a standing referral to such specialist for treatment of such condition. If the primary care provider in consultation with the

medical director of the plan or issuer and the specialist (if any), determines that such a standing referral is appropriate, the plan or issuer shall authorize such a referral to such a specialist. Such standing referral shall be consistent with a treatment plan.

''(B) TREATMENT PLANS.—A group health plan, or health insurance issuer, with the participation of the family and the health care providers of the child, shall develop a treatment plan for a child who requires ongoing care that covers a specified period of time (but in no event less than a 6-month period). Services provided for under the treatment plan shall not require additional approvals or referrals through a gatekeeper.

''(C) TERMS OF REFERRAL.—The provisions of subparagraph (C) and (D) of paragraph (1) shall apply with respect to referrals under subparagraph (A) in the same manner as they apply to referrals under paragraph (1)(A).

''(c) ADEQUACY OF ACCESS.—For purposes of subsections (a) and (b), a group health plan or health insurance issuer in connection with health insurance coverage shall ensure that a sufficient number, distribution, and va-

riety of qualified participating health care providers are available so as to ensure that all covered health care services, including specialty services, are available and accessible to all enrollees in a timely manner.

"(d) COVERAGE OF EMERGENCY SERVICES.—

"(1) IN GENERAL.—If a group health plan, or health insurance coverage offered by a health insurance issuer, provides any benefits for children with respect to emergency services (as defined in paragraph (2)(A)), 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 of benefits, or an affiliation or waiting period, permitted under section 2701).

"(2) DEFINITIONS.—In this subsection:

"(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—

''(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition (as defined in subparagraph (A)); and

''(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and

treatment as are required under section 1867 of such Act to stabilize the patient.

"(3) REIMBURSEMENT FOR MAINTENANCE CARE AND POST-STABILIZATION CARE.—A group health plan, and health insurance issuer offering health insurance coverage, shall provide, in covering services other than emergency services, for reimbursement with respect to services which are otherwise covered and which are provided to an enrollee other than through the plan or issuer if the services are maintenance care or post-stabilization care covered under the guidelines established under section 1852(d) of the Social Security Act (relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after an enrollee has been determined to be stable).

"(e) PROHIBITION ON FINANCIAL BARRIERS.—A health insurance issuer in connection with the provision of health insurance coverage may not impose any cost sharing for pediatric specialty services provided under such coverage to enrollee children in amounts that exceed the cost-sharing required for other specialty care under such coverage.

''(f) CHILDREN WITH SPECIAL HEALTH CARE NEEDS.—A health insurance issuer in connection with the provision of health insurance coverage shall ensure that such coverage provides special consideration for the provision of services to enrollee children with special health care needs. Appropriate procedures shall be implemented to provide care for children with special health care needs. The development of such procedures shall include participation by the families of such children.

''(g) DEFINITIONS.—In this part:

''(1) CHILD.—The term 'child' means an individual who is under 19 years of age.

''(2) CHILDREN WITH SPECIAL HEALTH CARE NEEDS.—The term 'children with special health care needs' means those children who have or are at elevated risk for chronic physical, developmental, behavioral or emotional conditions and who also require health and related services of a type and amount not usually required by children.

"SEC. 2771. CONTINUITY OF CARE.

''(a) IN GENERAL.—If a contract between a health insurance issuer, in connection with the provision of health insurance coverage, and a health care provider is terminated (other than by the issuer for failure to meet applicable quality standards or for fraud) and an enrollee is un-

dergoing a course of treatment from the provider at the time of such termination, the issuer shall—

''(1) notify the enrollee of such termination, and

''(2) subject to subsection (c), permit the enrollee to continue the course of treatment with the provider during a transitional period (provided under subsection (b)).

''(b) TRANSITIONAL PERIOD.—

''(1) IN GENERAL.—Except as provided in paragraphs (2) through (4), the transitional period under this subsection shall extend for at least—

''(A) 60 days from the date of the notice to the enrollee of the provider's termination in the case of a primary care provider, or

''(B) 120 days from such date in the case of another provider.

''(2) INSTITUTIONAL CARE.—The transitional period under this subsection for institutional or inpatient care from a provider shall extend until the discharge or termination of the period of institutionalization and shall include reasonable follow-up care related to the institutionalization and shall also include institutional care scheduled prior to the date of termination of the provider status.

''(3) PREGNANCY.—If—

''(A) an enrollee has entered the second trimester of pregnancy at the time of a provider's termination of participation, and

''(B) the provider was treating the pregnancy before date of the termination,

the transitional period under this subsection with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

''(4) TERMINAL ILLNESS.—

''(A) IN GENERAL.—If—

''(i) an enrollee was determined to be terminally ill (as defined in subparagraph (B)) at the time of a provider's termination of participation, and

''(ii) the provider was treating the terminal illness before the date of termination,

the transitional period under this subsection shall extend for the remainder of the enrollee's life for care directly related to the treatment of the terminal illness.

''(B) DEFINITION.—In subparagraph (A), an enrollee is considered to be 'terminally ill' if

the enrollee has a medical prognosis that the enrollee's life expectancy is 6 months or less.

''(c) PERMISSIBLE TERMS AND CONDITIONS.—An issuer may condition coverage of continued treatment by a provider under subsection (a)(2) upon the provider agreeing to the following terms and conditions:

''(1) The provider agrees to continue to accept reimbursement from the issuer at the rates applicable prior to the start of the transitional period as payment in full.

''(2) The provider agrees to adhere to the issuer's quality assurance standards and to provide to the issuer necessary medical information related to the care provided.

''(3) The provider agrees otherwise to adhere to the issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan approved by the issuer.

"SEC. 2772. CONTINUOUS QUALITY IMPROVEMENT.

''(a) IN GENERAL.—A health insurance issuer that offers health insurance coverage for children shall establish and maintain an ongoing, internal quality assurance program that at a minimum meets the requirements of subsection (b).

''(b) REQUIREMENTS.—The internal quality assurance program of an issuer under subsection (a) shall—

''(1) establish and measure a set of health care, functional assessments, structure, processes and outcomes, and quality indicators that are unique to children and based on nationally accepted standards or guidelines of care;

''(2) maintain written protocols consistent with recognized clinical guidelines or current consensus on the pediatric field, to be used for purposes of internal utilization review, with periodic updating and evaluation by pediatric specialists to determine effectiveness in controlling utilization;

''(3) provide for peer review by health care professionals of the structure, processes, and outcomes related to the provision of health services, including pediatric review of pediatric cases;

''(4) include in member satisfaction surveys, questions on child and family satisfaction and experience of care, including care to children with special needs;

''(5) monitor and evaluate the continuity of care with respect to children;

''(6) include pediatric measures that are directed at meeting the needs of at-risk children and

children with chronic conditions, disabilities and severe illnesses;

''(7) maintain written guidelines to ensure the availability of medications appropriate to children;

''(8) use focused studies of care received by children with certain types of chronic conditions and disabilities and focused studies of specialized services used by children with chronic conditions and disabilities;

''(9) monitor access to pediatric specialty services; and

''(10) monitor child health care professional satisfaction.

''(c) UTILIZATION REVIEW ACTIVITIES.—

''(1) COMPLIANCE WITH REQUIREMENTS.—

''(A) IN GENERAL.—A health insurance issuer that offers health insurance coverage for children shall conduct utilization review activities in connection with the provision of such coverage only in accordance with a utilization review program that meets at a minimum the requirements of this subsection.

''(B) DEFINITIONS.—In this subsection:

''(i) CLINICAL PEERS.—The term 'clinical peer' means, with respect to a re-

view, a physician or other health care professional who holds a non-restricted license in a State and in the same or similar specialty as typically manages the pediatric medical condition, procedure, or treatment under review.

''(ii) HEALTH CARE PROFESSIONAL.—The term 'health care professional' means a physician or other health care practitioner licensed or certified under State law to provide health care services and who is operating within the scope of such licensure or certification.

''(iii) UTILIZATION REVIEW.—The terms 'utilization review' and 'utilization review activities' mean procedures used to monitor or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings for children, and includes prospective review, concurrent review, second opinions, case management, discharge planning, or retrospective review specific to children.

''(2) WRITTEN POLICIES AND CRITERIA.—

"(A) WRITTEN POLICIES.—A utilization review program shall be conducted consistent with written policies and procedures that govern all aspects of the program.

"(B) USE OF WRITTEN CRITERIA.—A utilization review program shall utilize written clinical review criteria specific to children and developed pursuant to the program with the input of appropriate physicians, including pediatricians, nonprimary care pediatric specialists, and other child health professionals.

"(C) ADMINISTRATION BY HEALTH CARE PROFESSIONALS.—A utilization review program shall be administered by qualified health care professionals, including health care professionals with pediatric expertise who shall oversee review decisions.

"(3) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—

"(A) IN GENERAL.—A utilization review program shall provide for the conduct of utilization review activities only through personnel who are qualified and, to the extent required, who have received appropriate pediatric or child

health training in the conduct of such activities under the program.

''(B) PEER REVIEW OF ADVERSE CLINICAL DETERMINATIONS.—A utilization review program shall provide that clinical peers shall evaluate the clinical appropriateness of adverse clinical determinations and divergent clinical options.

''SEC. 2773. APPEALS AND GRIEVANCE MECHANISMS FOR CHILDREN.

''(a) INTERNAL APPEALS PROCESS.—A health insurance issuer in connection with the provision of health insurance coverage for children shall establish and maintain a system to provide for the resolution of complaints and appeals regarding all aspects of such coverage. Such a system shall include an expedited procedure for appeals on behalf of a child enrollee in situations in which the time frame of a standard appeal would jeopardize the life, health, or development of the child.

''(b) EXTERNAL APPEALS PROCESS.—A health insurance issuer in connection with the provision of health insurance coverage for children shall provide for an independent external review process that meets the following requirements:

''(1) External appeal activities shall be conducted through clinical peers, a physician or other health care professional who is appropriately credentialed in pediatrics with the same or similar specialty and typically manages the condition, procedure, or treatment under review or appeal.

''(2) External appeal activities shall be conducted through an entity that has sufficient pediatric expertise, including subspeciality expertise, and staffing to conduct external appeal activities on a timely basis.

''(3) Such a review process shall include an expedited procedure for appeals on behalf of a child enrollee in which the time frame of a standard appeal would jeopardize the life, health, or development of the child.

''SEC. 2774. ACCOUNTABILITY THROUGH DISTRIBUTION OF INFORMATION.

''(a) IN GENERAL.—A health insurance issuer in connection with the provision of health insurance coverage for children shall submit to enrollees (and prospective enrollees), and make available to the public, in writing the health-related information described in subsection (b).

''(b) INFORMATION.—The information to be provided under subsection (a) shall include a report of measures

of structures, processes, and outcomes regarding each health insurance product offered to participants and dependents in a manner that is separate for both the adult and child enrollees, using measures that are specific to each group.''.

(b) APPLICATION TO GROUP HEALTH INSURANCE COVERAGE.—

(1) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

''SEC. 2706. CHILDREN'S HEALTH ACCOUNTABILITY STANDARDS.

''(a) IN GENERAL.—Each health insurance issuer shall comply with children's health accountability requirement under part C with respect to group health insurance coverage it offers.

''(b) ASSURING COORDINATION.—The Secretary of Health and Human Services and the Secretary of Labor shall ensure, through the execution of an interagency memorandum of understanding between such Secretaries, that—

''(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which such Secretaries have responsibility under part C (and this section) and section 713 of

the Employee Retirement Income Security Act of 1974 are administered so as to have the same effect at all times; and

''(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.''.

(2) CONFORMING AMENDMENT.—Section 2792 of the Public Health Service Act (42 U.S.C. 300gg–92) is amended by inserting ''and section 2706(b)'' after ''of 1996''.

(c) APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.—Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2751 the following new section:

''SEC. 2752. CHILDREN'S HEALTH ACCOUNTABILITY STANDARDS.

''Each health insurance issuer shall comply with children's health accountability requirements under part C with respect to individual health insurance coverage it offers.''.

(d) MODIFICATION OF PREEMPTION STANDARDS.—

(1) GROUP HEALTH INSURANCE COVERAGE.—Section 2723 of the Public Health Service Act (42 U.S.C. 300gg–23) is amended—

(A) in subsection (a)(1), by striking ''subsection (b)'' and inserting ''subsection (b) and (c)'';

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

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

''(c) SPECIAL RULES IN CASE OF CHILDREN'S HEALTH ACCOUNTABILITY REQUIREMENTS.—Subject to subsection (a)(2), the provisions of section 2706 and part C, and part D insofar as it applies to section 2706 or part C, shall not prevent a State from establishing requirements relating to the subject matter of such provisions so long as such requirements are at least as stringent on health insurance issuers as the requirements imposed under such provisions.''.

(2) INDIVIDUAL HEALTH INSURANCE COVERAGE.—Section 2762 of the Public Health Service Act (42 U.S.C. 300gg–62), as added by section 605(b)(3)(B) of Public Law 104–204, is amended—

(A) in subsection (a), by striking ''subsection (b), nothing in this part'' and inserting ''subsections (b) and (c)'', and

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

''(c) SPECIAL RULES IN CASE OF CHILDREN'S HEALTH ACCOUNTABILITY REQUIREMENTS.—Subject to subsection (b), the provisions of section 2752 and part C, and part D insofar as it applies to section 2752 or part C, shall not prevent a State from establishing requirements relating to the subject matter of such provisions so long as such requirements are at least as stringent on health insurance issuers as the requirements imposed under such section.''.

SEC. 3. AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

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

''SEC. 713. CHILDREN'S HEALTH ACCOUNTABILITY STANDARDS.

''(a) IN GENERAL.—Subject to subsection (b), the provisions of part C of title XXVII of the Public Health Service Act shall apply under this subpart and part to a

group health plan (and group health insurance coverage offered in connection with a group health plan) as if such part were incorporated in this section.

''(b) APPLICATION.—In applying subsection (a) under this subpart and part, and reference in such part C—

''(1) to health insurance coverage is deemed to be a reference only to group health insurance coverage offered in connection with a group health plan and to also be a reference to coverage under a group health plan;

''(2) to a health insurance issuer is deemed to be a reference only to such an issuer in relation to group health insurance coverage or, with respect to a group health plan, to the plan;

''(3) to the Secretary is deemed to be a reference to the Secretary of Labor;

''(4) to an applicable State authority is deemed to be a reference to the Secretary of Labor; and

''(5) to an enrollee with respect to health insurance coverage is deemed to include a reference to a participant or beneficiary with respect to a group health plan.''.

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

(1) in subsection (a)(1), by striking ''subsection (b)'' and inserting ''subsections (b) and (c)'';

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

(3) by inserting after subsection (b) the following new subsection:

''(c) SPECIAL RULES IN CASE OF PATIENT ACCOUNTABILITY REQUIREMENTS.—Subject to subsection (a)(2), the provisions of section 713, shall not prevent a State from establishing requirements relating to the subject matter of such provisions so long as such requirements are at least as stringent on group health plans and health insurance issuers in connection with group health insurance coverage as the requirements imposed under such provisions.''.

(c) CONFORMING AMENDMENTS.—

(1) Section 732(a) of such Act (29 U.S.C. 1185(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 713''.

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

''Sec. 713. Children's health accountability standards.''.

SEC. 4. STUDIES.

(a) BY SECRETARY.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and

Human Services shall conduct a study, and prepare and submit to Congress a report, concerning—

(1) the unique characteristics of patterns of illness, disability, and injury in children;

(2) the development of measures of quality of care and outcomes related to the health care of children; and

(3) the access of children to primary mental health services and the coordination of managed behavioral health services.

(b) BY GAO.—

(1) MANAGED CARE.—Not later than 1 year after the date of enactment of this Act, the General Accounting Office shall conduct a study, and prepare and submit to the Committee on Labor and Human Resources of the Senate and the Committee on Commerce of the House of Representatives a report, concerning—

(A) an assessment of the structure and performance of non-governmental health plans, medicaid managed care organizations, plans under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), and the program under title XXI of the Social Security Act (42 U.S.C.

1397aa et seq.) serving the needs of children with special health care needs;

(B) an assessment of the structure and performance of non-governmental plans in serving the needs of children as compared to medicaid managed care organizations under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.); and

(C) the emphasis that private managed care health plans place on primary care and the control of services as it relates to care and services provided to children with special health care needs.

(2) PLAN SURVEY.—Not later than 1 year after the date of enactment of this Act, the General Accounting Office shall prepare and submit to the Committee on Labor and Human Resources of the Senate and the Committee on Commerce of the House of Representatives a report that contains a survey of health plan activities that address the unique health needs of adolescents, including quality measures for adolescents and innovative practice arrangement.

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