I

106TH CONGRESS
1ST SESSION

H. R. 3259

To amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to establish certain requirements for managed care plans.

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 8, 1999

Ms. VELÁZQUEZ introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committee on Education and the Workforce, 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

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A BILL

To amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to establish certain requirements for managed care 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 ''Managed Care Bill of Rights for Consumers Act of 1999''.

(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.

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. GUARANTEE OF MEDICALLY NECESSARY AND APPROPRIATE TREATMENT.

''(a) IN GENERAL.—A managed care plan may not impose limits on the delivery of services if such services are—

''(1) medically necessary and appropriate as determined by the treating health professional, in consultation with the enrollee; and

''(2) otherwise a covered benefit.

''(b) SECOND OPINION.—A managed care plan shall provide to an enrollee, upon request, a referral to a health care practitioner for a second opinion as to what constitutes medically necessary and appropriate treatment, and provide coverage for such opinion without regard to whether such health care practitioner has a contractual or other arrangement with the plan for the provision of such services to such enrollee.

''SEC. 2771. GUARANTEED ADEQUATE ACCESS TO HEALTH CARE.

''(a) ADEQUATE ACCESS.—A managed care plan shall provide adequate access to health care services.

''(b) AVAILABLE ITEMS AND SERVICES.—The Secretary shall ensure that items and services, including laboratory and specialist services, covered under the plan

shall be available through providers that are reasonably geographically accessible to all enrollees of such plan.

"SEC. 2772. RIGHT TO ADEQUATE PHYSICIAN NETWORK.

''(a) IN GENERAL.—A managed care plan shall maintain an adequate number, mix, and distribution of health professionals and providers to ensure that covered items and services are available and accessible to each enrollee.

''(b) ADEQUATE DISTRIBUTION.—The Secretary shall determine the adequate number, mix, and distribution of health professionals and providers within the service area of the managed care plan, including—

''(1) the existence of a primary care provider network that is sufficient to meet adult, pediatric, and primary obstetric and gynecological needs of all enrollees;

''(2) the existence of a network of specialists of sufficient number and diversity to meet the specialty needs of all enrollees;

''(3) the access to quality health services from institutional providers for all enrollees; and

''(4) the existence of at least one primary care physician for every 1,500 enrollees.

"SEC. 2773. MEANINGFUL CHOICE OF PROVIDERS.

''(a) MINIMUM NUMBER OF CHOICES.—A managed care plan shall provide to enrollees a choice of at least

3 providers within each category of providers based on the health care needs of such enrollees, taking into account the age, gender, health, native language, acute or chronic diseases, and special needs of the enrollee. The enrollee may change the selection of provider at any time.

''(b) ACCESS TO OUT–OF–NETWORK PROVIDER.—A managed care plan shall cover services that are furnished by a physician or provider obtained by the enrollee without regard to whether such physician or provider has a contractual or other arrangement with the plan for the provision of such services to such enrollees. The plan may impose a reasonable deductible and reasonable copayment subject to a reasonable annual limit on total annual out-of-pocket expenses.

"SEC. 2774. GUARANTEED CONTINUITY OF CARE.

''If a contract between a managed care plan and a health care provider is terminated (other than by the plan for failure to meet applicable quality standards or for fraud) and an enrollee is undergoing a course of treatment from the provider at the time of such termination, the plan shall—

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

''(2) permit the enrollee to continue the course of treatment with the provider during a transitional period as determined by the Secretary.

''SEC. 2775. RIGHT TO SPECIALTY CARE.

''(a) REFERRAL TO SPECIALISTS.—

''(1) CHOICE OF SPECIALIST.—A managed care plan shall permit each enrollee to receive specialty care from any qualified participating health care provider when such treatment is medically or clinically necessary. The plan shall make or provide for a referral to at least 3 specialists who are available and accessible to provide treatment for such condition or disease.

''(2) COST OF TREATMENT BY NONPARTICIPATING PROVIDERS.—In a case in which a plan refers an enrollee to a nonparticipating specialist, the plan shall cover any services provided by such specialist at the rate it covers comparable services provided by participating providers.

''(b) CONTINUOUS REFERRALS.—A managed care plan shall have a procedure by which an enrollee who has a condition that requires ongoing care from a specialist may receive a continuous referral to such specialist for treatment of such condition, without additional authorization from the primary care physician.

"SEC. 2776. REQUIRED OBSTETRIC AND GYNECOLOGICAL CARE.

"(a) OBSTETRICIAN-GYNECOLOGIST AS PRIMARY CARE PROVIDER.—In a case in which a managed care plan provides for an enrollee to designate a participating primary care provider, a female enrollee may designate a physician who specializes in obstetrics and gynecology as primary care provider.

"(b) NO DESIGNATION OF OBSTETRICIAN-GYNECOLOGIST.—In a case in which an enrollee does not designate an obstetrician-gynecologist under subsection (a) as a primary care provider, the plan shall not require prior authorization by the enrollee's primary care provider for coverage of routine gynecological care and pregnancy-related services provided by a participating physician who specializes in obstetrics and gynecology.

"SEC. 2777. ASSURING EQUITABLE COVERAGE OF EMERGENCY SERVICE.

"(a) IN GENERAL.—A managed care plan shall cover emergency services furnished to an enrollee of the plan—

"(1) whether or not the provider furnishing the emergency services has a contractual or other arrangement with the plan for the provision of such services to such enrollee; and

"(2) without regard to prior authorization.

''(b) EMERGENCY SERVICES.—Emergency services shall include—

''(1) health care items and services furnished in the emergency department of a hospital; and

''(2) ancillary services routinely available to such department.

''(c) EMERGENCY MEDICAL CONDITION.—An emergency medical condition is 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—

''(1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

''(2) serious impairment to bodily functions; or

''(3) serious dysfunction of any bodily organ or part.

''SEC. 2778. REQUIREMENT FOR SERVICE TO AREAS THAT INCLUDE A MEDICALLY UNDERSERVED POPULATION.

''A managed care plan seeking to provide services in an area that includes a medically underserved population must submit a plan to the Secretary outlining a proposal

for service that ensures access to quality care that is appropriate to the medically underserved population. The plan shall include the health needs of the medically underserved population with special consideration given to factors including age, gender, race, and potential chronic conditions.

"SEC. 2779. RIGHT TO LANGUAGE ASSISTANCE.

''In a case in which 2 percent of the enrollees of a managed care plan in a service area (as defined in section 2788(b)(9)) are members of a group that speaks English as a second language or requires special communication needs, the Secretary shall ensure that the managed care plan provides communication assistance and bilingual information, on a continuous basis, to such enrollees. The plan shall ensure that—

''(1) trained medical interpreters, whose primary responsibility is to interpret, are present in all health care settings; and

''(2) an adequate number of health professionals receive training in cultural competency and communication skills development as it relates to medical interviews.

"SEC. 2780. PROHIBITION ON FINANCIAL INCENTIVES TO LIMIT CARE.

"A managed care plan may not offer any financial incentives, directly or indirectly, to health professionals as an inducement to reduce or limit medically necessary services provided to an enrollee.

"SEC. 2781. PROHIBITION ON GAG CLAUSES.

"(a) IN GENERAL.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a managed care plan and a health professional shall not prohibit or restrict a health professional from engaging in medical communication with his or her patient.

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

"(c) MEDICAL COMMUNICATION DEFINED.—For purposes of this section, the term 'medical communication' means a communication made by a health professional with a patient of the health professional (or the guardian or legal representative of the patient) with respect to—

"(1) the patient's health status, medical care, or legal treatment options;

"(2) any utilization review requirements that may affect treatment options for the patient; or

''(3) any financial incentives that may affect the treatment of the patient.

"SEC. 2782. RIGHT TO APPEAL DENIAL OF CARE.

''(a) ESTABLISHMENT OF SYSTEM.—Not later than 90 days after the date of the enactment of the Managed Care Bill of Rights for Consumers Act of 1999, the Secretary, through the Health Care Financing Administration, shall establish and implement guidelines for grievance and appeals procedures regarding any aspect of a managed care plan's services, including complaints regarding quality of care, choice and accessibility of providers, network adequacy, and compliance with the requirements of this part.

''(b) NO REPRISAL FOR EXERCISE OF RIGHTS.—A managed care plan shall not take any action with respect to an enrollee or a health care provider that is intended to penalize the enrollee, a designee of the enrollee, or the health care provider for discussing or exercising any rights provided under this part (including the filing of a complaint or appeal pursuant to this section).

"SEC. 2783. EXTERNAL REVIEW.

''An external review process shall be available to enrollees after all internal appeal options have been exercised. The requirements for an external review process are as follows:

''(1) The process is established under State law and provides for review of decisions made pursuant to section 2784 by an independent review organization certified by the State.

''(2) If the process provides that decisions in such process are not binding on managed care plans, the process must provide for public methods of disclosing frequency of noncompliance with such decisions and for sanctioning plans that consistently refuse to take appropriate actions in response to such decisions.

''(3) Results of all such reviews under the process are disclosed to the public, along with at least annual disclosure of information on managed care plan compliance.

''(4) All decisions under the process shall be in writing and shall be accompanied by an explanation of the basis for the decision.

''(5) Direct costs of the process shall be borne by the managed care plan, and not by the enrollee.

''(6) The managed care plan shall provide for publication at least annually of information on the number of appeals and decisions considered under the process.

"SEC. 2784. NONDISCRIMINATION RIGHT.

"A managed care plan may not discriminate (directly or through contractual arrangements) against an enrollee or a provider on the basis of race, national origin, gender, language, socioeconomic status, age, disability, health status, or anticipated need for health services.

"SEC. 2785. PROTECTION OF PATIENT CONFIDENTIALITY.

"A managed care plan shall establish policies and procedures to ensure that all applicable laws that protect the confidentiality of an individual's medical information are followed.

"SEC. 2786. ESTABLISHMENT OF MANAGED CARE CONSUMER ADVISORY COMMISSION.

"(a) ESTABLISHMENT.—The Secretary shall establish and appoint a 5 member Managed Care Consumer Advisory Commission.

"(b) PURPOSE.—The purpose of the Commission is to assist consumers in the following areas:

"(1) Accessing appropriate and high–quality health care services.

"(2) Understanding and exercising their rights and responsibilities as managed care plan enrollees.

"(3) Making an informed and appropriate choice of a managed care plan.

"(c) MEMBERSHIP.—Members of the Commission shall—

''(1) be selected from nonpartisan labor, religious, human service, or consumer organizations; and

''(2) demonstrate a commitment to representing consumers in an equitable manner.

''(d) DUTIES.—

''(1) ANALYZE AND COLLECT INFORMATION.—The Commission shall collect and analyze information for the purpose of identifying—

''(A) recurring barriers to access to health care for persons enrolled in managed care plans;

''(B) patterns of national, regional, or local access problems with special focus on underserved and vulnerable populations and persons with chronic illness and disabilities;

''(C) quality of care problems; and

''(D) the extent to which managed care plans comply with Federal laws, regulations, and rules governing their responsibilities and performance.

''(2) PROMOTE SOLUTIONS.—The Commission shall investigate, identify, and promote solutions regarding managed care practices, policies, laws, or regulations that adversely affect, or fail to promote,

informed access of individuals and populations to high–quality health care.

''(3) REPORT.—Not later than January 1 of each year, the Secretary, through the Commission, shall submit a report to Congress which shall include—

''(A) a description of the efforts of the Commission; and

''(B) findings and recommendations based on problems identified to improve consumer and enrollee rights and protections so as to facilitate access to high–quality health care and improve health outcomes.''.

''SEC. 2787. REQUIREMENTS FOR PRESCRIPTION DRUG COVERAGE.

''(a) REQUIREMENT FOR COVERAGE OF MEDICALLY NECESSARY AND APPROPRIATE DRUGS.—In a case in which a managed care plan provides coverage for prescription drugs, such plan may not limit coverage if a treating health professional determines that such coverage is medically necessary and appropriate.

''(b) REQUIREMENT FOR SUBSTITUTING DRUGS.—

''(1) IN GENERAL.—A determination as to whether or not a drug prescribed to treat a medical condition may be substituted with a different drug

may only be made by a treating physician. A managed care plan may not provide a standard for substituting prescription drugs.

''(2) GENERIC DRUGS.—A generic drug may not be substituted for a name brand drug unless it has the same chemical composition as the name brand drug.

''(c) LIMITATION ON ACCESS.—A managed care plan that provides prescription drug coverage may not limit access to drugs covered solely on the basis of costs associated with providing coverage of such drugs.

"SEC. 2788. NOTICE; DEFINITIONS.

''(a) NOTICE.—A managed care plan 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 plan and such plan were a group health plan.

''(b) DEFINITIONS.—For purposes of this part:

''(1) ENROLLEE.—The term 'enrollee' means, with respect to health insurance coverage offered by a managed care plan, an individual enrolled with the plan to receive such coverage.

''(2) HEALTH PROFESSIONAL.—The term 'health professional' means a physician or other

health care practitioner licensed, accredited, or certified to perform specified health services consistent with law.

''(3) MANAGED CARE PLAN.—The term 'managed care plan' means a health plan that provides or arranges for the provision of health care items and services to participants, beneficiaries, or enrollees primarily through participating physicians and providers.

''(4) NETWORK.—The term 'network' means, with respect to a managed care plan, the participating health professionals and providers through which the plan provides health care items and services to enrollees.

''(5) NETWORK COVERAGE.—The term 'network coverage' means health insurance coverage offered by a managed care plan that provides or arranges for the provision of health care items and services to enrollees through participating health professionals and providers.

''(6) PARTICIPATING.—The term 'participating' means, with respect to a health professional or provider, a health professional or provider that provides health care items and services to enrollees under

network coverage under an agreement with the managed care plan offering the coverage.

''(7) PRIOR AUTHORIZATION.—The term 'prior authorization' means the process of obtaining prior approval from a managed care plan as to the necessity or appropriateness of receiving medical or clinical services for treatment of a medical or clinical condition.

''(8) PROVIDER.—The term 'provider' means a health organization, health facility, or health agency that is licensed, accredited, or certified to provide health care items and services.

''(9) SERVICE AREA.—The term 'service area' means, with respect to a managed care plan, the geographic area served by the plan with respect to the coverage.

SEC. 3. PATIENT PROTECTION STANDARDS UNDER 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 new section:

"SEC. 714. PATIENT PROTECTION STANDARDS.

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

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

"(1) to a managed care plan and health insurance coverage offered by such a plan is deemed to include a reference to a group health plan and coverage under such plan, respectively;

"(2) to the Secretary is deemed a reference to the Secretary of Labor;

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

"(4) 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.

"(c) ENSURING 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 such part C (and section 2706 of the Public Health Service Act) and this section 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.''.

(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 PROTECTION REQUIREMENTS.—Subject to subsection (a)(2), the provisions of section 714 and part C of title XXVII of the Public Health Service Act, and subpart C insofar as it applies to section 714 or such part, shall not be construed to preempt any State law, or the enactment or im-

plementation of such a State law, that provides protections for individuals that are equivalent to or stricter than the protections provided 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 714''.

(2) The table of contents in section 1 of such Act is amended by inserting after the item relating to section 713 the following new item:

''Sec. 714. Patient protection standards.''.

(3) Section 734 of such Act (29 U.S.C. 1187) is amended by inserting ''and section 714(d)'' after ''of 1996''.

(d) EFFECTIVE DATE.—(1) Subject to paragraph (2), the amendments made by this section shall apply with respect to group health plans for plan years beginning on or after 90 days after the date of the enactment of this Act, and also shall apply to portions of plan years occurring on and after January 1, 2000.

(2) In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the later of—

(A) the date on which the last collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment of this Act); or

(B) the general effective date.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by subsection (a) shall not be treated as a termination of such collective bargaining agreement.

SEC. 4. NONPREEMPTION OF STATE LAW RESPECTING LIABILITY OF GROUP HEALTH PLANS.

(a) IN GENERAL.—Section 514(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)) is amended by redesignating paragraph (9) as paragraph (10) and inserting the following new paragraph:

''(9) Subsection (a) of this section shall not be construed to preclude any State cause of action to recover damages for personal injury or wrongful death against any person that provides insurance or administrative services to or for an employee welfare benefit plan maintained to provide health care benefits.''.

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

SEC. 5. EFFECTIVE DATE.

The amendments made by this Act shall take effect 90 days after the date of the enactment of this Act.

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