106TH CONGRESS
1ST SESSION

S. 479

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 SENATE OF THE UNITED STATES

FEBRUARY 25, 1999

Mr. SCHUMER introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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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.

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 ''Equity in Womens Health Act''.

SEC. 2. HEALTH INSURANCE BILL OF RIGHTS.

Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended—

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

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

''PART C—NONDISCRIMINATION AND HEALTH PROSPECTUS

''SEC. 2770. NONDISCRIMINATION.

''(a) ENROLLEES.—A group health plan or health insurance issuer offering health insurance coverage (whether or not a managed care plan or coverage) may not discriminate or engage (directly or through contractual arrangements) in any activity, including the selection of service area, that has the effect of discriminating against an individual on the basis of race, culture, national origin, gender, sexual orientation, language, socio-economic status, age, disability, genetic makeup, health status, anticipated need for health care services, or payer source.

''(b) PROVIDERS.—Such a plan or issuer may not discriminate in the selection of members of the health provider or provider network (and in establishing the terms and conditions for membership in the network) of the plan or coverage based on any of the factors described in subsection (a).

''(c) SERVICES.—Such a plan or issuer may not exclude coverage (including procedures and drugs) if the effect is to discriminate in violation of subsection (a) or (b).

"SEC. 2771. HEALTH PROSPECTUS; DISCLOSURE OF INFORMATION.

"(a) DISCLOSURE.—Each group health plan, and each health insurance issuer providing health insurance coverage, shall provide to each enrollee at the time of enrollment and on an annual basis, and shall make available to each prospective enrollee upon request—

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

"(2) additional information described in subsection (c).

"(b) PROSPECTUS.—

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

"(A) shall contain the information described in paragraphs (2) through (4) concerning the plan or coverage,

"(B) shall contain such additional information as the Secretary deems appropriate, and

"(C) shall be no longer than 3 pages in length and in a format specified by the Secretary for purposes of comparison by prospective enrollees.

"(2) QUALITATIVE INFORMATION.—The information described in this paragraph is a summary of

the quality assessment data on the plan or coverage. The data shall—

"(A) be the similar to the types of data as are collected for managed care plans under title XVIII of the Social Security Act, as determined by the Secretary and taking into account differences between the populations covered under such title and the populations covered under this title;

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

"(C) include—

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

"(ii) cost-sharing requirements for enrollees.

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

require the disclosure of specific reimbursement rates.

''(3) QUANTITATIVE INFORMATION.—The information described in this paragraph is measures of performance of the plan or issuer (in relation to coverage offered) with respect to each of the following and such other salient data as the Secretary may specify:

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

''(B) The ratio of specialists to enrollees.

''(C) The incentive structure used for payment of primary care physicians and specialists.

''(D) Patient outcomes for procedures, including procedures specific to female enrollees.

''(E) The number of grievances filed under the plan or coverage.

''(F) The number of requests for procedures for which utilization review board review or approval is required and the number (and percentage) of such requests that are denied.

''(G) The number of appeals filed from denial of such requests and the number (and percentage) of such appeals that are approved,

such numbers and percentages broken down by gender of the enrollee involved.

''(H) Disenrollment data.

''(4) DESCRIPTION OF BENEFITS.—The information described in this paragraph is a description of the benefits provided under the plan or coverage, as well as explicit exclusions, including a description of the following:

''(A) Coverage policy with respect to coverage for female-specific benefits, including screening mammography, hormone replacement therapy, bone density testing, osteoporosis screening, maternity care, and reconstructive surgery following a mastectomy.

''(B) The costs of copayments for treatments, including any exceptions.

''(c) ADDITIONAL INFORMATION.—The additional information described in this subsection is information about each of the following:

''(1) The plan's or issuer's structure and provider network, including the names and credentials of physicians in the network.

''(2) Coverage provided and excluded, including out-of-area coverage.

''(3) Procedures for utilization management.

''(4) Procedures for determining coverage for investigational or experimental treatments, as well as definitions for coverage terms.

''(5) Any restrictive formularies or prior approval requirements for obtaining prescription drugs, including, upon request, information on whether or not specific drugs are covered.

''(6) Use of voluntary or mandatory arbitration.

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

''(A) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

''(B) the process and procedures for obtaining emergency services; and

''(C) the locations of (i) emergency departments, and (ii) other settings, in which physicians and hospitals provide emergency services and post-stabilization care.

''(8) How to contact agencies that regulate the plan or issuer.

''(9) How to contact consumer assistance agencies, such as ombudsmen programs.

''(10) How to obtain covered services.

''(11) How to receive preventive health services and health education.

''(12) How to select providers and obtain referrals.

''(13) How to appeal health plan decisions and file grievances.

''(d) STATE AUTHORITY TO REQUIRE ADDITIONAL INFORMATION.—

''(1) IN GENERAL.—Subject to paragraph (2), this section shall not be construed as preventing a State from requiring health insurance issuers, in relation to their offering of health insurance coverage, to disclose separately information (including comparative ratings of health insurance coverage) in addition to the information required to be disclosed under this section.

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

SEC. 3. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.

(a) APPLICATION TO GROUP HEALTH INSURANCE COVERAGE.—Subpart 2 of part A of title XXVII of the Public Health Service Act, as amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 (Public Law 105–277), is amended by adding at the end the following new section:

''SEC. 2707. MANAGED CARE REQUIREMENTS.

''Each health insurance issuer shall comply with the applicable requirements under part C with respect to group health insurance coverage it offers.''.

(b) APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.—Subpart 3 of part B of title XXVII of the Public Health Service Act, as amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 (Public Law 105–277), is amended by adding at the end the following new section:

''SEC. 2753. MANAGED CARE REQUIREMENTS.

''Each health insurance issuer shall comply with the applicable requirements under part C with respect to individual health insurance coverage it offers, in the same manner as such requirements apply to group health insurance coverage.''.

(c) MODIFICATION OF PREEMPTION STANDARDS.—

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

(A) in subsection (a)(1), by striking ''subsection (b)'' and inserting ''subsections (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 MANAGED CARE REQUIREMENTS.—Subject to subsection (a)(2), the provisions of section 2707 and part C, and part D insofar as it applies to section 2707 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) 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 MANAGED CARE REQUIREMENTS.—Subject to subsection (b), the provisions of section 2753 and part C, and part D insofar as it applies to section 2753 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.''.

(d) ADDITIONAL CONFORMING AMENDMENTS.—

(1) Section 2723(a)(1) of the Public Health Service Act (42 U.S.C. 300gg–23(a)(1)) is amended by striking ''part C'' and inserting ''parts C and D''.

(2) Section 2762(b)(1) of the Public Health Service Act (42 U.S.C. 300gg–62(b)(1)) is amended by striking ''part C'' and inserting ''part D''.

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

Act of 1974, and chapter 100 of the Internal Revenue Code of 1986''.

SEC. 4. MANAGED CARE REQUIREMENTS 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, as amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 (Public Law 105–277), is amended by adding at the end the following:

''SEC. 714. MANAGED CARE REQUIREMENTS.

''(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 applicable 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 health insurance issuer and health insurance coverage offered by such an issuer 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.''.

(b) MODIFICATION OF PREEMPTION STANDARDS.—Section 731 of the Employee Retirement Income Security Act of 1974 (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 MANAGED CARE 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 implementation of such a State law, that provides protections for individ-

uals that are equivalent to or stricter than the protections provided under such provisions.''.

(c) CONFORMING AMENDMENTS.—

(1) Section 732(a) of the Employee Retirement Income Security Act of 1974 (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 the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 713 the following new item:

''Sec. 714. Managed care requirements.''.

SEC. 5. MANAGED CARE REQUIREMENTS UNDER THE INTERNAL REVENUE CODE OF 1986.

(a) IN GENERAL.—Subchapter B of part B of part 7 of subtitle B of title I of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

''SEC. 9813. MANAGED CARE REQUIREMENTS.

''(a) IN GENERAL.—Subject to subsection (b), a group health plan shall comply with the applicable requirements of part C of title XXVII of the Public Health Service Act.

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

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

''(2) to an applicable State authority is deemed a reference to the Secretary.''.

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

''Sec. 9813. Managed care requirements.''.

SEC. 6. MANAGED CARE REQUIREMENTS UNDER MEDICARE, MEDICAID, AND THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM (FEHBP).

(a) MEDICARE.—Section 1852 of the Social Security Act (42 U.S.C. 1395w–22) is amended by adding at the end the following new subsection:

''(l) MANAGED CARE REQUIREMENTS.—Each Medicare+Choice organization that offers a Medicare+Choice plan described in section 1851(a)(1)(A) shall comply with the applicable requirements of part C of title XXVII of the Public Health Service Act in the same manner as such requirements apply with respect to health insurance coverage offered by a health insurance issuer, except to the extent such requirements are less protective of enrollees than the requirements established under this part.''.

(b) MEDICAID.—Section 1932(b)(8) of the Social Security Act (42 U.S.C. 1396u-2(b)(8))—

(1) by striking ''AND MENTAL HEALTH'' and inserting '', MENTAL HEALTH, AND MANAGED CARE'',

(2) by inserting ''and of part C'' after ''of part A'', and

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

(c) FEDERAL EMPLOYEES' HEALTH BENEFITS PROGRAM (FEHBP).—Chapter 89 of title 5, United States Code, is amended—

(1) by inserting after the item relating to section 8905a the following new section:

''§ 8905b. Application of managed care requirements

''Each health benefit plan offered under this chapter shall comply with the applicable requirements of part C of title XXVII of the Public Health Service Act in the same manner as such requirements apply with respect to health insurance coverage offered by a health insurance issuer, except to the extent such requirements are less protective of enrollees than the requirements established under this chapter.''; and

(2) in the table of sections, by inserting the following item after the item relating to section 8905a:

''8905b. Application of managed care requirements.''.

SEC. 7. EFFECTIVE DATES.

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

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by section 2, subsections (a), (c)(1), and (d) of section 3, and sections 5 and 6 shall apply with respect to group health insurance coverage for group health plan years beginning on or after July 1, 2000 (in this section referred to as the ''general effective date'') and also shall apply to portions of plan years occurring on and after January 1, 2001.

(2) TREATMENT OF GROUP HEALTH PLANS MAINTAINED PURSUANT TO CERTAIN COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan, or group health insurance coverage provided pursuant to 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 described in paragraph (1) 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 such amendments shall not be treated as a termination of such collective bargaining agreement.

(b) GENERAL EFFECTIVE DATE FOR HEALTH INSURANCE COVERAGE.—The amendments made by section 2 and subsections (b), (c)(2), and (d) of section 3 shall apply with respect to individual health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the general effective date.

(c) EFFECTIVE DATE FOR COORDINATION.—The amendment made by section 3(e) shall take effect on the date of the enactment of this Act.

(d) FEDERAL PROGRAMS.—The amendments made by section 6 shall take effect on January 1, 2001.

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