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105TH CONGRESS
2D SESSION

H. R. 3547

To amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to assure patient choice and access to services for enrollees in group health plans and health insurance coverage.

IN THE HOUSE OF REPRESENTATIVES

MARCH 25, 1998

Mr. WELDON of Florida (for himself, Mr. BROWN of Ohio, Mr. COBURN, Mr. STRICKLAND, Mr. COOKSEY, and Mr. GREEN) introduced the following bill; which was referred to the Committee on 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 assure patient choice and access to services for enrollees in group health plans and health insurance coverage.

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 ''Patient Choice and Access to Quality Health Care Act of 1998''.

SEC. 2. FINDINGS.

Congress finds the following:

(1) There should be no unreasonable barriers or impediments to the ability of individuals enrolled in health care plans to obtain appropriate specialized medical services.

(2) The patient's first point of contact in a health care plan must be encouraged to make all appropriate medical referrals and should not be constrained financially from making such referrals.

(3) Some health care plans may impede timely access to specialty care.

(4) Some contracts between health care plans and health care professionals may contain provisions which impede the professional in informing the patient of the full range of treatment options.

(5) Patients cannot make appropriate health care decisions without access to all relevant information relating to those decisions.

(6) Restrictions on the ability of health care professionals to provide full disclosure of all relevant information to patients making health care decisions violate the principles of informed consent and the ethical standards of the health care professions. Contractual clauses and other policies that interfere with communications between health care profes-

sionals and patients can impact the quality of care received by those patients.

(7) Patients should have the opportunity to access out-of-network items, treatment, and services at an additional cost to the patient, recognizing prevalent market conditions, which is not so prohibitive that they are deterred from seeing the health care professional of their own choice.

(8) Specialty care must be available for the full duration of the patient's medical needs at the discretion of the attending health care professional in consultation with the patient.

(9) Access to specialty care is essential for patients in emergency and non-emergency situations and for patients with chronic and temporary conditions.

SEC. 3. PROTECTION FOR HEALTH PLAN ENROLLEES.

(a) GROUP HEALTH PLANS.—

(1) PUBLIC HEALTH SERVICE ACT AMENDMENTS.—

(A) 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. ADDITIONAL ENROLLEE PROTECTIONS.

"(a) ASSURING ADEQUATE IN-NETWORK ACCESS.—

"(1) TIMELY ACCESS.—A group health plan, and a health insurance issuer offering group health insurance coverage, that restricts the health care professionals from whom benefits may be obtained shall guarantee to enrollees timely access to primary and specialty health care professionals who are appropriate to the enrollee's condition.

"(2) ACCESS TO SPECIALIZED CARE.—A group health plan, and a health insurance issuer offering group health insurance coverage, shall assure that enrollees have access to specialized treatment when medically necessary. This access may be satisfied through contractual arrangements with specialized providers outside of the network.

"(3) CONTINUITY OF CARE.—A group health plan, and a health insurance issuer offering group health insurance coverage, shall assure that the plan's or issuer's use of case management may not create an undue burden for enrollees under this section. The plan and issuer shall ensure direct access to specialists for ongoing care as so determined by the case manager in consultation with the specialty care professional. This continuity of care may be satisfied for enrollees with chronic conditions through the use of a specialist serving as case manager.

"(b) GRIEVANCE PROCESS.—

"(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide a meaningful and expedited procedure, which includes notice and hearing requirements, for resolving grievances between the plan or issuer (including any entity or individual through which the plan or issuer provides health care services) and enrollees. Under the procedure any such enrollee may at any time file a complaint to resolve grievances between the enrollee and the plan or issuer before a board of appeals established under paragraph (3).

"(2) NOTICE REQUIREMENTS.—

"(A) IN GENERAL.—Such a plan or issuer shall provide, in a timely manner, an enrollee a notice of any denial of services in-network or denial of payment for out-of-network care.

"(B) INFORMATION REQUIRED.—Such notice shall include the following:

"(i) A clear statement of the reason for the denial.

"(ii) An explanation of the complaint process under paragraph (3) which is available to the enrollee upon request.

"(iii) An explanation of all other appeal rights available to all enrollees.

"(iv) A description of how to obtain supporting evidence for the hearing described in paragraph (3), including the patient's medical records from the plan or issuer, as well as supporting affidavits from the attending health care professionals.

"(3) HEARING BOARD.—

"(A) IN GENERAL.—Each group health plan, and each health insurance issuer offering group health insurance coverage, shall establish a board of appeals to hear and make determinations on complaints by enrollees concerning denials of coverage or payment for services (whether in-network or out-of-network) and the medical necessity and appropriateness of covered items and services.

"(B) COMPOSITION.—A board of appeals of a plan or issuer shall consist of—

"(i) representatives of the plan or issuer, including physicians, nonphysicians, administrators, and enrollees;

"(ii) consumers who are not enrollees and who have no financial interest in the plan or issuer; and

"(iii) health care professionals who are not under contract with and have no financial interest in the plan or issuer and who are experts in the field of medicine which necessitates treatment.

"(C) DEADLINE FOR DECISION.—

"(i) IN GENERAL.—Except as provided in clause (ii), a board of appeals shall hear and resolve complaints within 30 days after the date the complaint is filed with the board.

"(ii) EXPEDITED PROCEDURE.—A board of appeals shall have an expedited procedure in order to hear and resolve complaints regarding urgent care.

"(c) NOTICE OF ENROLLEE RIGHTS AND ENROLLEE INFORMATION CHECKLIST.—

"(1) IN GENERAL.—Each group health plan, and each health insurance issuer offering group health insurance coverage, shall provide each enrollee, at the time of enrollment and not less frequently than annually thereafter, an explanation of the enrollee's rights under this section and a copy of the most recent enrollee information checklist for the plan or issuer (as described in paragraph (3)).

"(2) RIGHTS DESCRIBED.—The explanation of rights under paragraph (1) shall include an explanation of—

"(A) the enrollee's rights to benefits from the plan or issuer;

"(B) the restrictions on payments (if any) under the plan or coverage for services furnished other than by or through the plan or issuer;

"(C) out-of-area coverage provided under the plan or coverage;

"(D) the plan's or issuer's coverage of emergency services and urgently needed care;

"(E) the plan's or issuer's coverage of out-of-network services; and

"(F) appeal rights of enrollees.

"(3) ENROLLEE INFORMATION CHECKLIST.—For purposes of paragraph (1), the term 'enrollee information checklist' means, with respect to a plan or issuer for a year, a list containing the following information (provided in a manner that permits consumers to compare plans and issuers with respect to the information):

“(A) For each plan or coverage offered, information on the following:

“(i) The premium for the plan or coverage.

“(ii) The benefits offered under the plan or coverage.

“(iii) the amount of any deductibles, coinsurance, or any monetary limits on benefits.

“(iv) The identity, location, qualifications, and availability of health care professionals in any networks of the plan or issuer.

“(v) The procedures used by the plan or issuer to control utilization of services and expenditures, including any financial incentives.

“(vi) The procedures used by the plan or issuer to ensure quality of care.

“(vii) The rights and responsibilities of enrollees.

"(viii) The number of applications during the previous plan year requesting that the plan or issuer cover certain medical services that were denied by the plan or issuer (and the number of such denials that were subsequently reversed by the plan or issuer), stated as a percentage of the total number of applications during such period requesting that the plan or issuer cover such services.

"(ix) The number of times during the previous plan year that a court of law upheld or reversed a denial of a request that the plan or issuer cover certain medical services.

"(x) The restrictions (if any) on payment for services provided outside the plan's or issuer's health care professional network.

"(xi) The process by which services may be obtained through the plan's or issuer's health care professional network.

"(xii) Coverage for out-of-area services.

"(xiii) Any exclusions in the types of health care professionals participating in the plan's or issuer's health care professional network.

"(d) RESTRICTIONS ON HEALTH CARE PROFESSIONAL INCENTIVE PLANS.—A group health plan, and a health insurance issuer offering group health insurance coverage, may not operate any health care professional incentive plan under which a specific payment is made directly or indirectly under the plan to a health care professional or professional group as an inducement to reduce or limit medically necessary services provided with respect to enrollees.

"(e) PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.—

"(1) IN GENERAL.—

"(A) PROHIBITION OF CERTAIN PROVISIONS.—Subject to paragraph (3), a group health plan, and a health insurance issuer offering group health insurance coverage, may not include under the plan or coverage any provision that prohibits or restricts any medical communication (as defined in paragraph (2)) as part of—

"(i) a written contract or agreement with a health care professional,

"(ii) a written statement to such a professional, or

"(iii) an oral communication to such a professional.

"(B) NULLIFICATION.—Any provision described in clause (i) is null and void.

"(2) MEDICAL COMMUNICATION DEFINED.—In this paragraph, the term 'medical communication' means a communication made by a health care professional with a patient of the professional (or the guardian or legal representative of such patient) with respect to any of the following:

"(A) How participating physicians and health care professionals are paid.

"(B) Utilization review procedures.

"(C) The basis for specific utilization review decisions.

"(D) Whether a specific prescription drug or biological is included in the formulary.

"(E) How the plan or organization decides whether a treatment or procedure is experimental.

"(F) The patient's physical or mental condition or treatment options.

"(3) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing an entity from—

"(A) acting on information relating to the provision of (or failure to provide) treatment to a patient, or

"(B) restricting a medical communication that recommends one health plan over another if the sole purpose of the communication is to secure financial gain for the health care professional.

"(f) OUT-OF-NETWORK ACCESS.—

"(1) IN GENERAL.—Subject to paragraph (2), if a group health plan, or a health insurance issuer offering group health insurance coverage, offers to enrollees coverage for benefits for services only if such services are furnished through professionals and other persons who are members of a network of professionals and other persons who have entered into a contract with the plan or issuer to provide such services, the plan or issuer shall also offer to such enrollees (at the time of enrollment) the option of coverage of such services which are not furnished through professionals and other persons who are members of such a network.

"(2) EFFECTIVENESS.—Paragraph (1) shall apply only in accordance with section 3(b)(2) of the Patient Choice and Access to Quality Health Care Act of 1998 (relating to a finding by the Secretary that the other patient protections have not assured quality of care).

"(g) ADDITIONAL DEFINITIONS.—For purposes of this section:

"(1) HEALTH CARE PROFESSIONAL.—The term 'health care professional' means a physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with State law.

"(2) IN-NETWORK.—The term 'in-network' means services provided by health care professionals who have entered into a contract or agreement with a group health plan, or health insurance issuer offering group health insurance coverage in connection with such a plan, under which such professionals are obligated to provide items, treatment, and services under this section to individuals enrolled under the plan.

"(3) NETWORK.—The term 'network' means, with respect to a group health plan or a health insurance issuer that offers group health insurance coverage in connection with such a plan, the health care professionals who have entered into a contract or agreement with the plan or issuer under which such professionals are obligated to provide items, treatment, and services under this section to individuals enrolled under the plan.

"(4) OUT-OF-NETWORK.—The term 'out-of-network' means services provided by health care professionals who have not entered into a contract or agreement described in paragraph (2).

"(h) NOTICE.—A group health plan under this part shall comply with the notice requirement under section 713(b) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of this section as if such section applied to such plan.".

(B) REFERENCE TO NON-PREEMPTION PROVISION.—Pursuant to section 2723 of the Public Health Service Act, States may provide protections for individuals that are equivalent to or stricter than the protections provided under the amendment made by subparagraph (A).

(C) CONFORMING AMENDMENT.—Section 2723(c) of such Act (42 U.S.C. 300gg–23(c)), as amended by section 604(b)(2) of Public Law 104–204, is amended by striking ''section 2704'' and inserting ''sections 2704 and 2706''.

(2) ERISA AMENDMENTS.—

(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. 713. ADDITIONAL ENROLLEE PROTECTIONS.

''(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 section 2706 of the Public Health Service Act. For purposes of applying this subsection, any reference in such section 2706 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) NOTICE UNDER GROUP HEALTH PLAN.—The imposition of the requirement of this section shall be treated as a material modification in the terms of the plan described in section 102(a)(1), for purposes of assuring notice of such requirements under the plan; except that the summary description required to be provided under the last sentence of section 104(b)(1) with respect to such modification shall be provided by not later than 60 days after the first day of the first plan year in which such requirement apply.''.

(B) REFERENCE TO NON-PREEMPTION PROVISION.—Pursuant to section 731 of the Employee Retirement Income Security Act of 1974, States may provide protections for individuals that are equivalent to or stricter than the protections provided under the amendment made by subparagraph (A).

(C) CONFORMING AMENDMENTS.—(i) Section 731(c) of such Act (29 U.S.C. 1191(c)) is amended by striking ''section 711'' and inserting ''sections 711 and 713''.

(ii) Section 732(a) of such Act (29 U.S.C. 1191a(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 713''.

(D) 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. Additional enrollee protections.''.

(b) INDIVIDUAL HEALTH INSURANCE.—

(1) IN GENERAL.—Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2751 the following new section:

"SEC. 2752. ADDITIONAL ENROLLEE PROTECTIONS.

"(a) IN GENERAL.—The provisions of section 2706 (other than subsection (i)) shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

"(b) NOTICE.—A health insurance issuer under this part shall comply with the notice requirement under section 713(b) of the Employee Retirement Income Security Act of 1974 with respect to the requirements referred to in subsection (a) as if such section applied to such issuer and such issuer were a group health plan.".

(2) REFERENCE TO NON-PREEMPTION PROVISION.—Pursuant to section 2762 of the Public Health Service Act, States may provide protections for individuals that are equivalent to or stricter than the protections provided under the amendment made by paragraph (1).

(3) CONFORMING AMENDMENT.—Section 2762(b)(2) of such Act (42 U.S.C. 300gg–62(b)(2))

is amended by striking "section 2751" and inserting "sections 2751 and 2752".

(c) EFFECTIVE DATES.—

(1) GROUP HEALTH PLANS.—

(A) IN GENERAL.—Subject to subparagraph (B), the amendments made by subsection (a) shall apply with respect to group health plans for plan years beginning on or after January 1, 1999.

(B) RULE FOR CERTAIN COLLECTIVE BARGAINING AGREEMENTS.—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 subsection (a) shall not apply to plan years beginning before the later of—

(i) 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

(ii) January 1, 1999.

For purposes of clause (i), 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.

(2) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The amendment made by subsection (b) shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after such date.

(d) COORDINATED REGULATIONS.—Section 104(1) of Health Insurance Portability and Accountability Act of 1996 is amended by striking ''this subtitle (and the amendments made by this subtitle and section 401)'' and inserting ''the provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, the provisions of parts A and C of title XXVII of the Public Health Service Act, and chapter 100 of the Internal Revenue Code of 1986''.

SEC. 4. REPORT ON EFFECTIVENESS OF PATIENT PROTECTIONS.

(a) STUDY.—The Secretary of Health and Human Services shall provide for a study on the effectiveness of the amendments made by section 3 in assuring quality of care for patients. Such study shall also examine any additional costs imposed as a result of the enactment of such amendments.

(b) REPORT.—

(1) IN GENERAL.—The Secretary shall submit to Congress a report on such study not later than January 1, 2001.

(2) FINDING REGARDING QUALITY CARE.—The Secretary shall include in the report a specific finding as to whether, taking into account the patient protections provided under such amendments, individuals covered under health plans are not being provided quality care. If the Secretary makes such a finding that individuals covered under health plans are not being provided quality care and if Congress concurs by joint resolution or Act with such a finding, then subsection (f)(1) of section 2706 of the Public Health Service Act shall become effective in the same manner as amendments made by subsections (a) and (b) of section 3 become effective under section 3(c), except that (for purposes of this paragraph) any reference in such section 3(c) to January 1, 1999, shall be deemed a reference to January 1, 2002.

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