AMENDMENT IN THE NATURE OF A SUBSTITUTE TO H.R. 2046

OFFERED BY MR. FLETCHER

Strike all after the enacting clause and insert the following:

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the "Ensuring Informed
3 Health Consumers Act of 1999".

4 **SEC. 2. PATIENT ACCESS TO INFORMATION REGARDING**
5 **PLAN COVERAGE, MANAGED CARE PROCE-**
6 **DURES, HEALTH CARE PROVIDERS, AND**
7 **QUALITY OF MEDICAL CARE.**

8 (a) IN GENERAL.—Part 1 of subtitle B of title I of
9 the Employee Retirement Income Security Act of 1974 is
10 amended—

11 (1) by redesignating section 111 as section 112;
12 and

13 (2) by inserting after section 110 the following
14 new section:

15 "DISCLOSURE BY GROUP HEALTH PLANS

16 "SEC. 111. (a) DISCLOSURE REQUIREMENT.—

17 "(1) GROUP HEALTH PLANS.—The adminis-
18 trator of each group health plan shall take such ac-
19 tions as are necessary to ensure that the summary
20 plan description of the plan required under section

1 102 (or each summary plan description in any case
2 in which different summary plan descriptions are ap-
3 propriate under part 1 for different options of cov-
4 erage) contains, among any information otherwise
5 required under this part, the information required
6 under subsections (b), (c), (d), and (e)(2)(A).

7 "(2) HEALTH INSURANCE ISSUERS.—Each
8 health insurance issuer offering health insurance
9 coverage in connection with a group health plan
10 shall provide the administrator on a timely basis
11 with the information necessary to enable the admin-
12 istrator to comply with the requirements of para-
13 graph (1). To the extent that any such issuer pro-
14 vides on a timely basis to plan participants and
15 beneficiaries information otherwise required under
16 this part to be included in the summary plan de-
17 scription, the requirements of sections 101(a)(1) and
18 104(b) shall be deemed satisfied in the case of such
19 plan with respect to such information.

20 "(b) PLAN BENEFITS.—The information required
21 under subsection (a) includes the following:

22 "(1) COVERED ITEMS AND SERVICES.—

23 "(A) CATEGORIZATION OF INCLUDED BEN-
24 EFITS.—A description of covered benefits, cat-
25 egorized by—

1 "(i) types of items and services (in-
2 cluding any special disease management
3 program); and
4 "(ii) types of health care professionals
5 providing such items and services.
6 "(B) EMERGENCY MEDICAL CARE.—A de-
7 scription of the extent to which the plan covers
8 emergency medical care (including the extent to
9 which the plan provides for access to urgent
10 care centers), and any definitions provided
11 under the plan for the relevant plan terminol-
12 ogy referring to such care.
13 "(C) PREVENTATIVE SERVICES.—A de-
14 scription of the extent to which the plan pro-
15 vides benefits for preventative services.
16 "(D) DRUG FORMULARIES.—A description
17 of the extent to which covered benefits are de-
18 termined by the use or application of a drug
19 formulary and a summary of the process for de-
20 termining what is included in such formulary.
21 "(E) COBRA CONTINUATION COV-
22 ERAGE.—A description of the benefits available
23 under the plan pursuant to part 6.
24 "(2) LIMITATIONS, EXCLUSIONS, AND RESTRIC-
25 TIONS ON COVERED BENEFITS.—

1 "(A) CATEGORIZATION OF EXCLUDED
2 BENEFITS.—A description of benefits specifi-
3 cally excluded from coverage, categorized by
4 types of items and services.
5 "(B) UTILIZATION REVIEW AND
6 PREAUTHORIZATION REQUIREMENTS.—Whether
7 coverage for medical care is limited or excluded
8 on the basis of utilization review or
9 preauthorization requirements.
10 "(C) LIFETIME, ANNUAL, OR OTHER PE-
11 RIOD LIMITATIONS.—A description of the cir-
12 cumstances under which, and the extent to
13 which, coverage is subject to lifetime, annual, or
14 other period limitations, categorized by types of
15 benefits.
16 "(D) CUSTODIAL CARE.—A description of
17 the circumstances under which, and the extent
18 to which, the coverage of benefits for custodial
19 care is limited or excluded, and a statement of
20 the definition used by the plan for custodial
21 care.
22 "(E) EXPERIMENTAL TREATMENTS.—
23 Whether coverage for any medical care is lim-
24 ited or excluded because it constitutes experi-
25 mental treatment or technology, and any defini-

1 tions provided under the plan for the relevant
2 plan terminology referring to such limited or
3 excluded care.

4 "(F) MEDICAL APPROPRIATENESS OR NE-
5 CESSITY.—Whether coverage for medical care
6 may be limited or excluded by reason of a fail-
7 ure to meet the plan's requirements for medical
8 appropriateness or necessity, and any defini-
9 tions provided under the plan for the relevant
10 plan terminology referring to such limited or
11 excluded care.

12 "(G) SECOND OR SUBSEQUENT OPIN-
13 IONS.—A description of the circumstances
14 under which, and the extent to which, coverage
15 for second or subsequent opinions is limited or
16 excluded.

17 "(H) SPECIALTY CARE.—A description of
18 the circumstances under which, and the extent
19 to which, coverage of benefits for specialty care
20 is conditioned on referral from a primary care
21 provider.

22 "(I) CONTINUITY OF CARE.—A description
23 of the circumstances under which, and the ex-
24 tent to which, coverage of items and services
25 provided by any health care professional is lim-

ited or excluded by reason of the departure by the professional from any defined set of providers.

"(J) RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—A description of the circumstances under which, and the extent to which, the plan, in covering emergency medical care furnished to a participant or beneficiary of the plan imposes any financial responsibility described in subsection (c) on participants or beneficiaries or limits or conditions benefits for such care subject to any other term or condition of such plan.

"(c) PARTICIPANT'S FINANCIAL RESPONSIBILITIES.—The information required under subsection (a) includes an explanation of—

"(1) a participant's financial responsibility for payment of premiums, coinsurance, copayments, deductibles, and any other charges; and

"(2) the circumstances under which, and the extent to which, the participant's financial responsibility described in paragraph (1) may vary, including any distinctions based on whether a health care provider from whom covered benefits are obtained is included in a defined set of providers.

1 “(d) DISPUTE RESOLUTION PROCEDURES.—The in-
2 formation required under subsection (a) includes a de-
3 scription of the processes adopted by the plan pursuant
4 to section 503, including—
5 “(1) descriptions thereof relating specifically
6 to—
7 “(A) coverage decisions;
8 “(B) internal review of coverage decisions;
9 and
10 “(C) any external review of coverage deci-
11 sions; and
12 “(2) the procedures and time frames applicable
13 to each step of the processes referred to in subpara-
14 graphs (A), (B), and (C) of paragraph (1).
15 “(e) INFORMATION ON PATIENT SATISFACTION AND
16 OUTCOMES.—Any information required under subsection
17 (a) shall include a description of measures of patient satis-
18 faction and outcomes under a group health plan (or health
19 insurance coverage offered in connection with such a
20 plan), including information concerning the number of ex-
21 ternal reviews under section 503 that have been completed
22 during the prior plan year and the number of such reviews
23 in which a recommendation is made for modification or
24 reversal of an internal review decision under the plan. The
25 description of measures of patient outcomes shall be based

1 on data collected by the plan to the extent that such data
2 is available to the plan as a result of the type of coverage
3 options the plan provides.

4 "(f) INFORMATION AVAILABLE ON REQUEST.—

5 "(1) ACCESS TO PLAN BENEFIT INFORMATION
6 IN ELECTRONIC FORM.—

7 "(A) IN GENERAL.—In addition to the in-
8 formation required to be provided under section
9 104(b)(4), a group health plan (and a health
10 insurance issuer offering health insurance cov-
11 erage in connection with a group health plan)
12 may, upon written request (made not more fre-
13 quently than annually), make available to par-
14 ticipants and beneficiaries, in a generally recog-
15 nized electronic format—

16 "(i) the latest summary plan descrip-
17 tion, including the latest summary of ma-
18 terial modifications, and

19 "(ii) the actual plan provisions setting
20 forth the benefits available under the plan,

21 to the extent such information relates to the
22 coverage options under the plan available to the
23 participant or beneficiary. A reasonable charge
24 may be made to cover the cost of providing
25 such information in such generally recognized

1 electronic format. The Secretary may by regula-
2 tion prescribe a maximum amount which will
3 constitute a reasonable charge under the pre-
4 ceding sentence.
5 "(B) ALTERNATIVE ACCESS.—The require-
6 ments of this paragraph may be met by making
7 such information generally available (rather
8 than upon request) on the Internet or on a pro-
9 prietary computer network in a format which is
10 readily accessible to participants and bene-
11 ficiaries.
12 "(2) ADDITIONAL INFORMATION TO BE PRO-
13 VIDED ON REQUEST.—
14 "(A) INCLUSION IN SUMMARY PLAN DE-
15 SCRIPTION OF SUMMARY OF ADDITIONAL IN-
16 FORMATION.—The information required under
17 subsection (a) includes a summary description
18 of the types of information required by this
19 subsection to be made available to participants
20 and beneficiaries on request.
21 "(B) INFORMATION REQUIRED FROM
22 PLANS AND ISSUERS ON REQUEST.—In addition
23 to information required to be included in sum-
24 mary plan descriptions under this subsection, a
25 group health plan (and a health insurance

1 issuer offering health insurance coverage in
2 connection with a group health plan) shall pro-
3 vide the following information to a participant
4 or beneficiary on request:
5 ‘‘(i) NETWORK CHARACTERISTICS.—If
6 the plan (or issuer) utilizes a defined set of
7 providers under contract with the plan (or
8 issuer), a detailed list of the names of such
9 providers and their geographic location, set
10 forth separately with respect to primary
11 care providers and with respect to special-
12 ists.
13 ‘‘(ii) CARE MANAGEMENT INFORMA-
14 TION.—A description of the circumstances
15 under which, and the extent to which, the
16 plan has special disease management pro-
17 grams or programs for persons with dis-
18 abilities, indicating whether these pro-
19 grams are voluntary or mandatory and
20 whether a significant benefit differential
21 results from participation in such pro-
22 grams.
23 ‘‘(iii) INCLUSION OF DRUGS AND
24 BIOLOGICALS IN FORMULARIES.—A state-
25 ment of whether a specific drug or biologi-

1 cal is included in a formulary used to de-
2 termine benefits under the plan and a de-
3 scription of the procedures for considering
4 requests for any patient-specific waivers.
5 "(iv) PROCEDURES FOR DETERMINING
6 EXCLUSIONS BASED ON MEDICAL NECES-
7 SITY OR EXPERIMENTAL TREATMENTS.—
8 Upon receipt by the participant or bene-
9 ficiary of any notification of an adverse
10 coverage decision based on a determination
11 relating to medical necessity or an experi-
12 mental treatment or technology, a descrip-
13 tion of the procedures and medically-based
14 criteria used in such decision.
15 "(v) PREAUTHORIZATION AND UTILI-
16 ZATION REVIEW PROCEDURES.—Upon re-
17 ceipt by the participant or beneficiary of
18 any notification of an adverse coverage de-
19 cision, a description of the basis on which
20 any preauthorization requirement or any
21 utilization review requirement has resulted
22 in such decision.
23 "(vi) ACCREDITATION STATUS OF
24 HEALTH INSURANCE ISSUERS AND SERV-
25 ICE PROVIDERS.—A description of the ac-

1 creditation and licensing status (if any) of
2 each health insurance issuer offering
3 health insurance coverage in connection
4 with the plan and of any utilization review
5 organization utilized by the issuer or the
6 plan, together with the name and address
7 of the accrediting or licensing authority.
8 ''(vii) QUALITY PERFORMANCE MEAS-
9 URES.—The latest information (if any)
10 maintained by the plan, or by any health
11 insurance issuer offering health insurance
12 coverage in connection with the plan, relat-
13 ing to quality of performance of the deliv-
14 ery of medical care with respect to cov-
15 erage options offered under the plan and
16 of health care professionals and facilities
17 providing medical care under the plan.
18 ''(C) INFORMATION REQUIRED FROM
19 HEALTH CARE PROFESSIONALS ON REQUEST.—
20 Any health care professional treating a partici-
21 pant or beneficiary under a group health plan
22 shall provide to the participant or beneficiary,
23 on request, a description of his or her profes-
24 sional qualifications (including board certifi-
25 cation status, licensing status, and accreditation

1 status, if any), privileges, and experience and a
2 general description by category (including sal-
3 ary, fee-for-service, capitation, and such other
4 categories as may be specified in regulations of
5 the Secretary) of the applicable method by
6 which such professional is compensated in con-
7 nection with the provision of such medical care.
8 ''(D) INFORMATION REQUIRED FROM
9 HEALTH CARE FACILITIES ON REQUEST.—Any
10 health care facility from which a participant or
11 beneficiary has sought treatment under a group
12 health plan shall provide to the participant or
13 beneficiary, on request, a description of the fa-
14 cility's corporate form or other organizational
15 form and all forms of licensing and accredita-
16 tion status (if any) assigned to the facility by
17 standard-setting organizations.
18 ''(g) ACCESS TO INFORMATION RELEVANT TO THE
19 COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR
20 BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to
21 information otherwise required to be made available under
22 this section, a group health plan (and a health insurance
23 issuer offering health insurance coverage in connection
24 with a group health plan) shall, upon written request
25 (made not more frequently than annually), make available

1 to a participant (and an employee who, under the terms
2 of the plan, is eligible for coverage but not enrolled) in
3 connection with a period of enrollment the summary plan
4 description for any coverage option under the plan under
5 which the participant is eligible to enroll and any informa-
6 tion described in clauses (i), (ii), (iii), (vi), (vii), and (viii)
7 of subsection (e)(2)(B).

8 ''(h) ADVANCE NOTICE OF CHANGES IN DRUG
9 FORMULARIES.—Not later than 30 days before the effec-
10 tive of date of any exclusion of a specific drug or biological
11 from any drug formulary under the plan that is used in
12 the treatment of a chronic illness or disease, the plan shall
13 take such actions as are necessary to reasonably ensure
14 that plan participants are informed of such exclusion. The
15 requirements of this subsection may be satisfied—

16 ''(1) by inclusion of information in publications
17 broadly distributed by plan sponsors, employers, or
18 employee organizations;

19 ''(2) by electronic means of communication (in-
20 cluding the Internet or proprietary computer net-
21 works in a format which is readily accessible to par-
22 ticipants);

23 ''(3) by timely informing participants who,
24 under an ongoing program maintained under the

1 plan, have submitted their names for such notifica-
2 tion; or
3 "(4) by any other reasonable means of timely
4 informing plan participants.
5 "(i) DEFINITIONS.—For purposes of this section—
6 "(1) GROUP HEALTH PLAN.—The term 'group
7 health plan' has the meaning provided such term
8 under section 733(a)(1).
9 "(2) MEDICAL CARE.—The term 'medical care'
10 has the meaning provided such term under section
11 733(a)(2).
12 "(3) HEALTH INSURANCE COVERAGE.—The
13 term 'health insurance coverage' has the meaning
14 provided such term under section 733(b)(1).
15 "(4) HEALTH INSURANCE ISSUER.—The term
16 'health insurance issuer' has the meaning provided
17 such term under section 733(b)(2).".
18 (b) CONFORMING AMENDMENTS.—
19 (1) Section 102(b) of such Act (29 U.S.C.
20 1022(b)) is amended by inserting before the period
21 at the end the following: "; and, in the case of a
22 group health plan (as defined in section 111(i)(1)),
23 the information required to be included under sec-
24 tion 111(a)".

1 (2) The table of contents in section 1 of such
2 Act is amended by striking the item relating to sec-
3 tion 111 and inserting the following new items:

"Sec. 111. Disclosure by group health plans.
"Sec. 112. Repeal and effective date.".

4 **SEC. 4. EFFECTIVE DATE AND RELATED RULES.**

5 (a) IN GENERAL.—The amendments made by this
6 Act shall apply with respect to plan years beginning on
7 or after January 1 of the second calendar year following
8 the date of the enactment of this Act. The Secretary shall
9 first issue all regulations necessary to carry out the
10 amendments made by this subtitle before such date.

11 (b) LIMITATION ON ENFORCEMENT ACTIONS.—No
12 enforcement action shall be taken, pursuant to the amend-
13 ments made by this Act, against a group health plan or
14 health insurance issuer with respect to a violation of a re-
15 quirement imposed by such amendments before the date
16 of issuance of final regulations issued in connection with
17 such requirement, if the plan or issuer has sought to com-
18 ply in good faith with such requirement.