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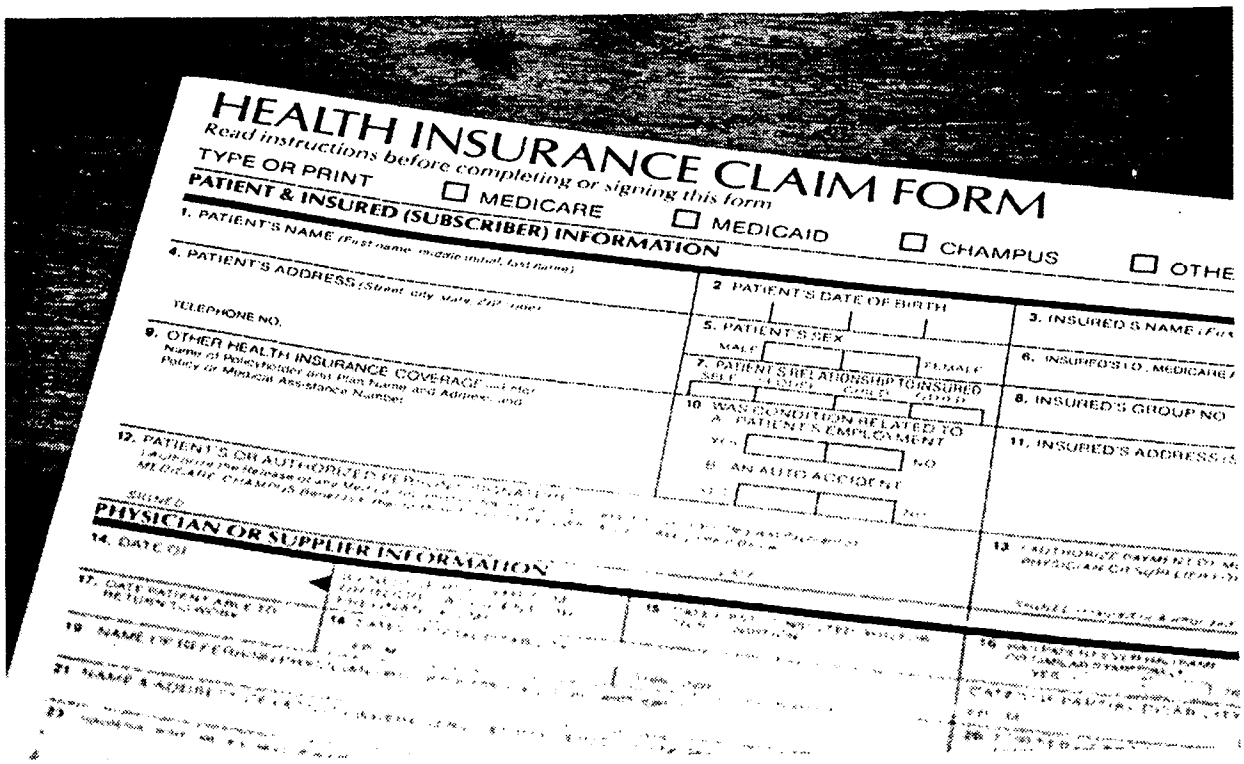
ABSTRACT

This report is designed to familiarize American Counseling Association members with the concepts and terminology of managed care, and the various options for regulating managed care to safeguard the interests and rights of professional counselors and their clients. Topics covered in this report include controlling costs, private sector oversight, growing federal interest in regulation of managed care, and coalition efforts. Summaries of New York's Managed Care Law and the Patient Access to Responsible Care Act (PACRA) of 1997 are provided. A glossary of managed care terms and information on the Employee Retirement and Income Security Act and the Mental Health Bill of Rights are also provided. A sample letter in support of PACRA and a copy of Bill S.644 proposed to amend PACRA are included. (MKA)

MANAGED CARE
A PRIMER ON ISSUES AND LEGISLATION



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INTRODUCTION

Today, health care in the United States means managed care. Gone are the days of traditional indemnity insurance, where insurers paid the bills and left treatment decisions to individual health care providers and hospitals. Under continual pressure from employers to keep costs down, insurers have now gotten into the business of both assuming financial risk involved in contracting for employees' needed health care services *and* overseeing and orchestrating the services actually provided. This sea change is being matched by efforts in federal and state legislatures and by the private sector to ensure that managed care does not result in poor quality care.

This report is designed to familiarize ACA members with the concepts and terminology of managed care, and the various options for regulating managed care to safeguard the interests and rights of professional counselors and their clients.

As this report will be updated in the future, we encourage your feedback. Please contact us at (800) 347-6647 x234 to share your thoughts, comments, or other information.

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Managed Care Takes Over

In a report released July 24th, 1997, the U.S. General Accounting Office (GAO) calculated that 70.5 percent of Americans under the age of 65 had private health insurance coverage. Of that population, it is estimated that roughly 4 out of 5 are covered by a managed care organization (MCO). By the year 2000, some experts predict that fewer than one in 10 employees will be covered by a traditional fee-for-service indemnity plan.

Managed care is coming to dominate the public health care sector, as well. Under the Balanced Budget Act of 1997, lawmakers made significant changes in both the Medicare and Medicaid programs in order to speed up the enrollment of beneficiaries in managed care organizations. The proliferation of managed care coverage in public sector health care programs will have a significant impact on the delivery of mental health services. Private sector MCO's typically provide care for people with mild to moderate affective disorders, while the public sector provides care primarily for those with long-term and severe mental and emotional disorders.

Managed care can create increased opportunities for professional counselors and other non-physician providers, and in greater access and in better patient care; it can also result in providers getting shut out of health plans and in reduced access to care. Professional counselors must be familiar with managed care, and should become actively involved in state, federal, and private sector initiatives to ensure that managed care works for both consumers and providers.

Managed care enrollment has been growing so rapidly because of its impact on health care costs. A recent study commissioned by the American Association of Health Plans, a managed care trade organization, estimated that between 1990 and 1996 managed care saved private employers over $80 billion in health care costs. Since mental health care costs have risen faster than general medical costs, the trend toward managed care in this sector has also been pronounced. As of 1996, an estimated 124 million Americans with private health insurance received their mental health and substance abuse services through a managed behavioral healthcare plan.

While there is some debate as to whether managed care savings are a one-time phenomenon lasting only for the first year or so of implementation, or are more permanent, there is general agreement that managed care does reduce costs. The question increasingly being asked by the public and by policymakers at the state and federal level is how those cost savings are achieved: is it through increased efficiency and quality of care, or is it through inappropriate denial of coverage and decreased payment levels?

Before discussing this issue in more detail, a definition of terms is in order. Although when someone hears the term "managed care organization" they typically envision a health maintenance organization, or "HMO", there are in fact many different kinds of managed care organizations. In fact, many consider the very term "managed care organization" to be outdated. In any case, what we usually think of as a managed care organization can take one of many forms. The short glossary on page three helps clarify some of the different varieties of managed care organizations, and common terms used in describing managed care plans.

A Glossary of Managed Care Terms

Managed Care Organization (MCO), Health Maintenance Organization (HMO) — a health care plan which delivers certain health care services to a group of individuals on a prepaid basis.

Carve-Out — an arrangement wherein a portion of a health benefit package is administered or provided by a subcontracting organization separate from the managed care organization responsible for the benefit package as a whole. Most carve-outs pertain to mental health and substance abuse benefits, which are provided by a managed behavioral healthcare organization.

Staff-model HMO — a health maintenance organization in which all health care providers are salaried employees of the organization, and the facilities and clinics in which enrollees receive services are owned by the organization. Patients generally may receive services only from these health care providers.

Group-model HMO — an HMO made up of one or more physician group practices that are not owned by the HMO, but that instead operate as independent partnerships or corporations. The HMO pays the group a negotiated rate, and each group in turn is responsible for paying its health care providers and other staff and for paying for hospital care or care from outside specialists.

Preferred Provider Organization (PPO) — uses a specific, select group of health care providers who agree to follow certain practice guidelines and accept specified payment levels for services. Enrollees are usually able to obtain services from PPO providers at lower cost than from non-network providers.

Managed Behavioral Healthcare Organization (MBHO) — contracts with a larger entity, typically another managed care organization, for the provision of mental health and substance abuse services to plan enrollees. This arrangement, wherein a portion of the benefit package is administered by a separate subcontracting organization, is known as a **"carve out"**.

Provider Sponsored Organization (PSO) — an organization established by a group of health care providers who join together to set up their own network of service-delivery personnel and facilities.

Management Services Organization (MSO) — a company which contracts with health care provider groups for handling their business needs, including billing, collecting fees, and the like.

Network — the collection of physicians, health care providers, clinics, hospitals, and other facilities and personnel that a managed care plan has selected to provide services to its enrollees.

Point Of Service option (POS) — a type of managed care plan coverage under which an enrollee is allowed to see providers outside of the managed care plan's network, usually at a slightly higher copayment or deductible cost.

Capitation — a method of paying for health care services on a per-person (or "per covered life") basis rather than on a per-procedure basis (as in traditional indemnity insurance). Under this form of payment, a managed care plan pays a health care provider a fixed amount of money for every plan enrollee he or she sees, regardless of how much or how little care the member receives.

Termination without Cause — many managed care plan provider contracts allow the plan to terminate the provider's contract "without cause," thus allowing the managed care plan to unilaterally end the contract without providing an explanation or access to an appeals procedure.

Incentive clause — a provision in a managed care plan employee contract which links compensation to denial or limiting of services provided to plan enrollees.

In any of its forms, a managed care organization is an entity which provides a specific set of benefits for a pre-determined amount of money, accepting the financial risk associated with being responsible for providing care. Managed care organizations exercise a degree of control over how services are provided and how providers are paid which traditional indemnity plans do not. Consequently, MCO's see themselves—and their providers—as responsible for the entire enrollee population, and thus obligated to ensure that limited resources are distributed equitably. This perspective often conflicts with the traditional caregiver-patient dyad, in which the individual patient is of paramount importance.

Managed care plans' control over service delivery manifests itself in many different ways. One is that MCOs typically exhibit a high degree of "vertical integration". In fact, many analysts prefer to use the term "integrated systems of care" instead of "managed care". When fee-for-service health care ruled the land, a hospital, independent health service provider, and health clinic would each operate largely independently. Each would see a patient, and then bill the patient's health insurance for the care provided. Today that same hospital, health clinic, and a number of health providers may be under contract with (if not "owned" by) a managed care firm. Thus, an individual enrollee receives care—or payment for care—from the same organization, regardless of whether that care is provided in a therapist's office, an outpatient clinic or day treatment facility, or a hospital.

Controlling Costs

Managed care plans control costs in a number of ways:

- **limiting who gets on provider pools and networks**—In general, the fewer providers a managed care plan has on staff, the fewer health care services it is likely to have to pay for. The influence of this practice can be subtle. A health plan could choose to sign up fewer specialists, who provide higher-cost services more frequently, or could choose to sign up fewer providers in low-income neighborhoods, whose residents may need more health care services.
- **limiting access to network providers**—Even though a managed care plan signs you up as a health care provider, it may simply decide not to refer any of its enrollees to you. Most managed care plans require enrollees to obtain care by first going through a primary care provider (PCP), often a family or general practitioner, who acts as a gatekeeper to any specialty care needed.
- **negotiating lower reimbursement rates** with hospitals, clinics, providers, and provider groups—This is a common occurrence. Managed care plans are frequently able to convince health care providers to accept lower payment rates in return for access to a large pool of patients. In New York, a class action lawsuit has been filed against nine managed care firms, alleging price fixing in their payments for mental health services.
- **limiting providers' use of services**—This is the most visible, and most complained about, aspect of managed care. Almost all managed care plans conduct utilization review ("UR") of providers' claims and activities, essentially employing someone to look over the practitioner's shoulder. Unfortunately, utilization reviewers are frequently *not* as highly trained as the health care providers administering the health care services in question, and as a rule tend to look at health care services with a skeptical eye. In fact, managed care plans have been known to pay their utilization reviewers based on the quantity of health care services they deny. One of the more frustrating managed care practices is the retrospective denial of coverage for needed services—even including emergency room services(!)—following which the patient may be stuck with the bill.

This control over expenditures is causing increasing concern among many health care providers and patients. Although studies have not conclusively shown that managed care results in poorer quality care, horror stories regarding inappropriate denials of care by managed care companies abound. Patients have been forced to wait for months to see a specialist, and in many cases have been denied coverage for needed treatments. In some cases, such denials are claimed to have led to the death of the patient. Individuals needing mental health treatment may find that their managed care plan will only pay for eight outpatient therapy sessions for their diagnosis, forcing them to either begin paying out-of-pocket or forcing the provider to enter into a negotiations with the plan's utilization reviewer. Utilization reviewers frequently request copies of the therapist's notes regarding a patient before approving payment.

Managed care's dominance has dramatically reduced the degree of control health care providers have over patient treatment. The traditional provider-patient relationship has been replaced with a new configuration: provider-patient-payer. There are now essentially three people in the room, and one of them holds the purse strings.

Private Sector Oversight

Although they are usually pleased with managed care's ability to hold down costs, employers have started paying more attention to what they are getting for their coverage dollar. In response, organizations have emerged to help gauge HMO's quality. Many people are familiar with JCAHO, the Joint Commission on Accrediation of Healthcare Organizations, a non-profit organization whose mission is to improve the quality of health care services. Over the years, JCAHO accreditation became the primary quality of care yardstick for hospitals and institutions, and was recognized by the Medicare and Medicaid programs as evidence of an acceptable level of care quality.

Similar accreditation and quality measurement efforts have developed in regard to managed care plans, involving a number of organizations. The most influential of these is the National Committee for Quality Assurance (NCQA), non-profit organization which accredits managed care organizations and reports on their quality of care. More than 75% of all Americans covered by HMOs are in HMOs that have been reviewed by NCQA; many employers require NCQA accredition of the managed care plans with which they contract. NCQA's 1997 standards for accreditation of managed behavioral healthcare organizations (MBHOs) include requirements for quality management and improvement programs, utilization management, credentialing and recredentialing of practitioners, members' rights and responsibilities, preventive health services, and use and maintenance of medical records.

In addition to accrediting managed care plans, NCQA has developed the Health Plan/Employer Data and Information Set (HEDIS, pronounced "HEE-dis"), a standardized performance measurement data set to measure health plan quality. Many states and employers require managed care plans to report HEDIS data to enable them to gauge plans' quality and performance, and the Health Care Financing Administration (HCFA) also requires all Medicare managed care plans to report such data. It is worth mentioning that one of the pieces of information regarding an MCO called for by the most recent version of HEDIS in use, HEDIS 3.0, is the number of mental health professionals it has on staff. ACA was able to convince NCQA that mental health counselors should be explicitly included in the definition of 'mental health professionals'.

Other organizations monitoring managed care plan service quality include JCAHO, which began accrediting managed care organizations in 1989. The American Accreditation Health Care Commission (formerly known as the Utilization Review Accreditation Commission, or URAC) accredits utilization review organizations, and is developing standards for measuring the performance of provider networks.

Although a help, private-sector accreditation of managed care plans has not eliminated "bad" managed care plan practices, nor should it be expected to. A managed care version of the Better Business Bureau can help smart consumers in purchasing quality health care. However, just as state and federal laws help maintain order and prevent abusive business practices in other areas of the economy, they are needed to do the same for the health insurance industry, including managed care.

Regulation of Managed Care — State and Federal Legislation

Managed care plans are principally regulated by states, which under the McCarran-Ferguson Act of 1945 are given authority to regulate the business of insurance. All states regulate HMOs to some extent, either through their insurance department or through other agencies, such as health departments. As discussed below, however, there are important limitations on states' authority to regulate health insurance. Despite this fact, states remain where the action is on managed care regulation.

Concerns about managed care's impact on patients' access to care, on the quality of that care, and on the provider-patient relationship have helped spur this action. According to a report by the organization Families USA, during 1996 managed care legislation and regulations were passed or issued in 40 states. More such laws were enacted in 1997. Because of the complex nature of health services and the way in which they are provided, managed care's influence over how services are delivered is omnipresent. States are fighting the general incentive to undertreat—and the specific managed care plan practices in which it manifests itself—through a number of initiatives. As with traditional insurance plans, most states regulate HMOs' protections against insolvency, consumer greivance systems, and marketing activities, and require that they cover a basic set of benefits. Types of laws designed specifically to protect consumer and providers from certain managed care plan practices include the following.

- **Access to providers**—some states require health plans to offer point-of-service coverage options, thus making it possible for consumers to maintain choice of health care practitioner. States may also require health plans to accept on their network or panel any health care practitioner willing to adhere to the plan's contract and practice requirements. These laws are known as "any willing provider" laws. Many states have enacted laws requiring health plans to provide direct access to certain types of specialists, such as obstetricians and gynecologists, and to ensure that plans cover needed emergency room care. Also in this category are laws prohibiting discrimination against providers based on their type of license or certification.

- **Plan information**—states are increasingly requiring plans to provide information regarding their practices to consumers and providers alike. In 1995 and 1996, 13 states passed laws or implemented regulations requiring health plans to provide information to enrollees and prospective enrollees regarding their referral, prior authorization, and utilization review policies and requirements. In the same time period, 12 states took the same step with regard to information about plans' provider compensation arrangements.

- **Provision of care**—Many states have placed restrictions on plans' use of gag-rule provisions in their contracts with providers. As of March of 1997, seven states had enacted laws requiring plans to allow enrollees, in certain circumstances, for a period of time, to continue seeing providers whose contracts with the plan had been terminated. A number of states have laws on the books requiring that plans' utilization review operations adhere to certain standards for timeliness of decisions, and for development and implementation of standards by appropriate specialists and medical personnel.

The primary example of legislation focused directly on managed care's impact on health care providers is known as "any willing provider" legislation. Under such a law, managed care plans are required to contract with or employ any provider willing to agree to the managed care plan's terms and conditions. States which have passed "any willing provider" laws include Washington, Idaho, Wyoming, Colorado, Illinois, Indiana, Kentucky, Virginia, and Arkansas. Generally, "any willing provider" laws apply to professional counselors if they are licensed or certified by the state. However, many states have passed such laws pertaining only to pharmacy services.

Any willing provider laws seem to be becoming less popular among policymakers. They are frequently not as effective as billed, as the laws may not apply to all forms of managed care plans, particularly staff-model HMO's. Those plans to whom the laws do apply often use delaying tactics to stall providers; for example, a plan may admit a practitioner onto their network, but may simply not refer any patients to the practitioner. Also, questions have been raised as to whether point-of-service plans meet "any willing provider" law requirements, and on whether the federal Employee Retirement Income Security Act (ERISA) preempts "any willing provider" laws. Insurers and managed care plans are fighting these laws and similar legislative proposals aggressively.

In the same category of provider-oriented legislation are laws establishing certain "due process" protections for health care practitioners. One example is legislation prohibiting managed care plans from terminating or not renewing a provider's contract unless the plan gives the provider, prior to termination, a written explanation of the reasons for the proposed termination, and gives the provider an opportunity for a review or hearing regarding the termination. Other such provisions are laws forbidding managed care plan-provider contracts from including "termination without cause" provisions.

In addition to regulating specific practices of managed care organizations, some states are considering a broader approach. Last year, New York enacted an initiative covering a range of consumer protection issues (see box on pages 7-8). Earlier this year, the state of Texas enacted a law holding managed care plans liable for negligent decisions when the denial of medically necessary treatment results in harm or injury to a patient. This law, the first of its kind enacted by a state, is viewed by many advocates as a suitable response to managed care plans' often intense micromanagement of patient care, and the frequency with which managed care plan administrators involve themselves in treatment decisions. Managed care plan liability legislation was also considered in 1997 by state legislatures in California, Connecticut, Georgia, Maine, Maryland, New York, Rhode Island, South Carolina, Tennessee, and West Virginia. A similar bill was passed by the Florida state legislature in 1996, but was vetoed by the governor. Other states—including Arkansas, Alabama, Hawaii, Idaho, Illinois, Missouri, New Hampshire, New York, Ohio, South Carolina, Washington, and West Virginia—are considering legislation prohibiting plans from including "hold harmless" provisions in their provider contracts.

These and other state laws show the widespread interest among states in making sure that managed care plans provide accessible, high-quality care to the patients they serve.

Summary of New York's Managed Care Law (S. 7553)

Access to Care

- HMOs must have a sufficient number of geographically accessible providers to meet enrollees' needs, and services provided must be culturally and linguistically appropriate;
- HMOs must have procedures for providing enrollees with a "standing referral" to specialists in cases where the enrollee needs ongoing specialty care;
- HMOs must permit new enrollees with life-threatening or disabling and degenerative conditions to continue seeing their current provider for 90 days, if the provider meets HMO requirements. For a provider disaffiliating with an HMO, the HMO must allow these enrollees (including enrollees in the 2nd or 3rd trimester of pregnancy, through post-partum care) to continue seeing the provider for up to 90 days;
- HMOs must provide out-of-network referrals for patients if the HMO does not have network providers with appropriate training and experience;
- HMOs cannot require prior authorization for emergency services, and may not deny payment for services needed to stabilize or treat an emergency condition;

Utilization Review

- Utilization review (UR) companies, including HMOs conducting UR on enrollee claims, must register with state's Commissioner of Insurance, and must provide a UR plan to the Commissioner. The plan must describe the process used for developing written clinical review criteria; practice guidelines and standards used to determine medical necessity; procedures for evaluation of written clinical review criteria; and the qualifications and experience of those involved in developing, evaluating, and interpreting UR criteria. Utilization review entities must develop written UR policies and procedures, and make a written description of these procedures available to enrollees and providers;
- Reviews of adverse coverage determinations made by an UR company/entity may only be made by a "clinical peer" of the practitioner who provided the service in question;
- UR companies/entities may not compensate employees or contractors using any method which would encourage the rendering of adverse coverage decisions;

Grievance Procedures

- HMOs must notify enrollees of the grievance procedure in the member handbook, and upon any denial of coverage or service referral;
- HMOs must allow enrollees to file grievances orally, including through a toll-free phone number open 40 hours a week during normal business hours;
- HMOs must resolve grievances within 48 hours if a delay would significantly harm the enrollee's health, and within 30 days in cases regarding referrals or determinations on benefit coverage;
- HMO grievance determinations must be in writing, and include detailed reasons for the determination and the relevant clinical basis for the determination, information on how to file an appeal of the determination, and the appeal form;
- Personnel responding to an appeal must be qualified to review the appeal and must not have been involved in the initial determination; at least one of the peer reviewers must be a licensed physician in the same or similar specialty as the practitioner managing the treatment under review;

Provider Protections

- HMOs cannot terminate a provider's contract or employment, or refuse to renew a contract solely because a provider advocates on behalf of an enrollee, has filed a complaint against the plan, appealed a plan decision, or provided information on plan quality to state agencies;
- Prior to terminating a provider's contract, HMOs must provide a notice including the reasons for the termination and notice of the right to request a hearing or review (this provision does not apply in cases of provider fraud, disciplinary action against the provider, or imminent harm to patient care);
- HMOS must inform providers of the information maintained to evaluate the provider's performance, including profiling data and analysis. Plans must take into account the health needs of the provider's patients when evaluating the provider's performance;
- Health plans may not adopt contracts or written policies or procedures that prohibit or restrict providers from disclosing to an enrollee (or prospective enrollee) information regarding a condition or course of treatment, the availability of therapies or tests, or the terms of the plan's coverage;
- Health plans may not prohibit or restrict a provider from advocating on behalf of an enrollee for coverage of a particular course of treatment or service;
- Health plans may not prohibit or restrict a provider's ability to file a complaint, make a report, or comment to a governmental body regarding the plan's policies or practices.

However, states frequently find themselves hamstrung by federal preemption of their general authority to regulate insurance plans, under a law known as "ERISA"—the Employee Retirement and Income Security Act. ERISA divides the the private health insurance universe into two parts: those businesses who purchase health insurance coverage from a health plan, and those businesses which self-insure, using their own money to pay for health services. These self-insured plans—which provide coverage to millions of Americans—are not subject to state regulation.

The ERISA Wall

ERISA has formed a long-standing barrier to state activity in the health insurance field. Passed by Congress and signed into law in 1974, ERISA was enacted to correct problems of fraud and mismanagement of employee benefit plans, and particularly pension funds. However, while the law places many specific requirements on pension programs, it imposes few standards on other benefit plans, including health benefit plans.

States have traditionally held primary responsibility for regulating the insurance industry within their borders. Although federal laws usually permit states to regulate in areas where federal law is silent, ERISA contains language which virtually prohibits states from enacting laws regulating or affecting employee health benefit plans. Thus, although a state can pass laws dictating specific practices among health insurance companies, it is forbidden from interfering with employers who operate their own health plans for their employees. As a result of ERISA, more and more employers are choosing to "self-insure"—and thus operate their health plans outside of state law—rather than purchase health insurance from an insurance company such as Blue Cross/Blue Shield. This broad preemption of state law was intended by lawmakers, although few could have foreseen its long-term effect on U.S. health policy. At the time of its enactment, few states were considering health care reform legislation, and many expected sweeping federal health care reform legislation to be enacted shortly.

ERISA preemption is affecting a large and growing number of people. According to a report by the federal General Accounting Office (GAO), of the 114 million Americans with employer-provided health coverage in 1993, roughly 40 percent were enrolled in a plan self-funded by their employer. Thus, the health insurance policies and practices applying to this population are outside the jurisdiction of state regulation. As the GAO report states, "Although ERISA includes fiduciary standards to protect employee benefit plan participants and beneficiaries from plan mismanagement and other requirements, in other areas no federal requirements comparable with state requirements for health insurers exist for self-funded health plans."

ERISA has preempted many different kinds of state laws, including laws requiring reimbursement of certain classes of health care providers or requiring coverage of specific benefits. In January of 1997, the U.S. District Court for the Eastern District of Arkansas ruled that Arkansas' Patient Protection Act, which required health plans to include any qualified health care service provider willing to meet the plan's participation terms, is preempted by ERISA, and issued an order permanently enjoining the Act's enforcement. In May, a similar ruling was issued against a Washington state law requiring health carriers to make available to subscribers all categories of certified health care providers. Texas' recent law allowing managed care plans to be held liable for inappropriate denials of care, mentioned above, is currently being held up in court. Aetna Health Plans of Texas is suing the state in federal court to block the law, arguing that it is preempted by ERISA. It is unclear whether

or not the law will ultimately be upheld.

This ongoing barrier to state action places added pressure on Congress to take up the slack. Somewhat surprisingly, there is currently no movement at the federal level towards lifting ERISA's preemption provisions. Instead, consideration is being given to allowing small employers to band together to form multiple employer welfare arrangements (MEWAs) for the purposes of buying health insurance. Under this proposal, MEWAs would be exempt from state regulation under ERISA, thus placing even more Americans out of the reach of state health insurance laws.

Federal Interest in Regulation Growing

Due to widespread public concern over managed care's impact on quality of care, federal lawmakers are beginning to follow state legislators down the path of managed care regulation. Federal legislation in this area would have the added benefit of applying to *all* health plans, including self-insured plans immune to state regulation due to ERISA. In 1996, Congress for the first time passed legislation, later signed into law by the President, to specifically mandate certain managed care plan practices. Under the Newborns' and Mothers' Health Protection Act (enacted as part of Public Law 104-204), all group health plans and individual insurers providing maternity benefits must cover no less than 48 hours of inpatient hospital care for mothers and their newborns. Inpatient stays for cesarean births must be covered for no less than 96 hours.

That same law included the Mental Health Parity Act, which prohibits health insurance policies from providing different lifetime and annual dollar coverage limits for mental health services than are provided for general medical services. Enactment of these laws demonstrates a new-found willingness on the part of the federal government to dictate private sector health benefit plan practices.

Just as states are considering broad legislative proposals to regulate HMOs, such legislation is being brought before Congress. Perhaps the leading proposal before the 105th Congress is the "Patient Access to Responsible Care Act of 1997" (PARCA). This legislation (H.R. 1415/S. 644), sponsored by Rep. Charles Norwood (R-GA) and Senator Alfonse D'Amato (R-NY), would place a number of requirements on health plans, including managed care plans (see page 11).

Perhaps most importantly for professional counselors, the legislation includes a provision prohibiting health plans from discriminating against a health care practitioner based on that practitioners' particular type of licensure or certification. Closed-panel HMOs would be required to offer point-of-service coverage, and would be required to ensure direct access to specialists as needed by enrollees with chronic conditions or special needs.

The Patient Access to Responsible Care Act ("PARCA") is unique because it includes a broad range of consumer *and* provider protections, and is sponsored by Republican members in the House and Senate. Counselors are encouraged to write or call their Representative and Senators to urge them to cosponsor the PARCA bills. A sample letter is included in this report on page 15. It is crucial that members of Congress know that this legislation is supported by their constituents. Other managed care bills have been introduced in the 105th Congress, and it is hoped that hearings on managed care issues will be held later in the Congress by the committees with jurisdiction over health care issues.

Summary of The Patient Access to Responsible Care Act of 1997 (H.R. 1415/S. 644)

Access to Care

- health plans would be required to maintain a sufficient number, mix, and distribution of health professionals and providers to ensure adequate access to care for enrollees;
- health plans would be prohibited from requiring prior authorization for coverage of emergency services to enrollees with symptoms that reasonably suggest an emergency medical condition;
- health plans must allow enrollees to select their provider from among the plan's participating health professionals, and to change that selection as appropriate;
- if the health plan utilizes a closed panel of health care providers, the plans must offer a point-of-service option to its enrollees;
- health plans must ensure direct access to relevant specialists as needed for the continued care of enrollees with special needs or chronic conditions;
- health plans would be required to establish an appeals process for adverse coverage decisions;

Nondiscrimination/Provider Protections

- health plans would be prohibited from discriminating against an individual on the basis of race, gender, socio-economic status, age, health status, or anticipated need for health services;
- health plans would be prohibited from disciminating in the selection of the members of its health professional network on the basis of race, age, gender, health status, or lack of affiliation with, or admitting privileges at, a hospital;
- health plans would be prohibited from discriminating in the selection, reimbursement, or indemnification of a licensed or certified health professional solely on the basis of the professional's license or certification;

(Nondiscrimination/Provider Protections continued)

- health plans would be prohibited from interfering with a health professional's medical communications with his or her patient;
- at least once each year, health plans would be required to provide all health professionals and providers in its service area with an opportunity to apply to become a participating provider;
- health plans would be prohibited from including in its contracts with participating health providers a provision permitting the health plan to terminate the contract without cause;
- health plans would be required to provide reasonable notice of any decision to terminate a health professional, and to provide an opportunity to review and discuss all of the information on which the determination is based;

Plan Information

- health plans would be required to provide enrollees and prospective enrollees with information regarding...
  - —benefits and benefit exclusions;
  - —the percentage of premium used for administration and marketing of the plan, and the percentage expended directly for patient care;
  - —the number, mix, and distribution of participating health professionals;
  - —the ratio of enrollees to participating health professionals;
  - —utilization review requirements issuer;
  - —financial arrangements and incentives that may limit or restrict access to services;
  - —the percentage of utilization review determinations that disagree with the judgement of the treating health professional and the percentage of such determinations that are reversed on appeal.

As in state legislatures, proponents of bills in Congress to regulate certain managed care plan practices are likely to find the going tough. Managed care plans and insurers argue that 'micromanagement' of their practices will lead to increased costs of operation, and will make health insurance less affordable to businesses and individuals. Not surprisingly, business groups have also typically opposed managed care regulation bills. Both insurers and business wield considerable influence on Capitol Hill, using a large corps of lobbyists and generous political campaign contributions. According to the watchdog organization Common Cause, in the first six months of 1997 the insurance industry contributed $1.67 million dollars in 'soft' money political contributions to the Republican Party, which currently controls Congress. Since 1987, the National Association of Business PACs has made similar contributions totaling $174 million. Neither of these dollar totals account for direct contributions made by these groups to the campaign committees of individual members of Congress. However, groups supporting initiatives aimed at regulating managed care plan practices enjoy broad public support, and include some organizations with deep pockets of their own, such as the American Medical Association.

Coalition Efforts

Although managed care plans and the insurance and business sectors are powerful, managed care regulation legislation can be enacted over their opposition. Typically, coalitions in support of managed care regulation legislation are comprised of health care consumer and health care provider groups. Some of the more well-known such groups are listed below, along with the acronyms of the corresponding national organizations.

ACA is currently involved in three different coalitions working specifically on managed care issues: a coalition supporting the Patient Access to Responsible Care Act; a group of mental health professional organizations which has drafted a set of principles for the provision of mental health and substance abuse treatment services within managed care organizations, released in February of this year (see pages 14-15); and a group of non-physician health practitioner organizations which have joined together to work with the National Committee on Quality Assurance on non-physician provider issues.

National Consumer groups	Phone number	web address	e-mail
Citizen Action	202 775-1580	www.citizenaction.org	
U.S. Public Interest Research Group	202 546-9707	www.pirg.org/pirg	uspirg@pirg.org
National Mental Health Association	703 684-7722	www.nmha.org	nmhainfo@aol.com
National Alliance for the Mentally Ill	800 950-6264	www.nami.org	namiofc@aol.com

A number of other state consumer organizations exist, under a variety of names. These can often be found by checking the phone book under "Consumer", trying one of the groups above, and/or asking the people you talk to for the names of other consumer organizations working on healthcare or managed care issues.

National Provider groups	Phone number	web address	e-mail
National Association of Social Workers	202 408-8600	www.naswdc.org	info@naswdc.org
American Chiropractic Association	703 276-8800	www.amerchiro.org	memberinfo@amerchiro.org
American Physical Therapy Association	703 684-2782	www.apta.org	components@apta.org
American Nurses Association	800 274-4262	www.ana.org	webfeedback@ana.org
American Medical Association	312 464-5000	www.ama-assn.org	WebAdmin@ama-assn.org
American Psychological Association	202 336-5500	www.apa.org	webmaster@apa.org
American Psychiatric Association	202 682-6060	www.psych.org	

MENTAL HEALTH BILL OF RIGHTS PROJECT

A Joint Initiative of Mental Health Professional Organizations

Principles for the Provision of Mental Health and Substance Abuse Treatment Services

A BILL OF RIGHTS

Our commitment is to provide quality mental health and substance abuse services to all individuals without regard to race, color, religion, national origin, gender, age, sexual orientation, or disabilities.

Right to Know

- **Benefits**

Individuals have the right to be provided information from the purchasing entity (such as employer or union or public purchaser) and the insurance/third party payer describing the nature and extent of their mental health and substance abuse treatment benefits. This information should include details on procedures to obtain access to services, on utilization management procedures, and on appeal rights. The information should be presented clearly in writing with language that the individual can understand.

- **Professional Expertise**

Individuals have the right to receive full information from the potential treating professional about thatpro-fessional's knowledge, skills, preparation, experience, and credentials. Individuals have the right to be informed about the options available for treatment interventions and the effectiveness of the recommended treatment.

- **Contractual Limitations**

Individuals have the right to be informed by the treating professional of any arrangements, restrictions, and/or covenants established between third party payer and the treating professional that could interfere with or influence treatment recommendations. Individuals have the right to be informed of the nature of information that may be disclosed for the purposes of paying benefits.

- **Appeals and Grievances**

Individuals have the right to receive information about the methods they can use to submit complaints or grievances regarding provision of care by the treating

(Appeals and Grievances, continued)
professional to that profession's regulatory board and to the professional association.

Individuals have the right to be provided information about the procedures they can use to appeal benefit utilization decisions to the third party payer systems, to the employer or purchasing entity, and to external regulatory entities.

Confidentiality

Individuals have the right to be guaranteed the protection of the confidentiality of their relationship with their mental health and substance abuse professional, except when laws or ethics dictate otherwise. Any disclosure to another party will be time limited and made with the full written, informed consent of the individuals.

Individuals shall not be required to disclose confidential, privileged or other information other than: diagnosis, prognosis, type of treatment, time and length of treatment, and cost.

Entities receiving information for the purposes of benefits determination, public agencies receiving information for health care planning, or any other organization with legitimate right to information will maintain clinical information in confidence with the same rigor and be subject to the same penalties for violation as is the direct provider of care.

Information technology will be used for transmission, storage, or data management only with methodologies that remove individual identifying information and assure the protection of the individual's privacy. Information should not be transferred, sold or otherwise utilized.

Choice

Individuals have the right to choose any duly licensed/certified professional for mental health and substance abuse services. Individuals have the right to receive full information regarding the education and training of professionals, treatment options (including risks and benefits), and cost implications to make an informed choice regarding the selection of care deemed appropriate by individual and professional.

Determination of Treatment

Recommendations regarding mental health and substance abuse treatment shall be made only by a duly licensed/certified professional in conjunction with the individual and his or her family as appropriate. Treatment decisions should not be made by third party payers. The individual has the right to make final decisions regarding treatment.

Parity

Individuals have the right to receive benefits for mental health and substance abuse treatment on the same basis as they do for any other illnesses, with the same provisions, co-payments, lifetime benefits, and catastrophic coverage in both insurance and self-funded/self-insured health plans.

Discrimination

Individuals who use mental health and substance abuse benefits shall not be penalized when seeking other health insurance or disability, life or any other insurance benefit.

Benefit Usage

The individual is entitled to the entire scope of the benefits within the benefit plan that will address his or her clinical needs.

Benefit Design

Whenever both federal and state law and/or regulations are applicable, the professional and all payers shall use whichever affords the individual the greatest level of protection and access.

Treatment Review

To assure that treatment review processes are fair and valid, individuals have the right to be guaranteed that any review of their mental health and substance abuse treatment shall involve a professional having the training, credentials and licensure required to provide the treatment in the jurisdiction in which it will be provided. The reviewer should have no financial interest in the decision and is subject to the section on confidentiality.

Accountability

Treating professionals may be held accountable and liable to individuals for any injury caused by gross incompetence or negligence on the part of the professional. The treating professional has the obligation to advocate for and document necessity of care and to advise the individual of options if payment authorization is denied.

Payers and other third parties may be held accountable and liable to individuals for any injury caused by gross incompetence or negligence or by their clinically unjustified decisions.

Participating Groups:

American Association for Marriage and Family Therapy (membership: 25,000)
American Counseling Association (membership: 56,000)
American Family Therapy Academy (membership: (1,000)
American Nurses Association (membership: 180,000)
American Psychological Association (membership: 142,000)
American Psychiatric Association (membership: 42,000)
American Psychiatric Nurses Association (membership: 3,000)
National Association of Social Workers (membership: 155,000)
National Federation of Societies for Clinical Social Work (membership: 11,000)

Supporting Groups:

National Mental Health Association
National Depressive and Manic-Depressive Association
American Group Psychotherapy Association
American Psychoanalytic Association
National Association of Drug and Alcohol Abuse Counselors

Sample Letter in Support of H.R. 1415 / S. 644 — "The Patient Access to Responsible Care Act of 1997"

Please try to put the following in your own words, and feel free to include anecdotes or descriptions of your experiences with managed care, and why you believe managed care legislation is needed.

The Honorable {full name}
U.S. House of Representatives
Washington, D.C. 20515

The Honorable {full name}
U.S. Senate
Washington, D.C. 20510

Dear (Representative/Senator) {last name}:

I am writing to ask for your support for legislation to help ensure that managed care delivers on its potential to improve patient quality of care. I am concerned that too many managed care firms go for short term profits at the expense of taking good care of their enrollees.

I do not believe that Congress should try to prohibit inappropriate managed care practices one body part at a time. Instead, I support holding managed care plans to more general quality standards to protect patients, and to help ensure that health care providers can give them the care they need. Consequently, I urge you to cosponsor the "Patient Access to Responsible Care Act", sponsored in the House (H.R. 1415) by Rep. Charles Norwood (R-GA) and in the Senate (S. 644) by Senator Al D'Amato (R-NY).

This legislation would require plans to give their enrollees the option of choosing a point-of-service coverage package. It would give consumers standardized information regarding plan policies and performance, so they can make informed decisions about which plan to purchase. It would require plans to have appeals processes for patients who believe they are inappropriately denied care, and it would require plans to cover needed emergency care. The legislation does NOT mandate that plans cover specific benefits. It simply gives people the ability to make good health care choices, and to regain a measure of control over their health care services.

I firmly believe that this legislation will actually help the better managed care firms who are already providing high-quality care. These plans are not the problem. The Patient Access to Responsible Care Act will make it harder for those managed care plans which are skimping on services to operate. Managed care plans shouldn't be allowed to make money by denying services, they should be pushed to make money by providing more efficient and effective care.

Please cosponsor the Patient Access to Responsible Care Act. I believe enactment of this bill would go a long way toward improving the quality of health care for the large majority of our nation's citizens who are enrolled in managed care plans, whether by choice or by the choice of their employer. Thank you for your time and attention on this issue. I look forward to hearing your reply, and I hope I can count on your support.

Sincerely,

{name}

105TH CONGRESS
1ST SESSION

S. 644

To amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to establish standards for relationships between group health plans and health insurance issuers with enrollees, health professionals, and providers.

IN THE SENATE OF THE UNITED STATES

APRIL 24, 1997

Mr. D'AMATO 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 the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to establish standards for relationships between group health plans and health insurance issuers with enrollees, health professionals, and providers.

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 "Patient Access to Responsible Care Act of 1997".

(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.

(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—PATIENT PROTECTION STANDARDS

"SEC. 2770. NOTICE; ADDITIONAL DEFINITIONS; CONSTRUCTION.

"(a) NOTICE.—A health insurance issuer 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 issuer and such issuer were a group health plan.

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

"(1) ENROLLEE.—The term 'enrollee' means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer 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 State law.

"(3) NETWORK.—The term 'network' means, with respect to a health insurance issuer offering health insurance coverage, the participating health professionals and providers through whom the plan or issuer provides health care items and services to enrollees.

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

"(5) PARTICIPATING.—The term 'participating' means, with respect to a health professional or pro-

vider, a health professional or provider that provides health care items and services to enrollees under network coverage under an agreement with the health insurance issuer offering the coverage.

"(6) PRIOR AUTHORIZATION.—The term 'prior authorization' means the process of obtaining prior approval from a health insurance issuer as to the necessity or appropriateness of receiving medical or clinical services for treatment of a medical or clinical condition.

"(7) 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 under applicable State law.

"(8) SERVICE AREA.—The term 'service area' means, with respect to a health insurance issuer with respect to health insurance coverage, the geographic area served by the issuer with respect to the coverage.

"(9) UTILIZATION REVIEW.—The term 'utilization review' means prospective, concurrent, or retrospective review of health care items and services for medical necessity, appropriateness, or quality of care

that includes prior authorization requirements for coverage of such items and services.

"(c) NO REQUIREMENT FOR ANY WILLING PROVIDER.—Nothing in this part shall be construed as requiring a health insurance issuer that offers network coverage to include for participation every willing provider or health professional who meets the terms and conditions of the plan or issuer.

"SEC. 2771. ENROLLEE ACCESS TO CARE.

"(a) GENERAL ACCESS.—

"(1) IN GENERAL.—Subject to paragraphs (2), and (3), a health insurance issuer shall establish and maintain adequate arrangements, as defined by the applicable State authority, with a sufficient number, mix, and distribution of health professionals and providers to assure that covered items and services are available and accessible to each enrollee under health insurance coverage—

"(A) in the service area of the issuer;

"(B) in a variety of sites of service;

"(C) with reasonable promptness (including reasonable hours of operation and after-hours services);

"(D) with reasonable proximity to the residences and workplaces of enrollees; and

"(E) in a manner that—

"(i) takes into account the diverse needs of enrollees, and

"(ii) reasonably assures continuity of care.

For a health insurance issuer that serves a rural or medically underserved area, the issuer shall be treated as meeting the requirement of this subsection if the issuer has arrangements with a sufficient number, mix, and distribution of health professionals and providers having a history of serving such areas. The use of telemedicine and other innovative means to provide covered items and services by a health insurance issuer that serves a rural or medically underserved area shall also be considered in determining whether the requirement of this subsection is met.

"(2) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as requiring a health insurance issuer to have arrangements that conflict with its responsibilities to establish measures designed to maintain quality and control costs.

"(3) DEFINITIONS.—For purposes of paragraph (1):

"(A) MEDICALLY UNDERSERVED AREA.—The term 'medically underserved area' means

an area that is designated as a health professional shortage area under section 332 of the Public Health Service Act or as a medically underserved area for purposes of section 330 or 1302(7) of such Act.

"(B) RURAL AREA.—The term 'rural area' means an area that is not within a Standard Metropolitan Statistical Area or a New England County Metropolitan Area (as defined by the Office of Management and Budget).

"(b) EMERGENCY AND URGENT CARE.—

"(1) IN GENERAL.—A health insurance issuer shall—

"(A) assure the availability and accessibility of medically or clinically necessary emergency services and urgent care services within the service area of the issuer 24 hours a day, 7 days a week;

"(B) require no prior authorization for items and services furnished in a hospital emergency department to an enrollee (without regard to whether the health professional or hospital has a contractual or other arrangement with the issuer) with symptoms that would reasonably suggest to a prudent layperson an

emergency medical condition (including items and services described in subparagraph (C)(iii));

"(C) cover (and make reasonable payments for)—

"(i) emergency services,

"(ii) services that are not emergency services but are described in subparagraph (B),

"(iii) medical screening examinations and other ancillary services necessary to diagnose, treat, and stabilize an emergency medical condition, and

"(iv) urgent care services, without regard to whether the health professional or provider furnishing such services has a contractual (or other) arrangement with the issuer; and

"(D) make prior authorization determinations for—

"(i) services that are furnished in a hospital emergency department (other than services described in clauses (i) and (iii) of subparagraph (C)), and

"(ii) urgent care services, within the time periods specified in (or pursuant to) section 2776(a)(8).

"(2) DEFINITIONS.—For purposes of this subsection:

"(A) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means a medical condition (including emergency labor and delivery) 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 could reasonably be expected to result in—

"(i) placing the patient's health in serious jeopardy,

"(ii) serious impairment to bodily functions, or

"(iii) serious dysfunction of any bodily organ or part.

"(B) EMERGENCY SERVICES.—The term 'emergency services' means health care items and services that are necessary for the diag-

nosis, treatment, and stabilization of an emergency medical condition.

"(C) URGENT CARE SERVICES.—The term 'urgent care services' means health care items and services that are necessary for the treatment of a condition that—

"(i) is not an emergency medical condition,

"(ii) requires prompt medical or clinical treatment, and

"(iii) poses a danger to the patient if not treated in a timely manner, as defined by the applicable State authority in consultation with relevant treating health professionals or providers.

"(c) SPECIALIZED SERVICES.—

"(1) IN GENERAL.—A health insurance issuer offering network coverage shall demonstrate that enrollees have access to specialized treatment expertise when such treatment is medically or clinically indicated in the professional judgment of the treating health professional, in consultation with the enrollee.

"(2) DEFINITION.—For purposes of paragraph (1), the term 'specialized treatment expertise' means expertise in diagnosing or treating—

"(A) unusual diseases or conditions, or

"(B) diseases and conditions that are unusually difficult to diagnose or treat.

"(d) INCENTIVE PLANS.—

"(1) IN GENERAL.—In the case of a health insurance issuer that offers network coverage, any health professional or provider incentive plan operated by the issuer with respect to such coverage shall meet the following requirements:

"(A) No specific payment is made directly or indirectly under the plan to a professional or provider or group of professionals or providers as an inducement to reduce or limit medically necessary services provided with respect to a specific enrollee.

"(B) If the plan places such a professional, provider, or group at substantial financial risk (as determined by the Secretary) for services not provided by the professional, provider, or group, the issuer—

"(i) provides stop-loss protection for the professional, provider, or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of professionals or providers placed at such substantial fi-

nancial risk in the group or under the coverage and the number of individuals enrolled with the issuer who receive services from the professional, provider, or group, and

"(ii) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the issuer to determine the degree of access of such individuals to services provided by the issuer and satisfaction with the quality of such services.

"(C) The issuer provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this paragraph.

"(2) In this subsection, the term 'health professional or provider incentive plan' means any compensation arrangement between a health insurance issuer and a health professional or provider or professional or provide group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the issuer.

"SEC. 2772. ENROLLEE CHOICE OF HEALTH PROFESSIONALS AND PROVIDERS.

"(a) CHOICE OF PERSONAL HEALTH PROFESSIONAL.—A health insurance issuer shall permit each enrollee under network coverage to—

"(1) select a personal health professional from among the participating health professionals of the issuer, and

"(2) change that selection as appropriate.

"(b) POINT-OF-SERVICE OPTION.—

"(1) IN GENERAL.—If a health insurance issuer offers to enrollees health insurance coverage which provides for coverage of services only if such services are furnished through health professionals and providers who are members of a network of health professionals and providers who have entered into a contract with the issuer to provide such services, the issuer shall also offer to such enrollees (at the time of enrollment) the option of health insurance coverage which provides for coverage of such services which are not furnished through health professionals and providers who are members of such a network.

"(2) FAIR PREMIUMS.—The amount of any additional premium required for the option described in paragraph (1) may not exceed an amount that is fair and reasonable, as established by the applicable

State authority, in consultation with the National Association of Insurance Commissioners, based on the nature of the additional coverage provided.

"(3) COST-SHARING.—Under the option described in paragraph (1), the health insurance coverage shall provide for reimbursement rates for covered services offered by health professionals and providers who are not participating health professionals or providers that are not less than the reimbursement rates for covered services offered by participating health professionals and providers. Nothing in this paragraph shall be construed as protecting an enrollee against balance billing by a health professional or provider that is not a participating health professional or provider.

"(c) CONTINUITY OF CARE.—A health insurance issuer offering network coverage shall—

"(1) ensure that any process established by the issuer to coordinate care and control costs does not create an undue burden, as defined by the applicable State authority, for enrollees with special health care needs or chronic conditions;

"(2) ensure direct access to relevant specialists for the continued care of such enrollees when medically or clinically indicated in the judgment of the

treating health professional, in consultation with the enrollee;

"(3) in the case of an enrollee with special health care needs or a chronic condition, determine whether, based on the judgment of the treating health professional, in consultation with the enrollee, it is medically or clinically necessary to use a specialist or a care coordinator from an interdisciplinary team to ensure continuity of care; and

"(4) in circumstances under which a change of health professional or provider might disrupt the continuity of care for an enrollee, such as—

"(A) hospitalization, or

"(B) dependency on high-technology home medical equipment,

provide for continued coverage of items and services furnished by the health professional or provider that was treating the enrollee before such change for a reasonable period of time.

For purposes of paragraph (4), a change of health professional or provider may be due to changes in the membership of an issuer's health professional and provider network, changes in the health coverage made available by an employer, or other similar circumstances.

"SEC. 2773. NONDISCRIMINATION AGAINST ENROLLEES AND IN THE SELECTION OF HEALTH PROFESSIONALS; EQUITABLE ACCESS TO NETWORKS.

"(a) NONDISCRIMINATION AGAINST ENROLLEES.—No health insurance issuer may discriminate (directly or through contractual arrangements) in any activity that has the effect of discriminating against an individual on the basis of race, national origin, gender, language, socioeconomic status, age, disability, health status, or anticipated need for health services.

"(b) NONDISCRIMINATION IN SELECTION OF NETWORK HEALTH PROFESSIONALS.—A health insurance issuer offering network coverage shall not discriminate in selecting the members of its health professional network (or in establishing the terms and conditions for membership in such network) on the basis of—

"(1) the race, national origin, gender, age, or disability (other than a disability that impairs the ability of an individual to provide health care services or that may threaten the health of enrollees) of the health professional; or

"(2) the health professional's lack of affiliation with, or admitting privileges at, a hospital (unless such lack of affiliation is a result of infractions of quality standards and is not due to a health professional's type of license).

"(c) NONDISCRIMINATION IN ACCESS TO HEALTH PLANS.—While nothing in this section shall be construed as an 'any willing provider' requirement (as referred to in section 2770(c)), a health insurance issuer shall not discriminate in participation, reimbursement, or indemnification against a health professional, who is acting within the scope of the health professional's license or certification under applicable State law, solely on the basis of such license or certification.

"SEC. 2774. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

"(a) IN GENERAL.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a health insurance issuer and a health professional shall not prohibit or restrict the health professional from engaging in medical communications 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. 2775. DEVELOPMENT OF PLAN POLICIES.

"A health insurance issuer that offers network coverage shall establish mechanisms to consider the recommendations, suggestions, and views of enrollees and participating health professionals and providers regarding—

"(1) the medical policies of the issuer (including policies relating to coverage of new technologies, treatments, and procedures);

"(2) the utilization review criteria and procedures of the issuer;

"(3) the quality and credentialing criteria of the issuer; and

"(4) the medical management procedures of the issuer.

"SEC. 2776. DUE PROCESS FOR ENROLLEES.

"(a) UTILIZATION REVIEW.—The utilization review program of a health insurance issuer shall—

"(1) be developed (including any screening criteria used by such program) with the involvement of participating health professionals and providers;

"(2) to the extent consistent with the protection of proprietary business information (as defined for purposes of section 552 of title 5, United States Code) release, upon request, to affected health professionals, providers, and enrollees the screening criteria, weighting elements, and computer algorithms used in reviews and a description of the method by which they were developed;

"(3) uniformly apply review criteria that are based on sound scientific principles and the most recent medical evidence;

"(4) use licensed, accredited, or certified health professionals to make review determinations (and for services requiring specialized training for their delivery, use a health professional who is qualified through equivalent specialized training and experience);

"(5) subject to reasonable safeguards, disclose to health professionals and providers, upon request, the names and credentials of individuals conducting utilization review;

"(6) not compensate individuals conducting utilization review for denials of payment or coverage of benefits;

"(7) comply with the requirement of section 2771 that prior authorization not be required for emergency and related services furnished in a hospital emergency department;

"(8) make prior authorization determinations—

"(A) in the case of services that are urgent care services described in section 2771(b)(2)(C), within 30 minutes of a request for such determination, and

"(B) in the case of other services, within 24 hours after the time of a request for determination;

"(9) include in any notice of such determination an explanation of the basis of the determination and the right to an immediate appeal;

"(10) treat a favorable prior authorization review determination as a final determination for purposes of making payment for a claim submitted for the item or service involved unless such determination was based on false information knowingly supplied by the person requesting the determination;

"(11) provide timely access, as defined by the applicable State authority, to utilization review personnel and, if such personnel are not available, waives any prior authorization that would otherwise be required; and

"(12) provide notice of an initial determination on payment of a claim within 30 days after the date the claim is submitted for such item or service, and include in such notice an explanation of the reasons for such determination and of the right to an immediate appeal.

"(b) APPEALS PROCESS.—A health insurance issuer shall establish and maintain an accessible appeals process that—

"(1) reviews an adverse prior authorization determination—

"(A) for urgent care services, described in subsection (a)(8)(A), within 1 hour after the time of a request for such review, and

"(B) for other services, within 24 hours after the time of a request for such review;

"(2) reviews an initial determination on payment of claims described in subsection (a)(12) within 30 days after the date of a request for such review;

"(3) provides for review of determinations described in paragraphs (1) and (2) by an appropriate clinical peer professional who is in the same or similar specialty as would typically provide the item or service involved (or another licensed, accredited, or certified health professional acceptable to the plan and the person requesting such review); and

"(4) provides for review of—

"(A) the determinations described in paragraphs (1), (2), and (3), and

"(B) enrollee complaints about inadequate access to any category or type of health professional or provider in the network of the issuer or other matters specified by this part,

by an appropriate clinical peer professional who is in the same or similar specialty as would typically provide the item or service involved (or another licensed, accredited, or certified health professional acceptable to the issuer and the person requesting such review) that is not involved in the operation of the plan or in making the determination or policy being appealed.

The procedures specified in this subsection shall not be construed as preempting or superseding any other reviews or appeals an issuer is required by law to make available.

"SEC. 2777. DUE PROCESS FOR HEALTH PROFESSIONALS AND PROVIDERS.

"(a) IN GENERAL.—A health insurance issuer with respect to its offering of network coverage shall—

"(1) allow all health professionals and providers in its service area to apply to become a participating health professional or provider during at least one period in each calendar year;

"(2) provide reasonable notice to such health professionals and providers of the opportunity to apply and of the period during which applications are accepted;

"(3) provide for review of each application by a credentialing committee with appropriate representation of the category or type of health professional or provider;

"(4) select participating health professionals and providers based on objective standards of quality developed with the suggestions and advice of professional associations, health professionals, and providers;

"(5) make such selection standards available to—

"(A) those applying to become a participating provider or health professional;

"(B) health plan purchasers, and

"(C) enrollees;

"(6) when economic considerations are taken into account in selecting participating health professionals and providers, use objective criteria that are available to those applying to become a participating provider or health professional and enrollees;

"(7) adjust any economic profiling to take into account patient characteristics (such as severity of illness) that may result in atypical utilization of services;

"(8) make the results of such profiling available to insurance purchasers, enrollees, and the health professional or provider involved;

"(9) notify any health professional or provider being reviewed under the process referred to in paragraph (3) of any information indicating that the health professional or provider fails to meet the standards of the issuer;

"(10) offer a health professional or provider receiving notice pursuant to the requirement of paragraph (9) with an opportunity to—

"(A) review the information referred to in such paragraph, and

"(B) submit supplemental or corrected information;

"(11) not include in its contracts with participating health professionals and providers a provision permitting the issuer to terminate the contract 'without cause';

"(12) provide a due process appeal that conforms to the process specified in section 412 of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11112) for all determinations that are adverse to a health professional or provider; and

"(13) unless a health professional or provider poses an imminent harm to enrollees or an adverse action by a governmental agency effectively impairs the ability to provide health care items and services, provide—

"(A) reasonable notice of any decision to terminate a health professional or provider 'for cause' (including an explanation of the reasons for the determination),

"(B) an opportunity to review and discuss all of the information on which the determination is based, and

"(C) an opportunity to enter into a corrective action plan, before the determination becomes subject to appeal under the process referred to in paragraph (12).

"(b) RULE OF CONSTRUCTION.—The requirements of subsection (a) shall not be construed as preempting or superseding any other reviews and appeals a health insurance issuer is required by law to make available.

"SEC. 2778. INFORMATION REPORTING AND DISCLOSURE.

"(a) IN GENERAL.—A health insurance issuer offering health insurance coverage shall provide enrollees and prospective enrollees with information about—

"(1) coverage provisions, benefits, and any exclusions—

"(A) by category of service,

"(B) by category or type of health professional or provider, and

"(C) if applicable, by specific service, including experimental treatments;

"(2) the percentage of the premium charged by the issuer that is set aside for administration and marketing of the issuer;

"(3) the percentage of the premium charged by the issuer that is expended directly for patient care;

"(4) the number, mix, and distribution of participating health professionals and providers;

"(5) the ratio of enrollees to participating health professionals and providers by category and type of health professional and provider;

"(6) the expenditures and utilization per enrollee by category and type of health professional and provider;

"(7) the financial obligations of the enrollee and the issuer, including premiums, copayments, deductibles, and established aggregate maximums on out-of-pocket costs, for all items and services, including—

"(A) those furnished by health professionals and providers that are not participating health professionals and providers, and

"(B) those furnished to an enrollee who is outside the service area of the coverage;

"(8) utilization review requirements of the issuer (including prior authorization review, concurrent review, post-service review, post-payment review, and any other procedures that may lead to denial of coverage or payment for a service);

"(9) financial arrangements and incentives that may—

"(A) limit the items and services furnished to an enrollee,

"(B) restrict referral or treatment options, or

"(C) negatively affect the fiduciary responsibility of a health professional or provider to an enrollee;

"(10) other incentives for health professionals and providers to deny or limit needed items or services;

"(11) quality indicators for the issuer and participating health professionals and providers, including performance measures such as appropriate referrals and prevention of secondary complications following treatment;

"(12) grievance procedures and appeals rights under the coverage, and summary information about the number and disposition of grievances and appeals in the most recent period for which complete and accurate information is available; and

"(13) the percentage of utilization review determinations made by the issuer that disagree with the judgment of the treating health professional or provider and the percentage of such determinations that are reversed on appeal.

"(b) REGULATIONS.—The Secretary, in collaboration with the Secretary of Labor, shall issue regulations to establish—

"(1) the styles and sizes of type to be used with respect to the appearance of the publication of the information required under subsection (a);

"(2) standards for the publication of information to ensure that such publication is—

"(A) readily accessible, and

"(B) in common language easily understood,

by individuals with little or no connection to or understanding of the language employed by health professionals and providers, health insurance issuers, or other entities involved in the payment or delivery of health care services, and

"(3) the placement and positioning of information in health plan marketing materials.

"SEC. 2779. CONFIDENTIALITY; ADEQUATE RESERVES.

"(a) CONFIDENTIALITY.—

"(1) IN GENERAL.—A health insurance issuer shall establish mechanisms and procedures to ensure compliance with applicable Federal and State laws to protect the confidentiality of individually identifiable information held by the issuer with respect to an enrollee, health professional, or provider.

"(2) DEFINITION.—For purposes of paragraph (1), the term 'individually identifiable information'

means, with respect to an enrollee, a health professional, or a provider, any information, whether oral or recorded in any medium or form, that identifies or can readily be associated with the identity of the enrollee, the health professional, or the provider.

"(b) FINANCIAL RESERVES; SOLVENCY.—A health insurance issuer shall—

"(1) meet such financial reserve or other solvency-related requirements as the applicable State authority may establish to assure the continued availability of (and appropriate payment for) covered items and services for enrollees; and

"(2) establish mechanisms specified by the applicable State authority to protect enrollees, health professionals, and providers in the event of failure of the issuer.

Such requirements shall not unduly impede the establishment of health insurance issuers owned and operated by health care professionals or providers or by non-profit community-based organizations.

"SEC. 2780. QUALITY IMPROVEMENT PROGRAM.

"(a) IN GENERAL.—A health insurance issuer shall establish a quality improvement program (consistent with subsection (b)) that systematically and continuously assesses and improves—

"(1) enrollee health status, patient outcomes, processes of care, and enrollee satisfaction associated with health care provided by the issuer; and

"(2) the administrative and funding capacity of the issuer to support and emphasize preventive care, utilization, access and availability, cost effectiveness, acceptable treatment modalities, specialists referrals, the peer review process, and the efficiency of the administrative process.

"(b) FUNCTIONS.—A quality improvement program established pursuant to subsection (a) shall—

"(1) assess the performance of the issuer and its participating health professionals and providers and report the results of such assessment to purchasers, participating health professionals and providers, and administrative personnel;

"(2) demonstrate measurable improvements in clinical outcomes and plan performance measured by identified criteria, including those specified in subsection (a)(1); and

"(3) analyze quality assessment data to determine specific interactions in the delivery system (both the design and funding of the health insurance coverage and the clinical provision of care) that have an adverse impact on the quality of care.".

(b) APPLICATION TO GROUP HEALTH INSURANCE COVERAGE.—

(1) 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. PATIENT PROTECTION STANDARDS.

"(a) IN GENERAL.—Each health insurance issuer shall comply with patient protection requirements 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) Section 2792 of such 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. PATIENT PROTECTION STANDARDS.

"Each health insurance issuer shall comply with patient protection 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 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 PATIENT PROTECTION 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 be construed to preempt any State law, or the enactment or implementation of such a State law, that provides protections for individuals that are equivalent to or stricter than the protections provided under such provisions.".

(2) INDIVIDUAL HEALTH INSURANCE COVERAGE.—Section 2762 of such 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 PATIENT PROTECTION 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 be construed to preempt any State law, or the enactment or implementation of such a State law, that provides protections for individuals that are equivalent to or stricter than the protections provided under such provisions.".

(c) ADDITIONAL CONFORMING AMENDMENTS.—

(1) Section 2723(a)(1) of such 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 such Act (42 U.S.C. 300gg–62(b)(1)) is amended by striking "part C" and inserting "part D".

(f) EFFECTIVE DATES.—(1)(A) Subject to subparagraph (B), the amendments made by subsections (a), (b), (d)(1), and (e) shall apply with respect to group health insurance coverage for group health plan years beginning on or after July 1, 1998 (in this subsection referred to as the "general effective date") and also shall apply to portions of plan years occurring on and after January 1, 1999.

(B) In the case of 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 made by subsections (a), (b), (d)(1), and (c) 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 (de-

termined without regard to any extension thereof agreed to after the date of enactment of this Act), or

(ii) the general effective date.

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) or (b) shall not be treated as a termination of such collective bargaining agreement.

(2) The amendments made by subsections (a), (c), (d)(2), and (e) 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.

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. 713. 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 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.

"(c) 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 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 713 and part C of title XXVII of the Public Health Service Act, and subpart C insofar as it applies to section 713 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 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 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. Patient protection standards.".

(3) Section 734 of such Act (29 U.S.C. 1187) is amended by inserting "and section 713(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 July 1, 1998 (in this subsection referred to as the "general effective date") and also shall apply to portions of plan years occurring on and after January 1, 1999.

(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. NON-PREEMPTION 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.

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