

105TH CONGRESS
2^D SESSION

H. R. 4118

To amend title XXVII of the Public Health Service Act and part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 to establish standards for the health quality improvement of children in managed care plans and other health plans.

IN THE HOUSE OF REPRESENTATIVES

JUNE 23, 1998

Mrs. MORELLA (for herself, Ms. ESHOO, Ms. SLAUGHTER, Mr. HILLIARD, Mr. SERRANO, Mr. KLECZKA, Mr. BALDACCI, Mr. ROMERO-BARCELÓ, and Mr. NADLER) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committee on Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title XXVII of the Public Health Service Act and part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 to establish standards for the health quality improvement of children in managed care plans and other health plans.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Children’s Health In-
5 surance Accountability Act of 1998”.

1 **SEC. 2. FINDINGS; PURPOSE.**

2 (a) FINDINGS.—Congress makes the following find-
3 ings:

4 (1) Children have health and development needs
5 that are markedly different than those for the adult
6 population.

7 (2) Children experience complex and continuing
8 changes during the continuum from birth to adult-
9 hood in which appropriate health care is essential
10 for optimal development. Their organ systems,
11 bones, immunologic and cognitive systems all go
12 through different developmental stages before reach-
13 ing maturation and therefore, depending on age and
14 state of development, respond differently to both ill-
15 ness and treatment.

16 (3) The vast majority of work done on develop-
17 ment methods to assess the effectiveness of health
18 care services and the impact of medical care on pa-
19 tient outcomes and patient satisfaction has been fo-
20 cused on adults.

21 (4) Health outcome measures need to be age,
22 gender, and developmentally appropriate to be useful
23 to families and children.

24 (5) Costly disorders of adulthood often have
25 their origins in childhood, making early access to ef-
26 fective health services in childhood essential.

1 (6) More than 200 chronic conditions, disabil-
2 ities and diseases affect children, including asthma,
3 diabetes, sickle cell anemia, spina bifida, epilepsy,
4 autism, cerebral palsy, congenital heart disease,
5 mental retardation, and cystic fibrosis. These chil-
6 dren need the services of specialists who have in-
7 depth knowledge about their particular condition.

8 (7) Children's patterns of illness, disability and
9 injury differ dramatically from adults.

10 (8) Children are dependent on adults and com-
11 munity institutions to promote their health and well-
12 being and so they are a particularly vulnerable popu-
13 lation.

14 (9) Children are smaller than adults, ranging in
15 size from very premature infants to adult-sized ado-
16 lescents. As a result, smaller children are vulnerable
17 to sudden shifts in conditions, medication must be
18 more finely calibrated, and procedures can be more
19 difficult.

20 (10) Children are our nation's poorest popu-
21 lation and with that poverty often comes increased
22 vulnerability and reduced access to needed health
23 care services that are characterized by lack of con-
24 tinuity of care, delays in obtaining care, and limited

1 choices about where and from whom care may be re-
2 ceived.

3 (11) Children with special health care needs are
4 particularly vulnerable because only a very small
5 percentage of children have a major illness, injury,
6 or congenital condition, and private managed care
7 plans often have little experience in serving such
8 children.

9 (12) Children do not command a large amount
10 of influence in the health care marketplace; they ac-
11 count for less than 15 percent of national health
12 care spending.

13 (13) Research related to child and adolescent
14 health and development is underrepresented in com-
15 parison to our nation's research commitment to
16 other national priorities.

17 (14) In comparison to children in other indus-
18 trialized nations, the health status of children in this
19 country continues to fall short in areas such as in-
20 fant mortality, death by injury or accident, and sui-
21 cide.

22 (15) An excellent delivery health care system
23 promoting improved pediatric health would be child
24 and family centered, accessible, continuous, com-
25 prehensive, coordinated, compassionate, offer spe-

1 cialized services, ensure quality assurance, and pro-
2 vide relevant data and information.

3 (16) Assuring that children receive what they
4 need from the health system is a special responsibil-
5 ity of adults—individually as parents and collectively
6 as a society—and problems found in the health care
7 system for children should be identified and cor-
8 rected quickly so that our children grow into healthy
9 and productive adults.

10 (b) PURPOSE.—It is the purpose of this Act to estab-
11 lish and implement quality standards for the protection
12 of children under group health plans and health insurance
13 coverage that are intended to supplement any consumer
14 protections intended to cover all individuals covered under
15 such plans or coverage.

16 **SEC. 3. AMENDMENTS TO THE PUBLIC HEALTH SERVICE**
17 **ACT.**

18 (a) IN GENERAL.—Title XXVII of the Public Health
19 Service Act is amended—

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

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

1 “(1) REFERRAL TO SPECIALITY CARE FOR
2 CHILDREN REQUIRING TREATMENT BY SPECIAL-
3 ISTS.—

4 “(A) IN GENERAL.—In the case of a child
5 who is covered under a group health plan, or
6 under health insurance coverage offered by a
7 health insurance issuer, and who has a mental
8 or physical condition, disability, or disease of
9 sufficient seriousness and complexity to require
10 diagnosis, evaluation or treatment by a special-
11 ist, the plan or issuer shall make or provide for
12 a referral to a specialist who has extensive ex-
13 perience or training, and is available and acces-
14 sible to provide the treatment for such condition
15 or disease, including the choice of a nonprimary
16 care physician specialist participating in the
17 plan or a referral to a nonparticipating provider
18 as provided for under subparagraph (D) if such
19 a provider is not available within the plan.

20 “(B) SPECIALIST DEFINED.—For purposes
21 of this subsection, the term ‘specialist’ means,
22 with respect to a condition, disability, or dis-
23 ease, a health care practitioner, facility, or cen-
24 ter (such as a center of excellence) that has ex-
25 tensive pediatric expertise through appropriate

1 training or experience to provide high quality
2 care in treating the condition, disability, or dis-
3 ease.

4 “(C) REFERRALS TO PARTICIPATING PRO-
5 VIDERS.—A plan or issuer is not required under
6 subparagraph (A) to provide for a referral to a
7 specialist that is not a participating provider,
8 unless the plan or issuer does not have an ap-
9 propriate specialist that is available and acces-
10 sible to treat the enrollee’s condition and that
11 is a participating provider with respect to such
12 treatment.

13 “(D) TREATMENT OF NONPARTICIPATING
14 PROVIDERS.—If a plan or issuer refers a child
15 enrollee to a nonparticipating specialist, services
16 provided pursuant to the referral shall be pro-
17 vided at no additional cost to the enrollee be-
18 yond what the enrollee would otherwise pay for
19 services received by such a specialist that is a
20 participating provider.

21 “(E) SPECIALISTS AS PRIMARY CARE PRO-
22 VIDERS.—A plan or issuer shall have in place a
23 procedure under which a child who is covered
24 under the coverage provided by the plan or
25 issuer who has a condition or disease that re-

1 quires specialized medical care over a prolonged
2 period of time shall receive a referral to a pedi-
3 atric specialist affiliated with the plan or issuer,
4 or if not available within the plan or coverage,
5 to a nonparticipating provider for such condi-
6 tion and such specialist may be responsible for
7 and capable of providing and coordinating the
8 child’s primary and specialty care.

9 “(2) STANDING REFERRALS.—

10 “(A) IN GENERAL.—A group health plan,
11 or health insurance issuer in connection with
12 the provision of health insurance coverage, shall
13 have a procedure by which a child who is a par-
14 ticipant, beneficiary, or enrollee under the plan
15 or coverage and who has a condition, disability,
16 or disease that requires ongoing care from a
17 specialist may request and obtain a standing re-
18 ferral to such specialist for treatment of such
19 condition. If the primary care provider in con-
20 sultation with the medical director of the plan
21 or issuer and the specialist (if any), determines
22 that such a standing referral is appropriate, the
23 plan or issuer shall authorize such a referral to
24 such a specialist. Such standing referral shall
25 be consistent with a treatment plan.

1 “(B) TREATMENT PLANS.—A group health
2 plan, or health insurance issuer, with the par-
3 ticipation of the family and the health care pro-
4 viders of the child, shall develop a treatment
5 plan for a child who requires ongoing care that
6 covers a specified period of time (but in no
7 event less than a 6-month period). Services pro-
8 vided for under the treatment plan shall not re-
9 quire additional approvals or referrals through
10 a gatekeeper.

11 “(C) TERMS OF REFERRAL.—The provi-
12 sions of subparagraph (C) and (D) of para-
13 graph (1) shall apply with respect to referrals
14 under subparagraph (A) in the same manner as
15 they apply to referrals under paragraph (1)(A).

16 “(c) ADEQUACY OF ACCESS.—For purposes of sub-
17 sections (a) and (b), a group health plan or health insur-
18 ance issuer in connection with health insurance coverage
19 shall ensure that a sufficient number, distribution, and va-
20 riety of qualified participating health care providers are
21 available so as to ensure that all covered health care serv-
22 ices, including specialty services, are available and acces-
23 sible to all enrollees who are children in a timely manner.

24 “(d) COVERAGE OF EMERGENCY SERVICES.—

1 “(1) IN GENERAL.—If a group health plan, or
2 health insurance coverage offered by a health insur-
3 ance issuer, provides any benefits for children with
4 respect to emergency services (as defined in para-
5 graph (2)(A)), the plan or issuer shall cover emer-
6 gency services furnished under the plan or coverage
7 to such enrollees—

8 “(A) without the need for any prior au-
9 thorization determination;

10 “(B) whether or not the physician or pro-
11 vider furnishing such services is a participating
12 physician or provider with respect to such serv-
13 ices; and

14 “(C) without regard to any other term or
15 condition of such coverage (other than exclusion
16 of benefits, or an affiliation or waiting period,
17 permitted under section 2701).

18 “(2) DEFINITIONS.—In this subsection:

19 “(A) EMERGENCY MEDICAL CONDITION
20 BASED ON PRUDENT LAYPERSON STANDARD.—
21 The term ‘emergency medical condition’ means
22 a medical condition manifesting itself by acute
23 symptoms of sufficient severity (including se-
24 vere pain) such that a prudent layperson, who
25 possesses an average knowledge of health and

1 medicine, could reasonably expect the absence
2 of immediate medical attention to result in a
3 condition described in clause (i), (ii), or (iii) of
4 section 1867(e)(1)(A) of the Social Security
5 Act.

6 “(B) EMERGENCY SERVICES.—The term
7 ‘emergency services’ means—

8 “(i) a medical screening examination
9 (as required under section 1867 of the So-
10 cial Security Act) that is within the capa-
11 bility of the emergency department of a
12 hospital, including ancillary services rou-
13 tinely available to the emergency depart-
14 ment to evaluate an emergency medical
15 condition (as defined in subparagraph
16 (A)); and

17 “(ii) within the capabilities of the
18 staff and facilities available at the hospital,
19 such further medical examination and
20 treatment as are required under section
21 1867 of such Act to stabilize the patient.

22 “(3) REIMBURSEMENT FOR MAINTENANCE
23 CARE AND POST-STABILIZATION CARE.—A group
24 health plan, and health insurance issuer offering
25 health insurance coverage, shall provide, in covering

1 services other than emergency services for enrollees
2 who are children, for reimbursement with respect to
3 services which are otherwise covered and which are
4 provided to an enrollee other than through the plan
5 or issuer if the services are maintenance care or
6 post-stabilization care covered under the guidelines
7 established under section 1852(d) of the Social Se-
8 curity Act (relating to promoting efficient and timely
9 coordination of appropriate maintenance and post-
10 stabilization care of an enrollee after an enrollee has
11 been determined to be stable).

12 “(e) PROHIBITION ON FINANCIAL BARRIERS.—A
13 health insurance issuer in connection with the provision
14 of health insurance coverage may not impose any cost
15 sharing for pediatric specialty services provided under
16 such coverage to children who are enrollees in amounts
17 that exceed the cost-sharing required for other specialty
18 care under such coverage.

19 “(f) CHILDREN WITH SPECIAL HEALTH CARE
20 NEEDS.—A health insurance issuer in connection with the
21 provision of health insurance coverage shall ensure that
22 such coverage provides special consideration for the provi-
23 sion of services to children with special health care needs
24 who are enrolled under the coverage. Appropriate proce-
25 dures shall be implemented to provide care for children

1 with special health care needs. The development of such
2 procedures shall include participation by the families of
3 such children.

4 “(g) DEFINITIONS.—In this part:

5 “(1) CHILD.—The term ‘child’ means an indi-
6 vidual who is under 19 years of age.

7 “(2) CHILDREN WITH SPECIAL HEALTH CARE
8 NEEDS.—The term ‘children with special health care
9 needs’ means those children who have or are at ele-
10 vated risk for chronic physical, developmental, be-
11 havioral or emotional conditions and who also re-
12 quire health and related services of a type and
13 amount not usually required by other children.

14 **“SEC. 2771. CONTINUITY OF CARE.**

15 “(a) IN GENERAL.—If a contract between a health
16 insurance issuer, in connection with the provision of health
17 insurance coverage, and a health care provider is termi-
18 nated (other than by the issuer for failure to meet applica-
19 ble quality standards or for fraud) and an enrollee who
20 is a child is undergoing a course of treatment from the
21 provider at the time of such termination, the issuer shall—

22 “(1) notify the parent or guardian of the en-
23 rollee of such termination, and

24 “(2) subject to subsection (c), permit the en-
25 rollee to continue the course of treatment with the

1 provider during a transitional period (provided under
2 subsection (b)).

3 “(b) TRANSITIONAL PERIOD.—

4 “(1) IN GENERAL.—Except as provided in para-
5 graphs (2) through (4), the transitional period under
6 this subsection shall extend for at least—

7 “(A) 60 days from the date of the notice
8 to the enrollee’s parent or guardian of the pro-
9 vider’s termination in the case of a primary
10 care provider, or

11 “(B) 120 days from such date in the case
12 of another provider.

13 “(2) INSTITUTIONAL CARE.—The transitional
14 period under this subsection for institutional or in-
15 patient care from a provider shall extend until the
16 discharge or termination of the period of institu-
17 tionalization and shall include reasonable follow-up
18 care related to the institutionalization and shall also
19 include institutional care scheduled prior to the date
20 of termination of the provider status.

21 “(3) PREGNANCY.—If—

22 “(A) an enrollee has entered the second
23 trimester of pregnancy at the time of a provid-
24 er’s termination of participation, and

1 “(B) the provider was treating the preg-
2 nancy before date of the termination,
3 the transitional period under this subsection with re-
4 spect to provider’s treatment of the pregnancy shall
5 extend through the provision of post-partum care di-
6 rectly related to the delivery.

7 “(4) TERMINAL ILLNESS.—

8 “(A) IN GENERAL.—If—

9 “(i) an enrollee was determined to be
10 terminally ill (as defined in subparagraph
11 (B)) at the time of a provider’s termi-
12 nation of participation, and

13 “(ii) the provider was treating the ter-
14 minal illness before the date of termi-
15 nation,

16 the transitional period under this subsection
17 shall extend for the remainder of the enrollee’s
18 life for care directly related to the treatment of
19 the terminal illness.

20 “(B) DEFINITION.—In subparagraph (A),
21 an enrollee is considered to be ‘terminally ill’ if
22 the enrollee has a medical prognosis that the
23 enrollee’s life expectancy is 6 months or less.

24 “(c) PERMISSIBLE TERMS AND CONDITIONS.—An
25 issuer may condition coverage of continued treatment by

1 a provider under subsection (a)(2) upon the provider
2 agreeing to the following terms and conditions:

3 “(1) The provider agrees to continue to accept
4 reimbursement from the issuer at the rates applica-
5 ble prior to the start of the transitional period as
6 payment in full.

7 “(2) The provider agrees to adhere to the
8 issuer’s quality assurance standards and to provide
9 to the issuer necessary medical information related
10 to the care provided.

11 “(3) The provider agrees otherwise to adhere to
12 the issuer’s policies and procedures, including proce-
13 dures regarding referrals and obtaining prior au-
14 thorization and providing services pursuant to a
15 treatment plan approved by the issuer.

16 **“SEC. 2772. CONTINUOUS QUALITY IMPROVEMENT.**

17 “(a) IN GENERAL.—A group health plan that covers
18 children, and a health insurance issuer that offers health
19 insurance coverage for children, shall establish and main-
20 tain an ongoing, internal quality assurance program that
21 at a minimum meets the requirements of subsection (b)
22 with respect to the coverage of children.

23 “(b) REQUIREMENTS.—The internal quality assur-
24 ance program of a plan or issuer under subsection (a)
25 shall—

1 “(1) establish and measure a set of health care,
2 functional assessments, structure, processes and out-
3 comes, and quality indicators that are unique to chil-
4 dren and based on nationally accepted standards or
5 guidelines of care;

6 “(2) maintain written protocols consistent with
7 recognized clinical guidelines or current consensus
8 on the pediatric field, to be used for purposes of in-
9 ternal utilization review, with periodic updating and
10 evaluation by pediatric specialists to determine effec-
11 tiveness in controlling utilization;

12 “(3) provide for peer review by health care pro-
13 fessionals of the structure, processes, and outcomes
14 related to the provision of health services, including
15 pediatric review of pediatric cases;

16 “(4) include in member satisfaction surveys,
17 questions on child and family satisfaction and expe-
18 rience of care, including care to children with special
19 needs;

20 “(5) monitor and evaluate the continuity of
21 care with respect to children;

22 “(6) include pediatric measures that are di-
23 rected at meeting the needs of children with special
24 health care needs, including at-risk children and

1 children with chronic conditions, disabilities and se-
2 vere illnesses;

3 “(7) maintain written guidelines to ensure the
4 availability of medications appropriate to children;

5 “(8) use focused studies of care received by
6 children with certain types of chronic conditions and
7 disabilities and focused studies of specialized services
8 used by children with chronic conditions and disabil-
9 ities;

10 “(9) monitor access to pediatric specialty serv-
11 ices; and

12 “(10) monitor child health care professional
13 satisfaction.

14 “(c) UTILIZATION REVIEW ACTIVITIES.—

15 “(1) COMPLIANCE WITH REQUIREMENTS.—

16 “(A) IN GENERAL.—A group health plan
17 that covers children, and a health insurance
18 issuer that offers health insurance coverage for
19 children, shall conduct utilization review activi-
20 ties in connection with the provision of such
21 coverage only in accordance with a utilization
22 review program that meets at a minimum the
23 requirements of this subsection.

24 “(B) DEFINITIONS.—In this subsection:

1 “(i) CLINICAL PEERS.—The term
2 ‘clinical peer’ means, with respect to a re-
3 view, a physician or other health care pro-
4 fessional who holds a non-restricted license
5 in a State and in the same or similar spe-
6 cialty as typically manages the pediatric
7 medical condition, procedure, or treatment
8 under review.

9 “(ii) HEALTH CARE PROFESSIONAL.—
10 The term ‘health care professional’ means
11 a physician or other health care practi-
12 tioner licensed or certified under State law
13 to provide health care services and who is
14 operating within the scope of such licen-
15 sure or certification.

16 “(iii) UTILIZATION REVIEW.—The
17 terms ‘utilization review’ and ‘utilization
18 review activities’ mean procedures used to
19 monitor or evaluate the clinical necessity,
20 appropriateness, efficacy, or efficiency of
21 health care services, procedures or settings
22 for children, and includes prospective re-
23 view, concurrent review, second opinions,
24 case management, discharge planning, or
25 retrospective review specific to children.

1 “(2) WRITTEN POLICIES AND CRITERIA.—

2 “(A) WRITTEN POLICIES.—A utilization
3 review program shall be conducted consistent
4 with written policies and procedures that govern
5 all aspects of the program.

6 “(B) USE OF WRITTEN CRITERIA.—A utili-
7 zation review program shall utilize written clini-
8 cal review criteria specific to children and devel-
9 oped pursuant to the program with the input of
10 appropriate physicians, including pediatricians,
11 nonprimary care pediatric specialists, and other
12 child health professionals.

13 “(C) ADMINISTRATION BY HEALTH CARE
14 PROFESSIONALS.—A utilization review program
15 shall be administered by qualified health care
16 professionals, including health care profes-
17 sionals with pediatric expertise who shall over-
18 see review decisions.

19 “(3) USE OF QUALIFIED, INDEPENDENT PER-
20 SONNEL.—

21 “(A) IN GENERAL.—A utilization review
22 program shall provide for the conduct of utiliza-
23 tion review activities only through personnel
24 who are qualified and, to the extent required,
25 who have received appropriate pediatric or child

1 health training in the conduct of such activities
2 under the program.

3 “(B) PEER REVIEW OF ADVERSE CLINICAL
4 DETERMINATIONS.—A utilization review pro-
5 gram shall provide that clinical peers shall
6 evaluate the clinical appropriateness of adverse
7 clinical determinations and divergent clinical
8 options.

9 **“SEC. 2773. APPEALS AND GRIEVANCE MECHANISMS FOR**
10 **CHILDREN.**

11 “(a) INTERNAL APPEALS PROCESS.—A group health
12 plan with respect to covered children, and a health insur-
13 ance issuer in connection with the provision of health in-
14 surance coverage for children, shall establish and maintain
15 a system to provide for the resolution of complaints and
16 appeals regarding all aspects of such coverage for children.
17 Such a system shall include an expedited procedure for
18 appeals on behalf of a child enrollee in situations in which
19 the time frame of a standard appeal would jeopardize the
20 life, health, or development of the child.

21 “(b) EXTERNAL APPEALS PROCESS.—A group health
22 plan that covers children, and a health insurance issuer
23 in connection with the provision of health insurance cov-
24 erage for children, shall provide for an independent exter-

1 nal review process with respect to claims for children that
2 meets the following requirements:

3 “(1) External appeal activities shall be con-
4 ducted through clinical peers, a physician or other
5 health care professional who is appropriately
6 credentialed in pediatrics with the same or similar
7 specialty and typically manages the condition, proce-
8 dure, or treatment under review or appeal.

9 “(2) External appeal activities shall be con-
10 ducted through an entity that has sufficient pedi-
11 atric expertise, including subspecialty expertise, and
12 staffing to conduct external appeal activities on a
13 timely basis.

14 “(3) Such a review process shall include an ex-
15 pedited procedure for appeals on behalf of a child in
16 which the time frame of a standard appeal would
17 jeopardize the life, health, or development of the
18 child.

19 **“SEC. 2774. ACCOUNTABILITY THROUGH DISTRIBUTION OF**
20 **INFORMATION.**

21 “(a) IN GENERAL.—A group health plan that covers
22 children and a health insurance issuer in connection with
23 the provision of health insurance coverage for children
24 shall submit to participants and enrollees (and prospective
25 participants and enrollees), and make available to the pub-

1 lic, in writing the health-related information described in
2 subsection (b).

3 “(b) INFORMATION.—The health-related information
4 to be provided under subsection (a) shall include a descrip-
5 tion of the distinctions in the benefits, processes and out-
6 comes under the plan or coverage between adult partici-
7 pants, beneficiaries, and enrollees and child beneficiaries
8 and enrollees and shall include measures with respect to
9 outcomes that are specific to each such group.”.

10 (b) APPLICATION TO GROUP HEALTH INSURANCE
11 COVERAGE.—

12 (1) IN GENERAL.—Subpart 2 of part A of title
13 XXVII of the Public Health Service Act is amended
14 by adding at the end the following new section:

15 **“SEC. 2706. CHILDREN’S HEALTH ACCOUNTABILITY STAND-**
16 **ARDS.**

17 “(a) IN GENERAL.—Each group health plan, and
18 each health insurance issuer with respect to group health
19 insurance coverage it offers, shall comply with children’s
20 health accountability requirements under part C.

21 “(b) ASSURING COORDINATION.—The Secretary of
22 Health and Human Services and the Secretary of Labor
23 shall ensure, through the execution of an interagency
24 memorandum of understanding between such Secretaries,
25 that—

1 with respect to individual health insurance coverage it of-
2 fers.”.

3 (d) MODIFICATION OF PREEMPTION STANDARDS.—

4 (1) GROUP HEALTH INSURANCE COVERAGE.—

5 Section 2723 of the Public Health Service Act (42
6 U.S.C. 300gg-23) is amended—

7 (A) in subsection (a)(1), by striking “sub-
8 section (b)” and inserting “subsection (b) and
9 (c)”;

10 (B) by redesignating subsections (c) and
11 (d) as subsections (d) and (e), respectively; and

12 (C) by inserting after subsection (b) the
13 following new subsection:

14 “(c) SPECIAL RULES IN CASE OF CHILDREN’S
15 HEALTH ACCOUNTABILITY REQUIREMENTS.—Subject to
16 subsection (a)(2), the provisions of section 2706 and part
17 C, and part D insofar as it applies to section 2706 or part
18 C, shall not prevent a State from establishing require-
19 ments relating to the subject matter of such provisions
20 so long as such requirements are at least as stringent on
21 health insurance issuers as the requirements imposed
22 under such provisions.”.

23 (2) INDIVIDUAL HEALTH INSURANCE COV-
24 ERAGE.—Section 2762 of the Public Health Service

1 Act (42 U.S.C. 300gg–62), as added by section
2 605(b)(3)(B) of Public Law 104–204, is amended—

3 (A) in subsection (a), by striking “sub-
4 section (b), nothing in this part” and inserting
5 “subsections (b) and (c)”, and

6 (B) by adding at the end the following new
7 subsection:

8 “(c) SPECIAL RULES IN CASE OF CHILDREN’S
9 HEALTH ACCOUNTABILITY REQUIREMENTS.—Subject to
10 subsection (b), the provisions of section 2752 and part C,
11 and part D insofar as it applies to section 2752 or part
12 C, shall not prevent a State from establishing require-
13 ments relating to the subject matter of such provisions
14 so long as such requirements are at least as stringent on
15 health insurance issuers as the requirements imposed
16 under such section.”.

17 **SEC. 3. AMENDMENTS TO THE EMPLOYEE RETIREMENT IN-**
18 **COME SECURITY ACT OF 1974.**

19 (a) IN GENERAL.—Subpart B of part 7 of subtitle
20 B of title I of the Employee Retirement Income Security
21 Act of 1974 is amended by adding at the end the follow-
22 ing:

1 **“SEC. 713. CHILDREN’S HEALTH ACCOUNTABILITY STAND-**
2 **ARDS.**

3 “(a) IN GENERAL.—Subject to subsection (b), the
4 provisions of part C of title XXVII of the Public Health
5 Service Act shall apply under this subpart and part to a
6 group health plan (and group health insurance coverage
7 offered in connection with a group health plan) as if such
8 part were incorporated in this section.

9 “(b) APPLICATION.—In applying subsection (a)
10 under this subpart and part, and reference in such part
11 C—

12 “(1) to health insurance coverage is deemed to
13 be a reference only to group health insurance cov-
14 erage offered in connection with a group health plan
15 and to also be a reference to coverage under a group
16 health plan;

17 “(2) to a health insurance issuer is deemed to
18 be a reference only to such an issuer in relation to
19 group health insurance coverage or, with respect to
20 a group health plan, to the plan;

21 “(3) to the Secretary is deemed to be a ref-
22 erence to the Secretary of Labor; and

23 “(4) to an enrollee with respect to health insur-
24 ance coverage is deemed to include a reference to a
25 participant or beneficiary with respect to a group
26 health plan.”.

1 (b) MODIFICATION OF PREEMPTION STANDARDS.—

2 Section 731 of such Act (42 U.S.C. 1191) is amended—

3 (1) in subsection (a)(1), by striking “subsection
4 (b)” and inserting “subsections (b) and (c)”;

5 (2) by redesignating subsections (c) and (d) as
6 subsections (d) and (e), respectively; and

7 (3) by inserting after subsection (b) the follow-
8 ing new subsection:

9 “(c) SPECIAL RULES IN CASE OF PATIENT AC-
10 COUNTABILITY REQUIREMENTS.—Subject to subsection
11 (a)(2), the provisions of section 713, shall not prevent a
12 State from establishing requirements relating to the sub-
13 ject matter of such provisions so long as such require-
14 ments are at least as stringent on group health plans and
15 health insurance issuers in connection with group health
16 insurance coverage as the requirements imposed under
17 such provisions.”.

18 (c) CONFORMING AMENDMENTS.—

19 (1) Section 732(a) of such Act (29 U.S.C.
20 1185(a)) is amended by striking “section 711” and
21 inserting “sections 711 and 713”.

22 (2) The table of contents in section 1 of such
23 Act is amended by inserting after the item relating
24 to section 712 the following new item:

“Sec. 713. Children’s health accountability standards.”.

1 **SEC. 4. STUDIES.**

2 (a) BY SECRETARY.—Not later than 1 year after the
3 date of enactment of this Act, the Secretary of Health and
4 Human Services shall conduct a study, and prepare and
5 submit to Congress a report, concerning—

6 (1) the unique characteristics of patterns of ill-
7 ness, disability, and injury in children;

8 (2) the development of measures of quality of
9 care and outcomes related to the health care of chil-
10 dren; and

11 (3) the access of children to primary mental
12 health services and the coordination of managed be-
13 havioral health services.

14 (b) BY GAO.—

15 (1) MANAGED CARE.—Not later than 1 year
16 after the date of enactment of this Act, the General
17 Accounting Office shall conduct a study, and pre-
18 pare and submit to the Committee on Labor and
19 Human Resources of the Senate and the Committee
20 on Commerce of the House of Representatives a re-
21 port, concerning—

22 (A) an assessment of the structure and
23 performance of non-governmental health plans,
24 medicaid managed care organizations, plans
25 under title XIX of the Social Security Act (42
26 U.S.C. 1396 et seq.), and the program under

1 title XXI of the Social Security Act (42 U.S.C.
2 1397aa et seq.) serving the needs of children
3 with special health care needs;

4 (B) an assessment of the structure and
5 performance of non-governmental plans in serv-
6 ing the needs of children as compared to medic-
7 aid managed care organizations under title XIX
8 of the Social Security Act (42 U.S.C. 1396 et
9 seq.); and

10 (C) the emphasis that private managed
11 care health plans place on primary care and the
12 control of services as it relates to care and serv-
13 ices provided to children with special health
14 care needs.

15 (2) PLAN SURVEY.—Not later than 1 year after
16 the date of enactment of this Act, the General Ac-
17 counting Office shall prepare and submit to the
18 Committee on Labor and Human Resources of the
19 Senate and the Committee on Commerce of the
20 House of Representatives a report that contains a
21 survey of health plan activities that address the
22 unique health needs of adolescents, including quality
23 measures for adolescents and innovative practice ar-
24 rangement.

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