

108TH CONGRESS  
1ST SESSION

# S. 1710

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.

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## IN THE SENATE OF THE UNITED STATES

OCTOBER 3, 2003

Mr. REED (for himself and Mrs. MURRAY) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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## A BILL

To amend 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 2003”.

6 **SEC. 2. FINDINGS.**

7 Congress makes the following findings:

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

4           (2) Children experience complex and continuing  
5 changes during the continuum from birth to adult-  
6 hood in which appropriate health care is essential  
7 for optimal development.

8           (3) The vast majority of work done on develop-  
9 ment methods to assess the effectiveness of health  
10 care services and the impact of medical care on pa-  
11 tient outcomes and patient satisfaction has been fo-  
12 cused on adults.

13           (4) Health outcome measures need to be age,  
14 gender, and developmentally appropriate to be useful  
15 to families and children.

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

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



1 mandatorily assigning such an enrollee to a pri-  
2 mary care provider.

3 “(2) CONSTRUCTION.—Nothing in paragraph  
4 (1) shall waive any requirements of coverage relating  
5 to medical necessity or appropriateness with respect  
6 to coverage of services.

7 “(b) ACCESS TO PEDIATRIC SPECIALTY SERVICES.—

8 “(1) REFERRAL TO SPECIALTY CARE FOR CHIL-  
9 DREN REQUIRING TREATMENT BY SPECIALISTS.—

10 “(A) IN GENERAL.—In the case of a child  
11 who is covered under a group health plan, or  
12 health insurance coverage offered by a health  
13 insurance issuer and who has a mental or phys-  
14 ical condition, disability, or disease of sufficient  
15 seriousness and complexity to require diagnosis,  
16 evaluation or treatment by a specialist, the plan  
17 or issuer shall make or provide for a referral to  
18 a specialist who has extensive experience or  
19 training, and is available and accessible to pro-  
20 vide the treatment for such condition or dis-  
21 ease, including the choice of a nonprimary care  
22 physician specialist participating in the plan or  
23 a referral to a nonparticipating provider as pro-  
24 vided for under subparagraph (D) if such a pro-  
25 vider is not available within the plan.

1           “(B) SPECIALIST DEFINED.—For purposes  
2 of this subsection, the term ‘specialist’ means,  
3 with respect to a condition, disability, or dis-  
4 ease, a health care practitioner, facility, or cen-  
5 ter (such as a center of excellence) that has ex-  
6 tensive pediatric expertise through appropriate  
7 training or experience to provide high quality  
8 care in treating the condition, disability or dis-  
9 ease.

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

19           “(D) TREATMENT OF NONPARTICIPATING  
20 PROVIDERS.—If a plan or issuer refers a child  
21 enrollee to a nonparticipating specialist, services  
22 provided pursuant to the referral shall be pro-  
23 vided at no additional cost to the enrollee be-  
24 yond what the enrollee would otherwise pay for

1 services received by such a specialist that is a  
2 participating provider.

3 “(E) SPECIALISTS AS PRIMARY CARE PRO-  
4 VIDERS.—A plan or issuer shall have in place a  
5 procedure under which a child who is covered  
6 under health insurance coverage provided by  
7 the plan or issuer who has a condition or dis-  
8 ease that requires specialized medical care over  
9 a prolonged period of time shall receive a refer-  
10 ral to a pediatric specialist affiliated with the  
11 plan, or if not available within the plan, to a  
12 nonparticipating provider for such condition  
13 and such specialist may be responsible for and  
14 capable of providing and coordinating the  
15 child’s primary and specialty care.

16 “(2) STANDING REFERRALS.—

17 “(A) IN GENERAL.—A group health plan,  
18 or health insurance issuer in connection with  
19 the provision of health insurance coverage of a  
20 child, shall have a procedure by which a child  
21 who has a condition, disability, or disease that  
22 requires ongoing care from a specialist may re-  
23 quest and obtain a standing referral to such  
24 specialist for treatment of such condition. If the  
25 primary care provider in consultation with the

1 medical director of the plan or issuer and the  
2 specialist (if any), determines that such a  
3 standing referral is appropriate, the plan or  
4 issuer shall authorize such a referral to such a  
5 specialist. Such standing referral shall be con-  
6 sistent with a treatment plan.

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

17 “(C) TERMS OF REFERRAL.—The provi-  
18 sions of subparagraph (C) and (D) of para-  
19 graph (1) shall apply with respect to referrals  
20 under subparagraph (A) in the same manner as  
21 they apply to referrals under paragraph (1)(A).

22 “(c) ADEQUACY OF ACCESS.—For purposes of sub-  
23 sections (a) and (b), a group health plan or health insur-  
24 ance issuer in connection with health insurance coverage  
25 shall ensure that a sufficient number, distribution, and va-

1 riety of qualified participating health care providers are  
 2 available so as to ensure that all covered health care serv-  
 3 ices, including specialty services, are available and acces-  
 4 sible to all enrollees in a timely manner.

5 “(d) COVERAGE OF EMERGENCY SERVICES.—

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

13 “(A) without the need for any prior au-  
 14 thorization determination;

15 “(B) whether or not the physician or pro-  
 16 vider furnishing such services is a participating  
 17 physician or provider with respect to such serv-  
 18 ices; and

19 “(C) without regard to any other term or  
 20 condition of such coverage (other than exclusion  
 21 of benefits, or an affiliation or waiting period,  
 22 permitted under section 2701).

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

24 “(A) EMERGENCY MEDICAL CONDITION  
 25 BASED ON PRUDENT LAYPERSON STANDARD.—

1           The term ‘emergency medical condition’ means  
2           a medical condition manifesting itself by acute  
3           symptoms of sufficient severity (including se-  
4           vere pain) such that a prudent layperson, who  
5           possesses an average knowledge of health and  
6           medicine, could reasonably expect the absence  
7           of immediate medical attention to result in a  
8           condition described in clause (i), (ii), or (iii) of  
9           section 1867(e)(1)(A) of the Social Security  
10          Act.

11                   “(B) EMERGENCY SERVICES.—The term  
12          ‘emergency services’ means—

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

22                           “(ii) within the capabilities of the  
23                           staff and facilities available at the hospital,  
24                           such further medical examination and

1 treatment as are required under section  
2 1867 of such Act to stabilize the patient.

3 “(3) REIMBURSEMENT FOR MAINTENANCE  
4 CARE AND POST-STABILIZATION CARE.—A group  
5 health plan, and health insurance issuer offering  
6 health insurance coverage, shall provide, in covering  
7 services other than emergency services, for reim-  
8 bursement with respect to services which are other-  
9 wise covered and which are provided to an enrollee  
10 other than through the plan or issuer if the services  
11 are maintenance care or post-stabilization care cov-  
12 ered under the guidelines established under section  
13 1852(d) of the Social Security Act (relating to pro-  
14 moting efficient and timely coordination of appro-  
15 priate maintenance and post-stabilization care of an  
16 enrollee after an enrollee has been determined to be  
17 stable).

18 “(e) PROHIBITION ON FINANCIAL BARRIERS.—A  
19 health insurance issuer in connection with the provision  
20 of health insurance coverage may not impose any cost  
21 sharing for pediatric specialty services provided under  
22 such coverage to enrollee children in amounts that exceed  
23 the cost-sharing required for other specialty care under  
24 such coverage.

1       “(f) CHILDREN WITH SPECIAL HEALTH CARE  
 2 NEEDS.—A health insurance issuer in connection with the  
 3 provision of health insurance coverage shall ensure that  
 4 such coverage provides special consideration for the provi-  
 5 sion of services to enrollee children with special health care  
 6 needs. Appropriate procedures shall be implemented to  
 7 provide care for children with special health care needs.  
 8 The development of such procedures shall include partici-  
 9 pation by the families of such children.

10       “(g) DEFINITIONS.—In this part:

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

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

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

21       “(a) IN GENERAL.—If a contract between a health  
 22 insurance issuer, in connection with the provision of health  
 23 insurance coverage, and a health care provider is termi-  
 24 nated (other than by the issuer for failure to meet applica-  
 25 ble quality standards or for fraud) and an enrollee is un-

1 dergoing a course of treatment from the provider at the  
2 time of such termination, the issuer shall—

3 “(1) notify the enrollee of such termination,  
4 and

5 “(2) subject to subsection (c), permit the en-  
6 rollee to continue the course of treatment with the  
7 provider during a transitional period (provided under  
8 subsection (b)).

9 “(b) TRANSITIONAL PERIOD.—

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

13 “(A) 60 days from the date of the notice  
14 to the enrollee of the provider’s termination in  
15 the case of a primary care provider, or

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

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

1 “(3) PREGNANCY.—If—

2 “(A) an enrollee has entered the second  
3 trimester of pregnancy at the time of a pro-  
4 vider’s termination of participation, and

5 “(B) the provider was treating the preg-  
6 nancy before date of the termination,

7 the transitional period under this subsection with re-  
8 spect to provider’s treatment of the pregnancy shall  
9 extend through the provision of post-partum care di-  
10 rectly related to the delivery.

11 “(4) TERMINAL ILLNESS.—

12 “(A) IN GENERAL.—If—

13 “(i) an enrollee was determined to be  
14 terminally ill (as defined in subparagraph  
15 (B)) at the time of a provider’s termi-  
16 nation of participation, and

17 “(ii) the provider was treating the ter-  
18 minal illness before the date of termi-  
19 nation,

20 the transitional period under this subsection  
21 shall extend for the remainder of the enrollee’s  
22 life for care directly related to the treatment of  
23 the terminal illness.

24 “(B) DEFINITION.—In subparagraph (A),  
25 an enrollee is considered to be ‘terminally ill’ if

1           the enrollee has a medical prognosis that the  
2           enrollee’s life expectancy is 6 months or less.

3           “(c) PERMISSIBLE TERMS AND CONDITIONS.—An  
4 issuer may condition coverage of continued treatment by  
5 a provider under subsection (a)(2) upon the provider  
6 agreeing to the following terms and conditions:

7           “(1) The provider agrees to continue to accept  
8 reimbursement from the issuer at the rates applica-  
9 ble prior to the start of the transitional period as  
10 payment in full.

11           “(2) The provider agrees to adhere to the  
12 issuer’s quality assurance standards and to provide  
13 to the issuer necessary medical information related  
14 to the care provided.

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

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

21           “(a) IN GENERAL.—A health insurance issuer that  
22 offers health insurance coverage for children shall estab-  
23 lish and maintain an ongoing, internal quality assurance  
24 program that at a minimum meets the requirements of  
25 subsection (b).

1       “(b) REQUIREMENTS.—The internal quality assur-  
2       ance program of an issuer under subsection (a) shall—

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

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

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

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

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

24               “(6) include pediatric measures that are di-  
25       rected at meeting the needs of 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 health insurance  
 17 issuer that offers health insurance coverage for  
 18 children shall conduct utilization review activi-  
 19 ties in connection with the provision of such  
 20 coverage only in accordance with a utilization  
 21 review program that meets at a minimum the  
 22 requirements of this subsection.

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

24 “(i) CLINICAL PEERS.—The term  
 25 ‘clinical peer’ means, with respect to a re-

1 view, a physician or other health care pro-  
2 fessional who holds a non-restricted license  
3 in a State and in the same or similar spe-  
4 cialty as typically manages the pediatric  
5 medical condition, procedure, or treatment  
6 under review.

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

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

24 “(2) WRITTEN POLICIES AND CRITERIA.—

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

5           “(B) USE OF WRITTEN CRITERIA.—A utili-  
6 zation review program shall utilize written clin-  
7 ical review criteria specific to children and de-  
8 veloped pursuant to the program with the input  
9 of appropriate physicians, including pediatri-  
10 cians, nonprimary care pediatric specialists, and  
11 other child health professionals.

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

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

20           “(A) IN GENERAL.—A utilization review  
21 program shall provide for the conduct of utiliza-  
22 tion review activities only through personnel  
23 who are qualified and, to the extent required,  
24 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 health insur-  
12 ance issuer in connection with the provision of health in-  
13 surance coverage for children shall establish and maintain  
14 a system to provide for the resolution of complaints and  
15 appeals regarding all aspects of such coverage. Such a sys-  
16 tem shall include an expedited procedure for appeals on  
17 behalf of a child enrollee in situations in which the time  
18 frame of a standard appeal would jeopardize the life,  
19 health, or development of the child.

20 “(b) EXTERNAL APPEALS PROCESS.—A health in-  
21 surance issuer in connection with the provision of health  
22 insurance coverage for children shall provide for an inde-  
23 pendent external review process that meets the following  
24 requirements:



1 of structures, processes, and outcomes regarding each  
2 health insurance product offered to participants and de-  
3 pendants in a manner that is separate for both the adult  
4 and child enrollees, using measures that are specific to  
5 each group.”.

6 (b) APPLICATION TO GROUP HEALTH INSURANCE  
7 COVERAGE.—

8 (1) IN GENERAL.—Subpart 2 of part A of title  
9 XXVII of the Public Health Service Act (42 U.S.C.  
10 300gg–4 et seq.) is amended by adding at the end  
11 the following:

12 **“SEC. 2707. CHILDREN’S HEALTH ACCOUNTABILITY STAND-**  
13 **ARDS.**

14 “(a) IN GENERAL.—Each health insurance issuer  
15 shall comply with children’s health accountability require-  
16 ment under part C with respect to group health insurance  
17 coverage it offers.

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

23 “(1) regulations, rulings, and interpretations  
24 issued by such Secretaries relating to the same mat-  
25 ter over which such Secretaries have responsibility

1 under part C (and this section) and section 714 of  
 2 the Employee Retirement Income Security Act of  
 3 1974 are administered so as to have the same effect  
 4 at all times; and

5 “(2) coordination of policies relating to enforce-  
 6 ing the same requirements through such Secretaries  
 7 in order to have a coordinated enforcement strategy  
 8 that avoids duplication of enforcement efforts and  
 9 assigns priorities in enforcement.”.

10 (2) CONFORMING AMENDMENT.—Section 2792  
 11 of the Public Health Service Act (42 U.S.C. 300gg–  
 12 92) is amended by inserting “and section 2707(b)”  
 13 after “of 1996”.

14 (c) APPLICATION TO INDIVIDUAL HEALTH INSUR-  
 15 ANCE COVERAGE.—Part B of title XXVII of the Public  
 16 Health Service Act (42 U.S.C. 300gg–41 et seq.) is  
 17 amended by inserting after section 2752 the following:

18 **“SEC. 2753. CHILDREN’S HEALTH ACCOUNTABILITY STAND-**

19 **ARDS.**

20 “Each health insurance issuer shall comply with chil-  
 21 dren’s health accountability requirements under part C  
 22 with respect to individual health insurance coverage it of-  
 23 fers.”.

24 (d) MODIFICATION OF PREEMPTION STANDARDS.—

1           (1) GROUP HEALTH INSURANCE COVERAGE.—  
2           Section 2723 of the Public Health Service Act (42  
3           U.S.C. 300gg-23) is amended—

4                   (A) in subsection (a)(1), by striking “sub-  
5                   section (b)” and inserting “subsection (b) and  
6                   (c)”;

7                   (B) by redesignating subsections (c) and  
8                   (d) as subsections (d) and (e), respectively; and

9                   (C) by inserting after subsection (b) the  
10                  following new subsection:

11           “(c) SPECIAL RULES IN CASE OF CHILDREN’S  
12           HEALTH ACCOUNTABILITY REQUIREMENTS.—Subject to  
13           subsection (a)(2), the provisions of section 2707 and part  
14           C, and part D insofar as it applies to section 2707 or part  
15           C, shall not prevent a State from establishing require-  
16           ments relating to the subject matter of such provisions  
17           so long as such requirements are at least as stringent on  
18           health insurance issuers as the requirements imposed  
19           under such provisions.”.

20           (2) INDIVIDUAL HEALTH INSURANCE COV-  
21           ERAGE.—Section 2762 of the Public Health Service  
22           Act (42 U.S.C. 300gg-62) is amended—

23                   (A) in subsection (a), by striking “sub-  
24                   section (b), nothing in this part” and inserting  
25                   “subsections (b) and (c)”;

1 (B) by adding at the end the following new  
2 subsection:

3 “(c) SPECIAL RULES IN CASE OF CHILDREN’S  
4 HEALTH ACCOUNTABILITY REQUIREMENTS.—Subject to  
5 subsection (b), the provisions of section 2753 and part C,  
6 and part D insofar as it applies to section 2753 or part  
7 C, shall not prevent a State from establishing require-  
8 ments relating to the subject matter of such provisions  
9 so long as such requirements are at least as stringent on  
10 health insurance issuers as the requirements imposed  
11 under such section.”.

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

14 (a) IN GENERAL.—Subpart B of part 7 of subtitle  
15 B of title I of (29 U.S.C. 1185 et seq.) is amended by  
16 adding at the end the following:

17 **“SEC. 714. CHILDREN’S HEALTH ACCOUNTABILITY STAND-**  
18 **ARDS.**

19 “(a) IN GENERAL.—Subject to subsection (b), the  
20 provisions of part C of title XXVII of the Public Health  
21 Service Act shall apply under this subpart and part to a  
22 group health plan (and group health insurance coverage  
23 offered in connection with a group health plan) as if such  
24 part were incorporated in this section.

1 “(b) APPLICATION.—In applying subsection (a)  
2 under this subpart and part, any reference in such part  
3 C—

4 “(1) to health insurance coverage is deemed to  
5 be a reference only to group health insurance cov-  
6 erage offered in connection with a group health plan  
7 and to also be a reference to coverage under a group  
8 health plan;

9 “(2) to a health insurance issuer is deemed to  
10 be a reference only to such an issuer in relation to  
11 group health insurance coverage or, with respect to  
12 a group health plan, to the plan;

13 “(3) to the Secretary is deemed to be a ref-  
14 erence to the Secretary of Labor;

15 “(4) to an applicable State authority is deemed  
16 to be a reference to the Secretary of Labor; and

17 “(5) to an enrollee with respect to health insur-  
18 ance coverage is deemed to include a reference to a  
19 participant or beneficiary with respect to a group  
20 health plan.”.

21 (b) MODIFICATION OF PREEMPTION STANDARDS.—  
22 Section 731 of the Employee Retirement Income Security  
23 Act of 1974 (42 U.S.C. 1191) is amended—

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

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

3           (3) by inserting after subsection (b) the fol-  
4 lowing new subsection:

5           “(c) SPECIAL RULES IN CASE OF PATIENT AC-  
6 COUNTABILITY REQUIREMENTS.—Subject to subsection  
7 (a)(2), the provisions of section 714, shall not prevent a  
8 State from establishing requirements relating to the sub-  
9 ject matter of such provisions so long as such require-  
10 ments are at least as stringent on group health plans and  
11 health insurance issuers in connection with group health  
12 insurance coverage as the requirements imposed under  
13 such provisions.”.

14           (c) CONFORMING AMENDMENTS.—

15           (1) Section 732(a) of the Employee Retirement  
16 Income Security Act of 1974 (29 U.S.C. 1185(a)) is  
17 amended by striking “section 711” and inserting  
18 “sections 711 and 714”.

19           (2) The table of contents in section 1 of the  
20 Employee Retirement Income Security Act of 1974  
21 is amended by inserting after the item relating to  
22 section 713 the following new item:

“Sec. 714. Children’s health accountability standards.”.

23 **SEC. 4. STUDIES.**

24           (a) BY SECRETARY.—Not later than 1 year after the  
25 date of enactment of this Act, the Secretary of Health and

1 Human Services shall conduct a study, and prepare and  
2 submit to Congress a report, concerning—

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

5 (2) the development of measures of quality of  
6 care and outcomes related to the health care of chil-  
7 dren; and

8 (3) the access of children to primary mental  
9 health services and the coordination of managed be-  
10 havioral health services.

11 (b) BY GAO.—

12 (1) MANAGED CARE.—Not later than 1 year  
13 after the date of enactment of this Act, the General  
14 Accounting Office shall conduct a study, and pre-  
15 pare and submit to the Committee on Health, Edu-  
16 cation, Labor, and Pensions of the Senate and the  
17 Committee on Commerce of the House of Represent-  
18 atives a report, concerning—

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

1           1397aa et seq.) serving the needs of children  
2           with special health care needs;

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

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

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

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