

105TH CONGRESS
2^D SESSION

S. 1808

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 SENATE OF THE UNITED STATES

MARCH 20, 1998

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

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”.

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 shall consider appropriate pediatric expertise in
2 mandatorily assigning such an enrollee to a pri-
3 mary care provider.

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

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

9 “(1) REFERRAL TO SPECIALITY CARE FOR
10 CHILDREN REQUIRING TREATMENT BY SPECIAL-
11 ISTS.—

12 “(A) IN GENERAL.—In the case of a child
13 who is covered under a group health plan, or
14 health insurance coverage offered by a health
15 insurance issuer and who has a mental or phys-
16 ical condition, disability, or disease of sufficient
17 seriousness and complexity to require diagnosis,
18 evaluation or treatment by a specialist, the plan
19 or issuer shall make or provide for a referral to
20 a specialist who has extensive experience or
21 training, and is available and accessible to pro-
22 vide the treatment for such condition or dis-
23 ease, including the choice of a nonprimary care
24 physician specialist participating in the plan or
25 a referral to a nonparticipating provider as pro-

1 provided for under subparagraph (D) if such a pro-
2 vider is not available within the plan.

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

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

20 “(D) TREATMENT OF NONPARTICIPATING
21 PROVIDERS.—If a plan or issuer refers a child
22 enrollee to a nonparticipating specialist, services
23 provided pursuant to the referral shall be pro-
24 vided at no additional cost to the enrollee be-
25 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 provid-
4 er’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 clini-
7 cal review criteria specific to children and devel-
8 oped pursuant to the program with the input of
9 appropriate physicians, including pediatricians,
10 nonprimary care pediatric specialists, and other
11 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 is amended
 10 by adding at the end the following new section:

11 **“SEC. 2706. CHILDREN’S HEALTH ACCOUNTABILITY STAND-**
 12 **ARDS.**

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

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

22 “(1) regulations, rulings, and interpretations
 23 issued by such Secretaries relating to the same mat-
 24 ter over which such Secretaries have responsibility
 25 under part C (and this section) and section 713 of

1 the Employee Retirement Income Security Act of
 2 1974 are administered so as to have the same effect
 3 at all times; and

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

9 (2) CONFORMING AMENDMENT.—Section 2792
 10 of the Public Health Service Act (42 U.S.C. 300gg–
 11 92) is amended by inserting “and section 2706(b)”
 12 after “of 1996”.

13 (c) APPLICATION TO INDIVIDUAL HEALTH INSUR-
 14 ANCE COVERAGE.—Part B of title XXVII of the Public
 15 Health Service Act is amended by inserting after section
 16 2751 the following new section:

17 **“SEC. 2752. CHILDREN’S HEALTH ACCOUNTABILITY STAND-**
 18 **ARDS.**

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

23 (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 2706 and part
14 C, and part D insofar as it applies to section 2706 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), as added by section
23 605(b)(3)(B) of Public Law 104-204, is amended—

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

4 (B) by adding at the end the following new
 5 subsection:

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

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

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

21 **“SEC. 713. CHILDREN’S HEALTH ACCOUNTABILITY STAND-**
 22 **ARDS.**

23 “(a) IN GENERAL.—Subject to subsection (b), the
 24 provisions of part C of title XXVII of the Public Health
 25 Service Act shall apply under this subpart and part to a

1 group health plan (and group health insurance coverage
2 offered in connection with a group health plan) as if such
3 part were incorporated in this section.

4 “(b) APPLICATION.—In applying subsection (a)
5 under this subpart and part, and reference in such part
6 C—

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

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

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

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

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

24 (b) MODIFICATION OF PREEMPTION STANDARDS.—
25 Section 731 of such Act (42 U.S.C. 1191) is amended—

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

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

5 (3) by inserting after subsection (b) the follow-
6 ing new subsection:

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

16 (c) CONFORMING AMENDMENTS.—

17 (1) Section 732(a) of such Act (29 U.S.C.
18 1185(a)) is amended by striking “section 711” and
19 inserting “sections 711 and 713”.

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

“Sec. 713. 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 Labor and
16 Human Resources of the Senate and the Committee
17 on Commerce of the House of Representatives a re-
18 port, 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 medic-
6 aid managed care organizations under title XIX
7 of the Social Security Act (42 U.S.C. 1396 et
8 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 Labor and Human Resources of the
18 Senate and the Committee on Commerce of the
19 House of Representatives a report that contains a
20 survey of health plan activities that address the
21 unique health needs of adolescents, including quality
22 measures for adolescents and innovative practice ar-
23 rangement.

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