

104TH CONGRESS
1ST SESSION

H. R. 2400

To establish standards for health plan relationships with enrollees, health professionals, and providers.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 27, 1995

Mr. NORWOOD (for himself and Mr. BREWSTER) introduced the following bill;
which was referred to the Committee on Commerce

A BILL

To establish standards for health plan relationships with
enrollees, health professionals, and providers.

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; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Family Health Care Fairness Act of 1995”.

6 (b) TABLE OF CONTENTS.—The table of contents of
7 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—DEFINITIONS; GENERAL PROVISIONS

Sec. 101. Definitions.

Sec. 102. Certification of health plans.

Sec. 103. Effect on certain State laws.

TITLE II—CERTIFICATION OF HEALTH PLANS

- Sec. 201. Enrollee access to care.
- Sec. 202. Enrollee choice of health professionals and providers.
- Sec. 203. Nondiscrimination; equitable access to networks.
- Sec. 204. Development of plan policies.
- Sec. 205. Due process for enrollees.
- Sec. 206. Due process for health professionals and providers.
- Sec. 207. Information reporting and disclosure by network plans.
- Sec. 208. Other health plan requirements.
- Sec. 209. Quality assurance program; case review.
- Sec. 210. Related provisions.

TITLE III—ENFORCEMENT

- Sec. 301. Health plan standards.
- Sec. 302. Health plan liability.

1 **TITLE I—DEFINITIONS;**
 2 **GENERAL PROVISIONS**

3 **SEC. 101. DEFINITIONS.**

4 For purposes of this Act:

5 (1) EMERGENCY MEDICAL CONDITION.—The
 6 term “emergency medical condition” means a medi-
 7 cal condition (including emergency labor and deliv-
 8 ery) manifesting itself by acute symptoms of suffi-
 9 cient severity (including severe pain) such that the
 10 absence of immediate medical attention could rea-
 11 sonably be expected to result in—

12 (A) placing the patient’s health in serious
 13 jeopardy,

14 (B) serious impairment to bodily functions,
 15 or

16 (C) serious dysfunction of any bodily organ
 17 or part.

1 (2) EMERGENCY SERVICES.—The term “emer-
2 gency services” means health care items and services
3 that are necessary for the treatment of an emer-
4 gency medical condition.

5 (3) ENROLLEE.—The term “enrollee” means,
6 with respect to a health plan, an individual enrolled
7 with the health plan.

8 (4) ENROLLEE WITH SPECIAL HEALTH CARE
9 NEEDS.—The term “enrollee with special health care
10 needs” means an enrollee who is an individual or a
11 member of a family that includes an individual with
12 a disability or chronic condition.

13 (A) For purposes of section 202(c)(2)(A),
14 relating to the Point-of-Service Option, such en-
15 rollee shall be additionally defined as having an
16 adjusted gross income that does not exceed 250
17 percent of the official poverty line (as defined
18 by the Office of Management and Budget, and
19 revised annually in accordance with section
20 673(2) of the Omnibus Budget Reconciliation
21 Act of 1981) applicable to a family of the size
22 involved.

23 (5) HEALTH PLAN.—The term “health plan” or
24 “plan” refers to any plan or arrangement that pro-

1 provides, or pays the cost of, health benefits, whether
2 through insurance, reimbursement, or otherwise.

3 (6) HEALTH PROFESSIONAL.—The term
4 “health professional” means only an individual who
5 is licensed, certified, accredited, or otherwise
6 credentialed to provide health care items and serv-
7 ices as authorized by State law (or a State regu-
8 latory mechanism provided by State law).

9 (7) INDIVIDUALLY IDENTIFIABLE INFORMA-
10 TION.—The term “individually identifiable informa-
11 tion” means, with respect to an enrollee, a health
12 professional, or a provider, any information, whether
13 oral or recorded in any medium or form, that identi-
14 fies or can readily be associated with the identity of
15 the enrollee, the health professional, or the provider.

16 (8) MEDICALLY UNDERSERVED AREA.—The
17 term “medically underserved area” means an area
18 that is designated as a health professional shortage
19 area under section 332 of the Public Health Service
20 Act or as a medically underserved area for purposes
21 of section 330 or 1302(7) of such Act.

22 (9) NETWORK.—The term “network” means,
23 with respect to a network plan, the participating
24 health professionals and providers through whom the

1 plan provides health care items and services to en-
2 rollees.

3 (10) NETWORK PLAN.—The term “network
4 plan” means a health plan that provides or arranges
5 for the provision of health care items and services to
6 enrollees through participating health professionals
7 and providers.

8 (11) PARTICIPATING.—The term “participat-
9 ing” means, with respect to a health professional or
10 provider, a health professional or provider that pro-
11 vides health care items and services to enrollees of
12 a network plan under an agreement with the plan.

13 (12) PROVIDER.—The term “provider” means a
14 health organization, health facility, or health agency
15 that is licensed, certified, credentialed, or otherwise
16 authorized to provide health care items and services
17 under applicable State law.

18 (13) RURAL AREA.—The term “rural area”
19 means an area that is not within a Standard Metro-
20 politan Statistical Area or a New England County
21 Metropolitan Area (as defined by the Office of Man-
22 agement and Budget).

23 (14) SECRETARY.—The term “Secretary”
24 means the Secretary of Health and Human Services.

1 (15) SERVICE AREA.—The term “service area”
2 means, with respect to a health plan, the geographic
3 area served by the plan.

4 (16) SPECIALIZED TREATMENT EXPERTISE.—
5 The term “specialized treatment expertise” means—

6 (A) expertise in diagnosing and treating
7 unusual diseases and conditions,

8 (B) diagnosing and treating diseases and
9 conditions that are unusually difficult to diag-
10 nose or treat, and

11 (C) providing other specialized health care.

12 (17) URGENT CARE SERVICES.—The term “ur-
13 gent care services” means health care items and
14 services that are necessary for the treatment of a
15 condition that—

16 (A) is not an emergency medical condition,

17 (B) requires prompt medical or clinical
18 treatment, and

19 (C) poses a danger to the patient if not
20 treated in a timely manner (as defined by the
21 Secretary).

22 (18) UTILIZATION REVIEW.—The term “utiliza-
23 tion review” means prospective, concurrent, or retro-
24 spective review of health care items and services for
25 medical necessity, appropriateness, or quality of care

1 that includes preauthorization requirements for cov-
2 erage of such items and services.

3 **SEC. 102. CERTIFICATION OF HEALTH PLANS.**

4 (a) IN GENERAL.—The Secretary, shall establish a
5 process under which—

6 (1) a health plan may apply to be certified
7 under this Act;

8 (2) such certification is periodically reviewed;
9 and

10 (3) such certification is terminated or not re-
11 newed if the health plan fails substantially to meet
12 the requirements of this Act.

13 To the extent practicable, the process shall be the same
14 as the process used to determine if an entity is an eligible
15 organization under section 1876 of the Social Security
16 Act. To the extent the Secretary does not use that process,
17 the Secretary shall submit a report to Congress that ex-
18 plains the reasons for the differences.

19 (b) CONDITIONS OF CERTIFICATION.—The Secretary
20 shall certify a health plan under this Act if the Secretary
21 finds that the plan meets the applicable requirements of—

22 (1) section 201 (relating to enrollee access to
23 care);

24 (2) section 202 (relating to enrollee choice for
25 network plans);

1 (3) section 203 (relating to nondiscrimination
2 and health professional and provider equity);

3 (4) section 204 (relating to development of plan
4 policies);

5 (5) section 205 (relating to due process for en-
6 rollees);

7 (6) section 206 (relating to due process for
8 health professionals and providers);

9 (7) section 207 (relating to information report-
10 ing and disclosure by network plans);

11 (8) section 208 (relating to other health plan
12 requirements), and

13 (9) section 209 (relating to quality assurance
14 program and case review).

15 **SEC. 103. EFFECT ON CERTAIN STATE LAWS.**

16 Nothing in this Act shall be construed as preempting
17 or otherwise superseding any State law that requires—

18 (1) a health plan to cover any item or service
19 furnished by a health professional or provider be-
20 longing to a category, class, or type of health profes-
21 sional or provider that is authorized under State law
22 to provide the item or service if the plan covers such
23 item or service when furnished by a health profes-
24 sional or provider belonging to another such cat-
25 egory, class, or type;

1 (2) a network plan to include as a participating
2 health professional or provider any health profes-
3 sional or provider that accepts the terms and condi-
4 tions established by the plan for other participating
5 providers; or

6 (3) a health plan to permit enrollees access to
7 a specified category, class, or type of health profes-
8 sional or provider without a referral from a physi-
9 cian.

10 **TITLE II—CERTIFICATION OF** 11 **HEALTH PLANS**

12 **SEC. 201. ENROLLEE ACCESS TO CARE.**

13 (a) IN GENERAL.—A health plan meets the require-
14 ments of this section if the plan meets—

15 (1) the general access requirements of sub-
16 section (b);

17 (2) the requirements for access to emergency
18 and urgent care services of subsection (c); and

19 (3) in the case of a network plan—

20 (A) the requirements for access to special-
21 ized services of subsection (d); and

22 (B) the requirements of subsection (e) re-
23 lating to incentive plans.

24 (b) GENERAL ACCESS.—

1 (1) IN GENERAL.—Subject to paragraphs (2),
2 (3), and (4), a health plan meets the requirements
3 of this subsection if the plan establishes and main-
4 tains adequate arrangements with a sufficient num-
5 ber, mix, and distribution of health professionals and
6 providers to assure that covered items and services
7 are available and accessible to each enrollee—

8 (A) in the service area of the plan;

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

10 (C) with reasonable promptness (including
11 reasonable hours of operation and after-hours
12 services);

13 (D) with reasonable proximity to the resi-
14 dences and workplaces of enrollees; and

15 (E) in a manner that—

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

18 (ii) reasonably assures continuity of
19 care.

20 (2) EXCLUSIVE CONTRACTS.—A health plan
21 that has an arrangement with only 1 provider to fur-
22 nish a particular service or category of services to
23 enrollees may not be treated as meeting the require-
24 ments of this subsection unless such provider is the
25 only provider of such service or category of service

1 in the service area of the plan and otherwise meets
2 the requirements of this Act.

3 (3) RURAL AND UNDERSERVED AREAS.—A
4 health plan that serves a geographic area that is
5 rural or medically underserved shall be treated as
6 meeting the requirement that it have a sufficient
7 number, mix, and distribution of health professionals
8 and providers with respect to such area if the plan—

9 (A) has arrangements with a sufficient
10 number of health professionals and providers in
11 those categories of health professionals and pro-
12 viders specified by the Secretary as having a
13 history of serving rural or medically under-
14 served areas, or

15 (B) meets such other conditions as the
16 Secretary may establish.

17 (4) RULE OF CONSTRUCTION.—Nothing in this
18 subsection shall be construed as requiring a health
19 plan to have arrangements that conflict with its re-
20 sponsibilities to establish measures designed to
21 maintain quality and control costs.

22 (c) EMERGENCY AND URGENT CARE.—A health plan
23 meets the requirements of this subsection if the plan—

24 (1) assures the availability and accessibility of
25 medically or clinically necessary emergency services

1 and urgent care services within the service area of
2 the plan 24 hours a day, 7 days a week;

3 (2) requires no preauthorization for items and
4 services furnished in a hospital emergency depart-
5 ment to an enrollee with symptoms that reasonably
6 suggest an emergency medical condition (including
7 items and services described in paragraph (3)(C));

8 (3) covers (and makes reasonable payments
9 for)—

10 (A) emergency services,

11 (B) services that are not emergency serv-
12 ices but are described in paragraph (2),

13 (C) medical screening examinations and
14 other ancillary services necessary to determine
15 if a medical condition is an emergency medical
16 condition, and

17 (D) urgent care services,

18 without regard to whether the health professional or
19 provider furnishing such services has a contractual
20 (or other) arrangement with the plan; and

21 (4) make preauthorization determinations for—

22 (A) services that are furnished in a hos-
23 pital emergency department (other than services
24 described in paragraph (3)), and

25 (B) urgent care services,

1 within the time periods specified in (or pursuant to)
2 section 205(b)(8).

3 (d) SPECIALIZED SERVICES.—

4 (1) IN GENERAL.—A network plan meets the
5 requirement of this subsection if the plan dem-
6 onstrates that enrollees have access to specialized
7 treatment expertise when such treatment is medi-
8 cally or clinically indicated in the professional judg-
9 ment of the treating health professional, in consulta-
10 tion with the enrollee.

11 (2) METHOD OF MEETING REQUIREMENT.—A
12 network plan may meet the requirement of this sub-
13 section by entering into agreements with, and dem-
14 onstrating sufficient referrals to, centers of special-
15 ized treatment expertise designated by the Secretary.

16 (e) INCENTIVE PLANS.—A network plan meets the
17 requirements of this subsection if any health professional
18 or provider incentive plan operated by the plan meets the
19 requirements of section 1876(i)(8)(A) of the Social Secu-
20 rity Act.

21 **SEC. 202. ENROLLEE CHOICE OF HEALTH PROFESSIONALS**
22 **AND PROVIDERS.**

23 (a) IN GENERAL.—A health plan meets the require-
24 ments of this section if the plan meets—

1 (1) the requirement of subsection (b) that en-
2 rollees have a choice of personal health professional;

3 (2) the requirement of subsection (c) that a
4 plan cover services furnished by out-of-network pro-
5 viders; and

6 (3) the requirements of subsection (d) that the
7 plan assure continuity of care.

8 (b) CHOICE OF PERSONAL HEALTH PROFES-
9 SIONAL.—The requirement of this subsection is that a net-
10 work plan permit each enrollee—

11 (1) to select a personal health professional from
12 among the participating health professionals of the
13 plan, and

14 (2) to change that selection as appropriate.

15 (c) POINT-OF-SERVICE OPTION.—

16 (1) IN GENERAL.—The requirement of this sub-
17 section is that a network plan—

18 (A) cover items and services furnished to
19 an enrollee by a health professional or provider
20 that is not a participating health professional or
21 provider; and

22 (B) establish cost-sharing requirements for
23 items and services described in subparagraph
24 (A) that do not exceed the limits on such cost
25 sharing established under paragraph (2).

1 (2) LIMITS.—The Secretary shall establish—

2 (A) a schedule of limits on cost sharing for
3 items and services described in paragraph
4 (1)(A) for enrollees with special health care
5 needs or a chronic condition, as defined in sec-
6 tion 101(4)(A), and

7 (B) a schedule of limits on cost sharing for
8 such items and services for other enrollees.

9 The limits established under subparagraph (A) shall,
10 on average, provide for cost-sharing requirements
11 that are at least 40 percent lower than the limits es-
12 tablished under subparagraph (B).

13 (d) CONTINUITY OF CARE.—The requirements of this
14 subsection are that a network plan—

15 (1) ensure that any process established by the
16 plan to coordinate care and control costs does not
17 create an undue burden for enrollees with special
18 health care needs or chronic conditions;

19 (2) ensure direct access to relevant specialists
20 for the continued care of such enrollees when medi-
21 cally or clinically indicated in the judgment of the
22 treating health professional, in consultation with the
23 enrollee;

24 (3) in the case of an enrollee with special health
25 care needs or a chronic condition, determine wheth-

1 er, based on the judgment of the treating health pro-
2 fessional, in consultation with the enrollee, it is
3 medically or clinically necessary or appropriate to
4 use a specialist or a care coordinator from an inter-
5 disciplinary team to ensure continuity of care; and

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

9 (A) hospitalization, or

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

12 provide for continued coverage of items and services
13 furnished by the health professional or provider that
14 was treating the enrollee before such change for a
15 reasonable period of time (as specified by the Sec-
16 retary) after such change would otherwise occur.

17 For purposes of paragraph (4), the Secretary shall specify
18 such reasonable period of time, ranging from no fewer
19 than 1 to no greater than 150 days (or not greater than
20 60 days after delivery in the case of a pregnancy), with
21 extension of such a period permitted in the cases of medi-
22 cal necessity. For purposes of such paragraph a change
23 of health professional or provider may be due to changes
24 in the membership of a plan's health professional and pro-
25 vider network, changes in the health plan made available

1 by an employer, and other similar circumstances specified
2 by the Secretary as beyond the control of an enrollee.

3 **SEC. 203. NONDISCRIMINATION; EQUITABLE ACCESS TO**
4 **NETWORKS.**

5 (a) IN GENERAL.—A health plan meets the require-
6 ments of this section if the plan—

7 (1) meets the requirement of subsection (b)
8 that the plan not discriminate;

9 (2) in the case of a network plan, meets the re-
10 quirement of subsection (c) that the plan not dis-
11 criminate in the selection of providers and health
12 professionals; and

13 (3) meets the requirement of subsection (d)
14 that the plan not discriminate in the payment of
15 health professionals and providers.

16 (b) NONDISCRIMINATION.—No health plan may dis-
17 criminate (directly or through contractual arrangements)
18 in any activity, including the selection of a service area,
19 that has the effect of discriminating against an individual
20 on the basis of race, national origin, gender, language, so-
21 cioeconomic status, age, disability, health status, or antici-
22 pated need for health services.

23 (c) NONDISCRIMINATION IN SELECTION OF NET-
24 WORK MEMBERS.—The requirement of this subsection is
25 that a network plan does not discriminate in selecting the

1 members of its health professional and provider network
2 (or in establishing the terms and conditions for member-
3 ship in such network) on the basis of—

4 (1) the race, national origin, gender, language,
5 age or disability of the health professional;

6 (2) the socioeconomic status, disability, health
7 status, or anticipated need for health services of the
8 patients of a health professional or provider; or

9 (3) the health professional or provider's lack of
10 affiliation with, or admitting privileges at, a hospital
11 (unless such lack of affiliation is a result of infrac-
12 tions of quality standards and is not due to a provid-
13 er's type of license).

14 (d) NONDISCRIMINATION IN ACCESS TO HEALTH
15 PLANS.—A health plan meets the requirements of this
16 subsection if the plan—

17 (1) does not—

18 (A) in the case of a network plan, discrimi-
19 nate in participation of, and

20 (B) in the case of a health plan that is not
21 a network plan, deny reimbursement or indem-
22 nification to,

23 a health professional who is acting within the scope
24 of the health professional's license under applicable

1 State law solely on the basis of such license or cer-
2 tification; and

3 (2) does not—

4 (A) in the case of a network plan, discrimi-
5 nate in participation of, and

6 (B) in the case of a health plan that is not
7 a network plan, deny reimbursement or indem-
8 nification to,

9 a provider that is providing services that are within
10 the scope of services that the provider is authorized
11 to provide under State law.

12 **SEC. 204. DEVELOPMENT OF PLAN POLICIES.**

13 The requirement of this section is that a network
14 plan establish mechanisms to incorporate the rec-
15 ommendations, suggestions, and views of enrollees and
16 participating health professionals and providers into—

17 (1) the medical policies of the plan (including
18 policies relating to coverage of new technologies,
19 treatments, and procedures);

20 (2) the utilization review criteria and proce-
21 dures of the plan;

22 (3) the quality and credentialing criteria of the
23 plan; and

24 (4) the medical management procedures of the
25 plan.

1 **SEC. 205. DUE PROCESS FOR ENROLLEES.**

2 (a) IN GENERAL.—A health plan meets the require-
3 ments of this section if the plan meets—

4 (1) the requirements of subsection (b) relating
5 to utilization review and payment of claims;

6 (2) the requirements of subsection (c) relating
7 to external appeals; and

8 (3) the requirements of subsection (d) relating
9 to internal grievance procedures.

10 (b) UTILIZATION REVIEW.—The requirements of this
11 subsection are that the utilization review program of a
12 health plan—

13 (1) is developed (including any screening cri-
14 teria used by such program) with the involvement of
15 participating health professionals and providers;

16 (2) to the extent consistent with the protection
17 of proprietary business information (as defined for
18 purposes of section 552 of title 5, United States
19 Code), releases, upon request, to affected health pro-
20 fessionals, providers, and enrollees the screening cri-
21 teria, weighting elements, and computer algorithms
22 used in reviews and a description of the method by
23 which they were developed;

24 (3) uniformly applies review criteria that are
25 based on sound scientific principles and the most re-
26 cent medical evidence;

1 (4) uses licensed, certified, or otherwise
2 credentialed health professionals to make review de-
3 terminations (and for services requiring specialized
4 training for their delivery, uses a health professional
5 who is qualified through equivalent specialized train-
6 ing);

7 (5) subject to reasonable safeguards specified
8 by the Secretary, discloses to health professionals
9 and providers, upon request, the names and creden-
10 tials of individuals conducting utilization review;

11 (6) does not compensate individuals conducting
12 utilization review for denials of payment or coverage
13 of benefits;

14 (7) complies with the requirement of section
15 201(c)(2) that preauthorization not be required for
16 emergency and related services furnished in a hos-
17 pital emergency department;

18 (8) makes preauthorization determinations—

19 (A) in the case of services to be furnished
20 in a hospital emergency department that are
21 not services described in section 201(c)(2),
22 within 30 minutes of a request for such deter-
23 mination, and

1 (B) in the case of other services, within 24
2 hours after the time of a request for determina-
3 tion;

4 (9) includes in any notice of such determination
5 an explanation of the basis of the determination and
6 the right to an immediate appeal;

7 (10) treats a favorable preauthorization review
8 determination as a final determination for purposes
9 of making payment for a claim submitted for the
10 item or service involved unless such determination
11 was based on fraudulent information supplied by the
12 person requesting the determination;

13 (11) provides timely access to review personnel
14 and, if such personnel are not available, waives any
15 preauthorization that would otherwise be required;
16 and

17 (12) provides notice of an initial determination
18 on payment of a claim within 30 days after the date
19 the claim is submitted for such item or service, and
20 includes in such notice an explanation of the reasons
21 for such determination and of the right to an imme-
22 diate appeal.

23 For purposes of paragraph (10), failure of a plan to make
24 a determination described in paragraph (8)(A) within the
25 period of time specified in such paragraph shall be treated

1 as a favorable determination for the items and services
2 for which the determination was requested.

3 (c) APPEALS PROCESS.—A health plan meets the re-
4 quirements of this subsection if the plan establishes and
5 maintains an accessible appeals process that—

6 (1) reviews an adverse preauthorization deter-
7 mination—

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

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

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

17 (3) provides for review of determinations de-
18 scribed in paragraphs (1) and (2) by an appropriate
19 clinical peer professional who is in the same or simi-
20 lar specialty as would typically provide the item or
21 service involved (or another licensed, certified, or
22 otherwise credentialed health professional acceptable
23 to the plan and the person requesting such review);
24 and

25 (4) provides for review of—

1 (A) the determinations described in para-
2 graphs (1), (2), and (3), and

3 (B) enrollee complaints about inadequate
4 access to any category, class, or type of health
5 professional or provider in the network of the
6 plan and other matters specified by this Act,

7 by a person that is not involved in the operation of
8 the plan or in making the determination or policy
9 being appealed.

10 The procedures specified in this subsection shall not be
11 construed as preempting or superseding any other reviews
12 or appeals a plan is required by law to make available.

13 **SEC. 206. DUE PROCESS FOR HEALTH PROFESSIONALS AND**
14 **PROVIDERS.**

15 (a) IN GENERAL.—The requirements of this section
16 are that a network plan—

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

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

1 (3) provide for review of each application by a
2 credentialing committee with appropriate representa-
3 tion of the category, class, or type of health profes-
4 sional or provider;

5 (4) select participating health professionals and
6 providers based on objective standards of quality de-
7 veloped with the suggestions and advice of profes-
8 sional associations, health professionals, and provid-
9 ers;

10 (5) make such standards available to—

11 (A) those applying to become a participat-
12 ing provider or health professional;

13 (B) health plan purchasers, and

14 (C) enrollees;

15 (6) when economic considerations are taken
16 into account in selecting participating health profes-
17 sionals and providers, uses objective criteria that are
18 available to those applying to become a participating
19 provider or health professional and enrollees;

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

1 (8) make the results of such profiling available
2 to plan purchasers, enrollees, and the health profes-
3 sional or provider involved;

4 (9) notify any health professional or provider
5 being reviewed under the process referred to in para-
6 graph (3) of any information indicating that the
7 health professional or provider fails to meet the
8 standards of the plan;

9 (10) offer a health professional or provider re-
10 ceiving notice pursuant to the requirement of para-
11 graph (9) with an opportunity to—

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

14 (B) submit supplemental or corrected in-
15 formation;

16 (11) not include in its contracts with participat-
17 ing health professionals and providers a provision
18 permitting the plan to terminate the contract “with-
19 out cause”;

20 (12) provide a due process appeal that con-
21 forms to the process specified in section 412 of the
22 Health Care Quality Improvement Act of 1986 (42
23 U.S.C. 11112) for all determinations that are ad-
24 verse to a health professional or provider; and

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

6 (A) reasonable notice of any determination
7 to terminate a health professional or provider
8 “for cause” (including an explanation of the
9 reasons for the determination),

10 (B) an opportunity to review and discuss
11 all of the information on which the determina-
12 tion is based, and

13 (C) an opportunity to enter into a correc-
14 tive action plan,
15 before the determination becomes subject to appeal
16 under the process referred to in paragraph (12).

17 (b) RULE OF CONSTRUCTION.—The requirements of
18 subsection (a) shall not be construed as preempting or su-
19 perseding any other reviews and appeals a plan is required
20 by law to make available.

21 **SEC. 207. INFORMATION REPORTING AND DISCLOSURE BY**
22 **NETWORK PLANS.**

23 (a) IN GENERAL.—The requirement of this section
24 is that a network plan provide enrollees and prospective

1 enrollees with truthful, accurate, and easily understand-
2 able marketing materials and information about—

3 (1) coverage provisions, benefits, and any exclu-
4 sions—

5 (A) by category of service,

6 (B) by category, class, or type of health
7 professional or provider, and

8 (C) if applicable, by specific service, includ-
9 ing experimental treatments;

10 (2) the specific amount of the premium charged
11 by the plan that is set aside for administration and
12 marketing of the plan;

13 (3) the specific amount of such premium that
14 is expended directly for patient care;

15 (4) the number, mix, and distribution of partici-
16 pating health professionals and providers;

17 (5) the ratio of enrollees to participating health
18 professionals and providers by category, class, and
19 type of health professional and provider,

20 (6) the expenditures and utilization per enrollee
21 by category, class, and type of health professional
22 and provider;

23 (7) the financial obligations of the enrollee and
24 the plan, including premiums, copayments,
25 deductibles, and established aggregate maximums on

1 out-of-pocket costs, for all items and services, includ-
2 ing—

3 (A) those furnished by health professionals
4 and providers that are not participating health
5 professionals and providers, and

6 (B) those furnished to an enrollee who is
7 outside the service area of the plan;

8 (8) utilization review requirements of the plan
9 (including preauthorization review, concurrent re-
10 view, post-service review, post-payment review, and
11 any other procedures that may lead to denial of cov-
12 erage or payment for a service);

13 (9) financial arrangements and incentives that
14 may—

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

17 (B) restrict referral or treatment options,
18 or

19 (C) negatively affect the fiduciary respon-
20 sibility of a health professional or provider to
21 an enrollee;

22 (10) other incentives for health professionals
23 and providers to control costs;

24 (11) the loss ratio of the plan;

1 (12) enrollee satisfaction statistics (that include
2 data for enrollees receiving services from health pro-
3 fessionals and providers that are not participating
4 health professionals and providers), including—

5 (A) the percentage of enrollees reenrolling
6 with the plan, and

7 (B) the percentage of enrollees disenrolling
8 from the plan;

9 (13) quality indicators for the plan and partici-
10 pating health professionals and providers, includ-
11 ing—

12 (A) population-based statistics such as im-
13 munization rates, and

14 (B) performance measures, such as—

15 (i) survival after surgery (adjusted for
16 case mix),

17 (ii) hospital readmissions, and

18 (iii) appropriate referrals and preven-
19 tion of secondary complications following
20 treatment;

21 (14) grievance procedures and appeals rights
22 under the plan, and summary information about the
23 number and disposition of grievances and appeals in
24 the most recent period for which complete and accu-
25 rate information is available; and

1 (15) the percentage of utilization review deter-
2 minations made by the plan that disagree with the
3 judgment of the treating health professional or pro-
4 vider and the percentage of such determinations that
5 are reversed on appeal.

6 (b) UNIFORM FORMAT.—The information required to
7 be provided pursuant to this section shall be displayed in
8 a uniform format specified by the State that includes the
9 service area of a plan. If a State fails to establish such
10 a format, such information shall be displayed in a uniform
11 format specified by the Secretary.

12 **SEC. 208. OTHER HEALTH PLAN REQUIREMENTS.**

13 (a) IN GENERAL.—A health plan meets the require-
14 ments of this section if the plan meets—

15 (1) the requirement of subsection (b) for pre-
16 serving confidentiality of records; and

17 (2) the requirements established pursuant to
18 subsection (c) to ensure the continued operation of
19 the plan.

20 (b) CONFIDENTIALITY.—The requirement of this
21 subsection is that a health plan establish mechanisms and
22 procedures to ensure compliance with applicable Federal
23 and State laws to protect the confidentiality of individually
24 identifiable information held by the plan with respect to
25 an enrollee, health professional, or provider.

1 (c) FINANCIAL RESERVES; SOLVENCY.—A health
2 plan meets the requirements of this subsection if the
3 plan—

4 (1) meets such financial reserve or other sol-
5 vency-related requirements as the Secretary may es-
6 tablish to assure the continued availability of (and
7 appropriate payment for) covered items and services
8 for enrollees; and

9 (2) establishes mechanisms specified by the
10 Secretary to protect enrollees, health professionals,
11 and providers in the event of plan failure.

12 Such requirements shall not unduly impede the establish-
13 ment of health plans owned and operated by health care
14 professionals or providers or by non-profit community-
15 based organizations.

16 **SEC. 209. QUALITY ASSURANCE PROGRAM; CASE REVIEW.**

17 (a) QUALITY ASSURANCE PROGRAM.—

18 (1) IN GENERAL.—A health plan meets the re-
19 quirements of this section if the plan establishes a
20 quality improvement program (consistent with sub-
21 section (b)) that systematically and continuously as-
22 sesses and improves—

23 (A) enrollee health status, patient out-
24 comes, processes of care, and enrollee satisfac-

1 tion associated with health care provided by the
2 plan; and

3 (B) the administrative and funding capac-
4 ity of the plan to support and emphasize pre-
5 ventive care, utilization, access and availability,
6 cost effectiveness, acceptable treatment modal-
7 ities, specialists referrals, the peer review proc-
8 ess, and the efficiency of the administrative
9 process.

10 (2) FUNCTIONS.—A quality improvement pro-
11 gram established pursuant to paragraph (1) shall—

12 (A) assess the performance of the plan and
13 its participating health professionals and pro-
14 viders and report the results of such assessment
15 to plan purchasers, participating health profes-
16 sionals and providers, and administrative per-
17 sonnel;

18 (B) demonstrate measurable improvements
19 in clinical outcomes and plan performance
20 measured by identified criteria, including those
21 specified in paragraph (1)(A); and

22 (C) analyze quality assessment data to de-
23 termine specific interactions in the delivery sys-
24 tem (both the design and funding of the plan

1 and the clinical provision of care) that have an
2 adverse impact on the quality of care.

3 (3) COLLABORATION.—(A) Congress shall ap-
4 point a time-limited commission, consisting of health
5 care consumers, providers, and experts in the field,
6 to devise and recommend to the Secretary a mecha-
7 nism for ongoing collaboration among health profes-
8 sionals and providers, consumers, and experts on
9 quality assurance to provide for—

10 (i) educational intervention when services
11 are characterized by underutilization,
12 overutilization, or poor clinical quality;

13 (ii) organizational and financial consulta-
14 tion when a health plan is characterized by poor
15 access, availability, and utilization of services,
16 limitations in the scope of acceptable treatment
17 modalities, or high administrative costs; and

18 (iii) other remedies if the interventions de-
19 scribed in subparagraphs (A) and (B) are un-
20 successful.

21 (B) The Secretary shall, in consultation with
22 the commission created in section (A), develop a
23 mechanism for ongoing collaboration among health
24 professionals and providers, consumers, and experts

1 on quality assurance, for the purposes delineated in
2 Section (A) subparts (i), (ii), and (iii).

3 (b) CASE REVIEW.—By January 1, 1998, a health
4 plan meets the requirements of this section only if the plan
5 has replaced individual case review with the analysis of
6 practice profiles, except for cases of health professionals
7 and providers identified as outliers which would require
8 individual case review to explain the health professional's
9 or provider's outlier status.

10 **SEC. 210. RELATED PROVISIONS.**

11 (a) INCENTIVES TO SERVE UNDERSERVED AREAS.—
12 The Secretary shall study and report to the Congress on
13 the feasibility and desirability of voluntary participation
14 by health plans in a system that—

15 (1) uses a risk adjustment mechanism to arrive
16 at appropriately enhanced premium payments to
17 health plans serving high risk or underserved popu-
18 lations, and

19 (2) requires part of such premiums to be passed
20 through to health professionals and providers serving
21 such populations in the form of bonus payments or
22 higher reimbursement rates.

1 **TITLE III—ENFORCEMENT**

2 **SEC. 301. HEALTH PLAN STANDARDS.**

3 The Secretary shall promulgate such regulations as
4 are necessary and appropriate to provide for the enforce-
5 ment of the requirements of this Act. The remedies speci-
6 fied in subsection (i) of section 1876 of the Social Security
7 Act shall apply to health plans under this Act in the same
8 manner as they apply to eligible organizations under title
9 XVIII of such Act.

10 **SEC. 302. HEALTH PLAN LIABILITY.**

11 (a) HEALTH PLAN LIABILITY.—No health plan may
12 engage in any activity that has the effect of inappropri-
13 ately limiting or denying care to any individual enrolled
14 in such plan through any utilization review or cost con-
15 tainment technique. Any such individual who alleges an
16 injury caused by the application of a clinically or medically
17 inappropriate decision resulting from defects in the design
18 or application of any utilization review or cost containment
19 technique by a health plan may commence a civil action
20 against the health plan in the appropriate State court or
21 district court of the United States.

22 (b) INDEMNITY RESTRICTION.—No health plan may
23 require any health professional or provider to indemnify
24 the plan for any recovery by an individual in an action
25 brought under subsection (a).

1 (c) RELIEF.—In any action commenced under sub-
2 section (a), a court that finds for the individual commenc-
3 ing the action may award appropriate relief to such indi-
4 vidual.

5 (d) PREEMPTION.—Notwithstanding any other provi-
6 sion of law, no State may limit the liability of a health
7 plan for any claim that is brought under subsection (a).

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HR 2400 IH—2

HR 2400 IH—3