

105TH CONGRESS
1ST SESSION

H. R. 337

To amend the Internal Revenue Code of 1986 and titles XVIII and XIX of the Social Security Act to ensure access to services and prevent fraud and abuse for enrollees of managed care plans, to amend standards for Medicare supplemental policies, to modify the Medicare select program, and to provide other protections for beneficiaries of health plans generally, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 7, 1997

Mr. STARK (for himself, Mr. LEWIS of Georgia, Mr. GEJDENSON, Mr. SERRANO, Mr. SANDERS, and Mr. FILNER) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend the Internal Revenue Code of 1986 and titles XVIII and XIX of the Social Security Act to ensure access to services and prevent fraud and abuse for enrollees of managed care plans, to amend standards for Medicare supplemental policies, to modify the Medicare select program, and to provide other protections for beneficiaries of health plans generally, and for other purposes.

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

1 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

2 (a) **SHORT TITLE.**—This Act may be cited as the
3 “Managed Care Consumer Protection Act of 1997”.

4 (b) **TABLE OF CONTENTS.**—The table of contents of
5 this Act is as follows:

Sec. 1. Short title; table of contents.

**TITLE I—PROTECTIONS FOR BENEFICIARIES ENROLLED IN
MANAGED CARE PLANS**

“Subtitle L—Protections for Beneficiaries Under Managed Care Plans

**“CHAPTER 101—PROTECTIONS FOR BENEFICIARIES
UNDER MANAGED CARE PLANS**

“SUBCHAPTER A—IMPOSITION OF TAX

“Sec. 9901. Excise tax on failure to meet requirement of beneficiary protection.

“Sec. 9902. Definitions.

“SUBCHAPTER B—REQUIREMENTS

“Sec. 9911. Requirements relating to managed care organizations and providers of health services.

“Sec. 9912. Grievance procedures and deadline for responding to requests for coverage of services.

“Sec. 9913. Requirements for organization service areas; nondiscrimination.

“Sec. 9914. Providing information.

“Sec. 9915. Restrictions on commissions for agents.

“Sec. 9916. Protection of patient right to know.

“Sec. 9917. Patient access to clinical studies.

“Sec. 9918. Required minimum childbirth benefits.

“Sec. 9919. Assuring equitable health plan coverage with respect to emergency services.

Subtitle C—Effective Date

Sec. 121. Effective date.

TITLE II—MEDICARE

Sec. 201. Prohibition on payments under Medicare until completion of orientation and medical profile.

Sec. 202. Changes in requirements for Medicare supplemental policies relating to community rating and loss ratios.

Sec. 203. Other additional consumer protections for Medicare supplemental insurance.

Sec. 204. Application of standards to Medicare select policies.

Sec. 205. Arrangements for out-of-area dialysis services.

Sec. 206. Coordination of Medicare enrollment and termination of enrollment.

Sec. 207. Annual publication of comparative information on Medicare managed care plans.

Sec. 208. Office of Medicare Advocacy.

Sec. 209. Hold-harmless provisions to protect managed care enrollees from amounts owed hospitals for emergency services.

Sec. 210. Automatic exclusion from Medicare and Medicaid for health plans that lie about quality data.

TITLE III—MEDICAID

Sec. 301. Prohibition on payments under Medicaid until completion of orientation, medical profile, and immunization.

Sec. 302. Requirement for Medicaid capitated plans to assure appropriate childhood immunizations.

1 **TITLE I—PROTECTIONS FOR** 2 **BENEFICIARIES ENROLLED** 3 **IN MANAGED CARE PLANS**

4 (a) IN GENERAL.—The Internal Revenue Code of
5 1986 (as amended by the Health Insurance Portability
6 and Accountability Act of 1996) is amended by adding at
7 the end the following:

8 **“Subtitle L—Protections for Bene-** 9 **ficiaries Under Managed Care** 10 **Plans**

11 **“CHAPTER 101—PROTECTIONS FOR BENE-** 12 **FICIARIES UNDER MANAGED CARE** 13 **PLANS**

“Subchapter A. Imposition of tax.

“Subchapter B. Requirements.

14 **“Subchapter A—Imposition of Tax**

“Sec. 9901. Excise tax on failure to meet requirement of beneficiary protection.

“Sec. 9902. Definitions.

1 **“SEC. 9901. EXCISE TAX ON FAILURE TO MEET REQUIRE-**
2 **MENT OF BENEFICIARY PROTECTION.**

3 “(a) IMPOSITION OF TAX.—There is hereby imposed
4 a tax on the failure of—

5 “(1) a managed care group health plan to meet
6 the requirements of subchapter B; and

7 “(2) an insurer that offers managed care health
8 insurance coverage (other than to a group health
9 plan subject to paragraph (1)) to meet the require-
10 ments of such subchapter.

11 “(b) AMOUNT OF TAX.—

12 “(1) GROUP HEALTH PLAN.—

13 “(A) IN GENERAL.—The amount of tax
14 imposed by subsection (a)(1) on any failure
15 with respect to a participant or beneficiary of a
16 group health plan shall be 25 percent of each
17 premium received by the group health plan for
18 the plan year in which such failure occurs.

19 “(B) SELF-INSURED PLANS.—In the case
20 that the group health plan is self-insured, the
21 cost to the plan of the coverage of participants
22 and beneficiaries shall be treated as the pre-
23 mium received for the purposes of subpara-
24 graph (A).

1 “(2) INSURER OFFERING INDIVIDUAL HEALTH
2 INSURANCE COVERAGE.—The amount of tax im-
3 posed by subsection (a)(2) on any failure of an in-
4 surer with respect to an individual described in para-
5 graph (1) or (2) of section 9902(b) shall be 25 per-
6 cent of the total amount of the premiums paid to the
7 insurer for such coverage for the plan year in which
8 such failure occurs.

9 “(c) LIMITATIONS ON AMOUNT OF TAX.—

10 “(1) TAX NOT TO APPLY WHERE FAILURE NOT
11 DISCOVERED EXERCISING REASONABLE DILI-
12 GENCE.—No tax shall be imposed by subsection (a)
13 on any failure during any period for which it is es-
14 tablished to the satisfaction of the Secretary that
15 none of the persons referred to in subsection (e)
16 knew, or exercising reasonable diligence would have
17 known, that such failure existed.

18 “(2) TAX NOT TO APPLY TO FAILURES COR-
19 RECTED WITHIN 30 DAYS.—No tax shall be imposed
20 by subsection (a) on any failure if—

21 “(A) such failure was due to reasonable
22 cause and not to willful neglect, and

23 “(B) such failure is corrected during the
24 30-day period beginning on the 1st date any of
25 the persons referred to in subsection (e) knew,

1 or exercising reasonable diligence would have
2 known, that such failure existed.

3 “(3) WAIVER.—In the case of a failure which is
4 due to reasonable cause and not to willful neglect,
5 the Secretary may waive part or all of the tax im-
6 posed by subsection (a) to the extent that the pay-
7 ment of such tax would be excessive relative to the
8 failure involved.

9 “(d) TAX NOT TO APPLY TO CERTAIN PLANS.—This
10 section shall not apply to—

11 “(1) any governmental plan (within the mean-
12 ing of section 414(d)), or

13 “(2) any church plan (within the meaning of
14 section 414(e)).

15 “(e) LIABILITY FOR TAX.—The following shall be re-
16 sponsible for the tax imposed by subsection (a):

17 “(1) In the case of the tax imposed by sub-
18 section (a)(1) on a group health plan, the plan.

19 “(2) In the case of the tax imposed by sub-
20 section (a)(2) on an insurer offering health insur-
21 ance coverage, the insurer.

22 **“SEC. 9902. DEFINITIONS.**

23 “(a) DEFINITIONS RELATING TO MANAGED CARE.—
24 For purposes of this chapter—

1 “(1) ENROLLEE.—The term ‘enrollee’ means,
2 with respect to a group health plan or health insur-
3 ance issuer offering health insurance coverage, an
4 individual enrolled with the plan or enrolled with the
5 issuer with respect to such coverage.

6 “(2) MANAGED CARE.—The term ‘managed
7 care’ means, with respect to a group health plan or
8 health insurance coverage offered by a health insur-
9 ance issuer, such a plan or coverage that—

10 “(A) provides or arranges for the provision
11 of health care items and services to enrollees
12 primarily through participating physicians and
13 providers, or

14 “(B) provides financial incentives (such as
15 variable copayments and deductibles) to induce
16 enrollees to obtain benefits primarily through
17 participating physicians and providers,
18 or both.

19 “(3) PARTICIPATING.—The term ‘participating’
20 means, with respect to a physician or provider in re-
21 lation to a group health plan or health insurance
22 coverage offered by a health insurance issuer, a phy-
23 sician or provider that furnishes health care items
24 and services to enrollees of the plan or issuer under
25 an agreement with the plan or issuer.

1 “(4) PROVIDER NETWORK.—The term ‘provider
2 network’ means, with respect to a plan or issuer,
3 providers of health care services provided by or
4 through the plan or issuer who have entered into an
5 agreement with the plan or issuer or an agreement
6 with a subcontracting organization under which the
7 providers are obligated to provide such services to
8 individuals enrolled with the plan or issuer.

9 “(b) ADDITIONAL DEFINITIONS.—The provisions of
10 section 9805 apply for purposes of this chapter in the
11 same manner as they apply for purposes of chapter 100.

12 “(c) CLARIFICATION RESPECTING COVERAGE OF
13 MEDICARE AND MEDICAID PREPAID PLANS.—For pur-
14 poses of this chapter—

15 “(1) the term ‘health insurance coverage’ in-
16 cludes—

17 “(A) coverage provided by an eligible orga-
18 nization, managed care entity, or other entity
19 under title XVIII of the Social Security Act and
20 paid on a prepaid basis under section
21 1833(a)(1)(A) or 1876 of such Act or other
22 provision of such title, and

23 “(B) coverage provided by a health mainte-
24 nance organization, health insuring organiza-
25 tion, or other entity under a State plan under

1 title XIX of such Act receiving payment on a
 2 prepaid basis under section 1903(m) of such
 3 Act or other provision of such title; and

4 “(2) the term ‘health insurance issuer’ means,
 5 with respect to coverage described in paragraph (1),
 6 the eligible organization, health maintenance organi-
 7 zation, or other entity at financial risk with respect
 8 to the provision of the coverage.

9 **“Subchapter B—Requirements**

“Sec. 9911. Requirements relating to managed care plans and
 coverage and providers of health services.

“Sec. 9912. Grievance procedures and deadline for responding to
 requests for coverage of services.

“Sec. 9913. Requirements for service areas; nondiscrimination.

“Sec. 9914. Providing information.

“Sec. 9915. Restrictions on commissions for agents.

“Sec. 9916. Protection of patient right to know.

“Sec. 9917. Patient access to clinical studies.

“Sec. 9918. Required minimum childbirth benefits.

“Sec. 9919. Assuring equitable health plan coverage with respect
 to emergency services.

10 **“SEC. 9911. REQUIREMENTS RELATING TO MANAGED CARE**

11 **PLANS AND COVERAGE AND PROVIDERS OF**

12 **HEALTH SERVICES.**

13 “(a) UTILIZATION REVIEW.—

14 “(1) MEETING REQUIREMENTS.—

15 “(A) IN GENERAL.—A managed care
 16 group health plan (or health insurance issuer
 17 that offers managed care health insurance cov-
 18 erage) may not deny coverage of or payment for
 19 items and services on the basis of a utilization

1 review program unless the Secretary of Health
2 and Human Services certifies (and periodically
3 recertifies) that the program meets the stand-
4 ards established by such Secretary under this
5 subsection.

6 “(B) CERTIFICATION.—The Secretary of
7 Health and Human Services may certify a man-
8 aged care plan or coverage as meeting such
9 standards if the Secretary determines that the
10 plan or coverage has met the utilization stand-
11 ards required for accreditation as applied by a
12 nationally recognized, independent, nonprofit
13 accreditation entity. Such Secretary shall peri-
14 odically review the standards used by the pri-
15 vate accreditation entity to ensure that such
16 standards meet or exceed the standards estab-
17 lished by the Secretary under this subsection.

18 “(2) STANDARDS.—Such Secretary shall estab-
19 lish standards for utilization review programs of
20 managed care group health plans and managed care
21 health insurance coverage, consistent with paragraph
22 (3), and shall periodically review and update such
23 standards to reflect changes in the delivery of health
24 care services. Such Secretary shall establish such
25 standards in consultation with appropriate parties.

1 “(3) DESCRIPTION.—Under the standards es-
2 tablished under paragraph (2)—

3 “(A) the plan or issuer offering the cov-
4 erage shall have a written description of the uti-
5 lization review program of the plan or relating
6 to the coverage, including a description of—

7 “(i) the delegated and nondelegated
8 activities under the program;

9 “(ii) the policies and procedures used
10 under the program to evaluate medical ne-
11 cessity; and

12 “(iii) the clinical review criteria, infor-
13 mation sources, and the process used to re-
14 view and approve the provision of medical
15 services under the program;

16 “(B) with respect to the administration of
17 the utilization review program, the plan or is-
18 suer may not employ utilization reviewers or
19 contract with a utilization management organi-
20 zation if the conditions of employment or the
21 contract terms include financial incentives to

1 reduce or limit the medically necessary or ap-
2 propriate services provided to covered individ-
3 uals and individuals performing utilization re-
4 view may not receive financial compensation
5 based upon the number of denials of coverage;

6 “(C) the plan or issuer shall develop proce-
7 dures for periodically reviewing and modifying
8 the utilization review of the plan or relating to
9 the coverage under which providers may partici-
10 pate in the plan or coverage in the development
11 and review of utilization review policies and
12 procedures;

13 “(D) utilization review—

14 “(i) shall be conducted in accordance
15 with uniformly applied standards that are
16 based on the most currently available med-
17 ical evidence,

18 “(ii) shall develop and apply recorded
19 (written or otherwise) utilization review de-
20 cision protocols based on sound medical
21 evidence;

22 “(E) the clinical review criteria used under
23 the utilization review decision protocols to as-
24 sess the appropriateness of medical services
25 shall be clearly documented and available to

1 participating health professionals upon request
2 and shall include a mechanism for assessing the
3 consistency of the application of the criteria
4 used under the protocols across reviewers, and
5 a mechanism for periodically updating such cri-
6 teria;

7 “(F) the procedures applied under a utili-
8 zation review program with respect to the
9 preauthorization and concurrent review of the
10 necessity and appropriateness of medical items,
11 services or procedures, shall require that quali-
12 fied medical professionals supervise review deci-
13 sions and, with respect to a decision to deny the
14 provision of medical items, services or proce-
15 dures, a provider licensed in the same field shall
16 conduct a subsequent review to determine the
17 medical appropriateness of such a denial and
18 physicians from the same medical branch
19 (allopathic or osteopathic medicine) and spe-
20 cialty (recognized by the American Board of
21 Medical Specialties or the American Osteo-
22 pathic Association) shall be utilized in the re-
23 view process, as appropriate;

24 “(G) negative determinations of the medi-
25 cal necessity or appropriateness of services or

1 the site at which services are furnished may be
2 made only by clinically qualified personnel;

3 “(H) the utilization review program shall
4 provide for a process under which an enrollee or
5 provider may obtain timely review of a denial of
6 coverage under section 9912; and

7 “(I) the plan or issuer shall provide each
8 covered individual, at the time of enrollment
9 and not less frequently than annually there-
10 after, an explanation of the utilization review
11 requirements of the plan or under the coverage
12 offered by the issuer.

13 “(b) ASSURANCE OF ACCESS.—

14 “(1) IN GENERAL.—Each managed care group
15 health plan, and each health insurance issuer offer-
16 ing managed care health insurance coverage, shall
17 demonstrate that the plan or issuer (in relation to
18 the coverage) has a sufficient number, distribution,
19 and variety of qualified health care providers to en-
20 sure that all covered health care services will be
21 available and accessible in a timely manner to all in-
22 dividuals enrolled under the plan or such coverage.

23 “(2) ACCESS TO SPECIALIZED TREATMENT EX-
24 PERTISE.—Such a plan or issuer shall demonstrate

1 that enrollees have access, when medically or clini-
2 cally indicated in the judgment of the treating health
3 professional, to specialized treatment expertise.

4 “(3) COORDINATION OF CARE.—

5 “(A) IN GENERAL.—Any process estab-
6 lished by such a plan or issuer to coordinate
7 care and control costs may not impose an
8 undue burden on enrollees with chronic health
9 conditions. Such a plan or issuer shall ensure a
10 continuity of care and shall, when medically or
11 clinically indicated in the judgment of the treat-
12 ing health professional, ensure direct access to
13 relevant specialists for continued care.

14 “(B) COMPLEX CONDITIONS.—In the case
15 of an enrollee who has a severe, complex, or
16 chronic condition, such a plan or issuer shall
17 determine, based on the judgment of the treat-
18 ing health professional, whether it is medically
19 or clinically necessary or appropriate to use a
20 care coordinator from an interdisciplinary team
21 or a specialist to ensure continuity of care.

22 “(4) NO WAIVER.—

23 “(A) IN GENERAL.—The requirements of
24 this subsection may not be waived and shall be

1 met in all areas where the plan or issuer (in re-
2 lation to managed care health insurance cov-
3 erage) has enrollees, including rural areas.

4 “(B) OUT-OF-PLAN COVERAGE.—If such a
5 plan or issuer fails to meet the requirements of
6 this subsection, the plan or issuer shall arrange
7 for the provision of out-of-plan or out-of-issuer
8 services to enrollees in a manner that provides
9 enrollees with access to services in accordance
10 with this subsection.

11 “(d) ACCESS TO CENTERS OF EXCELLENCE.—

12 “(1) IN GENERAL.—Each managed care group
13 health plan or health insurance issuer offering man-
14 aged care health insurance coverage shall dem-
15 onstrate that individuals enrolled with the plan or
16 under such coverage who have chronic diseases or
17 otherwise require specialized services have access
18 through the plan or issuer to specialized treatment
19 expertise of designated centers of excellence. Such a
20 plan or issuer shall demonstrate such access accord-
21 ing to standards developed by the Secretary of
22 Health and Human Services, including requirements
23 relating to arrangements with such centers and re-
24 ferral of enrollees to such centers.

1 “(2) DESIGNATION PROCESS.—Such Secretary
2 shall establish a process for the designation of facili-
3 ties as centers of excellence for purposes of this sub-
4 section. A facility may not be designated unless the
5 facility is determined—

6 “(A) to provide specialty care,

7 “(B) to deliver care for complex cases re-
8 quiring specialized treatment or for individuals
9 with chronic diseases, and

10 “(C) to meet other requirements that may
11 be established by such Secretary relating to spe-
12 cialized education and training of health profes-
13 sionals, participation in peer-reviewed research,
14 or treatment of patients from outside the geo-
15 graphic area of the facility.

16 “(d) RECOGNITION OF TRAUMA CENTERS.—

17 “(1) IN GENERAL.—A managed care group
18 health plan or health insurance issuer offering man-
19 aged care health insurance coverage shall provide for
20 health services contracted for and which are pro-
21 vided to such an individual other than through the
22 plan or coverage (including trauma services provided
23 by designated trauma centers), if (A) the services
24 were medically necessary and immediately required
25 because of an unforeseen illness, injury, or condition

1 and (B) it was not reasonable given the cir-
2 cumstances to obtain the services through the plan
3 or participating providers in relation to such cov-
4 erage.

5 “(2) DEFINITION.—In paragraph (1), the term
6 ‘designated trauma center’ has the meaning given
7 such term in section 1231 of the Public Health
8 Service Act, and includes a trauma center which the
9 Secretary finds meets the standards under section
10 1213 of such Act to be a designated trauma center
11 but is located in a State that has not designated
12 trauma centers under such section.

13 “(e) NO REFERRAL REQUIRED FOR OBSTETRICS
14 AND GYNECOLOGY.—A managed care group health plan
15 or health insurance issuer offering managed care health
16 insurance coverage may not require an individual to obtain
17 a referral from a physician in order to obtain covered
18 items and services from a physician who specializes in ob-
19 stetrics and gynecology.

20 “(f) COVERAGE OF SERVICES OF ESSENTIAL COM-
21 MUNITY PROVIDERS.—

22 “(1) IN GENERAL.—The Secretary of Health
23 and Human Services may require a managed care
24 group health plan or health insurance issuer that of-
25 fers managed health insurance coverage to enter into

1 agreements with essential community providers serv-
2 ing the plan’s or issuer’s service area (in relation to
3 the coverage) to join the plan’s or issuer’s provider
4 network if such Secretary finds that such agree-
5 ments are necessary for the plan or issuer to make
6 contracted for services (A) available and accessible
7 to each enrollee, within the area served by the plan
8 or issuer (in relation to such coverage), with reason-
9 able promptness and in a manner which assures con-
10 tinuity, and (B) when medically necessary, available
11 and accessible twenty-four hours a day and seven
12 days a week.

13 “(2) ESSENTIAL COMMUNITY PROVIDER DE-
14 FINED.—For purposes of paragraph (1), the term
15 ‘essential community provider’ means a rural health
16 clinic (described in section 1861(aa)(2) of the Social
17 Security Act), a Federally qualified health center
18 (described in section 1861(aa)(4) of such Act), and
19 any other provider meeting such standards as the
20 Secretary of Health and Human Services may re-
21 quire.

22 “(g) DUE PROCESS PROTECTIONS FOR PROVID-
23 ERS.—

24 (1) IN GENERAL.—In consultation with provid-
25 ers of health care services who are members of the

1 a plan’s or issuer’s provider network, each managed
2 care group health plan and each health insurance is-
3 suer offering managed care health insurance cov-
4 erage shall establish standards to be used by the
5 plan or issuer (in relation to such coverage) for con-
6 tracting with providers, and shall make descriptive
7 information regarding these standards available to
8 enrollees, providers who are members of the net-
9 work, and prospective enrollees and prospective
10 members of the network. Such standards shall en-
11 sure that, when establishing physician credentialing
12 criteria, plans and issuers must recognize both the
13 Accreditation Council on Graduate Medical Edu-
14 cation and the American Osteopathic Association-ap-
15 proved residency training, and when board certifi-
16 cation is a criterion, board certification by both the
17 American Board of Medical Specialities and the
18 American Osteopathic Association shall be consid-
19 ered.

20 “(2) LIMITATION ON TERMINATION.—

21 “(A) IN GENERAL.—Such a group health
22 plan or health insurance issuer may not termi-
23 nate or refuse to renew an agreement with a
24 provider of health care services to participate in
25 the plan’s or issuer’s provider network unless

1 the plan or issuer provides written notification
2 to the provider of the decision to terminate or
3 refuse to renew the agreement. The notification
4 shall include a statement of the reasons for the
5 plan's or issuer's decision, consistent with the
6 standards established under paragraph (1).

7 “(B) NOTICE.—Such a plan or issuer shall
8 provide the notification required under subpara-
9 graph (A) at least 45 days prior to the effective
10 date of the termination or expiration of the
11 agreement (whichever is applicable). The pre-
12 vious sentence shall not apply if failure to ter-
13 minate the agreement prior to the deadline
14 would adversely affect the health or safety of an
15 individual enrolled with the plan or issuer.

16 “(3) REVIEW PROCESS.—

17 “(A) IN GENERAL.—Each such plan or is-
18 suer shall provide a process under which a pro-
19 vider of health care services may request a re-
20 view of the plan's or issuer's decision to termi-
21 nate or refuse to renew the provider's participa-
22 tion agreement. Such review shall be conducted
23 by a group of individuals the majority of whom
24 are providers of health care services who are

1 members of the plan’s or issuer’s provider net-
2 work or employees of the plan or issuer, and, to
3 the extent possible, who are members of the
4 same profession as the provider who requests
5 the review and, for physicians, the same medi-
6 cal branch (allopathic or osteopathic medicine).

7 “(B) REPRESENTATION.—If the provider
8 requests in advance, the plan or issuer shall
9 permit an attorney representing the provider to
10 be present at the provider’s review.

11 “(C) ADVISORY FINDINGS.—The findings
12 and conclusions of a review under this para-
13 graph shall be advisory and non-binding.

14 “(D) CONSTRUCTION.—Nothing in this
15 paragraph shall be construed to affect any
16 other provision of law that provides an appeals
17 process or other form of relief to a provider of
18 health care services.

19 **“SEC. 9912. GRIEVANCE PROCEDURES AND DEADLINE FOR**
20 **RESPONDING TO REQUESTS FOR COVERAGE**
21 **OF SERVICES.**

22 “(a) GRIEVANCE PROCEDURES.—A managed care
23 group health plan and a health insurance issuer offering
24 managed care health insurance coverage shall provide

1 meaningful procedures for hearing and resolving griev-
2 ances between the plan or issuer (any entity or individual
3 through which the plan or issuer provides health care serv-
4 ices) and members enrolled with the plan or issuer.

5 “(b) DETAILS.—The procedures provided under sub-
6 section (a) shall include—

7 “(1) recorded (written or otherwise) procedures
8 for registering and responding to complaints and
9 grievances in a timely manner;

10 “(2) documentation concerning the substance of
11 complaints, grievances, and actions taken concerning
12 such complaints and grievances, which shall be in
13 writing.

14 “(3) procedures to ensure a resolution of a
15 complaint or grievance;

16 “(4) the compilation and analysis of complaint
17 and grievance data;

18 “(5) procedures to expedite the complaint proc-
19 ess if the complaint involves a dispute about the cov-
20 erage of an immediately and urgently needed service;
21 and

22 “(6) procedures to ensure that if an enrollee
23 orally notifies the plan or issuer about a complaint,
24 the plan or issuer (if requested) must send the en-
25 rollee a complaint form that includes the telephone

1 numbers and addresses of member services, and a
2 description of the plan's or issuer's grievance proce-
3 dure.

4 The Secretary of Health and Human Services may estab-
5 lish deadlines for the complaint procedures under para-
6 graph (5) in order to ensure timely resolution of disputes
7 involving immediately and urgently needed services.

8 “(c) APPEALS PROCESS.—Such a plan or issuer shall
9 adopt an appeals process to enable covered individuals to
10 appeal decisions that are adverse to the individuals. Such
11 a process shall include—

12 “(1) the right to a review by a grievance panel;

13 “(2) the right to a second review with a dif-
14 ferent panel, independent of the plan or issuer, or to
15 a review through an impartial arbitration process
16 which shall be described in writing by the plan or is-
17 suer; and

18 “(3) an expedited process for review in emer-
19 gency cases.

20 The Secretary of Health and Human Services shall de-
21 velop guidelines for the structure and requirements appli-
22 cable to the independent review panel and impartial arbi-
23 tration process described in paragraph (2).

24 “(d) WRITTEN DECISION.—With respect to the com-
25 plaint, grievance, and appeals processes required under

1 this section, the plan or issuer shall, upon the request of
2 an enrollee, provide the enrollee a written decision con-
3 cerning a complaint, grievance, or appeal in a timely fash-
4 ion.

5 “(e) CONSTRUCTION.—The complaint, grievance, and
6 appeals processes established in accordance with this sec-
7 tion may not be used in any fashion to discourage or pre-
8 vent an enrollee from receiving medically necessary care
9 in a timely manner.

10 “(f) PROMPT RESPONSE TO REQUESTS FOR SERV-
11 ICES.—In addition to the procedures available pursuant
12 to the previous provisions of this section, in the case of
13 the request of an enrollee with such a plan or issuer—

14 “(i) the plan or issuer shall respond to the re-
15 quest not later than 24 hours after the request is
16 made; and

17 “(ii) the plan or issuer shall hear and resolve
18 the enrollee’s appeal of a denial of coverage of such
19 services in accordance with a process meeting stand-
20 ards established by the Secretary of Health and
21 Human Services.

22 **“SEC. 9913. REQUIREMENTS FOR SERVICE AREAS; NON-**
23 **DISCRIMINATION.**

24 “(a) SERVICE AREA REQUIREMENTS.—

1 “(1) IN GENERAL.—Except as provided in para-
2 graph (2), if the service area of a group health plan
3 or health insurance issuer offering health insurance
4 coverage includes any part of a metropolitan statis-
5 tical area, the service area shall include the entire
6 metropolitan statistical area (including any area des-
7 ignated by the Secretary of Health and Human
8 Services as a health professional shortage area
9 under section 332(a)(1)(A) of the Public Health
10 Service Act within such metropolitan statistical
11 area).

12 “(2) EXCEPTION.—The Secretary of Health
13 and Human Services may permit a plan’s or issuer’s
14 service area to exclude any portion of a metropolitan
15 statistical area (other than the central county of
16 such metropolitan statistical area) if—

17 “(A) the plan or issuer demonstrates that
18 it lacks the financial or administrative capacity
19 to serve the entire metropolitan statistical area;
20 and

21 “(B) such Secretary finds that the com-
22 position of the plan’s or issuer’s service area
23 does not reduce the financial risk to the plan or
24 issuer of providing services to enrollees because

1 of the health status or other demographic char-
2 acteristics of individuals residing in the service
3 area (as compared to the health status or demo-
4 graphic characteristics of individuals residing in
5 the portion of the metropolitan statistical area
6 not included in the plan’s or issuer’s service
7 area).

8 “(b) NONDISCRIMINATION.—No group health plan
9 and no health insurance issuer offering health insurance
10 coverage may discriminate (directly or through contractual
11 arrangements) in any activity, including the selection of
12 a service area, that has the effect of discriminating against
13 an individual on the basis of race, national origin, gender,
14 language, socioeconomic status, age, disability, health sta-
15 tus, or anticipated need for health services.

16 **“SEC. 9914. PROVIDING INFORMATION.**

17 “(a) INFORMATION ON PHYSICIAN INCENTIVE
18 PLANS.—

19 “(1) IN GENERAL.—Upon the request of an en-
20 rollee of a managed care group health plan or under
21 managed care health insurance coverage offered by
22 a health insurance issuer or an individual consider-
23 ing enrollment with such a plan or for such cov-
24 erage, the plan or issuer shall provide the enrollee or
25 individual with descriptive information regarding any

1 physician incentive plan of the plan or issuer appli-
2 cable to such enrollment.

3 “(2) PHYSICIAN INCENTIVE PLAN DEFINED.—

4 In this subsection, the term ‘physician incentive
5 plan’ means any compensation arrangement between
6 a managed care group health plan or health insur-
7 ance issuer offering managed care health insurance
8 coverage and a physician or physician group that
9 may directly or indirectly have the effect of reducing
10 or limiting services provided with respect to individ-
11 uals enrolled with the plan or under such coverage.

12 “(b) INFORMATION ON PROVIDER CREDENTIALS.—

13 Each managed care group health plan and each health in-
14 surance issuer offering managed care health insurance
15 coverage shall provide each enrollee, at the time of enroll-
16 ment and not less frequently than annually thereafter, an
17 explanation of the credentials of the individuals and enti-
18 ties providing services to enrollees under the plan or cov-
19 erage.

20 “(c) INFORMATION ON MALPRACTICE LIABILITY FOR

21 PHYSICIANS.—Each managed care group health plan and
22 each health insurance issuer offering managed care health
23 insurance coverage shall provide each enrollee, at the time
24 of enrollment and not less frequently than annually there-
25 after, with a disclosure statement regarding whether the

1 plan or issuer restricts the plan’s or issuer’s malpractice
2 liability in relation to liability of physicians operating
3 under the plan or coverage.

4 “(d) OTHER INFORMATION.—Each such plan and is-
5 suer shall provide prospective enrollees with written infor-
6 mation concerning the following with respect to coverage
7 offered under the plan or coverage:

8 “(1) Coverage provisions, benefits, and any ex-
9 clusions by category of service or product, including
10 premiums, deductibles, and copayments associated
11 with any point-of-service benefits.

12 “(2) Loss ratios with an explanation that such
13 ratios reflect the percentage of the premiums ex-
14 pended for health services.

15 “(3) Prior authorization or other review re-
16 quirements including preauthorization review, con-
17 current review, post-service review, post-payment re-
18 view, and procedures that may lead the patient to be
19 denied coverage for, or not be provided, a particular
20 service or product.

21 “(4) Covered individual satisfaction statistics,
22 including disenrollment statistics.

23 “(5) Advance directives and organ donation.

1 “(6) The characteristics and availability of
2 health care professionals and institutions participat-
3 ing in the plan or coverage, including descriptions of
4 the financial arrangements or contractual provisions
5 with hospitals, utilization review organizations, phy-
6 sicians, or any other provider of health care services
7 that would affect the services offered, referral or
8 treatment options, or physician’s fiduciary respon-
9 sibility to patients, including financial incentives re-
10 garding the provision of medical or other services.

11 “(7) Quality indicators for the plan or issuer
12 and for participating health professionals and pro-
13 viders under the plan or coverage, including popu-
14 lation-based statistics such as immunization rates
15 and other preventive care and health outcomes
16 measures such as survival after surgery, adjusted for
17 case mix.

18 “(8) An explanation of the appeals process and
19 the grievance procedure.

20 “(9) Salaries and other compensation for key
21 executives of the plan or issuer.

22 “(10) Physician ownership and investment
23 structure of the plan or issuer.

24 “(11) Fiscal year reports of the plan or issuer.

1 “(12) A description of lawsuits that are filed
2 against the plan or issuer, insofar as they may have
3 a material bearing on the financial circumstances of
4 the plan or issuer or reveal quality and medical cov-
5 erage issues.

6 Information under this subsection shall be disclosed in a
7 standard format, specified by the Secretary of Health and
8 Human Services, so that prospective covered individuals
9 may compare the attributes of all such plans and coverage
10 offered within an area.

11 **“SEC. 9915. RESTRICTIONS ON COMMISSIONS FOR AGENTS.**

12 “In the case of a managed care group health plan
13 or health insurance issuer that offers managed care health
14 insurance coverage which employs or otherwise com-
15 pensates agents to enroll individuals under the plan or cov-
16 erage and which pays an agent a commission with respect
17 to the enrollment of an individual—

18 “(1) such commissions may not constitute the
19 predominant source of the agent’s total compensa-
20 tion from the plan or issuer (in accordance with
21 standards established by the Secretary of Health
22 and Human Services); and

23 “(2) if an agent receives a commission from the
24 plan or issuer with respect to an individual who en-
25 rolls with the plan or under such coverage and the

1 individual terminates enrollment with the plan or
2 such coverage during the 90-day period beginning on
3 the date of the individual's enrollment, the plan or
4 issuer shall recoup the commission from the agent.

5 **“SEC. 9916. PROTECTION OF PATIENT RIGHT TO KNOW.**

6 “(a) IN GENERAL.—

7 “(1) PROHIBITION OF CERTAIN PROVISION.—A
8 managed care group health plan and health insur-
9 ance issuer offering managed care health insurance
10 coverage may not include as part of such plan or in
11 relation to such coverage any provision that pro-
12 hibits, restricts, or interferes with any medical com-
13 munication (as defined in subsection (b)) as part
14 of—

15 “(A) a written contract or agreement with
16 a health care provider,

17 “(B) a written statement to such a pro-
18 vider, or

19 “(C) an oral communication to such a pro-
20 vider.

21 “(2) PROHIBITION OF ADVERSE ACTION.—Such
22 a plan or issuer may not take any of the following
23 actions against a health care provider on the basis
24 of a medical communication:

1 “(A) Refusal to contract with the health
2 care provider.

3 “(B) Termination or refusal to renew a
4 contract with the health care provider.

5 “(C) Refusal to refer patients to or allow
6 others to refer patients to the health care pro-
7 vider.

8 “(D) Refusal to compensate the health
9 care provider for covered services.

10 “(E) Any other retaliatory action against
11 the health care provider.

12 “(3) NULLIFICATION.—Any provision that is
13 prohibited under paragraph (1) is null and void.

14 “(b) MEDICAL COMMUNICATION DEFINED.—For
15 purposes of this section, the term ‘medical communica-
16 tion’—

17 “(1) means any communication, other than a
18 knowing and willful misrepresentation, made by the
19 health care provider—

20 “(A) regarding the mental or physical
21 health care needs or treatment of a patient and
22 the provisions, terms, or requirements of the
23 managed care group health plan or managed
24 care health insurance coverage or another plan

1 or coverage relating to such needs or treatment,
2 and

3 “(B) between—

4 “(i) the provider and a current,
5 former, or prospective patient (or the
6 guardian or legal representative of a pa-
7 tient),

8 “(ii) the provider and any employee or
9 representative of the plan or issuer, or

10 “(iii) the provider and any employee
11 or representative of any State or Federal
12 authority with responsibility for the licens-
13 ing or oversight with respect to the plan or
14 issuer; and

15 “(2) includes communications concerning—

16 “(A) any tests, consultations, and treat-
17 ment options,

18 “(B) any risks or benefits associated with
19 such tests, consultations, and options,

20 “(C) variation among any health care pro-
21 viders and any institutions providing such serv-
22 ices in experience, quality, or outcomes,

23 “(D) the basis or standard for the decision
24 of a managed care group health plan or health
25 insurance issuer in relation to managed care

1 health insurance coverage to authorize or deny
2 health care services or benefits,

3 “(E) the process used by the plan or issuer
4 to determine whether to authorize or deny
5 health care services or benefits, and

6 “(F) any financial incentives or disincen-
7 tives provided by the plan or issuer to a health
8 care provider that are based on service utiliza-
9 tion.

10 “(c) NON-PREEMPTION OF STATE LAW.—A State
11 may establish or enforce requirements with respect to the
12 subject matter of this section, but only if such require-
13 ments are more protective of medical communications
14 than the requirements established under this section.

15 “(d) CONSTRUCTION.—Nothing in this section shall
16 be construed as—

17 “(1) requiring a managed care group health
18 plan or health insurance issuer in relation to man-
19 aged care health insurance coverage to enter into or
20 renew a contract or agreement with any willing
21 health care provider, or

22 “(2) preventing such a plan or issuer from act-
23 ing on information relating to treatment actually
24 provided to a patient or the failure of a health care

1 provider to comply with legal standards relating to
2 the provision of care.

3 **“SEC. 9917. PATIENT ACCESS TO CLINICAL STUDIES.**

4 “(a) PERMITTING PARTICIPATION IN APPROVED
5 CLINICAL STUDIES.—A managed care group health plan
6 and a health insurance issuer offering managed care
7 health insurance coverage health plan may not deny (or
8 limit or impose additional conditions on) coverage of items
9 and services furnished to an enrollee if—

10 “(1) the enrollee is participating in an approved
11 clinical study,

12 “(2) the items and services are furnished ac-
13 cording to the design of the study or to treat condi-
14 tions resulting from participation in the study, and

15 “(3) the items and services would otherwise be
16 covered under the plan or coverage except for the
17 fact that they are provided in connection with par-
18 ticipation in such a study.

19 Such a plan or issuer may not discriminate against an
20 enrollee on the basis of the enrollee’s participation in such
21 a study.

22 “(b) CONSTRUCTION.—Nothing in subsection (a)
23 shall be construed as requiring a plan or issuer to provide
24 for payment for items and services routinely paid for as
25 part of an approved clinical study.

1 “(c) APPROVED CLINICAL STUDY DEFINED.—For
2 purposes of this section, the term ‘approved clinical study’
3 means—

4 “(1) a research study approved by the Sec-
5 retary of Health and Human Services, the Director
6 of the National Institutes of Health, the Commis-
7 sioner of the Food and Drug Administration, the
8 Secretary of Veterans Affairs, the Secretary of De-
9 fense, or a qualified nongovernmental research entity
10 (as defined in guidelines of the National Institute of
11 Health), or

12 “(2) a peer-reviewed and approved research
13 program, as defined by the Secretary of Health and
14 Human Services, conducted for the primary purpose
15 of determining whether or not a treatment is safe,
16 efficacious, or having any other characteristic of a
17 treatment which must be demonstrated in order for
18 the treatment to be medically necessary or appro-
19 priate.

20 **“SEC. 9918. REQUIRED MINIMUM CHILDBIRTH BENEFITS.**

21 “(a) MINIMUM CHILDBIRTH BENEFITS.—If a man-
22 aged care group health plan or managed care health insur-
23 ance coverage offered by a health insurance issuer pro-
24 vides coverage that includes any benefits for inpatient care
25 for childbirth for a mother or newborn child, the plan or

1 issuer (in relation to such coverage) shall meet the follow-
2 ing requirements:

3 “(1) MINIMUM LENGTH OF STAY FOR INPA-
4 TIENT CARE BENEFITS.—The plan or coverage shall
5 provide benefits for inpatient care for childbirth for
6 a minimum length of stay of 48 hours following a
7 vaginal delivery and a minimum length of stay of 96
8 hours following a caesarean section.

9 “(2) COVERAGE OF POST-DELIVERY FOLLOW-UP
10 CARE.—If an attending provider, in consultation
11 with the mother, decides to discharge a covered
12 mother or newborn child from an inpatient setting
13 before the expiration of the minimum length of stay
14 period described in paragraph (1), the plan or cov-
15 erage shall include benefits for timely post-delivery
16 care by a registered nurse, physician, nurse practi-
17 tioner, nurse midwife or physician assistant experi-
18 enced in maternal and child health in the home, a
19 provider’s office, a hospital, a federally qualified
20 health center, a federally qualified rural health clin-
21 ic, a State health department maternity clinic, or an-
22 other setting (such as a birthing center or an inter-
23 mediate care facility) determined appropriate under
24 regulations promulgated by the Secretary of Health
25 and Human Services.

1 “(3) NOTICE.—The plan or issuer shall provide
2 notice to each enrollee eligible for childbirth benefits
3 under this subsection regarding the requirements of
4 this section.

5 (b) PROHIBITIONS.—In implementing the require-
6 ments of subsection (a), such a plan or issuer may not—

7 “(1) require or condition the provision of bene-
8 fits under subsection (a) on any authorization or ap-
9 proval of an attending or other provider;

10 “(2) deny enrollment, renewal, or continued
11 coverage to a mother and her newborn child who are
12 otherwise eligible to be so covered based on compli-
13 ance with this section;

14 “(3) provide monetary incentives to mothers to
15 encourage such mothers to request less than the
16 minimum coverage required under subsection (a);

17 “(4) provide incentives (monetary or otherwise)
18 to an attending provider to induce such provider to
19 provide treatment in a manner inconsistent with this
20 section; or

21 “(5) penalize or otherwise reduce or limit the
22 reimbursement of an attending provider because
23 such provider provided treatment in accordance with
24 this section.

25 “(c) ADDITIONAL TERMS AND CONDITIONS.—

1 “(1) ATTENDING PROVIDER.—As used in this
2 section, the term ‘attending provider’ means, with
3 respect to a mother and her newborn child, an obstre-
4 trician-gynecologist, pediatrician, family physician,
5 or other physician, or any other health care provider
6 (such as a nurse midwife or nurse practitioner),
7 who, acting in accordance with applicable State law,
8 is primarily responsible for the care of the mother
9 and child.

10 (2) TIMELY CARE DEFINED.—As used in sub-
11 section (a)(2), the term ‘timely post-delivery care’
12 means health care that is provided—

13 “(A) following the discharge of a mother
14 and her newborn child from the inpatient set-
15 ting following childbirth; and

16 “(B) in a manner that meets the health
17 care needs of the mother and her newborn
18 child, that provides for the appropriate monitor-
19 ing of the conditions of the mother and child,
20 and that occurs within the 72-hour period im-
21 mediately following discharge.

22 “(3) REGULATIONS REGARDING APPROPRIATE
23 POST-CARE DELIVERY SETTINGS.—The Secretary of

1 Health and Human Services, with respect to regula-
2 tions promulgated under subsection (a)(2) concern-
3 ing appropriate post-delivery care settings—

4 “(A) shall ensure that, to the extent prac-
5 ticable, such regulations are consistent with
6 State licensing and practice laws,

7 “(B) shall consider telemedicine and other
8 innovative means to provide follow-up care, and

9 “(C) shall consider both urban and rural
10 settings.

11 “(4) RULE OF CONSTRUCTION.—Nothing in
12 this section shall be construed to require that a
13 mother—

14 “(A) give birth in a hospital; or

15 “(B) stay in the hospital for a fixed period
16 of time following the birth of her child.

17 “(5) REQUIREMENTS.—The notice required
18 under subsection (a)(3) shall be in accordance with
19 regulations promulgated by the Secretary of Health
20 and Human Services. Such regulations shall provide
21 that the notice shall be in writing, shall be conspicu-
22 ous and prominently positioned, and shall be re-
23 quired to be provided as follows:

1 “(A) HEALTH INSURANCE COVERAGE.—By
2 a health insurance issuer in relation to man-
3 aged care health insurance coverage—

4 “(i) to enrollees described in sub-
5 section (a) who are enrolled on the effec-
6 tive date of this chapter within 120 days
7 after such effective date and annually
8 thereafter, and

9 “(ii) to other enrollees at the time of
10 enrollment and annually thereafter.

11 “(B) GROUP HEALTH PLANS.—By a man-
12 aged care group health plan—

13 “(i) to enrollees described in sub-
14 section (a) who are enrolled on the effec-
15 tive date of this chapter within 120 days
16 after such effective date, and

17 “(ii) for plan years beginning on or
18 after such effective date, as part of its
19 summary plan description.

20 **“SEC. 9919. ASSURING EQUITABLE HEALTH PLAN COV-**
21 **ERAGE WITH RESPECT TO EMERGENCY SERV-**
22 **ICES.**

23 “(a) PROHIBITION OF CONTRACTUAL LIMITATIONS
24 ON COVERAGE OF EMERGENCY SERVICES.—A managed
25 care group health plan or managed care health insurance

1 coverage offered by a health insurance issuer that provides
2 any coverage with respect to emergency services shall
3 cover emergency services furnished to an enrollee of the
4 plan or issuer (with respect to such managed care cov-
5 erage)—

6 “(1) without regard to whether or not the pro-
7 vider furnishing the emergency services has a con-
8 tractual or other arrangement with the plan or is-
9 suer for the provision of such services to such enroll-
10 ees, and

11 “(2) without regard to prior authorization.

12 “(b) PROHIBITION OF DISCRIMINATORY PAYMENT
13 OR COST-SHARING.—

14 “(1) IN GENERAL.—Such a plan or issuer that
15 provides any coverage with respect to emergency
16 services—

17 “(A) shall determine and make prompt
18 payment in a reasonable and appropriate
19 amount for such services, and

20 “(B) subject to paragraph (2), may not
21 impose cost-sharing for services furnished in a
22 hospital emergency department that is cal-
23 culated in a manner (such as the use of a dif-
24 ferent percentage) that imposes greater cost
25 sharing with respect to such services compared

1 to comparable services furnished in other set-
2 tings.

3 “(2) IMPOSITION OF REASONABLE COPAYMENT
4 PERMITTED.—Such a plan or issuer may impose a
5 reasonable copayment (as determined in accordance
6 with standards established by the Secretary of
7 Health and Human Services) in lieu of coinsurance
8 to deter inappropriate use of services of hospital
9 emergency departments.

10 “(c) ASSURING TIMELINESS OF PRIOR AUTHORIZA-
11 TION DETERMINATION FOR NEEDED CARE IDENTIFIED
12 IN INITIAL EVALUATION.—

13 “(1) IN GENERAL.—

14 “(A) ACCESS TO PROCESS.—If an enrollee
15 of a managed care group health plan or health
16 insurance issuer in relation to managed care
17 health insurance coverage receives emergency
18 services from an emergency department pursu-
19 ant to a screening evaluation conducted by a
20 treating physician or other emergency depart-
21 ment personnel and pursuant to the evaluation
22 such physician or personnel identifies items and
23 services (other than emergency services)
24 promptly needed by the enrollee, the plan or is-
25 suer shall provide access 24 hours a day, 7 days

1 a week, to such persons as may be authorized
2 to make any prior authorization determinations
3 respecting coverage of such promptly needed
4 items and services.

5 “(B) DEEMED APPROVAL.—Such a plan or
6 issuer is deemed to have approved a request for
7 a prior authorization for such promptly needed
8 items and services if such physician or other
9 personnel—

10 “(i) has attempted to contact such a
11 person for authorization—

12 “(I) to provide an appropriate re-
13 ferral for the items and services, or

14 “(II) to provide the items and
15 services to the enrollee,

16 and access to the person has not been pro-
17 vided (as required under subparagraph
18 (A)), or

19 “(ii) has requested such authorization
20 from such a person and the person has not
21 denied the authorization within 30 minutes
22 after the time the request is made.

1 “(2) REFERRAL BY PHYSICIAN TO HOSPITAL
2 EMERGENCY DEPARTMENT DEEMED PRIOR AUTHOR-
3 IZATION.—If a participating physician or other per-
4 son authorized to make prior authorization deter-
5 minations for such a plan or issuer refers an enrollee
6 to a hospital emergency department for evaluation
7 or treatment, a request for prior authorization of the
8 items and services reasonably furnished the enrollee
9 pursuant to such referral shall be deemed to have
10 been made and approved.

11 “(3) EFFECT OF APPROVAL.—

12 “(A) IN GENERAL.—Approval of a request
13 for a prior authorization determination (includ-
14 ing a deemed approval under paragraph (1) or
15 (2)) shall be treated as approval of any health
16 care items and services required to treat the
17 medical condition identified pursuant to a
18 screening evaluation referred to in paragraph
19 (1)(A).

20 “(B) PAYMENT.—Such a plan or issuer
21 may not subsequently deny or reduce payment
22 for an item or service furnished pursuant to
23 such an approval unless the approval was based
24 on information about the medical condition of
25 an enrollee that was fraudulent.

1 “(d) ENCOURAGING APPROPRIATE USE OF 911
2 EMERGENCY TELEPHONE NUMBER.—Such a plan or is-
3 suer—

4 “(1) shall include, in any educational materials
5 the plan makes available to its enrollees on the pro-
6 cedures for obtaining emergency services—

7 “(A) a statement that it is appropriate for
8 an enrollee to use the 911 emergency telephone
9 number for an emergency medical condition (as
10 defined in subsection (f)(3)), and

11 “(B) an explanation of what is an emer-
12 gency medical condition;

13 “(2) shall not discourage appropriate use of the
14 911 emergency telephone number by enrollees with
15 emergency medical conditions; and

16 “(3) shall not deny coverage or payment for an
17 item or service solely on the basis that an enrollee
18 uses the 911 emergency telephone number to sum-
19 mon treatment for an emergency medical condition.

20 “(e) EFFECT ON STATE LAW.—

21 “(1) PREEMPTION.—Nothing in this section
22 shall be construed as preempting or otherwise super-
23 seding any provision of State law unless such provi-
24 sion directly conflicts with this section.

1 “(2) CONSUMER PROTECTIONS.—A provision of
2 State law shall not be considered to conflict directly
3 with this section if the provision provides the enroll-
4 ees with protections that exceed the protections of
5 this section.

6 “(f) DEFINITIONS.—For purposes of this section:

7 “(1) COST-SHARING.—The term ‘cost-sharing’
8 means any deductible, coinsurance amount, copay-
9 ment, or other out-of-pocket payment that an en-
10 rollee is responsible for paying with respect to a
11 health care item or service covered under a managed
12 care group health plan or managed care health in-
13 surance coverage.

14 “(2) EMERGENCY DEPARTMENT.—The term
15 ‘emergency department’ includes, with respect to a
16 hospital, a trauma center in the hospital if the cen-
17 ter—

18 “(A) is designated under section 1213 of
19 the Public Health Service Act, or

20 “(B) is in a State that has not made such
21 designations and is determined by the Secretary
22 to meet the standards under such section for
23 such designation.

24 “(3) EMERGENCY MEDICAL CONDITION.—The
25 term ‘emergency medical condition’ means a medical

1 condition, the onset of which or change in which is
2 sudden, that manifests itself by symptoms of suffi-
3 cient severity, including severe pain, that a prudent
4 layperson, who possesses an average knowledge of
5 health and medicine, could reasonably expect the ab-
6 sence of immediate medical attention to result in—

7 “(A) placing the person’s health in serious
8 jeopardy,

9 “(B) serious impairment to bodily func-
10 tions, or

11 “(C) serious dysfunction of any bodily
12 organ or part.

13 “(4) EMERGENCY SERVICES.—The term ‘emer-
14 gency services’ means—

15 “(A) health care items and services fur-
16 nished in the emergency department of a hos-
17 pital, and

18 “(B) ancillary services routinely available
19 to such department,

20 to the extent they are required to evaluate and treat
21 an emergency medical condition (as defined in para-
22 graph (3)) until the condition is stabilized.

23 “(5) PRIOR AUTHORIZATION DETERMINA-
24 TION.—The term ‘prior authorization determination’

1 means, with respect to health care items and serv-
2 ices for which coverage may be provided under a
3 group health plan or health insurance coverage, a
4 determination, before the provision of the items and
5 services and as a condition of coverage of the items
6 and services under the plan or coverage, that cov-
7 erage will be provided for the items and services
8 under the plan or coverage.

9 “(6) STABILIZED.—The term ‘stabilized’
10 means, with respect to an emergency medical condi-
11 tion, that no material deterioration of the condition
12 is likely, within reasonable medical probability, to re-
13 sult or occur before an individual can be transferred
14 in compliance with the requirements of section 1867
15 of the Social Security Act.

16 “(7) 911 EMERGENCY TELEPHONE NUMBER.—
17 The term ‘911 emergency telephone number’ in-
18 cludes, in the case of a geographic area where 911
19 is not in use for emergencies, such other telephone
20 number as is in use for emergencies.”

21 (b) CLERICAL AMENDMENT.—The table of contents
22 for the Internal Revenue Code of 1986 is amended by add-
23 ing after the item relating to subtitle K the following new
24 item:

“Subtitle L. Protection for Beneficiaries Under Managed Care
Plans.”

1 (c) EFFECTIVE DATE.—The requirement of section
2 9902 of the Internal Revenue Code of 1986 (as added by
3 subsection (a) of this section) shall take effect on January
4 1, 1998, and shall apply to coverage offered on or after
5 such date regardless of whether the plan year began before
6 such date.

7 **Subtitle C—Effective Date**

8 **SEC. 121. EFFECTIVE DATE.**

9 The amendments made by this title shall apply with
10 respect to contract years beginning on or after January
11 1, 1998.

12 **TITLE II—MEDICARE**

13 **SEC. 201. PROHIBITION ON PAYMENTS UNDER MEDICARE**

14 **UNTIL COMPLETION OF ORIENTATION AND**

15 **MEDICAL PROFILE.**

16 (a) IN GENERAL.—Section 1876(c)(3) of the Social
17 Security Act (42 U.S.C. 1395mm(c)(3)) is amended by
18 adding at the end the following:

19 “(G)(i) The Secretary may not make a payment to
20 an eligible organization under a risk-sharing contract
21 under this section with respect to an enrollee until the eli-
22 gible organization certifies to the Secretary that the orga-
23 nization—

24 “(I) has provided the enrollee an orientation as
25 described in clause (ii), and

1 “(II) has a medical profile described in clause
2 (iii) with respect to the enrollee.

3 “(ii) The orientation described in this clause includes
4 an explanation of the following features of the health plan
5 offered by such organization:

6 “(I) Access to care, including choice of physi-
7 cian, physician location, and hospital coverage.

8 “(II) The information required under section
9 9914 of the Internal Revenue Code of 1986.

10 “(iii) The medical profile described in this clause is
11 such profile of the medical condition of the enrollee as the
12 Secretary shall specify by regulation.”.

13 (b) PROMULGATION OF REQUIREMENTS FOR ORI-
14 ENTATION AND MEDICAL PROFILE.—Not later than 180
15 days after the date of the enactment of this Act, the Sec-
16 retary of Health and Human Services shall, by rule, first
17 specify the elements of the orientation and of the medical
18 profile described in clauses (ii) and (iii) of section
19 1876(c)(3)(G) of the Social Security Act (as added by sub-
20 section (a)). Chapter 8 of title 5, United States Code, shall
21 not apply to such rule. Such rule shall apply on a final
22 basis, pending notice and opportunity for public comment.

23 (c) EFFECTIVE DATE.—The amendment made by
24 subsection (a) applies with respect to enrollees as of the
25 first day of the first month that begins more than 60 days

1 after the date on which the Secretary first publishes the
2 rule under subsection (b) in the Federal Register.

3 **SEC. 202. CHANGES IN REQUIREMENTS FOR MEDICARE**
4 **SUPPLEMENTAL POLICIES RELATING TO**
5 **COMMUNITY RATING AND LOSS RATIOS.**

6 (a) REQUIREMENT OF COMMUNITY RATING.—

7 (1) IN GENERAL.—Section 1882(s) of the So-
8 cial Security Act (42 U.S.C. 1395ss(s)) is amend-
9 ed—

10 (A) in paragraph (3), by striking “para-
11 graphs (1) and (2)” and inserting “this sub-
12 section”, and by redesignating such paragraph
13 as paragraph (4), and

14 (B) by inserting after paragraph (2) the
15 following new paragraph:

16 “(3)(A) Except as provided in this paragraph, the is-
17 suer of a Medicare supplemental policy may not vary the
18 premium among individuals who reside in the same com-
19 munity rating area.

20 “(B)(i) In the first year for which this paragraph ap-
21 plies to such an issuer in a State, the premium rate
22 charged by the issuer for such a policy in a community
23 may vary so long as the premium range percentage (as
24 defined in clause (iii)) does not exceed $\frac{2}{3}$ of the premium
25 range percentage of premium rates charged by the insurer

1 for such policies in the community rating area in the pre-
2 vious year.

3 “(ii) In the second year for which this paragraph ap-
4 plies to such an issuer in a State, the premium rate
5 charged by the issuer for such a policy in a community
6 may vary so long as the premium range percentage (as
7 defined in clause (iii)) does not exceed $\frac{1}{2}$ of the maximum
8 premium range percentage permitted under clause (i) for
9 the previous year.

10 “(iii) In this paragraph, the term ‘premium range
11 percentage’ means—

12 “(I) the highest premium rate minus the lowest
13 premium rate, divided by

14 “(II) the lowest premium rate,
15 expressed as a percentage.

16 “(C) For purposes of this paragraph, each of the fol-
17 lowing is considered to be a separate ‘community rating
18 area’:

19 “(1) Each metropolitan statistical area.

20 “(2) The area of each State that is not within
21 a metropolitan statistical area.

22 (2) CONFORMING AMENDMENT.—Section
23 1882(s)(2)(A) of such Act (42 U.S.C.
24 1395ss(s)(2)(A)) is amended by striking “, or dis-
25 criminate in the pricing of the policy,”.

1 (b) INCREASE IN LOSS RATIO.—Section
2 1882(r)(1)(A) of such Act (42 U.S.C. 1395ss(r)(1)(A)) is
3 amended by striking “75 percent” and all that follows
4 through the semicolon and inserting “85 percent;”.

5 (c) EFFECTIVE DATE.—

6 (1) NAIC STANDARDS.—If, within 6 months
7 after the date of the enactment of this Act, the Na-
8 tional Association of Insurance Commissioners (in
9 this section referred to as the “NAIC”) makes
10 changes in the 1991 NAIC Model Regulation (as de-
11 fined in section 1882(p)(1)(A) of the Social Security
12 Act) to incorporate the additional requirements im-
13 posed by the amendments made by this section, sec-
14 tion 1882(g)(2)(A) of such Act shall be applied in
15 each State, effective for policies issued to policy-
16 holders on and after the date specified in paragraph
17 (3), as if the reference to the Model Regulation
18 adopted on June 6, 1979, were a reference to the
19 1991 NAIC Model Regulation (as so defined) as
20 changed under this section (such changed Regula-
21 tion referred to in this section as the “1996 NAIC
22 Model Regulation”).

23 (2) SECRETARY STANDARDS.—If the NAIC
24 does not make changes in the 1991 NAIC Model
25 Regulation (as so defined) within the 6-month period

1 specified in paragraph (1), the Secretary of Health
2 and Human Services (in this subsection as the “Sec-
3 retary”) shall promulgate a regulation and section
4 1882(g)(2)(A) of the Social Security Act shall be ap-
5 plied in each State, effective for policies issued to
6 policyholders on and after the date specified in para-
7 graph (3), as if the reference to the Model Regula-
8 tion adopted in June 6, 1979, were a reference to
9 the 1991 NAIC Model Regulation (as so defined) as
10 changed by the Secretary under this subsection
11 (such changed Regulation referred to in this sub-
12 section as the “1996 Federal Regulation”).

13 (3) DATE SPECIFIED.—

14 (A) IN GENERAL.—Subject to subpara-
15 graph (B), the date specified in this paragraph
16 for a State is the earlier of—

17 (i) the date the State adopts the 1996
18 NAIC Model Regulation or the 1996 Fed-
19 eral Regulation; or

20 (ii) 1 year after the date the NAIC or
21 the Secretary first adopts such regulations.

22 (B) ADDITIONAL LEGISLATIVE ACTION RE-
23 QUIRED.—In the case of a State which the Sec-
24 retary identifies, in consultation with the NAIC,
25 as—

1 (i) requiring State legislation (other
2 than legislation appropriating funds) in
3 order for Medicare supplemental policies to
4 meet the 1996 NAIC Model Regulation or
5 the 1996 Federal Regulation, but

6 (ii) having a legislature which is not
7 scheduled to meet in 1997 in a legislative
8 session in which such legislation may be
9 considered,

10 the date specified in this paragraph is the first
11 day of the first calendar quarter beginning after
12 the close of the first legislative session of the
13 State legislature that begins on or after Janu-
14 ary 1, 1997. For purposes of the previous sen-
15 tence, in the case of a State that has a 2-year
16 legislative session, each year of such session
17 shall be deemed to be a separate regular session
18 of the State legislature.

19 **SEC. 203. OTHER ADDITIONAL CONSUMER PROTECTIONS**
20 **FOR MEDICARE SUPPLEMENTAL INSURANCE.**

21 (a) **GUARANTEEING ISSUE WITHOUT PREEXISTING**
22 **CONDITIONS FOR CONTINUOUSLY COVERED INDIVID-**
23 **UALS.**—Section 1882(s) of the Social Security Act (42
24 U.S.C. 1395ss(s)), as amended by section 202(a), is
25 amended—

1 (1) by redesignating paragraph (4) as para-
2 graph (5), and

3 (2) by inserting after paragraph (3) the follow-
4 ing new paragraph:

5 “(4)(A) The issuer of a Medicare supplemental pol-
6 icy—

7 “(i) may not deny or condition the issuance or
8 effectiveness of a Medicare supplemental policy de-
9 scribed in subparagraph (C);

10 “(ii) may not discriminate in the pricing of the
11 policy on the basis of the individual’s health status,
12 medical condition (including both physical and men-
13 tal illnesses), claims experience, receipt of health
14 care, medical history, genetic information, evidence
15 of insurability (including conditions arising out of
16 acts of domestic violence), or disability; and

17 “(iii) may not impose an exclusion of benefits
18 based on a pre-existing condition,

19 in the case of an individual described in subparagraph (B)
20 who seeks to enroll under the policy not later than 63 days
21 after the date of the termination of enrollment described
22 in such subparagraph.

23 “(B) An individual described in this subparagraph is
24 an individual described in any of the following clauses:

1 “(i) The individual is enrolled with an eligible
2 organization under a contract under section 1876 or
3 with an organization under an agreement under sec-
4 tion 1833(a)(1)(A) and such enrollment ceases ei-
5 ther because the individual moves outside the service
6 area of the organization under the contract or agree-
7 ment or because of the termination or nonrenewal of
8 the contract or agreement.

9 “(ii) The individual is enrolled with an organi-
10 zation under a policy described in subsection (t) and
11 such enrollment ceases either because the individual
12 moves outside the service area of the organization
13 under the policy, because of the bankruptcy or insol-
14 vency of the insurer, or because the insurer closes
15 the block of business to new enrollment.

16 “(iii) The individual is covered under a Medi-
17 care supplemental policy and such coverage is termi-
18 nated because of the bankruptcy or insolvency of the
19 insurer issuing the policy, because the insurer closes
20 the block of business to new enrollment, or because
21 the individual changes residence so that the individ-
22 ual no longer resides in a State in which the issuer
23 of the policy is licensed.

1 “(iv) The individual is enrolled under an em-
2 ployee welfare benefit plan that provides health ben-
3 efits that supplement the benefits under this title
4 and the plan terminates or ceases to provide (or sig-
5 nificantly reduces) such supplemental health benefits
6 to the individual.

7 “(v)(I) The individual is enrolled with an eligi-
8 ble organization under a contract under section
9 1876 or with an organization under an agreement
10 under section 1833(a)(1)(A) and such enrollment is
11 terminated by the enrollee during the first 12
12 months of such enrollment, but only if the individual
13 never was previously enrolled with an eligible organi-
14 zation under a contract under section 1876 or with
15 an organization under an agreement under section
16 1833(a)(1)(A).

17 “(II) The individual is enrolled under a policy
18 described in subsection (t) and such enrollment is
19 terminated during the first 12 months of such en-
20 rollment, but only if the individual never was pre-
21 viously enrolled under such a policy under such sub-
22 section.

23 “(C)(i) Subject to clause (ii), a Medicare supple-
24 mental policy described in this subparagraph, with respect
25 to an individual described in subparagraph (B), is a policy

1 the benefits under which are comparable in relation to the
2 benefits under the enrollment described in subparagraph
3 (B) (or, in the case of an individual described in clause
4 (ii), under the most recent Medicare supplemental policy
5 described in clause (ii)(II)).

6 “(ii) An individual described in this clause is an indi-
7 vidual who—

8 “(I) is described in subparagraph (B)(v), and

9 “(II) was enrolled in a Medicare supplemental
10 policy within the 63 day period before the enrollment
11 described in such subparagraph.

12 “(iii) As a condition for approval of a State regu-
13 latory program under subsection (b)(1) and for purposes
14 of applying clause (i) to policies to be issued in the State,
15 the regulatory program shall provide for the method of
16 determining whether policy benefits are comparable or
17 lesser in relation to other benefits. With respect to a State
18 without such an approved program, the Secretary shall es-
19 tablish such method.

20 “(D) At the time of an event described in subpara-
21 graph (B) because of which an individual ceases enroll-
22 ment or loses coverage or benefits under a contract or
23 agreement, policy, or plan, the organization that offers the
24 contract or agreement, the insurer offering the policy, or
25 the administrator of the plan, respectively, shall notify the

1 individual of the rights of the individual, and obligations
2 of issuers of Medicare supplemental policies, under sub-
3 paragraph (A).”.

4 (b) LIMITATION ON IMPOSITION OF PREEXISTING
5 CONDITION EXCLUSION DURING INITIAL OPEN ENROLL-
6 MENT PERIOD.—Section 1882(s)(2)(B) of such Act (42
7 U.S.C. 1395ss(s)(2)(B)) is amended to read as follows:

8 “(B) In the case of a policy issued during the 6-
9 month period described in subparagraph (A), the policy
10 may not exclude benefits based on a pre-existing condi-
11 tion.”.

12 (c) CLARIFYING THE NONDISCRIMINATION REQUIRE-
13 MENTS DURING THE 6-MONTH INITIAL ENROLLMENT
14 PERIOD.—Section 1882(s)(2)(A) of such Act (42 U.S.C.
15 1395ss(s)(2)(A)) is amended to read as follows:

16 “(2)(A)(i) In the case of an individual described in
17 clause (ii), the issuer of a Medicare supplemental policy—

18 “(I) may not deny or condition the issuance or
19 effectiveness of a Medicare supplemental policy, and

20 “(II) may not discriminate in the pricing of the
21 policy on the basis of the individual’s health status,
22 medical condition (including both physical and men-
23 tal illnesses), claims experience, receipt of health
24 care, medical history, genetic information, evidence

1 of insurability (including conditions arising out of
2 acts of domestic violence), or disability.

3 “(ii) An individual described in this clause is an indi-
4 vidual for whom an application is submitted before the end
5 of the 6-month period beginning with the first month as
6 of the first day on which the individual is 65 years of age
7 or older and is enrolled for benefits under part B.”.

8 (d) EXTENDING 6-MONTH INITIAL ENROLLMENT
9 PERIOD TO NON-ELDERLY MEDICARE BENEFICIARIES.—
10 Section 1882(s)(2)(A)(ii) of such Act (42 U.S.C.
11 1395ss(s)(2)(A)), as amended by subsection (c), is amend-
12 ed by striking “is submitted” and all that follows and in-
13 serting the following: “is submitted—

14 “(I) before the end of the 6-month period be-
15 ginning with the first month as of the first day on
16 which the individual is 65 years of age or older and
17 is enrolled for benefits under part B; and

18 “(II) for each time the individual becomes eligi-
19 ble for benefits under part A pursuant to section
20 226(b) or 226A and is enrolled for benefits under
21 part B, before the end of the 6-month period begin-
22 ning with the first month as of the first day on
23 which the individual is so eligible and so enrolled.”.

24 (e) EFFECTIVE DATES.—

1 (1) GUARANTEED ISSUE.—The amendment
2 made by subsection (a) shall take effect on July 1,
3 1997.

4 (2) LIMIT ON PREEXISTING CONDITION EXCLU-
5 SIONS.—The amendment made by subsection (b)
6 shall apply to policies issued on or after July 1,
7 1997.

8 (3) CLARIFICATION OF NONDISCRIMINATION
9 REQUIREMENTS.—The amendment made by sub-
10 section (c) shall apply to policies issued on or after
11 July 1, 1997.

12 (4) EXTENSION OF ENROLLMENT PERIOD TO
13 DISABLED INDIVIDUALS.—

14 (A) IN GENERAL.—The amendment made
15 by subsection (d) shall take effect on July 1,
16 1997.

17 (B) TRANSITION RULE.—In the case of an
18 individual who first became eligible for benefits
19 under part A of title XVIII of the Social Secu-
20 rity Act pursuant to section 226(b) or 226A of
21 such Act and enrolled for benefits under part B
22 of such title before July 1, 1997, the 6-month
23 period described in section 1882(s)(2)(A) of
24 such Act shall begin on July 1, 1997. Before
25 July 1, 1997, the Secretary of Health and

1 Human Services shall notify any individual de-
2 scribed in the previous sentence of their rights
3 in connection with Medicare supplemental poli-
4 cies under section 1882 of such Act, by reason
5 of the amendment made by subsection (d).

6 (f) TRANSITION PROVISIONS.—

7 (1) IN GENERAL.—If the Secretary of Health
8 and Human Services identifies a State as requiring
9 a change to its statutes or regulations to conform its
10 regulatory program to the changes made by this sec-
11 tion, the State regulatory program shall not be con-
12 sidered to be out of compliance with the require-
13 ments of section 1882 of the Social Security Act due
14 solely to failure to make such change until the date
15 specified in paragraph (4).

16 (2) NAIC STANDARDS.—If, within 9 months
17 after the date of the enactment of this Act, the Na-
18 tional Association of Insurance Commissioners (in
19 this subsection referred to as the “NAIC”) modifies
20 its NAIC Model Regulation relating to section 1882
21 of the Social Security Act (referred to in such sec-
22 tion as the 1991 NAIC Model Regulation, as modi-
23 fied pursuant to section 171(m)(2) of the Social Se-
24 curity Act Amendments of 1994 (Public Law 103–
25 432) and as modified pursuant to section

1 1882(d)(3)(A)(vi)(IV) of the Social Security Act, as
2 added by section 271(a) of the Health Care Port-
3 ability and Accountability Act of 1996 (Public Law
4 104–191) to conform to the amendments made by
5 this section, such revised regulation incorporating
6 the modifications shall be considered to be the appli-
7 cable NAIC model regulation (including the revised
8 NAIC model regulation and the 1991 NAIC Model
9 Regulation) for the purposes of such section.

10 (3) SECRETARY STANDARDS.—If the NAIC
11 does not make the modifications described in para-
12 graph (2) within the period specified in such para-
13 graph, the Secretary of Health and Human Services
14 shall make the modifications described in such para-
15 graph and such revised regulation incorporating the
16 modifications shall be considered to be the appro-
17 priate Regulation for the purposes of such section.

18 (4) DATE SPECIFIED.—

19 (A) IN GENERAL.—Subject to subpara-
20 graph (B), the date specified in this paragraph
21 for a State is the earlier of—

22 (i) the date the State changes its stat-
23 utes or regulations to conform its regu-
24 latory program to the changes made by
25 this section, or

1 (ii) 1 year after the date the NAIC or
2 the Secretary first makes the modifications
3 under paragraph (2) or (3), respectively.

4 (B) ADDITIONAL LEGISLATIVE ACTION RE-
5 QUIRED.—In the case of a State which the Sec-
6 retary identifies as—

7 (i) requiring State legislation (other
8 than legislation appropriating funds) to
9 conform its regulatory program to the
10 changes made in this section, but

11 (ii) having a legislature which is not
12 scheduled to meet in 1998 in a legislative
13 session in which such legislation may be
14 considered,

15 the date specified in this paragraph is the first
16 day of the first calendar quarter beginning after
17 the close of the first legislative session of the
18 State legislature that begins on or after July 1,
19 1998. For purposes of the previous sentence, in
20 the case of a State that has a 2-year legislative
21 session, each year of such session shall be
22 deemed to be a separate regular session of the
23 State legislature.

1 **SEC. 204. APPLICATION OF STANDARDS TO MEDICARE SE-**
2 **LECT POLICIES.**

3 Section 1882(t) of the Social Security Act (42 U.S.C.
4 1395ss(t)) is amended—

5 (1) in the matter in paragraph (1) before sub-
6 paragraph (A), by inserting “, under the standards
7 established under paragraph (4)” after “if”;

8 (2) by striking “and” at the end of paragraph
9 (1)(E);

10 (3) by striking the period at the end of para-
11 graph (1)(F) and inserting a semicolon;

12 (4) by adding at the end of paragraph (1) the
13 following new subparagraphs:

14 “(G) notwithstanding any other provision
15 of this section to the contrary, if the issuer of
16 the policy meet the requirements of paragraph
17 (5).”;

18 (5) by adding at the end of paragraph (2) the
19 following: “The intermediate sanctions described in
20 clauses (ii) and (iii) of section 1876(i)(6)(B) shall
21 apply to actions described in the first sentence of
22 this paragraph in the same manner as they apply to
23 violations described in section 1876(i)(6)(A).”; and

24 (6) by adding at the end the following new
25 paragraphs:

1 “(4)(A) The Secretary shall establish by regulation
2 standards for policies in order to be provided special treat-
3 ment under paragraph (1). To the extent practicable, such
4 standards shall be the same as the standards established
5 by the National Association of Insurance Commissioners
6 with respect to such policies. Any additional standards
7 shall be developed in consultation with such Association.

8 “(B) If the Secretary determines that a State has es-
9 tablished an effective program to enforce the standards
10 established under subparagraph (A), any policy that a
11 State determines under such program to meet such stand-
12 ards shall be deemed to meet such standards for purposes
13 of this section.

14 “(5) For purposes of paragraph (1), the requirements
15 of this paragraph, with respect to a policy are as follows:

16 “(A) If the issuer of the policy—

17 “(i) is an eligible organization (as defined
18 in section 1876(a)), the benefits under the pol-
19 icy (in coordination with benefits made available
20 under this title) are the same as the benefits re-
21 quired to be made available by such an organi-
22 zation with a risk-sharing contract under sec-
23 tion 1876, or

24 “(ii) is not such an organization, the bene-
25 fits under the policy shall be either—

1 “(I) the benefits required under the
2 Standardized Medicare supplement benefit
3 plan ‘E’ (as specified in section 9E(5) of
4 the 1991 NAIC Model Regulation), plus
5 One Hundred Percent (100%) of the Medi-
6 care Part B Excess Charges (as defined in
7 section 8C(5) of such Regulation); or

8 “(II) the benefits required under the
9 Standardized Medicare supplement benefit
10 plan ‘J’ (as specified in section 9E(10) of
11 such Regulation).

12 “(B) The issuer of the policy (in relation to the
13 policy) meets the same requirements under section
14 1876 that would apply to an eligible organization
15 with a risk-sharing contract under that section (in-
16 cluding community rating of premiums and prior ap-
17 proval of marketing materials, but not including pro-
18 vision of benefits).”.

19 **SEC. 205. ARRANGEMENTS FOR OUT-OF-AREA DIALYSIS**
20 **SERVICES.**

21 Section 1876(c) of the Social Security Act (42 U.S.C.
22 1395mm(c)) is amended by adding at the end the follow-
23 ing new paragraph:

1 “(9) Each eligible organization shall assure that en-
2 rollees requiring renal dialysis services who are tempo-
3 rarily outside of the organization’s service area (within the
4 United States) have reasonable access to such services
5 by—

6 “(A) making such arrangements with providers
7 of services or renal dialysis facilities outside the
8 service area for the coverage of and payment for
9 such services furnished to enrollees as the Secretary
10 determines necessary to assure reasonable access; or

11 “(B) providing for the reimbursement of any
12 provider of services or renal dialysis facility outside
13 the service area for the furnishing of such services
14 to enrollees.”.

15 **SEC. 206. COORDINATION OF MEDICARE ENROLLMENT AND**
16 **TERMINATION OF ENROLLMENT.**

17 (a) UNIFORM OPEN ENROLLMENT PERIODS.—

18 (1) FOR MEDIGAP PLANS.—Section 1882(s) of
19 such Act (42 U.S.C. 1395ss(s)), as amended by sec-
20 tions 202(a) and 203(a), is amended—

21 (A) by redesignating paragraph (5) as
22 paragraph (6), and

23 (B) by inserting after paragraph (4) the
24 following new paragraph:

1 “(5) Each issuer of a Medicare supplemental policy
2 shall have an open enrollment period (which shall be the
3 period specified by the Secretary under section
4 1876(c)(3)(A)(i)), of at least 30 days duration every year,
5 during which the issuer may not deny or condition the is-
6 suance or effectiveness of a Medicare supplemental policy,
7 or discriminate in the pricing of the policy, because of age,
8 health status, claims experience, receipt of health care, or
9 medical condition. The policy may not provide any time
10 period applicable to pre-existing conditions, waiting peri-
11 ods, elimination periods, and probationary periods (except
12 as provided by paragraph (2)(B)). The Secretary may re-
13 quire enrollment through a third party designated under
14 section 1876(c)(3)(B).”.

15 (2) FOR MEDICARE SELECT POLICIES.—Section
16 1882(t)(5) of such Act (42 U.S.C. 1395ss(t)(5)), as
17 added by section 204(6), is amended by adding at
18 the end the following new subparagraph:

19 “(C) The periods for enrollment applicable for
20 the policy are the same periods applicable to a Medi-
21 care supplemental policy under section 1882(s)(4).”.

22 (b) ENROLLMENTS FOR NEW MEDICARE BENE-
23 FICIARIES AND THOSE WHO MOVE.—Section
24 1876(c)(3)(A) of such Act (42 U.S.C. 1395mm(c)(3)(A))
25 is amended—

1 (1) in clause (i), by striking “clause (ii)” and
2 inserting “clauses (ii) through (iv)”, and

3 (2) by adding at the end the following:

4 “(iii) Each eligible organization shall have an open
5 enrollment period for each individual eligible to enroll
6 under subsection (d) during any enrollment period speci-
7 fied by section 1837 that applies to that individual. Enroll-
8 ment under this clause shall be effective as specified by
9 section 1838.

10 “(iv) Each eligible organization shall have an open
11 enrollment period for each individual eligible to enroll
12 under subsection (d) who has previously resided outside
13 the geographic area which the organization serves. The en-
14 rollment period shall begin with the beginning of the
15 month that precedes the month in which the individual
16 becomes a resident of that geographic area and shall end
17 at the end of the following month. Enrollment under this
18 clause shall be effective as of the first of the month follow-
19 ing the month in which the individual enrolls.”.

20 (c) PROVISION BY SECRETARY OF ENROLLMENT IN-
21 FORMATION AND OTHER INFORMATION ON ELIGIBLE OR-
22 GANIZATIONS AND MEDICARE SUPPLEMENTAL POLI-
23 CIES.—

1 (1) IN GENERAL.—Section 1804(b) of such Act
2 (42 U.S.C. 1395b–2(b)) is amended to read as fol-
3 lows:

4 “(b) The Secretary shall provide information upon re-
5 quest (including through the mails and via a toll-free tele-
6 phone number) to any individual entitled to benefits under
7 this title on the programs under this title, including—

8 “(1) information to assist individuals in enroll-
9 ing with eligible organizations under section 1876
10 and in selecting among such organizations for enroll-
11 ment, including information on the premiums
12 charged by such organizations for enrollment; and

13 “(2) information on Medicare supplemental
14 policies under section 1882, including the relation-
15 ship of State programs under title XIX to such poli-
16 cies and the premiums charged by such policies for
17 enrollment (to the extent information on such pre-
18 miums is available to the Secretary).”.

19 (2) CONFORMING AMENDMENT; PAYMENT FOR
20 STANDARDIZED INFORMATION.—(A) Section 1882 of
21 such Act (42 U.S.C. 1395ss) is amended—

22 (i) by striking subsection (f) and by insert-
23 ing in lieu thereof the following:

24 “(f) Each entity that offers a Medicare supplemental
25 policy shall pay the Secretary for its pro rata share (as

1 determined by the Secretary) of the estimated costs to be
2 incurred by the Secretary in carry out section 1804(b) and
3 section 4360 of the Omnibus Budget Reconciliation Act
4 of 1990. Those payments are appropriate to defray the
5 costs described in the preceding sentence, to remain avail-
6 able until expended.”; and

7 (ii) in subsection (c)(5), by striking “(t)”
8 and inserting “(f)”.

9 (B) Section 4360(g) of the Omnibus Budget
10 Reconciliation Act of 1990 (42 U.S.C. 1395(b)–4(g))
11 is amended to read as follows:

12 “(g) FUNDING.—For funding provision, see section
13 1882(f) of the Social Security Act.”.

14 (d) EFFECTIVE DATE.—The amendments made by
15 this section apply to enrollments occurring after 1997 (but
16 only after the Secretary of Health and Human Services
17 has prescribed the relevant annual period), except that the
18 amendments made by subsection (b)(2) apply to enroll-
19 ments for a Medicare supplemental policy made after 1997
20 and the amendments made by subsection (c)(2) shall apply
21 to demonstrations occurring after the date of the enact-
22 ment of this Act and to other activities occurring after
23 1997.

1 **SEC. 207. ANNUAL PUBLICATION OF COMPARATIVE INFOR-**
2 **MATION ON MEDICARE MANAGED CARE**
3 **PLANS.**

4 (a) IN GENERAL.—Section 1804 of the Social Secu-
5 rity Act (42 U.S.C. 1395b–2) is amended by adding at
6 the end the following new subsection:

7 “(c) The Secretary shall provide on an annual basis
8 for the publication and wide dissemination (through the
9 Internet and otherwise) of information, in a comparative
10 form, on health plans offered under section 1876 in order
11 for Medicare beneficiaries to make more informed deci-
12 sions in enrolling with eligible organizations under that
13 section. Such information shall be in a standard format
14 and using standard terminology and shall include charts
15 that compare, for all the policies offered in a market area,
16 benefits and costs, disenrollment and complaint rates, and
17 summaries of the results of site monitoring visits con-
18 ducted by the Secretary.”.

19 (b) EFFECTIVE DATE.—The Secretary of Health and
20 Human Services shall first provide for the publication of
21 the information required under the amendment made by
22 subsection (a) for contract year 1998.

23 **SEC. 208. OFFICE OF MEDICARE ADVOCACY.**

24 Title XVIII of the Social Security Act is amended by
25 inserting after section 1804 the following new section:

1 “OFFICE OF MEDICARE ADVOCACY

2 “SEC. 1805. (a) ESTABLISHMENT.—The Secretary
3 shall establish, within the Health Care Financing Admin-
4 istration, an office of Medicare advocacy (in this section
5 referred to as the ‘office’), to be headed by a director ap-
6 pointed by the Secretary.

7 “(b) PURPOSE.—The office shall provide, in accord-
8 ance with this section, independent review of problems and
9 concerns of Medicare beneficiaries in relation to the pro-
10 grams under this title, including, but not limited to, com-
11 plaints concerning health plans offered under section
12 1876.

13 “(c) ACCESS.—In order to carry out its functions, the
14 office shall provide for a toll-free telephone number
15 through which Medicare beneficiaries can obtain assist-
16 ance in the programs under this title, including providing
17 comparative information on health plans offered under
18 section 1876. The office also shall undertake such addi-
19 tional outreach activities, such as the use of town meetings
20 and development of an appropriate Internet site, as most
21 effectively and efficiently promotes dissemination of infor-
22 mation to Medicare beneficiaries.

1 “(d) RECEIPT AND DISPOSITION OF COMPLAINTS.—

2 The office shall provide for a record of the types of com-
3 plaints and problems received and shall submit to the Sec-
4 retary and publish an annual report on the nature of such
5 complaints and problems, the disposition with respect to
6 such complaints and problems, and such other additional
7 information as the Secretary may specify.

8 “(e) EXPEDITED REVIEW PROCESS FOR COM-
9 PLAINTS UNDER EMERGENCY CIRCUMSTANCES.—

10 “(1) IN GENERAL.—Under regulations of the
11 Secretary, the office shall have authority to provide
12 for an expedited review and resolution of complaints
13 under emergency circumstances, including those de-
14 scribed in paragraph (2). Such reviews and resolu-
15 tions shall be conducted to the greatest extent prac-
16 ticable through regional and local agencies.

17 “(2) EMERGENCY CIRCUMSTANCES DE-
18 SCRIBED.—The emergency circumstances described
19 in this paragraph are cases in which—

20 “(A) a delay in treatment resulting from
21 application of the usual hearing and appeals
22 process may endanger the life of the bene-
23 ficiary, result in a loss of function or a signifi-
24 cant worsening of a condition, or render treat-
25 ment ineffective; or

1 “(B) an advanced directive (as defined in
2 section 1866(f)(3)) or other end-of-life pref-
3 erence is involved.”.

4 **SEC. 209. HOLD-HARMLESS PROVISIONS TO PROTECT MAN-**
5 **AGED CARE ENROLLEES FROM AMOUNTS**
6 **OWED HOSPITALS FOR EMERGENCY SERV-**
7 **ICES.**

8 (a) IN GENERAL.—Section 1866(a)(1) of the Social
9 Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

10 (1) by striking “, and” at the end of subpara-
11 graph (P) and inserting a semicolon,

12 (2) by striking the period at the end of sub-
13 paragraph (Q) and inserting “; and”, and

14 (3) by inserting after subparagraph (Q) the fol-
15 lowing new subparagraph:

16 “(R) in the case of a hospital that furnishes
17 emergency services (as defined in section 9919(f)(4)
18 of the Internal Revenue Code of 1986) with respect
19 to any individual who is enrolled in a managed care
20 group health plan (as defined for purposes of chap-
21 ter 101 of the Internal Revenue Code of 1986) or
22 covered under managed care health insurance cov-
23 erage (as defined for such purposes), not to impose
24 any liability with respect to such services (and not
25 to collect or attempt to collect from the individual

1 any amounts for such services) to the extent the
2 hospital is owed payment by the plan or issuer offer-
3 ing the coverage for such services.”.

4 (b) EFFECTIVE DATE.—The amendments made by
5 subsection (a) shall apply to participation agreements as
6 of the date that is 30 days after the date of the enactment
7 of this Act.

8 **SEC. 210. AUTOMATIC EXCLUSION FROM MEDICARE AND**
9 **MEDICAID FOR HEALTH PLANS THAT LIE**
10 **ABOUT QUALITY DATA.**

11 Notwithstanding any other provision of law, in the
12 case of an eligible organization, health maintenance orga-
13 nizations, or other entity that is receiving payment on a
14 prepaid basis for items and services provided under title
15 XVIII or XIX of the Social Security Act and that submits
16 information relating to the quality of such services pro-
17 vided that is material and false, the Secretary of Health
18 and Human Services shall take such steps as may be nec-
19 essary to assure the exclusion of the entity from continu-
20 ing to qualify for such payments under such title and shall
21 provide for the imposition of any intermediate sanctions
22 in lieu of such exclusion.

TITLE III—MEDICAID

SEC. 301. PROHIBITION ON PAYMENTS UNDER MEDICAID UNTIL COMPLETION OF ORIENTATION, MEDICAL PROFILE, AND IMMUNIZATION.

(a) REQUIREMENT FOR ORIENTATION AND MEDICAL
PROFILE.—

(1) IN GENERAL.—Notwithstanding any other provision of law, no payment shall be made to a State under title XIX of the Social Security Act with respect to expenditures incurred by it for payment (determined under a prepaid capitation basis or under any other risk basis) for services provided by any entity (including a health insuring organization) for an individual enrolled with the entity until the entity certifies to the Secretary of Health and Human Services that—

(A) the entity has provided the enrollee with such orientation as the Secretary of Health and Human Services specifies, which orientation shall include the explanation of rights described in paragraph (2) and the explanation of access to care described in paragraph (3);

1 (B) the entity has a medical profile de-
2 scribed in section 1876(e)(3)(G)(iii) of the So-
3 cial Security Act (as added by section 201(a))
4 with respect to the enrollee; and

5 (C) if the entity is responsible for the pro-
6 vision (directly or through arrangements with
7 providers of services) of immunizations for an
8 enrollee who is a child—

9 (i) the entity has obtained the immu-
10 nization status of such child, and

11 (ii) the entity has begun to provide
12 (or is providing) for immunizations of such
13 child in accordance with the standards es-
14 tablished for early and periodic screening,
15 diagnostic, and treatment services under
16 such title.

17 (2) EXPLANATION OF RIGHTS.—The expla-
18 nation of rights described in this paragraph shall in-
19 clude an explanation of an enrollee’s rights under
20 such title in relation to enrollment with the entity,
21 including an explanation of—

22 (A) the enrollee’s rights to benefits from the en-
23 tity,

1 (B) the restrictions on payments under such
2 title for services furnished other than by or through
3 the entity,

4 (C) out-of-area coverage provided by the entity,

5 (D) the entity's coverage of emergency services
6 and urgently needed care, and

7 (E) appeal rights of enrollees.

8 (3) EXPLANATION OF ACCESS TO CARE.—The
9 explanation of access to care described in this para-
10 graph includes an explanation of the following fea-
11 tures of the benefits offered by the entity under such
12 title:

13 (A) Access to care, including choice of phy-
14 sician, physician location, and hospital coverage.

15 (B) The information required under sec-
16 tion 9914 of the Internal Revenue Code of
17 1986.

18 (b) PROMULGATION OF REQUIREMENTS FOR ORI-
19 ENTATION AND MEDICAL PROFILE.—Not later than 180
20 days after the date of the enactment of this Act, the Sec-
21 retary of Health and Human Services shall, by rule, first
22 specify the elements of the orientation and of the medical
23 profile described in section 1876(c)(3)(G) of the Social Se-
24 curity Act. Chapter 8 of title 5, United States Code, shall

1 not apply to such rule. Such rule shall apply on a final
2 basis, pending notice and opportunity for public comment.

3 (c) EFFECTIVE DATES.—

4 (1) IN GENERAL.—Subject to paragraph (2),
5 subsection (a) applies with respect to enrollees as of
6 the date that is 60 days after the date on which the
7 Secretary first publishes the rule under subsection
8 (b) in the Federal Register.

9 (2) IMMUNIZATION REQUIREMENTS.—Sub-
10 section (a)(1)(C) applies with respect to enrollees as
11 of the first day of the first month that begins more
12 than 60 days after the date on which the Secretary
13 first publishes the rule under subsection (b) in the
14 Federal Register.

15 **SEC. 302. REQUIREMENT FOR MEDICAID CAPITATED PLANS**
16 **TO ASSURE APPROPRIATE CHILDHOOD IM-**
17 **MUNIZATIONS.**

18 (a) IN GENERAL.—Notwithstanding any other provi-
19 sion of law, no payment shall be made to a State under
20 title XIX of the Social Security Act with respect to ex-
21 penditures incurred by it for payment (determined under
22 a prepaid capitation basis or under any other risk basis)
23 for services provided by any entity (including a health in-
24 suring organization) which is responsible for the provision

1 (directly or through arrangements with providers of serv-
2 ices) of immunizations for children unless (and until)—

3 (1) the entity has obtained the immunization
4 status of each child enrolled with the entity, and

5 (2) the entity has begun to provide (or is pro-
6 viding) for immunizations of each such child in ac-
7 cordance with the standards established for early
8 and periodic screening, diagnostic, and treatment
9 services under such title.

10 (b) EFFECTIVE DATE.—Subsection (a) shall apply to
11 expenditures by States for months beginning more than
12 180 days after the date of the enactment of this Act.

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