

105TH CONGRESS
1ST SESSION

H. R. 1191

To provide patients with information and rights to promote better health care.

IN THE HOUSE OF REPRESENTATIVES

MARCH 20, 1997

Mr. OWENS introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committee on Ways and Means, 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 provide patients with information and rights to promote better health care.

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

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

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Patient and Health Care Provider Protection Act of
6 1997”.

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

Sec. 1. Short title; table of contents.
Sec. 2. Findings.

Sec. 3. Definitions.

TITLE I—HEALTH PLAN REQUIREMENTS

Sec. 101. Interference with medical communication prohibited.
 Sec. 102. Improper incentive plan prohibited.
 Sec. 103. Provisions regarding denial of care.
 Sec. 104. Quality of care.
 Sec. 105. Privacy.
 Sec. 106. Fee.
 Sec. 107. Enforcement through civil penalties.
 Sec. 108. Prohibition on adverse action.

TITLE II—OFFICE OF CONSUMER ADVOCACY FOR HEALTH

Sec. 201. Establishment of office.
 Sec. 202. Assistance to individuals with grievances against a health plan.
 Sec. 203. Assurance of access by all individuals to quality health care.
 Sec. 204. Federal investigation and emergency intervention.
 Sec. 205. Annual report to the secretary.
 Sec. 206. Office administration.
 Sec. 207. Oversight.
 Sec. 208. Funding of office.

TITLE III—INDEPENDENT CONSUMER ADVISORY COMMITTEES

Sec. 301. Establishment of committees.
 Sec. 302. Membership and chair.
 Sec. 303. Functions of committee.
 Sec. 304. Liability of members of committee.
 Sec. 305. Annual report to office.
 Sec. 306. Funding for committees.

TITLE IV—COORDINATION AMONG OFFICE, COMMITTEES, AND SECRETARY

Sec. 401. Interaction among office and other organizations.
 Sec. 402. Assistance to committees.
 Sec. 403. Coordinated data analysis and dissemination procedure.

1 **SEC. 2. FINDINGS.**

2 The Congress finds the following:

3 (1) The largest category of health spending is
 4 hospital services; in 1994, 35 percent of national
 5 health spending was for hospital services worth
 6 \$338,500,000,000.

7 (2) The hospital industry exhibits the fastest
 8 rising costs in the health care sector.

1 (3) The largest expenditures for the hospital in-
2 dustry are payroll (wages and salaries) and employee
3 benefits; in 1992, payroll and employee benefits ac-
4 counted for almost 55 percent of total hospital ex-
5 penses.

6 (4) Because registered nurses and licensed
7 practical nurses comprise the majority of a hospital's
8 expenses, in an effort to remain competitive, hos-
9 pitals are restructuring their operations by decreas-
10 ing payroll and benefit outlays for registered nurses
11 and licensed practical nurses and either decreasing
12 their number or replacing them with unlicensed
13 aides to care directly for patients.

14 (5) While this reorganization is taking place, no
15 mandatory, national, and systematic compilation of
16 data is being undertaken to determine the correla-
17 tion between skilled nursing care and patient safety.

18 (6) Several studies, however, have noted a basic
19 relationship between skilled nursing care and patient
20 safety: increased deaths result when inadequate
21 nursing and lower levels of registered nurses and li-
22 censed practical nurses in combination with higher
23 levels of unlicensed aides are utilized by health care
24 facilities.

1 (7) A comprehensive effort is needed at the na-
2 tional level to collect data and develop a research
3 and evaluation agenda so that informed policy devel-
4 opment, implementation and evaluation are under-
5 taken in a timely manner to protect the safety of pa-
6 tients, the well being of health care workers, and the
7 integrity of the United States medical system.

8 (8) The quality of available health care will suf-
9 fer in the United States if health care delivery is al-
10 lowed to set priorities in which profit is made at the
11 expense of patient care quality and safety.

12 (9) Core clinical staff, such as registered nurses
13 and licensed practical nurses, are a key component
14 in increasing quality, understanding patient care
15 needs, and balancing costs in any reformed health
16 care system.

17 (10) Health care is a basic and universal need;
18 therefore, the right of any consumer to have access
19 to one's own confidential medical records and perti-
20 nent information on the health care facility that is
21 delivering health care and to participate effectively
22 in the process of improving the delivery and quality
23 of such care should not be impaired.

24 **SEC. 3. DEFINITIONS.**

25 In this Act:

1 (1) HEALTH CARE PROVIDER.—The term
2 “health care provider” means a hospital or other in-
3 dividual or entity licensed or certified under State
4 law to provide health care services.

5 (2) HEALTH PLAN.—The term “health plan”
6 means any private health plan or arrangement (in-
7 cluding an employee welfare benefit plan) which pro-
8 vides, or pays the cost of, health care services.

9 (3) SECRETARY.—Except as otherwise expressly
10 provided, the term “Secretary” means Secretary of
11 Health and Human Services.

12 (4) COVERAGE OF THIRD PARTY ADMINISTRA-
13 TORS.—In the case of a health plan that is an em-
14 ployee welfare benefit plan (as defined in section
15 3(1) of the Employee Retirement Income Security
16 Act of 1974), any third party administrator or other
17 person with responsibility for contracts with health
18 care providers under the plan shall be considered,
19 for purposes of this Act, to be an entity offering
20 such health plan.

21 (5) ENROLLEE.—The term “enrollee” means a
22 person enrolled under a health plan.

23 (6) OFFICE.—The term “Office” means the Of-
24 fice of Consumer Advocacy for Health as described
25 in title II of this Act.

1 (7) COMMITTEE.—The term “Committee”
2 means an Independent Consumer Advisory Commit-
3 tee as described in title III of this Act.

4 **TITLE I—HEALTH PLAN**
5 **REQUIREMENTS**

6 **SEC. 101. INTERFERENCE WITH MEDICAL COMMUNICATION**
7 **PROHIBITED.**

8 (a) IN GENERAL.—A health plan may not as part of
9 any contract or agreement with a health care provider pro-
10 vide any restriction on or interference with any medical
11 communication, as defined in subsection (b).

12 (b) MEDICAL COMMUNICATION DEFINED.—For pur-
13 poses of subsection (a), the term “medical communica-
14 tion”—

15 (1) means any communication, other than a
16 knowing misrepresentation, made by the health care
17 provider—

18 (A) regarding the mental or physical
19 health care needs or treatment of a patient and
20 the provisions, terms, or requirements of the
21 health plan or another health plan relating to
22 such needs or treatment; and

23 (B) between—

1 (i) the provider and a current, former,
2 or prospective patient (or the guardian or
3 legal representative of a patient);

4 (ii) the provider and any employee or
5 representative of the such plan; or

6 (iii) the provider and any employee or
7 representative of any State or Federal au-
8 thority with responsibility for the licensing
9 or oversight with respect to such plan; and

10 (2) includes communications concerning—

11 (A) any tests, consultations, and treatment
12 options;

13 (B) any risks or benefits associated with
14 such test, consultations, and options;

15 (C) variation among any health care pro-
16 viders and any institutions providing such serv-
17 ices in experience, quality, or outcomes;

18 (D) the basis or standard for the decision
19 of a health plan to authorize or deny health
20 care services or benefits;

21 (E) the process used by such a plan to de-
22 termine whether to authorize or deny health
23 care services or benefits; and

1 (F) any financial incentives or disincentives provided by such a plan to a health care
 2 provider that are based on service utilization.
 3

4 (c) NON-PREEMPTION OF STATE LAW.—A State may
 5 establish or enforce requirements with respect to the sub-
 6 ject matter of this section, but only if such requirements
 7 are more protective of a medical communication than the
 8 requirements established under this section.

9 (d) EFFECTIVE DATE.—Subsection (a) shall apply to
 10 contracts or agreements entered into or renewed on or
 11 after the date of the enactment of this Act, and to con-
 12 tracts and agreements entered into before such date as
 13 of 30 days after the date of the enactment of this Act.

14 **SEC. 102. IMPROPER INCENTIVE PLAN PROHIBITED.**

15 (a) IN GENERAL.—A health plan may not as part of
 16 any contract or agreement with a health care provider op-
 17 erate an improper health care provider incentive plan as
 18 described in subsection (b).

19 (b) IMPROPER INCENTIVE PLAN.—For purposes of
 20 subsection (a), a health care provider incentive plan is im-
 21 proper, unless such plan meets the requirements of section
 22 1876(i)(8)(A) of the Social Security Act (42 U.S.C.
 23 1395mm(i)(8)(A)) for physician incentive plans in con-
 24 tracts with eligible organizations under section 1876 of
 25 such Act.

1 (c) INCENTIVE PLAN DEFINED.—In this section, the
2 term “health care provider incentive plan” means any
3 compensation or other financial arrangement between a
4 health plan and a health care provider that may directly
5 or indirectly have the effect of limiting services provided
6 with respect to an enrollee.

7 (d) EFFECTIVE DATE.—Subsection (a) shall apply to
8 contracts or agreements entered into or renewed on or
9 after the date of the enactment of this Act, and to con-
10 tracts and agreements entered into before such date as
11 of 30 days after the date of the enactment of this Act.

12 **SEC. 103. PROVISIONS REGARDING DENIAL OF CARE.**

13 (a) CRITERIA FOR DENIAL OF CARE.—A health plan
14 shall establish and maintain written criteria for the denial
15 of benefits under the plan. Such criteria shall be estab-
16 lished in consultation with the health care providers who
17 provide services for which benefits are provided under the
18 plan.

19 (b) PRELIMINARY PHYSICAL EXAMINATION.—A
20 health plan shall provide for an initial physical examina-
21 tion of an enrollee in a timely manner before denying bene-
22 fits under the plan to the enrollee. Such examination shall
23 not constitute services under the health plan.

24 (c) REASON FOR DENIAL OF CARE PROVIDED TO
25 ENROLLEE; COPY TO COMMITTEE.—

1 (1) EXPLANATION TO ENROLLEE.—A health
2 plan shall provide in writing to an enrollee, and to
3 the health care provider recommending care for the
4 enrollee, the reason for the denial of services under
5 the plan to the enrollee.

6 (2) COPY TO COMMITTEE.—The health plan
7 shall file with its Committee a copy of the reason for
8 such denial.

9 (d) PUBLICATION AND TRANSMISSION OF CRITERIA
10 FOR DENIAL OF CARE.—

11 (1) PUBLICATION.—A health plan shall put in
12 writing and make available to its enrollees through
13 the Office and its Committee the written criteria es-
14 tablished under subsection (a).

15 (2) TRANSMISSION.—The health plan shall
16 maintain on file with the State agency that regulates
17 such plan and to the Secretary a copy of such cri-
18 teria.

19 (e) EFFECTIVE DATE.—The criteria established and
20 maintained under this section shall apply to plan years
21 beginning on or after 180 days after the date of the enact-
22 ment of this Act.

23 **SEC. 104. QUALITY OF CARE.**

24 (a) CRITERIA FOR QUALITY OF CARE.—

1 (1) IN GENERAL.—A health plan, in consulta-
2 tion with the health care providers who provide
3 health services under the plan, shall establish cri-
4 teria to assure the quality of care provided under the
5 plan. Such plan shall establish such criteria utilizing
6 the data collected and analyzed under subsection (c)
7 and (d), and under section 403.

8 (2) DEADLINE.—The criteria under paragraph
9 (1) shall apply to plan years beginning on or after
10 2 years after the date of the enactment of this Act.

11 (b) PUBLIC ACCESS TO INFORMATION.—

12 (1) PUBLICATION OF CRITERIA TO ASSURE
13 QUALITY OF CARE.—A health plan shall put in writ-
14 ing, annually update, and make available the written
15 criteria established under subsection (a) to its enroll-
16 ees through the plan's Committee.

17 (2) SAFE STAFFING LEVELS.—

18 (A) IN GENERAL.—Not later than 1 year
19 after the date of the enactment of this Act, the
20 Secretary shall, by rule, establish guidelines
21 that determine the number and classifications
22 of health care providers necessary to ensure
23 safe and adequate staffing in relation to enroll-
24 ees under a health plan.

1 (B) FACTORS.—Such guidelines shall be
2 based on—

3 (i) the severity of illness of each en-
4 rollee;

5 (ii) factors affecting the period and
6 quality of recovery of each enrollee; and

7 (iii) any other factor substantially re-
8 lated to the condition and health care
9 needs of each enrollee.

10 (3) SAFE AND ADEQUATE STAFFING LEVELS.—

11 (A) IN GENERAL.—Not later than 180
12 days after the date the Secretary establishes the
13 guidelines under paragraph (2), a health plan
14 may not provide or pay for health care services
15 provided to an enrollee at an institution unless
16 such institution complies with such guidelines.

17 (B) SUBMISSION OF PROPOSED STAND-
18 ARDS TO COMMITTEE.—In the case of an insti-
19 tution that elects not to adopt the guidelines es-
20 tablished under paragraph (2), such institution
21 shall submit proposed staffing levels to the
22 health plan and its Committee for review. Such
23 institution shall include with its submission an
24 explanation of the method and criteria used in
25 developing the proposed staffing levels.

1 (C) DEFAULT FEDERAL GUIDELINES.—If
2 the health plan’s Committee determines that
3 the staffing levels proposed by such institution
4 fail to meet the guidelines established under
5 paragraph (2), then the health plan may not
6 provide or pay for health care services provided
7 to an enrollee at such institution unless such in-
8 stitution adopts such guidelines as its staffing
9 levels.

10 (D) CRITERIA AND CERTIFICATE OF COM-
11 PLIANCE.—Such plan shall file with the Sec-
12 retary and the Office of the State in which the
13 plan offers health care services a certificate of
14 compliance with the staffing levels adopted by
15 the institutions where the plan provides or pays
16 for health care services for its enrollees.

17 (E) PUBLIC INSPECTION.—Such institu-
18 tions shall keep on file, available for public in-
19 spection during regular business hours, daily re-
20 ports of staffing levels by department and of
21 patient census. Such information shall also be
22 posted in a public place.

23 (4) IDENTIFICATION TAG.—

24 (A) IN GENERAL.—A health plan may not
25 provide or pay for health care services provided

1 to an enrollee at an institution unless such in-
2 stitution prohibits a health care provider who is
3 not wearing an identification tag from providing
4 care to an enrollee.

5 (B) LICENSURE STATUS.—An identifica-
6 tion tag under subparagraph (A) shall state the
7 health care provider’s name and the health care
8 position for which such provider has been li-
9 censed or certified by the State.

10 (C) VISIBILITY.—Such tag shall be visible
11 to the enrollee.

12 (D) EXCEPTION.—The requirement under
13 subparagraph (A) shall not apply where wear-
14 ing such tag poses a threat to the health of a
15 patient (such as in an operating room).

16 (c) DATA COLLECTION.—

17 (1) MEDICAL DATA.—Except as provided in
18 section 105(a), a health plan, in conjunction with its
19 Committee, shall compile data on health care serv-
20 ices provided to enrollees under the health plan in-
21 cluding—

22 (A) enrollee outcome information, includ-
23 ing nosocomial infections, medication errors, en-
24 rollee injury, enrollee mortality, and rate of en-
25 rollee readmission;

1 (B) structure of care provided, including
2 nurse to enrollee ratios, general staffing ratios,
3 injuries to nurses and other staff, and quality
4 of staff; and

5 (C) process of care, including the planning
6 and delivery of care, an assessment of the deliv-
7 ery mechanisms, and safety measures.

8 (2) FINANCIAL DATA.—

9 (A) FINANCIAL REPORT.—Not later than
10 September 30th of each year, a health plan that
11 employs more than 150 individuals shall file,
12 with the Office of the State in which such plan
13 offers health care services, a copy of—

14 (i) any financial report or return filed
15 under Federal or State tax or securities
16 laws;

17 (ii) a statement of any financial inter-
18 est greater than 5 percent or \$5,000,
19 whichever is less, in any other health plan;
20 and

21 (iii) a statement of the nature and
22 outcome of any complaint, lawsuit, arbitra-
23 tion, or other legal proceeding brought
24 against the plan, unless such disclosure is
25 prohibited by court order or law.

1 (B) QUALITY REPORT.—Not later than
2 September 30th of each year, a health plan
3 shall file, with the Office of the State in which
4 that plan offers health care services and the
5 plan’s Committee, a report of all health care
6 quality indicators, criteria, data, or studies used
7 to evaluate, assess, or determine the nature,
8 scope, quality, or staffing of health care serv-
9 ices, and for reductions in or modifications of
10 the provision of health care services.

11 (C) FIRST REPORT.— Such plan shall file
12 its first report not later than September 30th
13 of its first plan year beginning on or after the
14 date of the enactment of this Act.

15 (d) DATA ANALYSIS AND DISSEMINATION.—

16 (1) INFORMATION AVAILABLE TO COMMIT-
17 TEE.—Not later than September 30th of each year,
18 a health plan shall provide the data compiled under
19 subsection (c)(1) to the State agency regulating the
20 plan and to the plan’s Committee. Such agency shall
21 analyze the data and shall submit such analysis to
22 Committees in such State under section 403(a)(2).

23 (2) DISCLOSURE OF NURSING CARE DATA TO
24 ENROLLEES.—Such plan shall provide information

1 to an enrollee about the ratio of non-administrative
2 nurses to enrollees provided under the plan.

3 **SEC. 105. PRIVACY.**

4 (a) ENROLLEE'S PRIVACY RIGHTS.—Prior to the col-
5 lection of data under section 104(c), a health plan shall
6 establish standards and procedures to protect from public
7 disclosure information that identifies an individual and re-
8 lates to such individual's physical or mental health. Such
9 standards and procedures shall not adversely affect the in-
10 tegrity of the data. The health plan shall submit such
11 standards and procedures to the State agency regulating
12 the plan.

13 (b) ENROLLEE'S MEDICAL RECORDS.—A health plan
14 shall protect the privacy of a enrollee's medical records,
15 and may only release such records—

16 (1) to a third party with the informed written
17 consent of the enrollee given at the time the release
18 is sought;

19 (2) to a law enforcement agency pursuant to a
20 warrant issued under the Federal Rules of Criminal
21 Procedure, an equivalent State warrant, a grand
22 jury subpoena, or a court order; or

23 (3) pursuant to a court order, in a civil pro-
24 ceeding upon a showing of compelling need for the

1 information that cannot be accommodated by any
2 other means, if—

3 (A) the enrollee is given reasonable notice,
4 by the person seeking the release, of the court
5 proceeding relevant to the issuance of the court
6 order; and

7 (B) the enrollee is afforded the opportunity
8 to appear and contest the claim of the person
9 seeking the release.

10 (c) EFFECTIVE DATE.—Subsection (b) takes effect
11 30 days after the date of the enactment of this Act.

12 **SEC. 106. FEE.**

13 (a) IN GENERAL.—A health plan, in each State
14 where the plan offers health care services, shall pay to the
15 State 1 percent of the total amount of the annual pre-
16 miums for each year with respect to enrollment in the
17 health plan for such year of individuals residing in the
18 State, as described in section 208.

19 (b) FIRST PAYMENT.—

20 (1) IN GENERAL.—A health plan shall make the
21 first payment under subsection (a) not later than 6
22 months after the first day of the first full month
23 after the date of the enactment of this Act.

24 (2) PAYMENTS PRORATED FROM DATE OF EN-
25 ACTMENT.—Payments due under subsection (a) for

1 the year in which this Act is enacted shall be pro-
2 rated to apply only with respect to months beginning
3 on or after the date of the enactment of this Act.

4 (c) STATE DEFINED.—As used in subsection (a), the
5 term “State” includes the District of Columbia, Puerto
6 Rico, the Virgin Islands, Guam, American Samoa, and the
7 Northern Mariana Islands.

8 **SEC. 107. ENFORCEMENT THROUGH CIVIL PENALTIES.**

9 (a) ENFORCEMENT THROUGH IMPOSITION OF CIVIL
10 MONEY PENALTY.—A health plan that violates any provi-
11 sion of sections 101 through 106 shall be subject to a civil
12 money penalty of—

13 (1) up to \$25,000 for each violation; or

14 (2) up to \$100,000 for each violation if the Sec-
15 retary determines that the plan has engaged, within
16 the 5 years immediately preceding such violation, in
17 a pattern of such violations.

18 (b) PROCEDURES.—The provisions of subsections (c)
19 through (l) of section 1128A of the Social Security Act
20 (42 U.S.C. 1320a–7a) shall apply to civil money penalties
21 under this section in the same manner as they apply to
22 a penalty or proceeding under section 1128A(a) of such
23 Act.

1 **SEC. 108. PROHIBITION ON ADVERSE ACTION.**

2 (a) IN GENERAL.—No health plan may terminate or
3 take other adverse action against any health care provider
4 for actions taken for the purpose of—

5 (1) notifying such plan of conditions which the
6 identifies, in communications with the plan, as dan-
7 gerous or potentially dangerous or injurious to—

8 (A) enrollees who currently receive health
9 care services under the plan;

10 (B) individuals who are likely to receive
11 such services; or

12 (C) health care providers who provide such
13 services;

14 (2) notifying a Federal or State agency or an
15 accreditation agency, compliance with the standards
16 of which have been deemed to demonstrate compli-
17 ance with conditions of participation under the Med-
18 icare program, of such conditions as are identified in
19 paragraph (1);

20 (3) notifying other individuals of conditions
21 which the provider or group of providers reasonably
22 believe to be such as are described in paragraph (1);

23 (4) discussing such conditions as are identified
24 in paragraph (1) with other providers for the pur-
25 poses of initiating action described in paragraph (1),
26 (2), or (3);

1 (5) a medical communication, as defined in sec-
2 tion 101(b); or

3 (6) other related activities as specified in rules
4 made by the Secretary.

5 (b) EXCEPTION.—The protections of this section
6 shall not apply to any health care provider who knowingly
7 or recklessly provides substantially false information to
8 the Secretary.

9 (c) SANCTION.—A determination by the Secretary
10 that a health plan has taken such action as described in
11 subsection (a) shall result in termination from participa-
12 tion in the Medicare program for a period of time to be
13 specified by the Secretary, such period to be not less than
14 1 month.

15 (d) CIVIL ACTION.—A health care provider aggrieved
16 by a violation of subsection (a) may in a civil action obtain
17 appropriate relief. Such relief may include, with respect
18 to a provider, the reinstatement of the provider to his or
19 her former position under the health plan together with
20 the compensation (including back pay), terms, conditions,
21 and privileges associated with such position.

22 (e) EFFECTIVE DATE.—Subsection (a) shall apply to
23 actions taken on or after the date of the enactment of this
24 Act, regardless of when the communication on which the
25 action is based occurred.

1 **TITLE II—OFFICE OF CONSUMER**
2 **ADVOCACY FOR HEALTH**

3 **SEC. 201. ESTABLISHMENT OF OFFICE.**

4 (a) IN GENERAL.—The Secretary, in consultation
5 with the Secretary of Labor, shall establish for each State
6 an independent Office for such State to assist consumers
7 in dealing with problems that arise with respect to health
8 plans and health care providers operating in such State.

9 (b) ESTABLISHMENT THROUGH GRANT PROCESS.—

10 (1) IN GENERAL.—The Secretary shall carry
11 out the requirements of subsection (a) with respect
12 to each State by designating a non-profit organiza-
13 tion located in the State to serve as the Office for
14 the State, under a grant awarded, in consultation
15 with the Secretary of Labor, under a competitive se-
16 lection process. The grant may be awarded only to
17 organizations headed by an individual with expertise
18 and experience in the fields of health care and
19 consumer advocacy, who shall be designated the
20 Consumer Advocate for Health for the State. In
21 awarding such grant, the Secretary, in consultation
22 with the Secretary of Labor, shall—

23 (A) consider any nominations submitted by
24 consumer advocacy organizations in the State;
25 and

1 (B) give preference to organizations that
2 represent a broad spectrum of the diverse
3 consumer interests in the State and that have
4 demonstrated a capability of representing, and
5 working with, a broad diversity of consumers,
6 including members of medically underserved
7 communities.

8 (2) REQUIREMENTS.—Each grant awarded
9 under this subsection shall provide as follows:

10 (A) CENTRAL OFFICE.—A central office of
11 the organization awarded the grant which is lo-
12 cated in the State shall be designated as the
13 Office.

14 (B) LOCAL OFFICES.—The organization
15 awarded the grant shall establish and maintain
16 local offices of the Office in accordance with
17 subsection (c).

18 (C) PERFORMANCE OF SPECIFIED FUNC-
19 TIONS.—The organization shall perform the
20 functions of the Office specified in this title and
21 otherwise ensure that the requirements of this
22 section applicable to the Office are met.

23 (D) EVALUATION OF QUALITY AND EFFEC-
24 TIVENESS OF GRANTEE.—The Secretary, in
25 consultation with the Secretary of Labor, shall

1 evaluate the quality and effectiveness of the or-
2 ganization in carrying out the functions of the
3 Office.

4 (E) TERM OF GRANT AND RENEWABIL-
5 ITY.—Each grant shall be awarded for a term
6 of 4 years and shall be renewable for succeeding
7 4-year terms without reopening the competitive
8 selection process if the grantee has performed
9 properly pursuant to this section and the terms
10 of the grant.

11 (F) NOTICE OF INTENT NOT TO RENEW;
12 RECONSIDERATION.—Not later than 180 days
13 before the expiration of any term under a grant
14 awarded to an organization, if the Secretary at
15 such time intends not to renew the grant with
16 such organization, the Secretary shall notify
17 such organization of such intent, and shall pro-
18 vide such organization an opportunity for recon-
19 sideration by the Secretary, in consultation with
20 the Secretary of Labor, of the Secretary's in-
21 tent not to renew and to present information in
22 support of renewal.

23 (G) TERMINATION BY GRANTEE.—The or-
24 ganization may terminate the grant prior to its

1 expiration upon 180 days notice to the Sec-
2 retary.

3 (H) TERMINATION BY THE SECRETARY.—

4 The Secretary, in consultation with the Sec-
5 retary of Labor, may terminate the grant prior
6 to its expiration upon 180 days notice to the or-
7 ganization if the Secretary, in consultation with
8 the Secretary of Labor, determines that the or-
9 ganization is not meeting the requirements of
10 this section or that the organization is failing
11 substantially to carry out the grant. The Sec-
12 retary, in consultation with the Secretary of
13 Labor, shall provide for an appropriate appeals
14 mechanism, including establishment of a panel
15 of peers, to implement this subparagraph.

16 (c) DELEGATIONS TO LOCAL OFFICES.—

17 (1) IN GENERAL.—The Secretary, in consulta-
18 tion with the Secretary of Labor, shall provide for
19 appropriate delegation by the Consumer Advocate
20 for Health of the authority and responsibilities of
21 the Office to local offices to the extent necessary to
22 effectively carry out the duties and responsibilities of
23 the Consumer Advocate for Health throughout the
24 State.

1 (2) MONITORING.—The Secretary, in consulta-
2 tion with the Secretary of Labor, shall develop and
3 maintain policies and procedures for monitoring
4 such local offices and ensuring compliance by such
5 local offices with the terms of such delegation.

6 (3) PLACEMENT OF LOCAL OFFICE IN EACH
7 COMMUNITY RATING AREA.—

8 (A) IN GENERAL.—Pursuant to such dele-
9 gation, the Consumer Advocate for Health shall
10 ensure that there is located in each community
11 rating area in the State an officer or employee
12 of the Office who is designated to assist individ-
13 uals residing in the area with respect to matters
14 relating to health plans and health care provid-
15 ers operating in the area.

16 (B) ASSIGNMENT OF STAFF FOR EACH
17 PLAN.—Each such office for such area shall
18 have an individual who is assigned with respect
19 to each health plan that enrolls individuals re-
20 siding in the area. Such an individual may be
21 assigned to more than one plan.

22 (C) APPROPRIATE STAFFING.—The Office
23 shall ensure that sufficient staff in each local
24 office is assigned to work with respect to mat-
25 ters relating to each health plan whose enrollees

1 are served by the local office so as to ensure ef-
2 fective and efficient service in such local office
3 with respect to matters relating to such plan.

4 (d) ESTABLISHMENT OF COMMUNITY RATING
5 AREAS.—

6 (1) IN GENERAL.—The Secretary shall provide
7 for the division of each State into 1 or more commu-
8 nity rating areas. Each portion of the State shall be
9 within 1, and only 1, community rating area. The
10 Secretary may revise the boundaries of such areas
11 from time to time consistent with this subsection.

12 (2) MULTIPLE AREAS.—With respect to a com-
13 munity rating area—

14 (A) no metropolitan statistical area in a
15 State may be incorporated into more than 1
16 such area in the State;

17 (B) the number of individuals residing
18 within such an area may not be less than
19 250,000; and

20 (C) no area incorporated in a community
21 rating area may be incorporated into another
22 such area.

23 (3) BOUNDARIES.—

24 (A) IN GENERAL.—In establishing bound-
25 aries for community rating areas, the Secretary

may not discriminate on the basis of or otherwise take into account race, age, language, religion, national origin, socio-economic status, sexual orientation, disability, or perceived health status.

(B) TREATMENT OF CONSOLIDATED METROPOLITAN STATISTICAL AREAS.—A community rating area that includes all of a Consolidated Metropolitan Statistical Area that is within a State is presumed to meet the requirement of subparagraph (A).

**SEC. 202. ASSISTANCE TO INDIVIDUALS WITH GRIEVANCES
AGAINST A HEALTH PLAN.**

(a) IN GENERAL.—An Office shall provide an individual assistance with determining, in connection with any stated grievance against a health plan, the manner and extent to which such grievance may be presented as—

- (1) an issue of denial of items or services, or reimbursement therefor;
- (2) an issue of denial of medical records;
- (3) an issue of malpractice;
- (4) an issue of discrimination;
- (5) an issue of eligibility and payment of subsidies for premium payments and cost sharing;
- (6) an issue of enrollment; or

1 (7) any other violation actionable under this
2 Act.

3 (b) GRIEVANCE ASSISTANCE.—Such Office shall pro-
4 vide, in person and by toll-free telephone access, assist-
5 ance to an individual with a grievance under subsection
6 (a).

7 (c) COMPLAINT FORMS.—Such Office shall create an
8 instruction sheet that explains how to file, maintain, and
9 resolve a complaint against a health plan, and provide
10 such sheet to an individual seeking to file a complaint
11 against a health plan. Such instruction sheet shall be writ-
12 ten in plain language understandable by a layperson, and
13 it shall use a step-by-step format to guide the layperson
14 through each stage of the complaint process.

15 **SEC. 203. ASSURANCE OF ACCESS BY ALL INDIVIDUALS TO**
16 **QUALITY HEALTH CARE.**

17 (a) IN GENERAL.—An Office shall identify, inves-
18 tigate, publicize, promote solutions to, and resolve griev-
19 ances stemming from, any practice, policy, law, or regula-
20 tion of a health plan that may adversely affect access by
21 an individual to quality health care, including a practice,
22 policy, law, or regulation relating to—

23 (1) marketing of the plan;

24 (2) availability of premium and cost sharing
25 subsidies;

13 SEC. 204. FEDERAL INVESTIGATION AND EMERGENCY
14 INTERVENTION.

(b) **FEDERAL INTERVENTION.**—The Secretary may, in cases of compromised safety that are life threatening, initiate emergency investigation of or remedial intervention in services provided or practices undertaken by a health plan.

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1 (1) IN GENERAL.—For purposes of subsection
2 (b), the Secretary shall, by rule, establish guidelines
3 for safety.

4 (2) CONSIDERATION OF DATA.—In establishing
5 and reviewing the guidelines under paragraph (1),
6 the Secretary shall base the guidelines to the maxi-
7 mum extent practicable on the data collected and the
8 analysis performed under this Act.

9 **SEC. 205. ANNUAL REPORT TO THE SECRETARY.**

10 (a) IN GENERAL.—Not later than December 31st of
11 each year, an Office shall submit a report to the Secretary.

12 (b) CONTENT OF REPORT.—The report required by
13 subsection (a) shall include—

14 (1) the nature of consumer complaints against
15 health plans;

16 (2) the percentage of unresolved or outstanding
17 complaints against health plans;

18 (3) discernible patterns from the data collected;

19 (4) recommendations for resolution of unre-
20 solved or outstanding complaints;

21 (5) recommendations to sanction a certain
22 health plan;

23 (6) a copy of any report received from a health
24 plan;

1 (7) a copy of any report received from the Com-
2 mittee which reports to such Office; and

3 (8) information provided by a State agency that
4 regulates health plans in the State.

5 (c) DATE OF FIRST REPORT.—An Office shall file its
6 first report not later than December 31st of the first full
7 calendar year after such Office is established.

8 **SEC. 206. OFFICE ADMINISTRATION.**

9 (a) IN GENERAL.—An Office shall ensure that indi-
10 viduals in each community rating area, as defined in sec-
11 tion 201(d), have regular and timely access to the services
12 provided through the Office and that the individual re-
13 ceives timely responses from a representative of the Office
14 to a request for assistance with a complaint against a
15 health plan.

16 (b) CONFIDENTIALITY OF COMPLAINANTS.—An Of-
17 fice shall provide for a system in the Office to treat as
18 confidential any identifying information regarding com-
19 plainants and other individuals with respect to whom the
20 Office maintain files or records.

21 (c) PERSONNEL QUALIFICATIONS.—An Office shall
22 establish and implement minimum qualification and train-
23 ing requirements for personnel, including volunteers.

1 **SEC. 207. OVERSIGHT.**

2 The Secretary shall ensure that an Office carries out
3 the functions under this title, and such other activities as
4 the Office and the Secretary determine to be appropriate.

5 **SEC. 208. FUNDING OF OFFICE.**

6 (a) FUNDS HELD IN ESCROW.—In accordance with
7 procedures which shall be made by rule under subsection
8 (d), each State shall provide for a mechanism under which
9 the State shall hold in an escrow account 1 percent of the
10 total amount of the annual premiums for each year with
11 respect to enrollment in a health plan for such year of
12 individuals residing in the State. Any funds held in such
13 escrow account shall be available solely for remittance to
14 the Secretary under subsection (b).

15 (b) REMITTANCE TO SECRETARY.—Not later than
16 December 31 of each calendar year, each State shall remit
17 to the Secretary, in such form and manner as shall be
18 prescribed in regulations, the amounts held in escrow pur-
19 suant to subsection (a) for the applicable fiscal year end-
20 ing with or during such calendar year.

21 (c) ALLOCATIONS.—The amounts remitted by each
22 State to the Secretary for each year under subsection (b)
23 shall be applied towards the establishment and operation
24 of the Office for such State under section 201 (including
25 amounts to be distributed to escrow accounts for Commit-
26 tees pursuant to section 306).

1 (d) RULES.—Not later than 180 days after the date
 2 of the enactment of this Act, the Secretary shall make
 3 rules to carry out this section.

4 **TITLE III—INDEPENDENT**
 5 **CONSUMER ADVISORY COM-**
 6 **MITTEES**

7 **SEC. 301. ESTABLISHMENT OF COMMITTEES.**

8 (a) IN GENERAL.—Except as provided in subsection
 9 (b), each health plan shall establish and maintain a Com-
 10 mittee in each community rating area.

11 (b) EXCEPTION.—In the case where there are more
 12 than 100,000 enrollees under a health plan in a commu-
 13 nity rating area, the plan shall establish and maintain as
 14 many Committees as may be necessary so that each Com-
 15 mittee within such area shall not represent more than
 16 100,000 enrollees.

17 **SEC. 302. MEMBERSHIP AND CHAIR.**

18 (a) MEMBERSHIP.—

19 (1) IN GENERAL.—A Committee shall consist of
 20 not fewer than 25 and not more than 50 members.

21 (2) QUALIFICATIONS.—Except as provided in
 22 paragraph (3)(B), members of a Committee shall be
 23 selected from enrollees who indicate interest in such
 24 positions and who are not health care providers, offi-

1 cers or employees of any health plan, or employees
2 of a health care provider.

3 (3) METHOD OF SELECTION.—

4 (A) ENROLLEES.—Except as provided in
5 subparagraph (B), members of a Committee
6 shall be selected biennially at random from each
7 of 4 categories of enrollees, in proportion to
8 their numbers among enrollees represented by
9 the Committee, as follows: senior citizens; par-
10 ents of children under 18 years of age; individ-
11 uals with disabilities; and all other enrollees.

12 (B) EMPLOYEES OF HEALTH PLAN.—Each
13 committee shall have as members at least 3, but
14 in no case more than 5, employees of the health
15 plan selected biennially at random from each of
16 3 categories as follows: staff nurses; physicians;
17 and administrators of the health plan.

18 (4) RECRUITMENT OF MEMBERS.—The Office
19 shall establish guidelines and methods for recruit-
20 ment of members to serve on Committees, including
21 informational inserts in material distributed by such
22 Committees.

23 (b) CHAIR.—Each Committee shall be headed by a
24 chair who shall be—

- 1 (1) a member of the Committee other than a
2 member who is an employee of a health plan; and
3 (2) elected by the Committee at its first meet-
4 ing.

5 (c) COMPENSATION AND EXPENDITURES FOR SERV-
6 ICES.—

7 (1) COMPENSATION OF MEMBERS.—Members of
8 each Committee shall serve without compensation,
9 except that the members shall be reimbursed by the
10 Committee for the reasonable expenses incurred in
11 carrying out their duties as members.

12 (2) EXPENDITURES FOR SERVICES.—The Com-
13 mittee may provide for acquiring the services of such
14 staff and temporary consultants as may be necessary
15 from time to time to carry out the requirements of
16 this title.

17 **SEC. 303. FUNCTIONS OF COMMITTEE.**

18 (a) OUTREACH PROGRAMS.—Each Committee shall
19 develop and coordinate programs for outreach to the com-
20 munity.

21 (b) FORUM TO FACILITATE COMMUNICATION.—Each
22 Committee shall conduct regular meetings of enrollees and
23 representatives of the health plan under such procedural
24 rules as the Committee considers appropriate, so that such

1 meetings will serve as effective forums for facilitating com-
 2 munication between such plan and enrollees.

3 (c) ENSURE ENROLLEE GRIEVANCES ARE AD-
 4 DRESSED.—Each Committee shall conduct such ad hoc
 5 meetings and other activities as may enable the Committee
 6 to ensure that the grievances of enrollees in the area are
 7 generally heard and addressed by the health plan.

8 (d) DISSEMINATION OF CRITERIA FOR ENROLLEE
 9 CARE QUALITY.—Each Committee shall provide to the
 10 community the enrollee care quality criteria established by
 11 the health plan under section 104(c).

12 (e) EVALUATION OF PERFORMANCE OF OFFICE OF
 13 CONSUMER ADVOCACY.—Each Committee shall evaluate
 14 annually the performance of the Office for the State in
 15 which the health plan is located and make recommenda-
 16 tions to the Secretary regarding the appropriateness for
 17 continued service of the Office.

18 **SEC. 304. LIABILITY OF MEMBERS OF COMMITTEE.**

19 No member of a Committee established under this
 20 section shall be liable under any law for the good faith
 21 performance of the functions specified in this title.

22 **SEC. 305. ANNUAL REPORT TO OFFICE.**

23 (a) IN GENERAL.—Not later than October 31st of
 24 each year, each Committee shall submit to the Office for
 25 the State in which the health plan offers health care serv-

1 ices a report providing recommendations for improvements
2 in health care delivery under the plan, and including as-
3 sessments of—

4 (1) the accessibility (by location) of offices and
5 clinics providing items and services under the plan;

6 (2) the condition of health care facilities em-
7 ployed under the plan;

8 (3) the ease with which prescriptions are filled
9 under the plan;

10 (4) delays occurring under the plan in receiving
11 requested medical attention;

12 (5) the time spent by enrollees in waiting rooms
13 under the plan;

14 (6) the complexity of paperwork required under
15 the plan;

16 (7) the courtesy of plan personnel; and

17 (8) such other concerns regarding the plan's
18 system of delivering health care services that the
19 Committee may choose to assess.

20 (b) DATE OF FIRST REPORT.—Each committee shall
21 file its first report not later than October 31st of the first
22 full calendar year after such Committee is established.

23 **SEC. 306. FUNDING FOR COMMITTEES.**

24 (a) ESCROW ACCOUNT FOR COMMITTEES.—In ac-
25 cordance with procedures which shall be made by rule

1 under subsection (e), an Office shall establish and main-
2 tain an escrow account for each Committee established in
3 the State served by the Office.

4 (b) DISTRIBUTION OF FUNDS TO ESCROW ACCOUNT
5 FOR COMMITTEES.—The Office shall annually distribute
6 an amount equal to 25 percent of the total amount remit-
7 ted for the year to the Secretary by the State under sec-
8 tion 208, on the basis of which funds are made available
9 to the Office for the year under title II, in the form of
10 deposits to the escrow accounts maintained by the Office
11 for Committees pursuant to subsection (a). The amounts
12 deposited to such escrow accounts shall be in proportion
13 to the numbers of enrollees represented by the Committees
14 for which such escrow accounts are maintained.

15 (c) WITHDRAWAL OF FUNDS FOR COMMITTEE AT
16 THE REQUEST OF THE CHAIR.—The funds maintained in
17 each such escrow account for a Committee shall be made
18 available for withdrawal by the chair of the Committee
19 upon request of the chair, specifying in writing the pur-
20 pose for the withdrawal.

21 (d) ANNUAL ACCOUNTING.—The Office shall provide
22 the Secretary an annual accounting of the receipts and
23 disbursements made with respect to each such escrow ac-
24 count.

1 (e) RULES.—Not later than 180 days after the date
2 of the enactment of this Act, the Secretary shall make
3 rules to carry out this section.

4 (f) RESTRICTION ON USE OF FUNDS.—Funds with-
5 drawn from an escrow account maintained pursuant to
6 this section for a Committee established pursuant to this
7 title shall be used by the Committee solely for purposes
8 of carrying out its duties under this title.

9 **TITLE IV—COORDINATION**
10 **AMONG OFFICE, COMMIT-**
11 **TEES, AND SECRETARY**

12 **SEC. 401. INTERACTION AMONG OFFICE AND OTHER ORGA-**
13 **NIZATIONS.**

14 An Office shall establish and maintain a system of
15 referrals among the Office, other consumer advocacy orga-
16 nizations, legal assistance providers serving low-income
17 persons, and protection and advocacy systems for individ-
18 uals with disabilities.

19 **SEC. 402. ASSISTANCE TO COMMITTEES.**

20 An Office shall provide technical assistance to the
21 Committees maintained by health plans pursuant to sec-
22 tion 301, and distribute and account for funding for such
23 Committees in accordance with section 306.

1 **SEC. 403. COORDINATED DATA ANALYSIS AND DISSEMINA-**
2 **TION PROCEDURE.**

3 (a) DATA COMPILATION AND SUBMISSION.—

4 (1) IN GENERAL.—Not later than December
5 31st of each year, each Committee shall prepare a
6 summary of its activities under sections 104 and
7 303 and shall submit such summary to the Office
8 from which such Committee received its funds under
9 section 306.

10 (2) TRANSMISSION FROM STATE TO COMMIT-
11 TEE.—Not later than October 31st of each year, the
12 State agency regulating health plans in the State
13 shall submit the analysis under 104(d)(1) to the
14 Committees in the State.

15 (3) TRANSMISSION FROM COMMITTEES TO OF-
16 FICE.—Not later than November 30th of each year,
17 Committees shall compile and analyze information
18 described in sections 104(c)(1) and (c)(2)(B) and
19 submit such information to the Office for the State
20 from which such Committee received its funds under
21 section 306.

22 (4) TRANSMISSION FROM OFFICE TO SEC-
23 RETARY.—Not later than December 31st of each
24 year, the Office shall compile all data received under
25 this Act and shall submit such data to the Secretary.

1 (b) DATA ANALYSIS AND PUBLICATION.—The Sec-
2 retary shall analyze the data received under subsection
3 (a)(4). Based upon such analysis, the Secretary shall de-
4 velop and publish guidelines for patient care quality and
5 shall publish the Secretary’s analysis.

6 (c) USE OF GUIDELINES FOR EVALUATION OF
7 HEALTH PLAN.—An Office and the Committees shall use
8 such guidelines and analysis to evaluate the performance
9 of health plans operating in their community rating areas.

○