105TH CONGRESS
1ST SESSION

S. 346

To assure fairness and choice to patients and health care providers, and for other purposes.

IN THE SENATE OF THE UNITED STATES

FEBRUARY 24, 1997

Mr. WELLSTONE introduced the following bill; which was read twice and referred to the Committee on Labor and Human Resources

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A BILL

To assure fairness and choice to patients and health care providers, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Patient Protection Act of 1997''.

(b) TABLE OF CONTENTS.—The table of contents for this Act are as follows:

SEC. 2. DEFINITIONS.

Unless specifically provided otherwise, as used in this Act:

(1) CARRIER.—The term ''carrier'' means a licensed insurance company, a hospital or medical service corporation (including an existing Blue Cross or Blue Shield organization, within the meaning of section 833(c)(2) of Internal Revenue Code of 1986 as in effect before the date of the enactment of this Act), a health maintenance organization, or other entity licensed or certified by the State to provide health insurance or health benefits.

(2) COVERED INDIVIDUAL.—The term ''covered individual'' means a member, enrollee, subscriber,

covered life, patient or other individual eligible to receive benefits under a health plan.

(3) EMERGENCY SERVICES.—The term ''emergency services'' means those health care services that are provided to a patient after the sudden onset of a health condition that manifests itself by symptoms of sufficient severity, including severe pain, and the absence of such immediate health care attention could reasonably be expected, to result in—

(A) placing the patient's health in serious jeopardy;

(B) serious impairment to bodily function; or

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

(4) HEALTH PLAN.—The term ''health plan'' includes any organization that seeks to arrange for, or provide for the financing and coordinated delivery of, health care services directly or through a contracted health provider panel, and shall include health maintenance organizations, preferred provider organizations, single service health maintenance organizations, single service preferred provider organizations, other entities such as provider-hospital or hospital-provider organizations, employee welfare

benefit plans (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(1)), and multiple employer welfare plans or other association plans, as well as carriers.

(5) HEALTH PROVIDER.—The term ''health provider'' means an individual who is licensed or certified under State law to provide health care services and who is operating within the scope of such licensure or certification.

(6) MANAGED CARE PLAN.—

(A) IN GENERAL.—The term ''managed care plan'' means a plan operated by a managed care entity (as defined in subparagraph (B)), that provides for the financing and delivery of health care services to persons enrolled in such plan through—

(i) arrangements with selected providers to furnish health care services;

(ii) explicit standards for the selection of participating providers;

(iii) organizational arrangements for ongoing quality assurance, utilization review programs, and dispute resolution; and

(iv) financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the plan.

(B) MANAGED CARE ENTITY.—The term ''managed care entity'' includes a licensed insurance company, hospital or medical service plan (including provider and provider-hospital networks), health maintenance organization, an employer or employee organization, or a managed care contractor (as defined in subparagraph (C)), that operates a managed care plan.

(C) MANAGED CARE CONTRACTOR.—The term ''managed care contractor'' means a person that—

(i) establishes, operates, or maintains a network of participating providers;

(ii) conducts or arranges for utilization review activities; and

(iii) contracts with an insurance company, a hospital or health service plan, an employer, an employee organization, or any other entity providing coverage for health care services to operate a managed care plan.

(7) PROVIDER NETWORK.—The term ''provider network'' means, with respect to a health plan that restricts access, those providers who have entered into a contract or agreement with the plan under which such providers are obligated to provide items and services under the plan to eligible individuals enrolled in the plan, or have an agreement to provide services on a fee-for-service basis.

(8) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services unless specifically provided otherwise.

(9) SPECIALIZED TREATMENT EXPERTISE.—The term ''specialized treatment expertise'' means expertise in diagnosing and treating unusual diseases and conditions, diagnosing and treating diseases and conditions that are usually difficult to diagnose or treat, and providing other specialized health care.

(10) SPONSOR.—The term ''sponsor'' means a carrier or employer that provides a health plan.

(11) UTILIZATION REVIEW.—The term ''utilization review'' means a set of formal techniques designed to monitor and evaluate the clinical necessity, appropriateness and efficiency of health care services, procedures, providers and facilities. Techniques

may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning and retrospective review.

TITLE I—OFFICE FOR CONSUMER INFORMATION, COUNSELING AND ASSISTANCE WITH HEALTH CARE

SEC. 101. ESTABLISHMENT.

(a) IN GENERAL.—The Secretary shall award a grant to each State and each State shall use amounts received under the grant to establish an Office for Consumer Information, Counseling and Assistance with Health Care (referred to in this section as the ''Office''). Each such Office shall perform public outreach and provide education and assistance concerning consumer rights with respect to health insurance and benefits as provided for in subsection (d).

(b) USE OF GRANT.—

(1) IN GENERAL.—A State shall use a grant under this section—

(A) to administer the Office and carry out the duties described in subsection (d);

(B) to solicit and award contracts to private, nonprofit organizations applying to the

State to administer the Office and carry out the duties described in subsection (d); or

(C) in the case of a State operating a consumer information counseling and assistance program on the date of enactment of this Act, to expand and improve such program.

(2) CONTRACTS.—With respect to the contract described in paragraph (1)(B), the contract period shall be not less than 2 years and not more than 4 years.

(c) STAFF.—A State shall ensure that the Office has sufficient staff (including volunteers) and local offices throughout the State to carry out its duties under this section and a demonstrated ability to represent and work with a broad spectrum of consumers, including vulnerable and underserved populations.

(d) DUTIES.—An Office established under this section shall—

(1) establish a State-wide toll-free hotline to enable consumers to contact the Office;

(2) have the ability to provide culturally appropriate assistance that as far as practicable takes into consideration under this subsection language needs;

(3) develop outreach programs to provide health insurance and health benefits information, counseling, and assistance;

(4) provide outreach and education relating to consumer rights and responsibilities under this Act, including the rights and services available through the Office;

(5) provide individuals with assistance in enrolling in health plans (including providing plan comparisons), or in obtaining services or reimbursements from health plans;

(6) provide individuals with assistance in filing applications for appropriate State health plan premium assistance programs;

(7) provide individuals with information and advocacy concerning existing grievance procedures and institute systems of referral to appropriate Federal or State departments or agencies for assistance with problems related to insurance coverage (including legal problems);

(8) ensure that regular and timely access is provided to the services available through the Office;

(9) implement training programs for staff members (including volunteer staff members) and collect

and disseminate timely and accurate health care information to staff members;

(10) not less than once each year, conduct public hearings to identify and address community health care needs;

(11) coordinate its activities with the staff of the appropriate departments and agencies of the State government and other appropriate entities within the State; and

(12) carry out any other activities determined appropriate by the Secretary.

(e) STATE DUTIES.—

(1) ACCESS TO INFORMATION.—The State shall ensure that, for purposes of carrying out the duties of the Office, the Office has appropriate access to relevant information, subject to the application of procedures to ensure confidentiality of enrollee and proprietary health plan information.

(2) REPORTING AND EVALUATION REQUIREMENTS.—

(A) REPORT.—The Office shall annually prepare and submit to the State a report on the nature and patterns of consumer complaints received by the Office during the year for which

the report is prepared. Such report shall contain any policy, regulatory, and legislative recommendations for improvements in the activities of the Office together with a record of the activities of the Office.

(B) EVALUATION.—The State shall annually evaluate the quality and effectiveness of the Office in carrying out the activities described in subsection (d).

(3) CONFLICTS OF INTEREST.—The State shall ensure that no individual involved in selecting the entity with which to enter into a contract under subsection (b)(1)(B), or involved in the operation of the Office, or any delegate of the Office, is subject to a conflict of interest.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

TITLE II—UTILIZATION MANAGEMENT

SEC. 201. DEFINITIONS.

As used in this title:

(1) ADVERSE DETERMINATION.—The term ''adverse determination'' means a determination that an admission to or continued stay at a hospital or that

another health care service that is required has been reviewed and, based upon the information provided, does not meet the requirements for clinical necessity, appropriateness, level of care, or effectiveness.

(2) AMBULATORY REVIEW.—The term ''ambulatory review'' means utilization review of health care services performed or provided in an outpatient setting.

(3) APPEALS PROCEDURE.—The term ''appeals procedure'' means a formal process under which a covered individual (or an individual acting on behalf of a covered individual), attending provider or facility may appeal an adverse utilization review decision rendered by the health plan or its designee utilization review organization.

(4) CARE COORDINATOR.—The term ''care coordinator'' means a health provider who performs case management functions in consultation with the interdisciplinary health care team, the patient, family, and community.

(5) CASE MANAGEMENT.—The term ''case management'' means a coordinated set of activities conducted for the individual patient management of serious, complicated, protracted or chronic health conditions that provides cost-effective and benefit-maximizing treatments for extremely resource-intensive conditions.

(6) CLINICAL REVIEW CRITERIA.—The term ''clinical review criteria'' means the recorded (written or otherwise) screening procedures, decision abstracts, clinical protocols and practice guidelines used by the health plan to determine necessity and appropriateness of health care services.

(7) COMPARABLE.—The term ''comparable'' means a health provider who is licensed or certified in a manner that permits the provider to authorize the equipment, services, or procedures that are the subject of a review.

(8) CONCURRENT REVIEW.—The term ''concurrent review'' means utilization review conducted during a patient's hospital stay or course of treatment.

(9) DISCHARGE PLANNING.—The term ''discharge planning'' means the formal process for determining, coordinating and managing the care a patient receives following the discharge of the patient from a facility.

(10) FACILITY.—The term ''facility'' means an institution or health care setting providing the prescribed health care services under review. Such term includes hospitals and other licensed inpatient facilities, ambulatory surgical or treatment centers, skilled nursing facilities, residential treatment centers, diagnostic, laboratory and imaging centers and rehabilitation and other therapeutic health care settings.

(11) PROSPECTIVE REVIEW.—The term ''prospective review'' means utilization review conducted prior to an admission or a course of treatment.

(12) RETROSPECTIVE REVIEW.—The term ''retrospective review'' means utilization review conducted after health care services have been provided to a patient. Such term does not include the retrospective review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding and adjudication for payment.

(13) SECOND OPINION.—The term ''second opinion'' means an opportunity or requirement to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service.

(14) UTILIZATION REVIEW ORGANIZATION.—The term ''utilization review organization'' means an entity that conducts utilization review.

SEC. 202. REQUIREMENT FOR UTILIZATION REVIEW PROGRAM.

A health plan shall have in place a utilization review program that meets the requirements of this title and that is certified by the State.

SEC. 203. STANDARDS FOR UTILIZATION REVIEW.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services, in consultation with the Secretary of Labor (referred to in this title as the ''Secretaries''), shall establish standards for the establishment, operation, and certification and periodic recertification of health plan utilization review programs.

(b) ALTERNATIVE STANDARDS.—

(1) IN GENERAL.—A State may certify a health plan as meeting the standards established under

subsection (a) if the State determines that the health plan has met the utilization standards required for accreditation as applied by a nationally recognized, independent, nonprofit accreditation entity.

(2) REVIEW BY STATE.—A State that makes a determination under paragraph (1) shall periodically review the standards used by the private accreditation entity to ensure that such standards meet or exceed the standards established by the Secretaries under this title.

(c) UTILIZATION REVIEW PROGRAM REQUIREMENTS.—The standards developed by the Secretaries under subsection (a) shall require that utilization review programs comply with the following:

(1) DOCUMENTATION.—A health plan shall provide a written description of the utilization review program of the plan, including a description of—

(A) any activities assigned from the health plan to other entities;

(B) the policies and procedures used under the program to evaluate clinical necessity; and

(C) the clinical review criteria, information sources, and the process used to review and approve the provision of health care services under the program.

(2) PROHIBITION.—With respect to the administration of the utilization review program, a health plan may not employ utilization reviewers or contract with a utilization management organization if the conditions of employment or the contract terms include financial incentives to reduce or limit the provision of clinically necessary or appropriate services to covered individuals.

(3) REVIEW AND MODIFICATION.—A health plan shall develop procedures for periodically reviewing and modifying the utilization review of the plan. Such procedures shall provide for the participation of providers and consumers in the health plan in the development and review of utilization review policies and procedures.

(4) DECISION PROTOCOLS.—

(A) IN GENERAL.—A utilization review program shall develop and apply recorded (written or otherwise) utilization review decision protocols. Such protocols shall be based on sound health care evidence.

(B) PROTOCOL CRITERIA.—The clinical review criteria used under the utilization review decision protocols to assess the appropriateness of health care services shall be clearly documented and available to participating health providers upon request. Such protocols shall include a mechanism for assessing the consistency of the application of the criteria used under the protocols across reviewers, and a mechanism for periodically updating such criteria.

(5) REVIEW AND DECISIONS.—

(A) REVIEW.—The procedures applied under a utilization review program with respect to the preauthorization and concurrent review of the necessity and appropriateness of health care devices, services or procedures, shall require that qualified, comparable health care providers supervise review decisions. With respect to a decision to deny the provision of health care devices, services or procedures, a comparable provider shall conduct a subsequent review to determine the clinical appropriateness of such a denial. Comparable health providers from the appropriate specialty area shall be utilized in the review process.

(B) DECISIONS.—All utilization review decisions shall be made in a timely manner, as determined appropriate when considering the urgency of the situation.

(C) ADVERSE DETERMINATIONS.—With respect to utilization review, an adverse determination or noncertification of an admission, continued stay, or service shall be clearly documented, including the specific clinical or other reason for the adverse determination or noncertification, and be available to the covered individual and the affected provider or facility. A health plan may not deny or limit coverage with respect to a service that the enrollee has already received solely on the basis of lack of prior authorization or second opinion, to the extent that the service would have otherwise been covered by the plan had such prior authorization or a second opinion been obtained.

(D) NOTIFICATION OF DENIAL.—A health plan shall provide a covered individual with timely notice of an adverse determination or noncertification of an admission, continued

stay, or service. Such a notification shall include information concerning the utilization review program appeals procedure as well as the telephone number for the Office.

(6) REQUESTS FOR AUTHORIZATION.—A health plan utilization review program shall ensure that requests by covered individuals or providers for prior authorization of a nonemergency service shall be answered in a timely manner after such request is received. If utilization review personnel are not available in a timely fashion, any health care services provided shall be considered approved.

(7) NEW TECHNOLOGIES.—A utilization review program shall implement policies and procedures to evaluate the appropriate use of new health care technologies or new applications of established technologies, including health care procedures, drugs, and devices. The program shall ensure that appropriate providers participate in the development of technology evaluation criteria.

(8) SPECIAL RULE.—Where prior authorization for a service or other covered item is obtained under a program under this section, the service shall be considered to be covered unless there was intentional fraud or intentionally incorrect information provided

at the time such prior authorization was obtained. If a provider intentionally supplied the incorrect information that led to the authorization of clinically unnecessary care, the provider shall be prohibited from collecting payment directly from the enrollee, and shall reimburse the plan and subscriber for any payments or copayments the provider may have received.

(d) HEALTH PLAN REQUIREMENTS.—

(1) DISCLOSURE OF INFORMATION.—

(A) PROSPECTIVE COVERED INDIVIDUALS.—A health plan shall, with respect to any materials distributed to prospective covered individuals, include a summary of the utilization review procedures of the plan.

(B) COVERED INDIVIDUALS.—A health plan shall, with respect to any materials distributed to newly covered individuals, include a clear and comprehensive description of utilization review procedures of the plan and a statement of patient rights and responsibilities with respect to such procedures.

(C) STATE OFFICIALS.—

(i) IN GENERAL.—A health plan shall disclose to the State insurance commissioner, or other designated State official, the health plan utilization review program policies, procedures, and reports required by the State for certification.

(ii) STREAMLINING OF PROCEDURES.—To the extent practicable, a State shall implement procedures to streamline the process by which a health plan documents compliance with the requirements of this Act, including procedures to condense the number of documents filed with the State concerning such compliance.

(2) TOLL-FREE NUMBER.—A health plan shall have a membership card which shall have printed on the card the toll-free telephone number that a covered individual should call to receive precertification utilization review decisions.

(3) EVALUATION.—A health plan shall establish mechanisms to evaluate the effects of the utilization review program of the plan through the use of member satisfaction data or through other appropriate means.

(e) EMERGENCY CARE.—

(1) EMERGENCY MEDICAL CONDITION.—For purposes of this section the term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

(A) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(B) serious impairment to bodily functions, or

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

(2) PREAUTHORIZATION.—With respect to emergency services furnished in a hospital emergency department, a health plan shall not require prior authorization for the provision of such services if the enrollee arrived at the emergency department with symptoms that reasonably suggested an emergency medical condition based on the judgment of a

prudent layperson, regardless of whether the hospital was affiliated with the health plan. All procedures performed during the evaluation and treatment of an emergency medical condition shall be covered under the health plan.

TITLE III—HEALTH PLAN STANDARDS

SEC. 301. HEALTH PLAN STANDARDS.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services, in conjunction with the Secretary of Labor (referred to in this title as the ''Secretaries''), shall establish standards for the certification and periodic recertification of health plans, including standards which require plans to meet the requirements of this title.

(b) STATE CERTIFICATION.—

(1) IN GENERAL.—A State shall provide for the certification of health plans if the certifying authority designated by the State determines that the plan meets the applicable requirements of this Act.

(2) REQUIREMENT.—Effective on January 1, 1999, a health plan sponsor may only offer a health plan in a State if such plan is certified by the State under paragraph (1).

(c) CONSTRUCTION.—Whenever in this title a requirement or standard is imposed on a health plan, the

requirement or standard is deemed to have been imposed on the sponsor of the plan in relation to that plan.

SEC. 302. MINIMUM SOLVENCY REQUIREMENTS.

(a) IN GENERAL.—Except as provided in subsection (b), each State shall apply minimum solvency requirements to all health plans offered or operating within the State to ensure the fiscal integrity of such plans. A health plan shall meet the financial reserve requirements that are established by the State to assure proper payment for health care services provided under the plan. Such requirements may include plan participation in a mechanism to provide for indemnification of plan failures even if a plan has met the reserve requirements.

(b) FEDERAL STANDARDS.—The Secretaries shall establish minimum solvency standards that shall apply to all self-insured health plans. Such standards shall at least meet the solvency requirements established by the National Association of Insurance Commissioners.

SEC. 303. INFORMATION ON TERMS OF PLAN.

(a) IN GENERAL.—A health plan shall provide prospective covered individuals with written information concerning the terms and conditions of the health plan to enable such individuals to make informed decisions with respect to a certain system of health care delivery. Such information shall be standardized so that prospective covered individuals may compare the attributes of all such plans offered within the coverage area.

(b) UNDERSTANDABILITY.—Information provided under this section, whether written or oral shall be easily understandable, truthful, linguistically appropriate and objective with respect to the terms used. Descriptions provided in such information shall be consistent with standards developed for supplemental insurance coverage under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(c) REQUIRED INFORMATION.—Information required under this section shall include information concerning—

(1) coverage provisions, benefits, and any exclusions by category of service or product;

(2) plan loss ratios with an explanation that such ratios reflect the percentage of the premiums expended for health services;

(3) prior authorization or other review requirements including preauthorization review, concurrent

review, post-service review, post-payment review and procedures that may lead the patient to be denied coverage for, or not be provided, a particular service or product;

(4) an explanation of how plan design impacts enrollees, including information on the financial responsibility of covered individuals for payment for coinsurance or other out-of-plan services;

(5) covered individual satisfaction statistics, including disenrollment statistics and satisfaction statistics from those who disenroll;

(6) advance directives and organ donation;

(7) the characteristics and availability of health care providers and institutions participating in the plan, including descriptions of the financial arrangements or contractual provisions with hospitals, utilization review organizations, physicians, or any other provider of health care services that would affect the services offered, referral or treatment options, or provider's fiduciary responsibility to patients, including financial incentives regarding the provision of services; and

(8) quality indicators for the plan and for participating health providers under the plan, including population-based statistics such as immunization

rates and performance measures such as survival after surgery, adjusted for case mix.

SEC. 304. ACCESS.

(a) IN GENERAL.—A health plan shall demonstrate that the plan has a sufficient number, distribution, and variety of qualified health care providers to ensure that all covered health care services will be available and accessible in a timely manner to adults, infants, children, and individuals with disabilities enrolled in the plan. Plans shall make reasonable efforts to address issues of cultural competence and appropriateness with respect to providers.

(b) AVAILABILITY OF SERVICES.—A health plan shall ensure that services covered under the plan are available in a timely manner that ensures a continuity of care, are accessible within a reasonable proximity to the residences of the enrollees, are available within reasonable hours of operation, and include emergency and urgent care services when clinically necessary and available which shall be accessible within the service area 24-hours a day, seven days a week.

(c) SPECIALIZED TREATMENT.—A health plan shall demonstrate that plan enrollees have meaningful access, when clinically indicated in the judgment of the treating health provider, to specialized treatment expertise.

(d) CHRONIC CONDITIONS.—

(1) IN GENERAL.—Any process established by a health plan to coordinate care and control costs may not impose an undue burden on enrollees with chronic health conditions. The plan shall ensure a continuity of care and shall, when clinically indicated in the judgment of the treating health provider, ensure ongoing direct access to relevant specialists for continued care.

(2) CARE COORDINATOR.—In the case of an enrollee who has a severe, complex, or chronic condition, the health plan shall determine, based on the judgment of the treating health provider, whether it is clinically necessary or appropriate to use a care coordinator from an interdisciplinary team.

(e) REQUIREMENT.—

(1) IN GENERAL.—The requirements of this section may not be waived and shall be met in all areas where the health plan has enrollees, including rural areas. With respect to children, such services shall include pediatric and pediatric specialty services.

(2) OUT-OF-NETWORK SERVICES.—If a health plan fails to meet the requirements of this section, the plan shall arrange for the provision of out-of-

network services to enrollees in a manner that provides enrollees with access to services in accordance with the principles and parameters set forth in this section.

SEC. 305. CREDENTIALING FOR HEALTH PROVIDERS.

(a) IN GENERAL.—A health plan shall credential health providers furnishing health care services under the plan.

(b) CREDENTIALING PROCESS.—

(1) IN GENERAL.—A health plan shall establish a credentialing process. Such process shall ensure that a health provider is credentialed prior to that provider being listed as a health provider in the health plan's marketing materials, in accordance with recorded (written or otherwise) policies and procedures.

(2) RESPONSIBILITY CHIEF HEALTH CARE OFFICER.—The chief health care officer of the health plan, or another designated health provider, shall have responsibility for the credentialing of health providers under the plan.

(3) UNIFORM APPLICATIONS.—A State shall develop a basic uniform application that shall be used by all health plans in the State for credentialing purposes.

(4) STANDARDS.—

(A) IN GENERAL.—Credentialing decisions under a health plan shall be based on objective standards with input from health providers credentialed under the plan. Information concerning all application and credentialing policies and procedures shall be made available for review by the health providers involved upon written request.

(B) RIGHT TO REVIEW INFORMATION.—A health provider who undergoes the credentialing process shall have the right to review the basis information, including the sources of that information, that was used to meet the designated credentialing criteria.

SEC. 306. GRIEVANCE PROCEDURES.

(a) IN GENERAL.—A health plan shall adopt a timely and organized system for resolving complaints and formal grievances filed by covered individuals. Such system shall include—

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

(2) documentation concerning the substance of complaints, grievances, and actions taken concerning

such complaints and grievances, which shall be in writing, and be available upon request to the Office for Consumer Information, Counseling and Assistance with Health Care;

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

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

(5) procedures to expedite the complaint process if the complaint involves a dispute about the coverage of an immediately and urgently needed service; and

(6) procedures to ensure that if an enrollee orally notifies a health plan about a complaint, the plan (if requested) must send the enrollee a complaint form that includes the telephone numbers and addresses of member services, a description of the plan's grievance procedure, and the telephone number of the Officer for Consumer Information, Counseling and Assistance with Health Care where enrollees may register complaints.

(b) APPEAL PROCESS.—A health plan shall adopt an appeals process to enable covered individuals and providers to appeal decisions that are adverse to the covered individuals. Such a process shall include—

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

(2) the right to a second review with a different panel, independent from the health plan; and

(3) an expedited process for review in emergency cases.

The Secretaries shall develop guidelines for the structure and requirements applicable to the independent review panel.

(c) NOTIFICATION.—With respect to the complaint, grievance, and appeals processes required under this section, a health plan shall, upon the request of a covered individual, provide the individual a written decision concerning a complaint, grievance, or appeal in a timely fashion.

(d) NON-IMPEDIMENT TO BENEFITS.—The complaint, grievance, and appeals processes established in accordance with this section may not be used in any fashion to discourage, prevent, or deny a covered individual from receiving clinically necessary care in a timely manner.

(e) DUE PROCESS WITH RESPECT TO CREDENTIALING.—

(1) RECEIPT OF INFORMATION.—A health provider who is subject to credentialing under section 305 shall, upon written request, receive from the health plan any information obtained by the plan

during the credentialing process that, as determined by the credentialing committee, does not meet the credentialing standards of the plan, or that varies substantially from the information provided to the health plan by the health provider.

(2) SUBMISSION OF CORRECTIONS.—A health plan shall have a formal, recorded (written or otherwise) process by which a health provider may submit supplemental information to the credentialing committee if the health provider determines that erroneous or misleading information has been previously submitted. The health provider may request that such information be reconsidered in the evaluation for credentialing purposes.

(3) NO ENTITLEMENT.—

(A) IN GENERAL.—A health provider is not entitled to be selected or retained by a health plan as a participating or contracting provider whether or not such provider meets the credentialing standards established under section 305.

(B) ECONOMIC CONSIDERATIONS.—If economic considerations, including the health care provider's patterns of expenditure per patient,

are part of a selection decision, objective criteria shall be used in examining such considerations and a written description of such criteria shall be provided to applicants, participating health providers, and enrollees. Any economic profiling of health providers must be adjusted to recognize case mix, severity of illness, and the age and gender of patients of a health provider's practice that may account for higher or lower than expected costs, to the extent appropriate data in this regard is available to the health plan.

(4) TERMINATION, REDUCTION, OR WITHDRAWAL.—

(A) PROCEDURES.—A health plan shall develop and implement procedures for the reporting, to appropriate authorities, of serious quality deficiencies that result in the suspension or termination of a contract with a health provider.

(B) REVIEW.—A health plan shall develop and implement policies and procedures under which the plan reviews the contract privileges of health providers who—

(i) have seriously violated policies and procedures of the health plan;

(ii) have lost their privilege to practice with a contracting institutional provider; or

(iii) otherwise pose a threat to the quality of service and care provided to the enrollees of the health plan.

At a minimum, the policies and procedures implemented under this subparagraph shall meet the requirements of the Health Care Quality Improvement Act of 1986.

(C) COMMUNICATION.—Health plans shall not restrict nor inhibit communication between providers and patients or penalize a provider making public the failure of the health plan to comply with the provisions of this Act.

(D) LIABILITY.—A health plan shall not require a provider to sign any type of hold-harmless agreement as a requirement for participation in the health plan.

(E) DUE PROCESS.—The policies and procedures implemented under subparagraph (B)

shall include requirements for the timely notification of the affected health provider of the reasons for the reduction, withdrawal, or termination of privileges, and shall provide the health provider with the right to appeal initially to the health plan and subsequently, upon failure to resolve a dispute, to an independent entity, the determination of reduction, withdrawal, or termination. No reduction, withdrawal, or termination of privileges shall be made without cause.

(F) AVAILABILITY.—A written copy of the policies and procedures implemented under this paragraph shall be made available to a health provider on request prior to the time at which the health provider contracts to provide services under the plan.

SEC. 307. CONFIDENTIALITY STANDARDS.

(a) IN GENERAL.—A health plan shall ensure that the confidentiality of specified enrollee patient information and records is protected.

(b) POLICIES AND PROCEDURES.—A health plan shall have written confidentiality policies and procedures. Such policies and procedures shall, at a minimum—

(1) protect the confidentiality of enrollee patient information within the administrative structure of the health plan with special attention to sensitive health conditions and history;

(2) protect health care record information;

(3) protect claim information;

(4) establish requirements for the release of information; and

(5) inform health plan employees of the confidentiality policies and procedures and enforce compliance with such policies and procedures.

(c) PATIENT CARE PROVIDERS AND FACILITIES.—A health plan shall ensure that providers, offices, and facilities responsible for providing covered items or services to plan enrollees have implemented policies and procedures to prevent the unauthorized or inadvertent disclosure of confidential patient information to individuals who should not have access to such information.

(d) RELEASE OF INFORMATION.—An enrollee in a health plan shall have the opportunity to approve or disapprove the release of identifiable personal patient information by the health plan, except where such release is required under applicable law.

SEC. 308. DISCRIMINATION.

(a) ENROLLEES.—A health plan (network or non-network) may not discriminate or engage (directly or through contractual arrangements) in any activity, including the selection of service area, that has the effect of discriminating against an individual on the basis of race, culture, national origin, gender, language, socio-economic status, age, disability, health status including genetic information, or anticipated utilization of health services.

(b) PROVIDERS.—A health plan may not discriminate in the selection of members of the health provider or provider network (and in establishing the terms and conditions for membership in the network) of the plan based on—

(1) the race, national origin, culture, age, or disability of the health provider; or

(2) the socio-economic status, disability, health status, or anticipated utilization of health services of the patients of the health provider.

SEC. 309. PROHIBITION ON SELECTIVE MARKETING.

A health plan may not engage in marketing or other practices intended to discourage or limit the issuance of health plans to individuals on the basis of health condition, geographic area, industry, or other risk factors.

TITLE IV—MISCELLANEOUS PROVISIONS

SEC. 401. ENFORCEMENT.

(a) IN GENERAL.—A State shall prohibit the offering or issuance of any health plan in such State if such plan does not—

(1) have in place a utilization review program that is certified by the State as meeting the requirements of title II;

(2) comply with the standards developed under title III;

(3) have in place a credentialing program that meets the requirements of section 305;

(4) comply with the requirements of title IV; and

(5) meet any other requirements determined appropriate by the Secretary.

(b) SELF-INSURED PLANS.—The Secretary of Labor may take corrective action to terminate or disqualify a self-insured plan that does not meet the standards developed under this subsection.

SEC. 402. EFFECTIVE DATE.

(a) IN GENERAL.—Except as otherwise provided in this section, this Act shall take effect on the date of enactment of this Act.

(b) STANDARDS.—The standards and programs required under this Act shall apply to health plans beginning on January 1, 1999.

(c) OFFICE FOR CONSUMER INFORMATION, COUNSELING, AND ASSISTANCE WITH HEALTH CARE.—A State shall have in place the Office required under section 101 on January 1, 1999. The Secretary may award grants for the establishment of such Offices beginning on the date of enactment of this Act.

(d) OTHER REQUIREMENTS.—The requirements of title IV shall apply to health plans beginning on January 1, 1999.

(e) REGULATIONS.—The Secretaries described in section 301(a) may promulgate regulations to carry out this Act.

SEC. 403. PREEMPTION.

Nothing in this Act shall be construed to preempt any State law, or the implementation of such a State law, that provides protections for individuals that are equivalent to or stricter than the provisions of this Act.

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