II

105TH CONGRESS
1ST SESSION

S. 795

To improve the quality of health plans and health care that is provided through the Federal Government and to protect health care consumers.

IN THE SENATE OF THE UNITED STATES

MAY 22, 1997

Mr. LIEBERMAN (for himself, Mr. JEFFORDS, Mr. CHAFEE, Mr. BREAUX, Ms. COLLINS, and Mr. ROCKEFELLER) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To improve the quality of health plans and health care that is provided through the Federal Government and to protect health care consumers.

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 ''Federal Health Care Quality, Consumer Information and Protection Act''.

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

SEC. 2. FINDINGS AND PURPOSES.

(a) FINDINGS.—Congress finds that—

(1) the Federal Government has unique influence in the health care marketplace due to its role as the largest purchaser of health care services;

(2) there are wide variations in the quality of care as well as concern with the minimum level of care offered to participants and beneficiaries in programs of the Federal Government;

(3) participants and beneficiaries lack information on the quality of health care services provided by health care plans to guide them in selecting a health plan and to support, maintain, and improve their health; and

(4) providing information about the quality of health care would assist competition based on quality that will increase the quality of health care services for all.

(b) PURPOSES.—It is the purpose of this Act—

(1) to use the purchasing power of the Federal Government to continually improve the quality of health care services for participants and beneficiaries in Federal health care programs by empowering health care professionals and participants and beneficiaries through the provision of better information for use in making health care decisions;

(2) to provide a mechanism for the development of health care benchmarks to be used to compare one Federal health plan contract with another;

(3) to provide for the dissemination of comparative information to participants and beneficiaries to assist them in their selection of health plans;

(4) to provide for the establishment of a Federal Health Plan Quality Council to develop certifi-

cation criteria for Federal health plan contractors and to otherwise promote the protection of participants and beneficiaries in Federal health care programs;

(5) to provide for ongoing research into better health care measurement systems;

(6) to provide uniformity across Federal agencies and health plans for participants and beneficiaries in Federal health care programs with respect to minimum criteria and comparative benchmarks used to evaluate health care quality;

(7) to provide a basis for valuing health care services provided by different health plans for participants and beneficiaries in Federal health care programs; and

(8) to increase coordination among private and public purchasers of health care services and patient and consumer representatives to develop an increased level of public involvement in improving the quality of health care and health status.

SEC. 3. DEFINITIONS.

In this Act:

(1) COUNCIL.—The term ''Council'' means the Federal Health Plan Quality Council established under section 101.

(2) FEDERAL HEALTH PLAN CONTRACTOR.—The term ''Federal health plan contractor'' means any entity that contracts with a Federal agency (or a State or local entity in the case of contracts under title XIX of the Social Security Act), as authorized under any Federal program, to provide or pay the cost of medical care, or to otherwise provide health insurance coverage through such program (referred to as a ''Federal health plan contract''), including—

(A) health insurance coverage under the Federal Employee Health Benefit Program under title 5, United States Code;

(B) coverage provided by an eligible organization under section 1876 of the Social Security Act (42 U.S.C. 1395mm) or an entity operating under a waiver from the provisions of the medicare program under title XVIII of such Act and providing items and services to individuals eligible for such program on a capitated basis;

(C) coverage through a health maintenance organization or other entity that contracts with the State to provide medical assistance to individuals under the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.);

(D) coverage through a health maintenance organization or other entity that contracts with the Secretary of Defense to provide medical assistance to individuals under the TRICARE program established under the authority of chapter 55 of title 10, United States Code; and

(E) coverage through a health maintenance organization or other entity that contracts with the Secretary of Veterans Affairs to provide medical assistance to individuals under a veterans health care program under chapter 17 of title 38, United States Code.

(3) HEALTH CARE PROVIDER.—The term ''health care provider'' means anyone licensed or certified under State law to provide health care services who is operating within the scope of such license.

(4) INSTITUTE.—The term ''Institute'' means the Quality Advisory Institute established under section 104.

(5) LICENSED CERTIFYING ENTITY.—The term ''licensed certifying entity'' means an entity licensed by the Council to provide certification services under title III.

(6) MEDICAL CARE.—The term ''medical care'' means amounts paid for—

(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body;

(B) transportation primarily for and essential to medical care referred to in subparagraph (A); and

(C) insurance covering medical care referred to in subparagraphs (A) and (B).

(7) STATE.—The term ''State'' means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

TITLE I—FEDERAL HEALTH PLAN QUALITY COUNCIL

SEC. 101. ESTABLISHMENT.

(a) IN GENERAL.—There is established an independent council to be known as the ''Federal Health Plan Quality Council''.

(b) GENERAL DUTIES.—The Council shall—

(1)(A) monitor, oversee, and ensure the effective evaluation of health care programs financed under the authority of the Federal Government, to

the extent authorized under this Act, through the development of—

(i) health plan or health system certification criteria;

(ii) comparative information concerning the quality of care and the dissemination of this information in accordance with this Act; and

(iii) payments for performance based or explicit quality standards; and

(B) endorse and direct the participation of the Federal Government in regional health care accountability initiatives that develop comparative information concerning the quality of care, disseminate quality information, and support quality initiatives;

(2) provide advice to the President and Congress concerning the protection and quality of the health of all participants and beneficiaries under Federal health plan contracts; and

(3) perform any other duties necessary to carry out this Act.

SEC. 102. MEMBERS OF THE COUNCIL.

(a) APPOINTMENT.—The Council shall be composed of at least 9 members of which—

(1) at least 4 members shall be the Federal trustees described in subsection (b)(1); and

(2) 5 members shall be public trustees appointed under subsection (b)(2) (in this section referred to as the ''public trustees'').

(b) MEMBERSHIP.—

(1) FEDERAL TRUSTEES.—The agency administrator of each of the health care programs described in section 3(2)(C) (or their designees) shall serve on the Council as a permanent Federal trustee. Such trustees shall include—

(A) the Secretary of Health and Human Service;

(B) the Secretary of Defense;

(C) the Secretary of Veterans Affairs; and

(D) the Director of the Office of Personnel Management.

(2) PUBLIC TRUSTEES.—The public trustees shall be appointed by the President by and with the advice and consent of the Senate, and shall have expertise pertaining to—

(A) the measurement of the quality of health care;

(B) the purchase of health care in the private market;

(C) medical ethics;

(D) the delivery and provision of health care; and

(E) the needs of participants and beneficiaries in health care plans described in section 3(2).

(3) TERMS AND VACANCIES.—

(A) TERMS.—Except as otherwise provided in this paragraph, the public trustees shall be appointed for a term of 3 years.

(B) INITIAL TRUSTEES.—Of the public trustees first appointed to the Council—

(i) 2 trustees shall be appointed for a term of 1 year;

(ii) 2 trustees shall be appointed for a term of 2 years; and

(iii) 1 trustee shall be appointed for a term of 3 years;

as designated by the President at the time of nomination of each such trustee.

(C) LIMITATION.—At the expiration of the term of office of a public trustee, that trustee shall continue to hold office until a successor for such trustee is appointed and has qualified, except that such trustee shall not continue to serve beyond the expiration of the next session

of Congress subsequent to the expiration of the fixed term of office.

(D) VACANCIES.—A vacancy in the membership of the Council shall not affect the powers of the Council and shall be filled in the same manner as the original appointment, except that any trustee appointed to fill a vacancy that occurs prior to the expiration of the term for which the predecessor of the trustee was appointed shall be appointed for the remainder of such term.

(c) CHAIRPERSON AND VICE CHAIRPERSON.—The Majority Leader of the Senate and the Speaker of the House of Representatives, in consultation with the Minority Leader of the Senate and the Minority Leader of the House of Representatives, shall select a Chairperson and Vice Chairperson from among the public trustees of the Council. A public trustee may not serve as Chairperson for more than 6 years.

(d) MEETINGS.—

(1) INITIAL MEETING.—Not later than 90 days after the date on which all public trustees of the Council have been appointed, the Council shall hold its first meeting.

(2) MEETINGS.—The Council shall meet at the call of the Chairperson but in no case less than quarterly.

(3) QUORUM.—A majority of the trustees of the Council shall constitute a quorum, but a lesser number of trustees may hold hearings.

(e) COMPENSATION OF PUBLIC TRUSTEES.—Section 5315 of title 5, United States Code, is amended by adding at the end the following:

''Public Trustee, Federal Health Plan Quality Council''.

(f) CONFLICT OF INTEREST.—No public trustee of the Council shall engage in any other business, vocation, or employment than that of serving as a public trustee of the Council, nor shall any such trustee participate, directly or indirectly, in any operations or transactions of a character subject to regulation by the Council pursuant to this Act.

SEC. 103. PERSONNEL AND EXPENSES.

(a) STAFF.—The Council may appoint and fix the compensation of such officers and other experts and employees as may be necessary for carrying out the functions of the Council under this Act and shall fix the salaries of such officers, experts, and employees in accordance with

chapter 51 and subchapter III of chapter 53 of title 5, United States Code.

(b) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Council without reimbursement (other than the regular compensation of the employee), and such detail shall be without interruption or loss of civil service status or privilege.

(c) CONTRACTING AUTHORITY.—Notwithstanding any other provision of law, the Council may enter directly into contracts with entities as the Council determines necessary to carry out the functions of the Council under this Act.

(d) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES.—The Chairperson of the Council may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(e) LEASING AUTHORITY.—Notwithstanding any other provision of law, the Council may enter directly into leases for real property for office, meeting, storage, and such other space as may be necessary to carry out the functions of the Council under this Act, and shall be ex-

empt from any General Services Administration space management regulations or directives.

(f) ACCEPTANCE OF PAYMENTS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, in accordance with regulations which the Council shall prescribe to prevent conflicts of interest, the Council may accept payment and reimbursement, in cash or in kind, from non-Federal agencies, organizations, and individuals for travel, subsistence, and other necessary expenses incurred by trustees of the Council in attending meetings and conferences concerning the functions or activities of the Council.

(2) CREDIT OF ACCOUNT.—Any payment or reimbursement accepted shall be credited to the appropriated funds of the Council.

(3) AMOUNT.—The amount of travel, subsistence, and other necessary expenses for trustees and employees paid or reimbursed under this subsection may exceed per diem amounts established in official travel regulations, but the Council may include in its regulations under this subsection a limitation on such amounts.

SEC. 104. QUALITY ADVISORY INSTITUTE.

(a) ESTABLISHMENT.—There is established an Institute to be known as the ''Quality Advisory Institute'' to make recommendations to the Council concerning licensing and certification criteria and comparative measurement methods under this Act.

(b) MEMBERSHIP.—

(1) COMPOSITION.—The Institute shall be composed of 5 members to be appointed by the Council from among individuals who have demonstrable expertise in—

(A) health care quality measurement;

(B) health plan certification criteria setting;

(C) the analysis of information that is useful to consumers in making choices regarding health coverage options, health plans, health care providers, and decisions regarding health treatments; and

(D) the analysis of health plan operations.

(2) TERMS AND VACANCIES.—The members of the Institute shall be appointed for 5 year terms with the terms of the initial members staggered as determined appropriate by the Council. Vacancies shall be filled in a manner provided for by the Council.

(c) DUTIES.—The Institute shall—

(1) not later than 1 year after the date on which all members of the Institute are appointed under subsection (b)(2), provide advice to the Council concerning the initial set of criteria for the certification of Federal health plan contracts and for comparative measurements necessary to provide consumer information concerning the quality of health care;

(2) analyze the use of the criteria and comparative measurements implemented by the Council under this Act and recommend modifications in such criteria and measurements as needed;

(3) enter into contracts with other entities for the development of such criteria and measurements and to otherwise carry out its duties under this section;

(4) recommend the implementation of comparative measurement requirements under this Act at differing intervals throughout the United States so as to account for regional differences and to permit computability and coordination with private sector purchasing efforts;

(5) develop recommendations for making risk-adjustment payments and risk-adjusted quality

bonus payments to Federal health plan contracts; and

(6) carry out any other activities determined appropriate by the Institute to carry out its duties under this section.

SEC. 105. POWERS.

(a) HEARINGS.—The Council may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Council considers advisable to carry out the purposes of this Act.

(b) INFORMATION FROM FEDERAL AGENCIES.—The Council may secure directly from any Federal department or agency such information as the Council considers necessary to carry out the provisions of this Act. Upon request of the Chairperson of the Council, the head of such department or agency shall furnish such information to the Council.

(c) POSTAL SERVICES.—The Council may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(d) GIFTS.—The Council may accept, use, and dispose of gifts or donations of services or property.

(e) ESTABLISHMENT OF COMMITTEES.—The Council may establish such advisory committees as the Council de-

termines are necessary to carry out its duties under this Act, including those intended to facilitate input and coordination with large private sector purchasers and purchasing coalitions.

SEC. 106. DUTIES.

(a) IN GENERAL.—The Council shall—

(1) adopt, adapt, or develop criteria in accordance with title III to be used in the licensing of certifying entities and in the certification of Federal health plan contracts, including any minimum criteria needed for the operation of Federal health plan contracts during the transition period described in section 301(c);

(2) issue licenses to certifying entities that meet the criteria developed under paragraph (1) for the purpose of enabling such entities to certify Federal health plan contracts in accordance with this Act;

(3) select from existing comparative health care measures, where such measures exist, and develop additional comparative health care measures to guide consumer choice and to improve the delivery of quality health care in accordance with title IV;

(4) develop procedures for the dissemination of certification and comparative quality information provided to the Council under this Act by Federal

health plan contracts, through the Agency for Health Care Policy and Research;

(5) contract with an independent entity for the conduct of audits concerning certification and quality measurement and require that as part of the certification process performed by licensed certification entities that there include an on-site evaluation, using performance-based standards, of the providers of clinical care under the health plans described in section 3(2);

(6) at least quarterly, meet jointly with the Agency for Health Care Policy and Research to review innovative health outcomes measures, new measurement processes, and other matters determined appropriate by the Council;

(7) at least annually, meet with the Institute concerning certification criteria and the collection and dissemination of comparative information;

(8) not later than January 1, 1999, and each January 1 thereafter, prepare and submit to the Federal officials responsible for administering the health care programs described in section 3(2) and to Congress, a report concerning the activities of the Council for the previous year;

(9) advise the President and Congress concerning health insurance and health care provided under the authority of a Federal program and make recommendations concerning measures that may be implemented to protect the health of all participants and beneficiaries in Federal health care programs; and

(10) carry out other activities determined appropriate by the Council.

(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to limit the authority of the Federal official responsible for administering each of the health care programs described in section 3(2) with respect to requirements other than those applied under this Act with respect to Federal health plan contracts.

SEC. 107. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—There are authorized to be appropriated to the Council such sums as may be necessary to carry out this Act.

(b) AVAILABILITY.—Any amounts appropriated under subsection (a) shall remain available, without fiscal year limitation, until expended.

TITLE II—COVERAGE OF FEDERAL HEALTH CARE PROGRAMS

SEC. 201. COMPLIANCE.

(a) IN GENERAL.—Not later than the effective date of this Act, the Federal official responsible for administering each health care program described in section 3(2) shall ensure that—

(1) health insurance coverage under any such program is available and provided only through Federal health plan contracts that have been certified in accordance with title III; and

(2) information concerning each such program is collected, available and disseminated in accordance with title IV.

(b) CONTRACTS OR REIMBURSEMENTS.—In carrying out subsection (a), the Federal official involved—

(1) may not enter into a contract with a Federal health plan contractor for the provision of health care under the program involved unless the Federal health plan contract involved is certified and provides comparative information in accordance with this Act;

(2) may not reimburse a Federal health plan contract for care provided under the program in-

volved unless such Federal health plan contract is certified and provides comparative information in accordance with this Act; and

(3) shall, after providing notice to the Federal health plan contract and an opportunity for the Federal health plan contract to be certified, and in accordance with any applicable grievance and appeals procedures under section 304, terminate any contract with a Federal health plan contractor under the program if such contract is not certified in accordance with this Act.

SEC. 202. PAYMENTS FOR VALUE.

(a) ESTABLISHMENT OF PROGRAM.—The Council shall establish a program under which payments are made to various Federal health plan contracts to reward such contracts for meeting or exceeding quality targets.

(b) PERFORMANCE MEASURES.—In carrying out the program under subsection (a), the Council shall establish broad categories of quality targets and performance measures. Such targets and measures shall be designed to permit the Council to determine whether a Federal health plan contract is being operated in a manner consistent with this Act.

(c) USE OF FUNDS.—The Council shall use amounts allocated under subsection (e) (or an amendment made by

such subsection) to make annual payments to those Federal health plan contracts that have been determined by the Council to meet or exceed the quality targets and performance measures established under subsection (b). Any amounts allocated under subsection (e) (or an amendment made by such subsection) for a fiscal year and remaining available after payments are made under subsection (d), shall be used for deficit reduction.

(d) AMOUNT OF PAYMENT.—

(1) FORMULA.—The amount of any payment made to a Federal health plan contract under this section shall be determined in accordance with a formula to be developed by the Council. The formula shall ensure that a payment made to a Federal health plan contract under this section be in an amount equal to—

(A) with respect to a contract that is determined to be in the first quintile, 1 percent of the amount allocated by the contract under subsection (e) (or an amendment made by such subsection);

(B) with respect to a contract that is determined to be in the second quintile, .75 percent of the amount allocated by the contract

under subsection (e) (or an amendment made by such subsection);

(C) with respect to a contract that is determined to be in the third quintile, .50 percent of the amount allocated by the contract under subsection (e) (or an amendment made by such subsection); and

(D) with respect to a contract that determined to be in the fourth quintile, .25 percent of the amount allocated by the contract under subsection (e) (or an amendment made by such subsection).

(2) NO PAYMENT.—A Federal health plan contract that is determined by the Council to be in the fifth quintile shall not be eligible to receive a payment under this section.

(3) DETERMINATION OF QUINTILES.—Not later than April 30 of each calendar year, the Council shall rank each Federal health plan contract based on the performance of the contract during the preceding year as determined using the quality targets and performance measures established under subsection (b). Such rankings shall be divided into quintiles with the first quintile containing the highest ranking contracts and the fifth quintile contain-

ing the lowest ranking contracts. Each such quintile shall contain contracts that in the aggregate cover an equal number of participants and beneficiaries as compared to another quintile.

(4) LIMITATION.—

(A) IN GENERAL.—In no case shall the formula developed by the Council under paragraph (1) permit the Council to make payments under this section to a class of Federal health plan contracts in an amount that exceeds the total amount allocated by such class of contracts under subsection (e) for the year involved.

(B) CLASS OF CONTRACTS.—For purposes of subparagraph (A), the Federal health plan contracts described in each of subparagraphs (A) through (E) of section 3(2) shall be considered to be in a separate class of Federal health plan contracts.

(e) ALLOCATION OF PREMIUM AMOUNTS.—

(1) FEDERAL HEALTH PLAN CONTRACTS.—A Federal health plan contract not covered under paragraphs (2) through (5) (or an amendment made by such paragraph) that is certified under title III shall annually allocate an amount equal to .50 per-

cent of all Federally-related health plan contract premium amounts received during the year involved to the Council.

(2) MEDICARE MANAGED CARE PLANS.—Section 1876 of the Social Security Act (42 U.S.C. 1395mm) is amended—

(A) in subsection (a)(1)(C), by striking ''The annual'' and inserting ''Subject to subsection (k), the annual''; and

(B) by adding at the end the following:

''(k) WITHHOLDING OF PAYMENTS TO ENCOURAGE QUALITY PERFORMANCE.—

''(1) WITHHOLDING.—The Secretary shall withhold .50 percent from any payment that an eligible organization under this section receives with respect to an individual enrolled under this section with the organization.

''(2) DISBURSEMENT.—From the total amount withheld under paragraph (1), the Secretary shall make payments to eligible organizations under this section in accordance with the formula established by the Federal Health Plan Quality Council under section 202(d) of the Federal Health Insurance Quality, Consumer Information and Protection Act. Any payments that an eligible organization receives

under this paragraph shall be taken into account in determining the average payment amount of the organization as part of the organization's adjusted community rate calculation.''.

(3) MEDICAID.—

(A) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(i) by striking ''and'' at the end of paragraph (62);

(ii) by striking the period at the end of paragraph (63) and inserting ''; and''; and

(iii) by inserting after paragraph (63) the following new paragraph:

''(64) provide for the withholding of .50 percent from any payment that any health maintenance organization or other entity that contracts with the State to provide medical assistance to individuals under this title receives with respect to such medical assistance and that, from the total amount withheld, the State shall make payments to such organizations or entities in accordance with the formula established by the Federal Health Plan Quality Council under section 202(d) of the Federal Health Insur-

ance Quality, Consumer Information and Protection Act.''.

(B) APPLICABILITY.—The amendments made by subparagraph (A) shall apply to contracts entered into under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) or under a waiver of such title of such Act.

(4) TRICARE.—The Secretary of Defense shall provide for the withholding of .50 percent from any payment that any health maintenance organization or other entity that contracts with the Secretary of Defense to provide medical assistance to individuals under the authority of chapter 55 of title 10, United States Code, principally section 1097 of such title, and from the total amount withheld, the Secretary of Defense shall make payments to such organizations or entities in accordance with the formula established by the Council under section 202(d).

(5) VETERANS AFFAIRS.—The Secretary of Veterans Affairs shall provide for the withholding of .50 percent from any payment that any health maintenance organization or other entity that contracts with the Secretary of Veterans Affairs to provide medical assistance to individuals under the authority of title 38, United States Code, and from the total

amount withheld, the Secretary of Veterans Affairs shall make payments to such organizations or entities in accordance with the formula established by the Council under section 202(d).

TITLE III—CERTIFICATION OF FEDERAL HEALTH PLAN CONTRACTS

SEC. 301. REQUIREMENT.

(a) IN GENERAL.—To be eligible to enter into a contract with the Federal Government to enroll individuals for health insurance coverage provided under a Federal program, an entity shall participate in the certification process and be certified in accordance with this title.

(b) EFFECT OF MERGERS OR PURCHASE.—

(1) CERTIFIED CONTRACTS.—Where two or more Federal health plan contractors offering certified Federal health plan contracts are merged or where one such contractor is purchased by another contractor, the resulting contractor may continue to operate and enroll individuals for coverage under the Federal health plan contract as if the Federal health plan contract involved were certified. The certification of any resulting Federal health plan contract shall be reviewed by the applicable certifying entity

to ensure the continued compliance of the contract with the certification criteria.

(2) NONCERTIFIED CONTRACTS.—The certification of a Federal health plan contract shall be terminated upon the merger of the Federal health plan contractor involved or the purchase of the contractor by another entity that does not offer any certified Federal health plans. Any Federal health plan contracts offered through the resulting contractor may reapply for certification after the completion of the merger or purchase.

(c) TRANSITION FOR NEW CONTRACTS.—

(1) IN GENERAL.—A Federal health plan contract that has not provided health insurance coverage to individuals prior to the effective date of this Act shall be permitted to contract with the Federal Government and operate and enroll individuals under the contract without being certified for the 2-year period beginning on the date on which such contract enrolls the first individual under the contract. The contract must be certified in order to continue to provide coverage under the contract after such period.

(2) LIMITATION.—A new contract described in paragraph (1) shall, during the period referred to in

paragraph (1) prior to certification, comply with the following requirements.

(A) The minimum criteria developed by the Council under section 106(1).

(B) The information collection and dissemination requirements described in section 303(b)(3).

SEC. 302. LICENSING OF CERTIFICATION ENTITIES.

(a) IN GENERAL.—The Council shall develop procedures for the licensing of entities to certify Federal health plan contracts under this Act.

(b) REQUIREMENTS.—The procedures developed under subsection (a) shall ensure that—

(1) to be licensed under this section a certification entity shall apply the requirements of this Act to Federal health plan contracts seeking certification;

(2) a certification entity has procedures in place to suspend or revoke the certification of a Federal health plan contract that is failing to comply with the certification requirements; and

(3) the Council will give priority to licensing entities that are accrediting health plans that contract with the Federal Government on the date of enactment of this Act.

SEC. 303. CERTIFICATION CRITERIA.

(a) ESTABLISHMENT.—The Council shall establish minimum criteria under this section (as may be appropriate with respect to each type of health plan arrangement involved) to be used by licensed certifying entities in the certification of Federal health plan contracts under this title.

(b) REQUIREMENTS.—Criteria established by the Council under subsection (a) shall require that, in order to be certified, a Federal health plan contract shall comply at a minimum with the following:

(1) QUALITY IMPROVEMENT PLAN.—The Federal health plan contract shall implement a total quality improvement plan that is designed to improve the clinical and administrative processes of the contract on an ongoing basis and demonstrate that improvements in the quality of contract services have occurred as a result of such plan.

(2) PROVIDER CREDENTIALS.—The Federal health plan contract shall compile and annually provide to the licensed certifying entity documentation concerning the credentials of the hospitals and health care providers reimbursed under the contract.

(3) ACCESS TO INFORMATION.—

(A) COMPARATIVE INFORMATION.—The Federal health plan contract, using data sup-

plied by the Council and in accordance with section 401(c), shall implement a program to provide participants and beneficiaries with access to appropriate comparative information in a manner that enables such participants and beneficiaries to make informed health care decisions by comparing the various health plans that participants and beneficiaries are eligible to enroll in. Such comparative information shall be in a standardized form that is adopted by the Council and is understandable to a reasonable layperson and shall include participant, beneficiary, and provider satisfaction data that is derived from the conduct of a period (not less than annually) survey by an independent organization of those enrolled in the plan and those who have disenrolled during the preceding 12-month period.

(B) PLAN SPECIFIC INFORMATION.—As part of the program implemented under subparagraph (A), the Federal health plan contract shall provide specific information concerning the contract that shall include—

(i) information concerning the quality of health care providers that may be reim-

bursed under, or that are employed by the contract, and the existence of any condition of employment that prohibits providers and other health professionals from fully informing the patient of all treatment options;

(ii) information concerning the service area of the contract and the qualifications and availability within the service area of health care providers under the contract;

(iii) information on procedures for filing grievances and appealing the denial of services;

(iv) information concerning the rights and responsibilities of participants and beneficiaries under the contract;

(v) information concerning the benefits offered under the contract, including any limitations or cost-sharing applicable, and the premiums, co-payments or other out-of-pocket costs that participants and beneficiaries may be liable for;

(vi) information concerning the availability and location of benefit counseling services and contract-specific disenrollment

statistics presented as a percentage of the total number of participants and beneficiaries who are disenrolled from the contract and information about physician disenrollment—

(I) during the 90-day period beginning on the date of their enrollment in the contract; and

(II) during the most recent 12-month period;

(vii) information concerning the procedures through which the contract monitors and improves the quality of services provided by the contract and services provided by health care providers under the contract;

(viii) information to assist health care professionals in delivering better health care and methods to assess health care professionals' perceptions on issues regarding quality of care; and

(ix) information concerning selection standards for participating providers.

(4) OTHER REQUIREMENTS.—The Federal health plan contract shall comply with other require-

ments authorized under this Act and implemented by the Council.

(5) AVAILABILITY.—A Federal health plan contract shall at least annually provide notice to participants and beneficiaries of the availability of comparative information and the manner by which such individuals may obtain such information.

SEC. 304. GRIEVANCE AND APPEALS.

The Council shall develop grievance and appeals procedures under which a Federal health plan contract that is denied certification under this title may appeal such denial to the Council.

TITLE IV—FEDERAL HEALTH PLAN CONTRACT PERFORMANCE

SEC. 401. UNIFORM PERFORMANCE CRITERIA.

(a) COMPARATIVE HEALTH MEASURES.—The Council, based on the data and information provided by the Agency for Health Care Policy and Research under this section, shall develop or select measures to be used by individuals to compare the overall quality of Federal health plan contracts. In developing or selecting such measures, the Council shall provide for the publication and distribution of comparative materials for use by individuals seeking to enroll in a Federal health plan contract.

(b) SUBMISSION OF DATA.—To be certified under this Act, a Federal health plan contract shall, at such intervals as determined appropriate by the Council, compile and submit to the Agency for Health Care Policy and Research data (in a manner that does not disclose the identity of patients) concerning the process and outcomes performance of the contract.

(c) DATA.—The data that a Federal health plan contract is required to submit under subsection (b) shall include—

(1) outcomes and process data and information concerning the effectiveness of care provided under the health plan contract, including process and outcomes measures which reflect the clinical health, well-being, and functional status of participants and beneficiaries;

(2) enrollment and disenrollment data (including short- and long-term rates);

(3) grievance and appeals data (including the average and median lengths of time for the resolution of appeals); and

(4) such other data or information as may be required by the Council to carry out the role of the Council.

(d) PROVISION OF DATA TO COUNCIL.—The Agency for Health Care Policy and Research shall annually prepare and submit to the Council a summary of the data provided to the Agency by Federal health plan contracts under this section.

(e) REASONABLE EFFORTS.—Reasonable efforts shall be made to ensure that data under this section is valid, timely and standardized prior to making such data public.

TITLE V—EXPANSION OF HEALTH CARE QUALITY ACTIVITIES

SEC. 501. EXPANDED ROLE FOR THE AGENCY FOR HEALTH CARE POLICY AND RESEARCH.

Part B of title IX of the Public Health Service Act (42 U.S.C. 299b et seq.) is amended by adding at the end the following:

"SEC. 915. NATIONAL HEALTH CARE QUALITY INFORMATION.

''(a) PURPOSE.—It is the purpose of this section to expand the duties and responsibilities of the Agency to include the collection, analysis, and dissemination of health care quality information both generally and with a focus on health plans.

''(b) DUTIES.—In carrying out this section, the Agency shall—

''(1) review measures of health care quality and other measures of health care processes and outcomes;

''(2) coordinate activities under paragraph (1) with the National Committee on Quality Assurance, the Joint Commission on the Accreditation of Health Organizations, the Foundation for Accountability, the Quality Advisory Institute established under section 104 of the Federal Health Care Quality, Consumer Information and Protection Act, the American Accreditation Health Care Commission, the National Committee on Vital and Health Statistics, State and local governments, and consumer advocacy groups;

''(3) develop methods for integrating risk assessment and risk adjustment methodology that are used to measure the quality of health care into data information sets for purposes of making quality of care comparisons and determinations under the reimbursement formula under section 202(d);

''(4) ensure the comparability of process and outcome measures through the development of data

dictionaries and of standardized data collection methods;

''(5) compile comparative quality data on health plans that is designed to facilitate the purchase of health insurance by participants and beneficiaries;

''(6) in consultation with the Council, disseminate data under paragraph (4) to Federal, State, and local governmental purchasers, employees, Federal, State, and local program beneficiaries, health insurance issuers, and the general public;

''(7) establish a directory of best operational practices for use by systems of health care; and

''(8) coordinate with other Federal entities with experience in health care and with State and local governments.''.

SEC. 502. INCREASE IN FUNDING FOR OUTCOMES RESEARCH.

(a) HEALTH PLAN PERFORMANCE, RESEARCH, AND DATA.—Section 902(a) of the Public Health Service Act (42 U.S.C. 299a(a)) is amended—

(1) in paragraph (7), by striking ''and'' at the end;

(2) in paragraph (8), by striking the period and inserting ''; and''; and

(3) by adding at the end the following:

''(9) health plan performance, research, and data.''.

(b) FUNDING.—Section 926 of the Public Health Service Act (42 U.S.C. 299c-5) is amended by adding at the end the following:

''(f) HEALTH PLAN PERFORMANCE, RESEARCH, AND DATA.—For the purpose of carrying out section 902(a)(9), there is authorized to be appropriated $20,000,000 for fiscal year 1998, and such sums as may be necessary for each of the fiscal years 1999 through 2002.''.

TITLE VI—MISCELLANEOUS PROVISIONS.

SEC. 601. EFFECTIVE DATE.

(a) FEDERAL HEALTH PLAN CONTRACTS.—Except as provided in subsection (b), the provisions of this Act shall apply to Federal health plan contracts on January 1, 1999.

(b) AMENDMENTS.—

(1) IN GENERAL.—The amendments made by section 202 shall take effect on January 1, 1999.

(2) AGENCY FOR HEALTH CARE POLICY AND RESEARCH.—The amendments made by title V shall take effect on the date of enactment of this Act.

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