I

106TH CONGRESS
1ST SESSION

H. R. 1133

To provide for comprehensive reform for managed health care plans.

IN THE HOUSE OF REPRESENTATIVES

MARCH 16, 1999

Mr. NADLER (for himself and Mr. FROST) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committees on Commerce, and Education and the Workforce, 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 for comprehensive reform for managed health care plans.

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 ''Comprehensive Managed Health Care Reform Act of 1999''.

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

SEC. 2. DEFINITIONS.

(a) IN GENERAL.—For purposes of this Act:

(1) ENROLLEE.—The term ''enrollee'' means, with respect to a managed care plan offered by a managed care organization, an individual enrolled with the organization for coverage under such a plan.

(2) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means a physician or other health care practitioner who is licensed under State law with respect to the health care services the practitioner furnishes.

(3) HEALTH PLAN.—The term ''health plan'' means a group health plan or health insurance coverage offered by a health insurance issuer.

(4) MANAGED CARE ORGANIZATION.—The term ''managed care organization'' means any entity, including a group health plan, health maintenance organization, or provider-sponsored organization, in re-

lation to its offering of a managed care plan, and includes any other entity that provides or manages the coverage under such a plan under a contract or arrangement with the entity.

(5) MANAGED CARE PLAN.—The term ''managed care plan'' means a health plan offered by an entity if the entity—

(A) provides or arranges for the provision of health care items and services to enrollees in the plan through participating health care professionals and providers, or

(B) provides financial incentives (such as variable copayments and deductibles) to induce enrollees to obtain benefits through participating health care professionals and providers, or both.

(6) PARTICIPATING.—The term ''participating'' means, with respect to a health care professional or provider in relation to a health plan offered by an entity, a physician or provider that furnishes health care items and services to enrollees of the entity under an agreement with the entity.

(7) PRIMARY CARE PROVIDER.—The term ''primary care provider'' means a health care profes-

sional who acts as a gatekeeper for the overall care of an enrollee.

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

(9) STATE.—The term ''State'' includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(b) INCORPORATION OF GENERAL DEFINITIONS FROM HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT.—For purposes of this Act, the definitions contained in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91) shall apply under this Act.

SEC. 3. ENFORCEMENT OF REQUIREMENTS.

(a) APPLICATION TO GROUP HEALTH PLANS.—

(1) PUBLIC HEALTH SERVICE ACT.—For purposes of applying title XXVII of the Public Health Service Act, the requirements of the succeeding sections of this Act shall be treated as though they were included in the subpart 2 of part A of such title (42 U.S.C. 300gg–4 et seq.).

(2) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—For purposes of applying part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, the requirements of the

succeeding sections of this Act shall be treated as though they were included in subpart B of such part (29 U.S.C. 1185 et seq.).

(3) INTERNAL REVENUE CODE OF 1986.—For purposes of applying chapter 100 of the Internal Revenue Code of 1986, the requirements of the succeeding sections of this Act shall be treated as though they were included in subchapter B of such chapter.

(b) APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.—For purposes of applying title XXVII of the Public Health Service Act, the requirements of the succeeding sections of this Act also shall be treated as though they were part of subpart 2 of part B of such title (42 U.S.C. 300gg–51 et seq.).

(c) MEDICARE.—The Secretary may not enter into a contract under section 1857 of the Social Security Act (42 U.S.C. 1395w–27) with a Medicare+Choice organization that is a managed care organization unless the contract contains assurances satisfactory to the Secretary that the organization will comply with the applicable requirements of the succeeding sections of this Act.

(d) MEDICAID.—Notwithstanding any other provision of law, no funds shall be paid to a State under section 1903(a)(1) of the Social Security Act (42 U.S.C.

1396b(a)(1)) with respect to medical assistance provided through payment to a Medicaid managed care organization (as defined in section 1903(m)(1)(A) of such Act, 42 U.S.C. 1396b(m)(1)(A)) unless the contract with such organization contains assurances satisfactory to the Secretary that the organization will comply with the applicable requirements of the succeeding sections of this Act.

(e) SECRETARIAL ENFORCEMENT AUTHORITY.—

(1) IN GENERAL.—In addition to any other authority provided under law, the Secretary shall establish sanctions, consistent with this subsection, for the enforcement of the requirements of the succeeding sections of this Act.

(2) PROGRESSIVE CIVIL MONETARY PENALTIES.—Such sanctions shall include the imposition of civil monetary penalties for violations of such requirements. The amount of such penalties shall increase as the frequency or severity of the violations by a managed care organization increases.

(3) OPPORTUNITY FOR CORRECTIVE ACTION PLAN.—The Secretary shall provide an opportunity for a managed care organization to implement a corrective action plan before imposing sanctions for violations of such requirements.

(4) DISQUALIFICATION FROM MEDICARE AND MEDICAID.—In cases of repeated or egregious violations of such requirements by such an organization that has entered into a contract under title XVIII or XIX of the Social Security Act—

(A) the Secretary initially shall prohibit the organization from enrolling any additional individuals under either such title, and

(B) if the Secretary finds that the violations continue, the Secretary shall terminate the contracts with the organization under such titles and require the termination of enrollment of individuals enrolled with the organization under either such title.

(5) PRINTING LIST OF VIOLATORS.—The Secretary shall periodically publish a list of the organizations which have been sanctioned under this subsection, the nature of such sanctions, and the violations for which such sanctions were imposed. The Secretary may exclude from such list an organization that, in lieu of imposition of a sanction, is implementing (or has completed implementation of) a corrective plan.

(f) ADDITIONAL LIABILITY FOR WITHHOLDING OF MEDICALLY NECESSARY CARE.—If a managed care orga-

nization in connection with a managed care plan fails (through the curtailment of a hospital stay, a limitation on covered tests, a limitation on treatment, or otherwise) to provide any such benefit in accordance with the terms of the plan, insofar as such failure occurs pursuant to a clinically or medically inappropriate decision or determination resulting from—

(1) the application of any cost containment technique,

(2) any utilization review directed at cost containment, or

(3) any other medical care delivery policy decision which restricts the ability of providers of medical care from utilizing their full discretion for treatment of enrollees,

the organization, and any agent of the organization having authority to make such decision or determination on behalf of the organization, shall be jointly and severally liable to any enrollee aggrieved by such failure for actual damages (including compensatory and consequential damages) proximately caused by such failure, and may, in the court's discretion, be liable to such enrollee for punitive damages. The remedies under this subsection are in addition to remedies otherwise provided under this section.

(g) NO PREEMPTION OF STRICTER STATE LAW.—

(1) IN GENERAL.—Subject to paragraph (2), this Act shall not be construed to supersede any provision of State law that provides protections in relation to health insurance coverage that are greater than the protections provided under this Act.

(2) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.—Nothing in this Act shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 with respect to group health plans.

(h) NULLIFICATION OF CONTRARY CONTRACTUAL PROVISIONS.—Any contract provision or agreement that is in violation of any provision of this Act (or amendment made by this Act) shall be null and void.

SEC. 4. ASSURING ADEQUATE ACCESS TO COVERED SERVICES AND PROVIDERS.

(a) GENERAL ACCESS.—

(1) IN GENERAL.—Subject to paragraph (2), a managed care organization offering a managed care plan shall establish and maintain adequate arrangements, as defined under regulations of the Secretary, with a sufficient number, mix, and distribution of health care professionals and providers to assure

that covered items and services are available and accessible to each enrollee under the plan—

(A) in the service area of the organization;

(B) in a variety of sites of service;

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

(D) with reasonable proximity to the residences and workplaces of enrollees; and

(E) in a manner that—

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

(ii) reasonably assures continuity of care.

(2) TREATMENT OF ORGANIZATIONS SERVING CERTAIN AREAS.—For a managed care organization that serves a rural or medically underserved area, the organization shall be treated as meeting the requirement of paragraph (1) if the organization has arrangements with a sufficient number, mix, and distribution of health care professionals and providers having a history of serving such areas. The use of telemedicine and other innovative means to provide covered items and services by a managed care organization that serves a rural or medically

underserved area shall also be considered in determining whether the requirement of such paragraph is met.

(3) DEFINITIONS.—For purposes of paragraph (1):

(A) MEDICALLY UNDERSERVED AREA.—The term ''medically underserved area'' means an area that is designated as a health professional shortage area under section 332 of the Public Health Service Act (42 U.S.C. 254e) or as a medically underserved area for purposes of section 330 or 1302(7) of such Act (42 U.S.C. 254c, 300e–1(7)).

(B) RURAL AREA.—The term ''rural area'' means an area that is not within a Standard Metropolitan Statistical Area or a New England County Metropolitan Area (as defined by the Office of Management and Budget).

(b) ACCESS TO SPECIALIZED SERVICES.—

(1) IN GENERAL.—A managed care organization shall demonstrate that enrollees have access to specialized treatment expertise when such treatment is medically or clinically indicated in the professional judgment of the treating health care professional, in consultation with the enrollee.

(2) MEDICAL SPECIALISTS.—A managed care organization shall develop a system to permit enrollees to use a medical specialist primary care provider as a primary care provider when the enrollee's medical conditions (including suffering from a chronic disease or medical condition) warrant it.

(3) STANDING REFERRALS TO SPECIALISTS.—A managed care organization shall provide for a standing referral to a medical specialist if the treating primary care provider, in consultation with such specialists, determines such a referral is necessary to provide adequate and continuous care for the patient.

(4) SPECIALIZED TREATMENT EXPERTISE DEFINED.—For purposes of this subsection, the term ''specialized treatment expertise'' means expertise in diagnosing or treating—

(A) unusual diseases or conditions, or

(B) diseases and conditions that are unusually difficult to diagnose or treat.

(5) MEDICAL SPECIALIST DEFINED.—For purposes of paragraph (2), the term ''medical specialist'' means, with respect to a managed care organization, a health care professional who is certified by a national accreditation board (or pursuant to

State licensing authority) as possessing specialized treatment expertise.

(c) USE OF GYNECOLOGISTS AS PRIMARY CARE PROVIDERS.—A managed care organization may not require an enrollee to obtain a referral from a physician in order to obtain covered items and services from a physician who specializes in obstetrics and gynecology.

(d) EMERGENCY AND URGENT CARE.—

(1) IN GENERAL.—A managed care organization shall—

(A) assure the availability and accessibility of medically or clinically necessary emergency services and urgent care services within the service area of the organization 24 hours a day, 7 days a week;

(B) require no prior authorization for items and services furnished in a hospital emergency department to an enrollee (without regard to whether the health care professional or hospital has a contractual or other arrangement with the organization) with symptoms that would reasonably suggest to a prudent layperson that there is an emergency medical condition (including items and services described in subparagraph (C)(iii));

(C) cover (and make reasonable payments for)—

(i) emergency services,

(ii) services that are not emergency services but are described in subparagraph (B),

(iii) medical screening examinations and other ancillary services necessary to diagnose, treat, and stabilize an emergency medical condition, and

(iv) urgent care services,

without regard to whether the health care professional or provider furnishing such services has a contractual (or other) arrangement with the organization; and

(D) make prior authorization determinations for—

(i) services that are furnished in a hospital emergency department (other than services described in clauses (i) and (iii) of subparagraph (C)), and

(ii) urgent care services,

within the time periods specified in (or pursuant to) sections 9(c)(3) and 10(f).

(2) DEFINITIONS.—For purposes of this subsection:

(A) EMERGENCY MEDICAL CONDITION.—The term ''emergency medical condition'' means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention might result in—

(i) placing the patient's health in serious jeopardy,

(ii) serious impairment to bodily functions, or

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

(B) EMERGENCY SERVICES.—The term ''emergency services'' means health care items and services that are necessary for the diagnosis, treatment, and stabilization of an emergency medical condition.

(C) URGENT CARE SERVICES.—The term ''urgent care services'' means health care items

and services that are necessary for the treatment of a condition that—

(i) is not an emergency medical condition,

(ii) requires prompt medical or clinical treatment, and

(iii) poses a danger to the patient if not treated in a timely manner, as defined by the Secretary in consultation with relevant treating health care professionals or providers.

(e) RIGHT TO REFERRAL TO NONPARTICIPATING PROVIDERS.—A managed care organization shall permit an enrollee to obtain a referral to a nonparticipating provider if the organization does not have a participating provider with appropriate training and experience to meet the enrollee's needs and shall pay for care provided pursuant to such a referral.

(f) ACCESS TO CENTERS OF EXCELLENCE FOR INDIVIDUALS REQUIRING SPECIALIZED CARE.—

(1) IN GENERAL.—Each managed care organization shall demonstrate that enrollees who have chronic diseases or otherwise require specialized services, as determined by the primary care provider or treating specialist, have access through the orga-

nization to specialized treatment expertise at designated centers of excellence in order to provide adequate and continuous care for such enrollees. Such an organization shall demonstrate such access according to standards developed by the Secretary, including requirements relating to arrangements with such centers and referral of enrollees to such centers.

(2) DESIGNATION PROCESS.—The Secretary shall establish a process for the designation of facilities as centers of excellence for purposes of this subsection. A facility may not be designated unless the facility is determined—

(A) to provide specialty care,

(B) to deliver care for complex cases requiring specialized treatment or for individuals with chronic diseases, and

(C) to meet other requirements that may be established by the Secretary relating to specialized education and training of health care professionals, participation in peer-reviewed research, or treatment of patients from outside the geographic area of the facility.

(g) PATIENT ACCESS TO CLINICAL STUDIES.—

(1) PERMITTING PARTICIPATION IN APPROVED CLINICAL STUDIES.—A managed care organization may not deny (or limit or impose additional conditions on) coverage of items and services furnished to an enrollee if—

(A) the enrollee is participating in an approved clinical study,

(B) the items and services are furnished according to the design of the study or to treat conditions resulting from participation in the study, and

(C) the items and services would otherwise be covered by the organization except for the fact that they are provided in connection with participation in such a study.

Such an organization may not discriminate against an enrollee on the basis of the enrollee's participation in such a study.

(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as requiring an organization to provide for payment for items and services routinely paid for as part of an approved clinical study.

(3) APPROVED CLINICAL STUDY DEFINED.—For purposes of this subsection, the term ''approved clinical study'' means—

(A) a research study approved by the Secretary, the Director of the National Institutes of Health, the Commissioner of the Food and Drug Administration, the Secretary of Veterans Affairs, the Secretary of Defense, or a qualified nongovernmental research entity (as defined in guidelines of the National Institute of Health), or

(B) a peer-reviewed and approved research program, as defined by the Secretary, conducted for the primary purpose of determining whether or not a treatment is safe, efficacious, or having any other characteristic of a treatment which must be demonstrated in order for the treatment to be medically necessary or appropriate.

(h) ACCESS TO EXPERIMENTAL TREATMENTS.—A managed care organization shall provide access to experimental treatments in the case of enrollees who have a life-threatening disease or condition, when determined to be medically necessary and appropriate by the treating health care provider in consultation with the enrollee.

(i) REQUIREMENTS REGARDING USE OF PRESCRIPTION DRUG FORMULARIES.—

(1) IN GENERAL.—A managed care organization shall provide coverage for a prescribed drug, approved for dispensing by the Food and Drug Administration, whether or not such drug is on a prescription drug formulary used by the organization if the use of such drug is judged to be medically necessary and appropriate by the prescribing health care professional.

(2) NOT PERMITTING CHANGES IN PRESCRIPTIONS.—No pharmacist or health care facility shall change the prescription prescribed by a health care provider, or change the drug dispensed to carry out a prescription for an enrollee of a managed care plan unless—

(A) the prescribing health care provider has approved the change, and

(B) the enrollee has been informed and given consent to the change.

(3) USE OF GENERICS PERMITTED.—Nothing in this subsection shall be construed as preventing a managed care organization from using medically approved generic drugs.

SEC. 5. ASSURING ADEQUATE SCOPE OF COVERAGE.

(a) COVERAGE OF PRESCRIPTION DRUGS, PREVENTIVE SERVICES, AND INPATIENT AND OUTPATIENT SERV-

ICES.—A managed care organization, in offering coverage under a managed care plan, shall include coverage of prescription drugs, preventive services, and inpatient and outpatient services, and shall—

(1) include coverage of annual screening mammography for any female enrollee who is 40 years of age or older and for any female enrollee who is less than 40 years of age and who has a medical condition that makes such coverage medically necessary and appropriate;

(2) not restrict benefits for any hospital length of stay in connection with—

(A) a mastectomy for the treatment of breast cancer to less than 48 hours, or

(B) a lymph node dissection for the treatment of breast cancer to less than 24 hours; and

(3) not exclude or restrict benefits—

(A) for prescription contraceptive drugs or devices approved by the Food and Drug Administration, or generic equivalents approved as substitutable by the Food and Drug Administration, or

(B) for outpatient contraceptive services (including consultations, examinations, proce-

dures, and medical services, provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy).

(b) MENTAL HEALTH PARITY.—A managed care organization, in offering a managed care plan, may not distinguish in the amount, duration, or scope of coverage under the plan among items and services based on whether the items and services relate to mental health (or treatment of mental illness or disease) or to physical health (or treatment of physical illness or disease).

(c) COVERAGE OF SERVICES OF ESSENTIAL COMMUNITY PROVIDERS.—

(1) IN GENERAL.—The Secretary may require a managed care organization to enter into agreements with essential community providers serving the organization's service area (in relation to the coverage) to join the organization's provider network if such Secretary finds that such agreements are necessary for the organization to make contracted for services (A) available and accessible to each enrollee, within the area served by the organization (in relation to such coverage), with reasonable promptness and in a manner which assures continuity, and (B) when

medically necessary, available and accessible 24 hours a day and 7 days a week.

(2) ESSENTIAL COMMUNITY PROVIDER DEFINED.—For purposes of paragraph (1), the term ''essential community provider'' means a rural health clinic (described in paragraph (2) of section 1861(aa) of the Social Security Act, 42 U.S.C. 1395x(aa)), a Federally qualified health center (described in paragraph (4) of such section), and any other provider meeting such standards as the Secretary may require.

(d) COVERAGE OF EMERGENCY SERVICES.—A managed care organization shall provide for coverage of emergency services (as defined in section 4(d)(2)(B)), 24-hours a day, 7-days-a-week, without the need for any prior approval for coverage of such services.

(e) REQUIREMENT FOR POINT OF SERVICE OPTION.—A managed care organization that offers a managed care plan shall offer each enrollee an enrollment option under which the enrollee may receive benefits for services provided by nonparticipating health care professionals and providers. The organization may require that the enrollee pay a reasonable premium to reflect the cost of such option.

(f) REQUIREMENT FOR CONTINUITY OF CARE.—A managed care organization shall provide for continuity of care following enrollment, including appropriate continuity of care following termination of participation of a provider that is providing a course of treatment to an enrollee at the time of the termination.

(g) COVERAGE OF CONSULTATION FOR SECOND OPINIONS.—A managed care organization shall provide enrollees with access to a consultation for a second opinion regarding treatment options.

SEC. 6. ASSURING UNBIASED MEDICAL DETERMINATIONS BY HEALTH CARE PROFESSIONALS AND PROVIDERS.

(a) REQUIRING MEDICAL DETERMINATIONS BY TREATING PROFESSIONAL.—A managed care organization may not deny payment for services covered under a managed care plan based upon the fact that the services are not medically necessary or appropriate with respect to an enrollee unless the determination is made solely by the health care professional treating the enrollee.

(b) PROHIBITION OF CERTAIN INCENTIVE ARRANGEMENTS.—

(1) IN GENERAL.—No managed care organization shall offer monetary rewards, penalties, or inducements (including varying the amount of com-

pensation) to a health care professional or provider, or condition the initial or continued participation of such a professional or provider in a managed care plan offered by the organization, on the basis of the professional's or provider's decision (or decisions) to reduce or limit the availability of appropriate medical tests, services, or treatment, on the basis of any utilization review decisions relating to the professional or provider, or the number of referrals, tests, or other procedures ordered or performed by the professional or provider.

(2) PENALTY.—Any managed care organization, or executive of such an organization, that knowingly offers a reward, penalty, or inducement in violation of paragraph (1) shall be fined in accordance with title 18, United States Code, imprisoned for not more than 2 years, or both.

(c) PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.—

(1) IN GENERAL.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a managed care organization and a health care professional shall not prohibit or restrict the health care professional from engaging

in medical communications with a patient of the professional.

(2) MEDICAL COMMUNICATION DEFINED.—For purposes of this subsection, the term ''medical communication'' means a communication made by a health care professional with a patient of the health care professional (or the guardian or legal representative of the patient) with respect to—

(A) the patient's health status, medical care, or treatment options;

(B) any utilization review requirements that may affect treatment options for the patient; or

(C) any financial incentives that may affect the treatment of the patient.

(d) WHISTLEBLOWER PROTECTION.—

(1) IN GENERAL.—No managed care organization may discharge or otherwise discriminate against any employee with respect to compensation, terms, conditions, or privileges of employment because the employee (or any person acting pursuant to the request of the employee) provided information to a Federal or State official with any enforcement responsibility or authority concerning the provisions of this Act regarding a possible violation of any provi-

sion of this Act, or any regulation under any such provision, by the organization or any director, officer, or employee of the organization.

(2) ENFORCEMENT.—Any employee or former employee who believes that such employee has been discharged or discriminated against in violation of paragraph (1) may file a civil action in the appropriate United States District Court before the end of the 2-year period beginning on the date of such discharge or discrimination.

(3) REMEDIES.—If the District Court determines that a violation has occurred, the court may order the organization which committed the violation—

(A) to reinstate the employee to the employee's former position;

(B) to pay compensatory damages; or

(C) to take other appropriate actions to remedy any past discrimination.

(4) LIMITATION.—The protections of this subsection shall not apply to any employee who—

(A) deliberately causes or participates in the alleged violation of law or regulation; or

(B) knowingly or recklessly provides substantially false information to the Federal or State official involved.

(e) PROTECTION OF ADVOCACY FUNCTIONS.—No managed care organization shall terminate, vary the compensation or working conditions, or refuse to renew a contract for participation with a health care professional because the professional has—

(1) advocated on behalf of an enrollee,

(2) filed a complaint against the organization,

(3) appealed a decision of the organization,

(4) provided information or filed a report with an appropriate Federal or State official, or

(5) requested a hearing or review pursuant to this Act.

SEC. 7. NONDISCRIMINATION AGAINST ENROLLEES AND IN THE SELECTION OF PARTICIPATING PROVIDERS; EQUITABLE ACCESS TO NETWORKS.

(a) NONDISCRIMINATION AGAINST ENROLLEES.—No managed care organization may discriminate (directly or through contractual arrangements) against any enrollee on the basis of age, gender, disability, health status, genetic information, or anticipated need for health services.

(b) NONDISCRIMINATION IN SELECTION OF PARTICIPATING HEALTH CARE PROFESSIONALS.—A managed

care organization shall not discriminate in selecting participating health care professionals (or in establishing the terms and conditions for such participation) on the basis of—

(1) the race, national origin, gender, age, or disability (other than a disability that impairs the ability of an individual to provide health care services or that may threaten the health of enrollees) of the professional; or

(2) the professional's lack of affiliation with, or admitting privileges at, a hospital (unless such lack of affiliation is a result of infractions of quality standards and is not due to a professional's type of license).

(c) NONDISCRIMINATION IN ACCESS TO HEALTH PLANS.—

(1) IN GENERAL.—Subject to paragraph (2), a managed care organization shall not discriminate in participation, reimbursement, or indemnification against a health care professional, who is acting within the scope of the professional's license or certification under applicable State law, solely on the basis of such license or certification.

(2) CONSTRUCTION.—Nothing in this subsection shall be construed as a requirement to in-

clude for participation every willing health care professional who meets the terms and conditions of a managed care organization.

SEC. 8. DISCLOSURE OF INFORMATION.

(a) PROVISION OF INFORMATION AND ORIENTATION.—

(1) GENERAL REQUIREMENT.—A managed care organization offering a managed care plan shall provide enrollees and, upon request, prospective enrollees with written information concerning the terms and conditions of the plan, including the information described in subsection (c).

(2) INFORMATION UPON REQUEST.—In addition to the information provided under subsection (c), a managed care organization offering a managed care plan shall provide, upon request of an enrollee or prospective enrollee, the information described in subsection (d).

(3) REQUIREMENT FOR INITIAL INFORMATION SESSION.—

(A) IN GENERAL.—Within 30 days of enrolling an individual under a managed care plan, the managed care organization shall provide for an in-person information session with

the enrollee for the purpose of outlining the information described in this section.

(B) PAYMENT.—Such a session shall be held with an enrollee before the enrollee is required to pay for services. This subparagraph shall not affect the coverage of items and services under the plan immediately upon the effective date of enrollment.

(4) COMPARATIVE FORM.—The information provided under this section shall be in a form, specified by the Secretary, so that prospective enrollees may compare the attributes of all such plans offered within a 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.

(c) REQUIRED INFORMATION.—Information required under subsection (a)(1) shall include information concerning each of the following:

(1) COVERAGE AND BENEFITS.—Coverage provisions, benefits, and any exclusions by category of service or product, including 24-hour coverage of emergency services without a requirement for prior approval.

(2) PRIOR AUTHORIZATION REQUIREMENTS.—Prior authorization requirements for coverage of benefits.

(3) UTILIZATION REVIEW POLICIES.—Utilization review procedures and policies (including preauthorization review, concurrent review, post-service review, post-payment review procedures that may lead an enrollee to be denied coverage for or not be provided a particular service or product), including time frames for review decisions and enrollee rights relating to notice, reconsideration, and appeal of utilization review decisions, and including information on the percentage of utilization review determinations that disagree with the judgment of the initial treating health care professional and the percentage of such determinations which are reversed (whether internally or externally) on appeal.

(4) PAYMENT METHODS.—Types of methodologies used by the organization to reimburse types of providers or for types of services.

(5) ENROLLEE FINANCIAL RESPONSIBILITIES.—Enrollees' financial responsibility for services, including any variation in the responsibility based on whether the provider is a participating provider.

(6) GRIEVANCE PROCEDURES.—Grievance procedures.

(7) PROVIDER SELECTION PROCEDURES.—Procedures used by enrollees to select and change primary and specialty providers and to be referred to nonparticipating providers and appropriate specialists, consistent with the requirements of this Act.

(8) ENROLLEE PARTICIPATION IN POLICY DEVELOPMENT.—Procedures which enrollees may use to participate in development of policy of the organization.

(9) PROCEDURES FOR NON-ENGLISH PROFICIENT ENROLLEES.—Procedures which the organization has established to meet the needs of enrollees who are not proficient in English.

(10) INFORMATION.—An address and phone number at which enrollees and prospective enrollees can obtain information about the organization and managed care plans offered by the organization.

(11) LIST OF CONTRACT FACILITIES.—A list, annually updated, of the facilities and providers, by specialty, through which the organization provides its benefits. For each such facility or provider the list shall include the name, address, phone number, and (in the case of a physician) board certification.

(12) NON-HEALTH CARE EXPENDITURES.—A statement of the percentage of health-care related revenues of the organization used for administration, the percentage of such revenues used for marketing, and the percentage of such revenues attributable to profit.

(13) ENROLLEE SATISFACTION.—Statistics on enrollee satisfaction, stated separately for those who continue enrollment and those who discontinue enrollment, and on the proportion of enrollees who disenroll.

(14) AVAILABILITY OF PROVIDERS; PROVIDER INCENTIVES.—The characteristics and availability of participating health care providers and professionals, including a description of any financial or contractual arrangements with hospitals, utilization review organizations, physicians, or other health care providers or professionals that would affect the services offered, referral or treatment options, or providers' fiduciary responsibility to patients, including any financial or other incentives regarding the provision, denial, or limitation of needed services.

(15) QUALITY INDICATORS.—Indicators that measure the quality of services provided by the organization and by participating health providers with

the organization, including population-based statistics such as immunization rates and performance measures such as survival after surgery, adjusted for case mix.

(16) PHYSICIAN CREDENTIALING STANDARDS.—Standards used by the organization in the credentialing of participating physicians.

(17) FORMULARIES.—Information on prescription drug formularies used by the organization, consistent with section 4(i).

(18) LOSS-RATIO.—Its loss-ratio.

(d) INFORMATION SUPPLIED UPON REQUEST.—For purposes of subsection (a)(2), the information described in this subsection concerning a managed care organization offering a managed care plan is as follows:

(1) ANNUAL FINANCIAL STATEMENT.—The most recent annual financial statement of the organization.

(2) SUBSCRIBER CONTRACT.—A copy of the most recent individual, direct pay subscriber contract, or, in the case of a group health plan, any contract between the plan and a health insurance issuer providing coverage under the plan.

(3) CONSUMER COMPLAINTS.—Information relating to consumer complaints compiled pursuant to insurance or other law.

(4) CHARGES AND BENEFITS FOR SERVICES.—Information on the enrollee charges for all covered items and services, including, for the point of service option described in section 5(e), the amounts that are payable with respect to items and services furnished by nonparticipating health care professionals and providers.

(5) CONFIDENTIALITY OF MEDICAL RECORDS.—Information on the procedures used by the organization to protect the confidentiality of medical records maintained in relation to enrollees.

(6) QUALITY ASSURANCE PROGRAMS.—A description of quality assurance programs maintained by the organization in relation to the plan.

(7) COVERAGE OF EXPERIMENTAL OR INVESTIGATIONAL DRUGS.—A description of procedures used by the organization to determine whether drugs, devices, or treatments in clinical trials are experimental or investigational.

(8) PROVIDER AFFILIATIONS.—Information on affiliations of participating health care professionals with participating hospitals.

(9) CLINICAL REVIEW CRITERIA.—Upon written request, a description of the specific clinical written review criteria relating to a particular condition or disease and how such criteria are used.

(10) PARTICIPATION PROCEDURES AND QUALIFICATIONS.—A description of the written application procedures and qualification requirements for providers to be considered for participation under the plan.

(11) OFFICIALS.—A list of the names, business addresses, and official positions of the membership of the board of directors, officers, or persons with an ownership or control interest in the organization.

(e) NOTICE OF TERMINATION OF PROVIDERS.—A managed care organization shall provide written notice to each enrollee within 15 business days of the date that the organization is aware that the participation of a health care provider, that is currently in a course of treating the enrollee, is being withdrawn or terminated. The organization shall include in such notice the procedures under section 5(f) for the enrollee to continue to receive care from the provider.

SEC. 9. GRIEVANCE PROCEDURES AND DEADLINE FOR RESPONDING TO REQUESTS FOR COVERAGE OF SERVICES.

(a) GRIEVANCE PROCEDURES.—A managed care organization shall provide meaningful procedures for hearing and resolving grievances between the organization (or any entity or individual through which the organization provides health care services) and its enrollees.

(b) DETAILS.—The procedures provided under subsection (a) 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;

(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 the organization about a complaint, the organization (if requested) must send the enrollee a complaint form that includes the telephone numbers and addresses of member services, and a description of the organization's grievance procedure.

The Secretary may establish deadlines for the complaint procedures under paragraph (5) in order to ensure timely resolution of disputes involving immediately and urgently needed services.

(c) APPEALS PROCESS.—Each managed care organization shall adopt an appeals process to enable enrollees to appeal decisions that are adverse to them. Such a process shall include—

(1) the right to a review by a grievance panel composed of clinical peer professionals who are in the same or similar specialty or field that would provide the item or service involved in the grievance;

(2) the right to a second review with a different panel that is independent of the organization and that is composed of clinical peer professionals who are in the same or similar specialty or field that would provide the item or service involved in the grievance, or to a review through an impartial arbi-

tration process which shall be described in writing by the organization;

(3) a process for completion of review in the case of urgent or emergency care services within 24 hours; and

(4) covering the costs of all appeals and not imposing any such costs on an enrollee.

The Secretary shall develop guidelines for the structure and requirements applicable to the independent review panel and impartial arbitration process described in paragraph (2).

(d) WRITTEN DECISION.—With respect to the complaint, grievance, and appeals processes required under this section, the organization shall, upon the request of an enrollee, provide the enrollee a written decision concerning a complaint, grievance, or appeal in a timely manner consistent with subsections (c)(3) and (f).

(e) CONSTRUCTION.—The complaint, grievance, and appeals processes established in accordance with this section may not be used in any fashion to discourage or prevent an enrollee from receiving medically necessary care in a timely manner.

(f) PROMPT RESPONSE TO REQUESTS FOR SERVICES.—In addition to the procedures available pursuant to the previous provisions of this section, in the case of

the request of an enrollee with a managed care organization—

(1) the organization shall respond to the request not later than 24 hours after the request is made; and

(2) the organization shall hear and resolve the enrollee's appeal of a denial of coverage of such services in accordance with a process meeting standards established by the Secretary.

SEC. 10. DUE PROCESS FOR HEALTH CARE PROFESSIONALS AND PROVIDERS.

(a) IN GENERAL.—A managed care organization shall—

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

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

(3) provide for review of each application by a credentialing committee with appropriate representation of the category or type of health care professional or provider;

(4) select participating health care professionals and providers based on objective standards of quality developed with the suggestions and advice of professional associations, health care professionals, and providers;

(5) make such selection standards available to—

(A) those applying to become a participating provider or health care professional,

(B) health plan purchasers, and

(C) enrollees;

(6) when economic considerations are taken into account in selecting participating health care professionals and providers, use objective criteria that are available to those applying to become a participating provider or health care professional and enrollees;

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

(8) make the results of such profiling available to insurance purchasers, enrollees, and the health care professional or provider involved;

(9) notify any health care professional or provider being reviewed under the process referred to in paragraph (3) of any information indicating that the health care professional or provider fails to meet the standards of the organization;

(10) offer a health care professional or provider receiving notice pursuant to the requirement of paragraph (9) with an opportunity to—

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

(B) submit supplemental or corrected information;

(11) not include in its contracts with participating health care professionals and providers a provision permitting the organization to terminate the contract ''without cause'';

(12) provide a due process appeal that conforms to the process specified in section 412 of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11112) for all determinations that are adverse to a health care professional or provider; and

(13) unless a health care professional or provider poses an imminent harm to enrollees or an adverse action by a governmental agency effectively im-

pairs the ability to provide health care items and services, provide—

(A) reasonable notice of any decision to terminate a health care professional or provider ''for cause'' (including an explanation of the reasons for the determination),

(B) an opportunity to review and discuss all of the information on which the determination is based, and

(C) an opportunity to enter into a corrective action plan, before the determination becomes subject to appeal under the process referred to in paragraph (12).

(b) LIMITATION ON USE OF NON-COMPETE CLAUSES.—A managed care organization may not (directly or indirectly) seek to enforce any contractual provision which prevents a health care professional or provider whose contractual obligations to the organization for the provision of services through the organization have ended from joining or forming any competing managed care organization, whether or not the organization serves the same geographic area.

(c) EQUAL COMPENSATION ARRANGEMENTS.—

(1) IN GENERAL.—Subject to paragraph (2), a managed care organization shall provide for com-

parable payment for all health care professionals and providers in the same field or specialty located in the same geographic area.

(2) ADJUSTMENTS AUTHORIZED.—A managed care organization may adjust the amount of compensation among professionals and providers for experience and other relevant factors, including bonus payments that reflect quality factors, such as enrollee satisfaction and medical chart reviews, unless such payments are based solely on cost-effectiveness of services provided.

(d) RULE OF CONSTRUCTION.—The requirements of subsection (a) shall not be construed as preempting or superseding any other reviews and appeals a managed care organization is required by law to make available.

SEC. 11. REQUIREMENTS FOR QUALITY IMPROVEMENT PROGRAM AND UTILIZATION REVIEW PROGRAMS.

(a) QUALITY IMPROVEMENT PROGRAM.—

(1) IN GENERAL.—A managed care organization shall establish a quality improvement program (consistent with paragraph (2)) that systematically and continuously assesses and improves—

(A) enrollee health status, patient outcomes, processes of care, and enrollee satisfac-

tion associated with health care provided by the organization; and

(B) the administrative and funding capacity of the organization to support and emphasize preventive care, utilization, access and availability, cost effectiveness, acceptable treatment modalities, specialists referrals, the peer review process, and the efficiency of the administrative process.

(2) FUNCTIONS.—A quality improvement program established pursuant to paragraph (1) shall—

(A) assess the performance of the organization and its participating health care professionals and providers and report the results of such assessment to purchasers, participating health care professionals and providers, and administrative personnel;

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

(C) analyze quality assessment data to determine specific interactions in the delivery system (both the design and funding of the health care coverage and the clinical provision of care)

that have an adverse impact on the quality of care.

(b) UTILIZATION REVIEW.—The utilization review program of a managed care organization shall—

(1) be developed (including any screening criteria used by such program) with the involvement of participating health professionals and providers;

(2) to the extent consistent with the protection of proprietary business information (as defined for purposes of section 552 of title 5, United States Code) release, upon request, to affected health professionals, providers, and enrollees the screening criteria, weighting elements, and computer algorithms used in reviews and a description of the method by which they were developed;

(3) uniformly apply review criteria that are based on sound scientific principles and the most recent medical evidence;

(4) use licensed, accredited, or certified health professionals to make review determinations (and for services requiring specialized training for their delivery, use a health professional who is qualified through equivalent specialized training and experience);

(5) subject to reasonable safeguards, disclose to health professionals and providers, upon request, the names and credentials of individuals conducting utilization review;

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

(7) comply with the requirement of section 4(d)(1) that prior authorization not be required for emergency and related services furnished in a hospital emergency department;

(8) make prior authorization determinations—

(A) in the case of services that are urgent care services described in section 4(d)(2)(C), within 30 minutes of a request for such determination, and

(B) in the case of other services, within 24 hours after the time of a request for determination;

(9) include in any notice of such determination an explanation of the basis of the determination and the right to an immediate appeal;

(10) treat a favorable prior authorization review determination as a final determination for purposes of making payment for a claim submitted for the

item or service involved unless such determination was based on false information knowingly supplied by the person requesting the determination;

(11) provide timely access, as defined by the applicable State authority, to utilization review personnel and, if such personnel are not available, waives any prior authorization that would otherwise be required; and

(12) provide notice of an initial determination on payment of a claim within 30 days after the date the claim is submitted for such item or service, and include in such notice an explanation of the reasons for such determination and of the right to an immediate appeal.

SEC. 12. MINIMUM LOSS RATIOS; GENERAL CONSUMER PROTECTIONS.

(a) MINIMUM LOSS RATIO.—The loss-ratio (as defined by the Secretary) for a managed care organization shall not be less than 85 percent with respect to managed care plans it offers.

(b) PARTICIPATION IN POLICY DEVELOPMENT.—A managed care organization shall have a procedure whereby enrollees may participate in the development of policies of the organization.

(c) NEEDS OF NON-ENGLISH PROFICIENT ENROLLEES.—A managed care organization shall have procedures for addressing the needs of enrollees who are not proficient in English.

○