

104<sup>TH</sup> CONGRESS  
2<sup>D</sup> SESSION

# H. R. 4220

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

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## IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 26, 1996

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

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## A BILL

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

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

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

2 (a) **SHORT TITLE.**—This Act may be cited as the  
3 “Managed Care Consumer Protection Act of 1996”.

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

Sec. 1. Short title; table of contents.

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

“Subtitle L—Protections for Beneficiaries Under Managed Care Plans

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

“SUBCHAPTER A—IMPOSITION OF TAX

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

“Sec. 9902. Definitions.

“SUBCHAPTER B—REQUIREMENTS

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

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

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

“Sec. 9914. Providing information.

“Sec. 9915. Restrictions on commissions for agents.

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

“Sec. 9917. Patient access to clinical studies.

“Sec. 9918. Required minimum childbirth benefits.

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

Subtitle C—Effective Date

Sec. 121. Effective date.

**TITLE II—MEDICARE**

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

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

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

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

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

Sec. 206. Coordination of Medicare enrollment.

## TITLE III—MEDICAID

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

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

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

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

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

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

“Subchapter A. Imposition of tax.

“Subchapter B. Requirements.

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

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

“Sec. 9902. Definitions.

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

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

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

3           “(2) an insurer that offers managed care health  
4 insurance coverage (other than to a group health  
5 plan subject to paragraph (1)) to meet the require-  
6 ments of such subchapter.

7           “(b) AMOUNT OF TAX.—

8           “(1) GROUP HEALTH PLAN.—

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

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

21           “(2) INSURER OFFERING INDIVIDUAL HEALTH  
22 INSURANCE COVERAGE.—The amount of tax im-  
23 posed by subsection (a)(2) on any failure of an in-  
24 surer with respect to an individual described in para-  
25 graph (1) or (2) of section 9902(b) shall be 25 per-

1 cent of the total amount of the premiums paid to the  
2 insurer for such coverage for the plan year in which  
3 such failure occurs.

4 “(c) LIMITATIONS ON AMOUNT OF TAX.—

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

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

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

18 “(B) such failure is corrected during the  
19 30-day period beginning on the 1st date any of  
20 the persons referred to in subsection (e) knew,  
21 or exercising reasonable diligence would have  
22 known, that such failure existed.

23 “(3) WAIVER.—In the case of a failure which is  
24 due to reasonable cause and not to willful neglect,  
25 the Secretary may waive part or all of the tax im-

1 posed by subsection (a) to the extent that the pay-  
2 ment of such tax would be excessive relative to the  
3 failure involved.

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

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

8 “(2) any church plan (within the meaning of  
9 section 414(e)).

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

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

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

17 **“SEC. 9902. DEFINITIONS.**

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

20 “(1) ENROLLEE.—The term ‘enrollee’ means,  
21 with respect to a group health plan or health insur-  
22 ance issuer offering health insurance coverage, an  
23 individual enrolled with the plan or enrolled with the  
24 issuer with respect to such coverage.

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

5                   “(A) provides or arranges for the provision  
6                   of health care items and services to enrollees  
7                   primarily through participating physicians and  
8                   providers, or

9                   “(B) provides financial incentives (such as  
10                  variable copayments and deductibles) to induce  
11                  enrollees to obtain benefits primarily through  
12                  participating physicians and providers,

13           or both.

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

21           “(4) PROVIDER NETWORK.—The term ‘provider  
22           network’ means, with respect to a plan or issuer,  
23           providers of health care services provided by or  
24           through the plan or issuer who have entered into an  
25           agreement with the plan or issuer or an agreement

1 with a subcontracting organization under which the  
 2 providers are obligated to provide such services to  
 3 individuals enrolled with the plan or issuer.

4 “(b) **ADDITIONAL DEFINITIONS.**—The provisions of  
 5 section 9805 apply for purposes of this chapter in the  
 6 same manner as they apply for purposes of chapter 100.

7 **“Subchapter B—Requirements**

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

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

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

“Sec. 9914. Providing information.

“Sec. 9915. Restrictions on commissions for agents.

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

“Sec. 9917. Patient access to clinical studies.

“Sec. 9918. Required minimum childbirth benefits.

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

8 **“SEC. 9911. REQUIREMENTS RELATING TO MANAGED CARE**  
 9 **PLANS AND COVERAGE AND PROVIDERS OF**  
 10 **HEALTH SERVICES.**

11 “(a) **UTILIZATION REVIEW.**—

12 “(1) **MEETING REQUIREMENTS.**—

13 “(A) **IN GENERAL.**—A managed care  
 14 group health plan (or health insurance issuer  
 15 that offers managed care health insurance cov-  
 16 erage) may not deny coverage of or payment for  
 17 items and services on the basis of a utilization  
 18 review program unless the Secretary of Health  
 19 and Human Services certifies (and periodically

1           recertifies) that the program meets the stand-  
2           ards established by such Secretary under this  
3           subsection.

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

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

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

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

5                   “(i) the delegated and nondelegated  
6                   activities under the program;

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

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

14           “(B) with respect to the administration of  
15           the utilization review program, the plan or is-  
16           suer may not employ utilization reviewers or  
17           contract with a utilization management organi-  
18           zation if the conditions of employment or the  
19           contract terms include financial incentives to  
20           reduce or limit the medically necessary or ap-  
21           propriate services provided to covered individ-  
22           uals and individuals performing utilization re-  
23           view may not receive financial compensation  
24           based upon the number of denials of coverage;

1           “(C) the plan or issuer shall develop proce-  
2           dures for periodically reviewing and modifying  
3           the utilization review of the plan or relating to  
4           the coverage under which providers may partici-  
5           pate in the plan or coverage in the development  
6           and review of utilization review policies and  
7           procedures;

8           “(D) utilization review—

9           “(i) shall be conducted in accordance  
10           with uniformly applied standards that are  
11           based on the most currently available med-  
12           ical evidence,

13           “(ii) shall develop and apply recorded  
14           (written or otherwise) utilization review de-  
15           cision protocols based on sound medical  
16           evidence;

17           “(E) the clinical review criteria used under  
18           the utilization review decision protocols to as-  
19           sess the appropriateness of medical services  
20           shall be clearly documented and available to  
21           participating health professionals upon request  
22           and shall include a mechanism for assessing the  
23           consistency of the application of the criteria  
24           used under the protocols across reviewers, and

1 a mechanism for periodically updating such cri-  
2 teria;

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

20 “(G) negative determinations of the medi-  
21 cal necessity or appropriateness of services or  
22 the site at which services are furnished may be  
23 made only by clinically qualified personnel;

24 “(H) the utilization review program shall  
25 provide for a process under which an enrollee or

1 provider may obtain timely review of a denial of  
2 coverage under section 9912; and

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

9 “(b) ASSURANCE OF ACCESS.—

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

19 “(2) ACCESS TO SPECIALIZED TREATMENT EX-  
20 PERTISE.—Such a plan or issuer shall demonstrate  
21 that enrollees have access, when medically or clini-  
22 cally indicated in the judgment of the treating health  
23 professional, to specialized treatment expertise.

24 “(3) COORDINATION OF CARE.—

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

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

18           “(4) NO WAIVER.—

19           “(A) IN GENERAL.—The requirements of  
20           this subsection may not be waived and shall be  
21           met in all areas where the plan or issuer (in re-  
22           lation to managed care health insurance cov-  
23           erage) has enrollees, including rural areas.

24           “(B) OUT-OF-PLAN COVERAGE.—If such a  
25           plan or issuer fails to meet the requirements of

1           this subsection, the plan or issuer shall arrange  
2           for the provision of out-of-plan or out-of-issuer  
3           services to enrollees in a manner that provides  
4           enrollees with access to services in accordance  
5           with this subsection.

6           “(c) ACCESS TO CENTERS OF EXCELLENCE.—

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

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

25                  “(A) to provide specialty care,

1           “(B) to deliver care for complex cases re-  
2           quiring specialized treatment or for individuals  
3           with chronic diseases, and

4           “(C) to meet other requirements that may  
5           be established by such Secretary relating to spe-  
6           cialized education and training of health profes-  
7           sionals, participation in peer-reviewed research,  
8           or treatment of patients from outside the geo-  
9           graphic area of the facility.

10          “(d) RECOGNITION OF TRAUMA CENTERS.—

11           “(1) IN GENERAL.—A managed care group  
12           health plan or health insurance issuer offering man-  
13           aged care health insurance coverage shall provide for  
14           health services contracted for and which are pro-  
15           vided to such an individual other than through the  
16           plan or coverage (including trauma services provided  
17           by designated trauma centers), if (A) the services  
18           were medically necessary and immediately required  
19           because of an unforeseen illness, injury, or condition  
20           and (B) it was not reasonable given the cir-  
21           cumstances to obtain the services through the plan  
22           or participating providers in relation to such cov-  
23           erage.

24           “(2) DEFINITION.—In paragraph (1), the term  
25           ‘designated trauma center’ has the meaning given

1 such term in section 1231 of the Public Health  
2 Service Act, and includes a trauma center which the  
3 Secretary finds meets the standards under section  
4 1213 of such Act to be a designated trauma center  
5 but is located in a State that has not designated  
6 trauma centers under such section.

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

14 “(f) COVERAGE OF SERVICES OF ESSENTIAL COM-  
15 MUNITY PROVIDERS.—

16 “(1) IN GENERAL.—The Secretary of Health  
17 and Human Services may require a managed care  
18 group health plan or health insurance issuer that of-  
19 fers managed health insurance coverage to enter into  
20 agreements with essential community providers serv-  
21 ing the plan’s or issuer’s service area (in relation to  
22 the coverage) to join the plan’s or issuer’s provider  
23 network if such Secretary finds that such agree-  
24 ments are necessary for the plan or issuer to make  
25 contracted for services (A) available and accessible

1 to each enrollee, within the area served by the plan  
2 or issuer (in relation to such coverage), with reason-  
3 able promptness and in a manner which assures con-  
4 tinuity, and (B) when medically necessary, available  
5 and accessible twenty-four hours a day and seven  
6 days a week.

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

16 “(g) DUE PROCESS PROTECTIONS FOR PROVID-  
17 ERS.—

18 (1) IN GENERAL.—In consultation with provid-  
19 ers of health care services who are members of the  
20 plan’s or issuer’s provider network, each managed  
21 care group health plan and each health insurance is-  
22 suer offering managed care health insurance cov-  
23 erage shall establish standards to be used by the  
24 plan or issuer (in relation to such coverage) for con-  
25 tracting with providers, and shall make descriptive

1 information regarding these standards available to  
2 enrollees, providers who are members of the net-  
3 work, and prospective enrollees and prospective  
4 members of the network.

5 “(2) LIMITATION ON TERMINATION.—

6 “(A) IN GENERAL.—Such a group health  
7 plan or health insurance issuer may not termi-  
8 nate or refuse to renew an agreement with a  
9 provider of health care services to participate in  
10 the plan’s or issuer’s provider network unless  
11 the plan or issuer provides written notification  
12 to the provider of the decision to terminate or  
13 refuse to renew the agreement. The notification  
14 shall include a statement of the reasons for the  
15 plan’s or issuer’s decision, consistent with the  
16 standards established under paragraph (1).

17 “(B) NOTICE.—Such a plan or issuer shall  
18 provide the notification required under subpara-  
19 graph (A) at least 45 days prior to the effective  
20 date of the termination or expiration of the  
21 agreement (whichever is applicable). The pre-  
22 vious sentence shall not apply if failure to ter-  
23 minate the agreement prior to the deadline  
24 would adversely affect the health or safety of an  
25 individual enrolled with the plan or issuer.

1 “(3) REVIEW PROCESS.—

2 “(A) IN GENERAL.—Each such plan or is-  
3 suer shall provide a process under which a pro-  
4 vider of health care services may request a re-  
5 view of the plan’s or issuer’s decision to termi-  
6 nate or refuse to renew the provider’s participa-  
7 tion agreement. Such review shall be conducted  
8 by a group of individuals the majority of whom  
9 are providers of health care services who are  
10 members of the plan’s or issuer’s provider net-  
11 work or employees of the plan or issuer, and, to  
12 the extent possible, who are members of the  
13 same profession as the provider who requests  
14 the review and, for physicians, the same medi-  
15 cal branch (allopathic or osteopathic medicine).

16 “(B) REPRESENTATION.—If the provider  
17 requests in advance, the plan or issuer shall  
18 permit an attorney representing the provider to  
19 be present at the provider’s review.

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

23 “(D) CONSTRUCTION.—Nothing in this  
24 paragraph shall be construed to affect any  
25 other provision of law that provides an appeals

1 process or other form of relief to a provider of  
2 health care services.

3 **“SEC. 9912. GRIEVANCE PROCEDURES AND DEADLINE FOR**  
4 **RESPONDING TO REQUESTS FOR COVERAGE**  
5 **OF SERVICES.**

6 “(a) GRIEVANCE PROCEDURES.—A managed care  
7 group health plan and a health insurance issuer offering  
8 managed care health insurance coverage shall provide  
9 meaningful procedures for hearing and resolving griev-  
10 ances between the plan or issuer (any entity or individual  
11 through which the plan or issuer provides health care serv-  
12 ices) and members enrolled with the plan or issuer.

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

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

18 “(2) documentation concerning the substance of  
19 complaints, grievances, and actions taken concerning  
20 such complaints and grievances, which shall be in  
21 writing.

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

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

1           “(5) procedures to expedite the complaint proc-  
2           ess if the complaint involves a dispute about the cov-  
3           erage of an immediately and urgently needed service;  
4           and

5           “(6) procedures to ensure that if an enrollee  
6           orally notifies the plan or issuer about a complaint,  
7           the plan or issuer (if requested) must send the en-  
8           rollee a complaint form that includes the telephone  
9           numbers and addresses of member services, and a  
10          description of the plan’s or issuer’s grievance proce-  
11          dure.

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

16       “(c) APPEALS PROCESS.—Such a plan or issuer shall  
17       adopt an appeals process to enable covered individuals to  
18       appeal decisions that are adverse to the individuals. Such  
19       a process shall include—

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

21           “(2) the right to a second review with a dif-  
22       ferent panel, independent of the plan or issuer, or to  
23       a review through an impartial arbitration process  
24       which shall be described in writing by the plan or is-  
25       suer; and

1           “(3) an expedited process for review in emer-  
2           gency cases.

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

7           “(d) WRITTEN DECISION.—With respect to the com-  
8 plaint, grievance, and appeals processes required under  
9 this section, the plan or issuer shall, upon the request of  
10 an enrollee, provide the enrollee a written decision con-  
11 cerning a complaint, grievance, or appeal in a timely fash-  
12 ion.

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

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

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

1           “(ii) the plan or issuer shall hear and resolve  
2           the enrollee’s appeal of a denial of coverage of such  
3           services in accordance with a process meeting stand-  
4           ards established by the Secretary of Health and  
5           Human Services.

6   **“SEC. 9913. REQUIREMENTS FOR SERVICE AREAS; NON-**  
7                           **DISCRIMINATION.**

8           “(a) SERVICE AREA REQUIREMENTS.—

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

20                   “(2) EXCEPTION.—The Secretary of Health  
21                  and Human Services may permit a plan’s or issuer’s  
22                  service area to exclude any portion of a metropolitan  
23                  statistical area (other than the central county of  
24                  such metropolitan statistical area) if—

1           “(A) the plan or issuer demonstrates that  
2           it lacks the financial or administrative capacity  
3           to serve the entire metropolitan statistical area;  
4           and

5           “(B) such Secretary finds that the com-  
6           position of the plan’s or issuer’s service area  
7           does not reduce the financial risk to the plan or  
8           issuer of providing services to enrollees because  
9           of the health status or other demographic char-  
10          acteristics of individuals residing in the service  
11          area (as compared to the health status or demo-  
12          graphic characteristics of individuals residing in  
13          the portion of the metropolitan statistical area  
14          not included in the plan’s or issuer’s service  
15          area).

16          “(b) NONDISCRIMINATION.—No group health plan  
17          and no health insurance issuer offering health insurance  
18          coverage may discriminate (directly or through contractual  
19          arrangements) in any activity, including the selection of  
20          a service area, that has the effect of discriminating against  
21          an individual on the basis of race, national origin, gender,  
22          language, socioeconomic status, age, disability, health sta-  
23          tus, or anticipated need for health services.

1 **“SEC. 9914. PROVIDING INFORMATION.**

2 “(a) INFORMATION ON PHYSICIAN INCENTIVE  
3 PLANS.—

4 “(1) IN GENERAL.—Upon the request of an en-  
5 rollee of a managed care group health plan or under  
6 managed care health insurance coverage offered by  
7 a health insurance issuer or an individual consider-  
8 ing enrollment with such a plan or for such cov-  
9 erage, the plan or issuer shall provide the enrollee or  
10 individual with descriptive information regarding any  
11 physician incentive plan of the plan or issuer appli-  
12 cable to such enrollment.

13 “(2) PHYSICIAN INCENTIVE PLAN DEFINED.—  
14 In this subsection, the term ‘physician incentive  
15 plan’ means any compensation arrangement between  
16 a managed care group health plan or health insur-  
17 ance issuer offering managed care health insurance  
18 coverage and a physician or physician group that  
19 may directly or indirectly have the effect of reducing  
20 or limiting services provided with respect to individ-  
21 uals enrolled with the plan or under such coverage.

22 “(b) INFORMATION ON PROVIDER CREDENTIALS.—  
23 Each managed care group health plan and each health in-  
24 surance issuer offering managed care health insurance  
25 coverage shall provide each enrollee, at the time of enroll-  
26 ment and not less frequently than annually thereafter, an

1 explanation of the credentials of the individuals and enti-  
2 ties providing services to enrollees under the plan or cov-  
3 erage.

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

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

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

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

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

23 “(5) Advance directives and organ donation.

24 “(6) The characteristics and availability of  
25 health care professionals and institutions participat-

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

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

16 “(8) An explanation of the appeals process and  
17 the grievance procedure.

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

20 “(10) Physician ownership and investment  
21 structure of the plan or issuer.

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

23 “(12) A description of lawsuits that are filed  
24 against the plan or issuer, insofar as they may have  
25 a material bearing on the financial circumstances of

1 the plan or issuer or reveal quality and medical cov-  
2 erage issues.

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

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

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

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

20 “(2) if an agent receives a commission from the  
21 plan or issuer with respect to an individual who en-  
22 rolls with the plan or under such coverage and the  
23 individual terminates enrollment with the plan or  
24 such coverage during the 90-day period beginning on

1 the date of the individual's enrollment, the plan or  
2 issuer shall recoup the commission from the agent.

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

4 “(a) IN GENERAL.—

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

13 “(A) a written contract or agreement with  
14 a health care provider,

15 “(B) a written statement to such a pro-  
16 vider, or

17 “(C) an oral communication to such a pro-  
18 vider.

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

23 “(A) Refusal to contract with the health  
24 care provider.

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

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

6           “(D) Refusal to compensate the health  
7 care provider for covered services.

8           “(E) Any other retaliatory action against  
9 the health care provider.

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

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

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

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

25           “(B) between—

1           “(i) the provider and a current,  
2           former, or prospective patient (or the  
3           guardian or legal representative of a pa-  
4           tient),

5           “(ii) the provider and any employee or  
6           representative of the plan or issuer, or

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

12          “(2) includes communications concerning—

13           “(A) any tests, consultations, and treat-  
14           ment options,

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

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

20           “(D) the basis or standard for the decision  
21           of a managed care group health plan or health  
22           insurance issuer in relation to managed care  
23           health insurance coverage to authorize or deny  
24           health care services or benefits,

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

4           “(F) any financial incentives or disincentives  
5           provided by the plan or issuer to a health  
6           care provider that are based on service utilization.  
7           tion.

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

13          “(d) CONSTRUCTION.—Nothing in this section shall  
14          be construed as—

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

20                 “(2) preventing such a plan or issuer from acting  
21                 on information relating to treatment actually  
22                 provided to a patient or the failure of a health care  
23                 provider to comply with legal standards relating to  
24                 the provision of care.

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

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

8               “(1) the enrollee is participating in an approved  
9       clinical study,

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

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

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

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

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

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

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

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

18          “(a) MINIMUM CHILDBIRTH BENEFITS.—If a man-  
19          aged care group health plan or managed care health insur-  
20          ance coverage offered by a health insurance issuer pro-  
21          vides coverage that includes any benefits for inpatient care  
22          for childbirth for a mother or newborn child, the plan or  
23          issuer (in relation to such coverage) shall meet the follow-  
24          ing requirements:

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

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

24          “(3) NOTICE.—The plan or issuer shall provide  
25          notice to each enrollee eligible for childbirth benefits

1 under this subsection regarding the requirements of  
2 this section.

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

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

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

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

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

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

23 “(c) ADDITIONAL TERMS AND CONDITIONS.—

24 “(1) ATTENDING PROVIDER.—As used in this  
25 section, the term ‘attending provider’ means, with

1 respect to a mother and her newborn child, an obste-  
2 trician-gynecologist, pediatrician, family physician,  
3 or other physician, or any other health care provider  
4 (such as a nurse midwife or nurse practitioner),  
5 who, acting in accordance with applicable State law,  
6 is primarily responsible for the care of the mother  
7 and child.

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

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

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

20 “(3) **REGULATIONS REGARDING APPROPRIATE**  
21 **POST-CARE DELIVERY SETTINGS.**—The Secretary of  
22 Health and Human Services, with respect to regula-  
23 tions promulgated under subsection (a)(2) concern-  
24 ing appropriate post-delivery care settings—

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

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

6           “(C) shall consider both urban and rural  
7           settings.

8           “(4) RULE OF CONSTRUCTION.—Nothing in  
9           this section shall be construed to require that a  
10          mother—

11          “(A) give birth in a hospital; or

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

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

21          “(A) HEALTH INSURANCE COVERAGE.—By  
22          a health insurance issuer in relation to man-  
23          aged care health insurance coverage—

24                  “(i) to enrollees described in sub-  
25                  section (a) who are enrolled on the effec-

1           tive date of this chapter within 120 days  
2           after such effective date and annually  
3           thereafter, and

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

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

8                           “(i) to enrollees described in sub-  
9                           section (a) who are enrolled on the effec-  
10                           tive date of this chapter within 120 days  
11                           after such effective date, and

12                                   “(ii) for plan years beginning on or  
13                                   after such effective date, as part of its  
14                                   summary plan description.

15 **“SEC. 9919. ASSURING EQUITABLE HEALTH PLAN COV-**  
16 **ERAGE WITH RESPECT TO EMERGENCY SERV-**  
17 **ICES.**

18           “(a) PROHIBITION OF CONTRACTUAL LIMITATIONS  
19 ON COVERAGE OF EMERGENCY SERVICES.—A managed  
20 care group health plan or managed care health insurance  
21 coverage offered by a health insurance issuer that provides  
22 any coverage with respect to emergency services shall  
23 cover emergency services furnished to an enrollee of the  
24 plan or issuer (with respect to such managed care cov-  
25 erage)—

1           “(1) without regard to whether or not the pro-  
2           vider furnishing the emergency services has a con-  
3           tractual or other arrangement with the plan or is-  
4           suer for the provision of such services to such enroll-  
5           ees, and

6           “(2) without regard to prior authorization.

7           “(b) PROHIBITION OF DISCRIMINATORY PAYMENT  
8           OR COST-SHARING.—

9           “(1) IN GENERAL.—Such a plan or issuer that  
10          provides any coverage with respect to emergency  
11          services—

12                 “(A) shall determine and make prompt  
13                 payment in a reasonable and appropriate  
14                 amount for such services, and

15                 “(B) subject to paragraph (2), may not  
16                 impose cost-sharing for services furnished in a  
17                 hospital emergency department that is cal-  
18                 culated in a manner (such as the use of a dif-  
19                 ferent percentage) that imposes greater cost  
20                 sharing with respect to such services compared  
21                 to comparable services furnished in other set-  
22                 tings.

23           “(2) IMPOSITION OF REASONABLE COPAYMENT  
24           PERMITTED.—Such a plan or issuer may impose a  
25           reasonable copayment (as determined in accordance

1 with standards established by the Secretary of  
2 Health and Human Services) in lieu of coinsurance  
3 to deter inappropriate use of services of hospital  
4 emergency departments.

5 “(c) ASSURING TIMELINESS OF PRIOR AUTHORIZA-  
6 TION DETERMINATION FOR NEEDED CARE IDENTIFIED  
7 IN INITIAL EVALUATION.—

8 “(1) IN GENERAL.—

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

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

6                   “(i) has attempted to contact such a  
7 person for authorization—

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

10                           “(II) to provide the items and  
11 services to the enrollee,

12                   and access to the person has not been pro-  
13 vided (as required under subparagraph  
14 (A)), or

15                   “(ii) has requested such authorization  
16 from such a person and the person has not  
17 denied the authorization within 30 minutes  
18 after the time the request is made.

19           “(2) REFERRAL BY PHYSICIAN TO HOSPITAL  
20 EMERGENCY DEPARTMENT DEEMED PRIOR AUTHOR-  
21 IZATION.—If a participating physician or other per-  
22 son authorized to make prior authorization deter-  
23 minations for such a plan or issuer refers an enrollee  
24 to a hospital emergency department for evaluation  
25 or treatment, a request for prior authorization of the

1 items and services reasonably furnished the enrollee  
2 pursuant to such referral shall be deemed to have  
3 been made and approved.

4 “(3) EFFECT OF APPROVAL.—

5 “(A) IN GENERAL.—Approval of a request  
6 for a prior authorization determination (includ-  
7 ing a deemed approval under paragraph (1) or  
8 (2)) shall be treated as approval of any health  
9 care items and services required to treat the  
10 medical condition identified pursuant to a  
11 screening evaluation referred to in paragraph  
12 (1)(A).

13 “(B) PAYMENT.—Such a plan or issuer  
14 may not subsequently deny or reduce payment  
15 for an item or service furnished pursuant to  
16 such an approval unless the approval was based  
17 on information about the medical condition of  
18 an enrollee that was fraudulent.

19 “(d) ENCOURAGING APPROPRIATE USE OF 911  
20 EMERGENCY TELEPHONE NUMBER.—Such a plan or is-  
21 suer—

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

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

5           “(B) an explanation of what is an emer-  
6           gency medical condition;

7           “(2) shall not discourage appropriate use of the  
8           911 emergency telephone number by enrollees with  
9           emergency medical conditions; and

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

14          “(e) EFFECT ON STATE LAW.—

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

19          “(2) CONSUMER PROTECTIONS.—A provision of  
20          State law shall not be considered to conflict directly  
21          with this section if the provision provides the enroll-  
22          ees with protections that exceed the protections of  
23          this section.

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

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

8           “(2) EMERGENCY DEPARTMENT.—The term  
9 ‘emergency department’ includes, with respect to a  
10 hospital, a trauma center in the hospital if the cen-  
11 ter—

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

14                   “(B) is in a State that has not made such  
15 designations and is determined by the Secretary  
16 to meet the standards under such section for  
17 such designation.

18           “(3) EMERGENCY MEDICAL CONDITION.—The  
19 term ‘emergency medical condition’ means a medical  
20 condition, the onset of which or change in which is  
21 sudden, that manifests itself by symptoms of suffi-  
22 cient severity, including severe pain, that a prudent  
23 layperson, who possesses an average knowledge of  
24 health and medicine, could reasonably expect the ab-  
25 sence of immediate medical attention to result in—

1           “(A) placing the person’s health in serious  
2           jeopardy,

3           “(B) serious impairment to bodily func-  
4           tions, or

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

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

9           “(A) health care items and services fur-  
10          nished in the emergency department of a hos-  
11          pital, and

12          “(B) ancillary services routinely available  
13          to such department,

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

17          “(5) PRIOR AUTHORIZATION DETERMINA-  
18          TION.—The term ‘prior authorization determination’  
19          means, with respect to health care items and serv-  
20          ices for which coverage may be provided under a  
21          group health plan or health insurance coverage, a  
22          determination, before the provision of the items and  
23          services and as a condition of coverage of the items  
24          and services under the plan or coverage, that cov-

1 erage will be provided for the items and services  
2 under the plan or coverage.

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

10 “(7) 911 EMERGENCY TELEPHONE NUMBER.—  
11 The term ‘911 emergency telephone number’ in-  
12 cludes, in the case of a geographic area where 911  
13 is not in use for emergencies, such other telephone  
14 number as is in use for emergencies.”

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

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

19 (c) EFFECTIVE DATE.—The requirement of section  
20 9902 of the Internal Revenue Code of 1986 (as added by  
21 subsection (a) of this section) shall take effect on January  
22 1, 1998, and shall apply to coverage offered on or after  
23 such date regardless of whether the plan year began before  
24 such date.

1           **Subtitle C—Effective Date**

2   **SEC. 121. EFFECTIVE DATE.**

3           The amendments made by this title shall apply with  
4 respect to contract years beginning on or after January  
5 1, 1998.

6           **TITLE II—MEDICARE**

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

8                   **UNTIL COMPLETION OF ORIENTATION AND**  
9                   **MEDICAL PROFILE.**

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

13          “(G)(i) The Secretary may not make a payment to  
14 an eligible organization under a risk-sharing contract  
15 under this section with respect to an enrollee until the eli-  
16 gible organization certifies to the Secretary that the orga-  
17 nization—

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

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

22          “(ii) The orientation required under this subpara-  
23 graph includes an explanation of the following features of  
24 the health plan offered by such organization:

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

3           “(II) The information required under section  
4           9914 of the Internal Revenue Code of 1986.

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

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

18          (c) EFFECTIVE DATE.—The amendment made by  
19          subsection (a) applies with respect to enrollees as of the  
20          first day of the first month that begins more than 60 days  
21          after the date on which the Secretary first publishes the  
22          rule under subsection (b) in the Federal Register.

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

4 (a) REQUIREMENT OF COMMUNITY RATING.—

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

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

12 (B) by inserting after paragraph (2) the  
13 following new paragraph:

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

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

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

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

10           “(I) the highest premium rate minus the lowest  
 11 premium rate, divided by

12           “(II) the lowest premium rate,  
 13 expressed as a percentage.

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

17           “(1) Each metropolitan statistical area.

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

20           (2) CONFORMING AMENDMENT.—Section  
 21 1882(s)(2)(A) of such Act (42 U.S.C.  
 22 1395ss(s)(2)(A)) is amended by striking “, or dis-  
 23 criminate in the pricing of the policy,”.

24           (b) INCREASE IN LOSS RATIO.—Section  
 25 1882(r)(1)(A) of such Act (42 U.S.C. 1395ss(r)(1)(A)) is

1 amended by striking “75 percent” and all that follows  
2 through the semicolon and inserting “85 percent;”.

3 (c) EFFECTIVE DATE.—

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

21 (2) SECRETARY STANDARDS.—If the NAIC  
22 does not make changes in the 1991 NAIC Model  
23 Regulation (as so defined) within the 6-month period  
24 specified in paragraph (1), the Secretary of Health  
25 and Human Services (in this subsection as the “Sec-

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

11               (3) DATE SPECIFIED.—

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

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

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

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

24                           (i) requiring State legislation (other  
25                           than legislation appropriating funds) in

1 order for medicare supplemental policies to  
2 meet the 1996 NAIC Model Regulation or  
3 the 1996 Federal Regulation, but

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

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

17 **SEC. 203. OTHER ADDITIONAL CONSUMER PROTECTIONS**  
18 **FOR MEDICARE SUPPLEMENTAL INSURANCE.**

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

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

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

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

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

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

15                “(iii) may not impose an exclusion of benefits  
16                based on a pre-existing condition,  
17                in the case of an individual described in subparagraph (B)  
18                who seeks to enroll under the policy not later than 63 days  
19                after the date of the termination of enrollment described  
20                in such subparagraph.

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

23                 “(i) The individual is enrolled with an eligible  
24                 organization under a contract under section 1876 or  
25                 with an organization under an agreement under sec-

1       tion 1833(a)(1)(A) and such enrollment ceases ei-  
2       ther because the individual moves outside the service  
3       area of the organization under the contract or agree-  
4       ment or because of the termination or nonrenewal of  
5       the contract or agreement.

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

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

21              “(iv) The individual is enrolled under an em-  
22      ployee welfare benefit plan that provides health ben-  
23      efits that supplement the benefits under this title  
24      and the plan terminates or ceases to provide (or sig-

1 significantly reduces) such supplemental health benefits  
2 to the individual.

3 “(v)(I) The individual is enrolled with an eligi-  
4 ble organization under a contract under section  
5 1876 or with an organization under an agreement  
6 under section 1833(a)(1)(A) and such enrollment is  
7 terminated by the enrollee during the first 12  
8 months of such enrollment, but only if the individual  
9 never was previously enrolled with an eligible organi-  
10 zation under a contract under section 1876 or with  
11 an organization under an agreement under section  
12 1833(a)(1)(A).

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

19 “(C)(i) Subject to clause (ii), a Medicare supple-  
20 mental policy described in this subparagraph, with respect  
21 to an individual described in subparagraph (B), is a policy  
22 the benefits under which are comparable or lesser in rela-  
23 tion to the benefits under the enrollment described in sub-  
24 paragraph (B) (or, in the case of an individual described

1 in clause (ii), under the most recent Medicare supple-  
2 mental policy described in clause (ii)(II)).

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

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

6 “(II) was enrolled in a Medicare supplemental  
7 policy within the 63 day period before the enrollment  
8 described in such subparagraph.

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

17 “(D) At the time of an event described in subpara-  
18 graph (B) because of which an individual ceases enroll-  
19 ment or loses coverage or benefits under a contract or  
20 agreement, policy, or plan, the organization that offers the  
21 contract or agreement, the insurer offering the policy, or  
22 the administrator of the plan, respectively, shall notify the  
23 individual of the rights of the individual, and obligations  
24 of issuers of Medicare supplemental policies, under sub-  
25 paragraph (A).”.

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

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

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

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

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

17 “(II) may not discriminate in the pricing of the  
18 policy on the basis of the individual’s health status,  
19 medical condition (including both physical and men-  
20 tal illnesses), claims experience, receipt of health  
21 care, medical history, genetic information, evidence  
22 of insurability (including conditions arising out of  
23 acts of domestic violence), or disability.

24 “(ii) An individual described in this clause is an indi-  
25 vidual for whom an application is submitted before the end

1 of the 6-month period beginning with the first month as  
2 of the first day on which the individual is 65 years of age  
3 or older and is enrolled for benefits under part B.”.

4 (d) EXTENDING 6-MONTH INITIAL ENROLLMENT  
5 PERIOD TO NON-ELDERLY MEDICARE BENEFICIARIES.—

6 Section 1882(s)(2)(A)(ii) of such Act (42 U.S.C.  
7 1395ss(s)(2)(A)), as amended by subsection (c), is amend-  
8 ed by striking “is submitted” and all that follows and in-  
9 serting the following: “is submitted—

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

14 “(II) for each time the individual becomes eligi-  
15 ble for benefits under part A pursuant to section  
16 226(b) or 226A and is enrolled for benefits under  
17 part B, before the end of the 6-month period begin-  
18 ning with the first month as of the first day on  
19 which the individual is so eligible and so enrolled.”.

20 (e) EFFECTIVE DATES.—

21 (1) GUARANTEED ISSUE.—The amendment  
22 made by subsection (a) shall take effect on July 1,  
23 1997.

24 (2) LIMIT ON PREEXISTING CONDITION EXCLU-  
25 SIONS.—The amendment made by subsection (b)

1 shall apply to policies issued on or after July 1,  
2 1997.

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

7 (4) EXTENSION OF ENROLLMENT PERIOD TO  
8 DISABLED INDIVIDUALS.—

9 (A) IN GENERAL.—The amendment made  
10 by subsection (d) shall take effect on July 1,  
11 1997.

12 (B) TRANSITION RULE.—In the case of an  
13 individual who first became eligible for benefits  
14 under part A of title XVIII of the Social Secu-  
15 rity Act pursuant to section 226(b) or 226A of  
16 such Act and enrolled for benefits under part B  
17 of such title before July 1, 1997, the 6-month  
18 period described in section 1882(s)(2)(A) of  
19 such Act shall begin on July 1, 1997. Before  
20 July 1, 1997, the Secretary of Health and  
21 Human Services shall notify any individual de-  
22 scribed in the previous sentence of their rights  
23 in connection with Medicare supplemental poli-  
24 cies under section 1882 of such Act, by reason  
25 of the amendment made by subsection (d).

1 (f) TRANSITION PROVISIONS.—

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

11 (2) NAIC STANDARDS.—If, within 9 months  
12 after the date of the enactment of this Act, the Na-  
13 tional Association of Insurance Commissioners (in  
14 this subsection referred to as the “NAIC”) modifies  
15 its NAIC Model Regulation relating to section 1882  
16 of the Social Security Act (referred to in such sec-  
17 tion as the 1991 NAIC Model Regulation, as modi-  
18 fied pursuant to section 171(m)(2) of the Social Se-  
19 curity Act Amendments of 1994 (Public Law 103–  
20 432) and as modified pursuant to section  
21 1882(d)(3)(A)(vi)(IV) of the Social Security Act, as  
22 added by section 271(a) of the Health Care Port-  
23 ability and Accountability Act of 1996 (Public Law  
24 104–191) to conform to the amendments made by  
25 this section, such revised regulation incorporating

1 the modifications shall be considered to be the appli-  
2 cable NAIC model regulation (including the revised  
3 NAIC model regulation and the 1991 NAIC Model  
4 Regulation) for the purposes of such section.

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

13 (4) DATE SPECIFIED.—

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

17 (i) the date the State changes its stat-  
18 utes or regulations to conform its regu-  
19 latory program to the changes made by  
20 this section, or

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

1 (B) ADDITIONAL LEGISLATIVE ACTION RE-  
2 QUIRED.—In the case of a State which the Sec-  
3 retary identifies as—

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

8 (ii) having a legislature which is not  
9 scheduled to meet in 1998 in a legislative  
10 session in which such legislation may be  
11 considered,

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

21 **SEC. 204. APPLICATION OF STANDARDS TO MEDICARE SE-**  
22 **LECT POLICIES.**

23 Section 1882(t) of the Social Security Act (42 U.S.C.  
24 1395ss(t)) is amended—

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

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

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

8           (4) by adding at the end of paragraph (1) the  
9           following new subparagraphs:

10           “(G) notwithstanding any other provision  
11           of this section to the contrary, if the issuer of  
12           the policy meet the requirements of paragraph  
13           (5).”;

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

20           (6) by adding at the end the following new  
21           paragraphs:

22           “(4)(A) The Secretary shall establish by regulation  
23           standards for policies in order to be provided special treat-  
24           ment under paragraph (1). To the extent practicable, such  
25           standards shall be the same as the standards established

1 by the National Association of Insurance Commissioners  
2 with respect to such policies. Any additional standards  
3 shall be developed in consultation with such Association.

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

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

12 “(A) If the issuer of the policy—

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

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

22 “(I) the benefits required under the  
23 Standardized Medicare supplement benefit  
24 plan ‘E’ (as specified in section 9E(5) of  
25 the 1991 NAIC Model Regulation), plus

1 One Hundred Percent (100%) of the Medi-  
2 care Part B Excess Charges (as defined in  
3 section 8C(5) of such Regulation); or

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

8 “(B) The issuer of the policy (in relation to the  
9 policy) meets the same requirements under section  
10 1876 that would apply to an eligible organization  
11 with a risk-sharing contract under that section (in-  
12 cluding community rating of premiums and prior ap-  
13 proval of marketing materials, but not including pro-  
14 vision of benefits).”.

15 **SEC. 205. ARRANGEMENTS FOR OUT-OF-AREA DIALYSIS**  
16 **SERVICES.**

17 Section 1876(c) of the Social Security Act (42 U.S.C.  
18 1395mm(c)) is amended by adding at the end the follow-  
19 ing new paragraph:

20 “(9) Each eligible organization shall assure that en-  
21 rollees requiring renal dialysis services who are tempo-  
22 rarily outside of the organization’s service area (within the  
23 United States) have reasonable access to such services  
24 by—

1           “(A) making such arrangements with providers  
2 of services or renal dialysis facilities outside the  
3 service area for the coverage of and payment for  
4 such services furnished to enrollees as the Secretary  
5 determines necessary to assure reasonable access; or

6           “(B) providing for the reimbursement of any  
7 provider of services or renal dialysis facility outside  
8 the service area for the furnishing of such services  
9 to enrollees.”.

10 **SEC. 206. COORDINATION OF MEDICARE ENROLLMENT.**

11       (a) UNIFORM OPEN ENROLLMENT PERIODS.—

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

15           (A) by redesignating paragraph (5) as  
16 paragraph (6), and

17           (B) by inserting after paragraph (4) the  
18 following new paragraph:

19       “(5) Each issuer of a Medicare supplemental policy  
20 shall have an open enrollment period (which shall be the  
21 period specified by the Secretary under section  
22 1876(c)(3)(A)(i)), of at least 30 days duration every year,  
23 during which the issuer may not deny or condition the is-  
24 suance or effectiveness of a Medicare supplemental policy,  
25 or discriminate in the pricing of the policy, because of age,

1 health status, claims experience, receipt of health care, or  
2 medical condition. The policy may not provide any time  
3 period applicable to pre-existing conditions, waiting peri-  
4 ods, elimination periods, and probationary periods (except  
5 as provided by paragraph (2)(B)). The Secretary may re-  
6 quire enrollment through a third party designated under  
7 section 1876(c)(3)(B).”.

8 (2) FOR MEDICARE SELECT POLICIES.—Section  
9 1882(t)(5) of such Act (42 U.S.C. 1395ss(t)(5)), as  
10 added by section 204(6), is amended by adding at  
11 the end the following new subparagraph:

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

15 (b) ENROLLMENTS FOR NEW MEDICARE BENE-  
16 FICIARIES AND THOSE WHO MOVE.—Section  
17 1876(c)(3)(A) of such Act (42 U.S.C. 1395mm(c)(3)(A))  
18 is amended—

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

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

22 “(iii) Each eligible organization shall have an open  
23 enrollment period for each individual eligible to enroll  
24 under subsection (d) during any enrollment period speci-  
25 fied by section 1837 that applies to that individual. Enroll-

1 ment under this clause shall be effective as specified by  
2 section 1838.

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

13 (c) PROVISION BY SECRETARY OF ENROLLMENT IN-  
14 FORMATION AND OTHER INFORMATION ON ELIGIBLE OR-  
15 GANIZATIONS AND MEDICARE SUPPLEMENTAL POLI-  
16 CIES.—

17 (1) IN GENERAL.—Section 1804(b) of such Act  
18 (42 U.S.C. 1395b–2(b)) is amended to read as fol-  
19 lows:

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

24 “(1) information to assist individuals in enroll-  
25 ing with eligible organizations under section 1876

1 and in selecting among such organizations for enroll-  
 2 ment, including information on the premiums  
 3 charged by such organizations for enrollment; and

4 “(2) information on Medicare supplemental  
 5 policies under section 1882, including the relation-  
 6 ship of State programs under title XIX to such poli-  
 7 cies and the premiums charged by such policies for  
 8 enrollment (to the extent information on such pre-  
 9 miums is available to the Secretary).”.

10 (2) CONFORMING AMENDMENT.—Section  
 11 1882(f) of such Act (42 U.S.C. 1395ss(f)) is re-  
 12 pealed.

13 (d) EFFECTIVE DATE.—The amendments made by  
 14 this section apply to enrollments occurring after 1997 (but  
 15 only after the Secretary of Health and Human Services  
 16 has prescribed the relevant annual period), except that the  
 17 amendments made by subsection (b)(2) apply to enroll-  
 18 ments for a Medicare supplemental policy made after  
 19 1997.

## 20 **TITLE III—MEDICAID**

### 21 **SEC. 301. PROHIBITION ON PAYMENTS UNDER MEDICAID**

#### 22 **UNTIL COMPLETION OF ORIENTATION, MEDI- 23 **CAL PROFILE, AND IMMUNIZATION.****

24 (a) REQUIREMENT FOR ORIENTATION AND MEDICAL  
 25 PROFILE.—

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

11                   (A) the entity has provided the enrollee  
12                   with such orientation as the Secretary of  
13                   Health and Human Services specifies, which  
14                   orientation shall include the explanation of  
15                   rights described in paragraph (2) and the expla-  
16                   nation of access to care described in paragraph  
17                   (3);

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

22                   (C) if the entity is responsible for the pro-  
23                   vision (directly or through arrangements with  
24                   providers of services) of immunizations for an  
25                   enrollee who is a child—

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

3 (ii) the entity has begun to provide  
4 (or is providing) for immunizations of such  
5 child in accordance with the standards es-  
6 tablished for early and periodic screening,  
7 diagnostic, and treatment services under  
8 such title.

9 (2) EXPLANATION OF RIGHTS.—The expla-  
10 nation of rights described in this paragraph shall in-  
11 clude an explanation of an enrollee’s rights under  
12 such title in relation to enrollment with the entity,  
13 including an explanation of—

14 (A) the enrollee’s rights to benefits from the en-  
15 tity,

16 (B) the restrictions on payments under such  
17 title for services furnished other than by or through  
18 the entity,

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

20 (D) the entity’s coverage of emergency services  
21 and urgently needed care, and

22 (E) appeal rights of enrollees.

23 (3) EXPLANATION OF ACCESS TO CARE.—The  
24 explanation of access to care described in this para-  
25 graph includes an explanation of the following fea-

1       tures of the benefits offered by the entity under such  
2       title:

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

5               (B) The information required under sec-  
6               tion 9914 of the Internal Revenue Code of  
7               1986.

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

17       (c) EFFECTIVE DATES.—

18               (1) IN GENERAL.—Subject to paragraph (2),  
19       subsection (a) applies with respect to enrollees as of  
20       the date that is 60 days after the date on which the  
21       Secretary first publishes the rule under subsection  
22       (b) in the Federal Register.

23               (2) IMMUNIZATION REQUIREMENTS.—Sub-  
24       section (a)(1)(C) applies with respect to enrollees as  
25       of the first day of the first month that begins more

1 than 60 days after the date on which the Secretary  
2 first publishes the rule under subsection (b) in the  
3 Federal Register.

4 **SEC. 302. REQUIREMENT FOR MEDICAID CAPITATED PLANS**  
5 **TO ASSURE APPROPRIATE CHILDHOOD IM-**  
6 **MUNIZATIONS.**

7 (a) IN GENERAL.—Notwithstanding any other provi-  
8 sion of law, no payment shall be made to a State under  
9 title XIX of the Social Security Act with respect to ex-  
10 penditures incurred by it for payment (determined under  
11 a prepaid capitation basis or under any other risk basis)  
12 for services provided by any entity (including a health in-  
13 suring organization) which is responsible for the provision  
14 (directly or through arrangements with providers of serv-  
15 ices) of immunizations for children unless (and until)—

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

18 (2) the entity has begun to provide (or is pro-  
19 viding) for immunizations of each such child in ac-  
20 cordance with the standards established for early  
21 and periodic screening, diagnostic, and treatment  
22 services under such title.

1           (b) EFFECTIVE DATE.—Subsection (a) shall apply to  
2 expenditures by States for months beginning more than  
3 180 days after the date of the enactment of this Act.

○