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104TH CONGRESS
2D SESSION

H. R. 4315

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

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 28, 1996

Mr. OWENS (for himself, Ms. NORTON, Ms. MCKINNEY, Mr. FRAZER, Mr. YATES, Mr. DELLUMS, Mr. PAYNE of New Jersey, Mr. HILLIARD, Mr. KILDEE, and Mrs. MINK of Hawaii) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

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

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Patient and Health Care Provider Protection Act of 1996".

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

SEC. 2. FINDINGS.

The Congress finds the following:

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

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

(3) The largest expenditures for the hospital industry are payroll (wages and salaries) and employee benefits; in 1992, payroll and employee benefits accounted for almost 55 percent of total hospital expenses.

(4) Because registered nurses comprise the majority of a hospital's expenses, in an effort to remain competitive, hospitals are restructuring their operations by decreasing payroll and benefit outlays for registered nurses and either decreasing their number or replacing them with unlicensed aides to care directly for patients.

(5) While this reorganization is taking place, no mandatory, national, and systematic compilation of data is being undertaken to determine the correlation between skilled nursing care and patient safety.

(6) Several studies, however, have noted a basic relationship between skilled nursing care and patient safety: increased deaths result when inadequate nursing and lower levels of registered nurses in combination with higher levels of unlicensed aides are utilized by health care facilities.

(7) A comprehensive effort is needed at the national level to collect data and develop a research and evaluation agenda so that informed policy development, implementation and evaluation are undertaken in a timely manner to protect the safety of patients, the well being of health care workers, and the integrity of the United States medical system.

(8) The quality of available health care will suffer in the United States if health care delivery is allowed to set priorities in which profit is made at the expense of patient care quality and safety.

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

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

SEC. 3. DEFINITIONS.

In this Act:

(1) HEALTH CARE PROVIDER.—The term ''health care provider'' means an individual or entity licensed or certified under State law to provide health care services.

(2) HEALTH PLAN.—The term ''health plan'' means any private health plan or arrangement (including an employee welfare benefit plan) which provides, or pays the cost of, health care services.

(3) SECRETARY.—Except as otherwise expressly provided, the term ''Secretary'' means Secretary of Health and Human Services.

(4) COVERAGE OF THIRD PARTY ADMINISTRATORS.—In the case of a health plan that is an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974), any third party administrator or other person with responsibility for contracts with health care providers under the plan shall be considered, for purposes of this Act, to be an entity offering such health plan.

(5) ENROLLEE.—The term ''enrollee'' means a person enrolled under a health plan.

(6) OFFICE.—The term ''Office'' means the Office of Consumer Advocacy for Health as described in title II of this Act.

(7) COMMITTEE.—The term ''Committee'' means an Independent Consumer Advisory Committee as described in title III of this Act.

TITLE I—HEALTH PLAN REQUIREMENTS

SEC. 101. INTERFERENCE WITH MEDICAL COMMUNICATION PROHIBITED.

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

(b) MEDICAL COMMUNICATION DEFINED.—For purposes of subsection (a), the term ''medical communication''—

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

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

(B) between—

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

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

(iii) the provider and any employee or representative of any State or Federal authority with responsibility for the licensing or oversight with respect to such plan; and

(2) includes communications concerning—

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

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

(C) variation among any health care providers and any institutions providing such services in experience, quality, or outcomes;

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

(E) the process used by such a plan to determine whether to authorize or deny health care services or benefits; and

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

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

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

SEC. 102. IMPROPER INCENTIVE PLAN PROHIBITED.

(a) IN GENERAL.—A health plan may not as part of any contract or agreement with a health care provider operate an improper health care provider incentive plan as described in subsection (b).

(b) IMPROPER INCENTIVE PLAN.—For purposes of subsection (a), a health care provider incentive plan is improper, unless such plan meets the requirements of section 1876(i)(8)(A) of the Social Security Act (42 U.S.C. 1395mm(i)(8)(A)) for physician incentive plans in contracts with eligible organizations under section 1876 of such Act.

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

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

SEC. 103. PROVISIONS REGARDING DENIAL OF CARE.

(a) CRITERIA FOR DENIAL OF CARE.—A health plan shall establish criteria, in consultation with the health care providers who provide services under the plan, for the denial of services under the plan.

(b) PRELIMINARY PHYSICAL EXAMINATION.—A health plan shall provide for an initial physical examination of an enrollee in a timely manner before denying services under the plan to the enrollee. Such examination shall not constitute services under the health plan.

(c) REASON FOR DENIAL OF CARE PROVIDED TO ENROLLEE.—A health plan shall provide in writing to an enrollee, and to the health care provider recommending

care for the enrollee, the reason for the denial of services under the plan to the enrollee.

(d) PUBLICATION OF CRITERIA FOR DENIAL OF CARE.—A health plan shall put in writing, annually update, and make available to its enrollees through the Office and its Committee the written criteria established under subsection (a).

(e) EFFECTIVE DATE.—The criteria under this section shall apply to plan years beginning on or after 180 days after the date of the enactment of this Act.

SEC. 104. QUALITY OF CARE.

(a) CRITERIA FOR QUALITY OF CARE.—

(1) IN GENERAL.—A health plan, in consultation with the health care providers who provide health services under the plan, shall establish criteria to assure the quality of care provided under the plan. Such plan shall establish such criteria utilizing the data collected and analyzed under subsection (c) and (d), and under section 403.

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

(b) PUBLIC ACCESS TO INFORMATION.—

(1) PUBLICATION OF CRITERIA TO ASSURE QUALITY OF CARE.—A health plan shall put in writ-

ing, annually update, and make available the written criteria established under subsection (a) to its enrollees through the plan's Committee.

(2) SAFE STAFFING LEVELS.—

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

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

(i) the severity of illness of each enrollee;

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

(iii) any other factor substantially related to the condition and health care needs of each enrollee.

(3) SAFE AND ADEQUATE STAFFING LEVELS.—

(A) IN GENERAL.—Not later than 180 days after the date the Secretary establishes the guidelines under paragraph (2), a health plan may not provide or pay for health care services

provided to an enrollee at an institution unless such institution complies with such guidelines.

(B) SUBMISSION OF PROPOSED STANDARDS TO COMMITTEE.—In the case of an institution that elects not to adopt the guidelines established under paragraph (2), such institution shall submit proposed staffing levels to the health plan and its Committee for review. Such institution shall include with its submission an explanation of the method and criteria used in developing the proposed staffing levels.

(C) DEFAULT FEDERAL GUIDELINES.—If the health plan's Committee determines that the staffing levels proposed by such institution fail to meet the guidelines established under paragraph (2), then the health plan may not provide or pay for health care services provided to an enrollee at such institution unless such institution adopts such guidelines as its staffing levels.

(D) CRITERIA AND CERTIFICATE OF COMPLIANCE.—Such plan shall file with the Secretary and the Office of the State in which the plan offers health care services a certificate of compliance with the staffing levels adopted by

the institutions where the plan provides or pays for health care services for its enrollees.

(E) PUBLIC INSPECTION.—Such institutions shall keep on file, available for public inspection during regular business hours, daily reports of staffing levels by department and of patient census.

(4) IDENTIFICATION TAG.—

(A) IN GENERAL.—A health plan may not provide or pay for health care services provided to an enrollee at an institution unless such institution prohibits a health care provider who is not wearing an identification tag from providing care to an enrollee.

(B) LICENSURE STATUS.—An identification tag under subparagraph (A) shall state the health care provider's name and the health care position for which such provider has been licensed or certified by the State.

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

(D) EXCEPTION.—The requirement under subparagraph (A) shall not apply where wearing such tag poses a threat to the health of a patient (such as in an operating room).

(c) DATA COLLECTION.—

(1) MEDICAL DATA.—Except as provided in section 105(a), a health plan, in conjunction with its Committee, shall compile data on health care services provided to enrollees under the health plan including—

(A) enrollee outcome information, including nosocomial infections, medication errors, enrollee injury, enrollee mortality, and rate of enrollee readmission;

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

(C) process of care, including the planning and delivery of care, an assessment of the delivery mechanisms, and safety measures.

(2) FINANCIAL DATA.—

(A) FINANCIAL REPORT.—Not later than December 31st of each year, a health plan that employs more than 150 individuals shall file, with the Office of the State in which such plan offers health care services, a copy of—

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

(ii) a statement of any financial interest greater than 5% or $5,000, whichever is less, in any other health plan; and

(iii) a statement of the nature and outcome of any complaint, lawsuit, arbitration, or other legal proceeding brought against the plan, unless such disclosure is prohibited by court order or law.

(B) QUALITY REPORT.—Not later than December 31st of each year, a health plan shall file, with the Office of the State in which that plan offers health care services, a report of all health care quality indicators, criteria, data, or studies used to evaluate, assess, or determine the nature, scope, quality, or staffing of health care services, and for reductions in or modifications of the provision of health care services.

(C) FIRST REPORT.— Such plan shall file its first report not later than December 31st of its first plan year beginning on or after the date of the enactment of this Act.

(d) DATA ANALYSIS AND DISSEMINATION.—

(1) INFORMATION SUBMITTED TO COMMITTEE.—For purposes of section 403, a health plan shall provide the data collected under subsection (c)(1) to its Committee.

(2) DISCLOSURE OF NURSING CARE DATA TO ENROLLEES.—Such plan shall provide information to an enrollee about the ratio of nurses to enrollees provided under the plan.

SEC. 105. PRIVACY.

(a) ENROLLEE'S PRIVACY RIGHTS.—Prior to the collection of data under section 104(c), a health plan shall establish standards and procedures to protect from public disclosure information that identifies an individual and relates to such individual's physical or mental health. Such standards and procedures may not adversely affect the integrity of the data.

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

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

(2) to a law enforcement agency pursuant to a warrant issued under the Federal Rules of Criminal

Procedure, an equivalent State warrant, a grand jury subpoena, or a court order; or

(3) pursuant to a court order, in a civil proceeding upon a showing of compelling need for the information that cannot be accommodated by any other means, if—

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

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

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

SEC. 106. FEE.

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

(b) FIRST PAYMENT.—

(1) IN GENERAL.—A health plan shall make the first payment under subsection (a) not later than 6

months after the first day of the first full month after the date of the enactment of this Act.

(2) PAYMENTS PRORATED FROM DATE OF ENACTMENT.—Payments due under subsection (a) for the year in which this Act is enacted shall be prorated to apply only with respect to months beginning on or after the date of the enactment of this Act.

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

SEC. 107. ENFORCEMENT THROUGH CIVIL PENALTIES.

(a) ENFORCEMENT THROUGH IMPOSITION OF CIVIL MONEY PENALTY.—A health plan that violates any provision of sections 101 through 106 shall be subject to a civil money penalty of—

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

(2) up to $100,000 for each violation if the Secretary determines that the plan has engaged, within the 5 years immediately preceding such violation, in a pattern of such violations.

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

a penalty or proceeding under section 1128A(a) of such Act.

SEC. 108. PROHIBITION ON ADVERSE ACTION.

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

(1) notifying such plan of conditions which the identifies, in communications with the plan, as dangerous or potentially dangerous or injurious to—

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

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

(C) health care providers who provide such services;

(2) notifying a Federal or State agency or an accreditation agency, compliance with the standards of which have been deemed to demonstrate compliance with conditions of participation under the Medicare program, of such conditions as are identified in paragraph (1);

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

(4) discussing such conditions as are identified in paragraph (1) with other providers for the purposes of initiating action described in paragraph (1), (2), or (3);

(5) a medical communication, as defined in section 101(b); or

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

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

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

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

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

TITLE II—OFFICE OF CONSUMER ADVOCACY FOR HEALTH

SEC. 201. ESTABLISHMENT OF OFFICE.

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

(b) ESTABLISHMENT THROUGH GRANT PROCESS.—

(1) IN GENERAL.—The Secretary shall carry out the requirements of subsection (a) with respect to each State by designating a non-profit organization located in the State to serve as the Office for the State, under a grant awarded, in consultation with the Secretary of Labor, under a competitive selection process. The grant may be awarded only to organizations headed by an individual with expertise and experience in the fields of health care and consumer advocacy, who shall be designated the Consumer Advocate for Health for the State. In

awarding such grant, the Secretary, in consultation with the Secretary of Labor, shall—

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

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

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

(A) CENTRAL OFFICE.—A central office of the organization awarded the grant which is located in the State shall be designated as the Office.

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

(C) PERFORMANCE OF SPECIFIED FUNCTIONS.—The organization shall perform the functions of the Office specified in this title and

otherwise ensure that the requirements of this section applicable to the Office are met.

(D) EVALUATION OF QUALITY AND EFFECTIVENESS OF GRANTEE.—The Secretary, in consultation with the Secretary of Labor, shall evaluate the quality and effectiveness of the organization in carrying out the functions of the Office.

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

(F) NOTICE OF INTENT NOT TO RENEW; RECONSIDERATION.—Not later than 180 days before the expiration of any term under a grant awarded to an organization, if the Secretary at such time intends not to renew the grant with such organization, the Secretary shall notify such organization of such intent, and shall provide such organization an opportunity for reconsideration by the Secretary, in consultation with the Secretary of Labor, of the Secretary's in-

tent not to renew and to present information in support of renewal.

(G) TERMINATION BY GRANTEE.—The organization may terminate the grant prior to its expiration upon 180 days notice to the Secretary.

(H) TERMINATION BY THE SECRETARY.—The Secretary, in consultation with the Secretary of Labor, may terminate the grant prior to its expiration upon 180 days notice to the organization if the Secretary, in consultation with the Secretary of Labor, determines that the organization is not meeting the requirements of this section or that the organization is failing substantially to carry out the grant. The Secretary, in consultation with the Secretary of Labor, shall provide for an appropriate appeals mechanism, including establishment of a panel of peers, to implement this subparagraph.

(c) DELEGATIONS TO LOCAL OFFICES.—

(1) IN GENERAL.—The Secretary, in consultation with the Secretary of Labor, shall provide for appropriate delegation by the Consumer Advocate for Health of the authority and responsibilities of the Office to local offices to the extent necessary to

effectively carry out the duties and responsibilities of the Consumer Advocate for Health throughout the State.

(2) MONITORING.—The Secretary, in consultation with the Secretary of Labor, shall develop and maintain policies and procedures for monitoring such local offices and ensuring compliance by such local offices with the terms of such delegation.

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

(A) IN GENERAL.—Pursuant to such delegation, the Consumer Advocate for Health shall ensure that there is located in each community rating area in the State an officer or employee of the Office who is designated to assist individuals residing in the area with respect to matters relating to health plans and health care providers operating in the area.

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

(C) APPROPRIATE STAFFING.—The Office shall ensure that sufficient staff in each local office is assigned to work with respect to matters relating to each health plan whose enrollees are served by the local office so as to ensure effective and efficient service in such local office with respect to matters relating to such plan.

(d) ESTABLISHMENT OF COMMUNITY RATING AREAS.—

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

(2) MULTIPLE AREAS.—With respect to a community rating area—

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

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

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

(3) BOUNDARIES.—

(A) IN GENERAL.—In establishing boundaries for community rating areas, the Secretary may not discriminate on the basis of or otherwise take into account race, age, language, religion, national origin, socio-economic status, sexual orientation, disability, or perceived health status.

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

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

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

(1) an issue of denial of items or services, or reimbursement therefor;

(2) an issue of denial of medical records;

(3) an issue of malpractice;

(4) an issue of discrimination;

(5) an issue of eligibility and payment of subsidies for premium payments and cost sharing;

(6) an issue of enrollment; or

(7) any other violation actionable under this Act.

(b) GRIEVANCE ASSISTANCE.—Such Office shall provide, in person and by toll–free telephone access, assistance to an individual with a grievance under subsection (a).

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

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

(a) IN GENERAL.—An Office shall identify, investigate, publicize, promote solutions to, and resolve grievances stemming from, any practice, policy, law, or regula-

tion of a health plan that may adversely affect access by an individual to quality health care, including a practice, policy, law, or regulation relating to—

(1) marketing of the plan;

(2) availability of premium and cost sharing subsidies;

(3) accessibility of services and resources in traditionally underserved areas;

(4) targeting of resources to traditionally underserved areas; and

(5) elimination of practices that impede access to available choices for individuals at health risk, including the proper implementation of community rating and risk adjustments.

(b) MONITORING OF HEALTH PLAN DENIAL PROCEDURES.—Such Office shall monitor procedures used by health plans for denial of services and for reconsideration of such denials.

SEC. 204. FEDERAL INVESTIGATION AND EMERGENCY INTERVENTION.

(a) IN GENERAL.—An Office shall provide, in person and by toll–free telephone access, assistance to an individual who seeks to report dangerous conditions in health care services offered under a health plan.

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

(c) RULES.—

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

(2) CONSIDERATION OF DATA.—In establishing and reviewing the guidelines under paragraph (1), the Secretary shall base the guidelines to the maximum extent practicable on the data collected and the analysis performed under this Act.

SEC. 205. ANNUAL REPORT TO THE SECRETARY.

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

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

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

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

(3) discernible patterns from the data collected;

(4) recommendations for resolution of unresolved or outstanding complaints;

(5) recommendations to sanction a certain health plan;

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

(7) a copy of any report received from the Committee which reports to such Office.

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

SEC. 206. OFFICE ADMINISTRATION.

(a) IN GENERAL.—An Office shall ensure that individuals in each community rating area, as defined in section 201(d), have regular and timely access to the services provided through the Office and that the individual receives timely responses from a representative of the Office to a request for assistance with a complaint against a health plan.

(b) CONFIDENTIALITY OF COMPLAINANTS.—An Office shall provide for a system in the Office to treat as confidential any identifying information regarding complainants and other individuals with respect to whom the Office maintain files or records.

(c) PERSONNEL QUALIFICATIONS.—An Office shall establish and implement minimum qualification and training requirements for personnel, including volunteers.

SEC. 207. OVERSIGHT.

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

SEC. 208. FUNDING OF OFFICE.

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

(b) REMITTANCE TO SECRETARY.—Not later than December 31 of each calendar year, each State shall remit to the Secretary, in such form and manner as shall be prescribed in regulations, the amounts held in escrow pursuant to subsection (a) for the applicable fiscal year ending with or during such calendar year.

(c) ALLOCATIONS.—The amounts remitted by each State to the Secretary for each year under subsection (b)

shall be applied towards the establishment and operation of the Office for such State under section 201 (including amounts to be distributed to escrow accounts for Committees pursuant to section 306).

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

TITLE III—INDEPENDENT CONSUMER ADVISORY COMMITTEES

SEC. 301. ESTABLISHMENT OF COMMITTEES.

Each health plan shall establish and maintain an Committee.

SEC. 302. MEMBERSHIP AND CHAIR.

(a) MEMBERSHIP.—

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

(2) QUALIFICATIONS.—Except as provided in paragraph (3)(B), members of a Committee shall be selected from enrollees who indicate interest in such positions and who are not health care providers, officers or employees of any health plan, or employees of a health care provider.

(3) METHOD OF SELECTION.—

(A) ENROLLEES.—Except as provided in subparagraph (B), members of a Committee shall be selected biennially at random from each of 4 categories of enrollees, in proportion to their numbers among enrollees represented by the Committee, as follows: senior citizens; parents of children under 18 years of age; individuals with disabilities; and all other enrollees.

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

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

(1) a member of the Committee other than a member who is an employee of a health plan; and

(2) elected by the Committee at its first meeting.

(c) COMPENSATION AND EXPENDITURES FOR SERVICES.—

(1) COMPENSATION OF MEMBERS.—Members of each Committee shall serve without compensation, except that the members shall be reimbursed by the

Committee for the reasonable expenses incurred in carrying out their duties as members.

(2) EXPENDITURES FOR SERVICES.—The Committee may provide for acquiring the services of such staff and temporary consultants as may be necessary from time to time to carry out the requirements of this title.

SEC. 303. FUNCTIONS OF COMMITTEE.

(a) OUTREACH PROGRAMS.—Each Committee shall develop and coordinate programs for outreach to the community.

(b) FORUM TO FACILITATE COMMUNICATION.—Each Committee shall conduct regular meetings of enrollees and representatives of the health plan under such procedural rules as the Committee considers appropriate, so that such meetings will serve as effective forums for facilitating communication between such plan and enrollees.

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

(d) DISSEMINATION OF CRITERIA FOR ENROLLEE CARE QUALITY.—Each Committee shall provide to the

community the enrollee care quality criteria established by the health plan under section 104(c).

(e) EVALUATION OF PERFORMANCE OF OFFICE OF CONSUMER ADVOCACY.—Each Committee shall evaluate annually the performance of the Office for the State in which the health plan is located and make recommendations to the Secretary regarding the appropriateness for continued service of the Office.

SEC. 304. LIABILITY OF MEMBERS OF COMMITTEE.

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

SEC. 305. ANNUAL REPORT TO OFFICE.

(a) IN GENERAL.—Not later than December 31st of each year, each Committee shall submit to the Office for the State in which the health plan offers health care services a report providing recommendations for improvements in health care delivery under the plan, and including assessments of—

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

(2) the condition of health care facilities employed under the plan;

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

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

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

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

(7) the courtesy of plan personnel; and

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

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

SEC. 306. FUNDING FOR COMMITTEES.

(a) ESCROW ACCOUNT FOR COMMITTEES.—In accordance with procedures which shall be made by rule under subsection (e), an Office shall establish and maintain an escrow account for each Committee established in the State served by the Office.

(b) DISTRIBUTION OF FUNDS TO ESCROW ACCOUNT FOR COMMITTEES.—The Office shall annually distribute an amount equal to 25 percent of the total amount remitted for the year to the Secretary by the State under section 208, on the basis of which funds are made available

to the Office for the year under title II, in the form of deposits to the escrow accounts maintained by the Office for Committees pursuant to subsection (a). The amounts deposited to such escrow accounts shall be in proportion to the numbers of enrollees represented by the Committees for which such escrow accounts are maintained.

(c) WITHDRAWAL OF FUNDS FOR COMMITTEE AT THE REQUEST OF THE CHAIR.—The funds maintained in each such escrow account for a Committee shall be made available for withdrawal by the chair of the Committee upon request of the chair, specifying in writing the purpose for the withdrawal.

(d) ANNUAL ACCOUNTING.—The Office shall provide the Secretary an annual accounting of the receipts and disbursements made with respect to each such escrow account.

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

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

TITLE IV—COORDINATION AMONG OFFICE, COMMITTEES, AND SECRETARY

SEC. 401. INTERACTION AMONG OFFICE AND OTHER ORGANIZATIONS.

An Office shall establish and maintain a system of referrals among the Office, other consumer advocacy organizations, legal assistance providers serving low-income persons, and protection and advocacy systems for individuals with disabilities.

SEC. 402. ASSISTANCE TO COMMITTEES.

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

SEC. 403. COORDINATED DATA ANALYSIS AND DISSEMINATION PROCEDURE.

(a) DATA COMPILATION AND SUBMISSION.—

(1) IN GENERAL.—Not later than December 31st of each year, each Committee shall compile the enrollee quality care data collected under section 104(c) and shall submit such data to the Office from which such Committee received its funds under section 306.

(2) TRANSMISSION FROM OFFICE TO SECRETARY.—Not later than 30 days after the receipt of the data submitted by the Committees under paragraph (1), the Office shall compile all data received from the Committees to which it transmits funds under section 306 and shall submit such data to the Secretary.

(b) DATA ANALYSIS AND PUBLICATION.—The Secretary shall analyze the data received under subsection (a)(2) with the purpose of using such data to develop Federal guidelines for patient care quality and shall publish its findings.

(c) USE OF GUIDELINES FOR EVALUATION OF HEALTH PLAN.—An Office and the Committees shall use such findings and guidelines to evaluate the performance of health plans operating in their community rating areas. If an order is granted pursuant to subparagraph (C) or (F), the court shall impose appropriate safeguards against unauthorized disclosure. Court orders authorizing disclosure under subparagraph (C) shall issue only with prior notice to the consumer and only if the law enforcement agency shows that there is probable cause to believe that the records or other information sought are relevant to a legitimate law enforcement inquiry. In the case of a State government authority, such a court order shall not

issue if prohibited by the law of such State. A court issuing an order pursuant to this section, on a motion made promptly by the video tape service provider, may quash or modify such order if the information or records requested are unreasonably voluminous in nature or if compliance with such order otherwise would cause an unreasonable burden on such provider.

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