

103^D CONGRESS
2^D SESSION

H. R. 4960

To provide health care quality safeguards for consumers of health care insurance and health care products and services.

IN THE HOUSE OF REPRESENTATIVES

AUGUST 12, 1994

Mr. WYDEN introduced the following bill; which was referred to the Committee on Energy and Commerce

A BILL

To provide health care quality safeguards for consumers of health care insurance and health care products and services.

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Consumer Health
5 Quality Protection Act of 1994”.

1 **TITLE I—DUTIES OF THE SECRETARY AND**
2 **THE STATES**

3 **SEC. 101. RESPONSIBILITIES OF THE SECRETARY.**

4 The responsibilities of the Secretary of Health and
5 Human Services (hereinafter referred to as “the Sec-
6 retary”) under this Act are the following:

7 (1) STATE QUALITY MANAGEMENT PROGRAM.—
8 Determination of initial and ongoing compliance of
9 each State health quality management program with
10 the requirements of section 102.

11 (2) NATIONAL QUALITY MANAGEMENT PRO-
12 GRAM.—Establish a national quality management
13 program (in accordance with section 201).

14 (3) HEALTH QUALITY IMPROVEMENT FOUNDA-
15 TIONS.—Establishment of health quality improve-
16 ment foundations (in accordance with section 202).

17 (4) CONSUMER HEALTH CARE ADVOCATE.—Es-
18 tablishment of consumer health care advocate in
19 each State (in accordance with section 203).

20 (5) NATIONAL CONSUMER REPRESENTATIVE
21 SUPPORT CENTER.—Establishment of a national
22 consumer representative support center (in accord-
23 ance with section 204).

24 (6) NATIONAL MEASURES OF QUALITY PER-
25 FORMANCE.—Establishment of national measures of

1 quality performance for health plans (in accordance
2 with section 205).

3 (7) RELATIVE VALUE SCALE FOR PHARMACY
4 COUNSELING.—Establishment of a relative value
5 scale for the purpose of reimbursing pharmacists for
6 the certain patient counseling services (in accord-
7 ance with section 206).

8 **SEC. 102. RESPONSIBILITIES OF THE STATES.**

9 STATE RESPONSIBILITIES.—As a condition of receipt
10 of Federal medical assistance payments under title XIX
11 of the Social Security Act, a State must comply with the
12 following requirements of this section:

13 (1) HEALTH PLANS.—Certifying health plan
14 compliance with the quality standards of section
15 301.

16 (2) MEDICAL LICENSURE BOARD.—Assuring
17 State medical licensure board compliance with the
18 requirements of section 302.

19 **TITLE II—NATIONAL HEALTH QUALITY**
20 **MANAGEMENT PROGRAM**

21 **SEC. 201. ESTABLISHMENT OF NATIONAL QUALITY MAN-**
22 **AGEMENT PROGRAM.**

23 (a) IN GENERAL.—Not later than one year after the
24 date of enactment of this Act, the Secretary shall establish
25 and oversee a performance-based program of quality man-

1 agement and improvement designed to enhance the qual-
2 ity, appropriateness, and effectiveness of health care items
3 and services, to be known as the national quality manage-
4 ment program.

5 (b) FUNDING.—

6 (1) IN GENERAL.—Beginning with the first
7 quarter of the first calendar year following enact-
8 ment of this Act and quarterly thereafter, the Sec-
9 retary shall collect from each health plan certified
10 under section 301 a fee amounting to 0.25 percent
11 of the premiums received by the plan.

12 (2) FUNDED ACTIVITIES.—Funds collected
13 under the authority of paragraph (1) shall be uti-
14 lized by the Secretary solely to support the activities
15 described under section 101.

16 **SEC. 202. HEALTH QUALITY IMPROVEMENT FOUNDATIONS.**

17 (a) IN GENERAL.—The Secretary shall, no later than
18 two years after the date of enactment of this Act, establish
19 a program of grants to eligible organizations to serve as
20 health quality improvement foundations and perform the
21 duties specified in subsection (d) for the population of
22 each State, and shall oversee the operation of such founda-
23 tions.

1 (b) ELIGIBILITY.—To be eligible for a grant under
2 this section, entities must demonstrate compliance with
3 the criteria of subparagraphs (1) through (5).

4 (1) GOVERNING BODY.—Each entity shall be
5 governed by a board consisting of health profes-
6 sionals and public members, no fewer than 51 per-
7 cent of whom shall be public members.

8 (2) DEFINITION OF PUBLIC MEMBER.—For
9 purposes of this paragraph, the term “public mem-
10 ber” means an individual who resides in the State
11 and is a person of integrity and good reputation who
12 has lived in the State for at least five years imme-
13 diately preceding appointment to the board, and has
14 not in the preceding five years been authorized to
15 practice a healing art or had a substantial personal,
16 business, professional, or pecuniary connection with
17 a health plan, healing art or with a medical edu-
18 cation or health care facility, except as a patient or
19 a potential patient.

20 (3) STAFFING.—Each entity shall be staffed by
21 individuals expert in quality improvement, and ex-
22 perts in the fields of epidemiology, measurement of
23 risk adjusted health outcomes, use of clinical prac-
24 tice guidelines, health services data analysis, and
25 provider education.

1 (4) CONTRACT WITH ACADEMIC HEALTH CEN-
2 TER.—

3 (A) IN GENERAL.—Each entity shall have
4 a contract with an academic health center to
5 assist in fulfilling the duties described under
6 subsection (d).

7 (B) DEFINITION.—For purposes of this
8 paragraph, an “academic health center” means
9 an entity that—

10 (i) operates a school of medicine or
11 osteopathic medicine accredited by the Li-
12 aision Committee on Medical Education of
13 the Association of American Medical Col-
14 leges and the American Medical Associa-
15 tion, or the American Osteopathic Associa-
16 tion;

17 (ii) operates or is affiliated with one
18 or more schools of nursing; and

19 (iii) operates or is affiliated with one
20 or more teaching hospitals.

21 (5) CONFLICT OF INTEREST.—

22 (A) IN GENERAL.—An entity seeking to re-
23 ceive a designation under this section shall be
24 considered a “disclosing entity” for purposes of

1 section 1124 (42 U.S.C. 1320a–3) of the Social
2 Security Act;

3 (B) Such entity may not—

4 (i) directly or indirectly (as deter-
5 mined by the regulations promulgated
6 under section 1124(a)(3) of the Social Se-
7 curity Act) possess an ownership interest
8 of one (1) percent or more in a health care
9 facility, a health plan, or association of
10 such;

11 (ii) own a whole or part interest in
12 any mortgage, deed of trust, note, or other
13 obligation secured (in whole or in part) by
14 a health care facility, health plan, associa-
15 tion of such, or any of the property or as-
16 sets thereof, which whole or part interest is
17 equal to or exceeds (1) percent of the total
18 property and assets of the facility, plan, or
19 association; or

20 (iii) utilize officers or members of the
21 governing body more than 10 percent of
22 whom are the officers or members of the
23 governing board of one or more health fa-
24 cilities, plans, or associations).

25 (C) GRANTS TO ENTITIES.—

1 (1) IN GENERAL.—The Secretary shall select,
2 through a competitive grantmaking process, no more
3 than one entity to serve as a health quality improve-
4 ment foundation in each State, and may designate
5 one entity to serve multiple contiguous States.

6 (2) PREFERENCES.—In making its designation,
7 the Secretary shall give preference to an entity—

8 (A) which can demonstrate the capacity to
9 fulfill the duties described under subsection (d)
10 for enrollees of health plans certified under sec-
11 tion 301, as well as enrollees of title XVIII of
12 the Social Security Act; and

13 (B) for which the primary place of busi-
14 ness is located in the State within which the
15 functions of the foundation will be conducted,
16 or, if one entity is to be designated to serve
17 multiple States, preference shall be given to an
18 entity for which the primary place of business
19 is located in one of the States.

20 (3) SCOPE OF WORK.—Each grant with an en-
21 tity under this section shall be pursuant to an agree-
22 ment providing—

23 (A) the entity shall perform the duties de-
24 scribed in subsection (d) for the benefit of—

1 (i) enrollees in health plans certified
2 under section 301,

3 (ii) individuals enrolled under title
4 XVIII of the Social Security Act, and

5 (iii) recipients entitled to benefits
6 under title XIX of the Social Security Act.

7 (B) the Secretary shall evaluate the per-
8 formance of the entity in carrying out the func-
9 tions specified in the grant;

10 (C) the grant shall be for a term of four
11 years and shall be renewable, based upon evi-
12 dence of successful quality improvement per-
13 formance, without reopening the competitive se-
14 lection process, except that an entity subject to
15 subsection (e)(3) shall have term(s) limited to
16 two years and shall be subject to competition at
17 the end of each contract period;

18 (D) if the Secretary decides not to renew
19 a grant with a foundation, the foundation shall
20 be notified of the decision at least one hundred
21 and eighty days prior to the expiration of the
22 grant term, and shall be afforded an oppor-
23 tunity to present information for the purposes
24 of appeal of the decision not to renew the grant;

1 (E) based on a finding by the Secretary
2 that the foundation has not met or no longer
3 meets the requirements of this section, the Sec-
4 retary may terminate the grant prior to its ex-
5 piration upon one hundred and eighty days no-
6 tice, during which notice period the Secretary
7 shall provide the foundation an opportunity to
8 seek an nonbinding opinion on the Secretary's
9 finding before a panel of representatives of
10 foundations convened by the Secretary;

11 (F) the entity may terminate the grant
12 upon one hundred and eighty days notice to the
13 Secretary; and

14 (G) the amount of the grant to be allo-
15 cated under a grant shall consist of a sum nec-
16 essary to perform the duties under paragraph
17 (d), which may be augmented with additional
18 funds for the performance of research by a
19 foundation selected by the Secretary for exem-
20 plary performance and the merit of research
21 proposals submitted.

22 (d) DUTIES.—A health quality improvement founda-
23 tion shall carry out the following duties in the State in
24 which the foundation operates:

1 (1) QUALITY IMPROVEMENT.—Collaboration
2 with physicians and other health care professionals
3 in ongoing efforts to improve the quality of health
4 care provided to individuals in the State, giving pri-
5 ority to health conditions and interventions which
6 are likely to produce the greatest impact in prevent-
7 ing or reducing morbidity, mortality, and functional
8 impairment.

9 (2) OVERSIGHT.—Analyze data obtained under
10 section 205 and other information obtained by the
11 foundation pertaining to health care delivered in the
12 State, for the purpose of—

13 (A) identifying opportunities for quality
14 improvement;

15 (B) documenting that such improvement is
16 being realized; and

17 (C) auditing samples of such information
18 and its source documents to assure the informa-
19 tion is valid, reliable, and comparable between
20 plans, and to inform recommendations for im-
21 proving the validity, reliability, and comparabil-
22 ity of the information.

23 (3) TECHNICAL ASSISTANCE.—Provide tech-
24 nical assistance to health plans and providers, in-
25 cluding—

1 (A) feedback to providers of information
2 on patterns of health care delivery, health sta-
3 tus, and outcomes;

4 (B) assistance in fulfilling the data report-
5 ing requirement of section 205;

6 (C) assistance in the development of pa-
7 tient education systems that enhance patient in-
8 volvement in decisions relating to their health
9 care;

10 (D) entering into agreements with selected
11 health plans to provide educational programs
12 for health care professionals.

13 (4) ANNUAL REPORT.—Submit to the Secretary
14 and make publicly available an annual report con-
15 cerning—

16 (A) recommendations for improving the
17 utility of clinical practice guidelines as a means
18 of identifying opportunities for improvement
19 and bringing about quality improvement;

20 (B) recommendations for improving the re-
21 liability and validity of the national measures of
22 quality performance and consumer survey data
23 described in section 205;

24 (C) selected measures of the health care
25 status of the population of the State, including

1 a description of activities underway and
2 progress achieved; and

3 (D) a description of activities undertaken
4 during the preceding year pursuant to sub-
5 section (b)(3) and subsection (d)(3)(D).

6 (5) MULTIPLAN COLLABORATIONS.—Sponsor of
7 statewide and other collaborations involving multiple
8 plans or providers to identify opportunities for qual-
9 ity improvement, and to bring about improvements
10 in health care.

11 (6) REFERRALS.—

12 (A) IN GENERAL.—If a health quality im-
13 provement foundation finds, after affording rea-
14 sonable opportunities for improvement, that a
15 provider or plan—

16 (i) continues to furnish services char-
17 acterized by underuse, overuse or poor
18 technical quality, or

19 (ii) is unwilling or unable to success-
20 fully engage in quality improvement activi-
21 ties related to the services described in
22 subparagraph (A),

23 the foundation shall provide notice of such finding to
24 the officials and entities described in subparagraph
25 (B), and shall make available to such officials and

1 entities upon request data and information relied
2 upon by the foundation in making the referral.

3 (B) NOTIFICATION.—A finding under
4 clause (i) shall be forwarded—

5 (i) if the finding pertains to a health
6 plan, to the appropriate alliance(s), accred-
7 itation organization(s), State officials re-
8 sponsible for plan certification under sec-
9 tion 301, the consumer health care advo-
10 cate authorized under section 203, and the
11 public;

12 (ii) if the finding pertains to a pro-
13 vider, to the appropriate State health facil-
14 ity or State professional licensure board(s),
15 the consumer health care advocate author-
16 ized under section 203, and health plan(s)
17 with which the provider is associated.

18 (iii) IMMINENT RISK.—If a foundation
19 identifies a provider who poses an immi-
20 nent risk to the health of patients receiving
21 or likely to receive health care from the
22 provider, the foundation shall immediately
23 notify the appropriate authorities listed
24 under clause (ii).

1 (e) LIMITATION ON LIABILITY.—No organization
2 having a grant from the Secretary under this section, and
3 no person who is employed by, or who has a fiduciary rela-
4 tionship with any such organization, or who furnishes pro-
5 fessional services to such organization, shall be held by
6 reason of the performance of any duty or activity author-
7 ized pursuant to this part to have violated any criminal
8 law, or to be civilly liable under any law of the United
9 States or of any State (or political subdivision thereof)
10 provided that the performance of such duty or activity was
11 not conducted in bad faith.

12 **SEC. 203 CONSUMER HEALTH CARE ADVOCATE.**

13 (a) IN GENERAL.—The Secretary shall, no later than
14 two years after the date of enactment of this Act, make
15 grants to an entity in each State which shall serve as the
16 consumer health care advocate for the population of the
17 State.

18 (b) SELECTION OF GRANTEES.—

19 (1) COMPETITION.—Grants shall be awarded
20 under subsection (a) on a competitive basis to appli-
21 cants meeting the criteria in paragraph (2).

22 (2) CRITERIA.—In awarding grants under sub-
23 section (a)—

24 (A) preference shall be given to private or-
25 ganizations which are exempt from taxation

1 under section 501(c)(3) or (4) of the Internal
2 Revenue Act of 1986;

3 (B) preference shall be given to organiza-
4 tions with a governing body which includes rep-
5 resentation of ethnic and low-income popu-
6 lations of the State;

7 (C) preference shall be given to an organi-
8 zation which has previously received, and satis-
9 factorily performed under the terms of a grant
10 from the Secretary for the purpose of providing
11 health insurance counseling for enrollees under
12 title XVIII of the Social Security Act; and

13 (D) an applicant for a grant under sub-
14 section (a) shall be ineligible if the applicant is,
15 or is affiliated with (through ownership, man-
16 agement, or common control), a health plan,
17 provider, State office responsible for health fa-
18 cilities or health professional licensing or certifi-
19 cation, health alliance, or association of such
20 entities.

21 (c) GRANT PROVISIONS.—Each grant with an organi-
22 zation under this section shall provide that—

23 (1) the organization shall perform the duties set
24 forth in subsection (d);

1 (2) the Secretary shall have access to docu-
2 ments and personnel necessary to evaluate the effec-
3 tiveness of the organization in fulfilling the provi-
4 sions of the grant;

5 (3) the grant shall be for an initial term of four
6 years and shall be renewable thereafter based upon
7 favorable performance without reopening the com-
8 petitive selection process;

9 (4) if the Secretary intends not to renew a
10 grant to an organization under this section, the or-
11 ganization shall be notified of the decision at least
12 one hundred and eighty days prior to the expiration
13 of the grant, and be afforded an opportunity to
14 present information for the purpose of appeal;

15 (5) the Secretary may terminate a grant to an
16 organization under this section if it determines that
17 the organization does not meet the requirements of
18 this section, and provides an opportunity for the or-
19 ganization to appeal its determination;

20 (6) an organization which has received a grant
21 under this section may terminate the grant upon one
22 hundred and eighty days notice to the Secretary;

23 (d) DUTIES.—An organization which has received a
24 grant under this section shall have the following duties—

1 (1) investigate and resolve complaints made by
2 or on behalf of individuals;

3 (2) provide information, referral and assistance
4 to individuals on the availability of health insurance
5 coverage and health care items and services;

6 (3) identify, investigate and promote solutions
7 to problems arising from public or private practices
8 and policies which adversely affect individuals' ac-
9 cess to quality health care, including—

10 (A) marketing of health plans, and

11 (B) accessibility of services, subsidies or
12 other resources;

13 (4) monitor, analyze, and comment on the de-
14 velopment and implementation of Federal, State, or
15 local laws affecting access to quality health care;

16 (5) facilitate public comment on Federal, State,
17 or local laws affecting access to quality health care;

18 (6) compile and report to the Secretary and na-
19 tional consumer representative support center data
20 regarding complaints received and actions taken, in
21 a form defined by the Secretary;

22 (7) protect the identity of any complainant, un-
23 less released from this responsibility by the com-
24 plainant;

1 (8) coordinate activities and advocacy with
2 other organizations, including legal assistance pro-
3 viders, State and local long-term care ombudsman
4 programs, and protection and advocacy programs es-
5 tablished for persons with disabilities under—

6 (A) part A of the Developmental Disabil-
7 ities Assistance and Bill of Rights Act (42
8 U.S.C. 6001 et seq.),

9 (B) the Protection and Advocacy for Men-
10 tally Ill Individuals Act of 1986 (42 U.S.C.
11 10801 et seq.), and

12 (C) the Americans with Disabilities Act;

13 (9) perform such other duties the Secretary
14 may specify.

15 (e) **AUTHORITY OF CONSUMER HEALTH CARE ADVO-**
16 **CATE.**—The consumer health care advocate in each State
17 shall be vested with the following powers and authorities:

18 (1) The advocate may establish local programs
19 with the same powers and authorities, subject to the
20 same restrictions regarding eligibility and conflict of
21 interest.

22 (2) Representatives of the consumer health care
23 advocate shall have access to health care facilities
24 for the purpose of communicating with individuals
25 receiving care on the premises.

1 (3) Representatives of the consumer health care
2 advocate shall have access to the medical and social
3 records of an individual if the individual, or the legal
4 representative of the individual, has granted permis-
5 sion to do so.

6 (4) The consumer health care advocate shall
7 have access to, and upon request copies of, all licens-
8 ing and certification reports and data pertaining to
9 health care providers and developed by a State.

10 (f) LIMITED LIABILITY.—No consumer health care
11 advocate or its local programs or representatives shall be
12 liable under State or Federal law for the good faith per-
13 formance of official duties.

14 (g) FUNDING.—The Secretary shall provide funding
15 for the entities described under this section through the
16 following mechanisms:

17 (1) BASE FUNDING.—The Secretary shall pro-
18 vide grants to the consumer health care advocate in
19 each State and the Center described under sub-
20 section (g) from the proceeds of the assessment
21 under section 201, up to a total of \$50,000,000; and

22 (2) VOLUNTARY CONTRIBUTIONS.—The Sec-
23 retary shall assist States in ensuring that consumer
24 health care advocate entities are permitted to seek
25 voluntary contributions through a prominent sollicita-

1 tion in the enrollment materials distributed by or on
2 behalf of each health plan.

3 **SEC. 204 NATIONAL CONSUMER REPRESENTATIVE SUP-**
4 **PORT CENTER**

5 The Secretary shall, no later than six months after
6 the date of enactment of this Act, make one or more
7 grants of a total amount not exceeding \$5,000,000 per
8 annum to establish national consumer representative sup-
9 port center(s) to assist consumer representatives serving
10 on State medical boards, quality improvement foundation
11 governing boards, and consumer health care advocates in
12 performing their duties. Entities eligible for a grant under
13 this section shall be nonprofit organizations with dem-
14 onstrated expertise in training and representing diverse
15 consumers of health care insurance, and health care items
16 and services.

17 **SEC. 205. NATIONAL MEASURES OF QUALITY PERFORM-**
18 **ANCE.**

19 (a) **IN GENERAL.**—The Secretary shall develop a set
20 of national measures of quality performance, which shall
21 be used to assess the provision of health care services and
22 access to such services.

23 (b) **SUBJECT OF MEASURES.**—National measures of
24 quality performance shall be selected in a manner that
25 provides information on the following subjects:

1 (1) Access to health care services by consumers;

2 (2) Appropriateness of health care services pro-
3 vided to consumers;

4 (3) Outcomes of health care services and proce-
5 dures;

6 (4) Health promotion;

7 (5) Prevention of diseases, disorders, and other
8 health conditions;

9 (6) Consumer satisfaction with care, including
10 satisfaction of consumers who disenroll from health
11 plans and those who utilize services from providers
12 not included in their plan network.

13 (c) SELECTION OF MEASURES.—

14 (1) CONSULTATION.—In developing and select-
15 ing the national measures of quality performance,
16 the Secretary shall consult with appropriate inter-
17 ested parties, including—

18 (A) States;

19 (B) health plans;

20 (C) employers and individuals purchasing
21 health care through regional and corporate alli-
22 ances;

23 (D) health care providers;

24 (E) health care consumers;

1 (F) the quality improvement foundations
2 established under section 202;

3 (G) the consumer health care advocate es-
4 tablished under section 203;

5 (H) nationally recognized accreditation or-
6 ganizations.

7 (2) CRITERIA.—The following criteria shall be
8 used in developing and selecting national measures
9 of quality performance:

10 (A) SIGNIFICANCE.—When a measure re-
11 lates to a specific disease, disorder, or other
12 health condition, the disease, disorder, or condi-
13 tion shall be of significance in terms of preva-
14 lence, morbidity, mortality, or the costs associ-
15 ated with the prevention, diagnosis, treatment,
16 or clinical management of the disease, disorder,
17 or condition.

18 (B) RANGE OF SERVICES.—The set of
19 measures, taken as a whole, shall be representa-
20 tive of the range of items and services provided
21 to consumers of health care by health care pro-
22 viders and suppliers.

23 (C) RELIABILITY AND VALIDITY.—The
24 measures shall be reliable and valid.

1 (D) UNDUE BURDEN.—The data needed to
2 calculate the measures shall be obtained with-
3 out undue burden on the entity or individual
4 providing the data.

5 (E) LINKAGE TO HEALTH OUTCOME.—
6 When a measure is a rate of a process of care,
7 the process shall, to the extent practicable, be
8 linked to a health outcome based upon the best
9 available scientific evidence.

10 (F) CONTROL AND RISK ADJUSTMENT.—
11 When a measure of a provider or plan is an
12 outcome of the provision of care, the outcome
13 shall be within the control of the provider or
14 plan and shall be one with respect to which an
15 adequate risk adjustment can be made.

16 (G) PUBLIC HEALTH.—The measures shall
17 incorporate standards identified by the Sec-
18 retary of Health and Human Services for meet-
19 ing public health objectives.

20 (d) UPDATING.—The Secretary shall review and up-
21 date the set of national measures of quality performance
22 annually to reflect changing goals for quality improve-
23 ment. The Secretary shall establish and maintain a prior-
24 ity list of performance measures that within a five-year
25 period it intends to consider for inclusion within the set

1 through the updating process. The Secretary may select
2 different performance measures for inclusion within the
3 set from year to year.

4 (e) CONSUMER SURVEYS.—

5 (1) IN GENERAL.—The Secretary shall conduct
6 periodic surveys of health care consumers to gather
7 information concerning access to care, use of health
8 services, health outcomes, and patient satisfaction.
9 The surveys shall monitor consumer reaction to the
10 implementation of this Act and be designed to assess
11 the impact of this Act on the general population of
12 the United States and potentially vulnerable popu-
13 lations.

14 (2) SURVEY ADMINISTRATION.—The Secretary
15 shall develop and approve a standard design for the
16 surveys, which shall be administered by the Adminis-
17 trator for Health Care Policy and Research on a
18 plan-by-plan and State-by-State basis. A State may
19 add survey questions on quality measures of local in-
20 terest to surveys conducted in the State.

21 (3) SAMPLING STRATEGIES.—The Secretary
22 shall develop sampling strategies that ensure survey
23 samples adequately measure populations considered
24 by the Secretary to be at risk of receiving inad-
25 equate health care or who may be difficult to reach

1 through consumer sampling methods, including indi-
2 viduals who—

3 (A) fail to enroll in a health plan;

4 (B) resign from a plan;

5 (C) are members of a vulnerable popu-
6 lation, as defined by the Secretary; or

7 (D) have received health care items or
8 services from providers or suppliers which were
9 not members of the network maintained by the
10 plan in which the individual was enrolled.

11 (f) EFFECTIVE DATE.—The requirements of this sec-
12 tion taken effect upon the date of enactment of this Act,
13 with the first publication for comment of draft perform-
14 ance measures defined under subsection (a), and the sur-
15 veys described under subsection (e), to take place no later
16 than two years after the date of enactment of this Act.
17 The Secretary shall publish, for use by the public in evalu-
18 ating health plans and providers, the first set of perform-
19 ance measures no later than three years after the date
20 of enactment of this Act.

21 **SEC. 206 PAYMENT FOR PHARMACIST COUNSELING.**

22 (a) RELATIVE VALUE SCALE FOR EVALUATION AND
23 MANAGEMENT SERVICES BY PHARMACISTS.—The Sec-
24 retary shall develop and publish, no later than three years
25 from the date of enactment of this Act, a relative value

1 scale that defines and establishes a numerical relationship
2 among various evaluation and management services per-
3 formed by pharmacists, taking into account—

4 (1) differences in skill levels and training re-
5 quired to perform the services;

6 (2) differences in level of risk associated with
7 use of individual drugs or groups of drugs; and

8 (3) differences in the level of risk associated
9 with drug use by certain individuals.

10 (b) REPORT TO CONGRESS.—No later than three
11 years after the date of enactment of this subsection, the
12 Secretary shall provide to Congress a report on the rel-
13 ative value scale developed under paragraph (1), together
14 with recommendations regarding adoption of such scale by
15 Federal health insurance programs and by health plans
16 certified under section 301.

17 **TITLE III—STATE HEALTH QUALITY**
18 **MANAGEMENT PROGRAMS**

19 **SEC. 301 CERTIFICATION OF HEALTH PLANS.**

20 (a) IN GENERAL.—(1) To be certified by a State, a
21 plan must be determined to be in substantial compliance
22 with the standards described in this section.

23 (2) OVERSIGHT.—The Secretary may conduct onsite
24 inspections and inspect documents generated by or in the
25 possession of a plan, accreditation organization, or State,

1 to verify the compliance of a plan with the requirements
2 of this section.

3 (b) ACCREDITATION.—A State may accept, in lieu of
4 making its own determination of compliance with these
5 standards, the determination of compliance by an accredi-
6 tation organization designated by the Secretary as utiliz-
7 ing a process consistent with subsection (c).

8 (c) PROCESS.—A State or accreditation organization
9 making a determination under subsection (a)—

10 (1) shall verify compliance with each of the
11 standards under this section.

12 (2) shall make available to the public its find-
13 ings related to a plan's compliance with each of the
14 standards under this section.

15 (3) may charge plans fees sufficient to cover the
16 cost of assuring compliance with the standards
17 under this section.

18 (d) QUALITY STANDARDS.—

19 (1) QUALITY IMPROVEMENT.—

20 (A) IN GENERAL.—Each health plan shall
21 establish a quality improvement program to sys-
22 tematically measure, assess and improve en-
23 rollee health status, patient outcomes, processes
24 of care, and enrollee satisfaction associated with
25 health care provided under the plan.

1 (B) FUNCTIONS.—Each quality improve-
2 ment program shall perform the following func-
3 tions—

4 (i) measure performance of the plan
5 and its member providers, using at least
6 the quality measures developed under sec-
7 tion 5003, and communicate findings of
8 such monitoring to such providers and plan
9 administrative personnel;

10 (ii) furnish the information required
11 under subtitle B of this title and provide
12 such other reports and information on the
13 quality of care delivered by providers as
14 may be required under this Act;

15 (iii) demonstrate measureable im-
16 provement in medical outcomes (including
17 morbidity, mortality, functional impair-
18 ment, and quality of life), as measured by
19 the plan and as assessed by plan enrollees
20 and patients;

21 (iv) establish procedures for—

22 (I) educational intervention when
23 services characterized by underuse,
24 overuse, or poor technical quality are
25 provided, and

1 (II) referral to State licensure
2 board or other appropriate regulatory
3 authorities if the interventions de-
4 scribed in subclause (I) are unsucces-
5 ful; and

6 (v) cooperate with the health quality
7 improvement foundation established under
8 section 5008, including providing access to
9 appropriate medical records and quality
10 performance data upon the request of such
11 foundation, and undertaking investigation
12 of quality problems and opportunities for
13 quality improvement identified by the foun-
14 dation.

15 (2) COMMUNITY HEALTH IMPROVEMENT.—

16 (A) IN GENERAL.—Each health plan shall
17 establish a community health improvement pro-
18 gram that meets the requirements of subpara-
19 graph (C) for the benefit of—

20 (i) plan enrollees; and

21 (ii) uninsured individuals residing in
22 the geographic area served by the plan, or,
23 with respect to self-insured plans, the geo-
24 graphic area served by insured plans in

1 which the plan's principle place of business
2 is located.

3 (B) REQUIREMENTS.—A community
4 health improvement program shall consist of:

5 (i) identification of baseline health
6 status problems in the population ad-
7 dressed by the program;

8 (ii) development of measures to ad-
9 dress such problems in consultation with
10 local public health officials, community or-
11 ganizations, and other health plans operat-
12 ing in the service area of the plan;

13 (iii) implementation of measures de-
14 veloped under clause (ii);

15 (iv) evaluation of the effectiveness of
16 such measures in improvement of health
17 status in the population; and

18 (v) an annual report of the results of
19 the evaluation.

20 (3) UTILIZATION MANAGEMENT.—

21 (A) IN GENERAL.—The utilization man-
22 agement activities of a plan are subject to the
23 requirements of this paragraph to the extent
24 such activities involve case by case review of
25 care proposed for or provided to individual pa-

1 tients. A plan may satisfy the requirements of
2 subparagraphs (C) through (G) by conducting
3 its utilization management efforts through its
4 quality improvement program.

5 (B) Disclosure of utilization management
6 criteria upon the request of practitioners or en-
7 rollees.

8 (C) Inclusion of utilization management
9 criteria to identify underutilization as well as
10 overutilization.

11 (D) Systematic updating of utilization re-
12 view criteria to reflect current scientific and
13 medical findings.

14 (E) Supervision of utilization determina-
15 tions by qualified medical professionals.

16 (F) Consistency in the application of utili-
17 zation review criteria.

18 (G) Personnel responsible for utilization
19 management shall—

20 (i) monitor the outcome of utilization
21 management decisions which are appealed
22 by an enrollee or provider, and

23 (ii) revise utilization management cri-
24 teria and procedures to eliminate future
25 reversed decisions to the extent practicable,

1 except where such reversals were not the
2 result of deficiencies in such criteria or
3 procedures.

4 (4) PHYSICIAN INCENTIVE PLANS.—

5 (A) IN GENERAL.—A health plan may es-
6 tablish and operate a physician incentive plan
7 (as defined in subparagraph (B)) if—

8 (i) the requirements specified in
9 clauses (i) through (iii) of section
10 1876(i)(8)(A) of the Social Security Act
11 are met (in the same manner as they apply
12 to eligible organizations under section
13 1876 of such Act); and

14 (ii) the plan prominently discloses to
15 the public, in its enrollment information,
16 the nature of the incentives provided to
17 providers under the plan.

18 (B) DEFINITION.—For purposes of this
19 paragraph, the term “physician incentive plan”
20 means any compensation or other financial ar-
21 rangement between a health plan and a physi-
22 cian or physician group that may directly or in-
23 directly have the effect of reducing or limiting
24 services provided with respect to individuals en-
25 rolled under the plan.

1 (5) ENROLLEE RIGHTS AND RESPONSIBIL-
2 ITIES.—

3 (A) IN GENERAL.—A plan shall provide to
4 all enrollees written information, translated for
5 the benefit of any population representing 5
6 percent or more of the plan’s enrollees whose
7 primary language is other than English, de-
8 scribing—

9 (i) enrollee rights and responsibilities,
10 including the grievance and appeals rights
11 defined in subpart C of this title, the
12 rights defined in subparagraphs (B)
13 through (H), and

14 (ii) any limitations of coverage, exclu-
15 sions, and out-of-pocket costs (including
16 any copayment, coinsurance, deductible)
17 and any limit(s) on out-of-pocket costs.

18 (B) WAIVER OF RIGHTS.—No health plan
19 or provider may require an individual or en-
20 rollee to waive the rights set forth in this para-
21 graph as a condition of enrollment in a plan,
22 admission to a health care facility, or provision
23 of treatment.

24 (C) RIGHT TO REFUSE TREATMENT.—
25 Each enrollee shall have the right—

1 (i) to refuse any health care item or
2 service;

3 (ii) to refuse to receive any health
4 care item or service from a specified pro-
5 vider;

6 (iii) to leave the premises of any pro-
7 vider, except as otherwise provided under
8 law;

9 (iv) to refuse participation in experi-
10 mental research, and to have either a re-
11 fusar or consent documented in the medical
12 record, except the (HHS) Secretary may
13 define in regulations circumstances under
14 which obtaining consent directly from a pa-
15 tient is not possible; and

16 (v) to receive an explanation of any
17 available alternative item, service, or pro-
18 vider, and any likely medical consequences
19 of the exercise of the rights described in
20 clauses (i)–(iv).

21 (D) RIGHT TO PARTICIPATE IN PLANNING
22 TREATMENT.—Enrollees shall have the right to
23 participate in the planning of their health care,
24 including the opportunity to discuss treatment
25 alternatives with providers and to be rep-

1 resented in such discussions by a family mem-
2 ber or other chosen representative.

3 (E) RIGHT TO CHOOSE PRIMARY CARE
4 PHYSICIAN.—Each plan shall permit enrollees
5 to choose a primary care physician from among
6 providers who are members of the plan, and
7 permit enrollees to change physicians upon re-
8 quest.

9 (F) RIGHT TO PRIVACY.—Enrollees shall
10 have the right—

11 (i) to privacy in regard to their health
12 care during discussion or consultation
13 among providers regarding their care,
14 physical examination, and treatment; and

15 (ii) while admitted to a health facility,
16 to associate and communicate privately
17 with persons of their choice, including
18 being afforded opportunities to commu-
19 nicate privately with a representative of
20 the consumer ombudsman or protection
21 and advocacy organization, upon the re-
22 quest of such representative.

23 (G) RIGHT TO MEDICAL RECORDS.—En-
24 rollees shall have a right to review and, for a

1 nominal charge, copy, their own medical records
2 during business hours.

3 (H) RIGHT TO CONFIDENTIALITY OF
4 RECORDS.—Enrollees shall be assured confiden-
5 tial treatment of their medical records, and
6 shall be afforded the opportunity to approve or
7 refuse their release to any individual other than
8 providers involved in their care, except the Sec-
9 retary, entities authorized under section 5008
10 of this Act, or others granted access to such
11 records by law.

12 (6) PRACTITIONER CREDENTIALING AND COM-
13 PETENCY.—Each health plan shall—

14 (A) establish an ongoing credentialing and
15 recredentialing process for all physicians and
16 other licensed practitioners which are members
17 of the plan;

18 (B) require practitioners applying for
19 membership to complete an application and
20 statement attesting to their professional stand-
21 ing and the accuracy of all information pro-
22 vided;

23 (C) assure the demonstrated competence of
24 member practitioners to perform the duties
25 under the plan's membership agreement, and

1 establish policies and procedures for educational
2 intervention or reduction, suspension, or termi-
3 nation of privileges of practitioners failing to
4 demonstrate competence.

5 (7) INFORMATION MANAGEMENT.—Each health
6 plan shall—

7 (A) protect the confidentiality and security
8 of information identifying any individual en-
9 rollee;

10 (B) standardize throughout the health plan
11 and its member providers, to the extent prac-
12 ticable and consistent with the requirements of
13 section 205, data sets, codes, definitions, classi-
14 fications, and terminology.

15 (8) DISCLOSURES RELATED TO MARKETING IN-
16 FORMATION.—

17 (A) Each health plan which sponsors or
18 distributes any comparative information per-
19 taining to plans marketed in an area shall
20 prominently disclose in such information—

21 (i) the identity of the plan (or related
22 organization) sponsoring or distributing
23 the comparative information, and whether
24 the performance of the plan (or organiza-
25 tion) is included in the comparative infor-

1 mation being sponsored or distributed by
2 such plan; and

3 (ii) if clinical outcomes or other clinical
4 performance data are included in such
5 information, whether such data were adjusted
6 to reflect the health status and severity
7 of illness of enrollees or patients included
8 in such comparisons, and the method by
9 which any severity adjustment was
10 accomplished.

11 (B) Enrollment materials provided to potential
12 enrollees by each health plan shall make
13 a prominent disclosure of the features, availability,
14 cost sharing and the additional premium
15 cost (if any) associated with purchase of the
16 self-referral option described in paragraph (11).

17 (9) COUNSELING REQUIREMENTS FOR PHARMACIES.—Each health plan shall ensure that no
18 pharmacy may receive payment from the plan for
19 dispensing a covered outpatient drug unless the
20 pharmacy agrees that a pharmacist employed by the
21 pharmacy will ask individuals enrolled in the plan
22 who receive a covered outpatient drug from the
23 pharmacy questions regarding—
24 pharmacy questions regarding—

25 (A) the appropriate use of the drug,

1 (B) major potential interactions between
2 the drug and other drugs used by the individ-
3 ual, and

4 (C) other questions necessary to determine,
5 in the professional judgment of the phar-
6 macist—

7 (i) whether the individual understands
8 and is likely to comply with instructions
9 for the safe and effective use of such
10 drugs, and

11 (ii) if any counseling or other action
12 by the pharmacist is needed.

13 (10) VOLUNTARY CONTRIBUTIONS.—Each
14 health plan shall, upon the request of the consumer
15 health care advocate described under section 203—

16 (A) publish in a prominent location in its
17 enrollment document a solicitation for voluntary
18 contributions for the consumer health care ad-
19 vocate designated by the Secretary to serve the
20 State; and

21 (B) collect such contributions, through the
22 same mechanism as periodic premium payments
23 of the enrollee are collected, and forward them
24 to the consumer health care advocate no less
25 frequently than monthly.

1 (11) POINT OF SERVICE OPTION.—

2 (A) IN GENERAL.—Each health plan which
3 utilizes a network of providers or suppliers shall
4 offer potential enrollees a point of service op-
5 tion, permitting such enrollees to receive all
6 covered items and services from suppliers and
7 providers that are not members of the plan's
8 network, subject to the conditions described in
9 paragraphs (B) through (D).

10 (B) COST SHARING.—For items and serv-
11 ices received from out-of-network providers or
12 suppliers, enrollees who have purchased the
13 point of service option shall be subject to—

14 (i) a deductible not to exceed \$200,
15 (ii) coinsurance at a rate no greater
16 than 150 percent of the coinsurance rate
17 established for items and services pur-
18 chased through the plan's network,
19 except that for individuals with incomes below
20 150 percent of the applicable poverty level, the
21 Secretary shall establish a deductible and coin-
22 surance level which is higher than the amounts
23 paid by such individuals for items and services
24 received from network providers and suppliers,

1 but which will not pose an unreasonable barrier
2 to exercise of the point of service option.

3 (C) SELF-REFERRAL.—With respect to an
4 enrollee who has purchased the point of service
5 option, no plan may require a referral from a
6 network provider as a precondition of coverage
7 of out-of-network items and services.

8 (D) MEDICAL NECESSITY.—A plan may
9 deny payment for items or services received
10 from an out-of-network provider or supplier if
11 such items or services were not medically nec-
12 essary.

13 **SEC. 302. STANDARDS FOR STATE MEDICAL BOARDS.**

14 (a) REQUIREMENTS FOR STATE BOARD OF MEDICAL
15 EXAMINERS.—

16 (1) PUBLIC ACCOUNTABILITY.—Each State
17 Board of Medical Examiners shall make available to
18 the public upon request:

19 (A) a description of any final actions (in-
20 cluding those described in paragraph (4)(E))
21 taken by the Board with respect to a physician;

22 (B) an annual performance report indicat-
23 ing the number and type of investigations un-
24 dertaken and actions taken by the Board dur-
25 ing the preceding year.

1 (2) COMPOSITION OF BOARD OF MEDICAL EX-
2 AMINERS AND COMMITTEES.—Each State Board
3 shall be structured so as to include:

4 (A) public members in sufficient numbers
5 that no fewer than fifty percent of board mem-
6 bers are public members;

7 (B) in the membership of each committee
8 or subdivision of the board, at least one public
9 member.

10 (3) FUNDING.—

11 (A) Each State medical licensure board
12 shall be adequately funded to fulfill the require-
13 ments of this section.

14 (B) All revenue generated by medical licen-
15 sure fees shall be used to fund the activities of
16 the State medical board, to the extent necessary
17 to fulfill the requirement of subparagraph (A).

18 (4) INVESTIGATIONS.—A State medical licen-
19 sure board shall—

20 (A) investigate any credible evidence which
21 alleges that a physician—

22 (i) is incompetent to perform the du-
23 ties reflected in the physician's license;

24 (ii) engages in unprofessional conduct
25 that jeopardized patients;

1 (iii) is mentally or physically unable to
2 safely and effectively perform the duties
3 reflected in the physician's license;

4 (B) employ or arrange for the availability
5 of personnel with the appropriate medical train-
6 ing necessary to investigate and document find-
7 ings related to allegations described in subpara-
8 graph (A);

9 (C) investigate allegations submitted to the
10 board by a health quality improvement founda-
11 tion established under section 202.

12 (D) possess the following investigative
13 powers:

14 (i) the power to subpoena documents
15 and individuals possessing information rel-
16 evant to investigations;

17 (ii) the power to require professional
18 competency examinations upon reasonable
19 suspicion of incompetence;

20 (iii) the power to obtain the involun-
21 tary temporary summary suspension of a
22 licensee from practice, based upon a rea-
23 sonable belief that the licensee poses an
24 imminent threat to patient health, followed
25 as soon as practicable by a formal hearing;

1 (E) possess the following authorities relat-
2 ed to disciplinary action:

3 (i) revocation or suspension of a li-
4 cense;

5 (ii) restriction or limitation of the ex-
6 tent, scope, or type of practice, including
7 the authority to order such limited practice
8 to be conducted under the supervision of
9 another licensee;

10 (iii) imposition of civil penalties;

11 (iv) issuance of a warning or rep-
12 rimand;

13 (v) probation with or without condi-
14 tions, such as submission to treatment,
15 continuing education, or reexamination;

16 (vi) the authority to condition a rein-
17 statement of a license or removal of license
18 limitations upon the licensee obtaining
19 minimum results on one or more forms of
20 competency examination, and

21 (vii) assessment of the reasonable
22 costs of investigation, hearings or reviews,
23 and supervision of practice.

24 (b) ELIGIBILITY FOR GRANTS.—

1 (1) IN GENERAL.—The Secretary may make a
2 grant to a State Board of Medical Examiners for
3 any purpose related to its duties under this section,
4 or for demonstration projects, if such Board dem-
5 onstrates it is eligible under paragraph (2).

6 (2) ELIGIBILITY.—A State Board of Medical
7 Examiners is eligible for a grant under paragraph
8 (1) if the Secretary determines that the Board is in
9 substantial compliance with this section and the cur-
10 rent model standards established by the Federation
11 of State Medical Boards.

12 (3) CONSTRUCTION.—If any of the model
13 standards referred to in paragraph (2) are inconsis-
14 tent with the provisions of this section, the Sec-
15 retary’s determination of eligibility shall be based
16 upon on compliance with the requirements of this
17 section.

18 (c) DEFINITIONS.—

19 (1) For purposes of this section, a “Board of
20 Medical Examiners” shall have the meaning given in
21 section 431(14) of the Health Care Quality Improve-
22 ment Act of 1986.

23 (2) For purposes of this section, a “public
24 member” means an individual who resides in the
25 State and is a person of integrity and good reputa-

1 tion who has lived in the State for at least five years
2 immediately preceding appointment to the Board,
3 and has never been authorized to practice a healing
4 art, and has never had a substantial personal, busi-
5 ness, professional, or pecuniary connection with a
6 healing art or with a medical education or health
7 care facility, except as a patient or a potential
8 patient.



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