I

104TH CONGRESS
2D SESSION

H. R. 4220

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

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 26, 1996

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

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A BILL

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

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 ''Managed Care Consumer Protection Act of 1996''.

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

TITLE I—PROTECTIONS FOR BENEFICIARIES ENROLLED IN MANAGED CARE PLANS

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

"Subtitle L—Protections for Beneficiaries Under Managed Care Plans

"CHAPTER 101—PROTECTIONS FOR BENEFICIARIES UNDER MANAGED CARE PLANS

"Subchapter A—Imposition of Tax

"SEC. 9901. EXCISE TAX ON FAILURE TO MEET REQUIREMENT OF BENEFICIARY PROTECTION.

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

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

''(2) an insurer that offers managed care health insurance coverage (other than to a group health plan subject to paragraph (1)) to meet the requirements of such subchapter.

''(b) AMOUNT OF TAX.—

''(1) GROUP HEALTH PLAN.—

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

''(B) SELF-INSURED PLANS.—In the case that the group health plan is self-insured, the cost to the plan of the coverage of participants and beneficiaries shall be treated as the premium received for the purposes of subparagraph (A).

''(2) INSURER OFFERING INDIVIDUAL HEALTH INSURANCE COVERAGE.—The amount of tax imposed by subsection (a)(2) on any failure of an insurer with respect to an individual described in paragraph (1) or (2) of section 9902(b) shall be 25 per-

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

''(c) LIMITATIONS ON AMOUNT OF TAX.—

''(1) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by subsection (a) on any failure during any period for which it is established to the satisfaction of the Secretary that none of the persons referred to in subsection (e) knew, or exercising reasonable diligence would have known, that such failure existed.

''(2) TAX NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) on any failure if—

''(A) such failure was due to reasonable cause and not to willful neglect, and

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

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

posed by subsection (a) to the extent that the payment of such tax would be excessive relative to the failure involved.

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

''(1) any governmental plan (within the meaning of section 414(d)), or

''(2) any church plan (within the meaning of section 414(e)).

''(e) LIABILITY FOR TAX.—The following shall be responsible for the tax imposed by subsection (a):

''(1) In the case of the tax imposed by subsection (a)(1) on a group health plan, the plan.

''(2) In the case of the tax imposed by subsection (a)(2) on an insurer offering health insurance coverage, the insurer.

''SEC. 9902. DEFINITIONS.

''(a) DEFINITIONS RELATING TO MANAGED CARE.—For purposes of this chapter—

''(1) ENROLLEE.—The term 'enrollee' means, with respect to a group health plan or health insurance issuer offering health insurance coverage, an individual enrolled with the plan or enrolled with the issuer with respect to such coverage.

''(2) MANAGED CARE.—The term 'managed care' means, with respect to a group health plan or health insurance coverage offered by a health insurance issuer, such a plan or coverage that—

''(A) provides or arranges for the provision of health care items and services to enrollees primarily through participating physicians and providers, or

''(B) provides financial incentives (such as variable copayments and deductibles) to induce enrollees to obtain benefits primarily through participating physicians and providers,

or both.

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

''(4) PROVIDER NETWORK.—The term 'provider network' means, with respect to a plan or issuer, providers of health care services provided by or through the plan or issuer who have entered into an agreement with the plan or issuer or an agreement

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

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

"Subchapter B—Requirements

"SEC. 9911. REQUIREMENTS RELATING TO MANAGED CARE PLANS AND COVERAGE AND PROVIDERS OF HEALTH SERVICES.

''(a) UTILIZATION REVIEW.—

''(1) MEETING REQUIREMENTS.—

''(A) IN GENERAL.—A managed care group health plan (or health insurance issuer that offers managed care health insurance coverage) may not deny coverage of or payment for items and services on the basis of a utilization review program unless the Secretary of Health and Human Services certifies (and periodically

recertifies) that the program meets the standards established by such Secretary under this subsection.

''(B) CERTIFICATION.—The Secretary of Health and Human Services may certify a managed care plan or coverage as meeting such standards if the Secretary determines that the plan or coverage has met the utilization standards required for accreditation as applied by a nationally recognized, independent, nonprofit accreditation entity. Such Secretary shall periodically review the standards used by the private accreditation entity to ensure that such standards meet or exceed the standards established by the Secretary under this subsection.

''(2) STANDARDS.—Such Secretary shall establish standards for utilization review programs of managed care group health plans and managed care health insurance coverage, consistent with paragraph (3), and shall periodically review and update such standards to reflect changes in the delivery of health care services. Such Secretary shall establish such standards in consultation with appropriate parties.

''(3) DESCRIPTION.—Under the standards established under paragraph (2)—

"(A) the plan or issuer offering the coverage shall have a written description of the utilization review program of the plan or relating to the coverage, including a description of—

"(i) the delegated and nondelegated activities under the program;

"(ii) the policies and procedures used under the program to evaluate medical necessity; and

"(iii) the clinical review criteria, information sources, and the process used to review and approve the provision of medical services under the program;

"(B) with respect to the administration of the utilization review program, the plan or issuer may not employ utilization reviewers or contract with a utilization management organization if the conditions of employment or the contract terms include financial incentives to reduce or limit the medically necessary or appropriate services provided to covered individuals and individuals performing utilization review may not receive financial compensation based upon the number of denials of coverage;

''(C) the plan or issuer shall develop procedures for periodically reviewing and modifying the utilization review of the plan or relating to the coverage under which providers may participate in the plan or coverage in the development and review of utilization review policies and procedures;

''(D) utilization review—

''(i) shall be conducted in accordance with uniformly applied standards that are based on the most currently available medical evidence,

''(ii) shall develop and apply recorded (written or otherwise) utilization review decision protocols based on sound medical evidence;

''(E) the clinical review criteria used under the utilization review decision protocols to assess the appropriateness of medical services shall be clearly documented and available to participating health professionals upon request and shall include a mechanism for assessing the consistency of the application of the criteria used under the protocols across reviewers, and

a mechanism for periodically updating such criteria;

''(F) the procedures applied under a utilization review program with respect to the preauthorization and concurrent review of the necessity and appropriateness of medical items, services or procedures, shall require that qualified medical professionals supervise review decisions and, with respect to a decision to deny the provision of medical items, services or procedures, a provider licensed in the same field shall conduct a subsequent review to determine the medical appropriateness of such a denial and physicians from the same medical branch (allopathic or osteopathic medicine) and specialty (recognized by the American Board of Medical Specialties or the American Osteopathic Association) shall be utilized in the review process as needed;

''(G) negative determinations of the medical necessity or appropriateness of services or the site at which services are furnished may be made only by clinically qualified personnel;

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

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

''(I) the plan or issuer shall provide each covered individual, at the time of enrollment and not less frequently than annually thereafter, an explanation of the utilization review requirements of the plan or under the coverage offered by the issuer.

''(b) ASSURANCE OF ACCESS.—

''(1) IN GENERAL.—Each managed care group health plan, and each health insurance issuer offering managed care health insurance coverage, shall demonstrate that the plan or issuer (in relation to the coverage) has a sufficient number, distribution, and variety of qualified health care providers to ensure that all covered health care services will be available and accessible in a timely manner to all individuals enrolled under the plan or such coverage.

''(2) ACCESS TO SPECIALIZED TREATMENT EXPERTISE.—Such a plan or issuer shall demonstrate that enrollees have access, when medically or clinically indicated in the judgment of the treating health professional, to specialized treatment expertise.

''(3) COORDINATION OF CARE.—

"(A) IN GENERAL.—Any process established by such a plan or issuer to coordinate care and control costs may not impose an undue burden on enrollees with chronic health conditions. Such a plan or issuer shall ensure a continuity of care and shall, when medically or clinically indicated in the judgment of the treating health professional, ensure direct access to relevant specialists for continued care.

"(B) COMPLEX CONDITIONS.—In the case of an enrollee who has a severe, complex, or chronic condition, such a plan or issuer shall determine, based on the judgment of the treating health professional, whether it is medically or clinically necessary or appropriate to use a care coordinator from an interdisciplinary team or a specialist to ensure continuity of care.

"(4) NO WAIVER.—

"(A) IN GENERAL.—The requirements of this subsection may not be waived and shall be met in all areas where the plan or issuer (in relation to managed care health insurance coverage) has enrollees, including rural areas.

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

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

''(c) ACCESS TO CENTERS OF EXCELLENCE.—

''(1) IN GENERAL.—Each managed care group health plan or health insurance issuer offering managed care health insurance coverage shall demonstrate that individuals enrolled with the plan or under such coverage who have chronic diseases or otherwise require specialized services have access through the plan or issuer to specialized treatment expertise of designated centers of excellence. Such a plan or issuer shall demonstrate such access according to standards developed by the Secretary of Health and Human Services, including requirements relating to arrangements with such centers and referral of enrollees to such centers.

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

''(A) to provide specialty care,

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

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

"(d) RECOGNITION OF TRAUMA CENTERS.—

"(1) IN GENERAL.—A managed care group health plan or health insurance issuer offering managed care health insurance coverage shall provide for health services contracted for and which are provided to such an individual other than through the plan or coverage (including trauma services provided by designated trauma centers), if (A) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition and (B) it was not reasonable given the circumstances to obtain the services through the plan or participating providers in relation to such coverage.

"(2) DEFINITION.—In paragraph (1), the term 'designated trauma center' has the meaning given

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

''(e) NO REFERRAL REQUIRED FOR OBSTETRICS AND GYNECOLOGY.—A managed care group health plan or health insurance issuer offering managed care health insurance coverage may not require an individual to obtain a referral from a physician in order to obtain covered items and services from a physician who specializes in obstetrics and gynecology.

''(f) COVERAGE OF SERVICES OF ESSENTIAL COMMUNITY PROVIDERS.—

''(1) IN GENERAL.—The Secretary of Health and Human Services may require a managed care group health plan or health insurance issuer that offers managed health insurance coverage to enter into agreements with essential community providers serving the plan's or issuer's service area (in relation to the coverage) to join the plan's or issuer's provider network if such Secretary finds that such agreements are necessary for the plan or issuer to make contracted for services (A) available and accessible

to each enrollee, within the area served by the plan or issuer (in relation to such coverage), with reasonable promptness and in a manner which assures continuity, and (B) when medically necessary, available and accessible twenty-four hours a day and seven days a week.

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

''(g) DUE PROCESS PROTECTIONS FOR PROVIDERS.—

(1) IN GENERAL.—In consultation with providers of health care services who are members of the plan's or issuer's provider network, each managed care group health plan and each health insurance issuer offering managed care health insurance coverage shall establish standards to be used by the plan or issuer (in relation to such coverage) for contracting with providers, and shall make descriptive

information regarding these standards available to enrollees, providers who are members of the network, and prospective enrollees and prospective members of the network.

''(2) LIMITATION ON TERMINATION.—

''(A) IN GENERAL.—Such a group health plan or health insurance issuer may not terminate or refuse to renew an agreement with a provider of health care services to participate in the plan's or issuer's provider network unless the plan or issuer provides written notification to the provider of the decision to terminate or refuse to renew the agreement. The notification shall include a statement of the reasons for the plan's or issuer's decision, consistent with the standards established under paragraph (1).

''(B) NOTICE.—Such a plan or issuer shall provide the notification required under subparagraph (A) at least 45 days prior to the effective date of the termination or expiration of the agreement (whichever is applicable). The previous sentence shall not apply if failure to terminate the agreement prior to the deadline would adversely affect the health or safety of an individual enrolled with the plan or issuer.

''(3) REVIEW PROCESS.—

''(A) IN GENERAL.—Each such plan or issuer shall provide a process under which a provider of health care services may request a review of the plan's or issuer's decision to terminate or refuse to renew the provider's participation agreement. Such review shall be conducted by a group of individuals the majority of whom are providers of health care services who are members of the plan's or issuer's provider network or employees of the plan or issuer, and, to the extent possible, who are members of the same profession as the provider who requests the review and, for physicians, the same medical branch (allopathic or osteopathic medicine).

''(B) REPRESENTATION.—If the provider requests in advance, the plan or issuer shall permit an attorney representing the provider to be present at the provider's review.

''(C) ADVISORY FINDINGS.—The findings and conclusions of a review under this paragraph shall be advisory and non-binding.

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

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

"SEC. 9912. GRIEVANCE PROCEDURES AND DEADLINE FOR RESPONDING TO REQUESTS FOR COVERAGE OF SERVICES.

''(a) GRIEVANCE PROCEDURES.—A managed care group health plan and a health insurance issuer offering managed care health insurance coverage shall provide meaningful procedures for hearing and resolving grievances between the plan or issuer (any entity or individual through which the plan or issuer provides health care services) and members enrolled with the plan or issuer.

''(b) DETAILS.—The procedures provided under subsection (a) shall include—

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

''(2) documentation concerning the substance of complaints, grievances, and actions taken concerning such complaints and grievances, which shall be in writing.

''(3) procedures to ensure a resolution of a complaint or grievance;

''(4) the compilation and analysis of complaint and grievance data;

''(5) procedures to expedite the complaint process if the complaint involves a dispute about the coverage of an immediately and urgently needed service; and

''(6) procedures to ensure that if an enrollee orally notifies the plan or issuer about a complaint, the plan or issuer (if requested) must send the enrollee a complaint form that includes the telephone numbers and addresses of member services, and a description of the plan's or issuer's grievance procedure.

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

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

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

''(2) the right to a second review with a different panel, independent of the plan or issuer, or to a review through an impartial arbitration process which shall be described in writing by the plan or issuer; and

''(3) an expedited process for review in emergency cases.

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

''(d) WRITTEN DECISION.—With respect to the complaint, grievance, and appeals processes required under this section, the plan or issuer shall, upon the request of an enrollee, provide the enrollee a written decision concerning a complaint, grievance, or appeal in a timely fashion.

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

''(f) PROMPT RESPONSE TO REQUESTS FOR SERVICES.—In addition to the procedures available pursuant to the previous provisions of this section, in the case of the request of an enrollee with such a plan or issuer—

''(i) the plan or issuer shall respond to the request not later than 24 hours after the request is made; and

''(ii) the plan or issuer shall hear and resolve the enrollee's appeal of a denial of coverage of such services in accordance with a process meeting standards established by the Secretary of Health and Human Services.

"SEC. 9913. REQUIREMENTS FOR SERVICE AREAS; NON-DISCRIMINATION.

''(a) SERVICE AREA REQUIREMENTS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), if the service area of a group health plan or health insurance issuer offering health insurance coverage includes any part of a metropolitan statistical area, the service area shall include the entire metropolitan statistical area (including any area designated by the Secretary of Health and Human Services as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act within such metropolitan statistical area).

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

"(A) the plan or issuer demonstrates that it lacks the financial or administrative capacity to serve the entire metropolitan statistical area; and

"(B) such Secretary finds that the composition of the plan's or issuer's service area does not reduce the financial risk to the plan or issuer of providing services to enrollees because of the health status or other demographic characteristics of individuals residing in the service area (as compared to the health status or demographic characteristics of individuals residing in the portion of the metropolitan statistical area not included in the plan's or issuer's service area).

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

"SEC. 9914. PROVIDING INFORMATION.

"(a) INFORMATION ON PHYSICIAN INCENTIVE PLANS.—

"(1) IN GENERAL.—Upon the request of an enrollee of a managed care group health plan or under managed care health insurance coverage offered by a health insurance issuer or an individual considering enrollment with such a plan or for such coverage, the plan or issuer shall provide the enrollee or individual with descriptive information regarding any physician incentive plan of the plan or issuer applicable to such enrollment.

"(2) PHYSICIAN INCENTIVE PLAN DEFINED.—In this subsection, the term 'physician incentive plan' means any compensation arrangement between a managed care group health plan or health insurance issuer offering managed care health insurance coverage and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the plan or under such coverage.

"(b) INFORMATION ON PROVIDER CREDENTIALS.—Each managed care group health plan and each health insurance issuer offering managed care health insurance coverage shall provide each enrollee, at the time of enrollment and not less frequently than annually thereafter, an

explanation of the credentials of the individuals and entities providing services to enrollees under the plan or coverage.

''(c) OTHER INFORMATION.—Each such plan and issuer shall provide prospective enrollees with written information concerning the following with respect to coverage offered under the plan or coverage:

''(1) Coverage provisions, benefits, and any exclusions by category of service or product, including premiums, deductibles, and copayments associated with any point-of-service benefits.

''(2) Loss ratios with an explanation that such ratios reflect the percentage of the premiums expended for health services.

''(3) Prior authorization or other review requirements including preauthorization review, concurrent review, post-service review, post-payment review, and procedures that may lead the patient to be denied coverage for, or not be provided, a particular service or product.

''(4) Covered individual satisfaction statistics, including disenrollment statistics.

''(5) Advance directives and organ donation.

''(6) The characteristics and availability of health care professionals and institutions participat-

ing in the plan or coverage, including descriptions of the financial arrangements or contractual provisions with hospitals, utilization review organizations, physicians, or any other provider of health care services that would affect the services offered, referral or treatment options, or physician's fiduciary responsibility to patients, including financial incentives regarding the provision of medical or other services.

''(7) Quality indicators for the plan or issuer and for participating health professionals and providers under the plan or coverage, including population-based statistics such as immunization rates and other preventive care and health outcomes measures such as survival after surgery, adjusted for case mix.

''(8) An explanation of the appeals process and the grievance procedure.

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

''(10) Physician ownership and investment structure of the plan or issuer.

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

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

the plan or issuer or reveal quality and medical coverage issues.

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

"SEC. 9915. RESTRICTIONS ON COMMISSIONS FOR AGENTS.

''In the case of a managed care group health plan or health insurance issuer that offers managed care health insurance coverage which employs or otherwise compensates agents to enroll individuals under the plan or coverage and which pays an agent a commission with respect to the enrollment of an individual—

''(1) such commissions may not constitute the predominant source of the agent's total compensation from the plan or issuer (in accordance with standards established by the Secretary of Health and Human Services); and

''(2) if an agent receives a commission from the plan or issuer with respect to an individual who enrolls with the plan or under such coverage and the individual terminates enrollment with the plan or such coverage during the 90-day period beginning on

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

"SEC. 9916. PROTECTION OF PATIENT RIGHT TO KNOW.

"(a) IN GENERAL.—

"(1) PROHIBITION OF CERTAIN PROVISION.—A managed care group health plan and health insurance issuer offering managed care health insurance coverage may not include as part of such plan or in relation to such coverage any provision that prohibits, restricts, or interferes with any medical communication (as defined in subsection (b)) as part of—

"(A) a written contract or agreement with a health care provider,

"(B) a written statement to such a provider, or

"(C) an oral communication to such a provider.

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

"(A) Refusal to contract with the health care provider.

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

''(C) Refusal to refer patients to or allow others to refer patients to the health care provider.

''(D) Refusal to compensate the health care provider for covered services.

''(E) Any other retaliatory action against the health care provider.

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

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

''(1) means any communication, other than a knowing and willful 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 managed care group health plan or managed care health insurance coverage or another plan or coverage 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 plan or issuer, 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 the plan or issuer; and

"(2) includes communications concerning—

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

"(B) any risks or benefits associated with such tests, 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 managed care group health plan or health insurance issuer in relation to managed care health insurance coverage to authorize or deny health care services or benefits,

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

''(F) any financial incentives or disincentives provided by the plan or issuer 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 medical communications than the requirements established under this section.

''(d) CONSTRUCTION.—Nothing in this section shall be construed as—

''(1) requiring a managed care group health plan or health insurance issuer in relation to managed care health insurance coverage to enter into or renew a contract or agreement with any willing health care provider, or

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

"SEC. 9917. PATIENT ACCESS TO CLINICAL STUDIES.

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

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

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

"(3) the items and services would otherwise be covered under the plan or coverage except for the fact that they are provided in connection with participation in such a study.

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

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

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

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

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

''SEC. 9918. REQUIRED MINIMUM CHILDBIRTH BENEFITS.

''(a) MINIMUM CHILDBIRTH BENEFITS.—If a managed care group health plan or managed care health insurance coverage offered by a health insurance issuer provides coverage that includes any benefits for inpatient care for childbirth for a mother or newborn child, the plan or issuer (in relation to such coverage) shall meet the following requirements:

''(1) MINIMUM LENGTH OF STAY FOR INPATIENT CARE BENEFITS.—The plan or coverage shall provide benefits for inpatient care for childbirth for a minimum length of stay of 48 hours following a vaginal delivery and a minimum length of stay of 96 hours following a caesarean section.

''(2) COVERAGE OF POST-DELIVERY FOLLOW-UP CARE.—If an attending provider, in consultation with the mother, decides to discharge a covered mother or newborn child from an inpatient setting before the expiration of the minimum length of stay period described in paragraph (1), the plan or coverage shall include benefits for timely post-delivery care by a registered nurse, physician, nurse practitioner, nurse midwife or physician assistant experienced in maternal and child health in the home, a provider's office, a hospital, a federally qualified health center, a federally qualified rural health clinic, a State health department maternity clinic, or another setting (such as a birthing center or an intermediate care facility) determined appropriate under regulations promulgated by the Secretary of Health and Human Services.

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

under this subsection regarding the requirements of this section.

(b) PROHIBITIONS.—In implementing the requirements of subsection (a), such a plan or issuer may not—

''(1) require or condition the provision of benefits under subsection (a) on any authorization or approval of an attending or other provider;

''(2) deny enrollment, renewal, or continued coverage to a mother and her newborn child who are otherwise eligible to be so covered based on compliance with this section;

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

''(4) provide incentives (monetary or otherwise) to an attending provider to induce such provider to provide treatment in a manner inconsistent with this section; or

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

''(c) ADDITIONAL TERMS AND CONDITIONS.—

''(1) ATTENDING PROVIDER.—As used in this section, the term 'attending provider' means, with

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

(2) TIMELY CARE DEFINED.—As used in subsection (a)(2), the term 'timely post-delivery care' means health care that is provided—

''(A) following the discharge of a mother and her newborn child from the inpatient setting following childbirth; and

''(B) in a manner that meets the health care needs of the mother and her newborn child, that provides for the appropriate monitoring of the conditions of the mother and child, and that occurs within the 72-hour period immediately following discharge.

''(3) REGULATIONS REGARDING APPROPRIATE POST-CARE DELIVERY SETTINGS.—The Secretary of Health and Human Services, with respect to regulations promulgated under subsection (a)(2) concerning appropriate post-delivery care settings—

"(A) shall ensure that, to the extent practicable, such regulations are consistent with State licensing and practice laws,

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

"(C) shall consider both urban and rural settings.

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

"(A) give birth in a hospital; or

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

"(5) REQUIREMENTS.—The notice required under subsection (a)(3) shall be in accordance with regulations promulgated by the Secretary of Health and Human Services. Such regulations shall provide that the notice shall be in writing, shall be conspicuous and prominently positioned, and shall be required to be provided as follows:

"(A) HEALTH INSURANCE COVERAGE.—By a health insurance issuer in relation to managed care health insurance coverage—

"(i) to enrollees described in subsection (a) who are enrolled on the effec-

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

''(ii) to other enrollees at the time of enrollment and annually thereafter.

''(B) GROUP HEALTH PLANS.—By a managed care group health plan—

''(i) to enrollees described in subsection (a) who are enrolled on the effective date of this chapter within 120 days after such effective date, and

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

''SEC. 9919. ASSURING EQUITABLE HEALTH PLAN COVERAGE WITH RESPECT TO EMERGENCY SERVICES.

''(a) PROHIBITION OF CONTRACTUAL LIMITATIONS ON COVERAGE OF EMERGENCY SERVICES.—A managed care group health plan or managed care health insurance coverage offered by a health insurance issuer that provides any coverage with respect to emergency services shall cover emergency services furnished to an enrollee of the plan or issuer (with respect to such managed care coverage)—

''(1) without regard to whether or not the provider furnishing the emergency services has a contractual or other arrangement with the plan or issuer for the provision of such services to such enrollees, and

''(2) without regard to prior authorization.

''(b) PROHIBITION OF DISCRIMINATORY PAYMENT OR COST-SHARING.—

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

''(A) shall determine and make prompt payment in a reasonable and appropriate amount for such services, and

''(B) subject to paragraph (2), may not impose cost-sharing for services furnished in a hospital emergency department that is calculated in a manner (such as the use of a different percentage) that imposes greater cost sharing with respect to such services compared to comparable services furnished in other settings.

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

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

''(c) ASSURING TIMELINESS OF PRIOR AUTHORIZATION DETERMINATION FOR NEEDED CARE IDENTIFIED IN INITIAL EVALUATION.—

''(1) IN GENERAL.—

''(A) ACCESS TO PROCESS.—If an enrollee of a managed care group health plan or health insurance issuer in relation to managed care health insurance coverage receives emergency services from an emergency department pursuant to a screening evaluation conducted by a treating physician or other emergency department personnel and pursuant to the evaluation such physician or personnel identifies items and services (other than emergency services) promptly needed by the enrollee, the plan or issuer shall provide access 24 hours a day, 7 days a week, to such persons as may be authorized to make any prior authorization determinations respecting coverage of such promptly needed items and services.

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

''(i) has attempted to contact such a person for authorization—

''(I) to provide an appropriate referral for the items and services, or

''(II) to provide the items and services to the enrollee,

and access to the person has not been provided (as required under subparagraph (A)), or

''(ii) has requested such authorization from such a person and the person has not denied the authorization within 30 minutes after the time the request is made.

''(2) REFERRAL BY PHYSICIAN TO HOSPITAL EMERGENCY DEPARTMENT DEEMED PRIOR AUTHORIZATION.—If a participating physician or other person authorized to make prior authorization determinations for such a plan or issuer refers an enrollee to a hospital emergency department for evaluation or treatment, a request for prior authorization of the

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

"(3) EFFECT OF APPROVAL.—

"(A) IN GENERAL.—Approval of a request for a prior authorization determination (including a deemed approval under paragraph (1) or (2)) shall be treated as approval of any health care items and services required to treat the medical condition identified pursuant to a screening evaluation referred to in paragraph (1)(A).

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

"(d) ENCOURAGING APPROPRIATE USE OF 911 EMERGENCY TELEPHONE NUMBER.—Such a plan or issuer—

"(1) shall include, in any educational materials the plan makes available to its enrollees on the procedures for obtaining emergency services—

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

''(B) an explanation of what is an emergency medical condition;

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

''(3) shall not deny coverage or payment for an item or service solely on the basis that an enrollee uses the 911 emergency telephone number to summon treatment for an emergency medical condition.

''(e) EFFECT ON STATE LAW.—

''(1) PREEMPTION.—Nothing in this section shall be construed as preempting or otherwise superseding any provision of State law unless such provision directly conflicts with this section.

''(2) CONSUMER PROTECTIONS.—A provision of State law shall not be considered to conflict directly with this section if the provision provides the enrollees with protections that exceed the protections of this section.

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

''(1) COST-SHARING.—The term 'cost-sharing' means any deductible, coinsurance amount, copayment, or other out-of-pocket payment that an enrollee is responsible for paying with respect to a health care item or service covered under a managed care group health plan or managed care health insurance coverage.

''(2) EMERGENCY DEPARTMENT.—The term 'emergency department' includes, with respect to a hospital, a trauma center in the hospital if the center—

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

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

''(3) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means a medical condition, the onset of which or change in which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

"(A) placing the person's health in serious jeopardy,

"(B) serious impairment to bodily functions, or

"(C) serious dysfunction of any bodily organ or part.

"(4) EMERGENCY SERVICES.—The term 'emergency services' means—

"(A) health care items and services furnished in the emergency department of a hospital, and

"(B) ancillary services routinely available to such department,

to the extent they are required to evaluate and treat an emergency medical condition (as defined in paragraph (3)) until the condition is stabilized.

"(5) PRIOR AUTHORIZATION DETERMINATION.—The term 'prior authorization determination' means, with respect to health care items and services for which coverage may be provided under a group health plan or health insurance coverage, a determination, before the provision of the items and services and as a condition of coverage of the items and services under the plan or coverage, that cov-

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

''(6) STABILIZED.—The term 'stabilized' means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result or occur before an individual can be transferred in compliance with the requirements of section 1867 of the Social Security Act.

''(7) 911 EMERGENCY TELEPHONE NUMBER.—The term '911 emergency telephone number' includes, in the case of a geographic area where 911 is not in use for emergencies, such other telephone number as is in use for emergencies.''

(b) CLERICAL AMENDMENT.—The table of contents for the Internal Revenue Code of 1986 is amended by adding after the item relating to subtitle K the following new item:

''Subtitle L. Protection for Beneficiaries Under Managed Care Plans.''

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

Subtitle C—Effective Date

SEC. 121. EFFECTIVE DATE.

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

TITLE II—MEDICARE

SEC. 201. PROHIBITION ON PAYMENTS UNDER MEDICARE UNTIL COMPLETION OF ORIENTATION AND MEDICAL PROFILE.

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

''(G)(i) The Secretary may not make a payment to an eligible organization under a risk-sharing contract under this section with respect to an enrollee until the eligible organization certifies to the Secretary that the organization—

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

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

''(ii) The orientation required under this subparagraph includes an explanation of the following features of the health plan offered by such organization:

''(I) Access to care, including choice of physician, physician location, and hospital coverage.

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

''(iii) The medical profile described in this clause is such profile of the medical condition of the enrollee as the Secretary shall specify by regulation.''.

(b) PROMULGATION OF REQUIREMENTS FOR ORIENTATION AND MEDICAL PROFILE.—Not later that 180 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall, by rule, first specify the elements of the orientation and of the medical profile described in clauses (ii) and (iii) of section 1876(c)(3)(G) of the Social Security Act (as added by subsection (a)). Chapter 8 of title 5, United States Code, shall not apply to such rule. Such rule shall apply on a final basis, pending notice and opportunity for public comment.

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

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

(a) REQUIREMENT OF COMMUNITY RATING.—

(1) IN GENERAL.—Section 1882(s) of the Social Security Act (42 U.S.C. 1395ss(s)) is amended—

(A) in paragraph (3), by striking ''paragraphs (1) and (2)'' and inserting ''this subsection'', and by redesignating such paragraph as paragraph (4), and

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

''(3)(A) Except as provided in this paragraph, the issuer of a Medicare supplemental policy may not vary the premium among individuals who reside in the same community rating area.

''(B)(i) In the first year for which this paragraph applies to such an issuer in a State, the premium rate charged by the issuer for such a policy in a community may vary so long as the premium range percentage (as defined in clause (iii)) does not exceed ⅔ of the premium range percentage of premium rates charged by the insurer for such policies in the community rating area in the previous year.

''(ii) In the second year for which this paragraph applies to such an issuer in a State, the premium rate charged by the issuer for such a policy in a community may vary so long as the premium range percentage (as defined in clause (iii)) does not exceed ½ of the maximum premium range percentage permitted under clause (i) for the previous year.

''(iii) In this paragraph, the term 'premium range percentage' means—

''(I) the highest premium rate minus the lowest premium rate, divided by

''(II) the lowest premium rate,

expressed as a percentage.

''(C) For purposes of this paragraph, each of the following is considered to be a separate 'community rating area':

''(1) Each metropolitan statistical area.

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

(2) CONFORMING AMENDMENT.—Section 1882(s)(2)(A) of such Act (42 U.S.C. 1395ss(s)(2)(A)) is amended by striking '', or discriminate in the pricing of the policy,''.

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

amended by striking ''75 percent'' and all that follows through the semicolon and inserting ''85 percent;''.

(c) EFFECTIVE DATE.—

(1) NAIC STANDARDS.—If, within 6 months after the date of the enactment of this Act, the National Association of Insurance Commissioners (in this section referred to as the ''NAIC'') makes changes in the 1991 NAIC Model Regulation (as defined in section 1882(p)(1)(A) of the Social Security Act) to incorporate the additional requirements imposed by the amendments made by this section, section 1882(g)(2)(A) of such Act shall be applied in each State, effective for policies issued to policyholders on and after the date specified in paragraph (3), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation (as so defined) as changed under this section (such changed Regulation referred to in this section as the ''1996 NAIC Model Regulation'').

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

retary'') shall promulgate a regulation and section 1882(g)(2)(A) of the Social Security Act shall be applied in each State, effective for policies issued to policyholders on and after the date specified in paragraph (3), as if the reference to the Model Regulation adopted in June 6, 1979, were a reference to the 1991 NAIC Model Regulation (as so defined) as changed by the Secretary under this subsection (such changed Regulation referred to in this subsection as the ''1996 Federal Regulation'').

(3) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State adopts the 1996 NAIC Model Regulation or the 1996 Federal Regulation; or

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

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies, in consultation with the NAIC, as—

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

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

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

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1997. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 203. OTHER ADDITIONAL CONSUMER PROTECTIONS FOR MEDICARE SUPPLEMENTAL INSURANCE.

(a) GUARANTEEING ISSUE WITHOUT PREEXISTING CONDITIONS FOR CONTINUOUSLY COVERED INDIVIDUALS.—Section 1882(s) of the Social Security Act (42 U.S.C. 1395ss(s)), as amended by section 202(a), is amended—

(1) by redesignating paragraph (4) as paragraph (5), and

(2) by inserting after paragraph (3) the following new paragraph:

''(4)(A) The issuer of a Medicare supplemental policy—

''(i) may not deny or condition the issuance or effectiveness of a Medicare supplemental policy described in subparagraph (C);

''(ii) may not discriminate in the pricing of the policy on the basis of the individual's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability; and

''(iii) may not impose an exclusion of benefits based on a pre-existing condition,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such subparagraph.

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

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

tion 1833(a)(1)(A) and such enrollment ceases either because the individual moves outside the service area of the organization under the contract or agreement or because of the termination or nonrenewal of the contract or agreement.

''(ii) The individual is enrolled with an organization under a policy described in subsection (t) and such enrollment ceases either because the individual moves outside the service area of the organization under the policy, because of the bankruptcy or insolvency of the insurer, or because the insurer closes the block of business to new enrollment.

''(iii) The individual is covered under a Medicare supplemental policy and such coverage is terminated because of the bankruptcy or insolvency of the insurer issuing the policy, because the insurer closes the block of business to new enrollment, or because the individual changes residence so that the individual no longer resides in a State in which the issuer of the policy is licensed.

''(iv) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under this title and the plan terminates or ceases to provide (or sig-

nificantly reduces) such supplemental health benefits to the individual.

''(v)(I) The individual is enrolled with an eligible organization under a contract under section 1876 or with an organization under an agreement under section 1833(a)(1)(A) and such enrollment is terminated by the enrollee during the first 12 months of such enrollment, but only if the individual never was previously enrolled with an eligible organization under a contract under section 1876 or with an organization under an agreement under section 1833(a)(1)(A).

''(II) The individual is enrolled under a policy described in subsection (t) and such enrollment is terminated during the first 12 months of such enrollment, but only if the individual never was previously enrolled under such a policy under such subsection.

''(C)(i) Subject to clause (ii), a Medicare supplemental policy described in this subparagraph, with respect to an individual described in subparagraph (B), is a policy the benefits under which are comparable or lesser in relation to the benefits under the enrollment described in subparagraph (B) (or, in the case of an individual described

in clause (ii), under the most recent Medicare supplemental policy described in clause (ii)(II)).

''(ii) An individual described in this clause is an individual who—

''(I) is described in subparagraph (B)(v), and

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

''(iii) As a condition for approval of a State regulatory program under subsection (b)(1) and for purposes of applying clause (i) to policies to be issued in the State, the regulatory program shall provide for the method of determining whether policy benefits are comparable or lesser in relation to other benefits. With respect to a State without such an approved program, the Secretary shall establish such method.

''(D) At the time of an event described in subparagraph (B) because of which an individual ceases enrollment or loses coverage or benefits under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, the insurer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the rights of the individual, and obligations of issuers of Medicare supplemental policies, under subparagraph (A).''.

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

''(B) In the case of a policy issued during the 6-month period described in subparagraph (A), the policy may not exclude benefits based on a pre-existing condition.''.

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

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

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

''(II) may not discriminate in the pricing of the policy on the basis of the individual's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability.

''(ii) An individual described in this clause is an individual for whom an application is submitted before the end

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

(d) EXTENDING 6-MONTH INITIAL ENROLLMENT PERIOD TO NON-ELDERLY MEDICARE BENEFICIARIES.—Section 1882(s)(2)(A)(ii) of such Act (42 U.S.C. 1395ss(s)(2)(A)), as amended by subsection (c), is amended by striking ''is submitted'' and all that follows and inserting the following: ''is submitted—

''(I) before the end of the 6-month period beginning with the first month as of the first day on which the individual is 65 years of age or older and is enrolled for benefits under part B; and

''(II) for each time the individual becomes eligible for benefits under part A pursuant to section 226(b) or 226A and is enrolled for benefits under part B, before the end of the 6-month period beginning with the first month as of the first day on which the individual is so eligible and so enrolled.''.

(e) EFFECTIVE DATES.—

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

(2) LIMIT ON PREEXISTING CONDITION EXCLUSIONS.—The amendment made by subsection (b)

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

(3) CLARIFICATION OF NONDISCRIMINATION REQUIREMENTS.—The amendment made by subsection (c) shall apply to policies issued on or after July 1, 1997.

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

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

(B) TRANSITION RULE.—In the case of an individual who first became eligible for benefits under part A of title XVIII of the Social Security Act pursuant to section 226(b) or 226A of such Act and enrolled for benefits under part B of such title before July 1, 1997, the 6-month period described in section 1882(s)(2)(A) of such Act shall begin on July 1, 1997. Before July 1, 1997, the Secretary of Health and Human Services shall notify any individual described in the previous sentence of their rights in connection with Medicare supplemental policies under section 1882 of such Act, by reason of the amendment made by subsection (d).

(f) TRANSITION PROVISIONS.—

(1) IN GENERAL.—If the Secretary of Health and Human Services identifies a State as requiring a change to its statutes or regulations to conform its regulatory program to the changes made by this section, the State regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act due solely to failure to make such change until the date specified in paragraph (4).

(2) NAIC STANDARDS.—If, within 9 months after the date of the enactment of this Act, the National Association of Insurance Commissioners (in this subsection referred to as the ''NAIC'') modifies its NAIC Model Regulation relating to section 1882 of the Social Security Act (referred to in such section as the 1991 NAIC Model Regulation, as modified pursuant to section 171(m)(2) of the Social Security Act Amendments of 1994 (Public Law 103–432) and as modified pursuant to section 1882(d)(3)(A)(vi)(IV) of the Social Security Act, as added by section 271(a) of the Health Care Portability and Accountability Act of 1996 (Public Law 104–191) to conform to the amendments made by this section, such revised regulation incorporating

the modifications shall be considered to be the applicable NAIC model regulation (including the revised NAIC model regulation and the 1991 NAIC Model Regulation) for the purposes of such section.

(3) SECRETARY STANDARDS.—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary of Health and Human Services shall make the modifications described in such paragraph and such revised regulation incorporating the modifications shall be considered to be the appropriate Regulation for the purposes of such section.

(4) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section, or

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

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies as—

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

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

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

SEC. 204. APPLICATION OF STANDARDS TO MEDICARE SELECT POLICIES.

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

(1) in the matter in paragraph (1) before subparagraph (A), by inserting ", under the standards established under paragraph (4)" after "if";

(2) by striking "and" at the end of paragraph (1)(E);

(3) by striking the period at the end of paragraph (1)(F) and inserting a semicolon;

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

"(G) notwithstanding any other provision of this section to the contrary, if the issuer of the policy meet the requirements of paragraph (5).";

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

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

"(4)(A) The Secretary shall establish by regulation standards for policies in order to be provided special treatment under paragraph (1). To the extent practicable, such standards shall be the same as the standards established

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

''(B) If the Secretary determines that a State has established an effective program to enforce the standards established under subparagraph (A), any policy that a State determines under such program to meet such standards shall be deemed to meet such standards for purposes of this section.

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

''(A) If the issuer of the policy—

''(i) is an eligible organization (as defined in section 1876(a)), the benefits under the policy (in coordination with benefits made available under this title) are the same as the benefits required to be made available by such an organization with a risk-sharing contract under section 1876, or

''(ii) is not such an organization, the benefits under the policy shall be either—

''(I) the benefits required under the Standardized Medicare supplement benefit plan 'E' (as specified in section 9E(5) of the 1991 NAIC Model Regulation), plus

One Hundred Percent (100%) of the Medicare Part B Excess Charges (as defined in section 8C(5) of such Regulation); or

''(II) the benefits required under the Standardized Medicare supplement benefit plan 'J' (as specified in section 9E(10) of such Regulation).

''(B) The issuer of the policy (in relation to the policy) meets the same requirements under section 1876 that would apply to an eligible organization with a risk-sharing contract under that section (including community rating of premiums and prior approval of marketing materials, but not including provision of benefits).''.

SEC. 205. ARRANGEMENTS FOR OUT-OF-AREA DIALYSIS SERVICES.

Section 1876(c) of the Social Security Act (42 U.S.C. 1395mm(c)) is amended by adding at the end the following new paragraph:

''(9) Each eligible organization shall assure that enrollees requiring renal dialysis services who are temporarily outside of the organization's service area (within the United States) have reasonable access to such services by—

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

''(B) providing for the reimbursement of any provider of services or renal dialysis facility outside the service area for the furnishing of such services to enrollees.''.

SEC. 206. COORDINATION OF MEDICARE ENROLLMENT.

(a) UNIFORM OPEN ENROLLMENT PERIODS.—

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

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

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

''(5) Each issuer of a Medicare supplemental policy shall have an open enrollment period (which shall be the period specified by the Secretary under section 1876(c)(3)(A)(i)), of at least 30 days duration every year, during which the issuer may not deny or condition the issuance or effectiveness of a Medicare supplemental policy, or discriminate in the pricing of the policy, because of age,

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

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

''(C) The periods for enrollment applicable for the policy are the same periods applicable to a Medicare supplemental policy under section 1882(s)(4).''.

(b) ENROLLMENTS FOR NEW MEDICARE BENEFICIARIES AND THOSE WHO MOVE.—Section 1876(c)(3)(A) of such Act (42 U.S.C. 1395mm(c)(3)(A)) is amended—

(1) in clause (i), by striking ''clause (ii)'' and inserting ''clauses (ii) through (iv)'', and

(2) by adding at the end the following:

''(iii) Each eligible organization shall have an open enrollment period for each individual eligible to enroll under subsection (d) during any enrollment period specified by section 1837 that applies to that individual. Enroll-

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

''(iv) Each eligible organization shall have an open enrollment period for each individual eligible to enroll under subsection (d) who has previously resided outside the geographic area which the organization serves. The enrollment period shall begin with the beginning of the month that precedes the month in which the individual becomes a resident of that geographic area and shall end at the end of the following month. Enrollment under this clause shall be effective as of the first of the month following the month in which the individual enrolls.''.

(c) PROVISION BY SECRETARY OF ENROLLMENT INFORMATION AND OTHER INFORMATION ON ELIGIBLE ORGANIZATIONS AND MEDICARE SUPPLEMENTAL POLICIES.—

(1) IN GENERAL.—Section 1804(b) of such Act (42 U.S.C. 1395b–2(b)) is amended to read as follows:

''(b) The Secretary shall provide information upon request (including through the mails and via a toll-free telephone number) to any individual entitled to benefits under this title on the programs under this title, including—

''(1) information to assist individuals in enrolling with eligible organizations under section 1876

and in selecting among such organizations for enrollment, including information on the premiums charged by such organizations for enrollment; and

''(2) information on Medicare supplemental policies under section 1882, including the relationship of State programs under title XIX to such policies and the premiums charged by such policies for enrollment (to the extent information on such premiums is available to the Secretary).''.

(2) CONFORMING AMENDMENT.—Section 1882(f) of such Act (42 U.S.C. 1395ss(f)) is repealed.

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

TITLE III—MEDICAID

SEC. 301. PROHIBITION ON PAYMENTS UNDER MEDICAID UNTIL COMPLETION OF ORIENTATION, MEDICAL PROFILE, AND IMMUNIZATION.

(a) REQUIREMENT FOR ORIENTATION AND MEDICAL PROFILE.—

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

(A) the entity has provided the enrollee with such orientation as the Secretary of Health and Human Services specifies, which orientation shall include the explanation of rights described in paragraph (2) and the explanation of access to care described in paragraph (3);

(B) the entity has a medical profile described in section 1876(c)(3)(G)(iii) of the Social Security Act (as added by section 201(a)) with respect to the enrollee; and

(C) if the entity is responsible for the provision (directly or through arrangements with providers of services) of immunizations for an enrollee who is a child—

(i) the entity has obtained the immunization status of such child, and

(ii) the entity has begun to provide (or is providing) for immunizations of such child in accordance with the standards established for early and periodic screening, diagnostic, and treatment services under such title.

(2) EXPLANATION OF RIGHTS.—The explanation of rights described in this paragraph shall include an explanation of an enrollee's rights under such title in relation to enrollment with the entity, including an explanation of—

(A) the enrollee's rights to benefits from the entity,

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

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

(D) the entity's coverage of emergency services and urgently needed care, and

(E) appeal rights of enrollees.

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

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

(A) Access to care, including choice of physician, physician location, and hospital coverage.

(B) The information required under section 9914 of the Internal Revenue Code of 1986.

(b) PROMULGATION OF REQUIREMENTS FOR ORIENTATION AND MEDICAL PROFILE.—Not later that 180 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall, by rule, first specify the elements of the orientation and of the medical profile described in section 1876(c)(3)(G) of the Social Security Act. Chapter 8 of title 5, United States Code, shall not apply to such rule. Such rule shall apply on a final basis, pending notice and opportunity for public comment.

(c) EFFECTIVE DATES.—

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

(2) IMMUNIZATION REQUIREMENTS.—Subsection (a)(1)(C) applies with respect to enrollees as of the first day of the first month that begins more

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

SEC. 302. REQUIREMENT FOR MEDICAID CAPITATED PLANS TO ASSURE APPROPRIATE CHILDHOOD IMMUNIZATIONS.

(a) IN GENERAL.—Notwithstanding any other provision of law, no payment shall be made to a State under title XIX of the Social Security Act with respect to expenditures incurred by it for payment (determined under a prepaid capitation basis or under any other risk basis) for services provided by any entity (including a health insuring organization) which is responsible for the provision (directly or through arrangements with providers of services) of immunizations for children unless (and until)—

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

(2) the entity has begun to provide (or is providing) for immunizations of each such child in accordance with the standards established for early and periodic screening, diagnostic, and treatment services under such title.

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

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