

104TH CONGRESS  
2D SESSION

# H. R. 4315

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

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## IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 28, 1996

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

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## A BILL

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

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; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the  
5 “Patient and Health Care Provider Protection Act of  
6 1996”.

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

- Sec. 1. Short title; table of contents.
- Sec. 2. Findings.
- Sec. 3. Definitions.

#### TITLE I—HEALTH PLAN REQUIREMENTS

- Sec. 101. Interference with medical communication prohibited.
- Sec. 102. Improper incentive plan prohibited.
- Sec. 103. Provisions regarding denial of care.
- Sec. 104. Quality of care.
- Sec. 105. Privacy.
- Sec. 106. Fee.
- Sec. 107. Enforcement through civil penalties.
- Sec. 108. Prohibition on adverse action.

#### TITLE II—OFFICE OF CONSUMER ADVOCACY FOR HEALTH

- Sec. 201. Establishment of office.
- Sec. 202. Assistance to individuals with grievances against a health plan.
- Sec. 203. Assurance of access by all individuals to quality health care.
- Sec. 204. Federal investigation and emergency intervention.
- Sec. 205. Annual report to the secretary.
- Sec. 206. Office administration.
- Sec. 207. Oversight.
- Sec. 208. Funding of office.

#### TITLE III—INDEPENDENT CONSUMER ADVISORY COMMITTEES

- Sec. 301. Establishment of committees.
- Sec. 302. Membership and chair.
- Sec. 303. Functions of committee.
- Sec. 304. Liability of members of committee.
- Sec. 305. Annual report to office.
- Sec. 306. Funding for committees.

#### TITLE IV—COORDINATION AMONG OFFICE, COMMITTEES, AND SECRETARY

- Sec. 401. Interaction among office and other organizations.
- Sec. 402. Assistance to committees.
- Sec. 403. Coordinated data analysis and dissemination procedure.

### 1 **SEC. 2. FINDINGS.**

2       The Congress finds the following:

- 3               (1) The largest category of health spending is
- 4       hospital services; in 1994, 35 percent of national
- 5       health spending was for hospital services worth
- 6       \$338,500,000,000.

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

3           (3) The largest expenditures for the hospital in-  
4 dustry are payroll (wages and salaries) and employee  
5 benefits; in 1992, payroll and employee benefits ac-  
6 counted for almost 55 percent of total hospital ex-  
7 penses.

8           (4) Because registered nurses comprise the ma-  
9 jority of a hospital's expenses, in an effort to remain  
10 competitive, hospitals are restructuring their oper-  
11 ations by decreasing payroll and benefit outlays for  
12 registered nurses and either decreasing their number  
13 or replacing them with unlicensed aides to care di-  
14 rectly for patients.

15           (5) While this reorganization is taking place, no  
16 mandatory, national, and systematic compilation of  
17 data is being undertaken to determine the correla-  
18 tion between skilled nursing care and patient safety.

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

1           (7) A comprehensive effort is needed at the na-  
2           tional level to collect data and develop a research  
3           and evaluation agenda so that informed policy devel-  
4           opment, implementation and evaluation are under-  
5           taken in a timely manner to protect the safety of pa-  
6           tients, the well being of health care workers, and the  
7           integrity of the United States medical system.

8           (8) The quality of available health care will suf-  
9           fer in the United States if health care delivery is al-  
10          lowed to set priorities in which profit is made at the  
11          expense of patient care quality and safety.

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

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

23 **SEC. 3. DEFINITIONS.**

24          In this Act:

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

5           (2) HEALTH PLAN.—The term “health plan”  
6           means any private health plan or arrangement (in-  
7           cluding an employee welfare benefit plan) which pro-  
8           vides, or pays the cost of, health care services.

9           (3) SECRETARY.—Except as otherwise expressly  
10          provided, the term “Secretary” means Secretary of  
11          Health and Human Services.

12          (4) COVERAGE OF THIRD PARTY ADMINISTRA-  
13          TORS.—In the case of a health plan that is an em-  
14          ployee welfare benefit plan (as defined in section  
15          3(1) of the Employee Retirement Income Security  
16          Act of 1974), any third party administrator or other  
17          person with responsibility for contracts with health  
18          care providers under the plan shall be considered,  
19          for purposes of this Act, to be an entity offering  
20          such health plan.

21          (5) ENROLLEE.—The term “enrollee” means a  
22          person enrolled under a health plan.

23          (6) OFFICE.—The term “Office” means the Of-  
24          fice of Consumer Advocacy for Health as described  
25          in title II of this Act.

1           (7) COMMITTEE.—The term “Committee”  
2 means an Independent Consumer Advisory Commit-  
3 tee as described in title III of this Act.

4                   **TITLE I—HEALTH PLAN**  
5                   **REQUIREMENTS**

6   **SEC. 101. INTERFERENCE WITH MEDICAL COMMUNICATION**  
7                   **PROHIBITED.**

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

12           (b) MEDICAL COMMUNICATION DEFINED.—For pur-  
13 poses of subsection (a), the term “medical communica-  
14 tion”—

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

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

23                           (B) between—

- 1 (i) the provider and a current, former,  
2 or prospective patient (or the guardian or  
3 legal representative of a patient);
- 4 (ii) the provider and any employee or  
5 representative of the such plan; or
- 6 (iii) the provider and any employee or  
7 representative of any State or Federal au-  
8 thority with responsibility for the licensing  
9 or oversight with respect to such plan; and
- 10 (2) includes communications concerning—
- 11 (A) any tests, consultations, and treatment  
12 options;
- 13 (B) any risks or benefits associated with  
14 such test, consultations, and options;
- 15 (C) variation among any health care pro-  
16 viders and any institutions providing such serv-  
17 ices in experience, quality, or outcomes;
- 18 (D) the basis or standard for the decision  
19 of a health plan to authorize or deny health  
20 care services or benefits;
- 21 (E) the process used by such a plan to de-  
22 termine whether to authorize or deny health  
23 care services or benefits; and

1 (F) any financial incentives or disincen-  
2 tives provided by such a plan to a health care  
3 provider that are based on service utilization.

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

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

14 **SEC. 102. IMPROPER INCENTIVE PLAN PROHIBITED.**

15 (a) IN GENERAL.—A health plan may not as part of  
16 any contract or agreement with a health care provider op-  
17 erate an improper health care provider incentive plan as  
18 described in subsection (b).

19 (b) IMPROPER INCENTIVE PLAN.—For purposes of  
20 subsection (a), a health care provider incentive plan is im-  
21 proper, unless such plan meets the requirements of section  
22 1876(i)(8)(A) of the Social Security Act (42 U.S.C.  
23 1395mm(i)(8)(A)) for physician incentive plans in con-  
24 tracts with eligible organizations under section 1876 of  
25 such Act.



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

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

12 **SEC. 103. PROVISIONS REGARDING DENIAL OF CARE.**

13 (a) CRITERIA FOR DENIAL OF CARE.—A health plan  
14 shall establish criteria, in consultation with the health care  
15 providers who provide services under the plan, for the de-  
16 nial of services under the plan.

17 (b) PRELIMINARY PHYSICAL EXAMINATION.—A  
18 health plan shall provide for an initial physical examina-  
19 tion of an enrollee in a timely manner before denying serv-  
20 ices under the plan to the enrollee. Such examination shall  
21 not constitute services under the health plan.

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

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

3 (d) PUBLICATION OF CRITERIA FOR DENIAL OF  
4 CARE.—A health plan shall put in writing, annually up-  
5 date, and make available to its enrollees through the Of-  
6 fice and its Committee the written criteria established  
7 under subsection (a).

8 (e) EFFECTIVE DATE.—The criteria under this sec-  
9 tion shall apply to plan years beginning on or after 180  
10 days after the date of the enactment of this Act.

11 **SEC. 104. QUALITY OF CARE.**

12 (a) CRITERIA FOR QUALITY OF CARE.—

13 (1) IN GENERAL.—A health plan, in consulta-  
14 tion with the health care providers who provide  
15 health services under the plan, shall establish cri-  
16 teria to assure the quality of care provided under the  
17 plan. Such plan shall establish such criteria utilizing  
18 the data collected and analyzed under subsection (c)  
19 and (d), and under section 403.

20 (2) DEADLINE.—The criteria under paragraph  
21 (1) shall apply to plan years beginning on or after  
22 2 years after the date of the enactment of this Act.

23 (b) PUBLIC ACCESS TO INFORMATION.—

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

1 ing, annually update, and make available the written  
2 criteria established under subsection (a) to its enroll-  
3 ees through the plan's Committee.

4 (2) SAFE STAFFING LEVELS.—

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

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

14 (i) the severity of illness of each en-  
15 rollee;

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

18 (iii) any other factor substantially re-  
19 lated to the condition and health care  
20 needs of each enrollee.

21 (3) SAFE AND ADEQUATE STAFFING LEVELS.—

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

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

3 (B) SUBMISSION OF PROPOSED STAND-  
4 ARDS TO COMMITTEE.—In the case of an insti-  
5 tution that elects not to adopt the guidelines es-  
6 tablished under paragraph (2), such institution  
7 shall submit proposed staffing levels to the  
8 health plan and its Committee for review. Such  
9 institution shall include with its submission an  
10 explanation of the method and criteria used in  
11 developing the proposed staffing levels.

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

21 (D) CRITERIA AND CERTIFICATE OF COM-  
22 PLIANCE.—Such plan shall file with the Sec-  
23 retary and the Office of the State in which the  
24 plan offers health care services a certificate of  
25 compliance with the staffing levels adopted by

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

3 (E) PUBLIC INSPECTION.—Such institu-  
4 tions shall keep on file, available for public in-  
5 spection during regular business hours, daily re-  
6 ports of staffing levels by department and of  
7 patient census.

8 (4) IDENTIFICATION TAG.—

9 (A) IN GENERAL.—A health plan may not  
10 provide or pay for health care services provided  
11 to an enrollee at an institution unless such in-  
12 stitution prohibits a health care provider who is  
13 not wearing an identification tag from providing  
14 care to an enrollee.

15 (B) LICENSURE STATUS.—An identifica-  
16 tion tag under subparagraph (A) shall state the  
17 health care provider's name and the health care  
18 position for which such provider has been li-  
19 censed or certified by the State.

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

22 (D) EXCEPTION.—The requirement under  
23 subparagraph (A) shall not apply where wear-  
24 ing such tag poses a threat to the health of a  
25 patient (such as in an operating room).

1 (c) DATA COLLECTION.—

2 (1) MEDICAL DATA.—Except as provided in  
3 section 105(a), a health plan, in conjunction with its  
4 Committee, shall compile data on health care serv-  
5 ices provided to enrollees under the health plan in-  
6 cluding—

7 (A) enrollee outcome information, includ-  
8 ing nosocomial infections, medication errors, en-  
9 rollee injury, enrollee mortality, and rate of en-  
10 rollee readmission;

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

15 (C) process of care, including the planning  
16 and delivery of care, an assessment of the deliv-  
17 ery mechanisms, and safety measures.

18 (2) FINANCIAL DATA.—

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

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

4 (ii) a statement of any financial inter-  
5 est greater than 5% or \$5,000, whichever  
6 is less, in any other health plan; and

7 (iii) a statement of the nature and  
8 outcome of any complaint, lawsuit, arbitra-  
9 tion, or other legal proceeding brought  
10 against the plan, unless such disclosure is  
11 prohibited by court order or law.

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

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

25 (d) DATA ANALYSIS AND DISSEMINATION.—

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

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

9   **SEC. 105. PRIVACY.**

10          (a) ENROLLEE’S PRIVACY RIGHTS.—Prior to the col-  
11          lection of data under section 104(c), a health plan shall  
12          establish standards and procedures to protect from public  
13          disclosure information that identifies an individual and re-  
14          lates to such individual’s physical or mental health. Such  
15          standards and procedures may not adversely affect the in-  
16          tegrity of the data.

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

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

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



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

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

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

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

14 (c) EFFECTIVE DATE.—Subsection (b) takes effect  
15 30 days after the date of the enactment of this Act.

16 **SEC. 106. FEE.**

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

23 (b) FIRST PAYMENT.—

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

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

3 (2) PAYMENTS PRORATED FROM DATE OF EN-  
4 ACTMENT.—Payments due under subsection (a) for  
5 the year in which this Act is enacted shall be pro-  
6 rated to apply only with respect to months beginning  
7 on or after the date of the enactment of this Act.

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

12 **SEC. 107. ENFORCEMENT THROUGH CIVIL PENALTIES.**

13 (a) ENFORCEMENT THROUGH IMPOSITION OF CIVIL  
14 MONEY PENALTY.—A health plan that violates any provi-  
15 sion of sections 101 through 106 shall be subject to a civil  
16 money penalty of—

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

18 (2) up to \$100,000 for each violation if the Sec-  
19 retary determines that the plan has engaged, within  
20 the 5 years immediately preceding such violation, in  
21 a pattern of such violations.

22 (b) PROCEDURES.—The provisions of subsections (c)  
23 through (l) of section 1128A of the Social Security Act  
24 (42 U.S.C. 1320a–7a) shall apply to civil money penalties  
25 under this section in the same manner as they apply to

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

3 **SEC. 108. PROHIBITION ON ADVERSE ACTION.**

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

7 (1) notifying such plan of conditions which the  
8 identifies, in communications with the plan, as dan-  
9 gerous or potentially dangerous or injurious to—

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

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

14 (C) health care providers who provide such  
15 services;

16 (2) notifying a Federal or State agency or an  
17 accreditation agency, compliance with the standards  
18 of which have been deemed to demonstrate compli-  
19 ance with conditions of participation under the Med-  
20 icare program, of such conditions as are identified in  
21 paragraph (1);

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

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

5           (5) a medical communication, as defined in sec-  
6           tion 101(b); or

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

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

13          (c) SANCTION.—A determination by the Secretary  
14          that a health plan has taken such action as described in  
15          subsection (a) shall result in termination from participa-  
16          tion in the Medicare program for a period of time to be  
17          specified by the Secretary, such period to be not less than  
18          1 month.

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

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

## 5 **TITLE II—OFFICE OF CONSUMER** 6 **ADVOCACY FOR HEALTH**

### 7 **SEC. 201. ESTABLISHMENT OF OFFICE.**

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

13 (b) ESTABLISHMENT THROUGH GRANT PROCESS.—

14 (1) IN GENERAL.—The Secretary shall carry  
15 out the requirements of subsection (a) with respect  
16 to each State by designating a non-profit organiza-  
17 tion located in the State to serve as the Office for  
18 the State, under a grant awarded, in consultation  
19 with the Secretary of Labor, under a competitive se-  
20 lection process. The grant may be awarded only to  
21 organizations headed by an individual with expertise  
22 and experience in the fields of health care and  
23 consumer advocacy, who shall be designated the  
24 Consumer Advocate for Health for the State. In

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

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

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

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

15               (A) CENTRAL OFFICE.—A central office of  
16      the organization awarded the grant which is lo-  
17      cated in the State shall be designated as the  
18      Office.

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

23               (C) PERFORMANCE OF SPECIFIED FUNC-  
24      TIONS.—The organization shall perform the  
25      functions of the Office specified in this title and

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

3 (D) EVALUATION OF QUALITY AND EFFEC-  
4 TIVENESS OF GRANTEE.—The Secretary, in  
5 consultation with the Secretary of Labor, shall  
6 evaluate the quality and effectiveness of the or-  
7 ganization in carrying out the functions of the  
8 Office.

9 (E) TERM OF GRANT AND RENEWABIL-  
10 ITY.—Each grant shall be awarded for a term  
11 of 4 years and shall be renewable for succeeding  
12 4-year terms without reopening the competitive  
13 selection process if the grantee has performed  
14 properly pursuant to this section and the terms  
15 of the grant.

16 (F) NOTICE OF INTENT NOT TO RENEW;  
17 RECONSIDERATION.—Not later than 180 days  
18 before the expiration of any term under a grant  
19 awarded to an organization, if the Secretary at  
20 such time intends not to renew the grant with  
21 such organization, the Secretary shall notify  
22 such organization of such intent, and shall pro-  
23 vide such organization an opportunity for recon-  
24 sideration by the Secretary, in consultation with  
25 the Secretary of Labor, of the Secretary's in-

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

3           (G) TERMINATION BY GRANTEE.—The or-  
4           ganization may terminate the grant prior to its  
5           expiration upon 180 days notice to the Sec-  
6           retary.

7           (H) TERMINATION BY THE SECRETARY.—  
8           The Secretary, in consultation with the Sec-  
9           retary of Labor, may terminate the grant prior  
10          to its expiration upon 180 days notice to the or-  
11          ganization if the Secretary, in consultation with  
12          the Secretary of Labor, determines that the or-  
13          ganization is not meeting the requirements of  
14          this section or that the organization is failing  
15          substantially to carry out the grant. The Sec-  
16          retary, in consultation with the Secretary of  
17          Labor, shall provide for an appropriate appeals  
18          mechanism, including establishment of a panel  
19          of peers, to implement this subparagraph.

20          (c) DELEGATIONS TO LOCAL OFFICES.—

21           (1) IN GENERAL.—The Secretary, in consulta-  
22          tion with the Secretary of Labor, shall provide for  
23          appropriate delegation by the Consumer Advocate  
24          for Health of the authority and responsibilities of  
25          the Office to local offices to the extent necessary to



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

4 (2) MONITORING.—The Secretary, in consulta-  
5 tion with the Secretary of Labor, shall develop and  
6 maintain policies and procedures for monitoring  
7 such local offices and ensuring compliance by such  
8 local offices with the terms of such delegation.

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

11 (A) IN GENERAL.—Pursuant to such dele-  
12 gation, the Consumer Advocate for Health shall  
13 ensure that there is located in each community  
14 rating area in the State an officer or employee  
15 of the Office who is designated to assist individ-  
16 uals residing in the area with respect to matters  
17 relating to health plans and health care provid-  
18 ers operating in the area.

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

1           (C) APPROPRIATE STAFFING.—The Office  
2           shall ensure that sufficient staff in each local  
3           office is assigned to work with respect to mat-  
4           ters relating to each health plan whose enrollees  
5           are served by the local office so as to ensure ef-  
6           fective and efficient service in such local office  
7           with respect to matters relating to such plan.

8           (d) ESTABLISHMENT OF COMMUNITY RATING  
9           AREAS.—

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

16           (2) MULTIPLE AREAS.—With respect to a com-  
17           munity rating area—

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

21                   (B) the number of individuals residing  
22                   within such an area may not be less than  
23                   250,000; and

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

4           (3) BOUNDARIES.—

5           (A) IN GENERAL.—In establishing bound-  
6 aries for community rating areas, the Secretary  
7 may not discriminate on the basis of or other-  
8 wise take into account race, age, language, reli-  
9 gion, national origin, socio-economic status, sex-  
10 ual orientation, disability, or perceived health  
11 status.

12           (B) TREATMENT OF CONSOLIDATED MET-  
13 ROPOLITAN STATISTICAL AREAS.—A community  
14 rating area that includes all of a Consolidated  
15 Metropolitan Statistical Area that is within a  
16 State is presumed to meet the requirement of  
17 subparagraph (A).

18 **SEC. 202. ASSISTANCE TO INDIVIDUALS WITH GRIEVANCES**

19 **AGAINST A HEALTH PLAN.**

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

24           (1) an issue of denial of items or services, or re-  
25 imbursement therefor;

- 1 (2) an issue of denial of medical records;
- 2 (3) an issue of malpractice;
- 3 (4) an issue of discrimination;
- 4 (5) an issue of eligibility and payment of sub-
- 5 sidies for premium payments and cost sharing;
- 6 (6) an issue of enrollment; or
- 7 (7) any other violation actionable under this
- 8 Act.

9 (b) GRIEVANCE ASSISTANCE.—Such Office shall pro-

10 vide, in person and by toll-free telephone access, assist-

11 ance to an individual with a grievance under subsection

12 (a).

13 (c) COMPLAINT FORMS.—Such Office shall create an

14 instruction sheet that explains how to file, maintain, and

15 resolve a complaint against a health plan, and provide

16 such sheet to an individual seeking to file a complaint

17 against a health plan. Such instruction sheet shall be writ-

18 ten in plain language understandable by a layperson, and

19 it shall use a step-by-step format to guide the layperson

20 through each stage of the complaint process.

21 **SEC. 203. ASSURANCE OF ACCESS BY ALL INDIVIDUALS TO**

22 **QUALITY HEALTH CARE.**

23 (a) IN GENERAL.—An Office shall identify, inves-

24 tigate, publicize, promote solutions to, and resolve griev-

25 ances stemming from, any practice, policy, law, or regula-

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

4 (1) marketing of the plan;

5 (2) availability of premium and cost sharing  
6 subsidies;

7 (3) accessibility of services and resources in tra-  
8 ditionally underserved areas;

9 (4) targeting of resources to traditionally un-  
10 derserved areas; and

11 (5) elimination of practices that impede access  
12 to available choices for individuals at health risk, in-  
13 cluding the proper implementation of community  
14 rating and risk adjustments.

15 (b) **MONITORING OF HEALTH PLAN DENIAL PROCE-**  
16 **DURES.**—Such Office shall monitor procedures used by  
17 health plans for denial of services and for reconsideration  
18 of such denials.

19 **SEC. 204. FEDERAL INVESTIGATION AND EMERGENCY**  
20 **INTERVENTION.**

21 (a) **IN GENERAL.**—An Office shall provide, in person  
22 and by toll-free telephone access, assistance to an individ-  
23 ual who seeks to report dangerous conditions in health  
24 care services offered under a health plan.

1 (b) FEDERAL INTERVENTION.—The Secretary may,  
2 in cases of compromised safety that are life threatening,  
3 initiate emergency investigation of or remedial interven-  
4 tion in services provided or practices undertaken by a  
5 health plan.

6 (c) RULES.—

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

10 (2) CONSIDERATION OF DATA.—In establishing  
11 and reviewing the guidelines under paragraph (1),  
12 the Secretary shall base the guidelines to the maxi-  
13 mum extent practicable on the data collected and the  
14 analysis performed under this Act.

15 **SEC. 205. ANNUAL REPORT TO THE SECRETARY.**

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

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

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

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

24 (3) discernible patterns from the data collected;

1           (4) recommendations for resolution of unre-  
2 solved or outstanding complaints;

3           (5) recommendations to sanction a certain  
4 health plan;

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

7           (7) a copy of any report received from the Com-  
8 mittee which reports to such Office.

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

12 **SEC. 206. OFFICE ADMINISTRATION.**

13           (a) IN GENERAL.—An Office shall ensure that indi-  
14 viduals in each community rating area, as defined in sec-  
15 tion 201(d), have regular and timely access to the services  
16 provided through the Office and that the individual re-  
17 ceives timely responses from a representative of the Office  
18 to a request for assistance with a complaint against a  
19 health plan.

20           (b) CONFIDENTIALITY OF COMPLAINANTS.—An Of-  
21 fice shall provide for a system in the Office to treat as  
22 confidential any identifying information regarding com-  
23 plainants and other individuals with respect to whom the  
24 Office maintain files or records.

1 (c) PERSONNEL QUALIFICATIONS.—An Office shall  
2 establish and implement minimum qualification and train-  
3 ing requirements for personnel, including volunteers.

4 **SEC. 207. OVERSIGHT.**

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

8 **SEC. 208. FUNDING OF OFFICE.**

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

18 (b) REMITTANCE TO SECRETARY.—Not later than  
19 December 31 of each calendar year, each State shall remit  
20 to the Secretary, in such form and manner as shall be  
21 prescribed in regulations, the amounts held in escrow pur-  
22 suant to subsection (a) for the applicable fiscal year end-  
23 ing with or during such calendar year.

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



1 shall be applied towards the establishment and operation  
 2 of the Office for such State under section 201 (including  
 3 amounts to be distributed to escrow accounts for Commit-  
 4 tees pursuant to section 306).

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

8 **TITLE III—INDEPENDENT**  
 9 **CONSUMER ADVISORY COM-**  
 10 **MITTEES**

11 **SEC. 301. ESTABLISHMENT OF COMMITTEES.**

12 Each health plan shall establish and maintain an  
 13 Committee.

14 **SEC. 302. MEMBERSHIP AND CHAIR.**

15 (a) MEMBERSHIP.—

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

18 (2) QUALIFICATIONS.—Except as provided in  
 19 paragraph (3)(B), members of a Committee shall be  
 20 selected from enrollees who indicate interest in such  
 21 positions and who are not health care providers, offi-  
 22 cers or employees of any health plan, or employees  
 23 of a health care provider.

24 (3) METHOD OF SELECTION.—

1           (A) ENROLLEES.—Except as provided in  
2           subparagraph (B), members of a Committee  
3           shall be selected biennially at random from each  
4           of 4 categories of enrollees, in proportion to  
5           their numbers among enrollees represented by  
6           the Committee, as follows: senior citizens; par-  
7           ents of children under 18 years of age; individ-  
8           uals with disabilities; and all other enrollees.

9           (B) EMPLOYEES OF HEALTH PLAN.—Each  
10          committee shall have as members at least 3, but  
11          in no case more than 5, employees of the health  
12          plan selected biennially at random from each of  
13          3 categories as follows: staff nurses; physicians;  
14          and administrators of the health plan.

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

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

19               (2) elected by the Committee at its first meet-  
20               ing.

21          (c) COMPENSATION AND EXPENDITURES FOR SERV-  
22          ICES.—

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

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

3 (2) EXPENDITURES FOR SERVICES.—The Com-  
4 mittee may provide for acquiring the services of such  
5 staff and temporary consultants as may be necessary  
6 from time to time to carry out the requirements of  
7 this title.

8 **SEC. 303. FUNCTIONS OF COMMITTEE.**

9 (a) OUTREACH PROGRAMS.—Each Committee shall  
10 develop and coordinate programs for outreach to the com-  
11 munity.

12 (b) FORUM TO FACILITATE COMMUNICATION.—Each  
13 Committee shall conduct regular meetings of enrollees and  
14 representatives of the health plan under such procedural  
15 rules as the Committee considers appropriate, so that such  
16 meetings will serve as effective forums for facilitating com-  
17 munication between such plan and enrollees.

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

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

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

3 (e) EVALUATION OF PERFORMANCE OF OFFICE OF  
4 CONSUMER ADVOCACY.—Each Committee shall evaluate  
5 annually the performance of the Office for the State in  
6 which the health plan is located and make recommenda-  
7 tions to the Secretary regarding the appropriateness for  
8 continued service of the Office.

9 **SEC. 304. LIABILITY OF MEMBERS OF COMMITTEE.**

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

13 **SEC. 305. ANNUAL REPORT TO OFFICE.**

14 (a) IN GENERAL.—Not later than December 31st of  
15 each year, each Committee shall submit to the Office for  
16 the State in which the health plan offers health care serv-  
17 ices a report providing recommendations for improvements  
18 in health care delivery under the plan, and including as-  
19 sessments of—

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

22 (2) the condition of health care facilities em-  
23 ployed under the plan;

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

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

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

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

7           (7) the courtesy of plan personnel; and

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

11       (b) DATE OF FIRST REPORT.—Each committee shall  
12 file its first report not later than December 31st of the  
13 first full calendar year after such Committee is estab-  
14 lished.

15 **SEC. 306. FUNDING FOR COMMITTEES.**

16       (a) ESCROW ACCOUNT FOR COMMITTEES.—In ac-  
17 cordance with procedures which shall be made by rule  
18 under subsection (e), an Office shall establish and main-  
19 tain an escrow account for each Committee established in  
20 the State served by the Office.

21       (b) DISTRIBUTION OF FUNDS TO ESCROW ACCOUNT  
22 FOR COMMITTEES.—The Office shall annually distribute  
23 an amount equal to 25 percent of the total amount remit-  
24 ted for the year to the Secretary by the State under sec-  
25 tion 208, on the basis of which funds are made available

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

7 (c) WITHDRAWAL OF FUNDS FOR COMMITTEE AT  
8 THE REQUEST OF THE CHAIR.—The funds maintained in  
9 each such escrow account for a Committee shall be made  
10 available for withdrawal by the chair of the Committee  
11 upon request of the chair, specifying in writing the pur-  
12 pose for the withdrawal.

13 (d) ANNUAL ACCOUNTING.—The Office shall provide  
14 the Secretary an annual accounting of the receipts and  
15 disbursements made with respect to each such escrow ac-  
16 count.

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

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

1 **TITLE**                    **IV—COORDINATION**  
2        **AMONG OFFICE, COMMIT-**  
3        **TEES, AND SECRETARY**

4 **SEC. 401. INTERACTION AMONG OFFICE AND OTHER ORGA-**  
5                                    **NIZATIONS.**

6        An Office shall establish and maintain a system of  
7 referrals among the Office, other consumer advocacy orga-  
8 nizations, legal assistance providers serving low-income  
9 persons, and protection and advocacy systems for individ-  
10 uals with disabilities.

11 **SEC. 402. ASSISTANCE TO COMMITTEES.**

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

16 **SEC. 403. COORDINATED DATA ANALYSIS AND DISSEMINA-**  
17                                    **TION PROCEDURE.**

18        (a) DATA COMPILATION AND SUBMISSION.—

19                (1) IN GENERAL.—Not later than December  
20 31st of each year, each Committee shall compile the  
21 enrollee quality care data collected under section  
22 104(c) and shall submit such data to the Office from  
23 which such Committee received its funds under sec-  
24 tion 306.

1           (2) TRANSMISSION FROM OFFICE TO SEC-  
2           RETARY.—Not later than 30 days after the receipt  
3           of the data submitted by the Committees under  
4           paragraph (1), the Office shall compile all data re-  
5           ceived from the Committees to which it transmits  
6           funds under section 306 and shall submit such data  
7           to the Secretary.

8           (b) DATA ANALYSIS AND PUBLICATION.—The Sec-  
9           retary shall analyze the data received under subsection  
10          (a)(2) with the purpose of using such data to develop Fed-  
11          eral guidelines for patient care quality and shall publish  
12          its findings.

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



1 issue if prohibited by the law of such State. A court issu-  
2 ing an order pursuant to this section, on a motion made  
3 promptly by the video tape service provider, may quash  
4 or modify such order if the information or records re-  
5 quested are unreasonably voluminous in nature or if com-  
6 pliance with such order otherwise would cause an unrea-  
7 sonable burden on such provider.

○