

104<sup>TH</sup> CONGRESS  
1<sup>ST</sup> SESSION

# S. 1024

To amend title XVIII of the Social Security Act to assure fairness and choice to patients under the medicare program, and for other purposes.

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## IN THE SENATE OF THE UNITED STATES

JULY 12 (legislative day, JULY 10), 1995

Mr. WELLSTONE introduced the following bill; which was read twice and referred to the Committee on Finance

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## A BILL

To amend title XVIII of the Social Security Act to assure fairness and choice to patients under the medicare program, and for other purposes.

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

3       **SECTION 1. SHORT TITLE.**

4       This Act may be cited as the “Medicare Health Care  
5       Quality Act of 1995”.

6       **SEC. 2. REFERENCES IN ACT; TABLE OF CONTENTS.**

7       (a) AMENDMENTS TO SOCIAL SECURITY ACT.—Ex-  
8       cept as otherwise specifically provided, whenever in this  
9       Act an amendment is expressed in terms of an amendment  
10      to or repeal of a section or other provision, the reference

1 shall be considered to be made to that section or other  
 2 provision of the Social Security Act.

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

- Sec. 1. Short title.
- Sec. 2. References in Act; table of contents.
- Sec. 3. Requirements relating to health professionals.
- Sec. 4. Grievance procedures.
- Sec. 5. Discrimination.
- Sec. 6. Requirement for utilization review program.
- Sec. 7. Access.
- Sec. 8. Requirements for organization service areas.
- Sec. 9. Other enrollee protections.
- Sec. 10. Information on eligible organization.
- Sec. 11. Enrollment by mail.
- Sec. 12. Waiver of certain medicare coinsurance and deductibles not remunera-  
 tion.
- Sec. 13. Effective date.

5 **SEC. 3. REQUIREMENTS RELATING TO HEALTH PROFES-**  
 6 **SIONALS.**

7 Section 1876(c) (42 U.S.C. 1395mm(c)) is amended  
 8 by adding at the end the following new paragraph:

9 “(9)(A) The eligible organization shall credential  
 10 health professionals furnishing health care services  
 11 through the organization.

12 “(B)(i) The eligible organization shall establish a  
 13 credentialing process. Such process shall ensure that a  
 14 health professional is credentialed prior to that profes-  
 15 sional being listed as a health professional in the eligible  
 16 organization’s marketing materials, in accordance with re-  
 17 corded (written or otherwise) policies and procedures. The  
 18 credentialing process shall provide for the review of an ap-

1 plication for credentialing by the credentialing committee  
2 established under clause (iii).

3 “(ii) The medical director of the eligible organization,  
4 or another designated health professional, shall have re-  
5 sponsibility for the credentialing of health professionals  
6 under the organization.

7 “(iii)(I) The eligible organization shall establish a  
8 credentialing committee that—

9 “(I) is composed of licensed physicians and  
10 other health professionals to review credentialing in-  
11 formation and supporting documents;

12 “(II) provides input to the eligible organization  
13 on the credentialing process and procedures; and

14 “(III) appropriately represents the medical spe-  
15 cialties of applicants for credentialing.

16 “(iv)(I) Credentialing decisions under the eligible or-  
17 ganization shall be based on objective standards with input  
18 from providers of health services credentialed under the  
19 organization. Information concerning all application and  
20 credentialing policies and procedures shall be made avail-  
21 able for review by the health professional involved upon  
22 written request.

23 “(II) The standards referred to in subclause (I) shall  
24 include determinations as to—

1           “(aa) whether the health professional has a cur-  
2           rent unrestricted valid license to practice the par-  
3           ticular health profession involved;

4           “(bb) whether the health professional has clini-  
5           cal privileges in good standing at the hospital des-  
6           ignated by the practitioner and the primary admit-  
7           ting facility, as applicable;

8           “(cc) whether the health professional has a  
9           valid DEA or CDS certificate, as applicable;

10           “(dd) whether the health professional has grad-  
11           uated from medical school (allopathic or osteo-  
12           pathic), completed a residency (accredited by the Ac-  
13           creditation Council on Graduate Medical Education  
14           or the American Osteopathic Association), or re-  
15           ceived Board certification (by medical specialty  
16           boards recognized by the American Board of Medical  
17           Specialties or the American Osteopathic Associa-  
18           tion), as applicable;

19           “(ee) the work history of the health profes-  
20           sional;

21           “(ff) whether the health professional has cur-  
22           rent, adequate malpractice insurance in accordance  
23           with the policy of the eligible organization;

24           “(gg) the professional liability claims history of  
25           the health professional;

1           “(hh) whether the health professional has been  
2 convicted of a crime or cited by a licensing board for  
3 professional misconduct; and

4           “(ii) whether the health professional has any  
5 malpractice payments or disciplinary actions reg-  
6 istered with the National Practitioner Data Bank  
7 under section 427(b) of the Health Care Quality Im-  
8 provement Act (42 U.S.C. 11134(b)).

9           “(III) A health professional who undergoes the  
10 credentialing process shall have the right to review the  
11 basis information, including the sources of that informa-  
12 tion, that was used to meet the designated credentialing  
13 criteria.

14          “(C)(i) A health professional who is subject to  
15 credentialing under this paragraph shall, upon written re-  
16 quest, receive from the eligible organization any informa-  
17 tion obtained by the organization during the credentialing  
18 process that, as determined by the credentialing commit-  
19 tee, does not meet the credentialing standards of the orga-  
20 nization, or that varies substantially from the information  
21 provided to the eligible organization by the health profes-  
22 sional.

23          “(ii) The eligible organization shall have a formal, re-  
24 corded (written or otherwise) process by which a health  
25 professional may submit supplemental information to the

1 credentialing committee if the health professional deter-  
2 mines that erroneous or misleading information has been  
3 previously submitted. The health professional may request  
4 that such information be reconsidered in the evaluation  
5 for credentialing purposes.

6       “(iii)(I) A health professional is not entitled to be se-  
7 lected or retained by the eligible organization as a partici-  
8 pating or contracting provider whether or not such profes-  
9 sional meets the credentialing standards established under  
10 this paragraph.

11       “(II) If economic considerations, including the health  
12 care professional’s patterns of expenditure per patient, are  
13 part of a selection decision, objective criteria shall be used  
14 in examining such considerations and a written description  
15 of such criteria shall be provided to applicants, participat-  
16 ing health professionals, and enrollees. Any economic  
17 profiling of health professionals must be adjusted to recog-  
18 nize case mix, severity of illness, and the age of patients  
19 of a health professional’s practice that may account for  
20 higher or lower than expected costs, to the extent appro-  
21 priate data in this regard is available to the eligible organi-  
22 zation.

23       “(iv)(I) The eligible organization shall develop and  
24 implement procedures for the reporting, to appropriate au-  
25 thorities, of serious quality deficiencies that result in the

1 suspension or termination of a contract with a health pro-  
2 fessional.

3 “(II) The eligible organization shall develop and im-  
4 plement policies and procedures under which the organiza-  
5 tion reviews the contract privileges of health professionals  
6 who—

7 “(aa) have seriously violated policies and proce-  
8 dures of the eligible organization;

9 “(bb) have lost their privilege to practice with  
10 a contracting institutional provider; or

11 “(cc) otherwise pose a threat to the quality of  
12 service and care provided to the enrollees of the eli-  
13 gible organization.

14 At a minimum, the policies and procedures implemented  
15 under this subparagraph shall meet the requirements of  
16 the Health Care Quality Improvement Act of 1986.

17 “(III) The policies and procedures implemented  
18 under subclause (II) shall include requirements for the  
19 timely notification of the affected health professional of  
20 the reasons for the reduction, withdrawal, or termination  
21 of privileges, and provide the health professional with the  
22 right to appeal the determination of reduction, withdrawal,  
23 or termination.

24 “(IV) A written copy of the policies and procedures  
25 implemented under this paragraph shall be made available

1 to a health professional on request prior to the time at  
2 which the health professional contracts to provide services  
3 under the organization.

4 “(D) For purposes of this paragraph, the term  
5 ‘health professional’ means an individual who is licensed,  
6 credited, accredited, or otherwise credentialed to provide  
7 health care items and services as authorized under State  
8 law.”.

9 **SEC. 4. GRIEVANCE PROCEDURES.**

10 Section 1876(c)(5)(A) (42 U.S.C. 1395mm(c)(5)(A))  
11 is amended—

12 (1) by adding “(i)” after “(A)”; and

13 (2) by adding at the end the following new  
14 clause:

15 “(ii) The procedures described under clause (i) shall  
16 include—

17 “(I) recorded (written or otherwise) procedures  
18 for registering and responding to complaints and  
19 grievances in a timely manner;

20 “(II) documentation concerning the substance  
21 of complaints, grievances, and actions taken con-  
22 cerning such complaints and grievances, which shall  
23 be in writing.

24 “(III) procedures to ensure a resolution of a  
25 complaint or grievance;

1           “(IV) the compilation and analysis of complaint  
2 and grievance data;

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

7           “(VI) procedures to ensure that if an enrollee  
8 orally notifies the eligible organization about a com-  
9 plaint, the organization (if requested) must send the  
10 enrollee a complaint form that includes the tele-  
11 phone numbers and addresses of member services, a  
12 description of the organization’s grievance proce-  
13 dure.

14           “(iii) The eligible organization shall adopt an appeals  
15 process to enable covered individuals to appeal decisions  
16 that are adverse to the individuals. Such a process shall  
17 include—

18           “(I) the right to a review by a grievance panel;

19           “(II) the right to a second review with a dif-  
20 ferent panel, independent from the eligible organiza-  
21 tion, or to a review through an impartial arbitration  
22 process which shall be described in writing by the or-  
23 ganization; and

24           “(III) an expedited process for review in emer-  
25 gency cases.

1 The Secretary shall develop guidelines for the structure  
2 and requirements applicable to the independent review  
3 panel and impartial arbitration process described in  
4 subclause (II).

5 “(iv) With respect to the complaint, grievance, and  
6 appeals processes required under this paragraph, the eligi-  
7 ble organization shall, upon the request of a covered indi-  
8 vidual, provide the individual a written decision concerning  
9 a complaint, grievance, or appeal in a timely fashion.

10 “(v) The complaint, grievance, and appeals processes  
11 established in accordance with this paragraph may not be  
12 used in any fashion to discourage or prevent a covered  
13 individual from receiving medically necessary care in a  
14 timely manner.”.

15 **SEC. 5. DISCRIMINATION.**

16 Section 1876(c) (42 U.S.C. 1395mm(c)), as amended  
17 by section 3, is amended by adding at the end the follow-  
18 ing new paragraph:

19 “(10)(A) The eligible organization may not discrimi-  
20 nate or engage (directly or through contractual arrange-  
21 ments) in any activity, including the selection of service  
22 area, that has the effect of discriminating against an indi-  
23 vidual on the basis of race, national origin, gender, lan-  
24 guage, socio-economic status, age, disability, health status,  
25 or anticipated need for health services.

1       “(B) The eligible organization may not engage in  
2 marketing or other practices intended to discourage or  
3 limit the enrollment of individuals on the basis of health  
4 condition, geographic area, industry, or other risk factors.

5       “(C) The eligible organization may not discriminate  
6 in the selection of members of the health professional or  
7 provider network (and in establishing the terms and condi-  
8 tions for membership in the network) of the organization  
9 based on—

10           “(i) the race, national origin, disability, gender,  
11           or age of the health professional;

12           “(ii) the socio-economic status, disability, health  
13           status, age, or anticipated need for health services of  
14           the patients of the health professional or provider; or

15           “(iii) the health professional or provider’s lack  
16           of affiliation with, or admitting privileges at, a hos-  
17           pital.

18       “(D) The eligible organization may not discriminate  
19 in participation, reimbursement, or indemnification  
20 against a health professional who is acting within the  
21 scope of the license, training, or certification of the profes-  
22 sional under applicable State law solely on the basis of  
23 the license, training, or certification of the health profes-  
24 sional. The eligible organization may not discriminate in  
25 participation, reimbursement, or indemnification against

1 a health provider that is providing services within the  
2 scope of services that it is authorized to perform under  
3 State law.”.

4 **SEC. 6. REQUIREMENT FOR UTILIZATION REVIEW PRO-**  
5 **GRAM.**

6 Section 1876(c) (42 U.S.C. 1395mm(c)), as amended  
7 by sections 3 and 5, is amended by adding at the end the  
8 following new paragraph:

9 “(11)(A) The eligible organization shall have in place  
10 a utilization review program that meets the requirements  
11 of this paragraph and that is certified by the Secretary.

12 “(B) The Secretary shall establish standards for the  
13 establishment, operation, and certification and periodic  
14 recertification of eligible organization utilization review  
15 programs.

16 “(C)(i) The Secretary may certify an eligible organi-  
17 zation as meeting the standards established under sub-  
18 paragraph (B) if the Secretary determines that the eligible  
19 organization has met the utilization standards required for  
20 accreditation as applied by a nationally recognized, inde-  
21 pendent, nonprofit accreditation entity.

22 “(ii) The Secretary shall periodically review the  
23 standards used by the private accreditation entity to en-  
24 sure that such standards meet or exceed the standards es-  
25 tablished by the Secretary under this paragraph.

1       “(D) The standards developed by the Secretary under  
2 subparagraph (B) shall require that utilization review pro-  
3 grams comply with the following:

4           “(i) The eligible organization shall provide a  
5 written description of the utilization review program  
6 of the organization, including a description of—

7               “(I) the delegated and nondelegated activi-  
8 ties under the program;

9               “(II) the policies and procedures used  
10 under the program to evaluate medical neces-  
11 sity; and

12               “(III) the clinical review criteria, informa-  
13 tion sources, and the process used to review and  
14 approve the provision of medical services under  
15 the program.

16           “(ii) With respect to the administration of the  
17 utilization review program, the eligible organization  
18 may not employ utilization reviewers or contract  
19 with a utilization management organization if the  
20 conditions of employment or the contract terms in-  
21 clude financial incentives to reduce or limit the  
22 medically necessary or appropriate services provided  
23 to covered individuals.

24           “(iii) The eligible organization shall develop  
25 procedures for periodically reviewing and modifying

1 the utilization review of the organization. Such pro-  
2 cedures shall provide for the participation of provid-  
3 ers in the eligible organization in the development  
4 and review of utilization review policies and proce-  
5 dures.

6 “(iv)(I) A utilization review program shall de-  
7 velop and apply recorded (written or otherwise) utili-  
8 zation review decision protocols. Such protocols shall  
9 be based on sound medical evidence.

10 “(II) The clinical review criteria used under the  
11 utilization review decision protocols to assess the ap-  
12 propriateness of medical services shall be clearly doc-  
13 umented and available to participating health profes-  
14 sionals upon request. Such protocols shall include a  
15 mechanism for assessing the consistency of the ap-  
16 plication of the criteria used under the protocols  
17 across reviewers, and a mechanism for periodically  
18 updating such criteria.

19 “(v)(I) The procedures applied under a utiliza-  
20 tion review program with respect to the  
21 preauthorization and concurrent review of the neces-  
22 sity and appropriateness of medical items, services  
23 or procedures, shall require that qualified medical  
24 professionals supervise review decisions. With re-  
25 spect to a decision to deny the provision of medical

1 items, services or procedures, a provider licensed in  
2 the same field shall conduct a subsequent review to  
3 determine the medical appropriateness of such a de-  
4 nial. Physicians from the same medical branch  
5 (allopathic or osteopathic medicine) and specialty  
6 (recognized by the American Board of Medical Spe-  
7 cialties or the American Osteopathic Association)  
8 shall be utilized in the review process as needed.

9 “(II) All utilization review decisions shall be  
10 made in a timely manner, as determined appropriate  
11 when considering the urgency of the situation.

12 “(III) With respect to utilization review, an ad-  
13 verse determination or noncertification of an admis-  
14 sion, continued stay, or service shall be clearly docu-  
15 mented, including the specific clinical or other rea-  
16 son for the adverse determination or  
17 noncertification, and be available to the covered indi-  
18 vidual or any individual acting on behalf of the cov-  
19 ered individual and the affected provider or facility.  
20 The eligible organization may not deny or limit cov-  
21 erage with respect to a service that the enrollee has  
22 already received solely on the basis of lack of prior  
23 authorization or second opinion, to the extent that  
24 the service would have otherwise been covered by the

1 organization had such prior authorization or a sec-  
2 ond opinion been obtained.

3 “(IV) The eligible organization shall provide a  
4 covered individual with timely notice of an adverse  
5 determination or noncertification of an admission,  
6 continued stay, or service. Such a notification shall  
7 include information concerning the utilization review  
8 program appeals procedure.

9 “(vi) An eligible organization utilization review  
10 program shall ensure that requests by covered indi-  
11 viduals or physicians for prior authorization of a  
12 nonemergency service shall be answered in a timely  
13 manner after such request is received. If utilization  
14 review personnel are not available in a timely fash-  
15 ion, any medical services provided shall be consid-  
16 ered approved.

17 “(vii) A utilization review program shall imple-  
18 ment policies and procedures to evaluate the appro-  
19 priate use of new medical technologies or new appli-  
20 cations of established technologies, including medical  
21 procedures, drugs, and devices. The program shall  
22 ensure that appropriate professionals participate in  
23 the development of technology evaluation criteria.

24 “(viii) Where prior authorization for a service  
25 or other covered item is obtained under a program

1 under this paragraph, the service shall be considered  
2 to be covered unless there was fraud or incorrect in-  
3 formation provided at the time such prior authoriza-  
4 tion was obtained. If a provider supplied the incor-  
5 rect information that led to the authorization of  
6 medically unnecessary care, the provider shall be  
7 prohibited from collecting payment directly from the  
8 enrollee, and shall reimburse the organization and  
9 subscriber for any payments or copayments the pro-  
10 vider may have received.

11 “(E)(i) The eligible organization shall, with respect  
12 to any materials distributed to prospective covered individ-  
13 uals, include a summary of the utilization review proce-  
14 dures of the organization.

15 “(ii) The eligible organization shall, with respect to  
16 any materials distributed to newly covered individuals, in-  
17 clude a clear and comprehensive description of utilization  
18 review procedures of the organization and a statement of  
19 patient rights and responsibilities with respect to such  
20 procedures.

21 “(iii) The eligible organization shall disclose to the  
22 Secretary of the eligible organization utilization review  
23 program policies, procedures, and reports required by the  
24 Secretary for certification.

1       “(iv) The eligible organization shall have a member-  
2 ship card which shall have printed on the card the toll-  
3 free telephone number that an enrollee should call for cus-  
4 tomer service issues.

5       “(v) The eligible organization shall establish mecha-  
6 nisms to evaluate the effects of the utilization review pro-  
7 gram of the organization through the use of member satis-  
8 faction data or through other appropriate means.”.

9       **SEC. 7. ACCESS.**

10       (a) IN GENERAL.—Section 1876(c) (42 U.S.C.  
11 1395mm(c)), as amended by sections 3, 5, and 6, is  
12 amended by adding at the end the following new para-  
13 graph:

14       “(12)(A) The eligible organization shall demonstrate  
15 that the organization has a sufficient number, distribu-  
16 tion, and variety of qualified health care providers to en-  
17 sure that all covered health care services will be available  
18 and accessible in a timely manner to all individuals en-  
19 rolled in the organization.

20       “(B) The eligible organization shall demonstrate that  
21 organization enrollees have access, when medically or clini-  
22 cally indicated in the judgment of the treating health pro-  
23 fessional, to specialized treatment expertise.

24       “(C)(i) Any process established by the eligible organi-  
25 zation to coordinate care and control costs may not impose

1 an undue burden on enrollees with chronic health condi-  
2 tions. The organization shall ensure a continuity of care  
3 and shall, when medically or clinically indicated in the  
4 judgment of the treating health professional, ensure direct  
5 access to relevant specialists for continued care.

6 “(ii) In the case of an enrollee who has a severe, com-  
7 plex, or chronic condition, the eligible organization shall  
8 determine, based on the judgment of the treating health  
9 professional, whether it is medically or clinically necessary  
10 or appropriate to use a care coordinator from an inter-  
11 disciplinary team or a specialist to ensure continuity of  
12 care.

13 “(D)(i) The requirements of this paragraph may not  
14 be waived and shall be met in all areas where the eligible  
15 organization has enrollees, including rural areas.

16 “(ii) If the eligible organization fails to meet the re-  
17 quirements of this paragraph, the organization shall ar-  
18 range for the provision of out-of-organization services to  
19 enrollees in a manner that provides enrollees with access  
20 to services in accordance with this paragraph.”.

21 (b) ACCESS TO EMERGENCY CARE SERVICES.—Sec-  
22 tion 1876(c)(4)(B) (42 U.S.C. 1395mm(c)(4)(B)) is  
23 amended—

24 (1) by inserting “emergency” before “services”  
25 the first place it appears;

1           (2) by striking “, if (i)” and all that follows  
2 through “the organization”; and

3           (3) by adding at the end the following new sen-  
4 tence: “In such subparagraph, ‘emergency services’  
5 are services provided to an individual after the sud-  
6 den onset of a medical condition that manifests itself  
7 by symptoms of sufficient severity (including severe  
8 pain) such that the absence of immediate medical at-  
9 tention could reasonably be expected by a prudent  
10 layperson (possessing an average knowledge of  
11 health and medicine) to result in placing the individ-  
12 ual’s health in serious jeopardy, the serious impair-  
13 ment of a bodily function, or the serious dysfunction  
14 of any bodily organ or part, and includes services  
15 provided as a result of a call through the 911 emer-  
16 gency system.”.

17 **SEC. 8. REQUIREMENTS FOR ORGANIZATION SERVICE**  
18 **AREAS.**

19           (a) IN GENERAL.—Section 1876 (42 U.S.C.  
20 1395mm) is amended by adding at the end the following  
21 new subsection:

22           “(k)(1) Except as provided in paragraph (2), for pur-  
23 poses of this section, if the eligible organization’s service  
24 area includes any part of a metropolitan statistical area,  
25 the service area shall include the entire metropolitan sta-

1 tistical area (including any area designated by the Sec-  
2 retary as a health professional shortage area under section  
3 332(a)(1)(A) of the Public Health Service Act within such  
4 metropolitan statistical area).

5 “(2) The Secretary may permit an organization’s  
6 service area to exclude any portion of a metropolitan sta-  
7 tistical area (other than the central county of such metro-  
8 politan statistical area) if—

9 “(A) the organization demonstrates that it  
10 lacks the financial or administrative capacity to  
11 serve the entire metropolitan statistical area; and

12 “(B) the Secretary finds that the composition  
13 of the organization’s service area does not reduce  
14 the financial risk to the organization of providing  
15 services to enrollees because of the health status or  
16 other demographic characteristics of individuals re-  
17 siding in the service area (as compared to the health  
18 status or demographic characteristics of individuals  
19 residing in the portion of the metropolitan statistical  
20 area not included in the organization’s service  
21 area).”.

22 (b) CONFORMING AMENDMENT.—Section  
23 1876(c)(4)(A)(i) (42 U.S.C. 1395mm(c)(4)(A)(i)) is  
24 amended by striking “the area served by the organization”  
25 and inserting “the organization’s service area”.

1 **SEC. 9. OTHER ENROLLEE PROTECTIONS.**

2 (a) CLARIFICATION OF RESTRICTIONS ON CHARGES  
3 FOR OUT-OF-PLAN SERVICES.—

4 (1) INPATIENT HOSPITAL AND EXTENDED CARE  
5 SERVICES.—Section 1866(a)(1)(O) (42 U.S.C.  
6 1395cc(a)(1)(O)) is amended in the matter preced-  
7 ing clause (i) by inserting after “this title” the fol-  
8 lowing: “(without regard to whether or not the serv-  
9 ices are furnished on an emergency basis)”.

10 (2) PHYSICIANS’ SERVICES AND RENAL DIALY-  
11 SIS SERVICES.—Section 1876(j)(2) (42 U.S.C.  
12 1395mm(j)(2)) is amended by striking “this setion”  
13 and inserting “this section (without regard to wheth-  
14 er or not the services are furnished on an emergency  
15 basis)”.

16 (b) ARRANGEMENTS FOR DIALYSIS SERVICES.—Sec-  
17 tion 1876(c) (42 U.S.C. 1395mm(c)), as amended by sec-  
18 tions 3, 5, 6, and 7 is amended by adding at the end the  
19 following new paragraph:

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

25 “(A) making such arrangements with providers  
26 of services or renal dialysis facilities outside the

1 service area for the coverage of and payment for  
2 such services furnished to enrollees as the Secretary  
3 determines necessary to assure reasonable access; or

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

8 **SEC. 10. INFORMATION ON ELIGIBLE ORGANIZATION.**

9 Section 1876(c)(3)(C) (42 U.S.C. 1395mm(c)(3)(C))  
10 is amended—

11 (1) by redesignating clauses (i) and (ii) as  
12 subclauses (I) and (II);

13 (2) by inserting “(i)” after “(C)”; and

14 (3) by adding at the end the following new  
15 clause:

16 “(ii)(I) The eligible organization shall provide pro-  
17 spective covered individuals with written information con-  
18 cerning the terms and conditions of the eligible organiza-  
19 tion to enable such individuals to make informed decisions  
20 with respect to a certain system of health care delivery.  
21 Such information shall be standardized so that prospective  
22 covered individuals may compare the attributes of all such  
23 organizations offered within the coverage area.

24 “(II) Information provided under this section, wheth-  
25 er written or oral shall be easily understandable, truthful,

1 linguistically appropriate and objective with respect to the  
2 terms used. Descriptions provided in such information  
3 shall be consistent with standards developed for medicare  
4 supplemental policies under section 1882.

5 “(III) Information required under this clause shall  
6 include information specific to medicare beneficiaries con-  
7 cerning—

8 “(aa) coverage provisions, benefits, and any ex-  
9 clusions by category of service or product;

10 “(bb) plan loss ratios with an explanation that  
11 such ratios reflect the percentage of the premiums  
12 expended for health services;

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

19 “(dd) an explanation of how organization de-  
20 sign impacts enrollees, including information on the  
21 financial responsibility of covered individuals for  
22 payment for coinsurance or other out-of-plan serv-  
23 ices;

24 “(ee) covered individual satisfaction statistics,  
25 including disenrollment statistics;

1 “(ff) advance directives and organ donation;

2 “(gg) the characteristics and availability of  
3 health care professionals and institutions participat-  
4 ing in the organization, including descriptions of the  
5 financial arrangements or contractual provisions  
6 with hospitals, utilization review organizations, phy-  
7 sicians, or any other provider of health care services  
8 that would affect the services offered, referral or  
9 treatment options, or physician’s fiduciary respon-  
10 sibility to patients, including financial incentives re-  
11 garding the provision of medical or other services;

12 “(hh) quality indicators for the organization  
13 and for participating health professionals and pro-  
14 viders under the organization, including population-  
15 based statistics such as immunization rates and  
16 other preventive care and health outcomes measures  
17 such as survival after surgery, adjusted for case mix;  
18 and

19 “(ii) an explanation of the appeals process and  
20 the grievance procedure.”.

21 **SEC. 11. ENROLLMENT BY MAIL.**

22 Section 1876(c)(3) (42 U.S.C. 1395mm(c)(3)) is  
23 amended by adding at the end the following new subpara-  
24 graphs:

1           “(H) Each eligible organization that pro-  
2           vides items and services pursuant to a contract  
3           under this section shall permit an individual en-  
4           titled to benefits under part A to obtain enroll-  
5           ment forms and information and to enroll under  
6           this section by mail, and no agent of an eligible  
7           organization may visit the residence of such an  
8           individual for purposes of enrolling the individ-  
9           ual under this section or providing enrollment  
10          information to the individual other than at the  
11          individual’s request.

12          “(I)(i) Each eligible organization that pro-  
13          vides items and services pursuant to a contract  
14          under this section shall include the information  
15          described in clause (ii) in any solicitation for  
16          enrollment in such organization sent by mail to  
17          an individual entitled to benefits under part A.

18          “(ii) The information described in this  
19          clause is—

20                  “(I) the toll-free number of the health  
21                  insurance advisory service program estab-  
22                  lished under section 4359 of the Omnibus  
23                  Budget Reconciliation Act of 1990 (42  
24                  U.S.C. 1395b-3); and

1                   “(II) an appropriate explanation of  
2                   the services provided by such program.”.

3 **SEC. 12. WAIVER OF CERTAIN MEDICARE COINSURANCE**  
4 **AND DEDUCTIBLES NOT REMUNERATION.**

5           (a) IN GENERAL.—The Secretary of Health and  
6 Human Services shall modify section 1001.952(k) of title  
7 42, Code of Federal Regulations, to provide that the term  
8 “remuneration” as used in section 1128B of the Social  
9 Security Act (42 U.S.C. 1320a-7b) does not include any  
10 reduction or waiver of a coinsurance or deductible amount  
11 owed to a provider furnishing patient services covered  
12 under part B of the medicare program under title XVIII  
13 of such Act if such reduction or waiver is provided under  
14 a program that—

15                   (1) facilitates access to health services for pa-  
16                   tients, who because of economic circumstances might  
17                   otherwise refrain from seeking needed health care;

18                   (2) initially and annually screens patients to de-  
19                   termine financial need and eligibility for the pro-  
20                   gram; and

21                   (3) establishes financial need and eligibility on  
22                   a case-by-case basis and grants such a reduction or  
23                   waiver only if the beneficiary—

24                                   (A) has an annual gross income (including  
25                   Social Security benefits, tax-exempt income,

1 and income from any other source) of 200 per-  
2 cent or less of the Federal poverty level;

3 (B) does not have assets in excess of  
4 \$30,300, excluding the homestead (as defined  
5 in State law) and one automobile;

6 (C) is not eligible for medical assistance  
7 under a State plan under title XIX of such Act;  
8 and

9 (D) is not enrolled in a prepaid health  
10 plan.

11 (b) ADDITIONAL EXCLUSION.—The modification de-  
12 scribed in subsection (a) shall be in addition to any exclu-  
13 sions contained in such section on the date of the enact-  
14 ment of this Act.

15 **SEC. 13. EFFECTIVE DATE.**

16 The amendments made by this Act shall apply with  
17 respect to contract years beginning on or after  
18 January 1, 1997.

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