

105TH CONGRESS  
1ST SESSION

# H. R. 475

To amend title XVIII of the Social Security Act to provide for offering the option of Medicare coverage through qualified provider-sponsored organizations (PSOs), and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

JANUARY 21, 1997

Mr. GREENWOOD (for himself and Mr. STENHOLM) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Ways and Means, and the Judiciary, 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 title XVIII of the Social Security Act to provide for offering the option of Medicare coverage through qualified provider-sponsored organizations (PSOs), 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; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the  
5 “Medicare Provider-Sponsored Organization Act of  
6 1997”.

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

- Sec. 1. Short title; table of contents.
- Sec. 2. Qualified provider-sponsored organizations as medicare health plan option.
- Sec. 3. Authorizing payment of all medicare health plans on a partial risk basis.
- Sec. 4. Elimination of enrollment composition requirement for eligible organizations meeting enhanced quality standards.
- Sec. 5. Clarification of use of provider-sponsored organizations under medicaid program.
- Sec. 6. Demonstration of coordinated acute and long-term care benefits under medicare and medicaid programs.
- Sec. 7. Rules on coverage of emergency services by all medicare health plans.
- Sec. 8. Preemption of State law restrictions on managed care arrangements.
- Sec. 9. Publication of antitrust guidelines on activities of provider-sponsored organizations.

3 **SEC. 2. QUALIFIED PROVIDER-SPONSORED ORGANIZA-**  
 4 **TIONS AS MEDICARE HEALTH PLAN OPTION.**

5 (a) QUALIFIED PROVIDER-SPONSORED ORGANIZA-  
 6 TIONS AS ELIGIBLE ORGANIZATIONS UNDER THE MEDI-  
 7 CARE PROGRAM.—Part C of title XVIII of the Social Se-  
 8 curity Act is amended—

9 (1) in section 1876(b) (42 U.S.C.  
 10 1395mm(b))—

11 (A) in the matter before paragraph (1), by  
 12 striking “or a competitive medical plan” and in-  
 13 serting “, a competitive medical plan, or a pro-  
 14 vider-sponsored organization”, and

15 (B) in paragraph (1), by inserting “or is a  
 16 qualified provider-sponsored organization (as  
 17 defined in section 1889(a))” after “Act”;

18 (2) by inserting after section 1888 the following  
 19 new section:

1 “REQUIREMENTS, STANDARDS, AND CERTIFICATION OF  
2 PROVIDER-SPONSORED ORGANIZATIONS

3 “SEC. 1889. (a) DEFINITIONS OF QUALIFIED PRO-  
4 VIDER-SPONSORED ORGANIZATION; PROVIDER-SPON-  
5 SORED ORGANIZATION.—For purposes of section 1876  
6 and this section—

7 “(1) QUALIFIED PROVIDER-SPONSORED ORGA-  
8 NIZATION.—The term ‘qualified provider-sponsored  
9 organization’ means a provider-sponsored organiza-  
10 tion that—

11 “(A) subject to subsection (b), is organized  
12 and licensed under State law to offer prepaid  
13 health services or health benefits coverage in  
14 each State in which the entity seeks to enroll  
15 individuals under section 1876 who are entitled  
16 to benefits under this title;

17 “(B) provides a substantial proportion (as  
18 defined by the Secretary in the standards estab-  
19 lished under subsection (g) consistent with  
20 paragraph (3)) of the health care items and  
21 services under the contract under section 1876  
22 directly through the provider or affiliated group  
23 of providers comprising the organization; and

24 “(C) is certified under subsection (h) as  
25 meeting the standards established under sub-

1 section (g), which except as provided in sub-  
2 section (c), shall be based on the requirements  
3 that apply to an entity described in section  
4 1876(b)(2) with a full risk contract under sec-  
5 tion 1876(g).

6 “(2) PROVIDER-SPONSORED ORGANIZATION.—  
7 The term ‘provider-sponsored organization’ means a  
8 public or private entity that is a provider or group  
9 of affiliated providers organized to deliver a spec-  
10 trum of health care services (including basic hospital  
11 and physicians services) under contract to pur-  
12 chasers of such services.

13 “(3) SUBSTANTIAL PROPORTION.—In defining  
14 what is a ‘substantial proportion’ for purposes of  
15 paragraph (1)(B), the Secretary—

16 “(A) shall take into account the need for  
17 such an organization to assume responsibility  
18 for providing—

19 “(i) significantly more than the ma-  
20 jority of the items and services under the  
21 contract under section 1876 through its  
22 own affiliated providers, and

23 “(ii) most of the remainder of items  
24 and services under such contract through  
25 providers with which the organization has

1           an agreement to provide such items and  
2           services,  
3           in order to assure financial stability and to ad-  
4           dress the practical considerations involved in in-  
5           tegrating the delivery of a wide range of service  
6           providers;

7           “(B) shall take into account the need for  
8           such an organization to provide a limited pro-  
9           portion of the items and services under such  
10          contract through providers that are neither af-  
11          filiated with nor have an agreement with such  
12          organization; and

13          “(C) may vary such proportion based upon  
14          relevant differences among organizations, such  
15          as their location in an urban or rural area.

16          “(4) AFFILIATION.—

17                 “(A) IN GENERAL.—For purposes of this  
18                 subsection, a provider is ‘affiliated’ with an-  
19                 other provider if, through contract, ownership,  
20                 or otherwise—

21                         “(i) one provider, directly or indi-  
22                         rectly, controls, is controlled by, or is  
23                         under common control with the other,

24                         “(ii) each provider is a participant in  
25                         a lawful combination under which each

1 provider shares, directly or indirectly, sub-  
2 stantial financial risk in connection with  
3 their operations,

4 “(iii) both providers are part of a con-  
5 trolled group of corporations under section  
6 1563 of the Internal Revenue Code of  
7 1986, or

8 “(iv) both providers are part of an af-  
9 filiated service group under section 414 of  
10 such Code.

11 “(B) CONTROL.—For purposes of subpara-  
12 graph (A), control is presumed to exist if one  
13 party, directly or indirectly, owns, controls, or  
14 holds the power to vote, or proxies for, not less  
15 than 51 percent of the voting rights or govern-  
16 ance rights of another.

17 “(b) APPLICATION AND WAIVER OF STATE LICEN-  
18 SURE REQUIREMENT.—

19 “(1) IN GENERAL.—Subject to paragraph (2),  
20 subsection (a)(1)(A) (relating to State licensure)  
21 shall not apply to a provider-sponsored organization.

22 “(2) DELAYED EXCEPTION.—Effective on and  
23 after January 1, 2002, subsection (a)(1)(A) shall  
24 only apply (and paragraph (1) of this subsection

1 shall no longer apply) to a provider-sponsored orga-  
2 nization in a State if—

3 “(A) the financial solvency and capital ade-  
4 quacy standards for licensure of the organiza-  
5 tion under the laws of the State are identical to  
6 the standards established under subsection (g),  
7 and

8 “(B) the standards for licensure of the or-  
9 ganization under the laws of the State (other  
10 than the standards referred to in subparagraph  
11 (A)) are substantially equivalent to the stand-  
12 ards established under subsection (g).

13 “(3) APPLICATION FOR WAIVER.—

14 “(A) IN GENERAL.—A provider-sponsored  
15 organization to which subsection (a)(1)(A) ap-  
16 plies that seeks to operate in a State under a  
17 full risk contract under section 1876(g) or a  
18 partial risk contract under section 1876(i) may  
19 apply for a waiver of the requirement of sub-  
20 section (a)(1)(A) for that organization operat-  
21 ing in that State.

22 “(B) ACTION ON APPLICATION.—The Sec-  
23 retary shall act on such an application within  
24 60 days after the date it is filed and shall grant

1 a waiver for an organization with respect to a  
2 State if the Secretary determines that—

3 “(i) the State did not act upon such  
4 a licensure application within 90 days after  
5 the date it was filed, or

6 “(ii)(I) the State denied such a licen-  
7 sure application, and

8 “(II) the State’s licensing standards  
9 or review process impose unreasonable bar-  
10 riers to market entry, including through  
11 the imposition of any requirements, proce-  
12 dures, or other standards on such organi-  
13 zations that are not generally applicable to  
14 any other entities engaged in substantially  
15 similar business.

16 “(C) EFFECTIVE PERIOD OF WAIVER.—In  
17 the case of a waiver granted under this para-  
18 graph for an organization—

19 “(i) the waiver shall be effective for a  
20 24-month period, except that it may be re-  
21 newed based on a subsequent application  
22 filed during the last 6 months of such pe-  
23 riod;

24 “(ii) if the State failed to meet the re-  
25 quirement of subparagraph (B)(i)—

1           “(I) any application for a renewal  
2           may be made on the basis described in  
3           subparagraph (B)(i) only if the State  
4           does not act on a pending licensure  
5           application during the 24-month pe-  
6           riod specified in clause (i),

7           “(II) any application for renewal  
8           (other than one made on the basis de-  
9           scribed in subparagraph (B)(i)) may  
10          be made only on the basis described in  
11          subparagraph (B)(ii), and

12          “(III) the waiver shall cease to  
13          be effective upon approval of the li-  
14          censure application by the State dur-  
15          ing such 24-month period; and

16          “(iii) any provisions of State law that  
17          relate to the licensing of the organization  
18          and prohibit the organization from provid-  
19          ing coverage pursuant to a contract under  
20          section 1876 shall be superseded during  
21          the period for which such waiver is effec-  
22          tive.

23          “(4) CONSTRUCTION.—Nothing in this sub-  
24          section shall be construed as—

1           “(A) limiting the number of times such a  
2           waiver may be renewed under paragraph  
3           (3)(C)(i), or

4           “(B) affecting the operation of section 514  
5           of the Employee Retirement Income Security  
6           Act of 1974.

7           “(c) APPLICATION OF CERTAIN REQUIREMENTS.—

8           “(1) WAIVER OF BENEFIT PACKAGE REQUIRE-  
9           MENT.—For purposes of carrying out subsection  
10          (a)(1)(C), the requirement of subsection (b)(2)(A)  
11          (relating to benefit package for commercial enroll-  
12          ees) of section 1876 shall not be applied.

13          “(2) EXCEPTION FOR METHOD OF DELIVERING  
14          PHYSICIANS SERVICES.—For purposes of carrying  
15          out subsection (a)(1)(C), the requirement of sub-  
16          section (b)(2)(C) (relating to delivery of physicians  
17          services) of section 1876 shall be applied, except  
18          that the Secretary shall by regulation specify alter-  
19          native delivery models or arrangements that may be  
20          used by such organizations in lieu of the models or  
21          arrangements specified in such subsection.

22          “(3) EXCEPTION FOR RISK ASSUMPTION.—For  
23          purposes of carrying out subsection (a)(1)(C), the  
24          requirement of subsection (b)(2)(D) (relating to risk  
25          assumption) of section 1876 shall be applied, except

1 that any provider-sponsored organization with a full  
2 risk contract under section 1876(g) may (with the  
3 concurrence of the Secretary) obtain insurance or  
4 make other arrangements for covering costs in ex-  
5 cess of those permitted to be covered by such insur-  
6 ance and arrangements under section  
7 1876(b)(2)(D)(iii).

8 “(4) TREATMENT OF MEETING FINANCIAL SOL-  
9 VENCY REQUIREMENT.—

10 “(A) IN GENERAL.—For purposes of carry-  
11 ing out subsection (a)(1)(C), a provider-spon-  
12 sored organization shall be treated as meeting  
13 the requirement of subsection (b)(2)(E) (relat-  
14 ing to adequate provision against risk of insol-  
15 vency) of section 1876 if the organization is fis-  
16 cally sound.

17 “(B) FISCAL SOUNDNESS.—A provider-  
18 sponsored organization shall be treated as fis-  
19 cally sound for purposes of subparagraph (A) if  
20 the organization—

21 “(i) has a net worth that is not less  
22 than the required net worth (as defined in  
23 clause (i) or (ii) of subparagraph (C), as  
24 the case may be), and

1           “(ii) has established adequate claims  
2 reserves (as defined in subparagraph (D)).

3           “(C) REQUIRED NET WORTH DEFINED.—

4 For purposes of subparagraph (B)(i)—

5           “(i) FULL RISK CONTRACTS.—The  
6 term ‘required net worth’ means, in the  
7 case of an organization with a full risk  
8 contract under section 1876(g), a net  
9 worth (determined in accordance with stat-  
10 utory accounting principles for insurance  
11 companies and health maintenance organi-  
12 zations) that is not less than the greatest  
13 of the following:

14           “(I) \$1,500,000 at the time of  
15 application and \$1,000,000 thereafter.

16           “(II) The sum of 8 percent of the  
17 cost of health services that are not  
18 provided directly by the organization  
19 or its affiliated providers to enrollees,  
20 plus 4 percent of the estimated annual  
21 costs of health services provided di-  
22 rectly by the organization or its affili-  
23 ated providers to enrollees.

24           “(III) 3 months of uncovered ex-  
25 penditures.

1           “(ii) PARTIAL RISK CONTRACTS.—The  
2           term ‘required net worth’ means, in the  
3           case of an organization with a partial risk  
4           contract under section 1876(i), an amount  
5           determined in accordance with clause (i),  
6           except that in applying subclause (II) of  
7           such clause, the Secretary shall substitute  
8           for the percentages specified in such sub-  
9           clause such lower percentages as are ap-  
10          propriate to reflect the risk-sharing ar-  
11          rangements under the contract.

12          “(D) ADEQUATE CLAIMS RESERVES.—For  
13          purposes of subparagraph (B)(ii), the term  
14          ‘adequate claims reserves’ means, with respect  
15          to an organization, reserves for claims that  
16          are—

17                 “(i) incurred but not reported, or

18                 “(ii) reported but unpaid,

19          that are determined in accordance with statu-  
20          tory accounting principles for insurance compa-  
21          nies and health maintenance organizations and  
22          with professional standards of actuarial practice  
23          and that are certified by an independent actu-  
24          ary as adequate in light of the operations and  
25          contracts of the organization.

1           “(E) APPLICATION OF ACCOUNTING PRIN-  
2           CIPLES.—In applying statutory accounting  
3           principles for purposes of determining the net  
4           worth of an organization under subparagraph  
5           (B)(i), the Secretary shall—

6                   “(i) treat as ‘admitted assets’—

7                           “(I) land, buildings, and equip-  
8                           ment of the organization used for the  
9                           direct provision of health care serv-  
10                          ices,

11                           “(II) any receivables from gov-  
12                           ernmental programs due for more  
13                           than 90 days, and

14                           “(III) any other assets des-  
15                           ignated by the Secretary; and

16                          “(ii) recognize, as a contribution to  
17                          surplus, amounts received under subordi-  
18                          nated debt (meeting such requirements as  
19                          the Secretary may specify).

20           “(F) METHODS OF DEMONSTRATING COM-  
21           PLIANCE.—The Secretary shall recognize ways  
22           of complying with the requirement of subpara-  
23           graph (A) other than by means of subpara-  
24           graph (B), including (alone or in combina-  
25           tion)—

- 1 “(i) letters of credit from a bank,  
2 “(ii) financial guarantees from finan-  
3 cially strong parties including affiliates,  
4 “(iii) unrestricted fund balances,  
5 “(iv) diversity of lines of business and  
6 presence of non risk related revenue,  
7 “(v) certification by an independent  
8 actuary,  
9 “(vi) reinsurance ceded to, or stop  
10 loss insurance purchased through, a recog-  
11 nized commercial insurance company, and  
12 “(vii) other methods acceptable to the  
13 Secretary.

14 “(d) REQUIREMENT FOR ONGOING QUALITY ASSUR-  
15 ANCE PROGRAM.—

16 “(1) IN GENERAL.—A provider-sponsored orga-  
17 nization shall not be treated as meeting the require-  
18 ments of subsection (c)(6) (relating to an ongoing  
19 quality assurance program) of section 1876 unless  
20 the quality assurance program of the organization  
21 meets the requirements of paragraphs (2) and (3).

22 “(2) REQUIRED ELEMENTS OF QUALITY ASSUR-  
23 ANCE PROGRAM.—A quality assurance program  
24 meets the requirements of this paragraph if the pro-  
25 gram—

1           “(A) stresses health outcomes;

2           “(B) provides opportunities for input by  
3 physicians and other health care professionals;

4           “(C) monitors and evaluates high volume  
5 and high risk services and the care of acute and  
6 chronic conditions;

7           “(D) evaluates the continuity and coordi-  
8 nation of care that enrollees receive;

9           “(E) establishes mechanisms to detect both  
10 underutilization and overutilization of services;

11           “(F) after identifying areas for improve-  
12 ment, establishes or alters practice parameters;

13           “(G) takes action to improve quality and  
14 assess the effectiveness of such action through  
15 systematic follow up;

16           “(H) makes available information on qual-  
17 ity and outcomes measures to facilitate bene-  
18 ficiary comparison and choice of health cov-  
19 erage options (in such form and on such quality  
20 and outcomes measures as the Secretary deter-  
21 mines to be appropriate); and

22           “(I) is evaluated on an ongoing basis as to  
23 its effectiveness.

24           “(3) TREATMENT OF CASE-BY-CASE UTILIZA-  
25 TION REVIEW.—If a provider-sponsored organization

1 utilizes case-by-case utilization review in its quality  
2 assurance program, the organization shall—

3 “(A) base such review on written protocols  
4 developed on the basis of current standards of  
5 medical practice; and

6 “(B) implement a plan under which—

7 “(i) such review is coordinated with  
8 the quality assurance program of the orga-  
9 nization, and

10 “(ii) a transition is made from relying  
11 predominantly on case-by-case review to  
12 review focusing on patterns of care.

13 “(4) COMPLIANCE THROUGH ACCREDITA-  
14 TION.—A provider-sponsored organization shall be  
15 treated as meeting the requirements of paragraphs  
16 (2) and (3) of this subsection and the requirements  
17 of section 1876(c)(6) if the organization is accred-  
18 ited (and periodically reaccredited) by a private or-  
19 ganization under a process that the Secretary has  
20 determined assures that the organization meets  
21 standards for quality assurance programs that are  
22 no less stringent than the standards established for  
23 such programs under subsection (g) to carry out this  
24 subsection and section 1876(c).

1       “(e) REQUIREMENT FOR PARTICIPATION PROCE-  
2 DURES.—A provider-sponsored organization shall not be  
3 treated as meeting the requirements of this section un-  
4 less—

5           “(1) the organization establishes reasonable  
6 procedures relating to the participation (under an  
7 agreement between a physician or group of physi-  
8 cians and the organization) of physicians under con-  
9 tracts under section 1876 and such procedures in-  
10 clude—

11           “(A) providing notice of the rules regard-  
12 ing participation,

13           “(B) providing written notice of participa-  
14 tion decisions that are adverse to physicians,  
15 and

16           “(C) providing a process within the organi-  
17 zation for appealing adverse decisions, including  
18 the presentation of information and views of the  
19 physician regarding such decision; and

20           “(2) the organization consults with physicians  
21 who have entered into participation agreements with  
22 the organization regarding the organization’s medi-  
23 cal policy, quality, and medical management proce-  
24 dures.

1 Paragraph (1)(C) shall not be construed as requiring a  
2 live evidentiary hearing, a verbatim record, or representa-  
3 tion of the appealing party by legal counsel.

4 “(f) OTHER SPECIAL RULES FOR TREATMENT OF  
5 PROVIDER-SPONSORED ORGANIZATIONS.—

6 “(1) WAIVER OF MINIMUM ENROLLMENT  
7 RULES.—In the case of a provider-sponsored organi-  
8 zation, paragraph (1) of section 1876(g)—

9 “(A) shall not apply for the first 3 con-  
10 tract years of the organization under section  
11 1876, and

12 “(B) shall be applied for contract years  
13 thereafter—

14 “(i) by substituting ‘1500’ for ‘5000’,  
15 and

16 “(ii) by substituting ‘at least 500’ for  
17 ‘fewer’.

18 “(2) ADJUSTED COMMUNITY RATE.—In the  
19 case of a provider-sponsored organization, the ad-  
20 justed community rate under subsections (e)(3) and  
21 (g)(2) of section 1876 may be computed (in a man-  
22 ner specified by the Secretary) using data in the  
23 general commercial marketplace or (during a transi-  
24 tion period) based on the costs incurred by the orga-  
25 nization in providing such a product.

1           “(g) ESTABLISHMENT OF STANDARDS FOR QUALI-  
2 FIED PROVIDER-SPONSORED ORGANIZATIONS.—

3                   “(1) INTERIM STANDARDS.—

4                           “(A) IN GENERAL.—The Secretary shall  
5 issue regulations regarding standards for quali-  
6 fied provider-sponsored organizations within  
7 180 days after the date of the enactment of this  
8 section. Such regulations shall be issued on an  
9 interim basis, but shall become effective upon  
10 publication and shall be effective through De-  
11 cember 31, 2001.

12                           “(B) SOLICITATION OF VIEWS.—In devel-  
13 oping standards under this paragraph, the Sec-  
14 retary shall solicit the views of the National As-  
15 sociation of Insurance Commissioners, the  
16 American Academy of Actuaries, State health  
17 departments, associations representing provider-  
18 sponsored organizations, quality experts (in-  
19 cluding private accreditation organizations),  
20 and medicare beneficiaries.

21                           “(C) CONTRACTS TO MONITOR PERFORM-  
22 ANCE.—The Secretary shall enter into contracts  
23 with appropriate State agencies to monitor per-  
24 formance and beneficiary access to services  
25 under this title during the period in which in-

1           terim standards are in effect under this para-  
2           graph.

3           “(2) PERMANENT STANDARDS.—

4                   “(A) IN GENERAL.—Not later than July 1,  
5           2001, the Secretary shall issue permanent  
6           standards under this paragraph.

7                   “(B) CONSULTATION.—In developing  
8           standards under this paragraph, the Secretary  
9           shall consult with the organizations and individ-  
10          uals referred to in paragraph (1)(B).

11                   “(C) EFFECTIVE DATE.—The standards  
12          under this paragraph shall be effective for peri-  
13          ods after December 31, 2001.

14           “(3) PREEMPTION.—The standards established  
15          under this subsection shall supersede any State law  
16          or regulation with respect to qualified provider-spon-  
17          sored organizations insofar as such law or regula-  
18          tion—

19                   “(A) applies to individuals enrolled with  
20          such an organization under a contract under  
21          section 1876, and

22                   “(B) does not meet the requirements of  
23          subsection (b)(2).

24          “(h) CERTIFICATION.—

1           “(1) ESTABLISHMENT OF PROCESS.—The Sec-  
2           retary shall establish a process for the certification  
3           of provider-sponsored organizations as qualified pro-  
4           vider-sponsored organizations under this section.  
5           Such process shall provide that an application for  
6           certification shall be approved or denied not later  
7           than 90 days after the date of receipt of the applica-  
8           tion.

9           “(2) APPLICATION OF ACCREDITATION.—

10           “(A) IN GENERAL.—The process under  
11           this subsection shall, to the maximum extent  
12           practical, provide that provider-sponsored orga-  
13           nizations that are accredited by a qualified pri-  
14           vate accreditation process that the Secretary  
15           finds applies standards that are no less strin-  
16           gent than the standards established under sub-  
17           section (g) are deemed to meet the correspond-  
18           ing standards of this title.

19           “(B) PERIOD OF VALIDITY OF ACCREDITA-  
20           TION.—The use of an accreditation under sub-  
21           paragraph (A) shall be valid only for such pe-  
22           riod as the Secretary specifies.

23           “(3) IMPOSITION OF CERTIFICATION FEE.—The  
24           Secretary may impose user fees on entities seeking  
25           certification under this subsection in such amounts

1 as the Secretary deems sufficient to finance the  
2 costs of such certification.

3 “(4) DECERTIFICATION.—If a provider-spon-  
4 sored organization is decertified under this sub-  
5 section, the organization shall notify each enrollee  
6 with the organization under section 1876 of such de-  
7 certification.”.

8 (b) EFFECTIVE DATE; USE OF INTERIM REGULA-  
9 TIONS.—

10 (1) IN GENERAL.—The amendments made by  
11 this section shall become effective on the date of the  
12 enactment of this Act and apply to contract years  
13 beginning on or after January 1, 1998.

14 (2) USE OF INTERIM FINAL REGULATIONS.—In  
15 order to carry out the amendments made by this  
16 section in a timely manner, the Secretary of Health  
17 and Human Services may promulgate regulations  
18 that take effect on an interim basis, after notice and  
19 pending opportunity for public comment.

20 **SEC. 3. AUTHORIZING PAYMENT OF ALL MEDICARE**  
21 **HEALTH PLANS ON A PARTIAL RISK BASIS.**

22 (a) IN GENERAL.—Section 1876 of the Social Secu-  
23 rity Act (42 U.S.C. 1395mm) is amended—

24 (1) by redesignating subsections (i) and (j) as  
25 subsections (k) and (l), respectively, and

1           (2) by inserting after subsection (h) the follow-  
2           ing:

3           “(i) The Secretary may enter into a partial risk con-  
4           tract with an eligible organization under which—

5                   “(1) notwithstanding subsection (b)(2)(D), the  
6                   organization and the program established under this  
7                   title share the financial risk associated with the serv-  
8                   ices the organization provides to individuals entitled  
9                   to benefits under part A and enrolled under part B  
10                  or enrolled under part B only;

11                  “(2) notwithstanding subsections (a)(1) and  
12                  (h)(2), payment is based on—

13                          “(A) a blend of—

14                                  (i) the payments that would otherwise  
15                                  be made to such organization under a risk-  
16                                  sharing contract under subsection (g), and

17                                  “(ii) the payments that would be  
18                                  made to such organization under a reason-  
19                                  able cost reimbursement contract under  
20                                  subsection (h), or

21                          “(B) any other methodology agreed upon  
22                          by the Secretary and the organization; and

23                  “(3) adjustments, if appropriate, are made to  
24                  the payments under this section to the organization  
25                  to reflect any risk assumed by such program.”.

1 (b) EFFECTIVE DATE.—The amendments made by  
2 subsection (a) shall become effective on the date of the  
3 enactment of this Act and apply to contract years begin-  
4 ning on or after January 1, 1998.

5 **SEC. 4. ELIMINATION OF ENROLLMENT COMPOSITION RE-**  
6 **QUIREMENT FOR ELIGIBLE ORGANIZATIONS**  
7 **MEETING ENHANCED QUALITY STANDARDS.**

8 (a) IN GENERAL.—Section 1876 of the Social Secu-  
9 rity Act (42 U.S.C. 1395mm), as amended by section 3,  
10 is amended by inserting after subsection (i) the following:

11 “(j)(1) An eligible organization shall be treated as  
12 meeting the requirement of section 1876(f) (relating to en-  
13 rollment composition) if the organization demonstrates  
14 that it—

15 “(A) is capable of providing coordinated care in  
16 accordance with the quality assurance standards es-  
17 tablished under subsection (c)(6) and paragraph (2)  
18 of section 1889(d), and

19 “(B) has experience, under a past or present  
20 arrangement, providing coordinated care to individ-  
21 uals (other than individuals who are entitled to bene-  
22 fits under this title) who are enrollees, participants,  
23 or beneficiaries of a health plan or a State plan ap-  
24 proved under title XIX.

1       “(2) An eligible organization shall be treated as meet-  
2 ing the standards referred to in paragraph (1)(A) if the  
3 organization is accredited (and periodically reaccredited)  
4 by a private organization under a process that the Sec-  
5 retary has determined assures that the organization meets  
6 standards for quality assurance programs that are no less  
7 stringent than the standards established for such pro-  
8 grams under subsection (c) and section 1889(g).

9       “(3) DEFINITIONS.—For purposes of this subsection:

10       “(A) HEALTH PLAN.—The term ‘health plan’  
11 means—

12               “(i) any contract of insurance, including  
13 any hospital or medical service policy or certifi-  
14 cate, hospital or medical service plan contract,  
15 or health maintenance organization contract,  
16 that is provided by a carrier (as defined in sub-  
17 paragraph (B)), and

18               “(ii) an employee welfare benefit plan inso-  
19 far as the plan provides health benefits and is  
20 funded in a manner other than through the  
21 purchase of one or more policies or contracts  
22 described in clause (i).

23       “(B) CARRIER.—The term ‘carrier’ means a li-  
24 censed insurance company, a hospital or medical  
25 service corporation (including an existing Blue Cross

1 or Blue Shield organization), or other entity licensed  
2 or certified by a State to provide health insurance or  
3 health benefits.

4 (b) EFFECTIVE DATE.—The amendments made by  
5 this subsection shall become effective on the date of the  
6 enactment of this Act and apply to contract years begin-  
7 ning on or after January 1, 1998.

8 **SEC. 5. CLARIFICATION OF USE OF PROVIDER-SPONSORED**  
9 **ORGANIZATIONS UNDER MEDICAID PRO-**  
10 **GRAM.**

11 Section 1903(m)(1)(A) of the Social Security Act (42  
12 U.S.C. 1396b(m)(1)(A)) is amended, in the matter before  
13 clause (i), by inserting “(which may be a provider-spon-  
14 sored organization, as defined in section 1889(a)(2))”  
15 after “public or private organization”.

16 **SEC. 6. DEMONSTRATION OF COORDINATED ACUTE AND**  
17 **LONG-TERM CARE BENEFITS UNDER MEDI-**  
18 **CARE AND MEDICAID PROGRAMS.**

19 The Secretary of Health and Human Services shall  
20 provide, in at least 10 States, for demonstration projects  
21 that permit Medicaid programs under title XIX to be  
22 treated as eligible organizations under section 1876 for  
23 individuals who are eligible to enroll with an organization  
24 under such section and are eligible to receive medical as-  
25 sistance under a State program approved under title XIX,

1 for the purpose of demonstrating the delivery of primary,  
2 acute, and long-term care through an integrated delivery  
3 network that emphasizes noninstitutional care.

4 **SEC. 7. RULES ON COVERAGE OF EMERGENCY SERVICES**  
5 **BY ALL MEDICARE HEALTH PLANS.**

6 (a) IN GENERAL.—Section 1876(c) of the Social Se-  
7 curity Act (42 U.S.C. 1395mm(c)) is amended—

8 (1) in paragraph (4)—

9 (A) by striking “and” at the end of sub-  
10 paragraph (A), and

11 (B) by striking subparagraph (B) and in-  
12 serting in lieu thereof the following:

13 “(B) provide for reimbursement with respect to  
14 services which are covered under subparagraph (A)  
15 which are provided to such an individual other than  
16 through the organization, if—

17 “(i) the services were medically necessary  
18 and immediately required because of an unfore-  
19 seen illness, injury, or condition, and

20 “(ii) it was not reasonable given the cir-  
21 cumstances to obtain the services through the  
22 organization;

23 “(C) provide coverage for emergency services  
24 (as defined in paragraph (9))—

1           “(i) without regard to prior authorization,  
2           and

3           “(ii) subject to the requirement of sub-  
4           paragraph (B)(ii), without regard to the emer-  
5           gency care provider’s contractual relationship  
6           with the organization; and

7           “(D) make available 24 hours a day and 7 days  
8           a week a person authorized to make any prior au-  
9           thorization determination that is required by the or-  
10          ganization as a condition of coverage or payment for  
11          items and services included in the benefits described  
12          in paragraph (2)(A) that are furnished with respect  
13          to—

14           “(i) a medical condition that is—

15           “(I) identified pursuant to an appro-  
16           priate screening examination (as described  
17           in section 1867(a)), and

18           “(II) not an emergency medical condi-  
19           tion (as defined in section 1867(e)(1)), or

20           “(ii) an emergency medical condition (as so  
21           defined) after that condition has been stabilized  
22           (as defined in section 1867(e)(3)(B)),

23           and makes such determinations within a period of  
24           time that meets standards established by the Sec-  
25           retary.”; and

1 (2) by adding at the end the following:

2 “(9) In this subsection, the term ‘emergency services’  
3 means—

4 “(A) an appropriate medical screening examina-  
5 tion and related ancillary services (as described in  
6 section 1867(a)) furnished in a hospital emergency  
7 department, and

8 “(B) necessary stabilizing examination and  
9 treatment services (as described in section 1867(b))  
10 for an emergency medical condition (as defined in  
11 section 1867(e)(1)).”.

12 (b) EFFECTIVE DATE.—The amendments made by  
13 subsection (a) shall become effective on the date of the  
14 enactment of this Act and shall apply to contract years  
15 beginning on or after January 1, 1998.

16 **SEC. 8. PREEMPTION OF STATE LAW RESTRICTIONS ON**  
17 **MANAGED CARE ARRANGEMENTS.**

18 (a) LIMITATION OF STATE LAW RESTRICTIONS ON  
19 MANAGED CARE ARRANGEMENTS.—Effective as of Janu-  
20 ary 1, 1998—

21 (1) a State may not prohibit a carrier or group  
22 health plan providing health coverage from including  
23 incentives for enrollees to use the services of partici-  
24 pating providers;

1           (2) a State may not prohibit such a carrier or  
2 plan from limiting coverage of services to those pro-  
3 vided by a participating provider;

4           (3) a State may not prohibit the negotiation of  
5 rates and forms of payments for providers by such  
6 a carrier or plan with respect to health coverage;

7           (4) a State may not prohibit such a carrier or  
8 plan from limiting the number of participating pro-  
9 viders;

10          (5) a State may not prohibit such a carrier or  
11 plan from requiring that services be provided (or au-  
12 thorized) by a practitioner selected by the enrollee  
13 from a list of available participating providers or, ex-  
14 cept for services of a physician who specializes in ob-  
15 stetrics and gynecology, from requiring enrollees to  
16 obtain referral in order to have coverage for treat-  
17 ment by a specialist or health institution;

18          (6) a State may not prohibit or limit the cor-  
19 porate practice of medicine; and

20          (7) a State may not prohibit the adoption and  
21 operation of a utilization review program.

22 (b) DEFINITIONS.—In this section:

23          (1) MANAGED CARE COVERAGE.—The term  
24 “managed care coverage” means health coverage to  
25 the extent the coverage is provided through a man-

1 aged care arrangement (as defined in paragraph  
2 (3)).

3 (2) PARTICIPATING PROVIDER.—The term  
4 “participating provider” means an entity or individ-  
5 ual which provides, sells, or leases health care serv-  
6 ices as part of a provider network (as defined in  
7 paragraph (4)).

8 (3) MANAGED CARE ARRANGEMENT.—The term  
9 “managed care arrangement” means, with respect to  
10 a group health plan or under health insurance cov-  
11 erage, an arrangement under such plan or coverage  
12 under which providers agree to provide items and  
13 services covered under the arrangement to individ-  
14 uals covered under the plan or who have such cov-  
15 erage.

16 (4) PROVIDER NETWORK.—The term “provider  
17 network” means, with respect to a group health plan  
18 or health insurance coverage, providers who have en-  
19 tered into an agreement described in paragraph (3).

20 (5) UTILIZATION REVIEW PROGRAM.—The term  
21 “utilization review program” means a system of re-  
22 viewing the medical necessity and appropriateness of  
23 patient services (which may include inpatient and  
24 outpatient services) using specified guidelines. Such  
25 a system may include pattern analysis, preadmission

1 certification, the application of practice guidelines,  
2 continued stay review, discharge planning,  
3 preauthorization of ambulatory procedures, and ret-  
4 rospective review.

5 (6) STATE.—The term “State” includes the  
6 District of Columbia, Puerto Rico, Guam, the Virgin  
7 Islands, the Northern Mariana Islands, and Amer-  
8 ican Samoa.

9 (c) EXEMPTION OF LAWS PREVENTING DENIAL OF  
10 LIFE SAVING MEDICAL TREATMENT PENDING TRANSFER  
11 TO ANOTHER HEALTH CARE PROVIDER.—Nothing in this  
12 section shall be construed to invalidate any State law that  
13 has the effect of preventing involuntary denial of life-pre-  
14 serving medical treatment when such denial would cause  
15 the involuntary death of the patient pending transfer of  
16 the patient to a health care provider willing to provide  
17 such treatment.

18 (d) PURPOSE; RULE OF CONSTRUCTION.—The pur-  
19 pose of this section is to permit use of the mechanisms  
20 specified in paragraphs (1) through (7) of subsection (a)  
21 in the States. Nothing in this section shall be construed  
22 as prohibiting a State from regulating or limiting abusive  
23 arrangements or practices that act inappropriately to  
24 withhold, limit, or delay access to covered services.

1 **SEC. 9. PUBLICATION OF ANTITRUST GUIDELINES ON AC-**  
2 **TIVITIES OF PROVIDER-SPONSORED ORGANI-**  
3 **ZATIONS.**

4 (a) **IN GENERAL.**—The Department of Justice and  
5 the Federal Trade Commission shall jointly provide for the  
6 development and publication of explicit guidelines on the  
7 application of antitrust laws to the activities of provider-  
8 sponsored organizations (as defined in section 1889(a)(2)  
9 of the Social Security Act). The guidelines shall—

10 (1) address issues relating to the formation, de-  
11 velopment, and operation of such organizations, and

12 (2) be designed to facilitate the development  
13 and operation of such organizations.

14 (b) **EFFECT OF GUIDELINES.**—The guidelines estab-  
15 lished under subsection (a) shall—

16 (1) be binding on all enforcement activities un-  
17 dertaken pursuant to the antitrust laws, and

18 (2) serve as guidance to the attorneys general  
19 and courts of the States in interpreting and applying  
20 the antitrust laws of the States to provider-spon-  
21 sored organizations.

22 (c) **DEFINITION.**—For purposes of this section, the  
23 term “antitrust laws” has the meaning given to such term  
24 in the first section of the Clayton Act (15 U.S.C. 12), ex-  
25 cept that such term includes section 5 of the Federal

1 Trade Commission Act (15 U.S.C. 45) to the extent such  
2 section applies to unfair competition.

3 (d) DEADLINE; ANNUAL UPDATES.—The guidelines  
4 required by subsection (a) shall be published not later  
5 than 180 days after the date of the enactment of this Act  
6 and shall be updated at least annually thereafter based  
7 on consultations with interested parties.

○