

105TH CONGRESS  
1ST SESSION

# H. R. 66

To amend title XVIII of the Social Security Act to provide protections for Medicare beneficiaries who enroll in Medicare managed care plans.

---

## IN THE HOUSE OF REPRESENTATIVES

JANUARY 7, 1997

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

---

## A BILL

To amend title XVIII of the Social Security Act to provide protections for Medicare beneficiaries who enroll in Medicare managed care plans.

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 Patient  
5       Choice and Access Act of 1997”.

6       **SEC. 2. FINDINGS.**

7       Congress finds the following:

1           (1) There should be no unreasonable barriers or  
2           impediments to the ability of individuals enrolled in  
3           health care plans to obtain appropriate specialized  
4           medical services.

5           (2) The patient's first point of contact in a  
6           health care plan must be encouraged to make all ap-  
7           propriate medical referrals and should not be con-  
8           strained financially from making such referrals.

9           (3) Some health care plans may impede timely  
10          access to specialty care.

11          (4) Some contracts between health care plans  
12          and providers may contain provisions which impede  
13          the provider in informing the patient of the full  
14          range of treatment options.

15          (5) Patients cannot make appropriate health  
16          care decisions without access to all relevant informa-  
17          tion relating to those decisions.

18          (6) Restrictions on the ability of health care  
19          providers to provide full disclosure of all relevant in-  
20          formation to patients making health care decisions  
21          violate the principles of informed consent and the  
22          ethical standards of the health care professions.  
23          Contractual clauses and other policies that interfere  
24          with communications between health care providers

1 and patients can impact the quality of care received  
2 by those patients.

3 (7) Patients should have the opportunity to ac-  
4 cess out-of-network items, treatment, and services at  
5 an additional cost to the patient which is not so pro-  
6 hibitive that they are deterred from seeing the  
7 health care provider of their own choice.

8 (8) Specialty care must be available for the full  
9 duration of the patient’s medical needs and not lim-  
10 ited by time or number of visits.

11 (9) Direct access to specialty care is essential  
12 for patients in emergency and non-emergency situa-  
13 tions and for patients with chronic and temporary  
14 conditions.

15 **SEC. 3. PROTECTION FOR MEDICARE HMO ENROLLEES.**

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

18 (1) in subsection (c)(1), by striking “subsection  
19 (e)” and inserting “subsections (e) and (k)”, and

20 (2) by adding at the end the following new sub-  
21 section:

22 “(k) BENEFICIARY PROTECTION.—

23 “(1) ASSURING ADEQUATE IN-NETWORK AC-  
24 CESS.—

1           “(A) **TIMELY ACCESS.**—An eligible organi-  
2           zation that restricts the providers from whom  
3           benefits may be obtained must guarantee to en-  
4           rollees under this section timely access to pri-  
5           mary and specialty health care providers who  
6           are appropriate to the enrollee’s condition.

7           “(B) **ACCESS TO SPECIALIZED CARE.**—En-  
8           rollees must have access to specialized treat-  
9           ment when necessary. This access may be satis-  
10          fied through contractual arrangements with  
11          specialized providers outside of the network.

12          “(C) **CONTINUITY OF CARE.**—An eligible  
13          organization’s use of case management may not  
14          create an undue burden for enrollees under this  
15          section. An organization must ensure direct ac-  
16          cess to specialists for ongoing care as so deter-  
17          mined by the case manager in consultation with  
18          the specialty care provider. This continuity of  
19          care may be satisfied for enrollees with chronic  
20          conditions through the use of a specialist serv-  
21          ing as case manager.

22          “(2) **OUT-OF-NETWORK ACCESS.**—If an eligible  
23          organization offers to members enrolled under this  
24          section a plan which provides for coverage of services  
25          covered under parts A and B only if such services

1 are furnished through providers and other persons  
2 who are members of a network of providers and  
3 other persons who have entered into a contract with  
4 the organization to provide such services, the con-  
5 tract with the organization under this section shall  
6 provide that the organization shall also offer to  
7 members enrolled under this section (at the time of  
8 enrollment) a plan which provides for coverage of  
9 such items which are not furnished through provid-  
10 ers and other persons who are members of such a  
11 network.

12 “(3) GRIEVANCE PROCESS.—

13 “(A) IN GENERAL.—An eligible organiza-  
14 tion must provide a meaningful and expedited  
15 procedure, which includes notice and hearing  
16 requirements, for resolving grievances between  
17 the organization (including any entity or indi-  
18 vidual through which the organization provides  
19 health care services) and members enrolled with  
20 the organization under this section. Under the  
21 procedure any member enrolled with the organi-  
22 zation may at any time file a complaint to re-  
23 solve grievances between the member and the  
24 organization before a board of appeals estab-  
25 lished under subparagraph (C).

1 “(B) NOTICE REQUIREMENTS.—

2 “(i) IN GENERAL.—The organization  
3 must provide, in a timely manner, an en-  
4 rollee a notice of any denial of services in-  
5 network or denial of payment for out-of-  
6 network care.

7 “(ii) INFORMATION REQUIRED.—Such  
8 notice shall include the following:

9 “(I) A clear statement of the rea-  
10 son for the denial.

11 “(II) An explanation of the com-  
12 plaint process under subparagraph  
13 (C) which is available to the enrollee  
14 upon request.

15 “(III) An explanation of all other  
16 appeal rights available to all enrollees.

17 “(IV) A description of how to ob-  
18 tain supporting evidence for this hear-  
19 ing, including the patient’s medical  
20 records from the organization, as well  
21 as supporting affidavits from the at-  
22 tending health care providers.

23 “(C) HEARING BOARD.—

1           “(i) IN GENERAL.—Each eligible or-  
2           ganization shall establish a board of ap-  
3           peals to hear and make determinations on  
4           complaints by enrollees concerning denials  
5           of coverage or payment for services  
6           (whether in-network or out-of-network)  
7           and the medical necessity and appropriate-  
8           ness of covered items and services.

9           “(ii) COMPOSITION.—A board of ap-  
10          peals of an eligible organization shall con-  
11          sist of—

12                   “(I) representatives of the orga-  
13                   nization, including physicians, non-  
14                   physicians, administrators, and enroll-  
15                   ees;

16                   “(II) consumers who are not en-  
17                   rollees; and

18                   “(III) providers with expertise in  
19                   the field of medicine which neces-  
20                   sitates treatment.

21          “(iii) DEADLINE FOR DECISION.—A  
22          board of appeals shall hear and resolve  
23          complaints within 30 days after the date  
24          the complaint is filed with the board.

1           “(D) APPEAL TO SECRETARY.—Nothing in  
2 this paragraph may be construed to replace or  
3 supersede any appeals mechanism otherwise  
4 provided for an individual entitled to benefits  
5 under this title.

6           “(4) NOTICE OF ENROLLEE RIGHTS AND EN-  
7 ROLLEE INFORMATION CHECKLIST.—

8           “(A) IN GENERAL.—Each eligible organi-  
9 zation shall provide each enrollee, at the time of  
10 enrollment and not less frequently than annu-  
11 ally thereafter, an explanation of the enrollee’s  
12 rights under this section and a copy of the most  
13 recent enrollee information checklist for the or-  
14 ganization (as described in subparagraph (C)).

15           “(B) RIGHTS DESCRIBED.—The expla-  
16 nation of rights under subparagraph (A) shall  
17 include an explanation of—

18                   “(i) the enrollee’s rights to benefits  
19 from the organization;

20                   “(ii) the restrictions on payments  
21 under this title for services furnished other  
22 than by or through the organization;

23                   “(iii) out-of-area coverage provided by  
24 the organization;

1 “(iv) the organization’s coverage of  
2 emergency services and urgently needed  
3 care;

4 “(v) the organization’s coverage of  
5 out-of-network services, including services  
6 that are additional to the items and serv-  
7 ices covered under parts A and B; and

8 “(vi) appeal rights of enrollees.

9 “(C) ENROLLEE INFORMATION CHECK-  
10 LIST.—For purposes of subparagraph (A), the  
11 term ‘enrollee information checklist’ means,  
12 with respect to an eligible organization for a  
13 year, a list containing the following information  
14 (provided in a manner that permits consumers  
15 to compare organizations with respect to the in-  
16 formation):

17 “(i) For each plan, information on—

18 “(I) the premium for the plan,

19 “(II) identity, location, qualifica-  
20 tions and availability of providers in  
21 any provider networks of the plan,

22 “(III) the number of individuals  
23 enrolling and disenrolling from the  
24 plan,

1 “(IV) procedures used by the  
2 plan to control utilization of services  
3 and expenditures,

4 “(V) procedures used by the plan  
5 to assure quality of care, and

6 “(VI) rights and responsibilities  
7 of enrollees.

8 “(ii) In addition, for each managed  
9 care plan, information on—

10 “(I) restrictions on payment for  
11 services provided outside the plan’s  
12 provider network,

13 “(II) the process by which serv-  
14 ices may be obtained through the  
15 plan’s provider network,

16 “(III) coverage for out-of-area  
17 services, and

18 “(IV) any exclusions in the types  
19 of providers participating in the plan’s  
20 provider network.

21 “(5) RESTRICTIONS ON PROVIDER INCENTIVE  
22 PLANS.—

23 “(A) IN GENERAL.—Each contract with an  
24 eligible organization under this section shall  
25 provide that the organization may not operate

1 any provider incentive plan (as defined in sub-  
2 paragraph (B)) unless the following require-  
3 ments are met:

4 “(i) No specific payment is made di-  
5 rectly or indirectly under the plan to a pro-  
6 vider or provider group as an inducement  
7 to reduce or limit medically necessary serv-  
8 ices.

9 “(ii) If the plan places a provider or  
10 provider group at substantial financial risk  
11 (as determined by the Secretary) for serv-  
12 ices not provided by the provider or pro-  
13 vider group, the organization—

14 “(I) provides stop-loss protection  
15 for the provider or group that is ade-  
16 quate and appropriate, based on  
17 standards developed by the Secretary  
18 that take into account the number  
19 (and type) of providers placed at such  
20 substantial financial risk in the group  
21 or under the plan and the number of  
22 individuals enrolled with the organiza-  
23 tion who receive services from the pro-  
24 vider or the group, and

1                   “(II) conducts periodic surveys of  
2                   both individuals enrolled and individ-  
3                   uals previously enrolled with the orga-  
4                   nization to determine the degree of  
5                   access of such individuals to services  
6                   provided by the organization and sat-  
7                   isfaction with the quality of such serv-  
8                   ices.

9                   “(iii) The organization provides the  
10                  Secretary with descriptive information re-  
11                  garding the plan, sufficient to permit the  
12                  Secretary to determine whether the plan is  
13                  in compliance with the requirements of this  
14                  subparagraph.

15                  “(B) PROVIDER INCENTIVE PLAN DE-  
16                  FINED.—In this paragraph, the term ‘provider  
17                  incentive plan’ means any compensation ar-  
18                  rangement between an eligible organization and  
19                  a provider or provider group that may directly  
20                  or indirectly have the effect of reducing or lim-  
21                  iting medically necessary services provided with  
22                  respect to individuals enrolled with the organi-  
23                  zation.

24                  “(6) PROHIBITION OF INTERFERENCE WITH  
25                  CERTAIN MEDICAL COMMUNICATIONS.—

1 “(A) IN GENERAL.—

2 “(i) PROHIBITION OF CERTAIN PROVI-  
3 SIONS.—Subject to subparagraph (C), an  
4 eligible organization may not include with  
5 respect to its plan under this section any  
6 provision that prohibits or restricts any  
7 medical communication (as defined in sub-  
8 paragraph (B)) as part of—

9 “(I) a written contract or agree-  
10 ment with a health care provider,

11 “(II) a written statement to such  
12 a provider, or

13 “(III) an oral communication to  
14 such a provider.

15 “(ii) NULLIFICATION.—Any provision  
16 described in clause (i) is null and void.

17 “(B) MEDICAL COMMUNICATION DE-  
18 FINED.—In this paragraph, the term ‘medical  
19 communication’ means a communication made  
20 by a health care provider with a patient of the  
21 provider (or the guardian or legal representative  
22 of such patient) with respect to any of the fol-  
23 lowing:

24 “(i) How participating physicians and  
25 providers are paid.

1 “(ii) Utilization review procedures.

2 “(iii) The basis for specific utilization  
3 review decisions.

4 “(iv) Whether a specific prescription  
5 drug or biological is included in the for-  
6 mulary.

7 “(v) How the eligible organization de-  
8 cides whether a treatment or procedure is  
9 experimental.

10 “(vi) The patient’s physical or mental  
11 condition or treatment options.

12 “(C) CONSTRUCTION.—Nothing in this  
13 paragraph shall be construed as preventing an  
14 entity from—

15 “(i) acting on information relating to  
16 the provision of (or failure to provide)  
17 treatment to a patient, or

18 “(ii) restricting a medical communica-  
19 tion that recommends one health plan over  
20 another if the sole purpose of the commu-  
21 nication is to secure financial gain for the  
22 health care provider.

23 “(7) ADDITIONAL DEFINITIONS.—For purposes  
24 of this subsection:

1           “(A) HEALTH CARE PROVIDER.—The term  
2           ‘health care provider’ means anyone licensed  
3           under State law to provide health care services  
4           under part A or part B.

5           “(B) IN-NETWORK.—The term ‘in-network’  
6           means services provided by health care provid-  
7           ers who have entered into a contract or agree-  
8           ment with the organization under which such  
9           providers are obligated to provide items, treat-  
10          ment, and services under this section to individ-  
11          uals enrolled with the organization under this  
12          section.

13          “(C) NETWORK.—The term ‘network’  
14          means, with respect to an eligible organization,  
15          the health care providers who have entered into  
16          a contract or agreement with the organization  
17          under which such providers are obligated to  
18          provide items, treatment, and services under  
19          this section to individuals enrolled with the or-  
20          ganization under this section.

21          “(D) OUT-OF-NETWORK.—The term ‘out-  
22          of-network’ means services provided by health  
23          care providers who have not entered into a con-  
24          tract agreement with the organization under  
25          which such providers are obligated to provide

1 items, treatment, and services under this sec-  
2 tion to individuals enrolled with the organiza-  
3 tion under this section.

4 “(8) NON-PREEMPTION OF STATE LAW.—A  
5 State may establish or enforce requirements with re-  
6 spect to the subject matter of this subsection, but  
7 only if such requirements are more stringent than  
8 the requirements established under this subsection.”.

9 (b) CONFORMING AMENDMENTS.—Section 1876 of  
10 such Act is further amended—

11 (1) by striking subparagraph (E) of subsection  
12 (c)(3);

13 (2) by striking paragraphs (4) and (5) of sub-  
14 section (c); and

15 (3) by striking paragraph (8) of subsection (i).

16 (c) EFFECTIVE DATE.—The amendments made by  
17 this section shall apply to contracts entered into or re-  
18 newed under section 1876 of the Social Security Act after  
19 the expiration of the 1-year period which begins on the  
20 date of the enactment of this Act.

21 **SEC. 4. APPLICATION OF PROTECTIONS TO MEDICARE SE-**  
22 **LECT POLICIES.**

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

1           (1) by striking “and” at the end of subpara-  
2           graph (E);

3           (2) by striking the period at the end of sub-  
4           paragraph (F) and inserting a semicolon; and

5           (3) by adding at the end the following new sub-  
6           paragraph:

7                   “(G) notwithstanding any other provision  
8                   of this section to the contrary, if the issuer of  
9                   the policy meets the requirements of section  
10                  1876(k) with respect to individuals enrolled  
11                  under the policy in the same manner such re-  
12                  quirements apply with respect to an eligible or-  
13                  ganization under such section with respect to  
14                  individuals enrolled with the organization under  
15                  such section.”.

16          (b) **EFFECTIVE DATE.**—The amendments made by  
17          subsection (a) shall apply to policies issued or renewed on  
18          or after the expiration of the 1-year period which begins  
19          on the date of the enactment of this Act.

○