

105TH CONGRESS  
2D SESSION

# S. 1997

To protect the right of a member of a health maintenance organization to receive continuing care at a facility selected by that member.

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IN THE SENATE OF THE UNITED STATES

APRIL 28, 1998

Ms. MIKULSKI (for herself and Mr. FAIRCLOTH) introduced the following bill; which was read twice and referred to the Committee on Labor and Human Resources

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## A BILL

To protect the right of a member of a health maintenance organization to receive continuing care at a facility selected by that member.

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 “Seniors’ Access to Con-  
5 tinuing Care Act of 1998”.

6 **SEC. 2. AMENDMENTS TO THE EMPLOYEE RETIREMENT IN-**  
7 **COME SECURITY ACT OF 1974.**

8 (a) IN GENERAL.—Subpart B of part 7 of subtitle  
9 B of title I of the Employee Retirement Income Security

1 Act of 1974 (as added by section 603(a) of the Newborns’  
2 and Mothers’ Health Protection Act of 1996 and amended  
3 by section 702(a) of the Mental Health Parity Act of  
4 1996) is amended by adding at the end the following new  
5 section:

6 **“SEC. 713. ENSURING CHOICE FOR CONTINUING CARE.**

7       “(a) IN GENERAL.—With respect to health insurance  
8 coverage provided to participants or beneficiaries through  
9 a managed care organization under a group health plan,  
10 or through a health insurance issuer providing health in-  
11 surance coverage in connection with a group health plan,  
12 such plan or issuer may not deny coverage for services  
13 provided to such participant or beneficiary by a continuing  
14 care retirement community, skilled nursing facility, or  
15 other qualified facility in which the participant or bene-  
16 ficiary resided prior to a hospitalization, regardless of  
17 whether such organization is under contract with such  
18 community or facility if the requirements described in sub-  
19 section (b) are met.

20       “(b) REQUIREMENTS.—The requirements of this sub-  
21 section are that—

22               “(1) the service involved is a service for which  
23 the managed care organization involved would be re-  
24 quired to provide or pay for under its contract with  
25 the participant or beneficiary if the continuing care

1 retirement community, skilled nursing facility, or  
2 other qualified facility were under contract with the  
3 organization;

4 “(2) the participant or beneficiary involved—

5 “(A) resided in the continuing care retire-  
6 ment community, skilled nursing facility, or  
7 other qualified facility prior to being hospital-  
8 ized;

9 “(B) had a contractual or other right to  
10 return to the facility after hospitalization; and

11 “(C) elects to return to the facility after  
12 hospitalization, whether or not the residence of  
13 the participant or beneficiary after returning  
14 from the hospital is the same part of the facility  
15 in which the beneficiary resided prior to hos-  
16 pitalization;

17 “(3) the continuing care retirement community,  
18 skilled nursing facility, or other qualified facility has  
19 the capacity to provide the services the participant  
20 or beneficiary needs;

21 “(4) the continuing care retirement community,  
22 skilled nursing facility, or other qualified facility is  
23 willing to accept substantially similar payment under  
24 the same terms and conditions that apply to simi-

1 larly situated health care facility providers under  
2 contract with the organization involved.

3 “(c) SERVICES TO PREVENT HOSPITALIZATION.—A  
4 group health plan or health insurance issuer to which this  
5 section applies may not deny payment for a skilled nursing  
6 service provided to a participant or beneficiary by a con-  
7 tinuing care retirement community, skilled nursing facil-  
8 ity, or other qualified facility in which the participant or  
9 beneficiary resides, without a preceding hospital stay, re-  
10 gardless of whether the organization is under contract  
11 with such community or facility, if—

12 “(1) the plan or issuer has determined that the  
13 service is necessary to prevent the hospitalization of  
14 the participant or beneficiary; and

15 “(2) the service to prevent hospitalization is  
16 provided as an additional benefit as described in sec-  
17 tion 417.594 of title 42, Code of Federal Regula-  
18 tions.

19 “(d) RIGHTS OF SPOUSES.—A group health plan or  
20 health insurance issuer to which this section applies shall  
21 not deny payment for services provided by a skilled nurs-  
22 ing facility for the care of a participant or beneficiary, re-  
23 gardless of whether the plan or issuer is under contract  
24 with such facility, if the spouse of the participant or bene-

1 ficiary is already a resident of such facility and the re-  
2 quirements described in subsection (b) are met.

3 “(e) EXCEPTIONS.—Subsection (a) shall not apply—

4 “(1) where the attending acute care physician  
5 and the participant or beneficiary (or a designated  
6 representative of the participant or beneficiary where  
7 the participant or beneficiary is physically or men-  
8 tally incapable of making an election under this  
9 paragraph) do not elect to pursue a course of treat-  
10 ment necessitating continuing care; or

11 “(2) unless the community or facility involved—

12 “(A) meets all applicable licensing and cer-  
13 tification requirements of the State in which it  
14 is located; and

15 “(B) agrees to reimbursement for the care  
16 of the participant or beneficiary at a rate simi-  
17 lar to the rate negotiated by the managed care  
18 organization with similar providers of care for  
19 similar services.

20 “(f) PROHIBITIONS.—A group health plan and a  
21 health insurance issuer providing health insurance cov-  
22 erage in connection with a group health plan may not—

23 “(1) deny to an individual eligibility, or contin-  
24 ued eligibility, to enroll or to renew coverage with a  
25 managed care organization under the plan, solely for

1 the purpose of avoiding the requirements of this sec-  
2 tion;

3 “(2) provide monetary payments or rebates to  
4 enrollees to encourage such enrollees to accept less  
5 than the minimum protections available under this  
6 section;

7 “(3) penalize or otherwise reduce or limit the  
8 reimbursement of an attending physician because  
9 such physician provided care to a participant or ben-  
10 eficiary in accordance with this section; or

11 “(4) provide incentives (monetary or otherwise)  
12 to an attending physician to induce such physician  
13 to provide care to a participant or beneficiary in a  
14 manner inconsistent with this section.

15 “(g) RULES OF CONSTRUCTION.—

16 “(1) HMO NOT OFFERING BENEFITS.—This  
17 section shall not apply with respect to any managed  
18 care organization under a group health plan, or  
19 through a health insurance issuer providing health  
20 insurance coverage in connection with a group health  
21 plan, that does not provide benefits for stays in a  
22 continuing care retirement community, skilled nurs-  
23 ing facility, or other qualified facility.

24 “(2) COST-SHARING.—Nothing in this section  
25 shall be construed as preventing a managed care or-

1 organization under a group health plan, or through a  
2 health insurance issuer providing health insurance  
3 coverage in connection with a group health plan,  
4 from imposing deductibles, coinsurance, or other  
5 cost-sharing in relation to benefits for care in a con-  
6 tinuing care facility.

7 “(h) PREEMPTION; EXCEPTION FOR HEALTH INSUR-  
8 ANCE COVERAGE IN CERTAIN STATES.—

9 “(1) IN GENERAL.—The requirements of this  
10 section shall not apply with respect to health insur-  
11 ance coverage if there is a State law (as defined in  
12 section 2723(d)(1)) for a State that regulates such  
13 coverage that is described in any of the following  
14 subparagraphs:

15 “(A) Such State law requires such cov-  
16 erage to provide for referral to a continuing  
17 care retirement community, skilled nursing fa-  
18 cility, or other qualified facility consistent with  
19 this section.

20 “(B) Such State law requires, in connec-  
21 tion with such coverage for continuing care,  
22 that the necessity for such care is left to the de-  
23 cision of (or required to be made by) the at-  
24 tending provider in consultation with the en-  
25 rollee.

1           “(C) Such State law expands the range of  
2           services or facilities covered under this section.

3           “(2) CONSTRUCTION.—Section 731(a)(1) shall  
4           not be construed as superseding a State law de-  
5           scribed in paragraph (1).

6           “(i) PENALTIES.—A participant or beneficiary may  
7           enforce the provisions of this section in an appropriate  
8           Federal district court. An action for injunctive relief or  
9           damages may be commenced on behalf of the participant  
10          or beneficiary by the participant’s or beneficiary’s legal  
11          representative. The court may award reasonable attorneys’  
12          fees to the prevailing party. If a beneficiary dies before  
13          conclusion of an action under this section, the action may  
14          be maintained by a representative of the participant’s or  
15          beneficiary’s estate.

16          “(j) DEFINITIONS.—In this section:

17               “(1) ATTENDING ACUTE CARE PROVIDER.—The  
18               term ‘attending acute care provider’ means anyone  
19               licensed or certified under State law to provide  
20               health care services who is operating within the  
21               scope of such license and who is primarily respon-  
22               sible for the care of the enrollee.

23               “(2) CONTINUING CARE RETIREMENT COMMU-  
24               NITY.—The term ‘continuing care retirement com-  
25               munity’ means an organization that provides or ar-

1 ranges for the provision of housing and health-relat-  
2 ed services to an older person under an agreement  
3 effective for the life of the person or for a specified  
4 period greater than 1 year.

5 “(3) MANAGED CARE ORGANIZATION.—The  
6 term ‘managed care organization’ means an organi-  
7 zation that provides comprehensive health services to  
8 participants or beneficiaries, directly or under con-  
9 tract or other agreement, on a prepayment basis to  
10 such individuals. For purposes of this section, the  
11 following shall be considered as managed care orga-  
12 nizations:

13 “(A) A Medicare+Choice plan authorized  
14 under section 1851(a) of the Social Security  
15 Act.

16 “(B) Any other entity that manages the  
17 cost, utilization, and delivery of health care  
18 through the use of predetermined periodic pay-  
19 ments to health care providers employed by or  
20 under contract or other agreement, directly or  
21 indirectly, with the entity.

22 “(4) OTHER QUALIFIED FACILITY.—The term  
23 ‘other qualified facility’ means any facility that can  
24 provide the services required by the participant or  
25 beneficiary consistent with State and Federal law.



1 insurance issuer providing health insurance coverage in  
2 connection with a group health plan, such plan or issuer  
3 may not deny coverage for services provided to such en-  
4 rollee by a continuing care retirement community, skilled  
5 nursing facility, or other qualified facility in which the en-  
6 rollee resided prior to a hospitalization, regardless of  
7 whether such organization is under contract with such  
8 community or facility if the requirements described in sub-  
9 section (b) are met.

10 “(b) REQUIREMENTS.—The requirements of this sub-  
11 section are that—

12 “(1) the service involved is a service for which  
13 the managed care organization involved would be re-  
14 quired to provide or pay for under its contract with  
15 the enrollee if the continuing care retirement com-  
16 munity, skilled nursing facility, or other qualified fa-  
17 cility were under contract with the organization;

18 “(2) the enrollee involved—

19 “(A) resided in the continuing care retire-  
20 ment community, skilled nursing facility, or  
21 other qualified facility prior to being hospital-  
22 ized;

23 “(B) had a contractual or other right to  
24 return to the facility after hospitalization; and

1           “(C) elects to return to the facility after  
2           hospitalization, whether or not the residence of  
3           the enrollee after returning from the hospital is  
4           the same part of the facility in which the bene-  
5           ficiary resided prior to hospitalization;

6           “(3) the continuing care retirement community,  
7           skilled nursing facility, or other qualified facility has  
8           the capacity to provide the services the enrollee  
9           needs;

10          “(4) the continuing care retirement community,  
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12          willing to accept substantially similar payment under  
13          the same terms and conditions that apply to simi-  
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15          contract with the organization involved.

16          “(c) SERVICES TO PREVENT HOSPITALIZATION.—A  
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21          fied facility in which the enrollee resides, without a preced-  
22          ing hospital stay, regardless of whether the plan or issuer  
23          is under contract with such community or facility, if—

1           “(1) the plan or issuer has determined that the  
2           service is necessary to prevent the hospitalization of  
3           the enrollee; and

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12          er the plan or issuer is under contract with such facility,  
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15          are met.

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17                 “(1) where the attending acute care physician  
18                 and the enrollee (or a designated representative of  
19                 the enrollee where the enrollee is physically or men-  
20                 tally incapable of making an election under this  
21                 paragraph) do not elect to pursue a course of treat-  
22                 ment necessitating continuing care; or

23                 “(2) unless the community or facility involved—

1           “(A) meets all applicable licensing and cer-  
2           tification requirements of the State in which it  
3           is located; and

4           “(B) agrees to reimbursement for the care  
5           of the enrollee at a rate similar to the rate ne-  
6           gotiated by the managed care organization with  
7           similar providers of care for similar services.

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13          managed care organization under the plan, solely for  
14          the purpose of avoiding the requirements of this sec-  
15          tion;

16           “(2) provide monetary payments or rebates to  
17          enrollees to encourage such enrollees to accept less  
18          than the minimum protections available under this  
19          section;

20           “(3) penalize or otherwise reduce or limit the  
21          reimbursement of an attending physician because  
22          such physician provided care to a enrollee in accord-  
23          ance with this section; or

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6 cility, or other qualified facility consistent with  
7 this section.

8 “(B) Such State law requires, in connec-  
9 tion with such coverage for continuing care,  
10 that the necessity for such care is left to the de-  
11 cision of (or required to be made by) the at-  
12 tending provider in consultation with the en-  
13 rollee.

14 “(C) Such State law expands the range of  
15 services or facilities covered under this section.

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17 not be construed as superseding a State law de-  
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19 “(i) PENALTIES.—An enrollee may enforce the provi-  
20 sions of this section in an appropriate Federal district  
21 court. An action for injunctive relief or damages may be  
22 commenced on behalf of the enrollee by the enrollee’s legal  
23 representative. The court may award reasonable attorneys’  
24 fees to the prevailing party. If a beneficiary dies before

1 conclusion of an action under this section, the action may  
2 be maintained by a representative of the enrollee's estate.

3 “(j) DEFINITIONS.—In this section:

4 “(1) ATTENDING ACUTE CARE PROVIDER.—The  
5 term ‘attending acute care provider’ means anyone  
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7 health care services who is operating within the  
8 scope of such license and who is primarily respon-  
9 sible for the care of the enrollee.

10 “(2) CONTINUING CARE RETIREMENT COMMU-  
11 NITY.—The term ‘continuing care retirement com-  
12 munity’ means an organization that provides or ar-  
13 ranges for the provision of housing and health-relat-  
14 ed services to an older person under an agreement  
15 effective for the life of the person or for a specified  
16 period greater than 1 year.

17 “(3) MANAGED CARE ORGANIZATION.—The  
18 term ‘managed care organization’ means an organi-  
19 zation that provides comprehensive health services to  
20 enrollees, directly or under contract or other agree-  
21 ment, on a prepayment basis to such individuals.  
22 For purposes of this section, the following shall be  
23 considered as managed care organizations:



1 tion Act of 1996) is amended by adding at the end the  
2 following new section:

3 **“SEC. 2752. ENSURING CHOICE FOR CONTINUING CARE.**

4       “The provisions of section 2706 shall apply to health  
5 maintenance organization coverage offered by a health in-  
6 surance issuer in the individual market in the same man-  
7 ner as they apply to such coverage offered by a health  
8 insurance issuer in connection with a group health plan  
9 in the small or large group market.”.

10       (b) EFFECTIVE DATE.—The amendment made by  
11 this section shall apply with respect to health insurance  
12 coverage offered, sold, issued, renewed, in effect, or oper-  
13 ated in the individual market on or after January 1, 1998.

○