

105TH CONGRESS  
1ST SESSION

# S. 701

To amend title XVIII of the Social Security Act to provide protections for medicare beneficiaries who enroll in medicare managed care plans, and for other purposes.

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## IN THE SENATE OF THE UNITED STATES

MAY 6, 1997

Mr. GRASSLEY (for himself, Mr. CONRAD, Mr. HELMS, Mr. D'AMATO, and Mr. DURBIN) 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 provide protections for medicare beneficiaries who enroll in medicare managed care plans, 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 Patient  
5 Choice and Access Act of 1997”.

6 **SEC. 2. FINDINGS.**

7 Congress makes the following findings:

8 (1) There should be no unreasonable barriers or  
9 impediments to the ability of individuals enrolled in

1 health care plans to obtain appropriate specialized  
2 medical services.

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

7 (3) Some health care plans may impede timely  
8 access to specialty care.

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

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

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

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

6           (8) Specialty care must be available for the full  
7           duration of the patient’s medical needs when medi-  
8           cally necessary and not limited by time or number  
9           of visits.

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

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

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

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

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

20          “(k) BENEFICIARY PROTECTION.—

21               “(1) ASSURING ADEQUATE IN-NETWORK AC-  
22               CESS.—

23                       “(A) TIMELY ACCESS.—An eligible organi-  
24                       zation that restricts the providers from whom  
25                       benefits may be obtained must guarantee to en-

1 enrollees under this section timely access to pri-  
2 mary and specialty health care providers who  
3 are appropriate for the enrollee's condition.

4 “(B) ACCESS TO SPECIALIZED CARE.—En-  
5 rollees must have access to specialized treat-  
6 ment when medically necessary. This access  
7 may be satisfied through contractual arrange-  
8 ments with specialized health care providers  
9 outside of the network.

10 “(C) CONTINUITY OF CARE.—An eligible  
11 organization's use of case management may not  
12 create an undue burden for enrollees under this  
13 section. An eligible organization must ensure di-  
14 rect access to specialists for ongoing care as so  
15 determined by the case manager in consultation  
16 with the specialty health care provider. This  
17 continuity of care may be satisfied for enrollees  
18 with chronic conditions through the use of a  
19 specialist serving as case manager.

20 “(2) OUT-OF-NETWORK ACCESS.—If an eligible  
21 organization offers to members enrolled under this  
22 section a plan which provides for coverage of items  
23 and services covered under parts A and B only if  
24 such items and services are furnished through health  
25 care providers and other persons who are members

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

11 “(3) GRIEVANCE PROCESS.—

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

25 “(B) NOTICE REQUIREMENTS.—

1           “(i) IN GENERAL.—The eligible orga-  
2 nization must provide, in a timely manner,  
3 to an enrollee a notice of any denial of  
4 services in-network or denial of payment  
5 for out-of-network care.

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

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

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

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

16                   “(IV) A description of how to ob-  
17 tain supporting evidence for the hear-  
18 ing described in subparagraph (C), in-  
19 cluding the patient’s medical records  
20 from the organization, as well as sup-  
21 porting affidavits from the attending  
22 health care providers.

23           “(C) HEARING BOARD.—

24           “(i) IN GENERAL.—Each eligible or-  
25 ganization shall establish a board of ap-

1 peals to hear and make determinations on  
 2 complaints by enrollees concerning denials  
 3 of coverage or payment for services  
 4 (whether in-network or out-of-network)  
 5 and the medical necessity and appropriate-  
 6 ness of covered items and services.

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

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

14 “(II) consumers who are not en-  
 15 rolled with an eligible organization  
 16 under this section; and

17 “(III) health care providers who  
 18 are not under contract with the eligi-  
 19 ble organization and who are experts  
 20 in the field of medicine which neces-  
 21 sitates treatment.

22 Members of the board of appeals described  
 23 in subclauses (II) and (III) shall have no  
 24 interest in the eligible organization.

25 “(iii) DEADLINE FOR DECISION.—

1           “(I) IN GENERAL.—Except as  
2           provided in subclause (II), a board of  
3           appeals shall hear and resolve com-  
4           plaints within 30 days after the date  
5           the complaint is filed with the board.

6           “(II) EXPEDITED PROCEDURE.—  
7           A board of appeals shall have an expe-  
8           dited procedure in order to hear and  
9           resolve complaints regarding urgent  
10          care (as determined by the Secretary  
11          in regulations).

12          “(D) OTHER REMEDIES.—Nothing in this  
13          paragraph may be construed to replace or su-  
14          persede any appeals mechanism otherwise pro-  
15          vided for an individual entitled to benefits  
16          under this title.

17          “(4) NOTICE OF ENROLLEE RIGHTS AND COM-  
18          PARATIVE REPORT.—

19                 “(A) IN GENERAL.—Each eligible organi-  
20                 zation shall provide in any marketing materials  
21                 distributed to individuals eligible to enroll under  
22                 this section and to each enrollee at the time of  
23                 enrollment and not less frequently than annu-  
24                 ally thereafter, an explanation of the individ-  
25                 ual’s rights under this section and a copy of the

1 most recent comparative report (as established  
2 by the Secretary under subparagraph (C)) for  
3 that organization.

4 “(B) RIGHTS DESCRIBED.—The expla-  
5 nation of rights under subparagraph (A) shall  
6 be in a standardized format (as established by  
7 the Secretary in regulations) and shall include  
8 an explanation of—

9 “(i) the enrollee’s rights to benefits  
10 from the organization;

11 “(ii) the restrictions (if any) on pay-  
12 ments under this title for services fur-  
13 nished other than by or through the orga-  
14 nization;

15 “(iii) out-of-area coverage provided by  
16 the organization;

17 “(iv) the organization’s coverage of  
18 emergency services and urgently needed  
19 care;

20 “(v) the organization’s coverage of  
21 out-of-network services, including services  
22 that are additional to the items and serv-  
23 ices covered under parts A and B;

24 “(vi) appeal rights of and grievance  
25 procedures available to enrollees; and

1           “(vii) any other rights that the Sec-  
2           retary determines would be helpful to bene-  
3           ficiaries in understanding their rights  
4           under the plan.

5           “(C) COMPARATIVE REPORT.—

6           “(i) IN GENERAL.—The Secretary  
7           shall develop an understandable standard-  
8           ized comparative report on the plans of-  
9           fered by eligible organizations, that will as-  
10          sist beneficiaries under this title in their  
11          decisionmaking regarding medical care and  
12          treatment by allowing the beneficiaries to  
13          compare the organizations that the bene-  
14          ficiaries are eligible to enroll with. In de-  
15          veloping such report the Secretary shall  
16          consult with outside organizations, includ-  
17          ing groups representing the elderly and  
18          health insurers, in order to assist the Sec-  
19          retary in developing the report.

20          “(ii) CONTENTS OF REPORT.—The re-  
21          port described in clause (i) shall include a  
22          comparison for each plan of—

23                   “(I) the premium for the plan;

24                   “(II) the benefits offered by the  
25                   plan, including any benefits that are

1 additional to the benefits offered  
2 under parts A and B;

3 “(III) the amount of any  
4 deductibles, coinsurance, or any mone-  
5 tary limits on benefits;

6 “(IV) the identity, location,  
7 qualifications, and availability of  
8 health care providers in any health  
9 care provider networks of the plan;

10 “(V) the number of individuals  
11 who disenrolled from the plan within  
12 3 months of enrollment and during  
13 the previous fiscal year, stated as per-  
14 centages of the total number of indi-  
15 viduals in the plan;

16 “(VI) the procedures used by the  
17 plan to control utilization of services  
18 and expenditures, including any finan-  
19 cial incentives;

20 “(VII) the procedures used by  
21 the plan to ensure quality of care;

22 “(VIII) the rights and respon-  
23 sibilities of enrollees;

24 “(IX) the number of applications  
25 during the previous fiscal year re-

1           questing that the plan cover certain  
2           medical services that were denied by  
3           the plan (and the number of such de-  
4           nials that were subsequently reversed  
5           by the plan), stated as a percentage  
6           of the total number of applications  
7           during such period requesting that the  
8           plan cover such services;

9                   “(X) the number of times during  
10           the previous fiscal year (after an ap-  
11           peal was filed with the Secretary) that  
12           the Secretary upheld or reversed a de-  
13           nial of a request that the plan cover  
14           certain medical services;

15                   “(XI) the restrictions (if any) on  
16           payment for services provided outside  
17           the plan’s health care provider net-  
18           work;

19                   “(XII) the process by which serv-  
20           ices may be obtained through the  
21           plan’s health care provider network;

22                   “(XIII) coverage for out-of-area  
23           services;

24                   “(XIV) any exclusions in the  
25           types of health care providers partici-

1                   pating in the plan’s health care pro-  
2                   vider network; and

3                   “(XV) any additional information  
4                   that the Secretary determines would  
5                   be helpful for beneficiaries to compare  
6                   the organizations that the bene-  
7                   ficiaries are eligible to enroll with.

8                   “(iii) ONGOING DEVELOPMENT OF RE-  
9                   PORT.—The Secretary shall, not less than  
10                  annually, update each comparative report.

11                  “(D) COMPLIANCE.—Each eligible organi-  
12                  zation shall disclose to the Secretary, as re-  
13                  quested by the Secretary, the information nec-  
14                  essary to complete the comparative report.

15                  “(5) RESTRICTIONS ON HEALTH CARE PRO-  
16                  VIDER INCENTIVE PLANS.—

17                  “(A) IN GENERAL.—Each contract with an  
18                  eligible organization under this section shall  
19                  provide that the organization may not operate  
20                  any health care provider incentive plan (as de-  
21                  fined in subparagraph (B)) unless the following  
22                  requirements are met:

23                  “(i) No specific payment is made di-  
24                  rectly or indirectly under the plan to a  
25                  health care provider or health care pro-

1 vider group as an inducement to reduce or  
2 limit medically necessary services.

3 “(ii) If the plan places a health care  
4 provider or health care provider group at  
5 substantial financial risk (as determined by  
6 the Secretary) for services not provided by  
7 the health care provider or health care pro-  
8 vider group, the organization—

9 “(I) provides stop-loss protection  
10 for the health care provider or health  
11 care provider group that is adequate  
12 and appropriate, based on standards  
13 developed by the Secretary that take  
14 into account the number (and type) of  
15 health care providers placed at such  
16 substantial financial risk in the group  
17 or under the plan and the number of  
18 individuals enrolled with the organiza-  
19 tion that receive services from the  
20 health care provider or the health care  
21 provider group; and

22 “(II) conducts periodic surveys of  
23 both individuals enrolled and individ-  
24 uals previously enrolled with the orga-  
25 nization to determine the degree of

1 access of such individuals to services  
2 provided by the organization and sat-  
3 isfaction with the quality of such serv-  
4 ices.

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

11 “(B) HEALTH CARE PROVIDER INCENTIVE  
12 PLAN DEFINED.—In this paragraph, the term  
13 ‘health care provider incentive plan’ means any  
14 compensation arrangement between an eligible  
15 organization and a health care provider or  
16 health care provider group that may directly or  
17 indirectly have the effect of reducing or limiting  
18 medically necessary services provided with re-  
19 spect to individuals enrolled with the organiza-  
20 tion.

21 “(6) PROHIBITION OF INTERFERENCE WITH  
22 CERTAIN MEDICAL COMMUNICATIONS.—

23 “(A) IN GENERAL.—

24 “(i) PROHIBITION OF CERTAIN PROVI-  
25 SIONS.—Subject to subparagraph (C), an

1 eligible organization may not include with  
2 respect to its plan under this section any  
3 provision that prohibits or restricts any  
4 medical communication (as defined in sub-  
5 paragraph (B)) as part of—

6 “(I) a written contract or agree-  
7 ment with a health care provider;

8 “(II) a written statement to such  
9 a provider; or

10 “(III) an oral communication to  
11 such a provider.

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

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

21 “(i) How participating physicians and  
22 health care providers are paid.

23 “(ii) Utilization review procedures.

24 “(iii) The basis for specific utilization  
25 review decisions.

1           “(iv) Whether a specific prescription  
2           drug or biological is included in the for-  
3           mulary.

4           “(v) How the eligible organization de-  
5           cides whether a treatment or procedure is  
6           experimental.

7           “(vi) The patient’s physical or mental  
8           condition or treatment options.

9           “(C) CONSTRUCTION.—Nothing in this  
10          paragraph shall be construed as preventing an  
11          entity from—

12           “(i) acting on information relating to  
13           the provision of (or failure to provide)  
14           treatment to a patient; or

15           “(ii) restricting a medical communica-  
16           tion that recommends 1 health plan over  
17           another if the sole purpose of the commu-  
18           nication is to secure financial gain for the  
19           health care provider.

20          “(7) ADDITIONAL DEFINITIONS.—In this sub-  
21          section:

22           “(A) HEALTH CARE PROVIDER.—The term  
23           ‘health care provider’ means anyone licensed  
24           under State law to provide health care services  
25           under part A or B.

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

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

17           “(D) OUT-OF-NETWORK.—The term ‘out-  
18 of-network’ means services provided by health  
19 care providers who have not entered into a con-  
20 tract agreement with the organization under  
21 which such providers are obligated to provide  
22 items, treatment, and services under this sec-  
23 tion to individuals enrolled with the organiza-  
24 tion under this section.

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

6           (b) CONFORMING AMENDMENTS.—Section 1876 of  
7 such Act is amended—

8           (1) in subsection (a)(1)(E)(ii)(II), by striking  
9 “subsection (c)(3)(E)” and inserting “subsection  
10 (k)(4)”;

11           (2) in subsection (c)—

12           (A) in paragraph (3)—

13           (i) by striking subparagraph (E); and

14           (ii) in subparagraph (G)(ii)(II), by  
15 striking “subparagraph (E)” and inserting  
16 “subsection (k)(4)”;

17           (B) by striking paragraph (4); and

18           (C) by striking “(5)(A) The organization”  
19 and all that follows through “(B) A member”  
20 and inserting “(5) A member”; and

21           (3) in subsection (i)—

22           (A) in paragraph (6)(A)(vi), by striking  
23 “paragraph (8)” and inserting “subsection  
24 (k)(5)”;

25           (B) by striking paragraph (8).

1           (c) EFFECTIVE DATE.—The amendments made by  
 2 this section shall apply to contracts entered into or re-  
 3 newed under section 1876 of the Social Security Act (42  
 4 U.S.C. 1395mm) after the expiration of the 1-year period  
 5 that begins on the date of enactment of this Act.

6   **SEC. 4. APPLICATION OF PROTECTIONS TO MEDICARE SE-**  
 7                                   **LECT POLICIES.**

8           (a) IN GENERAL.—Section 1882(t) of the Social Se-  
 9 curity Act (42 U.S.C. 1395ss(t)) is amended—

10                   (1) in paragraph (1)—

11                                   (A) by striking “and” at the end of sub-  
 12 paragraph (E);

13                                   (B) by striking the period at the end of  
 14 subparagraph (F) and inserting a semicolon;  
 15 and

16                                   (C) by adding at the end the following:

17                                   “(G) notwithstanding any other provision  
 18 of this section to the contrary, the issuer of the  
 19 policy meets the requirements of section  
 20 1876(k) (except for subparagraphs (C) and (D)  
 21 of paragraph (4) of that section) with respect  
 22 to individuals enrolled under the policy, in the  
 23 same manner such requirements apply with re-  
 24 spect to an eligible organization under such sec-

1           tion with respect to individuals enrolled with  
2           the organization under such section; and

3           “(H) the issuer of the policy discloses to  
4           the Secretary, as requested by the Secretary,  
5           the information necessary to complete the re-  
6           port described in paragraph (4).”; and

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

8           “(4) The Secretary shall develop an understandable  
9           standardized comparative report on the policies offered by  
10          entities pursuant to this subsection. Such report shall con-  
11          tain information similar to the information contained in  
12          the report developed by the Secretary pursuant to section  
13          1876(k)(4)(C).”.

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

18          **SEC. 5. STUDY AND RECOMMENDATIONS TO CONGRESS.**

19          (a) **STUDY.**—The Secretary of Health and Human  
20          Services (in this Act referred to as the “Secretary”) shall  
21          conduct a thorough study regarding the implementation  
22          of the amendments made by sections 3 and 4 of this Act.

23          (b) **REPORT.**—Not later than 2 years after the date  
24          of enactment of this Act and annually thereafter, the Sec-  
25          retary shall submit a report to Congress that shall contain

1 a detailed statement of the findings and conclusions of the  
2 Secretary regarding the study conducted pursuant to sub-  
3 section (a), together with the Secretary's recommenda-  
4 tions for such legislation and administrative actions as the  
5 Secretary considers appropriate.

6 (c) FUNDING.—The Secretary shall carry out the  
7 provisions of this section out of funds otherwise appro-  
8 priated to the Secretary.

9 **SEC. 6. NATIONAL INFORMATION CLEARINGHOUSE.**

10 Not later than 18 months after the date of enactment  
11 of this Act, the Secretary shall establish and operate, out  
12 of funds otherwise appropriated to the Secretary, a clear-  
13 inghouse and (if the Secretary determines it to be appro-  
14 priate) a 24-hour toll-free telephone hotline, to provide for  
15 the dissemination of the comparative reports created pur-  
16 suant to section 1876(k)(4)(C) of the Social Security Act  
17 (42 U.S.C. 1395mm(k)(4)(C)) (as added by section 3 of  
18 this Act) and section 1882(t)(4) of the Social Security Act  
19 (42 U.S.C. 1395ss(t)(4)) (as added by section 4 of this  
20 Act). In order to assist in the dissemination of the com-  
21 parative reports, the Secretary may also utilize medicare  
22 offices open to the general public, the beneficiary assist-  
23 ance program established under section 4359 of the Omni-  
24 bus Budget Reconciliation Act of 1990 (42 U.S.C. 1395b-  
25 3), and the health insurance information counseling and

1 assistance grants under section 4359 of that Act (42  
2 U.S.C. 1395b-4).

○