

106TH CONGRESS
1ST SESSION

S. 1142

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

IN THE SENATE OF THE UNITED STATES

MAY 27, 1999

Ms. MIKULSKI (for herself, Mr. DODD, Mr. HOLLINGS, Mr. JEFFORDS, Mr. KENNEDY, Mrs. MURRAY, and Mr. WELLSTONE) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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, 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 “Seniors’ Access to Con-
5 tinuing Care Act of 1999”.

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

3 (a) IN GENERAL.—Subpart B of part 7 of subtitle
4 B of title I of the Employee Retirement Income Security
5 Act of 1974 (29 U.S.C. 1185 et seq.) is amended by add-
6 ing at the end the following new section:

7 **“SEC. 714. ENSURING CHOICE FOR CONTINUING CARE.**

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

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

23 “(1) the service involved is a service for which
24 the managed care organization involved would be re-
25 quired to provide or pay for under its contract with
26 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, and would otherwise be covered as provided
 19 for in subsection (b)(1).

20 “(d) RIGHTS OF SPOUSES.—A group health plan or
 21 health insurance issuer to which this section applies shall
 22 not deny payment for services provided by a skilled nurs-
 23 ing facility for the care of a participant or beneficiary, re-
 24 gardless of whether the plan or issuer is under contract
 25 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 provider
 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 to the extent that a State law (as de-
 12 fined in section 2723(d)(1) of the Public Health
 13 Service Act) applies to such coverage and is de-
 14 scribed in any of the following 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 in a manner
 19 that is more protective of participants or bene-
 20 ficiaries than the provisions of this section.

21 “(B) Such State law expands the range of
 22 services or facilities covered under this section
 23 and is otherwise more protective of the rights of
 24 participants or beneficiaries than the provisions
 25 of this section.

1 “(2) CONSTRUCTION.—Section 731(a)(1) shall
2 not be construed to provide that any requirement of
3 this section applies with respect to health insurance
4 coverage, to the extent that a State law described in
5 paragraph (1) applies to such coverage.

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-re-
2 lated 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 (42 U.S.C. 1395w–21(a)).

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 rollee by a continuing care retirement community, skilled
2 nursing facility, or other qualified facility in which the en-
3 rollee resided prior to a hospitalization, regardless of
4 whether such organization is under contract with such
5 community or facility if the requirements described in sub-
6 section (b) are met.

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

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

15 “(2) the enrollee involved—

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

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

22 “(C) elects to return to the facility after
23 hospitalization, whether or not the residence of
24 the enrollee after returning from the hospital is

1 the same part of the facility in which the bene-
2 ficiary resided prior to hospitalization;

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

7 “(4) the continuing care retirement community,
8 skilled nursing facility, or other qualified facility is
9 willing to accept substantially similar payment under
10 the same terms and conditions that apply to simi-
11 larly situated health care facility providers under
12 contract with the organization involved.

13 “(c) SERVICES TO PREVENT HOSPITALIZATION.—A
14 group health plan or health insurance issuer to which this
15 section applies may not deny payment for a skilled nursing
16 service provided to a enrollee by a continuing care retire-
17 ment community, skilled nursing facility, or other quali-
18 fied facility in which the enrollee resides, without a pre-
19 ceding hospital stay, regardless of whether the plan or
20 issuer is under contract with such community or facility,
21 if—

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

1 “(2) the service to prevent hospitalization is
2 provided as an additional benefit as described in sec-
3 tion 417.594 of title 42, Code of Federal Regula-
4 tions, and would be covered as provided for in sub-
5 section (b)(1).

6 “(d) RIGHTS OF SPOUSES.—A group health plan or
7 health insurance issuer to which this section applies shall
8 not deny payment for services provided by a skilled nurs-
9 ing facility for the care of an enrollee, regardless of wheth-
10 er the plan or issuer is under contract with such facility,
11 if the spouse of the enrollee is already a resident of such
12 facility and the requirements described in subsection (b)
13 are met.

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

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

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

22 “(A) meets all applicable licensing and cer-
23 tification requirements of the State in which it
24 is located; and

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

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

8 “(1) deny to an individual eligibility, or contin-
9 ued eligibility, to enroll or to renew coverage with a
10 managed care organization under the plan, solely for
11 the purpose of avoiding the requirements of this sec-
12 tion;

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

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

21 “(4) provide incentives (monetary or otherwise)
22 to an attending physician to induce such physician
23 to provide care to an enrollee in a manner incon-
24 sistent with this section.

25 “(g) RULES OF CONSTRUCTION.—

1 “(1) HMO NOT OFFERING BENEFITS.—This
2 section shall not apply with respect to any managed
3 care organization under a group health plan, or
4 through a health insurance issuer providing health
5 insurance coverage in connection with a group health
6 plan, that does not provide benefits for stays in a
7 continuing care retirement community, skilled nurs-
8 ing facility, or other qualified facility.

9 “(2) COST-SHARING.—Nothing in this section
10 shall be construed as preventing a managed care or-
11 ganization under a group health plan, or through a
12 health insurance issuer providing health insurance
13 coverage in connection with a group health plan,
14 from imposing deductibles, coinsurance, or other
15 cost-sharing in relation to benefits for care in a con-
16 tinuing care facility.

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

19 “(1) IN GENERAL.—The requirements of this
20 section shall not apply with respect to health insur-
21 ance coverage to the extent that a State law (as de-
22 fined in section 2723(d)(1)) applies to such coverage
23 and is described in any of the following subpara-
24 graphs:

1 “(A) Such State law requires such cov-
2 erage to provide for referral to a continuing
3 care retirement community, skilled nursing fa-
4 cility, or other qualified facility in a manner
5 that is more protective of the enrollee than the
6 provisions of this section.

7 “(B) Such State law expands the range of
8 services or facilities covered under this section
9 and is otherwise more protective of enrollee
10 rights than the provisions of this section.

11 “(2) CONSTRUCTION.—Section 2723(a)(1) shall
12 not be construed to provide that any requirement of
13 this section applies with respect to health insurance
14 coverage, to the extent that a State law described in
15 paragraph (1) applies to such coverage.

16 “(i) PENALTIES.—An enrollee may enforce the provi-
17 sions of this section in an appropriate Federal district
18 court. An action for injunctive relief or damages may be
19 commenced on behalf of the enrollee by the enrollee’s legal
20 representative. The court may award reasonable attorneys’
21 fees to the prevailing party. If a beneficiary dies before
22 conclusion of an action under this section, the action may
23 be maintained by a representative of the enrollee’s estate.

24 “(j) DEFINITIONS.—In this section:

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

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

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

21 “(A) A Medicare+Choice plan authorized
22 under section 1851(a) of the Social Security
23 Act (42 U.S.C. 1395w–21(a)).

24 “(B) Any other entity that manages the
25 cost, utilization, and delivery of health care

1 through the use of predetermined periodic pay-
 2 ments to health care providers employed by or
 3 under contract or other agreement, directly or
 4 indirectly, with the entity.

5 “(4) OTHER QUALIFIED FACILITY.—The term
 6 ‘other qualified facility’ means any facility that can
 7 provide the services required by the enrollee con-
 8 sistent with State and Federal law.

9 “(5) SKILLED NURSING FACILITY.—The term
 10 ‘skilled nursing facility’ means a facility that meets
 11 the requirements of section 1819 of the Social Secu-
 12 rity Act (42 U.S.C. 1395i-3).”.

13 (b) EFFECTIVE DATE.—The amendments made by
 14 this section shall apply with respect to group health plans
 15 for plan years beginning on or after January 1, 2000.

16 **SEC. 4. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT**
 17 **RELATING TO THE INDIVIDUAL MARKET.**

18 (a) IN GENERAL.—The first subpart 3 of part B of
 19 title XXVII of the Public Health Service Act (42 U.S.C.
 20 300gg-51 et seq.) (relating to other requirements) is
 21 amended—

- 22 (1) by redesignating such subpart as subpart 2;
 23 and
 24 (2) by adding at the end the following new sec-
 25 tion:

1 **“SEC. 2753. ENSURING CHOICE FOR CONTINUING CARE.**

2 “The provisions of section 2707 shall apply to health
3 maintenance organization coverage offered by a health in-
4 surance issuer in the individual market in the same man-
5 ner as they apply to such coverage offered by a health
6 insurance issuer in connection with a group health plan
7 in the small or large group market.”.

8 (b) **EFFECTIVE DATE.**—The amendment made by
9 this section shall apply with respect to health insurance
10 coverage offered, sold, issued, renewed, in effect, or oper-
11 ated in the individual market on or after January 1, 2000.

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