103D CONGRESS
2D SESSION

S. 2196

To assure fairness and choice to patients and providers under managed care health benefit plans, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JUNE 15 (legislative day, JUNE 7), 1994

Mr. WELLSTONE (for himself and Mr. BURNS) 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 assure fairness and choice to patients and providers under managed care health benefit plans, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Patient Protection Act of 1994''.

TITLE I—PROTECTION OF CONSUMER CHOICE

SEC. 2. PROTECTION OF CONSUMER CHOICE.

Nothing in this Act shall be construed as prohibiting—

(1) an individual from purchasing any health care services with the individual's own funds, whether such services are covered within any benefits package otherwise available to the individual; and

(2) employers from providing coverage for benefits in addition to any benefits package otherwise available to an individual.

TITLE II—CERTIFICATION OF MANAGED CARE PLANS AND UTILIZATION REVIEW PROGRAMS

SEC. 3. DEFINITIONS.

For purposes of this title:

(1) QUALIFIED MANAGED CARE PLAN.—The term ''qualified managed care plan'' means a managed care plan that the Secretary certifies, upon application by the program, as meeting the requirements of section 4(b).

(2) QUALIFIED UTILIZATION REVIEW PROGRAM.—The term ''qualified utilization review program'' means a utilization review program that the Secretary certifies, upon application by the program, as meeting the requirements of section 4(c).

(3) UTILIZATION REVIEW PROGRAM.—The term ''utilization review program'' means a system of re-

viewing the medical necessity, appropriateness, or quality of health care services and supplies provided under a health insurance plan or a managed care plan using specified guidelines. Such a system may include preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of medical procedures, and retrospective review.

(4) MANAGED CARE PLAN.—

(A) IN GENERAL.—The term ''managed care plan'' means a plan operated by a managed care entity (as defined in subparagraph (B)), that provides for the financing and delivery of health care services to persons enrolled in such plan through—

(i) arrangements with selected providers to furnish health care services;

(ii) explicit standards for the selection of participating providers;

(iii) organizational arrangements for ongoing quality assurance, utilization review programs, and dispute resolution; and

(iv) financial incentives for persons enrolled in the plan to use the participat-

ing providers and procedures provided for by the plan.

(B) MANAGED CARE ENTITY.—The term ''managed care entity'' includes a licensed insurance company, hospital or medical service plan, health maintenance organization, an employer or employee organization, or a managed care contractor (as defined in subparagraph (C)), that operates a managed care plan.

(C) MANAGED CARE CONTRACTOR.—The term ''managed care contractor'' means a person that—

(i) establishes, operates, or maintains a network of participating providers;

(ii) conducts or arranges for utilization review activities; and

(iii) contracts with an insurance company, a hospital or medical service plan, an employer, an employee organization, or any other entity providing coverage for health care services to operate a managed care plan.

(5) PARTICIPATING PROVIDER.—The term ''participating provider'' means a physician, hospital, pharmacy, laboratory, or other appropriately author-

ized provider of health care services or supplies, that has entered into an agreement with a managed care entity to provide such services or supplies to a patient enrolled in a managed care plan.

(6) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

SEC. 4. CERTIFICATION OF MANAGED CARE PLANS AND UTILIZATION REVIEW PROGRAMS.

(a) IN GENERAL.—

(1) CERTIFICATION.—The Secretary shall establish a process for certification of managed care plans meeting the requirements of subsection (b) and utilization review programs meeting the requirements of subsection (c).

(2) REVIEW AND RECERTIFICATION.—The Secretary shall establish procedures for the periodic review and recertification of qualified managed care plans and qualified utilization review programs. Such procedures shall include steps by which a health plan may remedy any deficiencies cited.

(3) TERMINATION OF CERTIFICATION.—If the Secretary determines that a qualified managed care plan or qualified utilization review program no longer substantially meets the applicable requirements for certification, the Secretary shall establish

procedures for terminating the certification of the plan or program for reasons including the failure of remedies for deficiencies referred to in paragraph (2). Prior to the date a termination becomes effective, the Secretary shall provide the plan notice and opportunity for a hearing on the proposed termination.

(4) CERTIFICATION THROUGH ALTERNATIVE REQUIREMENTS.—

(A) CERTAIN ORGANIZATIONS RECOGNIZED.—An eligible organization (as defined in section 1876(b) of the Social Security Act), shall be deemed to meet the requirements of subsection (b) for certification as a qualified managed care plan.

(B) RECOGNITION OF ACCREDITATION.—If the Secretary finds that a State licensure program or a national accreditation body establishes requirements for accreditation of a managed care plan or utilization review program that are at least equivalent to requirements established under this section, the Secretary may, to the extent appropriate, treat a managed care plan or a utilization review program accredited

by such program or body as meeting the applicable requirements of this section.

(b) REQUIREMENTS FOR CERTIFICATION OF MANAGED CARE PLANS.—

(1) IN GENERAL.—The Secretary shall establish Federal standards for the certification of managed care plans, including standards which require managed care plans to meet the requirements described in paragraphs (2) through (6).

(2) INFORMATION ON TERMS OF PLAN.—Managed care plans shall provide prospective enrollees information on the terms and conditions of the plan so that the enrollees can make informed decisions about accepting a certain system of health care delivery. Easily understood, truthful, linguistically appropriate and objective terms must be used in all oral and written descriptions of a plan. Such descriptions shall be consistent with standards developed for supplemental insurance coverage under title XVIII of the Social Security Act. Descriptions of plans under this paragraph must be standardized so that customers can compare the attributes of the plans. Specific items that must be included in a description of a plan are—

(A) coverage provisions, benefits, and any exclusions by category of service, provider, or physician, and if applicable, any exclusions by specific service;

(B) any and all prior authorization or other review requirements including preauthorization review, concurrent review, post-service review, post-payment review and any procedures that may lead the patient to be denied coverage for, or not be provided, a particular service;

(C) financial arrangements or contractual provisions with hospitals, utilization review organizations, physicians, or any other provider of health care services that would limit the services offered, restrict referral or treatment options, or negatively affect a physician's fiduciary responsibility to patients, including financial incentives not to provide medical or other services;

(D) an explanation of how plan limitations impact enrollees, including information on enrollee financial responsibility for payment for coinsurance or other noncovered or out-of-plan services;

(E) the plan's loss ratios and an explanation that they reflect the percentage of premiums expended for health services; and

(F) enrollee satisfaction statistics, including reenrollment statistics and a description of enrollees' reasons for leaving the plan.

(3) ADEQUATE ACCESS TO PHYSICIANS.—Managed care plans shall be required to demonstrate that they have adequate access to physicians and other providers so that all covered health care services will be provided in a timely manner. This requirement may not be waived and must be met in all areas where the plan has enrollees, including rural areas.

(4) FINANCIAL RESERVES.—Managed care plans shall be required to meet financial reserve requirements that are established to assure proper payment for health care services provided under the plan. The Secretary shall establish a mechanism to provide adequately for indemnification of plan failures even when a plan has met the reserve requirements.

(5) PROVIDER INPUT.—Managed care plans shall be required to establish a mechanism under which physicians and other providers participating in

a plan have defined rights to provide input into the plan's medical policy (including coverage of new technology and procedures), utilization review criteria and procedures, quality and credentialing criteria, and medical management procedures.

(6) CREDENTIALS FOR PHYSICIANS.—

(A) IN GENERAL.—Managed care plans shall be required to credential physicians furnishing health care services under the plan. Any physicians within a plan's geographic service area may apply for credentials under the plan and at least once each year, the plan shall notify such physicians of the opportunity to apply for credentials.

(B) CREDENTIALING PROCESS.—

(i) IN GENERAL.—Each managed care plan shall establish a credentialing process. Such process shall begin upon application by a physician to be included under the plan. Each application by a physician shall be reviewed by a credentialing committee with appropriate representation of the applicant's medical specialty.

(ii) STANDARDS.—Credentialing under a plan shall be based on objective

standards of quality with input from physicians credentialed by the plan. Credentialing standards shall be available to applicants and enrollees.

(iii) ECONOMIC CONSIDERATIONS.—If economic considerations, including practitioners' patterns of expenditure per patient, are part of a credentialing decision, objective criteria must used in examining such considerations and such criteria must be available to applicants, participating physicians, and enrollees. Any economic profiling of physicians must be adjusted to recognize case mix, severity of illness, age of patients and other features of a physician's practice that may account for higher or lower than expected costs. Economic profiles must be made available to the physicians profiled.

(iv) GRADUATE MEDICAL EDUCATION.—If graduate medical education is a consideration in credentialing, equal recognition will be given to training programs accredited by the Accrediting Council on

Graduate Medical Education and by the American Osteopathic Association.

(v) RECORDING DECISIONS.—A record shall be maintained of all decisions made under the credentialing process and each applicant shall be provided with reasons for an application being denied or a contract not being renewed.

(vi) DUE PROCESS.—Prior to initiation of a proceeding leading to termination of a contract, the physician shall be provided notice, an opportunity for discussion, and an opportunity to enter into and complete a corrective action plan, except in cases where there is imminent harm to patient health or an action by a State medical board or other government agency that effectively impairs the physician's ability to practice medicine.

(vii) REDUCING OR WITHDRAWING CREDENTIALS.—The same standards and procedures used for an application for credentials shall also be used in those cases where the plan seeks to reduce or withdraw such credentials.

(viii) APPEALS.—There shall be allowed a due process appeal from all adverse decisions affecting practitioners with whom a plan has contracted. The due process appeal mechanisms shall be as set forth in the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101–11152).

(C) DISCRIMINATION AGAINST ENROLLEES.—Managed care plans shall be prohibited from discriminating against enrollees based on health status or anticipated need for medical services likely to lead to high expenses by excluding practitioners with practices containing a substantial number of such patients.

(7) CONFIDENTIALITY OF RECORDS.—Managed care plans shall be required to establish procedures to ensure that all applicable Federal and State laws designed to protect the confidentiality of provider and individual medical records are followed.

(c) REQUIREMENTS FOR CERTIFICATION OF UTILIZATION REVIEW PROGRAMS.—

(1) IN GENERAL.—The Secretary shall establish Federal standards for the certification of utilization review programs, including standards which require

such programs to meet the requirements described in paragraph (2).

(2) REQUIREMENTS.—Plans must have a medical director responsible for all clinical decisions by the plan and provide assurances that the medical review or utilization practices used by the plans, and the medical review or utilization practices of payers or reviewers with whom the plans contract, comply with the following requirements:

(A) Screening criteria used in the review process, the methods by which they are applied, and their method of development, must be released to physicians and the public upon request.

(B) Such criteria and methods must be based on sound scientific principles and developed in cooperation with practicing physicians and other affected health care providers.

(C) Any person who recommends denial of coverage or payment, or determines that a service should not be provided, based on medical necessity standards, must be of the same medical branch (allopathic or osteopathic medicine) and specialty (specialties as recognized by the American Board of Medical Specialties or the Amer-

ican Osteopathic Association) as the practitioner who provided the service.

(D) Each claimant or provider (upon assignment of a claim) who has had a claim denied as not medically necessary must be provided an opportunity for a due process appeal to a medical consultant or peer review group that is independent of the entity that performed the initial review.

(E) Any individual making a final, negative judgment or recommendation about the necessity or appropriateness of services or the site of service must be a comparably qualified health care professional licensed to practice in the jurisdiction from which the claim arose.

(F) Upon request, physicians and other professionals will be provided the names and credentials of all individuals conducting medical necessity or appropriateness review, subject to reasonable safeguards and standards.

(G) Prior authorization shall not be required for emergency care, and patient or physician requests for prior authorization of a non-emergency service must be answered within 24 hours and qualified personnel must be available

for same-day telephone responses to inquiries about medical necessity, including certification of continued length of stay. If review personnel are not available, medical services provided shall be considered approved.

(H) Plans must ensure that enrollees, in plans where prior authorization is a condition for coverage of a service, are offered the opportunity to sign medical information release consent forms upon enrollment for use where services requiring prior authorization are recommended or proposed by their physician.

(I) When prior approval for a service or other covered item is obtained, the service shall be considered to be covered unless there was fraud or incorrect information provided at the time such prior approval was obtained.

(J) Plans must establish procedures for ensuring that all applicable Federal and State laws designed to protect the confidentiality of provider and individual medical records are followed.

(d) CONSIDERATIONS IN DEVELOPING STANDARDS.—In developing standards under subsections (b) and (c), the Secretary shall—

(1) review standards in use by national private accreditation organizations and State licensure programs;

(2) recognize, to the extent appropriate, differences in the organizational structure and operation of managed care plans; and

(3) establish procedures for the timely consideration of applications for certification by managed care plans and utilization review programs.

(e) TIMETABLE FOR ESTABLISHMENT OF STANDARDS.—

(1) IN GENERAL.—Not later than 12 months after the date of the enactment of this Act standards shall first be established under this section.

(2) REVISION OF STANDARDS.—The Secretary shall periodically review the standards established under this section, and may revise the standards from time to time to assure that such standards continue to reflect appropriate policies and practices for the cost-effective and medically appropriate use of services within managed care plans and utilization review programs.

TITLE III—CHOICE OF HEALTH PLANS FOR ENROLLMENT

SEC. 5. CHOICE OF HEALTH PLANS FOR ENROLLMENT.

(a) IN GENERAL.—Each sponsor, including a self-insured sponsor, of a health benefit plan, who offers, provides, or makes available such plan must provide to each eligible enrollee a choice of health plans among available plans.

(b) OFFERING OF PLANS.—Each sponsor referred to in subsection (a) shall include among its health plan offerings at least one of each of the following types of health benefit plans, where available:

(1) A managed care plan, including a health maintenance organization or preferred provider organization.

(2) A traditional insurance plan (as defined in subsection (c)(1)).

(3) A benefit payment schedule plan (as defined in subsection (c)(2)), pursuant to the following activities of the Secretary:

(A) Not later than 12 months after the date of the enactment of this Act, the Secretary shall—

(i) conduct a study on the projected impact of benefit payment schedule plans

on enrollees and on the Nation's health care costs; and

(ii) submit a report to Congress on the results of such study.

(B) The Secretary shall promulgate regulations to—

(i) assure that benefit payment schedule plans, if approved, are affordable for all enrollees and contribute to health care cost containment; and

(ii) remedy any other significant deficiencies identified by the study described in subparagraph (A).

(c) DEFINITIONS.—For purposes of this section:

(1) TRADITIONAL INSURANCE PLAN.—The term ''traditional insurance plan'' includes plans that offer a health benefits package and that pay for medical services on a fee-for-service basis using a usual, customary, or reasonable payment methodology or a resource based relative value schedule, usually linked to an annual deductible and/or coinsurance payment on each allowed amount.

(2) BENEFIT PAYMENT SCHEDULE PLAN.—The term ''benefit payment schedule plan'' means a health plan that—

(A) provides coverage for all items and services included in a health benefits package that are furnished by any health care provider licensed under State law of the enrollee's choice;

(B) makes payment for the services of a provider on a fee-for-service basis without regard to whether or not there is a contractual arrangement between the plan and the provider;

(C) provides a benefit payment schedule that identifies covered services and the payment for each service covered by the plan; and

(D) applies no copayments or coinsurance.

SEC. 6. CHOICE REQUIREMENTS FOR POINT-OF-SERVICE PLANS.

(a) IN GENERAL.—Each sponsor, including a self-insured sponsor, of a health benefit plan that restricts access to providers, shall offer to all eligible enrollees the opportunity to obtain coverage for out-of-network items or services through a point-of-service plan (as defined under subsection (e)(1)), at the time of enrollment and at least for a continuous one-month period annually thereafter.

(b) COINSURANCE.—A point-of-service plan may require payment of coinsurance for an out-of-network item or service, as follows:

(1) The applicable coinsurance percentage shall not be greater than 20 percent of payment for items and services.

(2) The applicable coinsurance percentage may be applied differentially with respect to out-of-network items and services, subject to the requirements of paragraph (1).

(c) PAYMENT DISCLOSURE REQUIREMENT.—All sponsors of point-of-service plans and physicians and other professionals participating in such plans shall be required to disclose their fees, applicable payment schedules, coinsurance requirements, or any other financial requirements that affect patient payment levels.

(d) POVERTY EXCLUSION.—Any enrollee, including enrolled dependents, whose income does not exceed 200 percent of the established Federal poverty guideline for the applicable year, shall be charged no more than the amount allowed under applicable plan limits. Such amount shall be considered payment in full.

(e) DEFINITIONS.—For purposes of this section:

(1) POINT-OF-SERVICE PLAN.—The term ''point-of-service plan'' means a plan that offers services to enrollees through a provider network (as defined in paragraph (2)) and also offers additional

services and/or access to care by network or non-network providers.

(2) PROVIDER NETWORK.—The term ''provider network'' means, with respect to a health plan that restricts access, those providers who have entered into a contract or agreement with the plan under which such providers are obligated to provide items and services under the plan to eligible individuals enrolled in the plan, or have an agreement to provide services on a fee-for-service basis.

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