II

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.

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

---

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.

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 ''Seniors' Access to Continuing Care Act of 1998''.

SEC. 2. AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

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

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

"SEC. 713. ENSURING CHOICE FOR CONTINUING CARE.

''(a) IN GENERAL.—With respect to health insurance coverage provided to participants or beneficiaries through a managed care organization under a group health plan, or through a health insurance issuer providing health insurance coverage in connection with a group health plan, such plan or issuer may not deny coverage for services provided to such participant or beneficiary by a continuing care retirement community, skilled nursing facility, or other qualified facility in which the participant or beneficiary resided prior to a hospitalization, regardless of whether such organization is under contract with such community or facility if the requirements described in subsection (b) are met.

''(b) REQUIREMENTS.—The requirements of this subsection are that—

''(1) the service involved is a service for which the managed care organization involved would be required to provide or pay for under its contract with the participant or beneficiary if the continuing care

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

''(2) the participant or beneficiary involved—

''(A) resided in the continuing care retirement community, skilled nursing facility, or other qualified facility prior to being hospitalized;

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

''(C) elects to return to the facility after hospitalization, whether or not the residence of the participant or beneficiary after returning from the hospital is the same part of the facility in which the beneficiary resided prior to hospitalization;

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

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

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

''(c) SERVICES TO PREVENT HOSPITALIZATION.—A group health plan or health insurance issuer to which this section applies may not deny payment for a skilled nursing service provided to a participant or beneficiary by a continuing care retirement community, skilled nursing facility, or other qualified facility in which the participant or beneficiary resides, without a preceding hospital stay, regardless of whether the organization is under contract with such community or facility, if—

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

''(2) the service to prevent hospitalization is provided as an additional benefit as described in section 417.594 of title 42, Code of Federal Regulations.

''(d) RIGHTS OF SPOUSES.—A group health plan or health insurance issuer to which this section applies shall not deny payment for services provided by a skilled nursing facility for the care of a participant or beneficiary, regardless of whether the plan or issuer is under contract with such facility, if the spouse of the participant or bene-

ficiary is already a resident of such facility and the requirements described in subsection (b) are met.

''(e) EXCEPTIONS.—Subsection (a) shall not apply—

''(1) where the attending acute care physician and the participant or beneficiary (or a designated representative of the participant or beneficiary where the participant or beneficiary is physically or mentally incapable of making an election under this paragraph) do not elect to pursue a course of treatment necessitating continuing care; or

''(2) unless the community or facility involved—

''(A) meets all applicable licensing and certification requirements of the State in which it is located; and

''(B) agrees to reimbursement for the care of the participant or beneficiary at a rate similar to the rate negotiated by the managed care organization with similar providers of care for similar services.

''(f) PROHIBITIONS.—A group health plan and a health insurance issuer providing health insurance coverage in connection with a group health plan may not—

''(1) deny to an individual eligibility, or continued eligibility, to enroll or to renew coverage with a managed care organization under the plan, solely for

the purpose of avoiding the requirements of this section;

''(2) provide monetary payments or rebates to enrollees to encourage such enrollees to accept less than the minimum protections available under this section;

''(3) penalize or otherwise reduce or limit the reimbursement of an attending physician because such physician provided care to a participant or beneficiary in accordance with this section; or

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

''(g) RULES OF CONSTRUCTION.—

''(1) HMO NOT OFFERING BENEFITS.—This section shall not apply with respect to any managed care organization under a group health plan, or through a health insurance issuer providing health insurance coverage in connection with a group health plan, that does not provide benefits for stays in a continuing care retirement community, skilled nursing facility, or other qualified facility.

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

ganization under a group health plan, or through a health insurance issuer providing health insurance coverage in connection with a group health plan, from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for care in a continuing care facility.

''(h) PREEMPTION; EXCEPTION FOR HEALTH INSURANCE COVERAGE IN CERTAIN STATES.—

''(1) IN GENERAL.—The requirements of this section shall not apply with respect to health insurance coverage if there is a State law (as defined in section 2723(d)(1)) for a State that regulates such coverage that is described in any of the following subparagraphs:

''(A) Such State law requires such coverage to provide for referral to a continuing care retirement community, skilled nursing facility, or other qualified facility consistent with this section.

''(B) Such State law requires, in connection with such coverage for continuing care, that the necessity for such care is left to the decision of (or required to be made by) the attending provider in consultation with the enrollee.

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

''(2) CONSTRUCTION.—Section 731(a)(1) shall not be construed as superseding a State law described in paragraph (1).

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

''(j) DEFINITIONS.—In this section:

''(1) ATTENDING ACUTE CARE PROVIDER.—The term 'attending acute care provider' means anyone licensed or certified under State law to provide health care services who is operating within the scope of such license and who is primarily responsible for the care of the enrollee.

''(2) CONTINUING CARE RETIREMENT COMMUNITY.—The term 'continuing care retirement community' means an organization that provides or ar-

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

''(3) MANAGED CARE ORGANIZATION.—The term 'managed care organization' means an organization that provides comprehensive health services to participants or beneficiaries, directly or under contract or other agreement, on a prepayment basis to such individuals. For purposes of this section, the following shall be considered as managed care organizations:

''(A) A Medicare+Choice plan authorized under section 1851(a) of the Social Security Act.

''(B) Any other entity that manages the cost, utilization, and delivery of health care through the use of predetermined periodic payments to health care providers employed by or under contract or other agreement, directly or indirectly, with the entity.

''(4) OTHER QUALIFIED FACILITY.—The term 'other qualified facility' means any facility that can provide the services required by the participant or beneficiary consistent with State and Federal law.

''(5) SKILLED NURSING FACILITY.—The term 'skilled nursing facility' means a facility that meets the requirements of section 1819 of the Social Security Act (42 U.S.C. 1395i–3).''.

(b) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act, as amended by section 603 of the Newborns' and Mothers' Health Protection Act of 1996 and section 702 of the Mental Health Parity Act of 1996, is amended by inserting after the item relating to section 712 the following new item:

''Sec. 713. Ensuring choice for continuing care.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on or after January 1, 1998.

SEC. 3. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE GROUP MARKET.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (as added by section 604(a) of the Newborns' and Mothers' Health Protection Act of 1996 and amended by section 703(a) of the Mental Health Parity Act of 1996) is amended by adding at the end the following new section:

''SEC. 2706. ENSURING CHOICE FOR CONTINUING CARE.

''(a) IN GENERAL.—With respect to health insurance coverage provided to enrollees through a managed care organization under a group health plan, or through a health

insurance issuer providing health insurance coverage in connection with a group health plan, such plan or issuer may not deny coverage for services provided to such enrollee by a continuing care retirement community, skilled nursing facility, or other qualified facility in which the enrollee resided prior to a hospitalization, regardless of whether such organization is under contract with such community or facility if the requirements described in subsection (b) are met.

''(b) REQUIREMENTS.—The requirements of this subsection are that—

''(1) the service involved is a service for which the managed care organization involved would be required to provide or pay for under its contract with the enrollee if the continuing care retirement community, skilled nursing facility, or other qualified facility were under contract with the organization;

''(2) the enrollee involved—

''(A) resided in the continuing care retirement community, skilled nursing facility, or other qualified facility prior to being hospitalized;

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

''(C) elects to return to the facility after hospitalization, whether or not the residence of the enrollee after returning from the hospital is the same part of the facility in which the beneficiary resided prior to hospitalization;

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

''(4) the continuing care retirement community, skilled nursing facility, or other qualified facility is willing to accept substantially similar payment under the same terms and conditions that apply to similarly situated health care facility providers under contract with the organization involved.

''(c) SERVICES TO PREVENT HOSPITALIZATION.—A group health plan or health insurance issuer to which this section applies may not deny payment for a skilled nursing service provided to a enrollee by a continuing care retirement community, skilled nursing facility, or other qualified facility in which the enrollee resides, without a preceding hospital stay, regardless of whether the plan or issuer is under contract with such community or facility, if—

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

''(2) the service to prevent hospitalization is provided as an additional benefit as described in section 417.594 of title 42, Code of Federal Regulations.

''(d) RIGHTS OF SPOUSES.—A group health plan or health insurance issuer to which this section applies shall not deny payment for services provided by a skilled nursing facility for the care of an enrollee, regardless of whether the plan or issuer is under contract with such facility, if the spouse of the enrollee is already a resident of such facility and the requirements described in subsection (b) are met.

''(e) EXCEPTIONS.—Subsection (a) shall not apply—

''(1) where the attending acute care physician and the enrollee (or a designated representative of the enrollee where the enrollee is physically or mentally incapable of making an election under this paragraph) do not elect to pursue a course of treatment necessitating continuing care; or

''(2) unless the community or facility involved—

''(A) meets all applicable licensing and certification requirements of the State in which it is located; and

''(B) agrees to reimbursement for the care of the enrollee at a rate similar to the rate negotiated by the managed care organization with similar providers of care for similar services.

''(f) PROHIBITIONS.—A group health plan and a health insurance issuer providing health insurance coverage in connection with a group health plan may not—

''(1) deny to an individual eligibility, or continued eligibility, to enroll or to renew coverage with a managed care organization under the plan, solely for the purpose of avoiding the requirements of this section;

''(2) provide monetary payments or rebates to enrollees to encourage such enrollees to accept less than the minimum protections available under this section;

''(3) penalize or otherwise reduce or limit the reimbursement of an attending physician because such physician provided care to a enrollee in accordance with this section; or

''(4) provide incentives (monetary or otherwise) to an attending physician to induce such physician

to provide care to an enrollee in a manner inconsistent with this section.

''(g) RULES OF CONSTRUCTION.—

''(1) HMO NOT OFFERING BENEFITS.—This section shall not apply with respect to any managed care organization under a group health plan, or through a health insurance issuer providing health insurance coverage in connection with a group health plan, that does not provide benefits for stays in a continuing care retirement community, skilled nursing facility, or other qualified facility.

''(2) COST-SHARING.—Nothing in this section shall be construed as preventing a managed care organization under a group health plan, or through a health insurance issuer providing health insurance coverage in connection with a group health plan, from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for care in a continuing care facility.

''(h) PREEMPTION; EXCEPTION FOR HEALTH INSURANCE COVERAGE IN CERTAIN STATES.—

''(1) IN GENERAL.—The requirements of this section shall not apply with respect to health insurance coverage if there is a State law (as defined in section 2723(d)(1)) for a State that regulates such

coverage that is described in any of the following subparagraphs:

"(A) Such State law requires such coverage to provide for referral to a continuing care retirement community, skilled nursing facility, or other qualified facility consistent with this section.

"(B) Such State law requires, in connection with such coverage for continuing care, that the necessity for such care is left to the decision of (or required to be made by) the attending provider in consultation with the enrollee.

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

"(2) CONSTRUCTION.—Section 731(a)(1) shall not be construed as superseding a State law described in paragraph (1).

"(i) PENALTIES.—An enrollee may enforce the provisions of this section in an appropriate Federal district court. An action for injunctive relief or damages may be commenced on behalf of the enrollee by the enrollee's legal representative. The court may award reasonable attorneys' fees to the prevailing party. If a beneficiary dies before

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

''(j) DEFINITIONS.—In this section:

''(1) ATTENDING ACUTE CARE PROVIDER.—The term 'attending acute care provider' means anyone licensed or certified under State law to provide health care services who is operating within the scope of such license and who is primarily responsible for the care of the enrollee.

''(2) CONTINUING CARE RETIREMENT COMMUNITY.—The term 'continuing care retirement community' means an organization that provides or arranges for the provision of housing and health-related services to an older person under an agreement effective for the life of the person or for a specified period greater than 1 year.

''(3) MANAGED CARE ORGANIZATION.—The term 'managed care organization' means an organization that provides comprehensive health services to enrollees, directly or under contract or other agreement, on a prepayment basis to such individuals. For purposes of this section, the following shall be considered as managed care organizations:

"(A) A Medicare+Choice plan authorized under section 1851(a) of the Social Security Act.

"(B) Any other entity that manages the cost, utilization, and delivery of health care through the use of predetermined periodic payments to health care providers employed by or under contract or other agreement, directly or indirectly, with the entity.

"(4) OTHER QUALIFIED FACILITY.—The term 'other qualified facility' means any facility that can provide the services required by the enrollee consistent with State and Federal law.

"(5) SKILLED NURSING FACILITY.—The term 'skilled nursing facility' means a facility that meets the requirements of section 1819 of the Social Security Act (42 U.S.C. 1395i–3).".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.

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

(a) IN GENERAL.—Subpart 3 of part B of title XXVII of the Public Health Service Act (as added by section 605(a) of the Newborn's and Mother's Health Protec-

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

''SEC. 2752. ENSURING CHOICE FOR CONTINUING CARE.

''The provisions of section 2706 shall apply to health maintenance organization coverage offered by a health insurance issuer in the individual market in the same manner as they apply to such coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.''.

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

○