

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.

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 ganization 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.

“Sec. 713. Ensuring choice for continuing care.”.

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

22 **“SEC. 2706. ENSURING CHOICE FOR CONTINUING CARE.**

•S 1997 IS

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,
 11 skilled nursing facility, or other qualified facility is
 12 willing to accept substantially similar payment under
 13 the same terms and conditions that apply to simi-
 14 larly situated health care facility providers under
 15 contract with the organization involved.

16 “(c) SERVICES TO PREVENT HOSPITALIZATION.—A
 17 group health plan or health insurance issuer to which this
 18 section applies may not deny payment for a skilled nursing
 19 service provided to a enrollee by a continuing care retire-
 20 ment community, skilled nursing facility, or other quali-
 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

4 “(2) the service to prevent hospitalization is
 5 provided as an additional benefit as described in sec-
 6 tion 417.594 of title 42, Code of Federal Regula-
 7 tions.

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

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

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.

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

11 “(1) deny to an individual eligibility, or contin-
12 ued eligibility, to enroll or to renew coverage with a
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

24 “(4) provide incentives (monetary or otherwise)
25 to an attending physician to induce such physician

1 to provide care to an enrollee in a manner inconsis-
 2 ent with this section.

3 “(g) RULES OF CONSTRUCTION.—

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

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

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

22 “(1) IN GENERAL.—The requirements of this
 23 section shall not apply with respect to health insur-
 24 ance coverage if there is a State law (as defined in
 25 section 2723(d)(1)) for a State that regulates such

1 coverage that is described in any of the following
2 subparagraphs:

3 “(A) Such State law requires such cov-
4 erage to provide for referral to a continuing
5 care retirement community, skilled nursing fa-
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.

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

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
 6 licensed or certified under State law to provide
 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 “(A) A Medicare+Choice plan authorized
2 under section 1851(a) of the Social Security
3 Act.

4 “(B) Any other entity that manages the
5 cost, utilization, and delivery of health care
6 through the use of predetermined periodic pay-
7 ments to health care providers employed by or
8 under contract or other agreement, directly or
9 indirectly, with the entity.

10 “(4) OTHER QUALIFIED FACILITY.—The term
11 ‘other qualified facility’ means any facility that can
12 provide the services required by the enrollee consist-
13 ent with State and Federal law.

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

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

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

23 (a) IN GENERAL.—Subpart 3 of part B of title
24 XXVII of the Public Health Service Act (as added by sec-
25 tion 605(a) of the Newborn’s and Mother’s Health Protec-

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.

○