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.

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.

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 ''Medicare Patient Choice and Access Act of 1997''.

SEC. 2. FINDINGS.

Congress makes the following findings:

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

health care plans to obtain appropriate specialized medical services.

(2) The patient's first point of contact in a health care plan must be encouraged to make all appropriate medical referrals and should not be constrained financially from making such referrals.

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

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

(5) Patients cannot make appropriate health care decisions without access to all relevant information relating to those decisions.

(6) Restrictions on the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions violate the principles of informed consent and the ethical standards of the health care professions. Contractual clauses and other policies that interfere with communications between health care providers and patients can impact the quality of care received by those patients.

(7) Patients should have the opportunity to access out-of-network items, treatment, and services at an additional cost to the patient which is not so prohibitive that they are deterred from seeing the health care provider of their own choice.

(8) Specialty care must be available for the full duration of the patient's medical needs when medically necessary and not limited by time or number of visits.

(9) Direct access to specialty care is essential for patients in emergency and nonemergency situations and for patients with chronic and temporary conditions.

SEC. 3. PROTECTION FOR MEDICARE HMO ENROLLEES.

(a) IN GENERAL.—Section 1876 of the Social Security Act (42 U.S.C. 1395mm) is amended—

(1) in subsection (c)(1), by striking ''subsection (e)'' and inserting ''subsections (e) and (k)''; and

(2) by adding at the end the following:

''(k) BENEFICIARY PROTECTION.—

''(1) ASSURING ADEQUATE IN-NETWORK ACCESS.—

''(A) TIMELY ACCESS.—An eligible organization that restricts the providers from whom benefits may be obtained must guarantee to en-

rollees under this section timely access to primary and specialty health care providers who are appropriate for the enrollee's condition.

"(B) ACCESS TO SPECIALIZED CARE.—Enrollees must have access to specialized treatment when medically necessary. This access may be satisfied through contractual arrangements with specialized health care providers outside of the network.

"(C) CONTINUITY OF CARE.—An eligible organization's use of case management may not create an undue burden for enrollees under this section. An eligible organization must ensure direct access to specialists for ongoing care as so determined by the case manager in consultation with the specialty health care provider. This continuity of care may be satisfied for enrollees with chronic conditions through the use of a specialist serving as case manager.

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

of a network of health care providers and other persons who have entered into a contract with the organization to provide such services, the contract with the organization under this section shall provide that the organization shall also offer to members enrolled under this section (at the time of enrollment) a plan which provides for coverage of such items and services which are not furnished through health care providers and other persons who are members of such a network.

''(3) GRIEVANCE PROCESS.—

''(A) IN GENERAL.—An eligible organization must provide a meaningful and expedited procedure, which includes notice and hearing requirements, for resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and members enrolled with the organization under this section. Under that procedure, any member enrolled with the eligible organization may, at any time, file a complaint to resolve grievances between the member and the organization before a board of appeals established under subparagraph (C).

''(B) NOTICE REQUIREMENTS.—

''(i) IN GENERAL.—The eligible organization must provide, in a timely manner, to an enrollee a notice of any denial of services in-network or denial of payment for out-of-network care.

''(ii) INFORMATION REQUIRED.—Such notice shall include the following:

''(I) A clear statement of the reason for the denial.

''(II) An explanation of the complaint process under subparagraph (A) which is available to the enrollee upon request.

''(III) An explanation of all other appeal rights available to all enrollees.

''(IV) A description of how to obtain supporting evidence for the hearing described in subparagraph (C), including the patient's medical records from the organization, as well as supporting affidavits from the attending health care providers.

''(C) HEARING BOARD.—

''(i) IN GENERAL.—Each eligible organization shall establish a board of ap-

peals to hear and make determinations on complaints by enrollees concerning denials of coverage or payment for services (whether in-network or out-of-network) and the medical necessity and appropriateness of covered items and services.

''(ii) COMPOSITION.—A board of appeals of an eligible organization shall consist of—

''(I) representatives of the organization, including physicians, non-physicians, administrators, and enrollees;

''(II) consumers who are not enrolled with an eligible organization under this section; and

''(III) health care providers who are not under contract with the eligible organization and who are experts in the field of medicine which necessitates treatment.

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

''(iii) DEADLINE FOR DECISION.—

"(I) IN GENERAL.—Except as provided in subclause (II), a board of appeals shall hear and resolve complaints within 30 days after the date the complaint is filed with the board.

"(II) EXPEDITED PROCEDURE.—A board of appeals shall have an expedited procedure in order to hear and resolve complaints regarding urgent care (as determined by the Secretary in regulations).

"(D) OTHER REMEDIES.—Nothing in this paragraph may be construed to replace or supersede any appeals mechanism otherwise provided for an individual entitled to benefits under this title.

"(4) NOTICE OF ENROLLEE RIGHTS AND COMPARATIVE REPORT.—

"(A) IN GENERAL.—Each eligible organization shall provide in any marketing materials distributed to individuals eligible to enroll under this section and to each enrollee at the time of enrollment and not less frequently than annually thereafter, an explanation of the individual's rights under this section and a copy of the

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

''(B) RIGHTS DESCRIBED.—The explanation of rights under subparagraph (A) shall be in a standardized format (as established by the Secretary in regulations) and shall include an explanation of—

''(i) the enrollee's rights to benefits from the organization;

''(ii) the restrictions (if any) on payments under this title for services furnished other than by or through the organization;

''(iii) out-of-area coverage provided by the organization;

''(iv) the organization's coverage of emergency services and urgently needed care;

''(v) the organization's coverage of out-of-network services, including services that are additional to the items and services covered under parts A and B;

''(vi) appeal rights of and grievance procedures available to enrollees; and

"(vii) any other rights that the Secretary determines would be helpful to beneficiaries in understanding their rights under the plan.

"(C) COMPARATIVE REPORT.—

"(i) IN GENERAL.—The Secretary shall develop an understandable standardized comparative report on the plans offered by eligible organizations, that will assist beneficiaries under this title in their decisionmaking regarding medical care and treatment by allowing the beneficiaries to compare the organizations that the beneficiaries are eligible to enroll with. In developing such report the Secretary shall consult with outside organizations, including groups representing the elderly and health insurers, in order to assist the Secretary in developing the report.

"(ii) CONTENTS OF REPORT.—The report described in clause (i) shall include a comparison for each plan of—

"(I) the premium for the plan;

"(II) the benefits offered by the plan, including any benefits that are

additional to the benefits offered under parts A and B;

''(III) the amount of any deductibles, coinsurance, or any monetary limits on benefits;

''(IV) the identity, location, qualifications, and availability of health care providers in any health care provider networks of the plan;

''(V) the number of individuals who disenrolled from the plan within 3 months of enrollment and during the previous fiscal year, stated as percentages of the total number of individuals in the plan;

''(VI) the procedures used by the plan to control utilization of services and expenditures, including any financial incentives;

''(VII) the procedures used by the plan to ensure quality of care;

''(VIII) the rights and responsibilities of enrollees;

''(IX) the number of applications during the previous fiscal year re-

questing that the plan cover certain medical services that were denied by the plan (and the number of such denials that were subsequently reversed by the plan), stated as a percentage of the total number of applications during such period requesting that the plan cover such services;

''(X) the number of times during the previous fiscal year (after an appeal was filed with the Secretary) that the Secretary upheld or reversed a denial of a request that the plan cover certain medical services;

''(XI) the restrictions (if any) on payment for services provided outside the plan's health care provider network;

''(XII) the process by which services may be obtained through the plan's health care provider network;

''(XIII) coverage for out-of-area services;

''(XIV) any exclusions in the types of health care providers partici-

pating in the plan's health care provider network; and

''(XV) any additional information that the Secretary determines would be helpful for beneficiaries to compare the organizations that the beneficiaries are eligible to enroll with.

''(iii) ONGOING DEVELOPMENT OF REPORT.—The Secretary shall, not less than annually, update each comparative report.

''(D) COMPLIANCE.—Each eligible organization shall disclose to the Secretary, as requested by the Secretary, the information necessary to complete the comparative report.

''(5) RESTRICTIONS ON HEALTH CARE PROVIDER INCENTIVE PLANS.—

''(A) IN GENERAL.—Each contract with an eligible organization under this section shall provide that the organization may not operate any health care provider incentive plan (as defined in subparagraph (B)) unless the following requirements are met:

''(i) No specific payment is made directly or indirectly under the plan to a health care provider or health care pro-

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

''(ii) If the plan places a health care provider or health care provider group at substantial financial risk (as determined by the Secretary) for services not provided by the health care provider or health care provider group, the organization—

''(I) provides stop-loss protection for the health care provider or health care provider group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number (and type) of health care providers placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization that receive services from the health care provider or the health care provider group; and

''(II) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of

access of such individuals to services provided by the organization and satisfaction with the quality of such services.

''(iii) The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this subparagraph.

''(B) HEALTH CARE PROVIDER INCENTIVE PLAN DEFINED.—In this paragraph, the term 'health care provider incentive plan' means any compensation arrangement between an eligible organization and a health care provider or health care provider group that may directly or indirectly have the effect of reducing or limiting medically necessary services provided with respect to individuals enrolled with the organization.

''(6) PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.—

''(A) IN GENERAL.—

''(i) PROHIBITION OF CERTAIN PROVISIONS.—Subject to subparagraph (C), an

eligible organization may not include with respect to its plan under this section any provision that prohibits or restricts any medical communication (as defined in subparagraph (B)) as part of—

"(I) a written contract or agreement with a health care provider;

"(II) a written statement to such a provider; or

"(III) an oral communication to such a provider.

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

"(B) MEDICAL COMMUNICATION DEFINED.—In this paragraph, the term 'medical communication' means a communication made by a health care provider with a patient of the provider (or the guardian or legal representative of such patient) with respect to any of the following:

"(i) How participating physicians and health care providers are paid.

"(ii) Utilization review procedures.

"(iii) The basis for specific utilization review decisions.

''(iv) Whether a specific prescription drug or biological is included in the formulary.

''(v) How the eligible organization decides whether a treatment or procedure is experimental.

''(vi) The patient's physical or mental condition or treatment options.

''(C) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing an entity from—

''(i) acting on information relating to the provision of (or failure to provide) treatment to a patient; or

''(ii) restricting a medical communication that recommends 1 health plan over another if the sole purpose of the communication is to secure financial gain for the health care provider.

''(7) ADDITIONAL DEFINITIONS.—In this subsection:

''(A) HEALTH CARE PROVIDER.—The term 'health care provider' means anyone licensed under State law to provide health care services under part A or B.

"(B) IN-NETWORK.—The term 'in-network' means services provided by health care providers who have entered into a contract or agreement with the organization under which such providers are obligated to provide items, treatment, and services under this section to individuals enrolled with the organization under this section.

"(C) NETWORK.—The term 'network' means, with respect to an eligible organization, the health care providers who have entered into a contract or agreement with the organization under which such providers are obligated to provide items, treatment, and services under this section to individuals enrolled with the organization under this section.

"(D) OUT-OF-NETWORK.—The term 'out-of-network' means services provided by health care providers who have not entered into a contract agreement with the organization under which such providers are obligated to provide items, treatment, and services under this section to individuals enrolled with the organization under this section.

''(8) NONPREEMPTION OF STATE LAW.—A State may establish or enforce requirements with respect to the subject matter of this subsection, but only if such requirements are more stringent than the requirements established under this subsection.''.

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

(1) in subsection (a)(1)(E)(ii)(II), by striking ''subsection (c)(3)(E)'' and inserting ''subsection (k)(4)'';

(2) in subsection (c)—

(A) in paragraph (3)—

(i) by striking subparagraph (E); and

(ii) in subparagraph (G)(ii)(II), by striking ''subparagraph (E)'' and inserting ''subsection (k)(4)'';

(B) by striking paragraph (4); and

(C) by striking ''(5)(A) The organization'' and all that follows through ''(B) A member'' and inserting ''(5) A member''; and

(3) in subsection (i)—

(A) in paragraph (6)(A)(vi), by striking ''paragraph (8)'' and inserting ''subsection (k)(5)''; and

(B) by striking paragraph (8).

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

SEC. 4. APPLICATION OF PROTECTIONS TO MEDICARE SELECT POLICIES.

(a) IN GENERAL.—Section 1882(t) of the Social Security Act (42 U.S.C. 1395ss(t)) is amended—

(1) in paragraph (1)—

(A) by striking ''and'' at the end of subparagraph (E);

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

(C) by adding at the end the following:

''(G) notwithstanding any other provision of this section to the contrary, the issuer of the policy meets the requirements of section 1876(k) (except for subparagraphs (C) and (D) of paragraph (4) of that section) with respect to individuals enrolled under the policy, in the same manner such requirements apply with respect to an eligible organization under such sec-

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

''(H) the issuer of the policy discloses to the Secretary, as requested by the Secretary, the information necessary to complete the report described in paragraph (4).''; and

(2) by adding at the end the following:

''(4) The Secretary shall develop an understandable standardized comparative report on the policies offered by entities pursuant to this subsection. Such report shall contain information similar to the information contained in the report developed by the Secretary pursuant to section 1876(k)(4)(C).''.

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

SEC. 5. STUDY AND RECOMMENDATIONS TO CONGRESS.

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

(b) REPORT.—Not later than 2 years after the date of enactment of this Act and annually thereafter, the Secretary shall submit a report to Congress that shall contain

a detailed statement of the findings and conclusions of the Secretary regarding the study conducted pursuant to subsection (a), together with the Secretary's recommendations for such legislation and administrative actions as the Secretary considers appropriate.

(c) FUNDING.—The Secretary shall carry out the provisions of this section out of funds otherwise appropriated to the Secretary.

SEC. 6. NATIONAL INFORMATION CLEARINGHOUSE.

Not later than 18 months after the date of enactment of this Act, the Secretary shall establish and operate, out of funds otherwise appropriated to the Secretary, a clearinghouse and (if the Secretary determines it to be appropriate) a 24-hour toll-free telephone hotline, to provide for the dissemination of the comparative reports created pursuant to section 1876(k)(4)(C) of the Social Security Act (42 U.S.C. 1395mm(k)(4)(C)) (as added by section 3 of this Act) and section 1882(t)(4) of the Social Security Act (42 U.S.C. 1395ss(t)(4)) (as added by section 4 of this Act). In order to assist in the dissemination of the comparative reports, the Secretary may also utilize medicare offices open to the general public, the beneficiary assistance program established under section 4359 of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 1395b–3), and the health insurance information counseling and

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

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