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103D CONGRESS
2D SESSION

H. R. 4527

To assure fairness and choice to patients and providers under managed care health benefit plans.

IN THE HOUSE OF REPRESENTATIVES

MAY 26, 1994

Mr. PETERSON of Minnesota (for himself, Mr. LAUGHLIN, Mr. HALL of Texas, Mr. ROWLAND, Mr. BARCIA of Michigan, and Mr. ALLARD) introduced the following bill; which was referred jointly to the Committees on Energy and Commerce and Education and Labor

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A BILL

To assure fairness and choice to patients and providers under managed care health benefit plans.

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

(a) Nothing in this Act shall be construed as prohibiting the following:

(1) An individual from purchasing any health care services with that individual's own funds, whether such services are covered within the individual's standard benefit package or from another health care provider or plan.

(2) Employers from providing coverage for benefits in addition to the comprehensive benefit package.

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

(a) CERTIFICATION PROCESS.—

(1) CERTIFICATION.—The Secretary shall establish a process for certification of managed care plans meeting the requirements of subsection (b)(1) and of utilization review programs meeting the requirements of subsection (b)(2).

(2) QUALIFIED MANAGED CARE PLAN.—For purposes of this title, 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 this section.

(3) QUALIFIED UTILIZATION REVIEW PROGRAM.—For purposes of this title, 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 this section.

(4) UTILIZATION REVIEW PROGRAM.—For purposes of this title the term ''utilization review program'' means a system of reviewing 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 ambulatory procedures, and retrospective review.

(5) MANAGED CARE PLAN.—

(A) IN GENERAL.—For purposes of this title the term ''managed care plan'' means a plan operated by a managed care entity as described 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 participating providers and procedures provided for by the plan.

(B) MANAGED CARE ENTITY DEFINED.—For purposes of this title, a 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 described in subparagraph (C), that operates a managed care plan.

(C) MANAGED CARE CONTRACTOR DEFINED.—For purposes of this title, a 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.

(6) PARTICIPATING PROVIDER.—The term ''participating provider'' means a physician, hospital, pharmacy, laboratory, or other appropriately state licensed 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.

(7) REVIEW AND RECERTIFICATION.—The Secretary shall establish procedures for the periodic review and recertification of qualified managed care plans and qualified utilization review programs.

(8) TERMINATION OF CERTIFICATION.—The Secretary shall terminate the certification of a previously qualified managed care plan or a qualified utilization review program if the Secretary determines that such plan or program no longer meets the applicable requirements for certification. Before effecting a termination, the Secretary shall provide the plan notice and opportunity for a hearing on the proposed termination.

(9) CERTIFICATION THROUGH ALTERNATIVE REQUIREMENTS.—

(A) CERTAIN ORGANIZATIONS RECOGNIZED.—An eligible organization as defined in section 1876(b), 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 a requirement or requirements for accreditation of a managed care plan or utilization review program that are at least equivalent to a requirement(s) established under subsection (b), the Secretary may, to the extent appropriate, treat a managed care plan or a utilization review program thus accredited as meeting the requirement(s) of subsection (b).

(b) REQUIREMENTS FOR CERTIFICATION.—

(1) MANAGED CARE PLANS.—The Secretary shall establish Federal standards for the certification of qualified managed care plans, including standards whereby:

(A) Prospective enrollees in health insurance plans must be provided information as to the terms and conditions of the plan so that they can make informed decisions about accept-

ing a certain system of health care delivery. Where the plan is described orally to enrollees, easily understood, truthful, and objective terms must be used. All written plan descriptions must be in a readable and understandable format, consistent with standards developed for supplemental insurance coverage under Title XVIII of the Social Security Act. This format must be standardized so that customers can compare the attributes of the plans. Specific items that must be included are—

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

(ii) 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;

(iii) financial arrangements or contractual provisions with hospitals, review companies, physicians or any other pro-

vider of health care services that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patients, including but not limited to financial incentives not to provide medical or other services;

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

(v) loss ratios; and

(vi) enrollee satisfaction statistics (including percent reenrollment, reasons for leaving plan, etc.).

(B) Plans must demonstrate that they have adequate access to physicians and other providers, so that all covered health care services will be provided in a timely fashion. This requirement can not be waived and must be met in all areas where the plan has enrollees, including rural areas.

(C) Plans must meet financial reserve requirements that are established to assure prop-

er payment for covered services provided. An indemnity fund should be established to provide for plan failures even when a plan has met the reserve requirements.

(D) All plans shall be required to establish a mechanism, with defined rights, under which physicians participating in the plan 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.

(E) All plans shall be required to credential physicians within the plan, and will allow all physicians within the plan's geographic service area to apply for such credentials. At least once per year, plans shall notify physicians of the opportunity to apply for credentials.

(i) Such a credentialing process shall begin upon application of a physician to the plan for inclusion.

(ii) Each application shall be reviewed by a credentialing committee with appropriate representation of the applicant's medical specialty.

(iii) Credentialing shall be based on objective standards of quality with input from physicians credentialed in the plan and such standards shall be available to applicants and enrollees. When economic considerations are part of the decision, objective criteria must be used and 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 than or lower than expected costs. Profiles must be made available to those so profiled. When 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.

(iv) Plans shall be prohibited from discriminating against enrollees with expensive medical conditions by excluding

practitioners with practices containing a substantial number of such patients.

(v) All decisions shall be made on the record and the applicant shall be provided with all reasons used if the application is denied or the contract not renewed.

(vi) Plans shall not be allowed to include clauses in physician or other provider contracts that allow for the plan to terminate the contract ''without cause''.

(vii) There shall be a due process appeal from all adverse decisions. 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.

(viii) 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. Prior to initiation of a proceeding leading to termination of a contract ''for cause'', 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 within the jurisdiction.

(F) Procedures shall be established to ensure that all applicable Federal and State laws designed to protect the confidentiality of provider and individual medical records are followed.

(2) QUALIFIED UTILIZATION REVIEW PROGRAMS.—The Secretary, shall establish Federal standards for the certification of qualified utilization review programs, including:

(A) Plans must have a medical director responsible for all clinical decisions by the plan and provide assurances that the medical review or utilization practices they use, and the medical review or utilization practices of payers or reviewers with whom they contract, comply with the following requirements.

(B) Screening criteria, weighting elements, and computer algorithms utilized in the review

process and their method of development, must be released to physicians and the public.

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

(D) 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 American Osteopathic Association) as the practitioner who provided the service.

(E) Each claimant or provider (upon assignment of a claimant) 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 not involved in the organization that performed the initial review.

(F) Any individual making a negative judgment or recommendation about the necessity or appropriateness of services or the site of

service must be a physician licensed to practice medicine in the jurisdiction from which the claim arose.

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

(H) Patient or physician requests for prior authorization of a non-emergency service must be answered within two business days, and qualified personnel must be available for same-day telephone responses to inquiries about medical necessity, including certification of continued length of stay.

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

(J) When prior approval for a service or other covered item is obtained, it shall be considered approval for all purposes and the service

shall be considered to be covered unless there was fraud or incorrect information provided at the time such prior approval was obtained.

(K) Procedures for ensuring that all applicable Federal and State laws designed to protect the confidentiality of provider and individual medical records are followed.

(3) APPLICATION OF STANDARDS.—

(A) IN GENERAL.—Standards shall first be established under this subsection by not later than 12 months after the date of the enactment of this section. In developing standards under this subsection, the Secretary shall—

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

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

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

(B) REVISION OF STANDARDS.—The Secretary shall periodically review the standards established under this subsection, 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 REQUIREMENTS FOR POINT OF SERVICE PLANS

SEC. 3. (a) CHOICE REQUIREMENTS FOR POINT OF SERVICE PLANS.—

(1) Each sponsor of a health benefit plan that restricts access to providers (including such plans provided, offered, or made available by voluntary health purchasing co-operatives, employers, and self-insurers), shall offer to all eligible enrollees the opportunity to obtain coverage for out-of-network services through a ''point of service'' plan, as defined by subparagraph (2), at the time of enrollment and at least for a continuous one-month period annually thereafter.

(2) For purposes of this Act, an ''out-of-network'' or ''point of service'' plan provides additional

coverage and/or access to care to nonnetwork providers to an eligible enrollee of a health plan that restricts access to items and services provided by a health care provider who is not a member of the plan's provider network (as defined in subparagraph (2)), or, that may cover any other services the enrollee seeks, whether such services are provided in or outside of the enrollee's plan.

(3) A ''provider network'' means, with respect to a health plan that restricts access, those providers who have entered into a contract of agreement with the plan under which such providers are obligated to provide items and services in the standard benefits package to eligible individuals enrolled in the plan, or have an agreement to provide services on a fee-for-service basis.

(4) PREMIUMS.—A plan may charge an enrollee who opts to obtain point of service coverage an alternative premium that takes into account the actuarial value of such coverage.

(5) COPAYMENTS.—A point of service plan shall require payment of coinsurance for an out-of-network item or service, as follows:

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

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

(6) PAYMENT DISCLOSURE REQUIREMENT.—All sponsors of point of service plans and physicians 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.

(7) 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 amount allowed under applicable plan limits. Such amount, except for reasonable coinsurance, shall be considered payment in full.

TITLE IV—CHOICE OF HEALTH PLANS FOR ENROLLMENT

SEC. 4. (a) IN GENERAL.—Each sponsor of a health benefit plan, who offers, provides or makes available such benefit plan (including voluntary health insurance pur-

chasing co-operatives, employers, and selfinsurers), must provide to each eligible enrollee a choice of health plans among available plans.

(b) OFFERING OF PLANS BY VOLUNTARY HEALTH INSURANCE PURCHASING COOPERATIVES, EMPLOYERS, AND OTHER SPONSORS.—

(1) IN GENERAL.—Each voluntary health insurance purchasing cooperative, employer, or other sponsor shall include among its health plan offerings at least one of each of the following types of health benefit plans:

(A) A health maintenance organization or preferred provider organization, where available.

(B) A traditional insurance plan (as defined in paragraph (2)).

(C) A benefit payment schedule plan (as defined in paragraph (3)).

(2) TRADITIONAL INSURANCE PLAN DEFINED.—For purposes of this act, the term ''traditional insurance plan'' is defined to include those plans that offer the standard benefits package 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.

(3) BENEFIT PAYMENT SCHEDULE PLAN DEFINED.—For purposes of this Act, the term ''benefit payment schedule plan'' means a health plan that—

(A) provides coverage for all items and services included in the standard benefit package that are furnished by any lawful health care provider of the enrollee's choice (within the scope of state licensure);

(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; and

(C) provides a benefit payment schedule that identifies covered services and the payment for each service covered by the plan. No co-payments or coinsurance shall be applied.

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