

104TH CONGRESS
1ST SESSION

H. R. 2350

To amend title XVIII of the Social Security Act to provide protections for medicare beneficiaries who enroll in medicare managed care plans.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 18, 1995

Mr. COBURN introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title XVIII of the Social Security Act to provide protections for medicare beneficiaries who enroll in medicare managed care plans.

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 “Medicare Patient
5 Choice and Access Act of 1995”.

6 **SEC. 2. FINDINGS.**

7 Congress finds the following:

1 (1) There should be no unreasonable barriers or
2 impediments to the ability of individuals enrolled in
3 health care plans to obtain appropriate specialized
4 medical services.

5 (2) The patient's first point of contact in a
6 health care plan must be encouraged to make all ap-
7 propriate medical referrals and should not be con-
8 strained financially from making such referrals.

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

11 (4) At any time, patients must be able to access
12 out-of-network items, treatment, and services at an
13 additional cost to the patient which is not so prohibi-
14 tive that they are deterred from seeing the health
15 care provider of their own choice.

16 (5) Specialty care must be available for the full
17 duration of the patient's medical needs and not lim-
18 ited by time or number of visits.

19 (6) Direct access to specialty care is essential
20 for patients in emergency and non-emergency situa-
21 tions and for patients with chronic and temporary
22 conditions.

23 **SEC. 3. PROTECTION FOR MEDICARE HMO ENROLLEES.**

24 (a) IN GENERAL.—Section 1876 of the Social Secu-
25 rity Act (42 U.S.C. 1395mm) is amended—

1 (1) in subsection (c)(1), by striking “subsection
2 (e)” and inserting “subsections (e) and (k)”, and

3 (2) by adding at the end the following new sub-
4 section:

5 “(k) BENEFICIARY PROTECTION.—

6 “(1) MINIMUM LOSS RATIO.—

7 “(A) IN GENERAL.—Each eligible organi-
8 zation shall have a loss-ratio that is not less
9 than 85 percent for each contract year.

10 “(B) LOSS RATIO DEFINED.—In subpara-
11 graph (A), the term ‘loss-ratio’ means, with re-
12 spect to an organization for a contract year, the
13 ratio of (i) the anticipated aggregate benefits
14 provided under this section to enrollees for the
15 year, to (ii) the aggregate amount of the pre-
16 miums collected (including payments to the or-
17 ganization under subsection (a) for the year, as
18 estimated on the basis of incurred claims expe-
19 rience and earned premium for the year.

20 “(2) ASSURING ADEQUATE IN-NETWORK AC-
21 CESS.—

22 “(A) TIMELY ACCESS.—An eligible organi-
23 zation that restricts the providers from whom
24 benefits may be obtained must guarantee to en-
25 rollees under this section timely access to pri-

1 mary and specialty health care providers who
2 are appropriate to the enrollee’s condition.

3 “(B) ACCESS TO SPECIALIZED CARE.—En-
4 rollees must have access to specialized treat-
5 ment when the treating provider deems nec-
6 essary. This access may be satisfied through
7 contractual arrangements with specialized pro-
8 viders outside of the network.

9 “(C) CONTINUITY OF CARE.—An eligible
10 organization’s use of case management may not
11 create an undue burden for enrollees under this
12 section. An organization must ensure direct ac-
13 cess to specialists for ongoing care as so deter-
14 mined by the case manager in consultation with
15 the specialty care provider. This continuity of
16 care may be satisfied for enrollees with chronic
17 conditions through the use of a specialist serv-
18 ing as case manager.

19 “(3) ASSURING OUT-OF-NETWORK ACCESS.—

20 “(A) IN GENERAL.—An eligible organiza-
21 tion that contracts with a specific network of
22 providers must not limit the ability of its enroll-
23 ees under this section to seek at any time items,
24 treatment, and services from out-of-network
25 providers for all covered benefits.

1 “(B) REIMBURSEMENT FOR OUT-OF-NET-
2 WORK SERVICES.—An eligible organization
3 under this section shall provide for reimburse-
4 ment for the enrollee, consistent with the cost-
5 sharing schedule established under subpara-
6 graph (C), with respect to out-of-network serv-
7 ices which are described in subparagraph (A),
8 so long as the services were medically appro-
9 priate, and were covered benefits in-network.

10 “(C) ESTABLISHMENT OF COST-SHARING
11 SCHEDULE.—Each eligible organization shall
12 establish (by not later than one year after the
13 enactment of the Medicare Patient Choice and
14 Access Act of 1995) a cost-sharing schedule
15 which applies to payment required under sub-
16 paragraph (B) for out-of-network services.

17 “(4) GRIEVANCE AND APPEALS PROCESSES.—

18 “(A) GRIEVANCE PROCESS.—The organiza-
19 tion must provide meaningful procedures for
20 hearing and resolving grievances between the
21 organization (including any entity or individual
22 through which the organization provides health
23 care services) and members enrolled with the
24 organization under this section.

25 “(B) BOARD OF APPEALS.—

1 “(i) IN GENERAL.—Each eligible or-
2 organization shall establish a board of ap-
3 peals to hear and make determinations on
4 complaints by enrollees concerning denials
5 of coverage or payment for services
6 (whether in-network or out-of-network)
7 and the medical necessity and appropriate-
8 ness of covered items and services.

9 “(ii) COMPOSITION.—A board of ap-
10 peals of an eligible organization shall con-
11 sist of—

12 “(I) representatives of the orga-
13 nization, including physicians,
14 nonphysicians, administrators, and
15 enrollees;

16 “(II) consumers who are not en-
17 rollees; and

18 “(III) providers with expertise in
19 the field of medicine which neces-
20 sitates treatment.

21 “(iii) DEADLINE FOR DECISION.—A
22 board of appeals shall hear and resolve
23 complaints within 30 days after the date
24 the complaint is filed with the board.

1 “(C) APPEAL TO SECRETARY.—Nothing in
2 this paragraph may be construed to replace or
3 supercede any appeals mechanism otherwise
4 provided for an individual entitled to benefits
5 under this title.

6 “(5) NOTICE OF ENROLLEE RIGHTS AND EN-
7 ROLLEE INFORMATION CHECKLIST.—

8 “(A) IN GENERAL.—Each eligible organi-
9 zation shall provide each enrollee, at the time of
10 enrollment and not less frequently than annu-
11 ally thereafter, an explanation of the enrollee’s
12 rights under this section and a copy of the most
13 recent enrollee information checklist for the or-
14 ganization (as described in subparagraph (C)).

15 “(B) RIGHTS DESCRIBED.—The expla-
16 nation of rights under subparagraph (A) shall
17 include an explanation of—

18 “(i) the enrollee’s rights to benefits
19 from the organization;

20 “(ii) the restrictions on payments
21 under this title for services furnished other
22 than by or through the organization;

23 “(iii) out-of-area coverage provided by
24 the organization;

1 “(iv) the organization’s coverage of
2 emergency services and urgently needed
3 care;

4 “(v) the organization’s coverage of
5 out-of-network services, including services
6 that are additional to the items and serv-
7 ices covered under parts A and B; and

8 “(vi) appeal rights of enrollees.

9 “(C) ENROLLEE INFORMATION CHECK-
10 LIST.—For purposes of subparagraph (A), the
11 term ‘enrollee information checklist’ means,
12 with respect to an eligible organization for a
13 year, a list containing the following information
14 (provided in a manner that permits consumers
15 to compare organizations with respect to the in-
16 formation):

17 “(i) For each plan, on—

18 “(I) the premium for the plan,

19 “(II) identity, location, qualifica-
20 tions and availability of providers in
21 any provider networks of the plan,

22 “(III) the number of individuals
23 enrolling and disenrolling from the
24 plan,

1 “(IV) procedures used by the
2 plan to control utilization of services
3 and expenditures,

4 “(V) procedures used by the plan
5 to assure quality of care,

6 “(VI) the plan’s loss ratio, and

7 “(VII) rights and responsibilities
8 of enrollees.

9 “(ii) In addition, for each managed
10 care plan, on—

11 “(I) restrictions on payment for
12 services provided outside the plan’s
13 provider network,

14 “(II) the process by which serv-
15 ices may be obtained through the
16 plan’s provider network,

17 “(III) coverage for out-of-area
18 services, and

19 “(IV) any exclusions in the types
20 of providers participating in the plan’s
21 provider network.

22 “(6) RESTRICTIONS ON PROVIDER INCENTIVE
23 PLANS.—

24 “(A) IN GENERAL.—Each contract with an
25 eligible organization under this section shall

1 provide that the organization may not operate
2 any provider incentive plan (as defined in sub-
3 paragraph (B)) unless the following require-
4 ments are met:

5 “(i) No specific payment is made di-
6 rectly or indirectly under the plan to a pro-
7 vider or provider group as an inducement
8 to reduce or limit medically necessary serv-
9 ices provided with respect to a specific in-
10 dividual enrolled with the organization.

11 “(ii) If the plan places a provider or
12 provider group at substantial financial risk
13 (as determined by the Secretary) for serv-
14 ices not provided by the provider or pro-
15 vider group, the organization—

16 “(I) provides stop-loss protection
17 for the provider or group that is ade-
18 quate and appropriate, based on
19 standards developed by the Secretary
20 that take into account the number
21 (and type) of providers placed at such
22 substantial financial risk in the group
23 or under the plan and the number of
24 individuals enrolled with the organiza-

1 tion who receive services from the pro-
2 vider or the group, and

3 “(II) conducts periodic surveys of
4 both individuals enrolled and individ-
5 uals previously enrolled with the orga-
6 nization to determine the degree of
7 access of such individuals to services
8 provided by the organization and sat-
9 isfaction with the quality of such serv-
10 ices.

11 “(iii) The organization provides the
12 Secretary with descriptive information re-
13 garding the plan, sufficient to permit the
14 Secretary to determine whether the plan is
15 in compliance with the requirements of this
16 subparagraph.

17 “(B) PROVIDER INCENTIVE PLAN DE-
18 FINED.—In this paragraph, the term ‘provider
19 incentive plan’ means any compensation ar-
20 rangement between an eligible organization and
21 a provider or provider group that may directly
22 or indirectly have the effect of reducing or lim-
23 iting medically necessary services provided with
24 respect to individuals enrolled with the organi-
25 zation.

1 “(7) ADDITIONAL DEFINITIONS.—

2 “(A) IN-NETWORK.—The term ‘in-network’
3 means services provided by health care provid-
4 ers who have entered into a contract or agree-
5 ment with the organization under which such
6 providers are obligated to provide items, treat-
7 ment, and services under this section to individ-
8 uals enrolled with the organization under this
9 section.

10 “(B) NETWORK.—The term ‘network’
11 means, with respect to an eligible organization,
12 the health care providers who have entered into
13 a contract or agreement with the organization
14 under which such providers are obligated to
15 provide items, treatment, and services under
16 this section to individuals enrolled with the or-
17 ganization under this section.

18 “(C) OUT-OF-NETWORK.—The term ‘out-
19 of-network’ means services provided by health
20 care providers who have not entered into a con-
21 tract agreement with the organization under
22 which such providers are obligated to provide
23 items, treatment, and services under this sec-
24 tion to individuals enrolled with the organiza-
25 tion under this section.”.

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

3 (1) by striking subparagraph (E) of subsection
4 (c)(3);

5 (2) by striking paragraphs (4) and (5) of sub-
6 section (c); and

7 (3) by striking paragraph (8) of subsection (i).

8 (c) EFFECTIVE DATE.—The amendments made by
9 this section shall apply to contracts entered into or re-
10 newed under section 1876 of the Social Security Act after
11 the expiration of the 1-year period which begins on the
12 date of the enactment of this Act.

13 **SEC. 4. APPLICATION OF PROTECTIONS TO MEDICARE SE-**
14 **LECT POLICIES.**

15 (a) IN GENERAL.—Section 1882(t)(1) of the Social
16 Security Act (42 U.S.C. 1395ss(t)(1)) is amended—

17 (1) by striking “and” at the end of subpara-
18 graph (E);

19 (2) by striking the period at the end of sub-
20 paragraph (F) and inserting a semicolon; and

21 (3) by adding at the end the following new sub-
22 paragraph:

23 “(G) notwithstanding any other provision
24 of this section to the contrary, if the issuer of
25 the policy—

1 “(i) meets the requirements of section
2 1876(k) with respect to individuals en-
3 rolled under the policy in the same manner
4 such requirements apply with respect to an
5 eligible organization under such section
6 with respect to individuals enrolled with
7 the organization under such section, and

8 “(ii) discloses (in a form and manner
9 specified by the Secretary) the loss ratio
10 described in subsection (r)(1) most re-
11 cently calculated for purposes of such sub-
12 section.”.

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

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