

103^D CONGRESS
2^D 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

A BILL

To assure fairness and choice to patients and providers under managed care health benefit 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 “Patient Protection Act
5 of 1994”.

6 TITLE I—PROTECTION OF CONSUMER CHOICE

7 (a) Nothing in this Act shall be construed as prohibit-
8 ing the following:

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

6 (2) Employers from providing coverage for ben-
7 efits in addition to the comprehensive benefit pack-
8 age.

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

11 (a) CERTIFICATION PROCESS.—

12 (1) CERTIFICATION.—The Secretary shall es-
13 tablish a process for certification of managed care
14 plans meeting the requirements of subsection (b)(1)
15 and of utilization review programs meeting the re-
16 quirements of subsection (b)(2).

17 (2) QUALIFIED MANAGED CARE PLAN.—For
18 purposes of this title, the term “qualified managed
19 care plan” means a managed care plan that the Sec-
20 retary certifies, upon application by the program, as
21 meeting the requirements of this section.

22 (3) QUALIFIED UTILIZATION REVIEW PRO-
23 GRAM.—For purposes of this title, the term “quali-
24 fied utilization review program” means a utilization
25 review program that the Secretary certifies, upon

1 application by the program, as meeting the require-
2 ments of this section.

3 (4) UTILIZATION REVIEW PROGRAM.—For pur-
4 poses of this title the term “utilization review pro-
5 gram” means a system of reviewing the medical ne-
6 cessity, appropriateness, or quality of health care
7 services and supplies provided under a health insur-
8 ance plan or a managed care plan using specified
9 guidelines. Such a system may include preadmission
10 certification, the application of practice guidelines,
11 continued stay review, discharge planning,
12 preauthorization of ambulatory procedures, and ret-
13 rospective review.

14 (5) MANAGED CARE PLAN.—

15 (A) IN GENERAL.—For purposes of this
16 title the term “managed care plan” means a
17 plan operated by a managed care entity as de-
18 scribed in subparagraph (B), that provides for
19 the financing and delivery of health care serv-
20 ices to persons enrolled in such plan through—

21 (i) arrangements with selected provid-
22 ers to furnish health care services;

23 (ii) explicit standards for the selection
24 of participating providers;

1 (iii) organizational arrangements for
2 ongoing quality assurance, utilization re-
3 view programs, and dispute resolution; and

4 (iv) financial incentives for persons
5 enrolled in the plan to use the participat-
6 ing providers and procedures provided for
7 by the plan.

8 (B) MANAGED CARE ENTITY DEFINED.—

9 For purposes of this title, a managed care en-
10 tity includes a licensed insurance company, hos-
11 pital or medical service plan, health mainte-
12 nance organization, an employer or employee
13 organization, or a managed care contractor as
14 described in subparagraph (C), that operates a
15 managed care plan.

16 (C) MANAGED CARE CONTRACTOR DE-

17 FINED.—For purposes of this title, a managed
18 care contractor means a person that—

19 (i) establishes, operates or maintains
20 a network of participating providers;

21 (ii) conducts or arranges for utiliza-
22 tion review activities; and

23 (iii) contracts with an insurance com-
24 pany, a hospital or medical service plan, an
25 employer, an employee organization, or any

1 other entity providing coverage for health
2 care services to operate a managed care
3 plan.

4 (6) PARTICIPATING PROVIDER.—The term
5 “participating provider” means a physician, hospital,
6 pharmacy, laboratory, or other appropriately state li-
7 censed provider of health care services or supplies,
8 that has entered into an agreement with a managed
9 care entity to provide such services or supplies to a
10 patient enrolled in a managed care plan.

11 (7) REVIEW AND RECERTIFICATION.—The Sec-
12 retary shall establish procedures for the periodic re-
13 view and recertification of qualified managed care
14 plans and qualified utilization review programs.

15 (8) TERMINATION OF CERTIFICATION.—The
16 Secretary shall terminate the certification of a pre-
17 viously qualified managed care plan or a qualified
18 utilization review program if the Secretary deter-
19 mines that such plan or program no longer meets
20 the applicable requirements for certification. Before
21 effecting a termination, the Secretary shall provide
22 the plan notice and opportunity for a hearing on the
23 proposed termination.

24 (9) CERTIFICATION THROUGH ALTERNATIVE
25 REQUIREMENTS.—

1 (A) CERTAIN ORGANIZATIONS RECOG-
2 NIZED.—An eligible organization as defined in
3 section 1876(b), shall be deemed to meet the
4 requirements of subsection (b) for certification
5 as a qualified managed care plan.

6 (B) RECOGNITION OF ACCREDITATION.—If
7 the Secretary finds that a State licensure pro-
8 gram or a national accreditation body estab-
9 lishes a requirement or requirements for accred-
10 itation of a managed care plan or utilization re-
11 view program that are at least equivalent to a
12 requirement(s) established under subsection (b),
13 the Secretary may, to the extent appropriate,
14 treat a managed care plan or a utilization re-
15 view program thus accredited as meeting the
16 requirement(s) of subsection (b).

17 (b) REQUIREMENTS FOR CERTIFICATION.—

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

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

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

12 (i) coverage provisions, benefits, and
13 any exclusions by category of service, pro-
14 vider or physician, and if applicable, by
15 specific service;

16 (ii) any and all prior authorization or
17 other review requirements including
18 preauthorization review, concurrent review,
19 post-service review, post payment review
20 and any procedures that may lead the pa-
21 tient to be denied coverage for or not be
22 provided a particular service;

23 (iii) financial arrangements or con-
24 tractual provisions with hospitals, review
25 companies, physicians or any other pro-

1 vider of health care services that would
2 limit the services offered, restrict referral
3 or treatment options, or negatively affect
4 the physician's fiduciary responsibility to
5 his or her patients, including but not lim-
6 ited to financial incentives not to provide
7 medical or other services;

8 (iv) explanation of how plan limita-
9 tions impact enrollees, including informa-
10 tion on enrollee financial responsibility for
11 payment for coinsurance or other non-cov-
12 ered or out-of-plan services;

13 (v) loss ratios; and

14 (vi) enrollee satisfaction statistics (in-
15 cluding percent reenrollment, reasons for
16 leaving plan, etc.).

17 (B) Plans must demonstrate that they
18 have adequate access to physicians and other
19 providers, so that all covered health care serv-
20 ices will be provided in a timely fashion. This
21 requirement can not be waived and must be met
22 in all areas where the plan has enrollees, includ-
23 ing rural areas.

24 (C) Plans must meet financial reserve re-
25 quirements that are established to assure prop-

1 er payment for covered services provided. An in-
2 demnity fund should be established to provide
3 for plan failures even when a plan has met the
4 reserve requirements.

5 (D) All plans shall be required to establish
6 a mechanism, with defined rights, under which
7 physicians participating in the plan provide
8 input into the plan's medical policy (including
9 coverage of new technology and procedures),
10 utilization review criteria and procedures, qual-
11 ity and credentialing criteria, and medical man-
12 agement procedures.

13 (E) All plans shall be required to creden-
14 tial physicians within the plan, and will allow
15 all physicians within the plan's geographic serv-
16 ice area to apply for such credentials. At least
17 once per year, plans shall notify physicians of
18 the opportunity to apply for credentials.

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

22 (ii) Each application shall be reviewed
23 by a credentialing committee with appro-
24 priate representation of the applicant's
25 medical specialty.

1 (iii) Credentialing shall be based on
2 objective standards of quality with input
3 from physicians credentialed in the plan
4 and such standards shall be available to
5 applicants and enrollees. When economic
6 considerations are part of the decision, ob-
7 jective criteria must be used and must be
8 available to applicants, participating physi-
9 cians and enrollees. Any economic profiling
10 of physicians must be adjusted to recognize
11 case mix, severity of illness, age of patients
12 and other features of a physician's practice
13 that may account for higher than or lower
14 than expected costs. Profiles must be made
15 available to those so profiled. When grad-
16 uate medical education is a consideration
17 in credentialing, equal recognition will be
18 given to training programs accredited by
19 the Accrediting Council on Graduate Medi-
20 cal Education and by the American Osteo-
21 pathic Association.

22 (iv) Plans shall be prohibited from
23 discriminating against enrollees with ex-
24 pensive medical conditions by excluding

1 practitioners with practices containing a
2 substantial number of such patients.

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

7 (vi) Plans shall not be allowed to in-
8 clude clauses in physician or other provider
9 contracts that allow for the plan to termi-
10 nate the contract “without cause”.

11 (vii) There shall be a due process ap-
12 peal from all adverse decisions. The due
13 process appeal mechanisms shall be as set
14 forth in the Health Care Quality Improve-
15 ment Act of 1986, 42 U.S.C. §11101-
16 11152.

17 (viii) The same standards and proce-
18 dures used for an application for creden-
19 tials shall also be used in those cases
20 where the plan seeks to reduce or withdraw
21 such credentials. Prior to initiation of a
22 proceeding leading to termination of a con-
23 tract “for cause”, the physician shall be
24 provided notice, an opportunity for discus-
25 sion, and an opportunity to enter into and

1 complete a corrective action plan, except in
2 cases where there is imminent harm to pa-
3 tient health or an action by a state medical
4 board or other government agency that ef-
5 fectively impairs the physician's ability to
6 practice medicine within the jurisdiction.

7 (F) Procedures shall be established to en-
8 sure that all applicable Federal and State laws
9 designed to protect the confidentiality of pro-
10 vider and individual medical records are fol-
11 lowed.

12 (2) QUALIFIED UTILIZATION REVIEW PRO-
13 GRAMS.—The Secretary, shall establish Federal
14 standards for the certification of qualified utilization
15 review programs, including:

16 (A) Plans must have a medical director re-
17 sponsible for all clinical decisions by the plan
18 and provide assurances that the medical review
19 or utilization practices they use, and the medi-
20 cal review or utilization practices of payers or
21 reviewers with whom they contract, comply with
22 the following requirements.

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

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

3 (C) Such criteria must be based on sound
4 scientific principles and developed in coopera-
5 tion with practicing physicians and other af-
6 fected health care providers.

7 (D) Any person who recommends denial of
8 coverage or payment, or determines that a serv-
9 ice should not be provided, based on medical ne-
10 cessity standards, must be of the same medical
11 branch (allopathic or osteopathic medicine) and
12 specialty (specialties as recognized by the Amer-
13 ican Board of Medical Specialties or the Amer-
14 ican Osteopathic Association) as the practi-
15 tioner who provided the service.

16 (E) Each claimant or provider (upon as-
17 signment of a claimant) who has had a claim
18 denied as not medically necessary must be pro-
19 vided an opportunity for a due process appeal
20 to a medical consultant or peer review group
21 not involved in the organization that performed
22 the initial review.

23 (F) Any individual making a negative
24 judgment or recommendation about the neces-
25 sity or appropriateness of services or the site of

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

4 (G) Upon request, physicians will be pro-
5 vided the names and credentials of all individ-
6 uals conducting medical necessity or appro-
7 priateness review, subject to reasonable safe-
8 guards and standards.

9 (H) Patient or physician requests for prior
10 authorization of a non-emergency service must
11 be answered within two business days, and
12 qualified personnel must be available for same-
13 day telephone responses to inquiries about med-
14 ical necessity, including certification of contin-
15 ued length of stay.

16 (I) Plans must ensure that enrollees, in
17 plans where prior authorization is a condition
18 to coverage of a service, are required to sign
19 medical information release consent forms upon
20 enrollment for use where services requiring
21 prior authorization are recommended or pro-
22 posed by their physician.

23 (J) When prior approval for a service or
24 other covered item is obtained, it shall be con-
25 sidered approval for all purposes and the service

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

4 (K) Procedures for ensuring that all appli-
5 cable Federal and State laws designed to pro-
6 tect the confidentiality of provider and individ-
7 ual medical records are followed.

8 (3) APPLICATION OF STANDARDS.—

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

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

17 (ii) recognize, to the extent appro-
18 priate, differences in the organizational
19 structure and operation of managed care
20 plans; and

21 (iii) establish procedures for the time-
22 ly consideration of applications for certifi-
23 cation by managed care plans and utiliza-
24 tion review programs.

1 (B) REVISION OF STANDARDS.—The Sec-
2 retary shall periodically review the standards
3 established under this subsection, and may re-
4 vise the standards from time to time to assure
5 that such standards continue to reflect appro-
6 priate policies and practices for the cost-effec-
7 tive and medically appropriate use of services
8 within managed care plans and utilization re-
9 view programs.

10 TITLE III—CHOICE REQUIREMENTS FOR POINT
11 OF SERVICE PLANS

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

14 (1) Each sponsor of a health benefit plan that
15 restricts access to providers (including such plans
16 provided, offered, or made available by voluntary
17 health purchasing co-operatives, employers, and self-
18 insurers), shall offer to all eligible enrollees the op-
19 portunity to obtain coverage for out-of-network serv-
20 ices through a “point of service” plan, as defined by
21 subparagraph (2), at the time of enrollment and at
22 least for a continuous one-month period annually
23 thereafter.

24 (2) For purposes of this Act, an “out-of-net-
25 work” or “point of service” plan provides additional

1 coverage and/or access to care to nonnetwork provid-
2 ers to an eligible enrollee of a health plan that re-
3 stricts access to items and services provided by a
4 health care provider who is not a member of the
5 plan's provider network (as defined in subparagraph
6 (2)), or, that may cover any other services the en-
7 rollee seeks, whether such services are provided in or
8 outside of the enrollee's plan.

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

17 (4) PREMIUMS.—A plan may charge an enrollee
18 who opts to obtain point of service coverage an alter-
19 native premium that takes into account the actuarial
20 value of such coverage.

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

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

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

8 (6) PAYMENT DISCLOSURE REQUIREMENT.—All
9 sponsors of point of service plans and physicians
10 participating in such plans shall be required to dis-
11 close their fees, applicable payment schedules, coin-
12 surance requirements or any other financial require-
13 ments that affect patient payment levels.

14 (7) POVERTY EXCLUSION.—Any enrollee, in-
15 cluding enrolled dependents, whose income does not
16 exceed 200 percent of the established federal poverty
17 guideline for the applicable year, shall be charged no
18 more than amount allowed under applicable plan
19 limits. Such amount, except for reasonable coinsur-
20 ance, shall be considered payment in full.

21 TITLE IV—CHOICE OF HEALTH PLANS FOR
22 ENROLLMENT

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

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

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

7 (1) IN GENERAL.—Each voluntary health insur-
8 ance purchasing cooperative, employer, or other
9 sponsor shall include among its health plan offerings
10 at least one of each of the following types of health
11 benefit plans:

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

14 (B) A traditional insurance plan (as de-
15 fined in paragraph (2)).

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

18 (2) TRADITIONAL INSURANCE PLAN DE-
19 FINED.—For purposes of this act, the term “tradi-
20 tional insurance plan” is defined to include those
21 plans that offer the standard benefits package that
22 pay for medical services on a fee-for-service basis
23 using a usual, customary or reasonable payment
24 methodology or a resource-based relative value

1 schedule, usually linked to an annual deductible and/
2 or coinsurance payment on each allowed amount.

3 (3) BENEFIT PAYMENT SCHEDULE PLAN DE-
4 FINED.—For purposes of this Act, the term “benefit
5 payment schedule plan” means a health plan that—

6 (A) provides coverage for all items and
7 services included in the standard benefit pack-
8 age that are furnished by any lawful health care
9 provider of the enrollee’s choice (within the
10 scope of state licensure);

11 (B) makes payment for the services of a
12 provider on a fee-for-service basis without re-
13 gard to whether or not there is a contractual
14 arrangement between the plan and the provider;
15 and

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

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