

104<sup>TH</sup> CONGRESS  
1<sup>ST</sup> SESSION

# H. R. 2329

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

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## IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 14, 1995

Mr. BROWN of Ohio 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

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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.

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 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 nonemergency 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 offer its enrollees or their treat-  
23          ing provider with the patient’s authorization  
24          under this section, the ability at any time, to

1 seek items, services, and treatment from out-of-  
2 network providers for all covered benefits.

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

12 “(C) ESTABLISHMENT OF COST-SHARING  
13 SCHEDULE.—In consultation with the National  
14 Association of Insurance Commissioners, the  
15 Secretary shall establish (by not later than one  
16 year after enactment of this Act) a cost-sharing  
17 schedule which applies to payment required  
18 under subparagraph (B) for out-of-network  
19 services.

20 “(4) APPROPRIATE RANGE OF SERVICES.—A  
21 health plan shall not deny any health care profes-  
22 sionals, based solely on the license or certification as  
23 applicable under State law, the ability to participate  
24 in providing covered health care services, or be reim-  
25 bursed or indemnified or by a network plan for pro-

1       viding such services. Organizations must ensure a  
2       sufficient number, mix, and distribution of health  
3       care professionals within a network plan to ensure  
4       enrollees access to appropriate medical services.

5           “(5) GRIEVANCE AND APPEALS PROCESSES.—

6           “(A) GRIEVANCE PROCESS.—The organiza-  
7       tion must provide meaningful procedures for  
8       hearing and resolving grievances between the  
9       organization (including any entity or individual  
10      through which the organization provides health  
11      care services) and members enrolled with the  
12      organization under this section.

13          “(B) BOARD OF APPEALS.—

14          “(i) IN GENERAL.—Each eligible or-  
15      ganization shall establish a board of ap-  
16      peals to hear and make determinations on  
17      complaints by enrollees concerning denials  
18      of coverage or payment for services  
19      (whether in-network or out-of-network)  
20      and the medical necessity and appropriate-  
21      ness of covered items and services.

22          “(ii) COMPOSITION.—A board of ap-  
23      peals of an eligible organization shall con-  
24      sist of—

1           “(I) representatives of the orga-  
2           nization, including physicians,  
3           nonphysicians, administrators, and  
4           enrollees;

5           “(II) consumers who are not en-  
6           rollees and those who have disenrolled;  
7           and

8           “(III) providers with expertise in  
9           the field of medicine which neces-  
10          sitates treatment.

11          “(iii) DEADLINE FOR DECISION.—A  
12          board of appeals shall hear and resolve  
13          complaints within 30 days after the date  
14          the complaint is filed with the board.

15          “(C) APPEAL TO SECRETARY.—A member  
16          enrolled in an eligible organization under this  
17          section who is dissatisfied with a determination  
18          of a board of appeals of the organization under  
19          subparagraph (B) is entitled, if the amount in  
20          controversy is \$100 or more, to a hearing be-  
21          fore the Secretary to the same extent as is pro-  
22          vided in section 205(b), and in any such hear-  
23          ing the Secretary shall make the eligible organi-  
24          zation a party. If the amount in controversy is  
25          \$1,000 or more, the individual or eligible orga-

1           nization shall, upon notifying the other party,  
2           be entitled to judicial review of the Secretary’s  
3           final decision as provided in section 205(g), and  
4           both the individual and the eligible organization  
5           shall be entitled to be parties to that judicial re-  
6           view. In applying sections 205(b) and 205(g) as  
7           provided in this subparagraph, and in applying  
8           section 205(l) thereto, any reference therein to  
9           the Commissioner of Social Security or the So-  
10          cial Security Administration shall be considered  
11          a reference to the Secretary or the Department  
12          of Health and Human Services, respectively.

13           “(6) NOTICE OF ENROLLEE RIGHTS AND  
14          CONSUMER REPORT CARD.—

15           “(A) IN GENERAL.—Each eligible organi-  
16          zation shall provide each enrollee, at the time of  
17          enrollment and not less frequently than annu-  
18          ally thereafter, an explanation of the enrollee’s  
19          rights under this section and a copy of the most  
20          recent consumer report card for the organiza-  
21          tion (as described in subparagraph (C)).

22           “(B) RIGHTS DESCRIBED.—The expla-  
23          nation of rights under subparagraph (A) shall  
24          include an explanation of—

1           “(i) the enrollee’s rights to benefits  
2           from the organization;

3           “(ii) the restrictions on payments  
4           under this title for services furnished other  
5           than by or through the organization;

6           “(iii) out-of-area coverage provided by  
7           the organization;

8           “(iv) the organization’s coverage of  
9           emergency services and urgently needed  
10          care;

11          “(v) the organization’s coverage of  
12          out-of-network services, including services  
13          that are additional to the items and serv-  
14          ices covered under parts A and B; and

15          “(vi) appeal rights of enrollees.

16          “(C) CONSUMER REPORT CARD.—For pur-  
17          poses of subparagraph (A), the term ‘consumer  
18          report card’ means, with respect to an eligible  
19          organization for a year, a report issued by the  
20          organization which contains indicators of the  
21          quality of the services under this section pro-  
22          vided by the organization during the year. In-  
23          formation must be provided in a manner that  
24          permits consumers to compare organizations  
25          with respect to the following:

1 “(i) For each plan, on—

2 “(I) the premium for the plan,

3 “(II) identity, location, qualifica-  
4 tions, and availability of providers in  
5 any provider networks of the plan,

6 “(III) the number of individuals  
7 enrolling and disenrolling from the  
8 plan,

9 “(IV) procedures used by the  
10 plan to control utilization of services  
11 and expenditures,

12 “(V) procedures used by the plan  
13 to assure quality of care,

14 “(VI) the plan’s loss ratio, and

15 “(VII) rights and responsibilities  
16 of enrollees.

17 “(ii) In addition, for each managed  
18 care plan, on—

19 “(I) restrictions on payment for  
20 services provided outside the plan’s  
21 provider network,

22 “(II) the process by which serv-  
23 ices may be obtained through the  
24 plan’s provider network,

1 “(III) coverage for out-of-area  
2 services, and

3 “(IV) any exclusions in the types  
4 of providers participating in the plan’s  
5 provider network.

6 “(7) RESTRICTIONS ON PROVIDER INCENTIVE  
7 PLANS.—

8 “(A) IN GENERAL.—Each contract with an  
9 eligible organization under this section shall  
10 provide that the organization may not operate  
11 any provider incentive plan (as defined in sub-  
12 paragraph (B)) unless the following require-  
13 ments are met:

14 “(i) No specific payment is made di-  
15 rectly or indirectly under the plan to a pro-  
16 vider or provider group as an inducement  
17 to reduce or limit medically necessary serv-  
18 ices provided with respect to a specific in-  
19 dividual enrolled with the organization.

20 “(ii) If the plan places a provider or  
21 provider group at substantial financial risk  
22 (as determined by the Secretary) for serv-  
23 ices not provided by the provider or pro-  
24 vider group, the organization—

1           “(I) provides stop-loss protection  
2           for the provider or group that is ade-  
3           quate and appropriate, based on  
4           standards developed by the Secretary  
5           that take into account the number  
6           (and type) of providers placed at such  
7           substantial financial risk in the group  
8           or under the plan and the number of  
9           individuals enrolled with the organiza-  
10          tion who receive services from the pro-  
11          vider or the group, and

12           “(II) conducts periodic surveys of  
13          both individuals enrolled and individ-  
14          uals previously enrolled with the orga-  
15          nization to determine the degree of  
16          access of such individuals to services  
17          provided by the organization and sat-  
18          isfaction with the quality of such serv-  
19          ices.

20           “(iii) The organization provides the  
21          Secretary with descriptive information re-  
22          garding the plan, sufficient to permit the  
23          Secretary to determine whether the plan is  
24          in compliance with the requirements of this  
25          subparagraph.

1           “(B) PROVIDER INCENTIVE PLAN DE-  
2 FINED.—In this paragraph, the term ‘provider  
3 incentive plan’ means any compensation ar-  
4 rangement between an eligible organization and  
5 a provider or provider group that may directly  
6 or indirectly have the effect of reducing or lim-  
7 iting services provided with respect to individ-  
8 uals enrolled with the organization.

9           “(8) ADDITIONAL DEFINITIONS.—

10           “(A) IN-NETWORK.—The term ‘in-network’  
11 means services provided by health care provid-  
12 ers who have entered into a contract or agree-  
13 ment with the organization under which such  
14 providers are obligated to provide items, treat-  
15 ment, and services under this section to individ-  
16 uals enrolled with the organization under this  
17 section.

18           “(B) NETWORK.—The term ‘network’  
19 means, with respect to an eligible organization,  
20 the health care providers who have entered into  
21 a contract or agreement with the organization  
22 under which such providers are obligated to  
23 provide items, treatment, and services under  
24 this section to individuals enrolled with the or-  
25 ganization under this section.

1           “(C) OUT-OF-NETWORK.—The term ‘out-  
2           of-network’ means services provided by health  
3           care providers who have not entered into a con-  
4           tract agreement with the organization under  
5           which such providers are obligated to provide  
6           items, treatment, and services under this sec-  
7           tion to individuals enrolled with the organiza-  
8           tion under this section.”.

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

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

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

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

16           (c) EFFECTIVE DATE.—The amendments made by  
17 this section shall apply to contract years beginning at least  
18 60 days after the date the Secretary establishes the cost-  
19 sharing schedule for out-of-network services under section  
20 1876(k)(2)(C) of the Social Security Act (as added by sub-  
21 section (a)(2)).

22 **SEC. 4. APPLICATION OF PROTECTIONS TO MEDICARE SE-**  
23 **LECT POLICIES.**

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

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

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

5 (3) by adding at the end the following new sub-  
6 paragraph:

7 “(G) notwithstanding any other provision  
8 of this section to the contrary, if the issuer of  
9 the policy—

10 “(i) meets the requirements of section  
11 1876(k) with respect to individuals en-  
12 rolled under the policy in the same manner  
13 such requirements apply with respect to an  
14 eligible organization under such section  
15 with respect to individuals enrolled with  
16 the organization under such section, and

17 “(ii) discloses (in a form and manner  
18 specified by the Secretary) the loss ratio  
19 described in subsection (r)(1) most re-  
20 cently calculated for purposes of such sub-  
21 section.”.

22 (b) EFFECTIVE DATE.—The amendments made by  
23 subsection (a) shall apply to policies issued or renewed on  
24 or after the effective date described in section 3(c).

○