

103^D CONGRESS
2^D SESSION

S. 1796

To ensure that health coverage is portable and renewable, to enhance the ability of small businesses to purchase health care, to enhance efficiency through paperwork reduction, to provide antitrust reforms, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JANUARY 25, 1994

Mr. GRAMM (for himself, Mr. McCAIN, Mr. COATS, Mr. COVERDELL, Mrs. HUTCHISON, Mr. HELMS, Mr. LOTT, Mr. FAIRCLOTH, Mr. WALLOP, Mr. BENNETT, and Mr. BROWN) introduced the following bill; which was read twice and referred to the Committee on Labor and Human Resources

A BILL

To ensure that health coverage is portable and renewable, to enhance the ability of small businesses to purchase health care, to enhance efficiency through paperwork reduction, to provide antitrust reforms, and for other purposes.

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; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Consensus Interim Health Act”.

1 (b) TABLE OF CONTENTS.—The table of contents for
2 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—PORTABLE AND PERMANENT PRIVATE HEALTH
INSURANCE

Subtitle A—Portability

Sec. 101. Amendments to COBRA

Sec. 102. Penalty-free withdrawals from qualified retirement plans for COBRA coverage.

Subtitle B—Permanence

Sec. 111. General renewability requirements.

Sec. 112. Individual health insurance plans.

Sec. 113. Group health plans.

Sec. 114. Definitions.

Sec. 115. Failure of health plans to meet portability and permanence requirements.

TITLE II—SMALL BUSINESS HEALTH INSURANCE POOLS

Sec. 201. Prohibition of restrictions on groups purchasing health insurance.

Sec. 202. Prohibition of State benefit mandates for group health plans.

Sec. 203. Prohibition of restrictions on managed care.

Sec. 204. Definitions.

TITLE III—ENHANCED EFFICIENCY THROUGH PAPERWORK
REDUCTION

Sec. 301. Federal paperwork reduction and efficiency requirements.

Sec. 302. State paperwork reduction and efficiency requirements.

Sec. 303. Standardized Forms Commission.

TITLE IV—ANTITRUST REFORMS

Sec. 401. Establishment of limited exemption program for health care joint ventures.

Sec. 402. Issuance of health care certificates of public advantage.

Sec. 403. Interagency Advisory Committee on Competition, Antitrust Policy, and Health Care.

Sec. 404. Definitions.

1 **TITLE I—PORTABLE AND PER-**
2 **MANENT PRIVATE HEALTH**
3 **INSURANCE**

4 **Subtitle A—Portability**

5 **SEC. 101. AMENDMENTS TO COBRA**

6 (a) LOWER COST COVERAGE OPTIONS.—Subpara-
7 graph (A) of section 4980B(f)(2) of the Internal Revenue
8 Code of 1986 (relating to continuation coverage require-
9 ments of group health plans) is amended to read as
10 follows:

11 “(A) TYPE OF BENEFIT COVERAGE.—The
12 coverage must consist of coverage which, as of
13 the time the coverage is being provided—

14 “(i) is identical to the coverage pro-
15 vided under the plan to similarly situated
16 beneficiaries under the plan with respect to
17 whom a qualifying event has not occurred,

18 “(ii) is so identical, except such cov-
19 erage is offered with an annual \$1,000 de-
20 ductible, and

21 “(iii) is so identical, except such cov-
22 erage is offered with an annual \$3,000
23 deductible.

24 If coverage under the plan is modified for any
25 group of similarly situated beneficiaries, the

1 coverage shall also be modified in the same
 2 manner for all individuals who are qualified
 3 beneficiaries under the plan pursuant to this
 4 subsection in connection with such group.”.

5 (b) TERMINATION OF COBRA COVERAGE AFTER
 6 ELIGIBLE FOR EMPLOYER-BASED COVERAGE FOR 90
 7 DAYS.—Clause (iv) of section 4980B(f)(2)(B) of the In-
 8 ternal Revenue Code of 1986 (relating to period of cov-
 9 erage) is amended—

10 (1) by striking “or” at the end of subclause (I),

11 (2) by redesignating subclause (II) as subclause
 12 (III), and

13 (3) by inserting after subclause (I) the follow-
 14 ing new subclause:

15 “(II) eligible for such employer-
 16 based coverage for more than 90 days,
 17 or”.

18 (c) EFFECTIVE DATE.—The amendments made by
 19 this section shall apply to qualifying events occurring after
 20 the date of the enactment of this Act.

21 **SEC. 102. PENALTY-FREE WITHDRAWALS FROM QUALIFIED**

22 **RETIREMENT PLANS FOR COBRA COVERAGE.**

23 (a) IN GENERAL.—Subparagraph (A) of section
 24 72(t)(2) of the Internal Revenue Code of 1986 (relating

1 to additional tax not to apply to certain distributions) is
2 amended—

3 (1) by striking “or” at the end of clauses (iv)
4 and (v),

5 (2) by striking the period at the end of clause
6 (vi) and inserting “, or”, and

7 (3) by adding at the end the following new
8 clause:

9 “(vii) made to an employee who is a
10 qualified beneficiary during the period of
11 continuation coverage under section
12 4980B(f).”

13 (b) EFFECTIVE DATE.—The amendments made by
14 subsection (a) shall apply to distributions made after the
15 date of the enactment of this Act.

16 **Subtitle B—Permanence**

17 **SEC. 111. GENERAL RENEWABILITY REQUIREMENTS.**

18 (a) INSURERS.—

19 (1) IN GENERAL.—An insurer may not cancel
20 an individual health insurance plan or group health
21 plan or deny renewal of coverage under such a plan
22 other than—

23 (A) for nonpayment of premiums,

24 (B) for fraud or other misrepresentation

25 by the insured,

1 (C) for noncompliance with plan provi-
2 sions, or

3 (D) because the insurer is ceasing to pro-
4 vide any health insurance plan in a State, or,
5 in the case of a health maintenance organiza-
6 tion, in a geographic area.

7 (2) LIMITATION ON MARKET REENTRY.—If an
8 insurer terminates the offering of health insurance
9 plans or group health plans in an area, the insurer
10 may not offer such a plan in the area until 5 years
11 after the date of the termination.

12 (b) EMPLOYERS.—An employer may not cancel a
13 self-insured group health plan or deny renewal of coverage
14 under such a plan other than—

15 (1) for nonpayment of premiums,

16 (2) for fraud or other misrepresentation by the
17 insured,

18 (3) for noncompliance with plan provisions,

19 (4) because the plan is ceasing to provide any
20 coverage in a geographic area.

21 (c) EFFECTIVE DATE.—The provisions of this section
22 shall apply to any plan on or after the date of the enact-
23 ment of this Act.

1 **SEC. 112. INDIVIDUAL HEALTH INSURANCE PLANS.**

2 (a) EXISTING PLANS.—With respect to any individ-
3 ual health insurance plan in effect on the date of the en-
4 actment of this Act, the insurer shall offer the insured
5 the option to purchase a new individual health insurance
6 described in subsection (b).

7 (b) NEW PLANS.—With respect to any individual
8 health insurance plan, the effective date of which with re-
9 spect to the insured occurs after the date of the enactment
10 of this Act, the insurer may not increase the premium for
11 such a plan based on the health of the insured.

12 **SEC. 113. GROUP HEALTH PLANS.**

13 (a) EXISTING PLANS.—With respect to any group
14 health plan (other than a self-insured group health plan)
15 in effect on the date of the enactment of this Act, the
16 insurer shall offer—

17 (1) any insured of such plan the option to pur-
18 chase upon leaving the group a new individual health
19 insurance, the premium of which shall be rated
20 based on actuarial data, may be based on any pre-
21 existing condition of the insured, and may be in-
22 creased based on the health of such insured, and

23 (2) the employer or group sponsor of such plan
24 the option to purchase a new group health plan de-
25 scribed in subsection (b).

1 (b) NEW PLANS.—With respect to any group health
2 plan (other than a self-insured group health plan), the ef-
3 fective date of which with respect to the employer or group
4 sponsor occurs after the date of the enactment of this Act,
5 the insurer—

6 (1) may not increase the premium for such a
7 plan based on the health of the group’s insured, and

8 (2) shall offer any insured of such plan the op-
9 tion to purchase upon leaving the group a new indi-
10 vidual health insurance, the premium of which shall
11 be rated based on actuarial data, may not be based
12 on any preexisting condition of the insured, and may
13 not be increased based on the health of such in-
14 sured.

15 (c) SELF-INSURED GROUP HEALTH PLANS.—With
16 respect to a self-insured group health plan—

17 (1) in effect on the date of the enactment of
18 this Act—

19 (A) subsection (a)(1) shall apply through 1
20 or more insurers contracted with by such plan,
21 and

22 (B) subsection (a)(2) shall not apply, and

23 (2) the effective date of which with respect to
24 the employer or group sponsor occurs after the date
25 of the enactment of this Act, subsection (b) shall

1 apply through 1 or more insurers contracted with by
2 such plan.

3 **SEC. 114. DEFINITIONS.**

4 For purposes of this subtitle:

5 (1) **GROUP HEALTH PLAN.**—The term “group
6 health plan” has the meaning given such term by
7 section 5000(b)(1) of the Internal Revenue Code of
8 1986, but does not include any type of coverage ex-
9 cluded from the definition of a health insurance plan
10 under paragraph (2).

11 (2) **HEALTH INSURANCE PLAN.**—

12 (A) **IN GENERAL.**—Except as provided in
13 subparagraph (B), the term “health insurance
14 plan” means any hospital or medical service
15 policy or certificate, hospital or medical service
16 plan contract, or health maintenance organiza-
17 tion group contract offered by an insurer.

18 (B) **EXCEPTION.**—Such term does not in-
19 clude any of the following—

20 (i) coverage only for accident, dental,
21 vision, disability income, or long-term care
22 insurance, or any combination thereof,

23 (ii) medicare supplemental health in-
24 surance,

1 (iii) coverage issued as a supplement
2 to liability insurance,

3 (iv) worker's compensation or similar
4 insurance, or

5 (v) automobile medical-payment insur-
6 ance,

7 or any combination thereof.

8 (3) HEALTH MAINTENANCE ORGANIZATION.—

9 The term "health maintenance organization" in-
10 cludes a health insurance plan that offers to provide
11 health services on a prepaid, at-risk basis primarily
12 through a defined set of providers.

13 (4) INSURER.—The term "insurer" means a li-
14 censed insurance company, a prepaid hospital or
15 medical service plan, and a health maintenance orga-
16 nization offering such a plan to an employer, and in-
17 cludes a similar organization regulated under State
18 law for solvency.

19 **SEC. 115. FAILURE OF HEALTH PLANS TO MEET PORT-**
20 **ABILITY AND PERMANENCE REQUIREMENTS.**

21 (a) DEDUCTION FOR INDIVIDUAL HEALTH INSUR-
22 ANCE PLANS.—Paragraph (1) of section 213(d) of the In-
23 ternal Revenue Code of 1986 (defining medical care) is
24 amended—

1 (1) by striking “or” at the end of subparagraph
2 (B), and

3 (2) by striking subparagraph (C) and inserting
4 the following new subparagraphs:

5 “(C) for insurance—

6 “(i) meeting the requirements of sec-
7 tion 112 of the Consensus Interim Health
8 Act, and

9 “(ii) covering medical care referred to
10 in subparagraphs (A) and (B), or

11 “(D) as premiums under part B of title
12 XVIII of the Social Security Act, relating to
13 supplementary medical insurance for the
14 aged.”.

15 (b) TAX EXCLUSIONS FOR EMPLOYER-PROVIDED
16 HEALTH INSURANCE.—Section 106 of the Internal Reve-
17 nue Code of 1986 (relating to contributions by employer
18 to accident and health plans) is amended by striking “an
19 accident or health plan” and inserting “an accident or
20 health plan meeting the requirements of section 113 of
21 the Consensus Interim Health Act”.

22 (c) BUSINESS EXPENSE DEDUCTION FOR HEALTH
23 INSURANCE.—Section 162 of the Internal Revenue Code
24 of 1986 (relating to trade or business expenses) is amend-
25 ed by redesignating subsection (o) as subsection (p) and

1 by inserting after subsection (n) the following new sub-
2 section:

3 “(o) GROUP HEALTH PLANS.—The expenses paid or
4 incurred by an employer for a group health plan shall not
5 be allowed as a deduction under this section unless such
6 plan meets the requirements of section 113 of the Consen-
7 sus Interim Health Act.”.

8 (d) PAYROLL TAX EXCLUSION FOR EMPLOYER-PRO-
9 VIDED HEALTH INSURANCE.—Section 209(a)(2) of the
10 Social Security Act (42 U.S.C. 409(a)(2)) is amended by
11 inserting “or group health insurance” after “group-term
12 life insurance”.

13 (e) EFFECTIVE DATE.—The amendments made by
14 this section shall take effect on the date of the enactment
15 of this Act.

16 **TITLE II—SMALL BUSINESS**
17 **HEALTH INSURANCE POOLS**

18 **SEC. 201. PROHIBITION OF RESTRICTIONS ON GROUPS**
19 **PURCHASING HEALTH INSURANCE.**

20 No provision of State or local law shall apply that
21 prohibits 2 or more employers or groups from obtaining
22 coverage under a multiple employer health plan.

1 **SEC. 202. PROHIBITION OF STATE BENEFIT MANDATES FOR**
2 **GROUP HEALTH PLANS.**

3 In the case of a group health plan, no provision of
4 State or local law shall apply that requires the coverage
5 of one or more specific benefits, services, or categories of
6 health care, or services of any class or type of provider
7 of health care.

8 **SEC. 203. PROHIBITION OF RESTRICTIONS ON MANAGED**
9 **CARE.**

10 (a) **PREEMPTION OF STATE LAW PROVISIONS.**—Sub-
11 ject to subsection (c), the following provisions of State law
12 are preempted and may not be enforced:

13 (1) **RESTRICTIONS ON REIMBURSEMENT RATES**
14 **OR SELECTIVE CONTRACTING.**—Any law that re-
15 stricts the ability of a group health plan to negotiate
16 reimbursement rates with providers or to contract
17 selectively with one provider or a limited number of
18 providers.

19 (2) **RESTRICTIONS ON DIFFERENTIAL FINAN-**
20 **CIAL INCENTIVES.**—Any law that limits the financial
21 incentives that a group health plan may require a
22 beneficiary to pay when a non-plan provider is used
23 on a non-emergency basis.

24 (3) **RESTRICTIONS ON UTILIZATION REVIEW**
25 **METHODS.**—Any law that—

1 (A) prohibits utilization review of any or
2 all treatments and conditions,

3 (B) requires that such review be made (i)
4 by a resident of the State in which the treat-
5 ment is to be offered or by an individual li-
6 censed in such State, or (ii) by a physician in
7 any particular specialty or with any board cer-
8 tified specialty of the same medical specialty as
9 the provider whose services are being reviewed,

10 (C) requires the use of specified standards
11 of health care practice in such reviews or re-
12 quires the disclosure of the specific criteria used
13 in such reviews,

14 (D) requires payments to providers for the
15 expenses of responding to utilization review re-
16 quests, or

17 (E) imposes liability for delays in perform-
18 ing such review.

19 Nothing in subparagraph (B) shall be construed as
20 prohibiting a State from (i) requiring a licensed phy-
21 sician or other health care professional be available
22 at some time in the review or appeal process, or (ii)
23 requiring that any decision in an appeal from such
24 a review be made by a licensed physician.

25 (b) GAO STUDY.—

1 (1) IN GENERAL.—The Comptroller General of
2 the United States shall conduct a study of the regu-
3 latory and legal impediments at the Federal, State,
4 and local levels of government that restrict the abil-
5 ity of small businesses and other organizations to
6 group together voluntarily to allow their employees
7 or members to pool their health insurance purchases.

8 (2) REPORT.—By not later than 2 years after
9 the date of the enactment of this Act, the Comptrol-
10 ler General shall submit a report to Congress on the
11 study conducted under paragraph (1) and shall in-
12 clude in the report such recommendations (including
13 whether the provisions of subsection (a) should be
14 extended) as may be appropriate.

15 (c) SUNSET.—Unless otherwise provided, subsection
16 (a) shall not apply 5 years after the date of the enactment
17 of this Act.

18 **SEC. 204. DEFINITIONS.**

19 For purposes of this title—

20 (1) EMPLOYER.—The term “employer” shall
21 have the meaning applicable under section 3(5) of
22 the Employee Retirement Income Security Act of
23 1974.

1 (2) GROUP HEALTH PLAN.—The term “group
2 health plan” has the meaning given such term in
3 section 114(1).

4 (3) MULTIPLE EMPLOYER HEALTH PLAN.—The
5 term “multiple employer health plan” means a mul-
6 tiple employer welfare arrangement (as defined in
7 section 3(40) of the Employee Retirement Income
8 Security Act of 1974.

9 (4) STATE.—The term “State” means each of
10 the several States of the United States, the District
11 of Columbia, the Commonwealth of Puerto Rico, the
12 United States Virgin Islands, Guam, America
13 Samoa, and the Commonwealth of the Northern
14 Mariana Islands.

15 **TITLE III—ENHANCED EFFI-**
16 **CIENCY THROUGH PAPER-**
17 **WORK REDUCTION**

18 **SEC. 301. FEDERAL PAPERWORK REDUCTION AND EFFI-**
19 **CIENCY REQUIREMENTS.**

20 (a) IN GENERAL.—The Secretary of Health and
21 Human Services (hereafter referred to in this title as the
22 “Secretary”) shall, in consultation with the Director of the
23 Office of Management and Budget, the Secretary of Veter-
24 ans Affairs, the Secretary of Defense, the Director of Per-
25 sonnel Management, and other appropriate Federal offi-

1 cials, adopt standards to reduce the administrative and
2 paperwork burdens of all Federal health care programs
3 by—

4 (1) 50 percent within the 2-year period follow-
5 ing the date of the enactment of this Act, and

6 (2) an additional 50 percent over a subsequent
7 3-year period,

8 for a total reduction of 75 percent over the 5-year period
9 following the date of the enactment of this Act.

10 (b) INITIAL REDUCTION.—In order to achieve a pa-
11 perwork reduction described in subsection (a)(1), the Sec-
12 retary, shall adopt standards for Federal health care pro-
13 grams relating to each of the following:

14 (1) Data elements for use in paper and elec-
15 tronic claims processing under health insurance
16 plans, as well as for use in utilization review and
17 management of care (including data fields, formats,
18 and medical nomenclature, and including plan bene-
19 fit and insurance information).

20 (2) Uniform claims forms (including uniform
21 procedure and bill codes for use with such forms and
22 including information on other health insurance
23 plans that may be liable for benefits).

1 (3) Uniform electronic transmission of the data
2 elements (for purposes of billing and utilization re-
3 view).

4 Standards under paragraph (3) relating to electronic
5 transmission of data elements for claims for services shall
6 supersede (to the extent specified in such standards) the
7 standards adopted under paragraph (2) relating to the
8 submission of paper claims for such services. Standards
9 under paragraph (3) shall include protections to assure
10 the confidentiality of patient-specific information and to
11 protect against the unauthorized use and disclosure of in-
12 formation.

13 (c) SUBSEQUENT REDUCTION.—In order to achieve
14 a further paperwork reduction described in subsection
15 (a)(2), the Secretary shall modify by regulation the stand-
16 ards adopted under subsection (b). The modification of the
17 standards may include such recommendations as reported
18 by the Standardized Form Commission in section 303, or
19 any other provisions necessary to meet the goals for reduc-
20 tion in the paperwork burden of Federal health care pro-
21 grams.

22 (d) DEFINITION.—For purposes of this section, the
23 term “Federal health care program” means all Federal
24 programs related to health care, including programs de-
25 scribed in—

- 1 (1) title XVIII or XIX of the Social Security
2 Act,
3 (2) the Public Health Service Act,
4 (3) chapter 55 of title 10, United States Code,
5 (4) chapter 17 of title 38, United States Code,
6 (5) chapter 89 of title 5, United States Code,
7 or
8 (6) the Indian Health Care Improvement Act.

9 **SEC. 302. STATE PAPERWORK REDUCTION AND EFFI-**
10 **CIENCY REQUIREMENTS.**

11 (a) IN GENERAL.—In order to be eligible for Federal
12 funds in connection with any State-administered health
13 care program, each State shall standardize the processing
14 of paper and electronic claims to reduce the administrative
15 and paperwork burdens on such programs by 75 percent
16 during the 5-year period following the date of the enact-
17 ment of this Act.

18 (b) ENFORCEMENT.—

19 (1) INTERIM EVALUATION.—If at the end of the
20 4-year period following the date of the enactment of
21 this Act the Secretary determines that a State has
22 not achieved substantial progress toward the reduc-
23 tions required under subsection (a), the Secretary
24 shall notify such State regarding the proportion of
25 required reductions achieved and the further reduc-

1 tion necessary to achieve compliance with subsection
2 (a).

3 (2) FINAL COMPLIANCE.—If at the end of the
4 5-year period following the date of the enactment of
5 this Act the Secretary determines that a State has
6 not achieved the reductions required under sub-
7 section (a), the Secretary shall reduce Federal pay-
8 ments for health care programs administered by
9 such State by 10 percent. For each year that such
10 State fails to comply with the requirements of sub-
11 section (a), Federal payments for health care pro-
12 grams administered by the State shall be reduced by
13 an additional 10 percent.

14 (3) WAIVERS OF PAYMENT REDUCTIONS.—Any
15 State subject to a reduction in Federal payments
16 under paragraph (2) may appeal to the Secretary for
17 a 1-year waiver of such reduction. In granting such
18 a waiver, the Secretary shall make a determination
19 of the good faith effort of such State to comply with
20 the requirements of subsection (a), taking into ac-
21 count the technical, practical, and financial capabili-
22 ties of the State in meeting such requirements.

23 (c) DEFINITION.—For purposes of this section, the
24 term “State” means any of the States, territories, dis-
25 tricts, or possessions of the United States.

1 **SEC. 303. STANDARDIZED FORMS COMMISSION.**

2 (a) IN GENERAL.—

3 (1) ESTABLISHMENT.—Not later than 12
4 months after the date of the enactment of this Act,
5 the Secretary shall establish a Standardized Forms
6 Commission (hereafter referred to in this section as
7 the “Commission”) which shall make recommenda-
8 tions on the standardization of paper and electronic
9 claims processing so as to reduce the paperwork bur-
10 den associated with, and enhance the efficiency and
11 productivity of, such claims processing.

12 (2) MEMBERSHIP.—

13 (A) IN GENERAL.—The Commission shall
14 be composed of at least 12 but not more than
15 20 representatives of private health care provid-
16 ers and private insurers.

17 (B) CHAIR.—The Secretary shall appoint a
18 Chair of the Commission.

19 (3) REPORT ON FINDINGS AND RECOMMENDA-
20 TIONS.—Not later than 24 months after the date of
21 the enactment of this Act, the Chair of the Commis-
22 sion shall report to the Secretary on the findings
23 and recommendations of the Commission.

24 (4) PROHIBITION OF COMPENSATION.—Mem-
25 bers of the Commission shall serve without pay ex-
26 cept for reimbursement for travel expenses, includ-

1 ing per diem in lieu of subsistence, in accordance
2 with sections 5702 and 5703 of title 5, United
3 States Code.

4 (5) STAFF OF FEDERAL AGENCIES.—Upon re-
5 quest of the Chair, the head of any Federal depart-
6 ment or agency shall detail any of the personnel of
7 that department or agency to the Commission to as-
8 sist it in carrying out its duties under this section.

9 (6) OBTAINING OFFICIAL DATA.—The Commis-
10 sion may secure directly from any department or
11 agency of the United States information necessary
12 to enable it to carry out this section.

13 (7) ADMINISTRATIVE SUPPORT SERVICES.—
14 Upon request of the Chair, the Administrator of
15 General Services shall provide to the Commission the
16 administrative support services necessary for the
17 Commission to carry out its responsibilities under
18 this section.

19 (b) LEGISLATIVE PROPOSAL.—

20 (1) IN GENERAL.—

21 (A) DEVELOPMENT OF IMPLEMENTING
22 BILL.—Not later than 3 months after the Com-
23 mission has submitted its findings and rec-
24 ommendations to the Secretary, the Secretary
25 shall take such recommendations and submit

1 them to Congress in the form of an implement-
2 ing bill which contains the provisions necessary
3 or appropriate to implement the recommenda-
4 tions by either repealing or amending existing
5 laws or providing new statutory authority.

6 (B) CONSIDERATION OF IMPLEMENTING
7 BILL.—The implementing bill described in sub-
8 paragraph (A) shall be considered by Congress
9 under the procedures for consideration de-
10 scribed in paragraph (2).

11 (2) CONGRESSIONAL CONSIDERATION.—

12 (A) RULES OF HOUSE OF REPRESENTA-
13 TIVES AND SENATE.—This paragraph is en-
14 acted by Congress—

15 (i) as an exercise of the rulemaking
16 power of the House of Representatives and
17 the Senate, respectively, and as such is
18 deemed a part of the rules of each House,
19 respectively, but applicable only with re-
20 spect to the procedure to be followed in
21 that House in the case of an implementing
22 bill described in paragraph (1)(A), and su-
23 persedes other rules only to the extent that
24 such rules are inconsistent therewith; and

1 (ii) with full recognition of the con-
2 stitutional right of either House to change
3 the rules (so far as relating to the proce-
4 dure of that House) at any time, in the
5 same manner and to the same extent as in
6 the case of any other rule of that House.

7 (B) INTRODUCTION AND REFERRAL.—On
8 the day on which the implementing bill de-
9 scribed in paragraph (1)(A) is transmitted to
10 the House of Representatives and the Senate,
11 such bill shall be introduced (by request) in the
12 House of Representatives by the Majority Lead-
13 er of the House, for himself and the Minority
14 Leader of the House, or by Members of the
15 House designated by the Majority Leader and
16 Minority Leader of the House and shall be in-
17 troduced (by request) in the Senate by the Ma-
18 jority Leader of the Senate, for himself and the
19 Minority Leader of the Senate, or by Members
20 of the Senate designated by the Majority Lead-
21 er and Minority Leader of the Senate. If either
22 House is not in session on the day on which the
23 implementing bill is transmitted, the bill shall
24 be introduced in the House, as provided in the
25 preceding sentence, on the first day thereafter

1 on which the House is in session. The imple-
2 menting bill introduced in the House of Rep-
3 resentatives and the Senate shall be referred to
4 the appropriate committees of each House.

5 (C) AMENDMENTS PROHIBITED.—No
6 amendment to an implementing bill shall be in
7 order in either the House of Representatives or
8 the Senate and no motion to suspend the appli-
9 cation of this paragraph shall be in order in ei-
10 ther House, nor shall it be in order in either
11 House for the Presiding Officer to entertain a
12 request to suspend the application of this para-
13 graph by unanimous consent.

14 (D) PERIOD FOR COMMITTEE AND FLOOR
15 CONSIDERATION.—

16 (i) IN GENERAL.—Except as provided
17 in clause (ii), if the committee or commit-
18 tees of either House to which an imple-
19 menting bill has been referred have not re-
20 ported it at the close of the 45th day after
21 its introduction, such committee or com-
22 mittees shall be automatically discharged
23 from further consideration of the imple-
24 menting bill and it shall be placed on the
25 appropriate calendar. A vote on final pas-

1 sage of the implementing bill shall be
2 taken in each House on or before the close
3 of the 45th day after the implementing bill
4 is reported by the committees or committee
5 of that House to which it was referred, or
6 after such committee or committees have
7 been discharged from further consideration
8 of the implementing bill. If prior to the
9 passage by 1 House of an implementing
10 bill of that House, that House receives the
11 same implementing bill from the other
12 House then—

13 (I) the procedure in that House
14 shall be the same as if no implement-
15 ing bill had been received from the
16 other House; but

17 (II) the vote on final passage
18 shall be on the implementing bill of
19 the other House.

20 (ii) COMPUTATION OF DAYS.—For
21 purposes of clause (i), in computing a
22 number of days in either House, there
23 shall be excluded—

24 (I) the days on which either
25 House is not in session because of an

1 adjournment of more than 3 days to
2 a day certain, or an adjournment of
3 the Congress sine die, and

4 (II) any Saturday and Sunday
5 not excluded under subclause (I) when
6 either House is not in session.

7 (E) FLOOR CONSIDERATION IN THE
8 HOUSE OF REPRESENTATIVES.—

9 (i) MOTION TO PROCEED.—A motion
10 in the House of Representatives to proceed
11 to the consideration of an implementing
12 bill shall be highly privileged and not de-
13 batable. An amendment to the motion shall
14 not be in order, nor shall it be in order to
15 move to reconsider the vote by which the
16 motion is agreed to or disagreed to.

17 (ii) DEBATE.—Debate in the House of
18 Representatives on an implementing bill
19 shall be limited to not more than 20 hours,
20 which shall be divided equally between
21 those favoring and those opposing the bill.
22 A motion further to limit debate shall not
23 be debatable. It shall not be in order to
24 move to recommit an implementing bill or
25 to move to reconsider the vote by which an

1 implementing bill is agreed to or disagreed
2 to.

3 (iii) MOTION TO POSTPONE.—Motions
4 to postpone, made in the House of Rep-
5 resentatives with respect to the consider-
6 ation of an implementing bill, and motions
7 to proceed to the consideration of other
8 business, shall be decided without debate.

9 (iv) APPEALS.—All appeals from the
10 decisions of the Chair relating to the appli-
11 cation of the Rules of the House of Rep-
12 resentatives to the procedure relating to an
13 implementing bill shall be decided without
14 debate.

15 (v) GENERAL RULES APPLY.—Except
16 to the extent specifically provided in the
17 preceding provisions of this subparagraph,
18 consideration of an implementing bill shall
19 be governed by the Rules of the House of
20 Representatives applicable to other bills
21 and resolutions in similar circumstances.

22 (F) FLOOR CONSIDERATION IN THE SEN-
23 ATE.—

24 (i) MOTION TO PROCEED.—A motion in
25 the Senate to proceed to the consideration

1 of an implementing bill shall be privileged
2 and not debatable. An amendment to the
3 motion shall not be in order, nor shall it be
4 in order to move to reconsider the vote by
5 which the motion is agreed to or disagreed
6 to.

7 (ii) GENERAL DEBATE.—Debate in
8 the Senate on an implementing bill, and all
9 debatable motions and appeals in connec-
10 tion therewith, shall be limited to not more
11 than 20 hours. The time shall be equally
12 divided between, and controlled by, the
13 Majority Leader and the Minority Leader
14 or their designees.

15 (iii) DEBATE OF MOTIONS AND AP-
16 PEALS.—Debate in the Senate on any de-
17 batable motion or appeal in connection
18 with an implementing bill shall be limited
19 to not more than 1 hour, to be equally di-
20 vided between, and controlled by, the
21 mover and the manager of the implement-
22 ing bill, except that in the event the man-
23 ager of the implementing bill is in favor of
24 any such motion or appeal, the time in op-
25 position thereto, shall be controlled by the

1 of Health and Human Services and the Interagency
2 Advisory Committee on Competition, Antitrust Pol-
3 icy, and Health Care, shall promulgate specific
4 guidelines under which a health care joint venture
5 may submit an application requesting that the At-
6 torney General provide the entities participating in
7 the joint venture with an exemption under which
8 (notwithstanding any other provision of law)—

9 (A) monetary recovery on a claim under
10 the antitrust laws shall be limited to actual
11 damages if the claim results from conduct with-
12 in the scope of the joint venture that occurs
13 while the exemption is in effect; and

14 (B) the conduct of the entity in making or
15 performing a contract to carry out the joint
16 venture shall not be deemed illegal per se under
17 the antitrust laws but shall be judged on the
18 basis of its reasonableness, taking into account
19 all relevant factors affecting competition, in-
20 cluding (but not limited to) effects on competi-
21 tion in properly defined, relevant research, de-
22 velopment, product, process, and service mar-
23 kets (taking into consideration worldwide capac-
24 ity to the extent that it may be appropriate in
25 the circumstances).

1 (2) DEADLINE FOR RESPONSE.—The Attorney
2 General, after consultation with the Secretary and
3 the Advisory Committee, shall approve or disapprove
4 the application of a health care joint venture for an
5 exemption under this subsection not later than 30
6 days after the Attorney General receives the joint
7 venture’s application.

8 (3) PROVIDING REASONS FOR DISAPPROVAL.—
9 If the Attorney General disapproves the application
10 of a health care joint venture for an exemption
11 under this subsection, the Attorney General shall
12 provide the joint venture with a statement explaining
13 the reasons for the Attorney General’s disapproval.

14 (b) REQUIREMENTS FOR APPROVAL.—For purposes
15 of subsection (a), the Attorney General shall approve the
16 application of a health care joint venture for an exemption
17 under subsection (a) if an entity participating in the joint
18 venture submits to the Attorney General an application
19 not later than 30 days after the entity has entered into
20 a written agreement to participate in the joint venture (or
21 not later than 30 days after the date of the enactment
22 of this Act in the case of a joint venture in effect as of
23 such date) that contains the following information and as-
24 surances:

1 (1) The identities of the parties to the joint
2 venture.

3 (2) The nature, objectives, and planned activi-
4 ties of the joint venture.

5 (3) Assurances that the entities participating in
6 the joint venture shall notify the Attorney General
7 of any changes in the information described in para-
8 graphs (1) and (2) during the period for which the
9 exemption is in effect.

10 (c) REVOCATION OF EXEMPTION.—

11 (1) IN GENERAL.—The Attorney General, after
12 consultation with the Secretary, may revoke an ex-
13 emption provided to a health care joint venture
14 under this section if, at any time during which the
15 exemption is in effect, the Attorney General finds
16 that the joint venture no longer meets the applicable
17 requirements for approval under subsection (b), ex-
18 cept that the Attorney General may not revoke such
19 an exemption if the failure of the health care joint
20 venture to meet such requirements is merely tech-
21 nical in nature.

22 (2) TIMING.—The revocation of an exemption
23 under paragraph (1) shall apply only to conduct of
24 the health care joint venture occurring after the ex-
25 emption is no longer in effect.

1 (d) WITHDRAWAL OF APPLICATION.—Any party that
2 submits an application under this section may withdraw
3 such application at any time before the Attorney General’s
4 response to the application.

5 (e) REQUIREMENTS RELATING TO NOTICE AND PUB-
6 LICATION OF EXEMPTIONS AND RELATED INFORMA-
7 TION.—

8 (1) PUBLICATION OF APPROVED APPLICATIONS
9 FOR EXEMPTIONS IN FEDERAL REGISTER.—

10 (A) IN GENERAL.—With respect to each
11 exemption for a health care joint venture pro-
12 vided under subsection (a), the Attorney Gen-
13 eral (acting jointly with the Secretary) shall—

14 (i) prepare a notice with respect to
15 the joint venture that identifies the parties
16 to the venture and that describes the
17 planned activities of the venture;

18 (ii) submit the notice to the entities
19 participating in the joint venture; and

20 (iii) after submitting the notice to
21 such entities (but not later than 30 days
22 after approving the application for the ex-
23 emption for the joint venture), publish the
24 notice in the Federal Register.

1 (B) EFFECT OF PUBLICATION.—An ex-
2 emption provided by the Attorney General
3 under subsection (a) shall take effect as of the
4 date of the publication in the Federal Register
5 of the notice with respect to the exemption pur-
6 suant to subparagraph (A).

7 (2) WAIVER OF DISCLOSURE REQUIREMENTS
8 FOR INFORMATION RELATING TO APPLICATIONS FOR
9 EXEMPTIONS.—

10 (A) IN GENERAL.—All information and
11 documentary material submitted as part of an
12 application of a health care joint venture for an
13 exemption under subsection (a), together with
14 any other information obtained by the Attorney
15 General, the Secretary, or the Advisory Com-
16 mittee in the course of any investigation, ad-
17 ministrative proceeding, or case with respect to
18 a potential violation of the antitrust laws by the
19 joint venture with respect to which the exemp-
20 tion applies, shall be exempt from disclosure
21 under section 552 of title 5, United States
22 Code, and shall not be made publicly available
23 by any agency of the United States to which
24 such section applies, except as relevant to a law
25 enforcement investigation or in a judicial or ad-

1 ministrative proceeding in which such informa-
2 tion and material is subject to any protective
3 order.

4 (B) EXCEPTION FOR INFORMATION IN-
5 CLUDED IN FEDERAL REGISTER NOTICE.—Sub-
6 paragraph (A) shall not apply with respect to
7 information contained in a notice published in
8 the Federal Register pursuant to paragraph
9 (1).

10 (3) USE OF INFORMATION TO SUPPORT OR AN-
11 SWER CLAIMS UNDER ANTITRUST LAWS.—

12 (A) IN GENERAL.—Except as provided in
13 subparagraph (B), the fact of disclosure of con-
14 duct under an application for an exemption
15 under subsection (a) and the fact of publication
16 of a notice in the Federal Register under para-
17 graph (1) shall be admissible into evidence in
18 any judicial or administrative proceeding for the
19 sole purpose of establishing that a person is en-
20 titled to the protections provided by an exemp-
21 tion granted under subsection (a).

22 (B) EFFECT OF REJECTED APPLICA-
23 TION.—If the Attorney General denies, in whole
24 or in part, an application for an exemption
25 under subsection (a), or revokes an exemption

1 under such section, neither the negative deter-
2 mination nor the statement of reasons therefor
3 shall be admissible into evidence in any admin-
4 istrative or judicial proceeding for the purpose
5 of supporting or answering any claim under the
6 antitrust laws.

7 **SEC. 402. ISSUANCE OF HEALTH CARE CERTIFICATES OF**
8 **PUBLIC ADVANTAGE.**

9 (a) ISSUANCE AND EFFECT OF CERTIFICATE.—The
10 Attorney General, after consultation with the Secretary
11 and the Advisory Committee, shall issue in accordance
12 with this section a certificate of public advantage to each
13 eligible health care joint venture that complies with the
14 requirements in effect under this section on or after the
15 expiration of the 1-year period that begins on the date
16 of the enactment of this Act (without regard to whether
17 or not the Attorney General has promulgated regulations
18 to carry out this section by such date). Such venture, and
19 the parties to such venture, shall not be liable under any
20 of the antitrust laws for conduct described in such certifi-
21 cate and engaged in by such venture if such conduct oc-
22 curs while such certificate is in effect.

23 (b) REQUIREMENTS APPLICABLE TO ISSUANCE OF
24 CERTIFICATES.—

1 (1) STANDARDS TO BE MET.—The Attorney
2 General shall issue a certificate to an eligible health
3 care joint venture if the Attorney General finds
4 that—

5 (A) the benefits that are likely to result
6 from carrying out the venture outweigh the re-
7 duction in competition (if any) that is likely to
8 result from the venture, and

9 (B) such reduction in competition is rea-
10 sonably necessary to obtain such benefits.

11 (2) FACTORS TO BE CONSIDERED.—

12 (A) WEIGHING OF BENEFITS AGAINST RE-
13 DUCTION IN COMPETITION.—For purposes of
14 making the finding described in paragraph
15 (1)(A), the Attorney General shall consider
16 whether the venture is likely—

17 (i) to maintain or to increase the
18 quality of health care,

19 (ii) to increase access to health care,

20 (iii) to achieve cost efficiencies that
21 will be passed on to health care consumers,
22 such as economies of scale, reduced trans-
23 action costs, and reduced administrative
24 costs,

1 (iv) to preserve the operation of
2 health care facilities located in underserved
3 geographical areas,

4 (v) to improve utilization of health
5 care resources, and

6 (vi) to reduce inefficient health care
7 resource duplication.

8 (B) NECESSITY OF REDUCTION IN COM-
9 PETITION.—For purposes of making the finding
10 described in paragraph (1)(B), the Attorney
11 General shall consider—

12 (i) the ability of the providers of
13 health care services that are (or likely to
14 be) affected by the health care joint ven-
15 ture and the entities responsible for mak-
16 ing payments to such providers to nego-
17 tiate societally optimal payment and serv-
18 ice arrangements,

19 (ii) the effects of the health care joint
20 venture on premiums and other charges
21 imposed by the entities described in clause
22 (i), and

23 (iii) the availability of equally effi-
24 cient, less restrictive alternatives to achieve

1 the benefits that are intended to be
2 achieved by carrying out the venture.

3 (c) ESTABLISHMENT OF CRITERIA AND PROCE-
4 DURES.—Subject to subsections (d) and (e), not later than
5 1 year after the date of the enactment of this Act, the
6 Attorney General and the Secretary shall establish jointly
7 by rule the criteria and procedures applicable to the issu-
8 ance of certificates under subsection (a). The rules shall
9 specify the form and content of the application to be sub-
10 mitted to the Attorney General to request a certificate,
11 the information required to be submitted in support of
12 such application, the procedures applicable to denying and
13 to revoking a certificate, and the procedures applicable to
14 the administrative appeal (if such appeal is authorized by
15 rule) of the denial and the revocation of a certificate. Such
16 information may include the terms of the health care joint
17 venture (in the case of a venture in existence as of the
18 time of the application) and implementation plan for the
19 joint venture.

20 (d) ELIGIBLE HEALTH CARE JOINT VENTURE.—To
21 be an eligible health care joint venture for purposes of this
22 section, a health care joint venture shall submit to the At-
23 torney General an application that complies with the rules
24 in effect under subsection (c) and that includes—

1 (1) an agreement by the parties to the venture
2 that the venture will not foreclose competition by en-
3 tering into contracts that prevent health care provid-
4 ers from providing health care in competition with
5 the venture,

6 (2) an agreement that the venture will submit
7 to the Attorney General annually a report that de-
8 scribes the operations of the venture and informa-
9 tion regarding the impact of the venture on health
10 care and on competition in health care, and

11 (3) an agreement that the parties to the ven-
12 ture will notify the Attorney General and the Sec-
13 retary of the termination of the venture not later
14 than 30 days after such termination occurs.

15 (e) REVIEW OF APPLICATIONS FOR CERTIFICATES.—
16 Not later than 30 days after an eligible health care joint
17 venture submits to the Attorney General an application
18 that complies with the rules in effect under subsection (c)
19 and with subsection (d), the Attorney General shall issue
20 or deny the issuance of such certificate. If, before the expi-
21 ration of such 30-day period, the Attorney General fails
22 to issue or deny the issuance of such certificate, the Attor-
23 ney General shall be deemed to have issued such certifi-
24 cate.

1 (f) REVOCATION OF CERTIFICATE.—Whenever the
2 Attorney General finds that a health care joint venture
3 with respect to which a certificate is in effect does not
4 meet the standards specified in subsection (b), the Attor-
5 ney General shall revoke such certificate.

6 (g) WRITTEN REASONS; JUDICIAL REVIEW.—

7 (1) DENIAL AND REVOCATION OF CERTIFI-
8 CATES.—If the Attorney General denies an applica-
9 tion for a certificate or revokes a certificate, the At-
10 torney General shall include in the notice of denial
11 or revocation a statement of the reasons relied upon
12 for the denial or revocation of such certificate.

13 (2) JUDICIAL REVIEW.—

14 (A) AFTER ADMINISTRATIVE PROCEED-
15 ING.—(i) If the Attorney General denies an ap-
16 plication submitted or revokes a certificate is-
17 sued under this section after an opportunity for
18 hearing on the record, then any party to the
19 health care joint venture involved may com-
20 mence a civil action, not later than 60 days
21 after receiving notice of the denial or revoca-
22 tion, in an appropriate district court of the
23 United States for review of the record of such
24 denial or revocation.

1 (ii) As part of the Attorney General's an-
2 swer, the Attorney General shall file in such
3 court a certified copy of the record on which
4 such denial or revocation is based. The findings
5 of fact of the Attorney General may be set aside
6 only if found to be unsupported by substantial
7 evidence in such record taken as a whole.

8 (B) DENIAL OR REVOCATION WITHOUT AD-
9 MINISTRATIVE PROCEEDING.—If the Attorney
10 General denies an application submitted or re-
11 vokes a certificate issued under this section
12 without an opportunity for hearing on the
13 record, then any party to the health care joint
14 venture involved may commence a civil action,
15 not later than 60 days after receiving notice of
16 the denial or revocation, in an appropriate dis-
17 trict court of the United States for de novo re-
18 view of such denial or revocation.

19 (h) EXEMPTION.—A person shall not be liable under
20 any of the antitrust laws for conduct necessary—

21 (1) to prepare, agree to prepare, or attempt to
22 agree to prepare an application to request a certifi-
23 cate under this section, or

1 (2) to attempt to enter into any health care
2 joint venture with respect to which such a certificate
3 is in effect.

4 **SEC. 403. INTERAGENCY ADVISORY COMMITTEE ON COM-**
5 **PETITION, ANTITRUST POLICY, AND HEALTH**
6 **CARE.**

7 (a) ESTABLISHMENT.—There is hereby established
8 the Interagency Advisory Committee on Competition,
9 Antitrust Policy, and Health Care. The Advisory Commit-
10 tee shall be composed of—

11 (1) the Secretary of Health and Human Serv-
12 ices (or the designee of the Secretary);

13 (2) the Attorney General (or the designee of the
14 Attorney General);

15 (3) the Director of the Office of Management
16 and Budget (or the designee of the Director); and

17 (4) a representative of the Federal Trade Com-
18 mission.

19 (b) DUTIES.—The duties of the Advisory Committee
20 are—

21 (1) to discuss and evaluate competition and
22 antitrust policy, and their implications with respect
23 to the performance of health care markets;

24 (2) to analyze the effectiveness of health care
25 joint ventures receiving exemptions under the pro-

1 gram established under section 401(a) or certificates
2 under section 402 in reducing the costs of and ex-
3 panding access to the health care services that are
4 the subject of such ventures; and

5 (3) to make such recommendations to Congress
6 not later than 2 years after the date of the enact-
7 ment of this Act (and at such subsequent periods as
8 the Advisory Committee considers appropriate) re-
9 garding modifications to the program established
10 under section 401(a) or to section 402 as the Advi-
11 sory Committee considers appropriate, including
12 modifications relating to the costs to health care
13 providers of obtaining an exemption for a joint ven-
14 ture under such program.

15 **SEC. 404. DEFINITIONS.**

16 For purposes of this title:

17 (1) The term “Advisory Committee” means the
18 Interagency Advisory Committee on Competition,
19 Antitrust Policy, and Health Care established under
20 section 403.

21 (2) The term “antitrust laws”—

22 (A) has the meaning given it in subsection
23 (a) of the first section of the Clayton Act (15
24 U.S.C. 12(a)), except that such term includes
25 section 5 of the Federal Trade Commission Act

1 (15 U.S.C. 45) to the extent such section ap-
2 plies to unfair methods of competition; and

3 (B) includes any State law similar to the
4 laws referred to in subparagraph (A).

5 (3) The term “certificate” means a certificate
6 of public advantage authorized to be issued under
7 section 402(a).

8 (4) The term “health care joint venture” means
9 an agreement (whether existing or proposed) be-
10 tween 2 or more providers of health care services
11 that is entered into solely for the purpose of sharing
12 in the provision of health care services and that in-
13 volves substantial integration or financial risk-shar-
14 ing between the parties, but does not include the ex-
15 changing of information, the entering into of any
16 agreement, or the engagement in any other conduct
17 that is not reasonably required to carry out such
18 agreement.

19 (5) The term “health care services” includes
20 services related to the delivery or administration of
21 health care services.

22 (6) The term “liable” means liable for any civil
23 or criminal violation of the antitrust laws.

24 (7) The term “provider of health care services”
25 means any individual or entity that is engaged in the

1 delivery of health care services in a State and that
2 is required by State law or regulation to be licensed
3 or certified by the State to engage in the delivery of
4 such services in the State.

5 (8) The term “Secretary” means the Secretary
6 of Health and Human Services.

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S 1796 IS—2

S 1796 IS—3

S 1796 IS—4