

104TH CONGRESS
2D SESSION

H. R. 3070

To improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, and to simplify the administration of health insurance.

IN THE HOUSE OF REPRESENTATIVES

MARCH 12, 1996

Mr. BILIRAKIS (for himself and Mr. BILEY) introduced the following bill; which was referred to the Committee on Commerce, and Committees on Ways and Means, the Judiciary, and Economic and Educational Opportunities, 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 improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, and to simplify the administration of health insurance.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

2 (a) SHORT TITLE.—This Act may be cited as the
3 “Health Coverage Availability and Affordability Act of
4 1996”.

5 (b) TABLE OF CONTENTS.—The table of contents of
6 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—IMPROVED AVAILABILITY AND PORTABILITY OF
HEALTH INSURANCE COVERAGE

Subtitle A—Coverage Under Group Health Plans

Sec. 101. Portability of coverage for previously covered individuals.

Sec. 102. Limitation on preexisting condition exclusions; no application to cer-
tain newborns, adopted children, and pregnancy.

Sec. 103. Prohibiting exclusions based on health status and providing for en-
rollment periods.

Sec. 104. Enforcement.

Subtitle B—Certain Requirements for Insurers and HMOs in the Group and
Individual Markets

PART 1—AVAILABILITY OF GROUP HEALTH INSURANCE COVERAGE

Sec. 131. Guaranteed availability of general coverage in the small group mar-
ket.

Sec. 132. Guaranteed renewability of group coverage.

PART 2—AVAILABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE

Sec. 141. Guaranteed availability of individual health insurance coverage to cer-
tain individuals with prior group coverage.

Sec. 142. Guaranteed renewability of individual health insurance coverage.

PART 3—ENFORCEMENT

Sec. 151. Incorporation of provisions for State enforcement with Federal fall-
back authority.

Subtitle C—Definitions; General Provisions

Sec. 191. Definitions; scope of coverage.

Sec. 192. State flexibility to provide greater protection.

Sec. 193. Effective date.

Sec. 194. Rule of construction.

TITLE II—PREVENTING HEALTH CARE FRAUD AND ABUSE;
ADMINISTRATIVE SIMPLIFICATION

Sec. 200. References in title.

Subtitle A—Fraud and Abuse Control Program

- Sec. 201. Fraud and abuse control program.
- Sec. 202. Medicare integrity program.
- Sec. 203. Beneficiary incentive programs.
- Sec. 204. Application of certain health anti-fraud and abuse sanctions to fraud and abuse against Federal health care programs.
- Sec. 205. Guidance regarding application of health care fraud and abuse sanctions.

Subtitle B—Revisions to Current Sanctions for Fraud and Abuse

- Sec. 211. Mandatory exclusion from participation in medicare and State health care programs.
- Sec. 212. Establishment of minimum period of exclusion for certain individuals and entities subject to permissive exclusion from medicare and State health care programs.
- Sec. 213. Permissive exclusion of individuals with ownership or control interest in sanctioned entities.
- Sec. 214. Sanctions against practitioners and persons for failure to comply with statutory obligations.
- Sec. 215. Intermediate sanctions for medicare health maintenance organizations.
- Sec. 216. Additional exception to anti-kickback penalties for discounting and managed care arrangements.
- Sec. 217. Criminal penalty for fraudulent disposition of assets in order to obtain medicaid benefits.
- Sec. 218. Effective date.

Subtitle C—Data Collection

- Sec. 221. Establishment of the health care fraud and abuse data collection program.

Subtitle D—Civil Monetary Penalties

- Sec. 231. Social security act civil monetary penalties.
- Sec. 232. Clarification of level of intent required for imposition of sanctions.
- Sec. 233. Penalty for false certification for home health services.

Subtitle E—Revisions to Criminal Law

- Sec. 241. Definition of Federal health care offense.
- Sec. 242. Health care fraud.
- Sec. 243. Theft or embezzlement.
- Sec. 244. False statements.
- Sec. 245. Obstruction of criminal investigations of health care offenses.
- Sec. 246. Laundering of monetary instruments.
- Sec. 247. Injunctive relief relating to health care offenses.
- Sec. 248. Authorized investigative demand procedures.
- Sec. 249. Forfeitures for Federal health care offenses.

Subtitle F—Administrative Simplification

- Sec. 251. Purpose.
- Sec. 252. Administrative simplification.

“PART C—ADMINISTRATIVE SIMPLIFICATION

“Sec. 1171. Definitions.

“Sec. 1172. General requirements for adoption of standards.

“Sec. 1173. Standards for information transactions and data elements.

“Sec. 1174. Timetables for adoption of standards.

“Sec. 1175. Requirements.

“Sec. 1176. General penalty for failure to comply with requirements and standards.

“Sec. 1177. Wrongful disclosure of individually identifiable health information.

“Sec. 1178. Effect on State law.

“Sec. 1179. Health Information Advisory Committee.”.

1 TITLE I—IMPROVED AVAILABIL- **2 ITY AND PORTABILITY OF** **3 HEALTH INSURANCE COV-** **4 ERAGE**

5 Subtitle A—Coverage Under Group **6 Health Plans**

7 SEC. 101. PORTABILITY OF COVERAGE FOR PREVIOUSLY **8 COVERED INDIVIDUALS.**

9 (a) CREDITING PERIODS OF PREVIOUS COVERAGE
10 TOWARD PREEXISTING CONDITION RESTRICTIONS.—Sub-
11 ject to the succeeding provisions of this section, a group
12 health plan, and an insurer or health maintenance organi-
13 zation offering health insurance coverage in connection
14 with a group health plan, shall provide that any preexist-
15 ing condition limitation period (as defined in subsection
16 (b)(2)) is reduced by the length of the aggregate period
17 of qualified prior coverage (if any, as defined in subsection
18 (b)(3)) applicable to the participant or beneficiary as of
19 the date of commencement of coverage under the plan.

1 (b) DEFINITIONS AND OTHER PROVISIONS RELAT-
2 ING TO PREEXISTING CONDITIONS.—

3 (1) PREEXISTING CONDITION.—

4 (A) IN GENERAL.—For purposes of this
5 subtitle, subject to subparagraph (B), the term
6 “preexisting condition” means a condition, re-
7 gardless of the cause of the condition, for which
8 medical advice, diagnosis, care, or treatment
9 was recommended or received within the 6-
10 month period ending on the day before—

11 (i) the effective date of the coverage
12 of such participant or beneficiary, or

13 (ii) the earliest date upon which such
14 coverage could have been effective if there
15 were no waiting period applicable,

16 whichever is earlier.

17 (B) EXTENSION OF PERIOD IN THE CASE
18 OF LATE ENROLLMENT.—In the case of a par-
19 ticipant or beneficiary whose initial coverage
20 commences after the date the participant or
21 beneficiary first becomes eligible for coverage
22 under the group health plan, the reference in
23 subparagraph (A) to “6-month period” is
24 deemed a reference to “12-month period”.

1 (2) PREEXISTING CONDITION LIMITATION PE-
2 RIOD.—For purposes of this subtitle, the term “pre-
3 existing condition limitation period” means, with re-
4 spect to coverage of an individual under a group
5 health plan or under health insurance coverage, the
6 period during which benefits with respect to treat-
7 ment of a condition of such individual are not pro-
8 vided based on the fact that the condition is a pre-
9 existing condition.

10 (3) AGGREGATE PERIOD OF QUALIFIED PRIOR
11 COVERAGE.—

12 (A) IN GENERAL.—For purposes of this
13 section, the term “aggregate period of qualified
14 prior coverage” means, with respect to com-
15 mencement of coverage of an individual under
16 a group health plan or health insurance cov-
17 erage offered in connection with a group health
18 plan, the aggregate of the qualified coverage pe-
19 riods (as defined in subparagraph (B)) of such
20 individual occurring before the date of such
21 commencement. Such period shall be treated as
22 zero if there is more than a 60-day break in
23 coverage under a group health plan (or health
24 insurance coverage offered in connection with
25 such a plan) between the date the most recent

1 qualified coverage period ends and the date of
2 such commencement.

3 (B) QUALIFIED COVERAGE PERIOD.—

4 (i) IN GENERAL.—For purposes of
5 this paragraph, subject to subsection (c),
6 the term “qualified coverage period”
7 means, with respect to an individual, any
8 period of coverage of the individual under
9 a group health plan, health insurance cov-
10 erage, or under title XIX of the Social Se-
11 curity Act.

12 (ii) DISREGARDING PERIODS BEFORE
13 BREAKS IN COVERAGE.—Such term does
14 not include any period occurring before
15 any 60-day break in coverage described in
16 subparagraph (A).

17 (C) WAITING PERIOD NOT TREATED AS A
18 BREAK IN COVERAGE.—For purposes of sub-
19 paragraphs (A) and (B), any period that is in
20 a waiting period for any coverage under a
21 group health plan (or for health insurance cov-
22 erage offered in connection with a group health
23 plan) shall not be considered to be a break in
24 coverage described in subparagraph (B)(ii).

1 (D) ESTABLISHMENT OF PERIOD.—A
2 qualified coverage period with respect to an in-
3 dividual shall be established through presen-
4 tation of certifications described in subsection
5 (c) or in such other manner as may be specified
6 in regulations to carry out this section.

7 (c) CERTIFICATIONS OF COVERAGE; CONFORMING
8 COVERAGE.—

9 (1) IN GENERAL.—The plan administrator of a
10 group health plan, or the insurer or HMO offering
11 health insurance coverage in connection with a group
12 health plan, shall, on request made on behalf of an
13 individual covered (or previously covered within the
14 previous 18 months) under the plan or coverage,
15 provide for a certification of the period of coverage
16 of the individual under such plan or coverage and of
17 the waiting period (if any) imposed with respect to
18 the individual for any coverage under the plan.

19 (2) STANDARD METHOD.—Subject to paragraph
20 (3), a group health plan, or insurer or HMO offering
21 health insurance coverage in connection with a group
22 health plan, shall determine qualified coverage peri-
23 ods under subsection (b)(3)(B) by including all peri-
24 ods described in such subsection, without regard to
25 the specific benefits offered during such a period.

1 (3) ALTERNATIVE METHOD.—Such a plan, in-
2 surer, or HMO may elect to make such determina-
3 tion on a benefit-specific basis for all participants
4 and beneficiaries and not to include as a qualified
5 coverage period with respect to a specific benefit
6 coverage during a previous period unless such pre-
7 vious coverage for that benefit was included at the
8 end of the most recent period of coverage. In the
9 case of such an election—

10 (A) the plan, insurer, or HMO shall promi-
11 nently state in any disclosure statements con-
12 cerning the plan or coverage and to each en-
13 rollee at the time of enrollment under the plan
14 (or at the time the health insurance coverage is
15 offered for sale in the group health market)
16 that the plan or coverage has made such elec-
17 tion and shall include a description of the effect
18 of this election; and

19 (B) upon the request of the plan, insurer,
20 or HMO, the entity providing a certification
21 under paragraph (1)—

22 (i) shall promptly disclose to the re-
23 questing plan, insurer, or HMO the plan
24 statement (insofar as it relates to health
25 benefits under the plan) or other detailed

1 benefit information on the benefits avail-
2 able under the previous plan or coverage,
3 and

4 (ii) may charge for the reasonable
5 cost of providing such information.

6 **SEC. 102. LIMITATION ON PREEXISTING CONDITION EXCLU-**
7 **SIONS; NO APPLICATION TO CERTAIN**
8 **NEWBORNS, ADOPTED CHILDREN, AND PREG-**
9 **NANCY.**

10 (a) LIMITATION OF PERIOD.—

11 (1) IN GENERAL.—Subject to the succeeding
12 provisions of this section, a group health plan, and
13 an insurer or HMO offering health insurance cov-
14 erage in connection with a group health plan, shall
15 provide that any preexisting condition limitation pe-
16 riod (as defined in section 101(b)(2)) does not ex-
17 ceed 12 months, counting from the effective date of
18 coverage.

19 (2) EXTENSION OF PERIOD IN THE CASE OF
20 LATE ENROLLMENT.—In the case of a participant or
21 beneficiary whose initial coverage commences after
22 the date the participant or beneficiary first becomes
23 eligible for coverage under the group health plan,
24 the reference in paragraph (1) to “12 months” is
25 deemed a reference to “18 months”.

1 (b) EXCLUSION NOT APPLICABLE TO CERTAIN
2 NEWBORNS AND CERTAIN ADOPTIONS.—

3 (1) IN GENERAL.—Subject to paragraph (2), a
4 group health plan, and an insurer or HMO offering
5 health insurance coverage in connection with a group
6 health plan, may not provide any limitation on bene-
7 fits based on the existence of a preexisting condition
8 in the case of—

9 (A) an individual who within the 30-day
10 period beginning with the date of birth, or

11 (B) an adopted child or a child placed for
12 adoption beginning at the time of adoption or
13 placement if the individual, within the 30-day
14 period beginning on the date of adoption or
15 placement,

16 becomes covered under a group health plan or other-
17 wise becomes covered under health insurance cov-
18 erage (or covered for medical assistance under title
19 XIX of the Social Security Act).

20 (2) LOSS IF BREAK IN COVERAGE.—Paragraph
21 (1) shall no longer apply to an individual if the indi-
22 vidual does not have any coverage under a group
23 health plan, health insurance coverage, or under title
24 XIX of the Social Security Act for a continuous pe-
25 riod of 60 days, not counting in such period any

1 days that are in a waiting period for any coverage
2 under a group health plan.

3 (3) PLACED FOR ADOPTION DEFINED.—In this
4 subsection and section 103(d), the term “place-
5 ment”, or being “placed”, for adoption, in connec-
6 tion with any placement for adoption of a child with
7 any person, means the assumption and retention by
8 such person of a legal obligation for total or partial
9 support of such child in anticipation of adoption of
10 such child. The child’s placement with such person
11 terminates upon the termination of such legal obliga-
12 tion.

13 (c) EXCLUSION NOT APPLICABLE TO PREGNANCY.—
14 For purposes of this section, pregnancy shall not be treat-
15 ed as a preexisting condition.

16 (d) ELIGIBILITY PERIOD IMPOSED BY HEALTH
17 MAINTENANCE ORGANIZATIONS AS ALTERNATIVE TO
18 PREEXISTING CONDITION LIMITATION.—A health mainte-
19 nance organization which offers health insurance coverage
20 in connection with a group health plan and which does
21 not use the preexisting condition limitations allowed under
22 this section and section 101 with respect to any particular
23 coverage option may impose an eligibility period for such
24 coverage option, but only if such period does not exceed—

1 (1) 90 days, in the case of a participant or ben-
 2 eficiary whose initial coverage commences at the
 3 time such participant or beneficiary first becomes el-
 4 igible for coverage under the plan, or

5 (2) 180 days, in the case of a participant or
 6 beneficiary whose initial coverage commences after
 7 the date on which such participant or beneficiary
 8 first becomes eligible for coverage.

9 For purposes of this subsection, the term “eligibility pe-
 10 riod” means a period which, under the terms of the health
 11 insurance coverage offered by the health maintenance or-
 12 ganization, must expire before the health insurance cov-
 13 erage becomes effective. Any such eligibility period shall
 14 be treated for purposes of this subtitle as a waiting period
 15 under the plan and shall run concurrently with any other
 16 applicable waiting period under the plan.

17 **SEC. 103. PROHIBITING EXCLUSIONS BASED ON HEALTH**
 18 **STATUS AND PROVIDING FOR ENROLLMENT**
 19 **PERIODS.**

20 (a) PROHIBITION OF EXCLUSION OF PARTICIPANTS
 21 OR BENEFICIARIES BASED ON HEALTH STATUS.—

22 (1) IN GENERAL.—A group health plan, and an
 23 insurer or HMO offering health insurance coverage
 24 in connection with a group health plan, may not ex-
 25 clude an employee or his or her beneficiary from

1 being (or continuing to be) a participant or bene-
2 ficiary under the terms of such plan or coverage
3 based on health status (as defined in section
4 191(c)(6)).

5 (2) CONSTRUCTION.—Nothing in this sub-
6 section shall be construed as preventing the estab-
7 lishment of preexisting condition limitations and re-
8 strictions to the extent consistent with the provisions
9 of this subtitle.

10 (b) ENROLLMENT OF ELIGIBLE INDIVIDUALS WHO
11 LOSE OTHER COVERAGE.—A group health plan shall per-
12 mit an uncovered employee who is otherwise eligible for
13 coverage under the terms of the plan (or an uncovered
14 dependent, as defined under the terms of the plan, of such
15 an employee, if family coverage is available) to enroll for
16 coverage under the plan under at least one benefit option
17 if each of the following conditions is met:

18 (1) The employee or dependent was covered
19 under a group health plan or had health insurance
20 coverage at the time coverage was previously offered
21 to the employee or individual.

22 (2) The employee stated in writing at such time
23 that coverage under a group health plan or health
24 insurance coverage was the reason for declining en-
25 rollment.

1 (3) The employee or dependent lost coverage
2 under a group health plan or health insurance cov-
3 erage (as a result of loss of eligibility for the cov-
4 erage, termination of employment, or reduction in
5 the number of hours of employment).

6 (4) The employee requests such enrollment
7 within 30 days after the date of termination of such
8 coverage.

9 (c) DEPENDENT BENEFICIARIES.—

10 (1) IN GENERAL.—If a group health plan
11 makes family coverage available, the plan may not
12 require, as a condition of coverage of an individual
13 as a dependent (as defined under the terms of the
14 plan) of a participant in the plan, a waiting period
15 applicable to the coverage of a dependent who—

16 (A) is a newborn,

17 (B) is an adopted child or child placed for
18 adoption (within the meaning of section
19 102(b)(3)), at the time of adoption or place-
20 ment, or

21 (C) is a spouse, at the time of marriage,
22 if the participant has met any waiting period appli-
23 cable to that participant.

24 (2) TIMELY ENROLLMENT.—

1 (A) IN GENERAL.—Enrollment of a partici-
2 pant’s beneficiary described in paragraph (1)
3 shall be considered to be timely if a request for
4 enrollment is made within 30 days of the date
5 family coverage is first made available or, in the
6 case described in—

7 (i) paragraph (1)(A), within 30 days
8 of the date of the birth,

9 (ii) paragraph (1)(B), within 30 days
10 of the date of the adoption or placement
11 for adoption, or

12 (iii) paragraph (1)(C), within 30 days
13 of the date of the marriage with such a
14 beneficiary who is the spouse of the partici-
15 ipant,

16 if family coverage is available as of such date.

17 (B) COVERAGE.—If available coverage in-
18 cludes family coverage and enrollment is made
19 under such coverage on a timely basis under
20 subparagraph (A), the coverage shall become ef-
21 fective not later than the first day of the first
22 month beginning 15 days after the date the
23 completed request for enrollment is received.

1 **SEC. 104. ENFORCEMENT.**

2 (a) ENFORCEMENT THROUGH COBRA PROVISIONS
3 IN INTERNAL REVENUE CODE.—

4 (1) APPLICATION OF COBRA SANCTIONS.—Sub-
5 section (a) of section 4980B of the Internal Revenue
6 Code of 1986 is amended by striking “the require-
7 ments of” and all that follows and inserting “the re-
8 quirements of—

9 “(1) subsection (f) with respect to any qualified
10 beneficiary, or

11 “(2) subject to subsection (h)—

12 “(A) section 101 or 102 of the Health
13 Coverage Availability and Affordability Act of
14 1996 with respect to any individual covered
15 under the group health plan, or

16 “(B) section 103 of such Act with respect
17 to any individual.”.

18 (2) NOTICE REQUIREMENT.—Section
19 4980B(f)(6)(A) of such Code is amended by insert-
20 ing before the period the following: “and subtitle A
21 of title I of the Health Coverage Availability and Af-
22 fordability Act of 1996”.

23 (3) SPECIAL RULES.—Section 4980B of such
24 Code is amended by adding at the end the following:

25 “(h) SPECIAL RULES.—For purposes of applying this
26 section in the case of requirements described in subsection

1 (a)(2) relating to section 101, section 102, or section 103
2 of the Health Coverage Availability and Affordability Act
3 of 1996—

4 “(1) DEFERRAL TO STATE REGULATION.—No
5 tax shall be imposed by this section on any failure
6 to meet the requirements of such section by any en-
7 tity which offers health insurance coverage and
8 which is an insurer or health maintenance organiza-
9 tion (as defined in section 191(c) of the Health Cov-
10 erage Availability and Affordability Act of 1996)
11 regulated by a State if the Secretary of Health and
12 Human Services has made the determination de-
13 scribed in section 104(c)(2) of such Act with respect
14 to such State, section, and entity.

15 “(2) LIMITATION FOR INSURED PLANS.—In the
16 case of a group health plan of a small employer (as
17 defined in section 191 of the Health Coverage Avail-
18 ability and Affordability Act of 1996) that provides
19 health care benefits solely through a contract with
20 an insurer or health maintenance organization (as
21 defined in such section), no tax shall be imposed by
22 this section upon the employer on a failure to meet
23 such requirements if the failure is solely because of
24 the product offered by the insurer or organization
25 under such contract.

1 “(3) LIMITATION ON IMPOSITION OF TAX.—In
 2 no case shall a tax be imposed by this section for a
 3 failure to meet such a requirement if a sanction has
 4 been imposed—

5 “(A) by the Secretary of Labor under part
 6 5 of subtitle A of title I of the Employee Retire-
 7 ment Income Security Act of 1974 with respect
 8 to such failure, or

9 “(B) by the Secretary of Health and
 10 Human Services under section 109 of the
 11 Health Coverage Availability and Affordability
 12 Act of 1996 with respect to such failure.”.

13 (b) ENFORCEMENT THROUGH ERISA SANCTIONS
 14 FOR CERTAIN GROUP HEALTH PLANS.—

15 (1) IN GENERAL.—Subject to the succeeding
 16 provisions of this subsection, sections 101 through
 17 103 of this subtitle shall be deemed to be provisions
 18 of title I of the Employee Retirement Income Secu-
 19 rity Act of 1974 for purposes of applying such title.

20 (2) FEDERAL ENFORCEMENT ONLY IF NO EN-
 21 FORCEMENT THROUGH STATE.—The Secretary of
 22 Labor shall enforce each section referred to in para-
 23 graph (1) with respect to any entity which is an in-
 24 surer or health maintenance organization regulated

1 by a State only if the Secretary of Labor determines
2 that—

3 (A) such State has not provided for en-
4 forcement of State laws which govern the same
5 matters as are governed by such section and
6 which require compliance by such entity with at
7 least the same requirements as those provided
8 under such section, and

9 (B) such entity has failed to comply with
10 such requirements of such section as are appli-
11 cable to such entity.

12 (3) LIMITATIONS ON LIABILITY.—

13 (A) NO APPLICATION WHERE FAILURE
14 NOT DISCOVERED EXERCISING REASONABLE
15 DILIGENCE.—No liability shall be imposed
16 under this subsection on the basis of any failure
17 during any period for which it is established to
18 the satisfaction of the Secretary of Labor that
19 none of the persons against whom the liability
20 would be imposed knew, or exercising reason-
21 able diligence would have known, that such fail-
22 ure existed.

23 (B) NO APPLICATION WHERE FAILURE
24 CORRECTED WITHIN 30 DAYS.—No liability
25 shall be imposed under this subsection on the

basis of any failure if such failure was due to reasonable cause and not to willful neglect, and such failure is corrected during the 30-day period beginning on the first day any of the persons against whom the liability would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(4) AVOIDING DUPLICATION OF CERTAIN PENALTIES.—In no case shall a civil money penalty be imposed under the authority provided under paragraph (1) for a violation of this subtitle for which an excise tax has been imposed under section 4980B of the Internal Revenue Code of 1986 or a civil money penalty imposed under subsection (c).

(c) ENFORCEMENT THROUGH CIVIL MONEY PENALTIES.—

(1) IMPOSITION.—

(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, any group health plan, insurer, or organization that fails to meet a requirement of this subtitle is subject to a civil money penalty under this section.

(B) LIABILITY FOR PENALTY.—Rules similar to the rules described in section 4980B(e) of the Internal Revenue Code of 1986 for liability

1 for a tax imposed under section 4980B(a) of
2 such Code shall apply to liability for a penalty
3 imposed under subparagraph (A).

4 (C) AMOUNT OF PENALTY.—

5 (i) IN GENERAL.—The maximum
6 amount of penalty imposed under this
7 paragraph is \$100 for each day for each
8 individual with respect to which such a
9 failure occurs.

10 (ii) CONSIDERATIONS IN IMPOSI-
11 TION.—In determining the amount of any
12 penalty to be assessed under this para-
13 graph, the Secretary of Health and Human
14 Services shall take into account the pre-
15 vious record of compliance of the person
16 being assessed with the applicable require-
17 ments of this subtitle, the gravity of the
18 violation, and the overall limitations for
19 unintentional failures provided under sec-
20 tion 4980B(c)(4) of the Internal Revenue
21 Code of 1986.

22 (iii) LIMITATIONS.—

23 (I) PENALTY NOT TO APPLY
24 WHERE FAILURE NOT DISCOVERED
25 EXERCISING REASONABLE DILI-

1 GENCE.—No civil money penalty shall
2 be imposed under this paragraph on
3 any failure during any period for
4 which it is established to the satisfac-
5 tion of the Secretary that none of the
6 persons against whom the penalty
7 would be imposed knew, or exercising
8 reasonable diligence would have
9 known, that such failure existed.

10 (II) PENALTY NOT TO APPLY TO
11 FAILURES CORRECTED WITHIN 30
12 DAYS.—No civil money penalty shall
13 be imposed under this paragraph on
14 any failure if such failure was due to
15 reasonable cause and not to willful ne-
16 glect, and such failure is corrected
17 during the 30-day period beginning on
18 the first day any of the persons
19 against whom the penalty would be
20 imposed knew, or exercising reason-
21 able diligence would have known, that
22 such failure existed.

23 (D) ADMINISTRATIVE REVIEW.—

24 (i) OPPORTUNITY FOR HEARING.—

25 The person assessed shall be afforded an

1 opportunity for hearing by the Secretary
2 upon request made within 30 days after
3 the date of the issuance of a notice of as-
4 sessment. In such hearing the decision
5 shall be made on the record pursuant to
6 section 554 of title 5, United States Code.
7 If no hearing is requested, the assessment
8 shall constitute a final and unappealable
9 order.

10 (ii) HEARING PROCEDURE.—If a
11 hearing is requested, the initial agency de-
12 cision shall be made by an administrative
13 law judge, and such decision shall become
14 the final order unless the Secretary modi-
15 fies or vacates the decision. Notice of in-
16 tent to modify or vacate the decision of the
17 administrative law judge shall be issued to
18 the parties within 30 days after the date of
19 the decision of the judge. A final order
20 which takes effect under this paragraph
21 shall be subject to review only as provided
22 under subparagraph (D).

23 (E) JUDICIAL REVIEW.—

24 (i) FILING OF ACTION FOR REVIEW.—
25 Any person against whom an order impos-

1 ing a civil money penalty has been entered
2 after an agency hearing under this para-
3 graph may obtain review by the United
4 States district court for any district in
5 which such person is located or the United
6 States District Court for the District of
7 Columbia by filing a notice of appeal in
8 such court within 30 days from the date of
9 such order, and simultaneously sending a
10 copy of such notice by registered mail to
11 the Secretary.

12 (ii) CERTIFICATION OF ADMINISTRA-
13 TIVE RECORD.—The Secretary shall
14 promptly certify and file in such court the
15 record upon which the penalty was im-
16 posed.

17 (iii) STANDARD FOR REVIEW.—The
18 findings of the Secretary shall be set aside
19 only if found to be unsupported by sub-
20 stantial evidence as provided by section
21 706(2)(E) of title 5, United States Code.

22 (iv) APPEAL.—Any final decision,
23 order, or judgment of such district court
24 concerning such review shall be subject to

1 appeal as provided in chapter 83 of title 28
2 of such Code.

3 (F) FAILURE TO PAY ASSESSMENT; MAIN-
4 TENANCE OF ACTION.—

5 (i) FAILURE TO PAY ASSESSMENT.—If
6 any person fails to pay an assessment after
7 it has become a final and unappealable
8 order, or after the court has entered final
9 judgment in favor of the Secretary, the
10 Secretary shall refer the matter to the At-
11 torney General who shall recover the
12 amount assessed by action in the appro-
13 priate United States district court.

14 (ii) NONREVIEWABILITY.—In such ac-
15 tion the validity and appropriateness of the
16 final order imposing the penalty shall not
17 be subject to review.

18 (G) PAYMENT OF PENALTIES.—Except as
19 otherwise provided, penalties collected under
20 this paragraph shall be paid to the Secretary
21 (or other officer) imposing the penalty and shall
22 be available without appropriation and until ex-
23 pended for the purpose of enforcing the provi-
24 sions with respect to which the penalty was im-
25 posed.

1 (2) FEDERAL ENFORCEMENT ONLY IF NO EN-
2 FORCEMENT THROUGH STATE.—Paragraph (1) shall
3 not apply to enforcement of the requirements of sec-
4 tion 101, 102, or 103 with respect to any entity
5 which offers health insurance coverage and which is
6 an insurer or HMO regulated by a State if the Sec-
7 retary of Health and Human Services has deter-
8 mined that—

9 (A) such State has not provided for en-
10 forcement of State laws which govern the same
11 matters as are governed by such section and
12 which require compliance by such entity with at
13 least the same requirements as those provided
14 under such section, and

15 (B) such entity has failed to comply with
16 such requirements of such section as are appli-
17 cable to such entity.

18 (3) NONDUPLICATION OF SANCTIONS.—In no
19 case shall a civil money penalty be imposed under
20 this subsection for a violation of this subtitle for
21 which an excise tax has been imposed under section
22 4980B of the Internal Revenue Code of 1986 or for
23 which a civil money penalty has been imposed under
24 the authority provided under subsection (b).

1 (d) COORDINATION IN ADMINISTRATION.—The Sec-
 2 retaries of the Treasury, Labor, and Health and Human
 3 Services shall issue regulations that are nonduplicative to
 4 carry out this subtitle. Such regulations shall be issued
 5 in a manner that assures coordination and nonduplication
 6 in their activities under this subtitle.

7 **Subtitle B—Certain Requirements**
 8 **for Insurers and HMOs in the**
 9 **Group and Individual Markets**

10 **PART 1—AVAILABILITY OF GROUP HEALTH**
 11 **INSURANCE COVERAGE**

12 **SEC. 131. GUARANTEED AVAILABILITY OF GENERAL COV-**
 13 **ERAGE IN THE SMALL GROUP MARKET.**

14 (a) ISSUANCE OF COVERAGE.—

15 (1) IN GENERAL.—Subject to the succeeding
 16 subsections of this section, each insurer or HMO
 17 that offers health insurance coverage in the small
 18 group market in a State—

19 (A) must accept every small employer in
 20 the State that applies for such coverage; and

21 (B) must accept for enrollment under such
 22 coverage every eligible individual (as defined in
 23 paragraph (2)) who applies for enrollment dur-
 24 ing the initial period in which the individual
 25 first becomes eligible for coverage under the

1 group health plan and may not place any re-
2 striction which is inconsistent with section
3 103(a) on an individual being a participant or
4 beneficiary so long as such individual is an eli-
5 gible individual.

6 (2) ELIGIBLE INDIVIDUAL DEFINED.—In this
7 section, the term “eligible individual” means, with
8 respect to an insurer or HMO that offers health in-
9 surance coverage to any small employer in the small
10 group market, such an individual in relation to the
11 employer as shall be determined—

12 (A) in accordance with the terms of such
13 plan,

14 (B) as provided by the insurer or HMO
15 under rules of the insurer or HMO which are
16 uniformly applicable, and

17 (C) in accordance with all applicable State
18 laws governing such insurer or HMO.

19 (b) SPECIAL RULES FOR NETWORK PLANS AND
20 HMOs.—

21 (1) IN GENERAL.—In the case of an insurer
22 that offers health insurance coverage in the small
23 group market through a network plan and in the
24 case of an HMO that offers health insurance cov-

1 erage in connection with such a plan, the insurer or
2 HMO may—

3 (A) limit the employers that may apply for
4 such coverage to those with eligible individuals
5 whose place of employment or residence is in
6 the service area for such plan or HMO;

7 (B) limit the individuals who may be en-
8 rolled under such coverage to those whose place
9 of residence or employment is within the service
10 area for such plan or HMO; and

11 (C) within the service area of such plan or
12 HMO, deny such coverage to such employers if
13 the insurer or HMO demonstrates that—

14 (i) it will not have the capacity to de-
15 liver services adequately to enrollees of any
16 additional groups because of its obligations
17 to existing group contract holders and en-
18 rollees, and

19 (ii) it is applying this paragraph uni-
20 formly to all employers without regard to
21 the claims experience of those employers
22 and their employees (and their bene-
23 ficiaries) or the health status of such em-
24 ployees and beneficiaries.

1 (2) 180-DAY SUSPENSION UPON DENIAL OF
2 COVERAGE.—An insurer or HMO, upon denying
3 health insurance coverage in any service area in ac-
4 cordance with paragraph (1)(C), may not offer cov-
5 erage in the small group market within such service
6 area for a period of 180 days after such coverage is
7 denied.

8 (c) SPECIAL RULE FOR FINANCIAL CAPACITY LIM-
9 ITS.—

10 (1) IN GENERAL.—An insurer or HMO may
11 deny health insurance coverage in the small group
12 market if the insurer or HMO demonstrates to the
13 applicable State authority that—

14 (A) it does not have the financial reserves
15 necessary to underwrite additional coverage,
16 and

17 (B) it is applying this paragraph uniformly
18 to all employers without regard to the claims
19 experience or duration of coverage of those em-
20 ployers and their employees (and their bene-
21 ficiaries) or the health status of such employees
22 and beneficiaries.

23 (2) 180-DAY SUSPENSION UPON DENIAL OF
24 COVERAGE.—An insurer or HMO upon denying
25 health insurance coverage in connection with group

1 health plans in any service area in accordance with
2 paragraph (1) may not offer coverage in connection
3 with group health plans in the small group market
4 within such service area for a period of 180 days
5 after such coverage is denied.

6 (d) EXCEPTION TO REQUIREMENT FOR ISSUANCE OF
7 COVERAGE BY REASON OF FAILURE BY PLAN TO MEET
8 CERTAIN MINIMUM PARTICIPATION OR CONTRIBUTION
9 RULES.—

10 (1) IN GENERAL.—Subsection (a) shall not
11 apply in the case of any group health plan with re-
12 spect to which—

13 (A) participation rules of an insurer or
14 HMO which are described in paragraph (2) are
15 not met, or

16 (B) contribution rules of an insurer or
17 HMO which are described in paragraph (3) are
18 not met.

19 (2) PARTICIPATION RULES.—For purposes of
20 paragraph (1)(A), participation rules (if any) of an
21 insurer or HMO shall be treated as met with respect
22 to a group health plan only if such rules are uni-
23 formly applicable and in accordance with applicable
24 State law and the number or percentage of eligible
25 individuals who, under the plan, are participants or

1 beneficiaries equals or exceeds a level which is deter-
 2 mined in accordance with such rules.

3 (3) CONTRIBUTION RULES.—For purposes of
 4 paragraph (1)(B), contribution rules (if any) of an
 5 insurer or HMO shall be treated as met with respect
 6 to a group health plan only if such rules are in ac-
 7 cordance with applicable State law.

8 **SEC. 132. GUARANTEED RENEWABILITY OF GROUP COV-**
 9 **ERAGE.**

10 (a) IN GENERAL.—Except as provided in this section,
 11 if an insurer or health maintenance organization offers
 12 health insurance coverage in the small or large group mar-
 13 ket, the insurer or organization must renew or continue
 14 in force such coverage at the option of the employer.

15 (b) GENERAL EXCEPTIONS.—An insurer or organiza-
 16 tion may nonrenew or discontinue health insurance cov-
 17 erage offered an employer based only on one or more of
 18 the following:

19 (1) NONPAYMENT OF PREMIUMS.—The em-
 20 ployer has failed to pay premiums or contributions
 21 in accordance with the terms of the health insurance
 22 coverage or the insurer or organization has not re-
 23 ceived timely premium payments.

24 (2) FRAUD.—The employer has performed an
 25 act or practice that constitutes fraud or made an in-

1 tentional misrepresentation of material fact under
2 the terms of the coverage.

3 (3) VIOLATION WITH PARTICIPATION OR CON-
4 TRIBUTION RULES.—The group purchaser has failed
5 to comply with a material plan provision relating to
6 participation or contribution rules contributions in
7 accordance with section 131(d).

8 (4) TERMINATION OF PLAN.—Subject to sub-
9 section (c), the insurer or organization is ceasing to
10 offer coverage in the small or large group market in
11 a State (or, in the case of a network plan or HMO,
12 in a geographic area).

13 (5) MOVEMENT OUTSIDE SERVICE AREA.—The
14 employer has changed the place of employment in
15 such manner that employees and dependents reside
16 and are employed outside the service area of the in-
17 surer or organization or outside the area for which
18 the insurer or organization is authorized to do busi-
19 ness.

20 (c) EXCEPTIONS FOR UNIFORM TERMINATION OF
21 COVERAGE.—

22 (1) PARTICULAR TYPE OF COVERAGE NOT OF-
23 FERED.—In any case in which a insurer or HMO
24 decides to discontinue offering a particular type of
25 health insurance coverage in the small or large

1 group market, coverage of such type may be discon-
2 tinued by the insurer or organization only if—

3 (A) the insurer or organization provides
4 notice to each employer provided coverage of
5 this type in such market (and participants and
6 beneficiaries covered under such coverage) of
7 such discontinuation at least 90 days prior to
8 the date of the discontinuation of such cov-
9 erage;

10 (B) the insurer or organization offers to
11 each employer in the small employer or large
12 employer market provided coverage of this type,
13 the option to purchase any other health insur-
14 ance coverage currently being offered by the in-
15 surer or organization for employers in such
16 market; and

17 (C) in exercising the option to discontinue
18 coverage of this type and in offering one or
19 more replacement coverage, the insurer or orga-
20 nization acts uniformly without regard to the
21 health status or insurability of participants or
22 beneficiaries covered or new participants or
23 beneficiaries who may become eligible for such
24 coverage.

25 (2) DISCONTINUANCE OF ALL COVERAGE.—

1 (A) IN GENERAL.—Subject to subpara-
2 graph (C), in any case in which an insurer or
3 HMO elects to discontinue offering all health
4 insurance coverage in the small group market
5 or the large group market, or both markets, in
6 a State, health insurance coverage may be dis-
7 continued by the insurer or organization only
8 if—

9 (i) the insurer or organization pro-
10 vides notice to the applicable State author-
11 ity and to each employer (and participants
12 and beneficiaries covered under such cov-
13 erage) of such discontinuation at least 180
14 days prior to the date of the expiration of
15 such coverage, and

16 (ii) all health insurance issued or de-
17 livered for issuance in the State in such
18 market (or markets) are discontinued and
19 coverage under such health insurance cov-
20 erage in such market (or markets) is not
21 renewed.

22 (B) PROHIBITION ON MARKET REENTRY.—
23 In the case of a discontinuation under subpara-
24 graph (A) in one or both markets, the insurer
25 or organization may not provide for the issu-

1 ance of any health insurance coverage in the
 2 market and State involved during the 5-year pe-
 3 riod beginning on the date of the discontinu-
 4 ation of the last health insurance coverage not
 5 so renewed.

6 (d) EXCEPTION FOR UNIFORM MODIFICATION OF
 7 COVERAGE.—At the time of coverage renewal, an insurer
 8 or HMO may modify the coverage offered to a group
 9 health plan in the group health market so long as such
 10 modification is effective on a uniform basis among group
 11 health plans with that type of coverage.

12 **PART 2—AVAILABILITY OF INDIVIDUAL HEALTH**
 13 **INSURANCE COVERAGE**

14 **SEC. 141. GUARANTEED AVAILABILITY OF INDIVIDUAL**
 15 **HEALTH INSURANCE COVERAGE TO CERTAIN**
 16 **INDIVIDUALS WITH PRIOR GROUP COV-**
 17 **ERAGE.**

18 (a) GOALS.—The goals of this section are—

19 (1) to guarantee that any qualifying individual
 20 (as defined in subsection (b)(1)) is able to obtain
 21 qualifying coverage (as defined in subsection (b)(2));
 22 and

23 (2) to assure that qualifying individuals obtain-
 24 ing such coverage receive credit for their prior cov-
 25 erage toward the new coverage's preexisting condi-

1 tion exclusion period (if any) in a manner consistent
2 with subsection (b)(3).

3 (b) QUALIFYING INDIVIDUAL AND HEALTH INSUR-
4 ANCE COVERAGE DEFINED.—In this section—

5 (1) QUALIFYING INDIVIDUAL.—The term
6 “qualifying individual” means an individual—

7 (A) who is in a qualified coverage period
8 (as defined in section 101(b)(3)(C)) that—

9 (i) includes coverage under one or
10 more group health plans, and

11 (ii) commenced 18 or more months
12 before the date on which the individual
13 seeks coverage under this section;

14 (B) who is not eligible for coverage under
15 a group health plan;

16 (C) with respect to whom the most recent
17 coverage within the coverage period described in
18 subparagraph (A)(i) was not terminated based
19 on a factor described in paragraph (1) or (2) of
20 section 132(b);

21 (D) if the individual had been offered the
22 option of continuation coverage under a
23 COBRA continuation provision or under a simi-
24 lar State program, elected such coverage; and

1 (E) who, if the individual elected such con-
 2 tinuation coverage, has exhausted such continu-
 3 ation coverage.

4 (2) QUALIFYING COVERAGE.—

5 (A) IN GENERAL.—The term “qualifying
 6 coverage” means, with respect to an insurer or
 7 HMO in relation to a qualifying individual, in-
 8 dividual health insurance coverage for which the
 9 actuarial value of the benefits is not less than—

10 (i) the weighted average actuarial
 11 value of the benefits provided by all the in-
 12 dividual health insurance coverage issued
 13 by the insurer or HMO in the State during
 14 the previous year (not including coverage
 15 issued under this section), or

16 (ii) the weighted average of the actu-
 17 arial value of the benefits provided by all
 18 the individual health insurance coverage is-
 19 sued by all insurers and HMOs in the
 20 State during the previous year (not includ-
 21 ing coverage issued under this section),
 22 as elected by the plan or by the State under
 23 subsection (c)(1).

24 (B) ASSUMPTIONS.—For purposes of sub-
 25 paragraph (A), the actuarial value of benefits

1 provided under individual health insurance cov-
2 erage shall be calculated based on a standard-
3 ized population and a set of standardized utili-
4 zation and cost factors.

5 (3) CREDITING FOR PREVIOUS COVERAGE.—

6 Crediting is consistent with this paragraph only if
7 any preexisting condition exclusion period is reduced
8 at least to the extent such a period would be reduced
9 if the coverage under this section were under a
10 group health plan to which section 101(a) applies. In
11 carrying out this subsection, provisions similar to
12 the provisions of section 101(c) shall apply.

13 (c) OPTIONAL STATE ESTABLISHMENT OF MECHA-
14 NISMS TO ACHIEVE GOALS OF GUARANTEEING AVAIL-
15 ABILITY OF COVERAGE.—

16 (1) IN GENERAL.—Any State may establish
17 public or private mechanisms reasonably designed to
18 meet the goals specified in subsection (a). If a State
19 implements such a mechanism by the deadline speci-
20 fied in paragraph (4), the State may elect to have
21 such mechanisms apply instead of having subsection
22 (d) apply in the State. An election under this para-
23 graph shall be by notice to the Secretary of Health
24 and Human Services on a timely basis consistent
25 with the deadlines specified in paragraph (4). In es-

1 tablishing what is qualifying coverage under such a
 2 mechanism under this subsection, a State may exer-
 3 cise the election described in subsection (b)(2)(A)
 4 with respect to each insurer or HMO in the State
 5 (or on a collective basis after exercising such election
 6 for each such insurer or HMO).

7 (2) TYPES OF MECHANISMS.—State mecha-
 8 nisms under this subsection may include (but are
 9 not limited to)—

10 (A) health insurance coverage pools or pro-
 11 grams authorized or established by the State,

12 (B) mandatory group conversion policies,

13 (C) guaranteed issue of one or more plans
 14 of individual health insurance coverage to quali-
 15 fying individuals, or

16 (D) open enrollment by one or more insur-
 17 ers or HMOs.

18 (3) SAFE HARBOR FOR BENEFITS UNDER CUR-
 19 RENT RISK POOLS.—In the case of a State that has
 20 a health insurance coverage pool or risk pool in ef-
 21 fect on March 12, 1996, and that implements the
 22 mechanism described in paragraph (2)(A), the bene-
 23 fits under such mechanism (or benefits the actuarial
 24 value of which is not less than the actuarial value
 25 of such current benefits, using the assumptions de-

scribed in subsection (b)(2)(B)) are deemed, for purposes of this section, to constitute qualified coverage.

(4) DEADLINE FOR STATE IMPLEMENTATION.—

(A) IN GENERAL.—Subject to subparagraph (B), the deadline under this paragraph is July 1, 1997.

(B) EXTENSION TO PERMIT LEGISLATION.—The deadline under this paragraph is July 1, 1998, in the case of a State the legislature of which does not have a regular legislative session at any time between January 1, 1997, and June 30, 1997.

(C) CONSTRUCTION.—Nothing in this section shall be construed as preventing a State from—

(i) implementing guaranteed availability mechanisms before the deadline,

(ii) continuing in effect mechanisms that are in effect before the date of the enactment of this Act,

(iii) offering guaranteed availability of coverage that is not qualifying coverage, or

(iv) offering guaranteed availability of coverage to individuals who are not qualifying individuals.

1 (d) FALLBACK PROVISIONS.—

2 (1) NO STATE ELECTION.—If a State has not
3 provided notice to the Secretary of an election on a
4 timely basis under subsection (c), the Secretary shall
5 notify the State that paragraph (3) will be applied
6 in the State.

7 (2) PRELIMINARY DETERMINATION AFTER
8 STATE ELECTION.—If—

9 (A) a State has provided notice of an elec-
10 tion on a timely basis under subsection (c), and

11 (B) the Secretary finds, after consultation
12 with the chief executive officer of the State and
13 the insurance commissioner or chief insurance
14 regulatory official of the State, that such a
15 mechanism (for which notice was provided) is
16 not reasonably designed to meet the goals speci-
17 fied in subsection (a),

18 the Secretary shall notify the State of such prelimi-
19 nary determination, of the consequences under para-
20 graph (3) of a failure to implement such a mecha-
21 nism, and permit the State a reasonable opportunity
22 in which to modify the mechanism (or to adopt an-
23 other mechanism) that is reasonably designed to
24 meet the goals specified in subsection (a). If, after
25 providing such notice and opportunity, the Secretary

1 finds that the State has not implemented such a
2 mechanism, the Secretary shall notify the State that
3 paragraph (3) will be applied in the State.

4 (3) DESCRIPTION OF FALLBACK MECHANISM.—

5 As provided under paragraphs (1) and (2) and sub-
6 ject to paragraph (5), each insurer or HMO in the
7 State involved that issues individual health insurance
8 coverage—

9 (A) shall offer qualifying health insurance
10 coverage to each qualifying individual in the
11 State, and

12 (B) may not decline to issue such coverage
13 to such an individual based on health status
14 (except as permitted under paragraph (4)).

15 (4) APPLICATION OF NETWORK AND CAPACITY
16 LIMITS.—Under regulations, the provisions of sub-
17 sections (b) and (c) of section 131 shall apply to an
18 individual in the individual health insurance market
19 under this subsection in the same manner as they
20 apply under section 131 to an employer in the small
21 group market.

22 (5) TERMINATION OF FALLBACK MECHANISM.—

23 The provisions of this subsection shall cease to apply
24 to a State if the Secretary finds that a State has im-
25 plemented a mechanism that is reasonably designed

1 to meet the goals specified in subsection (a), and
2 until the Secretary finds that such mechanism is no
3 longer being implemented.

4 (e) CONSTRUCTION.—

5 (1) PREMIUMS.—Nothing in this section shall
6 be construed to affect the determination of an in-
7 surer or HMO as to the amount of the premium
8 payable under an individual health insurance cov-
9 erage under applicable state law.

10 (2) MARKET REQUIREMENTS.—

11 (A) IN GENERAL.—The provisions of sub-
12 section (a) shall not be construed to require
13 that an insurer or HMO offering health insur-
14 ance coverage only in connection with a group
15 health plan or an association offer individual
16 health insurance coverage.

17 (B) CONVERSION POLICIES.—An insurer
18 or HMO offering health insurance coverage in
19 connection with a group health plan under sub-
20 title A shall not be deemed to be an insurer or
21 HMO offering an individual health insurance
22 coverage solely because such insurer or HMO
23 offers a conversion policy.

24 (3) DISREGARD OF ASSOCIATION COVERAGE.—

25 An insurer or HMO that offers health insurance cov-

1 erage only in connection with a group health plan or
2 in connection with individuals based on affiliation
3 with one or more associations is not considered, for
4 purposes of this subtitle, to be offering individual
5 health insurance coverage.

6 (4) MARKETING OF PLANS.—Nothing in this
7 section shall be construed to prevent a State from
8 requiring insurer or HMOs offering individual health
9 insurance coverage to actively market such coverage.

10 **SEC. 142. GUARANTEED RENEWABILITY OF INDIVIDUAL**
11 **HEALTH INSURANCE COVERAGE.**

12 (a) GUARANTEED RENEWABILITY.—Subject to the
13 succeeding provisions of this section, an insurer or HMO
14 that provides individual health insurance coverage to an
15 individual shall renew or continue such coverage at the
16 option of the individual.

17 (b) NONRENEWAL PERMITTED IN CERTAIN CASES.—
18 An insurer or HMO may nonrenew or discontinue individ-
19 ual health insurance coverage of an individual only based
20 on one or more of the following:

21 (1) NONPAYMENT.—The individual fails to pay
22 payment of premiums or contributions in accordance
23 with the terms of the coverage or the insurer or or-
24 ganization has not failed to receive timely premium
25 payments.

1 (2) FRAUD.—The individual has performed an
2 act or practice that constitutes fraud or made an in-
3 tentional misrepresentation of material fact under
4 the terms of the coverage.

5 (3) TERMINATION OF COVERAGE.—Subject to
6 subsection (c), the insurer or HMO is ceasing to
7 offer health insurance coverage in the individual
8 market in a State (or, in the case of a network plan
9 or HMO, in a geographic area).

10 (c) TERMINATION OF INDIVIDUAL COVERAGE.—The
11 provisions of section 132(c) shall apply to this section in
12 the same manner as they apply under section 132, except
13 that any reference to an employer or market is deemed
14 a reference to a covered individual or the individual mar-
15 ket, respectively.

16 (d) EXCEPTION FOR UNIFORM MODIFICATION OF
17 COVERAGE.—The provisions of section 132(d) shall apply
18 to individual health insurance coverage in the individual
19 market under this section in the same manner as it applies
20 to health insurance coverage offered in connection with a
21 group health plan in the group market under such section.

PART 3—ENFORCEMENT

SEC. 151. INCORPORATION OF PROVISIONS FOR STATE ENFORCEMENT WITH FEDERAL FALLBACK AUTHORITY.

The provisions of paragraphs (1) and (2) of section 104(c) shall apply to enforcement of requirements in each section in part 1 or part 2 with respect to insurers and HMOs regulated by a State in the same manner as such provisions apply to enforcement of requirements in section 101, 102, or 103 with respect to insurers and HMOs regulated by a State.

Subtitle C—Definitions; General Provisions

SEC. 191. DEFINITIONS; SCOPE OF COVERAGE.

(a) GROUP HEALTH PLAN.—

(1) DEFINITION.—Subject to the succeeding provisions of this subsection and subsection (d)(1), the term “group health plan” means an employee welfare benefit plan to the extent that the plan provides medical care (as defined in subsection (b)()) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise, and includes a group health plan (within the meaning of section 5000B(b)(1) of the Internal Revenue Code of 1986).

1 (2) LIMITATION OF REQUIREMENTS TO PLANS
2 WITH 2 OR MORE EMPLOYEE PARTICIPANTS.—The
3 requirements of subtitle A and part 1 of subtitle B
4 shall apply in the case of a group health plan for
5 any plan year, or for health insurance coverage of-
6 fered in connection with a group health plan for a
7 year, only if the group health plan has two or more
8 participants as current employees on the first day of
9 the plan year.

10 (3) EXCLUSION OF PLANS WITH LIMITED COV-
11 ERAGE.—An employee welfare benefit plan shall be
12 treated as a group health plan under this title only
13 with respect to medical care which is provided under
14 the plan and which does not consist of coverage ex-
15 cluded from the definition of health insurance cov-
16 erage under subsection (c)(4)(B).

17 (3) TREATMENT OF CHURCH PLANS.—

18 (A) EXCLUSION.—The requirements of
19 this title insofar as they apply to group health
20 plans shall not apply to church plans.

21 (B) OPTIONAL DISREGARD IN DETERMIN-
22 ING PERIOD OF COVERAGE.—For purposes of
23 applying section 101(b)(3)(B)(i), a group health
24 plan may elect to disregard periods of coverage
25 of an individual under a church plan that, pur-

1 suant to subparagraph (A), is not subject to the
2 requirements of this title.

3 (4) TREATMENT OF GOVERNMENTAL PLANS.—

4 (A) ELECTION TO BE EXCLUDED.—If the
5 plan sponsor of a governmental plan which is a
6 group health plan to which the provisions of
7 this subtitle otherwise apply makes an election
8 under this paragraph for any specified period
9 (in such form and manner as the Secretary of
10 Health and Human Services may by regulations
11 prescribe), then the requirements of this title
12 insofar as they apply to group health plans
13 shall not apply to such governmental plans for
14 such period.

15 (B) OPTIONAL DISREGARD IN DETERMIN-
16 ING PERIOD OF COVERAGE IF ELECTION
17 MADE.—For purposes of applying section
18 101(b)(3)(B)(i), a group health plan may elect
19 to disregard periods of coverage of an individual
20 under a governmental plan that, under an elec-
21 tion under subparagraph (A), is not subject to
22 the requirements of this title.

23 (5) TREATMENT OF MEDICAID PLAN AS GROUP
24 HEALTH PLAN.—A State plan under title XIX of the
25 Social Security Act shall be treated as a group

1 health plan for purposes of applying section 101(c),
2 unless the State elects not to be so treated.

3 (b) INCORPORATION OF CERTAIN DEFINITIONS IN
4 EMPLOYEE RETIREMENT INCOME SECURITY ACT OF
5 1974.—Except as provided in this section, the terms “bene-
6 ficiary”, “church plan”, “employee”, “employee welfare
7 benefit plan”, “employer”, “governmental plan”, “multi-
8 employer plan”, “multiple employer welfare arrange-
9 ment”, “participant”, “plan sponsor”, and “State” have
10 the meanings given such terms in section 3 of the Em-
11 ployee Retirement Income Security Act of 1974.

12 (c) OTHER DEFINITIONS.—For purposes of this title:

13 (1) APPLICABLE STATE AUTHORITY.—The term
14 “applicable State authority” means, with respect to
15 an insurer or health maintenance organization in a
16 State, the State insurance commissioner or official
17 or officials designated by the State to enforce the re-
18 quirements of this title for the State involved with
19 respect to such insurer or organization.

20 (2) BONA FIDE ASSOCIATION.—The term “bona
21 fide association” means an association which—

22 (A) has been actively in existence for at
23 least 5 years,

1 (B) has been formed and maintained in
2 good faith for purposes other than obtaining in-
3 surance,

4 (C) does not condition membership in the
5 association on health status,

6 (D) makes health insurance coverage of-
7 fered through the association available to all
8 members regardless of health status,

9 (E) does not make health insurance cov-
10 erage offered through the association available
11 to any individual who is not a member (or de-
12 pendent of a member) of the association at the
13 time the coverage is initially issued,

14 (F) does not impose preexisting condition
15 exclusions except in a manner consistent with
16 the requirements of sections 101 and 102 as
17 they relate to group health plans, and

18 (G) provides for renewal and continuation
19 of health insurance coverage in a manner con-
20 sistent with the requirements of section 132 as
21 they relate to the renewal and continuation in
22 force of coverage in a group market.

23 (3) COBRA CONTINUATION PROVISION.—The
24 term “COBRA continuation provision” means any of
25 the following:

1 (A) Section 4980B of the Internal Revenue
2 Code of 1986, other than subsection (f)(1) of
3 such section insofar as it relates to pediatric
4 vaccines.

5 (B) Part 6 of subtitle B of title I of the
6 Employee Retirement Income Security Act of
7 1974 (29 U.S.C. 1161 et seq.), other than sec-
8 tion 609.

9 (C) Title XXII of the Public Health Serv-
10 ice Act.

11 (4) HEALTH INSURANCE COVERAGE.—

12 (A) IN GENERAL.—Except as provided in
13 subparagraph (B), the term “health insurance
14 coverage” means benefits consisting of medical
15 care (provided directly, through insurance or re-
16 imbursement, or otherwise) under any hospital
17 or medical service policy or certificate, hospital
18 or medical service plan contract, or health
19 maintenance organization group contract of-
20 fered by an insurer or a health maintenance or-
21 ganization.

22 (B) EXCEPTION.—Such term does not in-
23 clude coverage under any separate policy, cer-
24 tificate, or contract only for one or more of any
25 of the following:

1 (i) Coverage for accident, credit-only,
2 vision, disability income, long-term care,
3 nursing home care, community-based care
4 dental, on-site medical clinics, or employee
5 assistance programs, or any combination
6 thereof.

7 (ii) Medicare supplemental health in-
8 surance (within the meaning of section
9 1882(g)(1) of the Social Security Act (42
10 U.S.C. 1395ss(g)(1))) and similar supple-
11 mental coverage provided under a group
12 health plan.

13 (iii) Coverage issued as a supplement
14 to liability insurance.

15 (iv) Liability insurance, including gen-
16 eral liability insurance and automobile li-
17 ability insurance.

18 (v) Workers' compensation or similar
19 insurance.

20 (vi) Automobile medical-payment in-
21 surance.

22 (vii) Coverage consisting of benefit
23 payments made on a periodic basis for a
24 specified disease or illness or period of hos-
25 pitalization, without regard to the costs in-

1 curred or services rendered during the pe-
2 riod to which the payments relate.

3 (viii) Short-term limited duration in-
4 surance.

5 (ix) Such other coverage, comparable
6 to that described in previous clauses, as
7 may be specified in regulations prescribed
8 under this title.

9 (5) HEALTH MAINTENANCE ORGANIZATION;
10 HMO.—The terms “health maintenance organiza-
11 tion” and “HMO” mean—

12 (A) a Federally qualified health mainte-
13 nance organization (as defined in section
14 1301(a) of the Public Health Service Act (42
15 U.S.C. 300e(a))),

16 (B) an organization recognized under State
17 law as a health maintenance organization, or

18 (C) a similar organization regulated under
19 State law for solvency in the same manner and
20 to the same extent as such a health mainte-
21 nance organization,

22 if (other than for purposes of part 2 of subtitle B)
23 it is subject to State law which regulates insurance
24 (within the meaning of section 514(b)(2) of the Em-
25 ployee Retirement Income Security Act of 1974).

1 (6) HEALTH STATUS.—The term “health sta-
2 tus” includes, with respect to an individual, medical
3 condition, claims experience, receipt of health care,
4 medical history, evidence of insurability, or disabil-
5 ity.

6 (7) INDIVIDUAL HEALTH INSURANCE COV-
7 ERAGE.—The term “individual health insurance cov-
8 erage” means health insurance coverage offered to
9 individuals if the coverage is not offered in connec-
10 tion with a group health plan (other than such a
11 plan that has fewer than two participants as current
12 employees on the first day of the plan year).

13 (8) INSURER.—The term “insurer” means an
14 insurance company, insurance service, or insurance
15 organization which is licensed to engage in the busi-
16 ness of insurance in a State and (except for pur-
17 poses of part 2 of subtitle B) which is regulated by
18 a State (within the meaning of section 514(b)(2)(A)
19 of the Employee Retirement Income Security Act of
20 1974).

21 (9) MEDICAL CARE.—The term “medical care”
22 means—

23 (A) amounts paid for, or items or services
24 in the form of, the diagnosis, cure, mitigation,
25 treatment, or prevention of disease, or amounts

1 paid for, or items or services provided for, the
2 purpose of affecting any structure or function
3 of the body,

4 (B) amounts paid for, or services in the
5 form of, transportation primarily for and essen-
6 tial to medical care referred to in subparagraph
7 (A), and

8 (C) amounts paid for insurance covering
9 medical care referred to in subparagraphs (A)
10 and (B).

11 (10) NETWORK PLAN.—The term “network
12 plan” means, with respect to health insurance cov-
13 erage, an arrangement of an insurer or a health
14 maintenance organization under which the financing
15 and delivery of medical care are provided, in whole
16 or in part, through a defined set of providers under
17 contract with the insurer or health maintenance or-
18 ganization.

19 (11) WAITING PERIOD.—The term “waiting pe-
20 riod” means, with respect to a group health plan
21 and an individual who is a potential participant or
22 beneficiary in the plan, the minimum period that
23 must pass with respect to the individual before the
24 individual is eligible to be covered for benefits under
25 the plan.

1 (d) TREATMENT OF PARTNERSHIPS.—

2 (1) TREATMENT AS A GROUP HEALTH PLAN.—

3 Any plan, fund, or program which would not be (but
4 for this paragraph) an employee welfare benefit plan
5 and which is established or maintained by a partner-
6 ship, to the extent that such plan, fund, or program
7 provides medical care to present or former partners
8 in the partnership or to their dependents (as defined
9 under the terms of the plan, fund, or program), di-
10 rectly or through insurance, reimbursement, or oth-
11 erwise, shall be treated (subject to paragraph (1)) as
12 an employee welfare benefit plan which is a group
13 health plan.

14 (2) TREATMENT OF PARTNERSHIP AND PART-
15 NERS AND EMPLOYER AND PARTICIPANTS.—In the
16 case of a group health plan—

17 (A) the term “employer” includes the part-
18 nership in relation to any partner; and

19 (B) the term “participant” includes—

20 (i) in connection with a group health
21 plan maintained by a partnership, an indi-
22 vidual who is a partner in relation to the
23 partnership, or

24 (ii) in connection with a group health
25 plan maintained by a self-employed individ-

1 ual (under which one or more employees
2 are participants), the self-employed individ-
3 ual,
4 if such individual is or may become eligible to
5 receive a benefit under the plan or such individ-
6 ual’s beneficiaries may be eligible to receive any
7 such benefit.

8 (e) DEFINITIONS RELATING TO MARKETS AND
9 SMALL EMPLOYERS.—As used in this title:

10 (1) INDIVIDUAL MARKET.—The term “individ-
11 ual market” means the market for health insurance
12 coverage offered to individuals and not to employers
13 or in connection with a group health plan and does
14 not include the market for such coverage issued only
15 by an insurer or HMO that makes such coverage
16 available only on the basis of affiliation with an as-
17 sociation or other group.

18 (2) LARGE GROUP MARKET.—The term “large
19 group market” means the market for health insur-
20 ance coverage offered to employers (other than small
21 employers) on behalf of their employees (and their
22 dependents) and does not include health insurance
23 coverage available solely in connection with a bona
24 fide association (as defined in subsection (c)(2)).

1 (3) SMALL EMPLOYER.—The term “small em-
2 ployer” means, in connection with a group health
3 plan with respect to a calendar year, an employer
4 who employs at least 2 but fewer than 51 employees
5 on a typical business day in the year. For purposes
6 of this paragraph, two or more trades or businesses,
7 whether or not incorporated, shall be deemed a sin-
8 gle employer if such trades or businesses are within
9 the same control group (within the meaning of sec-
10 tion 3(40)(B)(ii)).

11 (4) SMALL GROUP MARKET.—The term “small
12 group market” means the health insurance market
13 under which individuals obtain health insurance cov-
14 erage (directly or through any arrangement) on be-
15 half of themselves (and their dependents) on the
16 basis of employment or other relationship with re-
17 spect to a small employer and does not include
18 health insurance coverage available solely in connec-
19 tion with a bona fide association (as defined in sub-
20 section (c)(2)).

21 **SEC. 192. STATE FLEXIBILITY TO PROVIDE GREATER PRO-**
22 **TECTION.**

23 (a) STATE FLEXIBILITY TO PROVIDE GREATER PRO-
24 TECTION.—Subject to subsection (b), nothing in this title
25 shall be construed to preempt State laws that—

1 (1) require insurers or HMOs to impose a limi-
2 tation or exclusion of benefits relating to the treat-
3 ment of a preexisting condition for a period that is
4 shorter than the applicable period provided for under
5 this title; or

6 (2) allow individuals, participants, and bene-
7 ficiaries to be considered to be in a period of pre-
8 vious qualifying coverage if such individual, partici-
9 pant, or beneficiary experiences a lapse in coverage
10 that is greater than the 60-day periods provided for
11 under sections 101(b)(3)(A), 101(b)(3)(B)(ii), and
12 102(b)(2).

13 (b) NO OVERRIDE OF ERISA PREEMPTION.—Noth-
14 ing in this Act shall be construed to affect or modify the
15 provisions of section 514 of the Employee Retirement In-
16 come Security Act of 1974 (29 U.S.C. 1144).

17 **SEC. 193. EFFECTIVE DATE.**

18 (a) IN GENERAL.—Except as otherwise provided for
19 in this title, the provisions of this title shall apply with
20 respect to—

21 (1) group health plans, and health insurance
22 coverage offered in connection with group health
23 plans, for plan years beginning on or after January
24 1, 1998, and

1 (2) individual health insurance coverage issued,
2 renewed, in effect, or operated on or after July 1,
3 1998.

4 (b) CONSIDERATION OF PREVIOUS COVERAGE.—The
5 Secretaries of Health and Human Services, Treasury, and
6 Labor shall jointly establish rules regarding the treatment
7 (in determining qualified coverage periods under sections
8 102(b) and 141(b)) of coverage before the applicable effec-
9 tive date specified in subsection (a).

10 (c) TIMELY ISSUANCE OF REGULATIONS.—The Sec-
11 retaries of Health and Human Services, the Treasury, and
12 Labor shall issue such regulations on a timely basis as
13 may be required to carry out this title.

14 **SEC. 194. RULE OF CONSTRUCTION.**

15 Nothing in this title or any amendment made thereby
16 may be construed to require the coverage of any specific
17 procedure, treatment, or service as part of a group health
18 plan or health insurance coverage under this title or
19 through regulation.

1 **TITLE II—PREVENTING HEALTH**
 2 **CARE FRAUD AND ABUSE; AD-**
 3 **MINISTRATIVE SIMPLIFICA-**
 4 **TION**

5 **SEC. 200. REFERENCES IN TITLE.**

6 Except as otherwise specifically provided, whenever in
 7 this title an amendment is expressed in terms of an
 8 amendment to or repeal of a section or other provision,
 9 the reference shall be considered to be made to that sec-
 10 tion or other provision of the Social Security Act.

11 **Subtitle A—Fraud and Abuse**
 12 **Control Program**

13 **SEC. 201. FRAUD AND ABUSE CONTROL PROGRAM.**

14 (a) ESTABLISHMENT OF PROGRAM.—Title XI (42
 15 U.S.C. 1301 et seq.) is amended by inserting after section
 16 1128B the following new section:

17 “FRAUD AND ABUSE CONTROL PROGRAM

18 “SEC. 1128C. (a) ESTABLISHMENT OF PROGRAM.—

19 “(1) IN GENERAL.—Not later than January 1,
 20 1997, the Secretary, acting through the Office of the
 21 Inspector General of the Department of Health and
 22 Human Services, and the Attorney General shall es-
 23 tablish a program—

1 “(A) to coordinate Federal, State, and
2 local law enforcement programs to control fraud
3 and abuse with respect to health plans,

4 “(B) to conduct investigations, audits,
5 evaluations, and inspections relating to the de-
6 livery of and payment for health care in the
7 United States,

8 “(C) to facilitate the enforcement of the
9 provisions of sections 1128, 1128A, and 1128B
10 and other statutes applicable to health care
11 fraud and abuse,

12 “(D) to provide for the modification and
13 establishment of safe harbors and to issue advi-
14 sory opinions and special fraud alerts pursuant
15 to section 1128D, and

16 “(E) to provide for the reporting and dis-
17 closure of certain final adverse actions against
18 health care providers, suppliers, or practitioners
19 pursuant to the data collection system estab-
20 lished under section 1128E.

21 “(2) COORDINATION WITH HEALTH PLANS.—In
22 carrying out the program established under para-
23 graph (1), the Secretary and the Attorney General
24 shall consult with, and arrange for the sharing of
25 data with representatives of health plans.

1 “(3) GUIDELINES.—

2 “(A) IN GENERAL.—The Secretary and the
3 Attorney General shall issue guidelines to carry
4 out the program under paragraph (1). The pro-
5 visions of sections 553, 556, and 557 of title 5,
6 United States Code, shall not apply in the issu-
7 ance of such guidelines.

8 “(B) INFORMATION GUIDELINES.—

9 “(i) IN GENERAL.—Such guidelines
10 shall include guidelines relating to the fur-
11 nishing of information by health plans,
12 providers, and others to enable the Sec-
13 retary and the Attorney General to carry
14 out the program (including coordination
15 with health plans under paragraph (2)).

16 “(ii) CONFIDENTIALITY.—Such guide-
17 lines shall include procedures to assure
18 that such information is provided and uti-
19 lized in a manner that appropriately pro-
20 tects the confidentiality of the information
21 and the privacy of individuals receiving
22 health care services and items.

23 “(iii) QUALIFIED IMMUNITY FOR PRO-
24 VIDING INFORMATION.—The provisions of
25 section 1157(a) (relating to limitation on

liability) shall apply to a person providing information to the Secretary or the Attorney General in conjunction with their performance of duties under this section.

“(4) ENSURING ACCESS TO DOCUMENTATION.—

The Inspector General of the Department of Health and Human Services is authorized to exercise such authority described in paragraphs (3) through (9) of section 6 of the Inspector General Act of 1978 (5 U.S.C. App.) as necessary with respect to the activities under the fraud and abuse control program established under this subsection.

“(5) AUTHORITY OF INSPECTOR GENERAL.—

Nothing in this Act shall be construed to diminish the authority of any Inspector General, including such authority as provided in the Inspector General Act of 1978 (5 U.S.C. App.).

“(b) ADDITIONAL USE OF FUNDS BY INSPECTOR GENERAL.—

“(1) REIMBURSEMENTS FOR INVESTIGA-

TIONS.—The Inspector General of the Department of Health and Human Services is authorized to receive and retain for current use reimbursement for the costs of conducting investigations and audits and for monitoring compliance plans when such costs are

1 ordered by a court, voluntarily agreed to by the
2 payor, or otherwise.

3 “(2) CREDITING.—Funds received by the In-
4 spector General under paragraph (1) as reimburse-
5 ment for costs of conducting investigations shall be
6 deposited to the credit of the appropriation from
7 which initially paid, or to appropriations for similar
8 purposes currently available at the time of deposit,
9 and shall remain available for obligation for 1 year
10 from the date of the deposit of such funds.

11 “(c) HEALTH PLAN DEFINED.—For purposes of this
12 section, the term ‘health plan’ means a plan or program
13 that provides health benefits, whether directly, through in-
14 surance, or otherwise, and includes—

15 “(1) a policy of health insurance;

16 “(2) a contract of a service benefit organiza-
17 tion; and

18 “(3) a membership agreement with a health
19 maintenance organization or other prepaid health
20 plan.”.

21 (b) ESTABLISHMENT OF HEALTH CARE FRAUD AND
22 ABUSE CONTROL ACCOUNT IN FEDERAL HOSPITAL IN-
23 SURANCE TRUST FUND.—Section 1817 (42 U.S.C. 1395i)
24 is amended by adding at the end the following new sub-
25 section:

1 “(k) HEALTH CARE FRAUD AND ABUSE CONTROL
2 ACCOUNT.—

3 “(1) ESTABLISHMENT.—There is hereby estab-
4 lished in the Trust Fund an expenditure account to
5 be known as the ‘Health Care Fraud and Abuse
6 Control Account’ (in this subsection referred to as
7 the ‘Account’).

8 “(2) APPROPRIATED AMOUNTS TO TRUST
9 FUND.—

10 “(A) IN GENERAL.—There are hereby ap-
11 propriated to the Trust Fund—

12 “(i) such gifts and bequests as may be
13 made as provided in subparagraph (B);

14 “(ii) such amounts as may be depos-
15 ited in the Trust Fund as provided in sec-
16 tions 242(b) and 249(c) of the Health Cov-
17 erage Availability and Affordability Act of
18 1996, and title XI; and

19 “(iii) such amounts as are transferred
20 to the Trust Fund under subparagraph
21 (C).

22 “(B) AUTHORIZATION TO ACCEPT GIFTS.—
23 The Trust Fund is authorized to accept on be-
24 half of the United States money gifts and be-
25 quests made unconditionally to the Trust Fund,

1 for the benefit of the Account or any activity fi-
2 nanced through the Account.

3 “(C) TRANSFER OF AMOUNTS.—The Man-
4 aging Trustee shall transfer to the Trust Fund,
5 under rules similar to the rules in section 9601
6 of the Internal Revenue Code of 1986, an
7 amount equal to the sum of the following:

8 “(i) Criminal fines recovered in cases
9 involving a Federal health care offense (as
10 defined in section 982(a)(6)(B) of title 18,
11 United States Code).

12 “(ii) Civil monetary penalties and as-
13 sessments imposed in health care cases, in-
14 cluding amounts recovered under titles XI,
15 XVIII, and XXI, and chapter 38 of title
16 31, United States Code (except as other-
17 wise provided by law).

18 “(iii) Amounts resulting from the for-
19 feiture of property by reason of a Federal
20 health care offense.

21 “(iv) Penalties and damages obtained
22 and otherwise creditable to miscellaneous
23 receipts of the general fund of the Treas-
24 ury obtained under sections 3729 through
25 3733 of title 31, United States Code

1 (known as the False Claims Act), in cases
2 involving claims related to the provision of
3 health care items and services (other than
4 funds awarded to a relator, for restitution
5 or otherwise authorized by law).

6 “(3) APPROPRIATED AMOUNTS TO ACCOUNT
7 FOR FRAUD AND ABUSE CONTROL PROGRAM, ETC.—

8 “(A) DEPARTMENTS OF HEALTH AND
9 HUMAN SERVICES AND JUSTICE.—

10 “(i) IN GENERAL.—There are hereby
11 appropriated to the Account from the
12 Trust Fund such sums as the Secretary
13 and the Attorney General certify are nec-
14 essary to carry out the purposes described
15 in subparagraph (C), to be available with-
16 out further appropriation, in an amount
17 not to exceed—

18 “(I) for fiscal year 1997,
19 \$104,000,000, and

20 “(II) for each of the fiscal years
21 1998 through 2003, the limit for the
22 preceding fiscal year, increased by 15
23 percent; and

1 “(III) for each fiscal year after
2 fiscal year 2003, the limit for fiscal
3 year 2003.

4 “(ii) MEDICARE AND MEDICAID AC-
5 TIVITIES.—For each fiscal year, of the
6 amount appropriated in clause (i), the fol-
7 lowing amounts shall be available only for
8 the purposes of the activities of the Office
9 of the Inspector General of the Depart-
10 ment of Health and Human Services with
11 respect to the medicare and medicaid pro-
12 grams—

13 “(I) for fiscal year 1997, not less
14 than \$60,000,000 and not more than
15 \$70,000,000;

16 “(II) for fiscal year 1998, not
17 less than \$80,000,000 and not more
18 than \$90,000,000;

19 “(III) for fiscal year 1999, not
20 less than \$90,000,000 and not more
21 than \$100,000,000;

22 “(IV) for fiscal year 2000, not
23 less than \$110,000,000 and not more
24 than \$120,000,000;

1 “(V) for fiscal year 2001, not
2 less than \$120,000,000 and not more
3 than \$130,000,000;

4 “(VI) for fiscal year 2002, not
5 less than \$140,000,000 and not more
6 than \$150,000,000; and

7 “(VII) for each fiscal year after
8 fiscal year 2002, not less than
9 \$150,000,000 and not more than
10 \$160,000,000.

11 “(B) FEDERAL BUREAU OF INVESTIGA-
12 TION.—There are hereby appropriated from the
13 general fund of the United States Treasury and
14 hereby appropriated to the Account for transfer
15 to the Federal Bureau of Investigation to carry
16 out the purposes described in subparagraph
17 (C), to be available without further appropria-
18 tion—

19 “(i) for fiscal year 1997, \$47,000,000;

20 “(ii) for fiscal year 1998,
21 \$56,000,000;

22 “(iii) for fiscal year 1999,
23 \$66,000,000;

24 “(iv) for fiscal year 2000,
25 \$76,000,000;

1 “(v) for fiscal year 2001,
2 \$88,000,000;

3 “(vi) for fiscal year 2002,
4 \$101,000,000; and

5 “(vii) for each fiscal year after fiscal
6 year 2002, \$114,000,000.

7 “(C) USE OF FUNDS.—The purposes de-
8 scribed in this subparagraph are to cover the
9 costs (including equipment, salaries and bene-
10 fits, and travel and training) of the administra-
11 tion and operation of the health care fraud and
12 abuse control program established under section
13 1128C(a), including the costs of—

14 “(i) prosecuting health care matters
15 (through criminal, civil, and administrative
16 proceedings);

17 “(ii) investigations;

18 “(iii) financial and performance audits
19 of health care programs and operations;

20 “(iv) inspections and other evalua-
21 tions; and

22 “(v) provider and consumer education
23 regarding compliance with the provisions of
24 title XI.

1 “(4) APPROPRIATED AMOUNTS TO ACCOUNT
2 FOR MEDICARE INTEGRITY PROGRAM.—

3 “(A) IN GENERAL.—There are hereby ap-
4 propriated to the Account from the Trust Fund
5 for each fiscal year such amounts as are nec-
6 essary to carry out the Medicare Integrity Pro-
7 gram under section 1893, subject to subpara-
8 graph (B) and to be available without further
9 appropriation.

10 “(B) AMOUNTS SPECIFIED.—The amount
11 appropriated under subparagraph (A) for a fis-
12 cal year is as follows:

13 “(i) For fiscal year 1997, such
14 amount shall be not less than
15 \$430,000,000 and not more than
16 \$440,000,000.

17 “(ii) For fiscal year 1998, such
18 amount shall be not less than
19 \$490,000,000 and not more than
20 \$500,000,000.

21 “(iii) For fiscal year 1999, such
22 amount shall be not less than
23 \$550,000,000 and not more than
24 \$560,000,000.

1 “(iv) For fiscal year 2000, such
2 amount shall be not less than
3 \$620,000,000 and not more than
4 \$630,000,000.

5 “(v) For fiscal year 2001, such
6 amount shall be not less than
7 \$670,000,000 and not more than
8 \$680,000,000.

9 “(vi) For fiscal year 2002, such
10 amount shall be not less than
11 \$690,000,000 and not more than
12 \$700,000,000.

13 “(vii) For each fiscal year after fiscal
14 year 2002, such amount shall be not less
15 than \$710,000,000 and not more than
16 \$720,000,000.

17 “(5) ANNUAL REPORT.—The Secretary and the
18 Attorney General shall submit jointly an annual re-
19 port to Congress on the amount of revenue which is
20 generated and disbursed, and the justification for
21 such disbursements, by the Account in each fiscal
22 year.”.

1 **SEC. 202. MEDICARE INTEGRITY PROGRAM.**

2 (a) ESTABLISHMENT OF MEDICARE INTEGRITY PRO-
3 GRAM.—Title XVIII is amended by adding at the end the
4 following new section:

5 “MEDICARE INTEGRITY PROGRAM

6 “SEC. 1893. (a) ESTABLISHMENT OF PROGRAM.—
7 There is hereby established the Medicare Integrity Pro-
8 gram (in this section referred to as the ‘Program’) under
9 which the Secretary shall promote the integrity of the
10 medicare program by entering into contracts in accord-
11 ance with this section with eligible private entities to carry
12 out the activities described in subsection (b).

13 “(b) ACTIVITIES DESCRIBED.—The activities de-
14 scribed in this subsection are as follows:

15 “(1) Review of activities of providers of services
16 or other individuals and entities furnishing items
17 and services for which payment may be made under
18 this title (including skilled nursing facilities and
19 home health agencies), including medical and utiliza-
20 tion review and fraud review (employing similar
21 standards, processes, and technologies used by pri-
22 vate health plans, including equipment and software
23 technologies which surpass the capability of the
24 equipment and technologies used in the review of
25 claims under this title as of the date of the enact-
26 ment of this section).

1 “(2) Audit of cost reports.

2 “(3) Determinations as to whether payment
3 should not be, or should not have been, made under
4 this title by reason of section 1862(b), and recovery
5 of payments that should not have been made.

6 “(4) Education of providers of services, bene-
7 ficiaries, and other persons with respect to payment
8 integrity and benefit quality assurance issues.

9 “(5) Developing (and periodically updating) a
10 list of items of durable medical equipment in accord-
11 ance with section 1834(a)(15) which are subject to
12 prior authorization under such section.

13 “(c) ELIGIBILITY OF ENTITIES.—An entity is eligible
14 to enter into a contract under the Program to carry out
15 any of the activities described in subsection (b) if—

16 “(1) the entity has demonstrated capability to
17 carry out such activities;

18 “(2) in carrying out such activities, the entity
19 agrees to cooperate with the Inspector General of
20 the Department of Health and Human Services, the
21 Attorney General of the United States, and other
22 law enforcement agencies, as appropriate, in the in-
23 vestigation and deterrence of fraud and abuse in re-
24 lation to this title and in other cases arising out of
25 such activities;

1 “(3) the entity demonstrates to the Secretary
2 that the entity’s financial holdings, interests, or rela-
3 tionships will not interfere with its ability to perform
4 the functions to be required by the contract in an ef-
5 fective and impartial manner; and

6 “(4) the entity meets such other requirements
7 as the Secretary may impose.

8 In the case of the activity described in subsection (b)(5),
9 an entity shall be deemed to be eligible to enter into a
10 contract under the Program to carry out the activity if
11 the entity is a carrier with a contract in effect under sec-
12 tion 1842.

13 “(d) PROCESS FOR ENTERING INTO CONTRACTS.—
14 The Secretary shall enter into contracts under the Pro-
15 gram in accordance with such procedures as the Secretary
16 shall by regulation establish, except that such procedures
17 shall include the following:

18 “(1) The Secretary shall determine the appro-
19 priate number of separate contracts which are nec-
20 essary to carry out the Program and the appropriate
21 times at which the Secretary shall enter into such
22 contracts.

23 “(2)(A) Except as provided in subparagraph
24 (B), the provisions of section 1153(e)(1) shall apply

1 to contracts and contracting authority under this
2 section.

3 “(B) Competitive procedures must be used
4 when entering into new contracts under this section,
5 or at any other time considered appropriate by the
6 Secretary, except that the Secretary may contract
7 with entities that are carrying out the activities de-
8 scribed in this section pursuant to agreements under
9 section 1816 or contracts under section 1842 in ef-
10 fect on the date of the enactment of this section.

11 “(3) A contract under this section may be re-
12 newed without regard to any provision of law requir-
13 ing competition if the contractor has met or ex-
14 ceeded the performance requirements established in
15 the current contract.

16 “(e) LIMITATION ON CONTRACTOR LIABILITY.—The
17 Secretary shall by regulation provide for the limitation of
18 a contractor’s liability for actions taken to carry out a con-
19 tract under the Program, and such regulation shall, to the
20 extent the Secretary finds appropriate, employ the same
21 or comparable standards and other substantive and proce-
22 dural provisions as are contained in section 1157.”.

23 (b) ELIMINATION OF FI AND CARRIER RESPONSIBIL-
24 ITY FOR CARRYING OUT ACTIVITIES SUBJECT TO PRO-
25 GRAM.—

1 (1) RESPONSIBILITIES OF FISCAL
2 INTERMEDIARIES UNDER PART A.—Section 1816
3 (42 U.S.C. 1395h) is amended by adding at the end
4 the following new subsection:

5 “(1) No agency or organization may carry out (or re-
6 ceive payment for carrying out) any activity pursuant to
7 an agreement under this section to the extent that the ac-
8 tivity is carried out pursuant to a contract under the Med-
9 icare Integrity Program under section 1893.”.

10 (2) RESPONSIBILITIES OF CARRIERS UNDER
11 PART B.—Section 1842(c) (42 U.S.C. 1395u(c)) is
12 amended by adding at the end the following new
13 paragraph:

14 “(6) No carrier may carry out (or receive payment
15 for carrying out) any activity pursuant to a contract under
16 this subsection to the extent that the activity is carried
17 out pursuant to a contract under the Medicare Integrity
18 Program under section 1893. The previous sentence shall
19 not apply with respect to the activity described in section
20 1893(b)(5) (relating to prior authorization of certain
21 items of durable medical equipment under section
22 1834(a)(15)).”.

23 **SEC. 203. BENEFICIARY INCENTIVE PROGRAMS.**

24 (a) CLARIFICATION OF REQUIREMENT TO PROVIDE
25 EXPLANATION OF MEDICARE BENEFITS.—The Secretary

1 of Health and Human Services (in this section referred
2 to as the “Secretary”) shall provide an explanation of ben-
3 efits under the medicare program under title XVIII of the
4 Social Security Act with respect to each item or service
5 for which payment may be made under the program which
6 is furnished to an individual, without regard to whether
7 or not a deductible or coinsurance may be imposed against
8 the individual with respect to the item or service.

9 (b) PROGRAM TO COLLECT INFORMATION ON FRAUD
10 AND ABUSE.—

11 (1) ESTABLISHMENT OF PROGRAM.—Not later
12 than 3 months after the date of the enactment of
13 this Act, the Secretary shall establish a program
14 under which the Secretary shall encourage individ-
15 uals to report to the Secretary information on indi-
16 viduals and entities who are engaging or who have
17 engaged in acts or omissions which constitute
18 grounds for the imposition of a sanction under sec-
19 tion 1128, section 1128A, or section 1128B of the
20 Social Security Act, or who have otherwise engaged
21 in fraud and abuse against the medicare program
22 for which there is a sanction provided under law.
23 The program shall discourage provision of, and not
24 consider, information which is frivolous or otherwise

1 not relevant or material to the imposition of such a
2 sanction.

3 (2) PAYMENT OF PORTION OF AMOUNTS COL-
4 LECTED.—If an individual reports information to
5 the Secretary under the program established under
6 paragraph (1) which serves as the basis for the col-
7 lection by the Secretary or the Attorney General of
8 any amount of at least \$100 (other than any
9 amount paid as a penalty under section 1128B of
10 the Social Security Act), the Secretary may pay a
11 portion of the amount collected to the individual
12 (under procedures similar to those applicable under
13 section 7623 of the Internal Revenue Code of 1986
14 to payments to individuals providing information on
15 violations of such Code).

16 (c) PROGRAM TO COLLECT INFORMATION ON PRO-
17 GRAM EFFICIENCY.—

18 (1) ESTABLISHMENT OF PROGRAM.—Not later
19 than 3 months after the date of the enactment of
20 this Act, the Secretary shall establish a program
21 under which the Secretary shall encourage individ-
22 uals to submit to the Secretary suggestions on meth-
23 ods to improve the efficiency of the medicare pro-
24 gram.

1 (2) PAYMENT OF PORTION OF PROGRAM SAV-
 2 INGS.—If an individual submits a suggestion to the
 3 Secretary under the program established under
 4 paragraph (1) which is adopted by the Secretary and
 5 which results in savings to the program, the Sec-
 6 retary may make a payment to the individual of
 7 such amount as the Secretary considers appropriate.

8 **SEC. 204. APPLICATION OF CERTAIN HEALTH ANTI-FRAUD**
 9 **AND ABUSE SANCTIONS TO FRAUD AND**
 10 **ABUSE AGAINST FEDERAL HEALTH CARE**
 11 **PROGRAMS.**

12 (a) IN GENERAL.—Section 1128B (42 U.S.C.
 13 1320a–7b) is amended as follows:

14 (1) In the heading, by striking “MEDICARE OR
 15 STATE HEALTH CARE PROGRAMS” and inserting
 16 “FEDERAL HEALTH CARE PROGRAMS”.

17 (2) In subsection (a)(1), by striking “a program
 18 under title XVIII or a State health care program (as
 19 defined in section 1128(h))” and inserting “a Fed-
 20 eral health care program”.

21 (3) In subsection (a)(5), by striking “a program
 22 under title XVIII or a State health care program”
 23 and inserting “a Federal health care program”.

24 (4) In the second sentence of subsection (a)—

1 (A) by striking “a State plan approved
2 under title XIX” and inserting “a Federal
3 health care program”, and

4 (B) by striking “the State may at its op-
5 tion (notwithstanding any other provision of
6 that title or of such plan)” and inserting “the
7 administrator of such program may at its op-
8 tion (notwithstanding any other provision of
9 such program)”.

10 (5) In subsection (b), by striking “title XVIII
11 or a State health care program” each place it ap-
12 pears and inserting “a Federal health care pro-
13 gram”.

14 (6) In subsection (c), by inserting “(as defined
15 in section 1128(h))” after “a State health care pro-
16 gram”.

17 (7) By adding at the end the following new sub-
18 section:

19 “(f) For purposes of this section, the term ‘Federal
20 health care program’ means—

21 “(1) any plan or program that provides health
22 benefits, whether directly, through insurance, or oth-
23 erwise, which is funded directly, in whole or in part,
24 by the United States Government (other than the

1 health insurance program under chapter 89 of title
2 5, United States Code); or

3 “(2) any State health care program, as defined
4 in section 1128(h).”.

5 (b) EFFECTIVE DATE.—The amendments made by
6 this section shall take effect on January 1, 1997.

7 **SEC. 205. GUIDANCE REGARDING APPLICATION OF HEALTH**
8 **CARE FRAUD AND ABUSE SANCTIONS.**

9 Title XI (42 U.S.C. 1301 et seq.), as amended by
10 section 201, is amended by inserting after section 1128C
11 the following new section:

12 “GUIDANCE REGARDING APPLICATION OF HEALTH CARE
13 FRAUD AND ABUSE SANCTIONS

14 “SEC. 1128D. (a) SOLICITATION AND PUBLICATION
15 OF MODIFICATIONS TO EXISTING SAFE HARBORS AND
16 NEW SAFE HARBORS.—

17 “(1) IN GENERAL.—

18 “(A) SOLICITATION OF PROPOSALS FOR
19 SAFE HARBORS.—Not later than January 1,
20 1997, and not less than annually thereafter, the
21 Secretary shall publish a notice in the Federal
22 Register soliciting proposals, which will be ac-
23 cepted during a 60-day period, for—

24 “(i) modifications to existing safe har-
25 bors issued pursuant to section 14(a) of
26 the Medicare and Medicaid Patient and

1 Program Protection Act of 1987 (42
2 U.S.C. 1320a–7b note);

3 “(ii) additional safe harbors specifying
4 payment practices that shall not be treated
5 as a criminal offense under section
6 1128B(b) and shall not serve as the basis
7 for an exclusion under section 1128(b)(7);

8 “(iii) advisory opinions to be issued
9 pursuant to subsection (b); and

10 “(iv) special fraud alerts to be issued
11 pursuant to subsection (c).

12 “(B) PUBLICATION OF PROPOSED MODI-
13 FICATIONS AND PROPOSED ADDITIONAL SAFE
14 HARBORS.—After considering the proposals de-
15 scribed in clauses (i) and (ii) of subparagraph
16 (A), the Secretary, in consultation with the At-
17 torney General, shall publish in the Federal
18 Register proposed modifications to existing safe
19 harbors and proposed additional safe harbors, if
20 appropriate, with a 60-day comment period.
21 After considering any public comments received
22 during this period, the Secretary shall issue
23 final rules modifying the existing safe harbors
24 and establishing new safe harbors, as appro-
25 priate.

1 “(C) REPORT.—The Inspector General of
2 the Department of Health and Human Services
3 (in this section referred to as the ‘Inspector
4 General’) shall, in an annual report to Congress
5 or as part of the year-end semiannual report re-
6 quired by section 5 of the Inspector General
7 Act of 1978 (5 U.S.C. App.), describe the pro-
8 posals received under clauses (i) and (ii) of sub-
9 paragraph (A) and explain which proposals
10 were included in the publication described in
11 subparagraph (B), which proposals were not in-
12 cluded in that publication, and the reasons for
13 the rejection of the proposals that were not in-
14 cluded.

15 “(2) CRITERIA FOR MODIFYING AND ESTAB-
16 LISHING SAFE HARBORS.—In modifying and estab-
17 lishing safe harbors under paragraph (1)(B), the
18 Secretary may consider the extent to which provid-
19 ing a safe harbor for the specified payment practice
20 may result in any of the following:

21 “(A) An increase or decrease in access to
22 health care services.

23 “(B) An increase or decrease in the quality
24 of health care services.

1 “(C) An increase or decrease in patient
2 freedom of choice among health care providers.

3 “(D) An increase or decrease in competi-
4 tion among health care providers.

5 “(E) An increase or decrease in the ability
6 of health care facilities to provide services in
7 medically underserved areas or to medically un-
8 derserved populations.

9 “(F) An increase or decrease in the cost to
10 Federal health care programs (as defined in
11 section 1128B(f)).

12 “(G) An increase or decrease in the poten-
13 tial overutilization of health care services.

14 “(H) The existence or nonexistence of any
15 potential financial benefit to a health care pro-
16 fessional or provider which may vary based on
17 their decisions of—

18 “(i) whether to order a health care
19 item or service; or

20 “(ii) whether to arrange for a referral
21 of health care items or services to a par-
22 ticular practitioner or provider.

23 “(I) Any other factors the Secretary deems
24 appropriate in the interest of preventing fraud

1 and abuse in Federal health care programs (as
2 so defined).

3 “(b) ADVISORY OPINIONS.—

4 “(1) ISSUANCE OF ADVISORY OPINIONS.—The
5 Secretary shall issue written advisory opinions as
6 provided in this subsection.

7 “(2) MATTERS SUBJECT TO ADVISORY OPIN-
8 IONS.—The Secretary shall issue advisory opinions
9 as to the following matters:

10 “(A) What constitutes prohibited remu-
11 neration within the meaning of section
12 1128B(b).

13 “(B) Whether an arrangement or proposed
14 arrangement satisfies the criteria set forth in
15 section 1128B(b)(3) for activities which do not
16 result in prohibited remuneration.

17 “(C) Whether an arrangement or proposed
18 arrangement satisfies the criteria which the
19 Secretary has established, or shall establish by
20 regulation for activities which do not result in
21 prohibited remuneration.

22 “(D) What constitutes an inducement to
23 reduce or limit services to individuals entitled to
24 benefits under title XVIII or title XIX or title
25 XXI within the meaning of section 1128B(b).

1 “(E) Whether any activity or proposed ac-
2 tivity constitutes grounds for the imposition of
3 a sanction under section 1128, 1128A, or
4 1128B.

5 “(3) MATTERS NOT SUBJECT TO ADVISORY
6 OPINIONS.—Such advisory opinions shall not address
7 the following matters:

8 “(A) Whether the fair market value shall
9 be, or was paid or received for any goods, serv-
10 ices or property.

11 “(B) Whether an individual is a bona fide
12 employee within the requirements of section
13 3121(d)(2) of the Internal Revenue Code of
14 1986.

15 “(4) EFFECT OF ADVISORY OPINIONS.—

16 “(A) BINDING AS TO SECRETARY AND
17 PARTIES INVOLVED.—Each advisory opinion is-
18 sued by the Secretary shall be binding as to the
19 Secretary and the party or parties requesting
20 the opinion.

21 “(B) FAILURE TO SEEK OPINION.—The
22 failure of a party to seek an advisory opinion
23 may not be introduced into evidence to prove
24 that the party intended to violate the provisions
25 of sections 1128, 1128A, or 1128B.

1 “(5) REGULATIONS.—

2 “(A) IN GENERAL.—Not later than 180
3 days after the date of the enactment of this sec-
4 tion, the Secretary shall issue regulations to
5 carry out this section. Such regulations shall
6 provide for—

7 “(i) the procedure to be followed by a
8 party applying for an advisory opinion;

9 “(ii) the procedure to be followed by
10 the Secretary in responding to a request
11 for an advisory opinion;

12 “(iii) the interval in which the Sec-
13 retary shall respond;

14 “(iv) the reasonable fee to be charged
15 to the party requesting an advisory opin-
16 ion; and

17 “(v) the manner in which advisory
18 opinions will be made available to the pub-
19 lic.

20 “(B) SPECIFIC CONTENTS.—Under the
21 regulations promulgated pursuant to subpara-
22 graph (A)—

23 “(i) the Secretary shall be required to
24 respond to a party requesting an advisory

1 opinion by not later than 30 days after the
2 request is received; and

3 “(ii) the fee charged to the party re-
4 questing an advisory opinion shall be equal
5 to the costs incurred by the Secretary in
6 responding to the request.

7 “(c) SPECIAL FRAUD ALERTS.—

8 “(1) IN GENERAL.—

9 “(A) REQUEST FOR SPECIAL FRAUD
10 ALERTS.—Any person may present, at any
11 time, a request to the Inspector General for a
12 notice which informs the public of practices
13 which the Inspector General considers to be
14 suspect or of particular concern under the med-
15 icare program or a State health care program,
16 as defined in section 1128(h) (in this subsection
17 referred to as a ‘special fraud alert’).

18 “(B) ISSUANCE AND PUBLICATION OF SPE-
19 CIAL FRAUD ALERTS.—Upon receipt of a re-
20 quest described in subparagraph (A), the In-
21 spector General shall investigate the subject
22 matter of the request to determine whether a
23 special fraud alert should be issued. If appro-
24 priate, the Inspector General shall issue a spe-
25 cial fraud alert in response to the request. All

1 special fraud alerts issued pursuant to this sub-
 2 paragraph shall be published in the Federal
 3 Register.

4 “(2) CRITERIA FOR SPECIAL FRAUD ALERTS.—
 5 In determining whether to issue a special fraud alert
 6 upon a request described in paragraph (1), the In-
 7 spector General may consider—

8 “(A) whether and to what extent the prac-
 9 tices that would be identified in the special
 10 fraud alert may result in any of the con-
 11 sequences described in subsection (a)(2); and

12 “(B) the volume and frequency of the con-
 13 duct that would be identified in the special
 14 fraud alert.”.

15 **Subtitle B—Revisions to Current** 16 **Sanctions for Fraud and Abuse**

17 **SEC. 211. MANDATORY EXCLUSION FROM PARTICIPATION** 18 **IN MEDICARE AND STATE HEALTH CARE PRO-** 19 **GRAMS.**

20 (a) INDIVIDUAL CONVICTED OF FELONY RELATING
 21 TO HEALTH CARE FRAUD.—

22 (1) IN GENERAL.—Section 1128(a) (42 U.S.C.
 23 1320a–7(a)) is amended by adding at the end the
 24 following new paragraph:

1 “(3) FELONY CONVICTION RELATING TO
2 HEALTH CARE FRAUD.—Any individual or entity
3 that has been convicted after the date of the enact-
4 ment of the Health Coverage Availability and Af-
5 fordability Act of 1996, under Federal or State law,
6 in connection with the delivery of a health care item
7 or service or with respect to any act or omission in
8 a health care program (other than those specifically
9 described in paragraph (1)) operated by or financed
10 in whole or in part by any Federal, State, or local
11 government agency, of a criminal offense consisting
12 of a felony relating to fraud, theft, embezzlement,
13 breach of fiduciary responsibility, or other financial
14 misconduct.”.

15 (2) CONFORMING AMENDMENT.—Paragraph (1)
16 of section 1128(b) (42 U.S.C. 1320a–7(b)) is
17 amended to read as follows:

18 “(1) CONVICTION RELATING TO FRAUD.—Any
19 individual or entity that has been convicted after the
20 date of the enactment of the Health Coverage Avail-
21 ability and Affordability Act of 1996, under Federal
22 or State law—

23 “(A) of a criminal offense consisting of a
24 misdemeanor relating to fraud, theft, embezzle-

ment, breach of fiduciary responsibility, or
other financial misconduct—

“(i) in connection with the delivery of
a health care item or service, or

“(ii) with respect to any act or omission in a health care program (other than those specifically described in subsection (a)(1)) operated by or financed in whole or in part by any Federal, State, or local government agency; or

“(B) of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program (other than a health care program) operated by or financed in whole or in part by any Federal, State, or local government agency.”.

(b) INDIVIDUAL CONVICTED OF FELONY RELATING
TO CONTROLLED SUBSTANCE.—

(1) IN GENERAL.—Section 1128(a) (42 U.S.C. 1320a–7(a)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

“(4) FELONY CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity

1 that has been convicted after the date of the enact-
 2 ment of the Health Coverage Availability and Af-
 3 fordability Act of 1996, under Federal or State law,
 4 of a criminal offense consisting of a felony relating
 5 to the unlawful manufacture, distribution, prescrip-
 6 tion, or dispensing of a controlled substance.”.

7 (2) CONFORMING AMENDMENT.—Section
 8 1128(b)(3) (42 U.S.C. 1320a–7(b)(3)) is amended—

9 (A) in the heading, by striking “CONVIC-
 10 TION” and inserting “MISDEMEANOR CONVIC-
 11 TION”; and

12 (B) by striking “criminal offense” and in-
 13 serting “criminal offense consisting of a mis-
 14 demeanor”.

15 **SEC. 212. ESTABLISHMENT OF MINIMUM PERIOD OF EX-**
 16 **CLUSION FOR CERTAIN INDIVIDUALS AND**
 17 **ENTITIES SUBJECT TO PERMISSIVE EXCLU-**
 18 **SION FROM MEDICARE AND STATE HEALTH**
 19 **CARE PROGRAMS.**

20 Section 1128(c)(3) (42 U.S.C. 1320a–7(c)(3)) is
 21 amended by adding at the end the following new subpara-
 22 graphs:

23 “(D) In the case of an exclusion of an individual or
 24 entity under paragraph (1), (2), or (3) of subsection (b),
 25 the period of the exclusion shall be 3 years, unless the

1 Secretary determines in accordance with published regula-
 2 tions that a shorter period is appropriate because of miti-
 3 gating circumstances or that a longer period is appro-
 4 priate because of aggravating circumstances.

5 “(E) In the case of an exclusion of an individual or
 6 entity under subsection (b)(4) or (b)(5), the period of the
 7 exclusion shall not be less than the period during which
 8 the individual’s or entity’s license to provide health care
 9 is revoked, suspended, or surrendered, or the individual
 10 or the entity is excluded or suspended from a Federal or
 11 State health care program.

12 “(F) In the case of an exclusion of an individual or
 13 entity under subsection (b)(6)(B), the period of the exclu-
 14 sion shall be not less than 1 year.”.

15 **SEC. 213. PERMISSIVE EXCLUSION OF INDIVIDUALS WITH**
 16 **OWNERSHIP OR CONTROL INTEREST IN**
 17 **SANCTIONED ENTITIES.**

18 Section 1128(b) (42 U.S.C. 1320a–7(b)) is amended
 19 by adding at the end the following new paragraph:

20 “(15) INDIVIDUALS CONTROLLING A SANC-
 21 TIONED ENTITY.—(A) Any individual—

22 “(i) who has a direct or indirect ownership
 23 or control interest in a sanctioned entity and
 24 who knows or should know (as defined in sec-
 25 tion 1128A(i)(6)) of the action constituting the

1 basis for the conviction or exclusion described
 2 in subparagraph (B); or

3 “(ii) who is an officer or managing em-
 4 ployee (as defined in section 1126(b)) of such
 5 an entity.

6 “(B) For purposes of subparagraph (A), the
 7 term ‘sanctioned entity’ means an entity—

8 “(i) that has been convicted of any offense
 9 described in subsection (a) or in paragraph (1),
 10 (2), or (3) of this subsection; or

11 “(ii) that has been excluded from partici-
 12 pation under a program under title XVIII or
 13 under a State health care program.”.

14 **SEC. 214. SANCTIONS AGAINST PRACTITIONERS AND PER-**
 15 **SONS FOR FAILURE TO COMPLY WITH STATU-**
 16 **TORY OBLIGATIONS.**

17 (a) MINIMUM PERIOD OF EXCLUSION FOR PRACTI-
 18 TIONERS AND PERSONS FAILING TO MEET STATUTORY
 19 OBLIGATIONS.—

20 (1) IN GENERAL.—The second sentence of sec-
 21 tion 1156(b)(1) (42 U.S.C. 1320c–5(b)(1)) is
 22 amended by striking “may prescribe)” and inserting
 23 “may prescribe, except that such period may not be
 24 less than 1 year)”.

1 (2) CONFORMING AMENDMENT.—Section
 2 1156(b)(2) (42 U.S.C. 1320c–5(b)(2)) is amended
 3 by striking “shall remain” and inserting “shall (sub-
 4 ject to the minimum period specified in the second
 5 sentence of paragraph (1)) remain”.

6 (b) REPEAL OF “UNWILLING OR UNABLE” CONDI-
 7 TION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1)
 8 (42 U.S.C. 1320c–5(b)(1)) is amended—

9 (1) in the second sentence, by striking “and de-
 10 termines” and all that follows through “such obliga-
 11 tions,”; and

12 (2) by striking the third sentence.

13 **SEC. 215. INTERMEDIATE SANCTIONS FOR MEDICARE**
 14 **HEALTH MAINTENANCE ORGANIZATIONS.**

15 (a) APPLICATION OF INTERMEDIATE SANCTIONS FOR
 16 ANY PROGRAM VIOLATIONS.—

17 (1) IN GENERAL.—Section 1876(i)(1) (42
 18 U.S.C. 1395mm(i)(1)) is amended by striking “the
 19 Secretary may terminate” and all that follows and
 20 inserting “in accordance with procedures established
 21 under paragraph (9), the Secretary may at any time
 22 terminate any such contract or may impose the in-
 23 termediate sanctions described in paragraph (6)(B)
 24 or (6)(C) (whichever is applicable) on the eligible or-

1 ganization if the Secretary determines that the orga-
 2 nization—

3 “(A) has failed substantially to carry out
 4 the contract;

5 “(B) is carrying out the contract in a man-
 6 ner substantially inconsistent with the efficient
 7 and effective administration of this section; or

8 “(C) no longer substantially meets the ap-
 9 plicable conditions of subsections (b), (c), (e),
 10 and (f).”.

11 (2) OTHER INTERMEDIATE SANCTIONS FOR
 12 MISCELLANEOUS PROGRAM VIOLATIONS.—Section
 13 1876(i)(6) (42 U.S.C. 1395mm(i)(6)) is amended by
 14 adding at the end the following new subparagraph:

15 “(C) In the case of an eligible organization for which
 16 the Secretary makes a determination under paragraph (1)
 17 the basis of which is not described in subparagraph (A),
 18 the Secretary may apply the following intermediate sanc-
 19 tions:

20 “(i) Civil money penalties of not more than
 21 \$25,000 for each determination under paragraph (1)
 22 if the deficiency that is the basis of the determina-
 23 tion has directly adversely affected (or has the sub-
 24 stantial likelihood of adversely affecting) an individ-
 25 ual covered under the organization’s contract.

1 “(ii) Civil money penalties of not more than
2 \$10,000 for each week beginning after the initiation
3 of procedures by the Secretary under paragraph (9)
4 during which the deficiency that is the basis of a de-
5 termination under paragraph (1) exists.

6 “(iii) Suspension of enrollment of individuals
7 under this section after the date the Secretary noti-
8 fies the organization of a determination under para-
9 graph (1) and until the Secretary is satisfied that
10 the deficiency that is the basis for the determination
11 has been corrected and is not likely to recur.”.

12 (3) PROCEDURES FOR IMPOSING SANCTIONS.—

13 Section 1876(i) (42 U.S.C. 1395mm(i)) is amended
14 by adding at the end the following new paragraph:

15 “(9) The Secretary may terminate a contract with an
16 eligible organization under this section or may impose the
17 intermediate sanctions described in paragraph (6) on the
18 organization in accordance with formal investigation and
19 compliance procedures established by the Secretary under
20 which—

21 “(A) the Secretary first provides the organiza-
22 tion with the reasonable opportunity to develop and
23 implement a corrective action plan to correct the de-
24 ficiencies that were the basis of the Secretary’s de-

1 termination under paragraph (1) and the organiza-
 2 tion fails to develop or implement such a plan;

3 “(B) in deciding whether to impose sanctions,
 4 the Secretary considers aggravating factors such as
 5 whether an organization has a history of deficiencies
 6 or has not taken action to correct deficiencies the
 7 Secretary has brought to the organization’s atten-
 8 tion;

9 “(C) there are no unreasonable or unnecessary
 10 delays between the finding of a deficiency and the
 11 imposition of sanctions; and

12 “(D) the Secretary provides the organization
 13 with reasonable notice and opportunity for hearing
 14 (including the right to appeal an initial decision) be-
 15 fore imposing any sanction or terminating the con-
 16 tract.”.

17 (4) CONFORMING AMENDMENTS.—Section
 18 1876(i)(6)(B) (42 U.S.C. 1395mm(i)(6)(B)) is
 19 amended by striking the second sentence.

20 (b) AGREEMENTS WITH PEER REVIEW ORGANIZA-
 21 TIONS.—Section 1876(i)(7)(A) (42 U.S.C.
 22 1395mm(i)(7)(A)) is amended by striking “an agreement”
 23 and inserting “a written agreement”.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall apply with respect to contract years be-
3 ginning on or after January 1, 1996.

4 **SEC. 216. ADDITIONAL EXCEPTION TO ANTI-KICKBACK PEN-**
5 **ALTIES FOR DISCOUNTING AND MANAGED**
6 **CARE ARRANGEMENTS.**

7 (a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C.
8 1320a-7b(b)(3)) is amended—

9 (1) by striking “and” at the end of subpara-
10 graph (D);

11 (2) by striking the period at the end of sub-
12 paragraph (E) and inserting “; and”; and

13 (3) by adding at the end the following new sub-
14 paragraph:

15 “(F) any remuneration between an organization
16 and an individual or entity providing items or serv-
17 ices, or a combination thereof, pursuant to a written
18 agreement between the organization and the individ-
19 ual or entity if the organization is an eligible organi-
20 zation under section 1876 or if the written agree-
21 ment places the individual or entity at substantial fi-
22 nancial risk for the cost or utilization of the items
23 or services, or a combination thereof, which the indi-
24 vidual or entity is obligated to provide, whether
25 through a withhold, capitation, incentive pool, per

1 diem payment, or any other similar risk arrange-
 2 ment which places the individual or entity at sub-
 3 stantial financial risk.”.

4 (b) EFFECTIVE DATE.—The amendments made by
 5 this section shall apply to written agreements entered into
 6 on or after January 1, 1997.

7 **SEC. 217. CRIMINAL PENALTY FOR FRAUDULENT DISPOSI-**
 8 **TION OF ASSETS IN ORDER TO OBTAIN MED-**
 9 **ICAID BENEFITS.**

10 Section 1128B(a) (42 U.S.C. 1320a–7b(a)) is
 11 amended—

12 (1) by striking “or” at the end of paragraph
 13 (4);

14 (2) by adding “or” at the end of paragraph (5);
 15 and

16 (3) by inserting after paragraph (5) the follow-
 17 ing new paragraph:

18 “(6) knowingly and willfully disposes of assets
 19 (including by any transfer in trust) in order for an
 20 individual to become eligible for medical assistance
 21 under a State plan under title XIX, if disposing of
 22 the assets results in the imposition of a period of in-
 23 eligibility for such assistance under section
 24 1917(c),”.

1 **SEC. 218. EFFECTIVE DATE.**

2 Except as otherwise provided, the amendments made
3 by this subtitle shall take effect January 1, 1997.

4 **Subtitle C—Data Collection**

5 **SEC. 221. ESTABLISHMENT OF THE HEALTH CARE FRAUD**
6 **AND ABUSE DATA COLLECTION PROGRAM.**

7 (a) IN GENERAL.—Title XI (42 U.S.C. 1301 et seq.),
8 as amended by sections 211 and 215, is amended by in-
9 serting after section 1128D the following new section:

10 “HEALTH CARE FRAUD AND ABUSE DATA COLLECTION
11 PROGRAM

12 “SEC. 1128E. (a) GENERAL PURPOSE.—Not later
13 than January 1, 1997, the Secretary shall establish a na-
14 tional health care fraud and abuse data collection program
15 for the reporting of final adverse actions (not including
16 settlements in which no findings of liability have been
17 made) against health care providers, suppliers, or practi-
18 tioners as required by subsection (b), with access as set
19 forth in subsection (c).

20 “(b) REPORTING OF INFORMATION.—

21 “(1) IN GENERAL.—Each Government agency
22 and health plan shall report any final adverse action
23 (not including settlements in which no findings of li-
24 ability have been made) taken against a health care
25 provider, supplier, or practitioner.

1 “(2) INFORMATION TO BE REPORTED.—The in-
2 formation to be reported under paragraph (1) in-
3 cludes:

4 “(A) The name and TIN (as defined in
5 section 7701(a)(41) of the Internal Revenue
6 Code of 1986) of any health care provider, sup-
7 plier, or practitioner who is the subject of a
8 final adverse action.

9 “(B) The name (if known) of any health
10 care entity with which a health care provider,
11 supplier, or practitioner is affiliated or associ-
12 ated.

13 “(C) The nature of the final adverse action
14 and whether such action is on appeal.

15 “(D) A description of the acts or omissions
16 and injuries upon which the final adverse action
17 was based, and such other information as the
18 Secretary determines by regulation is required
19 for appropriate interpretation of information re-
20 ported under this section.

21 “(3) CONFIDENTIALITY.—In determining what
22 information is required, the Secretary shall include
23 procedures to assure that the privacy of individuals
24 receiving health care services is appropriately pro-
25 tected.

1 “(4) TIMING AND FORM OF REPORTING.—The
2 information required to be reported under this sub-
3 section shall be reported regularly (but not less often
4 than monthly) and in such form and manner as the
5 Secretary prescribes. Such information shall first be
6 required to be reported on a date specified by the
7 Secretary.

8 “(5) TO WHOM REPORTED.—The information
9 required to be reported under this subsection shall
10 be reported to the Secretary.

11 “(c) DISCLOSURE AND CORRECTION OF INFORMA-
12 TION.—

13 “(1) DISCLOSURE.—With respect to the infor-
14 mation about final adverse actions (not including
15 settlements in which no findings of liability have
16 been made) reported to the Secretary under this sec-
17 tion respecting a health care provider, supplier, or
18 practitioner, the Secretary shall, by regulation, pro-
19 vide for—

20 “(A) disclosure of the information, upon
21 request, to the health care provider, supplier, or
22 licensed practitioner, and

23 “(B) procedures in the case of disputed ac-
24 curacy of the information.

1 “(2) CORRECTIONS.—Each Government agency
2 and health plan shall report corrections of informa-
3 tion already reported about any final adverse action
4 taken against a health care provider, supplier, or
5 practitioner, in such form and manner that the Sec-
6 retary prescribes by regulation.

7 “(d) ACCESS TO REPORTED INFORMATION.—

8 “(1) AVAILABILITY.—The information in this
9 database shall be available to Federal and State gov-
10 ernment agencies and health plans pursuant to pro-
11 cedures that the Secretary shall provide by regula-
12 tion.

13 “(2) FEES FOR DISCLOSURE.—The Secretary
14 may establish or approve reasonable fees for the dis-
15 closure of information in this database (other than
16 with respect to requests by Federal agencies). The
17 amount of such a fee shall be sufficient to recover
18 the full costs of operating the database. Such fees
19 shall be available to the Secretary or, in the Sec-
20 retary’s discretion to the agency designated under
21 this section to cover such costs.

22 “(e) PROTECTION FROM LIABILITY FOR REPORT-
23 ING.—No person or entity, including the agency des-
24 ignated by the Secretary in subsection (b)(5) shall be held
25 liable in any civil action with respect to any report made

1 as required by this section, without knowledge of the fal-
2 sity of the information contained in the report.

3 “(f) DEFINITIONS AND SPECIAL RULES.—For pur-
4 poses of this section:

5 “(1) FINAL ADVERSE ACTION.—

6 “(A) IN GENERAL.—The term ‘final ad-
7 verse action’ includes:

8 “(i) Civil judgments against a health
9 care provider, supplier, or practitioner in
10 Federal or State court related to the deliv-
11 ery of a health care item or service.

12 “(ii) Federal or State criminal convic-
13 tions related to the delivery of a health
14 care item or service.

15 “(iii) Actions by Federal or State
16 agencies responsible for the licensing and
17 certification of health care providers, sup-
18 pliers, and licensed health care practition-
19 ers, including—

20 “(I) formal or official actions,
21 such as revocation or suspension of a
22 license (and the length of any such
23 suspension), reprimand, censure or
24 probation,

1 “(II) any other loss of license or
2 the right to apply for, or renew, a li-
3 cense of the provider, supplier, or
4 practitioner, whether by operation of
5 law, voluntary surrender, non-renew-
6 ability, or otherwise, or

7 “(III) any other negative action
8 or finding by such Federal or State
9 agency that is publicly available infor-
10 mation.

11 “(iv) Exclusion from participation in
12 Federal or State health care programs.

13 “(v) Any other adjudicated actions or
14 decisions that the Secretary shall establish
15 by regulation.

16 “(B) EXCEPTION.—The term does not in-
17 clude any action with respect to a malpractice
18 claim.

19 “(2) PRACTITIONER.—The terms ‘licensed
20 health care practitioner’, ‘licensed practitioner’, and
21 ‘practitioner’ mean, with respect to a State, an indi-
22 vidual who is licensed or otherwise authorized by the
23 State to provide health care services (or any individ-
24 ual who, without authority holds himself or herself
25 out to be so licensed or authorized).

1 “(3) GOVERNMENT AGENCY.—The term ‘Gov-
2 ernment agency’ shall include:

3 “(A) The Department of Justice.

4 “(B) The Department of Health and
5 Human Services.

6 “(C) Any other Federal agency that either
7 administers or provides payment for the deliv-
8 ery of health care services, including, but not
9 limited to the Department of Defense and the
10 Veterans’ Administration.

11 “(D) State law enforcement agencies.

12 “(E) State medicaid fraud control units.

13 “(F) Federal or State agencies responsible
14 for the licensing and certification of health care
15 providers and licensed health care practitioners.

16 “(4) HEALTH PLAN.—The term ‘health plan’
17 has the meaning given such term by section
18 1128C(c).

19 “(5) DETERMINATION OF CONVICTION.—For
20 purposes of paragraph (1), the existence of a convic-
21 tion shall be determined under paragraph (4) of sec-
22 tion 1128(i).”.

23 (b) IMPROVED PREVENTION IN ISSUANCE OF MEDI-
24 CARE PROVIDER NUMBERS.—Section 1842(r) (42 U.S.C.
25 1395u(r)) is amended by adding at the end the following

1 new sentence: “Under such system, the Secretary may im-
 2 pose appropriate fees on such physicians to cover the costs
 3 of investigation and recertification activities with respect
 4 to the issuance of the identifiers.”.

5 **Subtitle D—Civil Monetary** 6 **Penalties**

7 **SEC. 231. SOCIAL SECURITY ACT CIVIL MONETARY PEN-** 8 **ALTIES.**

9 (a) GENERAL CIVIL MONETARY PENALTIES.—Sec-
 10 tion 1128A (42 U.S.C. 1320a–7a) is amended as follows:

11 (1) In the third sentence of subsection (a), by
 12 striking “programs under title XVIII” and inserting
 13 “Federal health care programs (as defined in section
 14 1128B(f)(1))”.

15 (2) In subsection (f)—

16 (A) by redesignating paragraph (3) as
 17 paragraph (4); and

18 (B) by inserting after paragraph (2) the
 19 following new paragraph:

20 “(3) With respect to amounts recovered arising
 21 out of a claim under a Federal health care program
 22 (as defined in section 1128B(f)), the portion of such
 23 amounts as is determined to have been paid by the
 24 program shall be repaid to the program, and the
 25 portion of such amounts attributable to the amounts

1 recovered under this section by reason of the amend-
2 ments made by the Health Coverage Availability and
3 Affordability Act of 1996 (as estimated by the Sec-
4 retary) shall be deposited into the Federal Hospital
5 Insurance Trust Fund pursuant to section
6 1817(k)(2)(C).”.

7 (3) In subsection (i)—

8 (A) in paragraph (2), by striking “title V,
9 XVIII, XIX, or XX of this Act” and inserting
10 “a Federal health care program (as defined in
11 section 1128B(f))”,

12 (B) in paragraph (4), by striking “a health
13 insurance or medical services program under
14 title XVIII or XIX of this Act” and inserting
15 “a Federal health care program (as so de-
16 fined)”, and

17 (C) in paragraph (5), by striking “title V,
18 XVIII, XIX, or XX” and inserting “a Federal
19 health care program (as so defined)”.

20 (4) By adding at the end the following new sub-
21 section:

22 “(m)(1) For purposes of this section, with respect to
23 a Federal health care program not contained in this Act,
24 references to the Secretary in this section shall be deemed
25 to be references to the Secretary or Administrator of the

1 department or agency with jurisdiction over such program
2 and references to the Inspector General of the Department
3 of Health and Human Services in this section shall be
4 deemed to be references to the Inspector General of the
5 applicable department or agency.

6 “(2)(A) The Secretary and Administrator of the de-
7 partments and agencies referred to in paragraph (1) may
8 include in any action pursuant to this section, claims with-
9 in the jurisdiction of other Federal departments or agen-
10 cies as long as the following conditions are satisfied:

11 “(i) The case involves primarily claims submit-
12 ted to the Federal health care programs of the de-
13 partment or agency initiating the action.

14 “(ii) The Secretary or Administrator of the de-
15 partment or agency initiating the action gives notice
16 and an opportunity to participate in the investiga-
17 tion to the Inspector General of the department or
18 agency with primary jurisdiction over the Federal
19 health care programs to which the claims were sub-
20 mitted.

21 “(B) If the conditions specified in subparagraph (A)
22 are fulfilled, the Inspector General of the department or
23 agency initiating the action is authorized to exercise all
24 powers granted under the Inspector General Act of 1978
25 with respect to the claims submitted to the other depart-

1 ments or agencies to the same manner and extent as pro-
 2 vided in that Act with respect to claims submitted to such
 3 departments or agencies.”.

4 (b) EXCLUDED INDIVIDUAL RETAINING OWNERSHIP
 5 OR CONTROL INTEREST IN PARTICIPATING ENTITY.—

6 Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

7 (1) by striking “or” at the end of paragraph
 8 (1)(D);

9 (2) by striking “, or” at the end of paragraph
 10 (2) and inserting a semicolon;

11 (3) by striking the semicolon at the end of
 12 paragraph (3) and inserting “; or”; and

13 (4) by inserting after paragraph (3) the follow-
 14 ing new paragraph:

15 “(4) in the case of a person who is not an orga-
 16 nization, agency, or other entity, is excluded from
 17 participating in a program under title XVIII or a
 18 State health care program in accordance with this
 19 subsection or under section 1128 and who, at the
 20 time of a violation of this subsection—

21 “(i) retains a direct or indirect ownership
 22 or control interest in an entity that is partici-
 23 pating in a program under title XVIII or a
 24 State health care program, and who knows or

1 should know of the action constituting the basis
2 for the exclusion; or

3 “(ii) is an officer or managing employee
4 (as defined in section 1126(b)) of such an en-
5 tity;”.

6 (c) MODIFICATIONS OF AMOUNTS OF PENALTIES
7 AND ASSESSMENTS.—Section 1128A(a) (42 U.S.C.
8 1320a–7a(a)), as amended by subsection (b), is amended
9 in the matter following paragraph (4)—

10 (1) by striking “\$2,000” and inserting
11 “\$10,000”;

12 (2) by inserting “; in cases under paragraph
13 (4), \$10,000 for each day the prohibited relationship
14 occurs” after “false or misleading information was
15 given”; and

16 (3) by striking “twice the amount” and insert-
17 ing “3 times the amount”.

18 (d) CLAIM FOR ITEM OR SERVICE BASED ON INCOR-
19 RECT CODING OR MEDICALLY UNNECESSARY SERV-
20 ICES.—Section 1128A(a)(1) (42 U.S.C. 1320a–7a(a)(1))
21 is amended—

22 (1) in subparagraph (A) by striking “claimed,”
23 and inserting “claimed, including any person who
24 engages in a pattern or practice of presenting or
25 causing to be presented a claim for an item or serv-

1 ice that is based on a code that the person knows
 2 or should know will result in a greater payment to
 3 the person than the code the person knows or should
 4 know is applicable to the item or service actually
 5 provided,”;

6 (2) in subparagraph (C), by striking “or” at
 7 the end;

8 (3) in subparagraph (D), by striking “; or” and
 9 inserting “, or”; and

10 (4) by inserting after subparagraph (D) the fol-
 11 lowing new subparagraph:

12 “(E) is for a medical or other item or serv-
 13 ice that a person knows or should know is not
 14 medically necessary; or”.

15 (e) SANCTIONS AGAINST PRACTITIONERS AND PER-
 16 SONS FOR FAILURE TO COMPLY WITH STATUTORY OBLI-
 17 GATIONS.—Section 1156(b)(3) (42 U.S.C. 1320c–5(b)(3))
 18 is amended by striking “the actual or estimated cost” and
 19 inserting “up to \$10,000 for each instance”.

20 (f) PROCEDURAL PROVISIONS.—Section 1876(i)(6)
 21 (42 U.S.C. 1395mm(i)(6)), as amended by section
 22 215(a)(2), is amended by adding at the end the following
 23 new subparagraph:

24 “(D) The provisions of section 1128A (other than
 25 subsections (a) and (b)) shall apply to a civil money pen-

1 alty under subparagraph (B)(i) or (C)(i) in the same man-
2 ner as such provisions apply to a civil money penalty or
3 proceeding under section 1128A(a).”.

4 (g) PROHIBITION AGAINST OFFERING INDUCEMENTS
5 TO INDIVIDUALS ENROLLED UNDER PROGRAMS OR
6 PLANS.—

7 (1) OFFER OF REMUNERATION.—Section
8 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

9 (A) by striking “or” at the end of para-
10 graph (1)(D);

11 (B) by striking “, or” at the end of para-
12 graph (2) and inserting a semicolon;

13 (C) by striking the semicolon at the end of
14 paragraph (3) and inserting “; or”; and

15 (D) by inserting after paragraph (3) the
16 following new paragraph:

17 “(4) offers to or transfers remuneration to any
18 individual eligible for benefits under title XVIII of
19 this Act, or under a State health care program (as
20 defined in section 1128(h)) that such person knows
21 or should know is likely to influence such individual
22 to order or receive from a particular provider, practi-
23 tioner, or supplier any item or service for which pay-
24 ment may be made, in whole or in part, under title

1 XVIII, or a State health care program (as so de-
2 fined);”.

3 (2) REMUNERATION DEFINED.—Section
4 1128A(i) (42 U.S.C. 1320a–7a(i)) is amended by
5 adding the following new paragraph:

6 “(6) The term ‘remuneration’ includes the waiv-
7 er of coinsurance and deductible amounts (or any
8 part thereof), and transfers of items or services for
9 free or for other than fair market value. The term
10 ‘remuneration’ does not include—

11 “(A) the waiver of coinsurance and deduct-
12 ible amounts by a person, if—

13 “(i) the waiver is not offered as part
14 of any advertisement or solicitation;

15 “(ii) the person does not routinely
16 waive coinsurance or deductible amounts;
17 and

18 “(iii) the person—

19 “(I) waives the coinsurance and
20 deductible amounts after determining
21 in good faith that the individual is in
22 financial need;

23 “(II) fails to collect coinsurance
24 or deductible amounts after making
25 reasonable collection efforts; or

1 “(III) provides for any permis-
2 sible waiver as specified in section
3 1128B(b)(3) or in regulations issued
4 by the Secretary;

5 “(B) differentials in coinsurance and de-
6 ductible amounts as part of a benefit plan de-
7 sign as long as the differentials have been dis-
8 closed in writing to all beneficiaries, third party
9 payers, and providers, to whom claims are pre-
10 sented and as long as the differentials meet the
11 standards as defined in regulations promulgated
12 by the Secretary not later than 180 days after
13 the date of the enactment of the Health Cov-
14 erage Availability and Affordability Act of
15 1996; or

16 “(C) incentives given to individuals to pro-
17 mote the delivery of preventive care as deter-
18 mined by the Secretary in regulations so pro-
19 mulgated.”.

20 (h) EFFECTIVE DATE.—The amendments made by
21 this section shall take effect January 1, 1997.

1 **SEC. 232. CLARIFICATION OF LEVEL OF INTENT REQUIRED**
2 **FOR IMPOSITION OF SANCTIONS.**

3 (a) CLARIFICATION OF LEVEL OF KNOWLEDGE RE-
4 QUIRED FOR IMPOSITION OF CIVIL MONETARY PEN-
5 ALTIES.—

6 (1) IN GENERAL.—Section 1128A(a) (42
7 U.S.C. 1320a–7a(a)) is amended—

8 (A) in paragraphs (1) and (2), by inserting
9 “knowingly” before “presents” each place it ap-
10 pears; and

11 (B) in paragraph (3), by striking “gives”
12 and inserting “knowingly gives or causes to be
13 given”.

14 (2) DEFINITION OF STANDARD.—Section
15 1128A(i) (42 U.S.C. 1320a–7a(i)) is amended by
16 adding at the end the following new paragraph:

17 “(6) The term ‘should know’ means that a per-
18 son, with respect to information—

19 “(A) acts in deliberate ignorance of the
20 truth or falsity of the information; or

21 “(B) acts in reckless disregard of the truth
22 or falsity of the information,
23 and no proof of specific intent to defraud is re-
24 quired.”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to acts or omissions occurring on
3 or after January 1, 1997.

4 **SEC. 233. PENALTY FOR FALSE CERTIFICATION FOR HOME**
5 **HEALTH SERVICES.**

6 (a) IN GENERAL.—Section 1128A(b) (42 U.S.C.
7 1320a–7a(b)) is amended by adding at the end the follow-
8 ing new paragraph:

9 “(3)(A) Any physician who executes a document de-
10 scribed in subparagraph (B) with respect to an individual
11 knowing that all of the requirements referred to in such
12 subparagraph are not met with respect to the individual
13 shall be subject to a civil monetary penalty of not more
14 than the greater of—

15 “(i) \$5,000, or

16 “(ii) three times the amount of the payments
17 under title XVIII for home health services which are
18 made pursuant to such certification.

19 “(B) A document described in this subparagraph is
20 any document that certifies, for purposes of title XVIII,
21 that an individual meets the requirements of section
22 1814(a)(2)(C) or 1835(a)(2)(A) in the case of home
23 health services furnished to the individual.”.

1 (b) EFFECTIVE DATE.—The amendment made by
 2 subsection (a) shall apply to certifications made on or
 3 after the date of the enactment of this Act.

4 **Subtitle E—Revisions to Criminal** 5 **Law**

6 **SEC. 241. DEFINITION OF FEDERAL HEALTH CARE OF-** 7 **FENSE.**

8 (a) IN GENERAL.—Chapter 1 of title 18, United
 9 States Code, is amended by adding at the end the follow-
 10 ing:

11 **“§ 24. Definition of Federal health care offense**

12 “(a) As used in this title, the term ‘Federal health
 13 care offense’ means a violation of, or a criminal conspiracy
 14 to violate—

15 “(1) section 669, 1035, or 1347 of this title; or

16 “(2) section 287, 371, 664, 666, 1001, 1027,
 17 1341, 1343, or 1954 of this title, if the violation or
 18 conspiracy relates to a health care benefit program.

19 “(b) As used in this title, the term ‘health care bene-
 20 fit program’ has the meaning given such term in section
 21 1347(b) of this title.”.

22 (b) CLERICAL AMENDMENT.—The table of sections
 23 at the beginning of chapter 2 of title 18, United States
 24 Code, is amended by inserting after the item relating to
 25 section 23 the following new item:

“24. Definition relating to Federal health care offense defined.”.

1 **SEC. 242. HEALTH CARE FRAUD.**

2 (a) OFFENSE.—

3 (1) IN GENERAL.—Chapter 63 of title 18, Unit-
4 ed States Code, is amended by adding at the end the
5 following:

6 **“§ 1347. Health care fraud**

7 “(a) Whoever knowingly executes, or attempts to exe-
8 cute, a scheme or artifice—

9 “(1) to defraud any health care benefit pro-
10 gram; or

11 “(2) to obtain, by means of false or fraudulent
12 pretenses, representations, or promises, any of the
13 money or property owned by, or under the custody
14 or control of, any health care benefit program,

15 in connection with the delivery of or payment for health
16 care benefits, items, or services, shall be fined under this
17 title or imprisoned not more than 10 years, or both. If
18 the violation results in serious bodily injury (as defined
19 in section 1365 of this title), such person shall be fined
20 under this title or imprisoned not more than 20 years, or
21 both; and if the violation results in death, such person
22 shall be fined under this title, or imprisoned for any term
23 of years or for life, or both.

24 “(b) As used in this section, the term ‘health care
25 benefit program’ means any public or private plan or con-
26 tract, affecting commerce, under which any medical bene-

1 fit, item, or service is provided to any individual, and in-
 2 cludes any individual or entity who is providing a medical
 3 benefit, item, or service for which payment may be made
 4 under the plan or contract.”.

5 (2) CLERICAL AMENDMENT.—The table of sec-
 6 tions at the beginning of chapter 63 of title 18,
 7 United States Code, is amended by adding at the
 8 end the following:

“1347. Health care fraud.”.

9 (b) CRIMINAL FINES DEPOSITED IN FEDERAL HOS-
 10 PITAL INSURANCE TRUST FUND.—The Secretary of the
 11 Treasury shall deposit into the Federal Hospital Insurance
 12 Trust Fund pursuant to section 1817(k)(2)(C) of the So-
 13 cial Security Act (42 U.S.C. 1395i) an amount equal to
 14 the criminal fines imposed under section 1347 of title 18,
 15 United States Code (relating to health care fraud).

16 **SEC. 243. THEFT OR EMBEZZLEMENT.**

17 (a) IN GENERAL.—Chapter 31 of title 18, United
 18 States Code, is amended by adding at the end the follow-
 19 ing:

20 **“§ 669. Theft or embezzlement in connection with**
 21 **health care**

22 “(a) Whoever embezzles, steals, or otherwise without
 23 authority willfully and unlawfully converts to the use of
 24 any person other than the rightful owner, or intentionally
 25 misapplies any of the moneys, funds, securities, premiums,

1 credits, property, or other assets of a health care benefit
 2 program, shall be fined under this title or imprisoned not
 3 more than 10 years, or both; but if the value of such prop-
 4 erty does not exceed the sum of \$100 the defendant shall
 5 be fined under this title or imprisoned not more than one
 6 year, or both.

7 “(b) As used in this section, the term ‘health care
 8 benefit program’ has the meaning given such term in sec-
 9 tion 1347(b) of this title.”.

10 (b) CLERICAL AMENDMENT.—The table of sections
 11 at the beginning of chapter 31 of title 18, United States
 12 Code, is amended by adding at the end the following:

“669. Theft or embezzlement in connection with health care.”.

13 **SEC. 244. FALSE STATEMENTS.**

14 (a) IN GENERAL.—Chapter 47 of title 18, United
 15 States Code, is amended by adding at the end the follow-
 16 ing:

17 **“§ 1035. False statements relating to health care mat-**
 18 **ters**

19 “(a) Whoever, in any matter involving a health care
 20 benefit program, knowingly—

21 “(1) falsifies, conceals, or covers up by any
 22 trick, scheme, or device a material fact; or

23 “(2) makes any false, fictitious, or fraudulent
 24 statements or representations, or makes or uses any
 25 false writing or document knowing the same to con-

tain any false, fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 5 years, or both.

“(b) As used in this section, the term ‘health care benefit program’ has the meaning given such term in section 1347(b) of this title.”.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 47 of title 18, United States Code, is amended by adding at the end the following new item:

“1035. False statements relating to health care matters.”.

SEC. 245. OBSTRUCTION OF CRIMINAL INVESTIGATIONS OF HEALTH CARE OFFENSES.

(a) IN GENERAL.—Chapter 73 of title 18, United States Code, is amended by adding at the end the following:

“§1518. Obstruction of criminal investigations of health care offenses

“(a) Whoever willfully prevents, obstructs, misleads, delays or attempts to prevent, obstruct, mislead, or delay the communication of information or records relating to a violation of a Federal health care offense to a criminal investigator shall be fined under this title or imprisoned not more than 5 years, or both.

1 “(b) As used in this section the term ‘criminal inves-
 2 tigator’ means any individual duly authorized by a depart-
 3 ment, agency, or armed force of the United States to con-
 4 duct or engage in investigations for prosecutions for viola-
 5 tions of health care offenses.”.

6 (b) CLERICAL AMENDMENT.—The table of sections
 7 at the beginning of chapter 73 of title 18, United States
 8 Code, is amended by adding at the end the following new
 9 item:

“1518. Obstruction of criminal investigations of health care offenses.”.

10 **SEC. 246. LAUNDERING OF MONETARY INSTRUMENTS.**

11 Section 1956(c)(7) of title 18, United States Code,
 12 is amended by adding at the end the following:

13 “(F) Any act or activity constituting an of-
 14 fense involving a Federal health care offense.”.

15 **SEC. 247. INJUNCTIVE RELIEF RELATING TO HEALTH CARE**
 16 **OFFENSES.**

17 (a) IN GENERAL.—Section 1345(a)(1) of title 18,
 18 United States Code, is amended—

19 (1) by striking “or” at the end of subparagraph
 20 (A);

21 (2) by inserting “or” at the end of subpara-
 22 graph (B); and

23 (3) by adding at the end the following:

24 “(C) committing or about to commit a
 25 Federal health care offense.”.

1 (b) FREEZING OF ASSETS.—Section 1345(a)(2) of
2 title 18, United States Code, is amended by inserting “or
3 a Federal health care offense”.

4 **SEC. 248. AUTHORIZED INVESTIGATIVE DEMAND PROCE-**
5 **DURES.**

6 (a) IN GENERAL.—Chapter 233 of title 18, United
7 States Code, is amended by adding after section 3485 the
8 following:

9 **“§ 3486. Authorized investigative demand procedures**

10 “(a) AUTHORIZATION.—In any investigation relating
11 to any act or activity involving a Federal health care of-
12 fense, the Attorney General or the Attorney General’s des-
13 ignee may issue in writing and cause to be served a sub-
14 poena requiring the production of any records (including
15 any books, papers, documents, electronic media, or other
16 objects or tangible things), which may be relevant to an
17 authorized law enforcement inquiry, that a person or legal
18 entity may possess or have care, custody, or control. A
19 subpoena shall describe the objects required to be pro-
20 duced and prescribe a return date within a reasonable pe-
21 riod of time within which the objects can be assembled
22 and made available.

23 “(b) SERVICE.—A subpoena issued under this section
24 may be served by any person designated in the subpoena
25 to serve it. Service upon a natural person may be made

1 by personal delivery of the subpoena to him. Service may
2 be made upon a domestic or foreign corporation or upon
3 a partnership or other unincorporated association which
4 is subject to suit under a common name, by delivering the
5 subpoena to an officer, to a managing or general agent,
6 or to any other agent authorized by appointment or by
7 law to receive service of process. The affidavit of the per-
8 son serving the subpoena entered on a true copy thereof
9 by the person serving it shall be proof of service.

10 “(c) ENFORCEMENT.—In the case of contumacy by
11 or refusal to obey a subpoena issued to any person, the
12 Attorney General may invoke the aid of any court of the
13 United States within the jurisdiction of which the inves-
14 tigation is carried on or of which the subpoenaed person
15 is an inhabitant, or in which he carries on business or may
16 be found, to compel compliance with the subpoena. The
17 court may issue an order requiring the subpoenaed person
18 to appear before the Attorney General to produce records,
19 if so ordered, or to give testimony touching the matter
20 under investigation. Any failure to obey the order of the
21 court may be punished by the court as a contempt thereof.
22 All process in any such case may be served in any judicial
23 district in which such person may be found.

24 “(d) IMMUNITY FROM CIVIL LIABILITY.—Notwith-
25 standing any Federal, State, or local law, any person, in-

1 cluding officers, agents, and employees, receiving a sum-
2 mons under this section, who complies in good faith with
3 the summons and thus produces the materials sought,
4 shall not be liable in any court of any State or the United
5 States to any customer or other person for such produc-
6 tion or for nondisclosure of that production to the cus-
7 tomer.

8 “(e) LIMITATION ON USE.—(1) Health information
9 about an individual that is disclosed under this section
10 may not be used in, or disclosed to any person for use
11 in, any administrative, civil, or criminal action or inves-
12 tigation directed against the individual who is the subject
13 of the information unless the action or investigation arises
14 out of and is directly related to receipt of health care or
15 payment for health care or action involving a fraudulent
16 claim related to health; or if authorized by an appropriate
17 order of a court of competent jurisdiction, granted after
18 application showing good cause therefor.

19 “(2) In assessing good cause, the court shall weigh
20 the public interest and the need for disclosure against the
21 injury to the patient, to the physician-patient relationship,
22 and to the treatment services.

23 “(3) Upon the granting of such order, the court, in
24 determining the extent to which any disclosure of all or

1 any part of any record is necessary, shall impose appro-
 2 priate safeguards against unauthorized disclosure.”.

3 (b) CLERICAL AMENDMENT.—The table of sections
 4 at the beginning of chapter 223 of title 18, United States
 5 Code, is amended by inserting after the item relating to
 6 section 3485 the following new item:

“3486. Authorized investigative demand procedures.”.

7 (c) CONFORMING AMENDMENT.—Section
 8 1510(b)(3)(B) of title 18, United States Code, is amended
 9 by inserting “or a Department of Justice subpoena (issued
 10 under section 3486 of title 18),” after “subpoena”.

11 **SEC. 249. FORFEITURES FOR FEDERAL HEALTH CARE OF-**
 12 **FENSES.**

13 (a) IN GENERAL.—Section 982(a) of title 18, United
 14 States Code, is amended by adding after paragraph (5)
 15 the following new paragraph:

16 “(6) The court, in imposing sentence on a person con-
 17 victed of a Federal health care offense, shall order the per-
 18 son to forfeit property, real or personal, that constitutes
 19 or is derived, directly or indirectly, from gross proceeds
 20 traceable to the commission of the offense.”.

21 (b) CONFORMING AMENDMENT.—Section
 22 982(b)(1)(A) of title 18, United States Code, is amended
 23 by inserting “or (a)(6)” after “(a)(1)”.

24 (c) PROPERTY FORFEITED DEPOSITED IN FEDERAL
 25 HOSPITAL INSURANCE TRUST FUND.—

1 (1) IN GENERAL.—After the payment of the
2 costs of asset forfeiture has been made, and notwith-
3 standing any other provision of law, the Secretary of
4 the Treasury shall deposit into the Federal Hospital
5 Insurance Trust Fund pursuant to section
6 1817(k)(2)(C) of the Social Security Act, as added
7 by section 301(b), an amount equal to the net
8 amount realized from the forfeiture of property by
9 reason of a Federal health care offense pursuant to
10 section 982(a)(6) of title 18, United States Code.

11 (2) COSTS OF ASSET FORFEITURE.—For pur-
12 poses of paragraph (1), the term “payment of the
13 costs of asset forfeiture” means—

14 (A) the payment, at the discretion of the
15 Attorney General, of any expenses necessary to
16 seize, detain, inventory, safeguard, maintain,
17 advertise, sell, or dispose of property under sei-
18 zure, detention, or forfeited, or of any other
19 necessary expenses incident to the seizure, de-
20 tention, forfeiture, or disposal of such property,
21 including payment for—

22 (i) contract services,

23 (ii) the employment of outside con-
24 tractors to operate and manage properties
25 or provide other specialized services nec-

1 necessary to dispose of such properties in an
2 effort to maximize the return from such
3 properties; and

4 (iii) reimbursement of any Federal,
5 State, or local agency for any expenditures
6 made to perform the functions described in
7 this subparagraph;

8 (B) at the discretion of the Attorney Gen-
9 eral, the payment of awards for information or
10 assistance leading to a civil or criminal forfeit-
11 ure involving any Federal agency participating
12 in the Health Care Fraud and Abuse Control
13 Account;

14 (C) the compromise and payment of valid
15 liens and mortgages against property that has
16 been forfeited, subject to the discretion of the
17 Attorney General to determine the validity of
18 any such lien or mortgage and the amount of
19 payment to be made, and the employment of at-
20 torneys and other personnel skilled in State real
21 estate law as necessary;

22 (D) payment authorized in connection with
23 remission or mitigation procedures relating to
24 property forfeited; and

1 (E) the payment of State and local prop-
 2 erty taxes on forfeited real property that ac-
 3 crued between the date of the violation giving
 4 rise to the forfeiture and the date of the forfeit-
 5 ure order.

6 **Subtitle F—Administrative**
 7 **Simplification**

8 **SEC. 251. PURPOSE.**

9 It is the purpose of this subtitle to improve the medi-
 10 care program under title XVIII of the Social Security Act,
 11 the medicaid program under title XIX of such Act, and
 12 the efficiency and effectiveness of the health care system,
 13 by encouraging the development of a health information
 14 system through the establishment of standards and re-
 15 quirements for the electronic transmission of certain
 16 health information.

17 **SEC. 252. ADMINISTRATIVE SIMPLIFICATION.**

18 (a) IN GENERAL.—Title XI (42 U.S.C. 1301 et seq.)
 19 is amended by adding at the end the following:

20 **“PART C—ADMINISTRATIVE SIMPLIFICATION**

21 **“SEC. 1171. DEFINITIONS.**

22 “For purposes of this part:

23 “(1) CLEARINGHOUSE.—The term ‘clearing-
 24 house’ means a public or private entity that—

1 “(A) processes or facilitates the processing
2 of nonstandard data elements of health infor-
3 mation into standard data elements; or

4 “(B) provides the means by which persons
5 may meet the requirements of this part.

6 “(2) CODE SET.—The term ‘code set’ means
7 any set of codes used for encoding data elements,
8 such as tables of terms, medical concepts, medical
9 diagnostic codes, or medical procedure codes.

10 “(3) COORDINATION OF BENEFITS.—The term
11 ‘coordination of benefits’ means determining and co-
12 ordinating the financial obligations of health plans
13 when health care benefits are payable under 2 or
14 more health plans.

15 “(4) HEALTH CARE PROVIDER.—The term
16 ‘health care provider’ includes a provider of services
17 (as defined in section 1861(u)), a provider of medi-
18 cal or other health services (as defined in section
19 1861(s)), and any other person furnishing health
20 care services or supplies.

21 “(5) HEALTH INFORMATION.—The term ‘health
22 information’ means any information, whether oral or
23 recorded in any form or medium that—

24 “(A) is created or received by a health care
25 provider, health plan, public health authority,

1 employer, life insurer, school or university, or
2 clearinghouse; and

3 “(B) relates to the past, present, or future
4 physical or mental health or condition of an in-
5 dividual, the provision of health care to an indi-
6 vidual, or the past, present, or future payment
7 for the provision of health care to an individual.

8 “(6) HEALTH PLAN.—The term ‘health plan’
9 means a plan which provides, or pays the cost of,
10 health benefits. Such term includes the following, or
11 any combination thereof:

12 “(A) Part A or part B of the medicare
13 program under title XVIII.

14 “(B) The medicaid program under title
15 XIX.

16 “(C) A medicare supplemental policy (as
17 defined in section 1882(g)(1)).

18 “(D) Coverage issued as a supplement to
19 liability insurance.

20 “(E) General liability insurance.

21 “(F) Worker’s compensation or similar in-
22 surance.

23 “(G) Automobile or automobile medical-
24 payment insurance.

1 “(H) A long-term care policy, including a
2 nursing home fixed indemnity policy (unless the
3 Secretary determines that such a policy does
4 not provide sufficiently comprehensive coverage
5 of a benefit so that the policy should be treated
6 as a health plan).

7 “(I) A hospital or fixed indemnity income-
8 protection policy.

9 “(J) An employee welfare benefit plan, as
10 defined in section 3(1) of the Employee Retirement
11 Income Security Act of 1974 (29 U.S.C.
12 1002(1)), but only to the extent the plan is es-
13 tablished or maintained for the purpose of pro-
14 viding health benefits and has 50 or more par-
15 ticipants (as defined in section 3(7) of such
16 Act).

17 “(K) An employee welfare benefit plan or
18 any other arrangement which is established or
19 maintained for the purpose of offering or pro-
20 viding health benefits to the employees of 2 or
21 more employers.

22 “(L) The health care program for active
23 military personnel under title 10, United States
24 Code.

1 “(M) The veterans health care program
2 under chapter 17 of title 38, United States
3 Code.

4 “(N) The Civilian Health and Medical Pro-
5 gram of the Uniformed Services (CHAMPUS),
6 as defined in section 1073(4) of title 10, United
7 States Code.

8 “(O) The Indian health service program
9 under the Indian Health Care Improvement Act
10 (25 U.S.C. 1601 et seq.).

11 “(P) The Federal Employees Health Bene-
12 fit Plan under chapter 89 of title 5, United
13 States Code.

14 “(Q) Such other plan or arrangement as
15 the Secretary determines is a health plan.

16 “(7) INDIVIDUALLY IDENTIFIABLE HEALTH IN-
17 FORMATION.—The term ‘individually identifiable
18 health information’ means any information, includ-
19 ing demographic information collected from an indi-
20 vidual, that—

21 “(A) is created or received by a health care
22 provider, health plan, employer, or clearing-
23 house; and

24 “(B) relates to the past, present, or future
25 physical or mental health or condition of an in-

dividual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and—

“(i) identifies an individual; or

“(ii) with respect to which there is a reasonable basis to believe that the information can be used to identify an individual.

“(8) STANDARD.—The term ‘standard’, when used with reference to a data element of health information or a transaction referred to in section 1173(a)(1), means any such data element or transaction that meets each of the standards and implementation specifications adopted or established by the Secretary with respect to the data element or transaction under sections 1172 and 1173.

“(9) STANDARD SETTING ORGANIZATION.—The term ‘standard setting organization’ means a standard setting organization accredited by the American National Standards Institute, including the National Council for Prescription Drug Programs, that develops standards for information transactions, data elements, or any other standard that is necessary to, or will facilitate, the implementation of this part.

1 **“SEC. 1172. GENERAL REQUIREMENTS FOR ADOPTION OF**
2 **STANDARDS.**

3 “(a) APPLICABILITY.—Any standard or modification
4 of a standard adopted under this part shall apply to the
5 following persons:

6 “(1) A health plan.

7 “(2) A clearinghouse.

8 “(3) A health care provider who transmits any
9 health information in electronic form in connection
10 with a transaction referred to in section 1173(a)(1).

11 “(b) REDUCTION OF COSTS.—Any standard or modi-
12 fication of a standard adopted under this part shall be
13 consistent with the objective of reducing the administra-
14 tive costs of providing and paying for health care.

15 “(c) ROLE OF STANDARD SETTING ORGANIZA-
16 TIONS.—

17 “(1) IN GENERAL.—Except as provided in para-
18 graph (2), any standard or modification of a stand-
19 ard adopted under this part shall be developed or
20 modified by a standard setting organization.

21 “(2) SPECIAL RULE.—The Secretary may adopt
22 a standard or modification of a standard that is dif-
23 ferent from any standard developed or modified by
24 a standard setting organization, if—

25 “(A) the different standard or modification
26 will substantially reduce administrative costs to

1 health care providers and health plans com-
2 pared to the alternatives; and

3 “(B) the standard or modification is pro-
4 mulgated in accordance with the rulemaking
5 procedures of subchapter III of chapter 5 of
6 title 5, United States Code.

7 “(d) IMPLEMENTATION SPECIFICATIONS.—The Sec-
8 retary shall establish specifications for implementing each
9 of the standards and modifications adopted under this
10 part.

11 “(e) PROTECTION OF TRADE SECRETS.—Except as
12 otherwise required by law, a standard or modification of
13 a standard adopted under this part shall not require dis-
14 closure of trade secrets or confidential commercial infor-
15 mation by a person required to comply with this part.

16 “(f) ASSISTANCE TO THE SECRETARY.—In complying
17 with the requirements of this part, the Secretary shall rely
18 on the recommendations of the Health Information Advi-
19 sory Committee established under section 1179 and shall
20 consult with appropriate Federal and State agencies and
21 private organizations. The Secretary shall publish in the
22 Federal Register the recommendations of the Health In-
23 formation Advisory Committee regarding the adoption of
24 a standard or modification of a standard under this part.

1 **“SEC. 1173. STANDARDS FOR INFORMATION TRANSACTIONS**
2 **AND DATA ELEMENTS.**

3 “(a) STANDARDS TO ENABLE ELECTRONIC EX-
4 CHANGE.—

5 “(1) IN GENERAL.—The Secretary shall adopt
6 standards for transactions, and data elements for
7 such transactions, to enable health information to be
8 exchanged electronically, that are—

9 “(A) appropriate for the financial and ad-
10 ministrative transactions described in para-
11 graph (2); and

12 “(B) related to other financial and admin-
13 istrative transactions determined appropriate by
14 the Secretary consistent with the goals of im-
15 proving the operation of the health care system
16 and reducing administrative costs.

17 “(2) TRANSACTIONS.—The transactions re-
18 ferred to in paragraph (1)(A) are the following:

19 “(A) Claims (including coordination of
20 benefits) or equivalent encounter information.

21 “(B) Claims attachments.

22 “(C) Enrollment and disenrollment.

23 “(D) Eligibility.

24 “(E) Health care payment and remittance
25 advice.

26 “(F) Premium payments.

1 “(G) First report of injury.

2 “(H) Claims status.

3 “(I) Referral certification and authoriza-
4 tion.

5 “(3) ACCOMMODATION OF SPECIFIC PROVID-
6 ERS.—The standards adopted by the Secretary
7 under paragraph (1) shall accommodate the needs of
8 different types of health care providers.

9 “(b) UNIQUE HEALTH IDENTIFIERS.—

10 “(1) IN GENERAL.—The Secretary shall adopt
11 standards providing for a standard unique health
12 identifier for each individual, employer, health plan,
13 and health care provider for use in the health care
14 system. In carrying out the preceding sentence for
15 each health plan and health care provider, the Sec-
16 retary shall take into account multiple uses for iden-
17 tifiers and multiple locations and specialty classifica-
18 tions for health care providers.

19 “(2) USE OF IDENTIFIERS.—The standards
20 adopted under paragraphs (1) shall specify the pur-
21 poses for which a unique health identifier may be
22 used.

23 “(c) CODE SETS.—

24 “(1) IN GENERAL.—The Secretary shall adopt
25 standards that—

1 “(A) select code sets for appropriate data
2 elements for the transactions referred to in sub-
3 section (a)(1) from among the code sets that
4 have been developed by private and public enti-
5 ties; or

6 “(B) establish code sets for such data ele-
7 ments if no code sets for the data elements
8 have been developed.

9 “(2) DISTRIBUTION.—The Secretary shall es-
10 tablish efficient and low-cost procedures for distribu-
11 tion (including electronic distribution) of code sets
12 and modifications made to such code sets under sec-
13 tion 1174(b).

14 “(d) SECURITY STANDARDS FOR HEALTH INFORMA-
15 TION.—

16 “(1) SECURITY STANDARDS.—The Secretary
17 shall adopt security standards that—

18 “(A) take into account—

19 “(i) the technical capabilities of record
20 systems used to maintain health informa-
21 tion;

22 “(ii) the costs of security measures;

23 “(iii) the need for training persons
24 who have access to health information;

1 “(iv) the value of audit trails in com-
2 puterized record systems; and

3 “(v) the needs and capabilities of
4 small health care providers and rural
5 health care providers (as such providers
6 are defined by the Secretary); and

7 “(B) ensure that a clearinghouse, if it is
8 part of a larger organization, has policies and
9 security procedures which isolate the activities
10 of the clearinghouse with respect to processing
11 information in a manner that prevents unau-
12 thorized access to such information by such
13 larger organization.

14 “(2) SAFEGUARDS.—Each person described in
15 section 1172(a) who maintains or transmits health
16 information shall maintain reasonable and appro-
17 priate administrative, technical, and physical safe-
18 guards—

19 “(A) to ensure the integrity and confiden-
20 tiality of the information;

21 “(B) to protect against any reasonably an-
22 ticipated—

23 “(i) threats or hazards to the security
24 or integrity of the information; and

1 “(ii) unauthorized uses or disclosures
2 of the information; and

3 “(C) otherwise to ensure compliance with
4 this part by the officers and employees of such
5 person.

6 “(e) PRIVACY STANDARDS FOR HEALTH INFORMA-
7 TION.—The Secretary shall adopt standards with respect
8 to the privacy of individually identifiable health informa-
9 tion. Such standards shall include standards concerning
10 at least the following:

11 “(1) The rights of an individual who is a sub-
12 ject of such information.

13 “(2) The procedures to be established for the
14 exercise of such rights.

15 “(3) The uses and disclosures of such informa-
16 tion that are authorized or required.

17 “(f) ELECTRONIC SIGNATURE.—

18 “(1) IN GENERAL.—The Secretary, in coordina-
19 tion with the Secretary of Commerce, shall adopt
20 standards specifying procedures for the electronic
21 transmission and authentication of signatures, com-
22 pliance with which shall be deemed to satisfy Fed-
23 eral and State statutory requirements for written
24 signatures with respect to the transactions referred
25 to in subsection (a)(1).

1 “(2) PAYMENTS FOR SERVICES AND PRE-
2 MIUMS.—Nothing in this part shall be construed to
3 prohibit payment for health care services or health
4 plan premiums by debit, credit, payment card or
5 numbers, or other electronic means.

6 “(g) COORDINATION OF BENEFITS.—The Secretary
7 shall adopt standards—

8 “(1) for determining the financial liability of
9 health plans when health care benefits are payable
10 under two or more health plans; and

11 “(2) for transferring among health plans appro-
12 priate standard data elements needed for the coordi-
13 nation of benefits, the sequential processing of
14 claims, and other data elements for individuals who
15 have more than one health plan.

16 **“SEC. 1174. TIMETABLES FOR ADOPTION OF STANDARDS.**

17 “(a) INITIAL STANDARDS.—The Secretary shall
18 carry out section 1173 not later than 18 months after the
19 date of the enactment of this part, except that standards
20 relating to claims attachments shall be adopted not later
21 than 30 months after such date.

22 “(b) ADDITIONS AND MODIFICATIONS TO STAND-
23 ARDS.—

24 “(1) IN GENERAL.—Except as provided in para-
25 graph (2), the Secretary shall review the standards

1 adopted under section 1173, and shall adopt addi-
2 tional or modified standards, as determined appro-
3 priate, but not more frequently than once every 6
4 months. Any addition or modification to a standard
5 shall be completed in a manner which minimizes the
6 disruption and cost of compliance.

7 “(2) SPECIAL RULES.—

8 “(A) FIRST 12-MONTH PERIOD.—Except
9 with respect to additions and modifications to
10 code sets under subparagraph (B), the Sec-
11 retary may not adopt any modification to a
12 standard adopted under this part during the
13 12-month period beginning on the date the
14 standard is initially adopted, unless the Sec-
15 retary determines that the modification is nec-
16 essary in order to permit compliance with the
17 standard.

18 “(B) ADDITIONS AND MODIFICATIONS TO
19 CODE SETS.—

20 “(i) IN GENERAL.—The Secretary
21 shall ensure that procedures exist for the
22 routine maintenance, testing, enhancement,
23 and expansion of code sets.

24 “(ii) ADDITIONAL RULES.—If a code
25 set is modified under this subsection, the

1 modified code set shall include instructions
2 on how data elements of health informa-
3 tion that were encoded prior to the modi-
4 fication may be converted or translated so
5 as to preserve the informational value of
6 the data elements that existed before the
7 modification. Any modification to a code
8 set under this subsection shall be imple-
9 mented in a manner that minimizes the
10 disruption and cost of complying with such
11 modification.

12 **“SEC. 1175. REQUIREMENTS.**

13 “(a) CONDUCT OF TRANSACTIONS BY PLANS.—

14 “(1) IN GENERAL.—If a person desires to con-
15 duct a transaction referred to in section 1173(a)(1)
16 with a health plan as a standard transaction—

17 “(A) the health plan may not refuse to
18 conduct such transaction as a standard trans-
19 action;

20 “(B) the health plan may not delay such
21 transaction, or otherwise adversely affect, or at-
22 tempt to adversely affect, the person or the
23 transaction on the ground that the transaction
24 is a standard transaction; and

1 “(C) the information transmitted and re-
2 ceived in connection with the transaction shall
3 be in the form of standard data elements of
4 health information.

5 “(2) SATISFACTION OF REQUIREMENTS.—A
6 health plan may satisfy the requirements under
7 paragraph (1) by—

8 “(A) directly transmitting and receiving
9 standard data elements of health information;
10 or

11 “(B) submitting nonstandard data ele-
12 ments to a clearinghouse for processing into
13 standard data elements and transmission by the
14 clearinghouse, and receiving standard data ele-
15 ments through the clearinghouse.

16 “(3) TIMETABLE FOR COMPLIANCE.—Para-
17 graph (1) shall not be construed to require a health
18 plan to comply with any standard, implementation
19 specification, or modification to a standard or speci-
20 fication adopted or established by the Secretary
21 under sections 1172 and 1173 at any time prior to
22 the date on which the plan is required to comply
23 with the standard or specification under subsection
24 (b).

25 “(b) COMPLIANCE WITH STANDARDS.—

1 “(1) INITIAL COMPLIANCE.—

2 “(A) IN GENERAL.—Not later than 24
3 months after the date on which an initial stand-
4 ard or implementation specification is adopted
5 or established under sections 1172 and 1173,
6 each person to whom the standard or imple-
7 mentation specification applies shall comply
8 with the standard or specification.

9 “(B) SPECIAL RULE FOR SMALL HEALTH
10 PLANS.—In the case of a small health plan,
11 paragraph (1) shall be applied by substituting
12 “36 months” for “24 months”. For purposes of
13 this subsection, the Secretary shall determine
14 the plans that qualify as small health plans.

15 “(2) COMPLIANCE WITH MODIFIED STAND-
16 ARDS.—If the Secretary adopts a modification to a
17 standard or implementation specification under this
18 part, each person to whom the standard or imple-
19 mentation specification applies shall comply with the
20 modified standard or implementation specification at
21 such time as the Secretary determines appropriate,
22 taking into account the time needed to comply due
23 to the nature and extent of the modification. The
24 time determined appropriate under the preceding
25 sentence may not be earlier than the last day of the

1 180-day period beginning on the date such modifica-
 2 tion is adopted. The Secretary may extend the time
 3 for compliance for small health plans, if the Sec-
 4 retary determines that such extension is appropriate.

5 **“SEC. 1176. GENERAL PENALTY FOR FAILURE TO COMPLY**
 6 **WITH REQUIREMENTS AND STANDARDS.**

7 “(a) GENERAL PENALTY.—

8 “(1) IN GENERAL.—Except as provided in sub-
 9 section (b), the Secretary shall impose on any person
 10 who violates a provision of this part a penalty of
 11 not more than \$100 for each such violation, except
 12 that the total amount imposed on the person for all
 13 violations of an identical requirement or prohibition
 14 during a calendar year may not exceed \$25,000.

15 “(2) PROCEDURES.—The provisions of section
 16 1128A (other than subsections (a) and (b) and the
 17 second sentence of subsection (f)) shall apply to the
 18 imposition of a civil money penalty under this sub-
 19 section in the same manner as such provisions apply
 20 to the imposition of a penalty under such section
 21 1128A.

22 “(b) LIMITATIONS.—

23 “(1) OFFENSES OTHERWISE PUNISHABLE.—A
 24 penalty may not be imposed under subsection (a)

1 with respect to an act if the act constitutes an of-
2 fense punishable under section 1177.

3 “(2) NONCOMPLIANCE NOT DISCOVERED.—A
4 penalty may not be imposed under subsection (a)
5 with respect to a provision of this part if it is estab-
6 lished to the satisfaction of the Secretary that the
7 person liable for the penalty did not know, and by
8 exercising reasonable diligence would not have
9 known, that such person violated the provision.

10 “(3) FAILURES DUE TO REASONABLE CAUSE.—

11 “(A) IN GENERAL.—Except as provided in
12 subparagraph (B), a penalty may not be im-
13 posed under subsection (a) if—

14 “(i) the failure to comply was due to
15 reasonable cause and not to willful neglect;
16 and

17 “(ii) the failure to comply is corrected
18 during the 30-day period beginning on the
19 1st date the person liable for the penalty
20 knew, or by exercising reasonable diligence
21 would have known, that the failure to com-
22 ply occurred.

23 “(B) EXTENSION OF PERIOD.—

24 “(i) NO PENALTY.—The period re-
25 ferred to in subparagraph (A)(ii) may be

1 extended as determined appropriate by the
2 Secretary based on the nature and extent
3 of the failure to comply.

4 “(ii) ASSISTANCE.—If the Secretary
5 determines that a person failed to comply
6 because the person was unable to comply,
7 the Secretary may provide technical assist-
8 ance to the person during the period de-
9 scribed in subparagraph (A)(ii). Such as-
10 sistance shall be provided in any manner
11 determined appropriate by the Secretary.

12 “(4) REDUCTION.—In the case of a failure to
13 comply which is due to reasonable cause and not to
14 willful neglect, any penalty under subsection (a) that
15 is not entirely waived under paragraph (3) may be
16 waived to the extent that the payment of such pen-
17 alty would be excessive relative to the compliance
18 failure involved.

19 **“SEC. 1177. WRONGFUL DISCLOSURE OF INDIVIDUALLY**
20 **IDENTIFIABLE HEALTH INFORMATION.**

21 “(a) OFFENSE.—A person who knowingly—

22 “(1) uses or causes to be used a unique health
23 identifier in violation of a provision of this part;

1 “(2) obtains individually identifiable health in-
2 formation relating to an individual in violation of a
3 provision of this part; or

4 “(3) discloses individually identifiable health in-
5 formation to another person in violation of a provi-
6 sion of this part,

7 shall be punished as provided in subsection (b).

8 “(b) PENALTIES.—A person described in subsection
9 (a) shall—

10 “(1) be fined not more than \$50,000, impris-
11 oned not more than 1 year, or both;

12 “(2) if the offense is committed under false pre-
13 tenses, be fined not more than \$100,000, imprisoned
14 not more than 5 years, or both; and

15 “(3) if the offense is committed with intent to
16 sell, transfer, or use individually identifiable health
17 information for commercial advantage, personal
18 gain, or malicious harm, fined not more than
19 \$250,000, imprisoned not more than 10 years, or
20 both.

21 **“SEC. 1178. EFFECT ON STATE LAW.**

22 “(a) GENERAL EFFECT.—

23 “(1) GENERAL RULE.—Except as provided in
24 paragraph (2), a provision or requirement under this
25 part, or a standard or implementation specification

1 adopted or established under sections 1172 and
2 1173, shall supersede any contrary provision of
3 State law, including a provision of State law that re-
4 quires medical or health plan records (including bill-
5 ing information) to be maintained or transmitted in
6 written rather than electronic form.

7 “(2) EXCEPTIONS.—A provision or requirement
8 under this part, or a standard or implementation
9 specification adopted or established under sections
10 1172 and 1173, shall not supersede a contrary pro-
11 vision of State law, if the provision of State law—

12 “(A) imposes requirements, standards, or
13 implementation specifications that are more
14 stringent than the requirements, standards, or
15 implementation specifications under this part
16 with respect to the privacy of individually iden-
17 tifiable health information; or

18 “(B) is a provision the Secretary deter-
19 mines—

20 “(i) is necessary to prevent fraud and
21 abuse, or for other purposes; or

22 “(ii) addresses controlled substances.

23 “(b) PUBLIC HEALTH REPORTING.—Nothing in this
24 part shall be construed to invalidate or limit the authority,
25 power, or procedures established under any law providing

1 for the reporting of disease or injury, child abuse, birth,
2 or death, public health surveillance, or public health inves-
3 tigation or intervention.

4 **“SEC. 1179. HEALTH INFORMATION ADVISORY COMMITTEE.**

5 “(a) ESTABLISHMENT.—There is established a com-
6 mittee to be known as the Health Information Advisory
7 Committee (in this section referred to as the ‘committee’).

8 “(b) DUTIES.—The committee shall—

9 “(1) provide assistance to the Secretary in com-
10 plying with the requirements imposed on the Sec-
11 retary under this part;

12 “(2) study the issues related to the adoption of
13 uniform data standards for patient medical record
14 information and the electronic exchange of such in-
15 formation;

16 “(3) report to the Secretary not later than 4
17 years after the date of the enactment of this part
18 recommendations and legislative proposals for such
19 standards and electronic exchange; and

20 “(4) generally be responsible for advising the
21 Secretary and the Congress on the status of the im-
22 plementation of this part.

23 “(c) MEMBERSHIP.—

24 “(1) IN GENERAL.—The committee shall con-
25 sist of 15 members of whom—

1 “(A) 3 shall be appointed by the President;

2 “(B) 6 shall be appointed by the Speaker
3 of the House of Representatives after consulta-
4 tion with the minority leader of the House of
5 Representatives; and

6 “(C) 6 shall be appointed by the President
7 pro tempore of the Senate after consultation
8 with the minority leader of the Senate.

9 The appointments of the members shall be made not
10 later than 60 days after the date of the enactment
11 of this part. The President shall designate 1 member
12 as the Chair.

13 “(2) EXPERTISE.—The membership of the com-
14 mittee shall consist of individuals who are of recog-
15 nized standing and distinction in the areas of infor-
16 mation systems, information networking and inte-
17 gration, consumer health, health care financial man-
18 agement, or privacy, and who possess the dem-
19 onstrated capacity to discharge the duties imposed
20 on the committee.

21 “(3) TERMS.—Each member of the committee
22 shall be appointed for a term of 5 years, except that
23 the members first appointed shall serve staggered
24 terms such that the terms of not more than 3 mem-
25 bers expire at one time.

1 “(4) INITIAL MEETING.—Not later than 30
2 days after the date on which a majority of the mem-
3 bers have been appointed, the committee shall hold
4 its first meeting.

5 “(d) REPORTS.—Not later than 1 year after the date
6 of the enactment of this part, and annually thereafter, the
7 committee shall submit to the Congress, and make public,
8 a report regarding—

9 “(1) the extent to which persons required to
10 comply with this part are cooperating in implement-
11 ing the standards adopted under this part;

12 “(2) the extent to which such entities are meet-
13 ing the privacy and security standards adopted
14 under this part and the types of penalties assessed
15 for noncompliance with such standards;

16 “(3) whether the Federal and State Govern-
17 ments are receiving information of sufficient quality
18 to meet their responsibilities under this part;

19 “(4) any problems that exist with respect to im-
20 plementation of this part; and

21 “(5) the extent to which timetables under this
22 part are being met.”.

23 (b) CONFORMING AMENDMENTS.—

1 (1) REQUIREMENT FOR MEDICARE PROVID-
2 ERS.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1))
3 is amended—

4 (A) by striking “and” at the end of sub-
5 paragraph (P);

6 (B) by striking the period at the end of
7 subparagraph (Q) and inserting “; and”; and

8 (C) by inserting immediately after sub-
9 paragraph (Q) the following new subparagraph:

10 “(R) to contract only with a clearinghouse
11 (as defined in section 1171) that meets each
12 standard and implementation specification
13 adopted or established under sections 1172 and
14 1173 on or after the date on which the clear-
15 inghouse is required to comply with the stand-
16 ard or specification.”.

17 (2) CLERICAL AMENDMENTS.—

18 (A) Title XI (42 U.S.C. 1301 et seq.) is
19 amended by striking the title heading and in-
20 serting the following:

21 “TITLE XI—GENERAL PROVISIONS, PEER RE-
22 VIEW, AND ADMINISTRATIVE SIMPLIFICA-
23 TION”.

24 (B) Parts A and B of title XI (42 U.S.C.
25 1301 et seq.) are amended by striking “this

- 1 title” each place such term appears and insert-
- 2 ing “parts A and B of this title”.

