105TH CONGRESS
1ST SESSION

H. R. 1836

IN THE SENATE OF THE UNITED STATES

NOVEMBER 5, 1997

Received; read twice and referred to the Committee on Governmental Affairs

AN ACT

To amend chapter 89 of title 5, United States Code, to improve administration of sanctions against unfit health care providers under the Federal Employees Health Benefits Program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Federal Employees Health Care Protection Act of 1997''.

SEC. 2. DEBARMENT AND OTHER SANCTIONS.

(a) AMENDMENTS.—Section 8902a of title 5, United States Code, is amended—

(1) in subsection (a)—

(A) in paragraph (1)—

(i) by striking ''and'' at the end of subparagraph (B);

(ii) by striking the period at the end of subparagraph (C) and inserting ''; and''; and

(iii) by adding at the end the following:

''(D) the term 'should know' means that a person, with respect to information, acts in deliberate ignorance of, or in reckless disregard of, the truth or falsity of the information, and no proof of specific intent to defraud is required;''; and

(B) in paragraph (2)(A), by striking ''subsection (b) or (c)'' and inserting ''subsection (b), (c), or (d)'';

(2) in subsection (b)—

(A) by striking ''The Office of Personnel Management may bar'' and inserting ''The Office of Personnel Management shall bar''; and

(B) by amending paragraph (5) to read as follows:

''(5) Any provider that is currently debarred, suspended, or otherwise excluded from any procurement or nonprocurement activity (within the meaning of section 2455 of the Federal Acquisition Streamlining Act of 1994).'';

(3) by redesignating subsections (c) through (i) as subsections (d) through (j), respectively, and by inserting after subsection (b) the following:

''(c) The Office may bar the following providers of health care services from participating in the program under this chapter:

''(1) Any provider—

''(A) whose license to provide health care services or supplies has been revoked, suspended, restricted, or not renewed, by a State licensing authority for reasons relating to the provider's professional competence, professional performance, or financial integrity; or

''(B) that surrendered such a license while a formal disciplinary proceeding was pending

before such an authority, if the proceeding concerned the provider's professional competence, professional performance, or financial integrity.

''(2) Any provider that is an entity directly or indirectly owned, or with a control interest of 5 percent or more held, by an individual who has been convicted of any offense described in subsection (b), against whom a civil monetary penalty has been assessed under subsection (d), or who has been debarred from participation under this chapter.

''(3) Any individual who directly or indirectly owns or has a control interest in a sanctioned entity and who knows or should know of the action constituting the basis for the entity's conviction of any offense described in subsection (b), assessment with a civil monetary penalty under subsection (d), or debarment from participation under this chapter.

''(4) Any provider that the Office determines, in connection with claims presented under this chapter, has charged for health care services or supplies in an amount substantially in excess of such provider's customary charge for such services or supplies (unless the Office finds there is good cause for such charge), or charged for health care services or supplies which are substantially in excess of the needs

of the covered individual or which are of a quality that fails to meet professionally recognized standards for such services or supplies.

''(5) Any provider that the Office determines has committed acts described in subsection (d).

Any determination under paragraph (4) relating to whether a charge for health care services or supplies is substantially in excess of the needs of the covered individual shall be made by trained reviewers based on written medical protocols developed by physicians. In the event such a determination cannot be made based on such protocols, a physician in an appropriate specialty shall be consulted.'';

(4) in subsection (d) (as so redesignated by paragraph (3)) by amending paragraph (1) to read as follows:

''(1) in connection with claims presented under this chapter, that a provider has charged for a health care service or supply which the provider knows or should have known involves—

''(A) an item or service not provided as claimed,

''(B) charges in violation of applicable charge limitations under section 8904(b), or

''(C) an item or service furnished during a period in which the provider was debarred from

participation under this chapter pursuant to a determination by the Office under this section, other than as permitted under subsection (g)(2)(B);'';

(5) in subsection (f) (as so redesignated by paragraph (3)) by inserting after ''under this section'' the first place it appears the following: ''(where such debarment is not mandatory)'';

(6) in subsection (g) (as so redesignated by paragraph (3))—

(A) by striking ''(g)(1)'' and all that follows through the end of paragraph (1) and inserting the following:

''(g)(1)(A) Except as provided in subparagraph (B), debarment of a provider under subsection (b) or (c) shall be effective at such time and upon such reasonable notice to such provider, and to carriers and covered individuals, as shall be specified in regulations prescribed by the Office. Any such provider that is debarred from participation may request a hearing in accordance with subsection (h)(1).

''(B) Unless the Office determines that the health or safety of individuals receiving health care services warrants an earlier effective date, the Office shall not make a determination adverse to a provider under subsection

(c)(5) or (d) until such provider has been given reasonable notice and an opportunity for the determination to be made after a hearing as provided in accordance with subsection (h)(1).'';

(B) in paragraph (3)—

(i) by inserting ''of debarment'' after ''notice''; and

(ii) by adding at the end the following: ''In the case of a debarment under paragraph (1), (2), (3), or (4) of subsection (b), the minimum period of debarment shall not be less than 3 years, except as provided in paragraph (4)(B)(ii).'';

(C) in paragraph (4)(B)(i)(I) by striking ''subsection (b) or (c)'' and inserting ''subsection (b), (c), or (d)''; and

(D) by striking paragraph (6);

(7) in subsection (h) (as so redesignated by paragraph (3)) by striking ''(h)(1)'' and all that follows through the end of paragraph (2) and inserting the following:

''(h)(1) Any provider of health care services or supplies that is the subject of an adverse determination by the Office under this section shall be entitled to reasonable notice and an opportunity to request a hearing of record,

and to judicial review as provided in this subsection after the Office renders a final decision. The Office shall grant a request for a hearing upon a showing that due process rights have not previously been afforded with respect to any finding of fact which is relied upon as a cause for an adverse determination under this section. Such hearing shall be conducted without regard to subchapter II of chapter 5 and chapter 7 of this title by a hearing officer who shall be designated by the Director of the Office and who shall not otherwise have been involved in the adverse determination being appealed. A request for a hearing under this subsection shall be filed within such period and in accordance with such procedures as the Office shall prescribe by regulation.

''(2) Any provider adversely affected by a final decision under paragraph (1) made after a hearing to which such provider was a party may seek review of such decision in the United States District Court for the District of Columbia or for the district in which the plaintiff resides or has his or her principal place of business by filing a notice of appeal in such court within 60 days after the date the decision is issued, and by simultaneously sending copies of such notice by certified mail to the Director of the Office and to the Attorney General. In answer to the appeal, the Director of the Office shall promptly file in

such court a certified copy of the transcript of the record, if the Office conducted a hearing, and other evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and evidence of record, a judgment affirming, modifying, or setting aside, in whole or in part, the decision of the Office, with or without remanding the case for a rehearing. The district court shall not set aside or remand the decision of the Office unless there is not substantial evidence on the record, taken as whole, to support the findings by the Office of a cause for action under this section or unless action taken by the Office constitutes an abuse of discretion.''; and

(8) in subsection (i) (as so redesignated by paragraph (3))—

(A) by striking ''subsection (c)'' and inserting ''subsection (d)''; and

(B) by adding at the end the following: ''The amount of a penalty or assessment as finally determined by the Office, or other amount the Office may agree to in compromise, may be deducted from any sum then or later owing by the United States to the party against whom the penalty or assessment has been levied.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall take effect on the date of the enactment of this Act.

(2) EXCEPTIONS.—(A) Paragraphs (2), (3), and (5) of section 8902a(c) of title 5, United States Code, as amended by subsection (a)(3), shall apply only to the extent that the misconduct which is the basis for debarment under such paragraph (2), (3), or (5), as applicable, occurs after the date of the enactment of this Act.

(B) Paragraph (1)(B) of section 8902a(d) of title 5, United States Code, as amended by subsection (a)(4), shall apply only with respect to charges which violate section 8904(b) of such title for items or services furnished after the date of the enactment of this Act.

(C) Paragraph (3) of section 8902a(g) of title 5, United States Code, as amended by subsection (a)(6)(B), shall apply only with respect to debarments based on convictions occurring after the date of the enactment of this Act.

SEC. 3. MISCELLANEOUS AMENDMENTS RELATING TO THE HEALTH BENEFITS PROGRAM FOR FEDERAL EMPLOYEES.

(a) DEFINITION OF A CARRIER.—Paragraph (7) of section 8901 of title 5, United States Code, is amended by striking ''organization;'' and inserting ''organization and an association of organizations or other entities described in this paragraph sponsoring a health benefits plan;''.

(b) SERVICE BENEFIT PLAN.—Paragraph (1) of section 8903 of title 5, United States Code, is amended by striking ''plan,'' and inserting ''plan, which may be underwritten by participating affiliates licensed in any number of States,''.

(c) PREEMPTION.—Section 8902(m) of title 5, United States Code, is amended by striking ''(m)(1)'' and all that follows through the end of paragraph (1) and inserting the following:

''(m)(1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.''.

SEC. 4. CONTINUED HEALTH INSURANCE COVERAGE FOR CERTAIN INDIVIDUALS.

(a) ENROLLMENT IN CHAPTER 89 PLAN.—For purposes of chapter 89 of title 5, United States Code, any period of enrollment—

(1) in a health benefits plan administered by the Federal Deposit Insurance Corporation before the termination of such plan on January 3, 1998, or

(2) subject to subsection (c), in a health benefits plan (not under chapter 89 of such title) with respect to which the eligibility of any employees or retired employees of the Board of Governors of the Federal Reserve System terminates on January 3, 1998,

shall be deemed to be a period of enrollment in a health benefits plan under chapter 89 of such title.

(b) CONTINUED COVERAGE.—(1) Subject to subsection (c), any individual who, on January 3, 1998, is enrolled in a health benefits plan described in subsection (a)(1) or (2) may enroll in an approved health benefits plan under chapter 89 of title 5, United States Code, either as an individual or for self and family, if, after taking into account the provisions of subsection (a), such individual—

(A) meets the requirements of such chapter for eligibility to become so enrolled as an employee, an-

nuitant, or former spouse (within the meaning of such chapter); or

(B) would meet those requirements if, to the extent such requirements involve either retirement system under such title 5, such individual satisfies similar requirements or provisions of the Retirement Plan for Employees of the Federal Reserve System.

Any determination under subparagraph (B) shall be made under guidelines which the Office of Personnel Management shall establish in consultation with the Board of Governors of the Federal Reserve System.

(2) Subject to subsection (c), any individual who, on January 3, 1998, is entitled to continued coverage under a health benefits plan described in subsection (a)(1) or (2) shall be deemed to be entitled to continued coverage under section 8905a of title 5, United States Code, but only for the same remaining period as would have been allowable under the health benefits plan in which such individual was enrolled on January 3, 1998, if—

(A) such individual had remained enrolled in such plan; and

(B) such plan did not terminate, or the eligibility of such individual with respect to such plan did not terminate, as described in subsection (a).

(3) Subject to subsection (c), any individual (other than an individual under paragraph (2)) who, on January 3, 1998, is covered under a health benefits plan described in subsection (a)(1) or (2) as an unmarried dependent child, but who does not then qualify for coverage under chapter 89 of title 5, United States Code, as a family member (within the meaning of such chapter) shall be deemed to be entitled to continued coverage under section 8905a of such title, to the same extent and in the same manner as if such individual had, on January 3, 1998, ceased to meet the requirements for being considered an unmarried dependent child of an enrollee under such chapter.

(4) Coverage under chapter 89 of title 5, United States Code, pursuant to an enrollment under this section shall become effective on January 4, 1998.

(c) ELIGIBILITY FOR FEHBP LIMITED TO INDIVIDUALS LOSING ELIGIBILITY UNDER FORMER HEALTH PLAN.—Nothing in subsection (a)(2) or any paragraph of subsection (b) (to the extent such paragraph relates to the plan described in subsection (a)(2)) shall be considered to apply with respect to any individual whose eligibility for coverage under such plan does not involuntarily terminate on January 3, 1998.

(d) TRANSFERS TO THE EMPLOYEES HEALTH BENEFITS FUND.—The Federal Deposit Insurance Corporation and the Board of Governors of the Federal Reserve System shall transfer to the Employees Health Benefits Fund under section 8909 of title 5, United States Code, amounts determined by the Director of the Office of Personnel Management, after consultation with the Federal Deposit Insurance Corporation and the Board of Governors of the Federal Reserve System, to be necessary to reimburse the Fund for the cost of providing benefits under this section not otherwise paid for by the individuals covered by this section. The amounts so transferred shall be held in the Fund and used by the Office in addition to amounts available under section 8906(g)(1) of such title.

(e) ADMINISTRATION AND REGULATIONS.—The Office of Personnel Management—

(1) shall administer the provisions of this section to provide for—

(A) a period of notice and open enrollment for individuals affected by this section; and

(B) no lapse of health coverage for individuals who enroll in a health benefits plan under chapter 89 of title 5, United States Code, in accordance with this section; and

(2) may prescribe regulations to implement this section.

SEC. 5. FULL DISCLOSURE IN HEALTH PLAN CONTRACTS.

The Office of Personnel Management shall encourage carriers offering health benefits plans described by section 8903 or section 8903a of title 5, United States Code, with respect to contractual arrangements made by such carriers with any person for purposes of obtaining discounts from providers for health care services or supplies furnished to individuals enrolled in such plan, to seek assurance that the conditions for such discounts are fully disclosed to the providers who grant them.

SEC. 6. PROVISIONS RELATING TO CERTAIN PLANS THAT HAVE DISCONTINUED THEIR PARTICIPATION IN FEHBP.

(a) AUTHORITY TO READMIT.—

(1) IN GENERAL.—Chapter 89 of title 5, United States Code, is amended by inserting after section 8903a the following:

"§ 8903b. Authority to readmit an employee organization plan

"(a) In the event that a plan described by section 8903(3) or 8903a is discontinued under this chapter (other than in the circumstance described in section 8909(d)), that discontinuation shall be disregarded, for

purposes of any determination as to that plan's eligibility to be considered an approved plan under this chapter, but only for purposes of any contract year later than the third contract year beginning after such plan is so discontinued.

''(b) A contract for a plan approved under this section shall require the carrier—

''(1) to demonstrate experience in service delivery within a managed care system (including provider networks) throughout the United States; and

''(2) if the carrier involved would not otherwise be subject to the requirement set forth in section 8903a(c)(1), to satisfy such requirement.''.

(2) CONFORMING AMENDMENT.—The analysis for chapter 89 of title 5, United States Code, is amended by inserting after the item relating to section 8903a the following:

''8903b. Authority to readmit an employee organization plan.''.

(3) APPLICABILITY.—

(A) IN GENERAL.—The amendments made by this subsection shall apply as of the date of enactment of this Act, including with respect to any plan which has been discontinued as of such date.

(B) TRANSITION RULE.—For purposes of applying section 8903b(a) of title 5, United States Code (as amended by this subsection)

with respect to any plan seeking to be readmitted for purposes of any contract year beginning before January 1, 2000, such section shall be applied by substituting ''second contract year'' for ''third contract year''.

(b) TREATMENT OF THE CONTINGENCY RESERVE OF A DISCONTINUED PLAN.—

(1) IN GENERAL.—Subsection (e) of section 8909 of title 5, United States Code, is amended by striking ''(e)'' and inserting ''(e)(1)'' and by adding at the end the following:

''(2) Any crediting required under paragraph (1) pursuant to the discontinuation of any plan under this chapter shall be completed by the end of the second contract year beginning after such plan is so discontinued.

''(3) The Office shall prescribe regulations in accordance with which this subsection shall be applied in the case of any plan which is discontinued before being credited with the full amount to which it would otherwise be entitled based on the discontinuation of any other plan.''.

(2) TRANSITION RULE.—In the case of any amounts remaining as of the date of enactment of this Act in the contingency reserve of a discontinued plan, such amounts shall be disposed of in accord-

ance with section 8909(e) of title 5, United States Code, as amended by this subsection, by—

(A) the deadline set forth in section 8909(e) of such title (as so amended); or

(B) if later, the end of the 6-month period beginning on such date of enactment.

SEC. 7. MAXIMUM PHYSICIANS COMPARABILITY ALLOWANCE PAYABLE.

(a) IN GENERAL.—Paragraph (2) of section 5948(a) of title 5, United States Code, is amended by striking ''$20,000'' and inserting ''$30,000''.

(b) AUTHORITY TO MODIFY EXISTING AGREEMENTS.—

(1) IN GENERAL.—Any service agreement under section 5948 of title 5, United States Code, which is in effect on the date of enactment of this Act may, with respect to any period of service remaining in such agreement, be modified based on the amendment made by subsection (a).

(2) LIMITATION.—A modification taking effect under this subsection in any year shall not cause an allowance to be increased to a rate which, if applied throughout such year, would cause the limitation under section 5948(a)(2) of such title (as amended

by this section), or any other applicable limitation, to be exceeded.

(c) RULE OF CONSTRUCTION.—Nothing in this section shall be considered to authorize additional or supplemental appropriations for the fiscal year in which occurs the date of enactment of this Act.

SEC. 8. CLARIFICATION RELATING TO SECTION 8902(k).

Section 8902(k) of title 5, United States Code, is amended—

(1) by redesignating paragraph (2) as paragraph (3); and

(2) by inserting after paragraph (1) the following:

''(2) Nothing in this subsection shall be considered to preclude a health benefits plan from providing direct access or direct payment or reimbursement to a provider in a health care practice or profession other than a practice or profession listed in paragraph (1), if such provider is licensed or certified as such under Federal or State law.''.

Passed the House of Representatives November 4, 1997.

Attest: ROBIN H. CARLE,

Clerk.