

103<sup>D</sup> CONGRESS  
1<sup>ST</sup> SESSION

# H. R. 237

To increase access to health care services for individuals in rural areas,  
and for other purposes.

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IN THE HOUSE OF REPRESENTATIVES

JANUARY 5, 1993

Mr. LARocco introduced the following bill; which was referred jointly to the  
Committees on Ways and Means, Energy and Commerce, and the Judiciary

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## A BILL

To increase access to health care services for individuals  
in rural areas, and for other purposes.

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

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

4 (a) SHORT TITLE.—This Act may be cited as the  
5 “Rural Health Care Access Improvement Act of 1993”.

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

Sec. 1. Short title; table of contents.

TITLE I—PROVISIONS RELATING TO PHYSICIANS’ SERVICES

Subtitle A—Incentives Under Medicare

Sec. 101. Elimination of medicare payment reductions for new doctors and  
practitioners for services furnished in any rural area.

- Sec. 102. No medicare secondary payor denial based on failure to complete questionnaire.
- Sec. 103. Limitations on use of extrapolation.
- Sec. 104. Limitation on carrier user fees.
- Sec. 105. Including physician input in annual carrier performance reviews.
- Sec. 106. Appeals of carrier violations.
- Sec. 107. Review of medical necessity denials in rural areas by physicians in same specialty.
- Sec. 108. Clarification of permissible substitute billing arrangements for physicians' services under the medicare and medicaid programs.
- Sec. 109. Repeal of PRO precertification requirement for certain surgical procedures performed in rural areas.

#### Subtitle B—Increasing Number of Physicians Practicing in Rural Areas

- Sec. 111. Deduction for medical school education loan interest incurred by physicians serving in medically underserved rural areas.
- Sec. 112. Determination of greatest shortage of health professionals with respect to assignment of members of National Health Service Corps.

#### Subtitle C—Expansion of Exceptions to Limitations on Physician Self-Referrals

- Sec. 121. Changes in exceptions.
- Sec. 122. Study and report on changes in costs.
- Sec. 123. Effective date.

### TITLE II—PROVISIONS RELATING TO HOSPITALS

- Sec. 201. Holding rural hospitals harmless from reductions in medicare payments for capital-related costs resulting from prospective payment methodology.
- Sec. 202. Extension of rural referral center classification.
- Sec. 203. Antitrust exemption for certain rural hospitals.

### TITLE III—MISCELLANEOUS PROVISIONS

#### Subtitle A—Administrative Simplification

- Sec. 301. Requirements for health benefit plans.
- Sec. 302. Requirements for health service providers.
- Sec. 303. Health claims clearinghouses.
- Sec. 304. Standards relating to electronic claims processing.
- Sec. 305. Excise tax on premiums received on group health plans which do not meet certain requirements.
- Sec. 306. Application of requirements to medicare and medicaid programs.

#### Subtitle B—Other Provisions

- Sec. 311. Telecommunications demonstration program for trauma care in rural areas.
- Sec. 312. Primary care nursing clinics in rural areas.
- Sec. 313. Identification, assessment, and reduction of paperwork burden associated with health care services.

1 **TITLE I—PROVISIONS RELATING**  
2 **TO PHYSICIANS’ SERVICES**  
3 **Subtitle A—Incentives Under**  
4 **Medicare**

5 **SEC. 101. ELIMINATION OF MEDICARE PAYMENT REDUC-**  
6 **TIONS FOR NEW DOCTORS AND PRACTITION-**  
7 **ERS FOR SERVICES FURNISHED IN ANY**  
8 **RURAL AREA.**

9 (a) IN GENERAL.—

10 (1) PAYMENTS TO PHYSICIANS.—The second  
11 sentence of section 1848(a)(4) of the Social Security  
12 Act (42 U.S.C. 1395w–4(a)(4)) is amended—

13 (A) by striking “or services” and inserting  
14 “, services”; and

15 (B) by inserting before the period at the  
16 end the following: “, or services furnished in a  
17 rural area (as so defined) by (or under the su-  
18 pervision of, or incident to services of) a physi-  
19 cian described in section 1861(r)(1)”.

20 (2) PAYMENTS TO OTHER PRACTITIONERS.—  
21 Section 1842(b)(4)(F)(i) of such Act (42 U.S.C.  
22 1395u(b)(4)(F)(i)) is amended—

23 (A) by striking “and other than services”  
24 and inserting “, services”; and

1 (B) by striking “area)” and inserting the  
2 following: “area, or services furnished in a rural  
3 area (as so defined) by (or under the super-  
4 vision of, or incident to services of) a physician  
5 described in section 1861(r)(1))”.

6 (b) EFFECTIVE DATE.—The amendments made by  
7 subsection (a) shall apply to services furnished after 1993.

8 **SEC. 102. NO MEDICARE SECONDARY PAYOR DENIAL**  
9 **BASED ON FAILURE TO COMPLETE QUES-**  
10 **TIONNAIRE.**

11 (a) IN GENERAL.—Section 1862(b)(2) of the Social  
12 Security Act (42 U.S.C. 1395y(b)(2)) is amended by add-  
13 ing at the end the following new subparagraph:

14 “(C) TREATMENT OF QUESTIONNAIRES.—  
15 The Secretary shall not fail to make payment  
16 under subparagraph (A) based upon the failure  
17 of an individual to complete a questionnaire  
18 concerning the existence of a primary plan.  
19 However, any such payment remains condi-  
20 tional (as provided under subparagraph (B)).”.

21 (b) EFFECTIVE DATE.—The amendment made by  
22 subsection (a) shall apply to services furnished on or after  
23 January 1, 1994.

1 **SEC. 103. LIMITATIONS ON USE OF EXTRAPOLATION.**

2 (a) IN GENERAL.—Section 1842(c) of the Social Se-  
3 curity Act (42 U.S.C. 1395u(c)) is amended by adding at  
4 the end the following new paragraph:

5 “(4) In carrying out its contract under subsection  
6 (b)(3) with respect to physicians’ services—

7 “(A) the carrier may use extrapolation in order  
8 to identify claims for which payment may be dis-  
9 allowed;

10 “(B) the carrier may not recoup or offset pay-  
11 ment amounts based on extrapolation if the physi-  
12 cian requests that disallowed claims be identified in-  
13 dividually; and

14 “(C) no refund, offset assessment, penalties, or  
15 interest shall accrue with respect to a claim that is  
16 disallowed until the date the administrative appeals  
17 process has been completed.”.

18 (b) EFFECTIVE DATE.—The amendment made by  
19 subsection (a) shall apply to services furnished on or after  
20 January 1, 1994.

21 **SEC. 104. LIMITATION ON CARRIER USER FEES.**

22 (a) IN GENERAL.—Section 1842(c) of the Social Se-  
23 curity Act (42 U.S.C. 1395u(c)), as amended by section  
24 103(a), is further amended by adding at the end the fol-  
25 lowing new paragraph:

1 “(5) Neither a carrier nor the Secretary may impose  
2 a fee under this title—

3 “(A) for the filing of a claim relating to physi-  
4 cians’ services,

5 “(B) for an error in filing a claim relating to  
6 physicians’ services or for such a claim which is de-  
7 nied,

8 “(C) for any appeal under this title with respect  
9 to physicians’ services,

10 “(D) for applying for (or obtaining) a unique  
11 identifier under subsection (r), or

12 “(E) for responding to inquiries respecting phy-  
13 sicians’ services or for providing information with re-  
14 spect to medical review of such services.”.

15 (b) EFFECTIVE DATE.—The amendment made by  
16 subsection (a) shall apply to services furnished on or after  
17 January 1, 1994.

18 **SEC. 105. INCLUDING PHYSICIAN INPUT IN ANNUAL CAR-**

19 **RIER PERFORMANCE REVIEWS.**

20 (a) IN GENERAL.—Section 1842(b)(2) of the Social  
21 Security Act (42 U.S.C. 1395u(b)(2)) is amended—

22 (1) in the second sentence of subparagraph (A),  
23 by inserting “(including the reduction of administra-  
24 tive burdens on physicians furnishing services for

1       which payment is made under this part)” after “con-  
2       tract obligations under this section”, and

3               (2) by adding at the end the following new sub-  
4       paragraph:

5       “(D) In applying the standards and criteria estab-  
6       lished under subparagraph (A), the Secretary shall con-  
7       sider any evaluations (with respect to such standards and  
8       criteria) submitted by medical societies representing physi-  
9       cians who are served by the carrier.”.

10       (b) EFFECTIVE DATE.—The amendment made by  
11       subsection (a) shall apply to services furnished on or after  
12       January 1, 1994.

13       **SEC. 106. APPEALS OF CARRIER VIOLATIONS.**

14       (a) IN GENERAL.—Section 1842(b)(2) of the Social  
15       Security Act (42 U.S.C. 1395u(b)(2)), as amended by sec-  
16       tion 105(a)(2), is further amended by adding at the end  
17       the following new subparagraph:

18       “(E) The Secretary shall provide that any individual  
19       (including a physician) who—

20               “(i) is aggrieved by the failure of a carrier to  
21       carry out policies established under this part, wheth-  
22       er established through the carrier manual, regional  
23       office transmittals, central office transmittals, or  
24       other means, and



1 by a physician in the same medical specialty as the medi-  
2 cal specialty of the physician who provided the services.”.

3 **SEC. 108. CLARIFICATION OF PERMISSIBLE SUBSTITUTE**  
4 **BILLING ARRANGEMENTS FOR PHYSICIANS’**  
5 **SERVICES UNDER THE MEDICARE AND MED-**  
6 **ICAID PROGRAMS.**

7 (a) MEDICARE PROGRAM.—

8 (1) IN GENERAL.—Clause (D) of section  
9 1842(b)(6) of the Social Security Act (42 U.S.C.  
10 1395u(b)(6)) is amended to read as follows: “(D)(i)  
11 payment may be made to a physician for physicians’  
12 services (and services incident to such services) to be  
13 provided by a second physician on a reciprocal basis  
14 to individuals who are patients of the first physician  
15 if (I) the first physician is unavailable to provide the  
16 services, (II) the services are not provided by the  
17 second physician over a continuous period of longer  
18 than 60 days, and (III) the claim form submitted to  
19 the carrier includes the second physician’s unique  
20 identifier (provided under the system established  
21 under subsection (r)) and indicates that the claim  
22 meets the requirements of this clause for payment to  
23 the first physician; and (ii) payment may be made  
24 to a physician for physicians’ services (and services  
25 incident to such services) which that physician pays

1 a second physician on a per diem or other fee-for-  
2 time basis to provide to individuals who are patients  
3 of the first physician if (I) the first physician is un-  
4 available to provide the services, (II) the services are  
5 not provided by the second physician over a continu-  
6 ous period of longer than 90 days (or such longer  
7 period as the Secretary may provide), and (III) the  
8 claim form submitted to the carrier includes the sec-  
9 ond physician's unique identifier (provided under the  
10 system established under subsection (r)) and indi-  
11 cates that the claim meets the requirements of this  
12 clause for payment to the first physician”.

13 (2) EFFECTIVE DATE.—The amendment made  
14 by paragraph (1) shall apply to services furnished on  
15 or after the first day of the first month beginning  
16 more than 60 days after the date of the enactment  
17 of this Act.

18 (b) MEDICAID PROGRAM.—

19 (1) IN GENERAL.—Section 1902(a)(32)(C) of  
20 the Social Security Act (42 U.S.C. 1396a(a)(32)(C))  
21 is amended to read as follows:

22 “(C) payment may be made to a physician  
23 for services furnished by a substitute physician  
24 under the circumstances described in subpara-  
25 graph (D) of section 1842(b)(6), except that,

1 for purposes of this subparagraph, any ref-  
2 erence in such subparagraph to ‘a carrier’ or  
3 ‘the system established under subsection (r)’ is  
4 deemed a reference to the State (or other fiscal  
5 agent under the State plan) and to the system  
6 established under subsection (x) of this section,  
7 respectively.’’.

8 (2) EFFECTIVE DATE.—(A) The amendment  
9 made by paragraph (1) shall apply to services fur-  
10 nished on or after the date of the enactment of this  
11 Act.

12 (B) Until the first day of the first calendar  
13 quarter beginning more than 60 days after the date  
14 the Secretary of Health and Human Services estab-  
15 lishes the physician identifier system under section  
16 1902(x) of the Social Security Act, the requirement  
17 under section 1902(a)(32)(C) of such Act that a  
18 claim form submitted must include the second physi-  
19 cian’s unique identifier is deemed to be satisfied if  
20 the claim form identifies (in a manner specified by  
21 the Secretary of Health and Human Services) the  
22 second physician.

1 **SEC. 109. REPEAL OF PRO PRECERTIFICATION REQUIRE-**  
2 **MENT FOR CERTAIN SURGICAL PROCEDURES**  
3 **PERFORMED IN RURAL AREAS.**

4 (a) IN GENERAL.—Section 1164(b) of the Social Se-  
5 curity Act (42 U.S.C. 1320c-13(b)) is amended by adding  
6 at the end the following new paragraph:

7 “(5) EXCEPTION FOR PROCEDURES PER-  
8 FORMED IN RURAL AREAS.—No surgical procedure  
9 performed in a rural area (as defined in section  
10 1886(d)(2)(D)) shall be covered under this section.”.

11 (b) EFFECTIVE DATE.—The amendment made by  
12 subsection (a) shall apply to services furnished on or after  
13 January 1, 1994.

14 **Subtitle B—Increasing Number of**  
15 **Physicians Practicing in Rural**  
16 **Areas**

17 **SEC. 111. DEDUCTION FOR MEDICAL SCHOOL EDUCATION**  
18 **LOAN INTEREST INCURRED BY PHYSICIANS**  
19 **SERVING IN MEDICALLY UNDERSERVED**  
20 **RURAL AREAS.**

21 (a) IN GENERAL.—Paragraph (1) of section 163(h)  
22 of the Internal Revenue Code of 1986 (relating to dis-  
23 allowance of deduction for personal interest) is amended  
24 by striking “and” at the end of subparagraph (D), by re-  
25 designating subparagraph (E) as subparagraph (F), and

1 by inserting after subparagraph (D) the following new  
2 subparagraph:

3           “(E) any qualified medical education loan  
4           interest (within the meaning of paragraph (5)),  
5           and”.

6           (b) QUALIFIED MEDICAL EDUCATION LOAN INTER-  
7           EST DEFINED.—Subsection (h) of section 163 of such  
8           Code is amended by redesignating paragraph (5) as para-  
9           graph (6) and by inserting after paragraph (4) the follow-  
10          ing new paragraph:

11           “(5) QUALIFIED MEDICAL EDUCATION LOAN IN-  
12          TEREST.—

13           “(A) IN GENERAL.—The term ‘qualified  
14          medical education loan interest’ means inter-  
15          est—

16           “(i) which is on a medical education  
17          loan of a physician,

18           “(ii) which is paid or accrued by such  
19          physician, and

20           “(iii) which accrues during the pe-  
21          riod—

22           “(I) such physician is providing  
23          primary care (including internal medi-  
24          cine, pediatrics, obstetrics/gynecology,  
25          family medicine, and osteopathy) to

1 residents of a medically underserved  
2 rural area, and

3 “(II) such physician’s principal  
4 place of abode is in such area.

5 “(B) MEDICAL EDUCATION LOAN.—The  
6 term ‘medical education loan’ means indebted-  
7 ness incurred to pay the individual’s—

8 “(i) qualified tuition and related ex-  
9 penses (as defined in section 117(b)) in-  
10 curred for the medical education of such  
11 individual, or

12 “(ii) reasonable living expenses while  
13 away from home in order to attend an edu-  
14 cational institution described in section  
15 170(b)(1)(A)(ii) for the medical education  
16 of such individual.

17 “(C) PHYSICIAN.—For purposes of sub-  
18 paragraph (A), the term ‘physician’ has the  
19 meaning given such term by section 1861(r)(1)  
20 of the Social Security Act.

21 “(D) MEDICALLY UNDERSERVED RURAL  
22 AREA.—The term ‘medically underserved rural  
23 area’ means any rural area which is a medically  
24 underserved area (as defined in section 330(b)  
25 or 1302(7) of the Public Health Service Act).”.

1 (c) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to taxable years ending after the  
3 date of the enactment of this Act.

4 **SEC. 112. DETERMINATION OF GREATEST SHORTAGE OF**  
5 **HEALTH PROFESSIONALS WITH RESPECT TO**  
6 **ASSIGNMENT OF MEMBERS OF NATIONAL**  
7 **HEALTH SERVICE CORPS.**

8 (a) IN GENERAL.—Section 333A(b) of the Public  
9 Health Service Act (42 U.S.C. 254f-1(b)) is amended by  
10 adding at the end the following paragraph:

11 “(3) The ratio of the estimated number of  
12 medically underserved individuals residing in the  
13 health professional shortage area involved to the ag-  
14 gregate population of all health professional shortage  
15 areas.”.

16 (b) EFFECTIVE DATE.—The amendment made by  
17 subsection (a) shall apply to assignments of members of  
18 the National Health Service Corps that are made on or  
19 after the date of the enactment of this Act.

20 **Subtitle C—Expansion of Excep-**  
21 **tions to Limitations on Physi-**  
22 **cian Self-Referrals**

23 **SEC. 121. CHANGES IN EXCEPTIONS.**

24 (a) HEALTH MAINTENANCE ORGANIZATIONS AND  
25 MANAGED CARE PLANS.—Paragraph (3) of section

1 1877(b) of the Social Security Act is amended to read as  
2 follows:

3 “(3) HEALTH MAINTENANCE ORGANIZATIONS  
4 AND MANAGED CARE PLANS.—

5 “(A) HEALTH MAINTENANCE ORGANIZA-  
6 TIONS.—In the case of services furnished by a  
7 health maintenance organization to an individ-  
8 ual enrolled with the health maintenance orga-  
9 nization, including services furnished by—

10 “(i) an eligible organization (as de-  
11 fined in section 1876(b));

12 “(ii) an organization described in sec-  
13 tion 1833(a)(1)(A);

14 “(iii) an organization receiving pay-  
15 ments on a prepaid basis under a dem-  
16 onstration project under section 402(a) of  
17 the Social Security Amendments of 1967  
18 or under section 222(a) of the Social Secu-  
19 rity Amendments of 1972; and

20 “(iv) any other entity designated by  
21 the Secretary as a health maintenance or-  
22 ganization for purposes of this subpara-  
23 graph.

24 “(B) CERTAIN MANAGED CARE PLANS.—In  
25 the case of services furnished by a managed

1 care plan (as defined by the Secretary) to an  
2 individual enrolled under the plan if—

3 “(i) the plan selectively contracts with  
4 physicians and with providers of des-  
5 ignated health services; and

6 “(ii) under the plan physicians bear a  
7 significant financial risk for the cost of  
8 designated health services furnished upon  
9 referral.”.

10 (b) EXCEPTION FOR SHARED FACILITY SERVICES.—

11 Section 1877 of such Act is amended—

12 (1) in subsection (b), by redesignating para-  
13 graphs (3), (4), and (5) as paragraphs (4), (6), and  
14 (7), respectively, and by inserting after paragraph  
15 (2) the following new paragraph:

16 “(3) SHARED FACILITY SERVICES.—

17 “(A) IN GENERAL.—In the case of shared  
18 facility services of a shared facility—

19 “(i) that are furnished—

20 “(I) personally by the referring  
21 physician who is a shared facility phy-  
22 sician or personally by an individual  
23 supervised by such a physician or by  
24 another shared facility physician and

1 employed under the shared facility ar-  
2 rangement,

3 “(II) by a shared facility in a  
4 building in which the referring physi-  
5 cian furnishes physician’s services un-  
6 related to the furnishing of shared fa-  
7 cility services, and

8 “(III) to a patient of a shared fa-  
9 cility physician;

10 “(ii) that are billed by the referring  
11 physician or by an entity that is wholly  
12 owned by such physician; and

13 “(iii) with respect to the referral for  
14 which the disclosure requirements of sub-  
15 paragraph (B) are met.

16 “(B) CONFLICT OF INTEREST DISCLOSURE  
17 REQUIREMENTS.—A shared facility meets the  
18 disclosure requirements of this subparagraph,  
19 with respect to a referral of an individual for  
20 the furnishing of shared facility services, if at  
21 the time of the referral (and before the provi-  
22 sion of shared facility services under the refer-  
23 ral) and in a form and manner specified by the  
24 Secretary—

1           “(i) the individual (I) is given infor-  
2           mation on the financial relationship be-  
3           tween the referring physician and the  
4           shared facility, and (II) is informed that a  
5           list of alternative providers (if any) that  
6           are available to provide such services will  
7           be given upon request,

8           “(ii) the individual is given, upon re-  
9           quest, a list of alternative providers (if  
10          any) that are available to provide such  
11          services, and

12          “(iii) the individual is informed that  
13          (I) the individual has the option to use any  
14          of the alternative providers and (II) the re-  
15          ferring physician will not treat the individ-  
16          ual differently if an alternative provider is  
17          selected to provide the designated health  
18          services.

19          “(C) CONSTRUCTION.—Nothing in sub-  
20          paragraph (B) shall be construed to limit the  
21          information that a shared facility or shared fa-  
22          cility physician may provide to an individual.”;  
23          and

24          (2) in subsection (h), by adding at the end the  
25          following new paragraph:

1           “(8) SHARED FACILITY RELATED DEFINI-  
2 TIONS.—

3           “(A) SHARED FACILITY SERVICES.—The  
4 term ‘shared facility services’ means, with re-  
5 spect to a shared facility, a type of service  
6 which is furnished by the facility to patients of  
7 shared facility physicians.

8           “(B) SHARED FACILITY.—The term  
9 ‘shared facility’ means an entity that furnishes  
10 shared facility services under a shared facility  
11 arrangement.

12           “(C) SHARED FACILITY PHYSICIAN.—The  
13 term ‘shared facility physician’ means, with re-  
14 spect to a shared facility, a physician who has  
15 a financial relationship under a shared facility  
16 arrangement with the facility.

17           “(D) SHARED FACILITY ARRANGEMENT.—  
18 The term ‘shared facility arrangement’ means,  
19 with respect to the provision of a type of service  
20 by a shared facility in a building, a financial ar-  
21 rangement—

22                   “(i) which is only between physicians  
23 who are providing services (unrelated to  
24 shared facility services) in the same build-  
25 ing,

1           “(ii) which makes one or more of the  
2           shared facility physicians responsible for  
3           the provision of shared facility services by  
4           the facility,

5           “(iii) in which the overhead expenses  
6           of the facility are shared, in accordance  
7           with methods previously determined by the  
8           physicians in the arrangement, among the  
9           physicians in the arrangement, and

10           “(iv) which, in the case of a corpora-  
11           tion, is wholly owned and controlled by  
12           shared facility physicians.”.

13           (c) EXCEPTION FOR VALUABLE COMMUNITY SERV-  
14           ICES.—Section 1877(b) of such Act is further amended  
15           by inserting after paragraph (4), as redesignated by sub-  
16           section (b)(1), the following new paragraph:

17           “(5) VALUABLE COMMUNITY SERVICES.—

18           “(A) IN GENERAL.—In the case of services  
19           furnished by an entity to individuals in a com-  
20           munity if the Secretary determines that—

21           “(i) individuals in the community will  
22           be deprived of adequate health care serv-  
23           ices without an exception under this para-  
24           graph for the entity and the services, and

1           “(ii) the requirements of subpara-  
2           graph (B) are met.

3           “(B) REQUIREMENTS.—The requirements  
4           of this subparagraph for an exception under  
5           subparagraph (A), for the furnishing of des-  
6           ignated health services by an entity, are as fol-  
7           lows:

8                   “(i) EQUAL INVESTMENT OPPOR-  
9                   TUNITY.—(I) Individuals who are not re-  
10                  ferring physicians must be given a bona  
11                  fide opportunity to invest in the entity on  
12                  the same terms that are offered to refer-  
13                  ring physicians.

14                   “(II) The terms on which investment  
15                  interests are offered to physicians must not  
16                  be related to the past or expected volume  
17                  of referrals or other business from the phy-  
18                  sicians.

19                   “(III) The return on investment for  
20                  interested investors must be tied to the in-  
21                  vestor’s equity in the entity and not be re-  
22                  lated to the volume of referrals attributable  
23                  to the investor.

24                   “(IV) There is no requirement that  
25                  any interested or other investor make re-

1           ferrals to the entity or otherwise generate  
2           business as a condition for remaining an  
3           investor.

4           “(V) The entity must not loan funds  
5           or guarantee a loan for interested investors  
6           or physicians in a position to refer to the  
7           entity.

8           “(VI) The entity must not market or  
9           furnish its items or services to interested  
10          investors differently from other investors.

11          “(ii)           PROHIBITION           OF  
12          NONCOMPETITION   CLAUSES.—Investment  
13          contracts   must   not   include   a  
14          ‘noncompetition clause’ that prevents phy-  
15          sicians or interested investors from invest-  
16          ing in other entities furnishing such serv-  
17          ices.

18          “(iii) DISCLOSURE REQUIREMENTS.—  
19          (I) The disclosure requirements of para-  
20          graph (3)(B) must be met.

21          “(II) The financial relationship with  
22          the referring physician must be disclosed,  
23          when required, to any third-party payor.

24          “(iv)   INTERNAL   UTILIZATION   RE-  
25          VIEW.—There must be in operation an in-

1           ternal utilization review program to ensure  
2           that physicians who are interested inves-  
3           tors do not exploit their patients in any  
4           way through inappropriate utilization or  
5           otherwise.

6           “(C) REVIEW.—In the case of any excep-  
7           tion provided an entity under this paragraph,  
8           the Secretary shall periodically review the entity  
9           to determine if the requirements of subpara-  
10          graph (B) continue to be met.

11          “(D) TERMINATION OF EXCEPTION.—The  
12          Secretary shall, after notice and opportunity for  
13          a hearing, terminate an exception granted an  
14          entity under this paragraph if the Secretary de-  
15          termines that—

16                  “(i) there was a misrepresentation of  
17                  material fact in the application for the ex-  
18                  ception; or

19                  “(ii) the entity has failed to comply  
20                  substantially with the requirements of sub-  
21                  paragraph (B).

22          “(E) COMMUNITY DEFINED.—In this para-  
23          graph, the term ‘community’ means—

24                  “(i) part or all of a metropolitan sta-  
25                  tistical area (or equivalent area), or

1                   “(ii) a county (or equivalent area)  
2                   outside such a metropolitan statistical area  
3                   (or equivalent area).”.

4           (d) EXCEPTION FOR HOSPITALS.—Subparagraph (A)  
5 of subsection (d)(3) of such section is amended to read  
6 as follows:

7                   “(A) at the time the services are furnished,  
8                   the hospital has a participation agreement in  
9                   effect under section 1866, and”.

10 **SEC. 122. STUDY AND REPORT ON CHANGES IN COSTS.**

11           The Secretary of Health and Human Services shall  
12 conduct a study in order to estimate the changes in aggre-  
13 gate costs for designated health services, under the medi-  
14 care program and other health plans, which will result  
15 from the implementation of the amendments made by this  
16 subtitle. Not later than 2 years after the date of the enact-  
17 ment of this Act the Secretary shall submit to Congress  
18 a report on such study.

19 **SEC. 123. EFFECTIVE DATE.**

20           (a) IN GENERAL.—Subject to subsection (b), the  
21 amendments made by this subtitle shall apply with respect  
22 to a referral by a physician made on or after the first day  
23 of the first month beginning 6 months after the date of  
24 the enactment of this Act.

1 (b) TIME-LIMITED EXCEPTION FOR CURRENT FI-  
2 NANCIAL RELATIONSHIPS.—

3 (1) IN GENERAL.—Subject to paragraph (3),  
4 the amendments made by this subtitle shall not  
5 apply in the case of a patient referral with respect  
6 to which a prohibited financial relationship (de-  
7 scribed in paragraph (2)) existed as of the date of  
8 the enactment of this Act if, at the time of the refer-  
9 ral (and before the receipt of services under the re-  
10 ferral), the patient is provided information on the  
11 prohibited financial relationship. Such information  
12 shall be disclosed in the same manner information  
13 must be disclosed under section 1877(b)(3)(B) of  
14 the Social Security Act (as amended by this sub-  
15 title). If such information is not so provided, the re-  
16 ferral shall be subject to such amendments (as pro-  
17 vided in subsection (a)).

18 (2) PROHIBITED FINANCIAL RELATIONSHIP.—A  
19 prohibited financial relationship described in this  
20 paragraph is a financial relationship described in  
21 subsection (a)(2) of section 1877 of the Social Secu-  
22 rity Act for which an exception described in sub-  
23 section (b), (c), (d), or (e) of such section (as  
24 amended by this subtitle) does not apply.

1           (3) TIME LIMIT.—Paragraph (1) shall only  
2 apply to referrals made before the first day of the  
3 first month beginning 4 years after the date of the  
4 enactment of this Act.

5                   **TITLE II—PROVISIONS**  
6                   **RELATING TO HOSPITALS**

7 **SEC. 201. HOLDING RURAL HOSPITALS HARMLESS FROM**  
8                   **REDUCTIONS IN MEDICARE PAYMENTS FOR**  
9                   **CAPITAL-RELATED COSTS RESULTING FROM**  
10                   **PROSPECTIVE PAYMENT METHODOLOGY.**

11           (a) IN GENERAL.—Section 1886(g)(1)(B) of the So-  
12 cial Security Act (42 U.S.C. 1395ww(g)(1)(B)) is amend-  
13 ed—

14                   (1) by striking “and” at the end of clause (iii);

15                   (2) by striking the period at the end of clause  
16 (iv) and inserting “, and”; and

17                   (3) by adding at the end the following new  
18 clause:

19                   “(v) shall provide that the amount of payment  
20 made under the system in a cost reporting period to  
21 any hospital located in a rural area (as defined in  
22 subsection (d)(2)(D)) shall be based on reasonable  
23 costs (as defined in section 1861(v)) or on the meth-  
24 odology used to determine the amount of payment  
25 for other hospitals, as elected by the hospital, except

1 that the method elected by the hospital shall apply  
2 to at least 3 consecutive cost reporting periods.”.

3 (b) EFFECTIVE DATE.—The amendment made by  
4 subsection (a) shall apply to portions of cost reporting pe-  
5 riods or discharges (as the case may be) occurring on or  
6 after October 1, 1991.

7 **SEC. 202. EXTENSION OF RURAL REFERRAL CENTER CLAS-**  
8 **SIFICATION.**

9 (a) EXTENSION THROUGH FISCAL YEAR 1994.—Sec-  
10 tion 6003(d) of the Omnibus Budget Reconciliation Act  
11 of 1989 (42 U.S.C. 1395ww note) is amended by striking  
12 “October 1, 1992” and inserting “October 1, 1994”.

13 (b) REPEAL OF SPECIAL TREATMENT FOR REFER-  
14 RAL CENTERS.—

15 (1) IN GENERAL.—Effective October 1, 1994,  
16 section 1886(d)(5) of the Social Security Act (42  
17 U.S.C. 1395ww(d)(5)) is amended by striking sub-  
18 paragraph (C).

19 (2) EXCEPTION FOR DETERMINING DISPROPOR-  
20 TIONATE SHARE PAYMENTS.—Section  
21 1886(d)(5)(F)(iv) of such Act (42 U.S.C.  
22 1395ww(d)(5)(F)(iv)) is amended by striking “sub-  
23 paragraph (C),” each place it appears in subclauses  
24 (IV) and (V) and inserting the following: “subpara-  
25 graph (C) (or, for cost reporting periods beginning

1 on or after October 1, 1994, would be so classified  
2 if such subparagraph were in effect for such a cost  
3 reporting period, or was so classified under such  
4 subparagraph for the most recent cost reporting pe-  
5 riod before such date),”.

6 **SEC. 203. ANTITRUST EXEMPTION FOR CERTAIN RURAL**  
7 **HOSPITALS.**

8 (a) IN GENERAL.—The antitrust laws shall not apply  
9 with respect to—

10 (1) the combination of, or the attempt to com-  
11 bine, 2 or more hospitals,

12 (2) a contract entered into solely by 2 or more  
13 hospitals to allocate hospital services, or

14 (3) the attempt by only 2 or more hospitals to  
15 enter into a contract to allocate hospital services,

16 if each of such hospitals satisfies all of the requirements  
17 of subsection (b) at the time such hospitals engage in the  
18 conduct described in paragraph (1), (2), or (3), as the case  
19 may be.

20 (b) REQUIREMENTS DESCRIBED.—The requirements  
21 referred to in subsection (a) are as follows:

22 (1) The hospital is located outside of a city, or  
23 in a city that has less than 125,000 inhabitants, as  
24 determined in accordance with the most recent data  
25 available from the Bureau of the Census.

1           (2) In the most recently concluded calendar  
2 year, the hospital received more than 40 percent of  
3 its gross revenue from payments made under Fed-  
4 eral programs.

5           (3) There is in effect with respect to the hos-  
6 pital a certificate issued by the Health Care Financ-  
7 ing Administration specifying that such Administra-  
8 tion has determined that Federal expenditures would  
9 be reduced, and consumer costs would not increase,  
10 if the 2 or more hospitals that request such certifi-  
11 cate merge, or allocate the hospital services specified  
12 in such request, as the case may be.

13       (c) DEFINITION.—For purposes of this section, the  
14 term “antitrust laws” has the meaning given such term  
15 in subsection (a) of the first section of the Clayton Act  
16 (15 U.S.C. 12), except that such term includes section 5  
17 of the Federal Trade Commission Act (15 U.S.C. 45) to  
18 the extent that such section 5 applies with respect to un-  
19 fair methods of competition.

1           **TITLE III—MISCELLANEOUS**  
2                           **PROVISIONS**  
3                   **Subtitle A—Administrative**  
4                           **Simplification**

5   **SEC. 301. REQUIREMENTS FOR HEALTH BENEFIT PLANS.**

6           (a) IN GENERAL.—Each health benefit plan (as de-  
7 fined in subsection (b)) shall, with respect to individuals  
8 entitled to benefits under the plan—

9                   (1) issue to each such individual who is residing  
10           in the United States a health claims card that meets  
11           the requirements of section 304(a);

12                   (2) provide to the health claims clearinghouse  
13           assigned to each such individual under section  
14           303(c)(1) information, in an electronic form consist-  
15           ent with standards established under section 304(b),  
16           on—

17                           (A) the eligibility of the individual for ben-  
18           efits under the plan, and

19                           (B) the benefits of the individual under the  
20           plan; and

21                   (3) accept the determinations of clean claims  
22           made by the health claims clearinghouse under sec-  
23           tion 303(e) for the individual.

24           (b) HEALTH BENEFIT PLAN DEFINED.—

1           (1) IN GENERAL.—In this subtitle, the term  
2           “health benefit plan” means, except as provided in  
3           paragraphs (2) through (4), any public or private  
4           entity or program that provides for payments for  
5           health care services, including—

6                   (A) a group health plan (as defined in sec-  
7                   tion 605 of the Employee Retirement Income  
8                   Security Act of 1974), a health plan of a mul-  
9                   tiple employer welfare association, and a health  
10                  plan of trustees of a fund established by one or  
11                  more employers or labor organizations (or com-  
12                  bination thereof), and

13                  (B) any other health insurance arrange-  
14                  ment, including any arrangement consisting of  
15                  a hospital or medical expense incurred policy or  
16                  certificate, hospital or medical service plan con-  
17                  tract, or health maintenance organization sub-  
18                  scriber contract.

19           (2) PLANS EXCLUDED.—Such term does not in-  
20           clude—

21                   (A) accident-only, credit, or disability in-  
22                   come insurance;

23                   (B) coverage issued as a supplement to li-  
24                   ability insurance;

1 (C) an individual making payment on the  
2 individual's own behalf (or on behalf of a rel-  
3 ative or other individual) for deductibles, coin-  
4 surance, or services not covered under a health  
5 benefit plan; and

6 (D) such other plans as the Secretary may  
7 determine, because of the limitation of benefits  
8 to a single type or kind of health care, such as  
9 dental services or hospital indemnity plans, or  
10 other reasons should not be subject to the re-  
11 quirements of this section.

12 (3) PLANS INCLUDED.—Such term includes—

13 (A) worker's compensation or similar in-  
14 surance, and

15 (B) automobile medical-payment insurance.

16 (c) OTHER DEFINITIONS.—In this subtitle:

17 (1) CLEAN CLAIM.—The term “clean claim”  
18 means a request for payment under a health benefits  
19 plan if the request has no defect or impropriety (in-  
20 cluding any lack of any required substantiating doc-  
21 umentation) or particular circumstance requiring  
22 special treatment that prevents timely payment from  
23 being made on the request under the plan.

24 (2) HEALTH CLAIMS CLEARINGHOUSE.—The  
25 terms “health claims clearinghouse” and “clearing-

1 house” mean an entity with a contract under section  
2 303 to perform functions as a clearinghouse under  
3 that section.

4 (3) SECRETARY.—The term “Secretary” means  
5 the Secretary of Health and Human Services.

6 (4) UNITED STATES.—The term “United  
7 States” means the 50 States and the District of Co-  
8 lumbia.

9 (d) EFFECTIVE DATE.—The requirements of sub-  
10 section (a) shall apply to plans as of a date specified by  
11 the Secretary, which date shall be not later than 27  
12 months after the date of the enactment of this Act.

13 **SEC. 302. REQUIREMENTS FOR HEALTH SERVICE PROVID-**  
14 **ERS.**

15 (a) SUBMISSION OF CLAIMS.—

16 (1) IN GENERAL.—Each health service provider  
17 which furnishes services in the United States for  
18 which payment may be made under a health benefit  
19 plan shall submit any claim for payment for such  
20 services—

21 (A) only to the health claims clearinghouse  
22 to which it is assigned, and

23 (B) only in a form and manner consistent  
24 with standards established under section  
25 304(b).

1 (2) ENFORCEMENT.—

2 (A) CIVIL MONEY PENALTY.—

3 (i) IN GENERAL.—In the case of a  
4 health service provider that submits a  
5 claim in violation of paragraph (1), the  
6 provider is subject to a civil money penalty  
7 of not to exceed \$100 (or, if greater, the  
8 amount of the claim) for each such viola-  
9 tion. The provisions of section 1128A of  
10 the Social Security Act (other than the  
11 first and second sentences of subsection (a)  
12 and subsection (b)) shall apply to a civil  
13 money penalty under this subparagraph in  
14 the same manner as such provisions apply  
15 to a penalty or proceeding under section  
16 1128A(a) of such Act.

17 (ii) SUNSET.—No civil money penalty  
18 may be imposed under clause (i) for sub-  
19 mission of any claim on or after the date  
20 that is 63 months after the date of the en-  
21 actment of this Act.

22 (B) DENIAL OF PAYMENT UNDER MEDI-  
23 CARE AND MEDICAID PROGRAMS.—In the case  
24 of a health service provider that submits a  
25 claim for services furnished under the medicare

1 program or medicaid program in violation of  
2 paragraph (1), no payment shall be made under  
3 such program for such services.

4 (3) HEALTH SERVICE PROVIDER DEFINED.—In  
5 this subsection, the term “health service provider”  
6 includes a provider of services (as defined in section  
7 1861(u) of the Social Security Act), physicians, sup-  
8 pliers, and other persons furnishing health care serv-  
9 ices for which benefits may be made available under  
10 a health benefit plan.

11 (4) EFFECTIVE DATE.—The requirements of  
12 paragraph (1) shall apply to providers for claims  
13 submitted on or after a date specified by the Sec-  
14 retary, which date shall be not later than 27 months  
15 after the date of the enactment of this Act.

16 (b) UNIFORM HOSPITAL REPORTING.—Each hos-  
17 pital, as a requirement under a participation agreement  
18 under section 1866(a) of the Social Security Act for each  
19 cost reporting period beginning during or after fiscal year  
20 1994, shall provide for the reporting of information to the  
21 Secretary with respect to any hospital care provided in a  
22 uniform manner consistent with standards established by  
23 the Secretary to carry out section 4007(c) of the Omnibus  
24 Budget Reconciliation Act of 1987.

1 **SEC. 303. HEALTH CLAIMS CLEARINGHOUSES.**

2 (a) DESIGNATION OF CLEARINGHOUSE AREAS.—For  
3 purposes of carrying out this section, the Secretary shall  
4 designate within the continental United States areas en-  
5 compassing approximately 5 million residents each. To the  
6 extent practicable, the areas shall be reasonably contig-  
7 uous with State boundaries. Each such area, and each of  
8 the States of Alaska and Hawaii, is referred to in this  
9 section as a “clearinghouse area”.

10 (b) CONTRACTS WITH HEALTH CLAIMS CLEARING-  
11 HOUSES.—

12 (1) IN GENERAL.—Taking into account the con-  
13 siderations listed in paragraph (2), the Secretary  
14 shall enter into a contract with a public or private  
15 organization to perform the functions of a health  
16 claims clearinghouse described in subsections (d)  
17 and (e) for residents and providers in each clearing-  
18 house area. The Secretary shall enter into a single  
19 and separate contract with respect to each such  
20 area. The Secretary shall first enter into such con-  
21 tracts by not later than 2 years after the date of the  
22 enactment of this Act.

23 (2) CONSIDERATIONS.—In selecting among or-  
24 ganizations to perform the functions of a health  
25 claims clearinghouse in an area, the Secretary shall  
26 consider at least the following:

1           (A) The price to be charged by the organi-  
2 zation for services performed by the organiza-  
3 tion under the contract, including the price per  
4 claim processed.

5           (B) The organization's ability to process,  
6 and experience in processing, claims on a timely  
7 and accurate basis and to perform other func-  
8 tions of such a clearinghouse.

9           (C) The organization's experience in proc-  
10 essing claims with respect to the various health  
11 service providers in the area.

12           (3) TERMS OF CONTRACTS.—

13           (A) IN GENERAL.—Contracts under this  
14 subsection shall be for a period, not to exceed  
15 3 years, specified by the Secretary. The Sec-  
16 retary may terminate such contract, at any  
17 time after appropriate notice and opportunity  
18 for correction, if the Secretary determines that  
19 the organization has substantially failed to  
20 carry out the contract.

21           (B) CHARGES FOR SERVICES.—A health  
22 claims clearinghouse may impose reasonable  
23 charges, consistent with the terms of its con-  
24 tract and subsections (d) and (e), for the per-

1           formance of required functions under such sub-  
2           sections.

3           (c) ASSIGNMENT OF RESIDENTS AND PROVIDERS TO  
4 HEALTH CLAIMS CLEARINGHOUSES.—For purposes of  
5 carrying out this subtitle—

6           (1) RESIDENTS.—Each individual entitled to  
7           benefits under a health benefits plan and who has a  
8           principal residence in a geographic area shall be as-  
9           signed to the clearinghouse for that area.

10          (2) PROVIDERS.—Each health service provider  
11          shall be assigned to the clearinghouse for the area  
12          in which the provider is located or provides services.

13          (3) EXCEPTIONS.—The Secretary may permit  
14          individuals and health service providers to be as-  
15          signed to clearinghouses other than those otherwise  
16          provided under this subsection in such cases as the  
17          Secretary may specify.

18          (4) EFFECTIVE DATE.—Individuals and provid-  
19          ers shall first be assigned to clearinghouses under  
20          this subsection by not later than 2 years after the  
21          date of the enactment of this Act.

22          (d) CLEARINGHOUSE REQUIRED FUNCTIONS RELAT-  
23          ING TO ELIGIBILITY AND BENEFIT VERIFICATION.—

24               (1) ELIGIBILITY AND BENEFIT VERIFICA-  
25               TION.—

1 (A) IN GENERAL.—As set forth in its con-  
2 tract with the Secretary, each health claims  
3 clearinghouse for an area shall verify, with re-  
4 spect to residents assigned to the clearinghouse,  
5 inquiries from health service providers who have  
6 furnished or are furnishing health services to  
7 such residents concerning—

8 (i) the health benefit plan (or plans)  
9 under which the residents are covered, and

10 (ii) the benefits under such a plan.

11 (B) INTER-CLEARINGHOUSE VERIFICATION  
12 PROCESS.—In addition, in the case of a service  
13 furnished to an individual assigned to another  
14 clearinghouse—

15 (i) the clearinghouse serving the pro-  
16 vider shall forward inquiries described in  
17 subparagraph (A) on behalf of the provider  
18 to the clearinghouse serving the individual,  
19 and

20 (ii) the clearinghouse serving the indi-  
21 vidual shall respond to the inquiry through  
22 the clearinghouse serving the provider.

23 The Secretary may provide for such inter-clear-  
24 inghouse electronic network as may expedite ac-  
25 tivities under this subparagraph.

1           (2) FORM OF INQUIRY.—Each clearinghouse  
2 shall be capable of accepting inquiries under this  
3 subsection in a variety of electronic and other forms,  
4 including—

5           (A) through electronic transmission of in-  
6 formation on the uniform health claims card (in  
7 a manner similar to that for verification of  
8 credit card purchases),

9           (B) through the use of a touch-tone tele-  
10 phone line, and

11           (C) through the use of a computer modem.

12 The clearinghouse shall also provide, for an addi-  
13 tional fee, for the acceptance of inquiries in a  
14 nonelectronic form.

15           (3) FORM OF RESPONSE.—Each clearinghouse  
16 shall be capable of responding to such inquiries  
17 under this subsection in a variety of electronic and  
18 other forms, including—

19           (A) through modem transmission of infor-  
20 mation,

21           (B) through computer synthesized voice  
22 communication, and

23           (C) through transmission of information to  
24 a facsimile (fax) machine.

1 The clearinghouse shall also provide, for an addi-  
2 tional fee, for the response to inquiries in a  
3 nonelectronic form.

4 (4) LIMITATION ON FEES.—A clearinghouse  
5 may not impose a fee for the acceptance or response  
6 to an inquiry under this subsection except where the  
7 acceptance or response is in a nonelectronic form.

8 (e) CLEARINGHOUSE REQUIRED FUNCTIONS RELAT-  
9 ING TO RECEIPT AND PROCESSING OF CLAIMS FOR BENE-  
10 FITS.—

11 (1) PROCESSING OF CLAIMS.—

12 (A) IN GENERAL.—As set forth in its con-  
13 tract with the Secretary, each clearinghouse  
14 serving residents of an area shall—

15 (i) receive claims for benefits under  
16 health benefit plans for such residents;

17 (ii) process the claims to determine if  
18 they are clean claims (as defined in section  
19 301(c)(1));

20 (iii) if a claim is not a clean claim, no-  
21 tify the person submitting the claim (I)  
22 that payment is not authorized for the  
23 claim, (II) of the reasons for the denial,  
24 and (III) concerning the process available  
25 for the appeal of such determination; and

1 (iv) if a claim is a clean claim—

2 (I) notify the person submitting  
3 the claim that payment may be made  
4 for the claim and the amount that is  
5 payable under the plan and the  
6 amount that is payable by the bene-  
7 ficiary as cost-sharing with respect to  
8 the provider and service, and

9 (II) notify the plan (or plans) lia-  
10 ble for payment with respect to the  
11 claim, of the submission and approval  
12 of the claim (and provide the plan  
13 with such additional information with  
14 respect to the person submitting the  
15 claim and the services under the claim  
16 as may be required for payment to be  
17 made on the claim).

18 (B) INTER-CLEARINGHOUSE VERIFICATION  
19 PROCESS.—In addition, in the case of a service  
20 furnished to an individual assigned to another  
21 clearinghouse—

22 (i) the clearinghouse serving the pro-  
23 vider shall forward claims described in sub-  
24 paragraph (A) on behalf of the provider to

1 the clearinghouse serving the individual for  
2 processing, and

3 (ii) the clearinghouse serving the indi-  
4 vidual shall respond to the claim through  
5 the clearinghouse serving the provider.

6 The Secretary may provide for such inter-clear-  
7 ighthouse electronic network as may expedite ac-  
8 tivities under this subparagraph.

9 (2) FORM OF CLAIM.—Each clearinghouse shall  
10 be capable of accepting claims under this subsection  
11 in an electronic form, including through electronic  
12 modem transmission. Each clearinghouse also shall  
13 provide, for an additional fee, for the acceptance of  
14 claims submitted on a uniform nonelectronic claims  
15 form.

16 (3) PROCESSING OF CLAIM.—For each claim  
17 submitted by health service provider for care fur-  
18 nished to an individual, the clearinghouse shall de-  
19 termine—

20 (A) if the claim is in proper form and the  
21 individual is covered under a health benefit  
22 plan,

23 (B) if so, whether under such plan the in-  
24 dividual is entitled to benefits with respect to  
25 that provider and that care, and

1           (C) any preconditions, such as prior au-  
2           thorization, that may exist for payment to be  
3           made for such care and, to the extent specified  
4           by the Secretary, whether such preconditions  
5           have been met.

6           (4) RESPONSE.—Each clearinghouse shall be  
7           capable of responding to such inquiries in a variety  
8           of electronic forms, including—

9                   (A) through modem transmission of infor-  
10                  mation, and

11                   (B) through transmission of information to  
12                  a facsimile (fax) machine.

13           The clearinghouse also shall provide, for an addi-  
14           tional fee, for the response to claims in a  
15           nonelectronic form.

16           (f) OPTIONAL PAYMENT FUNCTIONS.—

17                   (1) IN GENERAL.—Under a contractual ar-  
18                  rangement between a health benefit plan and a  
19                  clearinghouse, each clearinghouse may make pay-  
20                  ment of cleans claims received by the clearinghouse  
21                  for beneficiaries under the plan in return for pay-  
22                  ment from the plan. Any such contract shall be  
23                  made only on commercially reasonable terms, includ-  
24                  ing (if appropriate for non-Federal health plans) the  
25                  provision of a bonds or other assurances of payment

1 of the clearinghouse by the health benefit plan. If  
2 the clearinghouse enters into such a contractual ar-  
3 rangement with a health benefit plan, the clearing-  
4 house may not refuse to enter into such an arrange-  
5 ment with other health benefit plans that can meet  
6 the same (or comparable) commercial terms as  
7 under the previous arrangement.

8 (2) AUTHORIZATION.—The Secretary is author-  
9 ized to enter into contractual arrangements with  
10 clearinghouses to carry out the activities described in  
11 paragraph (1) with respect to the medicare program.

12 **SEC. 304. STANDARDS RELATING TO ELECTRONIC CLAIMS**  
13 **PROCESSING.**

14 (a) UNIFORM HEALTH CLAIMS CARDS.—

15 (1) IN GENERAL.—The Secretary shall establish  
16 standards consistent with this subsection respecting  
17 the form and information to be contained on uni-  
18 form health claims cards (for purposes of section  
19 301(a)(1)).

20 (2) ELECTRONIC.—

21 (A) IN GENERAL.—Subject to subpara-  
22 graph (B), the card shall be in a form similar  
23 to that of credit cards and shall have, encoded  
24 in electronic form—

1 (i) the identity of the individual (using  
2 the Social Security account number of the  
3 individual or, in the case of an infant or  
4 other individual to whom such a number  
5 has not been issued, such a Social Security  
6 account number of a parent or guardian or  
7 other number as the Secretary shall speci-  
8 fy), and

9 (ii) the health claims clearinghouse to  
10 which the individual is assigned under sec-  
11 tion 303(c).

12 (B) USE OF ELECTRONIC READ-AND-  
13 WRITE CARDS.—The Secretary may provide for  
14 cards in a electronic form that permit informa-  
15 tion on the card to be readily changed. Such in-  
16 formation may include information relating to  
17 the health coverage status of the individual and  
18 the medical history of the individual.

19 (3) ADDITIONAL INFORMATION.—The card  
20 shall include such additional information, in elec-  
21 tronic or other form, as the Secretary may require  
22 to carry out the purposes of this subtitle. In addi-  
23 tion, the health benefit plan issuing the card may in-  
24 clude such additional information on the card as the

1 plan desires, subject to such limitations as the Sec-  
2 retary may provide.

3 (4) ASSURING CONFIDENTIALITY OF INFORMA-  
4 TION.—In establishing standards under this sub-  
5 section, the Secretary shall include a requirement  
6 that, to the greatest extent possible, information on  
7 an individual’s medical condition or medical history  
8 shall be treated in a confidential manner.

9 (b) UNIFORM CLAIMS DATA SET.—

10 (1) IN GENERAL.—The Secretary shall establish  
11 standards with respect to the type and form of sub-  
12 stantiating documentation that—

13 (A) health claims clearinghouse may re-  
14 quire in order for a claim for benefits to be ac-  
15 cepted for processing, and

16 (B) claims for benefits under such plans  
17 may be required to provide in order to be treat-  
18 ed as clean claims and to obtain payment.

19 (2) SCOPE OF DATA SET.—The standards  
20 under this subsection are intended to cover substan-  
21 tially most claims that are filed under health benefit  
22 plans. Such data set need not include all elements  
23 that may potentially be required to be reported  
24 under utilization review provisions of plans.

1           (3) CONSISTENCY WITH ELECTRONIC MEDICAL  
2 RECORDS.—In establishing standards under this  
3 subsection, the Secretary shall assure that the  
4 standards—

5           (A) are consistent with standards being de-  
6 veloped for the maintenance of electronic medi-  
7 cal records, and

8           (B) would permit data elements from such  
9 medical records to be the elements which are  
10 transmitted for purposes of electronic submis-  
11 sion of claims.

12           (4) UNIFORM, UNIQUE PROVIDER IDENTIFICA-  
13 TION CODES.—In establishing standards under this  
14 subsection, the Secretary shall provide for a unique  
15 identifier for each health service provider (as defined  
16 in section 302(a)(3)) that submits claims for pay-  
17 ment to health benefit plans.

18           (5) UNIFORM DIAGNOSTIC AND PROCEDURE  
19 CODES.—In establishing standards under this sub-  
20 section, the Secretary shall develop a single, uniform  
21 coding system for diagnostic and procedure codes.

22           (c) FREE SOFTWARE TO PROVIDERS.—The Secretary  
23 shall provide for the development, and shall make available  
24 without charge to health service providers, such computer  
25 software as will enable the providers—

1           (1) to make inquiries, and receive responses,  
2           electronically respecting the eligibility and benefits of  
3           an individual under health benefit plans,

4           (2) to submit claims and to receive verification  
5           of claims status electronically, and

6           (3) in the case of hospitals to submit uniform  
7           reports.

8           (d) ADJUSTMENTS FOR RURAL PROVIDERS.—In es-  
9           tablishing standards under this section, the Secretary shall  
10          provide for such exceptions and adjustments as are nec-  
11          essary to take into account the circumstances faced by  
12          health service providers in rural areas and the need to en-  
13          sure the availability of health services to individuals resid-  
14          ing in such areas.

15          (e) DEADLINE.—The Secretary shall first provide for  
16          the standards for uniform health claims cards under sub-  
17          section (a) and for the standards for uniform claims data  
18          set under subsection (b) and shall develop (and make  
19          available) the software under subsection (c) by not later  
20          than 18 months after the date of the enactment of this  
21          Act.

1 **SEC. 305. EXCISE TAX ON PREMIUMS RECEIVED ON GROUP**  
2 **HEALTH PLANS WHICH DO NOT MEET CER-**  
3 **TAIN REQUIREMENTS.**

4 (a) IN GENERAL.—Chapter 47 of the Internal Reve-  
5 nue Code of 1986 (relating to taxes on group health plans)  
6 is amended by adding at the end thereof the following new  
7 section:

8 **“SEC. 5000A. FAILURE TO SATISFY CERTAIN STANDARDS**  
9 **FOR GROUP HEALTH PLANS.**

10 “(a) IN GENERAL.—

11 “(1) TAX.—In the case of any group health  
12 plan, there is hereby imposed a tax on the failure of  
13 such person to meet at any time during any taxable  
14 year the applicable requirements of section 301 of  
15 the Rural Health Care Access Improvement Act of  
16 1993.

17 “(2) DETERMINATION OF VIOLATIONS.—The  
18 Secretary of Health and Human Services shall de-  
19 termine whether any person meets the requirements  
20 of such section.

21 “(3) SUNSET.—

22 “(A) IN GENERAL.—No tax may be im-  
23 posed under this subsection for—

24 “(i) a violation of section 301(a)(1) of  
25 the Rural Health Care Access Improve-  
26 ment Act of 1993 with respect to individ-

1 uals who first become entitled to benefits  
2 under the group health plan on or after  
3 the sunset date (as defined in subpara-  
4 graph (B));

5 “(ii) a failure to provide under section  
6 301(a)(2) of such Act information on or  
7 after the sunset date; and

8 “(iii) a failure to accept under section  
9 301(a)(3) of such Act a determination of a  
10 health claims clearinghouse made on or  
11 after the sunset date.

12 “(B) SUNSET DATE.—For purposes of  
13 subparagraph (A), the term ‘sunset date’ means  
14 the date that is 63 months after the date of the  
15 enactment of this section.

16 “(b) AMOUNT OF TAX.—

17 “(1) IN GENERAL.—The amount of tax imposed  
18 by subsection (a) by reason of 1 or more failures  
19 during a taxable year shall be equal to 25 percent  
20 of the gross premiums received during such taxable  
21 year with respect to all group health plans issued by  
22 the person on whom such tax is imposed.

23 “(2) GROSS PREMIUMS.—For purposes of para-  
24 graph (1), gross premiums shall include any consid-

1       eration received with respect to any group health  
2       plan.

3           “(3) CONTROLLED GROUPS.—For purposes of  
4       paragraph (1)—

5           “(A) CONTROLLED GROUP OF CORPORA-  
6       TIONS.—All corporations which are members of  
7       the same controlled group of corporations shall  
8       be treated as 1 person. For purposes of the pre-  
9       ceding sentence, the term ‘controlled group of  
10      corporations’ has the meaning given to such  
11      term by section 1563(a), except that—

12           “(i) ‘more than 50 percent’ shall be  
13      substituted for ‘at least 80 percent’ each  
14      place it appears in section 1563(a)(1), and

15           “(ii) the determination shall be made  
16      without regard to subsections (a)(4) and  
17      (e)(3)(C) of section 1563.

18           “(B) PARTNERSHIPS, PROPRIETORSHIPS,  
19      ETC., WHICH ARE UNDER COMMON CONTROL.—  
20      Under regulations prescribed by the Secretary,  
21      all trades or business (whether or not incor-  
22      porated) which are under common control shall  
23      be treated as 1 person. The regulations pre-  
24      scribed under this subparagraph shall be based

1           on principles similar to the principles which  
2           apply in the case of subparagraph (A).

3           “(c) LIMITATION ON TAX.—

4           “(1) TAX NOT TO APPLY WHERE FAILURE NOT  
5           DISCOVERED EXERCISING REASONABLE DILI-  
6           GENCE.—No tax shall be imposed by subsection (a)  
7           with respect to any failure for which it is established  
8           to the satisfaction of the Secretary that the person  
9           on whom the tax is imposed did not know, and exer-  
10          cising reasonable diligence would not have known,  
11          that such failure existed.

12          “(2) TAX NOT TO APPLY WHERE FAILURES  
13          CORRECTED WITHIN 30 DAYS.—No tax shall be im-  
14          posed by subsection (a) with respect to any failure  
15          if—

16                  “(A) such failure was due to reasonable  
17                  cause and not to willful neglect, and

18                  “(B) such failure is corrected during the  
19                  30-day period beginning on the 1st date any of  
20                  the persons on whom the tax is imposed knew,  
21                  or exercising reasonable diligence would have  
22                  known, that such failure existed.

23          “(3) WAIVER BY SECRETARY.—In the case of a  
24          failure which is due to reasonable cause and not to  
25          willful neglect, the Secretary may waive part or all

1 of the tax imposed by subsection (a) to the extent  
2 that the payment of such tax would be excessive rel-  
3 ative to the failure involved.

4 “(d) GROUP HEALTH PLAN DEFINED.—For pur-  
5 poses of this section, the term ‘group health plan’ has the  
6 meaning given such term in section 5000(b)(1).”.

7 (b) NONDEDUCTIBILITY OF TAX.—Paragraph (6) of  
8 section 275(a) of such Code (relating to nondeductibility  
9 of certain taxes) is amended by inserting “47,” after  
10 “46,”.

11 (c) CLERICAL AMENDMENTS.—The table of sections  
12 for such chapter 47 is amended by adding at the end  
13 thereof the following new item:

“Sec. 5000A. Failure to satisfy certain standards for group health  
plans.”.

14 (d) EFFECTIVE DATES.—

15 (1) IN GENERAL.—The amendments made by  
16 subsections (a) and (c) shall take effect on the date  
17 of the enactment of this Act.

18 (2) NONDEDUCTIBILITY OF TAX.—The amend-  
19 ment made by subsection (b) shall apply to taxable  
20 years beginning after December 31, 1994.

21 **SEC. 306. APPLICATION OF REQUIREMENTS TO MEDICARE**  
22 **AND MEDICAID PROGRAMS.**

23 (a) APPLICATION TO MEDICARE PROGRAM.—The  
24 Secretary shall provide, in regulations promulgated to

1 carry out title XVIII of the Social Security Act, that iden-  
2 tification cards issued under that title and the claims proc-  
3 ess provided under that title are modified to the extent  
4 required to conform to the requirements of section 304  
5 for health benefits plans as of the applicable effective  
6 dates under this subtitle, so that hospitals, and other pro-  
7 viders of services, as well as physicians and other providers  
8 of medical and other services need not maintain a separate  
9 billing system in order to submit claims under the medi-  
10 care program.

11 (b) APPLICATION TO STATE MEDICAID PLANS.—As  
12 a condition for the approval of State plans under title XIX  
13 of the Social Security Act, effective as of the applicable  
14 effective dates under this subtitle, each such plan shall  
15 provide, in accordance with regulations of the Secretary,  
16 that identification cards issued under the plan and the  
17 claims process provided under the plan are modified to the  
18 extent required to conform to the requirements of section  
19 304 for health benefits plans, so that hospitals, and other  
20 providers of services, as well as physicians and other pro-  
21 viders of medical and other services need not maintain a  
22 separate billing system in order to submit claims under  
23 the medicaid program.

1           **Subtitle B—Other Provisions**

2   **SEC. 311. TELECOMMUNICATIONS DEMONSTRATION PRO-**  
3                   **GRAM FOR TRAUMA CARE IN RURAL AREAS.**

4           Section 1204 of the Public Health Service Area (42  
5 U.S.C. 300d-3) is amended—

6           (1) by redesignating subsection (c) as sub-  
7           section (d); and

8           (2) by inserting after subsection (b) the follow-  
9           ing new subsection:

10          “(c) DEMONSTRATION PROGRAM REGARDING TELE-  
11 COMMUNICATIONS.—

12           “(1) LINKAGES FOR RURAL FACILITIES.—  
13           Projects under subsection (a)(1) shall include dem-  
14           onstration projects to establish telecommunications  
15           between rural medical facilities and medical facilities  
16           that have expertise or equipment that can be utilized  
17           by the rural facilities through the telecommuni-  
18           cations.

19           “(2) MODES OF COMMUNICATIONS.—The Sec-  
20           retary shall ensure that the telecommunications  
21           technologies demonstrated under paragraph (1) in-  
22           clude interactive video telecommunications, static  
23           video imaging transmitted through the telephone  
24           system, and facsimiles transmitted through such sys-  
25           tem.”.

1 **SEC. 312. PRIMARY CARE NURSING CLINICS IN RURAL**  
2 **AREAS.**

3 Part C of title VII of the Public Health Service Act  
4 (42 U.S.C. 293j et seq.) is amended—

5 (1) by redesignating section 752 as section 753;

6 and

7 (2) by inserting after section 751 the following  
8 new section:

9 **“Subpart VII—Provision of Primary Care Services in**  
10 **Rural Areas**

11 **“SEC. 752. PROVISION OF PRIMARY CARE SERVICES IN**  
12 **RURAL AREAS.**

13 “(a) AUTHORIZATION TO USE AMOUNTS.—The Sec-  
14 retary may use not to exceed \$5,000,000, out of amounts  
15 appropriated to carry out programs under this part, in  
16 each of the fiscal years 1994 through 1996 to award  
17 grants to public or private schools of nursing for the estab-  
18 lishment of clinics that shall be administered by such  
19 schools.

20 “(b) APPLICATION.—A school desiring to receive a  
21 grant under subsection (a) shall prepare and submit to  
22 the Secretary, an application at such time, in such form,  
23 and containing such information as the Secretary may re-  
24 quire.

25 “(c) USE OF GRANTS.—Amounts received under  
26 grants awarded under subsection (a) shall be used to—



1           (2) by striking the period at the end of para-  
2 graph (6) and inserting “; and”; and

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

4           “(7) within 6 months after the date of the en-  
5 actment of the Rural Health Care Access Improve-  
6 ment Act of 1993, in consultation with the Secretary  
7 of Health and Human Services, shall—

8           “(A) identify, inventory, and assess the  
9 burden of federally conducted or sponsored in-  
10 formation collection requests associated with  
11 the delivery of health care services; and

12           “(B) for each of the fiscal years 1994,  
13 1995, 1996, 1997, 1998, and 1999, establish a  
14 goal for reducing the burden described in sub-  
15 paragraph (A) existing at the end of the preced-  
16 ing fiscal year by not less than 5 percent  
17 through more effective use of information re-  
18 sources management, regulatory flexibility, and  
19 other means.”.

○

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