

**Union Calendar No. 249**

104<sup>TH</sup> CONGRESS  
2D SESSION

**H. R. 3070**

**[Report No. 104-497, Part I]**

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**A BILL**

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

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MARCH 29, 1996

Committees on Ways and Means, the Judiciary, and Economic and Educational Opportunities discharged; committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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## IN THE HOUSE OF REPRESENTATIVES

MARCH 12, 1996

Mr. BILIRAKIS (for himself and Mr. BLILEY) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Ways and Means, the Judiciary, and Economic and Educational Opportunities, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

MARCH 25, 1996

Reported from the Committee on Commerce with an amendment  
[Strike out all after the enacting clause and insert the part printed in *italic*]

MARCH 25, 1996

Referral to the Committees on Ways and Means, the Judiciary, and Economic and Educational Opportunities extended for a period ending not later than March 29, 1996

MARCH 29, 1996

Additional sponsors: Mr. HASTERT, Mr. GILLMOR, Mr. STEARNS, Mr. KLUG, Mr. NORWOOD, and Mr. WELLER

MARCH 29, 1996

Committees on Ways and Means, the Judiciary, and Economic and Educational Opportunities discharged; committed to the Committee of the Whole House on the State of the Union and ordered to be printed

[For text of introduced bill, see copy of bill as introduced on March 12, 1996]

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# A BILL

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

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

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

4       (a) *SHORT TITLE.*—*This Act may be cited as the*  
 5 *“Health Coverage Availability and Affordability Act of*  
 6 *1996”.*

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

*Sec. 1. Short title; table of contents.*

**TITLE I—IMPROVED AVAILABILITY AND PORTABILITY OF HEALTH  
INSURANCE COVERAGE**

**SUBTITLE A—COVERAGE UNDER GROUP HEALTH PLANS**

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

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

*Sec. 103. Prohibiting exclusions based on health status and providing for enroll-*  
*ment periods.*

*Sec. 104. Enforcement.*

**SUBTITLE B—CERTAIN REQUIREMENTS FOR INSURERS AND HMOs IN THE  
GROUP AND INDIVIDUAL MARKETS**

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

*Sec. 131. Guaranteed availability of general coverage in the small group market.*

*Sec. 132. Guaranteed renewability of group coverage.*

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

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

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

## PART 3—ENFORCEMENT

*Sec. 151. Incorporation of provisions for State enforcement with Federal fallback authority.*

*Subtitle C—Sense of Committee on Additional Requirements*

*Sec. 161. Sense of Committee on Commerce on additional requirements.*

*Subtitle D—Definitions; General Provisions*

*Sec. 191. Definitions; scope of coverage.*

*Sec. 192. State flexibility to provide greater protection.*

*Sec. 193. Effective date.*

*Sec. 194. Rule of construction.*

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

*Sec. 200. References in title.*

*Subtitle A—Fraud and Abuse Control Program*

*Sec. 201. Fraud and abuse control program.*

*Sec. 202. Medicare integrity program.*

*Sec. 203. Beneficiary incentive programs.*

*Sec. 204. Application of certain health anti-fraud and abuse sanctions to fraud and abuse against Federal health care programs.*

*Sec. 205. Guidance regarding application of health care fraud and abuse sanctions.*

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

*Sec. 211. Mandatory exclusion from participation in medicare and State health care programs.*

*Sec. 212. Establishment of minimum period of exclusion for certain individuals and entities subject to permissive exclusion from medicare and State health care programs.*

*Sec. 213. Permissive exclusion of individuals with ownership or control interest in sanctioned entities.*

*Sec. 214. Sanctions against practitioners and persons for failure to comply with statutory obligations.*

*Sec. 215. Intermediate sanctions for medicare health maintenance organizations.*

*Sec. 216. Additional exception to anti-kickback penalties for discounting and managed care arrangements.*

*Sec. 217. Criminal penalty for fraudulent disposition of assets in order to obtain medicaid benefits.*

*Sec. 218. Effective date.*

*Subtitle C—Data Collection*

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

*Subtitle D—Civil Monetary Penalties*

*Sec. 231. Social security act civil monetary penalties.*

*Sec. 232. Clarification of level of intent required for imposition of sanctions.*

*Sec. 233. Penalty for false certification for home health services.*

*Subtitle E—Revisions to Criminal Law*

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

*Subtitle F—Administrative Simplification*

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

*“PART C—ADMINISTRATIVE SIMPLIFICATION*

- “Sec. 1171. Definitions.*  
*“Sec. 1172. General requirements for adoption of standards.*  
*“Sec. 1173. Standards for information transactions and data elements.*  
*“Sec. 1174. Timetables for adoption of standards.*  
*“Sec. 1175. Requirements.*  
*“Sec. 1176. General penalty for failure to comply with requirements and standards.*  
*“Sec. 1177. Wrongful disclosure of individually identifiable health information.*  
*“Sec. 1178. Effect on State law.*  
*“Sec. 1179. Health Information Advisory Committee.*

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

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

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

9 *(a) CREDITING PERIODS OF PREVIOUS COVERAGE TO-*  
 10 *WARD PREEXISTING CONDITION RESTRICTIONS.—Subject*  
 11 *to the succeeding provisions of this section, a group health*  
 12 *plan, and an insurer or health maintenance organization*

1 offering health insurance coverage in connection with a  
2 group health plan, shall provide that any preexisting condi-  
3 tion limitation period (as defined in subsection (b)(2)) is  
4 reduced by the length of the aggregate period of qualified  
5 prior coverage (if any, as defined in subsection (b)(3)) ap-  
6 plicable to the participant or beneficiary as of the date of  
7 commencement of coverage under the plan.

8 (b) DEFINITIONS AND OTHER PROVISIONS RELATING  
9 TO PREEXISTING CONDITIONS.—

10 (1) PREEXISTING CONDITION.—

11 (A) IN GENERAL.—For purposes of this sub-  
12 title, subject to subparagraph (B), the term “pre-  
13 existing condition” means a condition, regardless  
14 of the cause of the condition, for which medical  
15 advice, diagnosis, care, or treatment was rec-  
16 ommended or received within the 6-month period  
17 ending on the day before—

18 (i) the effective date of the coverage of  
19 such participant or beneficiary, or

20 (ii) the earliest date upon which such  
21 coverage could have been effective if there  
22 were no waiting period applicable,

23 whichever is earlier.

24 (B) TREATMENT OF GENETIC INFORMA-  
25 TION.—For purposes of this section, genetic in-

1           *formation shall not be considered to be a pre-*  
2           *existing condition, so long as treatment of the*  
3           *condition to which the information is applicable*  
4           *has not been sought during the 6-month period*  
5           *described in subparagraph (A).*

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

15          (3) *AGGREGATE PERIOD OF QUALIFIED PRIOR*  
16          *COVERAGE.—*

17                 (A) *IN GENERAL.—For purposes of this sec-*  
18                 *tion, the term “aggregate period of qualified*  
19                 *prior coverage” means, with respect to com-*  
20                 *mencement of coverage of an individual under a*  
21                 *group health plan or health insurance coverage*  
22                 *offered in connection with a group health plan,*  
23                 *the aggregate of the qualified coverage periods*  
24                 *(as defined in subparagraph (B)) of such indi-*  
25                 *vidual occurring before the date of such com-*

1           *mencement. Such period shall be treated as zero*  
2           *if there is more than a 60-day break in coverage*  
3           *under a group health plan (or health insurance*  
4           *coverage offered in connection with such a plan)*  
5           *between the date the most recent qualified cov-*  
6           *erage period ends and the date of such com-*  
7           *mencement.*

8           *(B) QUALIFIED COVERAGE PERIOD.—*

9           *(i) IN GENERAL.—For purposes of this*  
10          *paragraph, subject to subsection (c), the*  
11          *term “qualified coverage period” means,*  
12          *with respect to an individual, any period of*  
13          *coverage of the individual under a group*  
14          *health plan, health insurance coverage,*  
15          *under title XVIII or XIX of the Social Secu-*  
16          *rity Act, coverage under the TRICARE pro-*  
17          *gram under chapter 55 of title 10, United*  
18          *States Code, a program of the Indian*  
19          *Health Service, and State health insurance*  
20          *coverage or risk pool, and includes coverage*  
21          *under a health plan offered under chapter*  
22          *89 of title 5, United States Code.*

23          *(ii) DISREGARDING PERIODS BEFORE*  
24          *BREAKS IN COVERAGE.—Such term does not*  
25          *include any period occurring before any 60-*

1            *day break in coverage described in subpara-*  
2            *graph (A).*

3            *(C) WAITING PERIOD NOT TREATED AS A*  
4            *BREAK IN COVERAGE.—For purposes of subpara-*  
5            *graphs (A) and (B), any period that is in a*  
6            *waiting period for any coverage under a group*  
7            *health plan (or for health insurance coverage of-*  
8            *fered in connection with a group health plan)*  
9            *shall not be considered to be a break in coverage*  
10           *described in subparagraph (B)(ii).*

11           *(D) ESTABLISHMENT OF PERIOD.—A quali-*  
12           *fied coverage period with respect to an individ-*  
13           *ual shall be established through presentation of*  
14           *certifications described in subsection (c) or in*  
15           *such other manner as may be specified in regula-*  
16           *tions to carry out this section.*

17           *(e) CERTIFICATIONS OF COVERAGE; CONFORMING COV-*  
18           *ERAGE.—*

19           *(1) IN GENERAL.—The plan administrator of a*  
20           *group health plan, or the insurer or HMO offering*  
21           *health insurance coverage in connection with a group*  
22           *health plan, shall, on request made on behalf of an in-*  
23           *dividual covered (or previously covered within the*  
24           *previous 18 months) under the plan or coverage, pro-*  
25           *vide for a certification of the period of coverage of the*

1 *individual under such plan or coverage and of the*  
2 *waiting period (if any) imposed with respect to the*  
3 *individual for any coverage under the plan.*

4 (2) *STANDARD METHOD.—Subject to paragraph*  
5 *(3), a group health plan, or insurer or HMO offering*  
6 *health insurance coverage in connection with a group*  
7 *health plan, shall determine qualified coverage periods*  
8 *under subsection (b)(3)(B) by including all periods*  
9 *described in such subsection, without regard to the*  
10 *specific benefits offered during such a period.*

11 (3) *ALTERNATIVE METHOD.—Such a plan, in-*  
12 *surer, or HMO may elect to make such determination*  
13 *on a benefit-specific basis for all participants and*  
14 *beneficiaries and not to include as a qualified cov-*  
15 *erage period with respect to a specific benefit coverage*  
16 *during a previous period unless such previous cov-*  
17 *erage for that benefit was included at the end of the*  
18 *most recent period of coverage. In the case of such an*  
19 *election—*

20 (A) *the plan, insurer, or HMO shall promi-*  
21 *nently state in any disclosure statements con-*  
22 *cerning the plan or coverage and to each enrollee*  
23 *at the time of enrollment under the plan (or at*  
24 *the time the health insurance coverage is offered*  
25 *for sale in the group health market) that the*

1            *plan or coverage has made such election and*  
 2            *shall include a description of the effect of this*  
 3            *election; and*

4            *(B) upon the request of the plan, insurer, or*  
 5            *HMO, the entity providing a certification under*  
 6            *paragraph (1)—*

7            *(i) shall promptly disclose to the re-*  
 8            *questing plan, insurer, or HMO the plan*  
 9            *statement (insofar as it relates to health*  
 10           *benefits under the plan) or other detailed*  
 11           *benefit information on the benefits available*  
 12           *under the previous plan or coverage, and*

13           *(ii) may charge for the reasonable cost*  
 14           *of providing such information.*

15    **SEC. 102. LIMITATION ON PREEXISTING CONDITION EXCLU-**  
 16                            **SIONS; NO APPLICATION TO CERTAIN**  
 17                            **NEWBORNS, ADOPTED CHILDREN, AND PREG-**  
 18                            **NANCY.**

19            *(a) LIMITATION OF PERIOD.—*

20            *(1) IN GENERAL.—Subject to the succeeding pro-*  
 21            *visions of this section, a group health plan, and an*  
 22            *insurer or HMO offering health insurance coverage in*  
 23            *connection with a group health plan, shall provide*  
 24            *that any preexisting condition limitation period (as*

1 *defined in section 101(b)(2)) does not exceed 12*  
2 *months, counting from the effective date of coverage.*

3 (2) *EXTENSION OF PERIOD IN THE CASE OF*  
4 *LATE ENROLLMENT.—In the case of a participant or*  
5 *beneficiary whose initial coverage commences after the*  
6 *date the participant or beneficiary first becomes eligi-*  
7 *ble for coverage under the group health plan, the ref-*  
8 *erence in paragraph (1) to “12 months” is deemed a*  
9 *reference to “18 months”.*

10 (b) *EXCLUSION NOT APPLICABLE TO CERTAIN*  
11 *NEWBORNS AND CERTAIN ADOPTIONS.—*

12 (1) *IN GENERAL.—Subject to paragraph (2), a*  
13 *group health plan, and an insurer or HMO offering*  
14 *health insurance coverage in connection with a group*  
15 *health plan, may not provide any limitation on bene-*  
16 *fits based on the existence of a preexisting condition*  
17 *in the case of—*

18 (A) *an individual who within the 30-day*  
19 *period beginning with the date of birth, or*

20 (B) *an adopted child or a child placed for*  
21 *adoption beginning at the time of adoption or*  
22 *placement if the individual, within the 30-day*  
23 *period beginning on the date of adoption or*  
24 *placement,*

1 *becomes covered under a group health plan or other-*  
2 *wise becomes covered under health insurance coverage*  
3 *(or covered for medical assistance under title XIX of*  
4 *the Social Security Act).*

5 (2) *LOSS IF BREAK IN COVERAGE.—Paragraph*  
6 *(1) shall no longer apply to an individual if the indi-*  
7 *vidual does not have any coverage described in section*  
8 *101(b)(3)(B)(i) for a continuous period of 60 days,*  
9 *not counting in such period any days that are in a*  
10 *waiting period for any coverage under a group health*  
11 *plan.*

12 (3) *PLACED FOR ADOPTION DEFINED.—In this*  
13 *subsection and section 103(d), the term “placement”,*  
14 *or being “placed”, for adoption, in connection with*  
15 *any placement for adoption of a child with any per-*  
16 *son, means the assumption and retention by such per-*  
17 *son of a legal obligation for total or partial support*  
18 *of such child in anticipation of adoption of such*  
19 *child. The child’s placement with such person termi-*  
20 *nates upon the termination of such legal obligation.*

21 (c) *EXCLUSION NOT APPLICABLE TO PREGNANCY.—*  
22 *For purposes of this section, pregnancy shall not be treated*  
23 *as a preexisting condition.*

24 (d) *ELIGIBILITY PERIOD IMPOSED BY HEALTH MAIN-*  
25 *TENANCE ORGANIZATIONS AS ALTERNATIVE TO PREEXIST-*

1 *ING CONDITION LIMITATION.—A health maintenance orga-*  
2 *nization which offers health insurance coverage in connec-*  
3 *tion with a group health plan and which does not use the*  
4 *preexisting condition limitations allowed under this section*  
5 *and section 101 with respect to any particular coverage op-*  
6 *tion may impose an eligibility period for such coverage op-*  
7 *tion, but only if such period does not exceed—*

8           (1) *60 days, in the case of a participant or bene-*  
9           *ficiary whose initial coverage commences at the time*  
10          *such participant or beneficiary first becomes eligible*  
11          *for coverage under the plan, or*

12           (2) *90 days, in the case of a participant or bene-*  
13          *ficiary whose initial coverage commences after the*  
14          *date on which such participant or beneficiary first be-*  
15          *comes eligible for coverage.*

16 *Such an HMO may use alternative methods, from those de-*  
17 *scribed in the previous sentence, to address adverse selection*  
18 *as approved by the applicable State authority. For purposes*  
19 *of this subsection, the term “eligibility period” means a pe-*  
20 *riod which, under the terms of the health insurance coverage*  
21 *offered by the health maintenance organization, must expire*  
22 *before the health insurance coverage becomes effective. Any*  
23 *such eligibility period shall be treated for purposes of this*  
24 *subtitle as a waiting period under the plan and shall run*

1 *concurrently with any other applicable waiting period*  
2 *under the plan.*

3 **SEC. 103. PROHIBITING EXCLUSIONS BASED ON HEALTH**  
4 **STATUS AND PROVIDING FOR ENROLLMENT**  
5 **PERIODS.**

6 *(a) PROHIBITION OF EXCLUSION OF PARTICIPANTS OR*  
7 *BENEFICIARIES BASED ON HEALTH STATUS.—*

8 *(1) IN GENERAL.—A group health plan, and an*  
9 *insurer or HMO offering health insurance coverage in*  
10 *connection with a group health plan, may not exclude*  
11 *an employee or his or her beneficiary from being (or*  
12 *continuing to be) a participant or beneficiary under*  
13 *the terms of such plan or coverage based on health*  
14 *status (as defined in section 191(c)(6)).*

15 *(2) CONSTRUCTION.—Nothing in this subsection*  
16 *shall be construed as preventing the establishment of*  
17 *preexisting condition limitations and restrictions to*  
18 *the extent consistent with the provisions of this sub-*  
19 *title.*

20 *(b) ENROLLMENT OF ELIGIBLE INDIVIDUALS WHO*  
21 *LOSE OTHER COVERAGE.—A group health plan shall per-*  
22 *mit an uncovered employee who is otherwise eligible for cov-*  
23 *erage under the terms of the plan (or an uncovered depend-*  
24 *ent, as defined under the terms of the plan, of such an em-*  
25 *ployee, if family coverage is available) to enroll for coverage*

1 *under the plan under at least one benefit option if each*  
2 *of the following conditions is met:*

3           (1) *The employee or dependent was covered*  
4 *under a group health plan or had health insurance*  
5 *coverage at the time coverage was previously offered*  
6 *to the employee or individual.*

7           (2) *The employee stated in writing at such time*  
8 *that coverage under a group health plan or health in-*  
9 *surance coverage was the reason for declining enroll-*  
10 *ment.*

11           (3) *The employee or dependent lost coverage*  
12 *under a group health plan or health insurance cov-*  
13 *erage (as a result of loss of eligibility for the coverage,*  
14 *termination of employment, or reduction in the num-*  
15 *ber of hours of employment).*

16           (4) *The employee requests such enrollment within*  
17 *30 days after the date of termination of such coverage.*

18 *(c) DEPENDENT BENEFICIARIES.—*

19           (1) *IN GENERAL.—If a group health plan makes*  
20 *family coverage available, the plan may not require,*  
21 *as a condition of coverage of an individual as a de-*  
22 *pendent (as defined under the terms of the plan) of*  
23 *a participant in the plan, a waiting period applica-*  
24 *ble to the coverage of a dependent who—*

25                   (A) *is a newborn,*

1           (B) is an adopted child or child placed for  
2           adoption (within the meaning of section  
3           102(b)(3)), at the time of adoption or placement,  
4           or

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

8           (2) *TIMELY ENROLLMENT.*—

9           (A) *IN GENERAL.*—Enrollment of a partici-  
10          pant’s beneficiary described in paragraph (1)  
11          shall be considered to be timely if a request for  
12          enrollment is made within 30 days of the date  
13          family coverage is first made available or, in the  
14          case described in—

15               (i) paragraph (1)(A), within 30 days  
16               of the date of the birth,

17               (ii) paragraph (1)(B), within 30 days  
18               of the date of the adoption or placement for  
19               adoption, or

20               (iii) paragraph (1)(C), within 30 days  
21               of the date of the marriage with such a ben-  
22               eficiary who is the spouse of the partici-  
23               pant,

24           if family coverage is available as of such date.

1           (B) *COVERAGE.*—If available coverage in-  
2           cludes family coverage and enrollment is made  
3           under such coverage on a timely basis under sub-  
4           paragraph (A), the coverage shall become effec-  
5           tive not later than the first day of the first  
6           month beginning 15 days after the date the com-  
7           pleted request for enrollment is received.

8   **SEC. 104. ENFORCEMENT.**

9           (a) *ENFORCEMENT THROUGH COBRA PROVISIONS IN*  
10 *INTERNAL REVENUE CODE.*—

11           (1) *APPLICATION OF COBRA SANCTIONS.*—Sub-  
12           section (a) of section 4980B of the Internal Revenue  
13           Code of 1986 is amended by striking “the require-  
14           ments of” and all that follows and inserting “the re-  
15           quirements of—

16           “(1) subsection (f) with respect to any qualified  
17           beneficiary, or

18           “(2) subject to subsection (h)—

19           “(A) section 101 or 102 of the Health Cov-  
20           erage Availability and Affordability Act of 1996  
21           with respect to any individual covered under the  
22           group health plan, or

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

1           (2)       *NOTICE       REQUIREMENT.*—Section  
2       4980B(f)(6)(A) of such Code is amended by inserting  
3       before the period the following: “and subtitle A of title  
4       I of the Health Coverage Availability and Afford-  
5       ability Act of 1996”.

6           (3) *SPECIAL RULES.*—Section 4980B of such  
7       Code is amended by adding at the end the following:  
8       “(h) *SPECIAL RULES.*—For purposes of applying this  
9       section in the case of requirements described in subsection  
10      (a)(2) relating to section 101, section 102, or section 103  
11      of the Health Coverage Availability and Affordability Act  
12      of 1996—

13           “(1) *DEFERRAL TO STATE REGULATION.*—No tax  
14      shall be imposed by this section on any failure to  
15      meet the requirements of such section by any entity  
16      which offers health insurance coverage and which is  
17      an insurer or health maintenance organization (as  
18      defined in section 191(c) of the Health Coverage  
19      Availability and Affordability Act of 1996) regulated  
20      by a State if the Secretary of Health and Human  
21      Services has made the determination described in sec-  
22      tion 104(c)(2) of such Act with respect to such State,  
23      section, and entity.

24           “(2) *LIMITATION FOR INSURED PLANS.*—In the  
25      case of a group health plan of a small employer (as

1 *defined in section 191 of the Health Coverage Avail-*  
2 *ability and Affordability Act of 1996) that provides*  
3 *health care benefits solely through a contract with an*  
4 *insurer or health maintenance organization (as de-*  
5 *defined in such section), no tax shall be imposed by this*  
6 *section upon the employer on a failure to meet such*  
7 *requirements if the failure is solely because of the*  
8 *product offered by the insurer or organization under*  
9 *such contract.*

10 *“(3) LIMITATION ON IMPOSITION OF TAX.—In no*  
11 *case shall a tax be imposed by this section for a fail-*  
12 *ure to meet such a requirement if a sanction has been*  
13 *imposed—*

14 *“(A) by the Secretary of Labor under part*  
15 *5 of subtitle A of title I of the Employee Retire-*  
16 *ment Income Security Act of 1974 with respect*  
17 *to such failure, or*

18 *“(B) by the Secretary of Health and*  
19 *Human Services under section 109 of the Health*  
20 *Coverage Availability and Affordability Act of*  
21 *1996 with respect to such failure.”.*

22 *(b) ENFORCEMENT THROUGH ERISA SANCTIONS FOR*  
23 *CERTAIN GROUP HEALTH PLANS.—*

24 *(1) IN GENERAL.—Subject to the succeeding pro-*  
25 *visions of this subsection, sections 101 through 103 of*

1        *this subtitle shall be deemed to be provisions of title*  
2        *I of the Employee Retirement Income Security Act of*  
3        *1974 for purposes of applying such title.*

4                (2) *FEDERAL ENFORCEMENT ONLY IF NO EN-*  
5        *FORCEMENT THROUGH STATE.—The Secretary of*  
6        *Labor shall enforce each section referred to in para-*  
7        *graph (1) with respect to any entity which is an in-*  
8        *surer or health maintenance organization regulated*  
9        *by a State only if the Secretary of Labor determines*  
10       *that—*

11                (A) *such State has not provided for enforce-*  
12        *ment of State laws which govern the same mat-*  
13        *ters as are governed by such section and which*  
14        *require compliance by such entity with at least*  
15        *the same requirements as those provided under*  
16        *such section, and*

17                (B) *such entity has failed to comply with*  
18        *such requirements of such section as are applica-*  
19        *ble to such entity.*

20                (3) *LIMITATIONS ON LIABILITY.—*

21                (A) *NO APPLICATION WHERE FAILURE NOT*  
22        *DISCOVERED EXERCISING REASONABLE DILI-*  
23        *GENCE.—No liability shall be imposed under this*  
24        *subsection on the basis of any failure during any*  
25        *period for which it is established to the satisfac-*

1            *tion of the Secretary of Labor that none of the*  
2            *persons against whom the liability would be im-*  
3            *posed knew, or exercising reasonable diligence*  
4            *would have known, that such failure existed.*

5            *(B) NO APPLICATION WHERE FAILURE COR-*  
6            *RECTED WITHIN 30 DAYS.—No liability shall be*  
7            *imposed under this subsection on the basis of*  
8            *any failure if such failure was due to reasonable*  
9            *cause and not to willful neglect, and such failure*  
10           *is corrected during the 30-day period beginning*  
11           *on the first day any of the persons against whom*  
12           *the liability would be imposed knew, or exercis-*  
13           *ing reasonable diligence would have known, that*  
14           *such failure existed.*

15           *(4) AVOIDING DUPLICATION OF CERTAIN PEN-*  
16           *ALTIES.—In no case shall a civil money penalty be*  
17           *imposed under the authority provided under para-*  
18           *graph (1) for a violation of this subtitle for which an*  
19           *excise tax has been imposed under section 4980B of*  
20           *the Internal Revenue Code of 1986 or a civil money*  
21           *penalty imposed under subsection (c).*

22           *(c) ENFORCEMENT THROUGH CIVIL MONEY PEN-*  
23           *ALTIES.—*

24           *(1) IMPOSITION.—*

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

6           (B) *LIABILITY FOR PENALTY.*—Rules simi-  
7 lar to the rules described in section 4980B(e) of  
8 the Internal Revenue Code of 1986 for liability  
9 for a tax imposed under section 4980B(a) of such  
10 Code shall apply to liability for a penalty im-  
11 posed under subparagraph (A).

12           (C) *AMOUNT OF PENALTY.*—

13           (i) *IN GENERAL.*—The maximum  
14 amount of penalty imposed under this  
15 paragraph is \$100 for each day for each in-  
16 dividual with respect to which such a fail-  
17 ure occurs.

18           (ii) *CONSIDERATIONS IN IMPOSI-*  
19 *TION.*—In determining the amount of any  
20 penalty to be assessed under this paragraph,  
21 the Secretary of Health and Human Serv-  
22 ices shall take into account the previous  
23 record of compliance of the person being as-  
24 sessed with the applicable requirements of  
25 this subtitle, the gravity of the violation,

1           *and the overall limitations for uninten-*  
2           *tional failures provided under section*  
3           *4980B(c)(4) of the Internal Revenue Code of*  
4           *1986.*

5           *(iii) LIMITATIONS.—*

6                   *(I) PENALTY NOT TO APPLY*  
7                   *WHERE FAILURE NOT DISCOVERED EX-*  
8                   *ERCISING REASONABLE DILIGENCE.—*

9                   *No civil money penalty shall be im-*  
10                   *posed under this paragraph on any*  
11                   *failure during any period for which it*  
12                   *is established to the satisfaction of the*  
13                   *Secretary that none of the persons*  
14                   *against whom the penalty would be*  
15                   *imposed knew, or exercising reasonable*  
16                   *diligence would have known, that such*  
17                   *failure existed.*

18                   *(II) PENALTY NOT TO APPLY TO*  
19                   *FAILURES CORRECTED WITHIN 30*  
20                   *DAYS.—No civil money penalty shall*  
21                   *be imposed under this paragraph on*  
22                   *any failure if such failure was due to*  
23                   *reasonable cause and not to willful ne-*  
24                   *glect, and such failure is corrected dur-*  
25                   *ing the 30-day period beginning on the*

1           *first day any of the persons against*  
2           *whom the penalty would be imposed*  
3           *knew, or exercising reasonable diligence*  
4           *would have known, that such failure*  
5           *existed.*

6           (D) *ADMINISTRATIVE REVIEW.*—

7           (i) *OPPORTUNITY FOR HEARING.*—*The*  
8           *person assessed shall be afforded an oppor-*  
9           *tunity for hearing by the Secretary upon re-*  
10          *quest made within 30 days after the date of*  
11          *the issuance of a notice of assessment. In*  
12          *such hearing the decision shall be made on*  
13          *the record pursuant to section 554 of title 5,*  
14          *United States Code. If no hearing is re-*  
15          *quested, the assessment shall constitute a*  
16          *final and unappealable order.*

17          (ii) *HEARING PROCEDURE.*—*If a hear-*  
18          *ing is requested, the initial agency decision*  
19          *shall be made by an administrative law*  
20          *judge, and such decision shall become the*  
21          *final order unless the Secretary modifies or*  
22          *vacates the decision. Notice of intent to*  
23          *modify or vacate the decision of the admin-*  
24          *istrative law judge shall be issued to the*  
25          *parties within 30 days after the date of the*

1            *decision of the judge. A final order which*  
2            *takes effect under this paragraph shall be*  
3            *subject to review only as provided under*  
4            *subparagraph (D).*

5            *(E) JUDICIAL REVIEW.—*

6            *(i) FILING OF ACTION FOR REVIEW.—*

7            *Any person against whom an order impos-*  
8            *ing a civil money penalty has been entered*  
9            *after an agency hearing under this para-*  
10           *graph may obtain review by the United*  
11           *States district court for any district in*  
12           *which such person is located or the United*  
13           *States District Court for the District of Co-*  
14           *lumbia by filing a notice of appeal in such*  
15           *court within 30 days from the date of such*  
16           *order, and simultaneously sending a copy of*  
17           *such notice be registered mail to the Sec-*  
18           *retary.*

19           *(ii) CERTIFICATION OF ADMINISTRA-*  
20           *TIVE RECORD.—The Secretary shall*  
21           *promptly certify and file in such court the*  
22           *record upon which the penalty was imposed.*

23           *(iii) STANDARD FOR REVIEW.—The*  
24           *findings of the Secretary shall be set aside*  
25           *only if found to be unsupported by substan-*

1            *tial evidence as provided by section*  
2            *706(2)(E) of title 5, United States Code.*

3            *(iv) APPEAL.—Any final decision,*  
4            *order, or judgment of such district court*  
5            *concerning such review shall be subject to*  
6            *appeal as provided in chapter 83 of title 28*  
7            *of such Code.*

8            *(F) FAILURE TO PAY ASSESSMENT; MAINTENANCE OF ACTION.—*

10            *(i) FAILURE TO PAY ASSESSMENT.—If*  
11            *any person fails to pay an assessment after*  
12            *it has become a final and unappealable*  
13            *order, or after the court has entered final*  
14            *judgment in favor of the Secretary, the Sec-*  
15            *retary shall refer the matter to the Attorney*  
16            *General who shall recover the amount as-*  
17            *essed by action in the appropriate United*  
18            *States district court.*

19            *(ii) NONREVIEWABILITY.—In such ac-*  
20            *tion the validity and appropriateness of the*  
21            *final order imposing the penalty shall not*  
22            *be subject to review.*

23            *(G) PAYMENT OF PENALTIES.—Except as*  
24            *otherwise provided, penalties collected under this*  
25            *paragraph shall be paid to the Secretary (or*

1           other officer) imposing the penalty and shall be  
2           available without appropriation and until ex-  
3           pended for the purpose of enforcing the provi-  
4           sions with respect to which the penalty was im-  
5           posed.

6           (2) *FEDERAL ENFORCEMENT ONLY IF NO EN-*  
7           *FORCEMENT THROUGH STATE.*—Paragraph (1) shall  
8           apply to enforcement of the requirements of section  
9           101, 102, or 103 with respect to any entity which of-  
10          fers health insurance coverage and which is an in-  
11          surer or HMO regulated by a State if the Secretary  
12          of Health and Human Services has determined that  
13          such State has not provided for enforcement of State  
14          laws which govern the same matters as are governed  
15          by such section and which require compliance by such  
16          entity with at least the same requirements as those  
17          provided under such section.

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

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

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

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

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

14       (a) *ISSUANCE OF COVERAGE.*—

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

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

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

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

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

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

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

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

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

21                   (1) *IN GENERAL.—In the case of an insurer that*  
22                   *offers health insurance coverage in the small group*  
23                   *market through a network plan and in the case of an*  
24                   *HMO that offers health insurance coverage in connec-*  
25                   *tion with such a plan, the insurer or HMO may—*

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

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

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

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

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

23           (2) 180-DAY SUSPENSION UPON DENIAL OF COV-  
24 ERAGE.—An insurer or HMO, upon denying health  
25 insurance coverage in any service area in accordance

1       with paragraph (1)(C), may not offer coverage in the  
2       small group market within such service area for a pe-  
3       riod of 180 days after such coverage is denied.

4       (c) *SPECIAL RULE FOR FINANCIAL CAPACITY LIM-*  
5 *ITS.—*

6           (1) *IN GENERAL.—*An insurer or HMO may  
7       deny health insurance coverage in the small group  
8       market if the insurer or HMO demonstrates to the ap-  
9       plicable State authority that—

10           (A) it does not have the financial reserves  
11       necessary to underwrite additional coverage, and

12           (B) it is applying this paragraph uni-  
13       formly to all employers without regard to the  
14       claims experience or duration of coverage of those  
15       employers and their employees (and their bene-  
16       ficiaries) or the health status of such employees  
17       and beneficiaries.

18           (2) *180-DAY SUSPENSION UPON DENIAL OF COV-*  
19 *ERAGE.—*An insurer or HMO upon denying health  
20       insurance coverage in connection with group health  
21       plans in any service area in accordance with para-  
22       graph (1) may not offer coverage in connection with  
23       group health plans in the small group market within  
24       such service area for a period of 180 days after such  
25       coverage is denied.

1           (d) *EXCEPTION TO REQUIREMENT FOR ISSUANCE OF*  
2 *COVERAGE BY REASON OF FAILURE BY PLAN TO MEET*  
3 *CERTAIN MINIMUM PARTICIPATION OR CONTRIBUTION*  
4 *RULES.—*

5           (1) *IN GENERAL.—*Subsection (a) shall not apply  
6 *in the case of any group health plan with respect to*  
7 *which—*

8                   (A) *participation rules of an insurer or*  
9 *HMO which are described in paragraph (2) are*  
10 *not met, or*

11                   (B) *contribution rules of an insurer or*  
12 *HMO which are described in paragraph (3) are*  
13 *not met.*

14           (2) *PARTICIPATION RULES.—*For purposes of  
15 *paragraph (1)(A), participation rules (if any) of an*  
16 *insurer or HMO shall be treated as met with respect*  
17 *to a group health plan only if such rules are uni-*  
18 *formly applicable and in accordance with applicable*  
19 *State law and the number or percentage of eligible in-*  
20 *dividuals who, under the plan, are participants or*  
21 *beneficiaries equals or exceeds a level which is deter-*  
22 *mined in accordance with such rules.*

23           (3) *CONTRIBUTION RULES.—*For purposes of  
24 *paragraph (1)(B), contribution rules (if any) of an*  
25 *insurer or HMO shall be treated as met with respect*

1       to a group health plan only if such rules are in ac-  
2       cordance with applicable State law.

3       **SEC. 132. GUARANTEED RENEWABILITY OF GROUP COV-**  
4       **ERAGE.**

5       (a) *IN GENERAL.*—*Except as provided in this section,*  
6       *if an insurer or health maintenance organization offers*  
7       *health insurance coverage in the small or large group mar-*  
8       *ket, the insurer or organization must renew or continue in*  
9       *force such coverage at the option of the employer.*

10      (b) *GENERAL EXCEPTIONS.*—*An insurer or organiza-*  
11      *tion may nonrenew or discontinue health insurance cov-*  
12      *erage offered an employer based only on one or more of the*  
13      *following:*

14           (1) *NONPAYMENT OF PREMIUMS.*—*The employer*  
15           *has failed to pay premiums or contributions in ac-*  
16           *cordance with the terms of the health insurance cov-*  
17           *erage or the insurer or organization has not received*  
18           *timely premium payments.*

19           (2) *FRAUD.*—*The employer has performed an act*  
20           *or practice that constitutes fraud or made an inten-*  
21           *tional misrepresentation of material fact under the*  
22           *terms of the coverage.*

23           (3) *VIOLATION WITH PARTICIPATION OR CON-*  
24           *TRIBUTION RULES.*—*The employer has failed to com-*  
25           *ply with a material plan provision relating to par-*

1        *icipation or contribution rules in accordance with*  
2        *section 131(d).*

3            (4) *TERMINATION OF PLAN.*—*Subject to sub-*  
4        *section (c), the insurer or organization is ceasing to*  
5        *offer coverage in the small or large group market in*  
6        *a State (or, in the case of a network plan or HMO,*  
7        *in a geographic area).*

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

15 *Paragraph (5) shall apply to an insurer or HMO only if*  
16 *it is applied uniformly without regard to the claims experi-*  
17 *ence of employers and their employees (and their bene-*  
18 *ficiaries) or the health status of such employees and bene-*  
19 *ficiaries.*

20            (c) *EXCEPTIONS FOR UNIFORM TERMINATION OF COV-*  
21 *ERAGE.*—

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

1        *market, coverage of such type may be discontinued by*  
2        *the insurer or organization only if—*

3                *(A) the insurer or organization provides no-*  
4                *tice to each employer provided coverage of this*  
5                *type in such market (and participants and bene-*  
6                *ficiaries covered under such coverage) of such*  
7                *discontinuation at least 90 days prior to the*  
8                *date of the discontinuation of such coverage;*

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

16                *(C) in exercising the option to discontinue*  
17                *coverage of this type and in offering one or more*  
18                *replacement coverage, the insurer or organization*  
19                *acts uniformly without regard to the health sta-*  
20                *tus or insurability of participants or bene-*  
21                *ficiaries covered or new participants or bene-*  
22                *ficiaries who may become eligible for such cov-*  
23                *erage.*

24                *(2) DISCONTINUANCE OF ALL COVERAGE.—*

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

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

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

21           (B) *PROHIBITION ON MARKET REENTRY.*—  
22           In the case of a discontinuation under subpara-  
23           graph (A) in one or both markets, the insurer or  
24           organization may not provide for the issuance of  
25           any health insurance coverage in the market and

1           State involved during the 5-year period begin-  
2           ning on the date of the discontinuation of the  
3           last health insurance coverage not so renewed.

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

10    **PART 2—AVAILABILITY OF INDIVIDUAL HEALTH**  
11                            **INSURANCE COVERAGE**

12    **SEC. 141. GUARANTEED AVAILABILITY OF INDIVIDUAL**  
13                            **HEALTH INSURANCE COVERAGE TO CERTAIN**  
14                            **INDIVIDUALS WITH PRIOR GROUP COVERAGE.**

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

16                   (1) to guarantee that any qualifying individual  
17                   (as defined in subsection (b)(1)) is able to obtain  
18                   qualifying coverage (as defined in subsection (b)(2));  
19                   and

20                   (2) to assure that qualifying individuals obtain-  
21                   ing such coverage receive credit for their prior cov-  
22                   erage toward the new coverage’s preexisting condition  
23                   exclusion period (if any) in a manner consistent with  
24                   subsection (b)(3).

1           **(b) QUALIFYING INDIVIDUAL AND HEALTH INSURANCE**

2 *COVERAGE DEFINED.—In this section—*

3           **(1) QUALIFYING INDIVIDUAL.—***The term “quali-*  
4 *fying individual” means an individual—*

5                   **(A) who is in a qualified coverage period**  
6 *(as defined in section 101(b)(3)(C)) that—*

7                           **(i) includes coverage under one or more**  
8 *group health plans, and*

9                                   **(ii) commenced 18 or more months be-**  
10 *fore the date on which the individual seeks*  
11 *coverage under this section;*

12                                   **(B) is not eligible for coverage under (i) a**  
13 *group health plan, (ii) part A or part B of title*  
14 *XVIII of the Social Security Act, or (iii) a State*  
15 *plan under title XIX of such Act (or any succes-*  
16 *sor program);*

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

22                                   **(D) if the individual had been offered the**  
23 *option of continuation coverage under a COBRA*  
24 *continuation provision or under a similar State*  
25 *program, elected such coverage;*

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

4           (F) who does not have individual health in-  
5           surance coverage; and

6           (G) whose most recent prior coverage either  
7           (i) was under a group health plan, governmental  
8           plan, or church plan (or health insurance cov-  
9           erage offered in connection with any such plan),  
10          or (ii) was not under such a plan (or such cov-  
11          erage) but was terminated involuntarily because  
12          of the withdrawal of the plan or coverage, move-  
13          ment out of a service area, or similar involun-  
14          tary reasons.

15          (2) *QUALIFYING COVERAGE.*—

16               (A) *IN GENERAL.*—The term “qualifying  
17               coverage” means, with respect to an insurer or  
18               HMO in relation to an qualifying individual,  
19               individual health insurance coverage for which  
20               the actuarial value of the benefits is not less  
21               than—

22                       (i) the weighted average actuarial  
23                       value of the benefits provided by all the in-  
24                       dividual health insurance coverage issued  
25                       by the insurer or HMO in the State during

1           the previous year (not including coverage  
2           issued under this section), or

3                   (ii) the weighted average of the actuarial  
4           value of the benefits provided by all the  
5           individual health insurance coverage issued  
6           by all insurers and HMOs in the State during  
7           the previous year (not including coverage  
8           issued under this section),

9           as elected by the plan or by the State under subsection  
10          (c)(1).

11                   (B) ASSUMPTIONS.—For purposes of subparagraph  
12          (A), the actuarial value of benefits provided under individual  
13          health insurance coverage shall be calculated based on a  
14          standardized population and a set of standardized utilization  
15          and cost factors.

16                   (3) CREDITING FOR PREVIOUS COVERAGE.—  
17          Crediting is consistent with this paragraph only if  
18          any preexisting condition exclusion period is reduced  
19          at least to the extent such a period would be reduced  
20          if the coverage under this section were under a group  
21          health plan to which section 101(a) applies. In carrying  
22          out this subsection, provisions similar to the provisions  
23          of section 101(c) shall apply.  
24

1           (c) *OPTIONAL STATE ESTABLISHMENT OF MECHA-*  
2 *NISMS TO ACHIEVE GOALS OF GUARANTEEING AVAILABIL-*  
3 *ITY OF COVERAGE.—*

4           (1) *IN GENERAL.—Any State may establish pub-*  
5 *lic or private mechanisms reasonably designed to*  
6 *meet the goals specified in subsection (a). If a State*  
7 *implements such a mechanism by the deadline speci-*  
8 *fied in paragraph (4), the State may elect to have*  
9 *such mechanisms apply instead of having subsection*  
10 *(d) apply in the State. An election under this para-*  
11 *graph shall be by notice to the Secretary of Health*  
12 *and Human Services on a timely basis consistent*  
13 *with the deadlines specified in paragraph (4). In es-*  
14 *tablishing what is qualifying coverage under such a*  
15 *mechanism under this subsection, a State may exer-*  
16 *cise the election described in subsection (b)(2)(A) with*  
17 *respect to each insurer or HMO in the State (or on*  
18 *a collective basis after exercising such election for each*  
19 *such insurer or HMO).*

20           (2) *TYPES OF MECHANISMS.—State mechanisms*  
21 *under this subsection may include one or more (or a*  
22 *combination) of the following:*

23                   (A) *Health insurance coverage pools or pro-*  
24                   *grams authorized or established by the State.*

25                   (B) *Mandatory group conversion policies.*

1           (C) *Guaranteed issue of one or more plans*  
2           *of individual health insurance coverage to quali-*  
3           *fying individuals.*

4           (D) *Open enrollment by one or more insur-*  
5           *ers or HMOs.*

6           *The mechanisms described in the previous sentence*  
7           *are not an exclusive list of the mechanisms (or com-*  
8           *binations of mechanisms) that may be used under this*  
9           *subsection.*

10           (3) *SAFE HARBOR FOR BENEFITS UNDER CUR-*  
11           *RENT RISK POOLS.—In the case of a State that has*  
12           *a health insurance coverage pool or risk pool in effect*  
13           *on March 12, 1996, and that implements the mecha-*  
14           *nism described in paragraph (2)(A), the benefits*  
15           *under such mechanism (or benefits the actuarial value*  
16           *of which is not less than the actuarial value of such*  
17           *current benefits, using the assumptions described in*  
18           *subsection (b)(2)(B)) are deemed, for purposes of this*  
19           *section, to constitute qualified coverage.*

20           (4) *DEADLINE FOR STATE IMPLEMENTATION.—*

21           (A) *IN GENERAL.—Subject to subparagraph*  
22           *(B), the deadline under this paragraph is July*  
23           *1, 1997.*

24           (B) *EXTENSION TO PERMIT LEGISLATION.—*

25           *The deadline under this paragraph is July 1,*

1           1998, in the case of a State the legislature of  
2           which does not have a regular legislative session  
3           at any time between January 1, 1997, and June  
4           30, 1997.

5           (C) CONSTRUCTION.—Nothing in this sec-  
6           tion shall be construed as preventing a State  
7           from—

8                   (i) implementing guaranteed availabil-  
9                   ity mechanisms before the deadline,

10                   (ii) continuing in effect mechanisms  
11                   that are in effect before the date of the en-  
12                   actment of this Act,

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

15                   (iv) offering guaranteed availability of  
16                   coverage to individuals who are not qualify-  
17                   ing individuals.

18           (d) FALLBACK PROVISIONS.—

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

24                   (2) PRELIMINARY DETERMINATION AFTER STATE  
25                   ELECTION.—If—

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

3           (B) the Secretary finds, after consultation  
4           with the chief executive officer of the State and  
5           the insurance commissioner or chief insurance  
6           regulatory official of the State, that such a mech-  
7           anism (for which notice was provided) is not  
8           reasonably designed to meet the goals specified in  
9           subsection (a),

10          the Secretary shall notify the State of such prelimi-  
11          nary determination, of the consequences under para-  
12          graph (3) of a failure to implement such a mecha-  
13          nism, and permit the State a reasonable opportunity  
14          in which to modify the mechanism (or to adopt an-  
15          other mechanism) that is reasonably designed to meet  
16          the goals specified in subsection (a). If, after provid-  
17          ing such notice and opportunity, the Secretary finds  
18          that the State has not implemented such a mecha-  
19          nism, the Secretary shall notify the State that para-  
20          graph (3) will be applied in the State.

21               (3) *DESCRIPTION OF FALLBACK MECHANISM.*—  
22          As provided under paragraphs (1) and (2) and sub-  
23          ject to paragraph (5), each insurer or HMO in the  
24          State involved that issues individual health insurance  
25          coverage—

1           (A) shall offer qualifying health insurance  
2 coverage, in which qualifying individuals obtain-  
3 ing such coverage receive credit for their prior  
4 coverage toward the new coverage's preexisting  
5 condition exclusion period (if any) in a manner  
6 consistent with subsection (b)(3), to each qualify-  
7 ing individual in the State, and

8           (B) may not decline to issue such coverage  
9 to such an individual based on health status (ex-  
10 cept as permitted under paragraph (4)).

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

18           (5) *TERMINATION OF FALLBACK MECHANISM.*—  
19 The provisions of this subsection shall cease to apply  
20 to a State if the Secretary finds that a State has im-  
21 plemented a mechanism that is reasonably designed to  
22 meet the goals specified in subsection (a), and until  
23 the Secretary finds that such mechanism is no longer  
24 being implemented.

25           (e) *CONSTRUCTION.*—

1           (1) *PREMIUMS.*—*Nothing in this section shall be*  
2 *construed to affect the determination of an insurer or*  
3 *HMO as to the amount of the premium payable*  
4 *under an individual health insurance coverage under*  
5 *applicable state law.*

6           (2) *MARKET REQUIREMENTS.*—

7           (A) *IN GENERAL.*—*The provisions of sub-*  
8 *section (a) shall not be construed to require that*  
9 *an insurer or HMO offering health insurance*  
10 *coverage only in connection with a group health*  
11 *plan or an association offer individual health in-*  
12 *surance coverage.*

13           (B) *CONVERSION POLICIES.*—*An insurer or*  
14 *HMO offering health insurance coverage in con-*  
15 *nection with a group health plan under subtitle*  
16 *A shall not be deemed to be an insurer or HMO*  
17 *offering an individual health insurance coverage*  
18 *solely because such insurer or HMO offers a con-*  
19 *version policy.*

20           (3) *DISREGARD OF ASSOCIATION COVERAGE.*—  
21 *An insurer or HMO that offers health insurance cov-*  
22 *erage only in connection with a group health plan or*  
23 *in connection with individuals based on affiliation*  
24 *with one or more associations is not considered, for*

1        *purposes of this subtitle, to be offering individual*  
2        *health insurance coverage.*

3            (4) *MARKETING OF PLANS.*—*Nothing in this sec-*  
4        *tion shall be construed to prevent a State from requir-*  
5        *ing insurer or HMOs offering individual health in-*  
6        *surance coverage to actively market such coverage.*

7        **SEC. 142. GUARANTEED RENEWABILITY OF INDIVIDUAL**  
8            **HEALTH INSURANCE COVERAGE.**

9            (a) *GUARANTEED RENEWABILITY.*—*Subject to the suc-*  
10        *ceeding provisions of this section, an insurer or HMO that*  
11        *provides individual health insurance coverage to an indi-*  
12        *vidual shall renew or continue such coverage at the option*  
13        *of the individual.*

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

18            (1) *NONPAYMENT.*—*The individual fails to pay*  
19        *payment of premiums or contributions in accordance*  
20        *with the terms of the coverage or the insurer or orga-*  
21        *nization has not failed to receive timely premium*  
22        *payments.*

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

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

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

8            (4) *MOVEMENT OUTSIDE SERVICE AREA.—The*  
9        *individual has changed residence and resides outside*  
10       *the service area of the insurer or organization or out-*  
11       *side the area for which the insurer or organization is*  
12       *authorized to do business.*

13 *Paragraph (4) shall apply to an insurer or HMO only if*  
14 *it is applied uniformly without regard to the claims experi-*  
15 *ence of employers and their employees (and their bene-*  
16 *ficiaries) or the health status of such employees and bene-*  
17 *ficiaries.*

18        (c) *TERMINATION OF INDIVIDUAL COVERAGE.—The*  
19 *provisions of section 132(c) shall apply to this section in*  
20 *the same manner as they apply under section 132, except*  
21 *that any reference to an employer or market is deemed a*  
22 *reference to the a covered individual or the individual mar-*  
23 *ket, respectively.*

24        (d) *EXCEPTION FOR UNIFORM MODIFICATION OF COV-*  
25 *ERAGE.—The provisions of section 132(d) shall apply to in-*

1 *dividual health insurance coverage in the individual market*  
2 *under this section in the same manner as it applies to*  
3 *health insurance coverage offered in connection with a*  
4 *group health plan in the group market under such section.*

5 ***PART 3—ENFORCEMENT***

6 ***SEC. 151. INCORPORATION OF PROVISIONS FOR STATE EN-***  
7 ***FORCEMENT WITH FEDERAL FALLBACK AU-***  
8 ***THORITY.***

9 *The provisions of paragraphs (1) and (2) of section*  
10 *104(c) shall apply to enforcement of requirements in each*  
11 *section in part 1 or part 2 with respect to insurers and*  
12 *HMOs regulated by a State in the same manner as such*  
13 *provisions apply to enforcement of requirements in section*  
14 *101, 102, or 103 with respect to insurers and HMOs regu-*  
15 *lated by a State.*

16 ***Subtitle C—Sense of Committee on***  
17 ***Additional Requirements***

18 ***SEC. 161. SENSE OF COMMITTEE ON COMMERCE ON ADDI-***  
19 ***TIONAL REQUIREMENTS.***

20 *(a) FINDINGS.—The Committee on Commerce of the*  
21 *House of Representatives finds the following:*

22 *(1) The National Cancer Institute has stated*  
23 *that sufficient data do not exist to support wide-*  
24 *spread clinical applicability of autologous bone mar-*

1 *row transplants and high dosage chemotherapy for*  
2 *treatment of breast cancer.*

3 *(2) In relation to mandatory hospital stays for*  
4 *child birth, several studies have shown little associa-*  
5 *tion between initial hospital stays and subsequent*  
6 *hospital stays. For example, a review of 20,000 inpa-*  
7 *tient deliveries found no connection between the length*  
8 *of stay and a newborn's likelihood of developing*  
9 *health problems. Another study that tracked readmis-*  
10 *sion rates to 275,000 discharges showed no statis-*  
11 *tically significant differences for those who had hos-*  
12 *pital stays of 24 hours or less.*

13 *(b) SENSE OF COMMITTEE.—It is the sense of the Com-*  
14 *mittee on Commerce of the House of Representatives that—*

15 *(1) the impact, on health care costs and the pro-*  
16 *vision of necessary quality health services, of mandat-*  
17 *ing the inclusion in health insurance coverage and*  
18 *group health plans of bone marrow transplants for*  
19 *treatment of breast cancer and of minimum periods*  
20 *of inpatient care for child birth has not been evalu-*  
21 *ated;*

22 *(2) there is no legislative precedent for Congress*  
23 *requiring the coverage of specific benefits under pri-*  
24 *vate and State health insurance plans; and*

1           (3) *it is the intent of the Committee to conduct*  
2           *one or more hearings to examine issues relating to re-*  
3           *quiring the inclusion of benefits under group health*  
4           *plans and health insurance coverage offered in the*  
5           *group and individual markets.*

6           ***Subtitle D—Definitions; General***  
7                                   ***Provisions***

8           ***SEC. 191. DEFINITIONS; SCOPE OF COVERAGE.***

9           (a) *GROUP HEALTH PLAN.—*

10           (1) *DEFINITION.—Subject to the succeeding pro-*  
11           *visions of this subsection and subsection (d)(1), the*  
12           *term “group health plan” means an employee welfare*  
13           *benefit plan to the extent that the plan provides medi-*  
14           *cal care (as defined in subsection (c)(9)) to employees*  
15           *or their dependents (as defined under the terms of the*  
16           *plan) directly or through insurance, reimbursement,*  
17           *or otherwise, and includes a group health plan (with-*  
18           *in the meaning of section 5000(b)(1) of the Internal*  
19           *Revenue Code of 1986).*

20           (2) *LIMITATION OF REQUIREMENTS TO PLANS*  
21           *WITH 2 OR MORE EMPLOYEE PARTICIPANTS.—The re-*  
22           *quirements of subtitle A and part 1 of subtitle B shall*  
23           *apply in the case of a group health plan for any plan*  
24           *year, or for health insurance coverage offered in con-*  
25           *nection with a group health plan for a year, only if*

1        *the group health plan has two or more participants*  
2        *as current employees on the first day of the plan year.*

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

10           (4) *TREATMENT OF CHURCH PLANS.—*

11                (A) *EXCLUSION.—The requirements of this*  
12        *title insofar as they apply to group health plans*  
13        *shall not apply to church plans.*

14                (B) *OPTIONAL DISREGARD IN DETERMINING*  
15        *PERIOD OF COVERAGE.—For purposes of apply-*  
16        *ing section 101(b)(3)(B)(i), a group health plan*  
17        *may elect to disregard periods of coverage of an*  
18        *individual under a church plan that, pursuant*  
19        *to subparagraph (A), is not subject to the re-*  
20        *quirements of this title.*

21           (5) *TREATMENT OF GOVERNMENTAL PLANS.—*

22                (A) *ELECTION TO BE EXCLUDED.—If the*  
23        *plan sponsor of a governmental plan which is a*  
24        *group health plan to which the provisions of this*  
25        *subtitle otherwise apply makes an election under*

1           *this paragraph for any specified period (in such*  
2           *form and manner as the Secretary of Health and*  
3           *Human Services may by regulations prescribe),*  
4           *then the requirements of this title insofar as they*  
5           *apply to group health plans shall not apply to*  
6           *such governmental plans for such period.*

7           *(B) OPTIONAL DISREGARD IN DETERMINING*  
8           *PERIOD OF COVERAGE IF ELECTION MADE.—For*  
9           *purposes of applying section 101(b)(3)(B)(i), a*  
10          *group health plan may elect to disregard periods*  
11          *of coverage of an individual under a govern-*  
12          *mental plan that, under an election under sub-*  
13          *paragraph (A), is not subject to the requirements*  
14          *of this title.*

15          *(6) TREATMENT OF MEDICAID PLAN AS GROUP*  
16          *HEALTH PLAN.—A State plan under title XIX of the*  
17          *Social Security Act shall be treated as a group health*  
18          *plan for purposes of applying section 101(c)(1), un-*  
19          *less the State elects not to be so treated.*

20          *(7) TREATMENT OF MEDICARE AND INDIAN*  
21          *HEALTH SERVICE PROGRAMS AS GROUP HEALTH*  
22          *PLAN.—Title XVIII of the Social Security Act and a*  
23          *program of the Indian Health Service shall be treated*  
24          *as a group health plan for purposes of applying sec-*  
25          *tion 101(c)(1).*

1           (b) *INCORPORATION OF CERTAIN DEFINITIONS IN EM-*  
2 *PLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.*—  
3 *Except as provided in this section, the terms “beneficiary”,*  
4 *“church plan”, “employee”, “employee welfare benefit*  
5 *plan”, “employer”, “governmental plan”, “multiemployer*  
6 *plan”, “multiple employer welfare arrangement”, “partici-*  
7 *pant”, “plan sponsor”, and “State” have the meanings*  
8 *given such terms in section 3 of the Employee Retirement*  
9 *Income Security Act of 1974.*

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

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

18                   (2) *BONA FIDE ASSOCIATION.*—*The term “bona*  
19 *fide association” means an association which—*

20                           (A) *has been actively in existence for at*  
21 *least 5 years,*

22                           (B) *has been formed and maintained in*  
23 *good faith for purposes other than obtaining in-*  
24 *surance,*

1           (C) does not condition membership in the  
2           association on health status,

3           (D) makes health insurance coverage offered  
4           through the association available to all members  
5           regardless of health status,

6           (E) does not make health insurance coverage  
7           offered through the association available to any  
8           individual who is not a member (or dependent  
9           of a member) of the association at the time the  
10          coverage is initially issued,

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

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

20          (3) *COBRA CONTINUATION PROVISION.*—The  
21          term “COBRA continuation provision” means any of  
22          the following:

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

1           (B) Part 6 of subtitle B of title I of the Em-  
2           ployee Retirement Income Security Act of 1974  
3           (29 U.S.C. 1161 et seq.), other than section 609.

4           (C) Title XXII of the Public Health Service  
5           Act.

6           (4) HEALTH INSURANCE COVERAGE.—

7           (A) IN GENERAL.—Except as provided in  
8           subparagraph (B), the term “health insurance  
9           coverage” means benefits consisting of medical  
10          care (provided directly, through insurance or re-  
11          imbursement, or otherwise) under any hospital  
12          or medical service policy or certificate, hospital  
13          or medical service plan contract, or health main-  
14          tenance organization group contract offered by  
15          an insurer or a health maintenance organiza-  
16          tion.

17          (B) EXCEPTION.—Such term does not in-  
18          clude coverage under any separate policy, certifi-  
19          cate, or contract only for one or more of any of  
20          the following:

21               (i) Coverage for accident, credit-only,  
22               vision, disability income, long-term care,  
23               nursing home care, community-based care  
24               dental, on-site medical clinics, or employee

1           *assistance programs, or any combination*  
2           *thereof.*

3           *(ii) Medicare supplemental health in-*  
4           *surance (within the meaning of section*  
5           *1882(g)(1) of the Social Security Act (42*  
6           *U.S.C. 1395ss(g)(1))) and similar supple-*  
7           *mental coverage provided under a group*  
8           *health plan.*

9           *(iii) Coverage issued as a supplement*  
10          *to liability insurance.*

11          *(iv) Liability insurance, including*  
12          *general liability insurance and automobile*  
13          *liability insurance.*

14          *(v) Workers' compensation or similar*  
15          *insurance.*

16          *(vi) Automobile medical-payment in-*  
17          *surance.*

18          *(vii) Coverage consisting of benefit*  
19          *payments made on a periodic basis for a*  
20          *specified disease or illness or period of hos-*  
21          *pitalization, without regard to the costs in-*  
22          *curring or services rendered during the pe-*  
23          *riod to which the payments relate.*

24          *(viii) Short-term limited duration in-*  
25          *surance.*

1                   *(ix) Such other coverage, comparable to*  
2                   *that described in previous clauses, as may*  
3                   *be specified in regulations prescribed under*  
4                   *this title.*

5                   (5) *HEALTH MAINTENANCE ORGANIZATION;*  
6                   *HMO.—The terms “health maintenance organization”*  
7                   *and “HMO” mean—*

8                   (A) *a Federally qualified health mainte-*  
9                   *nance organization (as defined in section*  
10                   *1301(a) of the Public Health Service Act (42*  
11                   *U.S.C. 300e(a))),*

12                   (B) *an organization recognized under State*  
13                   *law as a health maintenance organization, or*

14                   (C) *a similar organization regulated under*  
15                   *State law for solvency in the same manner and*  
16                   *to the same extent as such a health maintenance*  
17                   *organization,*

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

22                   (6) *HEALTH STATUS.—The term “health status”*  
23                   *includes, with respect to an individual, medical con-*  
24                   *dition, claims experience, receipt of health care, medi-*  
25                   *cal history, genetic information, evidence of insurabil-*

1        *ity (including conditions arising out of acts of domes-*  
2        *tic violence), or disability.*

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

10           (8) *INSURER.—The term “insurer” means an in-*  
11        *surance company, insurance service, or insurance or-*  
12        *ganization which is licensed to engage in the business*  
13        *of insurance in a State and (except for purposes of*  
14        *part 2 of subtitle B) which is regulated by a State*  
15        *(within the meaning of section 514(b)(2)(A) of the*  
16        *Employee Retirement Income Security Act of 1974).*

17           (9) *MEDICAL CARE.—The term “medical care”*  
18        *means—*

19                (A) *amounts paid for, or items or services*  
20                *in the form of, the diagnosis, cure, mitigation,*  
21                *treatment, or prevention of disease, or amounts*  
22                *paid for, or items or services provided for, the*  
23                *purpose of affecting any structure or function of*  
24                *the body,*

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

5           (C) amounts paid for insurance covering  
6           medical care referred to in subparagraphs (A)  
7           and (B).

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

15          (11) WAITING PERIOD.—The term “waiting pe-  
16          riod” means, with respect to a group health plan and  
17          an individual who is a potential participant or bene-  
18          ficiary in the plan, the minimum period that must  
19          pass with respect to the individual before the individ-  
20          ual is eligible to be covered for benefits under the  
21          plan.

22          (d) TREATMENT OF PARTNERSHIPS.—

23                 (1) TREATMENT AS A GROUP HEALTH PLAN.—  
24                 Any plan, fund, or program which would not be (but  
25                 for this paragraph) an employee welfare benefit plan

1        *and which is established or maintained by a partner-*  
2        *ship, to the extent that such plan, fund, or program*  
3        *provides medical care to present or former partners*  
4        *in the partnership or to their dependents (as defined*  
5        *under the terms of the plan, fund, or program), di-*  
6        *rectly or through insurance, reimbursement, or other-*  
7        *wise, shall be treated (subject to paragraph (1)) as an*  
8        *employee welfare benefit plan which is a group health*  
9        *plan.*

10            (2) *TREATMENT OF PARTNERSHIP AND PART-*  
11            *NERS AND EMPLOYER AND PARTICIPANTS.—In the*  
12            *case of a group health plan—*

13                    (A) *the term “employer” includes the part-*  
14                    *nership in relation to any partner; and*

15                    (B) *the term “participant” includes—*

16                            (i) *in connection with a group health*  
17                            *plan maintained by a partnership, an indi-*  
18                            *vidual who is a partner in relation to the*  
19                            *partnership, or*

20                            (ii) *in connection with a group health*  
21                            *plan maintained by a self-employed indi-*  
22                            *vidual (under which one or more employees*  
23                            *are participants), the self-employed individ-*  
24                            *ual,*

1           *if such individual is or may become eligible to*  
2           *receive a benefit under the plan or such individ-*  
3           *ual's beneficiaries may be eligible to receive any*  
4           *such benefit.*

5           *(e) DEFINITIONS RELATING TO MARKETS AND SMALL*  
6           *EMPLOYERS.—As used in this title:*

7           *(1) INDIVIDUAL MARKET.—The term “individual*  
8           *market” means the market for health insurance cov-*  
9           *erage offered to individuals and not to employers or*  
10           *in connection with a group health plan and does not*  
11           *include the market for such coverage issued only by*  
12           *an insurer or HMO that makes such coverage avail-*  
13           *able only on the basis of affiliation with a bona fide*  
14           *association (as defined in subsection (c)(2)).*

15           *(2) LARGE GROUP MARKET.—The term “large*  
16           *group market” means the market for health insurance*  
17           *coverage offered to employers (other than small em-*  
18           *ployers) on behalf of their employees (and their de-*  
19           *pendents) and does not include health insurance cov-*  
20           *erage available solely in connection with a bona fide*  
21           *association (as defined in subsection (c)(2)).*

22           *(3) SMALL EMPLOYER.—The term “small em-*  
23           *ployer” means, in connection with a group health*  
24           *plan with respect to a calendar year, an employer*  
25           *who employs at least 2 but fewer than 51 employees*

1        *on a typical business day in the year. For purposes*  
2        *of this paragraph, two or more trades or businesses,*  
3        *whether or not incorporated, shall be deemed a single*  
4        *employer if such trades or businesses are within the*  
5        *same control group (within the meaning of section*  
6        *3(40)(B)(ii) of the Employee Retirement Income Se-*  
7        *curity Act of 1974.*

8                (4) *SMALL GROUP MARKET.—The term “small*  
9        *group market” means the health insurance market*  
10        *under which individuals obtain health insurance cov-*  
11        *erage (directly or through any arrangement) on behalf*  
12        *of themselves (and their dependents) on the basis of*  
13        *employment or other relationship with respect to a*  
14        *small employer and does not include health insurance*  
15        *coverage available solely in connection with a bona*  
16        *fide association (as defined in subsection (c)(2)).*

17        **SEC. 192. STATE FLEXIBILITY TO PROVIDE GREATER PRO-**  
18                **TECTION.**

19                (a) *STATE FLEXIBILITY TO PROVIDE GREATER PRO-*  
20        *TECTION.—Subject to subsection (b), nothing in this title*  
21        *shall be construed to preempt State laws that require insur-*  
22        *ers or HMOs—*

23                (1) *to impose a limitation or exclusion of bene-*  
24        *fits relating to the treatment of a preexisting condi-*

1        *tion for a period that is shorter than the applicable*  
2        *period provided for under this title;*

3            *(2) to allow individuals, participants, and bene-*  
4        *ficiaries to be considered to be in a period of previous*  
5        *qualifying coverage if such individual, participant, or*  
6        *beneficiary experiences a lapse in coverage that is*  
7        *greater than the 60-day periods provided for under*  
8        *sections 101(b)(3)(A), 101(b)(3)(B)(ii), and 102(b)(2);*  
9        *or*

10           *(3) in defining “pre-existing condition” to have*  
11        *a look-back period that is shorter than the 6-month*  
12        *period described in section 101(b)(1)(A).*

13        *(b) NO OVERRIDE OF ERISA PREEMPTION.—Nothing*  
14        *in this Act shall be construed to affect or modify the provi-*  
15        *sions of section 514 of the Employee Retirement Income Se-*  
16        *curity Act of 1974 (29 U.S.C. 1144).*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 *“FRAUD AND ABUSE CONTROL PROGRAM*

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

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

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

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

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

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

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

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

1           “(3) *GUIDELINES.*—

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

8                   “(B) *INFORMATION GUIDELINES.*—

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

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

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

1           *liability) shall apply to a person providing*  
2           *information to the Secretary or the Attor-*  
3           *ney General in conjunction with their per-*  
4           *formance of duties under this section.*

5           “(4) *ENSURING ACCESS TO DOCUMENTATION.—*  
6           *The Inspector General of the Department of Health*  
7           *and Human Services is authorized to exercise such*  
8           *authority described in paragraphs (3) through (9) of*  
9           *section 6 of the Inspector General Act of 1978 (5*  
10          *U.S.C. App.) as necessary with respect to the activi-*  
11          *ties under the fraud and abuse control program estab-*  
12          *lished under this subsection.*

13          “(5) *AUTHORITY OF INSPECTOR GENERAL.—*  
14          *Nothing in this Act shall be construed to diminish the*  
15          *authority of any Inspector General, including such*  
16          *authority as provided in the Inspector General Act of*  
17          *1978 (5 U.S.C. App.).*

18          “(b) *ADDITIONAL USE OF FUNDS BY INSPECTOR GEN-*  
19          *ERAL.—*

20          “(1) *REIMBURSEMENTS FOR INVESTIGATIONS.—*  
21          *The Inspector General of the Department of Health*  
22          *and Human Services is authorized to receive and re-*  
23          *tain for current use reimbursement for the costs of*  
24          *conducting investigations and audits and for mon-*  
25          *itoring compliance plans when such costs are ordered*

1       *by a court, voluntarily agreed to by the payor, or oth-*  
2       *erwise.*

3               “(2) *CREDITING.*—*Funds received by the Inspec-*  
4       *tor General under paragraph (1) as reimbursement*  
5       *for costs of conducting investigations shall be depos-*  
6       *ited to the credit of the appropriation from which ini-*  
7       *tially paid, or to appropriations for similar purposes*  
8       *currently available at the time of deposit, and shall*  
9       *remain available for obligation for 1 year from the*  
10       *date of the deposit of such funds.*

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

15                   “(1) *a policy of health insurance;*

16                   “(2) *a contract of a service benefit organization;*

17       *and*

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

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

1       “(k) *HEALTH CARE FRAUD AND ABUSE CONTROL AC-*  
2 *COUNT.—*

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

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

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

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

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

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

21               “(B) *AUTHORIZATION TO ACCEPT GIFTS.—*  
22 *The Trust Fund is authorized to accept on behalf*  
23 *of the United States money gifts and bequests*  
24 *made unconditionally to the Trust Fund, for the*

1           *benefit of the Account or any activity financed*  
2           *through the Account.*

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

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

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

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

21                  “(iv) *Penalties and damages obtained*  
22                  *and otherwise creditable to miscellaneous re-*  
23                  *ceipts of the general fund of the Treasury*  
24                  *obtained under sections 3729 through 3733*  
25                  *of title 31, United States Code (known as*

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

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

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

10           “(i) *IN GENERAL.—There are hereby*  
11           *appropriated to the Account from the Trust*  
12           *Fund such sums as the Secretary and the*  
13           *Attorney General certify are necessary to*  
14           *carry out the purposes described in sub-*  
15           *paragraph (C), to be available without fur-*  
16           *ther appropriation, in an amount not to ex-*  
17           *ceed—*

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

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

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

4                   “(i) *MEDICARE AND MEDICAID ACTIVITIES.*—For each fiscal year, of the amount  
5                   appropriated in clause (i), the following  
6                   amounts shall be available only for the pur-  
7                   poses of the activities of the Office of the In-  
8                   spector General of the Department of Health  
9                   and Human Services with respect to the  
10                  medicare and medicaid programs—

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

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

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

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

23

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

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

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

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

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

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

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

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

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

23                         “(vi) for fiscal year 2002,  
24                         \$101,000,000; and

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

3                   “(C) *USE OF FUNDS.*—*The purposes de-*  
4                   *scribed in this subparagraph are to cover the*  
5                   *costs (including equipment, salaries and benefits,*  
6                   *and travel and training) of the administration*  
7                   *and operation of the health care fraud and abuse*  
8                   *control program established under section*  
9                   *1128C(a), including the costs of—*

10                   “(i) *prosecuting health care matters*  
11                   *(through criminal, civil, and administrative*  
12                   *proceedings);*

13                   “(ii) *investigations;*

14                   “(iii) *financial and performance au-*  
15                   *ditions of health care programs and operations;*

16                   “(iv) *inspections and other evalua-*  
17                   *tions; and*

18                   “(v) *provider and consumer education*  
19                   *regarding compliance with the provisions of*  
20                   *title XI.*

21                   “(4) *APPROPRIATED AMOUNTS TO ACCOUNT FOR*  
22                   *MEDICARE INTEGRITY PROGRAM.—*

23                   “(A) *IN GENERAL.*—*There are hereby ap-*  
24                   *propriated to the Account from the Trust Fund*  
25                   *for each fiscal year such amounts as are nec-*

1           *essary to carry out the Medicare Integrity Pro-*  
2           *gram under section 1893, subject to subpara-*  
3           *graph (B) and to be available without further*  
4           *appropriation.*

5           “(B) AMOUNTS SPECIFIED.—*The amount*  
6           *appropriated under subparagraph (A) for a fis-*  
7           *cal year is as follows:*

8                   “(i) *For fiscal year 1997, such amount*  
9                   *shall be not less than \$430,000,000 and not*  
10                  *more than \$440,000,000.*

11                  “(ii) *For fiscal year 1998, such*  
12                  *amount shall be not less than \$490,000,000*  
13                  *and not more than \$500,000,000.*

14                  “(iii) *For fiscal year 1999, such*  
15                  *amount shall be not less than \$550,000,000*  
16                  *and not more than \$560,000,000.*

17                  “(iv) *For fiscal year 2000, such*  
18                  *amount shall be not less than \$620,000,000*  
19                  *and not more than \$630,000,000.*

20                  “(v) *For fiscal year 2001, such amount*  
21                  *shall be not less than \$670,000,000 and not*  
22                  *more than \$680,000,000.*

23                  “(vi) *For fiscal year 2002, such*  
24                  *amount shall be not less than \$690,000,000*  
25                  *and not more than \$700,000,000.*

1                   “(vii) For each fiscal year after fiscal  
2                   year 2002, such amount shall be not less  
3                   than \$710,000,000 and not more than  
4                   \$720,000,000.

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

10 **SEC. 202. MEDICARE INTEGRITY PROGRAM.**

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

14                   “MEDICARE INTEGRITY PROGRAM

15                   “SEC. 1893. (a) ESTABLISHMENT OF PROGRAM.—  
16 There is hereby established the Medicare Integrity Program  
17 (in this section referred to as the ‘Program’) under which  
18 the Secretary shall promote the integrity of the medicare  
19 program by entering into contracts in accordance with this  
20 section with eligible private entities to carry out the activi-  
21 ties described in subsection (b).

22                   “(b) ACTIVITIES DESCRIBED.—The activities described  
23 in this subsection are as follows:

24                   “(1) Review of activities of providers of services  
25                   or other individuals and entities furnishing items and  
26                   services for which payment may be made under this

1 *title (including skilled nursing facilities and home*  
2 *health agencies), including medical and utilization*  
3 *review and fraud review (employing similar stand-*  
4 *ards, processes, and technologies used by private*  
5 *health plans, including equipment and software tech-*  
6 *nologies which surpass the capability of the equip-*  
7 *ment and technologies used in the review of claims*  
8 *under this title as of the date of the enactment of this*  
9 *section).*

10 *“(2) Audit of cost reports.*

11 *“(3) Determinations as to whether payment*  
12 *should not be, or should not have been, made under*  
13 *this title by reason of section 1862(b), and recovery*  
14 *of payments that should not have been made.*

15 *“(4) Education of providers of services, bene-*  
16 *ficiaries, and other persons with respect to payment*  
17 *integrity and benefit quality assurance issues.*

18 *“(5) Developing (and periodically updating) a*  
19 *list of items of durable medical equipment in accord-*  
20 *ance with section 1834(a)(15) which are subject to*  
21 *prior authorization under such section.*

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

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

3           “(2) in carrying out such activities, the entity  
4           agrees to cooperate with the Inspector General of the  
5           Department of Health and Human Services, the At-  
6           torney General of the United States, and other law  
7           enforcement agencies, as appropriate, in the inves-  
8           tigation and deterrence of fraud and abuse in relation  
9           to this title and in other cases arising out of such ac-  
10          tivities;

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

16          “(4) the entity meets such other requirements as  
17          the Secretary may impose.

18          *In the case of the activity described in subsection (b)(5),*  
19          *an entity shall be deemed to be eligible to enter into a con-*  
20          *tract under the Program to carry out the activity if the*  
21          *entity is a carrier with a contract in effect under section*  
22          *1842.*

23          “(d) *PROCESS FOR ENTERING INTO CONTRACTS.—The*  
24          *Secretary shall enter into contracts under the Program in*  
25          *accordance with such procedures as the Secretary shall by*

1 *regulation establish, except that such procedures shall in-*  
2 *clude the following:*

3           “(1) *The Secretary shall determine the appro-*  
4 *prate number of separate contracts which are nec-*  
5 *essary to carry out the Program and the appropriate*  
6 *times at which the Secretary shall enter into such*  
7 *contracts.*

8           “(2)(A) *Except as provided in subparagraph*  
9 *(B), the provisions of section 1153(e)(1) shall apply*  
10 *to contracts and contracting authority under this sec-*  
11 *tion.*

12           “(B) *Competitive procedures must be used when*  
13 *entering into new contracts under this section, or at*  
14 *any other time considered appropriate by the Sec-*  
15 *retary, except that the Secretary may contract with*  
16 *entities that are carrying out the activities described*  
17 *in this section pursuant to agreements under section*  
18 *1816 or contracts under section 1842 in effect on the*  
19 *date of the enactment of this section.*

20           “(3) *A contract under this section may be re-*  
21 *newed without regard to any provision of law requir-*  
22 *ing competition if the contractor has met or exceeded*  
23 *the performance requirements established in the cur-*  
24 *rent contract.*

1       “(e) *LIMITATION ON CONTRACTOR LIABILITY.—The*  
2 *Secretary shall by regulation provide for the limitation of*  
3 *a contractor’s liability for actions taken to carry out a con-*  
4 *tract under the Program, and such regulation shall, to the*  
5 *extent the Secretary finds appropriate, employ the same or*  
6 *comparable standards and other substantive and procedural*  
7 *provisions as are contained in section 1157.”.*

8       (b) *ELIMINATION OF FI AND CARRIER RESPONSIBIL-*  
9 *ITY FOR CARRYING OUT ACTIVITIES SUBJECT TO PRO-*  
10 *GRAM.—*

11           (1)       *RESPONSIBILITIES       OF       FISCAL*  
12       *INTERMEDIARIES UNDER PART A.—Section 1816 (42*  
13       *U.S.C. 1395h) is amended by adding at the end the*  
14       *following new subsection:*

15       “(l) *No agency or organization may carry out (or re-*  
16 *ceive payment for carrying out) any activity pursuant to*  
17 *an agreement under this section to the extent that the activ-*  
18 *ity is carried out pursuant to a contract under the Medicare*  
19 *Integrity Program under section 1893.”.*

20           (2)       *RESPONSIBILITIES OF CARRIERS UNDER*  
21       *PART B.—Section 1842(c) (42 U.S.C. 1395u(c)) is*  
22       *amended by adding at the end the following new*  
23       *paragraph:*

24       “(6) *No carrier may carry out (or receive payment for*  
25 *carrying out) any activity pursuant to a contract under*

1 *this subsection to the extent that the activity is carried out*  
2 *pursuant to a contract under the Medicare Integrity Pro-*  
3 *gram under section 1893. The previous sentence shall not*  
4 *apply with respect to the activity described in section*  
5 *1893(b)(5) (relating to prior authorization of certain items*  
6 *of durable medical equipment under section 1834(a)(15)).”.*

7 **SEC. 203. BENEFICIARY INCENTIVE PROGRAMS.**

8       (a) *CLARIFICATION OF REQUIREMENT TO PROVIDE*  
9 *EXPLANATION OF MEDICARE BENEFITS.—The Secretary of*  
10 *Health and Human Services (in this section referred to as*  
11 *the “Secretary”) shall provide an explanation of benefits*  
12 *under the medicare program under title XVIII of the Social*  
13 *Security Act with respect to each item or service for which*  
14 *payment may be made under the program which is fur-*  
15 *nished to an individual, without regard to whether or not*  
16 *a deductible or coinsurance may be imposed against the in-*  
17 *dividual with respect to the item or service.*

18       (b) *PROGRAM TO COLLECT INFORMATION ON FRAUD*  
19 *AND ABUSE.—*

20           (1) *ESTABLISHMENT OF PROGRAM.—Not later*  
21 *than 3 months after the date of the enactment of this*  
22 *Act, the Secretary shall establish a program under*  
23 *which the Secretary shall encourage individuals to re-*  
24 *port to the Secretary information on individuals and*  
25 *entities who are engaging or who have engaged in*

1        *acts or omissions which constitute grounds for the im-*  
2        *position of a sanction under section 1128, section*  
3        *1128A, or section 1128B of the Social Security Act,*  
4        *or who have otherwise engaged in fraud and abuse*  
5        *against the medicare program for which there is a*  
6        *sanction provided under law. The program shall dis-*  
7        *courage provision of, and not consider, information*  
8        *which is frivolous or otherwise not relevant or mate-*  
9        *rial to the imposition of such a sanction.*

10            (2) *PAYMENT OF PORTION OF AMOUNTS COL-*  
11        *LECTED.—If an individual reports information to the*  
12        *Secretary under the program established under para-*  
13        *graph (1) which serves as the basis for the collection*  
14        *by the Secretary or the Attorney General of any*  
15        *amount of at least \$100 (other than any amount paid*  
16        *as a penalty under section 1128B of the Social Secu-*  
17        *rity Act), the Secretary may pay a portion of the*  
18        *amount collected to the individual (under procedures*  
19        *similar to those applicable under section 7623 of the*  
20        *Internal Revenue Code of 1986 to payments to indi-*  
21        *viduals providing information on violations of such*  
22        *Code).*

23            (c) *PROGRAM TO COLLECT INFORMATION ON PROGRAM*  
24        *EFFICIENCY.—*



1       *defined in section 1128(h))” and inserting “a Federal*  
2       *health care program”.*

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

6             (4) *In the second sentence of subsection (a)—*

7                 (A) *by striking “a State plan approved*  
8       *under title XIX” and inserting “a Federal health*  
9       *care program”, and*

10                (B) *by striking “the State may at its option*  
11       *(notwithstanding any other provision of that*  
12       *title or of such plan)” and inserting “the admin-*  
13       *istrator of such program may at its option (not-*  
14       *withstanding any other provision of such pro-*  
15       *gram)”.*

16             (5) *In subsection (b), by striking “title XVIII or*  
17       *a State health care program” each place it appears*  
18       *and inserting “a Federal health care program”.*

19             (6) *In subsection (c), by inserting “(as defined*  
20       *in section 1128(h))” after “a State health care pro-*  
21       *gram”.*

22             (7) *By adding at the end the following new sub-*  
23       *section:*

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

1           “(1) any plan or program that provides health  
2           benefits, whether directly, through insurance, or other-  
3           wise, which is funded directly, in whole or in part,  
4           by the United States Government (other than the  
5           health insurance program under chapter 89 of title 5,  
6           United States Code); or

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

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

11       **SEC. 205. GUIDANCE REGARDING APPLICATION OF HEALTH**  
12                               **CARE FRAUD AND ABUSE SANCTIONS.**

13           Title XI (42 U.S.C. 1301 et seq.), as amended by sec-  
14          tion 201, is amended by inserting after section 1128C the  
15          following new section:

16           “GUIDANCE REGARDING APPLICATION OF HEALTH CARE  
17                               FRAUD AND ABUSE SANCTIONS

18           “SEC. 1128D. (a) *SOLICITATION AND PUBLICATION OF*  
19          *MODIFICATIONS TO EXISTING SAFE HARBORS AND NEW*  
20          *SAFE HARBORS.*—

21                           “(1) *IN GENERAL.*—

22                                   “(A) *SOLICITATION OF PROPOSALS FOR*  
23                           *SAFE HARBORS.*—Not later than January 1,  
24                           1997, and not less than annually thereafter, the  
25                           Secretary shall publish a notice in the Federal

1           *Register soliciting proposals, which will be ac-*  
2           *cepted during a 60-day period, for—*

3                   “(i) *modifications to existing safe har-*  
4                   *bors issued pursuant to section 14(a) of the*  
5                   *Medicare and Medicaid Patient and Pro-*  
6                   *gram Protection Act of 1987 (42 U.S.C.*  
7                   *1320a–7b note);*

8                   “(ii) *additional safe harbors specifying*  
9                   *payment practices that shall not be treated*  
10                   *as a criminal offense under section*  
11                   *1128B(b) and shall not serve as the basis*  
12                   *for an exclusion under section 1128(b)(7);*

13                   “(iii) *advisory opinions to be issued*  
14                   *pursuant to subsection (b); and*

15                   “(iv) *special fraud alerts to be issued*  
16                   *pursuant to subsection (c).*

17                   “(B) *PUBLICATION OF PROPOSED MODIFICA-*  
18                   *TIONS AND PROPOSED ADDITIONAL SAFE HAR-*  
19                   *BORS.—After considering the proposals described*  
20                   *in clauses (i) and (ii) of subparagraph (A), the*  
21                   *Secretary, in consultation with the Attorney*  
22                   *General, shall publish in the Federal Register*  
23                   *proposed modifications to existing safe harbors*  
24                   *and proposed additional safe harbors, if appro-*  
25                   *priate, with a 60-day comment period. After*

1           *considering any public comments received dur-*  
2           *ing this period, the Secretary shall issue final*  
3           *rules modifying the existing safe harbors and es-*  
4           *tablishing new safe harbors, as appropriate.*

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

18          “(2) *CRITERIA FOR MODIFYING AND ESTABLISH-*  
19          *ING SAFE HARBORS.—In modifying and establishing*  
20          *safe harbors under paragraph (1)(B), the Secretary*  
21          *may consider the extent to which providing a safe*  
22          *harbor for the specified payment practice may result*  
23          *in any of the following:*

24                  “(A) *An increase or decrease in access to*  
25                  *health care services.*

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

3           “(C) An increase or decrease in patient free-  
4 dom of choice among health care providers.

5           “(D) An increase or decrease in competition  
6 among health care providers.

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

11           “(F) An increase or decrease in the cost to  
12 Federal health care programs (as defined in sec-  
13 tion 1128B(f)).

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

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

20                   “(i) whether to order a health care  
21 item or service; or

22                   “(ii) whether to arrange for a referral  
23 of health care items or services to a particu-  
24 lar practitioner or provider.

1           “(I) Any other factors the Secretary deems  
2           appropriate in the interest of preventing fraud  
3           and abuse in Federal health care programs (as  
4           so defined).

5           “(b) *ADVISORY OPINIONS.*—

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

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

12           “(A) What constitutes prohibited remunera-  
13           tion within the meaning of section 1128B(b).

14           “(B) Whether an arrangement or proposed  
15           arrangement satisfies the criteria set forth in sec-  
16           tion 1128B(b)(3) for activities which do not re-  
17           sult in prohibited remuneration.

18           “(C) Whether an arrangement or proposed  
19           arrangement satisfies the criteria which the Sec-  
20           retary has established, or shall establish by regu-  
21           lation for activities which do not result in pro-  
22           hibited remuneration.

23           “(D) What constitutes an inducement to re-  
24           duce or limit services to individuals entitled to

1           *benefits under title XVIII or title XIX or title*  
2           *XXI within the meaning of section 1128B(b).*

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

6           “(3) *MATTERS NOT SUBJECT TO ADVISORY OPIN-*  
7           *IONS.—Such advisory opinions shall not address the*  
8           *following matters:*

9           “(A) *Whether the fair market value shall be,*  
10           *or was paid or received for any goods, services*  
11           *or property.*

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

15           “(4) *EFFECT OF ADVISORY OPINIONS.—*

16           “(A) *BINDING AS TO SECRETARY AND PAR-*  
17           *TIES INVOLVED.—Each advisory opinion issued*  
18           *by the Secretary shall be binding as to the Sec-*  
19           *retary and the party or parties requesting the*  
20           *opinion.*

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

1           “(5) *REGULATIONS.*—

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

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

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

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

14                           “(iv) *the reasonable fee to be charged to*  
15 *the party requesting an advisory opinion;*  
16 *and*

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

20                   “(B) *SPECIFIC CONTENTS.*—*Under the regu-*  
21 *lations promulgated pursuant to subparagraph*  
22 *(A)—*

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

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

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

7           “(c) *SPECIAL FRAUD ALERTS.—*

8           “(1) *IN GENERAL.—*

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

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

1           *issued pursuant to this subparagraph shall be*  
 2           *published in the Federal Register.*

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

7                   “(A) *whether and to what extent the prac-*  
 8                   *tices that would be identified in the special fraud*  
 9                   *alert may result in any of the consequences de-*  
 10                   *scribed in subsection (a)(2); and*

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

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

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

19           “(a) *INDIVIDUAL CONVICTED OF FELONY RELATING TO*  
 20           *HEALTH CARE FRAUD.*—

21                   “(1) *IN GENERAL.*—*Section 1128(a) (42 U.S.C.*  
 22                   *1320a–7(a)) is amended by adding at the end the fol-*  
 23                   *lowing new paragraph:*

24                   “(3) *FELONY CONVICTION RELATING TO HEALTH*  
 25                   *CARE FRAUD.*—*Any individual or entity that has*

1       *been convicted after the date of the enactment of the*  
2       *Health Coverage Availability and Affordability Act of*  
3       *1996, under Federal or State law, in connection with*  
4       *the delivery of a health care item or service or with*  
5       *respect to any act or omission in a health care pro-*  
6       *gram (other than those specifically described in para-*  
7       *graph (1)) operated by or financed in whole or in*  
8       *part by any Federal, State, or local government agen-*  
9       *cy, of a criminal offense consisting of a felony relat-*  
10      *ing to fraud, theft, embezzlement, breach of fiduciary*  
11      *responsibility, or other financial misconduct.”.*

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

15           “(1) *CONVICTION RELATING TO FRAUD.—Any in-*  
16      *dividual or entity that has been convicted after the*  
17      *date of the enactment of the Health Coverage Avail-*  
18      *ability and Affordability Act of 1996, under Federal*  
19      *or State law—*

20               “(A) *of a criminal offense consisting of a*  
21              *misdemeanor relating to fraud, theft, embezzle-*  
22              *ment, breach of fiduciary responsibility, or other*  
23              *financial misconduct—*

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

1           “(ii) with respect to any act or omis-  
2           sion in a health care program (other than  
3           those specifically described in subsection  
4           (a)(1)) operated by or financed in whole or  
5           in part by any Federal, State, or local gov-  
6           ernment agency; or

7           “(B) of a criminal offense relating to fraud,  
8           theft, embezzlement, breach of fiduciary respon-  
9           sibility, or other financial misconduct with re-  
10          spect to any act or omission in a program (other  
11          than a health care program) operated by or fi-  
12          nanced in whole or in part by any Federal,  
13          State, or local government agency.”.

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

16                 (1) *IN GENERAL.—*Section 1128(a) (42 U.S.C.  
17                 1320a–7(a)), as amended by subsection (a), is amend-  
18                 ed by adding at the end the following new paragraph:

19                 “(4) *FELONY CONVICTION RELATING TO CON-*  
20                 *TROLLED SUBSTANCE.—*Any individual or entity that  
21                 has been convicted after the date of the enactment of  
22                 the Health Coverage Availability and Affordability  
23                 Act of 1996, under Federal or State law, of a crimi-  
24                 nal offense consisting of a felony relating to the un-

1 *lawful manufacture, distribution, prescription, or dis-*  
2 *persing of a controlled substance.”.*

3 (2) *CONFORMING AMENDMENT.*—Section  
4 *1128(b)(3) (42 U.S.C. 1320a–7(b)(3)) is amended—*

5 (A) *in the heading, by striking “CONVIC-*  
6 *TION” and inserting “MISDEMEANOR CONVIC-*  
7 *TION”;* and

8 (B) *by striking “criminal offense” and in-*  
9 *serting “criminal offense consisting of a mis-*  
10 *demeanor”.*

11 ***SEC. 212. ESTABLISHMENT OF MINIMUM PERIOD OF EXCLU-***  
12 ***SION FOR CERTAIN INDIVIDUALS AND ENTI-***  
13 ***TIES SUBJECT TO PERMISSIVE EXCLUSION***  
14 ***FROM MEDICARE AND STATE HEALTH CARE***  
15 ***PROGRAMS.***

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

19 *“(D) In the case of an exclusion of an individual or*  
20 *entity under paragraph (1), (2), or (3) of subsection (b),*  
21 *the period of the exclusion shall be 3 years, unless the Sec-*  
22 *retary determines in accordance with published regulations*  
23 *that a shorter period is appropriate because of mitigating*  
24 *circumstances or that a longer period is appropriate be-*  
25 *cause of aggravating circumstances.*

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

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

11 **SEC. 213. PERMISSIVE EXCLUSION OF INDIVIDUALS WITH**  
 12 **OWNERSHIP OR CONTROL INTEREST IN**  
 13 **SANCTIONED ENTITIES.**

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

16       “(15) INDIVIDUALS CONTROLLING A SANCTIONED  
 17 ENTITY.—(A) Any individual—

18               “(i) who has a direct or indirect ownership  
 19 or control interest in a sanctioned entity and  
 20 who knows or should know (as defined in section  
 21 1128A(i)(6)) of the action constituting the basis  
 22 for the conviction or exclusion described in sub-  
 23 paragraph (B); or

1           “(i) who is an officer or managing em-  
2           ployee (as defined in section 1126(b)) of such an  
3           entity.

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

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

9                   “(ii) that has been excluded from participa-  
10                  tion under a program under title XVIII or under  
11                  a State health care program.”.

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

15           (a) *MINIMUM PERIOD OF EXCLUSION FOR PRACTI-*  
16   *TIONERS AND PERSONS FAILING TO MEET STATUTORY OB-*  
17   *LIGATIONS.—*

18                   (1) *IN GENERAL.—The second sentence of section*  
19                   *1156(b)(1) (42 U.S.C. 1320c-5(b)(1)) is amended by*  
20                   *striking “may prescribe)” and inserting “may pre-*  
21                   *scribe, except that such period may not be less than*  
22                   *1 year)”.*

23                   (2) *CONFORMING AMENDMENT.—Section*  
24                   *1156(b)(2) (42 U.S.C. 1320c-5(b)(2)) is amended by*  
25                   *striking “shall remain” and inserting “shall (subject*

1       to the minimum period specified in the second sen-  
2       tence of paragraph (1)) remain”.

3       (b) *REPEAL OF “UNWILLING OR UNABLE” CONDITION*  
4 *FOR IMPOSITION OF SANCTION.*—Section 1156(b)(1) (42  
5 *U.S.C. 1320c–5(b)(1)) is amended—*

6             (1) *in the second sentence, by striking “and de-*  
7 *termines” and all that follows through “such obliga-*  
8 *tions,”; and*

9             (2) *by striking the third sentence.*

10 ***SEC. 215. INTERMEDIATE SANCTIONS FOR MEDICARE***  
11 ***HEALTH MAINTENANCE ORGANIZATIONS.***

12       (a) *APPLICATION OF INTERMEDIATE SANCTIONS FOR*  
13 *ANY PROGRAM VIOLATIONS.*—

14             (1) *IN GENERAL.*—Section 1876(i)(1) (42 *U.S.C.*  
15 *1395mm(i)(1)) is amended by striking “the Secretary*  
16 *may terminate” and all that follows and inserting*  
17 *“in accordance with procedures established under*  
18 *paragraph (9), the Secretary may at any time termi-*  
19 *nate any such contract or may impose the intermedi-*  
20 *ate sanctions described in paragraph (6)(B) or (6)(C)*  
21 *(whichever is applicable) on the eligible organization*  
22 *if the Secretary determines that the organization—*

23             “(A) *has failed substantially to carry out the*  
24 *contract;*

1           “(B) is carrying out the contract in a manner  
2           substantially inconsistent with the efficient and effec-  
3           tive administration of this section; or

4           “(C) no longer substantially meets the applicable  
5           conditions of subsections (b), (c), (e), and (f).”.

6           (2) *OTHER INTERMEDIATE SANCTIONS FOR MIS-*  
7           *CELLANEOUS PROGRAM VIOLATIONS.*—Section  
8           1876(i)(6) (42 U.S.C. 1395mm(i)(6)) is amended by  
9           adding at the end the following new subparagraph:

10          “(C) In the case of an eligible organization for which  
11          the Secretary makes a determination under paragraph (1)  
12          the basis of which is not described in subparagraph (A),  
13          the Secretary may apply the following intermediate sanc-  
14          tions:

15               “(i) Civil money penalties of not more than  
16               \$25,000 for each determination under paragraph (1)  
17               if the deficiency that is the basis of the determination  
18               has directly adversely affected (or has the substantial  
19               likelihood of adversely affecting) an individual cov-  
20               ered under the organization’s contract.

21               “(ii) Civil money penalties of not more than  
22               \$10,000 for each week beginning after the initiation  
23               of procedures by the Secretary under paragraph (9)  
24               during which the deficiency that is the basis of a de-  
25               termination under paragraph (1) exists.

1           “(iii) *Suspension of enrollment of individuals*  
2           *under this section after the date the Secretary notifies*  
3           *the organization of a determination under paragraph*  
4           *(1) and until the Secretary is satisfied that the defi-*  
5           *ciency that is the basis for the determination has been*  
6           *corrected and is not likely to recur.”.*

7           (3) *PROCEDURES FOR IMPOSING SANCTIONS.—*  
8           *Section 1876(i) (42 U.S.C. 1395mm(i)) is amended*  
9           *by adding at the end the following new paragraph:*

10          “(9) *The Secretary may terminate a contract with an*  
11          *eligible organization under this section or may impose the*  
12          *intermediate sanctions described in paragraph (6) on the*  
13          *organization in accordance with formal investigation and*  
14          *compliance procedures established by the Secretary under*  
15          *which—*

16               “(A) *the Secretary first provides the organiza-*  
17               *tion with the reasonable opportunity to develop and*  
18               *implement a corrective action plan to correct the defi-*  
19               *ciencies that were the basis of the Secretary’s deter-*  
20               *mination under paragraph (1) and the organization*  
21               *fails to develop or implement such a plan;*

22               “(B) *in deciding whether to impose sanctions,*  
23               *the Secretary considers aggravating factors such as*  
24               *whether an organization has a history of deficiencies*



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

3           (2) by striking the period at the end of subpara-  
4 graph (E) and inserting “; and”; and

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

7           “(F) any remuneration between an organization  
8 and an individual or entity providing items or serv-  
9 ices, or a combination thereof, pursuant to a written  
10 agreement between the organization and the individ-  
11 ual or entity if the organization is an eligible organi-  
12 zation under section 1876 or if the written agreement  
13 places the individual or entity at substantial finan-  
14 cial risk for the cost or utilization of the items or  
15 services, or a combination thereof, which the individ-  
16 ual or entity is obligated to provide, whether through  
17 a withhold, capitation, incentive pool, per diem pay-  
18 ment, or any other similar risk arrangement which  
19 places the individual or entity at substantial finan-  
20 cial risk.”.

21           (b) *EFFECTIVE DATE.*—The amendments made by this  
22 section shall apply to written agreements entered into on  
23 or after January 1, 1997.

1 **SEC. 217. CRIMINAL PENALTY FOR FRAUDULENT DISPOSI-**  
 2 **TION OF ASSETS IN ORDER TO OBTAIN MED-**  
 3 **ICAID BENEFITS.**

4 *Section 1128B(a) (42 U.S.C. 1320a-7b(a)) is amend-*  
 5 *ed—*

6 *(1) by striking “or” at the end of paragraph (4);*

7 *(2) by adding “or” at the end of paragraph (5);*

8 *and*

9 *(3) by inserting after paragraph (5) the follow-*  
 10 *ing new paragraph:*

11 *“(6) knowingly and willfully disposes of assets*  
 12 *(including by any transfer in trust) in order for an*  
 13 *individual to become eligible for medical assistance*  
 14 *under a State plan under title XIX, if disposing of*  
 15 *the assets results in the imposition of a period of in-*  
 16 *eligibility for such assistance under section 1917(c),”.*

17 **SEC. 218. EFFECTIVE DATE.**

18 *Except as otherwise provided, the amendments made*  
 19 *by this subtitle shall take effect January 1, 1997.*

20 **Subtitle C—Data Collection**

21 **SEC. 221. ESTABLISHMENT OF THE HEALTH CARE FRAUD**  
 22 **AND ABUSE DATA COLLECTION PROGRAM.**

23 *(a) IN GENERAL.—Title XI (42 U.S.C. 1301 et seq.),*  
 24 *as amended by sections 201 and 205, is amended by insert-*  
 25 *ing after section 1128D the following new section:*



1           *supplier, or practitioner is affiliated or associ-*  
2           *ated.*

3           “(C) *The nature of the final adverse action*  
4           *and whether such action is on appeal.*

5           “(D) *A description of the acts or omissions*  
6           *and injuries upon which the final adverse action*  
7           *was based, and such other information as the*  
8           *Secretary determines by regulation is required*  
9           *for appropriate interpretation of information re-*  
10          *ported under this section.*

11          “(3) *CONFIDENTIALITY.—In determining what*  
12          *information is required, the Secretary shall include*  
13          *procedures to assure that the privacy of individuals*  
14          *receiving health care services is appropriately pro-*  
15          *tected.*

16          “(4) *TIMING AND FORM OF REPORTING.—The in-*  
17          *formation required to be reported under this sub-*  
18          *section shall be reported regularly (but not less often*  
19          *than monthly) and in such form and manner as the*  
20          *Secretary prescribes. Such information shall first be*  
21          *required to be reported on a date specified by the Sec-*  
22          *retary.*

23          “(5) *TO WHOM REPORTED.—The information re-*  
24          *quired to be reported under this subsection shall be re-*  
25          *ported to the Secretary.*

1       “(c) *DISCLOSURE AND CORRECTION OF INFORMA-*  
2 *TION.*—

3               “(1) *DISCLOSURE.*—*With respect to the informa-*  
4 *tion about final adverse actions (not including settle-*  
5 *ments in which no findings of liability have been*  
6 *made) reported to the Secretary under this section re-*  
7 *specting a health care provider, supplier, or practi-*  
8 *tioner, the Secretary shall, by regulation, provide*  
9 *for—*

10                       “(A) *disclosure of the information, upon re-*  
11 *quest, to the health care provider, supplier, or li-*  
12 *censed practitioner, and*

13                       “(B) *procedures in the case of disputed ac-*  
14 *curacy of the information.*

15               “(2) *CORRECTIONS.*—*Each Government agency*  
16 *and health plan shall report corrections of informa-*  
17 *tion already reported about any final adverse action*  
18 *taken against a health care provider, supplier, or*  
19 *practitioner, in such form and manner that the Sec-*  
20 *retary prescribes by regulation.*

21       “(d) *ACCESS TO REPORTED INFORMATION.*—

22               “(1) *AVAILABILITY.*—*The information in this*  
23 *database shall be available to Federal and State gov-*  
24 *ernment agencies and health plans pursuant to proce-*  
25 *dures that the Secretary shall provide by regulation.*

1           “(2) *FEEES FOR DISCLOSURE.*—*The Secretary*  
2           *may establish or approve reasonable fees for the dis-*  
3           *closure of information in this database (other than*  
4           *with respect to requests by Federal agencies). The*  
5           *amount of such a fee shall be sufficient to recover the*  
6           *full costs of operating the database. Such fees shall be*  
7           *available to the Secretary or, in the Secretary’s dis-*  
8           *cretion to the agency designated under this section to*  
9           *cover such costs.*

10          “(e) *PROTECTION FROM LIABILITY FOR REPORTING.*—  
11          *No person or entity, including the agency designated by the*  
12          *Secretary in subsection (b)(5) shall be held liable in any*  
13          *civil action with respect to any report made as required*  
14          *by this section, without knowledge of the falsity of the infor-*  
15          *mation contained in the report.*

16          “(f) *DEFINITIONS AND SPECIAL RULES.*—*For pur-*  
17          *poses of this section:*

18                  “(1) *FINAL ADVERSE ACTION.*—

19                          “(A) *IN GENERAL.*—*The term ‘final adverse*  
20                          *action’ includes:*

21                                  “(i) *Civil judgments against a health*  
22                                  *care provider, supplier, or practitioner in*  
23                                  *Federal or State court related to the deliv-*  
24                                  *ery of a health care item or service.*

1           “(ii) *Federal or State criminal convictions related to the delivery of a health care item or service.*

2  
3  
4           “(iii) *Actions by Federal or State agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including—*

5  
6  
7  
8           “(I) *formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation,*

9  
10           “(II) *any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or*

11  
12  
13           “(III) *any other negative action or finding by such Federal or State agency that is publicly available information.*

14  
15  
16  
17  
18  
19  
20           “(iv) *Exclusion from participation in Federal or State health care programs.*

1                   “(v) *Any other adjudicated actions or*  
2                   *decisions that the Secretary shall establish*  
3                   *by regulation.*

4                   “(B) *EXCEPTION.—The term does not in-*  
5                   *clude any action with respect to a malpractice*  
6                   *claim.*

7                   “(2) *PRACTITIONER.—The terms ‘licensed health*  
8                   *care practitioner’, ‘licensed practitioner’, and ‘practi-*  
9                   *tioner’ mean, with respect to a State, an individual*  
10                  *who is licensed or otherwise authorized by the State*  
11                  *to provide health care services (or any individual*  
12                  *who, without authority holds himself or herself out to*  
13                  *be so licensed or authorized).*

14                  “(3) *GOVERNMENT AGENCY.—The term ‘Govern-*  
15                  *ment agency’ shall include:*

16                         “(A) *The Department of Justice.*

17                         “(B) *The Department of Health and*  
18                         *Human Services.*

19                         “(C) *Any other Federal agency that either*  
20                         *administers or provides payment for the delivery*  
21                         *of health care services, including, but not limited*  
22                         *to the Department of Defense and the Veterans’*  
23                         *Administration.*

24                         “(D) *State law enforcement agencies.*

25                         “(E) *State medicaid fraud control units.*

1           “(F) Federal or State agencies responsible  
2           for the licensing and certification of health care  
3           providers and licensed health care practitioners.

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

6           “(5) DETERMINATION OF CONVICTION.—For pur-  
7           poses of paragraph (1), the existence of a conviction  
8           shall be determined under paragraph (4) of section  
9           1128(i).”.

10          (b) IMPROVED PREVENTION IN ISSUANCE OF MEDI-  
11 CARE PROVIDER NUMBERS.—Section 1842(r) (42 U.S.C.  
12 1395u(r)) is amended by adding at the end the following  
13 new sentence: “Under such system, the Secretary may im-  
14 pose appropriate fees on such physicians to cover the costs  
15 of investigation and recertification activities with respect  
16 to the issuance of the identifiers.”.

17                   **Subtitle D—Civil Monetary**  
18                   **Penalties**

19          **SEC. 231. SOCIAL SECURITY ACT CIVIL MONETARY PEN-**  
20                   **ALTIES.**

21          (a) GENERAL CIVIL MONETARY PENALTIES.—Section  
22 1128A (42 U.S.C. 1320a–7a) is amended as follows:

23                  (1) In the third sentence of subsection (a), by  
24                  striking “programs under title XVIII” and inserting

1       *“Federal health care programs (as defined in section*  
2       *1128B(f)(1))”.*

3             *(2) In subsection (f)—*

4                     *(A) by redesignating paragraph (3) as*  
5                     *paragraph (4); and*

6                     *(B) by inserting after paragraph (2) the fol-*  
7                     *lowing new paragraph:*

8             *“(3) With respect to amounts recovered arising*  
9             *out of a claim under a Federal health care program*  
10            *(as defined in section 1128B(f)), the portion of such*  
11            *amounts as is determined to have been paid by the*  
12            *program shall be repaid to the program, and the por-*  
13            *tion of such amounts attributable to the amounts re-*  
14            *covered under this section by reason of the amend-*  
15            *ments made by the Health Coverage Availability and*  
16            *Affordability Act of 1996 (as estimated by the Sec-*  
17            *retary) shall be deposited into the Federal Hospital*  
18            *Insurance Trust Fund pursuant to section*  
19            *1817(k)(2)(C).”.*

20            *(3) In subsection (i)—*

21                     *(A) in paragraph (2), by striking “title V,*  
22                     *XVIII, XIX, or XX of this Act” and inserting “a*  
23                     *Federal health care program (as defined in sec-*  
24                     *tion 1128B(f))”.*

1           (B) in paragraph (4), by striking “a health  
2           insurance or medical services program under  
3           title XVIII or XIX of this Act” and inserting “a  
4           Federal health care program (as so defined)”,  
5           and

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

9           (4) By adding at the end the following new sub-  
10          section:

11          “(m)(1) For purposes of this section, with respect to  
12          a Federal health care program not contained in this Act,  
13          references to the Secretary in this section shall be deemed  
14          to be references to the Secretary or Administrator of the de-  
15          partment or agency with jurisdiction over such program  
16          and references to the Inspector General of the Department  
17          of Health and Human Services in this section shall be  
18          deemed to be references to the Inspector General of the appli-  
19          cable department or agency.

20          “(2)(A) The Secretary and Administrator of the de-  
21          partments and agencies referred to in paragraph (1) may  
22          include in any action pursuant to this section, claims with-  
23          in the jurisdiction of other Federal departments or agencies  
24          as long as the following conditions are satisfied:

1           “(i) The case involves primarily claims submit-  
2           ted to the Federal health care programs of the depart-  
3           ment or agency initiating the action.

4           “(ii) The Secretary or Administrator of the de-  
5           partment or agency initiating the action gives notice  
6           and an opportunity to participate in the investiga-  
7           tion to the Inspector General of the department or  
8           agency with primary jurisdiction over the Federal  
9           health care programs to which the claims were sub-  
10          mitted.

11          “(B) If the conditions specified in subparagraph (A)  
12          are fulfilled, the Inspector General of the department or  
13          agency initiating the action is authorized to exercise all  
14          powers granted under the Inspector General Act of 1978  
15          with respect to the claims submitted to the other depart-  
16          ments or agencies to the same manner and extent as pro-  
17          vided in that Act with respect to claims submitted to such  
18          departments or agencies.”.

19          (b) *EXCLUDED INDIVIDUAL RETAINING OWNERSHIP*  
20          *OR CONTROL INTEREST IN PARTICIPATING ENTITY.*—Sec-  
21          tion 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

22                  (1) by striking “or” at the end of paragraph  
23                  (1)(D);

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

1           (3) by striking the semicolon at the end of para-  
2 graph (3) and inserting “; or”; and

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

5           “(4) in the case of a person who is not an orga-  
6 nization, agency, or other entity, is excluded from  
7 participating in a program under title XVIII or a  
8 State health care program in accordance with this  
9 subsection or under section 1128 and who, at the time  
10 of a violation of this subsection—

11           “(A) retains a direct or indirect ownership  
12 or control interest in an entity that is partici-  
13 pating in a program under title XVIII or a  
14 State health care program, and who knows or  
15 should know of the action constituting the basis  
16 for the exclusion; or

17           “(B) is an officer or managing employee (as  
18 defined in section 1126(b)) of such an entity;”.

19           (c) *MODIFICATIONS OF AMOUNTS OF PENALTIES AND*  
20 *ASSESSMENTS.*—Section 1128A(a) (42 U.S.C. 1320a-  
21 7a(a)), as amended by subsection (b), is amended in the  
22 matter following paragraph (4)—

23           (1) by striking “\$2,000” and inserting  
24 “\$10,000”;

1           (2) by inserting “; in cases under paragraph (4),  
2           \$10,000 for each day the prohibited relationship oc-  
3           curs” after “false or misleading information was  
4           given”; and

5           (3) by striking “twice the amount” and inserting  
6           “3 times the amount”.

7           (d) *CLAIM FOR ITEM OR SERVICE BASED ON INCOR-*  
8 *RECT CODING OR MEDICALLY UNNECESSARY SERVICES.—*  
9 *Section 1128A(a)(1) (42 U.S.C. 1320a–7a(a)(1)) is amend-*  
10 *ed—*

11           (1) in subparagraph (A) by striking “claimed,”  
12           and inserting “claimed, including any person who  
13           engages in a pattern or practice of presenting or  
14           causing to be presented a claim for an item or service  
15           that is based on a code that the person knows or  
16           should know will result in a greater payment to the  
17           person than the code the person knows or should know  
18           is applicable to the item or service actually pro-  
19           vided,”;

20           (2) in subparagraph (C), by striking “or” at the  
21           end; and

22           (3) by inserting after subparagraph (D) the fol-  
23           lowing new subparagraph:

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

4           (e) *SANCTIONS AGAINST PRACTITIONERS AND PER-*  
5 *SONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGA-*  
6 *TIONS.*—Section 1156(b)(3) (42 U.S.C. 1320c-5(b)(3)) is  
7 amended by striking “the actual or estimated cost” and in-  
8 serting “up to \$10,000 for each instance”.

9           (f) *PROCEDURAL PROVISIONS.*—Section 1876(i)(6) (42  
10 U.S.C. 1395mm(i)(6)), as amended by section 215(a)(2), is  
11 amended by adding at the end the following new subpara-  
12 graph:

13           “(D) The provisions of section 1128A (other than sub-  
14 sections (a) and (b)) shall apply to a civil money penalty  
15 under subparagraph (B)(i) or (C)(i) in the same manner  
16 as such provisions apply to a civil money penalty or pro-  
17 ceeding under section 1128A(a).”.

18           (g) *PROHIBITION AGAINST OFFERING INDUCEMENTS*  
19 *TO INDIVIDUALS ENROLLED UNDER PROGRAMS OR*  
20 *PLANS.*—

21           (1) *OFFER OF REMUNERATION.*—Section  
22 1128A(a) (42 U.S.C. 1320a-7a(a)), as amended, is  
23 amended—

24           (A) by striking “or” at the end of para-  
25 graph (3);

1           (B) by striking the semicolon at the end of  
2           paragraph (4) and inserting “; or”; and

3           (D) by inserting after paragraph (4) the fol-  
4           lowing new paragraph:

5           “(5) offers to or transfers remuneration to any  
6           individual eligible for benefits under title XVIII of  
7           this Act, or under a State health care program (as de-  
8           fined in section 1128(h)) that such person knows or  
9           should know is likely to influence such individual to  
10          order or receive from a particular provider, practi-  
11          tioner, or supplier any item or service for which pay-  
12          ment may be made, in whole or in part, under title  
13          XVIII, or a State health care program (as so de-  
14          fined);”.

15          (2) *REMUNERATION DEFINED.*—Section 1128A(i)  
16          (42 U.S.C. 1320a–7a(i)) is amended by adding at the  
17          end the following new paragraph:

18          “(6) The term ‘remuneration’ includes the waiv-  
19          er of coinsurance and deductible amounts (or any  
20          part thereof), and transfers of items or services for  
21          free or for other than fair market value. The term ‘re-  
22          muneration’ does not include—

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

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

3           “(ii) the person does not routinely  
4           waive coinsurance or deductible amounts;  
5           and

6           “(iii) the person—

7                   “(I) waives the coinsurance and  
8                   deductible amounts after determining  
9                   in good faith that the individual is in  
10                  financial need;

11                   “(II) fails to collect coinsurance  
12                   or deductible amounts after making  
13                   reasonable collection efforts; or

14                   “(III) provides for any permis-  
15                   sible waiver as specified in section  
16                   1128B(b)(3) or in regulations issued  
17                   by the Secretary;

18           “(B) differentials in coinsurance and de-  
19           ductible amounts as part of a benefit plan design  
20           as long as the differentials have been disclosed in  
21           writing to all beneficiaries, third party payers,  
22           and providers, to whom claims are presented and  
23           as long as the differentials meet the standards as  
24           defined in regulations promulgated by the Sec-  
25           retary not later than 180 days after the date of

1           *the enactment of the Health Coverage Availabil-*  
 2           *ity and Affordability Act of 1996; or*

3           “(C) *incentives given to individuals to pro-*  
 4           *mote the delivery of preventive care as deter-*  
 5           *mined by the Secretary in regulations so pro-*  
 6           *mulgated.”.*

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

9           ***SEC. 232. CLARIFICATION OF LEVEL OF INTENT REQUIRED***  
 10           ***FOR IMPOSITION OF SANCTIONS.***

11           *(a) CLARIFICATION OF LEVEL OF KNOWLEDGE RE-*  
 12           *QUIRED FOR IMPOSITION OF CIVIL MONETARY PEN-*  
 13           *ALTIES.—*

14           *(1) IN GENERAL.—Section 1128A(a) (42 U.S.C.*  
 15           *1320a-7a(a)) is amended—*

16           *(A) in paragraphs (1) and (2), by inserting*  
 17           *“knowingly” before “presents” each place it ap-*  
 18           *pears; and*

19           *(B) in paragraph (3), by striking “gives”*  
 20           *and inserting “knowingly gives or causes to be*  
 21           *given”.*

22           *(2) DEFINITION OF STANDARD.—Section*  
 23           *1128A(i) (42 U.S.C. 1320a-7a(i)), as amended by*  
 24           *section 231(g)(2), is amended by adding at the end*  
 25           *the following new paragraph:*





1       “(b) *As used in this title, the term ‘health care benefit*  
2 *program’ has the meaning given such term in section*  
3 *1347(b) of this title.*”.

4       (b) *CLERICAL AMENDMENT.—The table of sections at*  
5 *the beginning of chapter 2 of title 18, United States Code,*  
6 *is amended by inserting after the item relating to section*  
7 *23 the following new item:*

      “24. *Definition of Federal health care offense.*”.

8       **SEC. 242. HEALTH CARE FRAUD.**

9       (a) *OFFENSE.—*

10               (1) *IN GENERAL.—Chapter 63 of title 18, United*  
11 *States Code, is amended by adding at the end the fol-*  
12 *lowing:*

13       **“§ 1347. Health care fraud**

14       “(a) *Whoever knowingly executes, or attempts to exe-*  
15 *cute, a scheme or artifice—*

16               “(1) *to defraud any health care benefit program;*  
17 *or*

18               “(2) *to obtain, by means of false or fraudulent*  
19 *pretenses, representations, or promises, any of the*  
20 *money or property owned by, or under the custody or*  
21 *control of, any health care benefit program,*

22 *in connection with the delivery of or payment for health*  
23 *care benefits, items, or services, shall be fined under this*  
24 *title or imprisoned not more than 10 years, or both. If the*  
25 *violation results in serious bodily injury (as defined in sec-*

1 *tion 1365 of this title), such person shall be fined under*  
2 *this title or imprisoned not more than 20 years, or both;*  
3 *and if the violation results in death, such person shall be*  
4 *fined under this title, or imprisoned for any term of years*  
5 *or for life, or both.*

6       “(b) *As used in this section, the term ‘health care bene-*  
7 *fit program’ means any public or private plan or contract,*  
8 *affecting commerce, under which any medical benefit, item,*  
9 *or service is provided to any individual, and includes any*  
10 *individual or entity who is providing a medical benefit,*  
11 *item, or service for which payment may be made under the*  
12 *plan or contract.’”.*

13       (2) *CLERICAL AMENDMENT.—The table of sec-*  
14 *tions at the beginning of chapter 63 of title 18, Unit-*  
15 *ed States Code, is amended by adding at the end the*  
16 *following:*

*“1347. Health care fraud.”.*

17       (b) *CRIMINAL FINES DEPOSITED IN FEDERAL HOS-*  
18 *PITAL INSURANCE TRUST FUND.—The Secretary of the*  
19 *Treasury shall deposit into the Federal Hospital Insurance*  
20 *Trust Fund pursuant to section 1817(k)(2)(C) of the Social*  
21 *Security Act (42 U.S.C. 1395i) an amount equal to the*  
22 *criminal fines imposed under section 1347 of title 18, Unit-*  
23 *ed States Code (relating to health care fraud).*

1 **SEC. 243. THEFT OR EMBEZZLEMENT.**

2 (a) *IN GENERAL.*—Chapter 31 of title 18, United  
3 States Code, is amended by adding at the end the following:

4 **“§ 669. Theft or embezzlement in connection with**  
5 **health care**

6 “(a) Whoever embezzles, steals, or otherwise without  
7 authority willfully and unlawfully converts to the use of  
8 any person other than the rightful owner, or intentionally  
9 misapplies any of the moneys, funds, securities, premiums,  
10 credits, property, or other assets of a health care benefit pro-  
11 gram, shall be fined under this title or imprisoned not more  
12 than 10 years, or both; but if the value of such property  
13 does not exceed the sum of \$100 the defendant shall be fined  
14 under this title or imprisoned not more than one year, or  
15 both.

16 “(b) As used in this section, the term ‘health care bene-  
17 fit program’ has the meaning given such term in section  
18 1347(b) of this title.”.

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

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

22 **SEC. 244. FALSE STATEMENTS.**

23 (a) *IN GENERAL.*—Chapter 47 of title 18, United  
24 States Code, is amended by adding at the end the following:

1 **“§ 1035. False statements relating to health care mat-**  
2 **ters**

3 “(a) *Whoever, in any matter involving a health care*  
4 *benefit program, knowingly—*

5 “(1) *falsifies, conceals, or covers up by any trick,*  
6 *scheme, or device a material fact; or*

7 “(2) *makes any false, fictitious, or fraudulent*  
8 *statements or representations, or makes or uses any*  
9 *false writing or document knowing the same to con-*  
10 *tain any false, fictitious, or fraudulent statement or*  
11 *entry,*

12 *in connection with the delivery of or payment for health*  
13 *care benefits, items, or services, shall be fined under this*  
14 *title or imprisoned not more than 5 years, or both.*

15 “(b) *As used in this section, the term ‘health care bene-*  
16 *fit program’ has the meaning given such term in section*  
17 *1347(b) of this title.”.*

18 (b) *CLERICAL AMENDMENT.—The table of sections at*  
19 *the beginning of chapter 47 of title 18, United States Code,*  
20 *is amended by adding at the end the following new item:*  
*“1035. False statements relating to health care matters.”.*

21 **SEC. 245. OBSTRUCTION OF CRIMINAL INVESTIGATIONS OF**  
22 **HEALTH CARE OFFENSES.**

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

1 **“§ 1518. Obstruction of criminal investigations of**  
 2 **health care offenses**

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

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

14 (b) CLERICAL AMENDMENT.—The table of sections at  
 15 the beginning of chapter 73 of title 18, United States Code,  
 16 is amended by adding at the end the following new item:  
 “1518. Obstruction of criminal investigations of health care offenses.”.

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

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

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

22 **SEC. 247. INJUNCTIVE RELIEF RELATING TO HEALTH CARE**  
 23 **OFFENSES.**

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

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

3           (2) by inserting “or” at the end of subparagraph  
4       (B); and

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

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

8       (b) *FREEZING OF ASSETS*.—Section 1345(a)(2) of title  
9       18, United States Code, is amended by inserting “or a Fed-  
10      eral health care offense” after “title”).

11   **SEC. 248. AUTHORIZED INVESTIGATIVE DEMAND PROCE-**  
12                                   **DURES.**

13       (a) *IN GENERAL*.—Chapter 223 of title 18, United  
14      States Code, is amended by adding after section 3485 the  
15      following:

16   **“§ 3486. Authorized investigative demand procedures**

17       “(a) *AUTHORIZATION*.—In any investigation relating  
18      to any act or activity involving a Federal health care of-  
19      fense, the Attorney General or the Attorney General’s des-  
20      ignee may issue in writing and cause to be served a sub-  
21      poena requiring the production of any records (including  
22      any books, papers, documents, electronic media, or other ob-  
23      jects or tangible things), which may be relevant to an au-  
24      thorized law enforcement inquiry, that a person or legal en-  
25      tity may possess or have care, custody, or control. A sub-

1 *poena shall describe the objects required to be produced and*  
2 *prescribe a return date within a reasonable period of time*  
3 *within which the objects can be assembled and made avail-*  
4 *able.*

5       “(b) *SERVICE*.—*A subpoena issued under this section*  
6 *may be served by any person designated in the subpoena*  
7 *to serve it. Service upon a natural person may be made*  
8 *by personal delivery of the subpoena to him. Service may*  
9 *be made upon a domestic or foreign corporation or upon*  
10 *a partnership or other unincorporated association which is*  
11 *subject to suit under a common name, by delivering the sub-*  
12 *poena to an officer, to a managing or general agent, or to*  
13 *any other agent authorized by appointment or by law to*  
14 *receive service of process. The affidavit of the person serving*  
15 *the subpoena entered on a true copy thereof by the person*  
16 *serving it shall be proof of service.*

17       “(c) *ENFORCEMENT*.—*In the case of contumacy by or*  
18 *refusal to obey a subpoena issued to any person, the Attor-*  
19 *ney General may invoke the aid of any court of the United*  
20 *States within the jurisdiction of which the investigation is*  
21 *carried on or of which the subpoenaed person is an inhab-*  
22 *itant, or in which he carries on business or may be found,*  
23 *to compel compliance with the subpoena. The court may*  
24 *issue an order requiring the subpoenaed person to appear*  
25 *before the Attorney General to produce records, if so ordered,*

1 *or to give testimony touching the matter under investiga-*  
2 *tion. Any failure to obey the order of the court may be pun-*  
3 *ished by the court as a contempt thereof. All process in any*  
4 *such case may be served in any judicial district in which*  
5 *such person may be found.*

6       “(d) *IMMUNITY FROM CIVIL LIABILITY.*—Notwith-  
7 *standing any Federal, State, or local law, any person, in-*  
8 *cluding officers, agents, and employees, receiving a sum-*  
9 *mons under this section, who complies in good faith with*  
10 *the summons and thus produces the materials sought, shall*  
11 *not be liable in any court of any State or the United States*  
12 *to any customer or other person for such production or for*  
13 *nondisclosure of that production to the customer.*

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

1           “(2) *In assessing good cause, the court shall weigh the*  
2 *public interest and the need for disclosure against the in-*  
3 *jury to the patient, to the physician-patient relationship,*  
4 *and to the treatment services.*

5           “(3) *Upon the granting of such order, the court, in*  
6 *determining the extent to which any disclosure of all or any*  
7 *part of any record is necessary, shall impose appropriate*  
8 *safeguards against unauthorized disclosure.”.*

9           (b) *CLERICAL AMENDMENT.—The table of sections at*  
10 *the beginning of chapter 223 of title 18, United States Code,*  
11 *is amended by inserting after the item relating to section*  
12 *3485 the following new item:*

*“3486. Authorized investigative demand procedures.”.*

13           (c)           *CONFORMING           AMENDMENT.—Section*  
14 *1510(b)(3)(B) of title 18, United States Code, is amended*  
15 *by inserting “or a Department of Justice subpoena (issued*  
16 *under section 3486 of title 18),” after “subpoena”.*

17           **SEC. 249. FORFEITURES FOR FEDERAL HEALTH CARE OF-**  
18                           **FENSES.**

19           (a) *IN GENERAL.—Section 982(a) of title 18, United*  
20 *States Code, is amended by adding after paragraph (5) the*  
21 *following new paragraph:*

22           “(6) *The court, in imposing sentence on a person con-*  
23 *victed of a Federal health care offense, shall order the person*  
24 *to forfeit property, real or personal, that constitutes or is*

1 *derived, directly or indirectly, from gross proceeds traceable*  
2 *to the commission of the offense.”*

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

6 (c) *PROPERTY FORFEITED DEPOSITED IN FEDERAL*  
7 *HOSPITAL INSURANCE TRUST FUND.*—

8 (1) *IN GENERAL.*—After the payment of the costs  
9 *of asset forfeiture has been made, and notwithstand-*  
10 *ing any other provision of law, the Secretary of the*  
11 *Treasury shall deposit into the Federal Hospital In-*  
12 *surance Trust Fund pursuant to section*  
13 *1817(k)(2)(C) of the Social Security Act, as added by*  
14 *section 301(b), an amount equal to the net amount re-*  
15 *alized from the forfeiture of property by reason of a*  
16 *Federal health care offense pursuant to section*  
17 *982(a)(6) of title 18, United States Code.*

18 (2) *COSTS OF ASSET FORFEITURE.*—For pur-  
19 *poses of paragraph (1), the term “payment of the*  
20 *costs of asset forfeiture” means—*

21 (A) *the payment, at the discretion of the At-*  
22 *torney General, of any expenses necessary to*  
23 *seize, detain, inventory, safeguard, maintain, ad-*  
24 *vertise, sell, or dispose of property under seizure,*  
25 *detention, or forfeited, or of any other necessary*

1 *expenses incident to the seizure, detention, for-*  
2 *feiture, or disposal of such property, including*  
3 *payment for—*

4 *(i) contract services,*

5 *(ii) the employment of outside contrac-*  
6 *tors to operate and manage properties or*  
7 *provide other specialized services necessary*  
8 *to dispose of such properties in an effort to*  
9 *maximize the return from such properties;*  
10 *and*

11 *(iii) reimbursement of any Federal,*  
12 *State, or local agency for any expenditures*  
13 *made to perform the functions described in*  
14 *this subparagraph;*

15 *(B) at the discretion of the Attorney Gen-*  
16 *eral, the payment of awards for information or*  
17 *assistance leading to a civil or criminal forfeit-*  
18 *ure involving any Federal agency participating*  
19 *in the Health Care Fraud and Abuse Control Ac-*  
20 *count;*

21 *(C) the compromise and payment of valid*  
22 *liens and mortgages against property that has*  
23 *been forfeited, subject to the discretion of the At-*  
24 *torney General to determine the validity of any*  
25 *such lien or mortgage and the amount of pay-*

1           *ment to be made, and the employment of attor-*  
 2           *neys and other personnel skilled in State real es-*  
 3           *tate law as necessary;*

4           *(D) payment authorized in connection with*  
 5           *remission or mitigation procedures relating to*  
 6           *property forfeited; and*

7           *(E) the payment of State and local property*  
 8           *taxes on forfeited real property that accrued be-*  
 9           *tween the date of the violation giving rise to the*  
 10          *forfeiture and the date of the forfeiture order.*

11           ***Subtitle F—Administrative***  
 12           ***Simplification***

13          ***SEC. 251. PURPOSE.***

14          *It is the purpose of this subtitle to improve the medi-*  
 15          *care program under title XVIII of the Social Security Act,*  
 16          *the medicaid program under title XIX of such Act, and the*  
 17          *efficiency and effectiveness of the health care system, by en-*  
 18          *couraging the development of a health information system*  
 19          *through the establishment of standards and requirements for*  
 20          *the electronic transmission of certain health information.*

21          ***SEC. 252. ADMINISTRATIVE SIMPLIFICATION.***

22          *(a) IN GENERAL.—Title XI (42 U.S.C. 1301 et seq.)*  
 23          *is amended by adding at the end the following:*

1       **“PART C—ADMINISTRATIVE SIMPLIFICATION**

2       **“SEC. 1171. DEFINITIONS.**

3           *“For purposes of this part:*

4                   *“(1) CLEARINGHOUSE.—The term ‘clearinghouse’*  
5           *means a public or private entity that—*

6                           *“(A) processes or facilitates the processing*  
7                   *of nonstandard data elements of health informa-*  
8                   *tion into standard data elements; or*

9                           *“(B) provides the means by which persons*  
10                   *may meet the requirements of this part.*

11                   *“(2) CODE SET.—The term ‘code set’ means any*  
12                   *set of codes used for encoding data elements, such as*  
13                   *tables of terms, medical concepts, medical diagnostic*  
14                   *codes, or medical procedure codes.*

15                   *“(3) HEALTH CARE PROVIDER.—The term*  
16                   *‘health care provider’ includes a provider of services*  
17                   *(as defined in section 1861(u)), a provider of medical*  
18                   *or other health services (as defined in section*  
19                   *1861(s)), and any other person furnishing health care*  
20                   *services or supplies.*

21                   *“(4) HEALTH INFORMATION.—The term ‘health*  
22                   *information’ means any information, whether oral or*  
23                   *recorded in any form or medium that—*

24                           *“(A) is created or received by a health care*  
25                   *provider, health plan, public health authority,*

1           *employer, life insurer, school or university, or*  
2           *clearinghouse; and*

3           “(B) *relates to the past, present, or future*  
4           *physical or mental health or condition of an in-*  
5           *dividual, the provision of health care to an indi-*  
6           *vidual, or the past, present, or future payment*  
7           *for the provision of health care to an individual.*

8           “(5) *HEALTH PLAN.—The term ‘health plan’*  
9           *means a plan which provides, or pays the cost of,*  
10          *health benefits. Such term includes the following, or*  
11          *any combination thereof:*

12           “(A) *Part A or part B of the medicare pro-*  
13           *gram under title XVIII.*

14           “(B) *The medicaid program under title*  
15           *XIX.*

16           “(C) *A medicare supplemental policy (as*  
17           *defined in section 1882(g)(1)).*

18           “(D) *Coverage issued as a supplement to li-*  
19           *ability insurance.*

20           “(E) *General liability insurance.*

21           “(F) *Worker’s compensation or similar in-*  
22           *surance.*

23           “(G) *Automobile or automobile medical-*  
24           *payment insurance.*

1           “(H) A long-term care policy, including a  
2           nursing home fixed indemnity policy (unless the  
3           Secretary determines that such a policy does not  
4           provide sufficiently comprehensive coverage of a  
5           benefit so that the policy should be treated as a  
6           health plan).

7           “(I) A hospital or fixed indemnity income-  
8           protection policy.

9           “(J) An employee welfare benefit plan, as  
10          defined in section 3(1) of the Employee Retirement  
11          Income Security Act of 1974 (29 U.S.C.  
12          1002(1)), but only to the extent the plan is estab-  
13          lished or maintained for the purpose of provid-  
14          ing health benefits and has 50 or more partici-  
15          pants (as defined in section 3(7) of such Act).

16          “(K) An employee welfare benefit plan or  
17          any other arrangement which is established or  
18          maintained for the purpose of offering or provid-  
19          ing health benefits to the employees of 2 or more  
20          employers.

21          “(L) The health care program for active  
22          military personnel under title 10, United States  
23          Code.

24          “(M) The veterans health care program  
25          under chapter 17 of title 38, United States Code.

1           “(N) *The Civilian Health and Medical Pro-*  
2           *gram of the Uniformed Services (CHAMPUS),*  
3           *as defined in section 1073(4) of title 10, United*  
4           *States Code.*

5           “(O) *The Indian health service program*  
6           *under the Indian Health Care Improvement Act*  
7           *(25 U.S.C. 1601 et seq.).*

8           “(P) *The Federal Employees Health Benefit*  
9           *Plan under chapter 89 of title 5, United States*  
10          *Code.*

11          “(Q) *Such other plan or arrangement as the*  
12          *Secretary determines is a health plan.*

13          “(6) *INDIVIDUALLY IDENTIFIABLE HEALTH IN-*  
14          *FORMATION.—The term ‘individually identifiable*  
15          *health information’ means any information, includ-*  
16          *ing demographic information collected from an indi-*  
17          *vidual, that—*

18                 “(A) *is created or received by a health care*  
19                 *provider, health plan, employer, or clearing-*  
20                 *house; and*

21                 “(B) *relates to the past, present, or future*  
22                 *physical or mental health or condition of an in-*  
23                 *dividual, the provision of health care to an indi-*  
24                 *vidual, or the past, present, or future payment*

1           *for the provision of health care to an individual,*  
2           *and—*

3                     *“(i) identifies the individual; or*

4                     *“(ii) with respect to which there is a*  
5                     *reasonable basis to believe that the informa-*  
6                     *tion can be used to identify the individual.*

7           “(7) *STANDARD.—The term ‘standard’, when*  
8           *used with reference to a data element of health infor-*  
9           *mation or a transaction referred to in section*  
10           *1173(a)(1), means any such data element or trans-*  
11           *action that meets each of the standards and imple-*  
12           *mentation specifications adopted or established by the*  
13           *Secretary with respect to the data element or trans-*  
14           *action under sections 1172 through 1174.*

15           “(8) *STANDARD SETTING ORGANIZATION.—The*  
16           *term ‘standard setting organization’ means a stand-*  
17           *ard setting organization accredited by the American*  
18           *National Standards Institute, including the National*  
19           *Council for Prescription Drug Programs, that devel-*  
20           *ops standards for information transactions, data ele-*  
21           *ments, or any other standard that is necessary to, or*  
22           *will facilitate, the implementation of this part.*

1 **“SEC. 1172. GENERAL REQUIREMENTS FOR ADOPTION OF**  
2 **STANDARDS.**

3 “(a) *APPLICABILITY.*—Any standard adopted under  
4 this part shall apply to the following persons:

5 “(1) *A health plan.*

6 “(2) *A clearinghouse.*

7 “(3) *A health care provider who transmits any*  
8 *health information in electronic form in connection*  
9 *with a transaction referred to in section 1173(a)(1).*

10 “(b) *REDUCTION OF COSTS.*—Any standard adopted  
11 under this part shall be consistent with the objective of re-  
12 ducing the administrative costs of providing and paying  
13 for health care.

14 “(c) *ROLE OF STANDARD SETTING ORGANIZATIONS.*—

15 “(1) *IN GENERAL.*—Except as provided in para-  
16 graph (2), any standard adopted under this part  
17 shall be developed or modified by a standard setting  
18 organization.

19 “(2) *SPECIAL RULES.*—

20 “(A) *DIFFERENT STANDARDS.*—The Sec-  
21 retary may adopt a standard that is different  
22 from any standard developed or modified by a  
23 standard setting organization, if—

24 “(i) *the different standard will sub-*  
25 *stantially reduce administrative costs to*

1           *health care providers and health plans com-*  
2           *pared to the alternatives; and*

3           “(ii) *the standard is promulgated in*  
4           *accordance with the rulemaking procedures*  
5           *of subchapter III of chapter 5 of title 5,*  
6           *United States Code.*

7           “(B) *NO STANDARD BY STANDARD SETTING*  
8           *ORGANIZATION.—If no standard setting organi-*  
9           *zation has adopted or modified any standard re-*  
10          *lating to a standard that the Secretary is au-*  
11          *thorized or required to adopt under this part—*

12                  “(i) *paragraph (1) shall not apply;*

13                  *and*

14                  “(ii) *subsection (f) shall apply.*

15          “(d) *IMPLEMENTATION SPECIFICATIONS.—The Sec-*  
16          *retary shall establish specifications for implementing each*  
17          *of the standards adopted under this part.*

18          “(e) *PROTECTION OF TRADE SECRETS.—Except as*  
19          *otherwise required by law, a standard adopted under this*  
20          *part shall not require disclosure of trade secrets or confiden-*  
21          *tial commercial information by a person required to comply*  
22          *with this part.*

23          “(f) *ASSISTANCE TO THE SECRETARY.—In complying*  
24          *with the requirements of this part, the Secretary shall rely*  
25          *on the recommendations of the Health Information Advi-*

1 sory Committee established under section 1179 and shall  
 2 consult with appropriate Federal and State agencies and  
 3 private organizations. The Secretary shall publish in the  
 4 Federal Register the recommendations of the Health Infor-  
 5 mation Advisory Committee regarding the adoption of a  
 6 standard under this part.

7 “(g) *APPLICATION TO MODIFICATIONS OF STAND-*  
 8 *ARDS.*—This section shall apply to a modification to a  
 9 standard (including an addition to a standard) adopted  
 10 under section 1174(b) in the same manner as it applies to  
 11 an initial standard adopted under section 1174(a).

12 **“SEC. 1173. STANDARDS FOR INFORMATION TRANSACTIONS**  
 13 **AND DATA ELEMENTS.**

14 “(a) *STANDARDS TO ENABLE ELECTRONIC EX-*  
 15 *CHANGE.*—

16 “(1) *IN GENERAL.*—The Secretary shall adopt  
 17 standards for transactions, and data elements for  
 18 such transactions, to enable health information to be  
 19 exchanged electronically, that are—

20 “(A) appropriate for the financial and ad-  
 21 ministrative transactions described in paragraph  
 22 (2); and

23 “(B) related to other financial and admin-  
 24 istrative transactions determined appropriate by  
 25 the Secretary consistent with the goals of im-

1           *proving the operation of the health care system*  
2           *and reducing administrative costs.*

3           “(2) *TRANSACTIONS.—The transactions referred*  
4           *to in paragraph (1)(A) are the following:*

5                   “(A) *Claims (including coordination of ben-*  
6                   *efits) or equivalent encounter information.*

7                   “(B) *Claims attachments.*

8                   “(C) *Enrollment and disenrollment.*

9                   “(D) *Eligibility.*

10                   “(E) *Health care payment and remittance*  
11                   *advice.*

12                   “(F) *Premium payments.*

13                   “(G) *First report of injury.*

14                   “(H) *Claims status.*

15                   “(I) *Referral certification and authoriza-*  
16                   *tion.*

17           “(3) *ACCOMMODATION OF SPECIFIC PROVID-*  
18           *ERS.—The standards adopted by the Secretary under*  
19           *paragraph (1) shall accommodate the needs of dif-*  
20           *ferent types of health care providers.*

21           “(b) *UNIQUE HEALTH IDENTIFIERS.—*

22                   “(1) *IN GENERAL.—The Secretary shall adopt*  
23                   *standards providing for a standard unique health*  
24                   *identifier for each individual, employer, health plan,*  
25                   *and health care provider for use in the health care*

1 *system. In carrying out the preceding sentence for*  
2 *each health plan and health care provider, the Sec-*  
3 *retary shall take into account multiple uses for iden-*  
4 *tifiers and multiple locations and specialty classifica-*  
5 *tions for health care providers.*

6 “(2) *USE OF IDENTIFIERS.—The standards*  
7 *adopted under paragraphs (1) shall specify the pur-*  
8 *poses for which a unique health identifier may be*  
9 *used.*

10 “(c) *CODE SETS.—*

11 “(1) *IN GENERAL.—The Secretary shall adopt*  
12 *standards that—*

13 “(A) *select code sets for appropriate data*  
14 *elements for the transactions referred to in sub-*  
15 *section (a)(1) from among the code sets that have*  
16 *been developed by private and public entities; or*

17 “(B) *establish code sets for such data ele-*  
18 *ments if no code sets for the data elements have*  
19 *been developed.*

20 “(2) *DISTRIBUTION.—The Secretary shall estab-*  
21 *lish efficient and low-cost procedures for distribution*  
22 *(including electronic distribution) of code sets and*  
23 *modifications made to such code sets under section*  
24 *1174(b).*

1       “(d) *SECURITY STANDARDS FOR HEALTH INFORMA-*  
2 *TION.—*

3               “(1) *SECURITY STANDARDS.—The Secretary*  
4 *shall adopt security standards that—*

5                       “(A) *take into account—*

6                               “(i) *the technical capabilities of record*  
7 *systems used to maintain health informa-*  
8 *tion;*

9                               “(ii) *the costs of security measures;*

10                              “(iii) *the need for training persons*  
11 *who have access to health information;*

12                              “(iv) *the value of audit trails in com-*  
13 *puterized record systems; and*

14                              “(v) *the needs and capabilities of small*  
15 *health care providers and rural health care*  
16 *providers (as such providers are defined by*  
17 *the Secretary); and*

18                              “(B) *ensure that a clearinghouse, if it is*  
19 *part of a larger organization, has policies and*  
20 *security procedures which isolate the activities of*  
21 *the clearinghouse with respect to processing in-*  
22 *formation in a manner that prevents unauthor-*  
23 *ized access to such information by such larger*  
24 *organization.*

1           “(2) *SAFEGUARDS.*—*Each person described in*  
2 *section 1172(a) who maintains or transmits health*  
3 *information shall maintain reasonable and appro-*  
4 *priate administrative, technical, and physical safe-*  
5 *guards—*

6                   “(A) *to ensure the integrity and confiden-*  
7 *tiality of the information;*

8                   “(B) *to protect against any reasonably an-*  
9 *ticipated—*

10                           “(i) *threats or hazards to the security*  
11 *or integrity of the information; and*

12                           “(ii) *unauthorized uses or disclosures*  
13 *of the information; and*

14                   “(C) *otherwise to ensure compliance with*  
15 *this part by the officers and employees of such*  
16 *person.*

17           “(e) *PRIVACY STANDARDS FOR HEALTH INFORMA-*  
18 *TION.*—*The Secretary shall adopt standards with respect to*  
19 *the privacy of individually identifiable health information.*  
20 *Such standards shall include standards concerning at least*  
21 *the following:*

22                   “(1) *The rights of an individual who is a subject*  
23 *of such information.*

24                   “(2) *The procedures to be established for the exer-*  
25 *cise of such rights.*

1           “(3) *The uses and disclosures of such informa-*  
2           *tion that are authorized or required.*

3           “(f) *ELECTRONIC SIGNATURE.—*

4           “(1) *IN GENERAL.—The Secretary, in coordina-*  
5           *tion with the Secretary of Commerce, shall adopt*  
6           *standards specifying procedures for the electronic*  
7           *transmission and authentication of signatures, com-*  
8           *pliance with which shall be deemed to satisfy Federal*  
9           *and State statutory requirements for written signa-*  
10           *tures with respect to the transactions referred to in*  
11           *subsection (a)(1).*

12           “(2) *PAYMENTS FOR SERVICES AND PRE-*  
13           *MIUMS.—Nothing in this part shall be construed to*  
14           *prohibit payment for health care services or health*  
15           *plan premiums by debit, credit, payment card or*  
16           *numbers, or other electronic means.*

17           “(g) *TRANSFER OF INFORMATION AMONG HEALTH*  
18           *PLANS.—The Secretary shall adopt standards for transfer-*  
19           *ring among health plans appropriate standard data ele-*  
20           *ments needed for the coordination of benefits, the sequential*  
21           *processing of claims, and other data elements for individ-*  
22           *uals who have more than one health plan.*

23           “**SEC. 1174. TIMETABLES FOR ADOPTION OF STANDARDS.**

24           “(a) *INITIAL STANDARDS.—The Secretary shall carry*  
25           *out section 1173 not later than 18 months after the date*

1 *of the enactment of this part, except that standards relating*  
2 *to claims attachments shall be adopted not later than 30*  
3 *months after such date.*

4       “(b) *ADDITIONS AND MODIFICATIONS TO STAND-*  
5 *ARDS.—*

6               “(1) *IN GENERAL.—Except as provided in para-*  
7 *graph (2), the Secretary shall review the standards*  
8 *adopted under section 1173, and shall adopt modi-*  
9 *fications to the standards (including additions to the*  
10 *standards), as determined appropriate, but not more*  
11 *frequently than once every 6 months. Any addition or*  
12 *modification to a standard shall be completed in a*  
13 *manner which minimizes the disruption and cost of*  
14 *compliance.*

15               “(2) *SPECIAL RULES.—*

16                       “(A) *FIRST 12-MONTH PERIOD.—Except*  
17 *with respect to additions and modifications to*  
18 *code sets under subparagraph (B), the Secretary*  
19 *may not adopt any modification to a standard*  
20 *adopted under this part during the 12-month pe-*  
21 *riod beginning on the date the standard is ini-*  
22 *tially adopted, unless the Secretary determines*  
23 *that the modification is necessary in order to*  
24 *permit compliance with the standard.*

1           “(B) *ADDITIONS AND MODIFICATIONS TO*  
2           *CODE SETS.—*

3                   “(i) *IN GENERAL.—The Secretary shall*  
4                   *ensure that procedures exist for the routine*  
5                   *maintenance, testing, enhancement, and ex-*  
6                   *pansion of code sets.*

7                   “(ii) *ADDITIONAL RULES.—If a code*  
8                   *set is modified under this subsection, the*  
9                   *modified code set shall include instructions*  
10                   *on how data elements of health information*  
11                   *that were encoded prior to the modification*  
12                   *may be converted or translated so as to pre-*  
13                   *serve the informational value of the data*  
14                   *elements that existed before the modifica-*  
15                   *tion. Any modification to a code set under*  
16                   *this subsection shall be implemented in a*  
17                   *manner that minimizes the disruption and*  
18                   *cost of complying with such modification.*

19           **“SEC. 1175. REQUIREMENTS.**

20                   “(a) *CONDUCT OF TRANSACTIONS BY PLANS.—*

21                           “(1) *IN GENERAL.—If a person desires to con-*  
22                           *duct a transaction referred to in section 1173(a)(1)*  
23                           *with a health plan as a standard transaction—*

24                                   “(A) *the health plan may not refuse to con-*  
25                                   *duct such transaction as a standard transaction;*

1           “(B) the health plan may not delay such  
2           transaction, or otherwise adversely affect, or at-  
3           tempt to adversely affect, the person or the trans-  
4           action on the ground that the transaction is a  
5           standard transaction; and

6           “(C) the information transmitted and re-  
7           ceived in connection with the transaction shall be  
8           in the form of standard data elements of health  
9           information.

10          “(2) *SATISFACTION OF REQUIREMENTS.*—A  
11          health plan may satisfy the requirements under para-  
12          graph (1) by—

13                 “(A) directly transmitting and receiving  
14                 standard data elements of health information; or

15                 “(B) submitting nonstandard data elements  
16                 to a clearinghouse for processing into standard  
17                 data elements and transmission by the clearing-  
18                 house, and receiving standard data elements  
19                 through the clearinghouse.

20          “(3) *TIMETABLE FOR COMPLIANCE.*—Paragraph  
21          (1) shall not be construed to require a health plan to  
22          comply with any standard, implementation specifica-  
23          tion, or modification to a standard or specification  
24          adopted or established by the Secretary under sections  
25          1172 through 1174 at any time prior to the date on

1 *which the plan is required to comply with the stand-*  
2 *ard or specification under subsection (b).*

3 *“(b) COMPLIANCE WITH STANDARDS.—*

4 *“(1) INITIAL COMPLIANCE.—*

5 *“(A) IN GENERAL.—Not later than 24*  
6 *months after the date on which an initial stand-*  
7 *ard or implementation specification is adopted*  
8 *or established under sections 1172 and 1173,*  
9 *each person to whom the standard or implemen-*  
10 *tation specification applies shall comply with the*  
11 *standard or specification.*

12 *“(B) SPECIAL RULE FOR SMALL HEALTH*  
13 *PLANS.—In the case of a small health plan,*  
14 *paragraph (1) shall be applied by substituting*  
15 *‘36 months’ for ‘24 months’. For purposes of this*  
16 *subsection, the Secretary shall determine the*  
17 *plans that qualify as small health plans.*

18 *“(2) COMPLIANCE WITH MODIFIED STAND-*  
19 *ARDS.—If the Secretary adopts a modification to a*  
20 *standard or implementation specification under this*  
21 *part, each person to whom the standard or implemen-*  
22 *tation specification applies shall comply with the*  
23 *modified standard or implementation specification at*  
24 *such time as the Secretary determines appropriate,*  
25 *taking into account the time needed to comply due to*

1 *the nature and extent of the modification. The time*  
2 *determined appropriate under the preceding sentence*  
3 *may not be earlier than the last day of the 180-day*  
4 *period beginning on the date such modification is*  
5 *adopted. The Secretary may extend the time for com-*  
6 *pliance for small health plans, if the Secretary deter-*  
7 *mines that such extension is appropriate.*

8 **“SEC. 1176. GENERAL PENALTY FOR FAILURE TO COMPLY**  
9 **WITH REQUIREMENTS AND STANDARDS.**

10 *“(a) GENERAL PENALTY.—*

11 *“(1) IN GENERAL.—Except as provided in sub-*  
12 *section (b), the Secretary shall impose on any person*  
13 *who violates a provision of this part a penalty of not*  
14 *more than \$100 for each such violation, except that*  
15 *the total amount imposed on the person for all viola-*  
16 *tions of an identical requirement or prohibition dur-*  
17 *ing a calendar year may not exceed \$25,000.*

18 *“(2) PROCEDURES.—The provisions of section*  
19 *1128A (other than subsections (a) and (b) and the*  
20 *second sentence of subsection (f)) shall apply to the*  
21 *imposition of a civil money penalty under this sub-*  
22 *section in the same manner as such provisions apply*  
23 *to the imposition of a penalty under such section*  
24 *1128A.*

25 *“(b) LIMITATIONS.—*

1           “(1) *OFFENSES OTHERWISE PUNISHABLE.*—A  
2           *penalty may not be imposed under subsection (a)*  
3           *with respect to an act if the act constitutes an offense*  
4           *punishable under section 1177.*

5           “(2) *NONCOMPLIANCE NOT DISCOVERED.*—A *pen-*  
6           *alty may not be imposed under subsection (a) with*  
7           *respect to a provision of this part if it is established*  
8           *to the satisfaction of the Secretary that the person lia-*  
9           *ble for the penalty did not know, and by exercising*  
10           *reasonable diligence would not have known, that such*  
11           *person violated the provision.*

12           “(3) *FAILURES DUE TO REASONABLE CAUSE.*—

13           “(A) *IN GENERAL.*—*Except as provided in*  
14           *subparagraph (B), a penalty may not be im-*  
15           *posed under subsection (a) if—*

16                   “(i) *the failure to comply was due to*  
17                   *reasonable cause and not to willful neglect;*  
18                   *and*

19                   “(ii) *the failure to comply is corrected*  
20                   *during the 30-day period beginning on the*  
21                   *first date the person liable for the penalty*  
22                   *knew, or by exercising reasonable diligence*  
23                   *would have known, that the failure to com-*  
24                   *ply occurred.*

25           “(B) *EXTENSION OF PERIOD.*—

1           “(i) *NO PENALTY.*—*The period referred*  
2           *to in subparagraph (A)(ii) may be extended*  
3           *as determined appropriate by the Secretary*  
4           *based on the nature and extent of the failure*  
5           *to comply.*

6           “(ii) *ASSISTANCE.*—*If the Secretary*  
7           *determines that a person failed to comply*  
8           *because the person was unable to comply,*  
9           *the Secretary may provide technical assist-*  
10           *ance to the person during the period de-*  
11           *scribed in subparagraph (A)(ii). Such as-*  
12           *istance shall be provided in any manner*  
13           *determined appropriate by the Secretary.*

14           “(4) *REDUCTION.*—*In the case of a failure to*  
15           *comply which is due to reasonable cause and not to*  
16           *willful neglect, any penalty under subsection (a) that*  
17           *is not entirely waived under paragraph (3) may be*  
18           *waived to the extent that the payment of such penalty*  
19           *would be excessive relative to the compliance failure*  
20           *involved.*

21   **“SEC. 1177. WRONGFUL DISCLOSURE OF INDIVIDUALLY**  
22           **IDENTIFIABLE HEALTH INFORMATION.**

23           “(a) *OFFENSE.*—*A person who knowingly and in vio-*  
24           *lation of this part—*

1           “(1) uses or causes to be used a unique health  
2     identifier;

3           “(2) obtains individually identifiable health in-  
4     formation relating to an individual; or

5           “(3) discloses individually identifiable health in-  
6     formation to another person,

7     shall be punished as provided in subsection (b).

8           “(b) *PENALTIES*.—A person described in subsection (a)  
9     shall—

10           “(1) be fined not more than \$50,000, imprisoned  
11     not more than 1 year, or both;

12           “(2) if the offense is committed under false pre-  
13     tenses, be fined not more than \$100,000, imprisoned  
14     not more than 5 years, or both; and

15           “(3) if the offense is committed with intent to  
16     sell, transfer, or use individually identifiable health  
17     information for commercial advantage, personal gain,  
18     or malicious harm, fined not more than \$250,000,  
19     imprisoned not more than 10 years, or both.

20     **“SEC. 1178. EFFECT ON STATE LAW.**

21           “(a) *GENERAL EFFECT*.—

22           “(1) *GENERAL RULE*.—Except as provided in  
23     paragraph (2), a provision or requirement under this  
24     part, or a standard or implementation specification  
25     adopted or established under sections 1172 through

1       1174, shall supersede any contrary provision of State  
2       law, including a provision of State law that requires  
3       medical or health plan records (including billing in-  
4       formation) to be maintained or transmitted in writ-  
5       ten rather than electronic form.

6               “(2) *EXCEPTIONS.*—A provision or requirement  
7       under this part, or a standard or implementation  
8       specification adopted or established under sections  
9       1172 through 1174, shall not supersede a contrary  
10      provision of State law, if the provision of State law—

11              “(A) imposes requirements, standards, or  
12              implementation specifications that are more  
13              stringent than the requirements, standards, or  
14              implementation specifications under this part  
15              with respect to the privacy of individually iden-  
16              tifiable health information; or

17              “(B) is a provision the Secretary deter-  
18              mines—

19                      “(i) is necessary to prevent fraud and  
20                      abuse, or for other purposes; or

21                      “(ii) addresses controlled substances.

22              “(b) *PUBLIC HEALTH REPORTING.*—Nothing in this  
23      part shall be construed to invalidate or limit the authority,  
24      power, or procedures established under any law providing  
25      for the reporting of disease or injury, child abuse, birth,

1 *or death, public health surveillance, or public health inves-*  
2 *tigation or intervention.*

3 **“SEC. 1179. HEALTH INFORMATION ADVISORY COMMITTEE.**

4       “(a) *ESTABLISHMENT.*—*There is established a com-*  
5 *mittee to be known as the Health Information Advisory*  
6 *Committee (in this section referred to as the ‘committee’).*

7       “(b) *DUTIES.*—*The committee shall—*

8               “(1) *provide assistance to the Secretary in com-*  
9 *plying with the requirements imposed on the Sec-*  
10 *retary under this part;*

11               “(2) *study the issues related to the adoption of*  
12 *uniform data standards for patient medical record*  
13 *information and the electronic exchange of such infor-*  
14 *mation;*

15               “(3) *report to the Secretary not later than 4*  
16 *years after the date of the enactment of this part rec-*  
17 *ommendations and legislative proposals for such*  
18 *standards and electronic exchange; and*

19               “(4) *generally be responsible for advising the*  
20 *Secretary and the Congress on the status of the imple-*  
21 *mentation of this part.*

22       “(c) *MEMBERSHIP.*—

23               “(1) *IN GENERAL.*—*The committee shall consist*  
24 *of 15 members of whom—*

25                       “(A) *3 shall be appointed by the President;*

1           “(B) 6 shall be appointed by the Speaker of  
2           the House of Representatives after consultation  
3           with the minority leader of the House of Rep-  
4           resentatives; and

5           “(C) 6 shall be appointed by the President  
6           pro tempore of the Senate after consultation with  
7           the minority leader of the Senate.

8           *The appointments of the members shall be made not*  
9           *later than 60 days after the date of the enactment of*  
10          *this part. The President shall designate 1 member as*  
11          *the Chair.*

12          “(2) *EXPERTISE.*—*The membership of the com-*  
13          *mittee shall consist of individuals who are of recog-*  
14          *nized standing and distinction in the areas of infor-*  
15          *mation systems, information networking and integra-*  
16          *tion, consumer health, health care financial manage-*  
17          *ment, or privacy, and who possess the demonstrated*  
18          *capacity to discharge the duties imposed on the com-*  
19          *mittee.*

20          “(3) *TERMS.*—*Each member of the committee*  
21          *shall be appointed for a term of 5 years, except that*  
22          *the members first appointed shall serve staggered*  
23          *terms such that the terms of not more than 3 members*  
24          *expire at one time.*

1           “(4) *INITIAL MEETING.*—Not later than 30 days  
2           after the date on which a majority of the members  
3           have been appointed, the committee shall hold its first  
4           meeting.

5           “(d) *REPORTS.*—Not later than 1 year after the date  
6           of the enactment of this part, and annually thereafter, the  
7           committee shall submit to the Congress, and make public,  
8           a report regarding—

9                   “(1) the extent to which persons required to com-  
10                  ply with this part are cooperating in implementing  
11                  the standards adopted under this part;

12                   “(2) the extent to which such entities are meeting  
13                  the privacy and security standards adopted under  
14                  this part and the types of penalties assessed for non-  
15                  compliance with such standards;

16                   “(3) whether the Federal and State Governments  
17                  are receiving information of sufficient quality to meet  
18                  their responsibilities under this part;

19                   “(4) any problems that exist with respect to im-  
20                  plementation of this part; and

21                   “(5) the extent to which timetables under this  
22                  part are being met.”.

23           (b) *CONFORMING AMENDMENTS.*—

1           (1) *REQUIREMENT FOR MEDICARE PROVIDERS.*—  
2     Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is  
3     amended—

4           (A) by striking “and” at the end of sub-  
5     paragraph (P);

6           (B) by striking the period at the end of sub-  
7     paragraph (Q) and inserting “; and”; and

8           (C) by inserting immediately after subpara-  
9     graph (Q) the following new subparagraph:

10          “(R) to contract only with a clearinghouse (as  
11     defined in section 1171) that meets each standard and  
12     implementation specification adopted or established  
13     under part C of title XI on or after the date on which  
14     the clearinghouse is required to comply with the  
15     standard or specification.”.

16          (2) *TITLE HEADING.*—Title XI (42 U.S.C. 1301  
17     et seq.) is amended by striking the title heading and  
18     inserting the following:

19     “*TITLE XI—GENERAL PROVISIONS, PEER RE-*  
20     *VIEW, AND ADMINISTRATIVE SIMPLIFICA-*  
21     *TION*”.