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104TH CONGRESS
1ST SESSION

H. R. 1912

To deter and penalize health care fraud and abuse and to simplify the administration of health benefit plans.

IN THE HOUSE OF REPRESENTATIVES

JUNE 22, 1995

Mr. STARK introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Ways and Means, and the Judiciary, 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

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A BILL

To deter and penalize health care fraud and abuse and to simplify the administration of health benefit plans.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Health Care Fraud Prevention and Paperwork Reduction Act of 1995".

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

Sec. 1. Short title; table of contents.
Sec. 2. Findings.

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Sec. 3. Inapplicability of McCarran-Ferguson Act.
Sec. 4. Definitions.

TITLE I—FRAUD AND ABUSE

Subtitle A—Amendments to Anti-Fraud and Abuse Provisions Applicable to Medicare, Medicaid, and State Health Care Programs

Sec. 101. Anti-kickback statutory provisions.
Sec. 102. Civil money penalties.
Sec. 103. Private right of action.
Sec. 104. Amendments to exclusionary provisions in fraud and abuse program.
Sec. 105. Sanctions against practitioners and persons for failure to comply with statutory obligations relating to quality of care.
Sec. 106. Revisions to criminal penalties.
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Subtitle B—Establishment of All-Payer Health Care Fraud and Abuse Control Program

Sec. 111. All-payer health care fraud and abuse control program.
Sec. 112. Establishment of all-payer health care fraud and abuse control account.

Subtitle C—Application of Fraud and Abuse Authorities Under the Social Security Act to Other Payers

Sec. 121. Application of civil money penalties to all payers.
Sec. 122. Application of certain criminal penalties to all payers.
Sec. 123. Construction of social security act references.

Subtitle D—Advisory Opinions on Kickbacks and Self-Referral

Sec. 131. Establishment of process for issuance of advisory opinions.
Sec. 132. Imposition of fees.

Subtitle E—Preemption of State Corporate Practice Laws

Sec. 141. Preemption of State laws prohibiting corporate practice of medicine.

TITLE II—INFORMATION SYSTEMS AND ADMINISTRATIVE SIMPLIFICATION

Sec. 201. Requirement for health benefit cards.
Sec. 202. National enrollment verification system.
Sec. 203. Requirements for uniform claims and electronic claims data set.
Sec. 204. Reporting of uniform clinical data sets.
Sec. 205. Uniform hospital cost reporting.
Sec. 206. Use of task forces.

SEC. 2. FINDINGS.

The Congress finds as follows:

(1) The costs of health care consume more than 14 percent of the gross domestic product of the

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United States, significantly affecting interstate commerce and the budget of the Federal Government.

(2) Federal outlays for the medicare program alone totaled $162,500,000,000 in fiscal year 1994 and are expected to exceed $177,000,000,000 in fiscal year 1995 and $198,000,000,000 in fiscal year 1996.

(3) According to the General Accounting Office, as much as 10 percent of all health care expenditures in the United States, or $100,000,000,000, is lost each year to health care fraud and abuse.

(4) As a direct provider of health care and as a source of payment for health care, the Federal Government has a significant interest in assessing the quality and costs of health care through the evaluative activities of several Federal agencies.

(5) The health care system existing throughout the United States has a significant effect on the amount, distribution, and use of Federal funds because of the large numbers of—

(A) individuals who receive health care benefits under programs operated or financed in whole or in part by the Federal Government;

(B) individuals who benefit because of the exclusion from Federal taxes of the amounts

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spent by their employers to provide them with health insurance benefits;

(C) health care providers and professionals who provide items and services for which the Federal Government makes payments; and

(D) health care providers and professionals who have received direct or indirect financial assistance from the Federal Government because of their status as such a provider or professional.

(6) It is in the interest of the United States that there be a national "all-payer" anti-fraud program, and a national administrative simplification program, for our health care industry.

SEC. 3. INAPPLICABILITY OF MCCARRAN-FERGUSON ACT.

For purposes of section 2(b) of the Act of March 9, 1945 (15 U.S.C. 1012(b); commonly known as the McCarran-Ferguson Act), this Act shall be considered to specifically relate to the business of insurance.

SEC. 4. DEFINITIONS.

For purposes of this Act:

(1) CARRIER.—The term "carrier" means a licensed insurance company, a hospital or medical service corporation (including an existing Blue Cross or Blue Shield organization, within the meaning of

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section 833(c)(2) of the Internal Revenue Code of 1986), a health maintenance organization, or other entity licensed or certified by a State to provide health insurance or health benefits. The Secretary may issue regulations that provide for affiliated carriers to be treated as a single carrier where appropriate under this title.

(2) HEALTH BENEFIT PLAN.—

(A) IN GENERAL.—The term "health benefit plan" means—

(i) a health plan, other than a plan described in subparagraph (B);

(ii) the medicare program;

(ii) medicare supplemental health insurance;

(iii) the medicaid program; and

(iv) except as the Secretary may provide, other Federal or State programs that provide for payments for health care services (other than coverage or insurance described in subparagraph (B)).

(B) EXCEPTION.—The term "health benefit plan" does not include any of the following (or any combination thereof):

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(i) Coverage only for accident, dental, vision, disability income, or long-term care insurance, or any combination thereof.

(ii) Coverage issued as a supplement to liability insurance.

(iii) Liability insurance, including general liability insurance and automobile liability insurance.

(iv) Worker's compensation or similar insurance.

(v) Automobile medical-payment insurance.

(vi) Coverage for a specified disease or illness.

(vii) A hospital or fixed indemnity policy.

(3) HEALTH BENEFIT PLAN SPONSOR.—The term "health benefit plan sponsor" means, in relation to a health benefit plan that—

(A) is an insured plan, the carrier providing the plan; or

(B) is a self-insured plan, the entity that sponsors the plan (as defined by the Secretary).

(4) HEALTH CARE PROVIDER.—The term "health care provider" includes a provider of services

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(as defined in section 1861(u) of the Social Security Act), a physician, a laboratory (as defined in section 353(a) of the Public Health Service Act), a supplier, and any other person furnishing health care in a State. Such term includes a Federal or State program that provides directly for the provision of health care to beneficiaries.

(5) HEALTH PLAN.—The term "health plan" means—

(A) any contract of health insurance, including any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract, that is provided by a carrier in a State; or

(B) an employee welfare benefit plan or other arrangement insofar as the plan or arrangement provides health benefits in a State and is funded in a manner other than through the purchase of one or more policies or contracts described in subparagraph (A).

(6) MANAGED CARE PLAN.—The term "managed care plan" means a health plan that provides for items and services covered under the plan pri-

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marily through providers in the provider network of the plan.

(7) POINT-OF-SERVICE PLAN.—The term "point-of-service plan" means a health plan other than a managed care plan that permits an enrollee to receive benefits through a provider network.

(8) PROVIDER NETWORK.—The term "provider network" means, with respect to a health plan, providers who have entered into an agreement with the plan under which such providers are obligated to provide items and services covered under the plan to individuals enrolled in the plan.

(9) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(10) SELF-INSURED.—The term "self-insured" means, with respect to a health plan, a plan that is described in paragraph (5)(B).

(11) STATE.—The term "State" means the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

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TITLE I—FRAUD AND ABUSE

Subtitle A—Amendments to Anti-Fraud and Abuse Provisions Applicable to Medicare, Medicaid, and State Health Care Programs

SEC. 101. ANTI-KICKBACK STATUTORY PROVISIONS.

(a) REVISION TO PENALTIES.—

(1) PERMITTING SECRETARY TO IMPOSE CIVIL MONETARY PENALTY.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)) is amended—

(A) by striking "or" at the end of paragraphs (1) and (2);

(B) by striking the semicolon at the end of paragraph (3) and inserting "; or"; and

(C) by inserting after paragraph (3) the following new paragraph:

"(4) carries out any activity in violation of paragraph (1) or (2) of section 1128B(b);".

(2) DESCRIPTION OF CIVIL MONETARY PENALTY APPLICABLE.—Section 1128A(a) of such Act (42 U.S.C. 1320a–7a(a)) is amended—

(A) by striking "given)." at the end of the first sentence and inserting the following:

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"given or, in cases under paragraph (4), $50,000 for each such violation)."; and

(B) by striking "claim." at the end of the second sentence and inserting the following: "claim (or, in cases under paragraph (4), damages of not more than three times the total amount of remuneration offered, paid, solicited, or received.".

(3) INCREASE IN CRIMINAL PENALTY.—Paragraphs (1) and (2) of section 1128B(b) of such Act (42 U.S.C. 1320a–7b(b)) are each amended—

(A) by striking "$25,000" and inserting "$50,000"; and

(B) by striking the period at the end and inserting the following: ", and shall be subject to damages of not more than three times the total remuneration offered, paid, solicited, or received.".

(b) REVISIONS TO EXCEPTIONS.—

(1) EXCEPTION FOR DISCOUNTS.—Section 1128B(b)(3)(A) of such Act (42 U.S.C. 1320a–7b(b)(3)(A)) is amended by striking "program;" and inserting "program and is not in the form of a cash payment;".

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(2) EXCEPTION FOR PAYMENTS TO EMPLOYEES.—Section 1128B(b)(3)(B) of such Act (42 U.S.C. 1320a–7b(b)(3)(B)) is amended by inserting at the end "if the amount of remuneration under the arrangement is consistent with the fair market value of the services and is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals, except that such employee can be paid remuneration in the form of a productivity bonus based on services personally performed by the employee.".

(3) EXCEPTION FOR WAIVER OF COINSURANCE BY CERTAIN PROVIDERS.—Section 1128B(b)(3)(D) of such Act (42 U.S.C. 1320a–7b(b)(3)(D)) is amended to read as follows:

"(D) a waiver or reduction of any coinsurance or other copayment if—

"(i) the waiver or reduction is made pursuant to a public schedule of discounts which the person is obligated as a matter of law to apply to certain individuals,

"(ii) the waiver or reduction is made pursuant to an established program and applies to a defined group of individuals whose incomes do not exceed 150 percent (or such higher percent-

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age as the Secretary may permit) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved,

"(iii) the waiver or reduction of coinsurance is not offered as part of any advertisement or solicitation and the person offering the waiver or reduction determines in good faith that the individual is in financial need,

"(iv) the person offering the waiver or reduction fails to collect the coinsurance or other payment after making reasonable collection efforts, or

"(v) the waiver or reduction of coinsurance is in accordance with a cost sharing schedule or a supplemental benefit package which may be offered by a managed care plan (as defined in section 4 of the Health Care Fraud Prevention and Paperwork Reduction Act of 1995); and".

(4) NEW EXCEPTION FOR CAPITATED PAYMENTS.—Section 1128B(b)(3) of such Act (42 U.S.C. 1320a–7b(b)(3)) is amended—

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(A) by striking "and" at the end of subparagraph (D);

(B) by striking the period at the end of subparagraph (E) and inserting "; and"; and

(C) by adding at the end the following new subparagraphs:

"(F) any reduction in cost sharing or increased benefits given to an individual, any amounts paid to a provider for an item or service furnished to an individual, or any discount or reduction in price given by the provider for such an item or service, if the individual is enrolled with and such item or service is covered under any of the following:

"(i) A health plan which is furnishing items or services under a risk-sharing contract under section 1876 or section 1903(m).

"(ii) A health plan receiving payments on a prepaid basis, under a demonstration project under section 402(a) of the Social Security Amendments of 1967 or under section 222(a) of the Social Security Amendments of 1972; and

"(G) any amounts paid to a provider for an item or service furnished to an individual or any discount or reduction in price given by the provider for

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such an item or service, if the individual is enrolled with and such item or service is covered under a health plan under which the provider furnishing the item or service is paid by the health plan for furnishing the item or service only on a capitated basis pursuant to a written arrangement between the plan and the provider in which the provider assumes financial risk for furnishing the item or service.".

(c) AUTHORIZATION FOR THE SECRETARY TO ISSUE REGULATIONS.—Section 1128B(b) of such Act (42 U.S.C. 1320a–7b(b)) is amended by adding at the end the following new paragraph:

"(4) The Secretary is authorized to impose by regulation such other requirements as needed to protect against program or patient abuse with respect to any of the exceptions described in paragraph (3).".

(d) CLARIFICATION OF OTHER ELEMENTS OF OFFENSE.—Section 1128B(b) of such Act (42 U.S.C. 1320a–7b(b)) is amended—

(1) in paragraph (1)(A), by striking "in return for referring" and inserting "to refer";

(2) in paragraph (1)(B), by striking "in return for purchasing, leasing, ordering, or arranging for or recommending" and inserting "to purchase, lease, order, or arrange for or recommend"; and

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(3) by adding at the end of paragraphs (1) and (2) the following sentence: "A violation exists under this paragraph if one or more purposes of the remuneration is unlawful under this paragraph.".

SEC. 102. CIVIL MONEY PENALTIES.

(a) PROHIBITION AGAINST OFFERING INDUCEMENTS TO INDIVIDUALS ENROLLED UNDER PLANS.—

(1) OFFER OF REMUNERATION.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)), as amended by section 101(a)(1), is amended—

(A) by striking "; or" at the end of paragraph (3) and inserting a semicolon;

(B) by striking the semicolon at the end of paragraph (4) and inserting "; or"; and

(C) by inserting after paragraph (4) the following new paragraph:

"(5) offers, pays, or transfers remuneration to any individual eligible for benefits under title XVIII of this Act, or under a State health care program (as defined in section 1128(h)) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in

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part, under title XVIII, or a State health care program, other than to influence an individual enrolled in a managed care plan or a point-of-service plan (as defined in section 4 of the Health Care Fraud Prevention and Paperwork Reduction Act of 1995 to receive benefits under the plan in accordance with established practice patterns for the delivery of medically necessary services;".

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

"(6) The term 'remuneration' includes the waiver or reduction of coinsurance amounts, and transfers of items or services for free or for other than fair market value, except that such term does not include the waiver or reduction of coinsurance amounts by a person or entity, if—

"(A) the waiver or reduction is made pursuant to a public schedule of discounts which the person is obligated as a matter of law to apply to certain individuals,

"(B) the waiver or reduction is made pursuant to an established program and applies to a defined group of individuals whose incomes do

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not exceed 150 percent (or such higher percentage as the Secretary may permit) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved,

"(C) the waiver or reduction of coinsurance is not offered as part of any advertisement or solicitation and the person offering the waiver or reduction determines in good faith that the individual is in financial need,

"(D) the person offering the waiver or reduction fails to collect the coinsurance or other payment after making reasonable collection efforts, or

"(E) the waiver or reduction of coinsurance is in accordance with a cost sharing schedule or a supplemental benefit package which may be offered by a managed care plan under section 4 of the Health Care Fraud Prevention and Paperwork Reduction Act of 1995.".

(b) ADDITIONAL OFFENSES.—Section 1128A(a) of such Act, as amended by section 101(a)(1) and subsection (a)(1), is further amended—

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(1) by striking "or" at the end of paragraph (4);

(2) by striking the semicolon at the end of paragraph (5) and inserting "; or"; and

(3) by inserting after paragraph (5) the following new paragraphs:

"(6) engages in a practice which has the effect of limiting or discouraging (as compared to other plan enrollees) the utilization of medically necessary health care services covered by law or under the service contract by title XIX or other publicly subsidized patients, including but not limited to differential standards for the location and hours of service offered by providers participating in the plan;

"(7) substantially fails to cooperate with a quality assurance program or a utilization review activity;

"(8) engaging in a pattern of failing substantially to provide or authorize medically necessary items and services that are required to be provided to an individual covered under a health plan (as defined in section 4 of the Health Care Fraud Prevention and Paperwork Reduction Act of 1995) or public program for the delivery of or payment for health care items or services, if the failure has adversely af-

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fected (or had a substantial likelihood of adversely affecting) the individual; or

"(9) submits false or fraudulent statements, data or information on claims to the Secretary, a State health care agency, or any other Federal, State or local agency charged with implementation or oversight of a health plan or a public program that the person knows or should know is fraudulent;".

(c) MODIFICATIONS OF AMOUNTS OF PENALTIES AND ASSESSMENTS.—Section 1128A(a) of such Act (42 U.S.C. 1320a–7a(a)), as amended by section 101(a), subsection (a)(1), and subsection (b), is amended in the matter following paragraph (9)—

(1) by striking "$2,000" and inserting "$10,000";

(2) by inserting after "under paragraph (4), $50,000 for each such violation" the following: "; in cases under paragraph (5), $10,000 for each such offer, payment, or transfer; in cases under paragraphs (6) through (9), an amount not to exceed $10,000 for each such determination by the Secretary"; and

(3) by striking "twice the amount" and inserting "three times the amount".

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(d) INTEREST ON PENALTIES.—Section 1128A(f) of such Act (42 U.S.C. 1320a–7a(f)) is amended by adding after the first sentence the following: "Interest shall accrue on the penalties and assessments imposed by a final determination of the Secretary in accordance with an annual rate established by the Secretary under the Federal Claims Collection Act. The rate of interest charged shall be the rate in effect on the date the determination becomes final and shall remain fixed at that rate until the entire amount due is paid. In addition, the Secretary is authorized to recover the costs of collection in any case where the penalties and assessments are not paid within 30 days after the determination becomes final, or in the case of a compromised amount, where payments are more than 90 days past due. In lieu of actual costs, the Secretary is authorized to impose a charge of up to 10 percent of the amount of penalties and assessments owed to cover the costs of collection.".

(e) AUTHORIZATION TO ACT.—

(1) IN GENERAL.—The first sentence of section 1128A(c)(1) of such Act (42 U.S.C. 1320a–7a(c)(1)) is amended by striking all that follows "(b)" and inserting the following: "unless, within one year after the date the Secretary presents a case to the Attorney General for consideration, the Attor-

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ney General brings an action in a district court of the United States.".

(2) EFFECTIVE DATE.—The amendment made by this paragraph (1) shall apply to cases presented by the Secretary of Health and Human Services for consideration on or after the date of the enactment of this Act.

(f) DEPOSIT OF PENALTIES COLLECTED INTO ALL-PAYER ACCOUNT.—Section 1128A(f)(3) of such Act (42 U.S.C. 1320a–7a(f)(3)) is amended by striking "as miscellaneous receipts of the Treasury of the United States" and inserting "in the All-Payer Health Care Fraud and Abuse Control Account established under section 112 of the Health Care Fraud Prevention and Paperwork Reduction Act of 1995".

(g) CLARIFICATION OF PENALTY IMPOSED ON EXCLUDED PROVIDER FURNISHING SERVICES.—Section 1128A(a)(1)(D) of such Act (42 U.S.C. 1320a–7a(a)(1)(D)) is amended by inserting "who furnished the service" after "in which the person".

SEC. 103. PRIVATE RIGHT OF ACTION.

Section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) is amended by adding at the end the following new subsection:

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"(m)(1) Subject to paragraphs (2) and (3), a carrier offering an insured health plan and the sponsor of a self-insured health plan that suffers financial harm as a direct result of the submission of claims by an individual or entity for payment for items and services furnished under the plan which makes the individual or entity subject to a civil monetary penalty under this section may, in a civil action against the individual or entity in the United States District Court, obtain damages against the individual or entity and such equitable relief as is appropriate.

"(2) A carrier or sponsor may bring a civil action under this subsection only if the carrier or sponsor provides the Secretary and the Attorney General with written notice of the intent to bring an action under this subsection, the identities of the individuals or entities the carrier or sponsor intends to name as defendants to the action, and all information the carrier or sponsor possesses regarding the activity that is the subject of the action that may materially affect the Secretary's decision to initiate a proceeding to impose a civil monetary penalty under this section against the defendants.

"(3) A carrier or sponsor may bring a civil action under this subsection only if any of the following conditions are met:

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"(A) During the 60-day period that begins on the date the Secretary receives the written notice described in paragraph (2), the Secretary does not notify the carrier or sponsor that the Secretary intends to initiate a proceeding to impose a civil monetary penalty under this section against the defendants.

"(B) If the Secretary notifies the carrier or sponsor during the 60-day period described in subparagraph (A) that the Secretary intends to initiate a proceeding to impose a civil monetary penalty under this section against the defendants, the Secretary subsequently notifies the carrier or sponsor that the Secretary no longer intends to initiate such a proceeding against the defendants.

"(C) After the expiration of the 2-year period that begins on the date the Secretary notifies the carrier or sponsor that the Secretary intends to initiate a proceeding to impose a civil monetary penalty under this section against the defendants, the Secretary has not made a good faith effort to initiate such a proceeding against the defendants.

"(4) If a carrier or sponsor is awarded any amounts in an action brought under this subsection that are in excess of the damages suffered by the carrier or sponsor as a result of the defendant's activities, 10 percent of such

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amounts shall be withheld from the carrier or sponsor for payment into the All-Payer Health Care Fraud and Abuse Control Account established under section 112 of the Health Care Fraud Prevention and Paperwork Reduction Act of 1995.

"(5) No action may be brought under this subsection more than 6 years after the date of the activity with respect to which the action is brought.".

SEC. 104. AMENDMENTS TO EXCLUSIONARY PROVISIONS IN FRAUD AND ABUSE PROGRAM.

(a) MANDATORY EXCLUSION OF INDIVIDUAL CONVICTED OF CRIMINAL OFFENSE RELATED TO HEALTH CARE FRAUD.—

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

"(3) FELONY CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted under Federal or State law, in connection with the delivery of a health care item or service on or after January 1, 1997, or with respect to any act or omission on or after such date in a program operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal

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offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.".

(2) CONFORMING AMENDMENT.—Section 1128(b)(1) of such Act (42 U.S.C. 1320a–7(b)(1)) is amended—

(A) in the heading, by striking "CONVICTION" and inserting "MISDEMEANOR CONVICTION"; and

(B) by striking "criminal offense" and inserting "criminal offense consisting of a misdemeanor".

(b) ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.—

(1) IN GENERAL.—Section 1128(c)(3) of such Act (42 U.S.C. 1320a–7(c)(3)) is amended by adding at the end the following new subparagraphs:

"(D) In the case of an exclusion of an individual or entity under paragraphs (1), (2), or (3) of subsection (b), the period of exclusion shall be a minimum of 3 years, unless the Secretary determines that an alternative period is appropriate because of aggravating or mitigating circumstances.

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"(E) In the case of an exclusion of an individual or entity under paragraph (4) or (5) of subsection (b), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

"(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.".

(2) CONFORMING AMENDMENT.—Section 1128(c)(3)(A) of such Act (42 U.S.C. 1320a–7(c)(3)(A)) is amended by striking "subsection (b)(12)" and inserting "paragraph (1), (2), (3), (4), (6)(B), or (12) of subsection (b)".

SEC. 105. SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS RELATING TO QUALITY OF CARE.

(a) MINIMUM PERIOD OF EXCLUSION FOR PRACTITIONERS AND PERSONS FAILING TO MEET STATUTORY OBLIGATIONS.—

(1) IN GENERAL.—The second sentence of section 1156(b)(1) of the Social Security Act (42 U.S.C. 1320c–5(b)(1)) is amended by striking "may

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prescribe)" and inserting "may prescribe, except that such period may not be less than one year)".

(2) CONFORMING AMENDMENT.—Section 1156(b)(2) of such Act (42 U.S.C. 1320c–5(b)(2)) is amended by striking "shall remain" and inserting "shall (subject to the minimum period specified in the second sentence of paragraph (1)) remain".

(b) AMOUNT OF CIVIL MONEY PENALTY.—Section 1156(b)(3) of such Act (42 U.S.C. 1320c–5(b)(3)) is amended by striking "the actual or estimated cost" and inserting the following: "$10,000 for each instance".

(c) REPEAL OF "UNWILLING OR UNABLE" CONDITION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1) of such Act (42 U.S.C. 1320c–5(b)(1)) is amended—

(1) in the second sentence, by striking "and determines" and all that follows through "such obligations," and

(2) by striking the third sentence.

SEC. 106. REVISIONS TO CRIMINAL PENALTIES.

(a) TREBLE DAMAGES FOR CRIMINAL SANCTIONS.—Section 1128B of the Social Security Act (42 U.S.C. 1320a–7b) is amended by adding at the end the following new subsection:

"(f) In addition to the fines that may be imposed under subsection (a) or (c) any individual found to have

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violated the provisions of any of such subsections may be subject to treble damages.".

(b) IDENTIFICATION OF COMMUNITY SERVICE OPPORTUNITIES.—Section 1128B of such Act (42 U.S.C. 1320a–7b), as amended by subsection (a), is further amended by adding at the end the following new subsection:

"(g) The Secretary shall—

"(1) in consultation with State and local health care officials, identify opportunities for the satisfaction of community service obligations that a court may impose upon the conviction of an offense under this section, and

"(2) make information concerning such opportunities available to Federal and State law enforcement officers and State and local health care officials.".

SEC. 107. EFFECTIVE DATE.

The amendments made by this subtitle shall take effect January 1, 1997.

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Subtitle B—Establishment of All-Payer Health Care Fraud and Abuse Control Program

SEC. 111. ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM.

(a) IN GENERAL.—Not later than January 1, 1997, the Secretary (acting through the Inspector General of the Department of Health and Human Services) and the Attorney General shall establish a program—

(1) to coordinate the functions of the Attorney General, the Secretary, and other organizations with respect to the prevention, detection, and control of health care fraud and abuse,

(2)(A) to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care services in the United States which are not subject to investigation, audit, evaluation, and inspection by the Inspector General of another executive department, and (B) to facilitate the conducting of such investigations, audits, evaluations, and inspections relating to the delivery of and payment for other health care services in the United States, and

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(3) to facilitate the enforcement of this subtitle and other statutes applicable to health care fraud and abuse.

(b) COORDINATION WITH LAW ENFORCEMENT AGENCIES.—In carrying out the program under subsection (a), the Secretary and Attorney General shall consult with, and arrange for the sharing of data and resources with Federal, State and local law enforcement agencies, State Medicaid Fraud Control Units, and State agencies responsible for the licensing and certification of health care providers.

(c) COORDINATION WITH HEALTH PLANS.—In carrying out the program under subsection (a), the Secretary and Attorney General shall consult with, and arrange for the sharing of data with representatives of qualified health plans.

(d) AUTHORITIES OF ATTORNEY GENERAL AND INSPECTOR GENERAL.—In carrying out duties under subsection (a), the Attorney General and the Inspector General are authorized—

(1) to conduct, supervise, and coordinate audits, civil and criminal investigations, inspections, and evaluations relating to the program established under such subsection; and

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(2) to have access (including on-line access as requested and available) to all records available to qualified health plans relating to the activities described in paragraph (1) (subject to restrictions based on the confidentiality of certain information under section 204(a)).

(e) FAILURE TO PROVIDE INFORMATION AS GROUNDS FOR PERMISSIVE EXCLUSION UNDER MEDICARE AND MEDICAID.—Section 1128(b)(9) of the Social Security Act (42 U.S.C. 1320a–7(b)(9)) is amended by striking the period at the end and inserting ", or provide any information requested by the Attorney General or the Inspector General of the Department of Health and Human Services to carry out the All-Payer Health Care Fraud and Abuse Control Program established under section 111 of the Health Care Fraud Prevention and Paperwork Reduction Act of 1995.";

(f) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) of the Social Security Act (relating to limitation on liability) shall apply to a person providing information or communications to the Secretary or Attorney General in conjunction with their performance of duties under this section, in the same manner as such section applies to information provided

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to organizations with a contract under part B of title XI of such Act.

(g) AUTHORIZATIONS OF APPROPRIATIONS FOR INVESTIGATORS AND OTHER PERSONNEL.—In addition to any other amounts authorized to be appropriated to the Secretary and the Attorney General for health care anti-fraud and abuse activities for a fiscal year, there are authorized to be appropriated such additional amounts as may be necessary to enable the Secretary and the Attorney General to conduct investigations, audits, evaluations, and inspections of allegations of health care fraud and abuse and otherwise carry out the program established under subsection (a) in a fiscal year.

(h) USE OF POWERS UNDER INSPECTOR GENERAL ACT OF 1978.—In carrying out duties and responsibilities under the program established under subsection (a), the Inspector General is authorized to exercise all powers granted under the Inspector General Act of 1978 to the same manner and extent as provided in that Act.

(i) DEFINITION.—In this subtitle, the term "Inspector General" means the Inspector General of the Department of Health and Human Services.

SEC. 112. ESTABLISHMENT OF ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.

(a) ESTABLISHMENT.—

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(1) IN GENERAL.—There is hereby created on the books of the Treasury of the United States an account to be known as the "All-Payer Health Care Fraud and Abuse Control Account" (in this section referred to as the "Anti-Fraud Account"). The Anti-Fraud Account shall consist of such gifts and bequests as may be made as provided in paragraph (2) and such amounts as may be deposited in such Anti-Fraud Account as provided in section 122(d)(2) and title XI of the Social Security Act. It shall also include the following:

(A) All criminal fines imposed in cases involving a Federal health care offense (as defined in subsection (d)).

(B) Penalties and damages imposed under the False Claims Act (31 U.S.C. 3729 et seq.), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator or for restitution).

(C) Administrative penalties and assessments imposed under titles XI, XVIII, and XIX of the Social Security Act and section 122 (except as otherwise provided by law).

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(D) Amounts resulting from the forfeiture of property by reason of a Federal health care offense.

(E) Amounts received from the payment of fees to the Secretary of Health and Human Services and the Attorney General under section 132 by individuals and entities requesting advisory opinions under section 131.

Any such funds received on or after the date of the enactment of this Act shall be deposited in the Anti-Fraud Account.

(2) AUTHORIZATION TO ACCEPT GIFTS.—The Anti-Fraud Account is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to the Anti-Fraud Account, for the benefit of the Anti-Fraud Account or any activity financed through the Anti-Fraud Account.

(3) ADMINISTRATION THROUGH BOARD OF TRUSTEES.—The Anti-Fraud Account shall have a Board of Trustees consisting of the Secretary of Treasury, the Attorney General, the Secretary of Health and Human Services, the Inspector General, and a State Attorney General selected by the Inspector General. The Board of Trustees shall allocate

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and dispense funds in the Account and generally administer the operations of the Account.

(b) USE OF FUNDS.—

(1) IN GENERAL.—Amounts in the Anti-Fraud Account shall be available without appropriation and until expended as determined jointly by the Secretary and Attorney General in carrying out the All-Payer Health Care Fraud and Abuse Control Program established under section 111 (including the administration of the Program), and may be used to cover costs incurred in operating the Program, including—

(A) costs of prosecuting health care matters (through criminal, civil and administrative proceedings);

(B) costs of investigations (including equipment, salaries, administratively uncontrollable work, travel, and training of law enforcement personnel);

(C) costs of financial and performance audits of health care programs and operations; and

(D) costs of inspections and other evaluations.

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(2) FUNDS USED TO SUPPLEMENT AGENCY APPROPRIATIONS.—It is intended that disbursements made from the Anti-Fraud Account to any Federal agency be used to increase and not supplant the recipient agency's appropriated operating budget.

(3) USE OF FUNDS FOR EDUCATIONAL ACTIVITIES.—Amounts in the Anti-Fraud Account may be used to carry out activities designed to educate providers of health care services about the provisions of this subtitle (and the provisions of law amended by this subtitle).

(4) START-UP COSTS OF PROCESS FOR ISSUANCE OF ADVISORY OPINIONS.—Amounts in the Anti-Fraud Account may be used to establish the process described in section 131 for the issuance of advisory opinions by the Secretary of Health and Human Services and the Attorney General, but only during the first year for which the process is in operation.

(c) ANNUAL REPORT.—The Board of Trustees shall submit an annual report to Congress on the amount of revenue which is generated and disbursed by the Anti-Fraud Account in each fiscal year.

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(d) FEDERAL HEALTH CARE OFFENSE DEFINED.—The term "Federal health care offense" means a violation of, or a criminal conspiracy to violate—

(1) sections 226, 668, 1033, or 1347 of title 18, United States Code;

(2) section 1128B of the Social Security Act;

(3) sections 287, 371, 664, 666, 1001, 1027, 1341, 1343, or 1954 of title 18, United States Code, if the violation or conspiracy relates to health care fraud;

(4) sections 501 or 511 of the Employee Retirement Income Security Act of 1974, if the violation or conspiracy relates to health care fraud; or

(5) sections 301, 303(a)(2), or 303(b) or (e) of the Federal Food, Drug and Cosmetic Act, if the violation or conspiracy relates to health care fraud.

Subtitle C—Application of Fraud and Abuse Authorities Under the Social Security Act to Other Payers

SEC. 121. APPLICATION OF CIVIL MONEY PENALTIES TO ALL PAYERS.

(a) ACTIONS SUBJECT TO PENALTY.—Any person who is determined by the Secretary to have committed any of the following actions with respect to a qualified health

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plan shall be subject to a penalty in accordance with subsection (b):

(1) ACTIONS SUBJECT TO PENALTY UNDER MEDICARE, MEDICAID, AND OTHER SOCIAL SECURITY HEALTH PROGRAMS.—Any action that would subject the person to a penalty under paragraphs (1) through (9) of section 1128A(a) of the Social Security Act if the action was taken with respect to title V, XVIII, XIX, or XX of such Act.

(2) DISCRIMINATING ON BASIS OF MEDICAL CONDITION.—The engagement in any practice that would reasonably be expected to have the effect of denying or discouraging the initial or continued enrollment in a health plan by individuals whose medical condition or history indicates a need for substantial future medical services.

(3) INDUCING ENROLLMENT ON FALSE PRETENSES.—The engagement in any practice to induce enrollment in a health plan through representations to individuals which the person knows or should know are false or fraudulent.

(b) PENALTIES DESCRIBED.—

(1) GENERAL RULE.—Any person who the Secretary determines has committed an action described in paragraphs (2) through (4) of subsection (a) shall

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be subject to a civil monetary penalty in an amount not to exceed $10,000 for each such determination.

(2) ACTIONS SUBJECT TO PENALTIES UNDER SOCIAL SECURITY ACT.—In the case of a person who the Secretary determines has committed an action described in paragraph (1) of subsection (a), the person shall be subject to the civil monetary penalty (together with any additional assessment) to which the person would be subject under section 1128A of the Social Security Act if the action on which the determination is based had been committed with respect to title V, XVIII, XIX, or XX of such Act.

(c) APPLICABILITY OF PROCEDURES UNDER SOCIAL SECURITY ACT.—The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to the imposition of a civil monetary penalty or assessment under this section in the same manner as such provisions apply with respect to the imposition of a penalty or assessment under section 1128A of such Act.

(d) TREATMENT OF AMOUNTS RECOVERED.—Any amounts recovered under this section shall be paid to the Secretary and disposed of as follows:

(1) Such portions of the amounts recovered as is determined to have been improperly paid from a

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qualified health plan for the delivery of or payment for health care items or services shall be repaid to such plan.

(2) The remainder of the amounts recovered shall be deposited in the All-Payer Health Care Fraud and Abuse Control Account established under section 112.

(e) NOTIFICATION OF LICENSING AUTHORITIES.—Whenever the Secretary's determination to impose a penalty or assessment under this section becomes final, the Secretary shall notify the appropriate State or local licensing agency or organization (including the agency specified in section 1864(a) and 1902(a)(33) of the Social Security Act) that such a penalty or assessment has become final and the reasons therefore.

SEC. 122. APPLICATION OF CERTAIN CRIMINAL PENALTIES TO ALL PAYERS.

Any person who is determined by the Attorney General (in consultation with the Secretary) to have committed any action with respect to a qualified health plan that would subject the person to a penalty under subsection (a) or (b) of section 1128B of the Social Security Act if the action was taken with respect to title V, XVIII, XIX, or XX of such Act shall be subject to the penalty (together

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with any assessment) that would apply if the action was taken with respect to any such title.

SEC. 123. CONSTRUCTION OF SOCIAL SECURITY ACT REFERENCES.

(a) INCORPORATION OF OTHER AMENDMENTS.—Any reference in this subtitle to a provision of the Social Security Act shall be considered a reference to the provision as amended under subtitle A.

(b) EFFECT OF SUBSEQUENT AMENDMENTS.—Except as provided in subsection (a), any reference to a provision of the Social Security Act in this subtitle shall be deemed to be a reference to such provision as in effect on the date of the enactment of this Act, and (except as Congress may otherwise provide) any amendments made to such provisions after such date shall not be taken into account in determining the applicability of such provisions to individuals and entities under this Act.

Subtitle D—Advisory Opinions on Kickbacks and Self-Referral

SEC. 131. ESTABLISHMENT OF PROCESS FOR ISSUANCE OF ADVISORY OPINIONS.

(a) ESTABLISHMENT.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services (in consultation with the Attorney General) shall establish a process under which indi-

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viduals and entities may submit a request to the Secretary for an advisory opinion regarding whether any conduct of the individual or entity—

(1) constitutes grounds for the imposition of a sanction under section 1128B(b) (relating to kickbacks, bribes, and rebates) of the Social Security Act or under subtitle C through the application of such section; or

(2) would result in the denial of payment for a service furnished by the individual or entity, or the imposition of a civil money penalty, on the basis described in section 1877 of the Social Security Act.

(b) DEADLINE FOR RESPONSE.—The Secretary of Health and Human Services shall respond to a request for an advisory opinion submitted under subsection (a) not later than 90 days after receiving the request.

(c) OPINIONS LIMITED TO QUESTIONS OF FACT.—An advisory opinion issued under subsection (a) may only respond to the facts presented by the individual or entity requesting the advisory opinion.

(d) ISSUANCE OF REGULATIONS.—The Secretary may issue such regulations as the Secretary considers appropriate to carry out this subtitle, including regulations concerning the process under which individuals and enti-

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ties submit and the Secretary responds to requests for advisory opinions.

SEC. 132. IMPOSITION OF FEES.

(a) IN GENERAL.—The Secretary of Health and Human Services and the Attorney General shall require an individual or entity requesting an advisory opinion under section 131 to submit a fee.

(b) AMOUNT.—The amount of the fee required under subsection (a) shall be equal to the costs incurred by the Secretary and the Attorney General in responding to the request.

Subtitle E—Preemption of State Corporate Practice Laws

SEC. 141. PREEMPTION OF STATE LAWS PROHIBITING CORPORATE PRACTICE OF MEDICINE.

No provision of State or local law shall apply that prohibits a corporation from practicing medicine.

TITLE II—INFORMATION SYSTEMS AND ADMINISTRATIVE SIMPLIFICATION

SEC. 201. REQUIREMENT FOR HEALTH BENEFIT CARDS.

(a) HEALTH BENEFIT CARDS.—

(1) REQUIREMENT.—Each health benefit plan sponsor shall issue a health benefit card that meets the requirements of subsection (c) for each individ-

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ual who is entitled to benefits under a health benefit plan provided or sponsored by the sponsor.

(2) DEADLINE FOR APPLICATION OF REQUIREMENT.—The deadline specified under this paragraph for the requirement under paragraph (1) is 12 months after the date the standards are established under subsection (c).

(b) ENFORCEMENT THROUGH CIVIL MONEY PENALTIES.—

(1) IN GENERAL.—In the case of a health benefit plan sponsor that fails to issue a health benefit card in accordance with subsection (a)(1), the sponsor is subject to a civil money penalty not to exceed $100 for each such violation. The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to a civil money penalty under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) EFFECTIVE DATE.—No penalty may be imposed under paragraph (1) for any failure occurring before the deadline specified in subsection (a)(2).

(c) HEALTH BENEFIT CARDS.—

(1) IN GENERAL.—The Secretary shall establish standards consistent with this subsection respecting

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the form and information to be contained on health benefit cards (for purposes of subsection (a)).

(2) ELECTRONIC.—

(A) IN GENERAL.—Subject to subparagraph (B), the card shall be in a form similar to that of a credit card and shall have, encoded in electronic form—

(i) the identity of the individual entitled to health benefits;

(ii) the health benefit plan in which the individual is enrolled;

(iii) the identity of each principal insured (as defined by the Secretary) for the family that includes the individual, in the case of an individual who is enrolled under a family class of enrollment;

(iv) the telephone number or numbers to be used for the submission electronically of claims under the plan under section 203; and

(v) information relating to organ donation.

(B) USE OF ELECTRONIC READ-AND-WRITE CARDS.—The Secretary may provide for cards in an electronic form that permits infor-

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mation on the card to be readily changed. Such information may include information relating to the health coverage status of the individual and the medical history of the individual.

(C) PERSONAL IDENTIFIER.—For purposes of subparagraph (A) and for purposes of claims processing and related purposes under section 203, the Social Security account number of the individual or, in the case of an infant or other individual to whom such a number has not been issued, such a Social Security account number of a parent or guardian or other number as the Secretary shall specify, shall be used as the personal identifier for the individual.

(3) ADDITIONAL INFORMATION.—The card shall include such additional information, in electronic or other form, as the Secretary may require to carry out the purposes of this Act. In addition, the health benefit plan sponsor issuing the card may include such additional information on the card as the sponsor desires, subject to such limitations as the Secretary may provide.

(4) PERMISSIBLE USES OF CARD.—A health benefit card that is issued to an individual who is entitled to benefits under a health benefit plan may

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be used by an individual or entity only for the purpose of providing or assisting the individual entitled to benefits in obtaining an item or service that is covered under such plan.

(5) DEADLINE.—The Secretary shall first establish the standards for health benefit cards under this subsection by not later than 18 months after the date of the enactment of this Act.

(d) APPLICATION TO MEDICARE AND MEDICAID PROGRAM.—

(1) MEDICARE PROGRAM.—The Secretary shall provide, in regulations promulgated to carry out the medicare program, that identification cards issued under that program are modified to the extent required to conform to the standards established under subsection (c), by not later than the deadline specified in subsection (a)(2).

(2) STATE MEDICAID PLANS.—As a condition for the approval of a State plan under the medicaid program, effective for calendar quarters beginning on or after the deadline specified in subsection (a)(2), each such plan shall provide, in accordance with regulations of the Secretary, that identification cards issued under the plan are modified to the extent required to conform to subsection (c).

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SEC. 202. NATIONAL ENROLLMENT VERIFICATION SYSTEM.

(a) ESTABLISHMENT.—The Secretary shall establish a national enrollment verification system for the verification of an individual's enrollment in a health benefit plan and entitlement to benefits under such plan. The system shall assist in the identification of, and collection from, parties responsible for the payment for health care items and services furnished to individuals enrolled under a health benefit plan.

(b) INFORMATION IN SYSTEM.—The enrollment verification system shall contain such information submitted by health benefit plan sponsors, employers, and other individuals and entities specified by the Secretary as the Secretary shall determine in standards established under this section. The information shall include the following with respect to each individual enrolled in a health benefit plan (regardless of whether the individual is enrolled under an individual or a family class of enrollment):

(1) The name, address, and personal identifier of the individual and the identity of each principal insured (as defined by the Secretary under section 201(c)(2)(A)(iii)) for the family that includes the individual, in the case of an individual who is enrolled under a family class of enrollment.

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(2) The name, address, and telephone number of each health benefit plan in which the individual is enrolled.

(3) The type of coverage elected.

(4) Race and ethnicity data.

(5) The period for which such coverage is elected.

(6) The status of individuals with respect to deductibles, copayments, coinsurance, or out-of-pocket limits on cost sharing.

(7) Coordination of benefit information appropriate in determining liability in cases in which benefits may be payable under 2 or more health benefit plans.

(c) PERIODICITY OF SUBMISSIONS.—The standards established by the Secretary under this subsection shall require the submission of information to the national enrollment verification system on a periodic basis (as determined by the Secretary) in order to report applicable changes with respect to enrollment status or eligibility.

(d) FORM OF INQUIRY.—The verification system shall be capable of accepting inquiries from health care providers, health benefit plan sponsors (and any other individual or entity determined appropriate by the Sec-

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retary) in a variety of electronic and other forms, including—

(1) through electronic transmission of information on the health benefit card (in a manner similar to that for verification of credit card purchases);

(2) through the use of a touch-tone telephone line; and

(3) through the use of a computer modem.

(e) FORM OF RESPONSE.—The system shall be capable of responding to inquiries under subsection (d) in a variety of electronic and other forms, including—

(1) through modem transmission of information;

(2) through computer synthesized voice communication; and

(3) through transmission of information to a facsimile (fax) machine.

(f) LIMITS ON DISCLOSURE OF INFORMATION REPORTED.—The disclosure of information reported to the national enrollment verification system shall be restricted by the Secretary under standards established by the Secretary.

(g) FEES.—The Secretary may impose a fee for the acceptance of, or response to, an inquiry to the verification system.

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(h) PUBLIC DOMAIN SOFTWARE TO PROVIDERS.—The Secretary shall provide for the development, and shall make available without charge to health care providers, such computer software as will enable such providers to make inquiries to, and receive responses from, the national enrollment verification system in electronic form.

(i) DEADLINE.—The Secretary shall establish the system and standards under this section (and shall develop and make available the software under subsection (h)) by not later than 12 months after the date of the enactment of this Act.

(j) CIVIL MONEY PENALTY.—In the case of a failure of an individual or entity to report information to the enrollment verification system under a standard established by the Secretary under this section, the individual or entity shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $100 for each day in which such failure persists. The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to a civil money penalty under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(k) ELIMINATION OF EMPLOYER REQUIREMENT TO REPORT CERTAIN INFORMATION TO MEDICARE AND

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MEDICAID COVERAGE DATA BANK.—Effective upon full implementation of the national enrollment verification system under this section—

(1) no employer is required to make any reports under section 1144(c) of the Social Security Act; and

(2) information and functions previously in or performed by the Medicare and Medicaid Coverage Data Bank under section 1144 of such Act shall be subsumed by the enrollment verification system.

SEC. 203. REQUIREMENTS FOR UNIFORM CLAIMS AND ELECTRONIC CLAIMS DATA SET.

(a) REQUIREMENTS.—

(1) SUBMISSION OF CLAIMS.—Each health care provider that furnishes services in the United States for which payment may be made under a health benefit plan shall submit any claim for payment for such services only in a form and manner consistent with the standards established under subsection (c).

(2) ACCEPTANCE OF CLAIMS.—A health benefit plan sponsor may not reject a claim for payment under the health benefit plan provided on the basis of the form or manner in which the claim is submitted if the claim is submitted in accordance with the standards established under subsection (c).

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(3) EFFECTIVE DATE.—This subsection shall apply to claims for services furnished on or after the date that is 6 months after the date standards are established under subsection (c).

(b) ENFORCEMENT THROUGH CIVIL MONEY PENALTIES.—

(1) IN GENERAL.—

(A) PROVIDERS.—In the case of a health care provider that submits a claim in violation of subsection (a)(1), the provider is subject to a civil money penalty of not to exceed $100 (or, if greater, the amount of the claim) for each such violation.

(B) HEALTH BENEFIT PLAN SPONSORS.—In the case of a health benefit plan sponsor that rejects a claim in violation of subsection (a)(2), the sponsor is subject to a civil money penalty of not to exceed $100 (or, if greater, the amount of the claim) for each such violation.

(2) PROCESS.—The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to a civil money penalty under paragraph (1) in the same manner as such

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provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(c) STANDARDS RELATING TO UNIFORM CLAIMS AND ELECTRONIC CLAIMS DATA SET.—

(1) ESTABLISHMENT OF STANDARDS.—The Secretary shall establish standards that relate to the form and manner of submission of claims for benefits under a health benefit plan. The standards—

(A) shall require that such claims be submitted electronically;

(B) shall define the data elements to be contained in a uniform electronic claims data set to be used with respect to such claims;

(C) establish a uniform electronic format for the electronic transmission of such elements;

(D) shall include instructions on record keeping in support of claims submitted; and

(E) shall ensure the suitability of electronic data as evidence in a court of law.

(2) SCOPE OF INFORMATION.—

(A) IN GENERAL.—The standards under this subsection are intended to cover substantially most claims that are filed under health benefit plans. Such information need not include all elements that may potentially be re-

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quired to be reported under utilization review provisions of plans.

(B) ENSURING ACCOUNTABILITY FOR CLAIMS SUBMITTED ELECTRONICALLY.—In establishing such standards, the Secretary, in consultation with appropriate agencies, shall include such methods of ensuring provider responsibility and accountability for claims submitted electronically that are designed to control fraud and abuse in the submission of such claims.

(C) COMPONENTS.—In establishing such standards the Secretary shall—

(i) with respect to data elements, define data fields, formats, and medical nomenclature, and plan benefit and insurance information; and

(ii) develop a single, uniform, up-to-date coding system for procedures, services, and diagnoses based, to the maximum extent possible, on the American Medical Association's Common Procedural Terminology, Fourth Edition or a revised version of such text (with respect to procedures and services) and the International Classi-

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fication of Diseases, 9th Revision, Clinical Modification, Third Edition or a revised version of such text (with respect to diagnoses), with additional coding developed as necessary by the Secretary.

(3) COORDINATION WITH STANDARDS FOR ELECTRONIC MEDICAL RECORDS.—In establishing standards under this subsection, the Secretary shall assure that—

(A) the development of such standards is coordinated with the development of the standards for reporting uniform clinical data sets under section 204; and

(B) the coding of data elements under the uniform electronic claims data set and the coding of the same elements in the uniform hospital clinical data set and the uniform patient information data set developed under section 204 are consistent.

(4) UNIFORM, UNIQUE PROVIDER IDENTIFICATION CODES.—In establishing standards under this subsection—

(A) the Secretary shall provide for a unique identifier code for each health care provider and group practice that furnishes services

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for which a claim may be submitted under a health benefit plan; and

(B) in the case of a provider that has a unique identifier issued for purposes of the medicare program, the code provided under subparagraph (A) shall be the same as such unique identifier.

(5) PUBLIC DOMAIN SOFTWARE TO PROVIDERS.—The Secretary shall provide for the development, and shall make available without charge to health care providers, such computer software as will enable the providers to submit claims and to receive verification of claims status electronically.

(6) STANDARDS FOR CLAIMS FOR CLINICAL LABORATORY TESTS.—The standards shall provide that claims for clinical laboratory tests for which benefits are provided under a health benefit plan shall be submitted directly by the person or entity that performed (or supervised the performance of) the tests to the plan in a manner consistent with (and subject to such exceptions as are provided under) the requirement for direct submission of such claims under the medicare program.

(7) DEADLINE.—The Secretary shall first provide for the standards for the uniform claims under

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this subsection (and shall develop and make available the software under paragraph (6)) by not later than 1 year after the date of the enactment of this Act.

(d) USE UNDER MEDICARE AND MEDICAID PROGRAMS.—

(1) REQUIREMENT FOR PROVIDERS.—In the case of a health care provider that submits a claim for services furnished under the medicare program or medicaid program in violation of subsection (a)(1), no payment shall be made under such program for such services.

(2) REQUIREMENTS OF INTERMEDIARIES AND CARRIERS UNDER MEDICARE PROGRAM.—The Secretary shall provide, in regulations promulgated to carry out title XVIII of the Social Security Act, that the claims process provided under that title is modified to the extent required to conform to the standards established under subsection (c).

(3) REQUIREMENTS OF STATE MEDICAID PLANS.—As a condition for the approval of State plans under the medicaid program, effective as of the effective date specified in subsection (a)(3), each such plan shall provide, in accordance with regulations of the Secretary, that the claims process pro-

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vided under the plan is modified to the extent required to conform to the standards established under subsection (c).

SEC. 204. REPORTING OF UNIFORM CLINICAL DATA SETS.

(a) STANDARDS FOR ELECTRONIC REPORTING OF UNIFORM CLINICAL DATA SETS.—

(1) PROMULGATION OF STANDARDS.—

(A) IN GENERAL.—Not later than the deadlines provided in paragraph (5), the Secretary shall promulgate standards described in paragraph (2) concerning the uniform clinical data sets described in such paragraph.

(B) REVISION.—The Secretary may from time to time revise the standards promulgated under this paragraph.

(2) CONTENTS OF STANDARDS.—The standards promulgated under paragraph (1) shall include at least the following:

(A) A definition of a uniform hospital clinical data set, including a definition of the set of comprehensive data elements, for use by utilization and quality control peer review organizations.

(B) A definition of a uniform patient information data set including data obtained at the

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point of care, for use by utilization and quality control peer review organizations with respect to physician care.

(C) A specification of, and manner of presentation of, the individual data elements of the sets under this paragraph.

(D) Standards concerning the electronic transmission of such data sets.

(E) Standards relating to confidentiality of health information reported under this section, which include the physical security of electronic data and the use of keys, passwords, encryption, and other means to ensure the protection of the confidentiality and privacy of electronic data.

(F) Standards to ensure the suitability of electronic data as evidence in a court of law.

(3) COORDINATION WITH STANDARDS FOR UNIFORM ELECTRONIC CLAIMS DATA SET.—In establishing standards under this subsection, the Secretary shall ensure that—

(A) the development of the standards is coordinated with the development of the standards for the uniform electronic claims data set under section 203;

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(B) the coding of the same data elements under the uniform hospital clinical data set, the uniform patient information data set, and the uniform electronic claims data set is consistent; and

(C) the standards under this subsection are consistent, to the maximum extent practicable, with other standards existing at the time the standards under this subsection are established, including any standard set by the American National Standards Institute.

(4) CONSULTATION.—in establishing standards under this subsection, the Secretary shall—

(A) consult with the American National Standards Institute, health care providers, health benefit plan sponsors, and other interested parties; and

(B) take into consideration the data set used by the utilization and quality control peer review program under part B of title XI of the Social Security Act.

(5) DEADLINES.—The Secretary shall promulgate standards described in paragraph (2) concerning the uniform hospital clinical data set prior to the expiration of the 1-year period beginning on the date

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of the enactment of this Act. The Secretary shall promulgate standards described in paragraph (2) concerning the uniform patient information clinical data set prior to January 1, 2001.

(b) REQUIREMENT FOR APPLICATION OF ELECTRONIC RECORDS STANDARDS TO HOSPITALS.—

(1) AS CONDITION OF MEDICARE PARTICIPATION.—As of January 1, 2001, each hospital, as a requirement of each participation agreement under section 1866 of the Social Security Act, shall, in accordance with the standards promulgated under subsection (a)(1)—

(A) maintain clinical data included in the uniform hospital clinical data set under subsection (a)(2)(A) in electronic form on all inpatients;

(B) upon request of the Secretary or of a utilization and quality control peer review organization (with which the Secretary has entered into a contract under part B of title XI of such Act), transmit electronically data requested from such data set; and

(C) upon request of the Secretary, or of a fiscal intermediary or carrier, transmit elec-

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tronically any data (with respect to a claim) from such data set.

(2) APPLICATION OF PRESENTATION AND TRANSMISSION STANDARDS TO ELECTRONIC TRANSMISSION TO FEDERAL AGENCIES.—Effective January 1, 2001, if a hospital is required under a Federal program to transmit a data element included in the uniform hospital clinical data set that is subject to a standard, promulgated under subsection (a)(1), described in subparagraph (C) or (D) of subsection (a)(2), the head of the Federal agency responsible for such program (if not otherwise authorized) is authorized to require the provider to present and transmit the data element electronically in accordance with such a standard.

(c) LIMITATION ON DATA REQUIREMENTS WHERE STANDARDS IN EFFECT.—

(1) IN GENERAL.—On or after January 1, 2001, a health benefit plan sponsor may not require, for the purpose of utilization review or as a condition of providing benefits or making payments under the plan provided, that a hospital—

(A) provide any data element not in the uniform hospital clinical data set specified

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under the standards promulgated under subsection (a); or

(B) transmit or present any such data element in a manner inconsistent with such standards applicable to such transmission or presentation.

(2) COMPLIANCE.—The Secretary may impose a civil money penalty on any health benefit plan sponsor that fails to comply with paragraph (1) in an amount not to exceed $100 for each such failure. The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(3) APPLICATION TO MEDICARE PROGRAM.—Effective as of January 1, 2001, neither the Secretary, nor any carrier or fiscal intermediary, nor any utilization and quality control peer review organization may require, for the purpose of utilization review or as a condition of providing benefits or making payments under the medicare program, that a hospital—

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(A) provide any data element not in the uniform hospital clinical data set specified under the standards promulgated under subsection (a); or

(B) transmit or present any such data element in a manner inconsistent with such standards applicable to such transmission or presentation.

(4) APPLICATION TO MEDICAID PROGRAM.—As a condition for the approval of State plans under the medicaid program and in accordance with regulations of the Secretary, effective as of January 1, 2001, each such plan may not require that a hospital, for the purpose of utilization review or as a condition of providing benefits or making payments under the plan—

(A) provide any data element not in the uniform hospital clinical data set specified under the standards promulgated under subsection (a), or

(B) transmit or present any such data element in a manner inconsistent with such standards applicable to such transmission or presentation.

(d) PREEMPTION OF STATE QUILL PEN LAWS.—

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(1) IN GENERAL.—Any provision of State law that requires medical or health insurance records (including billing information) to be maintained in written, rather than electronic, form is deemed to be satisfied if the records are maintained in an electronic form that meets standards established by the Secretary under paragraph (2).

(2) SECRETARIAL AUTHORITY.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall issue regulations to carry out paragraph (1). The regulations shall provide for an electronic substitute that is in the form of a unique identifier (assigned to each authorized individual) that serves the functional equivalent of a signature. The regulations may provide for such exceptions to paragraph (1) as the Secretary determines to be necessary to prevent fraud and abuse, to prevent the illegal distribution of controlled substances, and in such other cases as the Secretary deems appropriate.

(3) EFFECTIVE DATE.—Paragraph (1) shall take effect on the first day of the first month that begins more than 30 days after the date the Secretary issues the regulations referred to in paragraph (2).

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SEC. 205. UNIFORM HOSPITAL COST REPORTING.

Each hospital, as a requirement under a participation agreement under section 1866(a) of the Social Security Act for each cost reporting period beginning during or after fiscal year 1996, shall provide for the reporting of information to the Secretary with respect to any hospital care provided in a uniform manner consistent with standards established by the Secretary to carry out section 4007(c) of the Omnibus Budget Reconciliation Act of 1987 and in an electronic form consistent with standards established by the Secretary.

SEC. 206. USE OF TASK FORCES.

In adopting standards under this title, the Secretary—

(1) shall take into account the recommendations of—

(A) current task forces, including at least the Workgroup on Electronic Data Interchange, National Uniform Billing Committee, the Uniform Claim Task Force, and the Computer-based Patient Record Institute; and

(B) national organizations representing health care financial managers; and

(2) shall provide that electronic transmission standards are consistent, to the extent practicable, with the applicable standards established by the Ac-

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credited Standards Committee X–12 of the American National Standards Institute.

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