

103^D CONGRESS
1ST SESSION

H. R. 237

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

IN THE HOUSE OF REPRESENTATIVES

JANUARY 5, 1993

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

A BILL

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

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

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

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

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

Sec. 1. Short title; table of contents.

TITLE I—PROVISIONS RELATING TO PHYSICIANS’ SERVICES

Subtitle A—Incentives Under Medicare

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

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

Subtitle B—Increasing Number of Physicians Practicing in Rural Areas

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

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

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

TITLE II—PROVISIONS RELATING TO HOSPITALS

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

TITLE III—MISCELLANEOUS PROVISIONS

Subtitle A—Administrative Simplification

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

Subtitle B—Other Provisions

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

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

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

9 (a) IN GENERAL.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 **RIER PERFORMANCE REVIEWS.**

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

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

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

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

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

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

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

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

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

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

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

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

7 (a) MEDICARE PROGRAM.—

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

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

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

18 (b) MEDICAID PROGRAM.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 residents of a medically underserved
2 rural area, and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 (b) EXCEPTION FOR SHARED FACILITY SERVICES.—

11 Section 1877 of such Act is amended—

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

16 “(3) SHARED FACILITY SERVICES.—

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

19 “(i) that are furnished—

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

1 employed under the shared facility ar-
2 rangement,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 “(5) VALUABLE COMMUNITY SERVICES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 (b) HEALTH BENEFIT PLAN DEFINED.—

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

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

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

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

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

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

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

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

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

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

15 (B) automobile medical-payment insurance.

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

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

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

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

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

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

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

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

15 (a) SUBMISSION OF CLAIMS.—

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

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

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

1 (2) ENFORCEMENT.—

2 (A) CIVIL MONEY PENALTY.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 (3) TERMS OF CONTRACTS.—

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

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

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

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

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

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

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

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

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

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

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

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

10 (ii) the benefits under such a plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 (1) PROCESSING OF CLAIMS.—

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

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

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

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

1 (iv) if a claim is a clean claim—

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

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

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

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

1 the clearinghouse serving the individual for
2 processing, and

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

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

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

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

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

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

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

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

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

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

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

16 (f) OPTIONAL PAYMENT FUNCTIONS.—

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

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

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

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

14 (a) UNIFORM HEALTH CLAIMS CARDS.—

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

20 (2) ELECTRONIC.—

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

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

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

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

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

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

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

9 (b) UNIFORM CLAIMS DATA SET.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 “(a) IN GENERAL.—

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

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

21 “(3) SUNSET.—

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

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

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

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

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

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

16 “(b) AMOUNT OF TAX.—

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

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

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

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

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

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

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

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

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

3 “(c) LIMITATION ON TAX.—

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

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

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

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

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

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

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

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

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

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

14 (d) EFFECTIVE DATES.—

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

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

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

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

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

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

1 **Subtitle B—Other Provisions**

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

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

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

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

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

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

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

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

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

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

6 and

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

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

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

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

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

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

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

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

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

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

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

○

HR 237 IH—2

HR 237 IH—3

HR 237 IH—4

HR 237 IH—5