

105TH CONGRESS
1ST SESSION

H. R. 1836

IN THE SENATE OF THE UNITED STATES

NOVEMBER 5, 1997

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

AN ACT

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

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

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Federal Employees
3 Health Care Protection Act of 1997”.

4 **SEC. 2. DEBARMENT AND OTHER SANCTIONS.**

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

7 (1) in subsection (a)—

8 (A) in paragraph (1)—

9 (i) by striking “and” at the end of
10 subparagraph (B);

11 (ii) by striking the period at the end
12 of subparagraph (C) and inserting “; and”;

13 and

14 (iii) by adding at the end the follow-
15 ing:

16 “(D) the term ‘should know’ means that a per-
17 son, with respect to information, acts in deliberate
18 ignorance of, or in reckless disregard of, the truth
19 or falsity of the information, and no proof of specific
20 intent to defraud is required;” and

21 (B) in paragraph (2)(A), by striking “sub-
22 section (b) or (c)” and inserting “subsection
23 (b), (c), or (d)”;

24 (2) in subsection (b)—

1 (A) by striking “The Office of Personnel
2 Management may bar” and inserting “The Of-
3 fice of Personnel Management shall bar”; and

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

6 “(5) Any provider that is currently debarred,
7 suspended, or otherwise excluded from any procure-
8 ment or nonprocurement activity (within the mean-
9 ing of section 2455 of the Federal Acquisition
10 Streamlining Act of 1994).”;

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

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

17 “(1) Any provider—

18 “(A) whose license to provide health care
19 services or supplies has been revoked, sus-
20 pended, restricted, or not renewed, by a State
21 licensing authority for reasons relating to the
22 provider’s professional competence, professional
23 performance, or financial integrity; or

24 “(B) that surrendered such a license while
25 a formal disciplinary proceeding was pending

1 before such an authority, if the proceeding con-
2 cerned the provider's professional competence,
3 professional performance, or financial integrity.

4 “(2) Any provider that is an entity directly or
5 indirectly owned, or with a control interest of 5 per-
6 cent or more held, by an individual who has been
7 convicted of any offense described in subsection (b),
8 against whom a civil monetary penalty has been as-
9 sessed under subsection (d), or who has been
10 debarred from participation under this chapter.

11 “(3) Any individual who directly or indirectly
12 owns or has a control interest in a sanctioned entity
13 and who knows or should know of the action con-
14 stituting the basis for the entity's conviction of any
15 offense described in subsection (b), assessment with
16 a civil monetary penalty under subsection (d), or de-
17 barment from participation under this chapter.

18 “(4) Any provider that the Office determines, in
19 connection with claims presented under this chapter,
20 has charged for health care services or supplies in
21 an amount substantially in excess of such provider's
22 customary charge for such services or supplies (un-
23 less the Office finds there is good cause for such
24 charge), or charged for health care services or sup-
25 plies which are substantially in excess of the needs

1 of the covered individual or which are of a quality
2 that fails to meet professionally recognized stand-
3 ards for such services or supplies.

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

6 Any determination under paragraph (4) relating to wheth-
7 er a charge for health care services or supplies is substan-
8 tially in excess of the needs of the covered individual shall
9 be made by trained reviewers based on written medical
10 protocols developed by physicians. In the event such a de-
11 termination cannot be made based on such protocols, a
12 physician in an appropriate specialty shall be consulted.”;

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

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

20 “(A) an item or service not provided as
21 claimed,

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

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

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

5 (5) in subsection (f) (as so redesignated by
6 paragraph (3)) by inserting after “under this sec-
7 tion” the first place it appears the following:
8 “(where such debarment is not mandatory)”;

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

11 (A) by striking “(g)(1)” and all that fol-
12 lows through the end of paragraph (1) and in-
13 serting the following:

14 “(g)(1)(A) Except as provided in subparagraph (B),
15 debarment of a provider under subsection (b) or (c) shall
16 be effective at such time and upon such reasonable notice
17 to such provider, and to carriers and covered individuals,
18 as shall be specified in regulations prescribed by the Of-
19 fice. Any such provider that is debarred from participation
20 may request a hearing in accordance with subsection
21 (h)(1).

22 “(B) Unless the Office determines that the health or
23 safety of individuals receiving health care services war-
24 rants an earlier effective date, the Office shall not make
25 a determination adverse to a provider under subsection

1 (c)(5) or (d) until such provider has been given reasonable
2 notice and an opportunity for the determination to be
3 made after a hearing as provided in accordance with sub-
4 section (h)(1).”;

5 (B) in paragraph (3)—

6 (i) by inserting “of debarment” after
7 “notice”; and

8 (ii) by adding at the end the follow-
9 ing: “In the case of a debarment under
10 paragraph (1), (2), (3), or (4) of sub-
11 section (b), the minimum period of debar-
12 ment shall not be less than 3 years, except
13 as provided in paragraph (4)(B)(ii).”;

14 (C) in paragraph (4)(B)(i)(I) by striking
15 “subsection (b) or (c)” and inserting “sub-
16 section (b), (c), or (d)”;

17 (D) by striking paragraph (6);

18 (7) in subsection (h) (as so redesignated by
19 paragraph (3)) by striking “(h)(1)” and all that fol-
20 lows through the end of paragraph (2) and inserting
21 the following:

22 “(h)(1) Any provider of health care services or sup-
23 plies that is the subject of an adverse determination by
24 the Office under this section shall be entitled to reasonable
25 notice and an opportunity to request a hearing of record,

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

15 “(2) Any provider adversely affected by a final deci-
16 sion under paragraph (1) made after a hearing to which
17 such provider was a party may seek review of such deci-
18 sion in the United States District Court for the District
19 of Columbia or for the district in which the plaintiff re-
20 sides or has his or her principal place of business by filing
21 a notice of appeal in such court within 60 days after the
22 date the decision is issued, and by simultaneously sending
23 copies of such notice by certified mail to the Director of
24 the Office and to the Attorney General. In answer to the
25 appeal, the Director of the Office shall promptly file in

1 such court a certified copy of the transcript of the record,
2 if the Office conducted a hearing, and other evidence upon
3 which the findings and decision complained of are based.
4 The court shall have power to enter, upon the pleadings
5 and evidence of record, a judgment affirming, modifying,
6 or setting aside, in whole or in part, the decision of the
7 Office, with or without remanding the case for a rehear-
8 ing. The district court shall not set aside or remand the
9 decision of the Office unless there is not substantial evi-
10 dence on the record, taken as whole, to support the find-
11 ings by the Office of a cause for action under this section
12 or unless action taken by the Office constitutes an abuse
13 of discretion.”; and

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

16 (A) by striking “subsection (c)” and in-
17 serting “subsection (d)”;

18 (B) by adding at the end the following:

19 “The amount of a penalty or assessment as fi-
20 nally determined by the Office, or other amount
21 the Office may agree to in compromise, may be
22 deducted from any sum then or later owing by
23 the United States to the party against whom
24 the penalty or assessment has been levied.”.

25 (b) EFFECTIVE DATE.—

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

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

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

18 (C) Paragraph (3) of section 8902a(g) of title
19 5, United States Code, as amended by subsection
20 (a)(6)(B), shall apply only with respect to
21 debarments based on convictions occurring after the
22 date of the enactment of this Act.

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

4 (a) DEFINITION OF A CARRIER.—Paragraph (7) of
5 section 8901 of title 5, United States Code, is amended
6 by striking “organization;” and inserting “organization
7 and an association of organizations or other entities de-
8 scribed in this paragraph sponsoring a health benefits
9 plan;”.

10 (b) SERVICE BENEFIT PLAN.—Paragraph (1) of sec-
11 tion 8903 of title 5, United States Code, is amended by
12 striking “plan,” and inserting “plan, which may be under-
13 written by participating affiliates licensed in any number
14 of States,”.

15 (c) PREEMPTION.—Section 8902(m) of title 5, Unit-
16 ed States Code, is amended by striking “(m)(1)” and all
17 that follows through the end of paragraph (1) and insert-
18 ing the following:

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

1 **SEC. 4. CONTINUED HEALTH INSURANCE COVERAGE FOR**
2 **CERTAIN INDIVIDUALS.**

3 (a) ENROLLMENT IN CHAPTER 89 PLAN.—For pur-
4 poses of chapter 89 of title 5, United States Code, any
5 period of enrollment—

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

9 (2) subject to subsection (c), in a health bene-
10 fits plan (not under chapter 89 of such title) with
11 respect to which the eligibility of any employees or
12 retired employees of the Board of Governors of the
13 Federal Reserve System terminates on January 3,
14 1998,

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

17 (b) CONTINUED COVERAGE.—(1) Subject to sub-
18 section (c), any individual who, on January 3, 1998, is
19 enrolled in a health benefits plan described in subsection
20 (a)(1) or (2) may enroll in an approved health benefits
21 plan under chapter 89 of title 5, United States Code, ei-
22 ther as an individual or for self and family, if, after taking
23 into account the provisions of subsection (a), such individ-
24 ual—

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

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

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

8 Any determination under subparagraph (B) shall be made
9 under guidelines which the Office of Personnel Manage-
10 ment shall establish in consultation with the Board of
11 Governors of the Federal Reserve System.

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

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

22 (B) such plan did not terminate, or the eligi-
23 bility of such individual with respect to such plan
24 did not terminate, as described in subsection (a).

1 (3) Subject to subsection (c), any individual (other
2 than an individual under paragraph (2)) who, on January
3 3, 1998, is covered under a health benefits plan described
4 in subsection (a)(1) or (2) as an unmarried dependent
5 child, but who does not then qualify for coverage under
6 chapter 89 of title 5, United States Code, as a family
7 member (within the meaning of such chapter) shall be
8 deemed to be entitled to continued coverage under section
9 8905a of such title, to the same extent and in the same
10 manner as if such individual had, on January 3, 1998,
11 ceased to meet the requirements for being considered an
12 unmarried dependent child of an enrollee under such chap-
13 ter.

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

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

1 (d) TRANSFERS TO THE EMPLOYEES HEALTH BENE-
2 FITS FUND.—The Federal Deposit Insurance Corporation
3 and the Board of Governors of the Federal Reserve Sys-
4 tem shall transfer to the Employees Health Benefits Fund
5 under section 8909 of title 5, United States Code,
6 amounts determined by the Director of the Office of Per-
7 sonnel Management, after consultation with the Federal
8 Deposit Insurance Corporation and the Board of Gov-
9 ernors of the Federal Reserve System, to be necessary to
10 reimburse the Fund for the cost of providing benefits
11 under this section not otherwise paid for by the individuals
12 covered by this section. The amounts so transferred shall
13 be held in the Fund and used by the Office in addition
14 to amounts available under section 8906(g)(1) of such
15 title.

16 (e) ADMINISTRATION AND REGULATIONS.—The Of-
17 fice of Personnel Management—

18 (1) shall administer the provisions of this sec-
19 tion to provide for—

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

22 (B) no lapse of health coverage for individ-
23 uals who enroll in a health benefits plan under
24 chapter 89 of title 5, United States Code, in ac-
25 cordance with this section; and

1 (2) may prescribe regulations to implement this
2 section.

3 **SEC. 5. FULL DISCLOSURE IN HEALTH PLAN CONTRACTS.**

4 The Office of Personnel Management shall encourage
5 carriers offering health benefits plans described by section
6 8903 or section 8903a of title 5, United States Code, with
7 respect to contractual arrangements made by such carriers
8 with any person for purposes of obtaining discounts from
9 providers for health care services or supplies furnished to
10 individuals enrolled in such plan, to seek assurance that
11 the conditions for such discounts are fully disclosed to the
12 providers who grant them.

13 **SEC. 6. PROVISIONS RELATING TO CERTAIN PLANS THAT**
14 **HAVE DISCONTINUED THEIR PARTICIPATION**
15 **IN FEHBP.**

16 (a) AUTHORITY TO READMIT.—

17 (1) IN GENERAL.—Chapter 89 of title 5, United
18 States Code, is amended by inserting after section
19 8903a the following:

20 **“§ 8903b. Authority to readmit an employee organiza-**
21 **tion plan**

22 “(a) In the event that a plan described by section
23 8903(3) or 8903a is discontinued under this chapter
24 (other than in the circumstance described in section
25 8909(d)), that discontinuation shall be disregarded, for

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

5 “(b) A contract for a plan approved under this sec-
 6 tion shall require the carrier—

7 “(1) to demonstrate experience in service deliv-
 8 ery within a managed care system (including pro-
 9 vider networks) throughout the United States; and

10 “(2) if the carrier involved would not otherwise
 11 be subject to the requirement set forth in section
 12 8903a(e)(1), to satisfy such requirement.”.

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

“8903b. Authority to readmit an employee organization plan.”.

17 (3) APPLICABILITY.—

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

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

1 with respect to any plan seeking to be readmit-
2 ted for purposes of any contract year beginning
3 before January 1, 2000, such section shall be
4 applied by substituting “second contract year”
5 for “third contract year”.

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

8 (1) IN GENERAL.—Subsection (e) of section
9 8909 of title 5, United States Code, is amended by
10 striking “(e)” and inserting “(e)(1)” and by adding
11 at the end the following:

12 “(2) Any crediting required under paragraph (1) pur-
13 suant to the discontinuation of any plan under this chap-
14 ter shall be completed by the end of the second contract
15 year beginning after such plan is so discontinued.

16 “(3) The Office shall prescribe regulations in accord-
17 ance with which this subsection shall be applied in the case
18 of any plan which is discontinued before being credited
19 with the full amount to which it would otherwise be enti-
20 tled based on the discontinuation of any other plan.”.

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

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

3 (A) the deadline set forth in section
4 8909(e) of such title (as so amended); or

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

7 **SEC. 7. MAXIMUM PHYSICIANS COMPARABILITY ALLOW-**
8 **ANCE PAYABLE.**

9 (a) **IN GENERAL.**—Paragraph (2) of section 5948(a)
10 of title 5, United States Code, is amended by striking
11 “\$20,000” and inserting “\$30,000”.

12 (b) **AUTHORITY TO MODIFY EXISTING AGREE-**
13 **MENTS.**—

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

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

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

3 (c) **RULE OF CONSTRUCTION.**—Nothing in this sec-
4 tion shall be considered to authorize additional or supple-
5 mental appropriations for the fiscal year in which occurs
6 the date of enactment of this Act.

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

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

10 (1) by redesignating paragraph (2) as para-
11 graph (3); and

12 (2) by inserting after paragraph (1) the follow-
13 ing:

14 “(2) Nothing in this subsection shall be considered
15 to preclude a health benefits plan from providing direct
16 access or direct payment or reimbursement to a provider
17 in a health care practice or profession other than a prac-
18 tice or profession listed in paragraph (1), if such provider
19 is licensed or certified as such under Federal or State
20 law.”.

Passed the House of Representatives November 4,
1997.

Attest:

ROBIN H. CARLE,

Clerk.