103D CONGRESS
2D SESSION

S. 1796

To ensure that health coverage is portable and renewable, to enhance the ability of small businesses to purchase health care, to enhance efficiency through paperwork reduction, to provide antitrust reforms, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JANUARY 25, 1994

Mr. GRAMM (for himself, Mr. MCCAIN, Mr. COATS, Mr. COVERDELL, Mrs. HUTCHISON, Mr. HELMS, Mr. LOTT, Mr. FAIRCLOTH, Mr. WALLOP, Mr. BENNETT, and Mr. BROWN) introduced the following bill; which was read twice and referred to the Committee on Labor and Human Resources

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A BILL

To ensure that health coverage is portable and renewable, to enhance the ability of small businesses to purchase health care, to enhance efficiency through paperwork reduction, to provide antitrust reforms, and for other purposes.

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 ''Consensus Interim Health Act''.

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

TITLE I—PORTABLE AND PERMANENT PRIVATE HEALTH INSURANCE

Subtitle A—Portability

SEC. 101. AMENDMENTS TO COBRA

(a) LOWER COST COVERAGE OPTIONS.—Subparagraph (A) of section 4980B(f)(2) of the Internal Revenue Code of 1986 (relating to continuation coverage requirements of group health plans) is amended to read as follows:

''(A) TYPE OF BENEFIT COVERAGE.—The coverage must consist of coverage which, as of the time the coverage is being provided—

''(i) is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred,

''(ii) is so identical, except such coverage is offered with an annual $1,000 deductible, and

''(iii) is so identical, except such coverage is offered with an annual $3,000 deductible.

If coverage under the plan is modified for any group of similarly situated beneficiaries, the

coverage shall also be modified in the same manner for all individuals who are qualified beneficiaries under the plan pursuant to this subsection in connection with such group.''.

(b) TERMINATION OF COBRA COVERAGE AFTER ELIGIBLE FOR EMPLOYER-BASED COVERAGE FOR 90 DAYS.—Clause (iv) of section 4980B(f)(2)(B) of the Internal Revenue Code of 1986 (relating to period of coverage) is amended—

(1) by striking ''or'' at the end of subclause (I),

(2) by redesignating subclause (II) as subclause (III), and

(3) by inserting after subclause (I) the following new subclause:

''(II) eligible for such employer-based coverage for more than 90 days, or''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to qualifying events occurring after the date of the enactment of this Act.

SEC. 102. PENALTY-FREE WITHDRAWALS FROM QUALIFIED RETIREMENT PLANS FOR COBRA COVERAGE.

(a) IN GENERAL.—Subparagraph (A) of section 72(t)(2) of the Internal Revenue Code of 1986 (relating

to additional tax not to apply to certain distributions) is amended—

(1) by striking ''or'' at the end of clauses (iv) and (v),

(2) by striking the period at the end of clause (vi) and inserting '', or'', and

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

''(vii) made to an employee who is a qualified beneficiary during the period of continuation coverage under section 4980B(f).''

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to distributions made after the date of the enactment of this Act.

Subtitle B—Permanence

SEC. 111. GENERAL RENEWABILITY REQUIREMENTS.

(a) INSURERS.—

(1) IN GENERAL.—An insurer may not cancel an individual health insurance plan or group health plan or deny renewal of coverage under such a plan other than—

(A) for nonpayment of premiums,

(B) for fraud or other misrepresentation by the insured,

(C) for noncompliance with plan provisions, or

(D) because the insurer is ceasing to provide any health insurance plan in a State, or, in the case of a health maintenance organization, in a geographic area.

(2) LIMITATION ON MARKET REENTRY.—If an insurer terminates the offering of health insurance plans or group health plans in an area, the insurer may not offer such a plan in the area until 5 years after the date of the termination.

(b) EMPLOYERS.—An employer may not cancel a self-insured group health plan or deny renewal of coverage under such a plan other than—

(1) for nonpayment of premiums,

(2) for fraud or other misrepresentation by the insured,

(3) for noncompliance with plan provisions,

(4) because the plan is ceasing to provide any coverage in a geographic area.

(c) EFFECTIVE DATE.—The provisions of this section shall apply to any plan on or after the date of the enactment of this Act.

SEC. 112. INDIVIDUAL HEALTH INSURANCE PLANS.

(a) EXISTING PLANS.—With respect to any individual health insurance plan in effect on the date of the enactment of this Act, the insurer shall offer the insured the option to purchase a new individual health insurance described in subsection (b).

(b) NEW PLANS.—With respect to any individual health insurance plan, the effective date of which with respect to the insured occurs after the date of the enactment of this Act, the insurer may not increase the premium for such a plan based on the health of the insured.

SEC. 113. GROUP HEALTH PLANS.

(a) EXISTING PLANS.—With respect to any group health plan (other than a self-insured group health plan) in effect on the date of the enactment of this Act, the insurer shall offer—

(1) any insured of such plan the option to purchase upon leaving the group a new individual health insurance, the premium of which shall be rated based on actuarial data, may be based on any preexisting condition of the insured, and may be increased based on the health of such insured, and

(2) the employer or group sponsor of such plan the option to purchase a new group health plan described in subsection (b).

(b) NEW PLANS.—With respect to any group health plan (other than a self-insured group health plan), the effective date of which with respect to the employer or group sponsor occurs after the date of the enactment of this Act, the insurer—

(1) may not increase the premium for such a plan based on the health of the group's insured, and

(2) shall offer any insured of such plan the option to purchase upon leaving the group a new individual health insurance, the premium of which shall be rated based on actuarial data, may not be based on any preexisting condition of the insured, and may not be increased based on the health of such insured.

(c) SELF-INSURED GROUP HEALTH PLANS.—With respect to a self-insured group health plan—

(1) in effect on the date of the enactment of this Act—

(A) subsection (a)(1) shall apply through 1 or more insurers contracted with by such plan, and

(B) subsection (a)(2) shall not apply, and

(2) the effective date of which with respect to the employer or group sponsor occurs after the date of the enactment of this Act, subsection (b) shall

apply through 1 or more insurers contracted with by such plan.

SEC. 114. DEFINITIONS.

For purposes of this subtitle:

(1) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given such term by section 5000(b)(1) of the Internal Revenue Code of 1986, but does not include any type of coverage excluded from the definition of a health insurance plan under paragraph (2).

(2) HEALTH INSURANCE PLAN.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the term ''health insurance plan'' means any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract offered by an insurer.

(B) EXCEPTION.—Such term does not include any of the following—

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

(ii) medicare supplemental health insurance,

(iii) coverage issued as a supplement to liability insurance,

(iv) worker's compensation or similar insurance, or

(v) automobile medical-payment insurance,

or any combination thereof.

(3) HEALTH MAINTENANCE ORGANIZATION.—The term ''health maintenance organization'' includes a health insurance plan that offers to provide health services on a prepaid, at-risk basis primarily through a defined set of providers.

(4) INSURER.—The term ''insurer'' means a licensed insurance company, a prepaid hospital or medical service plan, and a health maintenance organization offering such a plan to an employer, and includes a similar organization regulated under State law for solvency.

SEC. 115. FAILURE OF HEALTH PLANS TO MEET PORTABILITY AND PERMANENCE REQUIREMENTS.

(a) DEDUCTION FOR INDIVIDUAL HEALTH INSURANCE PLANS.—Paragraph (1) of section 213(d) of the Internal Revenue Code of 1986 (defining medical care) is amended—

(1) by striking ''or'' at the end of subparagraph (B), and

(2) by striking subparagraph (C) and inserting the following new subparagraphs:

''(C) for insurance—

''(i) meeting the requirements of section 112 of the Consensus Interim Health Act, and

''(ii) covering medical care referred to in subparagraphs (A) and (B), or

''(D) as premiums under part B of title XVIII of the Social Security Act, relating to supplementary medical insurance for the aged.''.

(b) TAX EXCLUSIONS FOR EMPLOYER-PROVIDED HEALTH INSURANCE.—Section 106 of the Internal Revenue Code of 1986 (relating to contributions by employer to accident and health plans) is amended by striking ''an accident or health plan'' and inserting ''an accident or health plan meeting the requirements of section 113 of the Consensus Interim Health Act''.

(c) BUSINESS EXPENSE DEDUCTION FOR HEALTH INSURANCE.—Section 162 of the Internal Revenue Code of 1986 (relating to trade or business expenses) is amended by redesignating subsection (o) as subsection (p) and

by inserting after subsection (n) the following new subsection:

''(o) GROUP HEALTH PLANS.—The expenses paid or incurred by an employer for a group health plan shall not be allowed as a deduction under this section unless such plan meets the requirements of section 113 of the Consensus Interim Health Act.''.

(d) PAYROLL TAX EXCLUSION FOR EMPLOYER-PROVIDED HEALTH INSURANCE.—Section 209(a)(2) of the Social Security Act (42 U.S.C. 409(a)(2)) is amended by inserting ''or group health insurance'' after ''group-term life insurance''.

(e) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

TITLE II—SMALL BUSINESS HEALTH INSURANCE POOLS

SEC. 201. PROHIBITION OF RESTRICTIONS ON GROUPS PURCHASING HEALTH INSURANCE.

No provision of State or local law shall apply that prohibits 2 or more employers or groups from obtaining coverage under a multiple employer health plan.

SEC. 202. PROHIBITION OF STATE BENEFIT MANDATES FOR GROUP HEALTH PLANS.

In the case of a group health plan, no provision of State or local law shall apply that requires the coverage of one or more specific benefits, services, or categories of health care, or services of any class or type of provider of health care.

SEC. 203. PROHIBITION OF RESTRICTIONS ON MANAGED CARE.

(a) PREEMPTION OF STATE LAW PROVISIONS.—Subject to subsection (c), the following provisions of State law are preempted and may not be enforced:

(1) RESTRICTIONS ON REIMBURSEMENT RATES OR SELECTIVE CONTRACTING.—Any law that restricts the ability of a group health plan to negotiate reimbursement rates with providers or to contract selectively with one provider or a limited number of providers.

(2) RESTRICTIONS ON DIFFERENTIAL FINANCIAL INCENTIVES.—Any law that limits the financial incentives that a group health plan may require a beneficiary to pay when a non-plan provider is used on a non-emergency basis.

(3) RESTRICTIONS ON UTILIZATION REVIEW METHODS.—Any law that—

(A) prohibits utilization review of any or all treatments and conditions,

(B) requires that such review be made (i) by a resident of the State in which the treatment is to be offered or by an individual licensed in such State, or (ii) by a physician in any particular specialty or with any board certified specialty of the same medical specialty as the provider whose services are being reviewed,

(C) requires the use of specified standards of health care practice in such reviews or requires the disclosure of the specific criteria used in such reviews,

(D) requires payments to providers for the expenses of responding to utilization review requests, or

(E) imposes liability for delays in performing such review.

Nothing in subparagraph (B) shall be construed as prohibiting a State from (i) requiring a licensed physician or other health care professional be available at some time in the review or appeal process, or (ii) requiring that any decision in an appeal from such a review be made by a licensed physician.

(b) GAO STUDY.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study of the regulatory and legal impediments at the Federal, State, and local levels of government that restrict the ability of small businesses and other organizations to group together voluntarily to allow their employees or members to pool their health insurance purchases.

(2) REPORT.—By not later than 2 years after the date of the enactment of this Act, the Comptroller General shall submit a report to Congress on the study conducted under paragraph (1) and shall include in the report such recommendations (including whether the provisions of subsection (a) should be extended) as may be appropriate.

(c) SUNSET.—Unless otherwise provided, subsection (a) shall not apply 5 years after the date of the enactment of this Act.

SEC. 204. DEFINITIONS.

For purposes of this title—

(1) EMPLOYER.—The term ''employer'' shall have the meaning applicable under section 3(5) of the Employee Retirement Income Security Act of 1974.

(2) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given such term in section 114(1).

(3) MULTIPLE EMPLOYER HEALTH PLAN.—The term ''multiple employer health plan'' means a multiple employer welfare arrangement (as defined in section 3(40) of the Employee Retirement Income Security Act of 1974.

(4) STATE.—The term ''State'' means each of the several States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, America Samoa, and the Commonwealth of the Northern Mariana Islands.

TITLE III—ENHANCED EFFICIENCY THROUGH PAPERWORK REDUCTION

SEC. 301. FEDERAL PAPERWORK REDUCTION AND EFFICIENCY REQUIREMENTS.

(a) IN GENERAL.—The Secretary of Health and Human Services (hereafter referred to in this title as the ''Secretary'') shall, in consultation with the Director of the Office of Management and Budget, the Secretary of Veterans Affairs, the Secretary of Defense, the Director of Personnel Management, and other appropriate Federal offi-

cials, adopt standards to reduce the administrative and paperwork burdens of all Federal health care programs by—

(1) 50 percent within the 2-year period following the date of the enactment of this Act, and

(2) an additional 50 percent over a subsequent 3-year period,

for a total reduction of 75 percent over the 5-year period following the date of the enactment of this Act.

(b) INITIAL REDUCTION.—In order to achieve a paperwork reduction described in subsection (a)(1), the Secretary, shall adopt standards for Federal health care programs relating to each of the following:

(1) Data elements for use in paper and electronic claims processing under health insurance plans, as well as for use in utilization review and management of care (including data fields, formats, and medical nomenclature, and including plan benefit and insurance information).

(2) Uniform claims forms (including uniform procedure and bill codes for use with such forms and including information on other health insurance plans that may be liable for benefits).

(3) Uniform electronic transmission of the data elements (for purposes of billing and utilization review).

Standards under paragraph (3) relating to electronic transmission of data elements for claims for services shall supersede (to the extent specified in such standards) the standards adopted under paragraph (2) relating to the submission of paper claims for such services. Standards under paragraph (3) shall include protections to assure the confidentiality of patient-specific information and to protect against the unauthorized use and disclosure of information.

(c) SUBSEQUENT REDUCTION.—In order to achieve a further paperwork reduction described in subsection (a)(2), the Secretary shall modify by regulation the standards adopted under subsection (b). The modification of the standards may include such recommendations as reported by the Standardized Form Commission in section 303, or any other provisions necessary to meet the goals for reduction in the paperwork burden of Federal health care programs.

(d) DEFINITION.—For purposes of this section, the term ''Federal health care program'' means all Federal programs related to health care, including programs described in—

(1) title XVIII or XIX of the Social Security Act,

(2) the Public Health Service Act,

(3) chapter 55 of title 10, United States Code,

(4) chapter 17 of title 38, United States Code,

(5) chapter 89 of title 5, United States Code, or

(6) the Indian Health Care Improvement Act.

SEC. 302. STATE PAPERWORK REDUCTION AND EFFICIENCY REQUIREMENTS.

(a) IN GENERAL.—In order to be eligible for Federal funds in connection with any State-administered health care program, each State shall standardize the processing of paper and electronic claims to reduce the administrative and paperwork burdens on such programs by 75 percent during the 5-year period following the date of the enactment of this Act.

(b) ENFORCEMENT.—

(1) INTERIM EVALUATION.—If at the end of the 4-year period following the date of the enactment of this Act the Secretary determines that a State has not achieved substantial progress toward the reductions required under subsection (a), the Secretary shall notify such State regarding the proportion of required reductions achieved and the further reduc-

tion necessary to achieve compliance with subsection (a).

(2) FINAL COMPLIANCE.—If at the end of the 5-year period following the date of the enactment of this Act the Secretary determines that a State has not achieved the reductions required under subsection (a), the Secretary shall reduce Federal payments for health care programs administered by such State by 10 percent. For each year that such State fails to comply with the requirements of subsection (a), Federal payments for health care programs administered by the State shall be reduced by an additional 10 percent.

(3) WAIVERS OF PAYMENT REDUCTIONS.—Any State subject to a reduction in Federal payments under paragraph (2) may appeal to the Secretary for a 1-year waiver of such reduction. In granting such a waiver, the Secretary shall make a determination of the good faith effort of such State to comply with the requirements of subsection (a), taking into account the technical, practical, and financial capabilities of the State in meeting such requirements.

(c) DEFINITION.—For purposes of this section, the term ''State'' means any of the States, territories, districts, or possessions of the United States.

SEC. 303. STANDARDIZED FORMS COMMISSION.

(a) IN GENERAL.—

(1) ESTABLISHMENT.—Not later than 12 months after the date of the enactment of this Act, the Secretary shall establish a Standardized Forms Commission (hereafter referred to in this section as the ''Commission'') which shall make recommendations on the standardization of paper and electronic claims processing so as to reduce the paperwork burden associated with, and enhance the efficiency and productivity of, such claims processing.

(2) MEMBERSHIP.—

(A) IN GENERAL.—The Commission shall be composed of at least 12 but not more than 20 representatives of private health care providers and private insurers.

(B) CHAIR.—The Secretary shall appoint a Chair of the Commission.

(3) REPORT ON FINDINGS AND RECOMMENDATIONS.—Not later than 24 months after the date of the enactment of this Act, the Chair of the Commission shall report to the Secretary on the findings and recommendations of the Commission.

(4) PROHIBITION OF COMPENSATION.—Members of the Commission shall serve without pay except for reimbursement for travel expenses, includ-

ing per diem in lieu of subsistence, in accordance with sections 5702 and 5703 of title 5, United States Code.

(5) STAFF OF FEDERAL AGENCIES.—Upon request of the Chair, the head of any Federal department or agency shall detail any of the personnel of that department or agency to the Commission to assist it in carrying out its duties under this section.

(6) OBTAINING OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this section.

(7) ADMINISTRATIVE SUPPORT SERVICES.—Upon request of the Chair, the Administrator of General Services shall provide to the Commission the administrative support services necessary for the Commission to carry out its responsibilities under this section.

(b) LEGISLATIVE PROPOSAL.—

(1) IN GENERAL.—

(A) DEVELOPMENT OF IMPLEMENTING BILL.—Not later than 3 months after the Commission has submitted its findings and recommendations to the Secretary, the Secretary shall take such recommendations and submit

them to Congress in the form of an implementing bill which contains the provisions necessary or appropriate to implement the recommendations by either repealing or amending existing laws or providing new statutory authority.

(B) CONSIDERATION OF IMPLEMENTING BILL.—The implementing bill described in subparagraph (A) shall be considered by Congress under the procedures for consideration described in paragraph (2).

(2) CONGRESSIONAL CONSIDERATION.—

(A) RULES OF HOUSE OF REPRESENTATIVES AND SENATE.—This paragraph is enacted by Congress—

(i) as an exercise of the rulemaking power of the House of Representatives and the Senate, respectively, and as such is deemed a part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of an implementing bill described in paragraph (1)(A), and supersedes other rules only to the extent that such rules are inconsistent therewith; and

(ii) with full recognition of the constitutional right of either House to change the rules (so far as relating to the procedure of that House) at any time, in the same manner and to the same extent as in the case of any other rule of that House.

(B) INTRODUCTION AND REFERRAL.—On the day on which the implementing bill described in paragraph (1)(A) is transmitted to the House of Representatives and the Senate, such bill shall be introduced (by request) in the House of Representatives by the Majority Leader of the House, for himself and the Minority Leader of the House, or by Members of the House designated by the Majority Leader and Minority Leader of the House and shall be introduced (by request) in the Senate by the Majority Leader of the Senate, for himself and the Minority Leader of the Senate, or by Members of the Senate designated by the Majority Leader and Minority Leader of the Senate. If either House is not in session on the day on which the implementing bill is transmitted, the bill shall be introduced in the House, as provided in the preceding sentence, on the first day thereafter

on which the House is in session. The implementing bill introduced in the House of Representatives and the Senate shall be referred to the appropriate committees of each House.

(C) AMENDMENTS PROHIBITED.—No amendment to an implementing bill shall be in order in either the House of Representatives or the Senate and no motion to suspend the application of this paragraph shall be in order in either House, nor shall it be in order in either House for the Presiding Officer to entertain a request to suspend the application of this paragraph by unanimous consent.

(D) PERIOD FOR COMMITTEE AND FLOOR CONSIDERATION.—

(i) IN GENERAL.—Except as provided in clause (ii), if the committee or committees of either House to which an implementing bill has been referred have not reported it at the close of the 45th day after its introduction, such committee or committees shall be automatically discharged from further consideration of the implementing bill and it shall be placed on the appropriate calendar. A vote on final pas-

sage of the implementing bill shall be taken in each House on or before the close of the 45th day after the implementing bill is reported by the committees or committee of that House to which it was referred, or after such committee or committees have been discharged from further consideration of the implementing bill. If prior to the passage by 1 House of an implementing bill of that House, that House receives the same implementing bill from the other House then—

(I) the procedure in that House shall be the same as if no implementing bill had been received from the other House; but

(II) the vote on final passage shall be on the implementing bill of the other House.

(ii) COMPUTATION OF DAYS.—For purposes of clause (i), in computing a number of days in either House, there shall be excluded—

(I) the days on which either House is not in session because of an

adjournment of more than 3 days to a day certain, or an adjournment of the Congress sine die, and

(II) any Saturday and Sunday not excluded under subclause (I) when either House is not in session.

(E) FLOOR CONSIDERATION IN THE HOUSE OF REPRESENTATIVES.—

(i) MOTION TO PROCEED.—A motion in the House of Representatives to proceed to the consideration of an implementing bill shall be highly privileged and not debatable. An amendment to the motion shall not be in order, nor shall it be in order to move to reconsider the vote by which the motion is agreed to or disagreed to.

(ii) DEBATE.—Debate in the House of Representatives on an implementing bill shall be limited to not more than 20 hours, which shall be divided equally between those favoring and those opposing the bill. A motion further to limit debate shall not be debatable. It shall not be in order to move to recommit an implementing bill or to move to reconsider the vote by which an

implementing bill is agreed to or disagreed to.

(iii) MOTION TO POSTPONE.—Motions to postpone, made in the House of Representatives with respect to the consideration of an implementing bill, and motions to proceed to the consideration of other business, shall be decided without debate.

(iv) APPEALS.—All appeals from the decisions of the Chair relating to the application of the Rules of the House of Representatives to the procedure relating to an implementing bill shall be decided without debate.

(v) GENERAL RULES APPLY.—Except to the extent specifically provided in the preceding provisions of this subparagraph, consideration of an implementing bill shall be governed by the Rules of the House of Representatives applicable to other bills and resolutions in similar circumstances.

(F) FLOOR CONSIDERATION IN THE SENATE.—

(i) MOTION TO PROCEED.—A motion in the Senate to proceed to the consideration

of an implementing bill shall be privileged and not debatable. An amendment to the motion shall not be in order, nor shall it be in order to move to reconsider the vote by which the motion is agreed to or disagreed to.

(ii) GENERAL DEBATE.—Debate in the Senate on an implementing bill, and all debatable motions and appeals in connection therewith, shall be limited to not more than 20 hours. The time shall be equally divided between, and controlled by, the Majority Leader and the Minority Leader or their designees.

(iii) DEBATE OF MOTIONS AND APPEALS.—Debate in the Senate on any debatable motion or appeal in connection with an implementing bill shall be limited to not more than 1 hour, to be equally divided between, and controlled by, the mover and the manager of the implementing bill, except that in the event the manager of the implementing bill is in favor of any such motion or appeal, the time in opposition thereto, shall be controlled by the

Minority Leader or his designee. Such leaders, or either of them, may, from time under their control on the passage of an implementing bill, allot additional time to any Senator during the consideration of any debatable motion or appeal.

(iv) OTHER MOTIONS.—A motion in the Senate to further limit debate is not debatable. A motion to recommit an implementing bill is not in order.

(c) FAILURE TO COMPLY WITH RECOMMENDATIONS ENACTED.—A health care provider or health care insurer that fails to comply with any recommendations of the Commission that are enacted in accordance with subsection (b) and that are applicable to such provider or insurer shall be ineligible for payments of claims submitted under any provision of the Social Security Act or the Public Health Service Act.

TITLE IV—ANTITRUST REFORMS

SEC. 401. ESTABLISHMENT OF LIMITED EXEMPTION PROGRAM FOR HEALTH CARE JOINT VENTURES.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—Not later than 6 months after the date of the enactment of this Act, the Attorney General, after consultation with the Secretary

of Health and Human Services and the Interagency Advisory Committee on Competition, Antitrust Policy, and Health Care, shall promulgate specific guidelines under which a health care joint venture may submit an application requesting that the Attorney General provide the entities participating in the joint venture with an exemption under which (notwithstanding any other provision of law)—

(A) monetary recovery on a claim under the antitrust laws shall be limited to actual damages if the claim results from conduct within the scope of the joint venture that occurs while the exemption is in effect; and

(B) the conduct of the entity in making or performing a contract to carry out the joint venture shall not be deemed illegal per se under the antitrust laws but shall be judged on the basis of its reasonableness, taking into account all relevant factors affecting competition, including (but not limited to) effects on competition in properly defined, relevant research, development, product, process, and service markets (taking into consideration worldwide capacity to the extent that it may be appropriate in the circumstances).

(2) DEADLINE FOR RESPONSE.—The Attorney General, after consultation with the Secretary and the Advisory Committee, shall approve or disapprove the application of a health care joint venture for an exemption under this subsection not later than 30 days after the Attorney General receives the joint venture's application.

(3) PROVIDING REASONS FOR DISAPPROVAL.—If the Attorney General disapproves the application of a health care joint venture for an exemption under this subsection, the Attorney General shall provide the joint venture with a statement explaining the reasons for the Attorney General's disapproval.

(b) REQUIREMENTS FOR APPROVAL.—For purposes of subsection (a), the Attorney General shall approve the application of a health care joint venture for an exemption under subsection (a) if an entity participating in the joint venture submits to the Attorney General an application not later than 30 days after the entity has entered into a written agreement to participate in the joint venture (or not later than 30 days after the date of the enactment of this Act in the case of a joint venture in effect as of such date) that contains the following information and assurances:

(1) The identities of the parties to the joint venture.

(2) The nature, objectives, and planned activities of the joint venture.

(3) Assurances that the entities participating in the joint venture shall notify the Attorney General of any changes in the information described in paragraphs (1) and (2) during the period for which the exemption is in effect.

(c) REVOCATION OF EXEMPTION.—

(1) IN GENERAL.—The Attorney General, after consultation with the Secretary, may revoke an exemption provided to a health care joint venture under this section if, at any time during which the exemption is in effect, the Attorney General finds that the joint venture no longer meets the applicable requirements for approval under subsection (b), except that the Attorney General may not revoke such an exemption if the failure of the health care joint venture to meet such requirements is merely technical in nature.

(2) TIMING.—The revocation of an exemption under paragraph (1) shall apply only to conduct of the health care joint venture occurring after the exemption is no longer in effect.

(d) WITHDRAWAL OF APPLICATION.—Any party that submits an application under this section may withdraw such application at any time before the Attorney General's response to the application.

(e) REQUIREMENTS RELATING TO NOTICE AND PUBLICATION OF EXEMPTIONS AND RELATED INFORMATION.—

(1) PUBLICATION OF APPROVED APPLICATIONS FOR EXEMPTIONS IN FEDERAL REGISTER.—

(A) IN GENERAL.—With respect to each exemption for a health care joint venture provided under subsection (a), the Attorney General (acting jointly with the Secretary) shall—

(i) prepare a notice with respect to the joint venture that identifies the parties to the venture and that describes the planned activities of the venture;

(ii) submit the notice to the entities participating in the joint venture; and

(iii) after submitting the notice to such entities (but not later than 30 days after approving the application for the exemption for the joint venture), publish the notice in the Federal Register.

(B) EFFECT OF PUBLICATION.—An exemption provided by the Attorney General under subsection (a) shall take effect as of the date of the publication in the Federal Register of the notice with respect to the exemption pursuant to subparagraph (A).

(2) WAIVER OF DISCLOSURE REQUIREMENTS FOR INFORMATION RELATING TO APPLICATIONS FOR EXEMPTIONS.—

(A) IN GENERAL.—All information and documentary material submitted as part of an application of a health care joint venture for an exemption under subsection (a), together with any other information obtained by the Attorney General, the Secretary, or the Advisory Committee in the course of any investigation, administrative proceeding, or case with respect to a potential violation of the antitrust laws by the joint venture with respect to which the exemption applies, shall be exempt from disclosure under section 552 of title 5, United States Code, and shall not be made publicly available by any agency of the United States to which such section applies, except as relevant to a law enforcement investigation or in a judicial or ad-

ministrative proceeding in which such information and material is subject to any protective order.

(B) EXCEPTION FOR INFORMATION INCLUDED IN FEDERAL REGISTER NOTICE.—Subparagraph (A) shall not apply with respect to information contained in a notice published in the Federal Register pursuant to paragraph (1).

(3) USE OF INFORMATION TO SUPPORT OR ANSWER CLAIMS UNDER ANTITRUST LAWS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the fact of disclosure of conduct under an application for an exemption under subsection (a) and the fact of publication of a notice in the Federal Register under paragraph (1) shall be admissible into evidence in any judicial or administrative proceeding for the sole purpose of establishing that a person is entitled to the protections provided by an exemption granted under subsection (a).

(B) EFFECT OF REJECTED APPLICATION.—If the Attorney General denies, in whole or in part, an application for an exemption under subsection (a), or revokes an exemption

under such section, neither the negative determination nor the statement of reasons therefor shall be admissible into evidence in any administrative or judicial proceeding for the purpose of supporting or answering any claim under the antitrust laws.

SEC. 402. ISSUANCE OF HEALTH CARE CERTIFICATES OF PUBLIC ADVANTAGE.

(a) ISSUANCE AND EFFECT OF CERTIFICATE.—The Attorney General, after consultation with the Secretary and the Advisory Committee, shall issue in accordance with this section a certificate of public advantage to each eligible health care joint venture that complies with the requirements in effect under this section on or after the expiration of the 1-year period that begins on the date of the enactment of this Act (without regard to whether or not the Attorney General has promulgated regulations to carry out this section by such date). Such venture, and the parties to such venture, shall not be liable under any of the antitrust laws for conduct described in such certificate and engaged in by such venture if such conduct occurs while such certificate is in effect.

(b) REQUIREMENTS APPLICABLE TO ISSUANCE OF CERTIFICATES.—

(1) STANDARDS TO BE MET.—The Attorney General shall issue a certificate to an eligible health care joint venture if the Attorney General finds that—

(A) the benefits that are likely to result from carrying out the venture outweigh the reduction in competition (if any) that is likely to result from the venture, and

(B) such reduction in competition is reasonably necessary to obtain such benefits.

(2) FACTORS TO BE CONSIDERED.—

(A) WEIGHING OF BENEFITS AGAINST REDUCTION IN COMPETITION.—For purposes of making the finding described in paragraph (1)(A), the Attorney General shall consider whether the venture is likely—

(i) to maintain or to increase the quality of health care,

(ii) to increase access to health care,

(iii) to achieve cost efficiencies that will be passed on to health care consumers, such as economies of scale, reduced transaction costs, and reduced administrative costs,

(iv) to preserve the operation of health care facilities located in underserved geographical areas,

(v) to improve utilization of health care resources, and

(vi) to reduce inefficient health care resource duplication.

(B) NECESSITY OF REDUCTION IN COMPETITION.—For purposes of making the finding described in paragraph (1)(B), the Attorney General shall consider—

(i) the ability of the providers of health care services that are (or likely to be) affected by the health care joint venture and the entities responsible for making payments to such providers to negotiate societally optimal payment and service arrangements,

(ii) the effects of the health care joint venture on premiums and other charges imposed by the entities described in clause (i), and

(iii) the availability of equally efficient, less restrictive alternatives to achieve

the benefits that are intended to be achieved by carrying out the venture.

(c) ESTABLISHMENT OF CRITERIA AND PROCEDURES.—Subject to subsections (d) and (e), not later than 1 year after the date of the enactment of this Act, the Attorney General and the Secretary shall establish jointly by rule the criteria and procedures applicable to the issuance of certificates under subsection (a). The rules shall specify the form and content of the application to be submitted to the Attorney General to request a certificate, the information required to be submitted in support of such application, the procedures applicable to denying and to revoking a certificate, and the procedures applicable to the administrative appeal (if such appeal is authorized by rule) of the denial and the revocation of a certificate. Such information may include the terms of the health care joint venture (in the case of a venture in existence as of the time of the application) and implementation plan for the joint venture.

(d) ELIGIBLE HEALTH CARE JOINT VENTURE.—To be an eligible health care joint venture for purposes of this section, a health care joint venture shall submit to the Attorney General an application that complies with the rules in effect under subsection (c) and that includes—

(1) an agreement by the parties to the venture that the venture will not foreclose competition by entering into contracts that prevent health care providers from providing health care in competition with the venture,

(2) an agreement that the venture will submit to the Attorney General annually a report that describes the operations of the venture and information regarding the impact of the venture on health care and on competition in health care, and

(3) an agreement that the parties to the venture will notify the Attorney General and the Secretary of the termination of the venture not later than 30 days after such termination occurs.

(e) REVIEW OF APPLICATIONS FOR CERTIFICATES.—Not later than 30 days after an eligible health care joint venture submits to the Attorney General an application that complies with the rules in effect under subsection (c) and with subsection (d), the Attorney General shall issue or deny the issuance of such certificate. If, before the expiration of such 30-day period, the Attorney General fails to issue or deny the issuance of such certificate, the Attorney General shall be deemed to have issued such certificate.

(f) REVOCATION OF CERTIFICATE.—Whenever the Attorney General finds that a health care joint venture with respect to which a certificate is in effect does not meet the standards specified in subsection (b), the Attorney General shall revoke such certificate.

(g) WRITTEN REASONS; JUDICIAL REVIEW.—

(1) DENIAL AND REVOCATION OF CERTIFICATES.—If the Attorney General denies an application for a certificate or revokes a certificate, the Attorney General shall include in the notice of denial or revocation a statement of the reasons relied upon for the denial or revocation of such certificate.

(2) JUDICIAL REVIEW.—

(A) AFTER ADMINISTRATIVE PROCEEDING.—(i) If the Attorney General denies an application submitted or revokes a certificate issued under this section after an opportunity for hearing on the record, then any party to the health care joint venture involved may commence a civil action, not later than 60 days after receiving notice of the denial or revocation, in an appropriate district court of the United States for review of the record of such denial or revocation.

(ii) As part of the Attorney General's answer, the Attorney General shall file in such court a certified copy of the record on which such denial or revocation is based. The findings of fact of the Attorney General may be set aside only if found to be unsupported by substantial evidence in such record taken as a whole.

(B) DENIAL OR REVOCATION WITHOUT ADMINISTRATIVE PROCEEDING.—If the Attorney General denies an application submitted or revokes a certificate issued under this section without an opportunity for hearing on the record, then any party to the health care joint venture involved may commence a civil action, not later than 60 days after receiving notice of the denial or revocation, in an appropriate district court of the United States for de novo review of such denial or revocation.

(h) EXEMPTION.—A person shall not be liable under any of the antitrust laws for conduct necessary—

(1) to prepare, agree to prepare, or attempt to agree to prepare an application to request a certificate under this section, or

(2) to attempt to enter into any health care joint venture with respect to which such a certificate is in effect.

SEC. 403. INTERAGENCY ADVISORY COMMITTEE ON COMPETITION, ANTITRUST POLICY, AND HEALTH CARE.

(a) ESTABLISHMENT.—There is hereby established the Interagency Advisory Committee on Competition, Antitrust Policy, and Health Care. The Advisory Committee shall be composed of—

(1) the Secretary of Health and Human Services (or the designee of the Secretary);

(2) the Attorney General (or the designee of the Attorney General);

(3) the Director of the Office of Management and Budget (or the designee of the Director); and

(4) a representative of the Federal Trade Commission.

(b) DUTIES.—The duties of the Advisory Committee are—

(1) to discuss and evaluate competition and antitrust policy, and their implications with respect to the performance of health care markets;

(2) to analyze the effectiveness of health care joint ventures receiving exemptions under the pro-

gram established under section 401(a) or certificates under section 402 in reducing the costs of and expanding access to the health care services that are the subject of such ventures; and

(3) to make such recommendations to Congress not later than 2 years after the date of the enactment of this Act (and at such subsequent periods as the Advisory Committee considers appropriate) regarding modifications to the program established under section 401(a) or to section 402 as the Advisory Committee considers appropriate, including modifications relating to the costs to health care providers of obtaining an exemption for a joint venture under such program.

SEC. 404. DEFINITIONS.

For purposes of this title:

(1) The term ''Advisory Committee'' means the Interagency Advisory Committee on Competition, Antitrust Policy, and Health Care established under section 403.

(2) The term ''antitrust laws''—

(A) has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)), except that such term includes section 5 of the Federal Trade Commission Act

(15 U.S.C. 45) to the extent such section applies to unfair methods of competition; and

(B) includes any State law similar to the laws referred to in subparagraph (A).

(3) The term ''certificate'' means a certificate of public advantage authorized to be issued under section 402(a).

(4) The term ''health care joint venture'' means an agreement (whether existing or proposed) between 2 or more providers of health care services that is entered into solely for the purpose of sharing in the provision of health care services and that involves substantial integration or financial risk-sharing between the parties, but does not include the exchanging of information, the entering into of any agreement, or the engagement in any other conduct that is not reasonably required to carry out such agreement.

(5) The term ''health care services'' includes services related to the delivery or administration of health care services.

(6) The term ''liable'' means liable for any civil or criminal violation of the antitrust laws.

(7) The term ''provider of health care services'' means any individual or entity that is engaged in the

delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

(8) The term ''Secretary'' means the Secretary of Health and Human Services.

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