Section 5205 REVIEW BY FEDERAL HEALTH PLAN REVIEW BOARD.

(a) Establishment and Membership. The Secretary of Labor shall establish by regulation a Federal Health Plan Review Board (hereinafter in this subtitle referred to as the "Review Board"). The Review Board shall be composed of 5 members appointed by the Secretary of Labor from among persons who by reason of training, education, or experience are qualified to carry out the functions of the Review Board under this subtitle. The Secretary of Labor shall prescribe such rules as are necessary for the orderly transaction of proceedings by the Review Board. Every official act of the Review Board shall be entered of record, and its hearings and records shall be open to the public.

(b) Review Process. The Review Board shall ensure, in accordance with rules prescribed by the Secretary of Labor, that reasonable notice is provided for each appeal before the Review Board of a hearing officer's decision under section 5304, and shall provide for the orderly consideration of arguments by any party to the hearing upon which the hearing officer's decision is based. In the discretion of the Review Board, any other person may be allowed to intervene in the proceeding and to present written argument. The National Health Board may intervene in the proceeding as a matter of right.

(c) Scope of Review.The Review Board shall review the decision of the hearing officer from which the appeal is made, except that the review shall be only for the purposes of determining

(1) whether the determination is supported by substantial evidence on the record considered as a whole,

(2) in the case of any interpretation by the hearing officer of contractual terms (irrespective of the extent to which extrinsic evidence was considered), whether the determination is supported by a preponderance of the evidence,

(3) whether the determination is in excess of statutory jurisdiction, authority, or limitations, or in violation of a statutory right, or

(4) whether the determination is without observance of procedure required by law.

(d) Decision of Review Board. The decision of the hearing officer as affirmed or modified by the Review Board (or any reversal by the Review Board of the hearing officer's final disposition of the proceedings) shall become the final order of

the Review Board and binding on all parties, subject to review under subsection (e). The Review Board shall cause a copy of its decision to be served on the parties to the proceedings not later than 5 days after the date of the decision.

(e) Review of Final Orders.

(1) In general. Not later than 60 days after the entry of the final order, any person aggrieved by any such final order under which the amount or value in controversy exceeds $10,000 may seek a review of the order in the United States court of appeals for the circuit in which the violation is alleged to have occurred or in which the complainant resides.

(2) Further review. Upon the filing of the record with the court, the jurisdiction of the court shall be exclusive and its judgment shall be final, except that the judgment shall be subject to review by the Supreme Court of the United States upon writ of certiorari or certification as provided in section 1254 of title 28 of the United States Code.

(3) Enforcement decree in original review.If, upon appeal of an order under paragraph (1), the United States court of appeals does not reverse the order, the court shall have the jurisdiction to make and enter a decree enforcing the order of the Review Board.

(f) Awarding of Attorneys' Fees and Other Costs and Expenses. In any proceeding before the Review Board under this section or any judicial proceeding under subsection (e), the Review Board or the court (as the case may be) shall award to a prevailing complainant reasonable costs and expenses (including a reasonable attorney's fee) on the causes on which the complainant prevails.

Section 5206 RULES GOVERNING BENEFIT CLAIMS DETERMINATIONS.

(a) In General. Determinations made under this part or by any State court in connection with a complaint based on an act or practice described in section 5202(b) shall be in accordance with the provisions of this Act, the comprehensive benefit package as provided by this Act, the rules and regulations of the National Health Board prescribed under this Act, and decisions of the National Health Board under this Act.

(b) Rights and Remedies under State Law. Subject to subsection (a), the rights and remedies available in State court against a health plan providing services through a regional

alliance in connection with a complaint based on an act or practice described in section 5202(b) shall be governed by State law.

Section 5207 CIVIL MONEY PENALTIES.

(a) Denial or Delay in Payment or Provision of Benefits.

(1) In general. The Secretary of Labor may assess a civil penalty against any health plan, or against any other plan in connection with benefits provided thereunder under a supplemental benefit policy described in section 1421(b)(1) or a cost sharing policy described in section 1421(b)(2), for unreasonable denial or delay in the payment or provision of benefits thereunder, in an amount not to exceed

(A) $25,000 per violation, or $75,000 per violation in the case of a finding of bad faith on the part of the plan, and

(B) in the case of a finding of a pattern or practice of such violations engaged in by the plan, $1,000,000 in addition to the total amount of penalties assessed under subparagraph (A) with respect to such violations. For purposes of subparagraph (A), each violation with respect to any single individual shall be treated as a separate violation.

(2) Civil action to enforce civil penalty. The Secretary of Labor may commence a civil action in any court of competent jurisdiction to enforce a civil penalty assessed under paragraph (1).

(b) Civil Penalties for Certain Other Actions. The Secretary of Labor may assess a civil penalty described in section 5412(b)(1) against any corporate alliance health plan, or against any other plan sponsored by a corporate alliance in connection with benefits provided thereunder under a cost sharing policy described in section 1421(b)(2), for any action described in section 5412(a). The Secretary of Labor may initiate proceedings to impose such penalty in the same manner as the Secretary of Health and Human Services may initiate proceedings under section 5412 with respect to actions described in section 5412(a).

Subpart B Early Resolution Programs

Section 5211 ESTABLISHMENT OF EARLY RESOLUTION PROGRAMS IN COMPLAINT REVIEW OFFICES.

(a) Establishment of Programs. Each State shall establish

and maintain an Early Resolution Program in each complaint review office in such State. The Program shall include

(1) the establishment and maintenance of forums for mediation of disputes in accordance with this subpart, and

(2) the establishment and maintenance of such forums for other forms of alternative dispute resolution (including binding arbitration) as may be prescribed in regulations of the Secretary of Labor. Each State shall ensure that the standards applied in Early Resolution Programs administered in such State which apply to any form of alternative dispute resolution described in paragraph (2) and which relate to time requirements, qualifications of facilitators, arbitrators, or other mediators, and confidentiality are at least equivalent to the standards which apply to mediation proceedings under this subpart.

(b) Duties of Complaint Review Offices. Each complaint review office in a State

(1) shall administer its Early Resolution Program in accordance with regulations of the Secretary of Labor,

(2) shall, pursuant to subsection (a)(1)

(A) recruit and train individuals to serve as facilitators for mediation proceedings under the Early Resolution Program from attorneys who have the requisite expertise for such service, which shall be specified in regulations of the Secretary of Labor,

(B) provide meeting sites, maintain records, and provide facilitators with administrative support staff, and

(C) establish and maintain attorney referral panels,

(3) shall ensure that, upon the filing of a complaint with the office, the complainant is adequately apprised of the complainant's options for review under this part, and

(4) shall monitor and evaluate the Program on an ongoing basis.

Section 5212 INITIATION OF PARTICIPATION IN MEDIATION PROCEEDINGS.

(a) Eligibility of Cases for Submission to Early Resolution Program. A dispute may be submitted to the Early Resolution Program only if the following requirements are met with respect

to the dispute:

(1) Nature of dispute. The dispute consists of an assertion by an individual enrolled under a health plan of one or more claims against the health plan for payment or provision of benefits, or against any other plan maintained by the regional alliance or corporate alliance sponsoring the health plan with respect to benefits provided under a supplemental benefit policy described in section 1421(b)(1) or a cost sharing policy described in section 1421(b)(2), based on alleged coverage under the plan, and a denial of the claims, or a denial of appropriate reimbursement based on the claims, by the plan.

(2) Nature of disputed claim. Each claim consists of

(A) a claim for payment or provision of benefits under the plan; or

(B) a request for information or documents the disclosure of which is required under this Act (including claims of entitlement to disclosure based on colorable claims to rights to benefits under the plan).

(b) Filing of Election. A complainant with a dispute which is eligible for submission to the Early Resolution Program may make the election under section 5203(a)(2) to submit the dispute to mediation proceedings under the Program not later than 15 days after the date the complaint is filed with the complaint review office under section 5202(b).

(c) Agreement to Participate.

(1) Election by claimant. A complainant may elect participation in the mediation proceedings only by entering into a written participation agreement (including an agreement to comply with the rules of the Program and consent for the complaint review office to contact the health plan regarding the agreement), and by releasing plan records to the Program for the exclusive use of the facilitator assigned to the dispute.

(2) Participation by plans or health benefits contractors. Each party whose participation in the mediation proceedings has been elected by a claimant pursuant to paragraph (1) shall participate in, and cooperate fully with, the proceedings. The claims review office shall provide such party with a copy of the participation agreement described in paragraph (1), together with a written description of the Program. Such party shall submit the copy of the agreement, together with its authorized signature signifying receipt of notice of the

agreement, to the claims review office, and shall include in the submission to the claims review office a copy of the written record of the plan claims procedure completed pursuant to section 5201 with respect to the dispute and all relevant plan documents. The relevant documents shall include all documents under which the plan is or was administered or operated, including copies of any insurance contracts under which benefits are or were provided and any fee or reimbursement schedules for health care providers.

Section 5213 MEDIATION PROCEEDINGS.

(a) Role of Facilitator. In the course of mediation proceedings under the Early Resolution Program, the facilitator assigned to the dispute shall prepare the parties for a conference regarding the dispute and serve as a neutral mediator at such conference, with the goal of achieving settlement of the dispute.

(b) Preparations for Conference. In advance of convening the conference, after identifying the necessary parties and confirming that the case is eligible for the Program, the facilitator shall analyze the record of the claims procedure conducted pursuant to section 5201 and any position papers submitted by the parties to determine if further case development is needed to clarify the legal and factual issues in dispute, and whether there is any need for additional information and documents.

(c) Conference. Upon convening the conference, the facilitator shall assist the parties in identifying undisputed issues and exploring settlement. If settlement is reached, the facilitator shall assist in the preparation of a written settlement agreement. If no settlement is reached, the facilitator shall present the facilitator's evaluation, including an assessment of the parties' positions, the likely outcome of further administrative action or litigation, and suggestions for narrowing the issues in dispute.

(d) Time Limit. The facilitator shall ensure that mediation proceedings with respect to any dispute under the Early Resolution Program shall be completed within 120 days after the election to participate. The parties may agree to one extension of the proceedings by not more than 30 days if the proceedings are suspended to obtain an agency ruling or to reconvene the conference in a subsequent session.

(e) Inapplicability of Formal Rules. Formal rules of evidence shall not apply to mediation proceedings under the Early Resolution Program. All statements made and evidence presented in

the proceedings shall be admissible in the proceedings. The facilitator shall be the sole judge of the proper weight to be afforded to each submission. The parties to mediation proceedings under the Program shall not be required to make statements or present evidence under oath.

(f) Representation. Parties may participate pro se or be represented by attorneys throughout the proceedings of the Early Resolution Program.

(g) Confidentiality.

(1) In general. Under regulations of the Secretary of Labor, rules similar to the rules under section 574 of title 5, United States Code (relating to confidentiality in dispute resolution proceedings) shall apply to the mediation proceedings under the Early Resolution Program.

(2) Civil remedies. The Secretary of Labor may assess a civil penalty against any person who discloses information in violation of the regulations prescribed pursuant to paragraph (1) in the amount of three times the amount of the claim involved. The Secretary of Labor may bring a civil action to enforce such civil penalty in any court of competent jurisdiction.

Section 5214 LEGAL EFFECT OF PARTICIPATION IN MEDIATION PROCEEDINGS.

(a) Process Nonbinding. Findings and conclusions made in the mediation proceedings of the Early Resolution Program shall be treated as advisory in nature and nonbinding. Except as provided in subsection (b), the rights of the parties under subpart A shall not be affected by participation in the Program.

(b) Resolution Through Settlement Agreement. If a case is settled through participation in mediation proceedings under the Program, the facilitator shall assist the parties in drawing up an agreement which shall constitute, upon signature of the parties, a binding contract between the parties, which shall be enforceable under section 5215.

(c) Preservation of Rights of Non-Parties. The settlement agreement shall not have the effect of waiving or otherwise affecting any rights to review under subpart A, or any other right under this Act or the plan, with respect to any person who is not a party to the settlement agreement.

Section 5215 ENFORCEMENT OF SETTLEMENT AGREEMENTS.

(a) Enforcement. Any party to a settlement agreement entered pursuant to mediation proceedings under this subpart may petition any court of competent jurisdiction for the enforcement of the agreement, by filing in the court a written petition praying that the agreement be enforced. In such a proceeding, the order of the hearing officer shall not be subject to review.

(b) Court Review. It shall be the duty of the court to advance on the docket and to expedite to the greatest possible extent the disposition of any petition filed under this section, with due deference to the role of settlement agreements under this part in achieving prompt resolution of disputes involving health plans.

(c) Awarding of Attorney's Fees and Other Costs and Expenses. In any action by an individual enrolled under a health plan for court enforcement under this section, a prevailing plaintiff shall be entitled to reasonable costs and expenses (including a reasonable attorney's fee and reasonable expert witness fees) on the charges on which the plaintiff prevails.

Part 2 ADDITIONAL REMEDIES AND ENFORCEMENT PROVISIONS

Section 5231 JUDICIAL REVIEW OF FEDERAL ACTION ON STATE SYSTEMS.

(a) In General. Any State or alliance that is aggrieved by a determination by the National Health Board under subpart B of part 1 of subtitle F of title I shall be entitled to judicial review of such determination in accordance with this section.

(b) Judicial Review.

(1) Jurisdiction. The courts of appeals of the United States (other than the United States Court of Appeals for the Federal Circuit) shall have jurisdiction to review a determination described in subsection (a), to affirm the determination, or to set it aside, in whole or in part. A judgment of a court of appeals in such an action shall be subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code.

(2) Petition for review. A State or an alliance that desires judicial review of a determination described in subsection (a) shall, within 30 days after it has been notified of such determination, file with the United States court of appeals for the circuit in which the State or alliance is located a petition for review of such determination. A copy of the

petition shall be transmitted by the clerk of the court to the National Health Board, and the Board shall file in the court the record of the proceedings on which the determination or action was based, as provided in section 2112 of title 28, United States Code.

(3) Scope of review.The findings of fact of the National Health Board, if supported by substantial evidence, shall be conclusive; but the court, for good cause shown, may remand the case to the Board to take further evidence, and the Board may make new or modified findings of fact and may modify its previous action, and shall certify to the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence.

Section 5232 ADMINISTRATIVE AND JUDICIAL REVIEW RELATING TO COST CONTAINMENT.

There shall be no administrative or judicial review of any determination by the National Health Board respecting any matter under subtitle A of title VI.

Section 5233 CIVIL ENFORCEMENT.

Unless otherwise provided in this Act, the district courts of the United States shall have jurisdiction of civil actions brought by

(1) the Secretary of Labor to enforce any final order of such Secretary or to collect any civil monetary penalty assessed by such Secretary under this Act; and

(2) the Secretary of Health and Human Services to enforce any final order of such Secretary or to collect any civil monetary penalty assessed by such Secretary under this Act.

Section 5234 PRIORITY OF CERTAIN BANKRUPTCY CLAIMS.

Section 507(a)(8) of title 11, United States Code, is amended to read as follows:

"(8) Eighth, allowed unsecured claims

"(A) based upon any commitment by the debtor to the Federal Deposit Insurance Corporation, the Resolution Trust Corporation, the Director of the Office of Thrift Supervision, the Comptroller of the Currency, or the Board of Governors of the Federal Reserve System, or their predecessors or successors, to maintain the capital of an insured depository institution;

"(B) for payments under subtitle B of title IV of the Health Security Act owed to a regional alliance (as defined in section 1301 of such Act);

"(C) for payments owed to a corporate alliance health plan under trusteeship of the Secretary of Labor under section 1395 of the Health Security Act; or

"(D) for assessments and related amounts owed to the Secretary of Labor under section 1397 of the Health Security Act.".

Section 5235 PRIVATE RIGHT TO ENFORCE STATE RESPONSIBILITIES.

The failure of a participating State to carry out a responsibility applicable to participating States under this Act constitutes a deprivation of rights secured by this Act for the purposes of section 1977 of the Revised Statutes of the United States (42 U.S.C. 1983). In an action brought under such section, the court shall exercise jurisdiction without regard to whether the aggrieved person has exhausted any administrative or other remedies that may be provided by law.

Section 5236 PRIVATE RIGHT TO ENFORCE FEDERAL RESPONSIBILITIES IN OPERATING A SYSTEM IN A STATE.

(a) In General. The failure of the Secretary of Health and Human Services to carry out a responsibility under section 1522 (relating to operation of an alliance system in a State) confers an enforceable right of action on any person who is aggrieved by such failure. Such a person may commence a civil action against the Secretary in an appropriate State court or district court of the United States.

(b) Exhaustion of Remedies. In an action under subsection (a), the court shall exercise jurisdiction without regard to whether the aggrieved person has exhausted any administrative or other remedies that may be provided by law.

(c) Relief. In an action under subsection (a), if the court finds that a failure described in such subsection has occurred, the aggrieved person may recover compensatory and punitive damages and the court may order any other appropriate relief.

(d) Attorney's Fees. In an action under subsection (a), the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee (including

expert fees) as part of the costs, and the United States shall be liable for costs the same as a private person.

Section 5237 PRIVATE RIGHT TO ENFORCE RESPONSIBILITIES OF ALLIANCES.

(a) In General. The failure of a regional alliance or a corporate alliance to carry out a responsibility applicable to the alliance under this Act confers an enforceable right of action on any person who is aggrieved by such failure. Such a person may commence a civil action against the alliance in an appropriate State court or district court of the United States.

(b) Exhaustion of Remedies.

(1) In general. Except as provided in paragraph (2), in an action under subsection (a) the court may not exercise jurisdiction until the aggrieved person has exhausted any administrative remedies that may be provided by law.

(2) No exhaustion required. In an action under subsection (a), the court shall exercise jurisdiction without regard to whether the aggrieved person has exhausted any administrative or other remedies that may be provided by law if the action relates to

(A) whether the person is an eligible individual within the meaning of section 1001(c);

(B) whether the person is eligible for a premium discount under subpart A of part 1 of subtitle B of title VI;

(C) whether the person is eligible for a reduction in cost sharing under subpart D of part 3 of subtitle D of title I; or

(D) enrollment or disenrollment in a health plan.

(c) Relief. In an action under subsection (a), if the court finds that a failure described in such subsection has occurred, the aggrieved person may recover compensatory and punitive damages and the court may order any other appropriate relief.

(d) Attorney's Fees. In any action under subsection (a), the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee (including expert fees) as part of the costs, and the United States shall be liable for costs the same as a private person.

Section 5238 DISCRIMINATION CLAIMS.

(a) Civil Action by Aggrieved Person.

(1) In general. Any person who is aggrieved by the failure of a health plan to comply with section 1402(c) may commence a civil action against the plan in an appropriate State court or district court of the United States.

(2) Standards. The standards used to determine whether a violation has occurred in a complaint alleging discrimination on the basis of age or disability under section 1402(c) shall be the standards applied under the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.) and the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.).

(3) Relief. In an action under paragraph (1), if the court finds that the health plan has failed to comply with section 1402(c), the aggrieved person may recover compensatory and punitive damages and the court may order any other appropriate relief.

(4) Attorney's fees. In any action under paragraph (1), the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee (including expert fees) as part of the costs, and the United States shall be liable for costs the same as a private person.

(b) Action by Secretary. Whenever the Secretary of Health and Human Services finds that a health plan has failed to comply with section 1402(c), or with an applicable regulation issued under such section, the Secretary shall notify the plan. If within a reasonable period of time the health plan fails or refuses to comply, the Secretary may

(1) refer the matter to the Attorney General with a recommendation that an appropriate civil action be instituted;

(2) terminate the participation of the health plan in an alliance; or

(3) take such other action as may be provided by law.

(c) Action by Attorney General. When a matter is referred to the Attorney General under subsection (b)(1), the Attorney General may bring a civil action in a district court of the United States for such relief as may be appropriate, including injunctive relief. In a civil action under this section, the court

(1) may grant any equitable relief that the court considers to be appropriate;

(2) may award such other relief as the court considers to be appropriate, including compensatory and punitive damages; and

(3) may, to vindicate the public interest when requested by the Attorney General, assess a civil money penalty against the health plan in an amount

(A) not exceeding $50,000 for a first violation; and

(B) not exceeding $100,000 for any subsequent violation.

Section 5239 NONDISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS.

Federal payments to regional alliances under part 2 of subtitle C of title VI shall be treated as Federal financial assistance for purposes of section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), section 303 of the Age Discrimination Act of 1975 (42 U.S.C. 6102), and section 601 of the Civil Rights Act of 1964 (42 U.S.C. 2000d).

Section 5240 CIVIL ACTION BY ESSENTIAL COMMUNITY PROVIDER.

(a) In General.An electing essential community provider (as defined in section 1431(d)) who is aggrieved by the failure of a health plan to fulfill a duty imposed on the plan by section 1431 may commence a civil action against the plan in an appropriate State court or district court of the United States.

(b) Relief. In an action under subsection (a), if the court finds that the health plan has failed to fulfill a duty imposed on the plan by section 1431, the electing essential community provider may recover compensatory damages and the court may order any other appropriate relief.

(c) Attorney's Fees. In any action under subsection (a), the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee (including expert fees) as part of the costs, and the United States shall be liable for costs the same as a private person.

Section 5241 FACIAL CONSTITUTIONAL CHALLENGES.

(a) Jurisdiction. The United States District Court for the District of Columbia shall have original and exclusive jurisdiction of any civil action brought to invalidate this Act or a provision of this Act on the ground of its being repugnant to the Constitution of the United States on its face and for every purpose. In any action described in this subsection, the district court may not grant any temporary order or preliminary injunction restraining the enforcement, operation, or execution of this Act or any provision of this Act.

/* The final clause is of questionable constitutional validity. */

(b) Statute of Limitations. An action described in subsection (a) shall be commenced not later than 1 year after the date of the enactment of this Act.

(c) Convening of Three-Judge Court. An action described in subsection (a) shall be heard and determined by a district court of three judges in accordance with section 2284 of title 28, United States Code.

(d) Consolidation. When actions described in subsection (a) involving a common question of law or fact are pending before a district court, the court shall order all the actions consolidated.

(e) Direct Appeal to Supreme Court. In any action described in subsection (a), an appeal may be taken directly to the Supreme Court of the United States from any final judgment, decree, or order in which the district court

(1) holds this Act or any provision of this Act invalid; and

(2) makes a determination that its holding will materially undermine the application of the Act as whole.

(f) Construction. This section does not limit

(1) the right of any person

(A) to a litigation concerning the Act or any portion of the Act;
or

(B) to petition the Supreme Court for review of any

holding of a district court by writ of certiorari at any time before the rendition of judgment in a court of appeals; or

(2) the authority of the Supreme Court to grant a writ of certiorari for the review described in paragraph (1)(B).

Section 5242 TREATMENT OF PLANS AS PARTIES IN CIVIL ACTIONS.

(a) In General. A health plan may sue or be sued under this Act as an entity. Service of summons, subpoena, or other legal process of a court or hearing officer upon a trustee or an administrator of any such plan in his capacity as such shall constitute service upon the plan. In a case where a plan has not designated in applicable plan documents an individual as agent for the service of legal process, service upon the Secretary of Health and Human Services (in the case of a regional alliance health plan) or the Secretary of Labor (in the case of a corporate alliance health plan) shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(b) Other Parties. Any money judgment under this Act against a plan referred to in subsection (a) shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this Act.

Section 5243 GENERAL NONPREEMPTION OF EXISTING RIGHTS AND REMEDIES.

Nothing in this title shall be construed to deny, impair, or otherwise adversely affect a right or remedy available under law to any person on the date of the enactment of this Act or thereafter, except to the extent the right or remedy is inconsistent with this title.

Title V, Subtitle D

Subtitle D Medical Malpractice

Part 1 LIABILITY REFORM

Section 5301 FEDERAL TORT REFORM.

(a) Applicability.

(1) In general. Except as provided in section 5302, this

part shall apply with respect to any medical malpractice liability action brought in any State or Federal court, except that this part shall not apply to a claim or action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the claim or action.

(2) Preemption. The provisions of this part shall preempt any State law to the extent such law is inconsistent with the limitations contained in such provisions. The provisions of this part shall not preempt any State law that provides for defenses or places limitations on a person's liability in addition to those contained in this subtitle, places greater limitations on the amount of attorneys' fees that can be collected, or otherwise imposes greater restrictions than those provided in this part.

(3) Effect on sovereign immunity and choice of law or venue. Nothing in this part shall be construed to

(A) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(B) waive or affect any defense of sovereign immunity asserted by the United States;

(C) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(D) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(E) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum.

(4) Federal court jurisdiction not established on federal question grounds. Nothing in this part shall be construed to establish any jurisdiction in the district courts of the United States over medical malpractice liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

(b) Definitions. In this subtitle, the following definitions apply:

(1) Alternative dispute resolution system; ADR. The term "alternative dispute resolution system" or "ADR" means a system

that provides for the resolution of medical malpractice claims in a manner other than through medical malpractice liability actions.

(2) Claimant. The term "claimant" means any person who alleges a medical malpractice claim, and any person on whose behalf such a claim is alleged, including the decedent in the case of an action brought through or on behalf of an estate.

(3) Health care professional. The term "health care professional" means any individual who provides health care services in a State and who is required by the laws or regulations of the State to be licensed or certified by the State to provide such services in the State.

(4) Health care provider. The term "health care provider" means any organization or institution that is engaged in the delivery of health care services in a State and that is required by the laws or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

(5) Injury. The term "injury" means any illness, disease, or other harm that is the subject of a medical malpractice liability action or a medical malpractice claim.

(6) Medical malpractice liability action. The term "medical malpractice liability action" means a civil action brought in a State or Federal court against a health care provider or health care professional (regardless of the theory of liability on which the claim is based) in which the plaintiff alleges a medical malpractice claim.

(7) Medical malpractice claim. The term "medical malpractice claim" means a claim brought against a health care provider or health care professional in which a claimant alleges that injury was caused by the provision of (or the failure to provide) health care services, except that such term does not include

(A) any claim based on an allegation of an intentional tort; or

(B) any claim based on an allegation that a product is defective that is brought against any individual or entity that is not a health care professional or health care provider.

Section 5302 PLAN-BASED ALTERNATIVE DISPUTE RESOLUTION MECHANISMS.

(a) Application to Malpractice Claims Under Plans. In the case of any medical malpractice claim arising from the provision of (or failure to provide) health care services to an individual enrolled in a regional alliance health plan or a corporate alliance health plan, no medical malpractice liability action may be brought with respect to such claim until the final resolution of the claim under the alternative dispute resolution system adopted by the plan under subsection (b).

(b) Adoption of Mechanism by Plans. Each regional alliance health plan and corporate alliance health plan shall

(1) adopt at least one of the alternative dispute resolution methods specified under subsection (c) for the resolution of medical malpractice claims arising from the provision of (or failure to provide) health care services to individuals enrolled in the plan; and

(2) disclose to enrollees (and potential enrollees), in a manner specified by the regional alliance or the corporate alliance, the availability and procedures for consumer grievances under the plan, including the alternative dispute resolution method or methods adopted under this subsection.

(c) Specification of Permissible Alternative Dispute Resolution Methods.

(1) In general. The Board shall, by regulation, develop alternative dispute resolution methods for the use by regional alliance and corporate alliance health plans in resolving medical malpractice claims under subsection (a). Such methods shall include at least the following:

(A) Arbitration. The use of arbitration.

(B) Mediation. The use of required mediation.

(C) Early offers of settlement. The use of a process under which parties are required to make early offers of settlement.

(2) Standards for establishing methods. In developing alternative dispute resolution methods under paragraph (1), the Board shall assure that the methods promote the resolution of medical malpractice claims in a manner that

(A) is affordable for the parties involved;

(B) provides for timely resolution of claims;

(C) provides for the consistent and fair resolution of claims; and

(D) provides for reasonably convenient access to dispute resolution for individuals enrolled in plans.

(d) Further Redress. A plan enrollee dissatisfied with the determination reached as a result of an alternative dispute resolution method applied under this section may, after the final resolution of the enrollee's claim under the method, bring a cause of action to seek damages or other redress with respect to the claim to the extent otherwise permitted under State law.

Section 5303 REQUIREMENT FOR CERTIFICATE OF MERIT.

(a) Requiring Submission With Complaint. No medical malpractice liability action may be brought by any individual unless, at the time the individual brings the action (except as provided in subsection (b)(1)), the individual submits an affidavit

(1) declaring that the individual (or the individual's attorney) has consulted and reviewed the facts of the action with a qualified specialist (as defined in subsection (c));

(2) including a written report by a qualified specialist that clearly identifies the individual and that includes the specialist's determination that, after a review of the medical record and other relevant material, there is a reasonable and meritorious cause for the filing of the action against the defendant; and

(3) on the basis of the qualified specialist's review and consultation, that the individual (or the individual's attorney) has concluded that there is a reasonable and meritorious cause for the filing of the action.

(b) Extension in Certain Instances.

(1) In general. Subject to paragraph (2), subsection (a) shall not apply with respect to an individual who brings a medical malpractice liability action without submitting an affidavit described in such subsection if

(A) the individual is unable to obtain the affidavit before the expiration of the applicable statute of limitations; or

(B) at the time the individual brings the action, the individual has been unable to obtain medical records or other information necessary to prepare the affidavit requested pursuant to any applicable law.

(2) Deadline for submission where extension applies.In the case of an individual who brings an action for which paragraph (1) applies, the action shall be dismissed unless the individual submits the affidavit described in subsection (a) not later than

(A) in the case of an action for which subparagraph (A) of paragraph (1) applies, 90 days after bringing the action; or

(B) in the case of an action for which subparagraph (B) of paragraph (1) applies, 90 days after obtaining the information
described in such subparagraph.

(c) Qualified Specialist Defined. In subsection (a), a "qualified specialist" means, with respect to a medical malpractice liability action, a health care professional who--

(1) is knowledgeable of, and has expertise in, the same specialty area of practice that is the subject of the action; and

(2) is reasonably believed by the individual bringing the action (or the individual's attorney)

(A) to be knowledgeable in the relevant issues involved in the particular action,

(B) to practice (or to have practiced within the preceding 6 years) or to teach (or to have taught within the preceding 6 years) in the same area of health care or medicine that is at issue in the action, and

(C) to be qualified by experience or demonstrated competence in the subject matter of the case.

(d) Sanctions for Submitting False Allegations. Upon the motion of any party or its own initiative, the court in a medical malpractice liability action may impose a sanction on a party or the party's attorney (or both), including a requirement that the party reimburse the other party to the action for costs and reasonable attorney's fees, if any information contained in an affidavit described in subsection (a) is submitted without

reasonable cause and is found to be untrue.

Section 5304 LIMITATION ON AMOUNT OF ATTORNEY'S CONTINGENCY FEES.

(a) In General. An attorney who represents, on a contingency fee basis, a plaintiff in a medical malpractice liability action may not charge, demand, receive, or collect for services rendered in connection with such action (including the resolution of the claim that is the subject of the action under any alternative dispute resolution system) in excess of 33\1/3\ percent of the total amount recovered by judgment or settlement in such action.

(b) Calculation of periodic payments. In the event that a judgment or settlement includes periodic or future payments of damages, the amount recovered for purposes of computing the limitation on the contingency fee under subsection (a) shall be based on the cost of the annuity or trust established to make the payments. In any case in which an annuity or trust is not established to make such payments, such amount shall be based on the present value of the payments.

(c) Contingency Fee Defined. As used in this section, the term "contingency fee" means any fee for professional legal services which is, in whole or in part, contingent upon the recovery of any amount of damages, whether through judgment or settlement.

Section 5305 REDUCTION OF AWARDS FOR RECOVERY FROM COLLATERAL SOURCES.

The total amount of damages recovered by a plaintiff in a medical malpractice liability action shall be reduced by the amount of any past or future payment which the plaintiff has received or for which the plaintiff is eligible on account of the same injury for which the damages are awarded, including payment under

(1) Federal or State disability or sickness programs;

(2) Federal, State, or private health insurance programs;

(3) private disability insurance programs;

(4) employer wage continuation programs; and

(5) any other program, if the payment is intended to compensate the plaintiff for the same injury for which damages

are awarded.

Section 5306 PERIODIC PAYMENT OF AWARDS.

At the request of any party to a medical malpractice liability action, the defendant shall not be required to pay damages in a single, lump-sum payment, but shall be permitted to make such payments periodically based on such schedule as the court considers appropriate, taking into account the periods for which the injured party will need medical and other services.

Part 2 OTHER PROVISIONS RELATING TO MEDICAL MALPRACTICE LIABILITY

Section 5311 ENTERPRISE LIABILITY DEMONSTRATION PROJECT.

(a) Establishment. Not later than January 1, 1996, the Secretary shall establish a demonstration project under which the Secretary shall provide funds (in such amount as the Secretary considers appropriate) to one or more eligible States to demonstrate whether substituting liability for medical malpractice on the part of the health plan in which a physician participates for the personal liability of the physician will result in improvements in the quality of care provided under the plan, reductions in defensive medical practices, and better risk management.

(b) Eligibility of State. A State is eligible to participate in the demonstration project established under subsection (a) if the State submits an application to the Secretary (at such time and in such form as the Secretary may require) containing such information and assurances as the Secretary may require, including assurances that the State

(1) has entered into an agreement with a health plan (other than a fee-for-service plan) operating in the State under which the plan assumes legal liability with respect to any medical malpractice claim arising from the provision of (or failure to provide) services under the plan by any physician participating in the plan;

(2) has provided that, under the law of the State, a physician participating in a plan that has entered into an agreement with the State under paragraph (1) may not be liable in damages or otherwise for such a claim and the plan may not require such physician to indemnify the plan for any such liability; and

(3) will provide the Secretary with such reports on the operation of the project as the Secretary may require.

(c) Authorization of Appropriations. There are authorized to be appropriated such sums as may be necessary to carry out demonstration projects under this section.

Section 5312 PILOT PROGRAM APPLYING PRACTICE GUIDELINES TO MEDICAL MALPRACTICE LIABILITY ACTIONS.

(a) Establishment. Not later than 1 year after the Secretary determines that appropriate practice guidelines are available, the Secretary shall establish a pilot program under which the Secretary shall provide funds (in such amount as the Secretary considers appropriate) to one or more eligible States to determine the effect of applying practice guidelines in the resolution of medical malpractice liability actions.

(b) Eligibility of State. A State is eligible to participate in the pilot program established under subsection (a) if the State submits an application to the Secretary (at such time and in such form as the Secretary may require) containing

(1) assurances that, under the law of the State, in the resolution of any medical malpractice liability action, it shall be a complete defense to any allegation that a party against whom the action is filed was negligent that, in the provision of (or the failure to provide) the services that are the subject of the action, the party followed the appropriate practice guideline established by the National Quality Management Program under subtitle A; and

(2) such other information and assurances as the Secretary may require.

(c) Reports to Congress. Not later than 3 months after the last day of each year for which the pilot program established under subsection (a) is in effect, the Secretary shall submit a report to Congress describing the operation of the program during the previous year and containing such recommendations as the Secretary considers appropriate, including recommendations relating to revisions to the laws governing medical malpractice liability.

Title V, Subtitle E

Subtitle E Fraud and Abuse

Part 1 ESTABLISHMENT OF ALL-PAYER HEALTH CARE FRAUD AND

ABUSE CONTROL PROGRAM

Section 5401 ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM.

(a) In General. Not later than January 1, 1996, the Secretary (acting through the Inspector General of the Department of Health and Human Services) and the Attorney General shall establish a program

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

(2) to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States, and

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

(b) Coordination With Law Enforcement Agencies. In carrying out the program under subsection (a), the Secretary and Attorney General shall consult with, and arrange for the sharing of data and resources with Federal, State and local law enforcement agencies, State Medicaid Fraud Control Units, and State agencies responsible for the licensing and certification of health care providers.

(c) Coordination With Health Alliances and Health Plans. In carrying out the program under subsection (a), the Secretary and Attorney General shall consult with, and arrange for the sharing of data with representatives of health alliances and health plans.

(d) Authorities of Attorney General and Inspector General.In carrying out duties under subsection (a), the Attorney General and the Inspector General are authorized

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

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

B).

(e) Qualified Immunity for Providing Information. The provisions of section 1157(a) of the Social Security Act (relating to limitation on liability) shall apply to a person providing information or communications to the Secretary or Attorney General in conjunction with their performance of duties under this section, in the same manner as such section applies to information provided to organizations with a contract under part B of title XI of such Act.

(f) Authorizations of Appropriations for Investigators and Other Personnel. In addition to any other amounts authorized to be appropriated to the Secretary and the Attorney General for health care anti-fraud and abuse activities for a fiscal year, there are authorized to be appropriated such additional amounts as may be necessary to enable the Secretary and the Attorney General to conduct investigations, audits, evaluations, and inspections of allegations of health care fraud and abuse and otherwise carry out the program established under subsection (a) in a fiscal year.

(g) Use of Powers Under Inspector General Act of 1978. In carrying out duties and responsibilities under the program established under subsection (a), the Inspector General is authorized to exercise all powers granted under the Inspector General Act of 1978 to the same manner and extent as provided in that Act.

(h) Definition. In this part and part 2, the term "Inspector General" means the Inspector General of the Department of Health and Human Services.

Section 5402 ESTABLISHMENT OF ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.

(a) Establishment.

(1) In general. There is hereby created on the books of the Treasury of the United States an account to be known as the "All-Payer Health Care Fraud and Abuse Control Account" (in this section referred to as the "Anti-Fraud Account"). The Anti-Fraud Account shall consist of such gifts and bequests as may be made as provided in paragraph (2) and such amounts as may be deposited in such Anti-Fraud Account as provided in section 5412(d)(2) and title XI of the Social Security Act. It shall also include the following:

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

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

(C) Administrative penalties and assessments imposed under titles XI, XVIII, and XIX of the Social Security Act and section 5412 (except as otherwise provided by law).

(D) Amounts resulting from the forfeiture of property by reason of a Federal health care offense. Any such funds received on or after the date of the enactment of this Act shall be deposited in the Anti-Fraud Account.

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

(b) Use of Funds.

(1) In general. Amounts in the Anti-Fraud Account shall be available without appropriation and until expended as determined jointly by the Secretary and Attorney General in carrying out the All-Payer Health Care Fraud and Abuse Control Program established under section 5401 (including the administration of the Program), and may be used to cover costs incurred in operating the Program, including

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

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

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

(D) costs of inspections and other evaluations.

(2) Funds used to supplement agency appropriations. It is intended that disbursements made from the Anti-Fraud Account to any Federal agency be used to increase and not supplant the

recipient agency's appropriated operating budget.

(c) Annual Report. The Secretary and the Attorney General shall submit an annual report to Congress on the amount of revenue which is generated and disbursed by the Anti-Fraud Account in each fiscal year.

(d) Federal Health Care Offense Defined. The term "Federal health care offense" means a violation of, or a criminal conspiracy to violate

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

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

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

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

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

Section 5403 USE OF FUNDS BY INSPECTOR GENERAL.

(a) Reimbursements for Investigations.

(1) In general. The Inspector General is authorized to receive and retain for current use reimbursement for the costs of conducting investigations, when such restitution is ordered by a court, voluntarily agreed to by the payor, or otherwise.

(2) Crediting. Funds received by the Inspector General as reimbursement for costs of conducting investigations shall be deposited to the credit of the appropriation from which initially paid, or to appropriations for similar purposes currently available at the time of deposit, and shall remain available for obligation for 1 year from the date of their deposit.

(3) Exception for forfeitures. This subsection does not apply to investigative costs paid to the Inspector General from the Department of Justice Asset Forfeiture Fund, which monies shall be deposited and expended in accordance with subsection (b).

(b) HHS Office of Inspector General Asset Forfeiture Proceeds Fund.

(1) In general. There is established in the Treasury of the United States the "HHS Office of Inspector General Asset Forfeiture Proceeds Fund," to be administered by the Inspector General, which shall be available to the Inspector General without fiscal year limitation for expenses relating to the investigation of matters within the jurisdiction of the Inspector General.

(2) Deposits. There shall be deposited in the Fund all proceeds from forfeitures that have been transferred to the Inspector General from the Department of Justice Asset Forfeiture Fund under section 524 of title 28, United States Code.

Part 2 APPLICATION OF FRAUD AND ABUSE AUTHORITIES UNDER THE SOCIAL

Section

Section 5411 EXCLUSION FROM PARTICIPATION.

(a) Mandatory Exclusion. The Secretary shall exclude an individual or entity from participation in any applicable health plan if the individual or entity is excluded from participation in a public program under, or is otherwise described in, section 1128(a) of the Social Security Act (relating to individuals and entities convicted of health care-related crimes or patient abuse).

(b) Permissive Exclusion. The Secretary may exclude an individual or entity from participation in any applicable health plan if the individual or entity is excluded from participation in a public program under, or is otherwise described in, section 1128(b) of the Social Security Act (other than paragraphs (6)(A), (6)(C), (6)(D), (10), or (13) of such section).

(c) Notice, Effective Date, and Period of Exclusion. (1) An exclusion under this section or section 5412(b)(3) shall be effective at such time and upon such reasonable notice to the public and to the individual or entity excluded as may be specified in regulations consistent with paragraph (2).

(2) Such an exclusion shall be effective with respect to services furnished to an individual on or after the effective date of the exclusion.

(3) (A) The Secretary shall specify, in the notice of exclusion under paragraph (1) and the notice under section 5412(e), the minimum period (or, in the case of an exclusion of an individual excluded from participation in a public program under, or is otherwise described in, section 1128(b)(12) of the Social Security Act, the period) of the exclusion.

(B) In the case of a mandatory exclusion under subsection (a), the minimum period of exclusion shall be not less than 5 years.

(C) In the case of an exclusion of an individual excluded from participation in a public program under, or is otherwise described in, paragraph (1), (2), or (3) of section 1128(b) of the Social Security Act, the period of exclusion shall be a minimum of 3 years, unless the Secretary determines that a longer period is necessary because of aggravating circumstances.

(D) In the case of an exclusion of an individual or entity excluded from participation in a public program under, or is otherwise described in, paragraph (4), (5)(A), or (5)(B) of section 1128(b) of the Social Security Act, the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

(E) In the case of an exclusion of an individual or entity described in paragraph (6)(B) of section 1128(b) of the Social Security Act, the period of the exclusion shall be not less than 1 year.

(F) In the case of an exclusion of an individual described in paragraph (12) of section 1128(b) of the Social Security Act, the period of the exclusion shall be equal to the sum of

(i) the length of the period in which the individual failed to grant the immediate access described in that paragraph, and

(ii) an additional period, not to exceed 90 days, set by the Secretary.

(d) Notice to Entities Administering Public Programs for the Delivery of or Payment for Health Care Items or Services.(1) The Secretary shall exercise the authority under this section in a manner that results in an individual's or entity's exclusion from all applicable health plans for the delivery of or payment for

health care items or services.

(2) The Secretary shall promptly notify each sponsor of an applicable health plan and each entity that administers a State health care program described in section 1128(h) of the Social Security Act of the fact and circumstances of each exclusion (together with the period thereof) effected against an individual or entity under this section or under section 5412(b)(3).

(e) Notice to State Licensing Agencies. The provisions of section 1128(e) of the Social Security Act shall apply to this section in the same manner as such provisions apply to sections 1128 and 1128A of such Act.

(f) Notice, Hearing, and Judicial Review. (1) Subject to paragraph (2), any individual or entity that is excluded (or directed to be excluded) from participation under this section is entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b) of the Social Security Act, and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g) of such Act, except that such action shall be brought in the Court of Appeals of the United States for the judicial circuit in which the individual or entity resides, or has a principal place of business, or, if the individual or entity does not reside or have a principal place of business within any such judicial circuit, in the United States Court of Appeals for the District of Columbia Circuit.

(2) Unless the Secretary determines that the health or safety of individuals receiving services warrants the exclusion taking effect earlier, any individual or entity that is the subject of an adverse determination based on paragraphs (6)(B), (7), (8), (9), (11), (12), (14), or (15) of section 1128(b) of the Social Security Act, shall be entitled to a hearing by an administrative law judge (as provided under section 205(b) of the Social Security Act) on the determination before any exclusion based upon the determination takes effect. If a hearing is requested, the exclusion shall be effective upon the issuance of an order by the administrative law judge upholding the determination of the Secretary to exclude.

(3) The provisions of section 205(h) of the Social Security Act shall apply with respect to this section or section 5412(b)(3) to the same extent as such provisions apply with respect to title II of such Act.

(g) Application for Termination of Exclusion. (1) An

individual or entity excluded (or directed to be excluded) from participation under this section or section 5412(b)(3) may apply to the Secretary, in a manner specified by the Secretary in regulations and at the end of the minimum period of exclusion (or, in the case of an individual or entity described in section 1128(b)(12), the period of exclusion) provided under this section or section 5412(b)(3) and at such other times as the Secretary may provide, for termination of the exclusion.

(2) The Secretary may terminate the exclusion if the Secretary determines, on the basis of the conduct of the applicant which occurred after the date of the notice of exclusion or which was unknown to the Secretary at the time of the exclusion, that

(A) there is no basis under this section or section 5412(b)(3) for a continuation of the exclusion, and

(B) there are reasonable assurances that the types of actions which formed the basis for the original exclusion have not recurred and will not recur.

(3) The Secretary shall promptly notify each sponsor of an applicable health plan and each entity that administers a State health care program described in section 1128(h) of the Social Security Act of each termination of exclusion made under this subsection.

(h) Convicted Defined. In this section, the term "convicted" has the meaning given such term in section 1128(i) of the Social Security Act.

(i) Request for Exclusion. The sponsor of any applicable health plan (including a State in the case of a regional alliance health plan and the Secretary of Labor in the case of a corporate alliance health plan) may request that the Secretary of Health and Human Services exclude an individual or entity with respect to actions under such a plan in accordance with this section.

(j) Effect of Exclusion. Notwithstanding any other provision of this Act, no payment may be made under a health plan for the delivery of or payment for any item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished

(1) by an individual or entity during the period when such individual or entity is excluded pursuant to this section or section 5412(b)(3) from participation in a health plan; or

(2) at the medical direction or on the prescription of a physician during the period when the physician is excluded pursuant to this section or section 5412(b)(3) from participation in a health plan and the person furnishing the item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

(k) Delegation. The Secretary may delegate authority granted under this section to the Inspector General.

Section 5412 CIVIL MONETARY PENALTIES.

(a) Actions Subject to Penalty. Any person who is determined by the Secretary to have committed any of the following actions with respect to an applicable health plan shall be subject to a penalty in accordance with subsection (b):

(1) Actions subject to penalty under medicare, medicaid, and other social security health programs. Any action that would subject the person to a penalty under paragraphs (1) through (12) of section 1128A(a) of the Social Security Act if the action was taken with respect to title V, XVIII, XIX, or XX of such Act.

(2) Termination of enrollment. The termination of an individual's enrollment (including the refusal to re-enroll an individual) in violation of subtitle E of title I or State law.

(3) Discriminating on basis of medical condition. The engagement in any practice that would reasonably be expected to have the effect of denying or discouraging the initial or continued enrollment in a health plan by individuals whose medical condition or history indicates a need for substantial future medical services.

/* A section which would provide a substantial check on plans attempting to discourage those with AIDS from applying to a particular plan. */

(4) Inducing enrollment on false pretenses. The engagement in any practice to induce enrollment in an applicable health plan through representations to individuals which the person knows or should know are false or fraudulent.

(5) Providing incentives to enroll.The offer or payment of remuneration to any individual that such person knows or should know is likely to influence such individual to enroll in a particular plan, or to cause such individual to induce others to enroll in a particular plan.

(b) Penalties Described.

(1) General rule. Any person who the Secretary determines has committed an action described in paragraphs (2) through (5) of subsection (a) shall be subject to a civil monetary penalty in an amount not to exceed $50,000 for each such determination.

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

(3) Determinations to exclude permitted. In addition to any civil monetary penalty or assessment imposed under this subsection, the Secretary may make a determination in the same proceeding to exclude the person from participation in all applicable health plans for the delivery of or payment for health care items or services (in accordance with section 5411(c)).

(c) Procedures for Imposition of Penalties.

(1) Applicability of procedures under social security act. Except as otherwise provided in paragraph (2), the provisions of section 1128A of the Social Security Act (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to the imposition of a civil monetary penalty, assessment, or exclusion under this section in the same manner as such provisions apply with respect to the imposition of a penalty, assessment, or exclusion under section 1128A of such Act.

(2) Authority of secretary of labor and states to impose penalties, assessments, and exclusions.

(A) In general. The Secretary of Labor or a State may initiate an action to impose a civil monetary penalty, assessment, or exclusion under this section with respect to actions relating to a corporate alliance health plan or a regional alliance health plan, respectively, if authorized by the Attorney General and the Secretary pursuant to regulations promulgated by the Secretary in consultation with the Attorney General.

(B) Requirements described. Under the regulations promulgated under subparagraph (A), the Attorney General and the Secretary shall review an action proposed by the Secretary of Labor or a State, and not later than 120 days after receiving notice of the proposed action from the Secretary of Labor or the State, shall

(i) approve the proposed action to be taken by the Secretary of Labor or the State;

(ii) disapprove the proposed action; or

(iii) assume responsibility for initiating a criminal, civil, or administrative action based on the information provided in the notice.

(C) Action deemed approved if deadline missed. If the Attorney General and the Secretary fail to respond to a proposed action by the Secretary of Labor or a State within the period described in subparagraph (B), the Attorney General and the Secretary shall be deemed to have approved the proposed action to be taken by the Secretary of Labor or the State.

(d) Treatment of Amounts Recovered. Any amounts recovered under this section shall be paid to the Secretary and disposed of as follows:

(1) Such portions of the amounts recovered as is determined to have been improperly paid from an applicable health plan for the delivery of or payment for health care items or services shall be repaid to such plan.

(2) The remainder of the amounts recovered shall be deposited in the All-Payer Health Care Fraud and Abuse Control Account established under section 5402.

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

Section 5413 LIMITATIONS ON PHYSICIAN SELF-REFERRAL.

The provisions of section 1877 of the Social Security Act

shall apply

(1) to items and services (and payments and claims for payment for such items and services) furnished under any applicable health plan in the same manner as such provisions apply to designated health services (and payments and claims for payment for such services) under title XVIII of the Social Security Act; and

(2) to a State (with respect to an item or service furnished or payment made under a regional alliance health plan) and to the Secretary of Labor (with respect to an item or service furnished or payment made under a corporate alliance health plan) in the same manner as such provisions apply to the Secretary.

Section 5414 CONSTRUCTION OF SOCIAL SECURITY ACT REFERENCES.

(a) Incorporation of Other Amendments. Any reference in this part to a provision of the Social Security Act shall be considered a reference to the provision as amended under title IV.

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

Part 3 AMENDMENTS TO ANTI-FRAUD AND ABUSE PROVISIONS UNDER THE SOCIAL SECURITY ACT

Section 5421 REFERENCE TO AMENDMENTS.

For provisions amending the anti-fraud and abuse provisions existing under the Social Security Act, see part 5 of subtitle A of title IV.

Part 4 AMENDMENTS TO CRIMINAL LAW

Section 5431 HEALTH CARE FRAUD.

(a) In General. Chapter 63 of title 18, United States Code, is amended by adding at the end the following:

"1347. Health care fraud

"(a) Whoever knowingly executes, or attempts to execute, a scheme or artifice

"(1) to defraud any health alliance, health plan, or other person, in connection with the delivery of or payment for health care benefits, items, or services;

"(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health alliance, health plan, or person in connection with the delivery of or payment for health care benefits, items, or services; shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365 of this title) such person shall be imprisoned for life or any term of years.

"(b) As used in this section, the terms `health alliance' and `health plan' have the meanings given those terms in title I of the Health Security Act.".

(b) Clerical Amendment. The table of sections at the beginning of chapter 63 of title 18, United States Code, is amended by adding at the end the following:

"1347. Health care fraud.".

Section 5432 FORFEITURES FOR VIOLATIONS OF FRAUD STATUTES.

(a) In General. Section 982(a) of title 18, United States Code, is amended by inserting after paragraph (5) the following:

"(6) If the court determines that a Federal health care offense (as defined in section 5402(d) of the Health Security Act) is of a type that poses a serious threat to the health of any person or has a significant detrimental impact on the health care system, the court, in imposing sentence on a person convicted of that offense, shall order that person to forfeit property, real or personal, that

"(A)(i) is used in the commission of the offense; or

"(ii) constitutes or is derived from proceeds traceable to the commission of the offense; and

"(B) is of a value proportionate to the seriousness of the offense.".

(b) Proceeds of Health Care Fraud Forfeitures. Section 524(c)(4)(A) of title 28, United States Code, is amended by inserting "all proceeds of forfeitures relating to Federal health care offenses (as defined in section 5402(d) of the Health Security Act), and" after "except".

Section 5433 FALSE STATEMENTS.

(a) In General. Chapter 47 of title 18, United States Code, is amended by adding at the end the following:

"1033. False statements relating to health care matters

"(a) Whoever, in any matter involving a health alliance or health plan, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious, or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry, shall be fined under this title or imprisoned not more than 5 years, or both.

"(b) As used in this section the terms `health alliance' and `health plan' have the meanings given those terms in title I of the Health Security Act.".

(b) Clerical Ammendment. The table of sections at the beginningof chapter 47 of title 18, United States Code, is amended by adding at the end the following:

"1033. False statements relating to health care matters.".

Section 5434 BRIBERY AND GRAFT.

(a) In General. Chapter 11 of title 18, United States Code, is amended by adding at the end the following:

"226. Bribery and graft in connection with health care

"(a) Whoever

"(1) directly or indirectly, corruptly gives, offers, or promises anything of value to a health care official, or offers or promises a health care official to give anything of value to any other person, with intent

"(A) to influence any of the health care official's actions, decisions, or duties relating to a health alliance or health

plan;

"(B) to influence such an official to commit or aid in the committing, or collude in or allow, any fraud, or make opportunity for the commission of any fraud, on a health alliance or health plan; or

"(C) to induce such an official to engage in any conduct in violation of the lawful duty of such official; or

"(2) being a health care official, directly or indirectly, corruptly demands, seeks, receives, accepts, or agrees to accept anything of value personally or for any other person or entity, the giving of which violates paragraph (1) of this subsection; shall be fined under this title or imprisoned not more than 15 years, or both.

"(b) Whoever, otherwise than as provided by law for the proper discharge of any duty, directly or indirectly gives, offers, or promises anything of value to a health care official, for or because of any of the health care official's actions, decisions, or duties relating to a health care alliance or health plan, shall be fined under this title or imprisoned not more than two years, or both.

"(c) As used in this section

"(1) the term `health care official' means

"(A) an administrator, officer, trustee, fiduciary, custodian, counsel, agent, or employee of any health care alliance or health plan;

"(B) an officer, counsel, agent, or employee, of an organization that provides services under contract to any health alliance or health plan;

"(C) an official or employee of a State agency having regulatory authority over any health alliance or health plan;

"(D) an officer, counsel, agent, or employee of a health care sponsor; and

"(2) the term `health care sponsor' means any individual or entity serving as the sponsor of a health alliance or health plan for purposes of the Health Security Act, and includes the joint board of trustees or other similar body used by two or more employers to administer a health alliance or health plan for purposes of such Act.".

(b) Clerical Amendment. The table of chapters at the beginning of chapter 11 of title 18, United States Code, is amended by adding at the end the following:

"226. Bribery and graft in connection with health care.".

Section 5435 INJUNCTIVE RELIEF RELATING TO HEALTH CARE OFFENSES.

Section 1345(a)(1) of title 18, United States Code, is amended

(1) by striking "or" at the end of subparagraph (A);

(2) by inserting "or" at the end of subparagraph (B); and

(3) by adding at the end the following:

"(C) committing or about to commit a Federal health care offense (as defined in section 5402(d) of the Health Security Act);".

Section 5436 GRAND JURY DISCLOSURE.

Section 3322 of title 18, United States Code, is amended

(1) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(2) by inserting after subsection (b) the following:

"(c) A person who is privy to grand jury information concerning a health law violation

"(1) received in the course of duty as an attorney for the Government; or

"(2) disclosed under rule 6(e)(3)(A)(ii) of the Federal Rules of Criminal Procedure; may disclose that information to an attorney for the Government to use in any civil proceeding related to a Federal health care offense (as defined in section 5402(d) of the Health Security Act).".

Section 5437 THEFT OR EMBEZZLEMENT.

(a) In General. Chapter 31 of title 18, United States Code, is amended by adding at the end the following:

"668. Theft or embezzlement in connection with health care

"(a) Whoever embezzles, steals, willfully and unlawfully converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, securities, premiums, credits, property, or other assets of a health alliance, health plan, or of any fund connected with such an alliance or plan, shall be fined under this title or imprisoned not more than 10 years, or both.

"(b) As used in this section, the terms `health alliance' and `health plan' have the meanings given those terms under title I of the Health Security Act.".

(b) Clerical Amendment.-- The table of sections at the beginning of chapter 31 of title 18, United States Code, is amended by adding at the end the following:

"668. Theft or embezzlement in connection with health care.".

Section 5438 MISUSE OF HEALTH SECURITY CARD OR UNIQUE IDENTIFIER.

(a) In General. Chapter 33 of title 18, United States Code, is amended by adding at the end the following:

"716. Misuse of health security card or unique identifier

"Whoever

"(1) requires the display of, requires the use of, or uses a health security card that is issued under section 1001(b) of the Health Security Act for any purpose other than a purpose described in section 5105(a) of such Act;
or

"(2) requires the disclosure of, requires the use of, or uses a unique identifier number provided pursuant to section 5104 of such Act for any purpose that is not authorized by the National Health Board pursuant to such section; shall be fined under this title or imprisoned not more than 2 years, or both.".

(b) Amendment to Chapter Heading. The heading for chapter 33 of title 18, United States Code, is amended to read as follows:

"CHAPTER 33--EMBLEMS, INSIGNIA, IDENTIFIERS, AND NAMES".

(c) Clerical Amendment to Table of Sections. The table of

sections at the beginning of chapter 33, United States Code, is amended by adding at the end the following new item:

"716. Misuse of health security card or unique identifier.".

(d) Clerical Amendment to Table of Chapters. The item relating to chapter 33 in the table of chapters at the beginning of part 1 of title 18, United States Code, is amended to read as follows:

"33. Emblems, insignia, identifiers, and names 701".

Part 5 AMENDMENTS TO CIVIL FALSE CLAIMS ACT

Section 5441 AMENDMENTS TO CIVIL FALSE CLAIMS ACT.

Section 3729 of title 31, United States Code, is amended

(1) in subsection (a)(7), by inserting "or to a health plan" after "property to the Government";

(2) in the matter following subsection (a)(7), by inserting "or health plan" before "sustains because of the act of that person," ;

(3) at the end of the first sentence of subsection (a), by inserting "or health plan" before "sustains because of the act of the person." ;

(4) in subsection (c)

(A) by inserting "the term" after "section,"; and

(B) by adding at the end the following: "The term also includes any request or demand, whether under contract of otherwise, for money or property which is made or presented to a health plan." ; and

(5) by adding at the end the following:

"(f) Health Plan Defined.For purposes of this section, the term `health plan' has the meaning given such term under section 1400 of the Health Security Act.".

Title V, Subtitle F

Subtitle F McCarran-Ferguson Reform

Section 5501 REPEAL OF EXEMPTION FOR HEALTH

INSURANCE.

(a) In General. Section 3 of the Act of March 9, 1945 (15 U.S.C. 1013), known as the McCarran-Ferguson Act, is amended by adding at the end the following:

"(c) Notwithstanding that the business of insurance is regulated by State law, nothing in this Act shall limit the applicability of the following Acts to the business of insurance to the extent that such business relates to the provision of health benefits:

"(1) The Sherman Act (15 U.S.C. 1 et seq.).

"(2) The Clayton Act (15 U.S.C. 12 et seq.).

"(3) Federal Trade Commission Act (15 U.S.C. 41 et seq.).

"(4) The Act of June 19, 1936 (49 Stat. 1526; 15 U.S.C. 21a et seq.), known as the Robinson-Patman Antidiscrimination Act.".

(b) Effective Date.The amendment made by subsection (a) shall take effect on the first day of the sixth month beginning after the date of the enactment of this Act.