The original documents are located in Box 60, folder "10/8/76 HR9019 Health Maintenance Organization Amendments of 1976" of the White House Records Office: Legislation Case Files at the Gerald R. Ford Presidential Library.

APPROVED
OCT 08 1976

10/4/76
veto.

THE WHITE HOUSE

WASHINGTON

October 4, 1976

ACTION

Last Day: October 9

Posted
10/1/76

Archives
10/12/76

MEMORANDUM FOR THE PRESIDENT

FROM: JIM CANNON

SUBJECT: H.R. 9019 - Health Maintenance Organization Amendments of 1976

Attached for your consideration is H.R. 9019, sponsored by Representative Hastings and eight others.

The enrolled bill would amend the Health Maintenance Organization Act of 1973 to extend the HMO program for two years, through fiscal year 1979, and to generally make HMOs more competitive with traditional health insurance programs and health delivery systems. The current HMO authority expired on September 30.

A detailed discussion of the provisions of the enrolled bill is provided in OMB's enrolled bill report at Tab A.

OMB, Max Friedersdorf, Counsel's Office (Kilberg) and I recommend approval of the enrolled bill and the attached signing statement which has been cleared by the White House Editorial Office (Smith).

RECOMMENDATION

That you sign H.R. 9019 at Tab B.

That you approve the signing statement at Tab C.

Note -
No indication he
approved signing &
statement ~~~~~
although pressed
office had it &
sent returned
to
Trustee
10/11

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

OCT 2 1976

MEMORANDUM FOR THE PRESIDENT

Subject: Enrolled Bill H.R. 9019 - Health Maintenance Organization Amendments of 1976
Sponsor - Rep. Hastings (R) New York and 8 others

Last Day for Action

October 9, 1976 - Saturday

Purpose

Extends and modifies the authorizations of the Health Maintenance Organization (HMO) program and makes numerous amendments designed to improve the competitive position of HMOs.

Agency Recommendation

Office of Management and Budget	Approval
Department of Health, Education, and Welfare	Approval
Appalachian Regional Commission	Approval (Informally)
Department of Labor	No objection
Department of Justice	Defers to HEW
Civil Service Commission	Defers to HEW
Department of Commerce	Defers to HEW
Veterans Administration	Defers to HEW
Department of Defense	Defers to HEW (informal)
Department of the Treasury	Would support disapproval recommendation (informal)

Discussion

H.R. 9019 would amend the Health Maintenance Organization Act of 1973 (P.L. 93-222) to extend the HMO program administered by the Department of Health, Education, and

Welfare (HEW) for two years through fiscal year 1979 and to generally make HMOs more competitive with traditional health insurance programs and health delivery systems. The current HMO authority expired on September 30, 1977.

The HMO Act of 1973 authorized two major forms of Federal assistance to developing HMOs: (1) a five-year program of Federal grants, contracts, loans and loan guarantees, and (2) a requirement that employers who offer health insurance to their employees also offer them the option of joining a "qualified" HMO, i.e., one that met the specific requirements of P.L. 93-222.

The extensive 1973 HMO Act requirements slowed HMO development so that there were not enough qualified applicants for the funds appropriated. The Administration, therefore, proposed corrective legislation. H.R. 9019 would extend the HMO program one year beyond the time proposed by the Administration, but otherwise makes numerous changes in the HMO program generally along the lines proposed by HEW. The bill is the product of substantial negotiations between the Administration and the Congressional committees and passed the House in November 1975 by a vote of 309-46 and the Senate in June 1976 by a vote of 80-8. The conference version passed the House by a 298-29 vote and the Senate by voice vote.

Major Provisions

HEW has included a summary of the major provisions of H.R. 9019 in an attachment to its report. Provisions in H.R. 9019 designed to improve the marketing of HMOs would:

-- permit an HMO to choose which, if any, services it would offer as supplemental to the basic package, and provide for separation of the supplemental benefits package from the basic plan, i.e., a high option-low option alternative. Under current law HMOs have virtually no discretion to decide which services to include in a supplemental benefit package and must include them in the basic benefit plan.

-- permit HMOs to contract directly with other health professionals for their services. Current law requires an HMO to provide services only through its own staff or medical group.

-- eliminate the present annual open enrollment requirement, except for large, well-established HMOs,

-- eliminate the requirement that HMOs offer preventive dental care for children as a basic service, and

-- waive the requirement for four years after an HMO becomes qualified that it community rate its basic and supplemental health services payments. The open enrollment requirement coupled with community rating, i.e., a single rate for all groups of potential HMO enrollees regardless of health status, puts HMOs at an extreme disadvantage in competing with other health insurers who can offer rates based on the health status and actual medical utilization patterns of the groups applying for coverage.

H.R. 9019 also would make important changes in the requirement that employers offer HMO plans to employees in addition to other more conventional health insurance plans--the so-called "dual choice" requirement. H.R. 9019 would:

-- require an employer to offer "dual choice" only if at least 25 employees live in an area served by an HMO, (present law requires an employer to offer an HMO option if even one employee lives in an HMO service area),

-- transfer enforcement of the "dual choice" requirement from the Department of Labor to the Department of Health, Education, and Welfare, with the HEW Secretary having authority to assess civil penalties for violations,

-- require State and local entities to offer employees "dual choice" options as a condition of receiving certain Federal health grant funds,

-- require the Civil Service Commission to offer membership in an HMO qualified under the Public Health Service Act as a health benefits option to Federal employees.

The Administration supported these provisions or variations of them.

The bill also contains some provisions which are objectionable. These include:

-- an organizational requirement that HMO regulatory functions be administered through a separate unit in the Office of the Assistant Secretary for Health of HEW,

-- the establishment of a Health Services Policy Analysis Center to be supported by the National Center for Health Services Research,

-- a one-year extension of the home health demonstration project authorities,

-- an arbitrary requirement that HMOs restrict Medicare and Medicaid enrollment to 50%, and

-- a requirement that HMOs must provide immunizations, well-child care, physicals, family planning services and eye and ear examinations for children as a basic service.

Costs

H.R. 9019 would decrease the 1977 authorization for HMOs from $85 million to $45 million and add authorizations of $45 million for 1978 and $50 million for 1979. The Administration requested an authorization level of $18 million for each of the fiscal years 1977 and 1978. The actual 1976 funding level was $18.6 million. The appropriation for HMO programs in the Labor-HEW appropriation bill for 1977 is $22.6 million.

The bill also would authorize $12 million to extend the home health demonstration authorities through FY 1977. The Administration did not propose to extend this program.

Recommendations

HEW in its approval recommendation, states,

> "Under the enrolled bill, HMOs would have a better chance to offer a package of needed health services at prices which are more competitive with traditional methods of health financing. The enrolled bill would enable HMOs to obtain a fair test in the health marketplace."

Labor points out that H.R. 9019 makes changes to the HMO program which the Department has sought, but notes that through an oversight the bill would still define "employer" under the Fair Labor Standards Act, subject to certain statutory exceptions contained in the HMO Act. Labor believes "the legal complexities and uncertainties flowing from such joinder" could further complicate the administration of the HMO program.

Justice defers to HEW, but notes that some provisions of H.R. 9019, including the civil penalty section, could increase the number of civil collection actions brought by the Government.

Treasury objects to provisions in H.R. 9019 that would have the effect of providing HMOs with Federal loans at lower interest rates than are currently available under existing law, and, accordingly, states that it would concur in a recommendation to disapprove H.R. 9019.

* * * * * * *

We believe H.R. 9019 would improve HEW's implementation of the HMO demonstration program. Many of the provisions in H.R. 9019 incorporate Administration recommendations. The higher appropriation authorizations and the additional year do not commit the Federal Government to indefinite funding for HMOs. Accordingly, we recommend that you sign H.R. 9019.

Paul H. O'Neill
Acting Director

Enclosures

GENERAL COUNSEL OF THE
UNITED STATES DEPARTMENT OF COMMERCE
Washington, D.C. 20230

SEP 27 1976

Honorable James T. Lynn
Director, Office of Management and Budget
Washington, D. C. 20503

Attention: Assistant Director for Legislative Reference

Dear Mr. Lynn:

This is in reply to your request for the views of this Department concerning H.R. 9019, an enrolled enactment

> "To amend title XIII of the Public Health Service Act to revise and extend the program for the establishment and expansion of health maintenance organizations,"

to be cited as the "Health Maintenance Organization Amendments of 1976."

While this Department has no objections to make concerning H.R. 9019, we would defer to the views of the Department of Health, Education, and Welfare as to whether it should be approved by the President.

Enactment of H.R. 9019 will not involve the expenditure of any funds by this Department.

Sincerely,

General Counsel

VETERANS ADMINISTRATION
OFFICE OF THE ADMINISTRATOR OF VETERANS AFFAIRS
WASHINGTON, D.C. 20420

September 28, 1976

The Honorable
James T. Lynn
Director, Office of
Management and Budget
Washington, D. C. 20503

Dear Mr. Lynn:

This will respond to the request of the Assistant Director for Legislative Reference for the views of the Veterans Administration on the enrolled enactment of H.R. 9019, 94th Congress, a bill "To amend title XIII of the Public Health Service Act to revise and extend the program for the establishment and expansion of health maintenance organizations."

The bill would amend the Public Health Service Act to extend the definition of a health maintenance organization. The bill would insert provisions concerning staffing of such an organization and would define preventive health services. It would also outline medical group requirements and would provide for employee health plans.

Although the Veterans Administration is keenly aware of the beneficial services provided by health maintenance organizations, the bill would not affect the Veterans Administration. Accordingly, we defer to the Department of Health, Education, and Welfare regarding recommendations as to Presidential action and H.R. 9019, since it would be responsible for implementation.

Sincerely,

RICHARD L. ROUDEBUSH
Administrator

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

The Honorable James T. Lynn
Director, Office of Management
and Budget
Washington, D. C. 20503

SEP 2 8 1976

Dear Mr. Lynn:

This is in response to your request for a report on H.R. 9019, an enrolled bill "To amend title XIII of the Public Health Service Act to revise and extend the program for the establishment and expansion of health maintenance organizations."

We recommend that the President sign the enrolled bill. The bill would continue a program supported by the Administration, the health maintenance organization (HMO) program, and would make several changes in that program along lines which we have suggested.

The enrolled bill would extend this Department's HMO program through fiscal year 1979; the present appropriation authorization of $85 million for fiscal year 1977 would be reduced to $45 million, while $45 million would be authorized for FY 1978 and $50 million for FY 1979. The Administration requested an $18 million authorization for this program for each of the fiscal years 1977 and 1978. The bill would also effect a number of changes in the program; these changes would in general ease the requirements for the participation of HMOs in the program. The major changes are given in detail at Tab A. In addition, the bill would authorize $12 million to extend the home health demonstration authorities through FY 1977 (the Administration did not request any funds for these authorities for FY 1977), and would extend by one year, to July 29, 1977, the deadline for the report by the Committee on Mental Health and Illness of the Elderly.

The health maintenance organization program is one which is supported by the Administration, which the Administration has wished to extend, and for which the Administration has

recommended a number of changes designed to improve the competitive position of HMOs in the marketplace. The enrolled bill in general carries out these objectives. The enrolled bill extends the Federal HMO program through 1979, only one additional year beyond the time suggested by the Administration. The actual level of funding for the program would of course be worked out through the appropriations process. Although there are some provisions which we desired not to be included in the bill, such as the mandating of certain organizational arrangements within the Department, the bill as a whole would improve the program through such provisions as the elimination of the open enrollment requirement in most situations, the postponement of the community rating requirement for four years, permitting the Secretary to guarantee HMO loans to nonprofit entities, and permitting HMOs to add additional services to their basic health services package. Under the enrolled bill, HMOs would have a better chance to offer a package of needed health services at prices which are more competitive with traditional methods of health financing. The enrolled bill would enable HMOs to obtain a fair test in the health marketplace.

We recommend that the President sign the enrolled bill.

Sincerely,

Marjorie Lynch

Under Secretary

Enclosure

MAJOR PROVISIONS OF H.R. 9019

H.R. 9019 would reduce the fiscal year 1977 authorization for the health maintenance organization (HMO) program from $85 million to $45 million, and would extend the program for two more years by authorizing appropriations of $45 million for FY 1978 and $50 million for FY 1979.

H.R. 9019 would effect a number of changes in the HMO program:

1. An HMO could include in the basic package of services offered to all members "supplemental" services, which individual members may at present choose not to purchase.

2. An HMO could choose which, if any, services it would offer to members on an optional basis in addition to the basic package; at present, each member has the right to have provided to him any of a specified list of "supplemental" services (if appropriate personnel are available in the community to deliver a specific service).

3. An HMO could contract directly with health professionals for services costing up to 15 percent of its expenses for all physician services (30 percent for HMOs in rural areas), in addition to utilizing its own staff, a medical group, or an individual practice association, and could in addition utilize combinations of these arrangements.

4. A group of physicians could be considered to be a "medical group" for three years after an HMO had become qualified as such under the HMO title of the Public Health Service (PHS) Act even though the group did not meet requirements concerning the amount of time devoted by the physicians to the group practice and the delivery of services to the HMO; after the three year period, the Secretary could grant waivers of the requirements under appropriate circumstances.

5. The annual open enrollment requirement, which presently applies to all HMOs (except if the Secretary grants waivers under certain circumstances), would be eliminated

except for HMOs which have been in existence for at least five years, have at least 50,000 members, and have not incurred a deficit in the last fiscal year, and for those HMOs would not apply to persons confined to institutions and would be satisfied once the HMO had enrolled three percent of its enrollment increase during the preceding year, or had held an open enrollment period of one month. In addition, the Secretary could continue to grant waivers if the application of these open enrollment requirements would jeopardize an HMO's financial viability.

6. Preventive health services required to be part of the basic services package offered to members would no longer include preventive dental care for children, but would include, in addition to those others now specified, immunizations, well child care from birth, periodic health examinations for adults, and ear examinations for children.

7. The community rating requirement would be waived for four years from the time an organization qualified as an HMO under the PHS Act if that organization had previously been providing comprehensive health services on a prepayment basis.

8. The Secretary could guarantee loans made to nonprofit entities for planning concerning, the initial development of, or the initial operation of, HMOs.

9. An employer would be required to offer "dual choice" (membership in an HMO as one option in any health benefits plan offered by the employer) only if at least 25 employees lived in an area served by an HMO; at present, such an option must be offered even if only one employee lives in an HMO's service area.

10. Enforcement of the "dual choice" requirement would no longer be through the Department of Labor under the Fair Labor Standards Act of 1938. Instead, the Secretary of this Department could assess a civil penalty of up to $10,000 after giving an employer an opportunity to present its views concerning a claimed violation of the requirement. The civil penalty assessed could be collected through a civil action brought by the United States in a Federal district court, and the employer and the United States

would each have the right to obtain a trial de novo on the assessment of the penalty. Governmental entities (State and Federal) and church organizations would not be subject to this enforcement procedure.

11. The payment of funds to a State under the public health, communicable disease, venereal disease, family planning, health planning and development, and health resources development grant programs would be conditioned upon the State and its political subdivisions offering employees "dual choice".

12. The Civil Service Commission would be required to offer membership in an HMO qualified under the PHS Act as a health benefits option to Federal employees.

13. The Secretary would be required to carry out his functions in determining whether organizations qualified as HMOs for the purposes of "dual choice" through the same unit which administers the continuing regulation of HMOs, within the Office of the Assistant Secretary for Health. In addition, the remainder of the HMO program would have to be administered through a single identifiable administrative unit.

14. The requirements of the presently separate HMO programs under Medicare and Medicaid would be modified so that the determination of whether an organization qualified as an HMO would be made under the PHS Act HMO program. In addition, the general requirements for HMO qualification under the PHS Act would also apply to the Medicare and Medicaid programs, with specific exceptions to allow, for example, for the services for which Medicare and Medicaid reimburse, which differ from the basic health services provided by HMOs under the PHS Act. States could continue to contract under Medicaid with organizations offering health services on a prepaid capitation or other risk basis which were not qualified HMOs if (1) they were nonprofit primary health care entities located in a rural area, community health centers, or migrant health centers, in any case receiving funds under certain Federal programs and meeting other

conditions, or (2) had provided health services under Medicaid on a prepaid risk basis (not including inpatient hospital services) before 1970. The Medicaid provisions of the enrolled bill would not affect existing contracts for one year.

15. One of the six new centers now required to be established for multidisciplinary health services research, evaluations, and demonstrations would be required to focus on the development and evaluation of national policies with respect to health services, including specifically HMOs.

The enrolled bill would also authorize $12 million to extend the home health demonstration authorities through FY 1977, and would extend by one year, to July 29, 1977, the deadline for the report by the Committee on Mental Health and Illness of the Elderly.

U. S. DEPARTMENT OF LABOR

OFFICE OF THE SECRETARY

WASHINGTON

SEP 28 1976

Honorable James T. Lynn
Director
Office of Management and Budget
Washington, D.C. 20503

Dear Mr. Lynn:

This is in response to your request for our comments on an enrolled enactment, H.R. 9019, an Act "to amend Title XIII of the Public Health Service Act to revise and extend the program for the establishment and expansion of health maintenance organizations." The Department of Labor has no objection to Presidential signature of this enrolled enactment.

H.R. 9019 would make two changes to Section 1310 of the Public Health Service Act which this Department has supported in the past. First, Section 1310(a)(2) would settle any questions regarding the relationship between requirements of the health maintenance program and those of the Taft-Hartley Act. That section provides that where employees are represented by a collective bargaining agent, optional membership in a health maintenance organization would be offered to such employees only after offer to, and acceptance by, the bargaining agent. This provision of H.R. 9019 would lend more specific statutory support to a position which we understand has been taken administratively. We believe these provisions are consistent with the nation's traditional labor relations policies.

Second, H.R. 9019 would sever enforcement of the "dual option" requirements of Section 1310 from the enforcement provisions of the Fair Labor Standards Act, eliminating the legal complications and problems in resource allocation that flow from tying together a program administered

by HEW to one administered by this Department. An appropriate civil penalty system would be substituted by H.R. 9019 for the provisions of the Fair Labor Standards Act.

We further note, however, that H.R. 9019 would not sever the coverage under the "dual option" requirements from the definition of "employer" in the Fair Labor Standards Act. This oversight is regrettable, because the legal complexities and uncertainties flowing from such joinder may continue. Indeed, to some extent, H.R. 9019 would further complicate the existing situation by introducing certain specific exceptions to the term "employer" for the purposes of the "dual option" requirements, exceptions which are not consistent with those under the Fair Labor Standards Act. While we are concerned about these problems, we do not believe they justify Presidential veto of the enrolled enactment.

With regard to other provisions of the enrolled enactment, we would defer to the Department of Health, Education and Welfare.

Sincerely,

W. J. Usery Jr.

Secretary of Labor

ASSISTANT ATTORNEY GENERAL
LEGISLATIVE AFFAIRS

Department of Justice
Washington, D.C. 20530

September 28, 1976

Honorable James T. Lynn
Director, Office of Management
and Budget
Washington, D.C. 20503

Dear Mr. Lynn:

In compliance with your request, I have examined a facsimile of the enrolled bill, H.R. 9019, "To amend title XIII of the Public Health Service Act to revise and extend the program for the establishment and expansion of health maintenance organizations."

The bill amends the health maintenance provisions of the Public Health Service Act in 42 U.S.C. 300e et seq. and of the Social Security Act in 42 U.S.C. 1395 et seq. Section 108 of the bill may increase the number of civil collection actions brought by the Government. This section grants the Secretary of Health, Education, and Welfare authority to guarantee to non-Federal lenders loans made to nonprofit private entities for planning projects for the establishment or expansion of health maintenance organizations. Under existing law the Secretary may guarantee loans for such purposes only for health maintenance organizations which serve or will serve a medically-underserved population.

Section 110 of the bill also may increase the number of civil collection actions brought by the Government. The section provides for the assessment against, and collection of a civil penalty from, any employer who knowingly fails to comply with designated requirements concerning the offering to employees of an option of membership in a health maintenance organization. The penalty may not be more than $10,000. It may be assessed and collected for each 30-day period noncompliance continues. Notice and an opportunity to present its views must be afforded the employer prior to assessment of the penalty. The penalty may be collected in a civil action brought by the United States in a United States district court. An action by an employer for review of the assessment of a penalty may also be brought in a United States district court. In either situation, the court must hold a trial de novo on the assessment of the penalty if any party so requests.

Under existing law anyone who willfully violates designated requirements concerning the offering to employees of an option of membership in a health maintenance organization is subject to a criminal fine of not more than $10,000 and imprisonment for not more than six months. Compare 42 U.S.C. 300e-9(c) with 29 U.S.C. 215, 216. The civil penalty discussed above supplants these criminal penalties. Since the bill affords notice and an opportunity to be heard, the Department of Justice believes that a review of the assessment of a civil penalty according to the "substantial evidence" test of 5 U.S.C. 706(2)(E) would have been more appropriate than de novo review. The Department, however, considers the substitution of civil for criminal penalties appropriate. On balance, we do not object to those portions of the bill providing for loan guaranties and for civil penalties, and defer to the Department of Health, Education, and Welfare as to the other portions.

Therefore, the Department of Justice defers to the Department of Health, Education and Welfare as to whether this bill should receive Executive approval.

Sincerely,

Michael M. Uhlmann

Michael M. Uhlmann
Assistant Attorney General

UNITED STATES CIVIL SERVICE COMMISSION
WASHINGTON, D.C. 20415

CHAIRMAN

October 1, 1976

Honorable James T. Lynn
Director, Office of Management and Budget
Executive Office of the President
Washington, D.C. 20503

Dear Mr. Lynn:

This is in reply to your request for the Commission's views on enrolled bill, H.R. 9019 "The Health Maintenance Organization Amendments of 1976."

Sections 110 and 112 of the enrolled bill are the only sections directly affecting a program administered by the Commission.

Section 110(a) excludes the Government of the United States, the government of the District of Columbia, the United States territories, possessions, agencies and instrumentalities (including the United States Postal Service and Postal Rate Commission) from the term "employer" for the purposes of section 1310 of HMO Assistance Act of 1973, thereby exempting the Government from the mandatory offering of the HMO option to Federal employees.

However, section 110(b) requires the Commission to contract under the Federal Employee Health Benefits Program for a health benefits plan described in section 8903(4) of title 5, United States Code, with any qualified health maintenance carrier (as determined by the Commission) which offers such a plan. By maintaining authority to apply the provisions of chapter 89 of title 5 and the regulations thereunder in negotiating contracts with DHEW-approved health maintenance organizations, the Commission will be permitted to apply uniform contracting standards and maintain orderly administration of this provision.

Section 112 permits a benefit package for Federal employees negotiated with a DHEW approved HMO to be inconsistent with the DHEW mandated HMO benefit package.

The Commission has no objection to the provisions of sections 110 and 112 of H.R. 9019 and defers to the views of DHEW on other sections of the enrolled bill.

By direction of the Commission.

Sincerely yours,

Georgiana Sheldon

ACTING Chairman

THE WHITE HOUSE

ACTION MEMORANDUM WASHINGTON LOG NO.:

Date: October 2 Time: 430pm

FOR ACTION: Spencer Johnson
Max Friedersdorf
Bobbie Kilberg
Robert Hartmann

cc (for information): Jack Marsh
Jim Connor
Ed Schmults

FROM THE STAFF SECRETARY OMB on ss — changes

DUE: Date: October 4 Time: noon

SUBJECT:

H.R. 9019-Health Maintenance Organization Amendments

ACTION REQUESTED:

____ For Necessary Action ____ For Your Recommendations

____ Prepare Agenda and Brief ____ Draft Reply

x For Your Comments ____ Draft Remarks

REMARKS:

please return to judy johnston ground floor west wing

PLEASE ATTACH THIS COPY TO MATERIAL SUBMITTED.

If you have any questions or if you anticipate a delay in submitting the required material, please telephone the Staff Secretary immediately.

K. R. COLE, JR.
For the President

ACTION MEMORANDUM WASHINGTON LOG NO.:

D[redacted] October 2 Time: 430pm

FOR ACTION: Spencer Johnson
Max Friedersdorf
Bobbie Kilberg
Robert Hartmann

cc (for information): Jack Marsh
Jim Connor
Ed Schmults

FROM THE STAFF SECRETARY

DUE: Date: October 4 Time: noon

SUBJECT:

H.R. 9019-Health Maintenance Organization Amendments

ACTION REQUESTED:

____ For Necessary Action ____ For Your Recommendations

____ Prepare Agenda and Brief ____ Draft Reply

-x- For Your Comments ____ Draft Remarks

REMARKS:

please return to judy johnston,ground floor west wing

10/4
No objection
B Rath

PLEASE ATTACH THIS COPY TO MATERIAL SUBMITTED.

If you have any questions or if you anticipate a delay in submitting the required material, please telephone the Staff Secretary immediately.

James M. Cannon
For the President

ACTION MEMORANDUM WASHINGTON LOG NO.:

Date: October 2 Time: 430pm

FOR ACTION: Spencer Johnson
Max Friedersdorf M.B.
Bobbie Kilberg
Robert Hartmann

cc (for information): Jack Marsh
Jim Connor
Ed Schmults

FROM THE STAFF SECRETARY

DUE: Date: October 4 Time: noon

SUBJECT:

H.R. 9019-Health Maintenance Organization Amendments

ACTION REQUESTED:

____ For Necessary Action ____ For Your Recommendations

____ Prepare Agenda and Brief ____ Draft Reply

__x__ For Your Comments ____ Draft Remarks

REMARKS:

please return to judy johnston,ground floor west wing

Recommend Approval. JMC

PLEASE ATTACH THIS COPY TO MATERIAL SUBMITTED.

If you have any questions or if you anticipate a delay in submitting the required material, please telephone the Staff Secretary immediately.

James M. Cannon
For the President

From Doug Smith

SIGNING STATEMENT

H.R. 9019

Today I am pleased to sign into law H.R. 9019, the Health Maintenance Organization Amendments of 1976. It is ~~especially~~ particularly ~~significant~~ appropriate to have this ceremony in California where this concept was initiated over 30 years ago.

This legislation, which extends the HMO program for two years beyond the current expiration date of September 1977, is designed to make HMOs more competitive with traditional health insurance programs and health delivery systems.

The original HMO Act of 1973 authorized two major forms of federal assistance to stimulate the development of HMOs:

-- a program of grants, contracts, loans and loan guarantees, and

-- a requirement that employers who offer health insurance to their employees also offer them the option of joining a Federally qualified HMO.

Other requirements of the 1973 HMO Act, however, discouraged participation in the Federal HMO development and slowed the expansion of this important health industry. These amendments correct ~~these~~ their deficiencies and provide the foundation for a strong nationwide system of HMOs.

My Administration is concerned with the following fundamental areas of medical and health care problems:

-- the quality of medical care and rapidly rising costs,

-- local shortages of medical personnel and services due largely to maldistribution of physicians and other health personnel; and

-- the need to promote preventive medicine and maintain good health.

The HMO concept has demonstrated an ability to hold down rapidly rising medical costs while maintaining high quality standards, efficient utilization and maximization of medical personnel, and a focus on disease prevention and the maintenance of good health.

~~Although we do not expect everyone to be enrolled in an HMO,~~ this effort is another example of how our ~~pluralistic~~ present medical care system can adapt to the needs and demands of the nation's health consumers without massive Federal intervention.

Such careful restructuring of the delivery system, while maintaining the strength of the private sector, is the best way to achieve a viable long-term solution to the rapidly rising costs of medical care.

We must strive to develop other creative private sector mechanisms to accomplish these goals ~~and resist those who would work to supplant~~ so that America's strong private health care system will remain the best in the world, ~~with a government-controlled system.~~

DRAFT

SIGNING STATEMENT

H.R. 9019

Today I am pleased to sign into law H.R. 9019, the Health Maintenance Organization Amendments of 1976. It is especially significant to have this ceremony in California which led the way in initiating this concept over 30 years ago.

This legislation, which extends the HMO program for two years beyond the current expiration date of September 1977, is designed to make HMOs more competitive with traditional health insurance programs and health delivery systems.

The original HMO Act of 1973 authorized two major forms of federal assistance to developing HMOs:

--a five-year program of Federal grants, contracts, loans and loan guarantees, and

--a requirement that employers who offer health insurance to their employees also offer them the option of joining a Federally qualified HMO.

Other requirements of the 1973 HMO Act, however, discouraged participation in the Federal HMO development and ~~showed~~ slowed the expansion of this important health industry. These amendments correct these deficiences and provide the foundation for a strong nationwide system of HMOs.

My Administration is concerned with the following fundamental areas of medical and health care problems:

--rapidly rising medical and hospital costs,

--local shortages of medical personnel and services due largely to maldistribution of physicians and other health personnel; and

--the need to facilitate the development of medicine to prevent disease and maintain good health.

The HMO concept has demonstrated an ability to hold down rapidly rising medical costs while maintaining high quality standards, efficient utilization ~~and maximization~~ of medical personnel, and focus on disease prevention and the maintenance of good health.

~~Although we do not expect everyone to be enrolled in an HMO~~ this effort is another example of how our pluralistic medical care system can adapt to the needs and demands of the nation's health consumers without massive Federal intervention.

Such careful restructuring of the delivery system while maintaining the strength of the private sector ~~is the best way~~ to achieve a viable long-term solution to the rapidly rising costs of medical care.

We must strive to develop other creative private sector mechanisms to accomplish these goals and resist those who would ~~seek~~ to supplant America's strong private health care system, the best in the world, with a government-controlled system.

ACTION MEMORANDUM WASHINGTON LOG NO.: 10/2/76

Date: October 2 Time: 430pm

FOR ACTION: Spencer Johnson
Max Friedersdorf
Bobbie Kilberg
Robert Hartmann

cc (for information): Jack Marsh
Jim Connor
Ed Schmults

FROM THE STAFF SECRETARY

DUE: Date: October 4 Time: noon

SUBJECT:

H.R. 9019-Health Maintenance Organization Amendments

ACTION REQUESTED:

____ For Necessary Action ____ For Your Recommendations

____ Prepare Agenda and Brief ____ Draft Reply

-x- For Your Comments ____ Draft Remarks

REMARKS:

please return to judy johnston,ground floor west wing

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PLEASE ATTACH THIS COPY TO MATERIAL SUBMITTED.

If you have any questions or if you anticipate a delay in submitting the required material, please telephone the Staff Secretary immediately.

James M. Cannon
For the President

ACTION MEMORANDUM WASHINGTON LOG NO.: 10/2/76

Date: October 2 Time: 430pm

FOR ACTION: Spencer Johnson
Max Friedersdorf
Bobbie Kilberg
Robert Hartmann

cc (for information): Jack Marsh
Jim Connor
Ed Schmults

279 to Rec 10:55 10/4 GAm

to DJS 10/4 11:43 GAm

FROM THE STAFF SECRETARY

DUE: Date: October 4 Time: noon

SUBJECT:

H.R. 9019-Health Maintenance Organization Amendments

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—— For Necessary Action —— For Your Recommendations

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-x— For Your Comments —— Draft Remarks

REMARKS:

please return to judy johnston, ground floor west wing

10/4/76 - Copy sent for researching. nm

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OK/MWB

PLEASE ATTACH THIS COPY TO MATERIAL SUBMITTED.

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James M. Cannon
For the President

SIGNING STATEMENT

H.R. 9019

Today I am pleased to sign into law H.R. 9019, the Health Maintenance Organization Amendments of 1976. It is especially significant to have this ceremony in California which led the way in initiating this concept over 30 years ago.

This is being amended by Lyndon Johnson

This legislation, which extends the HMO program for two years beyond the current expiration date of September 1977, is designed to make HMOs more competitive with traditional health insurance programs and health delivery systems.

The original HMO Act of 1973 authorized two major forms of federal assistance to developing HMOs:

C.Q. Almanac Pg. 607

--a five-year program of Federal grants, contracts, loans and loan guarantees, and

--a requirement that employers who offer health insurance to their employees also offer them the option of joining a Federally qualified HMO.

Other requirements of the 1973 HMO Act, however, discouraged participation in the Federal HMO development and showed the expansion of this important health industry. These amendments correct these deficiences and provide the foundation for a strong nationwide system of HMOs.

My Administration is concerned with the following fundamental areas of medical and health care problems:

--rapidly rising medical and hospital costs,

--local shortages of medical personnel and services due largely to maldistribution of physicians and other health personnel; and

--the need to facilitate the development of medicine to prevent disease and maintain good health.

The HMO concept has demonstrated an ability to hold down rapidly rising medical costs while maintaining high quality standards, efficient utilization and maximization of medical personnel, and focus on disease prevention and the maintenance of good health.

Although we do not expect everyone to be enrolled in an HMO this effort is another example of how our pluralistic medical care system can adapt to the needs and demands of the nation's health consumers with massive Federal intervention.

Such careful restructuring of the delivery system while maintaining the strength of the private sector is the best way to achieve a viable long-term solution to the rapidly rising costs of medical care.

We must strive to develop other creative private sector mechanisms to accomplish these goals and resist those who would week to supplant America's strong private health care system, the best in the world, with a government-controlled system.

SIGNING STATEMENT

H.R. 9019

Today I am pleased to sign into law H.R. 9019, the Health Maintenance Organization Amendments of 1976. It is ~~especially~~ particularly ~~significant~~ appropriate to ~~have~~ do this ~~ceremony~~ in California where ~~this~~ the HMO concept ~~was initiated over 30 years ago.~~ has been broadly supported.

This legislation, which extends the HMO program for two years beyond the current expiration date of September 1977, is designed to make HMOs more competitive with traditional health insurance programs and health delivery systems.

The original HMO Act of 1973 authorized two major forms of federal assistance to stimulate the development of HMOs:

-- a program of grants, contracts, loans and loan guarantees, and

-- a requirement that employers who offer health insurance to their employees also offer them the option of joining a Federally qualified HMO.

Other requirements of the 1973 HMO Act, however, discouraged participation in the Federal HMO development and slowed the expansion of this important health industry. These amendments correct ~~those~~ those deficiencies and provide the foundation for a strong nationwide system of HMOs.

My Administration is concerned with the following fundamental areas of medical and health care problems:

-- the quality of medical care and rapidly rising costs,

-- local shortages of medical personnel and services due largely to maldistribution of physicians and other health personnel; and

-- the need to promote preventive medicine and maintain good health.

The HMO concept has demonstrated an ability to hold down rapidly rising medical costs while maintaining high quality standards, efficient utilization ~~and maximization~~ of medical personnel, and a focus on disease prevention and the maintenance of good health.

Same ¶

~~Although we do not expect everyone to be enrolled in an HMO,~~ this effort is another example of how our ~~pluralistic~~ present system medical care system can adapt to the needs and demands of the nation's health consumers without massive Federal intervention.

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We must strive to develop other creative private sector mechanisms to accomplish these goals ~~and resist those who would work to supplant~~ so that America's strong private health care system will remain the best in the world. ~~with a government controlled system~~.

STATEMENT BY THE PRESIDENT

Today I am pleased to sign into law H.R. 9019, the Health Maintenance Organization Amendments of 1976. It is particularly appropriate to do this in California where the HMO concept has been broadly supported.

This legislation, which extends the HMO program for two years beyond the current expiration date of September 1977, is designed to make HMOs more competitive with traditional health insurance programs and health delivery systems.

The original HMO Act of 1973 authorized two major forms of federal assistance to stimulate the development of HMOs:

-- a program of grants, contracts, loans and loan guarantees, and
-- a requirement that employers who offer health insurance to their employees also offer them the option of joining a Federally qualified HMO.

Other requirements of the 1973 HMO Act, however, discouraged participation in the Federal HMO development and slowed the expansion of this important health industry. These amendments correct those deficiencies and provide the foundation for a strong nationwide system of HMOs.

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-- the quality of medical care and rapidly rising costs,
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Such careful restructuring of the delivery system, while maintaining the strength of the private sector, is one way to achieve a viable long-term solution to the rapidly rising costs of medical care.

We must strive to develop other creative private sector mechanisms to accomplish these goals so that America's strong private health care system will remain the best in the world.

Calendar No. 840

94TH CONGRESS
2d Session

SENATE

REPORT
No. 94-884

HEALTH MAINTENANCE ORGANIZATION AMENDMENTS OF 1975

MAY 14, 1976.—Ordered to be printed
Filed under authority of the order of the Senate of May 13, 1976

Mr. SCHWEIKER, from the Committee on Labor and Public Welfare, submitted the following

REPORT

[To accompany H.R. 9019]

The Committee on Labor and Public Welfare, to which was referred the bill (H.R. 9019) to amend title XIII of the Public Health Service Act to revise and extend the program for the establishment and expansion of health maintenance organizations, having considered the same, reports thereon without recommendation.

○

94TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
2d Session } { No. 94-1513

HEALTH MAINTENANCE ORGANIZATION AMENDMENTS OF 1976

SEPTEMBER 13, 1976.—Ordered to be printed

Mr. STAGGERS, from the committee of conference, submitted the following

CONFERENCE REPORT

[To accompany H.R. 9019]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 9019) to amend title XIII of the Public Health Service Act to revise and extend the program for the establishment and expansion of health maintenance organizations, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

SHORT TITLE; REFERENCE TO ACT

SECTION 1. (a) This Act may be cited as the "Health Maintenance Organization Amendments of 1976".

(b) Whenever in title I an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.

TITLE I—AMENDMENTS TO TITLE XIII OF THE PUBLIC HEALTH SERVICE ACT

SUPPLEMENTAL HEALTH SERVICES

SEC. 101. (a) Section 1301(b)(1) is amended by adding at the end the following: "A health maintenance organization may include a health service, defined as a supplemental health service by section 1302(2), in the basic health services provided its members for a basic health services payment described in the first sentence.".

(b) The first sentence of section 1301(b)(2) is amended by striking out "the organization shall provide" and all that follows in that sentence and substituting "the organization may provide to each of its

members any of the health services which are included in supplemental health services (as defined in section 1302(2)).".

(c) Section 1301(b)(4) is amended by striking out "and supplemental health services in the case of the members who have contracted therefor" and substituting "and only such supplemental health services as members have contracted for".

STAFFING

SEC. 102. (a)(1) The first sentence of section 1301(b)(3) is amended (A) by striking out "or through" and by substituting ", through", (B) by striking out "(or groups) or" and substituting "(or groups), through an", and (C) by inserting after "(or associations)" the following: ", through health professionals who have contracted with the health maintenance organization for the provision of such services, or through any combination of such staff, medical group (or groups), individual practice association (or associations), or health professionals under contract with the organization".

(2) Section 1301(b)(3) is amended by adding after the first sentence the following: "A health maintenance organization may also, during the thirty-six month period beginning with the month following the month in which the organization becomes a qualified health maintenance organization (within the meaning of section 1310(d)), provide basic and supplemental health services through an entity which but for the requirement of section 1302(4)(C)(i) would be a medical group for purposes of this title. After the expiration of such period, the organization may provide basic or supplemental health services through such an entity only if authorized by the Secretary in accordance with regulations which take into consideration the unusual circumstances of such entity. A health maintenance organization may not, in any of its fiscal years, enter into contracts with health professionals or entities other than medical groups or individual practice associations if the amounts paid under such contracts for basic and supplemental health services exceed fifteen percent of the total amount to be paid in such fiscal year by the health maintenance organization to physicians for the provision of basic and supplemental health services, or, if the health maintenance organization principally serves a rural area, thirty percent of such amount, except that this sentence does not apply to the entering into of contracts for the purchase of basic and supplemental health services through an entity which but for the requirements of section 1302(4)(C)(i) would be a medical group for purposes of this title. Contracts between a health maintenance organization and health professionals for the provision of basic and supplemental health services shall include such provisions as the Secretary may require (including provisions requiring appropriate continuing education).".

(b)(1) Section 1302(4)(C) is amended (A) by striking out clause (iv), (B) by redesignating clause (v) as clause (iv), and (C) by inserting "and" at the end of clause (iii).

(2) Section 1302(5)(B) is amended (A) by striking out clause (i), and (B) by redesignating clauses (ii) and (iii) as clauses (i) and (ii), respectively.

OPEN ENROLLMENT

SEC. 103. (a) Section 1301(c) is amended by amending paragraph (4) to read as follows:

"(4) have an open enrollment period in accordance with the provisions of subsection (d);"

(b) Section 1301 is amended by adding at the end thereof the following:

"(d)(1)(A) A health maintenance organization which—

"(i) has for at least 5 years provided comprehensive health services on a prepaid basis, or

"(ii) has an enrollment of at least 50,000 members,

shall have at least once during each fiscal year next following a fiscal year in which it did not have a financial deficit an open enrollment period (determined under subparagraph (B)) during which it shall accept individuals for membership in the order in which they apply for enrollment and, except as provided in paragraph (2), without regard to preexisting illness, medical condition, or degree of disability.

"(B) An open enrollment period for a health maintenance organization shall be the lesser of—

"(i) 30 days, or

"(ii) the number of days in which the organization enrolls a number of individuals at least equal to 3 percent of its total net increase in enrollment (if any) in the fiscal year preceding the fiscal year in which such period is held.

For the purpose of determining the total net increase in enrollment in a health maintenance organization, there shall not be included any individual who is enrolled in the organization through a group which had a contract for health care services with the health maintenance organization at the time that such health maintenance organization was determined to be a qualified health maintenance organization under section 1310.

"(2) Notwithstanding the requirements of paragraph (1) a health maintenance organization shall not be required to enroll individuals who are confined to an institution because of chronic illness, permanent injury, or other infirmity which would cause economic impairment to the health maintenance organization if such individual were enrolled.

"(3) A health maintenance organization may not be required to make the effective date of benefits for individuals enrolled under this subsection less than 90 days after the date of enrollment.

"(4) The Secretary may waive the requirements of this subsection for a health maintenance organization which demonstrates that compliance with the provisions of this subsection would jeopardize its economic viability in its service area.".

DEFINITION OF SERVICES

SEC. 104. (a)(1) Paragraph (1)(H) of section 1302 is amended to read as follows:

"(H) preventive health services (including (i) immunizations, (ii) well-child care from birth, (iii) periodic health evaluations for adults, (iv) voluntary family planning services, (v) infertility

services, and (vi) children's eye and ear examinations conducted to determine the need for vision and hearing correction).".

(2) Paragraph (1) of section 1302 is amended by striking out "or podiatrist" each place it occurs and substituting "podiatrist, or other health care personnel".

(b) Paragraph (2) of such section is amended—

(1) by striking out "under paragraph (1)(A) or (1)(H)" in subparagraphs (B) and (C);

(2) by striking out "and" at the end of subparagraph (E), by striking out the period at the end of subparagraph (F) and substituting "; and", and by adding after subparagraph (F) the following:

"(G) other health services which are not included as basic health services and which have been approved by the Secretary for delivery as supplemental health services.";

(3) by striking out "or podiatrist" each place it occurs and substituting "podiatrist, or other health care personnel".

COMMUNITY RATING

SEC. 105. (a)(1) Section 1301(b)(1) is amended by adding at the end thereof the following new sentence: "In the case of an entity which before it became a qualified health maintenance organization (within the meaning of section 1310(d)) provided comprehensive health services on a prepaid basis, the requirement of clause (C) shall not apply to such entity until the expiration of the forty-eight month period beginning with the month following the month in which the entity became such a qualified health maintenance organization.".

(2) The last sentence of section 1301(b)(2) is amended by inserting before the period the following: "except that, in the case of an entity which before it became a qualified health maintenance organization (within the meaning of section 1310(d)) provided comprehensive health services on a prepaid basis, the requirement of this sentence shall not apply to such entity during the forty-eight month period beginning with the month following the month in which the entity became such a qualified health maintenance organization".

(3) Section 1306(b) is amended (A) by striking out "and" at the end of paragraph (6), (B) by redesignating paragraph (7) as paragraph (8), and (C) by inserting after paragraph (6) the following new paragraph:

"(7) the application contains such assurances as the Secretary may require respecting the intent and the ability of the applicant to meet the requirements of paragraphs (1) and (2) of section 1301(b) respecting the fixing of basic health services payments and supplemental health services payments under a community rating system; and"

(b) Section 1302(8)(A) is amended by inserting "differences in marketing costs and" after "reflect".

(c) Subparagraph (B) of section 1302(8) is redesignated as subparagraph (C) and the following new subparagraph is inserted after subparagraph (A):

"(B) Nominal differentials in such rates may be established to reflect the compositing of the rates of payment in a systematic manner to accommodate group purchasing practices of the various employers.".

MEDICAL GROUP REQUIREMENTS

SEC. 106. (a) Section 1302(4)(C) is amended by striking out "(i) as their principal professional activity and as a group responsibility engage in the coordinated practice of their profession for a health maintenance organization" and substituting "(i) as their principal professional activity engage in the cooordinated practice of their profession and as a group responsibility have substantial responsibility for the delivery of health services to members of a health maintenance organization".

(b) Section 1302(4)(C)(ii) is amended by striking out "plan" and substituting "similar plan unrelated to the provision of specific health services".

(c) 1302(4)(C) (as amended by section 102(b)(1)) is amended by—

(1) striking "and" before "(iv)", and

(2) striking the period at the end of subparagraph (C) and substituting "; and (v) establish an arrangement whereby a member's enrollment status is not known to the health professional who provides health services to the member.".

INCREASE IN LIMITS ON ASSISTANCE FOR FEASIBILITY SURVEYS, PLANNING, INITIAL DEVELOPMENT, AND INITIAL OPERATION

SEC. 107. (a) Section 1303(e) is amended by striking "$50,000" and substituting "$75,000".

(b)(1) Section 1304(f)(1)(A) is amended by striking "$125,000" and substituting "$200,000".

(2) Section 1304(f)(2)(A) is amended by inserting after "$1,000,000" the following: "or, in the case of a project for a health maintenance organization which will provide services to an additional service area (as defined by the Secretary) or which will provide services in one or more areas which are not contiguous, $1,600,000".

(c) Section 1305(a) is amended by striking out "first thirty-six months" each place it occurs and substituting "first sixty months".

LOAN GUARANTEES FOR PRIVATE ENTITIES

SEC. 108. (a) Section 1304(a)(2) is amended to read as follows:

"(2) guarantee to non-Federal lenders payment of the principal of and the interest on loans made to—

"(A) nonprofit private entities for planning projects for the establishment or expansion of health maintenance organizations, or

"(B) other private entities for such projects for health maintenance organizations which will serve medically underserved populations.".

(b) Section 1304(b)(1)(B) is amended to read as follows:

"(B) guarantee to non-Federal lenders payment of the principal of and the interest on loans made to—

"(i) nonprofit private entities for projects for the initial development of health maintenance organizations, or

"(ii) other private entities for such projects for health maintenance organizations which will serve medically underserved populations.".

(c) Section 1305(a)(3) is amended to read as follows:

"(3) guarantee to non-Federal lenders payment of the principal of and the interest on loans made to—

"(A) nonprofit private health maintenance organizations for the amounts referred to in paragraph (1) or (2), or

"(B) other private health maintenance organizations for such amounts but only if the health maintenance organization will serve a medically underserved population.".

(d)(1) Section 1304(d) is amended by adding at the end the following new sentence: "In considering applications for loan guarantees under this section, the Secretary shall give special consideration to applications for projects for health maintenance organizations which will serve medically underserved populations.".

(2) Section 1305 is amended by adding at the end thereof the following new subsection:

"(f) In considering applications for loan guarantees under this section, the Secretary shall give special consideration to applications for health maintenance organizations which will serve medically underserved populations.".

MISCELLANEOUS AMENDMENTS

SEC. 109. (a)(1) Section 1305(a) is amended by striking out "in the period of" in paragraphs (1) and (2) and substituting "during a period not to exceed".

(2) The last sentence of 1305(b)(1) is amended to read as follows: "In any fiscal year the amount disbursed to a health maintenance organization under this section (either directly by the Secretary or by an escrow agent under the terms of an escrow agreement or by a lender under a loan guaranteed under this section) may not exceed $1,000,000.".

(b)(1) Section 1307(e) is amended—

(A) by inserting "for a private health maintenance organization (other than a private nonprofit health maintenance organization)" after "may be made", and

(B) by inserting "for private health maintenance organizations (other than private nonprofit health maintenance organizations)" after "guaranteed".

(2) Section 1308(c) is amended by adding after paragraph (4) the following new paragraph:

"(5) Any reference in this title (other than in this subsection and in subsection (d)) to a loan guarantee under this title does not include a loan guarantee made under this subsection.".

(c)(1) Section 1308(a)(1)(A) is amended by striking out "for similar loans" and substituting "for loans with similar maturities, terms, conditions, and security".

(2) Section 1308(b)(2)(D) is amended by striking out "loans guaranteed under this title" and substituting "marketable obligations of the United States of comparable maturities, adjusted to provide for appropriate administrative charges".

(d)(1) The last sentence of section 1303(i) is amended—

(A) by striking "the fiscal year ending June 30, 1974, or June 30, 1975," and substituting "any fiscal year"; and

(B) by striking "for projects other than those described in clause (1) of such sentence" and substituting "for any project, with priority being given to projects described in clause (1) of such sentence".

(2) The last sentence of section 1304(k)(1) is amended—

(A) by striking "the fiscal year ending June 30, 1974, or June 30, 1975," and substituting "any fiscal year"; and

(B) by striking "for projects other than those described in clause (A) of such sentence" and substituting "for any project, with priority being given to projects described in clause (A) of such sentence".

(3) The last sentence of section 1304(k)(2) is amended—

(A) by striking "the fiscal year ending June 30, 1974, or in either of the next two fiscal years" and substituting "any fiscal year"; and

(B) by striking "for projects other than those described in clause (A) of such sentence" and substituting "for any project, with priority being given to projects described in clause (A) of such sentence".

(e) Section 1304(b)(2)(D) is amended by striking out "for such an organization" and substituting "who will engage in practice principally for the health maintenance organization".

EMPLOYEE HEALTH BENEFITS PLANS

SEC. 110. (a) Section 1310 is amended—

(1) by amending subsection (a) to read as follows:

"SEC. 1310. (a)(1) In accordance with regulations which the Secretary shall prescribe—

"(A) each employer—

"(i) which is now or hereafter required during any calendar quarter to pay its employees the minimum wage prescribed by section 6 of the Fair Labor Standards Act of 1938 (or would be required to pay its employees such wage but for section 13(a) of such Act), and

"(ii) which during such calendar quarter employed an average number of employees of not less than 25,

shall include in any health benefits plan, and

"(B) any State and each political subdivision thereof which during any calendar quarter employed an average number of employees of not less than 25, as a condition of the payment to the State of funds under section 314(d), 317, 318, 1002, 1525, or 1613, shall include in any health benefits plan,

offered to such employees in the calendar year beginning after such calendar quarter the option of membership in qualified health maintenance organizations which are engaged in the provision of basic health services in health maintenance organization service areas in which at least 25 of such employees reside.

"(2) If any of the employees of an employer or State or political subdivision thereof described in paragraph (1) are represented by a collective bargaining representative or other employee representative designated or selected under any law, offer of membership in a qualified

health maintenance organization required by paragraph (1) to be made in a health benefits plan offered to such employees (A) shall first be made to such collective bargaining representative or other employee representative, and (B) if such offer is accepted by such representative, shall then be made to each such employee.";

(2) by amending paragraphs (1) and (2) of subsection (b) to read as follows:

"(1) one or more of such organizations provides basic health services (A) without the use of an individual practice association and (B) without the use of contracts (except for contracts for unusual or infrequently used services) with health professionals, and

"(2) one or more of such organizations provides basic health services through (A) an individual practice association (or associations), (B) health professionals who have contracted with the health maintenance organization for the provision of such services, or (C) a combination of such association (or associations) or health professionals under contract with the organization,";

(3) by striking out the last sentence of subsection (c); and

(4) by adding after subsection (d) the following new subsections:

"(e)(1) Any employer who knowingly does not comply with one or more of the requirements of subsection (a) shall be subject to a civil penalty of not more than $10,000. If such noncompliance continues, a civil penalty may be assessed and collected under this subsection for each thirty-day period such noncompliance continues. Such penalty may be assessed by the Secretary and collected in a civil action brought by the United States in a United States district court.

"(2) In any proceeding by the Secretary to assess a civil penalty under this subsection, no penalty shall be assessed until the employer charged shall have been given notice and an opportunity to present its views on such charge. In determining the amount of the penalty, or the amount agreed upon in compromise, the Secretary shall consider the gravity of the noncompliance and the demonstrated good faith of the employer charged in attempting to achieve rapid compliance after notification by the Secretary of a noncompliance.

"(3) In any civil action brought to review the assessment of a civil penalty assessed under this subsection, the court shall, at the request of any party to such action, hold a trial de novo on the assessment of such civil penalty and in any civil action to collect such a civil penalty, the court shall, at the request of any party to such action, hold a trial de novo on the assessment of such civil penalty unless in a prior civil action to review the assessment of such penalty the court held a trial de novo on such assessment.

"(f) For purposes of this section, the term 'employer' does not include (1) the Government of the United States, the government of the District of Columbia or any territory or possession of the United States, a State or any political subdivision thereof, or any agency or instrumentality (including the United States Postal Service and Postal Rate Commission) of any of the foregoing; or (2) a church, convention or association of churches, or any organization operated, supervised or controlled by a church, convention or association of

churches which organization (A) is an organization described in section 501(c)(3) of the Internal Revenue Code of 1954, and (B) does not discriminate (i) in the employment, compensation, promotion, or termination of employment of any personnel, or (ii) in the extension of staff or other privileges to any physician or other health personnel, because such persons seek to obtain or obtained health care, or participate in providing health care, through a health maintenance organization.

"(g) If the Secretary, after reasonable notice and opportunity for hearing to a State, finds that it or any of its political subdivisions has failed to comply with one or more of the requirements of subsection (a), the Secretary shall terminate payments to such State under sections 314(d), 317, 318, 1002, 1525, and 1613 and notify the Governor of such State that further payments under such sections will not be made to the State until the Secretary is satisfied that there will no longer be any such failure to comply.

"(h) The duties and functions of the Secretary, insofar as they involve making determinations as to whether an organization is a qualified health maintenance organization within the meaning of subsection (d), shall be administered through the Assistant Secretary for Health and in the Office of the Assistant Secretary for Health, and the administration of such duties and functions shall be integrated with the administration of section 1312(a).".

(b) Section 8902 of title 5, United States Code, relating to Federal employee health insurance, is amended by adding at the end thereof the following new subsection:

"(l) The Commission shall contract under this chapter for a plan described in section 8903(4) of this title with any qualified health maintenance carrier which offers such a plan. For the purpose of this subsection, 'qualified health maintenance carrier' means any qualified carrier which is a qualified health maintenance organization within the meaning of section 1310(d)(1) of title XIII of the Public Health Service Act (42 U.S.C. 300e-9(d)).".

ENFORCEMENT REQUIREMENTS

SEC. 111. (a) Section 1312(a) is amended by striking out all of the section following paragraph (3) and substituting the following: "the Secretary may take the action authorized by subsection (b)."

(b) Section 1312(b) is amended to read as follows:

"(b)(1) If the Secretary makes, with respect to any entity which provided assurances to the Secretary under section 1310(d)(1), a determination described in subsection (a), the Secretary shall notify the entity in writing of the determination. Such notice shall specify the manner in which the entity has not complied with such assurances and direct that the entity initiate (within 30 days of the date the notice is issued by the Secretary or within such longer period as the Secretary determines is reasonable) such action as may be necessary to bring (within such period as the Secretary shall prescribe) the entity into compliance with the assurances. If the entity fails to initiate corrective action within the period prescribed by the notice or fails to comply with the assurances within such period as the Secretary prescribes (A) the entity shall not be a qualified health maintenance organization for purposes of section 1310 until such date as the Sec-

retary determines that it is in compliance with the assurances, and (B) each employer which has offered membership in the entity in compliance with section 1310, each lawfully recognized collective bargaining representative or other employee representative which represents the employees of each such employer, and the members of such entity shall be notified by the entity that the entity is not a qualified health maintenance organization for purposes of such section. The notice required by clause (B) of the preceding sentence shall contain, in readily understandable language, the reasons for the determination that the entity is not a qualified health maintenance organization. The Secretary shall publish in the Federal Register each determination referred to in this paragraph.

"(2) If the Secretary makes, with respect to an entity which has received a grant, contract, loan, or loan guarantee under this title, a determination described in subsection (a), the Secretary may, in addition to any other remedies available to him, bring a civil action in the United States district court for the district in which such entity is located to enforce its compliance with the assurances it furnished respecting the provision of basic and supplemental health services or its organization or operation, as the case may be, which assurances were made in connection with its application under this title for the grant, contract, loan, or loan guarantee.

(c) Section 1312 is amended by adding at the end the following new subsection:

"(c) The Secretary, acting through the Assistant Secretary for Health, shall administer subsections (a) and (b) in the Office of the Assistant Secretary for Health.".

HMO'S AND FEDERAL HEALTH BENEFITS PROGRAMS

SEC. 112. Section 1307 (d) is amended by adding after and below paragraph (2) the following new sentence: "An entity which provides health services to a defined population on a prepaid basis and which has members who are enrolled under the health benefits program authorized by chapter 89 of title 5, United States Code, may be considered as a health maintenance organization for purposes of receiving assistance under this title if with respect to its other members it provides health services in accordance with section 1301(b) and is organized and operated in the manner prescribed by section 1301(c).".

EXTENSIONS AND AUTHORIZATIONS

SEC. 113. (a) Section 1304(j) is amended (1) by striking out "September 30, 1976" and substituting "September 30, 1978", and (2) by striking out "September 30, 1977" and substituting "September 30, 1979".

(b) Subsection (d) of section 1305 is amended to read as follows:

"(d) No loan may be made or guaranteed under this section after September 30, 1980.".

(c) Section 1309(a) is amended—

(1) by striking out "and" after "1975,",

(2) by inserting after "1976" the following: ", $45,000,000 for the fiscal year ending September 30, 1977, and $45,000,000 for the fiscal year ending September 30, 1978",

(3) by striking out "ending June 30, 1977" and substituting "ending September 30, 1977", and

(4) by striking out "$85,000,000" the first time it occurs and substituting "$40,000,000", and by striking out "$85,000,000" the second time it occurs and substituting "$50,000,000".

RESTRICTIVE STATE LAWS

SEC. 114. Section 1311 is amended by adding at the end the following new subsection:

"(c) The Secretary shall, within 6 months after the date of the enactment of this subsection, develop a digest of State laws, regulations, and practices pertaining to development, establishment, and operation of health maintenance organizations which shall be updated at least quarterly and relevant sections of which shall be provided to the Governor of each State annually. Such digest shall indicate which State laws, regulations, and practices appear to be inconsistent with the operation of this section. The Secretary shall also insure that appropriate legal consultative assistance is available to the States for the purpose of complying with the provisions of this section."

PROGRAM EVALUATION BY THE COMPTROLLER GENERAL

SEC. 115. So much of section 1314(a) as precedes paragraph (1) thereof is amended to read as follows:

"SEC. 1314. (a) The Comptroller General shall evaluate the operations of at least ten or one-half (whichever is greater) of the health maintenance organizations for which assistance was provided under sections 1303, 1304, and 1305, and which, by December 31, 1976, have been designated by the Secretary under section 1310(d) as qualified health maintenance organizations. The Comptroller General shall report to the Congress the results of the evaluation by June 30, 1978. Such report shall contain findings—".

ADMINISTRATION OF PROGRAM

SEC. 116. Title XIII is amended by adding after section 1315 the following new section:

"ADMINISTRATION OF PROGRAM

"SEC. 1316. The Secretary shall administer this title (other than sections 1310 and 1312) through a single identifiable administrative unit of the Department.".

CONFORMING AMENDMENTS

SEC. 117. (a) Section 1532(c) is amended by adding the following sentence at the end thereof: "The criteria established by any health systems agency or State Agency under paragraph (8) shall be consistent with the standards and procedures established by the Secretary under section 1306(c) of this Act.".

(b) (1) Paragraph (6) of section 1302 is amended to read as follows:

"(6) The term 'health systems agency' means an entity which is designated in accordance with section 1515 of this Act.".

(2) Paragraph (7) of section 1302 is amended by—

(A) striking "section 314(a) State health planning agency whose section 314(a) plan" and substituting "State health planning and development agency which"; and

(B) striking "section 314(b) areawide health planning agency whose section 314(b) plan", and substituting "health systems agency designated for a health service area which".

(3) Paragraph (1) of section 1303(b) is amended by striking "section 314(b) areawide health planning agency (if any) whose section 314(b) plan" and substituting "each health systems agency designated for a health service area which".

(4) Paragraph (1) of section 1304(c) is amended by striking "section 314(b) areawide health planning agency (if any) whose section 314(b) plan" and substituting "each health systems agency designated for a health service area which".

(5) Section (b)(5) of section 1306 is amended to read as follows:

"(5) each health systems agency designated for a health service area which covers (in whole or in part) the area to be served by the health maintenance organization for which such application is submitted:".

(6) Subsection (c) of section 1306 is amended by striking "section 314(b) areawide health planning agencies and section 314(a) State health planning agencies" and substituting "health systems agencies".

EFFECTIVE DATES

SEC. 118. (a) Except as provided in subsection (b), the amendments made by this title shall take effect on the date of the enactment of this Act.

(b)(1) The amendments made by sections 101, 102, 103, 104, and 106 shall (A) apply with respect to grants, contracts, loans, and loan guarantees made under sections 1303, 1304, and 1305 of the Public Health Service Act for fiscal years beginning after September 30, 1976, (B) apply with respect to health benefit plans offered under section 1310 of such Act after such date, and (c) for purposes of section 1312 take effect October 1, 1976.

(2) Subsection (d) of section 1301 of the Public Health Service Act (added by section 103(b) of this Act) shall take effect with respect to fiscal years of health maintenance organizations beginning on or after the date of the enactment of this Act.

(3) The amendments made by section 107 shall apply with respect to grants, contracts, loans, and loan guarantees made under sections 1303, 1304, and 1305 of the Public Health Service Act for fiscal years beginning after September 30, 1976.

(4) The amendments made by sections 109(a)(1) and 109(c) shall apply with respect to loan guarantees made under section 1305 of the Public Health Service Act after September 30, 1976.

(5) The amendment made by section 109(e) shall apply with respect to projects assisted under section 1304 of the Public Health Service Act after September 30, 1976.

(6) The amendments made by paragraphs (1) and (2) of section 110(a) shall apply with respect to calendar quarters which begin after the date of the enactment of this Act.

(7) The amendments made by paragraphs (3) and (4) of section 110 shall apply with respect to failures of employers to comply with section 1310(a) of the Public Health Service Act after the date of the enactment of this Act.

(8) The amendment made by section 111 shall apply with respect to determinations of the Secretary of Health, Education, and Welfare described in section 1312(a) of the Public Health Service Act and made after the date of the enactment of this Act.

TITLE II—AMENDMENTS TO SOCIAL SECURITY ACT

MEDICARE AMENDMENTS

SEC. 201. (a) Section 1876(b) of the Social Security Act is amended to read as follows:

"(b)(1) The term 'health maintenance organization' means a legal entity which provides health services on a prepayment basis to individuals enrolled with such organizations and which—

"(A) provides to its enrollees who are insured for benefits under parts A and B of this title or for benefits under part B alone, through institutions, entities, and persons meeting the applicable requirements of section 1861, all of the services and benefits covered under such parts (to the extent applicable under subparagraph (A) or (B) of subsection (a)(1)) which are available to individuals residing in the geographic area served by the organization;

"(B) provides such services in the manner prescribed by section 1301(b) of the Public Health Service Act, except that solely for the purposes of this section—

"(i) the term 'basic health services' and references thereto shall be deemed to refer to the services and benefits included under parts A and B of this title;

"(ii) the organization shall not be required to fix the basic health services payment under a community rating system;

"(iii) the additional nominal payments authorized by section 1301(b)(1)(D) of such Act shall not exceed the limits applicable under subsection (g) of this section; and

"(iv) payment for basic health services provided by the organization to its enrollees under this section or for services such enrollees receive other than through the organization shall be made as provided for by this title;

"(C) is organized and operated in the manner prescribed by section 1301(c) of the Public Health Service Act, except that solely for the purposes of this section—

"(i) the term 'basic health services' and references thereto shall be deemed to refer to the services and benefits included under parts A and B of this title;

"(ii) the organization shall not be reimbursed for the cost of reinsurance except as permitted by subsection (i) of this section; and

"(iii) the organization shall have an open enrollment period as provided for in subsection (k) of this section.

"(2)(A) The duties and functions of the Secretary, insofar as they involve making determinations as to whether an organization is a

'health maintenance organization' within the meaning of paragraph (1), shall be administered through the Assistant Secretary for Health and in the Office of the Assistant Secretary for Health, and the administration of such duties and functions shall be integrated with the administration of section 1312 (a) and (b) of the Public Health Service Act.

"(B) Except as provided in subparagraph (A), the Secretary shall administer the provisions of this section through the Commissioner of Social Security.".

(b) Section 1876(h) of such Act is amended to read as follows:

"(h)(1) Except as provided in paragraph (2), each health maintenance organization with which the Secretary enters into a contract under this section shall have an enrolled membership at least half of which consists of individuals who have not attained age 65.

"(2) The Secretary may waive the requirement imposed in paragraph (1) for a period of not more than three years from the date a health maintenance organization first enters into an agreement with the Secretary pursuant to subsection (i), but only for so long as such organization demonstrates to the satisfaction of the Secretary by the submission of its plan for each year that it is making continuous efforts and progress toward compliance with the provisions of paragraph (1) within such three-year period.".

(c) Section 1876(i)(6)(B) of such Act is amended by striking out "(other than those with respect to out-of-area services)" and inserting in lieu thereof "(other than costs with respect to out-of-area services and, in the case of an organization which has entered into a risk-sharing contract with the Secretary pursuant to paragraph (2)(A), the cost of providing any member with basic health services the aggregate value of which exceeds $5,000 in any year)".

(d) Section 1876 is amended by adding at the end thereof the following—

"(k) Each health maintenance organization with which the Secretary enters into a contract under this section shall have an open enrollment period at least every year under which it accepts up to the limits of its capacity and without restrictions, except as may be authorized in regulations, individuals who are eligible to enroll under subsection (d) in the order in which they apply for enrollment (unless to do so would result in failure to meet the requirements of subsection (h)) or would result in enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the population in the geographic area served by such health maintenance organization.".

(e) The amendments made by this section shall be effective with respect to contracts entered into between the Secretary and health maintenance organizations under section 1876 of the Social Security Act on and after the first day of the first calendar month which begins more than 30 days after the date of enactment of this Act.

MEDICAID AMENDMENTS

SEC. 202. (a) Section 1903 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(m)(1)(A) The term 'health maintenance organization' means a legal entity which provides health services to individuals enrolled in such organization and which—

"(i) provides to its enrollees who are eligible for benefits under this title the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905, and, to the extent required by section 1902(a)(13)(A)(ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1905(a);

"(ii) provides such services and benefits in the manner prescribed in section 1301(b) of the Public Health Service Act (except that, solely for purposes of this paragraph, the term 'basic health services' and references thereto, when employed in such section, shall be deemed to refer to the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905(a), and, to the extent required by section 1902(a)(13)(A)(ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1905(a)); and

"(iii) is organized and operated in the manner prescribed by section 1301(c) of the Public Health Service Act (except that solely for purposes of this paragraph, the term 'basic health services' and references thereto, when employed in such section shall be deemed to refer to the services and benefits described in section 1905(a)(1), (2), (3) (4)(C), and (5), and to the extent required by section 1902(a)(13)(A)(ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1905(a)).

(B) The duties and functions of the Secretary, insofar as they involve making determinations as to whether an organization is a health maintenance organization within the meaning of subparagraph (A), shall be administered through the Assistant Secretary for Health and in the Office of the Assistant Secretary for Health, and the administration of such duties and functions shall be integrated with the administration of section 1312 (a) and (b) of the Public Health Service Act.

"(2)(A) Except as provided in subparagraphs (B) and (C), no payment shall be made under this title to a State with respect to expenditures incurred by it for payment for services provided by any entity—

"(i) which is responsible for the provision of—

"(I) inpatient hospital services and any other service described in paragraph (2), (3), (4), (5), or (7) of section 1905(a), or

"(II) any three or more of the services described in such paragraphs,

when payment for such services is determined under a prepaid capitation risk basis or under any other risk basis;

"(ii) which the Secretary (or the State as authorized by paragraph (3)) has not determined to be a health maintenance organization as defined in paragraph (1); and

"(iii) more than one-half of the membership of which consists of individuals who are insured under parts A and B of title XVIII or recipients of benefits under this title.

"(B) Subparagraph (A) does not apply with respect to payments under this title to a State with respect to expenditures incurred by it for payment for services provided by an entity which—

"(i) (I) received a grant of at least $100,000 in the fiscal year ending June 30, 1976, under section 319(d)(1)(A) or 330(d)(1) of the Public Health Service Act, and (II) for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this title has been the recipient of a grant under either such section; and

"(II) provides to its enrollees, on a prepaid capitation risk basis or on any other risk basis, all of the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905(a) and, to the extent required by section 1902(a)(13)(A)(ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of such section; or

"(ii) is a nonprofit primary health care entity located in a rural area (as defined by the Appalachian Regional Commission)—

"(I) which received in the fiscal year ending June 30, 1976, at least $100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965, and

"(II) for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this title either has been the recipient of a grant, subgrant, or subcontract under such Act or has provided services under a contract (initially entered into during a year in which the entity was the recipient of such a grant, subgrant, or subcontract) with a State agency under this title on a prepaid capitation risk basis or on any other risk basis; or

"(iii) which has contracted with the single State agency for the provision of services (but not including inpatient hospital services) to persons eligible under this title on a prepaid risk basis prior to 1970.

"(C) Subparagraph (A)(iii) shall not apply with respect to payments under this title to a State with respect to expenditures incurred by it for payment for services by an entity during the three-year period beginning on the date of enactment of this subsection or beginning on the date the entity enters into a contract with the State under this title for the provision of health services on a prepaid risk basis, whichever occurs later, but only if the entity demonstrates to the satisfaction of the Secretary by the submission of plans for each year of such three-year period that it is making continuous efforts and progress toward achieving compliance with subparagraph (A)(iii).

"(3) A State may, in the case of an entity which has submitted an application to the Secretary for determination that it is a health maintenance organization within the meaning of paragraph (1) and for which no such determination has been made within 90 days of the submission of the application, make a provisional determination for the purposes of this title that such entity is such a health maintenance organization. Such provisional determination shall remain in force until such time as the Secretary makes a determination regarding the entity's qualification under paragraph (1).".

(b) The amendment made by subsection (a) shall apply with respect to payments under title XIX of the Social Security Act to States for services provided—

(1) after the date of enactment of subsection (a) under contracts under such title entered into or renegotiated after such date, or

(2) after the expiration of the 1-year period beginning on such date of enactment,

whichever occurs first.

TITLE III—MISCELLANEOUS AMENDMENTS

CENTER FOR HEALTH SERVICES POLICY ANALYSIS

SEC. 301. Section 305(d)(1) of the Public Health Service Act is amended (1) by striking out "two national special emphasis centers" and substituting "three national special emphasis centers", (2) by striking out "and one" and substituting "one", and (3) by inserting before the last close parenthesis a semicolon and the following: "and one of which (to be designated as the Health Services Policy Analysis Center) shall focus on the development and evaluation of national policies with respect to health services, including the development of health maintenance organizations and other forms of group practice, with a view toward improving the efficiencies of the health services delivery system".

HOME HEALTH EXTENSION

SEC. 302. (a) Section 602(a)(5) of Public Law 94-63 is amended by inserting ", $2,000,000 for the period July 1, 1976, through September 30, 1976, $8,000,000 for the fiscal year ending September 30, 1977" after "1976".

(b) Section 602(b)(4) of Public Law 94-63 is amended by inserting ", $1,000,000 for the period July 1, 1976, through September 30, 1976, and $4,000,000 for the fiscal year ending September 30, 1977" after "1976".

EXTENSION OF REPORTING DATE

SEC. 303. Section 603(b) of Public Law 94-63 is amended by striking "Within one year" and substituting "Not later than 2 years".

TECHNICAL

SEC. 304. Section 514(a) of the Federal Food, Drug, and Cosmetic Act is amended by redesignating paragraphs (4) and (5) as paragraphs (3) and (4), respectively.

And the Senate agree to the same.

HARLEY O. STAGGERS,
PAUL G. ROGERS,
RICHARDSON PREYER,
JIM SYMINGTON,
TIM LEE CARTER,
JAMES T. BROYHILL,
Managers on the Part of the House.

EDWARD M. KENNEDY,
HARRISON A. WILLIAMS, JR.,
THOMAS F. EAGLETON,
ALAN CRANSTON,
CLAIBORNE PELL,
WALTER F. MONDALE,
W. D. HATHAWAY,
JOHN A. DURKIN,
DICK SCHWEIKER,
J. JAVITS,
J. GLENN BEALL, JR.,
BOB TAFT, JR.,
ROBERT T. STAFFORD,
PAUL LAXALT,
Managers on the Part of the Senate.

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 9019) to amend title XIII of the Public Health Service Act to revise and extend the program for the establishment and expansion of health maintenance organizations, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

The Senate amendment struck out all of the House bill after the enacting clause and inserted a substitute text.

The House recedes from its disagreement to the amendment of the Senate with an amendment which is a substitute for the House bill and the Senate amendment. The differences between the House bill, the Senate amendment, and the substitute agreed to in conference are noted below, except for clerical corrections, conforming changes made necessary by agreements reached by the conferees, and minor drafting and clarifying changes.

SUPPLEMENTAL HEALTH SERVICES

Combining of Basic and Supplemental Health Services

Existing Law: Requires HMOs to offer just basic health services, without inclusion of any supplemental health services, to any member or group of members who wish to purchase only the basic health services. Section 1301(b) of existing law.

House Bill: Allows HMOs to include supplemental health services in the basic health services which they require all members to purchase. Section 2(a) of H.R. 9019.

Senate Amendment: No comparable change in existing law.

Conference Substitute: Conforms to the House bill because there are some States which require HMOs under State law to offer services which are not included among the defined basic health services. Therefore in such States the Senate bill is inconsistent with State laws which are not preempted by the provisions of section 1311 of existing law.

Capacity to Deliver Supplemental Health Services

Existing Law: Requires that HMOs make supplemental health services available and accessible within the areas they serve to all members promptly, as appropriate, and in a manner which assures continuity. This has been interpreted to apply to all possible supplemental health services whether or not any member of the HMO has actually contracted for them. Section 1301(b)(4) of existing law.

House Bill: Limits the requirement for the availability of supplemental health services to only such supplemental health services for which members have actually contracted. Section 2(c) of H.R. 9019.

Senate Amendment: No comparable change.

Conference Substitute: Conforms to the House bill.

STAFFING OF HMO'S

Allowable Sources of Professional Staffing

Existing Law: Provides that the services of health professionals which the HMO offers as basic health services may be provided through the staff of the HMO, or through one or more medical groups, or through one or more individual practice associations (IPAs) but does not permit HMOs to make mixed use of staff, medical groups, and/or IPAs. Section 1301(b)(3) of existing law.

House Bill: Permits HMOs to provide professional services through any combination of staff, medical groups, IPAs, or professionals under contract. Section 3(a) of H.R. 9019.

Senate Amendment: No comparable change.

Conference Substitute: Conforms to the House bill.

Authority to Contract for Professional Services

Existing Law: Prevents HMOs from contracting with individual health professionals, or groups of health professionals which do not qualify as medical groups or IPAs as defined, except where their services are unusual or infrequently used. Section 1301(b)(3) of existing law.

House Bill: Permits contracting directly with health professionals for their services (subject to such provisions as the Secretary may require, including provisions requiring appropriate continuing education). Section 3(a) of H.R. 9019.

Senate Amendment: No comparable change.

Conference Substitute: Contains a compromise which provides that HMOs may contract for professional services with individual health professionals, or groups of health professionals which do not qualify as medical groups or IPAs, provided that the amount contracted for does not exceed 30 percent of the dollar value of the HMOs physician services if it is principally located in a rural area, or 15 percent if it is located in an area which is not principally rural. The Conferees noted their expectation that such arrangements would ordinarily be used only for services which cannot feasibly be provided any other way. The compromise was designed to recognize that the primary difficulties faced by HMOs in delivering services through their own employees, medical groups, or IPAs are in delivering the services of particular medical specialities, particularly in rural areas where the need for the subspecialty services is limited. It gives HMOs flexibility in contracting for these services in such situations while retaining limits to assure that the major provision of services will be by the HMO (or medical groups or IPAs contracting with them). This authority would also permit HMOs to contract with independent institutions such as cancer centers or visiting nurse associations for their specialized services.

Requirements that Members of a Medical Group Practice Their Profession for an HMO

Existing Law: Requires members of a medical group, by its definition to engage in the coordinated practice of their profession as their principal professional activity and as a group responsibility *for an HMO.* Section 1302(4)(C)(i) of existing law.

House Bill: Provides that, for a five year period beginning on the date which an HMO qualifies as such under section 1310 of existing law, an HMO may provide services using medical groups which do not meet the requirement that their members practice *for the HMO* as their principal professional activity. Further provides that, after the expiration of the five year period, the HMO may continue to use such deficient medical groups if authorized by the Secretary to do so in accordance with regulations. Section 3(a) of H.R. 9019.

Senate Amendment: No comparable waiver of the existing requirement, but changes the definition of a medical group to require that its members engage in the coordinated practice of their profession as their principal professional activity and as a group responsibility *having substantial responsibility for the delivery of medical services to enrollees in an HMO.* Section 7 of S. 1926.

Conference Substitute: Contains a conference substitute which would define medical groups so as to require that their members individually engage in coordinated group practice as their principal professional activity and collectively take substantial responsibility for the delivery of services to the members of the HMO. The Conferees understand this to mean that each member of the group will have to give over half his time to the group practice but that no such requirement would apply to the amount of time each group member served HMO members. However, a substantial portion (over 35 percent) of the whole group's services would have to go to HMO members.

HMO would not have to meet this requirement for the first three years after qualification. The Secretary would be authorized to waive the requirement beyond three years but only in the kinds of situations described in the Senate Committee report.

Requirement that IPA's be Legal Entities

Existing Law: Defines the term "individual practice association" (IPA) to mean "a partnership, corporation, association, or other legal entity . . .". Section 1302(5) of existing law.

House Bill: No change in existing law except to the extent that the use of the contracting authority allows HMOs to avoid using IPAs entirely.

Senate Amendment: Redefines an IPA to mean "a partnership, corporation, association, or an entity . . .". Section 3 of S. 1926.

Conference Substitute: Conforms to the House bill, a position consistent with the Conference compromise allowing HMOs to contract for professional services with health professionals under certain conditions.

Requirement That Employers Offer Employees a Choice of Types of HMO's in Which to Enroll

Existing Law: Requires employers to offer their employees the option of membership in at least one qualified HMO which provides

basic health services through professionals who are members of the staff of the organization or of one or more medical groups, and at least one HMO which provides services through one or more individual practice associations (if at least one of each type is engaged in the provision of services in the area in which the employees of the employer reside). Section 1310(b) of existing law.

House Bill: Requires employers to offer their employees the option of membership in at least one HMO which provides its services without the use of an IPA and without the use of contracts (except for contracts for unusual or infrequently used services) with health professionals, and at least one HMO which provides its services using one or more IPAs, health professionals who have contracts with the HMO for their services, or a combination of the two. This amendment conforms section 1310(b) to the change in the number of different types of HMOs, which may qualify under the law, made by the amendments previously described, which allow contracting with health professionals and combining of different sources of staff services. Section 3(c) of H.R. 9019.

Senate Amendment: No comparable change (such a change is unnecessary in the context of S. 1926 which does not make the corresponding changes in allowable staffing for HMOs).

Conference Substitute: Conforms to the House bill, a position consistent with the Conference compromises allowing HMOs to contract with health professionals and to combine different sources of staff services.

Income Pooling in Medical Groups

Existing Law: Requires the members of medical groups to pool their income from practice as members of the group and distribute it among themselves according to a prearranged salary or drawing account or other plan. Section 1302(4)(C)(ii) of existing law.

House Bill: No change.

Senate Amendment: Requires the members of medical groups to pool their income from practice as members of the group and distribute it among themselves according to a prearranged salary or drawing account or other *similar* plan *unrelated to the provision of specific health services.* Section 7(b) of S. 1926.

Conference Substitute: Conforms to the Senate amendment because this provision is seen as specifying and clarifying the law's original intent while adding flexibility to the ways in which that intent can be achieved by allowing "similar" plans to those described.

Requirement That Professionals Not Know Members' Enrollment Status

Existing Law: No requirement (see section 1302(4)).

House Bill: No requirement.

Senate Amendment: Requires the members of medical groups to establish an arrangement whereby an individual's enrollment status is not known to the health professional who provides health services. Section 7(c) of S. 1926.

Conference Substitute: Conforms to the Senate amendment because the feasibility of the practice has been demonstrated and it assists in assuring equitable treatment for members of an HMO by assuring that those who serve them do not know the source of their payment.

OPEN ENROLLMENT

Existing Law: Requires HMOs to have an open enrollment period, of not less than 30 days at least once during each consecutive year, during which they accept, up to their capacity, individuals in the order in which they apply for enrollment. The Secretary is authorized to waive compliance with the open enrollment requirement for not more than three consecutive years, and to provide additional waivers, if the HMO demonstrates to the satisfaction of the Secretary that:

(a) It has enrolled or will be compelled to enroll a disproportionate number of individuals who are likely to use its services more than the average and that such enrollment would jeopardize its economic viability, or

(b) If it maintained the required open enrollment period it would not be able to comply with the requirement that HMOs enroll persons who are broadly representative of the various age, social and income groups within its service area.

Section 1301(e)(4) of existing law.

House Bill: Eliminates the open enrollment requirement. Section 4 of H.R. 9019.

Senate Amendment: Replaces the existing open enrollment requirement with a modified one which, effective on the date of enactment, would require HMOs which:

(a) have been in existence for a period of five years or have an enrollment of 50,000 members, and

(b) for the most recent fiscal year did not incur a financial deficit,

to have an open enrollment period of not less than 30 days at least once during each year during which period they accepted individuals in the order in which they applied for enrollment without regard to preexisting illness, medical condition, or degree of disability.

HMOs would not be required to comply with the open enrollment requirement, if they had enrolled a number of individuals during each year in excess of 4 percent of their total net increase in enrollment during the preceding calendar year. In determining total net increases in enrollment, individuals who had enrolled in the HMO through a group which had an existing contract for health services with the HMO at the time that it became qualified under section 1310 would not be included among those considered as having enrolled in the preceding calendar year.

The open enrollment requirement notwithstanding, an HMO would not be required to enroll individuals who are, at the time of their application, confined to an institution because of chronic illness, permanent injury, or other infirmity which would cause economic impairment to the HMO if such individual were enrolled. HMOs would not be required to make the effective date of benefits for individuals enrolled under the open enrollment less than 90 days after the date of enrollment. The Secretary would be authorized to waive the requirement for open enrollment if the HMO demonstrated that compliance with its provisions would jeopardize its economic viability in the serve area which it served. Section 4 of S. 1926.

Conference Substitute: Contains a compromise which generally conforms to the Senate amendment except to provide that HMOs would

not be required to continue to comply with the open enrollment requirement if they had enrolled during the enrollment period a number of individuals equal to three percent of their total net increase in enrollment during the preceding calendar year. The compromise maintains the principle of open enrollment but sets a standard which HMOs believe is realistic and feasible to meet without jeopardizing their economic viability.

BASIC AND SUPPLEMENTAL HEALTH SERVICES

Alcohol and Addiction Services

Existing Law: Requires HMOs to offer as basic health services "medical treatment and referral services (including referral services to appropriate ancillary services) for the abuse of or addiction to alcohol and drugs". Section 1302(1)(E) of existing law.

House Bill: Drops alcohol and addiction services from the required basic health services and adds to the optional supplemental health services "referral services and medical treatment for the abuse of or addition to alcohol or drugs". Section 5(a) of H.R. 9019.

Senate Amendment: No comparable change.

Conference Substitute: Conforms to the Senate amendment and existing law because of indications that provision of alcohol and addiction services as part of basic services is not an economic burden on the HMO.

Preventive Health Services

Existing Law: Requires HMOs to offer as basic health services preventive health services (including voluntary family planning services, infertility services, preventive dental care for children, and children's eye examinations conducted to determine the need for vision correction). Section 1302(1)(H) of existing law.

House Bill: Amends the required preventive health services to omit preventive dental care for children, and to add, to those specified as included, immunizations, well child care from birth, periodic health evaluations for adults, and children's ear examinations conducted to determine the need for hearing correction. Section 5(a) of H.R. 9019.

Senate Amendment: Limits prevents health services to those specified, rather than merely specifying certain services which must be included in the preventive health services offered. Omits from preventive health services preventive dental care for children and adds to those specified immunizations, well child care from birth, and periodic health evaluations for adults. Section 5(a) of S. 1926.

Conference Substitute: Conforms to the House bill.

COMMUNITY RATING

Waiver of Community Rating

Existing Law: Requires HMOs to fix the payment for basic health services, and for supplemental health services whose payments are fixed on a prepayment basis, under a community rating system. No waiver or delay of the applicability of this requirement is provided. Section 1301(b) (1) and (2) of existing law.

House Bill: Provides that the requirement that basic and supplemental health services payments be fixed under a community rating system shall not apply until five years after the date on which the HMO becomes qualified under section 1310. Section 6(a) of H.R. 9019.

Senate Amendment: Provides that for any entity which, on the date of enactment, is providing comprehensive health services as a prepaid group practice, or otherwise providing comprehensive health services on a prepaid basis, the requirement that basic health services payments be fixed under a community rating system shall not apply until three years after the date of enactment. No waiver is provided for the requirement for community rating of supplemental health services payments. Section 6(a) of S. 1929.

Conference Substitute: Contains a compromise which generally conforms to the Senate amendment but provides that the four year postponement of the requirement for use of a community rating system apply to supplemental as well as basic health services, and similarly allows the Secretary to waive the community rating requirement for supplemental as well as basic health services. The compromise recognizes that existing, prototype HMOs which have not been community rating, or have community rated but not in the fashion required by the existing law, need time to come into compliance with the requirement, while new HMOs have generally been able to comply with it.

Variation in Community Rates

Existing Law: Provides only for the following differentials in rates of payment established under community rating systems:

(a) nominal differentials which reflect the different administrative costs of collecting payments from different categories of members, and

(b) differentials for members enrolled in an HMO under a Federal, State or local health benefits plan.

Section 1302(8) of existing law.

House Bill: No change.

Senate Amendment: Provides in addition for differentials in community rates which reflect the distribution or compositing of the rates of payment in a systematic and uniform manner to accommodate group purchasing practice of the various employers. Section 6(c) of S. 1926.

Conference Substitute: Conforms to the Senate amendment, except that the system is not required to be uniform so that three step rates are possible.

INCREASES IN LIMITS ON FEDERAL FINANCIAL ASSISTANCE

Limits on Feasibility Surveys

Existing Law: Limits the amount of Federal assistance under a grant or contract for a feasibility survey to $50,000 in each year. Section 1303(e) of existing law.

House Bill: No change.

Senate Amendment: Increases the limit to $75,000 in each year. Section 8(e) of S. 1926.

Conference Substitute: Conforms to the Senate amendment, because the experience of the existing program, with the effects of inflation since the original enactment of the HMO Act, is that $50,000 is often an inadequate amount for a satisfactory feasibility survey. Since feasibility surveys are effectively weeding impossible HMOs out and preventing their receiving more expensive planning grants, a satisfactory feasibility survey is recognizably a wise investment on the part of the Federal government.

Limits on Planning Projects

Existing Law: Limits the amount of Federal assistance for planning projects to $125,000 in each year. Section 1304(f)(1)(A) of existing law.

House Bill: No change.

Senate Amendment: Increases the limit to $200,000 in each year. Section 6(e) of S. 1926.

Conference Substitute: Conforms to the Senate amendment, because the present limit on planning projects, $125,000 a year, is substantially less than the present limit on the next stage in the development process, initial development with a limit of $1 million, and the Department has found that with a slightly higher limit on planning projects it can more reliably decide which projects do, and which do not, require the larger investment of initial development funds. Increasing these limits does not increase the total authorization for the program, or the amount which the Department must in fact give to HMOs since the amount of grants is discretionary.

Limits on Initial Development Projects

Existing Law: Limits the amount of Federal assistance for initial development projects to the lesser of $1,000,000 or 90 percent of the project's cost (unless the project will serve a medically underserved population in which case the limit is 100 percent of projected costs). Section 1304(f)(2) of existing law.

House Bill: No change.

Senate Amendment: Increases the limit to $2,000,000 in the case of a project where an HMO will provide services to an additional service area (as defined by the Secretary) or which will provide services in one or more areas which are not contiguous. Section 6(e) of S. 1926.

Conference Substitute: Contains a compromise which increases the limit to $1,600,000 in the case of a project where a qualified HMO will provide services to an additional service area or in one or more areas which are not contiguous because such increase may be necessary in view of inflation in costs.

Limits on Initial Operations Loans

Existing Law: Limits the number of years of Federal assistance for initial operation of HMOs to three: the amount of loans which may be made or guaranteed in any one year to $1,000,000 and the total amount of loans which may be made or guaranteed to $2,500,000. Section 1305 (a) and (b) of existing law.

House Bill: No change.

Senate Amendment: Increases the total amount of loans which may be made or guaranteed to $5,000,000 during a period not to exceed five years, but does not change the $1,000,000 annual limit, or the three

year limit on the period for which assistance may be made available for operating costs. Section 6(e) of S. 1926.

Conference Substitute: Contains a compromise which retains the existing annual limit of $1,000,000 in loan assistance and the existing $2,500,000 total limit on loan assistance, but extends the period for which loans may be made available from three to five years, because program experience has demonstrated that few HMOs need more than the existing maximum amount of loan assistance but that a reasonable number need to spread the availability of the $2,500,000 over a longer period than the existing three year limit.

EARMARKS FOR HMO'S WHICH WILL SERVE NONMETROPOLITAN AREAS

Existing Law: Requires that 20 percent of the funds appropriated in any fiscal year for feasibility surveys, planning projects, and initial development projects be set aside for projects which the Secretary determines may reasonably be expected to draw not less than 66 percent of their membership from residents of non-metropolitan areas. Sums thus set aside during fiscal years 1974 and 1975, but not obligated for lack of applicants, are to remain available in the succeeding fiscal year for projects which need not serve non-metropolitan areas. Sections 1303(i) and 1304(k) of existing law.

House Bill: No change.

Senate Amendment: Deletes reference to fiscal years 1974 and 1975 so that funds set aside in any fiscal year for projects to serve non-metropolitan areas will be available in the succeeding fiscal year for projects which need not serve such areas. Section 9(d) of S. 1926.

Conference Substitute: Contains a compromise which generally adopts the provisions of the Senate amendment, but requires that projects located in non-metropolitan areas have priority for receipt of funds carried over to a succeeding fiscal year.

DUAL CHOICE

Service Area

Existing Law: Requires employers of more than 25 employees to offer in any health benefits plan offered to their employees the option of membership in qualified HMOs which are engaged in the provision of basic and supplemental health services in the areas in which such employees reside. Section 1310(a) of existing law. Existing law refers on several occasions to the area served by an HMO but does not define such an area.

House Bill: Requires employers who employ more than 25 employees to offer in any health benefits plan offered to their employees the option of membership in qualified HMOs which are engaged in the provision of basic health services in health maintenance organization service areas in which at least 25 of such employees reside. Does not define such service areas. Section 9(a) of H.R. 9019.

Senate Amendment: Makes a comparable revision and also defines "service area" for the purposes of the dual choice section (section 1310) to mean a "defined geographic area within which those basic health services, included in section 1301 of the Act, are easily and conveniently accessible to each member of an HMO". Section 10(l) of S. 1926.

Conference Substitute: Conforms to the House bill without definition of "service area" because existing law refers to HMO service areas without defining them and this has not caused difficulty to date.

Penalties for Violation of Section 1310

Existing Law: Specifies that failure of any employer to comply with the requirements of section 1310 shall be considered a willful violation of section 15 of the Fair Labor Standards Act of 1938. Section 1310(c) of existing law.

House Bill: Deletes the existing penalty provision and substitutes a new one which provides that any employer who knowingly does not comply with one or more of the requirements of section 1310(a) shall be subject to a civil penalty of not more than $10,000. If such noncompliance continues, civil penalty may be assessed and collected for each thirty day period of noncompliance. Each penalty may be assessed by the Secretary and collected in a civil action brought by the U.S. in a U.S. District Court. In any proceeding to assess a civil penalty, no penalty is to be assessed until the employer charged shall have been given notice and an opportunity to present its views on the charges. In determining the amount of the penalty, or the amount agreed upon in compromise, the Secretary is to consider the gravity of noncompliance and the demonstrated good faith of the employer charged in attempting to achieve rapid compliance after notification by the Secretary. In any civil action brought to review the assessment of a civil penalty the Court is to, at the request of any party to the action, hold a trial *de novo* on the assessment of the penalty. In any civil action to collect such a penalty, the Court is to, at the request of any party to the action, hold a trial *de novo* on the assessment of the penalty unless in a prior civil action to review the assessment of such penalty the court held a trial *de novo* on the assessment. Section 9(a)(3) of the H.R. 9019.

Senate Amendment: Contains a similar new penalty provision except that:

1. Violations need not be "knowing".
2. No indication is given that the amount of a penalty may be agreed upon in compromise.
3. Court review may be obtained by any person against whom a violation is found and a penalty assessed in the Court of Appeals of the U.S. for the circuit in which such person resides or has his principle place of business, or in the U.S. Court of Appeals for the District of Columbia, by filing a notice of appeal in the court within thirty days from date of the assessment and by simultaneously sending a copy of the notice to the Secretary. The Secretary is to promptly file in such court a certified copy of the record upon which the violation was found and the penalty assessed as provided in section 2112 of title 28, U.S.C. If any person fails to pay assessment of a civil penalty, after it has become final or after the appropriate Court of Appeals has entered final judgment in favor of the Secretary, the Secretary is to recover the amount assessed in the appropriate District Court of the U.S. In such action, the validity and appropriateness of the final order imposing the civil penalty is not to be subject to review.

Section 10(3) of S. 1926.

Conference Substitute: Conforms to the House bill.

Exemptions of Churches From the Requirements of Section 1310

Existing Law: Exempts only employers who employ an average of fewer than 25 persons from the effects of section 1310.

House Bill: Adds exemption for the Government of the U.S., the District of Columbia or any territorial possession of the U.S., or any agency or instrumentality (including the U.S. Postal Service and the Postal Rate Commission) of any of the foregoing governments. Section 9(a)(3) of H.R. 9019.

Senate Amendment: Provides similar exemptions and also exempts a church, convention or association of churches, or any organization operated, supervised or controlled by a church, convention or association of churches which organization is included within the provisions of section 501(c)(3) of the Internal Revenue Code; provided, however, that any such entity may not discriminate—

(i) in the employment, promotion or termination of employment of any personnel, or

(ii) in the extension of staff or other privileges to any physician or other health personnel,

because such persons seek to obtain health care, or participate in providing health care through an HMO. Section 10(c) of S. 1926.

Conference Substitute: Conforms to Senate amendment with the addition or a requirement that exempt church organizations do not discriminate in the compensation of personnel because they use an HMO. Compensation in this case should be understood to include fringe and other indirect benefits of employment as well as direct compensation.

Administration of Section 1310

Existing Law: Leaves administration of section 1310 discretionary with the Secretary of HEW. Section 1310 of existing law.

House Bill: No change.

Senate Amendment: Requires that the duties and functions of the Secretary, when they involve determining whether an HMO is qualified within the meaning of subsection 1310(d), be administered through the Assistant Secretary for Health in the Office of Assistant Secretary for Health, and that the administration of such duties and functions be integrated with the administration of section 1312(a) (providing for continued regulation of HMOs). Section 10(3) of S. 1926.

Conference Substitute: Conforms to the Senate amendment, because the Department of Health, Education, and Welfare is presently administering qualification activities in conjunction with the administration of section 1312(a) in this manner, and to this extent acceptance of the Senate amendment reflects the existing situation, and because existing law already requires the administration of section 1312(a) to be located in the Office of the Assistant Secretary for Health, a requirement of the existing law which has always been flouted. The conferees expect that with passage of these amendments such an office will be established and adequately staffed.

FEDERAL EMPLOYEE HEALTH BENEFITS PROGRAM

Existing Law: Applies the dual choice requirements of section 1310 to the Federal government as an employer. Section 1310 of existing law.

House Bill: Exempts the Federal government from the requirements of section 1310 as an employer but amends the authority for the Federal employee's health benefits program, section 8902 of title 5, U.S.C., to require the Civil Service Commission to contract for a Federal employee health benefits plan with any qualified health maintenance carrier which offers such a plan. A qualified health maintenance carrier is defined as a qualified carrier (within the meaning of the Federal employees health benefits program) which is a qualified HMO within the meaning of section 1310(d) of the HMO Act. Section 9(b) of H.R. 9019, page 19 of the comparative print.

Senate Amendment: No comparable change.

Conference Substitute: Conforms to the House bill, because it is an appropriate way to effectively extend general policy relating to dual choice to Federal employees.

ENFORCEMENT OF REQUIREMENTS OF HMO'S

Existing Law: Requires the Secretary to undertake continuing regulation of HMOs and, for any HMO which fails to provide basic and supplemental health services, fails to provide services in the manner prescribed by section 1301(b) or is not organized and operated in the manner prescribed by section 1301(c), authorizes the Secretary (in addition to any other remedies available to him) to bring civil action in the U.S. District Court in which the HMO is located to enforce its compliance with assurances given in connection with receipt of assistance under the Act. Section 1312(a) of existing law.

House Bill: Revises the enforcement procedures under section 1312 to provide for formal notice to HMOs which fail to comply with the Act's requirements, and require loss of qualification under section 1310 and notification of parties affected by any failure by the HMO to comply with the law's requirements. Section 10 of H.R. 9019.

Senate Amendment: Makes similar revisions and in addition provides that an enrollee of an HMO may (in addition to any other remedy available to him) bring a civil action, notwithstanding the amount in controversy, in the U.S. District Court in which the HMO is located to enforce its compliance with assurances it furnished him, directly or indirectly, respecting the provision of basic and supplemental health services. Section 11 of S. 1926.

Conference Substitute: Conforms to the House bill. The Conferees noted that the resolution of these issues in this manner does not change any existing right of individuals to bring suit in State courts. Further, they agreed to examine the frequency and outcome of such suits when the program is next considered.

AUTHORIZATIONS OF APPROPRIATIONS

Authorizations of appropriations for HMO development are found in section 1309(a) and 1305(d) of existing law, section 12 of H.R. 9019, section 13 of S. 1926, and section 113 of the Conference substitute.

TABLE 1.—AUTHORIZATION OF APPROPRIATIONS FOR HMO DEVELOPMENT

[In millions of dollars]

	1976	1977	1978	1979	Total
Existing law	85	[1] 85			170
House bill	45	45	40	[1] 40	170
Senate amendment	40	55	70	85	250
Conference substitute	40	45	45	[1] 50	180

[1] Available only for initial development purposes.

RESTRICTIVE STATE LAWS

Notification of Preemption

Existing Law: No provision. Section 1311 of existing law.

House Bill: Requires the Secretary, within six months of the date of enactment, to notify the Governor of each State of each requirement or law which the Secretary determines the State imposes or has in effect to which section 1311 applies. Section 13(c) of H.R. 9019.

Senate Amendment: Requires the Secretary to develop, through grants or contracts, a digest of State laws and regulations pertaining to development, establishment and operation of HMOs which is to be updated at least quarterly and relevant sections of which are to be provided to the Governor of each State annually. The Secretary is also to assure that appropriate legal consultative assistance is available to the States for the purposes of complying with the provisions of section 1311. Section 11(d) of S. 1926.

Conference Substitute: Contains a compromise which generally conforms to the Senate amendment with the addition of the six month deadline for action on the part of the Secretary included in the House bill, and a requirement that the information which the Secretary provides to the Governors contains an indication of which State laws and practices appear to be inconsistent with the preemption of State laws and practices contained in section 1311.

Enforcement of Provisions Respecting Restrictive State Laws and Practices

Existing Law: States that specified State laws and practices shall not apply to entities seeking to operate as HMOs so as to prevent them from operating as HMOs in accordance with section 1301, but does not provide any mechanism for assuring that States will not apply such laws or practices. Section 1311 of existing law.

House Bill: No change.

Senate Amendment: Provides that an interested party may bring a civil action (notwithstanding the amount in controversy) in the U.S. District Court in which the HMO is located to enforce the provisions of section 1311. The District Court is authorized to award reasonable attorney's fees to a plaintiff for an action brought under section 1311, as amended. Section 11(d) of S. 1926.

Conference Substitute: Conforms to House bill.

PROGRAM EVALUATION BY THE COMPTROLLER GENERAL

Existing Law: Requires the Comptroller General to evaluate the operation of at least 50 HMOs for which financial assistance was pro-

vided under the Act and which have been in operation for at least 36 months. The Comptroller General is to report the results of such evaluation not less than 90 days after at least 50 such HMOs have been in operation for at least 36 months. Section 1314(a) of existing law.

House Bill: Requires the Comptroller General to evaluate the operation of at least 10 or one-half, whichever is greater, of the HMOs which have received financial assistance under the Act, and which have qualified as HMOs under section 1310 by December 31, 1976. The Comptroller General is to report the results of such evaluation by June 30, 1977. Section 16 of H.R. 9019.

Senate Amendment: Makes a similar change, except that the Comptroller General's report is to be made by the end of June 30, 1978. Section 17 of S. 1926.

Conference Substitute: Conforms to the Senate amendment.

TREATMENT OF HMO'S UNDER MEDICARE

Definition and Requirements of an HMO

Existing Law: Title XVIII of the Social Security Act defines and sets forth requirements for HMOs for the purposes of title XVIII without reference to the definition of an HMO found in title XIII of the PHS Act. The definition and requirements in title XVIII are, however, generally comparable to those in title XIII except that:

(1) The services required are those covered under Parts A and B of title XVIII rather than the basic health services.

(2) Physicians' services are to be provided primarily either directly through physicians who are employees or partners of the HMO or under arrangements with groups of physicians (whether organized on a group practice or individual practice basis) who are prepaid by the HMO, rather than by physicians who are either on the staff of the HMO, in a medical group or in an individual practice association.

(3) The definition specifically requires the HMO to provide both primary care and specialty care physicians for its members and defines a "specialty care physician".

(4) At least half of the members of the HMO are to be under age 65 (with a three year waiver provided for making the transition to meet this requirement).

(5) The institutions, entities, or persons who provide the covered service to Medicare beneficiaries, either directly or under arrangements, must meet Medicare definitions and requirements.

(6) Provision is made for enrollment of not only beneficiaries eligible for benefits under both Part A and Part B of Medicare, but for those eligible only for Part B benefits.

(7) The HMO premium rate or other charge to Medicare enrollees is based on the actuarial value of the Medicare deductible plus any coinsurance (rather than community-rated as under title XIII).

(8) HMOs participating in Medicare are not required to assume full financial risk; rather, payment to the HMOs is made either on a reasonable cost basis or under a special risk formula.

(9) Payments for out-of-area services are made directly to the institution, entity, or person who furnished the service (rather than through the beneficiary as under title XIII).

(10) There is no provision for waiver of the open enrollment requirement.

Section 1876(b) of title XVIII of the Social Security Act.

House Bill: No change.

Senate Amendment: Amends the definition and requirements of an HMO in section 1876(b) to rely upon, by cross reference, the definition and requirements of an HMO in title XIII of the PHS Act, except to specify that the services which the HMO must provide are those covered in Parts A and B of title XVIII rather than the basic health services defined in title XIII. The requirements of existing law (subparagraphs (4)–(10) above) which are additional to those in title XIII are preserved. The requirements for physicians' services are eliminated in deference to those in title XIII and the requirement for provision of primary and specialty care physicians is eliminated outright. Section 14 of S. 1926.

Conference Substitute: Conforms to the Senate amendment. The issues were discussed with both the House Committee on Ways and Means and Senate Committee on Finance. The Senate amendment was acceptable to all concerned; because it creates desirable uniformity in HMO policy and administration.

Administration

Existing Law: Makes no specific provision for the administration of the HMO provisions in title XVIII of the Social Security Act.

House Bill: No change.

Senate Amendment: Requires the Secretary to administer determinations of whether an organization is an HMO within the meaning of the amended definition in section 1876 through the Assistant Secretary for Health and in the Office of the Assistant Secretary for Health, and to administer the making of such determinations in an integrated fashion with the administration of section 1312 (a) and (b) of the PHS Act (concerning continued regulation of HMOs). Further specifies that the administration of the remainder of section 1876 shall be done through the Commissioner of Social Security. Section 14(a) of S. 1926.

Conference Substitute: Conforms to the Senate amendment.

Requirements Respecting Reinsurance Costs

Existing Law: Requires that each contract with an HMO under section 1876 provide that no reinsurance costs (other than those with respect to out-of-area services) including any underwriting of risk relating to costs in excess of adjusted average per capita cost, as defined in clause III of section 1876(a)(3)(A), shall be allowed for purposes of determining payment, authorized under section 1876. Section 1876 (i)(6)(B) of the Social Security Act.

House Bill: No change.

Senate Amendment: Strikes the requirement. Section 14(c) of S. 1926.

Conference Substitute: Contains a compromise which in general conforms to existing law, but is made consistent with the policy of reinsurance in existing title XIII of the PHS Act, by allowing HMOs at risk under title XVIII to reinsure for out-of-area and catastrophic costs.

TREATMENT OF HMO'S UNDER MEDICAID

Definition of an HMO

Existing Law: Title XIX of the Social Security Act does not include (or define) the term "health maintenance organization". However, provision is made in the law for contracts by the State with an organization which has agreed to provide care and services to individuals and allows such an organization to provide care and services in addition to those in the State Medicaid plan to its enrollees without violating the legal requirement that covered program services must be offered on a Statewide basis. Additionally, program regulations allow for State contracts for services on a paid capitation basis, which may be on a risk basis, and includes health maintenance organizations as potential contractors for services.

House Bill: No change.

Senate Amendment: Provides a definition of an HMO in Medicaid which relies upon, by cross reference, the definition of an HMO in section 1301 of the PHS Act, except to specify that for purposes of title XIX "basic health services" means the following mandatory Medicaid services: inpatient hospital services, outpatient hospital serviecs, other laboratory and X-ray services, family planning services, and physicians' services. The amendment also provides that an HMO under title XIX may have no more than a half of its enrollees who are either covered under Medicare or recipients of Medicaid, except that the Secretary may waive this requirement for up to three years if the organization demonstrates that it is making progress toward meeting the requirement. Section 15 of S. 1926.

Conference Substitute: Conforms to the Senate amendment with a technical correction to include home health services since they are a required service under title XIX. The amendment was agreed to because it will provide uniformity in policy in the major public health financing programs.

Administration

Existing Law: No provision.

House Bill: No change.

Senate Amendment: Requires the Secretary to administer determinations as to whether an organization is an HMO within the meaning of the new definition in Medicaid through the Assistant Secretary for Health and in the Office of the Assistant Secretary for Health, and to administer the making of such determinations in an integrated fashion with the administration of sections 1312 (a) and (b) of the PHS Act (concerning continued regulation of HMOs). Allows a State to make a provisional determination for purposes of its Medicaid program that an organization is an HMO where (1) the organization has applied to the Secretary to become a qualified HMO under section 1310(d) of the Public Health Service Act and (2) no determination has been made within 90 days. The provisional determination by the State remains in effect until the Secretary makes a determination. Section 15 of S. 1926.

Conference Substitute: Conforms to the Senate amendment because it assures uniformity in application of policy.

Prohibition on Payments to Other Organizations Providing Service on a Prepaid Risk Basis

Existing Law: No provision. Title XIX regulations allow States to contract for services with organizations on a prepaid capitation at-risk basis.

House Bill: No change.

Senate Amendment: The intent of the Senate amendment is to eliminate Federal matching funds under title XIX for State expenditures incurred for payment for services of an organization which provides on a prepaid capitation at-risk basis inpatient hospital services and any other mandated Medicaid service, or any three other Medicaid services, unless the organization either

(a) has qualified as an HMO, or

(b) has received a grant as a community health center or a migrant health center of $100,000 or more in fiscal year 1976 and a similar grant in subsequent fiscal years, and

(c) provides on a prepaid capitation at-risk basis inpatient and outpatient hospital services, laboratory and x-ray services, family planning services, and physicians' services.

Section 15 of S. 1926.

Conference Substitute: Contains a compromise which conforms to the Senate amendment but (1) delays the effective date for the provision for existing contracts for one year, or until the contract is renegotiated, whichever is earlier, and (2) adds two additional exceptions to the requirement that Federal matching be available for services provided by an organization providing hospital services and any other mandated Medicaid service, or any three other Medicaid services, on a prepaid risk basis only if that organization is determined to be an HMO. The additional exceptions are:

(1) The requirement will not apply to an organization which is a nonprofit primary health care entity located in a rural area which received a grant (or subgrant or subcontract) of $100,000 or greater under the Appalachian Regional Development Act in fiscal 1976, and in each year thereafter either continued to receive such grant or provided services under contract on a risk basis for title XIX recipients (this parallels the exception for community health centers and migrant health centers already contained in the Senate amendment);

(2) The requirement will not apply to an organization which has contracted for the provision of services (but not including inpatient hospital services) to persons eligible under title XIX on a prepaid risk basis prior to 1970.

The Conferees generally supported the Senate amendment because of the need for increased Federal oversight of arrangements under title XIX for services provided on a prepaid risk basis. The Conferees were concerned, however, that the provision should not preclude primary health care organizations receiving funds from the Appalachian Regional Commission, such as the Mountain Trails Health Plan in Middlesboro, Kentucky, from serving Medicaid recipients on a risk basis, or prevent continuing risk contracts with organizations, such as the Health Insurance Plan in New York City, which have had a long-standing contractual relationship to provide services to Medicaid re-

cipients on a prepaid risk basis. This concern was the source of the two changes in the Senate amendment agreed to by the Conferees. Additional concern was expressed about the impact of the change brought about by the Senate amendment on existing demonstration projects, such as the one underway in Newark, New Jersey. Since the demonstration project authority in section 1115 of the Social Security Act is unchanged by the amendment, and continues to allow the requirements of section 1902 to be waived and the requirements of section 1903 to be overridden in determining expenditures of sec- Federal matching, these demonstration projects, and other projects which are designed as legitimate demonstrations of new and previously undemonstrated ways to deliver health care more effectively to Medicaid recipients, would not be endangered.

RELATIONSHIP BETWEEN HMO'S AND HEALTH PLANNING PROGRAMS

Applicability of Certificate of Need

Existing Law: Specifically includes HMOs in the definition of "institutional health services" in section 1531(5) of the PHS Act. This subjects HMOs by law to the certificate of need process required by title XV in every State.

House Bill: No change.

Senate Amendment: Deletes reference to HMOs from the definition of institutional health services. This has the effect of subjecting those specific services of HMOs which are institutional health services as defined in regulations of the Secretary to certificate of need but not the specific services of HMOs which are not institutional health services nor the establishment of the HMO itself. Section 16(a) of S. 1926.

Conference Substitute: Conforms to the House bill. The Conferees noted that the entire subject of certificate of need for outpatient and ambulatory services in both prepaid and fee-for-service settings will be considered next year when P.L. 93–641 is reviewed for extension. Thus it was felt that it would be more appropriate to deal with inclusion of HMOs under the requirements of the planning act at that time.

Consistency in Procedures and Criteria

Existing Law: Section 1306(c) of the PHS Act requires the Secretary to establish standards and procedures for areawide and State health planning agencies to follow in reviewing HMO applications for assistance under title XIII. Section 1532 requires areawide and State health planning agencies to follow procedures and criteria, developed and published in accordance with regulations, which criteria are to include criteria respecting the special needs and circumstances of HMOs for which assistance is available under title XIII.

House Bill: No change.

Senate Amendment: Requires the criteria established by areawide and State health planning agencies under section 1532(c) to be consistent with standards and procedures established by the Secretary under section 1306(c). Section 16(b) of S. 1926.

Conference Substitute: Conforms to the Senate amendment, because although the procedures and criteria required of health planning programs by P.L. 93–641 were required to include special consideration of the needs and circumstances of HMOs, this provision was not enlarged

upon or specified in any way in regulations published by HEW. The Senate amendment would assist in correcting this situation because the standards and procedures established by the Secretary under section 1306(c) would be the responsibility of the HMO program rather than the health planning program.

Specification of criteria for HMOs is of critical importance because projects for the development and expansion of HMOs and their services should be judged on the basis of the need for HMOs and the need for their services for their enrolled members and reasonably anticipated new members and not on the need for the services in general if proposed by non-HMO providers.

Thus, in considering requests for new HMOs or the expansion of existing ones, the State agency and the health system agency should consider:

1. The number of HMOs of the same type in the area,
2. The number of persons in the area enrolled in qualified HMOs of the same type, and
3. The percentage of major employers and all employers of over 25 employees in the area which offer or will offer qualified HMOs as benefits for their employees.

In considering requests by HMOs to provide or arrange for new institutional health services, the agencies should consider whether the proposed service is available from non-HMO providers in a reasonable and cost-effective manner which is consistent with the basic method of operation of the HMO. In making such a determination, the agencies should consider:

1. Whether the alternative service would be more costly to the members of the HMO.
2. Whether the alternative service would be available to the members of the HMO on a long-term basis, and
3. Whether the alternative service would be available and conveniently accessible through physicians and other health professionals associated with the HMO. (For example, whether physicians associated with the HMO are granted full staff privileges at the hospital which is proposed to provide the alternative services.)

Proposals to provide new institutional health services, after feasibility of an HMO has been demonstrated, should not be subject to redetermination, subsequent reviews, public hearings, etc., at later stages of activity, if the proposals are consistent with the basic objectives, schedule and plan of the earlier application approved by the HSA. Similarly, certificate of need determinations should be made during the planning stage of the HMOs development. This is to prevent up to $1 million of initial development funds being awarded only to have a certificate of need denied, or the need for an HMO questioned by antagonistic groups late in the HMO's developmental sequence.

REQUIREMENTS FOR PUBLIC HEARINGS ON THE PART OF THE SECRETARY

Existing Law: No requirement.

House Bill: No requirement.

Senate Amendment: Requires the Secretary to conduct public hearing within the area which will be served by an applicant for HMO

assistance within 30 days after the receipt of an application for a feasibility survey, planning project, or initial development project. In each case the Secretary is required to provide individual written notice of the hearing, giving information as to the nature and purpose of the application to all mayors or other appropriate government officials, hospital administrators, medical societies and public health planning agencies or councils within the area proposed to be served by the applicant. The notice is to be given not less than 10 days prior to the date of the hearing and parties so notified are to be requested to submit written or oral recommendations concerning the proposed grant or contract. Section 18 of S. 1926.

Conference Substitute: Conforms to the House bill.

CENTER FOR POLICY ANALYSIS

Existing Law: No requirement.

House Bill: No requirement.

Senate Amendment: Adds a requirement for funding of an additional national special emphasis center to the two already required by section 305(d)(1) of the PHS Act (the authority for health services research and demonstrations). The required additional center is to be designated as the Health Services Policy Analysis Center and is to focus on the development and evaluation of national policies with respect to health services, including the development of HMOs and other forms of group practice, with a view toward improving the efficiencies of the health services delivery system. Section 21 of S. 1926.

Conference Substitute: Conforms to the Senate amendment. The Conferees noted that this Center should be chosen in accordance with the usual grant and contract review procedures applicable to this section to assure competence.

RECRUITMENT OF HEALTH PERSONNEL FOR HMO'S

Existing Law: Specifies some of the uses which financial assistance for initial development may be put to including the recruitment of personnel for HMOs and the conduct of training activities for them. Section 1304(b)(2)(D) of existing law.

House Bill: No change.

Senate Amendment: Changes the reference to recruitment to become the recruitment of personnel for "an HMO, medical group, or individual practice association who will provide health services through such organization, group or association". Section 22 of S. 1926.

Discussion and Staff Recommendation: Existing law has proved inflexible with respect to recruiting, particularly in rural areas, physicians who would work for either a medical group or individual practice association, rather than for an HMO itself. However, the argument has been made that it would be unreasonable to use Federal funds to recruit health professionals who might contribute only a small fraction of their time and services to the HMO under the terms of their agreement with the medical group or individual practice association.

Conference Substitute: Contains a compromise which conforms to the Senate amendment with a change specifying that funds may be used only for recruitment of personnel who will engage in practice principally for the HMO (thus requiring that over half of the time of people recruited using Federal funds be available for the purposes for which the Federal funds were made available).

HOME HEALTH SERVICES

Existing Law: P.L. 94–63, the Health Revenue Sharing and Health Services Act of 1975, includes authorization of appropriations for a one year demonstration grant program for home health services in fiscal year 1976. Section 602 of P.L. 94–63.

House Bill: No change.

Senate Amendment: Extends the one year demonstration grant program through the transitional quarter and fiscal year 1977 with a total authorization of appropriations of $15 million. Section 23 of S. 1926.

Conference Substitute: Conforms to Senate amendment.

The Conferees felt that a Senate one-year extension was appropriate, despite the fact that the original provision had been agreed to only as a "one year demonstration program", so that areas in which home health services are not otherwise available could be afforded the opportunity to develop new, or expand existing, home health agencies. There are over 600 counties within the United States containing over 58 million persons who are denied the benefits of home health services because there is no home health agency to provide that service. Further, many of the 2,264 home health agencies certified under Medicare provide only skilled nursing and one other service. This limited scope of home health services is particularly true in rural areas. The emphasis during the year of extended authorization should be on defining the kinds of home health services needed and the extent of the need, and building the capacity, in areas with a high percentage of elderly and medically indigent, to deliver home health service as defined under Title XVIII.

Cognizant of the concerns raised by the Congress during the passage of the initial home health authorization, the Conferees are encouraged by the recent efforts of the Under Secretary to achieve greater uniformity in the Medicaid and Medicare regulations, as they apply to home health services. The Conferees believe that the future of home health services is dependent in large measure upon the development of a consistent Federal approach to the establishment of and payment for these services.

In extending the current authorization, it is expected that the Secretary of HEW will use this opportunity to collect uniform data on the home health agencies which are funded through this provision. In addition, the Conferees strongly urge the Secretary of HEW to compile available data on the 2,264 home health agencies already in existence and to collect further information where necessary. Continuing Federal support for home health agencies requires that complete and accurate information be obtained from each home health agency concerning the number of individuals served, the number of visits provided, staffing patterns, the types of services provided, the unit cost of each service and the estimated number of hospital days saved by the service.

REGULATIONS

Existing Law: No provision.
House Bill: No provision.
Senate Amendment: Requires the Secretary to promulgate regulations under title XIII, and amendments made by the proposed legislation not later than 135 days after the date of enactment of the proposed legislation. Section 24 of S. 1926.
Conference Substitute: Conforms to House bill, because past experience with deadlines which have been included in law for the promulgation of regulations indicates that they have rarely been achieved, but the requirements are not enforced because of the lack of an effective enforcement mechanism. However, the Conferees specifically noted their dismay at the administration's inability to issue regulations within a reasonable period of time.

The Conferees recognize that many organizations have been working for some time to meet the requirements of the existing legislation and become qualified HMOs. Organizations who wish to qualify under existing regulations should therefore be allowed the opportunity to do so until regulations implementing the amendments are finalized since the existing requirements are more stringent than the new ones. However, the Conferees believe that HEW should issue provisional regulations as rapidly as possible to allow organizations to qualify pending final regulations under these amendments. The Conferees have noted the time left under this Act and find that it would be in the public interest to issue provisional regulations without notice of proposed rulemaking. Any organization which qualifies under such procedure would of course be required to resubmit its application upon the issuance of final regulations and to comply with them.

SEPARABILITY PROVISION

Existing Law: No provision.
House Bill: No provision.
Senate Amendment: Contains a separability provision providing that, if any provision of the proposed legislation or the amendments made by it or their application to any person or circumstances is held invalid, the remainder of the Act, its amendments and its application is not to be affected thereby. Section 25 of S. 1926.
Conference Substitute: Conforms to the House bill because the general provisions of U.S. law contain separability provisions which make the Senate provision unnecessary.

WATER TREATMENT PROGRAMS

Existing Law: No provision.
House Bill: No provision.
Senate Amendment: Authorizes the appropriation of $2 million for fiscal year 1977, $3 million for fiscal year 1978 and $4 million for fiscal year 1979 for grants (only in such instances where the applicant voluntarily requests such assistance) to States, political subdivisions of States and other public or nonprofit private agencies, organizations and institutions to assist them in initiating, in communities or in public elementary or secondary schools, water treatment programs designed to reduce the incidence of oral disease or dental defects among residents of such communities or the students of such schools. The grant funds are to be used for (but are not limited to) the purchase and installation of water treatment equipment. The grant amounts are not to exceed 80 percent of the cost of the treatment program. Section 26 of S. 1926.
Conference Substitute: Conforms to the House bill, because water treatment programs are more appropriately dealt with in separate legislation which the House Conferees expressed an intent to conduct hearings during the coming year.

EXTENSION OF REPORTING DATE FOR COMMITTEE ON MENTAL HEALTH AND ILLNESS OF THE ELDERLY

Existing Law: Section 603(b) of P.L. 94–63 requires a report within one year after the date of enactment from the required Committee on Mental Health and Illness of the Elderly.
House Bill: No change.
Senate Amendment: Changes the requirement from within one year to not later than two years. Section 27 of S. 1926.
Conference Substitute: Conforms to the Senate amendment, because the Committee on Mental Health and Illness of the Elderly has not yet been appointed. This delay necessitates extra time to prepare the report.

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H. R. 9019

Ninety-fourth Congress of the United States of America

AT THE SECOND SESSION

Begun and held at the City of Washington on Monday, the nineteenth day of January, one thousand nine hundred and seventy-six

An Act

To amend title XIII of the Public Health Service Act to revise and extend the program for the establishment and expansion of health maintenance organizations.

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

SHORT TITLE; REFERENCE TO ACT

SECTION 1. (a) This Act may be cited as the "Health Maintenance Organization Amendments of 1976".

(b) Whenever in title I an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.

TITLE I—AMENDMENTS TO TITLE XIII OF THE PUBLIC HEALTH SERVICE ACT

SUPPLEMENTAL HEALTH SERVICES

SEC. 101. (a) Section 1301(b)(1) is amended by adding at the end the following: "A health maintenance organization may include a health service, defined as a supplemental health service by section 1302(2), in the basic health services provided its members for a basic health services payment described in the first sentence.".

(b) The first sentence of section 1301(b)(2) is amended by striking out "the organization shall provide" and all that follows in that sentence and substituting "the organization may provide to each of its members any of the health services which are included in supplemental health services (as defined in section 1302(2)).".

(c) Section 1301(b)(4) is amended by striking out "and supplemental health services in the case of the members who have contracted therefor" and substituting "and only such supplemental health services as members have contracted for".

STAFFING

SEC. 102. (a)(1) The first sentence of section 1301(b)(3) is amended (A) by striking out "or through" and by substituting ", through", (B) by striking out "(or groups) or" and substituting "(or groups), through an", and (C) by inserting after "(or associations)" the following: ", through health professionals who have contracted with the health maintenance organization for the provision of such services, or through any combination of such staff, medical group (or groups), individual practice association (or associations), or health professionals under contract with the organization".

(2) Section 1301(b)(3) is amended by adding after the first sentence the following: "A health maintenance organization may also, during the thirty-six month period beginning with the month follow-

ing the month in which the organization becomes a qualified health maintenance organization (within the meaning of section 1310(d)), provide basic and supplemental health services through an entity which but for the requirement of section 1302(4)(C)(i) would be a medical group for purposes of this title. After the expiration of such period, the organization may provide basic or supplemental health services through such an entity only if authorized by the Secretary in accordance with regulations which take into consideration the unusual circumstances of such entity. A health maintenance organization may not, in any of its fiscal years, enter into contracts with health professionals or entities other than medical groups or individual practice associations if the amounts paid under such contracts for basic and supplemental health services exceed fifteen percent of the total amount to be paid in such fiscal year by the health maintenance organization to physicians for the provision of basic and supplemental health services, or, if the health maintenance organization principally serves a rural area, thirty percent of such amount, except that this sentence does not apply to the entering into of contracts for the purchase of basic and supplemental health services through an entity which but for the requirements of section 1302(4)(C)(i) would be a medical group for purposes of this title. Contracts between a health maintenance organization and health professionals for the provision of basic and supplemental health services shall include such provisions as the Secretary may require (including provisions requiring appropriate continuing education).".

(b)(1) Section 1302(4)(C) is amended (A) by striking out clause (iv), (B) by redesignating clause (v) as clause (iv), and (C) by inserting "and" at the end of clause (iii).

(2) Section 1302(5)(B) is amended (A) by striking out clause (i), and (B) by redesignating clauses (ii) and (iii) as clauses (i) and (ii), respectively.

OPEN ENROLLMENT

SEC. 103. (a) Section 1301(c) is amended by amending paragraph (4) to read as follows:

"(4) have an open enrollment period in accordance with the provisions of subsection (d);".

(b) Section 1301 is amended by adding at the end thereof the following:

"(d)(1)(A) A health maintenance organization which—

"(i) has for at least 5 years provided comprehensive health services on a prepaid basis, or

"(ii) has an enrollment of at least 50,000 members,

shall have at least once during each fiscal year next following a fiscal year in which it did not have a financial deficit an open enrollment period (determined under subparagraph (B)) during which it shall accept individuals for membership in the order in which they apply for enrollment and, except as provided in paragraph (2), without regard to preexisting illness, medical condition, or degree of disability.

"(B) An open enrollment period for a health maintenance organization shall be the lesser of—

"(i) 30 days, or

"(ii) the number of days in which the organization enrolls a number of individuals at least equal to 3 percent of its total net increase in enrollment (if any) in the fiscal year preceding the fiscal year in which such period is held.

For the purpose of determining the total net increase in enrollment in a health maintenance organization, there shall not be included any individual who is enrolled in the organization through a group which had a contract for health care services with the health maintenance organization at the time that such health maintenance organization was determined to be a qualified health maintenance organization under section 1310.

"(2) Notwithstanding the requirements of paragraph (1) a health maintenance organization shall not be required to enroll individuals who are confined to an institution because of chronic illness, permanent injury, or other infirmity which would cause economic impairment to the health maintenance organization if such individual were enrolled.

"(3) A health maintenance organization may not be required to make the effective date of benefits for individuals enrolled under this subsection less than 90 days after the date of enrollment.

"(4) The Secretary may waive the requirements of this subsection for a health maintenance organization which demonstrates that compliance with the provisions of this subsection would jeopardize its economic viability in its service area.".

DEFINITION OF SERVICES

SEC. 104. (a) (1) Paragraph (1) (H) of section 1302 is amended to read as follows:

"(H) preventive health services (including (i) immunizations, (ii) well-child care from birth, (iii) periodic health evaluations for adults, (iv) voluntary family planning services, (v) infertility services, and (vi) children's eye and ear examinations conducted to determine the need for vision and hearing correction).".

(2) Paragraph (1) of section 1302 is amended by striking out "or podiatrist" each place it occurs and substituting "podiatrist, or other health care personnel".

(b) Paragraph (2) of such section is amended—

(1) by striking out "under paragraph (1) (A) or (1) (H)" in subparagraphs (B) and (C);

(2) by striking out "and" at the end of subparagraph (E), by striking out the period at the end of subparagraph (F) and substituting "; and", and by adding after subparagraph (F) the following:

"(G) other health services which are not included as basic health services and which have been approved by the Secretary for delivery as supplemental health services.";

(3) by striking out "or podiatrist" each place it occurs and substituting "podiatrist, or other health care personnel".

COMMUNITY RATING

SEC. 105. (a) (1) Section 1301 (b) (1) is amended by adding at the end thereof the following new sentence: "In the case of an entity which before it became a qualified health maintenance organization (within the meaning of section 1310 (d)) provided comprehensive health services on a prepaid basis, the requirement of clause (C) shall not apply to such entity until the expiration of the forty-eight month period beginning with the month following the month in which the entity became such a qualified health organization.".

(2) The last sentence of section 1301(b)(2) is amended by inserting before the period the following: "except that, in the case of an entity which before it became a qualified health maintenance organization (within the meaning of section 1310(d)) provided comprehensive health services on a prepaid basis, the requirement of this sentence shall not apply to such entity during the forty-eight month period beginning with the month following the month in which the entity became such a qualified health maintenance organization".

(3) Section 1306(b) is amended (A) by striking out "and" at the end of paragraph (6), (B) by redesignating paragraph (7) as paragraph (8), and (C) by inserting after paragraph (6) the following new paragraph:

"(7) the application contains such assurances as the Secretary may require respecting the intent and the ability of the applicant to meet the requirements of paragraphs (1) and (2) of section 1301(b) respecting the fixing of basic health services payments and supplemental health services payments under a community rating system; and"

(b) Section 1302(8)(A) is amended by inserting "differences in marketing costs and" after "reflect".

(c) Subparagraph (B) of section 1302(8) is redesignated as subparagraph (C) and the following new subparagraph is inserted after subparagraph (A):

"(B) Nominal differentials in such rates may be established to reflect the compositing of the rates of payment in a systematic manner to accommodate group purchasing practices of the various employers.".

MEDICAL GROUP REQUIREMENTS

SEC. 106. (a) Section 1302(4)(C) is amended by striking out "(i) as their principal professional activity and as a group responsibility engage in the coordinated practice of their profession for a health maintenance organization" and substituting "(i) as their principal professional activity engage in the coordinated practice of their profession and as a group responsibility have substantial responsibility for the delivery of health services to members of a health maintenance organization".

(b) Section 1302(4)(C)(ii) is amended by striking out "plan" and substituting "similar plan unrelated to the provision of specific health services".

(c) 1302(4)(C) (as amended by section 102(b)(1)) is amended by—

(1) striking "and" before "(iv)", and

(2) striking the period at the end of subparagraph (C) and substituting "; and (v) establish an arrangement whereby a member's enrollment status is not known to the health professional who provides health services to the member.".

INCREASE IN LIMITS ON ASSISTANCE FOR FEASIBILITY SURVEYS, PLANNING, INITIAL DEVELOPMENT, AND INITIAL OPERATION

SEC. 107. (a) Section 1303(e) is amended by striking "$50,000" and substituting "$75,000".

(b)(1) Section 1304(f)(1)(A) is amended by striking "$125,000" and substituting "$200,000".

(2) Section 1304(f)(2)(A) is amended by inserting after "$1,000,000" the following: "or, in the case of a project for a health maintenance organization which will provide services to an additional

service area (as defined by the Secretary) or which will provide services in one or more areas which are not contiguous, $1,600,000".

(c) Section 1305(a) is amended by striking out "first thirty-six months" each place it occurs and substituting "first sixty months".

LOAN GUARANTEES FOR PRIVATE ENTITIES

SEC. 108. (a) Section 1304(a)(2) is amended to read as follows:

"(2) guarantee to non-Federal lenders payment of the principal of and the interest on loans made to—

"(A) nonprofit private entities for planning projects for the establishment or expansion of health maintenance organizations, or

"(B) other private entities for such projects for health maintenance organizations which will serve medically underserved populations.".

(b) Section 1304(b)(1)(B) is amended to read as follows:

"(B) guarantee to non-Federal lenders payment of the principal of and the interest on loans made to—

"(i) nonprofit private entities for projects for the initial development of health maintenance organizations, or

"(ii) other private entities for such projects for health maintenance organizations which will serve medically underserved populations.".

(c) Section 1305(a)(3) is amended to read as follows:

"(3) guarantee to non-Federal lenders payment of the principal of and the interest on loans made to—

"(A) nonprofit private health maintenance organizations for the amounts referred to in paragraph (1) or (2), or

"(B) other private health maintenance organizations for such amounts but only if the health maintenance organization will serve a medically underserved population.".

(d) (1) Section 1304(d) is amended by adding at the end the following new sentence: "In considering applications for loan guarantees under this section, the Secretary shall give special consideration to applications for projects for health maintenance organizations which will serve medically underserved populations.".

(2) Section 1305 is amended by adding at the end thereof the following new subsection:

"(f) In considering applications for loan guarantees under this section, the Secretary shall give special consideration to applications for health maintenance organizations which will serve medically underserved populations.".

MISCELLANEOUS AMENDMENTS

SEC. 109. (a)(1) Section 1305(a) is amended by striking out "in the period of" in paragraphs (1) and (2) and substituting "during a period not to exceed".

(2) The last sentence of 1305(b)(1) is amended to read as follows: "In any fiscal year the amount disbursed to a health maintenance organization under this section (either directly by the Secretary or by an escrow agent under the terms of an escrow agreement or by a lender under a loan guaranteed under this section) may not exceed $1,000,000.".

(b) (1) Section 1307(e) is amended—

(A) by inserting "for a private health maintenance organization (other than a private nonprofit health maintenance organization)" after "may be made", and

(B) by inserting "for private health maintenance organizations (other than private nonprofit health maintenance organizations)" after "guaranteed".

(2) Section 1308(c) is amended by adding after paragraph (4) the following new paragraph:

"(5) Any reference in this title (other than in this subsection and in subsection (d)) to a loan guarantee under this title does not include a loan guarantee made under this subsection.".

(c) (1) Section 1308(a)(1)(A) is amended by striking out "for similar loans" and substituting "for loans with similar maturities, terms, conditions, and security".

(2) Section 1308(b)(2)(D) is amended by striking out "loans guaranteed under this title" and substituting "marketable obligations of the United States of comparable maturities, adjusted to provide for appropriate administrative charges".

(d) (1) The last sentence of section 1303(i) is amended—

(A) by striking "the fiscal year ending June 30, 1974, or June 30, 1975," and substituting "any fiscal year"; and

(B) by striking "for projects other than those described in clause (1) of such sentence" and substituting "for any project, with priority being given to projects described in clause (1) of such sentence".

(2) The last sentence of section 1304(k)(1) is amended—

(A) by striking "the fiscal year ending June 30, 1974, or June 30, 1975," and substituting "any fiscal year"; and

(B) by striking "for projects other than those described in clause (A) of such sentence" and substituting "for any project, with priority being given to projects described in clause (A) of such sentence".

(3) The last sentence of section 1304(k)(2) is amended—

(A) by striking "the fiscal year ending June 30, 1974, or in either of the next two fiscal years" and substituting "any fiscal year"; and

(B) by striking "for projects other than those described in clause (A) of such sentence" and substituting "for any project, with priority being given to projects described in clause (A) of such sentence".

(e) Section 1304(b)(2)(D) is amended by striking out "for such an organization" and substituting "who will engage in practice principally for the health maintenance organization".

EMPLOYEE HEALTH BENEFITS PLANS

SEC. 110. (a) Section 1310 is amended—

(1) by amending subsection (a) to read as follows:

"SEC. 1310. (a)(1) In accordance with regulations which the Secretary shall prescribe—

"(A) each employer—

"(i) which is now or hereafter required during any calendar quarter to pay its employees the minimum wage prescribed by section 6 of the Fair Labor Standards Act of 1938 (or would be required to pay its employees such wage but for section 13(a) of such Act), and

"(ii) which during such calendar quarter employed an average number of employees of not less than 25,

shall include in any health benefits plan, and

"(B) any State and each political subdivision thereof which during any calendar quarter employed an average number of employees of not less than 25, as a condition of the payment to the State of funds under section 314(d), 317, 318, 1002, 1525, or 1613, shall include in any health benefits plan,

offered to such employees in the calendar year beginning after such calendar quarter the option of membership in qualified health maintenance organizations which are engaged in the provision of basic health services in health maintenance organization service areas in which at least 25 of such employees reside.

"(2) If any of the employees of an employer or State or political subdivision thereof described in paragraph (1) are represented by a collective bargaining representative or other employee representative designated or selected under any law, offer of membership in a qualified health maintenance organization required by paragraph (1) to be made in a health benefits plan offered to such employees (A) shall first be made to such collective bargaining representative or other employee representative, and (B) if such offer is accepted by such representative, shall then be made to each such employee.";

(2) by amending paragraphs (1) and (2) of subsection (b) to read as follows:

"(1) one or more of such organizations provides basic health services (A) without the use of an individual practice association and (B) without the use of contracts (except for contracts for unusual or infrequently used services) with health professionals, and

"(2) one or more of such organizations provides basic health services through (A) an individual practice association (or associations), (B) health professionals who have contracted with the health maintenance organization for the provision of such services, or (C) a combination of such association (or associations) or health professionals under contract with the organization,";

(3) by striking out the last sentence of subsection (c); and

(4) by adding after subsection (d) the following new subsections:

"(e)(1) Any employer who knowingly does not comply with one or more of the requirements of subsection (a) shall be subject to a civil penalty of not more than $10,000. If such noncompliance continues, a civil penalty may be assessed and collected under this subsection for each thirty-day period such noncompliance continues. Such penalty may be assessed by the Secretary and collected in a civil action brought by the United States in a United States district court.

"(2) In any proceeding by the Secretary to assess a civil penalty under this subsection, no penalty shall be assessed until the employer charged shall have been given notice and an opportunity to present its views on such charge. In determining the amount of the penalty, or the amount agreed upon in compromise, the Secretary shall consider the gravity of the noncompliance and the demonstrated good faith of the employer charged in attempting to achieve rapid compliance after notification by the Secretary of a noncompliance.

"(3) In any civil action brought to review the assessment of a civil penalty assessed under this subsection, the court shall, at the request of any party to such action, hold a trial de novo on the assessment of such civil penalty and in any civil action to collect such a civil

penalty, the court shall, at the request of any party to such action, hold a trial de novo on the assessment of such civil penalty unless in a prior civil action to review the assessment of such penalty the court held a trial de novo on such assessment.

"(f) For purposes of this section, the term 'employer' does not include (1) the Government of the United States, the government of the District of Columbia or any territory or possession of the United States, a State or any political subdivision thereof, or any agency or instrumentality (including the United States Postal Service and Postal Rate Commission) of any of the foregoing; or (2) a church, convention or association of churches, or any organization operated, supervised or controlled by a church, convention or association of churches which organization (A) is an organization described in section 501(c)(3) of the Internal Revenue Code of 1954, and (B) does not discriminate (i) in the employment, compensation, promotion, or termination of employment of any personnel, or (ii) in the extension of staff or other privileges to any physician or other health personnel, because such persons seek to obtain or obtained health care, or participate in providing health care, through a health maintenance organization.

"(g) If the Secretary, after reasonable notice and opportunity for hearing to a State, finds that it or any of its political subdivisions has failed to comply with one or more of the requirements of subsection (a), the Secretary shall terminate payments to such State under sections 314(d), 317, 318, 1002, 1525, and 1613 and notify the Governor of such State that further payments under such sections will not be made to the State until the Secretary is satisfied that there will no longer be any such failure to comply.

"(h) The duties and functions of the Secretary, insofar as they involve making determinations as to whether an organization is a qualified health maintenance organization within the meaning of subsection (d), shall be administered through the Assistant Secretary for Health and in the Office of the Assistant Secretary for Health, and the administration of such duties and functions shall be integrated with the administration of section 1312(a).".

(b) Section 8902 of title 5, United States Code, relating to Federal employee health insurance, is amended by adding at the end thereof the following new subsection:

"(l) The Commission shall contract under this chapter for a plan described in section 8903(4) of this title with any qualified health maintenance carrier which offers such a plan. For the purpose of this subsection, 'qualified health maintenance carrier' means any qualified carrier which is a qualified health maintenance organization within the meaning of section 1310(d)(1) of title XIII of the Public Health Service Act (42 U.S.C. 300c–9(d)).".

ENFORCEMENT REQUIREMENTS

SEC. 111. (a) Section 1312(a) is amended by striking out all of the section following paragraph (3) and substituting the following: "the Secretary may take the action authorized by subsection (b)."

(b) Section 1312(b) is amended to read as follows:

"(b)(1) If the Secretary makes, with respect to any entity which provided assurances to the Secretary under section 1310(d)(1), a determination described in subsection (a), the Secretary shall notify the entity in writing of the determination. Such notice shall specify the manner in which the entity has not complied with such assurances

and direct that the entity initiate (within 30 days of the date the notice is issued by the Secretary or within such longer period as the Secretary determines is reasonable) such action as may be necessary to bring (within such period as the Secretary shall prescribe) the entity into compliance with the assurances. If the entity fails to initiate corrective action within the period prescribed by the notice or fails to comply with the assurances within such period as the Secretary prescribes (A) the entity shall not be a qualified health maintenance organization for purposes of section 1310 until such date as the Secretary determines that it is in compliance with the assurances, and (B) each employer which has offered membership in the entity in compliance with section 1310, each lawfully recognized collective bargaining representative or other employee representative which represents the employees of each such employer, and the members of such entity shall be notified by the entity that the entity is not a qualified health maintenance organization for purposes of such section. The notice required by clause (B) of the preceding sentence shall contain, in readily understandable language, the reasons for the determination that the entity is not a qualified health maintenance organization. The Secretary shall publish in the Federal Register each determination referred to in this paragraph.

"(2) If the Secretary makes, with respect to an entity which has received a grant, contract, loan, or loan guarantee under this title, a determination described in subsection (a), the Secretary may, in addition to any other remedies available to him, bring a civil action in the United States district court for the district in which such entity is located to enforce its compliance with the assurances it furnished respecting the provision of basic and supplemental health services or its organization or operation, as the case may be, which assurances were made in connection with its application under this title for the grant, contract, loan, or loan guarantee.".

(c) Section 1312 is amended by adding at the end the following new subsection:

"(c) The Secretary, acting through the Assistant Secretary for Health, shall administer subsections (a) and (b) in the Office of the Assistant Secretary for Health.".

HMO'S AND FEDERAL HEALTH BENEFITS PROGRAMS

SEC. 112. Section 1307(d) is amended by adding after and below paragraph (2) the following new sentence: "An entity which provides health services to a defined population on a prepaid basis and which has members who are enrolled under the health benefits program authorized by chapter 89 of title 5, United States Code, may be considered as a health maintenance organization for purposes of receiving assistance under this title if with respect to its other members it provides health services in accordance with section 1301(b) and is organized and operated in the manner prescribed by section 1301(c).".

EXTENSIONS AND AUTHORIZATIONS

SEC. 113. (a) Section 1304(j) is amended (1) by striking out "September 30, 1976" and substituting "September 30, 1978", and (2) by striking out "September 30, 1977" and substituting "September 30, 1979".

(b) Subsection (d) of section 1305 is amended to read as follows:

"(d) No loan may be made or guaranteed under this section after September 30, 1980.".

(c) Section 1309(a) is amended—

(1) by striking out "and" after "1975,",

(2) by inserting after "1976" the following: ", $45,000,000 for the fiscal year ending September 30, 1977, and $45,000,000 for the fiscal year ending September 30, 1978",

(3) by striking out "ending June 30, 1977" and substituting "ending September 30, 1977", and

(4) by striking out "$85,000,000" the first time it occurs and substituting "$40,000,000", and by striking out "$85,000,000" the second time it occurs and substituting "$50,000,000".

RESTRICTIVE STATE LAWS

SEC. 114. Section 1311 is amended by adding at the end the following new subsection:

"(c) The Secretary shall, within 6 months after the date of the enactment of this subsection, develop a digest of State laws, regulations, and practices pertaining to development, establishment, and operation of health maintenance organizations which shall be updated at least quarterly and relevant sections of which shall be provided to the Governor of each State annually. Such digest shall indicate which State laws, regulations, and practices appear to be inconsistent with the operation of this section. The Secretary shall also insure that appropriate legal consultative assistance is available to the States for the purpose of complying with the provisions of this section."

PROGRAM EVALUATION BY THE COMPTROLLER GENERAL

SEC. 115. So much of section 1314(a) as precedes paragraph (1) thereof is amended to read as follows:

"SEC. 1314. (a) The Comptroller General shall evaluate the operations of at least ten or one-half (whichever is greater) of the health maintenance organizations for which assistance was provided under sections 1303, 1304, and 1305, and which, by December 31, 1976, have been designated by the Secretary under section 1310(d) as qualified health maintenance organizations. The Comptroller General shall report to the Congress the results of the evaluation by June 30, 1978. Such report shall contain findings—".

ADMINISTRATION OF PROGRAMS

SEC. 116. Title XIII is amended by adding after section 1315 the following new section:

"ADMINISTRATION OF PROGRAM

"SEC. 1316. The Secretary shall administer this title (other than sections 1310 and 1312) through a single identifiable administrative unit of the Department.".

CONFORMING AMENDMENTS

SEC. 117. (a) Section 1532(c) is amended by adding the following sentence at the end thereof: "The criteria established by any health systems agency or State Agency under paragraph (8) shall be consistent with the standards and procedures established by the Secretary under section 1306(c) of this Act.".

(b)(1) Paragraph (6) of section 1302 is amended to read as follows:

"(6) The term 'health systems agency' means an entity which is designated in accordance with section 1515 of this Act.".

(2) Paragraph (7) of section 1302 is amended by—

(A) striking "section 314(a) State health planning agency whose section 314(a) plan" and substituting "State health planning and development agency which"; and

(B) striking "section 314(b) areawide health planning agency whose section 314(b) plan", and substituting "health systems agency designated for a health service area which".

(3) Paragraph (1) of section 1303(b) is amended by striking "section 314(b) areawide health planning agency (if any) whose section 314(b) plan" and substituting "each health systems agency designated for a health service area which".

(4) Paragraph (1) of section 1304(c) is amended by striking "section 314(b) areawide health planning agency (if any) whose section 314(b) plan" and substituting "each health systems agency designated for a health service area which".

(5) Section (b)(5) of section 1306 is amended to read as follows:

"(5) each health systems agency designated for a health service area which covers (in whole or in part) the area to be served by the health maintenance organization for which such application is submitted:".

(6) Subsection (c) of section 1306 is amended by striking "section 314(b) areawide health planning agencies and section 314(a) State health planning agencies" and substituting "health systems agencies".

EFFECTIVE DATES

SEC. 118. (a) Except as provided in subsection (b), the amendments made by this title shall take effect on the date of the enactment of this Act.

(b)(1) The amendments made by sections 101, 102, 103, 104, and 106 shall (A) apply with respect to grants, contracts, loans, and loan guarantees made under sections 1303, 1304, and 1305 of the Public Health Service Act for fiscal years beginning after September 30, 1976, (B) apply with respect to health benefit plans offered under section 1310 of such Act after such date, and (C) for purposes of section 1312 take effect October 1, 1976.

(2) Subsection (d) of section 1301 of the Public Health Service Act (added by section 103(b) of this Act) shall take effect with respect to fiscal years of health maintenance organizations beginning on or after the date of the enactment of this Act.

(3) The amendments made by section 107 shall apply with respect to grants, contracts, loans, and loan guarantees made under sections 1303, 1304, and 1305 of the Public Health Service Act for fiscal years beginning after September 30, 1976.

(4) The amendments made by sections 109(a)(1) and 109(c) shall apply with respect to loan guarantees made under section 1305 of the Public Health Service Act after September 30, 1976.

(5) The amendment made by section 109(e) shall apply with respect to projects assisted under section 1304 of the Public Health Service Act after September 30, 1976.

(6) The amendments made by paragraphs (1) and (2) of section 110(a) shall apply with respect to calendar quarters which begin after the date of the enactment of this Act.

(7) The amendments made by paragraphs (3) and (4) of section 110 shall apply with respect to failures of employers to comply with section 1310(a) of the Public Health Service Act after the date of the enactment of this Act.

(8) The amendment made by section 111 shall apply with respect to determinations of the Secretary of Health, Education, and Welfare described in section 1312(a) of the Public Health Service Act and made after the date of the enactment of this Act.

TITLE II—AMENDMENTS TO SOCIAL SECURITY ACT

MEDICARE AMENDMENTS

SEC. 201. (a) Section 1876(b) of the Social Security Act is amended to read as follows:

"(b)(1) The term 'health maintenance organization' means a legal entity which provides health services on a prepayment basis to individuals enrolled with such organizations and which—

"(A) provides to its enrollees who are insured for benefits under parts A and B of this title or for benefits under part B alone, through institutions, entities, and persons meeting the applicable requirements of section 1861, all of the services and benefits covered under such parts (to the extent applicable under subparagraph (A) or (B) of subsection (a)(1)) which are available to individuals residing in the geographic area served by the organization;

"(B) provides such services in the manner prescribed by section 1301(b) of the Public Health Service Act, except that solely for the purposes of this section—

"(i) the term 'basic health services' and references thereto shall be deemed to refer to the services and benefits included under parts A and B of this title;

"(ii) the organization shall not be required to fix the basic health services payment under a community rating system;

"(iii) the additional nominal payments authorized by section 1301(b)(1)(D) of such Act shall not exceed the limits applicable under subsection (g) of this section; and

"(iv) payment for basic health services provided by the organization to its enrollees under this section or for services such enrollees receive other than through the organization shall be made as provided for by this title;

"(C) is organized and operated in the manner prescribed by section 1301(c) of the Public Health Service Act, except that solely for the purposes of this section—

"(i) the term 'basic health services' and references thereto shall be deemed to refer to the services and benefits included under parts A and B of this title;

"(ii) the organization shall not be reimbursed for the cost of reinsurance except as permitted by subsection (i) of this section; and

"(iii) the organization shall have an open enrollment period as provided for in subsection (k) of this section.

"(2)(A) The duties and functions of the Secretary, insofar as they involve making determinations as to whether an organization is a 'health maintenance organization' within the meaning of paragraph (1), shall be administered through the Assistant Secretary for Health and in the Office of the Assistant Secretary for Health, and the admin-

istration of such duties and functions shall be integrated with the administration of section 1312 (a) and (b) of the Public Health Service Act.

"(B) Except as provided in subparagraph (A), the Secretary shall administer the provisions of this section through the Commissioner of Social Security.".

(b) Section 1876(h) of such Act is amended to read as follows:

"(h)(1) Except as provided in paragraph (2), each health maintenance organization with which the Secretary enters into a contract under this section shall have an enrolled membership at least half of which consists of individuals who have not attained age 65.

"(2) The Secretary may waive the requirement imposed in paragraph (1) for a period of not more than three years from the date a health maintenance organization first enters into an agreement with the Secretary pursuant to subsection (i), but only for so long as such organization demonstrates to the satisfaction of the Secretary by the submission of its plan for each year that it is making continuous efforts and progress toward compliance with the provisions of paragraph (1) within such three-year period.".

(c) Section 1876(i)(6)(B) of such Act is amended by striking out "(other than those with respect to out-of-area services)" and inserting in lieu thereof "(other than costs with respect to out-of-area services and, in the case of an organization which has entered into a risk-sharing contract with the Secretary pursuant to paragraph (2)(A), the cost of providing any member with basic health services the aggregate value of which exceeds $5,000 in any year)".

(d) Section 1876 is amended by adding at the end thereof the following—

"(k) Each health maintenance organization with which the Secretary enters into a contract under this section shall have an open enrollment period at least every year under which it accepts up to the limits of its capacity and without restrictions, except as may be authorized in regulations, individuals who are eligible to enroll under subsection (d) in the order in which they apply for enrollment (unless to do so would result in failure to meet the requirements of subsection (h)) or would result in enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the population in the geographic area served by such health maintenance organization.".

(e) The amendments made by this section shall be effective with respect to contracts entered into between the Secretary and health maintenance organizations under section 1876 of the Social Security Act on and after the first day of the first calendar month which begins more than 30 days after the date of enactment of this Act.

MEDICAID AMENDMENTS

SEC. 202. (a) Section 1903 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(m)(1)(A) The term 'health maintenance organization' means a legal entity which provides health services to individuals enrolled in such organization and which—

"(i) provides to its enrollees who are eligible for benefits under this title the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905, and, to the extent required by section 1902(a)(13)(A)(ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1905(a);

"(ii) provides such services and benefits in the manner prescribed in section 1301(b) of the Public Health Service Act (except that, solely for purposes of this paragraph, the term 'basic health services' and references thereto, when employed in such section, shall be deemed to refer to the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905(a), and, to the extent required by section 1902(a)(13)(A)(ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1905(a)); and

"(iii) is organized and operated in the manner prescribed by section 1301(c) of the Public Health Service Act (except that solely for purposes of this paragraph, the term 'basic health services' and references thereto, when employed in such section shall be deemed to refer to the services and benefits described in section 1905(a)(1), (2), (3), (4)(C), and (5), and to the extent required by section 1902(a)(13)(A)(ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1905(a)).

"(B) The duties and functions of the Secretary, insofar as they involve making determinations as to whether an organization is a health maintenance organization within the meaning of subparagraph (A), shall be administered through the Assistant Secretary for Health and in the Office of the Assistant Secretary for Health, and the administration of such duties and functions shall be integrated with the administration of section 1312 (a) and (b) of the Public Health Service Act.

"(2)(A) Except as provided in subparagraphs (B) and (C), no payment shall be made under this title to a State with respect to expenditures incurred by it for payment for services provided by any entity—

"(i) which is responsible for the provision of—

"(I) inpatient hospital services and any other service described in paragraph (2), (3), (4), (5), or (7) of section 1905(a), or

"(II) any three or more of the services described in such paragraphs,

when payment for such services is determined under a prepaid capitation risk basis or under any other risk basis;

"(ii) which the Secretary (or the State as authorized by paragraph (3)) has not determined to be a health maintenance organization as defined in paragraph (1); and

"(iii) more than one-half of the membership of which consists of individuals who are insured under parts A and B of title XVIII or recipients of benefits under this title.

"(B) Subparagraph (A) does not apply with respect to payments under this title to a State with respect to expenditures incurred by it for payment for services provided by an entity which—

"(i)(I) received a grant of at least $100,000 in the fiscal year ending June 30, 1976, under section 319(d)(1)(A) or 330(d)(1) of the Public Health Service Act, and (II) for the period beginning July 1, 1976, and ending on the expiration of the peroid for which payments are to be made under this title has been the recipient of a grant under either such section; and

"(II) provides to its enrollees, on a prepaid capitation risk basis or on any other risk basis, all of the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905(a) and, to the extent required by section 1902(a)(13)(A)(ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of such section; or

"(ii) is a nonprofit primary health care entity located in a rural area (as defined by the Appalachian Regional Commission)—

"(I) which received in the fiscal year ending June 30, 1976, at least $100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965, and

"(II) for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this title either has been the recipient of a grant, subgrant, or subcontract under such Act or has provided services under a contract (initially entered into during a year in which the entity was the recipient of such a grant, subgrant, or subcontract) with a State agency under this title on a prepaid capitation risk basis or on any other risk basis; or

"(iii) which has contracted with the single State agency for the provision of services (but not including inpatient hospital services) to persons eligible under this title on a prepaid risk basis prior to 1970.

"(C) Subparagraph (A)(iii) shall not apply with respect to payments under this title to a State with respect to expenditures incurred by it for payment for services by an entity during the three-year period beginning on the date of enactment of this subsection or beginning on the date the entity enters into a contract with the State under this title for the provision of health services on a prepaid risk basis, whichever occurs later, but only if the entity demonstrates to the satisfaction of the Secretary by the submission of plans for each year of such three-year period that it is making continuous efforts and progress toward achieving compliance with subparagraph (A)(iii).

"(3) A State may, in the case of an entity which has submitted an application to the Secretary for determination that it is a health maintenance organization within the meaning of paragraph (1) and for which no such determination has been made within 90 days of the submission of the application, make a provisional determination for the purposes of this title that such entity is such a health maintenance organization. Such provisional determination shall remain in force until such time as the Secretary makes a determination regarding the entity's qualification under paragraph (1).".

(b) The amendment made by subsection (a) shall apply with respect to payments under title XIX of the Social Security Act to States for services provided—

(1) after the date of enactment of subsection (a) under contracts under such title entered into or renegotiated after such date, or

(2) after the expiration of the 1-year period beginning on such date of enactment,

whichever occurs first.

TITLE III—MISCELLANEOUS AMENDMENTS

CENTER FOR HEALTH SERVICES POLICY ANALYSIS

SEC. 301. Section 305(d)(1) of the Public Health Service Act is amended (1) by striking out "two national special emphasis centers" and substituting "three national special emphasis centers", (2) by striking out "and one" and substituting "one", and (3) by inserting before the last close parenthesis a semicolon and the following: "and one of which (to be designated as the Health Services Policy Analysis Center) shall focus on the development and evaluation of national policies with respect to health services, including the development of health maintenance organizations and other forms of group practice, with a view toward improving the efficiencies of the health services delivery system".

HOME HEALTH EXTENSION

SEC. 302. (a) Section 602(a)(5) of Public Law 94–63 is amended by inserting ", $2,000,000 for the period July 1, 1976, through September 30, 1976, $8,000,000 for the fiscal year ending September 30, 1977" after "1976".

(b) Section 602(b)(4) of Public Law 94–63 is amended by inserting ", $1,000,000 for the period July 1, 1976, through September 30, 1976, and $4,000,000 for the fiscal year ending September 30, 1977" after "1976".

EXTENSION OF REPORTING DATE

SEC. 303. Section 603(b) of Public Law 94–63 is amended by striking "Within one year" and substituting "Not later than 2 years".

TECHNICAL

SEC. 304. Section 514(a) of the Federal Food, Drug, and Cosmetic Act is amended by redesignating paragraphs (4) and (5) as paragraphs (3) and (4), respectively.

Speaker of the House of Representatives.

Vice President of the United States and
President of the Senate.