I

105TH CONGRESS
1ST SESSION

H. R. 475

To amend title XVIII of the Social Security Act to provide for offering the option of Medicare coverage through qualified provider-sponsored organizations (PSOs), and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 21, 1997

Mr. GREENWOOD (for himself and Mr. STENHOLM) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Ways and Means, and the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend title XVIII of the Social Security Act to provide for offering the option of Medicare coverage through qualified provider-sponsored organizations (PSOs), and for other purposes.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Provider-Sponsored Organization Act of 1997''.

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

SEC. 2. QUALIFIED PROVIDER-SPONSORED ORGANIZATIONS AS MEDICARE HEALTH PLAN OPTION.

(a) QUALIFIED PROVIDER-SPONSORED ORGANIZATIONS AS ELIGIBLE ORGANIZATIONS UNDER THE MEDICARE PROGRAM.—Part C of title XVIII of the Social Security Act is amended—

(1) in section 1876(b) (42 U.S.C. 1395mm(b))—

(A) in the matter before paragraph (1), by striking ''or a competitive medical plan'' and inserting '', a competitive medical plan, or a provider-sponsored organization'', and

(B) in paragraph (1), by inserting ''or is a qualified provider-sponsored organization (as defined in section 1889(a))'' after ''Act)''; and

(2) by inserting after section 1888 the following new section:

''REQUIREMENTS, STANDARDS, AND CERTIFICATION OF PROVIDER-SPONSORED ORGANIZATIONS

''SEC. 1889. (a) DEFINITIONS OF QUALIFIED PROVIDER-SPONSORED ORGANIZATION; PROVIDER-SPONSORED ORGANIZATION.—For purposes of section 1876 and this section—

''(1) QUALIFIED PROVIDER-SPONSORED ORGANIZATION.—The term 'qualified provider-sponsored organization' means a provider-sponsored organization that—

''(A) subject to subsection (b), is organized and licensed under State law to offer prepaid health services or health benefits coverage in each State in which the entity seeks to enroll individuals under section 1876 who are entitled to benefits under this title;

''(B) provides a substantial proportion (as defined by the Secretary in the standards established under subsection (g) consistent with paragraph (3)) of the health care items and services under the contract under section 1876 directly through the provider or affiliated group of providers comprising the organization; and

''(C) is certified under subsection (h) as meeting the standards established under sub-

section (g), which except as provided in subsection (c), shall be based on the requirements that apply to an entity described in section 1876(b)(2) with a full risk contract under section 1876(g).

''(2) PROVIDER-SPONSORED ORGANIZATION.—The term 'provider-sponsored organization' means a public or private entity that is a provider or group of affiliated providers organized to deliver a spectrum of health care services (including basic hospital and physicians services) under contract to purchasers of such services.

''(3) SUBSTANTIAL PROPORTION.—In defining what is a 'substantial proportion' for purposes of paragraph (1)(B), the Secretary—

''(A) shall take into account the need for such an organization to assume responsibility for providing—

''(i) significantly more than the majority of the items and services under the contract under section 1876 through its own affiliated providers, and

''(ii) most of the remainder of items and services under such contract through providers with which the organization has

an agreement to provide such items and services,

in order to assure financial stability and to address the practical considerations involved in integrating the delivery of a wide range of service providers;

''(B) shall take into account the need for such an organization to provide a limited proportion of the items and services under such contract through providers that are neither affiliated with nor have an agreement with such organization; and

''(C) may vary such proportion based upon relevant differences among organizations, such as their location in an urban or rural area.

''(4) AFFILIATION.—

''(A) IN GENERAL.—For purposes of this subsection, a provider is 'affiliated' with another provider if, through contract, ownership, or otherwise—

''(i) one provider, directly or indirectly, controls, is controlled by, or is under common control with the other,

''(ii) each provider is a participant in a lawful combination under which each

provider shares, directly or indirectly, substantial financial risk in connection with their operations,

''(iii) both providers are part of a controlled group of corporations under section 1563 of the Internal Revenue Code of 1986, or

''(iv) both providers are part of an affiliated service group under section 414 of such Code.

''(B) CONTROL.—For purposes of subparagraph (A), control is presumed to exist if one party, directly or indirectly, owns, controls, or holds the power to vote, or proxies for, not less than 51 percent of the voting rights or governance rights of another.

''(b) APPLICATION AND WAIVER OF STATE LICENSURE REQUIREMENT.—

''(1) IN GENERAL.—Subject to paragraph (2), subsection (a)(1)(A) (relating to State licensure) shall not apply to a provider-sponsored organization.

''(2) DELAYED EXCEPTION.—Effective on and after January 1, 2002, subsection (a)(1)(A) shall only apply (and paragraph (1) of this subsection

shall no longer apply) to a provider-sponsored organization in a State if—

''(A) the financial solvency and capital adequacy standards for licensure of the organization under the laws of the State are identical to the standards established under subsection (g), and

''(B) the standards for licensure of the organization under the laws of the State (other than the standards referred to in subparagraph (A)) are substantially equivalent to the standards established under subsection (g).

''(3) APPLICATION FOR WAIVER.—

''(A) IN GENERAL.—A provider-sponsored organization to which subsection (a)(1)(A) applies that seeks to operate in a State under a full risk contract under section 1876(g) or a partial risk contract under section 1876(i) may apply for a waiver of the requirement of subsection (a)(1)(A) for that organization operating in that State.

''(B) ACTION ON APPLICATION.—The Secretary shall act on such an application within 60 days after the date it is filed and shall grant

a waiver for an organization with respect to a State if the Secretary determines that—

"(i) the State did not act upon such a licensure application within 90 days after the date it was filed, or

"(ii)(I) the State denied such a licensure application, and

"(II) the State's licensing standards or review process impose unreasonable barriers to market entry, including through the imposition of any requirements, procedures, or other standards on such organizations that are not generally applicable to any other entities engaged in substantially similar business.

"(C) EFFECTIVE PERIOD OF WAIVER.—In the case of a waiver granted under this paragraph for an organization—

"(i) the waiver shall be effective for a 24-month period, except that it may be renewed based on a subsequent application filed during the last 6 months of such period;

"(ii) if the State failed to meet the requirement of subparagraph (B)(i)—

''(I) any application for a renewal may be made on the basis described in subparagraph (B)(i) only if the State does not act on a pending licensure application during the 24-month period specified in clause (i),

''(II) any application for renewal (other than one made on the basis described in subparagraph (B)(i)) may be made only on the basis described in subparagraph (B)(ii), and

''(III) the waiver shall cease to be effective upon approval of the licensure application by the State during such 24-month period; and

''(iii) any provisions of State law that relate to the licensing of the organization and prohibit the organization from providing coverage pursuant to a contract under section 1876 shall be superseded during the period for which such waiver is effective.

''(4) CONSTRUCTION.—Nothing in this subsection shall be construed as—

"(A) limiting the number of times such a waiver may be renewed under paragraph (3)(C)(i), or

"(B) affecting the operation of section 514 of the Employee Retirement Income Security Act of 1974.

"(c) APPLICATION OF CERTAIN REQUIREMENTS.—

"(1) WAIVER OF BENEFIT PACKAGE REQUIREMENT.—For purposes of carrying out subsection (a)(1)(C), the requirement of subsection (b)(2)(A) (relating to benefit package for commercial enrollees) of section 1876 shall not be applied.

"(2) EXCEPTION FOR METHOD OF DELIVERING PHYSICIANS SERVICES.—For purposes of carrying out subsection (a)(1)(C), the requirement of subsection (b)(2)(C) (relating to delivery of physicians services) of section 1876 shall be applied, except that the Secretary shall by regulation specify alternative delivery models or arrangements that may be used by such organizations in lieu of the models or arrangements specified in such subsection.

"(3) EXCEPTION FOR RISK ASSUMPTION.—For purposes of carrying out subsection (a)(1)(C), the requirement of subsection (b)(2)(D) (relating to risk assumption) of section 1876 shall be applied, except

that any provider-sponsored organization with a full risk contract under section 1876(g) may (with the concurrence of the Secretary) obtain insurance or make other arrangements for covering costs in excess of those permitted to be covered by such insurance and arrangements under section 1876(b)(2)(D)(iii).

''(4) TREATMENT OF MEETING FINANCIAL SOLVENCY REQUIREMENT.—

''(A) IN GENERAL.—For purposes of carrying out subsection (a)(1)(C), a provider-sponsored organization shall be treated as meeting the requirement of subsection (b)(2)(E) (relating to adequate provision against risk of insolvency) of section 1876 if the organization is fiscally sound.

''(B) FISCAL SOUNDNESS.—A provider-sponsored organization shall be treated as fiscally sound for purposes of subparagraph (A) if the organization—

''(i) has a net worth that is not less than the required net worth (as defined in clause (i) or (ii) of subparagraph (C), as the case may be), and

"(ii) has established adequate claims reserves (as defined in subparagraph (D)).

"(C) REQUIRED NET WORTH DEFINED.—For purposes of subparagraph (B)(i)—

"(i) FULL RISK CONTRACTS.—The term 'required net worth' means, in the case of an organization with a full risk contract under section 1876(g), a net worth (determined in accordance with statutory accounting principles for insurance companies and health maintenance organizations) that is not less than the greatest of the following:

"(I) $1,500,000 at the time of application and $1,000,000 thereafter.

"(II) The sum of 8 percent of the cost of health services that are not provided directly by the organization or its affiliated providers to enrollees, plus 4 percent of the estimated annual costs of health services provided directly by the organization or its affiliated providers to enrollees.

"(III) 3 months of uncovered expenditures.

"(ii) PARTIAL RISK CONTRACTS.—The term 'required net worth' means, in the case of an organization with a partial risk contract under section 1876(i), an amount determined in accordance with clause (i), except that in applying subclause (II) of such clause, the Secretary shall substitute for the percentages specified in such subclause such lower percentages as are appropriate to reflect the risk-sharing arrangements under the contract.

"(D) ADEQUATE CLAIMS RESERVES.—For purposes of subparagraph (B)(ii), the term 'adequate claims reserves' means, with respect to an organization, reserves for claims that are—

"(i) incurred but not reported, or

"(ii) reported but unpaid,

that are determined in accordance with statutory accounting principles for insurance companies and health maintenance organizations and with professional standards of actuarial practice and that are certified by an independent actuary as adequate in light of the operations and contracts of the organization.

''(E) APPLICATION OF ACCOUNTING PRINCIPLES.—In applying statutory accounting principles for purposes of determining the net worth of an organization under subparagraph (B)(i), the Secretary shall—

''(i) treat as 'admitted assets'—

''(I) land, buildings, and equipment of the organization used for the direct provision of health care services,

''(II) any receivables from governmental programs due for more than 90 days, and

''(III) any other assets designated by the Secretary; and

''(ii) recognize, as a contribution to surplus, amounts received under subordinated debt (meeting such requirements as the Secretary may specify).

''(F) METHODS OF DEMONSTRATING COMPLIANCE.—The Secretary shall recognize ways of complying with the requirement of subparagraph (A) other than by means of subparagraph (B), including (alone or in combination)—

''(i) letters of credit from a bank,

''(ii) financial guarantees from financially strong parties including affiliates,

''(iii) unrestricted fund balances,

''(iv) diversity of lines of business and presence of non risk related revenue,

''(v) certification by an independent actuary,

''(vi) reinsurance ceded to, or stop loss insurance purchased through, a recognized commercial insurance company, and

''(vii) other methods acceptable to the Secretary.

''(d) REQUIREMENT FOR ONGOING QUALITY ASSURANCE PROGRAM.—

''(1) IN GENERAL.—A provider-sponsored organization shall not be treated as meeting the requirements of subsection (c)(6) (relating to an ongoing quality assurance program) of section 1876 unless the quality assurance program of the organization meets the requirements of paragraphs (2) and (3).

''(2) REQUIRED ELEMENTS OF QUALITY ASSURANCE PROGRAM.—A quality assurance program meets the requirements of this paragraph if the program—

"(A) stresses health outcomes;

"(B) provides opportunities for input by physicians and other health care professionals;

"(C) monitors and evaluates high volume and high risk services and the care of acute and chronic conditions;

"(D) evaluates the continuity and coordination of care that enrollees receive;

"(E) establishes mechanisms to detect both underutilization and overutilization of services;

"(F) after identifying areas for improvement, establishes or alters practice parameters;

"(G) takes action to improve quality and assess the effectiveness of such action through systematic follow up;

"(H) makes available information on quality and outcomes measures to facilitate beneficiary comparison and choice of health coverage options (in such form and on such quality and outcomes measures as the Secretary determines to be appropriate); and

"(I) is evaluated on an ongoing basis as to its effectiveness.

"(3) TREATMENT OF CASE-BY-CASE UTILIZATION REVIEW.—If a provider-sponsored organization

utilizes case-by-case utilization review in its quality assurance program, the organization shall—

"(A) base such review on written protocols developed on the basis of current standards of medical practice; and

"(B) implement a plan under which—

"(i) such review is coordinated with the quality assurance program of the organization, and

"(ii) a transition is made from relying predominantly on case-by-case review to review focusing on patterns of care.

"(4) COMPLIANCE THROUGH ACCREDITATION.—A provider-sponsored organization shall be treated as meeting the requirements of paragraphs (2) and (3) of this subsection and the requirements of section 1876(c)(6) if the organization is accredited (and periodically reaccredited) by a private organization under a process that the Secretary has determined assures that the organization meets standards for quality assurance programs that are no less stringent than the standards established for such programs under subsection (g) to carry out this subsection and section 1876(c).

''(e) REQUIREMENT FOR PARTICIPATION PROCEDURES.—A provider-sponsored organization shall not be treated as meeting the requirements of this section unless—

''(1) the organization establishes reasonable procedures relating to the participation (under an agreement between a physician or group of physicians and the organization) of physicians under contracts under section 1876 and such procedures include—

''(A) providing notice of the rules regarding participation,

''(B) providing written notice of participation decisions that are adverse to physicians, and

''(C) providing a process within the organization for appealing adverse decisions, including the presentation of information and views of the physician regarding such decision; and

''(2) the organization consults with physicians who have entered into participation agreements with the organization regarding the organization's medical policy, quality, and medical management procedures.

Paragraph (1)(C) shall not be construed as requiring a live evidentiary hearing, a verbatim record, or representation of the appealing party by legal counsel.

''(f) OTHER SPECIAL RULES FOR TREATMENT OF PROVIDER-SPONSORED ORGANIZATIONS.—

''(1) WAIVER OF MINIMUM ENROLLMENT RULES.—In the case of a provider-sponsored organization, paragraph (1) of section 1876(g)—

''(A) shall not apply for the first 3 contract years of the organization under section 1876, and

''(B) shall be applied for contract years thereafter—

''(i) by substituting '1500' for '5000', and

''(ii) by substituting 'at least 500' for 'fewer'.

''(2) ADJUSTED COMMUNITY RATE.—In the case of a provider-sponsored organization, the adjusted community rate under subsections (e)(3) and (g)(2) of section 1876 may be computed (in a manner specified by the Secretary) using data in the general commercial marketplace or (during a transition period) based on the costs incurred by the organization in providing such a product.

"(g) ESTABLISHMENT OF STANDARDS FOR QUALIFIED PROVIDER-SPONSORED ORGANIZATIONS.—

"(1) INTERIM STANDARDS.—

"(A) IN GENERAL.—The Secretary shall issue regulations regarding standards for qualified provider-sponsored organizations within 180 days after the date of the enactment of this section. Such regulations shall be issued on an interim basis, but shall become effective upon publication and shall be effective through December 31, 2001.

"(B) SOLICITATION OF VIEWS.—In developing standards under this paragraph, the Secretary shall solicit the views of the National Association of Insurance Commissioners, the American Academy of Actuaries, State health departments, associations representing provider-sponsored organizations, quality experts (including private accreditation organizations), and medicare beneficiaries.

"(C) CONTRACTS TO MONITOR PERFORMANCE.—The Secretary shall enter into contracts with appropriate State agencies to monitor performance and beneficiary access to services under this title during the period in which in-

terim standards are in effect under this paragraph.

''(2) PERMANENT STANDARDS.—

''(A) IN GENERAL.—Not later than July 1, 2001, the Secretary shall issue permanent standards under this paragraph.

''(B) CONSULTATION.—In developing standards under this paragraph, the Secretary shall consult with the organizations and individuals referred to in paragraph (1)(B).

''(C) EFFECTIVE DATE.—The standards under this paragraph shall be effective for periods after December 31, 2001.

''(3) PREEMPTION.—The standards established under this subsection shall supersede any State law or regulation with respect to qualified provider-sponsored organizations insofar as such law or regulation—

''(A) applies to individuals enrolled with such an organization under a contract under section 1876, and

''(B) does not meet the requirements of subsection (b)(2).

''(h) CERTIFICATION.—

''(1) ESTABLISHMENT OF PROCESS.—The Secretary shall establish a process for the certification of provider-sponsored organizations as qualified provider-sponsored organizations under this section. Such process shall provide that an application for certification shall be approved or denied not later than 90 days after the date of receipt of the application.

''(2) APPLICATION OF ACCREDITATION.—

''(A) IN GENERAL.—The process under this subsection shall, to the maximum extent practical, provide that provider-sponsored organizations that are accredited by a qualified private accreditation process that the Secretary finds applies standards that are no less stringent than the standards established under subsection (g) are deemed to meet the corresponding standards of this title.

''(B) PERIOD OF VALIDITY OF ACCREDITATION.—The use of an accreditation under subparagraph (A) shall be valid only for such period as the Secretary specifies.

''(3) IMPOSITION OF CERTIFICATION FEE.—The Secretary may impose user fees on entities seeking certification under this subsection in such amounts

as the Secretary deems sufficient to finance the costs of such certification.

''(4) DECERTIFICATION.—If a provider-sponsored organization is decertified under this subsection, the organization shall notify each enrollee with the organization under section 1876 of such decertification.''.

(b) EFFECTIVE DATE; USE OF INTERIM REGULATIONS.—

(1) IN GENERAL.—The amendments made by this section shall become effective on the date of the enactment of this Act and apply to contract years beginning on or after January 1, 1998.

(2) USE OF INTERIM FINAL REGULATIONS.—In order to carry out the amendments made by this section in a timely manner, the Secretary of Health and Human Services may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

SEC. 3. AUTHORIZING PAYMENT OF ALL MEDICARE HEALTH PLANS ON A PARTIAL RISK BASIS.

(a) IN GENERAL.—Section 1876 of the Social Security Act (42 U.S.C. 1395mm) is amended—

(1) by redesignating subsections (i) and (j) as subsections (k) and (l), respectively, and

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

''(i) The Secretary may enter into a partial risk contract with an eligible organization under which—

''(1) notwithstanding subsection (b)(2)(D), the organization and the program established under this title share the financial risk associated with the services the organization provides to individuals entitled to benefits under part A and enrolled under part B or enrolled under part B only;

''(2) notwithstanding subsections (a)(1) and (h)(2), payment is based on—

''(A) a blend of—

(i) the payments that would otherwise be made to such organization under a risk-sharing contract under subsection (g), and

''(ii) the payments that would be made to such organization under a reasonable cost reimbursement contract under subsection (h), or

''(B) any other methodology agreed upon by the Secretary and the organization; and

''(3) adjustments, if appropriate, are made to the payments under this section to the organization to reflect any risk assumed by such program.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall become effective on the date of the enactment of this Act and apply to contract years beginning on or after January 1, 1998.

SEC. 4. ELIMINATION OF ENROLLMENT COMPOSITION REQUIREMENT FOR ELIGIBLE ORGANIZATIONS MEETING ENHANCED QUALITY STANDARDS.

(a) IN GENERAL.—Section 1876 of the Social Security Act (42 U.S.C. 1395mm), as amended by section 3, is amended by inserting after subsection (i) the following:

''(j)(1) An eligible organization shall be treated as meeting the requirement of section 1876(f) (relating to enrollment composition) if the organization demonstrates that it—

''(A) is capable of providing coordinated care in accordance with the quality assurance standards established under subsection (c)(6) and paragraph (2) of section 1889(d), and

''(B) has experience, under a past or present arrangement, providing coordinated care to individuals (other than individuals who are entitled to benefits under this title) who are enrollees, participants, or beneficiaries of a health plan or a State plan approved under title XIX.

''(2) An eligible organization shall be treated as meeting the standards referred to in paragraph (1)(A) if the organization is accredited (and periodically reaccredited) by a private organization under a process that the Secretary has determined assures that the organization meets standards for quality assurance programs that are no less stringent than the standards established for such programs under subsection (c) and section 1889(g).

''(3) DEFINITIONS.—For purposes of this subsection:

''(A) HEALTH PLAN.—The term 'health plan' means—

''(i) any contract of insurance, including any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract, that is provided by a carrier (as defined in subparagraph (B)), and

''(ii) an employee welfare benefit plan insofar as the plan provides health benefits and is funded in a manner other than through the purchase of one or more policies or contracts described in clause (i).

''(B) CARRIER.—The term 'carrier' means a licensed insurance company, a hospital or medical service corporation (including an existing Blue Cross

or Blue Shield organization), or other entity licensed or certified by a State to provide health insurance or health benefits.

(b) EFFECTIVE DATE.—The amendments made by this subsection shall become effective on the date of the enactment of this Act and apply to contract years beginning on or after January 1, 1998.

SEC. 5. CLARIFICATION OF USE OF PROVIDER-SPONSORED ORGANIZATIONS UNDER MEDICAID PROGRAM.

Section 1903(m)(1)(A) of the Social Security Act (42 U.S.C. 1396b(m)(1)(A)) is amended, in the matter before clause (i), by inserting ''(which may be a provider-sponsored organization, as defined in section 1889(a)(2))'' after ''public or private organization''.

SEC. 6. DEMONSTRATION OF COORDINATED ACUTE AND LONG-TERM CARE BENEFITS UNDER MEDICARE AND MEDICAID PROGRAMS.

The Secretary of Health and Human Services shall provide, in at least 10 States, for demonstration projects that permit Medicaid programs under title XIX to be treated as eligible organizations under section 1876 for individuals who are eligible to enroll with an organization under such section and are eligible to receive medical assistance under a State program approved under title XIX,

for the purpose of demonstrating the delivery of primary, acute, and long-term care through an integrated delivery network that emphasizes noninstitutional care.

SEC. 7. RULES ON COVERAGE OF EMERGENCY SERVICES BY ALL MEDICARE HEALTH PLANS.

(a) IN GENERAL.—Section 1876(c) of the Social Security Act (42 U.S.C. 1395mm(c)) is amended—

(1) in paragraph (4)—

(A) by striking ''and'' at the end of subparagraph (A), and

(B) by striking subparagraph (B) and inserting in lieu thereof the following:

''(B) provide for reimbursement with respect to services which are covered under subparagraph (A) which are provided to such an individual other than through the organization, if—

''(i) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition, and

''(ii) it was not reasonable given the circumstances to obtain the services through the organization;

''(C) provide coverage for emergency services (as defined in paragraph (9))—

''(i) without regard to prior authorization, and

''(ii) subject to the requirement of subparagraph (B)(ii), without regard to the emergency care provider's contractual relationship with the organization; and

''(D) make available 24 hours a day and 7 days a week a person authorized to make any prior authorization determination that is required by the organization as a condition of coverage or payment for items and services included in the benefits described in paragraph (2)(A) that are furnished with respect to—

''(i) a medical condition that is—

''(I) identified pursuant to an appropriate screening examination (as described in section 1867(a)), and

''(II) not an emergency medical condition (as defined in section 1867(e)(1)), or

''(ii) an emergency medical condition (as so defined) after that condition has been stabilized (as defined in section 1867(e)(3)(B)),

and makes such determinations within a period of time that meets standards established by the Secretary.''; and

(2) by adding at the end the following:

''(9) In this subsection, the term 'emergency services' means—

''(A) an appropriate medical screening examination and related ancillary services (as described in section 1867(a)) furnished in a hospital emergency department, and

''(B) necessary stabilizing examination and treatment services (as described in section 1867(b)) for an emergency medical condition (as defined in section 1867(e)(1)).''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall become effective on the date of the enactment of this Act and shall apply to contract years beginning on or after January 1, 1998.

SEC. 8. PREEMPTION OF STATE LAW RESTRICTIONS ON MANAGED CARE ARRANGEMENTS.

(a) LIMITATION OF STATE LAW RESTRICTIONS ON MANAGED CARE ARRANGEMENTS.—Effective as of January 1, 1998—

(1) a State may not prohibit a carrier or group health plan providing health coverage from including incentives for enrollees to use the services of participating providers;

(2) a State may not prohibit such a carrier or plan from limiting coverage of services to those provided by a participating provider;

(3) a State may not prohibit the negotiation of rates and forms of payments for providers by such a carrier or plan with respect to health coverage;

(4) a State may not prohibit such a carrier or plan from limiting the number of participating providers;

(5) a State may not prohibit such a carrier or plan from requiring that services be provided (or authorized) by a practitioner selected by the enrollee from a list of available participating providers or, except for services of a physician who specializes in obstetrics and gynecology, from requiring enrollees to obtain referral in order to have coverage for treatment by a specialist or health institution;

(6) a State may not prohibit or limit the corporate practice of medicine; and

(7) a State may not prohibit the adoption and operation of a utilization review program.

(b) DEFINITIONS.—In this section:

(1) MANAGED CARE COVERAGE.—The term ''managed care coverage'' means health coverage to the extent the coverage is provided through a man-

aged care arrangement (as defined in paragraph (3)).

(2) PARTICIPATING PROVIDER.—The term ''participating provider'' means an entity or individual which provides, sells, or leases health care services as part of a provider network (as defined in paragraph (4)).

(3) MANAGED CARE ARRANGEMENT.—The term ''managed care arrangement'' means, with respect to a group health plan or under health insurance coverage, an arrangement under such plan or coverage under which providers agree to provide items and services covered under the arrangement to individuals covered under the plan or who have such coverage.

(4) PROVIDER NETWORK.—The term ''provider network'' means, with respect to a group health plan or health insurance coverage, providers who have entered into an agreement described in paragraph (3).

(5) UTILIZATION REVIEW PROGRAM.—The term ''utilization review program'' means a system of reviewing the medical necessity and appropriateness of patient services (which may include inpatient and outpatient services) using specified guidelines. Such a system may include pattern analysis, preadmission

certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory procedures, and retrospective review.

(6) STATE.—The term ''State'' includes the District of Columbia, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and American Samoa.

(c) EXEMPTION OF LAWS PREVENTING DENIAL OF LIFE SAVING MEDICAL TREATMENT PENDING TRANSFER TO ANOTHER HEALTH CARE PROVIDER.—Nothing in this section shall be construed to invalidate any State law that has the effect of preventing involuntary denial of life-preserving medical treatment when such denial would cause the involuntary death of the patient pending transfer of the patient to a health care provider willing to provide such treatment.

(d) PURPOSE; RULE OF CONSTRUCTION.—The purpose of this section is to permit use of the mechanisms specified in paragraphs (1) through (7) of subsection (a) in the States. Nothing in this section shall be construed as prohibiting a State from regulating or limiting abusive arrangements or practices that act inappropriately to withhold, limit, or delay access to covered services.

SEC. 9. PUBLICATION OF ANTITRUST GUIDELINES ON ACTIVITIES OF PROVIDER-SPONSORED ORGANIZATIONS.

(a) IN GENERAL.—The Department of Justice and the Federal Trade Commission shall jointly provide for the development and publication of explicit guidelines on the application of antitrust laws to the activities of provider-sponsored organizations (as defined in section 1889(a)(2) of the Social Security Act). The guidelines shall—

(1) address issues relating to the formation, development, and operation of such organizations, and

(2) be designed to facilitate the development and operation of such organizations.

(b) EFFECT OF GUIDELINES.—The guidelines established under subsection (a) shall—

(1) be binding on all enforcement activities undertaken pursuant to the antitrust laws, and

(2) serve as guidance to the attorneys general and courts of the States in interpreting and applying the antitrust laws of the States to provider-sponsored organizations.

(c) DEFINITION.—For purposes of this section, the term ''antitrust laws'' has the meaning given to such term in the first section of the Clayton Act (15 U.S.C. 12), except that such term includes section 5 of the Federal

Trade Commission Act (15 U.S.C. 45) to the extent such section applies to unfair competition.

(d) DEADLINE; ANNUAL UPDATES.—The guidelines required by subsection (a) shall be published not later than 180 days after the date of the enactment of this Act and shall be updated at least annually thereafter based on consultations with interested parties.

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