''(d) The Office of Personnel Management—

''(1) shall administer the provisions of this section to provide for—

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

''(B) no lapse of health coverage for individuals who enroll in a health benefits plan under chapter 89 of title 5, United States Code, in accordance with this section; and

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

CONTINUED COVERAGE FOR INDIVIDUALS ENROLLED IN PLAN ADMINISTERED BY OFFICE OF THE COMPTROLLER OF THE CURRENCY OR OFFICE OF THRIFT SUPERVISION

Pub. L. 103–409, § 5, Oct. 25, 1994, 108 Stat. 4232, provided that:

''(a) ENROLLMENT IN CHAPTER 89 PLAN.—For purposes of the administration of chapter 89 of title 5, United States Code, any period of enrollment under a health benefits plan administered by the Office of the Comptroller of the Currency or the Office of Thrift Supervision before the termination of such plans on January 7, 1995, shall be deemed to be a period of enrollment in a health benefits plan under chapter 89 of such title.

''(b) CONTINUED COVERAGE.—(1) Any individual who, on January 7, 1995, is covered by a health benefits plan administered by the Office of the Comptroller of the Currency or the Office of Thrift Supervision may enroll in an approved health benefits plan described under section 8903 or 8903a of title 5, United States Code—

''(A) either as an individual or for self and family, if such individual is an employee, annuitant, or former spouse as defined under section 8901 of such title; and

''(B) for coverage effective on and after January 8, 1995.

''(2) An individual who, on January 7, 1995, is entitled to continued coverage under a health benefits plan administered by the Office of the Comptroller of the Currency or the Office of Thrift Supervision—

''(A) shall be deemed to be entitled to continued coverage under section 8905a of title 5, United States Code, for the same period that would have been permitted under the plan administered by the Office of the Comptroller of the Currency or the Office of Thrift Supervision; and

''(B) may enroll in an approved health benefits plan described under section 8903 or 8903a of such title in accordance with section 8905a of such title for coverage effective on and after January 8, 1995.

''(3) An individual who, on January 7, 1995, is covered as an unmarried dependent child under a health benefits plan administered by the Office of the Comptroller of the Currency or the Office of Thrift Supervision and who is not a member of family as defined under section 8901(5) of title 5, United States Code—

''(A) shall be deemed to be entitled to continued coverage under section 8905a of such title as though the individual had, on January 7, 1995, ceased to meet the requirements for being considered an unmarried dependent child under chapter 89 of such title; and

''(B) may enroll in an approved health benefits plan described under section 8903 or 8903a of such title in accordance with section 8905a for continued coverage effective on and after January 8, 1995.

''(c) TRANSFERS TO THE EMPLOYEES HEALTH BENEFITS FUND.—The Office of the Comptroller of the Currency and the Office of Thrift Supervision shall transfer to the Employees Health Benefits Fund established under section 8909 of title 5, United States Code, amounts determined by the Director of the Office of Personnel Management, after consultation with the Office of the Comptroller of the Currency and the Office of Thrift Supervision, to be necessary to reimburse the Fund for the cost of providing benefits under this section not otherwise paid for by the individuals covered by this section. The amounts so transferred shall be held in the Fund and used by the Office in addition to amounts available under section 8906(g)(1) of such title.

''(d) ADMINISTRATION AND REGULATIONS.—The Office of Personnel Management—

''(1) shall administer the provisions of this section to provide for—

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

''(B) no lapse of health coverage for individuals who enroll in a health benefits plan under chapter 89 of title 5, United States Code, in accordance with this section; and

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

CONTINUED COVERAGE UNDER CERTAIN FEDERAL EMPLOYEE BENEFIT PROGRAMS FOR CERTAIN EMPLOYEES OF SAINT ELIZABETHS HOSPITAL

For provisions relating to treatment of certain Federal employees of Saint Elizabeths Hospital under certain Federal employee benefit programs, see section 207(*o*) of Pub. L. 99–335, set out as a note under section 8331 of this title.

§ 8902. Contracting authority

(a) The Office of Personnel Management may contract with qualified carriers offering plans described by section 8903 or 8903a of this title, without regard to section 6101(b) to (d) of title 41 or other statute requiring competitive bidding. Each contract shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party.

(b) To be eligible as a carrier for the plan described by section 8903(2) of this title, a company must be licensed to issue group health insurance in all the States and the District of Columbia.

(c) A contract for a plan described by section 8903(1) or (2) of this title shall require the carrier—

(1) to reinsure with other companies which elect to participate, under an equitable formula based on the total amount of their group health insurance benefit payments in the United States during the latest year for which the information is available, to be determined by the carrier and approved by the Office; or

(2) to allocate its rights and obligations under the contract among its affiliates which elect to participate, under an equitable formula to be determined by the carrier and the affiliates and approved by the Office.

(d) Each contract under this chapter shall contain a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as the Office considers necessary or desirable.

(e) The Office may prescribe reasonable minimum standards for health benefits plans described by section 8903 or 8903a of this title and for carriers offering the plans. Approval of a plan may be withdrawn only after notice and opportunity for hearing to the carrier concerned without regard to subchapter II of chapter 5 and chapter 7 of this title. The Office may terminate the contract of a carrier effective at the end of the contract term, if the Office finds that at no time during the preceding two contract terms did the carrier have 300 or more employees and annuitants, exclusive of family members, enrolled in the plan.

(f) A contract may not be made or a plan approved which excludes an individual because of

race, sex, health status, or, at the time of the first opportunity to enroll, because of age.

(g) A contract may not be made or a plan approved which does not offer to each employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title whose enrollment in the plan is ended, except by a cancellation of enrollment, a temporary extension of coverage during which he may exercise the option to convert, without evidence of good health, to a nongroup contract providing health benefits. An employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title who exercises this option shall pay the full periodic charges of the nongroup contract.

(h) The benefits and coverage made available under subsection (g) of this section are noncancelable by the carrier except for fraud, over-insurance, or nonpayment of periodic charges.

(i) Rates charged under health benefits plans described by section 8903 or 8903a of this title shall reasonably and equitably reflect the cost of the benefits provided. Rates under health benefits plans described by section 8903(1) and (2) of this title shall be determined on a basis which, in the judgment of the Office, is consistent with the lowest schedule of basic rates generally charged for new group health benefit plans issued to large employers. The rates determined for the first contract term shall be continued for later contract terms, except that they may be readjusted for any later term, based on past experience and benefit adjustments under the later contract. Any readjustment in rates shall be made in advance of the contract term in which they will apply and on a basis which, in the judgment of the Office, is consistent with the general practice of carriers which issue group health benefit plans to large employers.

(j) Each contract under this chapter shall require the carrier to agree to pay for or provide a health service or supply in an individual case if the Office finds that the employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title is entitled thereto under the terms of the contract.

(k)(1) When a contract under this chapter requires payment or reimbursement for services which may be performed by a clinical psychologist, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/clinical specialist, licensed or certified as such under Federal or State law, as applicable, or by a qualified clinical social worker as defined in section 8901(11), an employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title covered by the contract shall be free to select, and shall have direct access to, such a clinical psychologist, qualified clinical social worker, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/nurse clinical specialist without supervision or referral by another health practitioner and shall be entitled under the contract to have payment or reimbursement made to him or on his behalf for the services performed.

(2) Nothing in this subsection shall be considered to preclude a health benefits plan from providing direct access or direct payment or reimbursement to a provider in a health care practice or profession other than a practice or profession listed in paragraph (1), if such provider is licensed or certified as such under Federal or State law.

(3) The provisions of this subsection shall not apply to comprehensive medical plans as described in section 8903(4) of this title.

(*l*) The Office 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)[1] of title XIII of the Public Health Service Act (42 U.S.C. 300c–9(d)).

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

(2)(A) Notwithstanding the provisions of paragraph (1) of this subsection, if a contract under this chapter provides for the provision of, the payment for, or the reimbursement of the cost of health services for the care and treatment of any particular health condition, the carrier shall provide, pay, or reimburse up to the limits of its contract for any such health service properly provided by any person licensed under State law to provide such service if such service is provided to an individual covered by such contract in a State where 25 percent or more of the population is located in primary medical care manpower shortage areas designated pursuant to section 332 of the Public Health Service Act (42 U.S.C. 254e).

(B) The provisions of subparagraph (A) shall not apply to contracts entered into providing prepayment plans described in section 8903(4) of this title.

(n) A contract for a plan described by section 8903(1), (2), or (3), or section 8903a, shall require the carrier—

(1) to implement hospitalization-cost-containment measures, such as measures—

(A) for verifying the medical necessity of any proposed treatment or surgery;

(B) for determining the feasibility or appropriateness of providing services on an outpatient rather than on an inpatient basis;

(C) for determining the appropriate length of stay (through concurrent review or otherwise) in cases involving inpatient care; and

(D) involving case management, if the circumstances so warrant; and

(2) to establish incentives to encourage compliance with measures under paragraph (1).

(*o*) A contract may not be made or a plan approved which includes coverage for any benefit, item, or service for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

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[1] See References in Text note below.

(Pub. L. 89–554, Sept. 6, 1966, 80 Stat. 601; Pub. L. 93–246, §3, Jan. 31, 1974, 88 Stat. 4; Pub. L. 93–363, §1, July 30, 1974, 88 Stat. 398; Pub. L. 94–183, §2(43), Dec. 31, 1975, 89 Stat. 1059; Pub. L. 94–460, title I, §110(b), Oct. 8, 1976, 90 Stat. 1952; Pub. L. 95–368, §1, Sept. 17, 1978, 92 Stat. 606; Pub. L. 95–454, title IX, §906(a)(2), (3), Oct. 13, 1978, 92 Stat. 1224; Pub. L. 96–179, §3, Jan. 2, 1980, 93 Stat. 1299; Pub. L. 98–615, §3(2), Nov. 8, 1984, 98 Stat. 3203; Pub. L. 99–53, §2(a), June 17, 1985, 99 Stat. 94; Pub. L. 99–251, title I, §§105(b), 106(a)(3), Feb. 27, 1986, 100 Stat. 15, 16; Pub. L. 100–202, §101(m) [title VI, §626], Dec. 22, 1987, 101 Stat. 1329–390, 1329–430; Pub. L. 100–654, title II, §§201(b), 202(a), Nov. 14, 1988, 102 Stat. 3845; Pub. L. 101–508, title VII, §7002(a), Nov. 5, 1990, 104 Stat. 1388–329; Pub. L. 101–509, title IV, §1, Nov. 5, 1990, 104 Stat. 1421; Pub. L. 102–393, title V, §537(a), (b), Oct. 6, 1992, 106 Stat. 1765; Pub. L. 105–12, §9(g), Apr. 30, 1997, 111 Stat. 27; Pub. L. 105–266, §§3(c), 8, Oct. 19, 1998, 112 Stat. 2366, 2370; Pub. L. 111–350, §5(a)(15), Jan. 4, 2011, 124 Stat. 3842.)

HISTORICAL AND REVISION NOTES

Derivation	*U.S. Code*	*Revised Statutes and Statutes at Large*
.....	5 U.S.C. 3005.	Sept. 28, 1959, Pub. L. 86–382, §6, 73 Stat. 712. Mar. 17, 1964, Pub. L. 88–284, §1(7)–(9), 78 Stat. 165.

Standard changes are made to conform with the definitions applicable and the style of this title as outlined in the preface to the report.

REFERENCES IN TEXT

Section 1310(d)(1) of title XIII of the Public Health Service Act (42 U.S.C. 300c–9(d)), referred to in subsec. (*l*), probably is intended as a reference to section 300e–9(d) of Title 42, The Public Health and Welfare. Section 300e–9(d) of Title 42 was redesignated section 300e–9(c) of Title 42 by Pub. L. 100–517, §7(b), Oct. 24, 1988, 102 Stat. 2580.

The Assisted Suicide Funding Restriction Act of 1997, referred to in subsec. (*o*), is Pub. L. 105–12, Apr. 30, 1997, 111 Stat. 23, which is classified principally to chapter 138 (§14401 et seq.) of Title 42, The Public Health and Welfare. For complete classification of this Act to the Code, see Short Title note set out under section 14401 of Title 42 and Tables.

CODIFICATION

Another section 1 of title IV of Pub. L. 101–509, 104 Stat. 1416, enacted sections 2701 to 2706 of Title 44, Public Printing and Documents, and provisions set out as a note under section 2102 of Title 44.

AMENDMENTS

2011—Subsec. (a). Pub. L. 111–350 substituted ''section 6101(b) to (d) of title 41'' for ''section 5 of title 41''.

1998—Subsec. (k)(2), (3). Pub. L. 105–266, §8, added par. (2) and redesignated former par. (2) as (3).

Subsec. (m)(1). Pub. L. 105–266, §3(c), added par. (1) and struck out former par. (1) which read as follows: ''The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.''

1997—Subsec. (*o*). Pub. L. 105–12 added subsec. (*o*).

1992—Pub. L. 102–393 amended subsec. (k) generally. Prior to amendment, subsec. (k) read as follows:

''(1) When a contract under this chapter requires payment or reimbursement for services which may be performed by a clinical psychologist, optometrist, nurse midwife, or nurse practitioner/clinical specialist, licensed or certified as such under Federal or State law, as applicable, or by a qualified clinical social worker as defined in section 8901(11), an employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title covered by the contract shall be free to select, and shall have direct access to, such a clinical psychologist, qualified clinical social worker, optometrist, nurse midwife, or nurse practitioner/nurse clinical specialist without supervision or referral by another health practitioner and shall be entitled under the contract to have payment or reimbursement made to him or on his behalf for the services performed.

''(2) The provisions of this subsection shall not apply to group practice prepayment plans.''

1990—Subsec. (k)(1). Pub. L. 101–509 substituted ''performed by a clinical psychologist, optometrist, nurse midwife, or nurse practitioner/clinical specialist'' for ''performed by a clinical psychologist or optometrist'' and ''qualified clinical social worker, optometrist, nurse midwife, or nurse practitioner/nurse clinical specialist'' for ''qualified clinical social worker or optometrist''.

Subsec. (n). Pub. L. 101–508 added subsec. (n).

1988—Subsecs. (g), (j), (k)(1). Pub. L. 100–654 substituted ''former spouse, or person having continued coverage under section 8905a of this title'' for ''or former spouse'' wherever appearing.

1987—Subsec. (k)(1). Pub. L. 100–202, §101(m) [title VI, §626(1), (2)], inserted ''or by a qualified clinical social worker as defined in section 8901(11),'' after ''as applicable,'', and '', qualified clinical social worker'' after ''such a clinical psychologist''.

Subsec. (k)(2), (3). Pub. L. 100–202, §101(m) [title VI, §626(3)], redesignated par. (3) as (2) and struck out former par. (2) which read as follows: ''When a contract under this chapter requires payment or reimbursement for services which may be performed by a qualified clinical social worker, an employee, annuitant, family member, or former spouse covered by the contract shall be entitled under the contract to have payment or reimbursement made to him or on his behalf for the services performed. As a condition for the payment or reimbursement, the contract—

''(A) may require that the services be performed pursuant to a referral by a psychiatrist; but

''(B) may not require that the services be performed under the supervision of a psychiatrist or other health practitioner.''

Subsec. (m)(2)(A). Pub. L. 100–202, §101(m) [title VI, §626(4)], struck out ''This paragraph shall apply with respect to a qualified clinical social worker covered by subsection (k)(2) of this section without regard to whether such contract contains the requirement authorized by clause (i) of the second sentence of subparagraph (A) of such subsection (k)(2).''

1986—Subsec. (k). Pub. L. 99–251, §105(b), designated existing provisions as par. (1), struck out last sentence providing that the provisions of this subsection shall not apply to group practice prepayment plans, and added pars. (2) and (3).

Subsec. (m)(2)(A). Pub. L. 99–251, §106(a)(3), inserted last sentence relating to applicability of this paragraph with respect to a qualified clinical social worker covered by subsection (k)(2) of this section.

1985—Subsecs. (a), (e), (i). Pub. L. 99–53 inserted reference to section 8903a of this title.

1984—Subsec. (g). Pub. L. 98–615, §3(2)(A), substituted ''employee, annuitant, family member, or former spouse'' for ''employee or annuitant'' in two places.

Subsecs. (j), (k). Pub. L. 98–615, §3(2)(B), substituted ''family member, or former spouse'' for ''or family member''.

1980—Subsec. (m)(2)(A). Pub. L. 96–179 substituted ''in a State where 25 percent or more of the population is located in primary medical care manpower shortage areas designated pursuant to section 332 of the Public Health Service Act (42 U.S.C. 254e)'' for ''who is a mem-

ber of a medically underserved population (within the meaning of section 1302(7) of the Public Health Service Act (42 U.S.C. 300e–17))''.

1978—Subsecs. (a), (c) to (e), (i), (j), (*l*). Pub. L. 95–454 substituted ''Office of Personnel Management'' for ''Civil Service Commission'' and ''Office'' for ''Commission'' wherever appearing.

Subsec. (m). Pub. L. 95–368 added subsec. (m).

1976—Subsec. (*l*). Pub. L. 94–460 added subsec. (*l*).

1975—Subsecs. (j), (k). Pub. L. 94–183 redesignated subsec. (j), added by Pub. L. 93–363 and relating to services performed by a clinical psychologist or optometrist, as (k).

1974—Subsec. (j). Pub. L. 93–363 added subsec. (j) covering services performed by a clinical psychologist or optometrist.

Pub. L. 93–246 added subsec. (j) requiring the carrier to pay for or provide a health service or supply in specified cases.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–12 effective Apr. 30, 1997, and applicable to Federal payments made pursuant to obligations incurred after Apr. 30, 1997, for items and services provided on or after such date, subject to also being applicable with respect to contracts entered into, renewed, or extended after Apr. 30, 1997, as well as contracts entered into before Apr. 30, 1997, to the extent permitted under such contracts, see section 11 of Pub. L. 105–12, set out as an Effective Date note under section 14401 of Title 42, The Public Health and Welfare.

EFFECTIVE DATE OF 1992 AMENDMENT

Pub. L. 102–393, title V, §537(c), Oct. 6, 1992, 106 Stat. 1765, provided that: ''The amendments made by this section [amending this section] shall be effective with respect to contract years beginning after the date of enactment of this Act [Oct. 6, 1992].''

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title VII, §7002(g), Nov. 5, 1990, 104 Stat. 1388–331, provided that: ''Except as provided in subsection (f) [set out as a note under section 8904 of this title], the amendments made by this section [amending this section, sections 8904, 8909, and 8910 of this title, and provisions set out as a note under section 8906 of this title] shall apply with respect to contract years beginning on or after January 1, 1991.''

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–654, title II, §203, Nov. 14, 1988, 102 Stat. 3845, provided that:

''(a) IN GENERAL.—The amendments made by this title [enacting section 8905a of this title and amending this section and sections 8903, 8905, and 8909 of this title] shall apply with respect to—

''(1) any calendar year beginning, and contracts entered into or renewed for any calendar year beginning, after the end of the 9-month period beginning on the date of the enactment of this Act [Nov. 14, 1988]; and

''(2) any qualifying event occurring on or after the first day of the first calendar year beginning after the end of the 9-month period referred to in paragraph (1).

''(b) DEFINITION.—For the purpose of this section, the term 'qualifying event' means any of the following events:

''(1) A separation from Government service.

''(2) A divorce, annulment, or legal separation.

''(3) Any change in circumstances which causes an individual to become ineligible to be considered an unmarried dependent child under chapter 89 of such title [section 8901 et seq. of this title].''

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by section 105(b) of Pub. L. 99–251 effective with respect to contracts entered into or renewed for calendar years beginning after Dec. 31, 1986, see section 105(c) of Pub. L. 99–251, set out as a note under section 8901 of this title.

Pub. L. 99–251, title I, §106(b), Feb. 27, 1986, 100 Stat. 16, provided that: ''The amendments made by subsection (a) [amending this section and provisions set out as notes under this section] shall take effect with respect to services provided after December 31, 1984.''

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–615 effective May 7, 1985, with enumerated exceptions, and applicable to any individual who is married to an employee or annuitant on or after that date, see section 4(a)(2) of Pub. L. 98–615, as amended, set out as a note under section 8341 of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96–179, §5(b), Jan. 2, 1980, 93 Stat. 1300, as amended by Pub. L. 99–251, title I, §106(a)(2), Feb. 27, 1986, 100 Stat. 16, provided that: ''The amendments made by section 3 [amending this section] shall apply to services provided after December 31, 1979, under any contract entered into or renewed after December 31, 1979.''

EFFECTIVE DATE OF 1978 AMENDMENTS

Amendment by Pub. L. 95–454 effective 90 days after Oct. 13, 1978, see section 907 of Pub. L. 95–454, set out as a note under section 1101 of this title.

Pub. L. 95–368, §3, Sept. 17, 1978, 92 Stat. 606, as amended by Pub. L. 99–251, title I, §106(a)(1), Feb. 27, 1986, 100 Stat. 16, provided that: ''The provisions of section 8902(m)(2) of title 5, United States Code, as added by the first section of this Act, shall apply to services provided under any contract entered into or renewed after December 31, 1979.''

EFFECTIVE DATE OF 1976 AMENDMENT

Amendment by Pub. L. 94–460 effective Oct. 8, 1976, see section 118 of Pub. L. 94–460, set out as a note under section 300e of Title 42, The Public Health and Welfare.

EFFECTIVE DATE OF 1974 AMENDMENTS

Pub. L. 93–363, §2, July 30, 1974, 88 Stat. 398, provided that: ''The amendment made by this Act [amending this section] shall become effective with respect to any contract entered into or renewed on or after the date of enactment of this Act [July 30, 1974].''

Pub. L. 93–246, §4(c), Jan. 31, 1974, 88 Stat. 4, provided that: ''Section 3 [amending this section] shall become effective with respect to any contract entered into or renewed on or after the date of enactment of this Act [Jan. 31, 1974].''

FULL DISCLOSURE IN HEALTH PLAN CONTRACTS

Pub. L. 105–266, §5, Oct. 19, 1998, 112 Stat. 2368, provided that: ''The Office of Personnel Management shall encourage carriers offering health benefits plans described by section 8903 or section 8903a of title 5, United States Code, with respect to contractual arrangements made by such carriers with any person for purposes of obtaining discounts from providers for health care services or supplies furnished to individuals enrolled in such plan, to seek assurance that the conditions for such discounts are fully disclosed to the providers who grant them.''

RATE REDUCTION FOR MEDICARE ELIGIBLE FEDERAL ANNUITANTS

Pub. L. 100–360, title IV, §422, July 1, 1988, 102 Stat. 810, which directed the Office of Personnel Management to reduce the rates charged medicare eligible individuals participating in health benefit plans by a prorated amount, was repealed by Pub. L. 101–234, title III, §301(a), Dec. 13, 1989, 103 Stat. 1985.

AUTHORITY OF CARRIER TO CONTRACT FOR COMPREHENSIVE MEDICAL SERVICES FROM A GROUP PRACTICE UNIT OR ORGANIZATION

Pub. L. 91–515, title IV, §401, Oct. 30, 1970, 84 Stat. 1309, authorized Secretary of Health, Education, and

Welfare to permit any carrier which is a party to a contract entered into under this chapter or under the Retired Federal Employees Health Benefits Act, or which participates in carrying out of any such contract, to issue in any State contracts entitling any person as a beneficiary to receive comprehensive medical services from a group practice unit or organization with which such carrier has contracted or otherwise arranged for the provision of such services.

§ 8902a. Debarment and other sanctions

(a)(1) For the purpose of this section—

(A) the term ''provider of health care services or supplies'' or ''provider'' means a physician, hospital, or other individual or entity which furnishes health care services or supplies;

(B) the term ''individual covered under this chapter'' or ''covered individual'' means an employee, annuitant, family member, or former spouse covered by a health benefits plan described by section 8903 or 8903a;

(C) an individual or entity shall be considered to have been ''convicted'' of a criminal offense if—

(i) a judgment of conviction for such offense has been entered against the individual or entity by a Federal, State, or local court;

(ii) there has been a finding of guilt against the individual or entity by a Federal, State, or local court with respect to such offense;

(iii) a plea of guilty or nolo contendere by the individual or entity has been accepted by a Federal, State, or local court with respect to such offense; or

(iv) in the case of an individual, the individual has entered a first offender or other program pursuant to which a judgment of conviction for such offense has been withheld;

without regard to the pendency or outcome of any appeal (other than a judgment of acquittal based on innocence) or request for relief on behalf of the individual or entity; and

(D) the term ''should know'' means that a person, with respect to information, acts in deliberate ignorance of, or in reckless disregard of, the truth or falsity of the information, and no proof of specific intent to defraud is required;[1]

(2)(A) Notwithstanding section 8902(j) or any other provision of this chapter, if, under subsection (b), (c), or (d) a provider is barred from participating in the program under this chapter, no payment may be made by a carrier pursuant to any contract under this chapter (either to such provider or by reimbursement) for any service or supply furnished by such provider during the period of the debarment.

(B) Each contract under this chapter shall contain such provisions as may be necessary to carry out subparagraph (A) and the other provisions of this section.

(b) The Office of Personnel Management shall bar the following providers of health care services or supplies from participating in the program under this chapter:

(1) Any provider that has been convicted, under Federal or State law, of a criminal offense relating to fraud, corruption, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of a health care service or supply.

(2) Any provider that has been convicted, under Federal or State law, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care service or supply.

(3) Any provider that has been convicted, under Federal or State law, in connection with the interference with or obstruction of an investigation or prosecution of a criminal offense described in paragraph (1) or (2).

(4) Any provider that has been convicted, under Federal or State law, of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

(5) Any provider that is currently debarred, suspended, or otherwise excluded from any procurement or nonprocurement activity (within the meaning of section 2455 of the Federal Acquisition Streamlining Act of 1994).

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

(1) Any provider—

(A) whose license to provide health care services or supplies has been revoked, suspended, restricted, or not renewed, by a State licensing authority for reasons relating to the provider's professional competence, professional performance, or financial integrity; or

(B) that surrendered such a license while a formal disciplinary proceeding was pending before such an authority, if the proceeding concerned the provider's professional competence, professional performance, or financial integrity.

(2) Any provider that is an entity directly or indirectly owned, or with a control interest of 5 percent or more held, by an individual who has been convicted of any offense described in subsection (b), against whom a civil monetary penalty has been assessed under subsection (d), or who has been debarred from participation under this chapter.

(3) Any individual who directly or indirectly owns or has a control interest in a sanctioned entity and who knows or should know of the action constituting the basis for the entity's conviction of any offense described in subsection (b), assessment with a civil monetary penalty under subsection (d), or debarment from participation under this chapter.

(4) Any provider that the Office determines, in connection with claims presented under this chapter, has charged for health care services or supplies in an amount substantially in excess of such provider's customary charge for such services or supplies (unless the Office finds there is good cause for such charge), or charged for health care services or supplies which are substantially in excess of the needs of the covered individual or which are of a quality that fails to meet professionally recognized standards for such services or supplies.

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

[1] So in original. The semicolon probably should be a period.