

PUBLIC LAW 104-191—AUG. 21, 1996

HEALTH INSURANCE PORTABILITY AND
ACCOUNTABILITY ACT OF 1996

Public Law 104-191
104th Congress

An Act

To amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes.

Aug. 21, 1996
[H.R. 3103]

Health Insurance
Portability and
Accountability
Act of 1996.
42 USC 201 note.

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 “Health Insurance Portability and Accountability Act of 1996”.

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

Sec. 1. Short title; table of contents.

TITLE I—HEALTH CARE ACCESS, PORTABILITY, AND RENEWABILITY

Subtitle A—Group Market Rules

PART 1—PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS

Sec. 101. Through the Employee Retirement Income Security Act of 1974.

“PART 7—GROUP HEALTH PLAN PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS

“Sec. 701. Increased portability through limitation on preexisting condition exclusions.

“Sec. 702. Prohibiting discrimination against individual participants and beneficiaries based on health status.

“Sec. 703. Guaranteed renewability in multiemployer plans and multiple employer welfare arrangements.

“Sec. 704. Preemption; State flexibility; construction.

“Sec. 705. Special rules relating to group health plans.

“Sec. 706. Definitions.

“Sec. 707. Regulations.”

Sec. 102. Through the Public Health Service Act.

“TITLE XXVII—ASSURING PORTABILITY, AVAILABILITY, AND RENEWABILITY OF HEALTH INSURANCE COVERAGE

“PART A—GROUP MARKET REFORMS

“Subpart 1—Portability, Access, and Renewability Requirements

“Sec. 2701. Increased portability through limitation on preexisting condition exclusions.

“Sec. 2702. Prohibiting discrimination against individual participants and beneficiaries based on health status.

“Subpart 2—Provisions Applicable Only to Health Insurance Issuers

“Sec. 2711. Guaranteed availability of coverage for employers in the group market.

"Sec. 2712. Guaranteed renewability of coverage for employers in the group market.

"Sec. 2713. Disclosure of information.

"Subpart 3—Exclusion of Plans; Enforcement; Preemption

"Sec. 2721. Exclusion of certain plans.

"Sec. 2722. Enforcement.

"Sec. 2723. Preemption; State flexibility; construction.

"PART C—DEFINITIONS; MISCELLANEOUS PROVISIONS

"Sec. 2791. Definitions.

"Sec. 2792. Regulations."

Sec. 103. Reference to implementation through the Internal Revenue Code of 1986.

Sec. 104. Assuring coordination.

Subtitle B—Individual Market Rules

Sec. 111. Amendment to Public Health Service Act.

"PART B—INDIVIDUAL MARKET RULES

"Sec. 2741. Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage.

"Sec. 2742. Guaranteed renewability of individual health insurance coverage.

"Sec. 2743. Certification of coverage.

"Sec. 2744. State flexibility in individual market reforms.

"Sec. 2745. Enforcement.

"Sec. 2746. Preemption.

"Sec. 2747. General exceptions."

Subtitle C—General and Miscellaneous Provisions

Sec. 191. Health coverage availability studies.

Sec. 192. Report on Medicare reimbursement of telemedicine.

Sec. 193. Allowing federally-qualified HMOs to offer high deductible plans.

Sec. 194. Volunteer services provided by health professionals at free clinics.

Sec. 195. Findings; severability.

TITLE II—PREVENTING HEALTH CARE FRAUD AND ABUSE;
ADMINISTRATIVE SIMPLIFICATION; MEDICAL LIABILITY REFORM

Sec. 200. References in title.

Subtitle A—Fraud and Abuse Control Program

Sec. 201. Fraud and abuse control program.

Sec. 202. Medicare integrity program.

Sec. 203. Beneficiary incentive programs.

Sec. 204. Application of certain health antifraud and abuse sanctions to fraud and abuse against Federal health care programs.

Sec. 205. Guidance regarding application of health care fraud and abuse sanctions.

Subtitle B—Revisions to Current Sanctions for Fraud and Abuse

Sec. 211. Mandatory exclusion from participation in Medicare and State health care programs.

Sec. 212. Establishment of minimum period of exclusion for certain individuals and entities subject to permissive exclusion from Medicare and State health care programs.

Sec. 213. Permissive exclusion of individuals with ownership or control interest in sanctioned entities.

Sec. 214. Sanctions against practitioners and persons for failure to comply with statutory obligations.

Sec. 215. Intermediate sanctions for Medicare health maintenance organizations.

Sec. 216. Additional exception to anti-kickback penalties for risk-sharing arrangements.

Sec. 217. Criminal penalty for fraudulent disposition of assets in order to obtain medicaid benefits.

Sec. 218. Effective date.

Subtitle C—Data Collection

Sec. 221. Establishment of the health care fraud and abuse data collection program.

Subtitle D—Civil Monetary Penalties

Sec. 231. Social Security Act civil monetary penalties.

Subtitle A—Fraud and Abuse Control Program

SEC. 201. FRAUD AND ABUSE CONTROL PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—Title XI (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128B the following new section:

“FRAUD AND ABUSE CONTROL PROGRAM

42 USC 1320a-
7c.

“SEC. 1128C. (a) ESTABLISHMENT OF PROGRAM.—

“(1) IN GENERAL.—Not later than January 1, 1997, the Secretary, acting through the Office of the Inspector General of the Department of Health and Human Services, and the Attorney General shall establish a program—

“(A) to coordinate Federal, State, and local law enforcement programs to control fraud and abuse with respect to health plans,

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

“(C) to facilitate the enforcement of the provisions of sections 1128, 1128A, and 1128B and other statutes applicable to health care fraud and abuse,

“(D) to provide for the modification and establishment of safe harbors and to issue advisory opinions and special fraud alerts pursuant to section 1128D, and

“(E) to provide for the reporting and disclosure of certain final adverse actions against health care providers, suppliers, or practitioners pursuant to the data collection system established under section 1128E.

“(2) COORDINATION WITH HEALTH PLANS.—In carrying out the program established under paragraph (1), the Secretary and the Attorney General shall consult with, and arrange for the sharing of data with representatives of health plans.

“(3) GUIDELINES.—

“(A) IN GENERAL.—The Secretary and the Attorney General shall issue guidelines to carry out the program under paragraph (1). The provisions of sections 553, 556, and 557 of title 5, United States Code, shall not apply in the issuance of such guidelines.

“(B) INFORMATION GUIDELINES.—

“(i) IN GENERAL.—Such guidelines shall include guidelines relating to the furnishing of information by health plans, providers, and others to enable the Secretary and the Attorney General to carry out the program (including coordination with health plans under paragraph (2)).

“(ii) CONFIDENTIALITY.—Such guidelines shall include procedures to assure that such information is provided and utilized in a manner that appropriately protects the confidentiality of the information and the privacy of individuals receiving health care services and items.

“(iii) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) (relat-

ing to limitation on liability) shall apply to a person providing information to the Secretary or the Attorney General in conjunction with their performance of duties under this section.

“(4) ENSURING ACCESS TO DOCUMENTATION.—The Inspector General of the Department of Health and Human Services is authorized to exercise such authority described in paragraphs (3) through (9) of section 6 of the Inspector General Act of 1978 (5 U.S.C. App.) as necessary with respect to the activities under the fraud and abuse control program established under this subsection.

“(5) AUTHORITY OF INSPECTOR GENERAL.—Nothing in this Act shall be construed to diminish the authority of any Inspector General, including such authority as provided in the Inspector General Act of 1978 (5 U.S.C. App.).

“(b) ADDITIONAL USE OF FUNDS BY INSPECTOR GENERAL.—

“(1) REIMBURSEMENTS FOR INVESTIGATIONS.—The Inspector General of the Department of Health and Human Services is authorized to receive and retain for current use reimbursement for the costs of conducting investigations and audits and for monitoring compliance plans when such costs are ordered by a court, voluntarily agreed to by the payor, or otherwise.

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

“(c) HEALTH PLAN DEFINED.—For purposes of this section, the term ‘health plan’ means a plan or program that provides health benefits, whether directly, through insurance, or otherwise, and includes—

“(1) a policy of health insurance;

“(2) a contract of a service benefit organization; and

“(3) a membership agreement with a health maintenance organization or other prepaid health plan.”

(b) ESTABLISHMENT OF HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT IN FEDERAL HOSPITAL INSURANCE TRUST FUND.—Section 1817 (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

“(k) HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.—

“(1) ESTABLISHMENT.—There is hereby established in the Trust Fund an expenditure account to be known as the ‘Health Care Fraud and Abuse Control Account’ (in this subsection referred to as the ‘Account’).

“(2) APPROPRIATED AMOUNTS TO TRUST FUND.—

“(A) IN GENERAL.—There are hereby appropriated to the Trust Fund—

“(i) such gifts and bequests as may be made as provided in subparagraph (B);

“(ii) such amounts as may be deposited in the Trust Fund as provided in sections 242(b) and 249(c) of the Health Insurance Portability and Accountability Act of 1996, and title XI; and

“(iii) such amounts as are transferred to the Trust Fund under subparagraph (C).

“(B) AUTHORIZATION TO ACCEPT GIFTS.—The Trust Fund is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to the Trust Fund, for the benefit of the Account or any activity financed through the Account.

“(C) TRANSFER OF AMOUNTS.—The Managing Trustee shall transfer to the Trust Fund, under rules similar to the rules in section 9601 of the Internal Revenue Code of 1986, an amount equal to the sum of the following:

“(i) Criminal fines recovered in cases involving a Federal health care offense (as defined in section 982(a)(6)(B) of title 18, United States Code).

“(ii) Civil monetary penalties and assessments imposed in health care cases, including amounts recovered under titles XI, XVIII, and XIX, and chapter 38 of title 31, United States Code (except as otherwise provided by law).

“(iii) Amounts resulting from the forfeiture of property by reason of a Federal health care offense.

“(iv) Penalties and damages obtained and otherwise creditable to miscellaneous receipts of the general fund of the Treasury obtained under sections 3729 through 3733 of title 31, United States Code (known as the False Claims Act), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator, for restitution or otherwise authorized by law).

“(D) APPLICATION.—Nothing in subparagraph (C)(iii) shall be construed to limit the availability of recoveries and forfeitures obtained under title I of the Employee Retirement Income Security Act of 1974 for the purpose of providing equitable or remedial relief for employee welfare benefit plans, and for participants and beneficiaries under such plans, as authorized under such title.

“(3) APPROPRIATED AMOUNTS TO ACCOUNT FOR FRAUD AND ABUSE CONTROL PROGRAM, ETC.—

“(A) DEPARTMENTS OF HEALTH AND HUMAN SERVICES AND JUSTICE.—

“(i) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund such sums as the Secretary and the Attorney General certify are necessary to carry out the purposes described in subparagraph (C), to be available without further appropriation, in an amount not to exceed—

“(I) for fiscal year 1997, \$104,000,000,

“(II) for each of the fiscal years 1998 through 2003, the limit for the preceding fiscal year, increased by 15 percent; and

“(III) for each fiscal year after fiscal year 2003, the limit for fiscal year 2003.

“(ii) MEDICARE AND MEDICAID ACTIVITIES.—For each fiscal year, of the amount appropriated in clause (i), the following amounts shall be available only for the purposes of the activities of the Office of the Inspector General of the Department of Health and Human Services with respect to the Medicare and medicaid programs—

“(I) for fiscal year 1997, not less than \$60,000,000 and not more than \$70,000,000;

“(II) for fiscal year 1998, not less than \$80,000,000 and not more than \$90,000,000;

“(III) for fiscal year 1999, not less than \$90,000,000 and not more than \$100,000,000;

“(IV) for fiscal year 2000, not less than \$110,000,000 and not more than \$120,000,000;

“(V) for fiscal year 2001, not less than \$120,000,000 and not more than \$130,000,000;

“(VI) for fiscal year 2002, not less than \$140,000,000 and not more than \$150,000,000; and

“(VII) for each fiscal year after fiscal year 2002, not less than \$150,000,000 and not more than \$160,000,000.

“(B) FEDERAL BUREAU OF INVESTIGATION.—There are hereby appropriated from the general fund of the United States Treasury and hereby appropriated to the Account for transfer to the Federal Bureau of Investigation to carry out the purposes described in subparagraph (C), to be available without further appropriation—

“(i) for fiscal year 1997, \$47,000,000;

“(ii) for fiscal year 1998, \$56,000,000;

“(iii) for fiscal year 1999, \$66,000,000;

“(iv) for fiscal year 2000, \$76,000,000;

“(v) for fiscal year 2001, \$88,000,000;

“(vi) for fiscal year 2002, \$101,000,000; and

“(vii) for each fiscal year after fiscal year 2002, \$114,000,000.

“(C) USE OF FUNDS.—The purposes described in this subparagraph are to cover the costs (including equipment, salaries and benefits, and travel and training) of the administration and operation of the health care fraud and abuse control program established under section 1128C(a), including the costs of—

“(i) prosecuting health care matters (through criminal, civil, and administrative proceedings);

“(ii) investigations;

“(iii) financial and performance audits of health care programs and operations;

“(iv) inspections and other evaluations; and

“(v) provider and consumer education regarding compliance with the provisions of title XI.

“(4) APPROPRIATED AMOUNTS TO ACCOUNT FOR MEDICARE INTEGRITY PROGRAM.—

“(A) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund for each fiscal year such amounts as are necessary to carry out the Medicare Integrity Program under section 1893, subject to subparagraph (B) and to be available without further appropriation.

“(B) AMOUNTS SPECIFIED.—The amount appropriated under subparagraph (A) for a fiscal year is as follows:

“(i) For fiscal year 1997, such amount shall be not less than \$430,000,000 and not more than \$440,000,000.