for a fiscal year to award grants to safety net trauma centers described in paragraph (1)(A)(ii).

(d) Use of funds

The recipient of a grant under subsection (b) shall carry out 1 or more of the following activities consistent with subsection (b):

(1) Providing trauma centers with funding to support physician compensation in trauma-related physician specialties where shortages exist in the region involved, with priority provided to safety net trauma centers described in subsection (c)(1)(A)(ii).

(2) Providing for individual safety net trauma center fiscal stability and costs related to having service that is available 24 hours a day, 7 days a week, with priority provided to safety net trauma centers described in subsection (c)(1)(A)(ii) located in urban, border, and rural areas.

(3) Reducing trauma center overcrowding at specific trauma centers related to throughput of trauma patients.

(4) Establishing new trauma services in underserved areas as defined by the State.

(5) Enhancing collaboration between trauma centers and other hospitals and emergency medical services personnel related to trauma service availability.

(6) Making capital improvements to enhance access and expedite trauma care, including providing helipads and associated safety infrastructure.

(7) Enhancing trauma surge capacity at specific trauma centers.

(8) Ensuring expedient receipt of trauma patients transported by ground or air to the appropriate trauma center.

(9) Enhancing interstate trauma center collaboration.

(e) Limitation

(1) In general

A State may use not more than 20 percent of the amount available to the State under this part for a fiscal year for administrative costs associated with awarding grants and related costs.

(2) Maintenance of effort

The Secretary may not provide funding to a State under this part unless the State agrees that such funds will be used to supplement and not supplant State funding otherwise available for the activities and costs described in this part.

(f) Distribution of funds

The following shall apply with respect to grants provided in this part:

(1) Less than $10,000,000

If the amount of appropriations for this part in a fiscal year is less than $10,000,000, the Secretary shall divide such funding evenly among only those States that have 1 or more trauma centers eligible for funding under section 300d–41(b)(3)(A) of this title.

(2) Less than $20,000,000

If the amount of appropriations in a fiscal year is less than $20,000,000, the Secretary shall divide such funding evenly among only those States that have 1 or more trauma centers eligible for funding under subparagraphs (A) and (B) of section 300d–41(b)(3) of this title.

(3) Less than $30,000,000

If the amount of appropriations for this part in a fiscal year is less than $30,000,000, the Secretary shall divide such funding evenly among only those States that have 1 or more trauma centers eligible for funding under section 300d–41(b)(3) of this title.

(4) $30,000,000 or more

If the amount of appropriations for this part in a fiscal year is $30,000,000 or more, the Secretary shall divide such funding evenly among all States.

(July 1, 1944, ch. 373, title XII, § 1281, as added Pub. L. 111–148, title III, § 3505(b), Mar. 23, 2010, 124 Stat. 525.)

§ 300d–82. Authorization of appropriations

For the purpose of carrying out this part, there is authorized to be appropriated $100,000,000 for each of fiscal years 2010 through 2015.

(July 1, 1944, ch. 373, title XII, § 1282, as added Pub. L. 111–148, title III, § 3505(b), Mar. 23, 2010, 124 Stat. 527.)

SUBCHAPTER XI—HEALTH MAINTENANCE ORGANIZATIONS

§ 300e. Requirements of health maintenance organizations

(a) "Health maintenance organization" defined

For purposes of this subchapter, the term ''health maintenance organization'' means a public or private entity which is organized under the laws of any State and which (1) provides basic and supplemental health services to its members in the manner prescribed by subsection (b) of this section, and (2) is organized and operated in the manner prescribed by subsection (c) of this section.

(b) Manner of supplying basic and supplemental health services to members

A health maintenance organization shall provide, without limitations as to time or cost other than those prescribed by or under this subchapter, basic and supplemental health services to its members in the following manner:

(1) Each member is to be provided basic health services for a basic health services payment which (A) is to be paid on a periodic basis without regard to the dates health services (within the basic health services) are provided; (B) is fixed without regard to the frequency, extent, or kind of health service (within the basic health services) actually furnished; (C) except in the case of basic health services provided a member who is a full-time student (as defined by the Secretary) at an accredited institution of higher education, is fixed under a community rating system; and (D) may be supplemented by additional nominal payments which may be required for the provision of specific services (within the basic

health services), except that such payments may not be required where or in such a manner that they serve (as determined under regulations of the Secretary) as a barrier to the delivery of health services. Such additional nominal payments shall be fixed in accordance with the regulations of the Secretary. If a health maintenance organization offers to its members the opportunity to obtain basic health services through a physician not described in subsection (b)(3)(A) of this section, the organization may require, in addition to payments described in clause (D) of this paragraph, a reasonable deductible to be paid by a member when obtaining a basic health service from such a physician. A health maintenance organization may include a health service, defined as a supplemental health service by section 300e–1(2) of this title, in the basic health services provided its members for a basic health services payment described in the first sentence. In the case of an entity which before it became a qualified health maintenance organization (within the meaning of section 300e–9(d)[1] of this title) 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. The requirements of this paragraph respecting the basic health services payment shall not apply to the provision of basic health services to a member for an illness or injury for which the member is entitled to benefits under a workmen's compensation law or an insurance policy but only to the extent such benefits apply to such services. For the provision of such services for an illness or injury for which a member is entitled to benefits under such a law, the health maintenance organization may, if authorized by such law, charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law, the insurance carrier, employer, or other entity which under such law is to pay for the provision of such services or, to the extent that such member has been paid under such law for such services, such member. For the provision of such services for an illness or injury for which a member is entitled to benefits under an insurance policy, a health maintenance organization may charge or authorize the provider of such services to charge the insurance carrier under such policy or, to the extent that such member has been paid under such policy for such services, such member.

(2) For such payment or payments (hereinafter in this subchapter referred to as ''supplemental health services payments'') as the health maintenance organization may require in addition to the basic health services payment, 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 300e–1(2) of this title). Supplemental health services payments which are fixed on a prepayment basis shall be fixed under a community rating system unless the supplemental health services payment is for a supplemental health service provided a member who is a full-time student (as defined by the Secretary) at an accredited institution of higher education, except that, in the case of an entity which before it became a qualified health maintenance organization (within the meaning of section 300e–9(d)[1] of this title) 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)(A) Except as provided in subparagraph (B), at least 90 percent of the services of a physician which are provided as basic health services shall be provided through—

(i) members of the staff of the health maintenance organization,

(ii) a medical group (or groups),

(iii) an individual practice association (or associations),

(iv) physicians or other health professionals who have contracted with the health maintenance organization for the provision of such services, or

(v) any combination of such staff, medical group (or groups), individual practice association (or associations) or physicians or other health professionals under contract with the organization.

(B) Subparagraph (A) does not apply to the provision of the services of a physician—

(i) which the health maintenance organization determines, in conformity with regulations of the Secretary, are unusual or infrequently used, or

(ii) which are provided a member of the organization in a manner other than that prescribed by subparagraph (A) because of an emergency which made it medically necessary that the service be provided to the member before it could be provided in a manner prescribed by subparagraph (A).

(C) 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, but only to the extent that such requirements are designed to insure the delivery of quality health care services and sound fiscal management.

(D) For purposes of this paragraph the term ''health professional'' means physicians, dentists, nurses, podiatrists, optometrists, and such other individuals engaged in the delivery of health services as the Secretary may by regulation designate.

(4) Basic health services (and only such supplemental health services as members have contracted for) shall within the area served by the health maintenance organization be available and accessible to each of its members with reasonable promptness and in a manner which assures continuity, and when medically necessary be available and accessible twenty-four hours a day and seven days a week, except

[1] See References in Text note below.

that a health maintenance organization which has a service area located wholly in a nonmetropolitan area may make a basic health service available outside its service area if that basic health service is not a primary care or emergency health care service and if there is an insufficient number of providers of that basic health service within the service area who will provide such service to members of the health maintenance organization. A member of a health maintenance organization shall be reimbursed by the organization for his expenses in securing basic and supplemental health services other than through the organization if the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition.

(5) To the extent that a natural disaster, war, riot, civil insurrection, or any other similar event not within the control of a health maintenance organization (as determined under regulations of the Secretary) results in the facilities, personnel, or financial resources of a health maintenance organization not being available to provide or arrange for the provision of a basic or supplemental health service in accordance with the requirements of paragraphs (1) through (4) of this subsection, such requirements only require the organization to make a good-faith effort to provide or arrange for the provision of such service within such limitation on its facilities, personnel, or resources.

(6) A health maintenance organization that otherwise meets the requirements of this subchapter may offer a high-deductible health plan (as defined in section 220(c)(2) of title 26).

(c) Organizational requirements

Each health maintenance organization shall—

(1)(A) have—

(i) a fiscally sound operation, and

(ii) adequate provision against the risk of insolvency,

which is satisfactory to the Secretary, and (B) have administrative and managerial arrangements satisfactory to the Secretary;

(2) assume full financial risk on a prospective basis for the provision of basic health services, except that a health maintenance organization may (A) obtain insurance or make other arrangements for the cost of providing to any member basic health services the aggregate value of which exceeds $5,000 in any year, (B) obtain insurance or make other arrangements for the cost of basic health services provided to its members other than through the organization because medical necessity required their provision before they could be secured through the organization, (C) obtain insurance or make other arrangements for not more than 90 per centum of the amount by which its costs for any of its fiscal years exceed 115 per centum of its income for such fiscal year, and (D) make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions;

(3)(A) enroll persons who are broadly representative of the various age, social, and income groups within the area it serves, except that in the case of a health maintenance organization which has a medically underserved population located (in whole or in part) in the area it serves, not more than 75 per centum of the members of that organization may be enrolled from the medically underserved population unless the area in which such population resides is also a rural area (as designated by the Secretary), and (B) carry out enrollment of members who are entitled to medical assistance under a State plan approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] in accordance with procedures approved under regulations promulgated by the Secretary;

(4) not expel or refuse to re-enroll any member because of his health status or his requirements for health services;

(5) be organized in such a manner that provides meaningful procedures for hearing and resolving grievances between the health maintenance organization (including the medical group or groups and other health delivery entities providing health services for the organization) and the members of the organization;

(6) have organizational arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for its health services which program (A) stresses health outcomes, and (B) provides review by physicians and other health professionals of the process followed in the provision of health services;

(7) adopt at least one of the following arrangements to protect its members from incurring liability for payment of any fees which are the legal obligation of such organization—

(A) a contractual arrangement with any hospital that is regularly used by the members of such organization prohibiting such hospital from holding any such member liable for payment of any fees which are the legal obligation of such organization;

(B) insolvency insurance, acceptable to the Secretary;

(C) adequate financial reserve, acceptable to the Secretary; and

(D) other arrangements, acceptable to the Secretary, to protect members,

except that the requirements of this paragraph shall not apply to a health maintenance organization if applicable State law provides the members of such organization with protection from liability for payment of any fees which are the legal obligation of such organization; and

(8) provide, in accordance with regulations of the Secretary (including safeguards concerning the confidentiality of the doctor-patient relationship), and effective procedure for developing, compiling, evaluating, and reporting to the Secretary, statistics and other information (which the Secretary shall publish and disseminate on an annual basis and which the health maintenance organization shall disclose, in a manner acceptable to the Secretary, to its members and the general public) relating to (A) the cost of its operations, (B)

the patterns of utilization of its services, (C) the availability, accessibility, and acceptability of its services, (D) to the extent practical, developments in the health status of its members, and (E) such other matters as the Secretary may require.

The Secretary shall issue regulations stating the circumstances under which the Secretary, in administering paragraph (1)(A), will consider the resources of an organization which owns or controls a health maintenance organization. Such regulations shall require as a condition to consideration of resources that an organization which owns or controls a health maintenance organization shall provide satisfactory assurances that it will assume the financial obligations of the health maintenance organization.

(d) Application of rules by certain health maintenance organizations

An organization that offers health benefits coverage shall not be considered as failing to meet the requirements of this section notwithstanding that it provides, with respect to coverage offered in connection with a group health plan in the small or large group market (as defined in section 300gg–91(e) of this title), an affiliation period consistent with the provisions of section 2701(g).[1]

(July 1, 1944, ch. 373, title XIII, §1301, as added Pub. L. 93–222, §2, Dec. 29, 1973, 87 Stat. 914; amended Pub. L. 94–460, title I, §§101, 102(a), 103, 105(a), Oct. 8, 1976, 90 Stat. 1945–1947; Pub. L. 95–559, §§9(b), 10, 11(a)–(d), Nov. 1, 1978, 92 Stat. 2137–2139; Pub. L. 96–32, §2(b), July 10, 1979, 93 Stat. 82; Pub. L. 97–35, title IX, §942(a)(1), (2), (b)–(e), Aug. 13, 1981, 95 Stat. 573, 574; Pub. L. 100–517, §§2–4(a), 5(a)(1), (2), (b), Oct. 24, 1988, 102 Stat. 2578, 2579; Pub. L. 104–191, title I, §§102(b), 193, Aug. 21, 1996, 110 Stat. 1976, 1988.)

REFERENCES IN TEXT

Section 300e–9(d) of this title, referred to in subsec. (b)(1), (2), was redesignated section 300e–9(c) of this title by Pub. L. 100–517, §7(b), Oct. 24, 1988, 102 Stat. 2580.

The Social Security Act, referred to in subsec. (c)(3)(B), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Title XIX of the Social Security Act is classified generally to subchapter XIX (§1396 et seq.) of chapter 7 of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

Section 2701, referred to in subsec. (d), is a reference to section 2701 of act July 1, 1944. Section 2701, which was classified to section 300gg of this title, was renumbered section 2704, effective for plan years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111–148, title I, §§1201(2), 1563(c)(1), formerly §1562(c)(1), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and was transferred to section 300gg–3 of this title. A new section 2701 of act July 1, 1944, related to fair health insurance premiums, was added, effective for plan years beginning on or after Jan. 1, 2014, and amended, by Pub. L. 111–148, title I, §1201(4), title X, §10103(a), Mar. 23, 2010, 124 Stat. 155, 892, and is classified to section 300gg of this title.

CODIFICATION

Amendment to subsec. (b)(3)(D) by section 942(b)(2) of Pub. L. 97–35 was executed before redesignation by section 942(a)(1)(B) of Pub. L. 97–35, to reflect the probable intent of Congress.

AMENDMENTS

1996—Subsec. (b)(6). Pub. L. 104–191, §193, added par. (6).

Subsec. (d). Pub. L. 104–191, §102(b), added subsec. (d).

1988—Subsec. (a). Pub. L. 100–517, §2, substituted ''public or private entity which is organized under the laws of any State and'' for ''legal entity''.

Subsec. (b)(1). Pub. L. 100–517, §3, inserted after second sentence ''If a health maintenance organization offers to its members the opportunity to obtain basic health services through a physician not described in subsection (b)(3)(A) of this section, the organization may require, in addition to payments described in clause (D) of this paragraph, a reasonable deductible to be paid by a member when obtaining a basic health service from such a physician.''

Subsec. (b)(3)(A). Pub. L. 100–517, §4(a), substituted ''at least 90 percent of the services of a physician'' for ''the services of a physician''.

Subsec. (c). Pub. L. 100–517, §5(a)(2), inserted at end ''The Secretary shall issue regulations stating the circumstances under which the Secretary, in administering paragraph (1)(A), will consider the resources of an organization which owns or controls a health maintenance organization. Such regulations shall require as a condition to consideration of resources that an organization which owns or controls a health maintenance organization shall provide satisfactory assurances that it will assume the financial obligations of the health maintenance organization.''

Subsec. (c)(1)(A). Pub. L. 100–517, §5(a)(1), amended subpar. (A) generally. Prior to amendment, subpar. (A) read as follows: ''have a fiscally sound operation and adequate provision against the risk of insolvency which is satisfactory to the Secretary, and''.

Subsec. (c)(5) to (9). Pub. L. 100–517, §5(b), redesignated pars. (6) to (9) as (5) to (8), respectively, and struck out former par. (5) which read as follows: ''(A) in the case of a private health maintenance organization, be organized in such a manner that assures that (i) at least one-third of the membership of the policymaking body of the health maintenance organization will be members of the organization, and (ii) there will be equitable representation on such body of members from medically underserved populations served by the organization, and (B) in the case of a public health maintenance organization, have an advisory board to the policymaking body of the public entity operating the organization which board meets the requirements of clause (A) of this paragraph and to which may be delegated policymaking authority for the organization;''.

1981—Subsec. (b)(3)(A)(iv). Pub. L. 97–35, §942(a)(2), substituted ''physicians'' for ''subject to subparagraph (C), physicians''.

Subsec. (b)(3)(B). Pub. L. 97–35, §942(b)(1), substituted ''(B)'' for ''(B)(i)'', ''(i)'' for ''(I)'', and ''(ii)'' for ''(II)'' and struck out former cl. (ii) which related to the forty-eight-month period beginning after the month of qualification of a health maintenance organization.

Subsec. (b)(3)(C). Pub. L. 97–35, §942(a)(1), redesignated subpar. (D) as (C) and struck out former subpar. (C) which related to the expiration of the first four fiscal years as a qualified organization.

Subsec. (b)(3)(D). Pub. L. 97–35, §942(b)(2), amended subpar. (D) generally. Prior to amendment, subpar. (D) read as follows: ''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).'' See Codification note above.

Pub. L. 97–35, §942(a)(1)(B), redesignated subpar. (E) as (D). Former subpar. (D) redesignated (C).

Subsec. (b)(4). Pub. L. 97–35, §942(c), substituted ''with reasonable promptness'' for ''promptly as appropriate'' and inserted '', except that a health maintenance organization which has a service area located wholly in a nonmetropolitan area may make a basic health service available outside its service area if that basic health service is not a primary care or emergency health care service and if there is an insufficient number of providers of that basic health service within the service area who will provide such service to members of the health maintenance organization'' after ''week''.

Subsec. (c). Pub. L. 97–35, § 942(d)(1), (e), in par. (2) substituted provisions specifying requirements with respect to insurance, etc., for provisions generalizing such insurance, etc., requirements, and added cl. (D), struck out par. (4) which related to open enrollment period, redesignated pars. (5) to (8) as (4) to (7), respectively, added par. (8), struck out pars. (9) and (10) which related to medical social and health education services, and continuing education, respectively, and redesignated par. (11) as (9).

Subsec. (d). Pub. L. 97–35, § 942(d)(2), struck out subsec. (d) which related to requirements, etc., respecting open enrollment period.

1979—Subsec. (b)(3). Pub. L. 96–32 amended directory language of section 11(a) of Pub. L. 95–559 by substituting reference to section ''1301'' for ''1310'' of the Public Health Service Act, as section to be amended, and required no change in text because amendment made by Pub. L. 95–559 had been executed to this section as the probable intent of Congress.

1978—Subsec. (b)(1). Pub. L. 95–559, §§ 10(a), 11(b), inserted ''except in the case of basic health services provided a member who is a full-time student (as defined by the Secretary) at an accredited institution of higher education,'' after ''the requirement of clause (C)'' and inserted provisions permitting the health maintenance organization to seek reimbursement for the cost of services provided to a member who is entitled to benefits under a workmen's compensation law or insurance policy.

Subsec. (b)(2). Pub. L. 95–559, § 10(a), inserted ''unless the supplemental health services payment is for a supplemental health service provided a member who is a full-time student (as defined by the Secretary) at an accredited institution of higher education,'' after ''community rating system''.

Subsec. (b)(3). Pub. L. 95–559, § 11(a), as amended by Pub. L. 96–32, inserted provisions limiting the health maintenance organization from entering into contracts for health services with physicians other than members of the staff of the health maintenance organization, medical groups, or individual practice associations.

Subsec. (b)(4). Pub. L. 95–559, § 11(c), substituted ''basic and supplemental'' for ''basic or supplemental'' and ''if the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition'' for ''if it was medically necessary that the services be provided before it could secure them through the organization''.

Subsec. (b)(5). Pub. L. 95–559, § 11(d), added par. (5).

Subsec. (c)(1). Pub. L. 95–559, § 10(b), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (c)(3). Pub. L. 95–559, § 9(b), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (c)(6). Pub. L. 95–559, § 10(c), designated existing provisions as subpar. (A), inserted ''in the case of a private health maintenance organization,'' before ''be organized in such'', and substituted ''(i)'' for ''(A)'' and ''(ii)'' for ''(B)'', and added subpar. (B).

1976—Subsec. (b)(1). Pub. L. 94–460, §§ 101(a), 105(a)(1), provided that a health maintenance organization may include a health service, defined as a supplemental health service by section 300e–1(2) of this title, in the basic health services provided its members for a basic health service payment described in the first sentence, and also provided that, in the case of an entity which before it became a qualified health maintenance organization (within the meaning of section 300e–9(d) of this title) provided comprehensive health services on a prepaid basis, the requirement of clause (C) would 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.

Subsec. (b)(2). Pub. L. 94–460, §§ 101(b), 105(a)(2), substituted ''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 300e–1(2) of this title)'' for ''the organization shall provide to each of its members each health service (A) which is included in supplemental health services (as defined in section 300e–1(2) of this title), (B) for which the required health manpower are available in the area served by the organization, and (C) for the provision of which the member has contracted with the organization'' and inserted ''except that, in the case of an entity which before it became a qualified health maintenance organization (within the meaning of section 300e–9(d) of this title) 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'' after ''Supplemental health services payments which are fixed on a prepayment basis shall be fixed under a community rating system''.

Subsec. (b)(3). Pub. L. 94–460, § 102(a), inserted references to health professionals who have contracted with the health maintenance organization for the provision of such services and to the combination of staff, medical groups, individual practice associations, or health professionals under contract with the health maintenance organization, and inserted provisions allowing a health maintenance organization, 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 300e–9(d) of this title), to provide basic and supplemental health services through an entity which but for the requirement of section 300e–1(4)(C)(i) of this title would be a medical group for purposes of this subchapter, directing that 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, directing that 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 the sentence would 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 300e–1(4)(C)(i) of this title would be a medical group for purposes of this subchapter, and directing that contracts between a health maintenance organization and health professionals for the provision of basic and supplemental health services include such provisions as the Secretary may require (including provisions requiring appropriate continuing education).

Subsec. (b)(4). Pub. L. 94–460, § 101(c), substituted ''and only such supplemental health services as members have contracted for'' for ''and supplemental health services in the case of the members who have contracted therefor''.

Subsec. (c)(4). Pub. L. 94–460, § 103(a), substituted provisions making a simple reference to an open enrollment period in accordance with the provisions of subsec. (d) of this section for provisions spelling out in detail the requirements for a health maintenance organization with regard to an open enrollment period.

Subsec. (d). Pub. L. 94–460, § 103(b), added subsec. (d).

EFFECTIVE DATE OF 1976 AMENDMENT

Pub. L. 94–460, title I, § 118, Oct. 8, 1976, 90 Stat. 1955, provided that:

''(a) Except as provided in subsection (b), the amendments made by this title [enacting section 300e–15 of this title and amending this section, sections 300e–1 to 300e–11, 300e–13, and 300n–1 of this title, and section 8902 of Title 5, Government Organization and Employees]

shall take effect on the date of the enactment of this Act [Oct. 8, 1976].

''(b)(1) The amendments made by sections 101 [amending this section], 102 [amending this section and section 300e–1 of this title], 103 [amending this section], 104 [amending section 300e–1 of this title], and 106 [amending section 300e–1 of this title] 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 [sections 300e–2, 300e–3, and 300e–4 of this title] for fiscal years beginning after September 30, 1976, (B) apply with respect to health benefit plans offered under section 1310 of such Act [section 300e–9 of this title] after such date, and (C) for purposes of section 1312 [section 300e–11 of this title] take effect October 1, 1976.

''(2) Subsection (d) of section 1301 of the Public Health Service Act [subsec. (d) of this section] (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 [Oct. 8, 1976].

''(3) The amendments made by section 107 [amending sections 300e–2, 300e–3, and 300e–4 of this title] shall apply with respect to grants, contracts, loans, and loan guarantees made under sections 1303, 1304, and 1305 of the Public Health Service Act [sections 300e–2, 300e–3 and 300e–4 of this title] for fiscal years beginning after September 30, 1976.

''(4) The amendments made by sections 109(a)(1) [amending section 300e–4 of this title] and 109(c) [amending section 300e–7 of this title] shall apply with respect to loan guarantees made under section 1305 of the Public Health Service Act [section 300e–4 of this title] after September 30, 1976.

''(5) The amendment made by section 109(e) [amending section 300e–3 of this title] shall apply with respect to projects assisted under section 1304 of the Public Health Service Act [section 300e–3 of this title] after September 30, 1976.

''(6) The amendments made by paragraphs (1) and (2) of section 110(a) [amending section 300e–9 of this title] shall apply with respect to calendar quarters which begin after the date of the enactment of this Act [Oct. 8, 1976].

''(7) The amendments made by paragraphs (3) and (4) of section 110 [amending section 300e–9 of this title] shall apply with respect to failures of employers to comply with section 1310(a) of the Public Health Service Act [section 300e–9 of this title] after the date of the enactment of this Act [Oct. 8, 1976].

''(8) The amendment made by section 111 [amending section 300e–11 of this title] 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 [section 300e–11(a) of this title] and made after the date of the enactment of this Act [Oct. 8, 1976].''

SHORT TITLE OF 1978 AMENDMENT

For short title of Pub. L. 95–559 as the ''Health Maintenance Organization Amendments of 1978'', see section 1 of Pub. L. 95–559, set out as a note under section 201 of this title.

SHORT TITLE OF 1976 AMENDMENT

For short title of Pub. L. 94–460 which substantially amended this subchapter, as the ''Health Maintenance Organization Amendments of 1976'', see section 1(a) of Pub. L. 94–460, set out as a note under section 201 of this title.

SHORT TITLE

For short title of Pub. L. 93–222, which enacted this subchapter, as the ''Health Maintenance Organization Act of 1973'', see section 1 of Pub. L. 93–222, set out as a Short Title of 1973 Amendments note under section 201 of this title.

QUALIFICATION OF HEALTH MAINTENANCE ORGANIZATION CONTINGENT UPON CONTROLLING ORGANIZATION'S ASSUMPTION OF FINANCIAL OBLIGATIONS AND MEETING OTHER REQUIREMENTS

Section 5(a)(3) of Pub. L. 100–517 provided that: ''During the period prior to the effective date of regulations issued under section 1301(c) of the Public Health Service Act [subsec. (c) of this section] (as amended by paragraph (2)), the Secretary of Health and Human Services shall consider the application for qualification under section 1301(c)(1)(A) of such Act of a health maintenance organization—

''(A) which is owned or controlled by another organization, and

''(B) which requests that the resources of the other organization be considered in determining its qualification under such section,

if the Secretary receives satisfactory assurances from the other organization that it will assume the financial obligations of the health maintenance organization and if the Secretary determines that the other organization meets such other requirements as the Secretary determines are necessary.''

STUDY ON HEALTH MAINTENANCE ORGANIZATION PROGRAM

Pub. L. 99–660, title VIII, § 813, Nov. 14, 1986, 100 Stat. 3801, which provided for a study to assess the operation and impact of the provisions of this subchapter and a report to Congress on the findings and conclusions of such study within 18 months after Nov. 14, 1986, was repealed by Pub. L. 102–531, title III, § 311(a), Oct. 27, 1992, 106 Stat. 3503, effective as if such repeal was enacted on Nov. 14, 1986.

HEALTH CARE QUALITY ASSURANCE PROGRAMS STUDY

Section 4 of Pub. L. 93–222 required Secretary of Health, Education, and Welfare to contract for conduct of a study of health care quality assurance programs and submit a final report to specific committees of Congress by Jan. 31, 1976.

§ 300e–1. Definitions

For purposes of this subchapter:

(1) The term ''basic health services'' means—

(A) physician services (including consultant and referral services by a physician);

(B) inpatient and outpatient hospital services;

(C) medically necessary emergency health services;

(D) short-term (not to exceed twenty visits), outpatient evaluative and crisis intervention mental health services;

(E) medical treatment and referral services (including referral services to appropriate ancillary services) for the abuse of or addiction to alcohol and drugs;

(F) diagnostic laboratory and diagnostic and therapeutic radiologic services;

(G) home health services; and

(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).

Such term does not include a health service which the Secretary, upon application of a health maintenance organization, determines is