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reduce the rates charged medicare eligible individuals participating in health benefit plans by a prorated amount, was repealed by Pub.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.

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

(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).

Any determination under paragraph (4) relating to whether a charge for health care services or supplies is substantially in excess of the needs of the covered individual shall be made by trained reviewers based on written medical protocols developed by physicians. In the event such a determination cannot be made based on such protocols, a physician in an appropriate specialty shall be consulted.

(d) Whenever the Office determines—

(1) in connection with claims presented under this chapter, that a provider has charged for a health care service or supply which the provider knows or should have known involves—

(A) an item or service not provided as claimed;

(B) charges in violation of applicable charge limitations under section 8904(b); or

(C) an item or service furnished during a period in which the provider was debarred from participation under this chapter pursuant to a determination by the Office under this section, other than as permitted under subsection (g)(2)(B);

(2) that a provider of health care services or supplies has knowingly made, or caused to be made, any false statement or misrepresentation of a material fact which is reflected in a claim presented under this chapter; or

(3) that a provider of health care services or supplies has knowingly failed to provide any information required by a carrier or by the Office to determine whether a payment or reimbursement is payable under this chapter or the amount of any such payment or reimbursement;

the Office may, in addition to any other penalties that may be prescribed by law, and after consultation with the Attorney General, impose a civil monetary penalty of not more than $10,000 for any item or service involved. In addition, such a provider shall be subject to an assessment of not more than twice the amount claimed for each such item or service. In addition, the Office may make a determination in the same proceeding to bar such provider from participating in the program under this chapter.

(e) The Office—

(1) may not initiate any debarment proceeding against a provider, based on such provider's having been convicted of a criminal offense, later than 6 years after the date on which such provider is so convicted; and

(2) may not initiate any action relating to a civil penalty, assessment, or debarment under this section, in connection with any claim, later than 6 years after the date the claim is presented, as determined under regulations prescribed by the Office.

(f) In making a determination relating to the appropriateness of imposing or the period of any debarment under this section (where such debarment is not mandatory), or the appropriateness of imposing or the amount of any civil penalty or assessment under this section, the Office shall take into account—

(1) the nature of any claims involved and the circumstances under which they were presented;

(2) the degree of culpability, history of prior offenses or improper conduct of the provider involved; and

(3) such other matters as justice may require.

(g)(1)(A) Except as provided in subparagraph (B), debarment of a provider under subsection (b) or (c) shall be effective at such time and upon such reasonable notice to such provider, and to carriers and covered individuals, as shall be specified in regulations prescribed by the Office. Any such provider that is debarred from participation may request a hearing in accordance with subsection (h)(1).

(B) Unless the Office determines that the health or safety of individuals receiving health

care services warrants an earlier effective date, the Office shall not make a determination adverse to a provider under subsection (c)(5) or (d) until such provider has been given reasonable notice and an opportunity for the determination to be made after a hearing as provided in accordance with subsection (h)(1).

(2)(A) Except as provided in subparagraph (B), a debarment shall be effective with respect to any health care services or supplies furnished by a provider on or after the effective date of such provider's debarment.

(B) A debarment shall not apply with respect to inpatient institutional services furnished to an individual who was admitted to the institution before the date the debarment would otherwise become effective until the passage of 30 days after such date, unless the Office determines that the health or safety of the individual receiving those services warrants that a shorter period, or that no such period, be afforded.

(3) Any notice of debarment referred to in paragraph (1) shall specify the date as of which debarment becomes effective and the minimum period of time for which such debarment is to remain effective. In the case of a debarment under paragraph (1), (2), (3), or (4) of subsection (b), the minimum period of debarment shall not be less than 3 years, except as provided in paragraph (4)(B)(ii).

(4)(A) A provider barred from participating in the program under this chapter may, after the expiration of the minimum period of debarment referred to in paragraph (3), apply to the Office, in such manner as the Office may by regulation prescribe, for termination of the debarment.

(B) The Office may—

(i) terminate the debarment of a provider, pursuant to an application filed by such provider after the end of the minimum debarment period, if the Office determines, based on the conduct of the applicant, that—

(I) there is no basis under subsection (b), (c), or (d) for continuing the debarment; and

(II) there are reasonable assurances that the types of actions which formed the basis for the original debarment have not recurred and will not recur; or

(ii) notwithstanding any provision of subparagraph (A), terminate the debarment of a provider, pursuant to an application filed by such provider before the end of the minimum debarment period, if the Office determines that—

(I) based on the conduct of the applicant, the requirements of subclauses (I) and (II) of clause (i) have been met; and

(II) early termination under this clause is warranted based on the fact that the provider is the sole community provider or the sole source of essential specialized services in a community, or other similar circumstances.

(5) The Office shall—

(A) promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of a provider barred from participation in the program under this chapter of the fact of the debarment, as well as the reasons for such debarment;

(B) request that appropriate investigations be made and sanctions invoked in accordance with applicable law and policy; and

(C) request that the State or local agency or authority keep the Office fully and currently informed with respect to any actions taken in response to the request.

(h)(1) Any provider of health care services or supplies that is the subject of an adverse determination by the Office under this section shall be entitled to reasonable notice and an opportunity to request a hearing of record, and to judicial review as provided in this subsection after the Office renders a final decision. The Office shall grant a request for a hearing upon a showing that due process rights have not previously been afforded with respect to any finding of fact which is relied upon as a cause for an adverse determination under this section. Such hearing shall be conducted without regard to subchapter II of chapter 5 and chapter 7 of this title by a hearing officer who shall be designated by the Director of the Office and who shall not otherwise have been involved in the adverse determination being appealed. A request for a hearing under this subsection shall be filed within such period and in accordance with such procedures as the Office shall prescribe by regulation.

(2) Any provider adversely affected by a final decision under paragraph (1) made after a hearing to which such provider was a party may seek review of such decision in the United States District Court for the District of Columbia or for the district in which the plaintiff resides or has his or her principal place of business by filing a notice of appeal in such court within 60 days after the date the decision is issued, and by simultaneously sending copies of such notice by certified mail to the Director of the Office and to the Attorney General. In answer to the appeal, the Director of the Office shall promptly file in such court a certified copy of the transcript of the record, if the Office conducted a hearing, and other evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and evidence of record, a judgment affirming, modifying, or setting aside, in whole or in part, the decision of the Office, with or without remanding the case for a rehearing. The district court shall not set aside or remand the decision of the Office unless there is not substantial evidence on the record, taken as whole, to support the findings by the Office of a cause for action under this section or unless action taken by the Office constitutes an abuse of discretion.

(3) Matters that were raised or that could have been raised in a hearing under paragraph (1) or an appeal under paragraph (2) may not be raised as a defense to a civil action by the United States to collect a penalty or assessment imposed under this section.

(i) A civil action to recover civil monetary penalties or assessments under subsection (d) shall be brought by the Attorney General in the name of the United States, and may be brought in the United States district court for the district where the claim involved was presented or where the person subject to the penalty resides. Amounts recovered under this section shall be paid to the Office for deposit into the Employees

Health Benefits Fund. The amount of a penalty or assessment as finally determined by the Office, or other amount the Office may agree to in compromise, may be deducted from any sum then or later owing by the United States to the party against whom the penalty or assessment has been levied.

(j) The Office shall prescribe regulations under which, with respect to services or supplies furnished by a debarred provider to a covered individual during the period of such provider's debarment, payment or reimbursement under this chapter may be made, notwithstanding the fact of such debarment, if such individual did not know or could not reasonably be expected to have known of the debarment. In any such instance, the carrier involved shall take appropriate measures to ensure that the individual is informed of the debarment and the minimum period of time remaining under the terms of the debarment.

(Added Pub. L. 100–654, title I, §101(a), Nov. 14, 1988, 102 Stat. 3837; amended Pub. L. 105–266, §2(a), Oct. 19, 1998, 112 Stat. 2363.)

REFERENCES IN TEXT

Section 2455 of the Federal Acquisition Streamlining Act of 1994, referred to in subsec. (b)(5), is section 2455 of Pub. L. 103–355, which is set out as a note under section 6101 of Title 31, Money and Finance.

AMENDMENTS

1998—Subsec. (a)(1)(D). Pub. L. 105–266, §2(a)(1)(A), added subpar. (D).

Subsec. (a)(2)(A). Pub. L. 105–266, §2(a)(1)(B), substituted ''subsection (b), (c), or (d)'' for ''subsection (b) or (c)''.

Subsec. (b). Pub. L. 105–266, §2(a)(2)(A), substituted ''shall'' for ''may'' in introductory provisions.

Subsec. (b)(5). Pub. L. 105–266, §2(a)(2)(B), amended par. (5) generally. Prior to amendment, par. (5) read as follows: ''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.''

Subsec. (c). Pub. L. 105–266, §2(a)(3), added subsec. (c). Former subsec. (c) redesignated (d).

Subsec. (d). Pub. L. 105–266, §2(a)(3), redesignated subsec. (c) as (d). Former subsec. (d) redesignated (e).

Subsec. (d)(1). Pub. L. 105–266, §2(a)(4), amended par. (1) generally. Prior to amendment, par. (1) read as follows: ''in connection with a claim presented under this chapter, that a provider of health care services or supplies—

''(A) has charged for health care services or supplies that the provider knows or should have known were not provided as claimed; or

''(B) has charged for health care services or supplies in an amount substantially in excess of such provider's customary charges for such services or supplies, 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;''.

Subsec. (e). Pub. L. 105–266, §2(a)(3), redesignated subsec. (d) as (e). Former subsec. (e) redesignated (f).

Subsec. (f). Pub. L. 105–266, §2(a)(3), (5), redesignated subsec. (e) as (f) and inserted ''(where such debarment is not mandatory)'' after ''debarment under this section''. Former subsec. (f) redesignated (g).

Subsec. (g). Pub. L. 105–266, §2(a)(3), redesignated subsec. (f) as (g). Former subsec. (g) redesignated (h).

Subsec. (g)(1). Pub. L. 105–266, §2(a)(6)(A), added par. (1) and struck out former par. (1) which read as follows: ''The debarment of a provider under subsection (b) or (c) shall be effective at such time and upon such reasonable notice to such provider, and to carriers and covered individuals, as may be specified in regulations prescribed by the Office.''

Subsec. (g)(3). Pub. L. 105–266, §2(a)(6)(B), inserted ''of debarment'' after ''notice'' and inserted at end ''In the case of a debarment under paragraph (1), (2), (3), or (4) of subsection (b), the minimum period of debarment shall not be less than 3 years, except as provided in paragraph (4)(B)(ii).''

Subsec. (g)(4)(B)(i)(I). Pub. L. 105–266, §2(a)(6)(C), substituted ''subsection (b), (c), or (d)'' for ''subsection (b) or (c)''.

Subsec. (g)(6). Pub. L. 105–266, §2(a)(6)(D), struck out par. (6) which read as follows: ''The Office shall, upon written request and payment of a reasonable charge to defray the cost of complying with such request, furnish a current list of any providers barred from participating in the program under this chapter, including the minimum period of time remaining under the terms of each provider's debarment.''

Subsec. (h). Pub. L. 105–266, §2(a)(3), redesignated subsec. (g) as (h). Former subsec. (h) redesignated (i).

Subsec. (h)(1), (2). Pub. L. 105–266, §2(a)(7), added pars. (1) and (2) and struck out former pars. (1) and (2) which read as follows:

''(1) The Office may not make a determination under subsection (b) or (c) adverse to a provider of health care services or supplies until such provider has been given written notice and an opportunity for a hearing on the record. A provider is entitled to be represented by counsel, to present witnesses, and to cross-examine witnesses against the provider in any such hearing.

''(2) Notwithstanding section 8912, any person adversely affected by a final decision under paragraph (1) may obtain review of such decision in the United States Court of Appeals for the Federal Circuit. A written petition requesting that the decision be modified or set aside must be filed within 60 days after the date on which such person is notified of such decision.''

Subsec. (i). Pub. L. 105–266, §2(a)(3), (8), redesignated subsec. (h) as (i), substituted ''subsection (d)'' for ''subsection (c)'', and inserted at end ''The amount of a penalty or assessment as finally determined by the Office, or other amount the Office may agree to in compromise, may be deducted from any sum then or later owing by the United States to the party against whom the penalty or assessment has been levied.'' Former subsec. (i) redesignated (j).

Subsec. (j). Pub. L. 105–266, §2(a)(3), redesignated subsec. (i) as (j).

EFFECTIVE DATE OF 1998 AMENDMENT

Pub. L. 105–266, §2(b), Oct. 19, 1998, 112 Stat. 2366, provided that:

''(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section [amending this section] shall take effect on the date of the enactment of this Act [Oct. 19, 1998].

''(2) EXCEPTIONS.—(A) Paragraphs (2), (3), and (5) of section 8902a(c) of title 5, United States Code, as amended by subsection (a)(3), shall apply only to the extent that the misconduct which is the basis for debarment under paragraph (2), (3), or (5), as applicable, occurs after the date of the enactment of this Act.

''(B) Paragraph (1)(B) of section 8902a(d) of title 5, United States Code, as amended by subsection (a)(4), shall apply only with respect to charges which violate section 8904(b) of such title for items or services furnished after the date of the enactment of this Act.

''(C) Paragraph (3) of section 8902a(g) of title 5, United States Code, as amended by subsection (a)(6)(B), shall apply only with respect to debarments based on convic-

tions occurring after the date of the enactment of this Act.''

EFFECTIVE DATE; PRIOR CONDUCT

Pub. L. 100–654, title I, §102, Nov. 14, 1988, 102 Stat. 3841, provided that:

''(a) APPLICABILITY.—The amendments made by this title [enacting this section] shall be effective with respect to any calendar year beginning, and contracts entered into or renewed for any calendar year beginning, after the date of the enactment of this Act [Nov. 14, 1988].

''(b) PRIOR CONDUCT NOT TO BE CONSIDERED.—In carrying out section 8902a of title 5, United States Code, as added by this title, no debarment, civil monetary penalty, or assessment may be imposed under such section based on any criminal or other conduct occurring before the beginning of the first calendar year which begins after the date of the enactment of this Act [Nov. 14, 1988].''

§ 8903. Health benefits plans

The Office of Personnel Management may contract for or approve the following health benefits plans:

(1) SERVICE BENEFIT PLAN.—One Government-wide plan, which may be underwritten by participating affiliates licensed in any number of States, offering two levels of benefits, under which payment is made by a carrier under contracts with physicians, hospitals, or other providers of health services for benefits of the types described by section 8904(1) of this title given to employees, annuitants, members of their families, former spouses, or persons having continued coverage under section 8905a of this title, or, under certain conditions, payment is made by a carrier to the employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title.

(2) INDEMNITY BENEFIT PLAN.—One Government-wide plan, offering two levels of benefits, under which a carrier agrees to pay certain sums of money, not in excess of the actual expenses incurred, for benefits of the types described by section 8904(2) of this title.

(3) EMPLOYEE ORGANIZATION PLANS.—Employee organization plans which offer benefits of the types referred to by section 8904(3) of this title, which are sponsored or underwritten, and are administered, in whole or substantial part, by employee organizations described in section 8901(8)(A) of this title, which are available only to individuals, and members of their families, who at the time of enrollment are members of the organization.

(4) COMPREHENSIVE MEDICAL PLANS.—

(A) GROUP-PRACTICE PREPAYMENT PLANS.—Group-practice prepayment plans which offer health benefits of the types referred to by section 8904(4) of this title, in whole or in substantial part on a prepaid basis, with professional services thereunder provided by physicians practicing as a group in a common center or centers. The group shall include at least 3 physicians who receive all or a substantial part of their professional income from the prepaid funds and who represent 1 or more medical specialties appropriate and necessary for the population proposed to be served by the plan.

(B) INDIVIDUAL-PRACTICE PREPAYMENT PLANS.—Individual-practice prepayment plans which offer health services in whole or substantial part on a prepaid basis, with professional services thereunder provided by individual physicians who agree, under certain conditions approved by the Office, to accept the payments provided by the plans as full payment for covered services given by them including, in addition to in-hospital services, general care given in their offices and the patients' homes, out-of-hospital diagnostic procedures, and preventive care, and which plans are offered by organizations which have successfully operated similar plans before approval by the Office of the plan in which employees may enroll.

(C) MIXED MODEL PREPAYMENT PLANS.—Mixed model prepayment plans which are a combination of the type of plans described in subparagraph (A) and the type of plans described in subparagraph (B).

(Pub. L. 89–554, Sept. 6, 1966, 80 Stat. 602; Pub. L. 95–454, title IX, §906(a)(2), (3), Oct. 13, 1978, 92 Stat. 1224; Pub. L. 98–615, §3(3), Nov. 8, 1984, 98 Stat. 3203; Pub. L. 99–53, §2(b), June 17, 1985, 99 Stat. 94; Pub. L. 99–251, title I, §§102, 111, Feb. 27, 1986, 100 Stat. 14, 19; Pub. L. 100–654, title II, §202(b), Nov. 14, 1988, 102 Stat. 3845; Pub. L. 105–266, §3(b), Oct. 19, 1998, 112 Stat. 2366.)

HISTORICAL AND REVISION NOTES

Derivation	*U.S. Code*	*Revised Statutes and Statutes at Large*
.....	5 U.S.C. 3003.	Sept. 28, 1959, Pub. L. 86–382, §4, 73 Stat. 711. July 8, 1963, Pub. L. 88–59, §1(b), 77 Stat. 77.

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

AMENDMENTS

1998—Par. (1). Pub. L. 105–266 substituted ''plan, which may be underwritten by participating affiliates licensed in any number of States,'' for ''plan,''.

1988—Par. (1). Pub. L. 100–654 substituted ''former spouses, or persons having continued coverage under section 8905a of this title,'' for ''or former spouses,'' and ''former spouse, or person having continued coverage under section 8905a of this title.'' for ''or former spouse.''

1986—Par. (4)(A). Pub. L. 99–251, §102, amended second sentence generally, substituting ''at least 3 physicians'' for ''physicians representing at least three major medical specialties'' and inserted ''and who represent 1 or more medical specialties appropriate and necessary for the population proposed to be served by the plan''.

Par. (4)(C). Pub. L. 99–251, §111, added subpar. (C).

1985—Par. (3). Pub. L. 99–53 inserted ''described in section 8901(8)(A) of this title'' after ''employee organizations''.

1984—Par. (1). Pub. L. 98–615, §3(3), substituted ''employees, annuitants, members of their families, or former spouses'' for ''employees or annuitants, or members of their families'' and ''employee, annuitant, family member, or former spouse'' for ''employee or annuitant or member of his family''.

1978—Pub. L. 95–454 substituted ''Office of Personnel Management'' and ''Office'' for ''Civil Service Commission'' and ''Commission'', respectively, wherever appearing.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–654 applicable with respect to any calendar year beginning, and contracts en-