

105TH CONGRESS  
1ST SESSION

# H. R. 2606

To amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to establish certain requirements for managed care plans.

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## IN THE HOUSE OF REPRESENTATIVES

OCTOBER 2, 1997

Ms. VELÁZQUEZ (for herself, Mr. DELLUMS, Mr. FROST, Mr. CONYERS, Mr. NADLER, Mr. SERRANO, Mrs. MCCARTHY of New York, Mr. FILNER, Mr. OWENS, Ms. SLAUGHTER, Mr. TOWNS, Mr. FLAKE, Mrs. MALONEY of New York, Mr. SCHUMER, Mr. BONIOR, Mr. MILLER of California, Mrs. LOWEY, Mr. HINCHEY, Mr. RANGEL, Mr. EVANS, and Mr. ACKERMAN) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committee on Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

To amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to establish certain requirements for managed care plans.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

2 (a) SHORT TITLE.—This Act may be cited as the  
 3 “Managed Care Bill of Rights for Consumers Act of  
 4 1997”.

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

Sec. 1. Short title; table of contents.

Sec. 2. Patient protection standards under the Public Health Service Act.

“PART C—PATIENT PROTECTION STANDARDS

“Sec. 2770. Notice; additional definitions.

“Sec. 2771. Guarantee of medically necessary and appropriate treatment.

“Sec. 2772. Guaranteed adequate access to health care.

“Sec. 2773. Right to adequate physician network.

“Sec. 2774. Meaningful choice of providers.

“Sec. 2775. Guaranteed continuity of care.

“Sec. 2776. Right to specialty care.

“Sec. 2777. Required obstetric and gynecological care.

“Sec. 2778. Assuring equitable coverage of emergency services.

“Sec. 2779. Requirement for service to areas that include a medically un-  
 derserved population.

“Sec. 2780. Right to language assistance.

“Sec. 2781. Prohibition on financial incentives to limit care.

“Sec. 2782. Prohibition on gag clauses.

“Sec. 2783. Right to appeal denial of care.

“Sec. 2784. External review.

“Sec. 2785. Nondiscrimination right.

“Sec. 2786. Protection of patient confidentiality.

“Sec. 2787. Establishment of Managed Care Consumer Advisory Commis-  
 sion.

Sec. 3. Patient protection standards under the Employee Retirement Income  
 Security Act of 1974.

“Sec. 713. Patient protection standards.

Sec. 4. Nonpreemption of State law respecting liability of group health plans.

Sec. 5. Effective date.

7 **SEC. 2. PATIENT PROTECTION STANDARDS UNDER THE**  
 8 **PUBLIC HEALTH SERVICE ACT.**

9 Title XXVII of the Public Health Service Act is  
 10 amended—

11 (1) by redesignating part C as part D; and

1           (2) by inserting after part B the following new  
2       part:

3           “PART C—PATIENT PROTECTION STANDARDS

4   **“SEC. 2770. NOTICE; DEFINITIONS.**

5           “(a) NOTICE.—A managed care plan under this part  
6       shall comply with the notice requirement under section  
7       711(d) of the Employee Retirement Income Security Act  
8       of 1974 with respect to the requirements of this part as  
9       if such section applied to such plan and such plan were  
10      a group health plan.

11          “(b) DEFINITIONS.—For purposes of this part:

12               “(1) ENROLLEE.—The term ‘enrollee’ means,  
13       with respect to health insurance coverage offered by  
14       a managed care plan, an individual enrolled with the  
15       plan to receive such coverage.

16               “(2) HEALTH PROFESSIONAL.—The term  
17       ‘health professional’ means a physician or other  
18       health care practitioner licensed, accredited, or cer-  
19       tified to perform specified health services consistent  
20       with law.

21               “(3) MANAGED CARE PLAN.—The term ‘man-  
22       aged care plan’ means a health plan that provides or  
23       arranges for the provision of health care items and  
24       services to enrollees primarily through participating  
25       physicians and providers.

1           “(4) NETWORK.—The term ‘network’ means,  
2           with respect to a managed care plan, the participat-  
3           ing health professionals and providers through which  
4           the plan provides health care items and services to  
5           enrollees.

6           “(5) NETWORK COVERAGE.—The term ‘network  
7           coverage’ means health insurance coverage offered  
8           by a managed care plan that provides or arranges  
9           for the provision of health care items and services to  
10          enrollees through participating health professionals  
11          and providers.

12          “(6) PARTICIPATING.—The term ‘participating’  
13          means, with respect to a health professional or pro-  
14          vider, a health professional or provider that provides  
15          health care items and services to enrollees under  
16          network coverage under an agreement with the man-  
17          aged care plan offering the coverage.

18          “(7) PRIOR AUTHORIZATION.—The term ‘prior  
19          authorization’ means the process of obtaining prior  
20          approval from a managed care plan as to the neces-  
21          sity or appropriateness of receiving medical or clinical  
22          services for treatment of a medical or clinical  
23          condition.

24          “(8) PROVIDER.—The term ‘provider’ means a  
25          health organization, health facility, or health agency

1       that is licensed, accredited, or certified to provide  
2       health care items and services.

3               “(9) SERVICE AREA.—The term ‘service area’  
4       means, with respect to a managed care plan, the ge-  
5       ographic area served by the plan with respect to the  
6       coverage.

7   **“SEC. 2771. GUARANTEE OF MEDICALLY NECESSARY AND**  
8               **APPROPRIATE TREATMENT.**

9               “(a) IN GENERAL.—A managed care plan may not  
10      impose limits on the delivery of services if the services  
11      are—

12              “(1) medically necessary and appropriate as de-  
13      termined by the treating health professional, in con-  
14      sultation with the enrollee; and

15              “(2) otherwise a covered benefit.

16              “(b) SECOND OPINION.—A managed care plan shall  
17      provide to enrollees, upon request, a referral to a health  
18      care practitioner for a second opinion as to what con-  
19      stitutes medically necessary and appropriate treatment,  
20      and provide coverage for such opinion without regard to  
21      whether such health care practitioner has a contractual  
22      or other arrangement with the plan for the provision of  
23      such services to such enrollees.

1 **“SEC. 2772. GUARANTEED ADEQUATE ACCESS TO HEALTH**  
2 **CARE.**

3 “(a) ADEQUATE ACCESS.—A managed care plan  
4 shall provide adequate access to health care services.

5 “(b) AVAILABLE ITEMS AND SERVICES.—The Sec-  
6 retary shall ensure that items and services, including lab-  
7 oratory and specialist services, covered under the plan  
8 shall be available through providers that are reasonably  
9 geographically accessible to all enrollees of such plan.

10 **“SEC. 2773. RIGHT TO ADEQUATE PHYSICIAN NETWORK.**

11 “(a) IN GENERAL.—A managed care plan shall main-  
12 tain an adequate number, mix, and distribution of health  
13 professionals and providers to ensure that covered items  
14 and services are available and accessible to each enrollee.

15 “(b) ADEQUATE DISTRIBUTION.—The Secretary  
16 shall determine the adequate number, mix, and distribu-  
17 tion of health professionals and providers within the serv-  
18 ice area of the managed care plan, including, but not lim-  
19 ited to—

20 “(1) the existence of a primary care provider  
21 network that is sufficient to meet adult, pediatric,  
22 and primary obstetrician gynecological needs of all  
23 enrollees, including the average number and length  
24 of visits per year per enrollee;

1           “(2) the existence of a network of specialist of  
2           sufficient number and diversity to meet the specialty  
3           needs of all enrollees;

4           “(3) the access to quality health services from  
5           institutional providers for all enrollees; and

6           “(4) the existence of at least one primary care  
7           physician for every 1,500 enrollees.

8   **“SEC. 2774. MEANINGFUL CHOICE OF PROVIDERS.**

9           “(a) MINIMUM NUMBER OF CHOICES.—A managed  
10          care plan shall provide to enrollees a choice of at least  
11          3 providers within each category of providers based on the  
12          health care needs of such enrollees, taking into account  
13          the age, gender, health, native language, acute or chronic  
14          diseases, and special needs of the enrollee. The enrollee  
15          may change the selection of provider at any time.

16          “(b) ACCESS TO OUT-OF-NETWORK PROVIDER.—A  
17          managed care plan shall cover services that are furnished  
18          by a physician or provider obtained by the enrollee without  
19          regard to whether such physician or provider has a con-  
20          tractual or other arrangement with the plan for the provi-  
21          sion of such services to such enrollees. The plan may im-  
22          pose a reasonable deductible and reasonable copayment  
23          subject to a reasonable annual limit on total annual out-  
24          of-pocket expenses.

1 **“SEC. 2775. GUARANTEED CONTINUITY OF CARE.**

2 “If a contract between a managed care plan and a  
3 health care provider is terminated (other than by the plan  
4 for failure to meet applicable quality standards or for  
5 fraud) and an enrollee is undergoing a course of treatment  
6 from the provider at the time of such termination, the plan  
7 shall—

8 “(1) notify the enrollee of such termination;  
9 and

10 “(2) permit the enrollee to continue the course  
11 of treatment with the provider during a transitional  
12 period as determined by the Secretary.

13 **“SEC. 2776. RIGHT TO SPECIALTY CARE.**

14 “(a) REFERRAL TO SPECIALISTS.—

15 “(1) CHOICE OF SPECIALIST.—A managed care  
16 plan shall permit each enrollee to receive specialty  
17 care from any qualified participating health care  
18 provider when such treatment is medically or clini-  
19 cally necessary. The plan shall make or provide for  
20 a referral to at least 3 specialists who are available  
21 and accessible to provide treatment for such condi-  
22 tion or disease.

23 “(2) COST OF TREATMENT BY NONPARTICIPAT-  
24 ING PROVIDERS.—In a case in which a plan refers  
25 an enrollee to a nonparticipating specialist, the plan  
26 shall cover any services provided by such specialist



1 at the rate it covers comparable services provided by  
2 participating providers.

3 “(b) CONTINUOUS REFERRALS.—A managed care  
4 plan shall have a procedure by which an enrollee who has  
5 a condition that requires ongoing care from a specialist  
6 may receive a continuous referral to such specialist for  
7 treatment of such condition, without additional authoriza-  
8 tion from the primary care physician.

9 **“SEC. 2777. REQUIRED OBSTETRIC AND GYNECOLOGICAL**  
10 **CARE.**

11 “(a) OBSTETRICIAN-GYNECOLOGIST AS PRIMARY  
12 CARE PROVIDER.—In a case in which a managed care  
13 plan requires or provides for an enrollee to designate a  
14 participating primary care provider, a female enrollee may  
15 designate a physician who specializes in obstetrics and  
16 gynecology as primary care provider.

17 “(b) NO DESIGNATION OF OBSTETRICIAN-GYNE-  
18 COLOGIST.—In a case in which an enrollee does not des-  
19 ignated an obstetrician-gynecologist under subsection (a)  
20 as a primary care provider, the plan shall not require prior  
21 authorization by the enrollee’s primary care provider for  
22 coverage of routine gynecological care and pregnancy-re-  
23 lated services provided by a participating physician who  
24 specializes in obstetrics and gynecology.

1 **“SEC. 2778. ASSURING EQUITABLE COVERAGE OF EMER-**  
2 **GENCY SERVICE.**

3 “(a) IN GENERAL.—A managed care plan shall cover  
4 emergency services furnished to an enrollee of the plan—

5 “(1) whether or not the provider furnishing the  
6 emergency services has a contractual or other ar-  
7 rangement with the plan for the provision of such  
8 services to such enrollee; and

9 “(2) without regard to prior authorization.

10 “(b) EMERGENCY SERVICES.—Emergency services  
11 shall include—

12 “(1) health care items and services furnished in  
13 the emergency department of a hospital; and

14 “(2) ancillary services routinely available to  
15 such department.

16 “(c) EMERGENCY MEDICAL CONDITION.—An emer-  
17 gency medical condition is a medical condition manifesting  
18 itself by acute symptoms of sufficient severity (including  
19 severe pain) such that a prudent layperson, who possesses  
20 an average knowledge of health and medicine, could rea-  
21 sonably expect the absence of immediate medical attention  
22 to result in—

23 “(1) placing the health of the individual (or,  
24 with respect to a pregnant woman, the health of the  
25 woman or her unborn child) in serious jeopardy;

26 “(2) serious impairment to bodily functions; or

1           “(3) serious dysfunction of any bodily organ or  
2           part.

3   **“SEC. 2779. REQUIREMENT FOR SERVICE TO AREAS THAT**  
4                   **INCLUDE A MEDICALLY UNDERSERVED POP-**  
5                   **ULATION.**

6           “A managed care plan seeking to provide services in  
7   an area that includes a medically underserved population  
8   must submit a plan to the Secretary outlining a proposal  
9   for service that ensures access to quality care that is ap-  
10   propriate to the medically underserved population. The  
11   plan shall include the health needs of the medically under-  
12   served population with special consideration given to fac-  
13   tors including age, gender, race, and potential chronic con-  
14   ditions.

15   **“SEC. 2780. RIGHT TO LANGUAGE ASSISTANCE.**

16           “In a case in which 2 percent of the enrollees of a  
17   managed care plan in a service area (as defined in section  
18   2770(b)(9)) are members of a group that speaks English  
19   as a second language or requires special communication  
20   needs, the Secretary shall ensure that the managed care  
21   plan provide communication assistance and bilingual in-  
22   formation, on a continuous basis, to such enrollees. The  
23   plan shall ensure that—

1           “(1) trained medical interpreters, whose pri-  
2           mary responsibility is to interpret, are present in all  
3           health care settings; and

4           “(2) an adequate number of health profes-  
5           sionals receive training in cultural competency and  
6           communication skills development as it relates to  
7           medical interviews.

8   **“SEC. 2781. PROHIBITION ON FINANCIAL INCENTIVES TO**  
9                           **LIMIT CARE.**

10          “A managed care plan may not offer any financial  
11          incentives, directly or indirectly, to health professionals as  
12          an inducement to reduce or limit medically necessary serv-  
13          ices provided to an enrollee.

14   **“SEC. 2782. PROHIBITION ON GAG CLAUSES.**

15          “(a) IN GENERAL.—The provisions of any contract  
16          or agreement, or the operation of any contract or agree-  
17          ment, between a managed care plan and a health profes-  
18          sional shall not prohibit or restrict the health professional  
19          from engaging in medical communication with his or her  
20          patient.

21          “(b) NULLIFICATION.—Any contract provision or  
22          agreement described in subsection (a) shall be null and  
23          void.

24          “(c) MEDICAL COMMUNICATION DEFINED.—For  
25          purposes of this section, the term ‘medical communication’

1 means a communication made by a health professional  
2 with a patient of the health professional (or the guardian  
3 or legal representative of the patient) with respect to—

4 “(1) the patient’s health status, medical care,  
5 or legal treatment options;

6 “(2) any utilization review requirements that  
7 may affect treatment options for the patient; or

8 “(3) any financial incentives that may affect  
9 the treatment of the patient.

10 **“SEC. 2783. RIGHT TO APPEAL DENIAL OF CARE.**

11 “(a) ESTABLISHMENT OF SYSTEM.—Not later than  
12 90 days after the date of the enactment of this Act, the  
13 Secretary, through the Health Care Financing Adminis-  
14 tration, shall establish and implement guidelines for griev-  
15 ance and appeals procedures regarding any aspect of a  
16 managed care plan’s services, including complaints regard-  
17 ing quality of care, choice and accessibility of providers,  
18 network adequacy, and compliance with the requirements  
19 of this part.

20 “(b) NO REPRISAL FOR EXERCISE OF RIGHTS.—A  
21 managed care plan shall not take any action with respect  
22 to an enrollee or a health care provider that is intended  
23 to penalize the enrollee, a designee of the enrollee, or the  
24 health care provider for discussing or exercising any rights

1 provided under this part (including the filing of a com-  
2 plaint or appeal pursuant to this section).

3 **“SEC. 2784. EXTERNAL REVIEW.**

4 “An external review process shall be available to en-  
5 rollees after all internal appeal options have been exer-  
6 cised. The requirements for an external review process are  
7 as follows:

8 “(1) The process is established under State law  
9 and provides for review of decisions made pursuant  
10 to section 2783 by an independent review organiza-  
11 tion certified by the State.

12 “(2) If the process provides that decisions in  
13 such process are not binding on managed care plans,  
14 the process must provide for public methods of dis-  
15 closing frequency of noncompliance with such deci-  
16 sions and for sanctioning plans that consistently  
17 refuse to take appropriate actions in response to  
18 such decisions.

19 “(3) Results of all such reviews under the proc-  
20 ess are disclosed to the public, along with at least  
21 annual disclosure of information on managed care  
22 plan compliance.

23 “(4) All decisions under the process shall be in  
24 writing and shall be accompanied by an explanation  
25 of the basis for the decision.

1           “(5) Direct costs of the process shall be borne  
2       by the managed care plan, and not by the enrollee.

3           “(6) The managed care plan shall provide for  
4       publication at least annually of information on the  
5       number of appeals and decisions considered under  
6       the process.

7   **“SEC. 2785. NONDISCRIMINATION RIGHT.**

8       “A managed care plan may not discriminate (directly  
9   or through contractual arrangements) against enrollees or  
10   providers on the basis of race, national origin, gender, lan-  
11   guage, socioeconomic status, age, disability, health status,  
12   or anticipated need for health services.

13   **“SEC. 2786. PROTECTION OF PATIENT CONFIDENTIALITY.**

14       “A managed care plan shall establish policies and  
15   procedures to ensure that all applicable laws that protect  
16   the confidentiality of an individual’s medical information  
17   are followed.

18   **“SEC. 2787. ESTABLISHMENT OF MANAGED CARE**  
19                   **CONSUMER ADVISORY COMMISSION.**

20       “(a) ESTABLISHMENT.—The Secretary shall estab-  
21   lish and appoint a 5 member Managed Care Consumer  
22   Advisory Commission.

23       “(b) PURPOSE.—The purpose of the Commission is  
24   to assist consumers in the following areas:

1           “(1) Accessing appropriate and high-quality  
2 health care services.

3           “(2) Understanding and exercising their rights  
4 and responsibilities as managed care plan enrollees.

5           “(3) Making an informed and appropriate  
6 choice of a managed care plan.

7           “(c) MEMBERSHIP.—Members of the Commission  
8 shall—

9           “(1) be selected from nonpartisan labor, reli-  
10 gious, human service, or consumer organizations;  
11 and

12           “(2) demonstrate a commitment to representing  
13 consumers in an equitable manner.

14           “(d) DUTIES.—

15           “(1) ANALYZE AND COLLECT INFORMATION.—  
16 The Commission shall collect and analyze informa-  
17 tion for the purpose of identifying—

18           “(A) recurring barriers to access to health  
19 care for persons enrolled in managed care  
20 plans;

21           “(B) patterns of national, regional, or local  
22 access problems with special focus on under-  
23 served and vulnerable populations and persons  
24 with chronic illness and disabilities;

25           “(C) quality of care problems; and



1           “(D) the extent to which managed care  
2           plans comply with Federal laws, regulations,  
3           and rules governing their responsibilities and  
4           performance.

5           “(2) PROMOTE SOLUTIONS.—The Commission  
6           shall investigate, identify, and promote solutions re-  
7           garding managed care practices, policies, laws, or  
8           regulations that adversely affect, or fail to promote,  
9           informed access of individuals and populations to  
10          high-quality health care.

11          “(3) REPORT.—Not later than January 1 of  
12          each year, the Secretary, through the Commission,  
13          shall submit a report to Congress which shall in-  
14          clude—

15                 “(A) a description of the efforts of the  
16                 Commission; and

17                 “(B) findings and recommendations based  
18                 on problems identified to improve consumer and  
19                 enrollee rights and protections so as to facilitate  
20                 access to high-quality health care and improve  
21                 health outcomes.”.

1 **SEC. 3. PATIENT PROTECTION STANDARDS UNDER THE EM-**  
 2 **PLOYEE RETIREMENT INCOME SECURITY**  
 3 **ACT OF 1974.**

4 (a) IN GENERAL.—Subpart B of part 7 of subtitle  
 5 B of title I of the Employee Retirement Income Security  
 6 Act of 1974 is amended by adding at the end the following  
 7 new section:

8 **“SEC. 713. PATIENT PROTECTION STANDARDS.**

9 “(a) IN GENERAL.—Subject to subsection (b), a  
 10 group health plan (and a managed care plan offering  
 11 group health insurance coverage in connection with such  
 12 a plan) shall comply with the requirements of part C of  
 13 title XXVII of the Public Health Service Act.

14 “(b) REFERENCES IN APPLICATION.—In applying  
 15 subsection (a) under this part, any reference in such part  
 16 C—

17 “(1) to a managed care plan and health insur-  
 18 ance coverage offered by such a plan is deemed to  
 19 include a reference to a group health plan and cov-  
 20 erage under such plan, respectively;

21 “(2) to the Secretary is deemed a reference to  
 22 the Secretary of Labor;

23 “(3) to an applicable State authority is deemed  
 24 a reference to the Secretary of Labor; and

25 “(4) to an enrollee with respect to health insur-  
 26 ance coverage is deemed to include a reference to a

1 participant or beneficiary with respect to a group  
2 health plan.

3 “(c) ENSURING COORDINATION.—The Secretary of  
4 Health and Human Services and the Secretary of Labor  
5 shall ensure, through the execution of an interagency  
6 memorandum of understanding between such Secretaries,  
7 that—

8 “(1) regulations, rulings, and interpretations is-  
9 sued by such Secretaries relating to the same matter  
10 over which such Secretaries have responsibility  
11 under such part C (and section 2706 of the Public  
12 Health Service Act) and this section are adminis-  
13 tered so as to have the same effect at all times; and

14 “(2) coordination of policies relating to enforce-  
15 ing the same requirements through such Secretaries  
16 in order to have a coordinated enforcement strategy  
17 that avoids duplication of enforcement efforts and  
18 assigns priorities in enforcement.”.

19 (b) MODIFICATION OF PREEMPTION STANDARDS.—  
20 Section 731 of such Act (42 U.S.C. 1191) is amended—

21 (1) in subsection (a)(1), by striking “subsection  
22 (b)” and inserting “subsections (b) and (c)”;

23 (2) by redesignating subsections (c) and (d) as  
24 subsections (d) and (e), respectively; and

1           (3) by inserting after subsection (b) the follow-  
2           ing new subsection:

3           “(c) SPECIAL RULES IN CASE OF PATIENT PROTEC-  
4           TION REQUIREMENTS.—Subject to subsection (a)(2), the  
5           provisions of section 713 and part C of title XXVII of  
6           the Public Health Service Act, and subpart C insofar as  
7           it applies to section 713 or such part, shall not be con-  
8           strued to preempt any State law, or the enactment or im-  
9           plementation of such a State law, that provides protections  
10          for individuals that are equivalent to or stricter than the  
11          protections provided under such provisions.”.

12          (c) CONFORMING AMENDMENTS.—(1) Section 732(a)  
13          of such Act (29 U.S.C. 1185(a)) is amended by striking  
14          “section 711” and inserting “sections 711 and 713”.

15          (2) The table of contents in section 1 of such Act  
16          is amended by inserting after the item relating to section  
17          712 the following new item:

          “Sec. 713. Patient protection standards.”.

18          (3) Section 734 of such Act (29 U.S.C. 1187) is  
19          amended by inserting “and section 713(d)” after “of  
20          1996”.

21          (d) EFFECTIVE DATE.—(1) Subject to paragraph  
22          (2), the amendments made by this section shall apply with  
23          respect to group health plans for plan years beginning on  
24          or after 90 days after the date of the enactment of this

1 Act, and also shall apply to portions of plan years occur-  
2 ring on and after January 1, 1999.

3 (2) In the case of a group health plan maintained  
4 pursuant to 1 or more collective bargaining agreements  
5 between employee representatives and 1 or more employ-  
6 ers ratified before the date of enactment of this Act, the  
7 amendments made by this section shall not apply to plan  
8 years beginning before the later of—

9 (A) the date on which the last collective bar-  
10 gaining agreements relating to the plan terminates  
11 (determined without regard to any extension thereof  
12 agreed to after the date of enactment of this Act);  
13 or

14 (B) the general effective date.

15 For purposes of subparagraph (A), any plan amendment  
16 made pursuant to a collective bargaining agreement relat-  
17 ing to the plan which amends the plan solely to conform  
18 to any requirement added by subsection (a) shall not be  
19 treated as a termination of such collective bargaining  
20 agreement.

21 **SEC. 4. NONPREEMPTION OF STATE LAW RESPECTING LI-**  
22 **ABILITY OF GROUP HEALTH PLANS.**

23 (a) IN GENERAL.—Section 514(b) of the Employee  
24 Retirement Income Security Act of 1974 (29 U.S.C.  
25 1144(b)) is amended by redesignating paragraph (9) as

1 paragraph (10) and inserting the following new para-  
2 graph:

3 “(9) Subsection (a) of this section shall not be con-  
4 strued to preclude any State cause of action to recover  
5 damages for personal injury or wrongful death against any  
6 person that provides insurance or administrative services  
7 to or for an employee welfare benefit plan maintained to  
8 provide health care benefits.”.

9 (b) EFFECTIVE DATE.—The amendment made by  
10 subsection (a) shall apply to causes of action arising on  
11 or after the date of the enactment of this Act.

12 **SEC. 5. EFFECTIVE DATE.**

13 The amendments made by this Act shall take effect  
14 90 days after the date of the enactment of this Act.

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