

106TH CONGRESS  
1ST SESSION

# H. R. 2089

To amend title I of the Employee Retirement Income Security Act of 1974 to provide new procedures and access to review for grievances arising under group health plans.

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## IN THE HOUSE OF REPRESENTATIVES

JUNE 9, 1999

Mr. BOEHNER introduced the following bill; which was referred to the Committee on Education and the Workforce

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## A BILL

To amend title I of the Employee Retirement Income Security Act of 1974 to provide new procedures and access to review for grievances arising under group health plans.

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Group Health Plan  
5 Review Standards Act of 1999”.

6 **SEC. 2. SPECIAL RULES FOR GROUP HEALTH PLANS.**

7 (a) IN GENERAL.—Section 503 of the Employee Re-  
8 tirement Income Security Act of 1974 (29 U.S.C. 1133)  
9 is amended—

1           (1) by inserting “(a) IN GENERAL.—” after  
2           “SEC. 503.”;

3           (2) by inserting “(other than a group health  
4           plan)” after “employee benefit plan”; and

5           (3) by adding at the end the following new sub-  
6           section:

7           “(b) SPECIAL RULES FOR GROUP HEALTH PLANS.—

8           “(1) COVERAGE DETERMINATIONS.—Every  
9           group health plan shall—

10                   “(A) provide adequate notice in writing in  
11                   accordance with this subsection to any partici-  
12                   pant or beneficiary of any adverse coverage de-  
13                   cision with respect to benefits of such partici-  
14                   pant or beneficiary under the plan, setting forth  
15                   the specific reasons for such coverage decision  
16                   and any rights of review provided under the  
17                   plan, written in a manner calculated to be un-  
18                   derstood by the average participant;

19                   “(B) provide such notice in writing also to  
20                   any treating medical care provider of such par-  
21                   ticipant or beneficiary, if such provider has  
22                   claimed reimbursement for any item or service  
23                   involved in such coverage decision, or if a claim  
24                   submitted by the provider initiated the pro-  
25                   ceedings leading to such decision;

“(C) afford a reasonable opportunity to any participant or beneficiary who is in receipt of the notice of such adverse coverage decision, and who files a written request for review of the initial coverage decision within 90 days after receipt of the notice of the initial decision, for a full and fair review of the decision by an appropriate named fiduciary who did not make the initial decision; and

“(D) meet the additional requirements of this subsection.

“(2) TIME LIMITS FOR MAKING INITIAL COVERAGE DECISIONS FOR BENEFITS AND COMPLETING INTERNAL APPEALS.—

“(A) TIME LIMITS FOR DECIDING REQUESTS FOR BENEFIT PAYMENTS, REQUESTS FOR ADVANCE DETERMINATION OF COVERAGE, AND REQUESTS FOR REQUIRED DETERMINATION OF MEDICAL NECESSITY.—Except as provided in subparagraph (B)—

“(i) INITIAL DECISIONS.—If a request for benefit payments, a request for advance determination of coverage, or a request for required determination of medical necessity is submitted to a group health plan in such

1 reasonable form as may be required under  
2 the plan, the plan shall issue in writing an  
3 initial coverage decision on the request be-  
4 fore the end of the initial decision period  
5 under paragraph (10)(I) following the fil-  
6 ing completion date. Failure to issue a cov-  
7 erage decision on such a request before the  
8 end of the period required under this  
9 clause shall be treated as an adverse cov-  
10 erage decision for purposes of internal re-  
11 view under clause (ii).

12 “(ii) INTERNAL REVIEWS OF INITIAL  
13 DENIALS.—Upon the written request of a  
14 participant or beneficiary for review of an  
15 initial adverse coverage decision under  
16 clause (i), a review by an appropriate  
17 named fiduciary (subject to paragraph (3))  
18 of the initial coverage decision shall be  
19 completed, including issuance by the plan  
20 of a written decision affirming, reversing,  
21 or modifying the initial coverage decision,  
22 setting forth the grounds for such decision,  
23 before the end of the internal review period  
24 following the review filing date. Such deci-  
25 sion shall be treated as the final decision

1 of the plan, subject to any applicable re-  
2 consideration under paragraph (4). Failure  
3 to issue before the end of such period such  
4 a written decision requested under this  
5 clause shall be treated as a final decision  
6 affirming the initial coverage decision.

7 “(B) TIME LIMITS FOR MAKING COVERAGE  
8 DECISIONS RELATING TO ACCELERATED NEED  
9 MEDICAL CARE AND FOR COMPLETING INTER-  
10 NAL APPEALS.—

11 “(i) INITIAL DECISIONS.—A group  
12 health plan shall issue in writing an initial  
13 coverage decision on any request for expe-  
14 dited advance determination of coverage or  
15 for expedited required determination of  
16 medical necessity submitted, in such rea-  
17 sonable form as may be required under the  
18 plan before the end of the accelerated need  
19 decision period under paragraph (10)(K),  
20 in cases involving accelerated need medical  
21 care, following the filing completion date.  
22 Failure to approve or deny such a request  
23 before the end of the applicable decision  
24 period shall be treated as a denial of the

1 request for purposes of internal review  
2 under clause (ii).

3 “(ii) INTERNAL REVIEWS OF INITIAL  
4 DENIALS.—Upon the written request of a  
5 participant or beneficiary for review of an  
6 initial adverse coverage decision under  
7 clause (i), a review by an appropriate  
8 named fiduciary (subject to paragraph (3))  
9 of the initial coverage decision shall be  
10 completed, including issuance by the plan  
11 of a written decision affirming, reversing,  
12 or modifying the initial converge decision,  
13 setting forth the grounds for the decision  
14 before the end of the accelerated need deci-  
15 sion period under paragraph (10)(K) fol-  
16 lowing the review filing date. Such decision  
17 shall be treated as the final decision of the  
18 plan, subject to any applicable reconsider-  
19 ation under paragraph (4). Failure to issue  
20 before the end of the applicable decision  
21 period such a written decision requested  
22 under this clause shall be treated as a final  
23 decision affirming the initial coverage deci-  
24 sion.

1           “(3) MEDICAL PROFESSIONALS MUST REVIEW  
2           INITIAL COVERAGE DECISIONS INVOLVING MEDICAL  
3           APPROPRIATENESS OR NECESSITY OR INVESTIGA-  
4           TIONAL ITEMS OR EXPERIMENTAL TREATMENT OR  
5           TECHNOLOGY.—If an initial coverage decision under  
6           paragraph (2)(A)(i) or (2)(B)(i) is based on a deter-  
7           mination that provision of a particular item or serv-  
8           ice is excluded from coverage under the terms of the  
9           plan because the provision of such item or service  
10          does not meet the plan’s requirements for medical  
11          appropriateness or necessity or would constitute in-  
12          vestigational items or experimental treatment or  
13          technology, the review under paragraph (2)(A)(ii) or  
14          (2)(B)(ii), to the extent that it relates to medical ap-  
15          propriateness or necessity or to investigational items  
16          or experimental treatment or technology, shall be  
17          conducted by a physician or, if appropriate, another  
18          medical professional, who is selected by the plan and  
19          who did not make the initial denial.

20           “(4) ELECTIVE EXTERNAL REVIEW BY INDE-  
21          PENDENT MEDICAL EXPERT AND RECONSIDERATION  
22          OF INITIAL REVIEW DECISION.—

23           “(A) IN GENERAL.—In any case in which  
24          a participant or beneficiary, who has received  
25          an adverse coverage decision which is not re-

versed upon review conducted pursuant to paragraph (1)(C) (including review under paragraph (2)(A)(ii) or (2)(B)(ii)) and who has not commenced review of the coverage decision under section 502, makes a request in writing, within 30 days after the date of such review decision, for reconsideration of such review decision, the requirements of subparagraphs (B), (C), (D) and (E) shall apply in the case of such adverse coverage decision, if the requirements of clause (i), (ii), or (iii) are met.

“(i) MEDICAL APPROPRIATENESS OR INVESTIGATIONAL ITEM OR EXPERIMENTAL TREATMENT OR TECHNOLOGY.—

The requirements of this clause are met if such coverage decision is based on a determination that provision of a particular item or service that would otherwise be covered under the terms of the plan is excluded from coverage under the terms of the plan because the provision of such item or service—

“(I) does not meet the plan’s requirements for medical appropriateness or necessity; or



1 “(II) would constitute an inves-  
2 tigational item or experimental treat-  
3 ment or technology.

4 “(ii) CATEGORICAL EXCLUSION OF  
5 ITEM OR SERVICE REQUIRING EVALUATION  
6 OF MEDICAL FACTS OR EVIDENCE.—The  
7 requirements of this clause are met if—

8 “(I) such coverage decision is  
9 based on a determination that a par-  
10 ticular item or service is not covered  
11 under the terms of the plan because  
12 provision of such item or service is  
13 categorically excluded from coverage  
14 under the terms of the plan, and

15 “(II) an independent contract ex-  
16 pert finds under subparagraph (C), in  
17 advance of any review of the decision  
18 under subparagraph (D), that such  
19 determination primarily requires the  
20 evaluation of medical facts or medical  
21 evidence by a health professional.

22 “(iii) SPECIFIC EXCLUSION OF ITEM  
23 OR SERVICE REQUIRING EVALUATION OF  
24 MEDICAL FACTS OR EVIDENCE.—The re-  
25 quirements of this clause are met if—

1 “(I) such coverage decision is  
2 based on a determination that a par-  
3 ticular item or service is not covered  
4 under the terms of the plan because  
5 provision of such item or service is  
6 specifically excluded from coverage  
7 under the terms of the plan, and

8 “(II) an independent contract ex-  
9 pert finds under subparagraph (C), in  
10 advance of any review of the decision  
11 under subparagraph (D), that such  
12 determination primarily requires the  
13 evaluation of medical facts or medical  
14 evidence by a health professional.

15 “(iv) MATTERS SPECIFICALLY NOT  
16 SUBJECT TO REVIEW.—The requirements  
17 of subparagraphs (B), (C), (D), and (E)  
18 shall not apply in the case of any adverse  
19 coverage decision if such decision is based  
20 on—

21 “(I) a determination of eligibility  
22 for benefits,

23 “(II) the application of explicit  
24 plan limits on the number, cost, or  
25 duration of any benefit, or

1                   “(III) a limitation on the amount  
2                   of any benefit payment or a require-  
3                   ment to make copayments under the  
4                   terms of the plan.

5                   Review under this paragraph shall not be avail-  
6                   able for any coverage decision that has pre-  
7                   viously undergone review under this paragraph.

8                   “(B) LIMITS ON ALLOWABLE ADVANCE  
9                   PAYMENTS.—The review under this paragraph  
10                  in connection with an adverse coverage decision  
11                  shall be available subject to any requirement of  
12                  the plan (unless waived by the plan for financial  
13                  or other reasons) for payment in advance to the  
14                  plan by the participant or beneficiary seeking  
15                  review of an amount not to exceed the greater  
16                  of (i) the lesser of \$100 or 10 percent of the  
17                  cost of the medical care involved in the decision,  
18                  or (ii) \$25, with such dollar amount subject to  
19                  compounded annual adjustments in the same  
20                  manner and to the same extent as apply under  
21                  section 215(i) of the Social Security Act, except  
22                  that, for any calendar year, such amount as so  
23                  adjusted shall be deemed, solely for such cal-  
24                  endar year, to be equal to such amount rounded  
25                  to the nearest \$10. No such payment may be

1 required in the case of any participant or bene-  
2 ficiary whose enrollment under the plan is paid  
3 for, in whole or in part, under a State plan  
4 under title XIX or XXI of the Social Security  
5 Act. Any such advance payment shall be subject  
6 to reimbursement if the recommendation of the  
7 independent medical expert or experts under  
8 subparagraph (D)(iii) is to reverse or modify  
9 the coverage decision.

10 “(C) REQUEST TO INDEPENDENT CON-  
11 TRACT EXPERTS FOR DETERMINATION OF  
12 WHETHER COVERAGE DECISION REQUIRED  
13 EVALUATION OF MEDICAL FACTS OR EVI-  
14 DENCE.—

15 “(i) IN GENERAL.—In the case of a  
16 request for review made by a participant or  
17 beneficiary as described in subparagraph  
18 (A), if the requirements of clause (ii) or  
19 (iii) of subparagraph (A) are met (and re-  
20 view is not otherwise precluded under sub-  
21 paragraph (A)(iv)), the terms of the plan  
22 shall provide for a procedure for initial re-  
23 view by an independent contract expert se-  
24 lected by the plan under which the expert  
25 will determine whether the coverage deci-

1           sion requires the evaluation of medical  
2           facts or evidence by a health professional.  
3           If the expert determines that the coverage  
4           decision requires such evaluation, reconsid-  
5           eration of such adverse decision shall pro-  
6           ceed under this paragraph. If the expert  
7           determines that the coverage decision does  
8           not require such evaluation, the adverse  
9           decision shall remain the final decision of  
10          the plan.

11           “(ii) INDEPENDENT CONTRACT EX-  
12          PERTS.—For purposes of this subpara-  
13          graph, the term ‘independent contract ex-  
14          pert’ means a professional—

15                   “(I) who has appropriate creden-  
16                   tials and has attained recognized ex-  
17                   pertise in the applicable area of con-  
18                   tract interpretation;

19                   “(II) who was not involved in the  
20                   initial decision or any earlier review  
21                   thereof; and

22                   “(III) who is selected in accord-  
23                   ance with subparagraph (G)(i) and  
24                   meets the requirements of subpara-  
25                   graph (G)(ii).

1           “(D) RECONSIDERATION OF INITIAL RE-  
2           VIEW DECISION.—

3           “(i) IN GENERAL.—In the case of a  
4           request for review made by a participant or  
5           beneficiary as described in subparagraph  
6           (A), if the requirements of subparagraph  
7           (A)(i) are met or reconsideration proceeds  
8           under this paragraph pursuant to subpara-  
9           graph (C), the terms of the plan shall pro-  
10          vide for a procedure for such reconsider-  
11          ation in accordance with clause (ii).

12          “(ii) PROCEDURE FOR RECONSIDER-  
13          ATION.—The procedure required under  
14          clause (i) shall include the following—

15               “(I) One or more independent  
16               medical experts will be selected in ac-  
17               cordance with subparagraph (F) to re-  
18               consider any coverage decision de-  
19               scribed in subparagraph (A) to deter-  
20               mine whether such decision was in ac-  
21               cordance with the terms of the plan  
22               and this title.

23               “(II) The record for review (in-  
24               cluding a specification of the terms of  
25               the plan and other criteria serving as

1 the basis for the initial review deci-  
2 sion) will be presented to such expert  
3 or experts and maintained in a man-  
4 ner which will ensure confidentiality  
5 of such record.

6 “(III) Such expert or experts will  
7 reconsider the initial review decision  
8 to determine whether such decision  
9 was in accordance with the terms of  
10 the plan and this title. Such reconsid-  
11 eration shall include the initial deci-  
12 sion of the plan, the medical condition  
13 of the patient, and the recommenda-  
14 tions of the treating physician. The  
15 experts shall take into account in the  
16 course of such reconsideration any  
17 guidelines adopted by the plan  
18 through a process involving medical  
19 practitioners and peer-reviewed med-  
20 ical literature identified as such under  
21 criteria established by the Food and  
22 Drug Administration.

23 “(IV) Such expert or experts will  
24 issue a written decision affirming,  
25 modifying, or reversing the initial re-

1 view decision, setting forth the  
2 grounds for the decision.

3 “(E) TIME LIMITS FOR RECONSIDER-  
4 ATION.—Any review under this paragraph (in-  
5 cluding any review under subparagraph (C))  
6 shall be completed before the end of the recon-  
7 sideration period (as defined in paragraph  
8 (10)(L)) following the review filing date in con-  
9 nection with such review. The decision under  
10 this paragraph affirming, reversing, or modi-  
11 fying the initial review decision of the plan shall  
12 be the final decision of the plan. Failure to  
13 issue a written decision before the end of the  
14 reconsideration period in any reconsideration  
15 requested under this paragraph shall be treated  
16 as a final decision affirming the initial review  
17 decision of the plan.

18 “(F) INDEPENDENT MEDICAL EXPERTS.—  
19 “(i) IN GENERAL.—For purposes of  
20 this paragraph, the term ‘independent  
21 medical expert’ means, in connection with  
22 any coverage decision by a group health  
23 plan, a professional—



1 “(I) who is a physician or, if ap-  
2 propriate, another medical profes-  
3 sional;

4 “(II) who has appropriate cre-  
5 dentials and has attained recognized  
6 expertise in the applicable medical  
7 field;

8 “(III) who was not involved in  
9 the initial decision or any earlier re-  
10 view thereof;

11 “(IV) who has not history of dis-  
12 ciplinary action or sanctions (includ-  
13 ing, but not limited to, loss of staff  
14 privileges or participation restriction)  
15 taken or pending by any hospital,  
16 health carrier, government, or regu-  
17 latory body; and

18 “(V) who is selected in accord-  
19 ance with subparagraph (G)(i) and  
20 meets the requirements of subpara-  
21 graph (G)(ii).

22 “(G) SELECTION OF EXPERTS.—

23 “(i) IN GENERAL.—An independent  
24 contract expert or independent medical ex-

1           pert is selected in accordance with this  
2           clause if—

3                       “(I) the expert is selected by an  
4                       intermediary which itself meets the re-  
5                       quirements of clause (ii), by means of  
6                       a method which ensures that the iden-  
7                       tity of the expert is not disclosed to  
8                       the plan, any health insurance issuer  
9                       offering health insurance coverage to  
10                      the aggrieved participant or bene-  
11                      ficiary in connection with the plan,  
12                      and the aggrieved participant or bene-  
13                      ficiary under the plan, and the identi-  
14                      ties of the plan, the issuer, and the  
15                      aggrieved participant or beneficiary  
16                      are not disclosed to the expert; or

17                      “(II) the expert is selected, by an  
18                      intermediary or otherwise, in a man-  
19                      ner that is, under regulations issued  
20                      pursuant to negotiated rulemaking,  
21                      sufficient to ensure the expert’s inde-  
22                      pendence, including selection by the  
23                      plan in cases where it is determined  
24                      that a suitable intermediary is not  
25                      reasonably available,

1 and the method of selection is devised to  
2 reasonably ensure that the expert selected  
3 meets the independence requirements of  
4 clause (ii).

5 “(ii) INDEPENDENCE REQUIRE-  
6 MENTS.—An independent contract expert  
7 or independent medical expert or another  
8 entity described in clause (i) meets the  
9 independence requirements of this clause  
10 if—

11 “(I) the expert or entity is not  
12 affiliated with any related party;

13 “(II) any compensation received  
14 by such expert or entity in connection  
15 with the external review is reasonable  
16 and not contingent on any decision  
17 rendered by the expert or entity;

18 “(III) under the terms of the  
19 plan and any health insurance cov-  
20 erage offered in connection with the  
21 plan, the plan and the issuer (if any)  
22 have no recourse against the expert or  
23 entity in connection with the external  
24 review; and

1 “(IV) the expert or entity does  
2 not otherwise have a conflict of inter-  
3 est with a related party as determined  
4 under any regulations which the Sec-  
5 retary may prescribe.

6 “(iii) RELATED PARTY.—For pur-  
7 poses of clause (i)(I), the term ‘related  
8 party’ means—

9 “(I) the plan or any health insur-  
10 ance issuer offering health insurance  
11 coverage in connection with the plan  
12 (or any officer, director, or manage-  
13 ment employee of such plan or issuer);

14 “(II) the physician or other med-  
15 ical care provider that provided the  
16 medical care involved in the coverage  
17 decision;

18 “(III) the institution at which  
19 the medical care involved in the cov-  
20 erage decision is provided;

21 “(IV) the manufacturer of any  
22 drug or other item that was included  
23 in the medical care involved in the  
24 coverage decision; or

1                   “(V) any other party determined  
2                   under any regulations which the Sec-  
3                   retary may prescribe to have a sub-  
4                   stantial interest in the coverage deci-  
5                   sion.

6                   “(iv) AFFILIATED.—For purposes of  
7                   clause (ii)(I), the term ‘affiliated’ means,  
8                   in connection with any entity, having a fa-  
9                   milial, financial, or professional relation-  
10                  ship with, or interest in, such entity.

11                  “(H) MISBEHAVIOR BY EXPERTS.—Any  
12                  action by the expert or experts in applying for  
13                  their selection under this paragraph or in the  
14                  course of carrying out their duties under this  
15                  paragraph which constitutes—

16                  “(i) fraud or intentional misrepresen-  
17                  tation by such expert or experts, or

18                  “(ii) demonstrates failure to adhere to  
19                  the standards for selection set forth in sub-  
20                  paragraph (G)(ii),

21                  shall be treated as a failure to meet the require-  
22                  ments of this paragraph and therefore as a  
23                  cause of action which may be brought by a fidu-  
24                  ciary under section 502(a)(3).

1           “(5) PERMITTED ALTERNATIVES TO REQUIRED  
2 INTERNAL REVIEW.—

3           “(A) IN GENERAL.—In accordance with  
4 such regulations (if any) as may be prescribed  
5 by the Secretary for purposes of this paragraph,  
6 in the case of any initial coverage decision for  
7 benefits under paragraph (2)(A)(ii) or  
8 (2)(B)(ii), a group health plan may provide an  
9 alternative dispute resolution procedure meeting  
10 the requirements of subparagraph (B) for use  
11 in lieu of the procedures set forth under the  
12 preceding provisions of this subsection relating  
13 review of such decision. Such procedure may be  
14 provided in one form for all participants and  
15 beneficiaries or in a different form each group  
16 of similarly situated participants and bene-  
17 ficiaries.

18           “(B) REQUIREMENTS.—An alternative dis-  
19 pute resolution procedure meets the require-  
20 ments of this subparagraph, in connection with  
21 any initial coverage decision, if—

22           “(i) such procedure is utilized solely—  
23           “(I) accordance with the applica-  
24 ble terms of a bona fide collective bar-  
25 gaining agreement pursuant to which

1 the plan (or the applicable portion  
2 thereof governed by the agreement) is  
3 established or maintained, or

4 “(II) upon election by all parties  
5 to such decision,

6 “(ii) the procedure incorporates time  
7 limits not exceeding the time limits other-  
8 wise applicable under paragraphs (2)(A)(ii)  
9 and (2)(B)(ii);

10 “(iii) the procedure incorporates any  
11 otherwise applicable requirement for review  
12 by a physician under paragraph (3), unless  
13 waived by the participant or beneficiary (in  
14 a manner consistent with such regulations  
15 as the Secretary may prescribe to ensure  
16 equitable procedures); and

17 “(iv) the means of resolution of dis-  
18 pute allow for adequate presentation by  
19 each party of scientific and medical evi-  
20 dence supporting the position of such  
21 party.

22 “(C) WAIVERS.—In any case in which uti-  
23 lization of the alternative dispute resolution  
24 procedure is voluntarily elected by all parties in  
25 connection with a coverage decision, the plan

1           may require or allow under such procedure (in  
2           a manner consistent with such regulations as  
3           the Secretary may prescribe to ensure equitable  
4           procedures) any party to waive review of the  
5           coverage decision under paragraph (3), to waive  
6           further review of the coverage decision under  
7           paragraph (4) or section 502, and to elect an  
8           alternative means of external review (other than  
9           review under paragraph (4)).

10           “(6) PERMITTED ALTERNATIVES TO REQUIRED  
11           EXTERNAL REVIEW.—A group health plan shall not  
12           be treated as failing to meet the requirements of this  
13           subsection in connection with review of coverage de-  
14           cisions under paragraph (4) if the aggrieved partici-  
15           pant or beneficiary elects to utilize a procedure in  
16           connection with such review which is made generally  
17           available under the plan (in a manner consistent  
18           with such regulations as the Secretary may prescribe  
19           to ensure equitable procedures) under which—

20                   “(A) the plan agrees in advance of the rec-  
21                   ommendations of the independent medical ex-  
22                   pert or experts under paragraph (4)(C)(iii) to  
23                   render a final decision in accordance with such  
24                   recommendations; and



1           “(B) the participant or beneficiary waives  
2           in advance any right to review of the final deci-  
3           sion under section 502.

4           “(7) REVIEW REQUIREMENTS.—In any review  
5           of a decision issued under this subsection—

6           “(A) the record below shall be maintained  
7           for purposes of review in accordance with  
8           standards which shall be prescribed in regula-  
9           tions of the Secretary designed to facilitate  
10          such review, and

11          “(B) any decision upon review which modi-  
12          fies or reverses a decision below shall specifi-  
13          cally set forth a determination that the record  
14          upon review is sufficient to rebut a presumption  
15          in favor of the decision below.

16          “(8) COMPLIANCE WITH FIDUCIARY STAND-  
17          ARDS.—The issuance of a decision under a plan  
18          upon review in good faith compliance with the re-  
19          quirements of this subsection shall not be treated as  
20          a violation of part 4.

21          “(9) GROUP HEALTH PLAN DEFINED.—For  
22          purposes of this section—

23          “(A) IN GENERAL.—The term ‘group  
24          health plan’ shall have the meaning provided in  
25          section 733(a).

1 “(B) TREATMENT OF PARTNERSHIPS.—

2 The provisions of paragraphs (1), (2), and (3)  
3 of section 732(d) shall apply.

4 “(10) OTHER DEFINITIONS.—For purposes of  
5 this subsection—

6 “(A) REQUEST FOR BENEFIT PAY-  
7 MENTS.—The term ‘request for benefit pay-  
8 ments’ means a request, for payment of benefits  
9 by a group health plan for medical care, which  
10 is made by, or (if expressly authorized) on be-  
11 half of, a participant or beneficiary after such  
12 medical care has been provided.

13 “(B) REQUIRED DETERMINATION OF MED-  
14 ICAL NECESSITY.—The term ‘required deter-  
15 mination of medical necessity’ means a deter-  
16 mination required under a group health plan  
17 solely that proposed medical care meets, under  
18 the facts and circumstances at the time of the  
19 determination, the plan’s requirements for med-  
20 ical appropriateness or necessity (which may be  
21 subject to exceptions under the plan for fraud  
22 or misrepresentation), irrespective of whether  
23 the proposed medical care otherwise meets  
24 other terms and conditions of coverage, but  
25 only if such determination does not constitute

1 an advance determination of coverage (as de-  
2 fined in subparagraph (C)).

3 “(C) ADVANCE DETERMINATION OF COV-  
4 ERAGE.—The term ‘advance determination of  
5 coverage’ means a determination under a group  
6 health plan that proposed medical care meets,  
7 under the facts and circumstances at the time  
8 of the determination, the plan’s terms and con-  
9 ditions of coverage (which may be subject to ex-  
10 ceptions under the plan for fraud or misrepre-  
11 sentation).

12 “(D) REQUEST FOR ADVANCE DETERMINA-  
13 TION OF COVERAGE.—The term ‘request for ad-  
14 vance determination of coverage’ means a re-  
15 quest for an advance determination of coverage  
16 of medical care which is made by, or (if ex-  
17 pressly authorized) on behalf of, a participant  
18 or beneficiary before such medical care is pro-  
19 vided.

20 “(E) REQUEST FOR EXPEDITED ADVANCE  
21 DETERMINATION OF COVERAGE.—The term ‘re-  
22 quest for expedited advance determination of  
23 coverage’ means a request for advance deter-  
24 mination of coverage, in any case in which the

1 proposed medical care constitutes accelerated  
2 need medical care.

3 “(F) REQUEST FOR REQUIRED DETER-  
4 MINATION OF MEDICAL NECESSITY.—The term  
5 ‘request for required determination of medical  
6 necessity’ means a request for a required deter-  
7 mination of medical necessity for medical care  
8 which is made by or on behalf of a participant  
9 or beneficiary before the medical care is pro-  
10 vided.

11 “(G) REQUEST FOR EXPEDITED REQUIRED  
12 DETERMINATION OF MEDICAL NECESSITY.—  
13 The term ‘request for expedited required deter-  
14 mination of medical necessity’ means a request  
15 for required determination of medical necessity  
16 in any case in which the proposed medical care  
17 constitutes accelerated need medical care.

18 “(H) ACCELERATED NEED MEDICAL  
19 CARE.—The term ‘accelerated need medical  
20 care’ means medical care in any case in which  
21 an appropriate physician has certified in writing  
22 (or as otherwise provided in regulations of the  
23 Secretary) that the participant or beneficiary is  
24 stabilized and—

1 “(i) that failure to immediately pro-  
2 vide the care to the participant or bene-  
3 ficiary could reasonably be expected to re-  
4 sult in—

5 “(I) placing the health of such  
6 participant or beneficiary (or, with re-  
7 spect to such a participant or bene-  
8 ficiary who is a pregnant woman, the  
9 health of the woman or her unborn  
10 child) in serious jeopardy;

11 “(II) serious impairment to bod-  
12 ily functions; or

13 “(III) serious dysfunction of any  
14 bodily organ or part; or

15 “(ii) that immediate provision of the  
16 care is necessary because the participant  
17 or beneficiary has made or is at serious  
18 risk of making an attempt to harm himself  
19 or herself or another individual.

20 “(I) INITIAL DECISION PERIOD.—The term  
21 ‘initial decision period’ means a period of 30  
22 days, or such longer period as may be pre-  
23 scribed in regulations of the Secretary.

24 “(J) INTERNAL REVIEW PERIOD.—The  
25 term ‘internal review period’ means a period of

1           30 days, or such longer period as may be pre-  
2           scribed in regulations of the Secretary.

3           “(K) ACCELERATED NEED DECISION PE-  
4           RIOD.—The term ‘accelerated need decision pe-  
5           riod’ means a period of 5 days, or such longer  
6           period as may be prescribed in regulations of  
7           the Secretary.

8           “(L) RECONSIDERATION PERIOD.—The  
9           term ‘reconsideration period’ means a period of  
10          25 days, or such longer period as may be pre-  
11          scribed in regulations of the Secretary, except  
12          that—

13               “(i) in the case of a decision involving  
14               urgent medical care, such term means the  
15               urgent decision period; and

16               “(ii) in the case of a decision involving  
17               accelerated need medical care, such term  
18               means the accelerated need decision period.

19          “(M) FILING COMPLETION DATE.—The  
20          term ‘filing completion date’ means, in connec-  
21          tion with a group health plan, the date as of  
22          which the plan is in receipt of all information  
23          reasonably required (in writing or in such other  
24          reasonable form as may be specified by the  
25          plan) to make an initial coverage decision.

1           “(N) REVIEW FILING DATE.—The term  
2           ‘review filing date’ means, in connection with a  
3           group health plan, the date as of which the ap-  
4           propriate named fiduciary (or the independent  
5           medical expert or experts in the case of a review  
6           under paragraph (4)) is in receipt of all infor-  
7           mation reasonably required (in writing or in  
8           such other reasonable form as may be specified  
9           by the plan) to make a decision to affirm, mod-  
10          ify, or reverse a coverage decision.

11          “(O) MEDICAL CARE.—The term ‘medical  
12          care’ has the meaning provided such term by  
13          section 733(a)(2).

14          “(P) HEALTH INSURANCE COVERAGE.—  
15          The term ‘health insurance coverage’ has the  
16          meaning provided such term by section  
17          733(b)(1).

18          “(Q) HEALTH INSURANCE ISSUER.—The  
19          term ‘health insurance issuer’ has the meaning  
20          provided such term by section 733(b)(2).

21          “(R) WRITTEN OR IN WRITING.—

22                 “(i) IN GENERAL.—A request or deci-  
23                 sion shall be deemed to be ‘written’ or ‘in  
24                 writing’ if such request or decision is pre-  
25                 sented in a generally recognized printable

1 or electronic format. The Secretary may by  
 2 regulation provide for presentation of in-  
 3 formation otherwise required to be in writ-  
 4 ten form in such other forms as may be  
 5 appropriate under the circumstances.

6 “(ii) MEDICAL APPROPRIATENESS OR  
 7 INVESTIGATIONAL ITEMS OR EXPERI-  
 8 MENTAL TREATMENT DETERMINATIONS.—

9 For purposes of this subparagraph, in the  
 10 case of a request for advance determina-  
 11 tion of coverage, a request for expedited  
 12 advance determination of coverage, a re-  
 13 quest for required determination of medical  
 14 necessity, or a request for expedited re-  
 15 quired determination of medical necessity,  
 16 if the decision on such request is conveyed  
 17 to the provider of medical care or to the  
 18 participant or beneficiary by means of tele-  
 19 phonic or other electronic communications,  
 20 such decision shall be treated as a written  
 21 decision.”.

22 **SEC. 3. CLARIFICATION OF ERISA PREEMPTION RULES.**

23 (a) IN GENERAL.—Section 514 of the Employee Re-  
 24 tirement Income Security Act of 1974 (29 U.S.C. 1144)  
 25 is amended—



1           (1) by redesignating subsection (d) as sub-  
2       section (e); and

3           (2) by inserting after subsection (c) the fol-  
4       lowing new subsection:

5       “(d) The procedures and remedies required or pro-  
6       vided under sections 502 and 503 in connection with—

7           “(1) review of claims for benefits under em-  
8       ployee benefit plans and for review of decisions deny-  
9       ing such claims (including review of coverage deci-  
10      sions referred to in section 503(b) and decisions  
11      upon review of such coverage decisions), and

12          “(2) causes of action brought to recover plan  
13      benefits, to enforce rights under the terms of the  
14      plan or this title, or to clarify rights to future bene-  
15      fits under the terms of the plan or this title,

16      are the exclusive procedures and remedies with respect to  
17      any such review or cause of action and supersede any pro-  
18      vision of State law providing for any such review or cause  
19      of action.”.

20      (b)       CONFORMING        AMENDMENT.—Section  
21      514(b)(2)(A) of such Act (42 U.S.C. 1144(b)(2)(A)) is  
22      amended by inserting “or subsection (d)” after “subpara-  
23      graph (B)”.

1 **SEC. 4. EFFECTIVE DATE.**

2 (a) IN GENERAL.—The amendments made by this  
3 Act shall apply with respect to grievances arising in plan  
4 years beginning on or after January 1 of the second cal-  
5 endar year following 12 months after the date the Sec-  
6 retary of Labor issues all regulations necessary to carry  
7 out amendments made by this Act.

8 (b) LIMITATION ON ENFORCEMENT ACTIONS.—No  
9 enforcement action shall be taken, pursuant to the amend-  
10 ments made by this Act, against a group health plan or  
11 health insurance issuer with respect to a violation of a re-  
12 quirement imposed by such amendments before the date  
13 of issuance of final regulations issued in connection with  
14 such requirement, if the plan or issuer has sought to com-  
15 ply in good faith with such requirement.

16 (c) COLLECTIVE BARGAINING AGREEMENTS.—Any  
17 plan amendment made pursuant to a collective bargaining  
18 agreement relating to the plan which amends the plan  
19 solely to conform to any requirement added by this Act  
20 shall not be treated as a termination of such collective bar-  
21 gaining agreement.

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