I

106TH CONGRESS
1ST SESSION

H. R. 2095

To amend title I of the Employee Retirement Income Security Act of 1974 to make needed reforms relating to group health plans.

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

A BILL

To amend title I of the Employee Retirement Income Security Act of 1974 to make needed reforms relating to group health plans.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Health Care Quality and Access Act of 1999".

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

TITLE II—PATIENT RIGHT TO EMERGENCY MEDICAL CARE

TITLE III—PATIENT RIGHT TO OBSTETRIC AND GYNECOLOGICAL CARE

TITLE IV—PATIENT RIGHT TO PEDIATRIC CARE

TITLE V—PATIENT ACCESS TO INFORMATION

TITLE VI—GROUP HEALTH PLAN REVIEW STANDARDS

TITLE VII—SMALL BUSINESS ACCESS AND CHOICE FOR ENTREPRENEURS

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

TITLE I—PATIENT RIGHT TO UNRESTRICTED MEDICAL ADVICE

SEC. 101. PATIENT ACCESS TO UNRESTRICTED PROFESSIONAL HEALTH CARE ADVICE.

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

"SEC. 714. PATIENT ACCESS TO UNRESTRICTED PROFESSIONAL HEALTH CARE ADVICE.

''(a) IN GENERAL.—A group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not prohibit or otherwise restrict a health care professional from advising a participant or beneficiary under the plan who is a patient of the professional about the health status of the participant or beneficiary or the medical care or treatment for the condition or disease of the participant or beneficiary, regardless of whether benefits for such care or treatment are provided under the plan or coverage, if the professional is acting within the lawful scope of practice of the professional.

“(b) RULES OF CONSTRUCTION.—Nothing in this section shall be construed—

“(1) to prohibit the enforcement, as part of a contract or agreement to which a health care professional is a party, of any mutually agreed upon terms and conditions, including terms and conditions requiring a health care professional to participate in, and cooperate with, all programs, policies, and procedures developed or operated by a group health plan or health insurance issuer to assure, review, or improve the quality and effective utilization of health care services (if such utilization is according to guidelines or protocols that are based on clinical or scientific evidence and the professional judgment of the professional) but only if the guidelines or protocols under such utilization do not prohibit or restrict advice described in subsection (a) between health care professionals and their patients; or

“(2) to permit a health care professional to misrepresent the scope of benefits covered under the group health plan or health insurance coverage or to otherwise require a group health plan or health insurance issuer to reimburse health care professionals for benefits (including services and advice) not covered under the plan or coverage.

"(c) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this section, the term 'health care professional' means a physician (as defined in section 1861(r) of the Social Security Act) or other health care professional if coverage for the professional's services is provided under the group health plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.".

(b) CONFORMING AMENDMENT.—Section 732(a) of such Act (29 U.S.C. 1191a(a)) is amended by striking "section 711" and inserting "sections 711 and 714".

(c) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act is amended by adding at the end of the items relating to subpart B of part 7 of subtitle B of title I of such Act the following new item:

"Sec. 714. Patient access to unrestricted professional health care advice.".

SEC. 102. EFFECTIVE DATE AND RELATED RULES.

(a) EFFECTIVE DATE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by this title apply with respect to group health plans for plan years beginning on or after the first day of the first month that begins more than 1 year after the date of the enactment of this Act.

(2) COLLECTIVE BARGAINING EXCEPTION.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made by this title shall not apply to plan years beginning before the later of—

(A) the date on which the last collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment of this Act), or

(B) the first day described in paragraph (1).

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this title shall not be treated as a termination of such collective bargaining agreement.

(c) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this title, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments, and no penalty shall be imposed on any failure by such plan to comply with any requirement imposed by such amendments, to the extent that violation or failure occurs before the date of issuance of final regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

TITLE II—PATIENT RIGHT TO EMERGENCY MEDICAL CARE

SEC. 201. PATIENT ACCESS TO EMERGENCY MEDICAL CARE.

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

"SEC. 715. PATIENT ACCESS TO EMERGENCY MEDICAL CARE.

"(a) IN GENERAL.—To the extent that a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) provides for any benefits consisting of emergency medical care, except for items or services specifically excluded—

"(1) the plan or issuer shall provide benefits, without requiring preauthorization and without regard to otherwise applicable network limitations, for appropriate emergency medical screening examinations (within the capability of the emergency facility, including ancillary services routinely available to the emergency facility) to the extent that a prudent layperson, who possesses an average knowledge of health and medicine, would determine such examinations to be necessary in order to determine whether emergency medical care is required; and

"(2) the plan or issuer shall provide benefits for additional emergency medical services following an emergency medical screening examination (if determined necessary under paragraph (1)) to the extent that a prudent emergency medical professional would determine such additional emergency services to be necessary to avoid the consequences described in subsection (c).

“(b) UNIFORM COST-SHARING REQUIRED.—Nothing in this section shall be construed as preventing a group health plan or issuer from imposing any form of cost-sharing applicable to any participant or beneficiary (including coinsurance, copayments, deductibles, and any other charges) in relation to benefits described in subsection (a), if such form of cost-sharing is uniformly applied under such plan, with respect to similarly situated participants and beneficiaries, to all benefits consisting of emergency medical care provided to such similarly situated participants and beneficiaries under the plan.

“(c) EMERGENCY MEDICAL CARE.—For purposes of this section, the term ‘emergency medical care’ means medical care in any case in which an appropriate physician has certified in writing (or as otherwise provided in regulations of the Secretary)—

“(1) that failure to immediately provide the care to the participant or beneficiary could reasonably be expected to result in—

“(A) placing the health of such participant or beneficiary (or, with respect to such a participant or beneficiary who is a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

"(B) serious impairment to bodily functions; or

"(C) serious dysfunction of any bodily organ or part; or

"(2) that immediate provision of the care is necessary because the participant or beneficiary has made or is at serious risk of making an attempt to harm himself or herself or another individual.".

(b) CONFORMING AMENDMENT.—The table of contents in section 1 of such Act (as amended by the preceding provisions of this Act) is amended further by adding at the end of the items relating to subpart B of part 7 of subtitle B of title I of such Act the following new item:

SEC. 202. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this title shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act, except that the Secretary of Labor may issue regulations before such date under such amendments. The Secretary shall first issue regulations necessary to carry out the amendments made by this title before the effective date thereof.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this title, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

(c) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this title shall not apply with respect to plan years beginning before the later of—

(1) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act); or

(2) January 1, 2002.

For purposes of this subsection, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this title shall not be treated as a termination of such collective bargaining agreement.

TITLE III—PATIENT RIGHT TO OBSTETRIC AND GYNECOLOGICAL CARE

SEC. 301. PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE.

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

"SEC. 716. PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE

''(a) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan)—

''(1) provides benefits under the terms of the plan consisting of—

''(A) routine gynecological care (such as preventive women's health examinations); or

''(B) routine obstetric care (such as routine pregnancy-related services),

provided by a participating physician who specializes in such care (or provides benefits consisting of payment for such care); and

"(2) requires or provides for designation by a participant or beneficiary of a participating primary care provider,

if the primary care provider designated by such a participant or beneficiary is not such a physician, then the plan (or issuer) shall meet the requirements of subsection (b).

"(b) REQUIREMENTS.—A group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) meets the requirements of this subsection, in connection with benefits described in subsection (a) consisting of care described in subparagraph (A) or (B) of subsection (a)(1) (or consisting of payment therefor), if the plan (or issuer)—

"(1) does not require authorization or a referral by the primary care provider in order to obtain such benefits; and

"(2) treats the ordering of other routine care of the same type, by the participating physician providing the care described in subparagraph (A) or (B) of subsection (a)(1), as the authorization of the primary care provider with respect to such care.

"(c) CONSTRUCTION.—Nothing in subsection (b)(2) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological or obstetric care so ordered.

"(d) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a plan providing benefits under two or more coverage options, the requirements of this section shall apply separately with respect to each coverage option.".

(b) CONFORMING AMENDMENT.—The table of contents in section 1 of such Act (as amended by the preceding provisions of this Act) is amended further by adding at the end of the items relating to subpart B of part 7 of subtitle B of title I of such Act the following new item:

"Sec. 716. Patient access to obstetric and gynecological care.".

SEC. 302. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this title shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act, except that the Secretary of Labor may issue regulations before such date under such amendments. The Secretary shall first issue regulations necessary to carry out the amendments made by this title before the effective date thereof.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this title, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

(c) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this title shall not apply with respect to plan years beginning before the later of—

(1) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act); or

(2) January 1, 2002.

For purposes of this subsection, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this title shall not be treated as a termination of such collective bargaining agreement.

TITLE IV—PATIENT RIGHT TO PEDIATRIC CARE

SEC. 401. PATIENT ACCESS TO PEDIATRIC CARE.

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

"SEC. 717. PATIENT ACCESS TO PEDIATRIC CARE.

"(a) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) provides benefits consisting of routine pediatric care provided by a participating physician who specializes in pediatrics (or consisting of payment for such care) and the plan requires or provides for designation by a participant or beneficiary of a participating primary care provider, the plan (or issuer) shall provide that such a participating physician may be designated, if available, by a parent or guardian of any beneficiary under the plan is who under 18 years of age, as the primary care provider with respect to any such benefits.

"(b) CONSTRUCTION.—Nothing in subsection (a) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of pediatric care.

"(c) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a plan providing benefits under two or more coverage options, the requirements of this section shall apply separately with respect to each coverage option.".

(b) CONFORMING AMENDMENT.—The table of contents in section 1 of such Act (as amended by the preceding provisions of this Act) is amended further by adding at the end of the items relating to subpart B of part 7 of subtitle B of title I of such Act the following new item:

"Sec. 717. Patient access to pediatric care.".

SEC. 402. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this title shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act, except that the Secretary of Labor may issue regulations before such date under such amendments. The Secretary shall first issue regulations necessary to carry out the amendments made by this title before the effective date thereof.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this title, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

(c) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this title shall not apply with respect to plan years beginning before the later of—

(1) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act); or

(2) January 1, 2002.

For purposes of this subsection, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this title shall not be treated as a termination of such collective bargaining agreement.

TITLE V—PATIENT ACCESS TO INFORMATION

SEC. 501. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

(a) IN GENERAL.—Part 1 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended—

(1) by redesignating section 111 as section 112; and

(2) by inserting after section 110 the following new section:

"DISCLOSURE BY GROUP HEALTH PLANS

"SEC. 111. (a) DISCLOSURE REQUIREMENT.—

"(1) GROUP HEALTH PLANS.—The administrator of each group health plan shall take such actions as are necessary to ensure that the summary plan description of the plan required under section 102 (or each summary plan description in any case in which different summary plan descriptions are appropriate under part 1 for different options of coverage) contains, among any information otherwise required under this part, the information required under subsections (b), (c), (d), and (e)(2)(A).

"(2) HEALTH INSURANCE ISSUERS.—Each health insurance issuer offering health insurance coverage in connection with a group health plan shall provide the administrator on a timely basis with the information necessary to enable the administrator to comply with the requirements of paragraph (1). To the extent that any such issuer provides on a timely basis to plan participants and beneficiaries information otherwise required under this part to be included in the summary plan description, the requirements of sections 101(a)(1) and 104(b) shall be deemed satisfied in the case of such plan with respect to such information.

"(b) PLAN BENEFITS.—The information required under subsection (a) includes the following:

"(1) COVERED ITEMS AND SERVICES.—

"(A) CATEGORIZATION OF INCLUDED BENEFITS.—A description of covered benefits, categorized by—

"(i) types of items and services (including any special disease management program); and

"(ii) types of health care professionals providing such items and services.

"(B) EMERGENCY MEDICAL CARE.—A description of the extent to which the plan covers emergency medical care (including the extent to which the plan provides for access to urgent care centers), and any definitions provided under the plan for the relevant plan terminology referring to such care.

"(C) PREVENTATIVE SERVICES.—A description of the extent to which the plan provides benefits for preventative services.

"(D) DRUG FORMULARIES.—A description of the extent to which covered benefits are determined by the use or application of a drug formulary and a summary of the process for determining what is included in such formulary.

"(E) COBRA CONTINUATION COVERAGE.—A description of the benefits available under the plan pursuant to part 6.

"(2) LIMITATIONS, EXCLUSIONS, AND RESTRICTIONS ON COVERED BENEFITS.—

"(A) CATEGORIZATION OF EXCLUDED BENEFITS.—A description of benefits specifically excluded from coverage, categorized by types of items and services.

"(B) UTILIZATION REVIEW AND PREAUTHORIZATION REQUIREMENTS.—Whether coverage for medical care is limited or excluded on the basis of utilization review or preauthorization requirements.

"(C) LIFETIME, ANNUAL, OR OTHER PERIOD LIMITATIONS.—A description of the circumstances under which, and the extent to which, coverage is subject to lifetime, annual, or other period limitations, categorized by types of benefits.

"(D) CUSTODIAL CARE.—A description of the circumstances under which, and the extent to which, the coverage of benefits for custodial care is limited or excluded, and a statement of the definition used by the plan for custodial care.

"(E) EXPERIMENTAL TREATMENTS.—Whether coverage for any medical care is limited or excluded because it constitutes experimental treatment or technology, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

"(F) MEDICAL APPROPRIATENESS OR NECESSITY.—Whether coverage for medical care may be limited or excluded by reason of a failure to meet the plan's requirements for medical appropriateness or necessity, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

"(G) SECOND OR SUBSEQUENT OPINIONS.—A description of the circumstances under which, and the extent to which, coverage for second or subsequent opinions is limited or excluded.

"(H) SPECIALTY CARE.—A description of the circumstances under which, and the extent to which, coverage of benefits for specialty care is conditioned on referral from a primary care provider.

"(I) CONTINUITY OF CARE.—A description of the circumstances under which, and the extent to which, coverage of items and services provided by any health care professional is limited or excluded by reason of the departure by the professional from any defined set of providers.

"(J) RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—A description of the circumstances under which, and the extent to which, the plan, in covering emergency medical care furnished to a participant or beneficiary of the plan imposes any financial responsibility described in subsection (c) on participants or beneficiaries or limits or conditions benefits for such care subject to any other term or condition of such plan.

"(c) PARTICIPANT'S FINANCIAL RESPONSIBILITIES.—The information required under subsection (a) includes an explanation of—

"(1) a participant's financial responsibility for payment of premiums, coinsurance, copayments, deductibles, and any other charges; and

"(2) the circumstances under which, and the extent to which, the participant's financial responsibility described in paragraph (1) may vary, including any distinctions based on whether a health care provider from whom covered benefits are obtained is included in a defined set of providers.

"(d) DISPUTE RESOLUTION PROCEDURES.—The information required under subsection (a) includes a description of the processes adopted by the plan pursuant to section 503, including—

"(1) descriptions thereof relating specifically to—

"(A) coverage decisions;

"(B) internal review of coverage decisions; and

"(C) any external review of coverage decisions; and

"(2) the procedures and time frames applicable to each step of the processes referred to in subparagraphs (A), (B), and (C) of paragraph (1).

"(e) INFORMATION AVAILABLE ON REQUEST.—

"(1) ACCESS TO PLAN BENEFIT INFORMATION IN ELECTRONIC FORM.—

"(A) IN GENERAL.—In addition to the information required to be provided under section 104(b)(4), a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to participants and beneficiaries, in a generally recognized electronic format, the following information:

"(i) the latest summary plan description, including the latest summary of material modifications; and

"(ii) the actual plan provisions setting forth the benefits available under the plan to the extent such information relates to the coverage options under the plan available to the participant or beneficiary. A reasonable charge may be made to cover the cost of providing such information in such generally recognized electronic format. The Secretary may by regulation prescribe a maximum amount which will constitute a reasonable charge under the preceding sentence.

"(B) ALTERNATIVE ACCESS.—The requirements of this paragraph may be met by making such information generally available (rather than upon request) on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries.

"(2) ADDITIONAL INFORMATION TO BE PROVIDED ON REQUEST.—

"(A) INCLUSION IN SUMMARY PLAN DESCRIPTION OF SUMMARY OF ADDITIONAL IN-

FORMATION.—The information required under subsection (a) includes a summary description of the types of information required by this subsection to be made available to participants and beneficiaries on request.

"(B) INFORMATION REQUIRED FROM PLANS AND ISSUERS ON REQUEST.—In addition to information required to be included in summary plan descriptions under this subsection, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall provide the following information to a participant or beneficiary on request:

"(i) NETWORK CHARACTERISTICS.—If the plan (or issuer) utilizes a defined set of providers under contract with the plan (or issuer), a detailed list of the names of such providers and their geographic location, set forth separately with respect to primary care providers and with respect to specialists.

"(ii) CARE MANAGEMENT INFORMATION.—A description of the circumstances under which, and the extent to which, the plan has special disease management programs or programs for persons with disabilities, indicating whether these programs are voluntary or mandatory and whether a significant benefit differential results from participation in such programs.

"(iii) INCLUSION OF DRUGS AND BIOLOGICALS IN FORMULARIES.—A statement of whether a specific drug or biological is included in a formulary used to determine benefits under the plan and a description of the procedures for considering requests for any patient-specific waivers.

"(iv) PROCEDURES FOR DETERMINING EXCLUSIONS BASED ON MEDICAL NECESSITY OR EXPERIMENTAL TREATMENTS.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision based on a determination relating to medical necessity or an experimental treatment or technology, a description of the procedures and medically-based criteria used in such decision.

"(v) PREAUTHORIZATION AND UTILIZATION REVIEW PROCEDURES.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision, a description of the basis on which any preauthorization requirement or any utilization review requirement has resulted in such decision.

"(vi) ACCREDITATION STATUS OF HEALTH INSURANCE ISSUERS AND SERVICE PROVIDERS.—A description of the accreditation and licencing status (if any) of each health insurance issuer offering health insurance coverage in connection with the plan and of any utilization review organization utilized by the issuer or the plan, together with the name and address of the accrediting or licencing authority.

"(vii) MEASURES OF ENROLLEE SATISFACTION.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to enrollee satisfaction.

"(viii) QUALITY PERFORMANCE MEASURES.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to quality of performance of the delivery of medical care with respect to coverage options offered under the plan and of health care professionals and facilities providing medical care under the plan.

"(ix) INFORMATION RELATING TO EXTERNAL REVIEWS.—The number of any external reviews under section 503 that have been completed during the prior plan year and the number of such reviews in which a recommendation is made for modification or reversal of an internal review decision under the plan.

"(C) INFORMATION REQUIRED FROM HEALTH CARE PROFESSIONALS ON REQUEST.—Any health care professional treating a participant or beneficiary under a group health plan shall provide to the participant or beneficiary, on request, a description of his or her professional qualifications (including board certification status, licensing status, and accreditation status, if any), privileges, and experience and a general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which such professional is compensated in connection with the provision of such medical care.

"(D) INFORMATION REQUIRED FROM HEALTH CARE FACILITIES ON REQUEST.—Any health care facility from which a participant or beneficiary has sought treatment under a group health plan shall provide to the participant or beneficiary, on request, a description of the facility's corporate form or other organizational form and all forms of licensing and accreditation status (if any) assigned to the facility by standard-setting organizations.

"(f) ACCESS TO INFORMATION RELEVANT TO THE COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to information otherwise required to be made available under this section, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to a participant (and an employee who, under the terms of the plan, is eligible for coverage but not enrolled) in connection with a period of enrollment the summary plan description for any coverage option under the plan under which the participant is eligible to enroll and any information described in clauses (i), (ii), (iii), (vi), (vii), and (viii) of subsection (e)(2)(B).

"(g) ADVANCE NOTICE OF CHANGES IN DRUG FORMULARIES.—Not later than 30 days before the effective of date of any exclusion of a specific drug or biological from any drug formulary under the plan that is used in the treatment of a chronic illness or disease, the plan shall take such actions as are necessary to reasonably ensure that plan participants are informed of such exclusion. The requirements of this subsection may be satisfied—

"(1) by inclusion of information in publications broadly distributed by plan sponsors, employers, or employee organizations;

"(2) by electronic means of communication (including the Internet or proprietary computer networks in a format which is readily accessible to participants);

"(3) by timely informing participants who, under an ongoing program maintained under the plan, have submitted their names for such notification; or

"(4) by any other reasonable means of timely informing plan participants.

"(h) DEFINITIONS.—For purposes of this section—

"(1) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided such term under section 733(a)(1).

"(2) MEDICAL CARE.—The term 'medical care' has the meaning provided such term under section 733(a)(2).

"(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided such term under section 733(b)(1).

"(4) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided such term under section 733(b)(2).".

(b) CONFORMING AMENDMENTS.—

(1) Section 102(b) of such Act (29 U.S.C. 1022(b)) is amended by inserting before the period at the end the following: "; and, in the case of a group health plan (as defined in section 111(h)(1)), the information required to be included under section 111(a)".

(2) The table of contents in section 1 of such Act is amended by striking the item relating to section 111 and inserting the following new items:

SEC. 502. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this title shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary shall first issue all regulations necessary to carry out the amendments made by this title before such date.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this title, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of final regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

TITLE VI—GROUP HEALTH PLAN REVIEW STANDARDS

SEC. 601. SPECIAL RULES FOR GROUP HEALTH PLANS.

(a) IN GENERAL.—Section 503 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1133) is amended—

(1) by inserting "(a) IN GENERAL.—" after "SEC. 503.";

(2) by inserting "(other than a group health plan)" after "employee benefit plan"; and

(3) by adding at the end the following new subsection:

"(b) SPECIAL RULES FOR GROUP HEALTH PLANS.—

"(1) COVERAGE DETERMINATIONS.—Every group health plan shall—

"(A) provide adequate notice in writing in accordance with this subsection to any participant or beneficiary of any adverse coverage decision with respect to benefits of such participant or beneficiary under the plan, setting forth the specific reasons for such coverage decision and any rights of review provided under the plan, written in a manner calculated to be understood by the average participant;

"(B) provide such notice in writing also to any treating medical care provider of such participant or beneficiary, if such provider has claimed reimbursement for any item or service involved in such coverage decision, or if a claim submitted by the provider initiated the proceedings 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 reasonable form as may be required under the plan, the plan shall issue in writing an initial coverage decision on the request before the end of the initial decision period under paragraph (10)(I) following the filing completion date. Failure to issue a coverage decision on such a request before the end of the period required under this clause shall be treated as an adverse coverage decision for purposes of internal review under clause (ii).

"(ii) INTERNAL REVIEWS OF INITIAL DENIALS.—Upon the written request of a participant or beneficiary for review of an initial adverse coverage decision under clause (i), a review by an appropriate named fiduciary (subject to paragraph (3)) of the initial coverage decision shall be completed, including issuance by the plan of a written decision affirming, reversing, or modifying the initial coverage decision, setting forth the grounds for such decision, before the end of the internal review period following the review filing date. Such decision shall be treated as the final decision of the plan, subject to any applicable reconsideration under paragraph (4). Failure to issue before the end of such period such a written decision requested under this clause shall be treated as a final decision affirming the initial coverage decision.

"(B) TIME LIMITS FOR MAKING COVERAGE DECISIONS RELATING TO ACCELERATED NEED MEDICAL CARE AND FOR COMPLETING INTERNAL APPEALS.—

"(i) INITIAL DECISIONS.—A group health plan shall issue in writing an initial coverage decision on any request for expedited advance determination of coverage or for expedited required determination of medical necessity submitted, in such reasonable form as may be required under the plan before the end of the accelerated need decision period under paragraph (10)(K), in cases involving accelerated need medical care, following the filing completion date. Failure to approve or deny such a request before the end of the applicable decision period shall be treated as a denial of the request for purposes of internal review under clause (ii).

"(ii) INTERNAL REVIEWS OF INITIAL DENIALS.—Upon the written request of a participant or beneficiary for review of an initial adverse coverage decision under clause (i), a review by an appropriate named fiduciary (subject to paragraph (3)) of the initial coverage decision shall be completed, including issuance by the plan of a written decision affirming, reversing, or modifying the initial converge decision, setting forth the grounds for the decision before the end of the accelerated need decision period under paragraph (10)(K) following the review filing date. Such decision shall be treated as the final decision of the plan, subject to any applicable reconsideration under paragraph (4). Failure to issue before the end of the applicable decision period such a written decision requested under this clause shall be treated as a final decision affirming the initial coverage decision.

"(3) MEDICAL PROFESSIONALS MUST REVIEW INITIAL COVERAGE DECISIONS INVOLVING MEDICAL APPROPRIATENESS OR NECESSITY OR INVESTIGATIONAL ITEMS OR EXPERIMENTAL TREATMENT OR TECHNOLOGY.—If an initial coverage decision under paragraph (2)(A)(i) or (2)(B)(i) is based on a determination that provision of a particular item or service is excluded from coverage under the terms of the plan because the provision of such item or service does not meet the plan's requirements for medical appropriateness or necessity or would constitute investigational items or experimental treatment or technology, the review under paragraph (2)(A)(ii) or (2)(B)(ii), to the extent that it relates to medical appropriateness or necessity or to investigational items or experimental treatment or technology, shall be conducted by a physician or, if appropriate, another medical professional, who is selected by the plan and who did not make the initial denial.

"(4) ELECTIVE EXTERNAL REVIEW BY INDEPENDENT MEDICAL EXPERT AND RECONSIDERATION OF INITIAL REVIEW DECISION.—

"(A) IN GENERAL.—In any case in which a participant or beneficiary, who has received an adverse coverage decision which is not reversed 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

"(II) would constitute an investigational item or experimental treatment or technology.

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

"(I) such coverage decision is based on a determination that a particular item or service is not covered under the terms of the plan because provision of such item or service is categorically excluded from coverage under the terms of the plan, and

"(II) an independent contract expert finds under subparagraph (C), in advance of any review of the decision under subparagraph (D), that such determination primarily requires the evaluation of medical facts or medical evidence by a health professional.

"(iii) SPECIFIC EXCLUSION OF ITEM OR SERVICE REQUIRING EVALUATION OF MEDICAL FACTS OR EVIDENCE.—The requirements of this clause are met if—

“(I) such coverage decision is based on a determination that a particular item or service is not covered under the terms of the plan because provision of such item or service is specifically excluded from coverage under the terms of the plan, and

“(II) an independent contract expert finds under subparagraph (C), in advance of any review of the decision under subparagraph (D), that such determination primarily requires the evaluation of medical facts or medical evidence by a health professional.

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

“(I) a determination of eligibility for benefits,

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

"(III) a limitation on the amount of any benefit payment or a requirement to make copayments under the terms of the plan.

Review under this paragraph shall not be available for any coverage decision that has previously undergone review under this paragraph.

"(B) LIMITS ON ALLOWABLE ADVANCE PAYMENTS.—The review under this paragraph in connection with an adverse coverage decision shall be available subject to any requirement of the plan (unless waived by the plan for financial or other reasons) for payment in advance to the plan by the participant or beneficiary seeking review of an amount not to exceed the greater of (i) the lesser of $100 or 10 percent of the cost of the medical care involved in the decision, or (ii) $25, with such dollar amount subject to compounded annual adjustments in the same manner and to the same extent as apply under section 215(i) of the Social Security Act, except that, for any calendar year, such amount as so adjusted shall be deemed, solely for such calendar year, to be equal to such amount rounded to the nearest $10. No such payment may be required in the case of any participant or beneficiary whose enrollment under the plan is paid for, in whole or in part, under a State plan under title XIX or XXI of the Social Security Act. Any such advance payment shall be subject to reimbursement if the recommendation of the independent medical expert or experts under subparagraph (D)(iii) is to reverse or modify the coverage decision.

''(C) REQUEST TO INDEPENDENT CONTRACT EXPERTS FOR DETERMINATION OF WHETHER COVERAGE DECISION REQUIRED EVALUATION OF MEDICAL FACTS OR EVIDENCE.—

''(i) IN GENERAL.—In the case of a request for review made by a participant or beneficiary as described in subparagraph (A), if the requirements of clause (ii) or (iii) of subparagraph (A) are met (and review is not otherwise precluded under subparagraph (A)(iv)), the terms of the plan shall provide for a procedure for initial review by an independent contract expert selected by the plan under which the expert will determine whether the coverage decision requires the evaluation of medical facts or evidence by a health professional. If the expert determines that the coverage decision requires such evaluation, reconsideration of such adverse decision shall proceed under this paragraph. If the expert determines that the coverage decision does not require such evaluation, the adverse decision shall remain the final decision of the plan.

"(ii) INDEPENDENT CONTRACT EXPERTS.—For purposes of this subparagraph, the term 'independent contract expert' means a professional—

"(I) who has appropriate credentials and has attained recognized expertise in the applicable area of contract interpretation;

"(II) who was not involved in the initial decision or any earlier review thereof; and

"(III) who is selected in accordance with subparagraph (G)(i) and meets the requirements of subparagraph (G)(ii).

"(D) RECONSIDERATION OF INITIAL REVIEW DECISION.—

"(i) IN GENERAL.—In the case of a request for review made by a participant or beneficiary as described in subparagraph (A), if the requirements of subparagraph (A)(i) are met or reconsideration proceeds under this paragraph pursuant to subparagraph (C), the terms of the plan shall provide for a procedure for such reconsideration in accordance with clause (ii).

"(ii) PROCEDURE FOR RECONSIDERATION.—The procedure required under clause (i) shall include the following—

"(I) One or more independent medical experts will be selected in accordance with subparagraph (F) to reconsider any coverage decision described in subparagraph (A) to determine whether such decision was in accordance with the terms of the plan and this title.

"(II) The record for review (including a specification of the terms of the plan and other criteria serving as the basis for the initial review decision) will be presented to such expert or experts and maintained in a manner which will ensure confidentiality of such record.

"(III) Such expert or experts will reconsider the initial review decision to determine whether such decision was in accordance with the terms of the plan and this title. Such reconsideration shall include the initial decision of the plan, the medical condition of the patient, and the recommendations of the treating physician. The experts shall take into account in the course of such reconsideration any guidelines adopted by the plan through a process involving medical practitioners and peer-reviewed medical literature identified as such under criteria established by the Food and Drug Administration.

"(IV) Such expert or experts will issue a written decision affirming, modifying, or reversing the initial review decision, setting forth the grounds for the decision.

"(E) TIME LIMITS FOR RECONSIDERATION.—Any review under this paragraph (including any review under subparagraph (C)) shall be completed before the end of the reconsideration period (as defined in paragraph (10)(L)) following the review filing date in connection with such review. The decision under this paragraph affirming, reversing, or modifying the initial review decision of the plan shall be the final decision of the plan. Failure to issue a written decision before the end of the reconsideration period in any reconsideration requested under this paragraph shall be treated as a final decision affirming the initial review decision of the plan.

"(F) INDEPENDENT MEDICAL EXPERTS.—

"(i) IN GENERAL.—For purposes of this paragraph, the term 'independent medical expert' means, in connection with any coverage decision by a group health plan, a professional—

"(I) who is a physician or, if appropriate, another medical professional;

"(II) who has appropriate credentials and has attained recognized expertise in the applicable medical field;

"(III) who was not involved in the initial decision or any earlier review thereof;

"(IV) who has not history of disciplinary action or sanctions (including, but not limited to, loss of staff privileges or participation restriction) taken or pending by any hospital, health carrier, government, or regulatory body; and

"(V) who is selected in accordance with subparagraph (G)(i) and meets the requirements of subparagraph (G)(ii).

"(G) SELECTION OF EXPERTS.—

"(i) IN GENERAL.—An independent contract expert or independent medical expert is selected in accordance with this clause if—

"(I) the expert is selected by an intermediary which itself meets the requirements of clause (ii), by means of a method which ensures that the identity of the expert is not disclosed to the plan, any health insurance issuer offering health insurance coverage to the aggrieved participant or beneficiary in connection with the plan, and the aggrieved participant or beneficiary under the plan, and the identities of the plan, the issuer, and the aggrieved participant or beneficiary are not disclosed to the expert; or

"(II) the expert is selected, by an intermediary or otherwise, in a manner that is, under regulations issued pursuant to negotiated rulemaking, sufficient to ensure the expert's independence, including selection by the plan in cases where it is determined that a suitable intermediary is not reasonably available, and the method of selection is devised to reasonably ensure that the expert selected meets the independence requirements of clause (ii).

"(ii) INDEPENDENCE REQUIREMENTS.—An independent contract expert or independent medical expert or another entity described in clause (i) meets the independence requirements of this clause if—

"(I) the expert or entity is not affiliated with any related party;

"(II) any compensation received by such expert or entity in connection with the external review is reasonable and not contingent on any decision rendered by the expert or entity;

"(III) under the terms of the plan and any health insurance coverage offered in connection with the plan, the plan and the issuer (if any) have no recourse against the expert or entity in connection with the external review; and

"(IV) the expert or entity does not otherwise have a conflict of interest with a related party as determined under any regulations which the Secretary may prescribe.

"(iii) RELATED PARTY.—For purposes of clause (i)(I), the term 'related party' means—

"(I) the plan or any health insurance issuer offering health insurance coverage in connection with the plan (or any officer, director, or management employee of such plan or issuer);

"(II) the physician or other medical care provider that provided the medical care involved in the coverage decision;

"(III) the institution at which the medical care involved in the coverage decision is provided;

"(IV) the manufacturer of any drug or other item that was included in the medical care involved in the coverage decision; or

"(V) any other party determined under any regulations which the Secretary may prescribe to have a substantial interest in the coverage decision.

"(iv) AFFILIATED.—For purposes of clause (ii)(I), the term 'affiliated' means, in connection with any entity, having a familial, financial, or professional relationship with, or interest in, such entity.

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

"(i) fraud or intentional misrepresentation by such expert or experts, or

"(ii) demonstrates failure to adhere to the standards for selection set forth in subparagraph (G)(ii),

shall be treated as a failure to meet the requirements of this paragraph and therefore as a cause of action which may be brought by a fiduciary under section 502(a)(3).

"(5) PERMITTED ALTERNATIVES TO REQUIRED INTERNAL REVIEW.—

"(A) IN GENERAL.—In accordance with such regulations (if any) as may be prescribed by the Secretary for purposes of this paragraph, in the case of any initial coverage decision for benefits under paragraph (2)(A)(ii) or (2)(B)(ii), a group health plan may provide an alternative dispute resolution procedure meeting the requirements of subparagraph (B) for use in lieu of the procedures set forth under the preceding provisions of this subsection relating review of such decision. Such procedure may be provided in one form for all participants and beneficiaries or in a different form each group of similarly situated participants and beneficiaries.

"(B) REQUIREMENTS.—An alternative dispute resolution procedure meets the requirements of this subparagraph, in connection with any initial coverage decision, if—

"(i) such procedure is utilized solely—

"(I) accordance with the applicable terms of a bona fide collective bargaining agreement pursuant to which the plan (or the applicable portion thereof governed by the agreement) is established or maintained, or

"(II) upon election by all parties to such decision,

"(ii) the procedure incorporates time limits not exceeding the time limits otherwise applicable under paragraphs (2)(A)(ii) and (2)(B)(ii);

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

"(iv) the means of resolution of dispute allow for adequate presentation by each party of scientific and medical evidence supporting the position of such party.

"(C) WAIVERS.—In any case in which utilization of the alternative dispute resolution procedure is voluntarily elected by all parties in connection with a coverage decision, the plan may require or allow under such procedure (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures) any party to waive review of the coverage decision under paragraph (3), to waive further review of the coverage decision under paragraph (4) or section 502, and to elect an alternative means of external review (other than review under paragraph (4)).

"(6) PERMITTED ALTERNATIVES TO REQUIRED EXTERNAL REVIEW.—A group health plan shall not be treated as failing to meet the requirements of this subsection in connection with review of coverage decisions under paragraph (4) if the aggrieved participant or beneficiary elects to utilize a procedure in connection with such review which is made generally available under the plan (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures) under which—

"(A) the plan agrees in advance of the recommendations of the independent medical expert or experts under paragraph (4)(C)(iii) to render a final decision in accordance with such recommendations; and

''(B) the participant or beneficiary waives in advance any right to review of the final decision under section 502.

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

''(A) the record below shall be maintained for purposes of review in accordance with standards which shall be prescribed in regulations of the Secretary designed to facilitate such review, and

''(B) any decision upon review which modifies or reverses a decision below shall specifically set forth a determination that the record upon review is sufficient to rebut a presumption in favor of the decision below.

''(8) COMPLIANCE WITH FIDUCIARY STANDARDS.—The issuance of a decision under a plan upon review in good faith compliance with the requirements of this subsection shall not be treated as a violation of part 4.

''(9) GROUP HEALTH PLAN DEFINED.—For purposes of this section—

''(A) IN GENERAL.—The term 'group health plan' shall have the meaning provided in section 733(a).

"(B) TREATMENT OF PARTNERSHIPS.—The provisions of paragraphs (1), (2), and (3) of section 732(d) shall apply.

"(10) OTHER DEFINITIONS.—For purposes of this subsection—

"(A) REQUEST FOR BENEFIT PAYMENTS.—The term 'request for benefit payments' means a request, for payment of benefits by a group health plan for medical care, which is made by, or (if expressly authorized) on behalf of, a participant or beneficiary after such medical care has been provided.

"(B) REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term 'required determination of medical necessity' means a determination required under a group health plan solely that proposed medical care meets, under the facts and circumstances at the time of the determination, the plan's requirements for medical appropriateness or necessity (which may be subject to exceptions under the plan for fraud or misrepresentation), irrespective of whether the proposed medical care otherwise meets other terms and conditions of coverage, but only if such determination does not constitute an advance determination of coverage (as defined in subparagraph (C)).

"(C) ADVANCE DETERMINATION OF COVERAGE.—The term 'advance determination of coverage' means a determination under a group health plan that proposed medical care meets, under the facts and circumstances at the time of the determination, the plan's terms and conditions of coverage (which may be subject to exceptions under the plan for fraud or misrepresentation).

"(D) REQUEST FOR ADVANCE DETERMINATION OF COVERAGE.—The term 'request for advance determination of coverage' means a request for an advance determination of coverage of medical care which is made by, or (if expressly authorized) on behalf of, a participant or beneficiary before such medical care is provided.

"(E) REQUEST FOR EXPEDITED ADVANCE DETERMINATION OF COVERAGE.—The term 'request for expedited advance determination of coverage' means a request for advance determination of coverage, in any case in which the proposed medical care constitutes accelerated need medical care.

"(F) REQUEST FOR REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term 'request for required determination of medical necessity' means a request for a required determination of medical necessity for medical care which is made by or on behalf of a participant or beneficiary before the medical care is provided.

"(G) REQUEST FOR EXPEDITED REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term 'request for expedited required determination of medical necessity' means a request for required determination of medical necessity in any case in which the proposed medical care constitutes accelerated need medical care.

"(H) ACCELERATED NEED MEDICAL CARE.—The term 'accelerated need medical care' means medical care in any case in which an appropriate physician has certified in writing (or as otherwise provided in regulations of the Secretary) that the participant or beneficiary is stabilized and—

"(i) that failure to immediately provide the care to the participant or beneficiary could reasonably be expected to result in—

"(I) placing the health of such participant or beneficiary (or, with respect to such a participant or beneficiary who is a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

"(II) serious impairment to bodily functions; or

"(III) serious dysfunction of any bodily organ or part; or

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

"(I) INITIAL DECISION PERIOD.—The term 'initial decision period' means a period of 30 days, or such longer period as may be prescribed in regulations of the Secretary.

"(J) INTERNAL REVIEW PERIOD.—The term 'internal review period' means a period of

30 days, or such longer period as may be prescribed in regulations of the Secretary.

"(K) ACCELERATED NEED DECISION PERIOD.—The term 'accelerated need decision period' means a period of 5 days, or such longer period as may be prescribed in regulations of the Secretary.

"(L) RECONSIDERATION PERIOD.—The term 'reconsideration period' means a period of 25 days, or such longer period as may be prescribed in regulations of the Secretary, except that—

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

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

"(M) FILING COMPLETION DATE.—The term 'filing completion date' means, in connection with a group health plan, the date as of which the plan is in receipt of all information reasonably required (in writing or in such other reasonable form as may be specified by the plan) to make an initial coverage decision.

"(N) REVIEW FILING DATE.—The term 'review filing date' means, in connection with a group health plan, the date as of which the appropriate named fiduciary (or the independent medical expert or experts in the case of a review under paragraph (4)) is in receipt of all information reasonably required (in writing or in such other reasonable form as may be specified by the plan) to make a decision to affirm, modify, or reverse a coverage decision.

"(O) MEDICAL CARE.—The term 'medical care' has the meaning provided such term by section 733(a)(2).

"(P) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided such term by section 733(b)(1).

"(Q) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided such term by section 733(b)(2).

"(R) WRITTEN OR IN WRITING.—

"(i) IN GENERAL.—A request or decision shall be deemed to be 'written' or 'in writing' if such request or decision is presented in a generally recognized printable or electronic format. The Secretary may by regulation provide for presentation of information otherwise required to be in written form in such other forms as may be appropriate under the circumstances.

"(ii) MEDICAL APPROPRIATENESS OR INVESTIGATIONAL ITEMS OR EXPERIMENTAL TREATMENT DETERMINATIONS.—For purposes of this subparagraph, in the case of a request for advance determination of coverage, a request for expedited advance determination of coverage, a request for required determination of medical necessity, or a request for expedited required determination of medical necessity, if the decision on such request is conveyed to the provider of medical care or to the participant or beneficiary by means of telephonic or other electronic communications, such decision shall be treated as a written decision.".

SEC. 602. CLARIFICATION OF ERISA PREEMPTION RULES.

(a) IN GENERAL.—Section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) is amended—

(1) by redesignating subsection (d) as subsection (e); and

(2) by inserting after subsection (c) the following new subsection:

''(d) The procedures and remedies required or provided under sections 502 and 503 in connection with—

''(1) review of claims for benefits under employee benefit plans and for review of decisions denying such claims (including review of coverage decisions referred to in section 503(b) and decisions upon review of such coverage decisions), and

''(2) causes of action brought to recover plan benefits, to enforce rights under the terms of the plan or this title, or to clarify rights to future benefits under the terms of the plan or this title,

are the exclusive procedures and remedies with respect to any such review or cause of action and supersede any provision of State law providing for any such review or cause of action.''.

(b) CONFORMING AMENDMENT.—Section 514(b)(2)(A) of such Act (42 U.S.C. 1144(b)(2)(A)) is amended by inserting ''or subsection (d)'' after ''subparagraph (B)''.

SEC. 603. EFFECTIVE DATE.

(a) IN GENERAL.—The amendments made by this title shall apply with respect to grievances arising in plan years beginning on or after January 1 of the second calendar year following 12 months after the date the Secretary of Labor issues all regulations necessary to carry out amendments made by this title.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this title, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of final regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

(c) COLLECTIVE BARGAINING AGREEMENTS.—Any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this title shall not be treated as a termination of such collective bargaining agreement.

TITLE VII—SMALL BUSINESS ACCESS AND CHOICE FOR ENTREPRENEURS

SEC. 701. RULES GOVERNING ASSOCIATION HEALTH PLANS.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding after part 7 the following new part:

"PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

"SEC. 801. ASSOCIATION HEALTH PLANS.

"(a) IN GENERAL.—For purposes of this part, the term 'association health plan' means a group health plan—

"(1) whose sponsor is (or is deemed under this part to be) described in subsection (b); and

"(2) under which at least one option of health insurance coverage offered by a health insurance issuer (which may include, among other options, managed care options, point of service options, and preferred provider options) is provided to participants and beneficiaries, unless, for any plan year, such coverage remains unavailable to the plan despite good faith efforts exercised by the plan to secure such coverage.

"(b) SPONSORSHIP.—The sponsor of a group health plan is described in this subsection if such sponsor—

"(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a bona fide trade association, a bona fide industry association (including a rural electric cooperative association or a rural telephone cooperative association), a bona fide professional association, or a bona fide chamber of commerce (or similar bona fide business association, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining or providing medical care;

"(2) is established as a permanent entity which receives the active support of its members and collects from its members on a periodic basis dues or payments necessary to maintain eligibility for membership in the sponsor; and

"(3) does not condition membership, such dues or payments, or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation.

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1), (2), and (3) shall be deemed to be a sponsor described in this subsection.

"SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH PLANS.

"(a) IN GENERAL.—The applicable authority shall prescribe by regulation, through negotiated rulemaking, a procedure under which, subject to subsection (b), the applicable authority shall certify association health plans which apply for certification as meeting the requirements of this part.

"(b) STANDARDS.—Under the procedure prescribed pursuant to subsection (a), in the case of an association health plan that provides at least one benefit option which does not consist of health insurance coverage, the applicable authority shall certify such plan as meeting the requirements of this part only if the applicable authority is satisfied that—

"(1) such certification—

"(A) is administratively feasible;

"(B) is not adverse to the interests of the individuals covered under the plan; and

"(C) is protective of the rights and benefits of the individuals covered under the plan; and

"(2) the applicable requirements of this part are met (or, upon the date on which the plan is to commence operations, will be met) with respect to the plan.

"(c) REQUIREMENTS APPLICABLE TO CERTIFIED PLANS.—An association health plan with respect to which certification under this part is in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

"(d) REQUIREMENTS FOR CONTINUED CERTIFICATION.—The applicable authority may provide by regulation, through negotiated rulemaking, for continued certification of association health plans under this part.

"(e) CLASS CERTIFICATION FOR FULLY INSURED PLANS.—The applicable authority shall establish a class certification procedure for association health plans under which all benefits consist of health insurance coverage. Under such procedure, the applicable authority shall provide for the granting of certification under this part to the plans in each class of such association health plans upon appropriate filing under such procedure in connection with plans in such class and payment of the prescribed fee under section 807(a).

"(f) CERTIFICATION OF SELF-INSURED ASSOCIATION HEALTH PLANS.—An association health plan which offers one or more benefit options which do not consist of health insurance coverage may be certified under this part only if such plan consists of any of the following:

"(1) a plan which offered such coverage on the date of the enactment of the Small Business Access and Choice for Entrepreneurs Act of 1999,

"(2) a plan under which the sponsor does not restrict membership to one or more trades and businesses or industries and whose eligible participating employers represent a broad cross-section of trades and businesses or industries, or

"(3) a plan whose eligible participating employers represent one or more trades or businesses, or one or more industries, which have been indicated as having average or above-average health insurance risk or health claims experience by reason of State rate filings, denials of coverage, proposed premium rate levels, and other means demonstrated by such plan in accordance with regulations which the Secretary shall prescribe through negotiated rulemaking, including (but not limited to) the following: agriculture; automobile dealerships; barbering and cosmetology; child care; construction; dance, theatrical, and orchestra productions; disinfecting and pest control; eating and drinking establishments; fishing; hospitals; labor organizations; logging; manufacturing (metals); mining; medical and dental practices; medical laboratories; sanitary services; transportation (local and freight); and warehousing.

"SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND BOARDS OF TRUSTEES.

"(a) SPONSOR.—The requirements of this subsection are met with respect to an association health plan if the sponsor has met (or is deemed under this part to have met) the requirements of section 801(b) for a continuous period of not less than 3 years ending with the date of the application for certification under this part.

"(b) BOARD OF TRUSTEES.—The requirements of this subsection are met with respect to an association health plan if the following requirements are met:

"(1) FISCAL CONTROL.—The plan is operated, pursuant to a trust agreement, by a board of trustees which has complete fiscal control over the plan and which is responsible for all operations of the plan.

"(2) RULES OF OPERATION AND FINANCIAL CONTROLS.—The board of trustees has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the plan and to meet all requirements of this title applicable to the plan.

"(3) RULES GOVERNING RELATIONSHIP TO PARTICIPATING EMPLOYERS AND TO CONTRACTORS.—

"(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

"(B) LIMITATION.—

"(i) GENERAL RULE.—Except as provided in clauses (ii) and (iii), no such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the plan.

"(ii) LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON BEHALF

OF THE SPONSOR.—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

"(iii) TREATMENT OF PROVIDERS OF MEDICAL CARE.—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, clause (i) shall not apply in the case of any service provider described in subparagraph (A) who is a provider of medical care under the plan.

"(C) CERTAIN PLANS EXCLUDED.—Subparagraph (A) shall not apply to an association health plan which is in existence on the date of the enactment of the Small Business Access and Choice for Entrepreneurs Act of 1999.

"(D) SOLE AUTHORITY.—The board has sole authority under the plan to approve applications for participation in the plan and to contract with a service provider to administer the day-to-day affairs of the plan.

"(c) TREATMENT OF FRANCHISE NETWORKS.—In the case of a group health plan which is established and maintained by a franchiser for a franchise network consisting of its franchisees—

"(1) the requirements of subsection (a) and section 801(a)(1) shall be deemed met if such requirements would otherwise be met if the franchiser were deemed to be the sponsor referred to in section 801(b), such network were deemed to be an association described in section 801(b), and each franchisee were deemed to be a member (of the association and the sponsor) referred to in section 801(b); and

"(2) the requirements of section 804(a)(1) shall be deemed met.

The Secretary may by regulation, through negotiated rulemaking, define for purposes of this subsection the terms 'franchiser', 'franchise network', and 'franchisee'.

"(d) CERTAIN COLLECTIVELY BARGAINED PLANS.—

"(1) IN GENERAL.—In the case of a group health plan described in paragraph (2)—

"(A) the requirements of subsection (a) and section 801(a)(1) shall be deemed met;

"(B) the joint board of trustees shall be deemed a board of trustees with respect to which the requirements of subsection (b) are met; and

"(C) the requirements of section 804 shall be deemed met.

"(2) REQUIREMENTS.—A group health plan is described in this paragraph if—

"(A) the plan is a multiemployer plan; or

"(B) the plan is in existence on April 1, 1997, and would be described in section 3(40)(A)(i) but solely for the failure to meet the requirements of section 3(40)(C)(ii).

"SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

"(a) COVERED EMPLOYERS AND INDIVIDUALS.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan—

"(1) each participating employer must be—

"(A) a member of the sponsor,

"(B) the sponsor, or

"(C) an affiliated member of the sponsor with respect to which the requirements of subsection (b) are met, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or such an affiliated member of the sponsor, participating employers may also include such employer; and

"(2) all individuals commencing coverage under the plan after certification under this part must be—

"(A) active or retired owners (including self-employed individuals), officers, directors, or employees of, or partners in, participating employers; or

"(B) the beneficiaries of individuals described in subparagraph (A).

"(b) COVERAGE OF PREVIOUSLY UNINSURED EMPLOYEES.—In the case of an association health plan in existence on the date of the enactment of the Small Business Access and Choice for Entrepreneurs Act of 1999, an affiliated member of the sponsor of the plan may be offered coverage under the plan as a participating employer only if—

"(1) the affiliated member was an affiliated member on the date of certification under this part; or

"(2) during the 12-month period preceding the date of the offering of such coverage, the affiliated member has not maintained or contributed to a group health plan with respect to any of its employees who would otherwise be eligible to participate in such association health plan.

"(c) INDIVIDUAL MARKET UNAFFECTED.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any employee not covered under the plan which is similar to the coverage contemporaneously provided to employees of the employer under the plan, if such exclusion of the employee from coverage under the plan is based on a health status-related factor with respect to the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the plan.

"(d) PROHIBITION OF DISCRIMINATION AGAINST EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.—The requirements of this subsection are met with respect to an association health plan if—

"(1) under the terms of the plan, all employers meeting the preceding requirements of this section are eligible to qualify as participating employers for all geographically available coverage options, unless, in the case of any such employer, participation or contribution requirements of the type referred to in section 2711 of the Public Health Service Act are not met;

"(2) upon request, any employer eligible to participate is furnished information regarding all coverage options available under the plan; and

"(3) the applicable requirements of sections 701, 702, and 703 are met with respect to the plan.

"SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS.

"(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if the following requirements are met:

"(1) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

"(A) provides that the board of trustees serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A));

"(B) provides that the sponsor of the plan is to serve as plan sponsor (referred to in section 3(16)(B)); and

"(C) incorporates the requirements of section 806.

"(2) CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.—

"(A) The contribution rates for any participating small employer do not vary on the basis of the claims experience of such employer and do not vary on the basis of the type of business or industry in which such employer is engaged.

"(B) Nothing in this title or any other provision of law shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from—

"(i) setting contribution rates based on the claims experience of the plan; or

"(ii) varying contribution rates for small employers in a State to the extent that such rates could vary using the same methodology employed in such State for regulating premium rates in the small group market with respect to health insurance coverage offered in connection with bona fide associations (within the meaning of section 2791(d)(3) of the Public Health Service Act),

subject to the requirements of section 702(b) relating to contribution rates.

"(3) FLOOR FOR NUMBER OF COVERED INDIVIDUALS WITH RESPECT TO CERTAIN PLANS.—If any benefit option under the plan does not consist of health insurance coverage, the plan has as of the beginning of the plan year not fewer than 1,000 participants and beneficiaries.

"(4) MARKETING REQUIREMENTS.—

"(A) IN GENERAL.—If a benefit option which consists of health insurance coverage is offered under the plan, State-licensed insurance agents shall be used to distribute to small employers coverage which does not consist of health insurance coverage in a manner comparable to the manner in which such agents are used to distribute health insurance coverage.

"(B) STATE-LICENSED INSURANCE AGENTS.—For purposes of subparagraph (A), the term 'State-licensed insurance agents' means one or more agents who are licensed in a State and are subject to the laws of such State relating to licensure, qualification, testing, examination, and continuing education of persons authorized to offer, sell, or solicit health insurance coverage in such State.

"(5) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority determines are necessary to carry out the purposes of this part, which shall be prescribed by the applicable authority by regulation through negotiated rulemaking.

"(b) ABILITY OF ASSOCIATION HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Subject to section 514(d), nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from exercising its sole discretion in selecting the specific items and services consisting of medical care to be included as benefits under such plan or coverage, except (subject to section 514) in the case of any law to the extent that it (1) prohibits an exclusion of a specific disease from such coverage, or (2) is not preempted under section 731(a)(1) with respect to matters governed by section 711 or 712.

"SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS FOR SOLVENCY FOR PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

"(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if—

"(1) the benefits under the plan consist solely of health insurance coverage; or

"(2) if the plan provides any additional benefit options which do not consist of health insurance coverage, the plan—

"(A) establishes and maintains reserves with respect to such additional benefit options, in amounts recommended by the qualified actuary, consisting of—

"(i) a reserve sufficient for unearned contributions;

"(ii) a reserve sufficient for benefit liabilities which have been incurred, which have not been satisfied, and for which risk of loss has not yet been transferred, and for expected administrative costs with respect to such benefit liabilities;

"(iii) a reserve sufficient for any other obligations of the plan; and

"(iv) a reserve sufficient for a margin of error and other fluctuations, taking into account the specific circumstances of the plan; and

"(B) establishes and maintains aggregate and specific excess/stop loss insurance and solvency indemnification, with respect to such additional benefit options for which risk of loss has not yet been transferred, as follows:

"(i) The plan shall secure aggregate excess/stop loss insurance for the plan with an attachment point which is not greater than 125 percent of expected gross annual claims. The applicable authority may by regulation, through negotiated rulemaking, provide for upward adjustments in the amount of such percentage in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

"(ii) The plan shall secure specific excess/stop loss insurance for the plan with an attachment point which is at least equal to an amount recommended by the plan's qualified actuary (but not more than $175,000). The applicable authority may by regulation, through negotiated rulemaking, provide for adjustments in the amount of such insurance in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

"(iii) The plan shall secure indemnification insurance for any claims which the plan is unable to satisfy by reason of a plan termination.

Any regulations prescribed by the applicable authority pursuant to clause (i) or (ii) of subparagraph (B) may allow for such adjustments in the required levels of excess/stop loss insurance as the qualified actuary may recommend, taking into account the specific circumstances of the plan.

“(b) MINIMUM SURPLUS IN ADDITION TO CLAIMS RESERVES.—In the case of any association health plan described in subsection (a)(2), the requirements of this subsection are met if the plan establishes and maintains surplus in an amount at least equal to—

“(1) $500,000, or

“(2) such greater amount (but not greater than $2,000,000) as may be set forth in regulations prescribed by the applicable authority through negotiated rulemaking, based on the level of aggregate and specific excess/stop loss insurance provided with respect to such plan.

“(c) ADDITIONAL REQUIREMENTS.—In the case of any association health plan described in subsection (a)(2), the applicable authority may provide such additional requirements relating to reserves and excess/stop loss insurance as the applicable authority considers appropriate. Such requirements may be provided by regulation, through negotiated rulemaking, with respect to any such plan or any class of such plans.

“(d) ADJUSTMENTS FOR EXCESS/STOP LOSS INSURANCE.—The applicable authority may provide for adjustments to the levels of reserves otherwise required under subsections (a) and (b) with respect to any plan or class of plans to take into account excess/stop loss insurance provided with respect to such plan or plans.

"(e) ALTERNATIVE MEANS OF COMPLIANCE.—The applicable authority may permit an association health plan described in subsection (a)(2) to substitute, for all or part of the requirements of this section (except subsection (a)(2)(B)(iii)), such security, guarantee, hold-harmless arrangement, or other financial arrangement as the applicable authority determines to be adequate to enable the plan to fully meet all its financial obligations on a timely basis and is otherwise no less protective of the interests of participants and beneficiaries than the requirements for which it is substituted. The applicable authority may take into account, for purposes of this subsection, evidence provided by the plan or sponsor which demonstrates an assumption of liability with respect to the plan. Such evidence may be in the form of a contract of indemnification, lien, bonding, insurance, letter of credit, recourse under applicable terms of the plan in the form of assessments of participating employers, security, or other financial arrangement.

"(f) MEASURES TO ENSURE CONTINUED PAYMENT OF BENEFITS BY CERTAIN PLANS IN DISTRESS.—

"(1) PAYMENTS BY CERTAIN PLANS TO ASSOCIATION HEALTH PLAN FUND.—

"(A) IN GENERAL.—In the case of an association health plan described in subsection (a)(2), the requirements of this subsection are met if the plan makes payments into the Association Health Plan Fund under this subparagraph when they are due. Such payments shall consist of annual payments in the amount of $5,000, and, in addition to such annual payments, such supplemental payments as the Secretary may determine to be necessary under paragraph (2). Payments under this paragraph are payable to the Fund at the time determined by the Secretary. Initial payments are due in advance of certification under this part. Payments shall continue to accrue until a plan's assets are distributed pursuant to a termination procedure.

"(B) PENALTIES FOR FAILURE TO MAKE PAYMENTS.—If any payment is not made by a plan when it is due, a late payment charge of not more than 100 percent of the payment which was not timely paid shall be payable by the plan to the Fund.

"(C) CONTINUED DUTY OF THE SECRETARY.—The Secretary shall not cease to carry out the provisions of paragraph (2) on account of the failure of a plan to pay any payment when due.

"(2) PAYMENTS BY SECRETARY TO CONTINUE EXCESS/STOP LOSS INSURANCE COVERAGE AND INDEMNIFICATION INSURANCE COVERAGE FOR CERTAIN PLANS.—In any case in which the applicable authority determines that there is, or that there is reason to believe that there will be: (A) a failure to take necessary corrective actions under section 809(a) with respect to an association health plan described in subsection (a)(2); or (B) a termination of such a plan under section 809(b) or 810(b)(8) (and, if the applicable authority is not the Secretary, certifies such determination to the Secretary), the Secretary shall determine the amounts necessary to make payments to an insurer (designated by the Secretary) to maintain in force excess/stop loss insurance coverage or indemnification insurance coverage for such plan, if the Secretary determines that there is a reasonable expectation that, without such payments, claims would not be satisfied by reason of termination of such coverage. The Secretary shall, to the extent provided in advance in appropriation Acts, pay such amounts so determined to the insurer designated by the Secretary.

"(3) ASSOCIATION HEALTH PLAN FUND.—

"(A) IN GENERAL.—There is established on the books of the Treasury a fund to be known as the 'Association Health Plan Fund'. The Fund shall be available for making payments pursuant to paragraph (2). The Fund shall be credited with payments received pursuant to paragraph (1)(A), penalties received pursuant to paragraph (1)(B); and earnings on investments of amounts of the Fund under subparagraph (B).

"(B) INVESTMENT.—Whenever the Secretary determines that the moneys of the fund are in excess of current needs, the Secretary may request the investment of such amounts as the Secretary determines advisable by the Secretary of the Treasury in obligations issued or guaranteed by the United States.

"(g) EXCESS/STOP LOSS INSURANCE.—For purposes of this section—

"(1) AGGREGATE EXCESS/STOP LOSS INSURANCE.—The term 'aggregate excess/stop loss insurance' means, in connection with an association health plan, a contract—

"(A) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation through negotiated rulemaking) provides for payment to the plan with respect to aggregate claims under the plan in excess of an amount or amounts specified in such contract;

"(B) which is guaranteed renewable; and

"(C) which allows for payment of premiums by any third party on behalf of the insured plan.

"(2) SPECIFIC EXCESS/STOP LOSS INSURANCE.—The term 'specific excess/stop loss insurance' means, in connection with an association health plan, a contract—

"(A) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation through negotiated rulemaking) provides for payment to the plan with respect to claims under the plan in connection with a covered individual in excess of an amount or amounts specified in such contract in connection with such covered individual;

"(B) which is guaranteed renewable; and

"(C) which allows for payment of premiums by any third party on behalf of the insured plan.

"(h) INDEMNIFICATION INSURANCE.—For purposes of this section, the term 'indemnification insurance' means, in connection with an association health plan, a contract—

"(1) under which an insurer (meeting such minimum standards as the applicable authority may prescribe through negotiated rulemaking) provides for payment to the plan with respect to claims under the plan which the plan is unable to satisfy by reason of a termination pursuant to section 809(b) (relating to mandatory termination);

"(2) which is guaranteed renewable and noncancellable for any reason (except as the applicable authority may prescribe by regulation through negotiated rulemaking); and

"(3) which allows for payment of premiums by any third party on behalf of the insured plan.

"(i) RESERVES.—For purposes of this section, the term 'reserves' means, in connection with an association health plan, plan assets which meet the fiduciary standards under part 4 and such additional requirements regarding liquidity as the applicable authority may prescribe through negotiated rulemaking.

"(j) SOLVENCY STANDARDS WORKING GROUP.—

"(1) IN GENERAL.—Within 90 days after the date of the enactment of the Small Business Access and Choice for Entrepreneurs Act of 1999, the applicable authority shall establish a Solvency Standards Working Group. In prescribing the initial regulations under this section, the applicable authority shall take into account the recommendations of such Working Group.

"(2) MEMBERSHIP.—The Working Group shall consist of not more than 15 members appointed by the applicable authority. The applicable authority shall include among persons invited to membership on the Working Group at least one of each of the following:

"(A) a representative of the National Association of Insurance Commissioners;

"(B) a representative of the American Academy of Actuaries;

"(C) a representative of the State governments, or their interests;

"(D) a representative of existing self-insured arrangements, or their interests;

"(E) a representative of associations of the type referred to in section 801(b)(1), or their interests; and

"(F) a representative of multiemployer plans that are group health plans, or their interests.

"SEC. 807. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

"(a) FILING FEE.—Under the procedure prescribed pursuant to section 802(a), an association health plan shall pay to the applicable authority at the time of filing an application for certification under this part a filing fee in the amount of $5,000, which shall be available in the case of the Secretary, to the extent provided in appropriation Acts, for the sole purpose of administering the certification procedures applicable with respect to association health plans.

"(b) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form which shall be prescribed by the applicable authority through negotiated rulemaking, at least the following information:

"(1) IDENTIFYING INFORMATION.—The names and addresses of—

''(A) the sponsor; and

''(B) the members of the board of trustees of the plan.

''(2) STATES IN WHICH PLAN INTENDS TO DO BUSINESS.—The States in which participants and beneficiaries under the plan are to be located and the number of them expected to be located in each such State.

''(3) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

''(4) PLAN DOCUMENTS.—A copy of the documents governing the plan (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

''(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the plan and contract administrators and other service providers.

''(6) FUNDING REPORT.—In the case of association health plans providing benefits options in addition to health insurance coverage, a report setting forth information with respect to such additional benefit options determined as of a date within the 120-day period ending with the date of the application, including the following:

"(A) RESERVES.—A statement, certified by the board of trustees of the plan, and a statement of actuarial opinion, signed by a qualified actuary, that all applicable requirements of section 806 are or will be met in accordance with regulations which the applicable authority shall prescribe through negotiated rulemaking.

"(B) ADEQUACY OF CONTRIBUTION RATES.—A statement of actuarial opinion, signed by a qualified actuary, which sets forth a description of the extent to which contribution rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the plan for the 12-month period beginning with such date within such 120-day period, taking into account the expected coverage and experience of the plan. If the contribution rates are not fully adequate, the statement of actuarial opinion shall indicate the extent to which the rates are inadequate and the changes needed to ensure adequacy.

"(C) CURRENT AND PROJECTED VALUE OF ASSETS AND LIABILITIES.—A statement of actuarial opinion signed by a qualified actuary, which sets forth the current value of the assets and liabilities accumulated under the plan and a projection of the assets, liabilities, income, and expenses of the plan for the 12-month period referred to in subparagraph (B). The income statement shall identify separately the plan's administrative expenses and claims.

"(D) COSTS OF COVERAGE TO BE CHARGED AND OTHER EXPENSES.—A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and other expenses associated with the operation of the plan.

"(E) OTHER INFORMATION.—Any other information as may be determined by the applicable authority, by regulation through negotiated rulemaking, as necessary to carry out the purposes of this part.

"(c) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted under this part to an association health plan shall not be effective unless written notice of such certification is filed with the applicable State authority of each State in which at least 25 percent of the participants and beneficiaries under the plan are located. For purposes of this subsection, an individual shall be considered to be located in the State in which a known address of such individual is located or in which such individual is employed.

"(d) NOTICE OF MATERIAL CHANGES.—In the case of any association health plan certified under this part, descriptions of material changes in any information which was required to be submitted with the application for the certification under this part shall be filed in such form and manner as shall be prescribed by the applicable authority by regulation through negotiated rulemaking. The applicable authority may require by regulation, through negotiated rulemaking, prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

"(e) REPORTING REQUIREMENTS FOR CERTAIN ASSOCIATION HEALTH PLANS.—An association health plan certified under this part which provides benefit options in addition to health insurance coverage for such plan year shall meet the requirements of section 103 by filing an annual report under such section which shall include information described in subsection (b)(6) with respect to the plan year and, notwithstanding section 104(a)(1)(A), shall be filed with the applicable authority not later than 90 days after the close of the plan year (or on such later date as may be prescribed by the applicable authority). The applicable authority may require by regulation through negotiated rulemaking such interim reports as it considers appropriate.

"(f) ENGAGEMENT OF QUALIFIED ACTUARY.—The board of trustees of each association health plan which provides benefits options in addition to health insurance coverage and which is applying for certification under this part or is certified under this part shall engage, on behalf of all participants and beneficiaries, a qualified actuary who shall be responsible for the preparation of the materials comprising information necessary to be submitted by a qualified actuary under this part. The qualified actuary shall utilize such assumptions and techniques as are necessary to enable such actuary to form an opinion as to whether the contents of the matters reported under this part—

"(1) are in the aggregate reasonably related to the experience of the plan and to reasonable expectations; and

"(2) represent such actuary's best estimate of anticipated experience under the plan.

The opinion by the qualified actuary shall be made with respect to, and shall be made a part of, the annual report.

"SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

"Except as provided in section 809(b), an association health plan which is or has been certified under this part may terminate (upon or at any time after cessation of accruals in benefit liabilities) only if the board of trustees—

"(1) not less than 60 days before the proposed termination date, provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date;

"(2) develops a plan for winding up the affairs of the plan in connection with such termination in a manner which will result in timely payment of all benefits for which the plan is obligated; and

"(3) submits such plan in writing to the applicable authority.

Actions required under this section shall be taken in such form and manner as may be prescribed by the applicable authority by regulation through negotiated rulemaking.

"SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

"(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—An association health plan which is certified under this part and which provides benefits other than health insurance coverage shall continue to meet the requirements of section 806, irrespective of whether such certification continues in effect. The board of trustees of such plan shall determine quarterly whether the requirements of section 806 are met. In any case in which the board determines that there is reason to believe that there is or will be a failure to meet such requirements, or the applicable authority makes such a determination and so notifies the board, the board shall immediately notify the qualified actuary engaged by the plan, and such actuary shall, not later than the end of the next following month, make such recommendations to the board for corrective action as the actuary determines necessary to ensure compliance with section 806. Not later than 30 days after receiving from the actuary recommendations for corrective actions, the board shall notify the applicable authority (in such form and manner as the applicable authority may prescribe by regulation through negotiated rulemaking) of such recommendations of the actuary for corrective action, together with a description of the actions (if any) that the board has taken or plans to take in response to such recommendations. The board shall thereafter report to the applicable authority, in such form and frequency as the applicable authority may specify to the board, regarding corrective action taken by the board until the requirements of section 806 are met.

“(b) MANDATORY TERMINATION.—In any case in which—

“(1) the applicable authority has been notified under subsection (a) of a failure of an association health plan which is or has been certified under this part and is described in section 806(a)(2) to meet the requirements of section 806 and has not been notified by the board of trustees of the plan that corrective action has restored compliance with such requirements; and

“(2) the applicable authority determines that there is a reasonable expectation that the plan will continue to fail to meet the requirements of section 806,

the board of trustees of the plan shall, at the direction of the applicable authority, terminate the plan and, in the course of the termination, take such actions as the applicable authority may require, including satisfying any claims referred to in section 806(a)(2)(B)(iii) and recovering for the plan any liability under subsection (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure that the affairs of the plan will be, to the maximum extent possible, wound up in a manner which will result in timely provision of all benefits for which the plan is obligated.

"SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOLVENT ASSOCIATION HEALTH PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

"(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR INSOLVENT PLANS.—Whenever the Secretary determines that an association health plan which is or has been certified under this part and which is described in section 806(a)(2) will be unable to provide benefits when due or is otherwise in a financially hazardous condition, as shall be defined by the Secretary by regulation through negotiated rulemaking, the Secretary shall, upon notice to the plan, apply to the appropriate United States district court for appointment of the Secretary as trustee to administer the plan for the duration of the insolvency. The plan may appear as a party and other interested persons may intervene in the proceedings at the discretion of the court. The court shall appoint such Secretary trustee if the court determines that the trusteeship is necessary to protect the interests of the participants and beneficiaries or providers of medical care or to avoid any unreasonable deterioration of the financial condition of the plan. The trusteeship of such Secretary shall continue until the conditions described in the first sentence of this subsection are remedied or the plan is terminated.

"(b) POWERS AS TRUSTEE.—The Secretary, upon appointment as trustee under subsection (a), shall have the power—

"(1) to do any act authorized by the plan, this title, or other applicable provisions of law to be done by the plan administrator or any trustee of the plan;

"(2) to require the transfer of all (or any part) of the assets and records of the plan to the Secretary as trustee;

"(3) to invest any assets of the plan which the Secretary holds in accordance with the provisions of the plan, regulations prescribed by the Secretary through negotiated rulemaking, and applicable provisions of law;

"(4) to require the sponsor, the plan administrator, any participating employer, and any employee organization representing plan participants to furnish any information with respect to the plan which the Secretary as trustee may reasonably need in order to administer the plan;

"(5) to collect for the plan any amounts due the plan and to recover reasonable expenses of the trusteeship;

"(6) to commence, prosecute, or defend on behalf of the plan any suit or proceeding involving the plan;

"(7) to issue, publish, or file such notices, statements, and reports as may be required by the Secretary by regulation through negotiated rulemaking or required by any order of the court;

"(8) to terminate the plan (or provide for its termination accordance with section 809(b)) and liquidate the plan assets, to restore the plan to the responsibility of the sponsor, or to continue the trusteeship;

"(9) to provide for the enrollment of plan participants and beneficiaries under appropriate coverage options; and

"(10) to do such other acts as may be necessary to comply with this title or any order of the court and to protect the interests of plan participants and beneficiaries and providers of medical care.

"(c) NOTICE OF APPOINTMENT.—As soon as practicable after the Secretary's appointment as trustee, the Secretary shall give notice of such appointment to—

"(1) the sponsor and plan administrator;

"(2) each participant;

"(3) each participating employer; and

"(4) if applicable, each employee organization which, for purposes of collective bargaining, represents plan participants.

"(d) ADDITIONAL DUTIES.—Except to the extent inconsistent with the provisions of this title, or as may be otherwise ordered by the court, the Secretary, upon appointment as trustee under this section, shall be subject to the same duties as those of a trustee under section 704 of title 11, United States Code, and shall have the duties of a fiduciary for purposes of this title.

"(e) OTHER PROCEEDINGS.—An application by the Secretary under this subsection may be filed notwithstanding the pendency in the same or any other court of any bankruptcy, mortgage foreclosure, or equity receivership proceeding, or any proceeding to reorganize, conserve, or liquidate such plan or its property, or any proceeding to enforce a lien against property of the plan.

"(f) JURISDICTION OF COURT.—

"(1) IN GENERAL.—Upon the filing of an application for the appointment as trustee or the issuance of a decree under this section, the court to which the application is made shall have exclusive jurisdiction of the plan involved and its property wherever located with the powers, to the extent consistent with the purposes of this section, of a court of the United States having jurisdiction over cases under chapter 11 of title 11, United States Code. Pending an adjudication under this section such court shall stay, and upon appointment by it of the Secretary as trustee, such court shall continue the stay of, any pending mortgage foreclosure, equity receivership, or other proceeding to reorganize, conserve, or liquidate the plan, the sponsor, or property of such plan or sponsor, and any other suit against any receiver, conservator, or trustee of the plan, the sponsor, or property of the plan or sponsor. Pending such adjudication and upon the appointment by it of the Secretary as trustee, the court may stay any proceeding to enforce a lien against property of the plan or the sponsor or any other suit against the plan or the sponsor.

"(2) VENUE.—An action under this section may be brought in the judicial district where the sponsor or the plan administrator resides or does business or where any asset of the plan is situated. A district court in which such action is brought may issue process with respect to such action in any other judicial district.

''(g) PERSONNEL.—In accordance with regulations which shall be prescribed by the Secretary through negotiated rulemaking, the Secretary shall appoint, retain, and compensate accountants, actuaries, and other professional service personnel as may be necessary in connection with the Secretary's service as trustee under this section.

''SEC. 811. STATE ASSESSMENT AUTHORITY.

''(a) IN GENERAL.—Notwithstanding section 514, a State may impose by law a contribution tax on an association health plan described in section 806(a)(2), if the plan commenced operations in such State after the date of the enactment of the Small Business Access and Choice for Entrepreneurs Act of 1999.

''(b) CONTRIBUTION TAX.—For purposes of this section, the term 'contribution tax' imposed by a State on an association health plan means any tax imposed by such State if—

''(1) such tax is computed by applying a rate to the amount of premiums or contributions, with respect to individuals covered under the plan who are residents of such State, which are received by the plan from participating employers located in such State or from such individuals;

"(2) the rate of such tax does not exceed the rate of any tax imposed by such State on premiums or contributions received by insurers or health maintenance organizations for health insurance coverage offered in such State in connection with a group health plan;

"(3) such tax is otherwise nondiscriminatory; and

"(4) the amount of any such tax assessed on the plan is reduced by the amount of any tax or assessment otherwise imposed by the State on premiums, contributions, or both received by insurers or health maintenance organizations for health insurance coverage, aggregate excess/stop loss insurance (as defined in section 806(g)(1)), specific excess/stop loss insurance (as defined in section 806(g)(2)), other insurance related to the provision of medical care under the plan, or any combination thereof provided by such insurers or health maintenance organizations in such State in connection with such plan.

"SEC. 812. DEFINITIONS AND RULES OF CONSTRUCTION.

"(a) DEFINITIONS.—For purposes of this part—

"(1) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided in section 733(a)(1) (after applying subsection (b) of this section).

"(2) MEDICAL CARE.—The term 'medical care' has the meaning provided in section 733(a)(2).

"(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided in section 733(b)(1).

"(4) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided in section 733(b)(2).

"(5) APPLICABLE AUTHORITY.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'applicable authority' means, in connection with an association health plan—

"(i) the State recognized pursuant to subsection (c) of section 506 as the State to which authority has been delegated in connection with such plan; or

"(ii) if there if no State referred to in clause (i), the Secretary.

"(B) EXCEPTIONS.—

"(i) JOINT AUTHORITIES.—Where such term appears in section 808(3), section 807(e) (in the first instance), section 809(a) (in the second instance), section 809(a) (in the fourth instance), and section 809(b)(1), such term means, in connection with an association health plan, the Secretary and the State referred to in subparagraph (A)(i) (if any) in connection with such plan.

"(ii) REGULATORY AUTHORITIES.—Where such term appears in section 802(a) (in the first instance), section 802(d), section 802(e), section 803(d), section 805(a)(5), section 806(a)(2), section 806(b), section 806(c), section 806(d), paragraphs (1)(A) and (2)(A) of section 806(g), section 806(h), section 806(i), section 806(j), section 807(a) (in the second instance), section 807(b), section 807(d), section 807(e) (in the second instance), section 808 (in the matter after paragraph (3)), and section 809(a) (in the third instance), such term means, in connection with an association health plan, the Secretary.

"(6) HEALTH STATUS-RELATED FACTOR.—The term 'health status-related factor' has the meaning provided in section 733(d)(2).

"(7) INDIVIDUAL MARKET.—

"(A) IN GENERAL.—The term 'individual market' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

"(B) TREATMENT OF VERY SMALL GROUPS.—

"(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

"(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

"(8) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with an association health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

"(9) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

"(10) QUALIFIED ACTUARY.—The term 'qualified actuary' means an individual who is a member of the American Academy of Actuaries or meets such reasonable standards and qualifications as the

Secretary may provide by regulation through negotiated rulemaking.

"(11) AFFILIATED MEMBER±±.—The term 'affiliated member' means, in connection with a sponsor—

"(A) a person who is otherwise eligible to be a member of the sponsor but who elects an affiliated status with the sponsor,

"(B) in the case of a sponsor with members which consist of associations, a person who is a member of any such association and elects an affiliated status with the sponsor, or

"(C) in the case of an association health plan in existence on the date of the enactment of the Small Business Access and Choice for Entrepreneurs Act of 1999, a person eligible to be a member of the sponsor or one of its member associations.

"(12) LARGE EMPLOYER.—The term 'large employer' means, in connection with a group health plan with respect to a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

"(13) SMALL EMPLOYER.—The term 'small employer' means, in connection with a group health plan with respect to a plan year, an employer who is not a large employer.

"(b) RULES OF CONSTRUCTION.—

"(1) EMPLOYERS AND EMPLOYEES.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is an association health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

"(A) in the case of a partnership, the term 'employer' (as defined in section (3)(5)) includes the partnership in relation to the partners, and the term 'employee' (as defined in section (3)(6)) includes any partner in relation to the partnership; and

"(B) in the case of a self-employed individual, the term 'employer' (as defined in section 3(5)) and the term 'employee' (as defined in section 3(6)) shall include such individual.

"(2) PLANS, FUNDS, AND PROGRAMS TREATED AS EMPLOYEE WELFARE BENEFIT PLANS.—In the case of any plan, fund, or program which was established or is maintained for the purpose of providing medical care (through the purchase of insurance or otherwise) for employees (or their dependents) covered thereunder and which demonstrates to the Secretary that all requirements for certification under this part would be met with respect to such plan, fund, or program if such plan, fund, or program were a group health plan, such plan, fund, or program shall be treated for purposes of this title as an employee welfare benefit plan on and after the date of such demonstration.''.

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

(1) Section 514(b)(6) of such Act (29 U.S.C. 1144(b)(6)) is amended by adding at the end the following new subparagraph:

``(E) The preceding subparagraphs of this paragraph do not apply with respect to any State law in the case of an association health plan which is certified under part 8.''.

(2) Section 514 of such Act (29 U.S.C. 1144) is amended—

(A) in subsection (b)(4), by striking ``Subsection (a)'' and inserting ``Subsections (a) and (d)'';

(B) in subsection (b)(5), by striking "subsection (a)" in subparagraph (A) and inserting "subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805", and by striking "subsection (a)" in subparagraph (B) and inserting "subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805";

(C) by redesignating subsection (d) as subsection (e); and

(D) by inserting after subsection (c) the following new subsection:

"(d)(1) Except as provided in subsection (b)(4), the provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude, or have the effect of precluding, a health insurance issuer from offering health insurance coverage in connection with an association health plan which is certified under part 8.

"(2) Except as provided in paragraphs (4) and (5) of subsection (b) of this section—

"(A) In any case in which health insurance coverage of any policy type is offered under an association health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may preclude a health insurance issuer from offering health insurance coverage of the same policy type to other employers operating in the State which are eligible for coverage under such association health plan, whether or not such other employers are participating employers in such plan.

''(B) In any case in which health insurance coverage of any policy type is offered under an association health plan in a State and the filing, with the applicable State authority, of the policy form in connection with such policy type is approved by such State authority, the provisions of this title shall supersede any and all laws of any other State in which health insurance coverage of such type is offered, insofar as they may preclude, upon the filing in the same form and manner of such policy form with the applicable State authority in such other State, the approval of the filing in such other State.

''(3) For additional provisions relating to association health plans, see subsections (a)(2)(B) and (b) of section 805.

''(4) For purposes of this subsection, the term 'association health plan' has the meaning provided in section 801(a), and the terms 'health insurance coverage', 'participating employer', and 'health insurance issuer' have the meanings provided such terms in section 811, respectively.''.

(3) Section 514(b)(6)(A) of such Act (29 U.S.C. 1144(b)(6)(A)) is amended—

(A) in clause (i)(II), by striking ''and'' at the end;

(B) in clause (ii), by inserting ''and which does not provide medical care (within the meaning of section 733(a)(2)),'' after ''arrangement,'', and by striking ''title.'' and inserting ''title, and''; and

(C) by adding at the end the following new clause:

''(iii) subject to subparagraph (E), in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement and which provides medical care (within the meaning of section 733(a)(2)), any law of any State which regulates insurance may apply.''.

(4) Section 514(e) of such Act (as redesignated by paragraph (2)(C)) is amended—

(A) by striking ''Nothing'' and inserting ''(1) Except as provided in paragraph (2), nothing''; and

(B) by adding at the end the following new paragraph:

"(2) Nothing in any other provision of law enacted on or after the date of the enactment of the Small Business Access and Choice for Entrepreneurs Act of 1999 shall be construed to alter, amend, modify, invalidate, impair, or supersede any provision of this title, except by specific cross-reference to the affected section.".

(c) PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 102(16)(B)) is amended by adding at the end the following new sentence: "Such term also includes a person serving as the sponsor of an association health plan under part 8.".

(d) DISCLOSURE OF SOLVENCY PROTECTIONS RELATED TO SELF-INSURED AND FULLY INSURED OPTIONS UNDER ASSOCIATION HEALTH PLANS.—Section 102(b) of such Act (29 U.S.C. 102(b)) is amended by adding at the end the following: "An association health plan shall include in its summary plan description, in connection with each benefit option, a description of the form of solvency or guarantee fund protection secured pursuant to this Act or applicable State law, if any.".

(e) SAVINGS CLAUSE.—Section 731(c) of such Act is amended by inserting "or part 8" after "this part".

(f) REPORT TO THE CONGRESS REGARDING CERTIFICATION OF SELF-INSURED ASSOCIATION HEALTH PLANS.—Not later than January 1, 2004, the Secretary of Labor shall report to the Committee on Education and the Workforce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate the effect association health plans have had, if any, on reducing the number of uninsured individuals.

(g) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 734 the following new items:

"PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

SEC. 702. CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.

Section 3(40)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amended—

(1) in clause (i), by inserting ‘‘for any plan year of any such plan, or any fiscal year of any such other arrangement;’’ after ‘‘single employer’’, and by inserting ‘‘during such year or at any time during the preceding 1-year period’’ after ‘‘control group’’;

(2) in clause (iii)—

(A) by striking ‘‘common control shall not be based on an interest of less than 25 percent’’ and inserting ‘‘an interest of greater than 25 percent may not be required as the minimum interest necessary for common control’’; and

(B) by striking ‘‘similar to’’ and inserting ‘‘consistent and coextensive with’’;

(3) by redesignating clauses (iv) and (v) as clauses (v) and (vi), respectively; and

(4) by inserting after clause (iii) the following new clause:

‘‘(iv) in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only one participating employer if, after the application of clause (i), the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 75 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement;''.

SEC. 703. CLARIFICATION OF TREATMENT OF CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.

(a) IN GENERAL.—Section 3(40)(A)(i) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(A)(i)) is amended to read as follows:

``(i)(I) under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws, and (II) in accordance with subparagraphs (C), (D), and (E);''.

(b) LIMITATIONS.—Section 3(40) of such Act (29 U.S.C. 1002(40)) is amended by adding at the end the following new subparagraphs:

``(C) For purposes of subparagraph (A)(i)(II), a plan or other arrangement shall be treated as established or maintained in accordance with this subparagraph only if the following requirements are met:

"(i) The plan or other arrangement, and the employee organization or any other entity sponsoring the plan or other arrangement, do not—

"(I) utilize the services of any licensed insurance agent or broker for soliciting or enrolling employers or individuals as participating employers or covered individuals under the plan or other arrangement; or

"(II) pay any type of compensation to a person, other than a full time employee of the employee organization (or a member of the organization to the extent provided in regulations prescribed by the Secretary through negotiated rulemaking), that is related either to the volume or number of employers or individuals solicited or enrolled as participating employers or covered individuals under the plan or other arrangement, or to the dollar amount or size of the contributions made by participating employers or covered individuals to the plan or other arrangement;

except to the extent that the services used by the plan, arrangement, organization, or other entity consist solely of preparation of documents necessary for compliance with the reporting and disclosure requirements of part 1 or administrative, investment, or consulting services unrelated to solicitation or enrollment of covered individuals.

''(ii) As of the end of the preceding plan year, the number of covered individuals under the plan or other arrangement who are neither—

''(I) employed within a bargaining unit covered by any of the collective bargaining agreements with a participating employer (nor covered on the basis of an individual's employment in such a bargaining unit); nor

''(II) present employees (or former employees who were covered while employed) of the sponsoring employee organization, of an employer who is or was a party to any of the collective bargaining agreements, or of the plan or other arrangement or a related plan or arrangement (nor covered on the basis of such present or former employment);

does not exceed 15 percent of the total number of individuals who are covered under the plan or arrangement and who are present or former employees who are or were covered under the plan or arrangement pursuant to a collective bargaining agreement with a participating employer. The requirements of the preceding provisions of this clause shall be treated as satisfied if, as of the end of the preceding plan year, such covered individuals are comprised solely of individuals who were covered individuals under the plan or other arrangement as of the date of the enactment of the Small Business Access and Choice for Entrepreneurs Act of 1999 and, as of the end of the preceding plan year, the number of such covered individuals does not exceed 25 percent of the total number of present and former employees enrolled under the plan or other arrangement.

''(iii) The employee organization or other entity sponsoring the plan or other arrangement certifies to the Secretary each year, in a form and manner which shall be prescribed by the Secretary through negotiated rulemaking that the plan or other arrangement meets the requirements of clauses (i) and (ii).

''(D) For purposes of subparagraph (A)(i)(II), a plan or arrangement shall be treated as established or maintained in accordance with this subparagraph only if—

“(i) all of the benefits provided under the plan or arrangement consist of health insurance coverage; or

“(ii)(I) the plan or arrangement is a multiemployer plan; and

“(II) the requirements of clause (B) of the proviso to clause (5) of section 302(c) of the Labor Management Relations Act, 1947 (29 U.S.C. 186(c)) are met with respect to such plan or other arrangement.

“(E) For purposes of subparagraph (A)(i)(II), a plan or arrangement shall be treated as established or maintained in accordance with this subparagraph only if—

“(i) the plan or arrangement is in effect as of the date of the enactment of the Small Business Access and Choice for Entrepreneurs Act of 1999; or

“(ii) the employee organization or other entity sponsoring the plan or arrangement—

“(I) has been in existence for at least 3 years; or

“(II) demonstrates to the satisfaction of the Secretary that the requirements of subparagraphs (C) and (D) are met with respect to the plan or other arrangement.”.

(c) CONFORMING AMENDMENTS TO DEFINITIONS OF PARTICIPANT AND BENEFICIARY.—Section 3(7) of such Act (29 U.S.C. 1002(7)) is amended by adding at the end the following new sentence: ''Such term includes an individual who is a covered individual described in paragraph (40)(C)(ii).''.

SEC. 704. ENFORCEMENT PROVISIONS RELATING TO ASSOCIATION HEALTH PLANS.

(a) CRIMINAL PENALTIES FOR CERTAIN WILLFUL MISREPRESENTATIONS.—Section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131) is amended—

(1) by inserting ''(a)'' after ''SEC. 501.''; and

(2) by adding at the end the following new subsection:

''(b) Any person who willfully falsely represents, to any employee, any employee's beneficiary, any employer, the Secretary, or any State, a plan or other arrangement established or maintained for the purpose of offering or providing any benefit described in section 3(1) to employees or their beneficiaries as—

''(1) being an association health plan which has been certified under part 8;

''(2) having been established or maintained under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws; or

"(3) being a plan or arrangement with respect to which the requirements of subparagraph (C), (D), or (E) of section 3(40) are met;

shall, upon conviction, be imprisoned not more than 5 years, be fined under title 18, United States Code, or both.".

(b) CEASE ACTIVITIES ORDERS.—Section 502 of such Act (29 U.S.C. 1132) is amended by adding at the end the following new subsection:

"(n)(1) Subject to paragraph (2), upon application by the Secretary showing the operation, promotion, or marketing of an association health plan (or similar arrangement providing benefits consisting of medical care (as defined in section 733(a)(2))) that—

"(A) is not certified under part 8, is subject under section 514(b)(6) to the insurance laws of any State in which the plan or arrangement offers or provides benefits, and is not licensed, registered, or otherwise approved under the insurance laws of such State; or

"(B) is an association health plan certified under part 8 and is not operating in accordance with the requirements under part 8 for such certification,

a district court of the United States shall enter an order requiring that the plan or arrangement cease activities.

"(2) Paragraph (1) shall not apply in the case of an association health plan or other arrangement if the plan or arrangement shows that—

"(A) all benefits under it referred to in paragraph (1) consist of health insurance coverage; and

"(B) with respect to each State in which the plan or arrangement offers or provides benefits, the plan or arrangement is operating in accordance with applicable State laws that are not superseded under section 514.

"(3) The court may grant such additional equitable relief, including any relief available under this title, as it deems necessary to protect the interests of the public and of persons having claims for benefits against the plan.".

(c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—Section 503 of such Act (29 U.S.C. 1133) (as amended by title I) is amended by adding at the end the following new subsection:

"(c) ASSOCIATION HEALTH PLANS.—The terms of each association health plan which is or has been certified under part 8 shall require the board of trustees or the named fiduciary (as applicable) to ensure that the requirements of this section are met in connection with claims filed under the plan.".

SEC. 705. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

"(c) RESPONSIBILITY OF STATES WITH RESPECT TO ASSOCIATION HEALTH PLANS.—

"(1) AGREEMENTS WITH STATES.—A State may enter into an agreement with the Secretary for delegation to the State of some or all of—

"(A) the Secretary's authority under sections 502 and 504 to enforce the requirements for certification under part 8;

"(B) the Secretary's authority to certify association health plans under part 8 in accordance with regulations of the Secretary applicable to certification under part 8; or

''(C) any combination of the Secretary's authority authorized to be delegated under subparagraphs (A) and (B).

''(2) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this paragraph may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.

''(3) RECOGNITION OF PRIMARY DOMICILE STATE.—In entering into any agreement with a State under subparagraph (A), the Secretary shall ensure that, as a result of such agreement and all other agreements entered into under subparagraph (A), only one State will be recognized, with respect to any particular association health plan, as the State to which all authority has been delegated pursuant to such agreements in connection with such plan. In carrying out this paragraph, the Secretary shall take into account the places of residence of the participants and beneficiaries under the plan and the State in which the trust is maintained.''.

SEC. 706. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) EFFECTIVE DATE.—The amendments made by sections 701, 704, and 705 shall take effect on January 1, 2001. The amendments made by sections 702 and 703 shall take effect on the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this title before January 1, 2001. Such regulations shall be issued through negotiated rulemaking.

(b) EXCEPTION.—Section 801(a)(2) of the Employee Retirement Income Security Act of 1974 (added by section 701) does not apply in connection with an association health plan (certified under part 8 of subtitle B of title I of such Act) existing on the date of the enactment of this Act, if no benefits provided thereunder as of the date of the enactment of this Act consist of health insurance coverage (as defined in section 733(b)(1) of such Act).

(c) TREATMENT OF CERTAIN EXISTING HEALTH BENEFITS PROGRAMS.—

(1) IN GENERAL.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the purpose of providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make

contributions to such arrangement, such arrangement has been in existence for at least 10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 812(a)(5) of the Employee Retirement Income Security Act of 1974 (as amended by this Act)) by the arrangement of an application for certification of the arrangement under part 8 of subtitle B of title I of such Act—

(A) such arrangement shall be deemed to be a group health plan for purposes of title I of such Act;

(B) the requirements of sections 801(a)(1) and 803(a)(1) of the Employee Retirement Income Security Act of 1974 shall be deemed met with respect to such arrangement;

(C) the requirements of section 803(b) of such Act shall be deemed met, if the arrangement is operated by a board of directors which—

(i) is elected by the participating employers, with each employer having one vote; and

(ii) has complete fiscal control over the arrangement and which is responsible for all operations of the arrangement;

(D) the requirements of section 804(a) of such Act shall be deemed met with respect to such arrangement; and

(E) the arrangement may be certified by any applicable authority with respect to its operations in any State only if it operates in such State on the date of certification.

The provisions of this subsection shall cease to apply with respect to any such arrangement at such time after the date of the enactment of this Act as the applicable requirements of this subsection are not met with respect to such arrangement.

(2) DEFINITIONS.—For purposes of this subsection, the terms ''group health plan'', ''medical care'', and ''participating employer'' shall have the meanings provided in section 812 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an ''association health plan'' shall be deemed a reference to an arrangement referred to in this subsection.

TITLE VIII—HEALTH CARE ACCESS, AFFORDABILITY, AND QUALITY COMMISSION

SEC. 801. ESTABLISHMENT OF COMMISSION.

Part 5 of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

"SEC. 518. HEALTH CARE ACCESS, AFFORDABILITY AND QUALITY COMMISSION.

"(a) ESTABLISHMENT.—There is hereby established a commission to be known as the Health Care Access, Affordability, and Quality Commission (hereinafter in this Act referred to as the 'Commission').

"(b) DUTIES OF COMMISSION.—The duties of the Commission shall be as follows:

"(1) ESTABLISHMENT OF MODEL GUIDELINES.—Based on information gathered by appropriate Federal agencies, advisory groups, and other appropriate sources for health care information, studies, and data, the Commission shall establish model guidelines in each of the following areas:

"(A) Independent expert external review programs.

"(B) Consumer friendly information programs.

''(C) Systems for measuring patient satisfaction and patient outcomes.

''(D) Systems to ensure the timely processing of claims.

''(2) EVALUATION OF HEALTH BENEFITS MANDATES.—At the request of the chairmen or ranking minority members of the appropriate committees of Congress, the Commission shall evaluate, taking into consideration the overall cost effect, availability of treatment, and the effect on the health of the general population, existing and proposed benefit requirements for group health plans.

''(3) COMMENTS ON CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to policies under this section, the Secretary shall transmit a copy of the report to the Commission. The Commission shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress written comments on such report. Such comments may include such recommendations as the Commission deems appropriate.

"(4) AGENDA AND ADDITIONAL REVIEW.—The Commission shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding the Commission's agenda and progress toward achieving the agenda. The Commission may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics as may be requested by such chairmen and members and as the Commission deems appropriate.

"(5) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

"(c) MEMBERSHIP.—

"(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 11 members appointed by the Comptroller General.

"(2) QUALIFICATIONS.—

"(A) IN GENERAL.—The membership of the Commission shall include—

"(i) physicians and other health professionals;

"(ii) representatives of employers, including multiemployer plans;

"(ii) representatives of insured employees;

"(iv) third-party payers; and

"(v) health services and health economics researchers with expertise in outcomes and effectiveness research and technology assessment.

"(B) ETHICAL DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members.

"(3) TERMS.—

"(A) IN GENERAL.—Each member shall be appointed for a term of 3 years, except that the Comptroller shall designate staggered terms for the members first appointed.

"(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

"(4) BASIC PAY.—

"(A) RATES OF PAY.—Except as provided in subparagraph (B), members shall each be paid at a rate equal to the rate of basic pay payable for level IV of the Executive Schedule for each day (including travel time) during which they are engaged in the actual performance of duties vested in the Commission.

"(B) PROHIBITION OF COMPENSATION OF FEDERAL EMPLOYEES.—Members of the Commission who are full-time officers or employees of the United States (or Members of Congress) may not receive additional pay, allowances, or benefits by reason of their service on the Commission.

"(5) TRAVEL EXPENSES.—Each member shall receive travel expenses, including per diem in lieu of subsistence, in accordance with sections 5702 and 5703 of title 5, United States Code.

"(6) CHAIRPERSON.—The Chairperson of the Commission shall be designated by the Comptroller at the time of the appointment. The term of office of the Chairperson shall be 3 years.

"(7) MEETINGS.—The Commission shall meet 4 times each year.

"(d) DIRECTOR AND STAFF OF COMMISSION.—

"(1) DIRECTOR.—The Commission shall have a Director who shall be appointed by the Chairperson. The Director shall be paid at a rate not to exceed the maximum rate of basic pay payable for GS–13 of the General Schedule.

"(2) STAFF.—The Director may appoint 2 additional staff members.

"(3) APPLICABILITY OF CERTAIN CIVIL SERVICE LAWS.—The Director and staff of the Commission shall be appointed subject to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid in accordance with the provisions of chapter 51 and subchapter III of chapter 53 of that title relating to classification and General Schedule pay rates.

"(e) POWERS OF COMMISSION.—

"(1) HEARINGS AND SESSIONS.—The Commission may, for the purpose of carrying out this Act, hold hearings, sit and act at times and places, take testimony, and receive evidence as the Commission considers appropriate. The Commission may administer oaths or affirmations to witnesses appearing before it.

"(2) POWERS OF MEMBERS AND AGENTS.—Any member or agent of the Commission may, if authorized by the Commission, take any action which the Commission is authorized to take by this section.

"(3) OBTAINING OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this Act. Upon request of the Chairperson of the Commission, the head of that department or agency shall furnish that information to the Commission.

"(4) MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the United States.

"(5) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission, on a reimbursable basis, the administrative support services necessary for the Commission to carry out its responsibilities under this Act.

"(6) CONTRACT AUTHORITY.—The Commission may contract with and compensate government and private agencies or persons for services, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

"(f) REPORTS.—Beginning December 31, 2000, and each year thereafter, the Commission shall submit to the Congress an annual report detailing the following information:

"(1) Access to care, affordability to employers and employees, and quality of care under employer-sponsored health plans and recommendations for improving such access, affordability, and quality.

"(2) Any issues the Commission deems appropriate or any issues (such as the appropriateness and availability of particular medical treatment) that the chairmen or ranking members of the appropriate committees of Congress requested the Commission to evaluate.

"(g) DEFINITION OF APPROPRIATE COMMITTEES OF CONGRESS.—For purposes of this section the term 'appropriate committees of Congress' means any committee in the Senate or House of Representatives having jurisdiction over the Employee Retirement Income Security Act of 1974.

"(h) TERMINATION.—Section 14(a)(2)(B) of the Federal Advisory Committee Act (5 U.S.C. App.; relating to the termination of advisory committees) shall not apply to the Commission.

"(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated for fiscal years 2000 through 2004 such sums as may be necessary to carry out this Act.".

SEC. 802. EFFECTIVE DATE.

This title shall be effective 6 months after the date of the enactment of this Act.

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