

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.

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

3 **SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.**

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

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

Sec. 1. Short title and table of contents.

TITLE I—PATIENT RIGHT TO UNRESTRICTED MEDICAL ADVICE

Sec. 101. Patient access to unrestricted professional health care advice.

Sec. 102. Effective date and related rules.

TITLE II—PATIENT RIGHT TO EMERGENCY MEDICAL CARE

- Sec. 201. Patient access to emergency medical care.
- Sec. 202. Effective date and related rules.

TITLE III—PATIENT RIGHT TO OBSTETRIC AND GYNECOLOGICAL CARE

- Sec. 301. Patient access to obstetric and gynecological care.
- Sec. 302. Effective date and related rules.

TITLE IV—PATIENT RIGHT TO PEDIATRIC CARE

- Sec. 401. Patient access to pediatric care.
- Sec. 402. Effective date and related rules.

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.
- Sec. 502. Effective date and related rules.

TITLE VI—GROUP HEALTH PLAN REVIEW STANDARDS

- Sec. 601. Special rules for group health plans.
- Sec. 602. Clarification of ERISA preemption rules.
- Sec. 603. Effective date.

TITLE VII—SMALL BUSINESS ACCESS AND CHOICE FOR ENTREPRENEURS

- Sec. 701. Rules governing association health plans.

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

- “Sec. 801. Association health plans.
- “Sec. 802. Certification of association health plans.
- “Sec. 803. Requirements relating to sponsors and boards of trustees.
- “Sec. 804. Participation and coverage requirements.
- “Sec. 805. Other requirements relating to plan documents, contribution rates, and benefit options.
- “Sec. 806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.
- “Sec. 807. Requirements for application and related requirements.
- “Sec. 808. Notice requirements for voluntary termination.
- “Sec. 809. Corrective actions and mandatory termination.
- “Sec. 810. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.
- “Sec. 811. State assessment authority.
- “Sec. 812. Definitions and rules of construction.
- Sec. 702. Clarification of treatment of single employer arrangements.
- Sec. 703. Clarification of treatment of certain collectively bargained arrangements.
- Sec. 704. Enforcement provisions relating to association health plans.
- Sec. 705. Cooperation between Federal and State authorities.
- Sec. 706. Effective date and transitional and other rules.

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

Sec. 801. Establishment of commission.

Sec. 802. Effective date.

1 **TITLE I—PATIENT RIGHT TO UN-**
2 **RESTRICTED MEDICAL AD-**
3 **VICE**

4 **SEC. 101. PATIENT ACCESS TO UNRESTRICTED PROFES-**
5 **SIONAL HEALTH CARE ADVICE.**

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

10 **“SEC. 714. PATIENT ACCESS TO UNRESTRICTED PROFES-**
11 **SIONAL HEALTH CARE ADVICE.**

12 “(a) IN GENERAL.—A group health plan, or a health
13 insurance issuer offering health insurance coverage in con-
14 nection with a group health plan, shall not prohibit or oth-
15 erwise restrict a health care professional from advising a
16 participant or beneficiary under the plan who is a patient
17 of the professional about the health status of the partici-
18 pant or beneficiary or the medical care or treatment for
19 the condition or disease of the participant or beneficiary,
20 regardless of whether benefits for such care or treatment
21 are provided under the plan or coverage, if the professional
22 is acting within the lawful scope of practice of the profes-
23 sional.

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

3 “(1) to prohibit the enforcement, as part of a
4 contract or agreement to which a health care profes-
5 sional is a party, of any mutually agreed upon terms
6 and conditions, including terms and conditions re-
7 quiring a health care professional to participate in,
8 and cooperate with, all programs, policies, and pro-
9 cedures developed or operated by a group health
10 plan or health insurance issuer to assure, review, or
11 improve the quality and effective utilization of health
12 care services (if such utilization is according to
13 guidelines or protocols that are based on clinical or
14 scientific evidence and the professional judgment of
15 the professional) but only if the guidelines or proto-
16 cols under such utilization do not prohibit or restrict
17 advice described in subsection (a) between health
18 care professionals and their patients; or

19 “(2) to permit a health care professional to
20 misrepresent the scope of benefits covered under the
21 group health plan or health insurance coverage or to
22 otherwise require a group health plan or health in-
23 surance issuer to reimburse health care professionals
24 for benefits (including services and advice) not cov-
25 ered under the plan or coverage.

1 “(c) HEALTH CARE PROFESSIONAL DEFINED.—For
 2 purposes of this section, the term ‘health care professional’
 3 means a physician (as defined in section 1861(r) of the
 4 Social Security Act) or other health care professional if
 5 coverage for the professional’s services is provided under
 6 the group health plan for the services of the professional.
 7 Such term includes a podiatrist, optometrist, chiropractor,
 8 psychologist, dentist, physician assistant, physical or occu-
 9 pational therapist and therapy assistant, speech-language
 10 pathologist, audiologist, registered or licensed practical
 11 nurse (including nurse practitioner, clinical nurse spe-
 12 cialist, certified registered nurse anesthetist, and certified
 13 nurse-midwife), licensed certified social worker, registered
 14 respiratory therapist, and certified respiratory therapy
 15 technician.”.

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

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

“Sec. 714. Patient access to unrestricted professional health care advice.”.

23 **SEC. 102. EFFECTIVE DATE AND RELATED RULES.**

24 (a) EFFECTIVE DATE.—

1 (1) IN GENERAL.—Subject to paragraph (2),
2 the amendments made by this title apply with re-
3 spect to group health plans for plan years beginning
4 on or after the first day of the first month that be-
5 gins more than 1 year after the date of the enact-
6 ment of this Act.

7 (2) COLLECTIVE BARGAINING EXCEPTION.—In
8 the case of a group health plan maintained pursuant
9 to 1 or more collective bargaining agreements be-
10 tween employee representatives and 1 or more em-
11 ployers ratified before the date of enactment of this
12 Act, the amendments made by this title shall not
13 apply to plan years beginning before the later of—

14 (A) the date on which the last collective
15 bargaining agreements relating to the plan ter-
16 minates (determined without regard to any ex-
17 tension thereof agreed to after the date of en-
18 actment of this Act), or

19 (B) the first day described in paragraph
20 (1).

21 For purposes of subparagraph (A), any plan amend-
22 ment made pursuant to a collective bargaining
23 agreement relating to the plan which amends the
24 plan solely to conform to any requirement added by

1 this title shall not be treated as a termination of
2 such collective bargaining agreement.

3 (c) LIMITATION ON ENFORCEMENT ACTIONS.—No
4 enforcement action shall be taken, pursuant to the amend-
5 ments made by this title, against a group health plan or
6 health insurance issuer with respect to a violation of a re-
7 quirement imposed by such amendments, and no penalty
8 shall be imposed on any failure by such plan to comply
9 with any requirement imposed by such amendments, to the
10 extent that violation or failure occurs before the date of
11 issuance of final regulations issued in connection with
12 such requirement, if the plan or issuer has sought to com-
13 ply in good faith with such requirement.

14 **TITLE II—PATIENT RIGHT TO**
15 **EMERGENCY MEDICAL CARE**

16 **SEC. 201. PATIENT ACCESS TO EMERGENCY MEDICAL**
17 **CARE.**

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

1 **“SEC. 715. PATIENT ACCESS TO EMERGENCY MEDICAL**
2 **CARE.**

3 “(a) IN GENERAL.—To the extent that a group
4 health plan (or a health insurance issuer offering health
5 insurance coverage in connection with the plan) provides
6 for any benefits consisting of emergency medical care, ex-
7 cept for items or services specifically excluded—

8 “(1) the plan or issuer shall provide benefits,
9 without requiring preauthorization and without re-
10 gard to otherwise applicable network limitations, for
11 appropriate emergency medical screening examina-
12 tions (within the capability of the emergency facility,
13 including ancillary services routinely available to the
14 emergency facility) to the extent that a prudent
15 layperson, who possesses an average knowledge of
16 health and medicine, would determine such examina-
17 tions to be necessary in order to determine whether
18 emergency medical care is required; and

19 “(2) the plan or issuer shall provide benefits for
20 additional emergency medical services following an
21 emergency medical screening examination (if deter-
22 mined necessary under paragraph (1)) to the extent
23 that a prudent emergency medical professional
24 would determine such additional emergency services
25 to be necessary to avoid the consequences described
26 in subsection (c).

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

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

17 “(1) that failure to immediately provide the
18 care to the participant or beneficiary could reason-
19 ably be expected to result in—

20 “(A) placing the health of such participant
21 or beneficiary (or, with respect to such a partic-
22 ipant or beneficiary who is a pregnant woman,
23 the health of the woman or her unborn child)
24 in serious jeopardy;

1 “(B) serious impairment to bodily func-
2 tions; or

3 “(C) serious dysfunction of any bodily
4 organ or part; or

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

9 (b) CONFORMING AMENDMENT.—The table of con-
10 tents in section 1 of such Act (as amended by the pre-
11 ceding provisions of this Act) is amended further by add-
12 ing at the end of the items relating to subpart B of part
13 7 of subtitle B of title I of such Act the following new
14 item:

 “Sec. 715. Patient access to emergency medical care.”.

15 **SEC. 202. EFFECTIVE DATE AND RELATED RULES.**

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

24 (b) LIMITATION ON ENFORCEMENT ACTIONS.—No
25 enforcement action shall be taken, pursuant to the amend-

1 ments made by this title, against a group health plan or
2 health insurance issuer with respect to a violation of a re-
3 quirement imposed by such amendments before the date
4 of issuance of regulations issued in connection with such
5 requirement, if the plan or issuer has sought to comply
6 in good faith with such requirement.

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

15 (1) the date on which the last of the collective
16 bargaining agreements relating to the plan termi-
17 nates (determined without regard to any extension
18 thereof agreed to after the date of the enactment of
19 this Act); or

20 (2) January 1, 2002.

21 For purposes of this subsection, any plan amendment
22 made pursuant to a collective bargaining agreement relat-
23 ing to the plan which amends the plan solely to conform
24 to any requirement added by this title shall not be treated
25 as a termination of such collective bargaining agreement.

1 **TITLE III—PATIENT RIGHT TO**
2 **OBSTETRIC AND GYNECO-**
3 **LOGICAL CARE**

4 **SEC. 301. PATIENT ACCESS TO OBSTETRIC AND GYNECO-**
5 **LOGICAL CARE.**

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

11 **“SEC. 716. PATIENT ACCESS TO OBSTETRIC AND GYNECO-**
12 **LOGICAL CARE**

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

16 “(1) provides benefits under the terms of the
17 plan consisting of—

18 “(A) routine gynecological care (such as
19 preventive women’s health examinations); or

20 “(B) routine obstetric care (such as rou-
21 tine pregnancy-related services),

22 provided by a participating physician who specializes
23 in such care (or provides benefits consisting of pay-
24 ment for such care); and

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

4 if the primary care provider designated by such a partici-
5 pant or beneficiary is not such a physician, then the plan
6 (or issuer) shall meet the requirements of subsection (b).

7 “(b) REQUIREMENTS.—A group health plan (or a
8 health insurance issuer offering health insurance coverage
9 in connection with the plan) meets the requirements of
10 this subsection, in connection with benefits described in
11 subsection (a) consisting of care described in subpara-
12 graph (A) or (B) of subsection (a)(1) (or consisting of
13 payment therefor), if the plan (or issuer)—

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

17 “(2) treats the ordering of other routine care of
18 the same type, by the participating physician pro-
19 viding the care described in subparagraph (A) or (B)
20 of subsection (a)(1), as the authorization of the pri-
21 mary care provider with respect to such care.

22 “(c) CONSTRUCTION.—Nothing in subsection (b)(2)
23 shall waive any requirements of coverage relating to med-
24 ical necessity or appropriateness with respect to coverage
25 of gynecological or obstetric care so ordered.

1 “(d) TREATMENT OF MULTIPLE COVERAGE OP-
 2 TIONS.—In the case of a plan providing benefits under two
 3 or more coverage options, the requirements of this section
 4 shall apply separately with respect to each coverage op-
 5 tion.”.

6 (b) CONFORMING AMENDMENT.—The table of con-
 7 tents in section 1 of such Act (as amended by the pre-
 8 ceding provisions of this Act) is amended further by add-
 9 ing at the end of the items relating to subpart B of part
 10 7 of subtitle B of title I of such Act the following new
 11 item:

“Sec. 716. Patient access to obstetric and gynecological care.”.

12 **SEC. 302. EFFECTIVE DATE AND RELATED RULES.**

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

21 (b) LIMITATION ON ENFORCEMENT ACTIONS.—No
 22 enforcement action shall be taken, pursuant to the amend-
 23 ments made by this title, against a group health plan or
 24 health insurance issuer with respect to a violation of a re-
 25 quirement imposed by such amendments before the date

1 of issuance of regulations issued in connection with such
2 requirement, if the plan or issuer has sought to comply
3 in good faith with such requirement.

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

12 (1) the date on which the last of the collective
13 bargaining agreements relating to the plan termi-
14 nates (determined without regard to any extension
15 thereof agreed to after the date of the enactment of
16 this Act); or

17 (2) January 1, 2002.

18 For purposes of this subsection, any plan amendment
19 made pursuant to a collective bargaining agreement relat-
20 ing to the plan which amends the plan solely to conform
21 to any requirement added by this title shall not be treated
22 as a termination of such collective bargaining agreement.

1 **TITLE IV—PATIENT RIGHT TO**
2 **PEDIATRIC CARE**

3 **SEC. 401. PATIENT ACCESS TO PEDIATRIC CARE.**

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

9 **“SEC. 717. PATIENT ACCESS TO PEDIATRIC CARE.**

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

23 “(b) CONSTRUCTION.—Nothing in subsection (a)
24 shall waive any requirements of coverage relating to med-

1 ical necessity or appropriateness with respect to coverage
2 of pediatric care.

3 “(c) TREATMENT OF MULTIPLE COVERAGE OP-
4 TIONS.—In the case of a plan providing benefits under two
5 or more coverage options, the requirements of this section
6 shall apply separately with respect to each coverage op-
7 tion.”.

8 (b) CONFORMING AMENDMENT.—The table of con-
9 tents in section 1 of such Act (as amended by the pre-
10 ceding provisions of this Act) is amended further by add-
11 ing at the end of the items relating to subpart B of part
12 7 of subtitle B of title I of such Act the following new
13 item:

“Sec. 717. Patient access to pediatric care.”.

14 **SEC. 402. EFFECTIVE DATE AND RELATED RULES.**

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

23 (b) LIMITATION ON ENFORCEMENT ACTIONS.—No
24 enforcement action shall be taken, pursuant to the amend-
25 ments made by this title, against a group health plan or

1 health insurance issuer with respect to a violation of a re-
2 quirement imposed by such amendments before the date
3 of issuance of regulations issued in connection with such
4 requirement, if the plan or issuer has sought to comply
5 in good faith with such requirement.

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

14 (1) the date on which the last of the collective
15 bargaining agreements relating to the plan termi-
16 nates (determined without regard to any extension
17 thereof agreed to after the date of the enactment of
18 this Act); or

19 (2) January 1, 2002.

20 For purposes of this subsection, any plan amendment
21 made pursuant to a collective bargaining agreement relat-
22 ing to the plan which amends the plan solely to conform
23 to any requirement added by this title shall not be treated
24 as a termination of such collective bargaining agreement.

1 **TITLE V—PATIENT ACCESS TO**
2 **INFORMATION**

3 **SEC. 501. PATIENT ACCESS TO INFORMATION REGARDING**
4 **PLAN COVERAGE, MANAGED CARE PROCE-**
5 **DURES, HEALTH CARE PROVIDERS, AND**
6 **QUALITY OF MEDICAL CARE.**

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

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

11 and

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

14 “DISCLOSURE BY GROUP HEALTH PLANS

15 “SEC. 111. (a) DISCLOSURE REQUIREMENT.—

16 “(1) GROUP HEALTH PLANS.—The adminis-
17 trator of each group health plan shall take such ac-
18 tions as are necessary to ensure that the summary
19 plan description of the plan required under section
20 102 (or each summary plan description in any case
21 in which different summary plan descriptions are ap-
22 propriate under part 1 for different options of cov-
23 erage) contains, among any information otherwise
24 required under this part, the information required
25 under subsections (b), (c), (d), and (e)(2)(A).

1 “(2) HEALTH INSURANCE ISSUERS.—Each
2 health insurance issuer offering health insurance
3 coverage in connection with a group health plan
4 shall provide the administrator on a timely basis
5 with the information necessary to enable the admin-
6 istrator to comply with the requirements of para-
7 graph (1). To the extent that any such issuer pro-
8 vides on a timely basis to plan participants and
9 beneficiaries information otherwise required under
10 this part to be included in the summary plan de-
11 scription, the requirements of sections 101(a)(1) and
12 104(b) shall be deemed satisfied in the case of such
13 plan with respect to such information.

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

16 “(1) COVERED ITEMS AND SERVICES.—

17 “(A) CATEGORIZATION OF INCLUDED BEN-
18 EFITS.—A description of covered benefits, cat-
19 egorized by—

20 “(i) types of items and services (in-
21 cluding any special disease management
22 program); and

23 “(ii) types of health care professionals
24 providing such items and services.

1 “(B) EMERGENCY MEDICAL CARE.—A de-
2 scription of the extent to which the plan covers
3 emergency medical care (including the extent to
4 which the plan provides for access to urgent
5 care centers), and any definitions provided
6 under the plan for the relevant plan termi-
7 nology referring to such care.

8 “(C) PREVENTATIVE SERVICES.—A de-
9 scription of the extent to which the plan pro-
10 vides benefits for preventative services.

11 “(D) DRUG FORMULARIES.—A description
12 of the extent to which covered benefits are de-
13 termined by the use or application of a drug
14 formulary and a summary of the process for de-
15 termining what is included in such formulary.

16 “(E) COBRA CONTINUATION COV-
17 ERAGE.—A description of the benefits available
18 under the plan pursuant to part 6.

19 “(2) LIMITATIONS, EXCLUSIONS, AND RESTRIC-
20 TIONS ON COVERED BENEFITS.—

21 “(A) CATEGORIZATION OF EXCLUDED
22 BENEFITS.—A description of benefits specifi-
23 cally excluded from coverage, categorized by
24 types of items and services.

1 “(B) UTILIZATION REVIEW AND
2 PREAUTHORIZATION REQUIREMENTS.—Whether
3 coverage for medical care is limited or excluded
4 on the basis of utilization review or
5 preauthorization requirements.

6 “(C) LIFETIME, ANNUAL, OR OTHER PE-
7 RIOD LIMITATIONS.—A description of the cir-
8 cumstances under which, and the extent to
9 which, coverage is subject to lifetime, annual, or
10 other period limitations, categorized by types of
11 benefits.

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

18 “(E) EXPERIMENTAL TREATMENTS.—
19 Whether coverage for any medical care is lim-
20 ited or excluded because it constitutes experi-
21 mental treatment or technology, and any defini-
22 tions provided under the plan for the relevant
23 plan terminology referring to such limited or
24 excluded care.

1 “(F) MEDICAL APPROPRIATENESS OR NE-
2 CESSITY.—Whether coverage for medical care
3 may be limited or excluded by reason of a fail-
4 ure to meet the plan’s requirements for medical
5 appropriateness or necessity, and any defini-
6 tions provided under the plan for the relevant
7 plan terminology referring to such limited or
8 excluded care.

9 “(G) SECOND OR SUBSEQUENT OPIN-
10 IONS.—A description of the circumstances
11 under which, and the extent to which, coverage
12 for second or subsequent opinions is limited or
13 excluded.

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

19 “(I) CONTINUITY OF CARE.—A description
20 of the circumstances under which, and the ex-
21 tent to which, coverage of items and services
22 provided by any health care professional is lim-
23 ited or excluded by reason of the departure by
24 the professional from any defined set of pro-
25 viders.

1 “(J) RESTRICTIONS ON COVERAGE OF
2 EMERGENCY SERVICES.—A description of the
3 circumstances under which, and the extent to
4 which, the plan, in covering emergency medical
5 care furnished to a participant or beneficiary of
6 the plan imposes any financial responsibility de-
7 scribed in subsection (c) on participants or
8 beneficiaries or limits or conditions benefits for
9 such care subject to any other term or condition
10 of such plan.

11 “(c) PARTICIPANT’S FINANCIAL RESPONSIBIL-
12 ITIES.—The information required under subsection (a) in-
13 cludes an explanation of—

14 “(1) a participant’s financial responsibility for
15 payment of premiums, coinsurance, copayments,
16 deductibles, and any other charges; and

17 “(2) the circumstances under which, and the
18 extent to which, the participant’s financial responsi-
19 bility described in paragraph (1) may vary, including
20 any distinctions based on whether a health care pro-
21 vider from whom covered benefits are obtained is in-
22 cluded in a defined set of providers.

23 “(d) DISPUTE RESOLUTION PROCEDURES.—The in-
24 formation required under subsection (a) includes a de-

1 description of the processes adopted by the plan pursuant
2 to section 503, including—

3 “(1) descriptions thereof relating specifically
4 to—

5 “(A) coverage decisions;

6 “(B) internal review of coverage decisions;

7 and

8 “(C) any external review of coverage deci-
9 sions; and

10 “(2) the procedures and time frames applicable
11 to each step of the processes referred to in subpara-
12 graphs (A), (B), and (C) of paragraph (1).

13 “(e) INFORMATION AVAILABLE ON REQUEST.—

14 “(1) ACCESS TO PLAN BENEFIT INFORMATION
15 IN ELECTRONIC FORM.—

16 “(A) IN GENERAL.—In addition to the in-
17 formation required to be provided under section
18 104(b)(4), a group health plan (and a health
19 insurance issuer offering health insurance cov-
20 erage in connection with a group health plan)
21 shall, upon written request (made not more fre-
22 quently than annually), make available to par-
23 ticipants and beneficiaries, in a generally recog-
24 nized electronic format, the following informa-
25 tion:

1 “(i) the latest summary plan descrip-
2 tion, including the latest summary of ma-
3 terial modifications; and

4 “(ii) the actual plan provisions setting
5 forth the benefits available under the plan
6 to the extent such information relates to the
7 coverage options under the plan available to the
8 participant or beneficiary. A reasonable charge
9 may be made to cover the cost of providing
10 such information in such generally recognized
11 electronic format. The Secretary may by regula-
12 tion prescribe a maximum amount which will
13 constitute a reasonable charge under the pre-
14 ceding sentence.

15 “(B) ALTERNATIVE ACCESS.—The require-
16 ments of this paragraph may be met by making
17 such information generally available (rather
18 than upon request) on the Internet or on a pro-
19 prietary computer network in a format which is
20 readily accessible to participants and bene-
21 ficiaries.

22 “(2) ADDITIONAL INFORMATION TO BE PRO-
23 VIDED ON REQUEST.—

24 “(A) INCLUSION IN SUMMARY PLAN DE-
25SCRIPTION OF SUMMARY OF ADDITIONAL IN-

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

6 “(B) INFORMATION REQUIRED FROM
7 PLANS AND ISSUERS ON REQUEST.—In addition
8 to information required to be included in sum-
9 mary plan descriptions under this subsection, a
10 group health plan (and a health insurance
11 issuer offering health insurance coverage in
12 connection with a group health plan) shall pro-
13 vide the following information to a participant
14 or beneficiary on request:

15 “(i) NETWORK CHARACTERISTICS.—If
16 the plan (or issuer) utilizes a defined set of
17 providers under contract with the plan (or
18 issuer), a detailed list of the names of such
19 providers and their geographic location, set
20 forth separately with respect to primary
21 care providers and with respect to special-
22 ists.

23 “(ii) CARE MANAGEMENT INFORMA-
24 TION.—A description of the circumstances
25 under which, and the extent to which, the

1 plan has special disease management pro-
2 grams or programs for persons with dis-
3 abilities, indicating whether these pro-
4 grams are voluntary or mandatory and
5 whether a significant benefit differential
6 results from participation in such pro-
7 grams.

8 “(iii) INCLUSION OF DRUGS AND
9 BIOLOGICALS IN FORMULARIES.—A state-
10 ment of whether a specific drug or biologi-
11 cal is included in a formulary used to de-
12 termine benefits under the plan and a de-
13 scription of the procedures for considering
14 requests for any patient-specific waivers.

15 “(iv) PROCEDURES FOR DETERMINING
16 EXCLUSIONS BASED ON MEDICAL NECES-
17 SITY OR EXPERIMENTAL TREATMENTS.—
18 Upon receipt by the participant or bene-
19 ficiary of any notification of an adverse
20 coverage decision based on a determination
21 relating to medical necessity or an experi-
22 mental treatment or technology, a descrip-
23 tion of the procedures and medically-based
24 criteria used in such decision.

1 “(v) PREAUTHORIZATION AND UTILI-
2 ZATION REVIEW PROCEDURES.—Upon re-
3 ceipt by the participant or beneficiary of
4 any notification of an adverse coverage de-
5 cision, a description of the basis on which
6 any preauthorization requirement or any
7 utilization review requirement has resulted
8 in such decision.

9 “(vi) ACCREDITATION STATUS OF
10 HEALTH INSURANCE ISSUERS AND SERV-
11 ICE PROVIDERS.—A description of the ac-
12 creditation and licencing status (if any) of
13 each health insurance issuer offering
14 health insurance coverage in connection
15 with the plan and of any utilization review
16 organization utilized by the issuer or the
17 plan, together with the name and address
18 of the accrediting or licencing authority.

19 “(vii) MEASURES OF ENROLLEE SAT-
20 ISFACTION.—The latest information (if
21 any) maintained by the plan, or by any
22 health insurance issuer offering health in-
23 surance coverage in connection with the
24 plan, relating to enrollee satisfaction.

1 “(viii) QUALITY PERFORMANCE MEAS-
2 URES.—The latest information (if any)
3 maintained by the plan, or by any health
4 insurance issuer offering health insurance
5 coverage in connection with the plan, relat-
6 ing to quality of performance of the deliv-
7 ery of medical care with respect to cov-
8 erage options offered under the plan and
9 of health care professionals and facilities
10 providing medical care under the plan.

11 “(ix) INFORMATION RELATING TO EX-
12 TERNAL REVIEWS.—The number of any
13 external reviews under section 503 that
14 have been completed during the prior plan
15 year and the number of such reviews in
16 which a recommendation is made for modi-
17 fication or reversal of an internal review
18 decision under the plan.

19 “(C) INFORMATION REQUIRED FROM
20 HEALTH CARE PROFESSIONALS ON REQUEST.—
21 Any health care professional treating a partici-
22 pant or beneficiary under a group health plan
23 shall provide to the participant or beneficiary,
24 on request, a description of his or her profes-
25 sional qualifications (including board certifi-

1 cation status, licensing status, and accreditation
2 status, if any), privileges, and experience and a
3 general description by category (including sal-
4 ary, fee-for-service, capitation, and such other
5 categories as may be specified in regulations of
6 the Secretary) of the applicable method by
7 which such professional is compensated in con-
8 nection with the provision of such medical care.

9 “(D) INFORMATION REQUIRED FROM
10 HEALTH CARE FACILITIES ON REQUEST.—Any
11 health care facility from which a participant or
12 beneficiary has sought treatment under a group
13 health plan shall provide to the participant or
14 beneficiary, on request, a description of the fa-
15 cility’s corporate form or other organizational
16 form and all forms of licensing and accredita-
17 tion status (if any) assigned to the facility by
18 standard-setting organizations.

19 “(f) ACCESS TO INFORMATION RELEVANT TO THE
20 COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT
21 OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition
22 to information otherwise required to be made available
23 under this section, a group health plan (and a health in-
24 surance issuer offering health insurance coverage in con-
25 nection with a group health plan) shall, upon written re-

1 quest (made not more frequently than annually), make
 2 available to a participant (and an employee who, under
 3 the terms of the plan, is eligible for coverage but not en-
 4 rolled) in connection with a period of enrollment the sum-
 5 mary plan description for any coverage option under the
 6 plan under which the participant is eligible to enroll and
 7 any information described in clauses (i), (ii), (iii), (vi),
 8 (vii), and (viii) of subsection (e)(2)(B).

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

17 “(1) by inclusion of information in publications
 18 broadly distributed by plan sponsors, employers, or
 19 employee organizations;

20 “(2) by electronic means of communication (in-
 21 cluding the Internet or proprietary computer net-
 22 works in a format which is readily accessible to par-
 23 ticipants);

24 “(3) by timely informing participants who,
 25 under an ongoing program maintained under the

1 plan, have submitted their names for such notifica-
2 tion; or

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

5 “(h) DEFINITIONS.—For purposes of this section—

6 “(1) GROUP HEALTH PLAN.—The term ‘group
7 health plan’ has the meaning provided such term
8 under section 733(a)(1).

9 “(2) MEDICAL CARE.—The term ‘medical care’
10 has the meaning provided such term under section
11 733(a)(2).

12 “(3) HEALTH INSURANCE COVERAGE.—The
13 term ‘health insurance coverage’ has the meaning
14 provided such term under section 733(b)(1).

15 “(4) HEALTH INSURANCE ISSUER.—The term
16 ‘health insurance issuer’ has the meaning provided
17 such term under section 733(b)(2).”.

18 (b) CONFORMING AMENDMENTS.—

19 (1) Section 102(b) of such Act (29 U.S.C.
20 1022(b)) is amended by inserting before the period
21 at the end the following: “; and, in the case of a
22 group health plan (as defined in section 111(h)(1)),
23 the information required to be included under sec-
24 tion 111(a)”.

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

“Sec. 111. Disclosure by group health plans.

“Sec. 112. Repeal and effective date.”.

4 **SEC. 502. EFFECTIVE DATE AND RELATED RULES.**

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

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

19 **TITLE VI—GROUP HEALTH PLAN** 20 **REVIEW STANDARDS**

21 **SEC. 601. SPECIAL RULES FOR GROUP HEALTH PLANS.**

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

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

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

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

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

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

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

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

1 “(C) afford a reasonable opportunity to
2 any participant or beneficiary who is in receipt
3 of the notice of such adverse coverage decision,
4 and who files a written request for review of the
5 initial coverage decision within 90 days after re-
6 ceipt of the notice of the initial decision, for a
7 full and fair review of the decision by an appro-
8 priate named fiduciary who did not make the
9 initial decision; and

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

12 “(2) TIME LIMITS FOR MAKING INITIAL COV-
13 ERAGE DECISIONS FOR BENEFITS AND COMPLETING
14 INTERNAL APPEALS.—

15 “(A) TIME LIMITS FOR DECIDING RE-
16 QUESTS FOR BENEFIT PAYMENTS, REQUESTS
17 FOR ADVANCE DETERMINATION OF COVERAGE,
18 AND REQUESTS FOR REQUIRED DETERMINA-
19 TION OF MEDICAL NECESSITY.—Except as pro-
20 vided in subparagraph (B)—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 “(G) SELECTION OF EXPERTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 “(i) such procedure is utilized solely—

23 “(I) accordance with the applica-
24 ble terms of a bona fide collective bar-
25 gaining agreement pursuant to which

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 “(B) TREATMENT OF PARTNERSHIPS.—

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

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

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

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

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

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

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

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

1 proposed medical care constitutes accelerated
2 need medical care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 “(R) WRITTEN OR IN WRITING.—

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

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

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

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

22 **SEC. 602. CLARIFICATION OF ERISA PREEMPTION RULES.**

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

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

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

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

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

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

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

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

1 **SEC. 603. EFFECTIVE DATE.**

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

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

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

1 **TITLE VII—SMALL BUSINESS AC-**
2 **CESS AND CHOICE FOR EN-**
3 **TREPRENEURS**

4 **SEC. 701. RULES GOVERNING ASSOCIATION HEALTH**
5 **PLANS.**

6 (a) IN GENERAL.—Subtitle B of title I of the Em-
7 ployee Retirement Income Security Act of 1974 is amend-
8 ed by adding after part 7 the following new part:

9 “PART 8—RULES GOVERNING ASSOCIATION HEALTH
10 PLANS

11 **“SEC. 801. ASSOCIATION HEALTH PLANS.**

12 “(a) IN GENERAL.—For purposes of this part, the
13 term ‘association health plan’ means a group health
14 plan—

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

17 “(2) under which at least one option of health
18 insurance coverage offered by a health insurance
19 issuer (which may include, among other options,
20 managed care options, point of service options, and
21 preferred provider options) is provided to partici-
22 pants and beneficiaries, unless, for any plan year,
23 such coverage remains unavailable to the plan de-
24 spite good faith efforts exercised by the plan to se-
25 cure such coverage.

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

3 “(1) is organized and maintained in good faith,
4 with a constitution and bylaws specifically stating its
5 purpose and providing for periodic meetings on at
6 least an annual basis, as a bona fide trade associa-
7 tion, a bona fide industry association (including a
8 rural electric cooperative association or a rural tele-
9 phone cooperative association), a bona fide profes-
10 sional association, or a bona fide chamber of com-
11 merce (or similar bona fide business association, in-
12 cluding a corporation or similar organization that
13 operates on a cooperative basis (within the meaning
14 of section 1381 of the Internal Revenue Code of
15 1986)), for substantial purposes other than that of
16 obtaining or providing medical care;

17 “(2) is established as a permanent entity which
18 receives the active support of its members and col-
19 lects from its members on a periodic basis dues or
20 payments necessary to maintain eligibility for mem-
21 bership in the sponsor; and

22 “(3) does not condition membership, such dues
23 or payments, or coverage under the plan on the
24 basis of health status-related factors with respect to
25 the employees of its members (or affiliated mem-

1 bers), or the dependents of such employees, and does
2 not condition such dues or payments on the basis of
3 group health plan participation.

4 Any sponsor consisting of an association of entities which
5 meet the requirements of paragraphs (1), (2), and (3)
6 shall be deemed to be a sponsor described in this sub-
7 section.

8 **“SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH**
9 **PLANS.**

10 “(a) IN GENERAL.—The applicable authority shall
11 prescribe by regulation, through negotiated rulemaking, a
12 procedure under which, subject to subsection (b), the ap-
13 plicable authority shall certify association health plans
14 which apply for certification as meeting the requirements
15 of this part.

16 “(b) STANDARDS.—Under the procedure prescribed
17 pursuant to subsection (a), in the case of an association
18 health plan that provides at least one benefit option which
19 does not consist of health insurance coverage, the applica-
20 ble authority shall certify such plan as meeting the re-
21 quirements of this part only if the applicable authority is
22 satisfied that—

23 “(1) such certification—

24 “(A) is administratively feasible;

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

3 “(C) is protective of the rights and benefits
4 of the individuals covered under the plan; and

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

9 “(c) REQUIREMENTS APPLICABLE TO CERTIFIED
10 PLANS.—An association health plan with respect to which
11 certification under this part is in effect shall meet the ap-
12 plicable requirements of this part, effective on the date
13 of certification (or, if later, on the date on which the plan
14 is to commence operations).

15 “(d) REQUIREMENTS FOR CONTINUED CERTIFI-
16 CATION.—The applicable authority may provide by regula-
17 tion, through negotiated rulemaking, for continued certifi-
18 cation of association health plans under this part.

19 “(e) CLASS CERTIFICATION FOR FULLY INSURED
20 PLANS.—The applicable authority shall establish a class
21 certification procedure for association health plans under
22 which all benefits consist of health insurance coverage.
23 Under such procedure, the applicable authority shall pro-
24 vide for the granting of certification under this part to
25 the plans in each class of such association health plans

1 upon appropriate filing under such procedure in connec-
2 tion with plans in such class and payment of the pre-
3 scribed fee under section 807(a).

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

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

12 “(2) a plan under which the sponsor does not
13 restrict membership to one or more trades and busi-
14 nesses or industries and whose eligible participating
15 employers represent a broad cross-section of trades
16 and businesses or industries, or

17 “(3) a plan whose eligible participating employ-
18 ers represent one or more trades or businesses, or
19 one or more industries, which have been indicated as
20 having average or above-average health insurance
21 risk or health claims experience by reason of State
22 rate filings, denials of coverage, proposed premium
23 rate levels, and other means demonstrated by such
24 plan in accordance with regulations which the Sec-
25 retary shall prescribe through negotiated rule-

1 making, including (but not limited to) the following:
2 agriculture; automobile dealerships; barbering and
3 cosmetology; child care; construction; dance, theat-
4 rical, and orchestra productions; disinfecting and
5 pest control; eating and drinking establishments;
6 fishing; hospitals; labor organizations; logging; man-
7 ufacturing (metals); mining; medical and dental
8 practices; medical laboratories; sanitary services;
9 transportation (local and freight); and warehousing.

10 **“SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND**
11 **BOARDS OF TRUSTEES.**

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

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

21 “(1) FISCAL CONTROL.—The plan is operated,
22 pursuant to a trust agreement, by a board of trust-
23 ees which has complete fiscal control over the plan
24 and which is responsible for all operations of the
25 plan.

1 “(2) RULES OF OPERATION AND FINANCIAL
2 CONTROLS.—The board of trustees has in effect
3 rules of operation and financial controls, based on a
4 3-year plan of operation, adequate to carry out the
5 terms of the plan and to meet all requirements of
6 this title applicable to the plan.

7 “(3) RULES GOVERNING RELATIONSHIP TO
8 PARTICIPATING EMPLOYERS AND TO CONTRAC-
9 TORS.—

10 “(A) IN GENERAL.—Except as provided in
11 subparagraphs (B) and (C), the members of the
12 board of trustees are individuals selected from
13 individuals who are the owners, officers, direc-
14 tors, or employees of the participating employ-
15 ers or who are partners in the participating em-
16 ployers and actively participate in the business.

17 “(B) LIMITATION.—

18 “(i) GENERAL RULE.—Except as pro-
19 vided in clauses (ii) and (iii), no such
20 member is an owner, officer, director, or
21 employee of, or partner in, a contract ad-
22 ministrator or other service provider to the
23 plan.

24 “(ii) LIMITED EXCEPTION FOR PRO-
25 VIDERS OF SERVICES SOLELY ON BEHALF

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

9 “(iii) TREATMENT OF PROVIDERS OF
10 MEDICAL CARE.—In the case of a sponsor
11 which is an association whose membership
12 consists primarily of providers of medical
13 care, clause (i) shall not apply in the case
14 of any service provider described in sub-
15 paragraph (A) who is a provider of medical
16 care under the plan.

17 “(C) CERTAIN PLANS EXCLUDED.—Sub-
18 paragraph (A) shall not apply to an association
19 health plan which is in existence on the date of
20 the enactment of the Small Business Access
21 and Choice for Entrepreneurs Act of 1999.

22 “(D) SOLE AUTHORITY.—The board has
23 sole authority under the plan to approve appli-
24 cations for participation in the plan and to con-

1 tract with a service provider to administer the
2 day-to-day affairs of the plan.

3 “(c) TREATMENT OF FRANCHISE NETWORKS.—In
4 the case of a group health plan which is established and
5 maintained by a franchiser for a franchise network con-
6 sisting of its franchisees—

7 “(1) the requirements of subsection (a) and sec-
8 tion 801(a)(1) shall be deemed met if such require-
9 ments would otherwise be met if the franchiser were
10 deemed to be the sponsor referred to in section
11 801(b), such network were deemed to be an associa-
12 tion described in section 801(b), and each franchisee
13 were deemed to be a member (of the association and
14 the sponsor) referred to in section 801(b); and

15 “(2) the requirements of section 804(a)(1) shall
16 be deemed met.

17 The Secretary may by regulation, through negotiated rule-
18 making, define for purposes of this subsection the terms
19 ‘franchiser’, ‘franchise network’, and ‘franchisee’.

20 “(d) CERTAIN COLLECTIVELY BARGAINED PLANS.—

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

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

1 “(B) the joint board of trustees shall be
 2 deemed a board of trustees with respect to
 3 which the requirements of subsection (b) are
 4 met; and

5 “(C) the requirements of section 804 shall
 6 be deemed met.

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

9 “(A) the plan is a multiemployer plan; or

10 “(B) the plan is in existence on April 1,
 11 1997, and would be described in section
 12 3(40)(A)(i) but solely for the failure to meet
 13 the requirements of section 3(40)(C)(ii).

14 **“SEC. 804. PARTICIPATION AND COVERAGE REQUIRE-**
 15 **MENTS.**

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

20 “(1) each participating employer must be—

21 “(A) a member of the sponsor,

22 “(B) the sponsor, or

23 “(C) an affiliated member of the sponsor
 24 with respect to which the requirements of sub-
 25 section (b) are met,

1 except that, in the case of a sponsor which is a pro-
2 fessional association or other individual-based asso-
3 ciation, if at least one of the officers, directors, or
4 employees of an employer, or at least one of the in-
5 dividuals who are partners in an employer and who
6 actively participates in the business, is a member or
7 such an affiliated member of the sponsor, partici-
8 pating employers may also include such employer;
9 and

10 “(2) all individuals commencing coverage under
11 the plan after certification under this part must
12 be—

13 “(A) active or retired owners (including
14 self-employed individuals), officers, directors, or
15 employees of, or partners in, participating em-
16 ployers; or

17 “(B) the beneficiaries of individuals de-
18 scribed in subparagraph (A).

19 “(b) COVERAGE OF PREVIOUSLY UNINSURED EM-
20 PLOYEES.—In the case of an association health plan in
21 existence on the date of the enactment of the Small Busi-
22 ness Access and Choice for Entrepreneurs Act of 1999,
23 an affiliated member of the sponsor of the plan may be
24 offered coverage under the plan as a participating em-
25 ployer only if—

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

4 “(2) during the 12-month period preceding the
5 date of the offering of such coverage, the affiliated
6 member has not maintained or contributed to a
7 group health plan with respect to any of its employ-
8 ees who would otherwise be eligible to participate in
9 such association health plan.

10 “(c) INDIVIDUAL MARKET UNAFFECTED.—The re-
11 quirements of this subsection are met with respect to an
12 association health plan if, under the terms of the plan,
13 no participating employer may provide health insurance
14 coverage in the individual market for any employee not
15 covered under the plan which is similar to the coverage
16 contemporaneously provided to employees of the employer
17 under the plan, if such exclusion of the employee from cov-
18 erage under the plan is based on a health status-related
19 factor with respect to the employee and such employee
20 would, but for such exclusion on such basis, be eligible
21 for coverage under the plan.

22 “(d) PROHIBITION OF DISCRIMINATION AGAINST
23 EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICI-
24 PATE.—The requirements of this subsection are met with
25 respect to an association health plan if—

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

9 “(2) upon request, any employer eligible to par-
 10 ticipate is furnished information regarding all cov-
 11 erage options available under the plan; and

12 “(3) the applicable requirements of sections
 13 701, 702, and 703 are met with respect to the plan.

14 **“SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN**
 15 **DOCUMENTS, CONTRIBUTION RATES, AND**
 16 **BENEFIT OPTIONS.**

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

20 “(1) CONTENTS OF GOVERNING INSTRU-
 21 MENTS.—The instruments governing the plan in-
 22 clude a written instrument, meeting the require-
 23 ments of an instrument required under section
 24 402(a)(1), which—

1 “(A) provides that the board of trustees
2 serves as the named fiduciary required for plans
3 under section 402(a)(1) and serves in the ca-
4 pacity of a plan administrator (referred to in
5 section 3(16)(A));

6 “(B) provides that the sponsor of the plan
7 is to serve as plan sponsor (referred to in sec-
8 tion 3(16)(B)); and

9 “(C) incorporates the requirements of sec-
10 tion 806.

11 “(2) CONTRIBUTION RATES MUST BE NON-
12 DISCRIMINATORY.—

13 “(A) The contribution rates for any par-
14 ticipating small employer do not vary on the
15 basis of the claims experience of such employer
16 and do not vary on the basis of the type of
17 business or industry in which such employer is
18 engaged.

19 “(B) Nothing in this title or any other pro-
20 vision of law shall be construed to preclude an
21 association health plan, or a health insurance
22 issuer offering health insurance coverage in
23 connection with an association health plan,
24 from—

1 “(i) setting contribution rates based
2 on the claims experience of the plan; or

3 “(ii) varying contribution rates for
4 small employers in a State to the extent
5 that such rates could vary using the same
6 methodology employed in such State for
7 regulating premium rates in the small
8 group market with respect to health insur-
9 ance coverage offered in connection with
10 bona fide associations (within the meaning
11 of section 2791(d)(3) of the Public Health
12 Service Act),

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

15 “(3) FLOOR FOR NUMBER OF COVERED INDI-
16 VIDUALS WITH RESPECT TO CERTAIN PLANS.—If
17 any benefit option under the plan does not consist
18 of health insurance coverage, the plan has as of the
19 beginning of the plan year not fewer than 1,000 par-
20 ticipants and beneficiaries.

21 “(4) MARKETING REQUIREMENTS.—

22 “(A) IN GENERAL.—If a benefit option
23 which consists of health insurance coverage is
24 offered under the plan, State-licensed insurance
25 agents shall be used to distribute to small em-

1 employers coverage which does not consist of
 2 health insurance coverage in a manner com-
 3 parable to the manner in which such agents are
 4 used to distribute health insurance coverage.

5 “(B) STATE-LICENSED INSURANCE
 6 AGENTS.—For purposes of subparagraph (A),
 7 the term ‘State-licensed insurance agents’
 8 means one or more agents who are licensed in
 9 a State and are subject to the laws of such
 10 State relating to licensure, qualification, test-
 11 ing, examination, and continuing education of
 12 persons authorized to offer, sell, or solicit
 13 health insurance coverage in such State.

14 “(5) REGULATORY REQUIREMENTS.—Such
 15 other requirements as the applicable authority deter-
 16 mines are necessary to carry out the purposes of this
 17 part, which shall be prescribed by the applicable au-
 18 thority by regulation through negotiated rulemaking.

19 “(b) ABILITY OF ASSOCIATION HEALTH PLANS TO
 20 DESIGN BENEFIT OPTIONS.—Subject to section 514(d),
 21 nothing in this part or any provision of State law (as de-
 22 fined in section 514(e)(1)) shall be construed to preclude
 23 an association health plan, or a health insurance issuer
 24 offering health insurance coverage in connection with an
 25 association health plan, from exercising its sole discretion

1 in selecting the specific items and services consisting of
 2 medical care to be included as benefits under such plan
 3 or coverage, except (subject to section 514) in the case
 4 of any law to the extent that it (1) prohibits an exclusion
 5 of a specific disease from such coverage, or (2) is not pre-
 6 empted under section 731(a)(1) with respect to matters
 7 governed by section 711 or 712.

8 **“SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS**
 9 **FOR SOLVENCY FOR PLANS PROVIDING**
 10 **HEALTH BENEFITS IN ADDITION TO HEALTH**
 11 **INSURANCE COVERAGE.**

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

14 “(1) the benefits under the plan consist solely
 15 of health insurance coverage; or

16 “(2) if the plan provides any additional benefit
 17 options which do not consist of health insurance cov-
 18 erage, the plan—

19 “(A) establishes and maintains reserves
 20 with respect to such additional benefit options,
 21 in amounts recommended by the qualified actu-
 22 ary, consisting of—

23 “(i) a reserve sufficient for unearned
 24 contributions;

1 “(ii) a reserve sufficient for benefit li-
2 abilities which have been incurred, which
3 have not been satisfied, and for which risk
4 of loss has not yet been transferred, and
5 for expected administrative costs with re-
6 spect to such benefit liabilities;

7 “(iii) a reserve sufficient for any other
8 obligations of the plan; and

9 “(iv) a reserve sufficient for a margin
10 of error and other fluctuations, taking into
11 account the specific circumstances of the
12 plan; and

13 “(B) establishes and maintains aggregate
14 and specific excess/stop loss insurance and sol-
15 vency indemnification, with respect to such ad-
16 ditional benefit options for which risk of loss
17 has not yet been transferred, as follows:

18 “(i) The plan shall secure aggregate
19 excess/stop loss insurance for the plan
20 with an attachment point which is not
21 greater than 125 percent of expected gross
22 annual claims. The applicable authority
23 may by regulation, through negotiated
24 rulemaking, provide for upward adjust-
25 ments in the amount of such percentage in

1 specified circumstances in which the plan
2 specifically provides for and maintains re-
3 serves in excess of the amounts required
4 under subparagraph (A).

5 “(ii) The plan shall secure specific ex-
6 cess/stop loss insurance for the plan with
7 an attachment point which is at least equal
8 to an amount recommended by the plan’s
9 qualified actuary (but not more than
10 \$175,000). The applicable authority may
11 by regulation, through negotiated rule-
12 making, provide for adjustments in the
13 amount of such insurance in specified cir-
14 cumstances in which the plan specifically
15 provides for and maintains reserves in ex-
16 cess of the amounts required under sub-
17 paragraph (A).

18 “(iii) The plan shall secure indem-
19 nification insurance for any claims which
20 the plan is unable to satisfy by reason of
21 a plan termination.

22 Any regulations prescribed by the applicable authority
23 pursuant to clause (i) or (ii) of subparagraph (B) may
24 allow for such adjustments in the required levels of excess/
25 stop loss insurance as the qualified actuary may rec-

1 commend, taking into account the specific circumstances
2 of the plan.

3 “(b) MINIMUM SURPLUS IN ADDITION TO CLAIMS
4 RESERVES.—In the case of any association health plan de-
5 scribed in subsection (a)(2), the requirements of this sub-
6 section are met if the plan establishes and maintains sur-
7 plus in an amount at least equal to—

8 “(1) \$500,000, or

9 “(2) such greater amount (but not greater than
10 \$2,000,000) as may be set forth in regulations pre-
11 scribed by the applicable authority through nego-
12 tiated rulemaking, based on the level of aggregate
13 and specific excess/stop loss insurance provided with
14 respect to such plan.

15 “(c) ADDITIONAL REQUIREMENTS.—In the case of
16 any association health plan described in subsection (a)(2),
17 the applicable authority may provide such additional re-
18 quirements relating to reserves and excess/stop loss insur-
19 ance as the applicable authority considers appropriate.
20 Such requirements may be provided by regulation, through
21 negotiated rulemaking, with respect to any such plan or
22 any class of such plans.

23 “(d) ADJUSTMENTS FOR EXCESS/STOP LOSS INSUR-
24 ANCE.—The applicable authority may provide for adjust-
25 ments to the levels of reserves otherwise required under

1 subsections (a) and (b) with respect to any plan or class
2 of plans to take into account excess/stop loss insurance
3 provided with respect to such plan or plans.

4 “(e) ALTERNATIVE MEANS OF COMPLIANCE.—The
5 applicable authority may permit an association health plan
6 described in subsection (a)(2) to substitute, for all or part
7 of the requirements of this section (except subsection
8 (a)(2)(B)(iii)), such security, guarantee, hold-harmless ar-
9 rangement, or other financial arrangement as the applica-
10 ble authority determines to be adequate to enable the plan
11 to fully meet all its financial obligations on a timely basis
12 and is otherwise no less protective of the interests of par-
13 ticipants and beneficiaries than the requirements for
14 which it is substituted. The applicable authority may take
15 into account, for purposes of this subsection, evidence pro-
16 vided by the plan or sponsor which demonstrates an as-
17 sumption of liability with respect to the plan. Such evi-
18 dence may be in the form of a contract of indemnification,
19 lien, bonding, insurance, letter of credit, recourse under
20 applicable terms of the plan in the form of assessments
21 of participating employers, security, or other financial ar-
22 rangement.

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

1 “(1) PAYMENTS BY CERTAIN PLANS TO ASSO-
2 CIATION HEALTH PLAN FUND.—

3 “(A) IN GENERAL.—In the case of an as-
4 sociation health plan described in subsection
5 (a)(2), the requirements of this subsection are
6 met if the plan makes payments into the Asso-
7 ciation Health Plan Fund under this subpara-
8 graph when they are due. Such payments shall
9 consist of annual payments in the amount of
10 \$5,000, and, in addition to such annual pay-
11 ments, such supplemental payments as the Sec-
12 retary may determine to be necessary under
13 paragraph (2). Payments under this paragraph
14 are payable to the Fund at the time determined
15 by the Secretary. Initial payments are due in
16 advance of certification under this part. Pay-
17 ments shall continue to accrue until a plan’s as-
18 sets are distributed pursuant to a termination
19 procedure.

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

1 “(C) CONTINUED DUTY OF THE SEC-
2 RETARY.—The Secretary shall not cease to
3 carry out the provisions of paragraph (2) on ac-
4 count of the failure of a plan to pay any pay-
5 ment when due.

6 “(2) PAYMENTS BY SECRETARY TO CONTINUE
7 EXCESS/STOP LOSS INSURANCE COVERAGE AND IN-
8 DEMNIFICATION INSURANCE COVERAGE FOR CER-
9 TAIN PLANS.—In any case in which the applicable
10 authority determines that there is, or that there is
11 reason to believe that there will be: (A) a failure to
12 take necessary corrective actions under section
13 809(a) with respect to an association health plan de-
14 scribed in subsection (a)(2); or (B) a termination of
15 such a plan under section 809(b) or 810(b)(8) (and,
16 if the applicable authority is not the Secretary, cer-
17 tifies such determination to the Secretary), the Sec-
18 retary shall determine the amounts necessary to
19 make payments to an insurer (designated by the
20 Secretary) to maintain in force excess/stop loss in-
21 surance coverage or indemnification insurance cov-
22 erage for such plan, if the Secretary determines that
23 there is a reasonable expectation that, without such
24 payments, claims would not be satisfied by reason of
25 termination of such coverage. The Secretary shall, to

1 the extent provided in advance in appropriation
2 Acts, pay such amounts so determined to the insurer
3 designated by the Secretary.

4 “(3) ASSOCIATION HEALTH PLAN FUND.—

5 “(A) IN GENERAL.—There is established
6 on the books of the Treasury a fund to be
7 known as the ‘Association Health Plan Fund’.
8 The Fund shall be available for making pay-
9 ments pursuant to paragraph (2). The Fund
10 shall be credited with payments received pursu-
11 ant to paragraph (1)(A), penalties received pur-
12 suant to paragraph (1)(B); and earnings on in-
13 vestments of amounts of the Fund under sub-
14 paragraph (B).

15 “(B) INVESTMENT.—Whenever the Sec-
16 retary determines that the moneys of the fund
17 are in excess of current needs, the Secretary
18 may request the investment of such amounts as
19 the Secretary determines advisable by the Sec-
20 retary of the Treasury in obligations issued or
21 guaranteed by the United States.

22 “(g) EXCESS/STOP LOSS INSURANCE.—For pur-
23 poses of this section—

24 “(1) AGGREGATE EXCESS/STOP LOSS INSUR-
25 ANCE.—The term ‘aggregate excess/stop loss insur-

1 ance’ means, in connection with an association
2 health plan, a contract—

3 “(A) under which an insurer (meeting such
4 minimum standards as the applicable authority may
5 prescribe by regulation through negotiated rule-
6 making) provides for payment to the plan with re-
7 spect to aggregate claims under the plan in excess
8 of an amount or amounts specified in such contract;

9 “(B) which is guaranteed renewable; and

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

12 “(2) SPECIFIC EXCESS/STOP LOSS INSUR-
13 ANCE.—The term ‘specific excess/stop loss insur-
14 ance’ means, in connection with an association
15 health plan, a contract—

16 “(A) under which an insurer (meeting such
17 minimum standards as the applicable authority
18 may prescribe by regulation through negotiated
19 rulemaking) provides for payment to the plan
20 with respect to claims under the plan in connec-
21 tion with a covered individual in excess of an
22 amount or amounts specified in such contract
23 in connection with such covered individual;

24 “(B) which is guaranteed renewable; and

1 “(C) which allows for payment of pre-
2 miums by any third party on behalf of the in-
3 sured plan.

4 “(h) INDEMNIFICATION INSURANCE.—For purposes
5 of this section, the term ‘indemnification insurance’
6 means, in connection with an association health plan, a
7 contract—

8 “(1) under which an insurer (meeting such min-
9 imum standards as the applicable authority may pre-
10 scribe through negotiated rulemaking) provides for
11 payment to the plan with respect to claims under the
12 plan which the plan is unable to satisfy by reason
13 of a termination pursuant to section 809(b) (relating
14 to mandatory termination);

15 “(2) which is guaranteed renewable and
16 noncancellable for any reason (except as the applica-
17 ble authority may prescribe by regulation through
18 negotiated rulemaking); and

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

21 “(i) RESERVES.—For purposes of this section, the
22 term ‘reserves’ means, in connection with an association
23 health plan, plan assets which meet the fiduciary stand-
24 ards under part 4 and such additional requirements re-

1 garding liquidity as the applicable authority may prescribe
2 through negotiated rulemaking.

3 “(j) SOLVENCY STANDARDS WORKING GROUP.—

4 “(1) IN GENERAL.—Within 90 days after the
5 date of the enactment of the Small Business Access
6 and Choice for Entrepreneurs Act of 1999, the ap-
7 plicable authority shall establish a Solvency Stand-
8 ards Working Group. In prescribing the initial regu-
9 lations under this section, the applicable authority
10 shall take into account the recommendations of such
11 Working Group.

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

18 “(A) a representative of the National Asso-
19 ciation of Insurance Commissioners;

20 “(B) a representative of the American
21 Academy of Actuaries;

22 “(C) a representative of the State govern-
23 ments, or their interests;

24 “(D) a representative of existing self-in-
25 sured arrangements, or their interests;

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

4 “(F) a representative of multiemployer
 5 plans that are group health plans, or their in-
 6 terests.

7 **“SEC. 807. REQUIREMENTS FOR APPLICATION AND RE-**
 8 **LATED REQUIREMENTS.**

9 “(a) FILING FEE.—Under the procedure prescribed
 10 pursuant to section 802(a), an association health plan
 11 shall pay to the applicable authority at the time of filing
 12 an application for certification under this part a filing fee
 13 in the amount of \$5,000, which shall be available in the
 14 case of the Secretary, to the extent provided in appropria-
 15 tion Acts, for the sole purpose of administering the certifi-
 16 cation procedures applicable with respect to association
 17 health plans.

18 “(b) INFORMATION TO BE INCLUDED IN APPLICA-
 19 TION FOR CERTIFICATION.—An application for certifi-
 20 cation under this part meets the requirements of this sec-
 21 tion only if it includes, in a manner and form which shall
 22 be prescribed by the applicable authority through nego-
 23 tiated rulemaking, at least the following information:

24 “(1) IDENTIFYING INFORMATION.—The names
 25 and addresses of—

1 “(A) the sponsor; and

2 “(B) the members of the board of trustees
3 of the plan.

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

9 “(3) BONDING REQUIREMENTS.—Evidence pro-
10 vided by the board of trustees that the bonding re-
11 quirements of section 412 will be met as of the date
12 of the application or (if later) commencement of op-
13 erations.

14 “(4) PLAN DOCUMENTS.—A copy of the docu-
15 ments governing the plan (including any bylaws and
16 trust agreements), the summary plan description,
17 and other material describing the benefits that will
18 be provided to participants and beneficiaries under
19 the plan.

20 “(5) AGREEMENTS WITH SERVICE PRO-
21 VIDERS.—A copy of any agreements between the
22 plan and contract administrators and other service
23 providers.

24 “(6) FUNDING REPORT.—In the case of asso-
25 ciation health plans providing benefits options in ad-

1 dition to health insurance coverage, a report setting
2 forth information with respect to such additional
3 benefit options determined as of a date within the
4 120-day period ending with the date of the applica-
5 tion, including the following:

6 “(A) RESERVES.—A statement, certified
7 by the board of trustees of the plan, and a
8 statement of actuarial opinion, signed by a
9 qualified actuary, that all applicable require-
10 ments of section 806 are or will be met in ac-
11 cordance with regulations which the applicable
12 authority shall prescribe through negotiated
13 rulemaking.

14 “(B) ADEQUACY OF CONTRIBUTION
15 RATES.—A statement of actuarial opinion,
16 signed by a qualified actuary, which sets forth
17 a description of the extent to which contribution
18 rates are adequate to provide for the payment
19 of all obligations and the maintenance of re-
20 quired reserves under the plan for the 12-
21 month period beginning with such date within
22 such 120-day period, taking into account the
23 expected coverage and experience of the plan. If
24 the contribution rates are not fully adequate,
25 the statement of actuarial opinion shall indicate

1 the extent to which the rates are inadequate
2 and the changes needed to ensure adequacy.

3 “(C) CURRENT AND PROJECTED VALUE OF
4 ASSETS AND LIABILITIES.—A statement of ac-
5 tuarial opinion signed by a qualified actuary,
6 which sets forth the current value of the assets
7 and liabilities accumulated under the plan and
8 a projection of the assets, liabilities, income,
9 and expenses of the plan for the 12-month pe-
10 riod referred to in subparagraph (B). The in-
11 come statement shall identify separately the
12 plan’s administrative expenses and claims.

13 “(D) COSTS OF COVERAGE TO BE
14 CHARGED AND OTHER EXPENSES.—A state-
15 ment of the costs of coverage to be charged, in-
16 cluding an itemization of amounts for adminis-
17 tration, reserves, and other expenses associated
18 with the operation of the plan.

19 “(E) OTHER INFORMATION.—Any other
20 information as may be determined by the appli-
21 cable authority, by regulation through nego-
22 tiated rulemaking, as necessary to carry out the
23 purposes of this part.

24 “(c) FILING NOTICE OF CERTIFICATION WITH
25 STATES.—A certification granted under this part to an

1 association health plan shall not be effective unless written
2 notice of such certification is filed with the applicable
3 State authority of each State in which at least 25 percent
4 of the participants and beneficiaries under the plan are
5 located. For purposes of this subsection, an individual
6 shall be considered to be located in the State in which a
7 known address of such individual is located or in which
8 such individual is employed.

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

20 “(e) REPORTING REQUIREMENTS FOR CERTAIN AS-
21 SOCIATION HEALTH PLANS.—An association health plan
22 certified under this part which provides benefit options in
23 addition to health insurance coverage for such plan year
24 shall meet the requirements of section 103 by filing an
25 annual report under such section which shall include infor-

1 mation described in subsection (b)(6) with respect to the
2 plan year and, notwithstanding section 104(a)(1)(A), shall
3 be filed with the applicable authority not later than 90
4 days after the close of the plan year (or on such later date
5 as may be prescribed by the applicable authority). The ap-
6 plicable authority may require by regulation through nego-
7 tiated rulemaking such interim reports as it considers ap-
8 propriate.

9 “(f) ENGAGEMENT OF QUALIFIED ACTUARY.—The
10 board of trustees of each association health plan which
11 provides benefits options in addition to health insurance
12 coverage and which is applying for certification under this
13 part or is certified under this part shall engage, on behalf
14 of all participants and beneficiaries, a qualified actuary
15 who shall be responsible for the preparation of the mate-
16 rials comprising information necessary to be submitted by
17 a qualified actuary under this part. The qualified actuary
18 shall utilize such assumptions and techniques as are nec-
19 essary to enable such actuary to form an opinion as to
20 whether the contents of the matters reported under this
21 part—

22 “(1) are in the aggregate reasonably related to
23 the experience of the plan and to reasonable expecta-
24 tions; and

1 “(2) represent such actuary’s best estimate of
2 anticipated experience under the plan.

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

5 **“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TER-**
6 **MINATION.**

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

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

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

20 “(3) submits such plan in writing to the appli-
21 cable authority.

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

1 **“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMI-**
2 **NATION.**

3 “(a) ACTIONS TO AVOID DEPLETION OF RE-
4 SERVES.—An association health plan which is certified
5 under this part and which provides benefits other than
6 health insurance coverage shall continue to meet the re-
7 quirements of section 806, irrespective of whether such
8 certification continues in effect. The board of trustees of
9 such plan shall determine quarterly whether the require-
10 ments of section 806 are met. In any case in which the
11 board determines that there is reason to believe that there
12 is or will be a failure to meet such requirements, or the
13 applicable authority makes such a determination and so
14 notifies the board, the board shall immediately notify the
15 qualified actuary engaged by the plan, and such actuary
16 shall, not later than the end of the next following month,
17 make such recommendations to the board for corrective
18 action as the actuary determines necessary to ensure com-
19 pliance with section 806. Not later than 30 days after re-
20 ceiving from the actuary recommendations for corrective
21 actions, the board shall notify the applicable authority (in
22 such form and manner as the applicable authority may
23 prescribe by regulation through negotiated rulemaking) of
24 such recommendations of the actuary for corrective action,
25 together with a description of the actions (if any) that the
26 board has taken or plans to take in response to such rec-

1 ommendations. The board shall thereafter report to the
2 applicable authority, in such form and frequency as the
3 applicable authority may specify to the board, regarding
4 corrective action taken by the board until the requirements
5 of section 806 are met.

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

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

16 “(2) the applicable authority determines that
17 there is a reasonable expectation that the plan will
18 continue to fail to meet the requirements of section
19 806,

20 the board of trustees of the plan shall, at the direction
21 of the applicable authority, terminate the plan and, in the
22 course of the termination, take such actions as the appli-
23 cable authority may require, including satisfying any
24 claims referred to in section 806(a)(2)(B)(iii) and recov-
25 ering for the plan any liability under subsection

1 (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure
2 that the affairs of the plan will be, to the maximum extent
3 possible, wound up in a manner which will result in timely
4 provision of all benefits for which the plan is obligated.

5 **“SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOL-**
6 **VENT ASSOCIATION HEALTH PLANS PRO-**
7 **VIDING HEALTH BENEFITS IN ADDITION TO**
8 **HEALTH INSURANCE COVERAGE.**

9 “(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR
10 INSOLVENT PLANS.—Whenever the Secretary determines
11 that an association health plan which is or has been cer-
12 tified under this part and which is described in section
13 806(a)(2) will be unable to provide benefits when due or
14 is otherwise in a financially hazardous condition, as shall
15 be defined by the Secretary by regulation through nego-
16 tiated rulemaking, the Secretary shall, upon notice to the
17 plan, apply to the appropriate United States district court
18 for appointment of the Secretary as trustee to administer
19 the plan for the duration of the insolvency. The plan may
20 appear as a party and other interested persons may inter-
21 vene in the proceedings at the discretion of the court. The
22 court shall appoint such Secretary trustee if the court de-
23 termines that the trusteeship is necessary to protect the
24 interests of the participants and beneficiaries or providers
25 of medical care or to avoid any unreasonable deterioration

1 of the financial condition of the plan. The trusteeship of
2 such Secretary shall continue until the conditions de-
3 scribed in the first sentence of this subsection are rem-
4 edied or the plan is terminated.

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

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

11 “(2) to require the transfer of all (or any part)
12 of the assets and records of the plan to the Sec-
13 retary as trustee;

14 “(3) to invest any assets of the plan which the
15 Secretary holds in accordance with the provisions of
16 the plan, regulations prescribed by the Secretary
17 through negotiated rulemaking, and applicable provi-
18 sions of law;

19 “(4) to require the sponsor, the plan adminis-
20 trator, any participating employer, and any employee
21 organization representing plan participants to fur-
22 nish any information with respect to the plan which
23 the Secretary as trustee may reasonably need in
24 order to administer the plan;

1 “(5) to collect for the plan any amounts due the
2 plan and to recover reasonable expenses of the trust-
3 eeship;

4 “(6) to commence, prosecute, or defend on be-
5 half of the plan any suit or proceeding involving the
6 plan;

7 “(7) to issue, publish, or file such notices, state-
8 ments, and reports as may be required by the Sec-
9 retary by regulation through negotiated rulemaking
10 or required by any order of the court;

11 “(8) to terminate the plan (or provide for its
12 termination accordance with section 809(b)) and liq-
13 uidate the plan assets, to restore the plan to the re-
14 sponsibility of the sponsor, or to continue the trust-
15 eeship;

16 “(9) to provide for the enrollment of plan par-
17 ticipants and beneficiaries under appropriate cov-
18 erage options; and

19 “(10) to do such other acts as may be nec-
20 essary to comply with this title or any order of the
21 court and to protect the interests of plan partici-
22 pants and beneficiaries and providers of medical
23 care.

1 “(c) NOTICE OF APPOINTMENT.—As soon as prac-
2 ticable after the Secretary’s appointment as trustee, the
3 Secretary shall give notice of such appointment to—

4 “(1) the sponsor and plan administrator;

5 “(2) each participant;

6 “(3) each participating employer; and

7 “(4) if applicable, each employee organization
8 which, for purposes of collective bargaining, rep-
9 resents plan participants.

10 “(d) ADDITIONAL DUTIES.—Except to the extent in-
11 consistent with the provisions of this title, or as may be
12 otherwise ordered by the court, the Secretary, upon ap-
13 pointment as trustee under this section, shall be subject
14 to the same duties as those of a trustee under section 704
15 of title 11, United States Code, and shall have the duties
16 of a fiduciary for purposes of this title.

17 “(e) OTHER PROCEEDINGS.—An application by the
18 Secretary under this subsection may be filed notwith-
19 standing the pendency in the same or any other court of
20 any bankruptcy, mortgage foreclosure, or equity receiver-
21 ship proceeding, or any proceeding to reorganize, conserve,
22 or liquidate such plan or its property, or any proceeding
23 to enforce a lien against property of the plan.

24 “(f) JURISDICTION OF COURT.—

1 “(1) IN GENERAL.—Upon the filing of an appli-
2 cation for the appointment as trustee or the issuance
3 of a decree under this section, the court to which the
4 application is made shall have exclusive jurisdiction
5 of the plan involved and its property wherever lo-
6 cated with the powers, to the extent consistent with
7 the purposes of this section, of a court of the United
8 States having jurisdiction over cases under chapter
9 11 of title 11, United States Code. Pending an adju-
10 dication under this section such court shall stay, and
11 upon appointment by it of the Secretary as trustee,
12 such court shall continue the stay of, any pending
13 mortgage foreclosure, equity receivership, or other
14 proceeding to reorganize, conserve, or liquidate the
15 plan, the sponsor, or property of such plan or spon-
16 sor, and any other suit against any receiver, conser-
17 vator, or trustee of the plan, the sponsor, or prop-
18 erty of the plan or sponsor. Pending such adjudica-
19 tion and upon the appointment by it of the Sec-
20 retary as trustee, the court may stay any proceeding
21 to enforce a lien against property of the plan or the
22 sponsor or any other suit against the plan or the
23 sponsor.

24 “(2) VENUE.—An action under this section
25 may be brought in the judicial district where the

1 sponsor or the plan administrator resides or does
2 business or where any asset of the plan is situated.
3 A district court in which such action is brought may
4 issue process with respect to such action in any
5 other judicial district.

6 “(g) PERSONNEL.—In accordance with regulations
7 which shall be prescribed by the Secretary through nego-
8 tiated rulemaking, the Secretary shall appoint, retain, and
9 compensate accountants, actuaries, and other professional
10 service personnel as may be necessary in connection with
11 the Secretary’s service as trustee under this section.

12 **“SEC. 811. STATE ASSESSMENT AUTHORITY.**

13 “(a) IN GENERAL.—Notwithstanding section 514, a
14 State may impose by law a contribution tax on an associa-
15 tion health plan described in section 806(a)(2), if the plan
16 commenced operations in such State after the date of the
17 enactment of the Small Business Access and Choice for
18 Entrepreneurs Act of 1999.

19 “(b) CONTRIBUTION TAX.—For purposes of this sec-
20 tion, the term ‘contribution tax’ imposed by a State on
21 an association health plan means any tax imposed by such
22 State if—

23 “(1) such tax is computed by applying a rate to
24 the amount of premiums or contributions, with re-
25 spect to individuals covered under the plan who are

1 residents of such State, which are received by the
2 plan from participating employers located in such
3 State or from such individuals;

4 “(2) the rate of such tax does not exceed the
5 rate of any tax imposed by such State on premiums
6 or contributions received by insurers or health main-
7 tenance organizations for health insurance coverage
8 offered in such State in connection with a group
9 health plan;

10 “(3) such tax is otherwise nondiscriminatory;
11 and

12 “(4) the amount of any such tax assessed on
13 the plan is reduced by the amount of any tax or as-
14 sessment otherwise imposed by the State on pre-
15 miums, contributions, or both received by insurers or
16 health maintenance organizations for health insur-
17 ance coverage, aggregate excess/stop loss insurance
18 (as defined in section 806(g)(1)), specific excess/
19 stop loss insurance (as defined in section 806(g)(2)),
20 other insurance related to the provision of medical
21 care under the plan, or any combination thereof pro-
22 vided by such insurers or health maintenance organi-
23 zations in such State in connection with such plan.

24 **“SEC. 812. DEFINITIONS AND RULES OF CONSTRUCTION.**

25 “(a) DEFINITIONS.—For purposes of this part—

1 “(1) GROUP HEALTH PLAN.—The term ‘group
2 health plan’ has the meaning provided in section
3 733(a)(1) (after applying subsection (b) of this sec-
4 tion).

5 “(2) MEDICAL CARE.—The term ‘medical care’
6 has the meaning provided in section 733(a)(2).

7 “(3) HEALTH INSURANCE COVERAGE.—The
8 term ‘health insurance coverage’ has the meaning
9 provided in section 733(b)(1).

10 “(4) HEALTH INSURANCE ISSUER.—The term
11 ‘health insurance issuer’ has the meaning provided
12 in section 733(b)(2).

13 “(5) APPLICABLE AUTHORITY.—

14 “(A) IN GENERAL.—Except as provided in
15 subparagraph (B), the term ‘applicable author-
16 ity’ means, in connection with an association
17 health plan—

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

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

24 “(B) EXCEPTIONS.—

1 “(i) JOINT AUTHORITIES.—Where
 2 such term appears in section 808(3), sec-
 3 tion 807(e) (in the first instance), section
 4 809(a) (in the second instance), section
 5 809(a) (in the fourth instance), and sec-
 6 tion 809(b)(1), such term means, in con-
 7 nection with an association health plan, the
 8 Secretary and the State referred to in sub-
 9 paragraph (A)(i) (if any) in connection
 10 with such plan.

11 “(ii) REGULATORY AUTHORITIES.—
 12 Where such term appears in section 802(a)
 13 (in the first instance), section 802(d), sec-
 14 tion 802(e), section 803(d), section
 15 805(a)(5), section 806(a)(2), section
 16 806(b), section 806(c), section 806(d),
 17 paragraphs (1)(A) and (2)(A) of section
 18 806(g), section 806(h), section 806(i), sec-
 19 tion 806(j), section 807(a) (in the second
 20 instance), section 807(b), section 807(d),
 21 section 807(e) (in the second instance),
 22 section 808 (in the matter after paragraph
 23 (3)), and section 809(a) (in the third in-
 24 stance), such term means, in connection

1 with an association health plan, the Sec-
2 retary.

3 “(6) HEALTH STATUS-RELATED FACTOR.—The
4 term ‘health status-related factor’ has the meaning
5 provided in section 733(d)(2).

6 “(7) INDIVIDUAL MARKET.—

7 “(A) IN GENERAL.—The term ‘individual
8 market’ means the market for health insurance
9 coverage offered to individuals other than in
10 connection with a group health plan.

11 “(B) TREATMENT OF VERY SMALL
12 GROUPS.—

13 “(i) IN GENERAL.—Subject to clause
14 (ii), such term includes coverage offered in
15 connection with a group health plan that
16 has fewer than 2 participants as current
17 employees or participants described in sec-
18 tion 732(d)(3) on the first day of the plan
19 year.

20 “(ii) STATE EXCEPTION.—Clause (i)
21 shall not apply in the case of health insur-
22 ance coverage offered in a State if such
23 State regulates the coverage described in
24 such clause in the same manner and to the
25 same extent as coverage in the small group

1 market (as defined in section 2791(e)(5) of
2 the Public Health Service Act) is regulated
3 by such State.

4 “(8) PARTICIPATING EMPLOYER.—The term
5 ‘participating employer’ means, in connection with
6 an association health plan, any employer, if any indi-
7 vidual who is an employee of such employer, a part-
8 ner in such employer, or a self-employed individual
9 who is such employer (or any dependent, as defined
10 under the terms of the plan, of such individual) is
11 or was covered under such plan in connection with
12 the status of such individual as such an employee,
13 partner, or self-employed individual in relation to the
14 plan.

15 “(9) APPLICABLE STATE AUTHORITY.—The
16 term ‘applicable State authority’ means, with respect
17 to a health insurance issuer in a State, the State in-
18 surance commissioner or official or officials des-
19 ignated by the State to enforce the requirements of
20 title XXVII of the Public Health Service Act for the
21 State involved with respect to such issuer.

22 “(10) QUALIFIED ACTUARY.—The term ‘quali-
23 fied actuary’ means an individual who is a member
24 of the American Academy of Actuaries or meets
25 such reasonable standards and qualifications as the

1 Secretary may provide by regulation through nego-
2 tiated rulemaking.

3 “(11) ~~AFFILIATED MEMBER~~~~±±~~.—The term ‘af-
4 ~~filiated member’ means, in connection with a~~
5 ~~sponsor—~~

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

9 “(B) in the case of a sponsor with mem-
10 bers which consist of associations, a person who
11 is a member of any such association and elects
12 an affiliated status with the sponsor, or

13 “(C) in the case of an association health
14 plan in existence on the date of the enactment
15 of the Small Business Access and Choice for
16 Entrepreneurs Act of 1999, a person eligible to
17 be a member of the sponsor or one of its mem-
18 ber associations.

19 “(12) ~~LARGE EMPLOYER~~.—The term ‘large em-
20 ployer’ means, in connection with a group health
21 plan with respect to a plan year, an employer who
22 employed an average of at least 51 employees on
23 business days during the preceding calendar year
24 and who employs at least 2 employees on the first
25 day of the plan year.

1 “(13) SMALL EMPLOYER.—The term ‘small em-
2 ployer’ means, in connection with a group health
3 plan with respect to a plan year, an employer who
4 is not a large employer.

5 “(b) RULES OF CONSTRUCTION.—

6 “(1) EMPLOYERS AND EMPLOYEES.—For pur-
7 poses of determining whether a plan, fund, or pro-
8 gram is an employee welfare benefit plan which is an
9 association health plan, and for purposes of applying
10 this title in connection with such plan, fund, or pro-
11 gram so determined to be such an employee welfare
12 benefit plan—

13 “(A) in the case of a partnership, the term
14 ‘employer’ (as defined in section (3)(5)) in-
15 cludes the partnership in relation to the part-
16 ners, and the term ‘employee’ (as defined in
17 section (3)(6)) includes any partner in relation
18 to the partnership; and

19 “(B) in the case of a self-employed indi-
20 vidual, the term ‘employer’ (as defined in sec-
21 tion 3(5)) and the term ‘employee’ (as defined
22 in section 3(6)) shall include such individual.

23 “(2) PLANS, FUNDS, AND PROGRAMS TREATED
24 AS EMPLOYEE WELFARE BENEFIT PLANS.—In the
25 case of any plan, fund, or program which was estab-

1 lished or is maintained for the purpose of providing
2 medical care (through the purchase of insurance or
3 otherwise) for employees (or their dependents) cov-
4 ered thereunder and which demonstrates to the Sec-
5 retary that all requirements for certification under
6 this part would be met with respect to such plan,
7 fund, or program if such plan, fund, or program
8 were a group health plan, such plan, fund, or pro-
9 gram shall be treated for purposes of this title as an
10 employee welfare benefit plan on and after the date
11 of such demonstration.”.

12 (b) CONFORMING AMENDMENTS TO PREEMPTION
13 RULES.—

14 (1) Section 514(b)(6) of such Act (29 U.S.C.
15 1144(b)(6)) is amended by adding at the end the
16 following new subparagraph:

17 “(E) The preceding subparagraphs of this paragraph
18 do not apply with respect to any State law in the case
19 of an association health plan which is certified under part
20 8.”.

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

23 (A) in subsection (b)(4), by striking “Sub-
24 section (a)” and inserting “Subsections (a) and
25 (d)”;

1 (B) in subsection (b)(5), by striking “sub-
2 section (a)” in subparagraph (A) and inserting
3 “subsection (a) of this section and subsections
4 (a)(2)(B) and (b) of section 805”, and by strik-
5 ing “subsection (a)” in subparagraph (B) and
6 inserting “subsection (a) of this section or sub-
7 section (a)(2)(B) or (b) of section 805”;

8 (C) by redesignating subsection (d) as sub-
9 section (e); and

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

12 “(d)(1) Except as provided in subsection (b)(4), the
13 provisions of this title shall supersede any and all State
14 laws insofar as they may now or hereafter preclude, or
15 have the effect of precluding, a health insurance issuer
16 from offering health insurance coverage in connection with
17 an association health plan which is certified under part
18 8.

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

21 “(A) In any case in which health insurance cov-
22 erage of any policy type is offered under an associa-
23 tion health plan certified under part 8 to a partici-
24 pating employer operating in such State, the provi-
25 sions of this title shall supersede any and all laws

1 of such State insofar as they may preclude a health
2 insurance issuer from offering health insurance cov-
3 erage of the same policy type to other employers op-
4 erating in the State which are eligible for coverage
5 under such association health plan, whether or not
6 such other employers are participating employers in
7 such plan.

8 “(B) In any case in which health insurance cov-
9 erage of any policy type is offered under an associa-
10 tion health plan in a State and the filing, with the
11 applicable State authority, of the policy form in con-
12 nection with such policy type is approved by such
13 State authority, the provisions of this title shall su-
14 persede any and all laws of any other State in which
15 health insurance coverage of such type is offered, in-
16 sofar as they may preclude, upon the filing in the
17 same form and manner of such policy form with the
18 applicable State authority in such other State, the
19 approval of the filing in such other State.

20 “(3) For additional provisions relating to association
21 health plans, see subsections (a)(2)(B) and (b) of section
22 805.

23 “(4) For purposes of this subsection, the term ‘asso-
24 ciation health plan’ has the meaning provided in section
25 801(a), and the terms ‘health insurance coverage’, ‘par-

1 participating employer’, and ‘health insurance issuer’ have
 2 the meanings provided such terms in section 811, respec-
 3 tively.”.

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

6 (A) in clause (i)(II), by striking “and” at
 7 the end;

8 (B) in clause (ii), by inserting “and which
 9 does not provide medical care (within the mean-
 10 ing of section 733(a)(2)),” after “arrange-
 11 ment,” and by striking “title.” and inserting
 12 “title, and”; and

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

15 “(iii) subject to subparagraph (E), in the case
 16 of any other employee welfare benefit plan which is
 17 a multiple employer welfare arrangement and which
 18 provides medical care (within the meaning of section
 19 733(a)(2)), any law of any State which regulates in-
 20 surance may apply.”.

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

23 (A) by striking “Nothing” and inserting
 24 “(1) Except as provided in paragraph (2), noth-
 25 ing”; and

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

3 “(2) Nothing in any other provision of law enacted
4 on or after the date of the enactment of the Small Busi-
5 ness Access and Choice for Entrepreneurs Act of 1999
6 shall be construed to alter, amend, modify, invalidate, im-
7 pair, or supersede any provision of this title, except by
8 specific cross-reference to the affected section.”.

9 (c) PLAN SPONSOR.—Section 3(16)(B) of such Act
10 (29 U.S.C. 102(16)(B)) is amended by adding at the end
11 the following new sentence: “Such term also includes a
12 person serving as the sponsor of an association health plan
13 under part 8.”.

14 (d) DISCLOSURE OF SOLVENCY PROTECTIONS RE-
15 LATED TO SELF-INSURED AND FULLY INSURED OPTIONS
16 UNDER ASSOCIATION HEALTH PLANS.—Section 102(b)
17 of such Act (29 U.S.C. 102(b)) is amended by adding at
18 the end the following: “An association health plan shall
19 include in its summary plan description, in connection
20 with each benefit option, a description of the form of sol-
21 vency or guarantee fund protection secured pursuant to
22 this Act or applicable State law, if any.”.

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

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

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

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

“Sec. 801. Association health plans.

“Sec. 802. Certification of association health plans.

“Sec. 803. Requirements relating to sponsors and boards of trustees.

“Sec. 804. Participation and coverage requirements.

“Sec. 805. Other requirements relating to plan documents, contribution rates,
and benefit options.

“Sec. 806. Maintenance of reserves and provisions for solvency for plans pro-
viding health benefits in addition to health insurance coverage.

“Sec. 807. Requirements for application and related requirements.

“Sec. 808. Notice requirements for voluntary termination.

“Sec. 809. Corrective actions and mandatory termination.

“Sec. 810. Trusteeship by the Secretary of insolvent association health plans
providing health benefits in addition to health insurance cov-
erage.

“Sec. 811. State assessment authority.

“Sec. 812. Definitions and rules of construction.”.

13 **SEC. 702. CLARIFICATION OF TREATMENT OF SINGLE EM-**
 14 **PLOYER ARRANGEMENTS.**

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

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

6 (2) in clause (iii)—

7 (A) by striking “common control shall not
8 be based on an interest of less than 25 percent”
9 and inserting “an interest of greater than 25
10 percent may not be required as the minimum
11 interest necessary for common control”; and

12 (B) by striking “similar to” and inserting
13 “consistent and coextensive with”;

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

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

18 “(iv) in determining, after the application of
19 clause (i), whether benefits are provided to employ-
20 ees of two or more employers, the arrangement shall
21 be treated as having only one participating employer
22 if, after the application of clause (i), the number of
23 individuals who are employees and former employees
24 of any one participating employer and who are cov-
25 ered under the arrangement is greater than 75 per-

1 cent of the aggregate number of all individuals who
 2 are employees or former employees of participating
 3 employers and who are covered under the arrange-
 4 ment;”.

5 **SEC. 703. CLARIFICATION OF TREATMENT OF CERTAIN**
 6 **COLLECTIVELY BARGAINED ARRANGE-**
 7 **MENTS.**

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

11 “(i)(I) under or pursuant to one or more collec-
 12 tive bargaining agreements which are reached pursu-
 13 ant to collective bargaining described in section 8(d)
 14 of the National Labor Relations Act (29 U.S.C.
 15 158(d)) or paragraph Fourth of section 2 of the
 16 Railway Labor Act (45 U.S.C. 152, paragraph
 17 Fourth) or which are reached pursuant to labor-
 18 management negotiations under similar provisions of
 19 State public employee relations laws, and (II) in ac-
 20 cordance with subparagraphs (C), (D), and (E);”.

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

24 “(C) For purposes of subparagraph (A)(i)(II), a plan
 25 or other arrangement shall be treated as established or

1 maintained in accordance with this subparagraph only if
2 the following requirements are met:

3 “(i) The plan or other arrangement, and the
4 employee organization or any other entity sponsoring
5 the plan or other arrangement, do not—

6 “(I) utilize the services of any licensed in-
7 surance agent or broker for soliciting or enroll-
8 ing employers or individuals as participating
9 employers or covered individuals under the plan
10 or other arrangement; or

11 “(II) pay any type of compensation to a
12 person, other than a full time employee of the
13 employee organization (or a member of the or-
14 ganization to the extent provided in regulations
15 prescribed by the Secretary through negotiated
16 rulemaking), that is related either to the volume
17 or number of employers or individuals solicited
18 or enrolled as participating employers or cov-
19 ered individuals under the plan or other ar-
20 rangement, or to the dollar amount or size of
21 the contributions made by participating employ-
22 ers or covered individuals to the plan or other
23 arrangement;

24 except to the extent that the services used by the
25 plan, arrangement, organization, or other entity con-

1 sist solely of preparation of documents necessary for
2 compliance with the reporting and disclosure re-
3 quirements of part 1 or administrative, investment,
4 or consulting services unrelated to solicitation or en-
5 rollment of covered individuals.

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

9 “(I) employed within a bargaining unit
10 covered by any of the collective bargaining
11 agreements with a participating employer (nor
12 covered on the basis of an individual’s employ-
13 ment in such a bargaining unit); nor

14 “(II) present employees (or former employ-
15 ees who were covered while employed) of the
16 sponsoring employee organization, of an em-
17 ployer who is or was a party to any of the col-
18 lective bargaining agreements, or of the plan or
19 other arrangement or a related plan or arrange-
20 ment (nor covered on the basis of such present
21 or former employment);

22 does not exceed 15 percent of the total number of
23 individuals who are covered under the plan or ar-
24 rangement and who are present or former employees
25 who are or were covered under the plan or arrange-

1 ment pursuant to a collective bargaining agreement
2 with a participating employer. The requirements of
3 the preceding provisions of this clause shall be treat-
4 ed as satisfied if, as of the end of the preceding plan
5 year, such covered individuals are comprised solely
6 of individuals who were covered individuals under
7 the plan or other arrangement as of the date of the
8 enactment of the Small Business Access and Choice
9 for Entrepreneurs Act of 1999 and, as of the end of
10 the preceding plan year, the number of such covered
11 individuals does not exceed 25 percent of the total
12 number of present and former employees enrolled
13 under the plan or other arrangement.

14 “(iii) The employee organization or other entity
15 sponsoring the plan or other arrangement certifies
16 to the Secretary each year, in a form and manner
17 which shall be prescribed by the Secretary through
18 negotiated rulemaking that the plan or other ar-
19 rangement meets the requirements of clauses (i) and
20 (ii).

21 “(D) For purposes of subparagraph (A)(i)(II), a plan
22 or arrangement shall be treated as established or main-
23 tained in accordance with this subparagraph only if—

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

4 “(ii)(I) the plan or arrangement is a multiem-
5 ployer plan; and

6 “(II) the requirements of clause (B) of the pro-
7 viso to clause (5) of section 302(c) of the Labor
8 Management Relations Act, 1947 (29 U.S.C.
9 186(c)) are met with respect to such plan or other
10 arrangement.

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

14 “(i) the plan or arrangement is in effect as of
15 the date of the enactment of the Small Business Ac-
16 cess and Choice for Entrepreneurs Act of 1999; or

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

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

21 “(II) demonstrates to the satisfaction of
22 the Secretary that the requirements of subpara-
23 graphs (C) and (D) are met with respect to the
24 plan or other arrangement.”.

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

7 **SEC. 704. ENFORCEMENT PROVISIONS RELATING TO ASSO-**
 8 **CIATION HEALTH PLANS.**

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

13 (1) by inserting “(a)” after “SEC. 501.”; and

14 (2) by adding at the end the following new sub-
 15 section:

16 “(b) Any person who willfully falsely represents, to
 17 any employee, any employee’s beneficiary, any employer,
 18 the Secretary, or any State, a plan or other arrangement
 19 established or maintained for the purpose of offering or
 20 providing any benefit described in section 3(1) to employ-
 21 ees or their beneficiaries as—

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

24 “(2) having been established or maintained
 25 under or pursuant to one or more collective bar-

1 gaining agreements which are reached pursuant to
2 collective bargaining described in section 8(d) of the
3 National Labor Relations Act (29 U.S.C. 158(d)) or
4 paragraph Fourth of section 2 of the Railway Labor
5 Act (45 U.S.C. 152, paragraph Fourth) or which are
6 reached pursuant to labor-management negotiations
7 under similar provisions of State public employee re-
8 lations laws; or

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

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

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

18 “(n)(1) Subject to paragraph (2), upon application
19 by the Secretary showing the operation, promotion, or
20 marketing of an association health plan (or similar ar-
21 rangement providing benefits consisting of medical care
22 (as defined in section 733(a)(2))) that—

23 “(A) is not certified under part 8, is subject
24 under section 514(b)(6) to the insurance laws of any
25 State in which the plan or arrangement offers or

1 provides benefits, and is not licensed, registered, or
2 otherwise approved under the insurance laws of such
3 State; or

4 “(B) is an association health plan certified
5 under part 8 and is not operating in accordance with
6 the requirements under part 8 for such certification,
7 a district court of the United States shall enter an order
8 requiring that the plan or arrangement cease activities.

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

12 “(A) all benefits under it referred to in para-
13 graph (1) consist of health insurance coverage; and

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

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

23 (c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—
24 Section 503 of such Act (29 U.S.C. 1133) (as amended

1 by title I) is amended by adding at the end the following
 2 new subsection:

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

9 **SEC. 705. COOPERATION BETWEEN FEDERAL AND STATE**
 10 **AUTHORITIES.**

11 Section 506 of the Employee Retirement Income Se-
 12 curity Act of 1974 (29 U.S.C. 1136) is amended by adding
 13 at the end the following new subsection:

14 “(c) RESPONSIBILITY OF STATES WITH RESPECT TO
 15 ASSOCIATION HEALTH PLANS.—

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

19 “(A) the Secretary’s authority under sec-
 20 tions 502 and 504 to enforce the requirements
 21 for certification under part 8;

22 “(B) the Secretary’s authority to certify
 23 association health plans under part 8 in accord-
 24 ance with regulations of the Secretary applica-
 25 ble to certification under part 8; or

1 “(C) any combination of the Secretary’s
2 authority authorized to be delegated under sub-
3 paragraphs (A) and (B).

4 “(2) DELEGATIONS.—Any department, agency,
5 or instrumentality of a State to which authority is
6 delegated pursuant to an agreement entered into
7 under this paragraph may, if authorized under State
8 law and to the extent consistent with such agree-
9 ment, exercise the powers of the Secretary under
10 this title which relate to such authority.

11 “(3) RECOGNITION OF PRIMARY DOMICILE
12 STATE.—In entering into any agreement with a
13 State under subparagraph (A), the Secretary shall
14 ensure that, as a result of such agreement and all
15 other agreements entered into under subparagraph
16 (A), only one State will be recognized, with respect
17 to any particular association health plan, as the
18 State to which all authority has been delegated pur-
19 suant to such agreements in connection with such
20 plan. In carrying out this paragraph, the Secretary
21 shall take into account the places of residence of the
22 participants and beneficiaries under the plan and the
23 State in which the trust is maintained.”.

1 **SEC. 706. EFFECTIVE DATE AND TRANSITIONAL AND**
2 **OTHER RULES.**

3 (a) **EFFECTIVE DATE.**—The amendments made by
4 sections 701, 704, and 705 shall take effect on January
5 1, 2001. The amendments made by sections 702 and 703
6 shall take effect on the date of the enactment of this Act.
7 The Secretary of Labor shall first issue all regulations
8 necessary to carry out the amendments made by this title
9 before January 1, 2001. Such regulations shall be issued
10 through negotiated rulemaking.

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

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

21 (1) **IN GENERAL.**—In any case in which, as of
22 the date of the enactment of this Act, an arrange-
23 ment is maintained in a State for the purpose of
24 providing benefits consisting of medical care for the
25 employees and beneficiaries of its participating em-
26 ployers, at least 200 participating employers make

1 contributions to such arrangement, such arrange-
2 ment has been in existence for at least 10 years, and
3 such arrangement is licensed under the laws of one
4 or more States to provide such benefits to its par-
5 ticipating employers, upon the filing with the appli-
6 cable authority (as defined in section 812(a)(5) of
7 the Employee Retirement Income Security Act of
8 1974 (as amended by this Act)) by the arrangement
9 of an application for certification of the arrangement
10 under part 8 of subtitle B of title I of such Act—

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

14 (B) the requirements of sections 801(a)(1)
15 and 803(a)(1) of the Employee Retirement In-
16 come Security Act of 1974 shall be deemed met
17 with respect to such arrangement;

18 (C) the requirements of section 803(b) of
19 such Act shall be deemed met, if the arrange-
20 ment is operated by a board of directors
21 which—

22 (i) is elected by the participating em-
23 ployers, with each employer having one
24 vote; and

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

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

7 (E) the arrangement may be certified by
8 any applicable authority with respect to its op-
9 erations in any State only if it operates in such
10 State on the date of certification.

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

16 (2) DEFINITIONS.—For purposes of this sub-
17 section, the terms “group health plan”, “medical
18 care”, and “participating employer” shall have the
19 meanings provided in section 812 of the Employee
20 Retirement Income Security Act of 1974, except
21 that the reference in paragraph (7) of such section
22 to an “association health plan” shall be deemed a
23 reference to an arrangement referred to in this sub-
24 section.

1 **TITLE VIII—HEALTH CARE AC-**
2 **CESS, AFFORDABILITY, AND**
3 **QUALITY COMMISSION**

4 **SEC. 801. ESTABLISHMENT OF COMMISSION.**

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

8 “SEC. 518. HEALTH CARE ACCESS, AFFORDABILITY AND
9 QUALITY COMMISSION.

10 “(a) ESTABLISHMENT.—There is hereby established
11 a commission to be known as the Health Care Access, Af-
12 fordability, and Quality Commission (hereinafter in this
13 Act referred to as the ‘Commission’).

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

16 “(1) ESTABLISHMENT OF MODEL GUIDE-
17 LINES.—Based on information gathered by appro-
18 priate Federal agencies, advisory groups, and other
19 appropriate sources for health care information,
20 studies, and data, the Commission shall establish
21 model guidelines in each of the following areas:

22 “(A) Independent expert external review
23 programs.

24 “(B) Consumer friendly information pro-
25 grams.

1 “(C) Systems for measuring patient satis-
2 faction and patient outcomes.

3 “(D) Systems to ensure the timely proc-
4 essing of claims.

5 “(2) EVALUATION OF HEALTH BENEFITS MAN-
6 DATES.—At the request of the chairmen or ranking
7 minority members of the appropriate committees of
8 Congress, the Commission shall evaluate, taking into
9 consideration the overall cost effect, availability of
10 treatment, and the effect on the health of the gen-
11 eral population, existing and proposed benefit re-
12 quirements for group health plans.

13 “(3) COMMENTS ON CERTAIN SECRETARIAL RE-
14 PORTS.—If the Secretary submits to Congress (or a
15 committee of Congress) a report that is required by
16 law and that relates to policies under this section,
17 the Secretary shall transmit a copy of the report to
18 the Commission. The Commission shall review the
19 report and, not later than 6 months after the date
20 of submittal of the Secretary’s report to Congress,
21 shall submit to the appropriate committees of Con-
22 gress written comments on such report. Such com-
23 ments may include such recommendations as the
24 Commission deems appropriate.

1 “(4) AGENDA AND ADDITIONAL REVIEW.—The
2 Commission shall consult periodically with the chair-
3 men and ranking minority members of the appro-
4 priate committees of Congress regarding the Com-
5 mission’s agenda and progress toward achieving the
6 agenda. The Commission may conduct additional re-
7 views, and submit additional reports to the appro-
8 priate committees of Congress, from time to time on
9 such topics as may be requested by such chairmen
10 and members and as the Commission deems appro-
11 priate.

12 “(5) AVAILABILITY OF REPORTS.—The Com-
13 mission shall transmit to the Secretary a copy of
14 each report submitted under this subsection and
15 shall make such reports available to the public.

16 “(c) MEMBERSHIP.—

17 “(1) NUMBER AND APPOINTMENT.—The Com-
18 mission shall be composed of 11 members appointed
19 by the Comptroller General.

20 “(2) QUALIFICATIONS.—

21 “(A) IN GENERAL.—The membership of
22 the Commission shall include—

23 “(i) physicians and other health pro-
24 fessionals;

1 “(ii) representatives of employers, in-
2 cluding multiemployer plans;

3 “(ii) representatives of insured em-
4 ployees;

5 “(iv) third-party payers; and

6 “(v) health services and health eco-
7 nomics researchers with expertise in out-
8 comes and effectiveness research and tech-
9 nology assessment.

10 “(B) ETHICAL DISCLOSURE.—The Comp-
11 troller General shall establish a system for pub-
12 lic disclosure by members of the Commission of
13 financial and other potential conflicts of interest
14 relating to such members.

15 “(3) TERMS.—

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

20 “(B) VACANCIES.—Any member appointed
21 to fill a vacancy occurring before the expiration
22 of the term for which the member’s predecessor
23 was appointed shall be appointed only for the
24 remainder of that term. A member may serve
25 after the expiration of that member’s term until

1 a successor has taken office. A vacancy in the
2 Commission shall be filled in the manner in
3 which the original appointment was made.

4 “(4) BASIC PAY.—

5 “(A) RATES OF PAY.—Except as provided
6 in subparagraph (B), members shall each be
7 paid at a rate equal to the rate of basic pay
8 payable for level IV of the Executive Schedule
9 for each day (including travel time) during
10 which they are engaged in the actual perform-
11 ance of duties vested in the Commission.

12 “(B) PROHIBITION OF COMPENSATION OF
13 FEDERAL EMPLOYEES.—Members of the Com-
14 mission who are full-time officers or employees
15 of the United States (or Members of Congress)
16 may not receive additional pay, allowances, or
17 benefits by reason of their service on the Com-
18 mission.

19 “(5) TRAVEL EXPENSES.—Each member shall
20 receive travel expenses, including per diem in lieu of
21 subsistence, in accordance with sections 5702 and
22 5703 of title 5, United States Code.

23 “(6) CHAIRPERSON.—The Chairperson of the
24 Commission shall be designated by the Comptroller

1 at the time of the appointment. The term of office
2 of the Chairperson shall be 3 years.

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

5 “(d) DIRECTOR AND STAFF OF COMMISSION.—

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

11 “(2) STAFF.—The Director may appoint 2 ad-
12 ditional staff members.

13 “(3) APPLICABILITY OF CERTAIN CIVIL SERV-
14 ICE LAWS.—The Director and staff of the Commis-
15 sion shall be appointed subject to the provisions of
16 title 5, United States Code, governing appointments
17 in the competitive service, and shall be paid in ac-
18 cordance with the provisions of chapter 51 and sub-
19 chapter III of chapter 53 of that title relating to
20 classification and General Schedule pay rates.

21 “(e) POWERS OF COMMISSION.—

22 “(1) HEARINGS AND SESSIONS.—The Commis-
23 sion may, for the purpose of carrying out this Act,
24 hold hearings, sit and act at times and places, take
25 testimony, and receive evidence as the Commission

1 considers appropriate. The Commission may admin-
2 ister oaths or affirmations to witnesses appearing
3 before it.

4 “(2) POWERS OF MEMBERS AND AGENTS.—Any
5 member or agent of the Commission may, if author-
6 ized by the Commission, take any action which the
7 Commission is authorized to take by this section.

8 “(3) OBTAINING OFFICIAL DATA.—The Com-
9 mission may secure directly from any department or
10 agency of the United States information necessary
11 to enable it to carry out this Act. Upon request of
12 the Chairperson of the Commission, the head of that
13 department or agency shall furnish that information
14 to the Commission.

15 “(4) MAILS.—The Commission may use the
16 United States mails in the same manner and under
17 the same conditions as other departments and agen-
18 cies of the United States.

19 “(5) ADMINISTRATIVE SUPPORT SERVICES.—
20 Upon the request of the Commission, the Adminis-
21 trator of General Services shall provide to the Com-
22 mission, on a reimbursable basis, the administrative
23 support services necessary for the Commission to
24 carry out its responsibilities under this Act.

1 “(6) CONTRACT AUTHORITY.—The Commission
2 may contract with and compensate government and
3 private agencies or persons for services, without re-
4 gard to section 3709 of the Revised Statutes (41
5 U.S.C. 5).

6 “(f) REPORTS.—Beginning December 31, 2000, and
7 each year thereafter, the Commission shall submit to the
8 Congress an annual report detailing the following informa-
9 tion:

10 “(1) Access to care, affordability to employers
11 and employees, and quality of care under employer-
12 sponsored health plans and recommendations for im-
13 proving such access, affordability, and quality.

14 “(2) Any issues the Commission deems appro-
15 priate or any issues (such as the appropriateness
16 and availability of particular medical treatment) that
17 the chairmen or ranking members of the appropriate
18 committees of Congress requested the Commission
19 to evaluate.

20 “(g) DEFINITION OF APPROPRIATE COMMITTEES OF
21 CONGRESS.—For purposes of this section the term ‘appro-
22 priate committees of Congress’ means any committee in
23 the Senate or House of Representatives having jurisdiction
24 over the Employee Retirement Income Security Act of
25 1974.

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

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

9 **SEC. 802. EFFECTIVE DATE.**

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

