

106TH CONGRESS
1ST SESSION

H. R. 216

To amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and preserve against preemption certain State causes of action.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 6, 1999

Mr. NORWOOD introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committee on Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and preserve against preemption certain State causes of action.

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; TABLE OF CONTENTS.**

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

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

Sec. 1. Short title; table of contents.

TITLE I—ACCESS TO QUALITY CARE

Subtitle A—Promoting Quality Care by Ensuring Access to Health Care Professionals

- Sec. 101. Consumer choice option.
- Sec. 102. Choice of health professionals and providers.
- Sec. 103. Access to care.
- Sec. 104. Exclusions.

Subtitle B—Promoting Quality Care by Ensuring Access to Health Care Services.

- Sec. 111. Access to specialists.
- Sec. 112. Continuity of care.
- Sec. 113. Access to emergency room care.
- Sec. 114. Patient access to obstetric and gynecological care.
- Sec. 115. Patient access to pediatric care.
- Sec. 116. Exclusions.

Subtitle C—Promoting Quality Care by Ensuring Fair Resolution of Grievances.

- Sec. 121. Utilization review standards.
- Sec. 122. Internal and external review procedures.

Subtitle D—Promoting Quality Care by Ensuring Fair Plan Administration.

- Sec. 131. Restrictions on incentive plans.
- Sec. 132. Development of issuer policies.
- Sec. 133. Patient access to information.
- Sec. 134. Protection of patient confidentiality.
- Sec. 135. Due process for health professionals and providers.
- Sec. 136. Prohibition of interference with certain medical communications.
- Sec. 137. Plan solvency.
- Sec. 138. Quality assessment program.

Subtitle E—Definitions

- Sec. 151. Definitions.
- Sec. 152. Preemption; State flexibility; construction.
- Sec. 153. Regulations.

TITLE II—APPLICATION OF QUALITY CARE STANDARDS TO GROUP HEALTH PLANS AND HEALTH INSURANCE COVERAGE UNDER PUBLIC HEALTH SERVICE ACT

- Sec. 201. Application to group health plans and group health insurance coverage.
- Sec. 202. Application to individual health insurance coverage.

TITLE III—AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

- Sec. 301. Application of patient protection standards to group health plans and group health insurance coverage under the Employee Retirement Income Security Act of 1974.

Sec. 401. Effective dates.

Sec. 402. Coordination in implementation.

6 SEC. 101. CONSUMER CHOICE OPTION.

(b) FAIR PREMIUMS.—The amount of any additional premium required for the additional cost of the option described in subsection (a) may not exceed an amount that

1 is fair and reasonable, as established by the applicable
2 State authority, in consultation with the National Associa-
3 tion of Insurance Commissioners, based on the nature of
4 the additional coverage provided.

5 (c) ADDITIONAL COSTS.—The amount of any addi-
6 tional premium charged by the health insurance issuer for
7 the additional cost of the creation and maintenance of the
8 option described in subsection (a) shall be borne by the
9 enrollee unless it is paid by the health plan sponsor
10 through agreement with the health insurance issuer.

11 (d) OPEN SEASON.—An enrollee may only change to
12 the offering provided under this section only during a time
13 period determined by the health insurance issuer. Such
14 time period shall occur at least annually.

15 (e) COST SHARING.—Under the option described in
16 subsection (a), the health insurance coverage shall provide
17 for reimbursement rates for covered services offered by
18 health professionals and providers who are not participat-
19 ing health professionals or providers that are not less than
20 the reimbursement rates for covered services offered by
21 participating health professionals and providers. Nothing
22 in this section shall be construed as protecting an enrollee
23 against balance billing by a health professional or provider
24 that is not a participating health professional or provider.

1 **SEC. 102. CHOICE OF HEALTH PROFESSIONALS AND PRO-**
2 **VIDERS.**

3 (a) CHOICE OF PERSONAL HEALTH PROFES-
4 SIONAL.—A group health plan, and a health insurance
5 issuer that offers health insurance coverage, shall permit
6 each participant, beneficiary, and enrollee to—

7 (1) select a personal health professional from
8 among the participating health professionals of the
9 issuer, and

10 (2) change such selection—

11 (A) in the event of a disciplinary complaint
12 against the provider; or

13 (B) at least once every 4 months.

14 **SEC. 103. ACCESS TO CARE.**

15 (a) IN GENERAL.—A group health plan, and a health
16 insurance issuer that offers health insurance coverage
17 shall establish and maintain adequate arrangements, as
18 defined by the applicable State authority, with a sufficient
19 number, mix, and distribution of health professionals and
20 providers to assure that covered items and services are
21 available and accessible to each participant, beneficiary,
22 and enrollee under health insurance coverage—

23 (1) in the service area of the issuer;

24 (2) in a variety of sites of service;

25 (3) with reasonable promptness (including rea-
26 sonable hours of operation and after hours services);

1 (4) with reasonable proximity to the residences
2 or workplaces of enrollees; and

3 (5) in a manner that—

4 (A) takes into account the diverse needs of
5 enrollees, and

6 (B) reasonably assures continuity of care.

7 A group health plan, and a health insurance issuer
8 that offers health insurance coverage that serves a
9 rural or medically underserved area shall be treated
10 as meeting the requirement of this subsection if the
11 plan or issuer has arrangements with a sufficient
12 number, mix, and distribution of health professionals
13 and providers having a history of serving such areas.
14 The use of telemedicine and other innovative means
15 to provide covered items and services by a group
16 health plan, and a health insurance issuer that of-
17 fers health insurance coverage that serves a rural or
18 medically under served area shall also be considered
19 in determining whether the requirement of this sub-
20 section is met.

21 (b) RULE OF CONSTRUCTION.—Nothing in this sub-
22 section shall be construed as requiring a group health
23 plan, and a health insurance issuer that offers health in-
24 surance coverage—

1 (1) to have arrangements that conflict with its
2 responsibilities to establish measures designed to
3 maintain quality and control costs; or

4 (2) to build or establish health care facilities to
5 meet the requirements of this sub section.

6 (c) DEFINITIONS.—For purposes of this section:

7 (1) MEDICALLY UNDERSERVED AREA.—The
8 term medically underserved area means an area that
9 is designated as a health professional shortage area
10 under section 332 of the Public Health Service Act
11 or as a medically underserved area for purposes of
12 section 330 or 1302(7) of such Act.

13 (2) RURAL AREA.—The term rural area means
14 an area that is not within a Standard Metropolitan
15 Statistical Area or a New England County Metro-
16 politan Area (as defined by the Office of Manage-
17 ment and Budget).

18 (d) IMPLEMENTATION.—The Secretary shall submit
19 to Congress not later than January 1, 2000, a report de-
20 tailing regulations and a plan for implementation of the
21 details of this section. Such regulations and plan for im-
22 plementation shall not proceed without the concurrence by
23 joint resolution or Act of the Congress.

24 **SEC. 104. EXCLUSIONS.**

25 Nothing in this subtitle shall be construed—

1 (1) to require a group health plan, and a health
 2 insurance issuer offering health insurance
 3 coverage—

4 (A) to provide particular benefits other
 5 than those provided under the terms of such
 6 coverage; or

7 (B) to comply with this subtitle with re-
 8 spect to abortion services or euthanasia serv-
 9 ices, even if the issuer covers such services;

10 (2) as forbidding a plan or issuer from offering
 11 (or requiring a plan or issuer to offer) abortion or
 12 euthanasia services; or

13 (3) as applying to a fee-for-service plan.

14 **Subtitle B—Promoting Quality**
 15 **Care by Ensuring Access to**
 16 **Health Care Services**

17 **SEC. 111. ACCESS TO SPECIALISTS.**

18 (a) IN GENERAL.—A group health plan, and a health
 19 insurance issuer that offers health insurance coverage that
 20 provides benefits, in whole or in part, through participat-
 21 ing health care providers shall demonstrate that partici-
 22 pants, beneficiaries, and enrollees have access to a special-
 23 ist when treatment by such specialist is medically or clini-
 24 cally indicated in the professional judgment of the treating

1 health professional, in consultation with the participant,
2 beneficiary, or enrollee.

3 (b) DEFINITION.—For purposes of subsection (a),
4 the term “specialist” means a health professional or pro-
5 vider (including a specialty institution) that, through
6 training or experience, has developed the expertise nec-
7 essary to treat individuals with special health care needs
8 or a chronic condition or disease.

9 **SEC. 112. CONTINUITY OF CARE.**

10 A group health plan, and a health insurance issuer
11 offer health insurance coverage that provides benefits, in
12 whole or in part, through participating health care profes-
13 sionals shall—

14 (1) ensure that any process established by the
15 issuer to coordinate care and control costs does not
16 create an undue burden, as defined by the applicable
17 State authority, for participants, beneficiaries, and
18 enrollees with special health care needs or chronic
19 conditions;

20 (2) ensure direct access to relevant specialists
21 for the continued care of participants, beneficiaries,
22 and enrollees when medically or clinically indicated
23 in the judgment of the treating health professional,
24 in consultation with the participant, beneficiary, or
25 enrollee;

1 (3) in the case of a participant, beneficiary, or
2 enrollee with special health care needs or a chronic
3 condition, determine whether, based on the judgment
4 of the treating health professional, in consultation
5 with the participant, beneficiary, or enrollee, it is
6 medically or clinically necessary to use a specialist or
7 a care coordinator from an interdisciplinary team to
8 ensure continuity of care; and

9 (4) in circumstances under which a change of
10 health professional or provider might disrupt the
11 continuity of care for a participant, beneficiary, or
12 enrollee, provide for continued coverage of items and
13 services furnished by the health professional or pro-
14 vider that was treating the participant, beneficiary,
15 or enrollee before such change for a reasonable pe-
16 riod of time.

17 A change of health professional or provider may be due
18 to changes in the membership of an issuer's health profes-
19 sional and provider network, changes in the health cov-
20 erage made available by an employer, or other similar cir-
21 cumstances.

22 **SEC. 113. ACCESS TO EMERGENCY ROOM CARE.**

23 (a) EMERGENCY CARE.—

24 (1) IN GENERAL.—If a group health plan, or a
25 health insurance issuer offering health insurance

1 coverage provides any benefits with respect to emer-
2 gency services (as defined in subsection (b)(2)), the
3 plan or issuer shall cover emergency services fur-
4 nished under the plan or coverage—

5 (A) without the need for any prior author-
6 ization determination;

7 (B) whether or not the health care profes-
8 sional or provider furnishing such services is a
9 participating professional or provider with re-
10 spect to such services;

11 (C) in a manner so that, if such services
12 are provided to a participant, beneficiary, or en-
13 rollee by a non-participating health care profes-
14 sional or provider, the participant, beneficiary,
15 or enrollee is not liable for an amount that ex-
16 ceeds the amount of financial liability that
17 would be incurred if the services were provided
18 by a participating health care professional or
19 provider; and

20 (D) without regard to any other term or
21 condition of such plan or coverage (other than
22 exclusion or coordination of benefits, or an af-
23 filiation or waiting period, permitted under sec-
24 tion 2701 of the Public Health Service Act, sec-
25 tion 701 of the Employee Retirement Income

1 Security Act of 1974, and other than applicable
2 through cost-sharing).

3 (b) DEFINITIONS.—For purposes of this section:

4 (1) EMERGENCY MEDICAL CONDITION.—The
5 term “emergency medical condition” means a medi-
6 cal condition (including emergency labor and deliv-
7 ery) manifesting itself by acute symptoms of suffi-
8 cient severity (including, but not limited to, severe
9 pain) such that a prudent layperson, who possesses
10 an average knowledge of health and medicine, could
11 reasonably expect the absence of immediate medical
12 attention to result in a condition described in clause
13 (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social
14 Security Act.

15 (2) EMERGENCY SERVICES.—The term “emer-
16 gency services” means—

17 (A) a medical screening examination (as
18 required under section 1867 of the Social Secu-
19 rity Act) that is within the capabilities of the
20 emergency department of a hospital, including
21 ancillary services routinely available to the
22 emergency department to evaluate an emer-
23 gency medical condition (as defined in para-
24 graph (1)), and

1 (B) within the capabilities of the staff and
2 facilities available at the hospital, such further
3 medical examination and treatment as required
4 under section 1867 of such Act to stabilize the
5 patient.

6 (3) STABILIZE.—The term “to stabilize”
7 means, with respect to an emergency medical condi-
8 tion, to provide such medical treatment of the condi-
9 tion as may be necessary to assure, within reason-
10 able medical probability, that no material deteriora-
11 tion of the condition is likely to result from or occur
12 during the transfer of the individual from a facility.

13 (c) REIMBURSEMENT FOR MAINTENANCE CARE AND
14 POST-STABILIZATION CARE.—In the case of services
15 (other than emergency services) for which benefits are
16 available under a group health plan or health insurance
17 issuer offering health insurance coverage, the plan or
18 issuer shall provide for reimbursement with respect to
19 such services provided to a participant, beneficiary, or en-
20 rollee other than through a participating health care pro-
21 fessional or provider in a manner consistent with sub-
22 section (a)(1)(C) if the services are maintenance care or
23 post-stabilization care covered under the guidelines estab-
24 lished under section 1852(d)(2) of the Social Security Act
25 (relating to promoting efficient and timely coordination of

1 appropriate maintenance and post-stabilization care of an
 2 enrollee after an enrollee has been determined to be sta-
 3 ble), in accordance with regulations established to carry
 4 out such section.

5 **SEC. 114. PATIENT ACCESS TO OBSTETRIC AND GYNECO-**
 6 **LOGICAL CARE.**

7 (a) IN GENERAL.—In any case in which a group
 8 health plan or a health insurance issuer in connection with
 9 the provision of health insurance coverage, requires or pro-
 10 vides for designation by a participant, beneficiary, or en-
 11 rollee of a participating primary care provider, and pro-
 12 vides benefits under the terms of the plan consisting of—

13 (1) routine gynecological care (such as preven-
 14 tive women’s health examinations), or

15 (2) routine obstetric care (such as routine preg-
 16 nancy-related services), provided by a participating
 17 professional who specializes in such care (or provides
 18 benefits consisting of payment for such care),

19 if the primary care provider designated by such a partici-
 20 pant, beneficiary, or enrollee is not such a professional,
 21 then the plan or issuer shall meet the requirements of sub-
 22 section (b).

23 (b) REQUIREMENTS.—A group health plan, or a
 24 health insurance issuer in connection with the provision
 25 of health insurance coverage, meets the requirements of

1 this paragraph, in connection with benefits described in
2 subsection (a), if the plan or issuer—

3 (1) does not require authorization or a referral
4 by the primary care provider in order to obtain such
5 benefits, and

6 (2) treats the ordering of other routine care of
7 the same type, by the participating professional pro-
8 viding the care described in subsection (a) as the au-
9 thorization of the primary care provider with respect
10 to such care.

11 (c) CONSTRUCTION.—Nothing in subsection (b) shall
12 waive any exclusions of coverage under the terms of the
13 plan with respect to coverage of gynecological or obstetric
14 care so ordered.

15 **SEC. 115. PATIENT ACCESS TO PEDIATRIC CARE.**

16 (a) IN GENERAL.—In any case in which a group
17 health plan, or a health insurance issuer in connection
18 with the provision of health insurance coverage, provides
19 benefits consisting of routine pediatric care provided by
20 a participating physician who specializes in pediatrics (or
21 consisting of payment for such care) and the plan or issuer
22 requires or provides for designation by a participant, bene-
23 ficiary, or enrollee of a participating primary care pro-
24 vider, the plan or issuer shall provide that such a partici-
25 pating physician may be designated, if available, by a par-

1 ent or guardian of any beneficiary under the plan who is
2 under 18 years of age, as the primary care provider with
3 respect to any such benefits.

4 (b) CONSTRUCTION.—Nothing in subsection (a) shall
5 waive any exclusions of coverage under the terms of the
6 plan with respect to coverage of pediatric care.

7 **SEC. 116. EXCLUSIONS.**

8 Nothing in this subtitle shall be construed—

9 (1) to require a group health plan, and a health
10 insurance issuer offering health insurance
11 coverage—

12 (A) to provide particular benefits other
13 than those provided under the terms of such
14 coverage; or

15 (B) to comply with this subtitle with re-
16 spect to abortion services or euthanasia serv-
17 ices, even if the issuer covers such services;

18 (2) as forbidding a plan or issuer from offering
19 (or requiring a plan or issuer to offer) abortion or
20 euthanasia services; or

21 (3) as applying to a fee-for-service plan.

1 **Subtitle C—Promoting Quality**
2 **Care by Ensuring Fair Resolu-**
3 **tion of Grievances**

4 **SEC. 121. UTILIZATION REVIEW STANDARDS.**

5 The utilization review program of a group health
6 plan, and a health insurance issuer that provides health
7 insurance coverage, shall—

8 (1) be developed (including any screening cri-
9 teria used by such program) with the involvement of
10 participating health professionals and providers;

11 (2) to the extent consistent with the protection
12 of proprietary business information (as defined for
13 purposes of section 552 of title 5, United States
14 Code) release, upon request, to affected health pro-
15 fessionals, providers, and enrollees the screening cri-
16 teria, weighting elements, and computer algorithms
17 used in reviews and a description of the method by
18 which they were developed;

19 (3) uniformly apply review criteria;

20 (4) subject to reasonable safeguards, disclose to
21 health professionals and providers and enrollees,
22 upon request, the names and credentials of individ-
23 uals conducting utilization review;

24 (5) not compensate individuals conducting utili-
25 zation review under a system that provides financial

1 or other incentives or bonuses for denials of payment
 2 or coverage of benefits;

3 (6) comply with the requirement of section 113
 4 that prior authorization not be required for emer-
 5 gency and related services furnished in a hospital
 6 emergency department; and

7 (7) provide timely access, as defined by the ap-
 8 plicable State authority, to utilization review person-
 9 nel and, if such personnel are not available, waives
 10 any prior authorization that would otherwise be re-
 11 quired.

12 **SEC. 122. INTERNAL AND EXTERNAL REVIEW PROCEDURES.**

13 (a) **COVERAGE DETERMINATIONS.**—A group health
 14 plan and a health insurance issuer offering health insur-
 15 ance coverage shall—

16 (1) provide notice in writing in accordance with
 17 this section to any participant or beneficiary in a
 18 group health plan, or any enrollee in health insur-
 19 ance coverage offered by a health insurance issuer,
 20 of any adverse coverage decision with respect to ben-
 21 efits of such participant, beneficiary, or enrollee, set-
 22 ting forth the specific reasons for such coverage de-
 23 cision and any rights of review, written in a manner
 24 calculated to be understood by the participant, bene-
 25 ficiary, or enrollee;

1 (2) provide written notice to any treating health
2 care professional of such participant, beneficiary, or
3 enrollee if such professional has claimed reimburse-
4 ment for any item or service involved in such cov-
5 erage decision, or if a claim submitted by the profes-
6 sional initiated the proceedings leading to such deci-
7 sion;

8 (3) afford an opportunity to any participant,
9 beneficiary, or enrollee who is in receipt of the notice
10 of such adverse coverage decision and who files a
11 written request for review of the initial coverage de-
12 cision within 180 days after receipt of the notice of
13 the initial decision, for a full and fair de novo review
14 of the decision by a person who did not make the
15 initial decision; and

16 (4) meet the additional requirements of this
17 section.

18 (b) TIME LIMITS FOR MAKING INITIAL COVERAGE
19 DECISIONS FOR BENEFITS AND COMPLETING INTERNAL
20 APPEALS.—

21 (1) TIME LIMITS FOR DECIDING REQUESTS FOR
22 BENEFIT PAYMENTS AND REQUESTS FOR ADVANCE
23 DETERMINATION OF COVERAGE.—Except as pro-
24 vided in paragraph (2)—

1 (A) INITIAL DECISIONS.—If a request for
2 benefit payments, or a request for advance de-
3 termination of coverage is submitted to a group
4 health plan or a health insurance issuer offering
5 health insurance coverage in such form as may
6 be required under the plan or coverage, the
7 plan or issuer shall issue in writing an initial
8 coverage decision on the request not later than
9 7 days (or such longer period as may be pre-
10 scribed in regulations of the Secretary) after
11 the date as of which the plan or issuer is in re-
12 ceipt of all information required (in writing or
13 in such other form as may be specified under
14 the plan or coverage) to make an initial cov-
15 erage decision. Failure to issue a coverage deci-
16 sion on such a request by such deadline shall be
17 treated as an adverse coverage decision for pur-
18 poses of internal review under subparagraph
19 (B).

20 (B) INTERNAL REVIEWS OF INITIAL DENI-
21 ALS.—Upon the written request of a partici-
22 pant, beneficiary, or enrollee for review of an
23 initial adverse coverage decision under subpara-
24 graph (A), a review by an internal appeals en-
25 tity of the initial coverage decision shall be com-

1 pleted, including issuance by the plan or issuer
2 of a written decision affirming, reversing, or
3 modifying the initial coverage decision, setting
4 forth the grounds for such decision, not later
5 than 14 days (or such longer period as may be
6 prescribed in regulations of the Secretary) after
7 the date as of which the entity is in receipt of
8 all information required (in writing or in such
9 other form as may be specified under the plan
10 or coverage) to make a decision to affirm, mod-
11 ify, or reverse the coverage decision. Such deci-
12 sion shall be treated as the final decision of the
13 plan, subject to any applicable reconsideration.
14 Failure to issue by such deadline such a written
15 decision requested under this subparagraph
16 shall be treated as a final decision affirming the
17 initial coverage decision, subject to any applica-
18 ble reconsideration.

19 (2) TIME LIMITS FOR MAKING COVERAGE DECI-
20 SIONS RELATING TO URGENT HEALTH CARE AND
21 FOR COMPLETING INTERNAL APPEALS.—

22 (A) INITIAL DECISIONS.—A group health
23 plan and a health insurance issuer offering
24 health insurance coverage shall issue in writing
25 an initial coverage decision on any request for

1 expedited advance determination of coverage, in
2 such form as may be required under the plan
3 or coverage, not later than 2 days (or such
4 longer period as may be prescribed in regula-
5 tions of the Secretary) after the date as of
6 which the plan or issuer is in receipt of all in-
7 formation required (in writing or in such other
8 form as may be specified under the plan or cov-
9 erage) to make an initial coverage decision.
10 Such decision shall be treated as the final deci-
11 sion of the plan or issuer, subject to any appli-
12 cable reconsideration. Failure to issue before
13 the end of the applicable decision period such a
14 written decision requested under this subpara-
15 graph shall be treated as a final decision af-
16 firming the initial coverage decision, subject to
17 any applicable reconsideration.

18 (B) INTERNAL REVIEWS OF INITIAL DENI-
19 ALS.—Upon the written request of a partici-
20 pant, beneficiary, or enrollee for review of an
21 initial adverse coverage decision under subpara-
22 graph (A), if the case involves urgent health
23 care, a review by an internal review entity of
24 the initial coverage decision shall be completed,
25 including issuance by the plan or issuer of a

1 written decision affirming, reversing, or modify-
2 ing the initial coverage decision, setting forth
3 the grounds for the decision, not later than 2
4 days (or such longer period as may be pre-
5 scribed in regulations of the Secretary) after
6 the date as of which the entity is in receipt of
7 all information required (in writing or in such
8 other form as may be specified under the plan
9 or coverage) to make a decision to affirm, mod-
10 ify, or reverse the coverage decision. Such deci-
11 sion shall be treated as the final decision of the
12 plan or issuer, subject to any applicable recon-
13 sideration. Failure to issue before such deadline
14 such a written decision requested under this
15 subparagraph shall be treated as a final deci-
16 sion affirming the initial coverage decision, sub-
17 ject to any applicable reconsideration.

18 (c) REQUIREMENT FOR REVIEW OF INITIAL COV-
19 ERAGE DECISIONS BY A PHYSICIAN.—If an initial cov-
20 erage decision is based on a determination other than that
21 provision of a particular item or service is excluded from
22 coverage under the terms of the plan or coverage, the re-
23 view shall be conducted by a physician who is selected to
24 serve as an internal appeals entity under the plan or cov-
25 erage and who did not make the initial denial.

1 (d) EXTERNAL REVIEW BY INDEPENDENT MEDICAL
2 EXPERTS AND RECONSIDERATION OF INITIAL REVIEW
3 DECISION.—

4 (1) IN GENERAL.—The requirements of para-
5 graphs (2), (3), and (4) shall apply—

6 (A) in the case of any failure to timely
7 issue a coverage decision upon internal review
8 which is deemed to be an adverse coverage deci-
9 sion (thereby failing to constitute a coverage de-
10 cision for which specific reasons have been set
11 forth as required), and

12 (B) in the case of any adverse coverage de-
13 cision not based on a determination that provi-
14 sion of a particular item or service is excluded
15 from coverage under the terms of the plan or
16 coverage because the provision of such item or
17 service is specifically excluded as a benefit of
18 the plan or coverage.

19 (2) RECONSIDERATION OF INITIAL REVIEW DE-
20 CISION.—In any case in which a participant, bene-
21 ficiary, or enrollee who has received an adverse deci-
22 sion of the plan or issuer upon review of the initial
23 coverage decision and who has not commenced re-
24 view of the initial coverage decision makes a request
25 in writing, within 30 days after the date of such re-

1 view decision, for reconsideration of such review de-
2 cision, the terms of the plan or coverage shall pro-
3 vide for a procedure for such reconsideration paid
4 for by the plan or issuer under which—

5 (A) one or more independent medical ex-
6 perts will be selected to review the coverage de-
7 cision described;

8 (B) the record for review (including a spec-
9 ification of the terms of the plan or coverage
10 and other criteria serving as the basis for the
11 initial review decision) shall be presented to
12 such expert or experts and maintained in a
13 manner which shall ensure confidentiality of
14 such record;

15 (C) such expert or experts will make and
16 report in writing to the plan or issuer a deter-
17 mination as to whether such coverage decision
18 should be affirmed, modified, or reversed, set-
19 ting forth the grounds (including the clinical
20 basis) for the determination; and

21 (D) the determination of such expert or ex-
22 perts pursuant to subparagraph (C) shall be
23 considered binding on the plan or issuer.

24 (3) TIME LIMITS FOR RECONSIDERATION.—Any
25 review under this subsection shall be completed not

1 later than 14 days (or, in the case of a decision in-
2 volving urgent health care, 2 days, or such longer
3 period as may be prescribed in regulations of the
4 Secretary) after the date as of which the independ-
5 ent medical expert or experts involved is in receipt
6 of all information required (in writing or in such
7 other form as may be specified under the plan or
8 coverage) to make a decision to affirm, modify, or
9 reverse the coverage decision. Failure to issue a
10 written decision before such deadline in any recon-
11 sideration requested under this subsection shall be
12 treated as a final decision affirming the initial re-
13 view decision of the plan or issuer.

14 (4) INDEPENDENT MEDICAL EXPERTS.—

15 (A) IN GENERAL.—For purposes of this
16 section, the term “independent medical expert”
17 means, in connection with any coverage decision
18 by a group health plan or health insurance
19 issuer, a health care professional who—

20 (i) is a physician or, if appropriate,
21 another health care professional;

22 (ii) has appropriate credentials and
23 has attained recognized expertise in the
24 applicable health care field;

1 (iii) was not involved in the initial de-
2 cision or any earlier review thereof; and

3 (iv) is selected in accordance with sub-
4 paragraph (B).

5 (B) SELECTION OF MEDICAL EXPERTS.—

6 An independent medical expert is selected in ac-
7 cordance with this subparagraph if—

8 (i) the expert is selected by an inter-
9 mediary which itself meets the require-
10 ments of subparagraph (C), by means of a
11 method which ensures that the identity of
12 the expert is not disclosed to the plan or
13 issuer, any health insurance issuer offering
14 health insurance coverage to the aggrieved
15 participant, beneficiary, or enrollee in con-
16 nection with the plan, and the aggrieved
17 participant, beneficiary, or enrollee under
18 the plan, and the identities of the plan, the
19 issuer, and the aggrieved participant, bene-
20 ficiary, or enrollee are not disclosed to the
21 expert;

22 (ii) the expert is selected, by an ap-
23 propriately credentialed panel of health
24 care professionals meeting the require-
25 ments of subparagraph (C) established by

1 a fully accredited teaching hospital meeting
2 such requirements;

3 (iii) the expert is selected by an orga-
4 nization described in section 1152(1)(A) of
5 the Social Security Act which meets the re-
6 quirements of subparagraph (C);

7 (iv) the expert is selected by an exter-
8 nal review organization which meets the re-
9 quirements of subparagraph (C) and is ac-
10 credited by a private standard-setting or-
11 ganization meeting such requirements and
12 recognized as such by the Secretary; or

13 (v) the expert is selected under regu-
14 lations issued pursuant to negotiated rule-
15 making, sufficient to ensure the expert's
16 independence, and the method of selection
17 is devised to reasonably ensure that the ex-
18 pert selected meets the independence re-
19 quirements of subparagraph (C).

20 (C) INDEPENDENCE REQUIREMENTS.—An
21 independent medical expert or another entity
22 described in subparagraph (B) meets the inde-
23 pendence requirements of this subparagraph
24 if—

1 (i) the expert or entity is not affiliated
2 with any related party;

3 (ii) any compensation received by such
4 expert or entity in connection with the ex-
5 ternal review is reasonable and not contin-
6 gent on any decision rendered by the ex-
7 pert or entity;

8 (iii) under the terms of the plan and
9 any health insurance coverage involved, the
10 plan and the issuer (if any) have no re-
11 course against the expert or entity in con-
12 nection with the external review; and

13 (iv) the expert or entity does not oth-
14 erwise have a conflict of interest with a re-
15 lated party as determined under any regu-
16 lations which the Secretary may prescribe.

17 (D) RELATED PARTY.—For purposes of
18 this paragraph, the term “related party”
19 means—

20 (i) with respect to—

21 (I) a group health plan or health
22 insurance coverage offered in connec-
23 tion with such a plan, the plan or the
24 health insurance issuer offering such
25 coverage, or

1 (II) individual health insurance
2 coverage, the health insurance issuer
3 offering such coverage,

4 or any officer, director, or management
5 employee of such plan or issuer;

6 (ii) the health care professional that
7 provided the health care involved in the
8 coverage decision;

9 (iii) the institution at which the health
10 care involved in the coverage decision is
11 provided;

12 (iv) the manufacturer of any drug or
13 other item that was included in the health
14 care involved in the coverage decision; or

15 (v) any other party determined under
16 any regulations which the Secretary may
17 prescribe to have a substantial interest in
18 the coverage decision.

19 (E) AFFILIATED.—For purposes of this
20 paragraph, the term “affiliated” means, in con-
21 nection with any entity, having a familial, fi-
22 nancial, or professional relationship with, or in-
23 terest in, such entity.

24 (F) LIMITATION ON LIABILITY.—An indi-
25 vidual serving on as an independent medical ex-

1 pert or an entity acting as such under this
2 paragraph shall not be held liable for any deci-
3 sion made except in cases of gross negligence,
4 recklessness, or intentional misconduct by such
5 individual or entity.

6 (5) INAPPLICABILITY WITH RESPECT TO ITEMS
7 AND SERVICES SPECIFICALLY EXCLUDED FROM COV-
8 ERAGE.—An adverse coverage decision based on a
9 determination that an item or service is excluded
10 from coverage under the terms of a plan or health
11 insurance coverage shall not be subject to review
12 under this section.

13 (e) PENALTIES AGAINST AUTHORIZED OFFICIALS
14 FOR DENIAL OF EXTERNAL REVIEW.—

15 (1) MONETARY PENALTIES.—In any case in
16 which review by an independent medical expert or
17 experts of a benefit is denied by a group health plan,
18 or by a health insurance issuer offering health insur-
19 ance coverage, any person who, acting in the capac-
20 ity of determining the necessity of such a review,
21 causes such denial may, in the court's discretion, be
22 liable to the aggrieved participant, beneficiary, or
23 enrollee for a civil penalty in an amount of up to
24 \$750 a day from the date on which the rec-
25 ommendation was made to the plan or issuer until

1 the date the failure to provide review is corrected, up
2 to a total amount not to exceed \$250,000.

3 (2) CEASE AND DESIST ORDER AND ORDER OF
4 ATTORNEY'S FEES.—In any action described in
5 paragraph (1) brought by a participant, beneficiary,
6 or enrollee with respect to a group health plan, or
7 a health insurance issuer offering health insurance
8 coverage, in which the plaintiff alleges that a person
9 referred to in such paragraph has taken an action
10 resulting in a denial of review by independent medi-
11 cal expert or experts in violation of such terms of
12 the plan, coverage, or this title, or has failed to take
13 an action for which such person is responsible under
14 the plan, coverage, or this title and which is nec-
15 essary under the plan or coverage for allowing such
16 review, the court shall cause to be served on the de-
17 fendant an order requiring the defendant—

18 (i) to cease and desist from the alleged ac-
19 tion or failure to act; and

20 (ii) to pay to the plaintiff a reasonable at-
21 torney's fee and other reasonable costs relating
22 to the prosecution of the action on the charges
23 on which the plaintiff prevails.

24 (3) ADDITIONAL CIVIL PENALTIES.—

1 (A) IN GENERAL.—In addition to any pen-
2 alty imposed under paragraph (1) or (2), the
3 appropriate Secretary may assess a civil penalty
4 against a person acting in the capacity of deter-
5 mining the necessity of external review for one
6 or more group health plans, or health insurance
7 issuers offering health insurance coverage,
8 for—

9 (i) any pattern or practice of repeated
10 denial of review by independent medical ex-
11 pert or experts in violation of the terms of
12 such a plan, coverage, or this title; or

13 (ii) any pattern or practice of re-
14 peated violations of the requirements of
15 this section with respect to such plan or
16 plans or coverage.

17 (B) STANDARD OF PROOF AND AMOUNT OF
18 PENALTY.—Such penalty shall be payable only
19 upon proof by clear and convincing evidence of
20 such pattern or practice and shall be in an
21 amount not to exceed the lesser of—

22 (i) 25 percent of the aggregate value
23 of benefits shown by the appropriate Sec-
24 retary to have not been provided, or unlaw-

1 fully delayed, in violation of this section
2 under such pattern or practice, or

3 (ii) \$500,000.

4 (4) REMOVAL AND DISQUALIFICATION.—Any
5 person acting in the capacity of determining the ne-
6 cessity of external review who has engaged in any
7 such pattern or practice described in paragraph
8 (3)(A) with respect to a plan or coverage, upon the
9 petition of the appropriate Secretary, may be re-
10 moved by the court from that position, and from any
11 other involvement, with respect to such a plan or
12 coverage, and may be precluded from returning to
13 any such position or involvement for a period deter-
14 mined by the court.

15 (f) DEFINITIONS.—For purposes of this section:

16 (1) ADVANCE DETERMINATION OF COV-
17 ERAGE.—The term “advance determination of cov-
18 erage” means a determination under a group health
19 plan, and a health insurance issuer offering health
20 insurance coverage that proposed health care meets,
21 under the facts and circumstances at the time of the
22 determination, the plan or issuer’s terms and condi-
23 tions of coverage (which may be subject to excep-
24 tions under the plan for fraud or misrepresentation).

1 (2) ADVERSE COVERAGE DECISION.—The term
2 “adverse coverage decision” means any request for
3 payment of benefits, determination of coverage, ad-
4 vance determination of coverage, or expedited ad-
5 vance determination of coverage made by a group
6 health plan, or a health insurance issuer offering
7 health insurance coverage, that does not affirm the
8 treatment decision of the treating health care profes-
9 sional.

10 (3) REQUEST FOR ADVANCE DETERMINATION
11 OF COVERAGE.—The term “request for advance de-
12 termination of coverage” means a request for an ad-
13 vance determination of coverage of health care which
14 is made by or on behalf of a participant, beneficiary,
15 or enrollee before such health care is provided.

16 (4) REQUEST FOR BENEFIT PAYMENTS.—The
17 term “request for benefit payments” means a re-
18 quest, for payment of benefits by a group health
19 plan, or health insurance issuer offering health in-
20 surance coverage for health care, which is made by
21 or on behalf of a participant, beneficiary, or enrollee
22 after such health care has been provided.

23 (5) REQUEST FOR EXPEDITED ADVANCE DE-
24 TERMINATION OF COVERAGE.—The term “request
25 for expedited advance determination of coverage”

1 means a request for advance determination of cov-
2 erage, in any case in which the proposed health care
3 constitutes urgent health care.

4 (6) URGENT HEALTH CARE.—The term “urgent
5 health care” means health care in any case in which
6 a physician has certified in writing (or as otherwise
7 provided in regulations of the Secretary) that failure
8 to provide the participant, beneficiary, or enrollee
9 with such health care within 7 days can reasonably
10 be expected to result in either—

11 (A) the imminent death of the participant,
12 beneficiary, or enrollee; or

13 (B) the immediate, serious, and irrevers-
14 ible deterioration of the health of the partici-
15 pant or beneficiary which will significantly in-
16 crease the likelihood of death of, or irreparable
17 harm to, the participant, beneficiary, or en-
18 rollee.

19 (7) WRITTEN OR IN WRITING.—A request or
20 decision shall be deemed to be “written” or “in writ-
21 ing” if such request or decision is presented in a
22 generally recognized printable or electronic format.
23 The appropriate Secretary may by regulation provide
24 for presentation of information otherwise required to

1 be in written form in such other forms as may be
 2 appropriate under the circumstances.

3 **Subtitle D—Promoting Quality**
 4 **Care by Ensuring Fair Plan Ad-**
 5 **ministration**

6 **SEC. 131. RESTRICTIONS ON INCENTIVE PLANS.**

7 (a) INCENTIVE PLANS.—

8 (1) IN GENERAL.—In the case of a group
 9 health plan, and a health insurance issuer that of-
 10 fers network coverage, any health professional or
 11 provider incentive plan operated by the plan or
 12 issuer with respect to such coverage shall meet the
 13 following requirements:

14 (A) No specific payment shall be made di-
 15 rectly or indirectly under the plan to a profes-
 16 sional or provider or group of professionals or
 17 providers as an inducement to reduce or limit
 18 medically necessary services provided with re-
 19 spect to a specific participant, beneficiary, or
 20 enrollee.

21 (B) If a plan or issuer places such a pro-
 22 fessional, provider, or group at substantial fi-
 23 nancial risk (as determined by the Secretary)
 24 for services not provided by the professional,
 25 provider, or group, the plan issuer shall provide

1 stop-loss protection for the professional, pro-
2 vider, or group that is adequate and appro-
3 priate, based on standards developed by the
4 Secretary that take into account the number of
5 professionals or providers placed at such sub-
6 stantial financial risk in the group or under the
7 coverage and the number of individuals enrolled
8 with the plan or issuer who receive services
9 from the professional, provider, or group.

10 (2) NOTIFICATION.—The plan or issuer shall
11 provide the Secretary with descriptive information
12 regarding the plan, sufficient to permit the Sec-
13 retary to determine whether the plan is in compli-
14 ance with the requirements of this section.

15 (b) HEALTH PROFESSIONAL OR PROVIDER INCEN-
16 TIVE PLAN DEFINED.—In this subsection, the term health
17 professional or provider incentive plan means any com-
18 pensation arrangement between a health insurance issuer
19 and a health professional or provider or professional or
20 provider group that has the effect of reducing or limiting
21 services provided with respect to individuals enrolled with
22 the plan or issuer.

23 (c) CONSTRUCTION.—Nothing in this section shall be
24 construed as prohibiting all capitation and similar ar-
25 rangements or all provider discount arrangements.

1 (d) IMPLEMENTATION.—The Secretary shall submit
 2 to Congress not later than January 1, 2000 a report de-
 3 tailing regulations and a plan for implementation of the
 4 details of this section. Such regulations and plan for im-
 5 plementation shall not proceed without the concurrence by
 6 joint resolution or Act of the Congress.

7 **SEC. 132. DEVELOPMENT OF PLAN AND ISSUER POLICIES.**

8 A group health plan, and a health insurance issuer
 9 that offers network coverage shall establish mechanisms
 10 to consider the recommendations, suggestions, and views
 11 of participants, beneficiaries, enrollees and participating
 12 health professionals and providers regarding—

13 (1) the medical policies of the plan or issuer
 14 (including policies relating to coverage of new tech-
 15 nologies, treatments, and procedures);

16 (2) the utilization review criteria and proce-
 17 dures of the plan or issuer;

18 (3) the quality and credentialing criteria of the
 19 plan or issuer; and

20 (4) the medical management procedures of the
 21 plan or issuer.

22 **SEC. 133. PATIENT ACCESS TO INFORMATION.**

23 (a) DISCLOSURE REQUIREMENTS.—

24 (1) IN GENERAL.—A group health plan or
 25 health insurance issuer providing health insurance

1 coverage shall take such actions as necessary to en-
2 sure that—

3 (A) information required under subsections
4 (b) through (k) is provided at the time of en-
5 rollment, at least annually thereafter, and upon
6 written request; and

7 (B) the information described in subsection
8 (l) is provided upon written request,
9 to plan participants and beneficiaries and to enroll-
10 ees, respectively.

11 (2) INCLUSION IN SUMMARY PLAN DESCRIP-
12 TION.—In the case of a group health plan, the infor-
13 mation described in paragraph (1)(A) shall be made
14 available as part of the summary plan description of
15 the plan.

16 (3) CHARGING FOR INFORMATION MADE AVAIL-
17 ABLE UPON REQUEST.—In cases in which the infor-
18 mation is made available upon written request under
19 paragraph (1), the plan or issuer may impose a rea-
20 sonable charge to cover the cost of making the infor-
21 mation so available. The Secretary may by regula-
22 tion prescribe a maximum amount which will con-
23 stitute a reasonable charge under this paragraph.

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

1 (1) COVERED ITEMS AND SERVICES.—

2 (A) CATEGORIZATION OF INCLUDED BENE-
3 FITS.—A description of covered benefits, cat-
4 egorized by—

5 (i) types of items and services (includ-
6 ing any special disease management pro-
7 gram); and

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

10 (B) EMERGENCY MEDICAL CARE.—A de-
11 scription of—

12 (i) the extent to which the plan or
13 health insurance coverage covers emer-
14 gency medical care;

15 (ii) the locations of hospital emer-
16 gency departments, urgent care centers,
17 and other sites or settings in which the
18 plan or health insurance coverage makes
19 available emergency medical care or post-
20 stabilization care; and

21 (iii) the appropriate use of emergency
22 services, including use of the 911 telephone
23 system or its local equivalent in emergency
24 situations, and an explanation of what con-
25 stitutes an emergency situation.

1 (C) PREVENTATIVE SERVICES.—A descrip-
2 tion of the extent to which the plan or health
3 insurance coverage provides benefits for pre-
4 ventative services.

5 (D) DRUG FORMULARIES.—A description
6 of the extent to which covered benefits are de-
7 termined by the use or application of a drug
8 formulary and a summary of the process for de-
9 termining what is included in such formulary.

10 (E) COBRA CONTINUATION COVERAGE.—
11 In the case of a group health plan, a descrip-
12 tion of the benefits available under the plan
13 pursuant to part 6 of the Employee Retirement
14 Income Security Act.

15 (2) LIMITATIONS, EXCLUSIONS, AND RESTRIC-
16 TIONS ON COVERED BENEFITS.—

17 (A) CATEGORIZATION OF EXCLUDED BEN-
18 EFITS.—A description of benefits specifically
19 excluded from coverage, categorized by types of
20 items and services.

21 (B) UTILIZATION REVIEW AND
22 PREAUTHORIZATION REQUIREMENTS.—Whether
23 coverage for health care is limited or excluded
24 on the basis of utilization review or
25 preauthorization requirements.

1 (C) LIFETIME, ANNUAL, OR OTHER PE-
2 RIOD LIMITATIONS.—A description of the cir-
3 cumstances under which, and the extent to
4 which, coverage is subject to lifetime, annual, or
5 other period limitations, categorized by types of
6 benefits.

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

13 (E) EXPERIMENTAL TREATMENTS.—
14 Whether coverage for any health care is limited
15 or excluded because it constitutes experimental
16 treatment or technology, and any definitions
17 provided under the plan or coverage for the rel-
18 evant terminology referring to such limited or
19 excluded care.

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

24 (G) SPECIALTY CARE.—A description of
25 the circumstances under which, and the extent

1 to which, coverage of benefits for specialty care
2 is conditioned on referral from a primary care
3 provider.

4 (H) CONTINUITY OF CARE.—A description
5 of the circumstances under which, and the ex-
6 tent to which, coverage of items and services
7 provided by any health care professional is lim-
8 ited or excluded by reason of the departure by
9 the professional from any defined set of provid-
10 ers.

11 (I) RESTRICTIONS ON COVERAGE OF
12 EMERGENCY SERVICES.—A description of the
13 circumstances under which, and the extent to
14 which, the plan or health insurance coverage, in
15 covering emergency medical care furnished to a
16 participant or beneficiary of the plan or enrollee
17 imposes any financial responsibility described in
18 subsection (c) on participants or beneficiaries or
19 enrollees or limits or conditions benefits for
20 such care subject to any other term or condition
21 of such plan or coverage.

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

1 (1) a participant's or enrollee's financial re-
2 sponsibility for payment of premiums, coinsurance,
3 copayments, deductibles, and any other charges; and

4 (2) the circumstances under which, and the ex-
5 tent to which, the participant's or enrollee's financial
6 responsibility described in paragraph (1) may vary,
7 including any distinctions based on whether a health
8 care provider from whom covered benefits are ob-
9 tained is included in a defined set of providers.

10 (d) DISPUTE RESOLUTION PROCEDURES.—The in-
11 formation required under subsection (a) includes a de-
12 scription of the processes adopted by the plan pursuant
13 to section 122, including—

14 (1) descriptions relating specifically to—

15 (A) coverage decisions;

16 (B) internal review of coverage decisions;

17 and

18 (C) any external review of coverage deci-
19 sions;

20 (2) the procedures and time frames applicable
21 to each step of the processes referred to in subpara-
22 graphs (A), (B), and (C) of paragraph (1); and

23 (3) the number of external review cases con-
24 ducted annually and, of such number, the number of
25 such cases where the decision of the plan or issuer

1 is upheld and the number of such cases where the
2 decision of the plan or issuer is modified or over-
3 turned.

4 (e) NETWORK CHARACTERISTICS.—If the plan or
5 health insurance issuer utilizes a defined set of providers
6 under contract with the plan or issuer, the information
7 required under subsection (a) includes a detailed list of
8 the names of such providers and their geographic location,
9 set forth separately with respect to primary care providers
10 and with respect to specialists.

11 (f) CARE MANAGEMENT INFORMATION.—The infor-
12 mation required under subsection (a) includes a descrip-
13 tion of the circumstances under which, and the extent to
14 which, the plan or health insurance issuer has special dis-
15 ease management programs or programs for persons with
16 disabilities, indicating whether these programs are vol-
17 untary or mandatory and whether a significant benefit dif-
18 ferential results from participation in such programs.

19 (g) INCLUSION OF DRUGS AND BIOLOGICALS IN
20 FORMULARIES.—The information required under sub-
21 section (a) includes a statement of whether a specific drug
22 or biological is included in a formulary used to determine
23 benefits under the plan or health insurance coverage and
24 a description of the procedures for considering requests
25 for any patient-specific waivers.

1 (h) PREAUTHORIZATION AND UTILIZATION REVIEW

2 PROCEDURES.—The information required under sub-
3 section (a) includes, upon receipt by the participant or
4 beneficiary or enrollee of any notification of an adverse
5 coverage decision, a description of the basis on which any
6 preauthorization requirement or any utilization review re-
7 quirement has resulted in such decision.

8 (i) ACCREDITATION STATUS OF HEALTH INSURANCE

9 ISSUERS AND SERVICE PROVIDERS.—The information re-
10 quired under subsection (a) includes a description of the
11 accreditation and licensing status (if any) of each health
12 insurance issuer (or each such issuer offering health insur-
13 ance coverage in connection with the plan) and of any uti-
14 lization review organization utilized by the issuer or the
15 plan, together with the name and address of the accredit-
16 ing or licensing authority.

17 (j) MEASURES OF ENROLLEE SATISFACTION.—The

18 information required under subsection (a) includes the lat-
19 est information (if any) maintained by the plan (or by any
20 health insurance issuer offering health insurance coverage
21 in connection with the plan) or by the health insurance
22 issuer relating to enrollee satisfaction.

23 (k) QUALITY PERFORMANCE MEASURES.—The infor-

24 mation required under subsection (a) includes the latest
25 information (if any) maintained by the plan (or by any

1 health insurance issuer offering health insurance coverage
2 in connection with the plan) or by the health insurance
3 issuer, relating to quality of performance of the delivery
4 of health care with respect to coverage options offered
5 under the plan or health insurance coverage and of health
6 care professionals and facilities providing health care
7 under the plan or coverage.

8 (l) INFORMATION AVAILABLE ON REQUEST.—Pursu-
9 ant to written request under subsection (a)(1)(B)—

10 (1) INFORMATION REQUIRED FROM INDIVIDUAL
11 HEALTH CARE PROFESSIONALS ON REQUEST.— Any
12 health care professional treating a participant or
13 beneficiary under a group health plan or an enrollee
14 under health insurance coverage shall provide to the
15 participant or beneficiary or enrollee, on request, a
16 description of his or her professional qualifications
17 (including board certification status, licensing sta-
18 tus, and accreditation status, if any), privileges, and
19 experience and a general description by category (in-
20 cluding salary, fee-for-service, capitation, and such
21 other categories as may be specified in regulations of
22 the Secretary) of the applicable method by which
23 such professional is compensated in connection with
24 the provision of such health care under the plan or
25 coverage.

1 (2) INFORMATION REQUIRED FROM INDIVIDUAL
2 HEALTH CARE FACILITIES ON REQUEST.—Any
3 health care facility from which a participant, bene-
4 ficiary, or enrollee has sought treatment under a
5 group health plan or health insurance coverage shall
6 provide to the participant, beneficiary, or enrollee,
7 on request, a description of the facility’s corporate
8 form or other organizational form and all forms of
9 licensing and accreditation status (if any) assigned
10 to the facility by standard-setting organizations.

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

21 (1) in the case of a group health plan, by inclu-
22 sion of information in publications broadly distrib-
23 uted by plan sponsors, employers, or employee orga-
24 nizations;

1 (2) by timely informing participants or enrollees
2 who, under an ongoing program maintained under
3 the plan or health insurance issuer, have submitted
4 their names for such notification; or
5 (3) by any other reasonable means of timely in-
6 forming participants or enrollees.

7 **SEC. 134. PROTECTION OF CONFIDENTIALITY.**

8 (a) IN GENERAL.—A group health plan, and a health
9 insurance issuer offering health insurance coverage, shall
10 establish mechanisms and procedures to ensure compli-
11 ance with applicable Federal and State laws to protect the
12 confidentiality of individually identifiable information held
13 by the plan issuer with respect to a participant, bene-
14 ficiary, enrollee, health professional, or provider.

15 (b) INDIVIDUALLY IDENTIFIABLE INFORMATION DE-
16 FINED.—For purposes of subsection (a), the term “indi-
17 vidually identifiable information” means, with respect to
18 a participant, beneficiary, enrollee, a health professional,
19 or a provider, any information, whether oral or recorded
20 in any medium or form, that identifies or can readily be
21 associated with the identity of the participant, beneficiary,
22 enrollee, the health professional, or the provider.

1 **SEC. 135. DUE PROCESS FOR HEALTH PROFESSIONALS AND**
2 **PROVIDERS.**

3 (a) IN GENERAL.—A group health plan, and a health
4 insurance issuer, with respect to its offering of network
5 coverage shall—

6 (1) allow all health professionals and providers
7 in its service area who are licensed, accredited, or
8 certified to perform specific health services consist-
9 ent with State law and those services covered under
10 the network coverage to apply to become a partici-
11 pating health professional or provider as openings in
12 a network become available during at least one pe-
13 riod in each calendar year;

14 (2) provide reasonable notice to such health
15 professionals and providers of the opportunity to
16 apply and of the period during which applications
17 are accepted;

18 (3) provide for review of each application by a
19 credentialing committee with representation of the
20 category or type of health professional or provider
21 being credentialed;

22 (4) select participating health professionals and
23 providers using objective standards of quality devel-
24 oped with the suggestions and advice of professional
25 associations, health professionals, and providers;

1 (5) make such selection standards available
2 to—

3 (A) those applying to become a participat-
4 ing provider or health professional;

5 (B) purchasers of health insurance cov-
6 erage; and

7 (C) participants, beneficiaries, or enrollees;

8 (6) when economic considerations are taken
9 into account in selecting participating health profes-
10 sionals and providers, use objective criteria that are
11 available to those applying to become a participating
12 provider or health professional and participants,
13 beneficiaries, or enrollees;

14 (7) adjust any economic profiling to take into
15 account patient characteristics (such as severity of
16 illness) that may result in atypical utilization of
17 services;

18 (8) make the results of such profiling available
19 to insurance purchasers, enrollees, and the health
20 professional or provider involved;

21 (9) notify any health professional or provider
22 being reviewed under the process referred to in para-
23 graph (3) of any information indicating that the
24 health professional or provider fails to meet the
25 standards of the issuer;

1 (10) offer a health professional or provider re-
2 ceiving notice pursuant to the requirement of para-
3 graph (9) with an opportunity to—

4 (A) review the information referred to in
5 such paragraph; and

6 (B) submit supplemental or corrected in-
7 formation;

8 (11) not include in its contracts with participat-
9 ing health professionals and providers a provision
10 permitting the issuer to terminate the contract with-
11 out cause;

12 (12) provide a due process appeal that con-
13 forms to the process specified in section 412 of the
14 Health Care Quality Improvement Act of 1986 (42
15 U.S.C. 11112) for all determinations that are ad-
16 verse to a health professional or provider; and

17 (13) unless a health professional or provider
18 poses an imminent harm to enrollees or an adverse
19 action by a governmental agency effectively impairs
20 the ability to provide health care items and services,
21 provide—

22 (A) reasonable notice of any decision to
23 terminate a health professional or provider for
24 cause (including an explanation of the reasons
25 for the determination);

1 (B) an opportunity to review and discuss
 2 all of the information on which the determina-
 3 tion is based; and

4 (C) an opportunity to enter into a correc-
 5 tive action plan, before the determination be-
 6 comes subject to appeal under the process re-
 7 ferred to in paragraph (12).

8 (b) RULES OF CONSTRUCTION.—The requirements of
 9 subsection (a) shall not be construed as preempting or su-
 10 perseding any other reviews and appeals a group health
 11 plan, or a health insurance issuer are required by law to
 12 make available. Nothing in subsection (a) shall be con-
 13 strued to require a group health plan or a health insurance
 14 issuer to renew a contract with a participating provider.

15 **SEC. 136. PROHIBITION OF INTERFERENCE WITH CERTAIN**
 16 **MEDICAL COMMUNICATIONS.**

17 (a) IN GENERAL.—Subject to subsections (b) and (c),
 18 a group health plan, and a health insurance issuer (in rela-
 19 tion to an individual enrolled under health insurance cov-
 20 erage offered by the issuer) shall not prohibit or otherwise
 21 restrict a covered health care professional (as defined in
 22 subsection (d)) from advising such an individual who is
 23 a patient of the professional about the health status of
 24 the individual or health care or treatment for the individ-
 25 uals condition or disease, regardless of whether benefits

1 for such care or treatment are provided under the cov-
2 erage, if the professional is acting within the lawful scope
3 of practice.

4 (b) CONSCIENCE PROTECTION.—Subsection (a) shall
5 not be construed as requiring a group health plan or a
6 health insurance issuer to provide, reimburse for, or pro-
7 vide coverage of a counseling or referral service if the
8 issuer—

9 (1) objects to the provision of such service on
10 moral or religious grounds; and

11 (2) in the manner and through the written in-
12 strumentalities such issuer deems appropriate,
13 makes available information on its policies regarding
14 such service to prospective enrollees before or during
15 enrollment and to enrollees within 90 days after the
16 date that the issuer adopts a change in policy re-
17 garding such a counseling or referral service.

18 (c) CONSTRUCTION.—Nothing in subsection (b) shall
19 be construed to affect disclosure requirements under State
20 law or under the Employee Retirement Income Security
21 Act of 1974.

22 **SEC. 137. PLAN SOLVENCY.**

23 A group health plan and a health insurance issuer
24 offering health insurance coverage shall—

1 (1) meet such financial reserve or other sol-
2 vency-related requirements as the applicable State
3 authority may establish to assure the continued
4 availability of (and appropriate payment for) covered
5 items and services for enrollees; and

6 (2) establish mechanisms specified by the appli-
7 cable State authority to protect enrollees, health pro-
8 fessionals, and providers in the event of failure of
9 the issuer.

10 Such requirements shall not unduly impede the establish-
11 ment of health insurance issuers owned and operated by
12 health care professionals or providers or by nonprofit com-
13 munity-based organizations.

14 **SEC. 138. QUALITY ASSESSMENT PROGRAM.**

15 (a) IN GENERAL.—A group health plan and a health
16 insurance issuer offering health insurance coverage shall
17 establish a quality assessment program (consistent with
18 subsection (b)) that systematically and continuously
19 assesses—

20 (1) participant, beneficiary, or enrollee health
21 status, patient outcomes, processes of care, and par-
22 ticipant, beneficiary, or enrollee satisfaction associ-
23 ated with health care provided by the plan or issuer;
24 and

1 (2) the administrative and funding capacity of
2 the issuer to support and emphasize preventive care,
3 utilization, access and availability, cost effectiveness,
4 acceptable treatment modalities, specialists referrals,
5 the peer review process, and the efficiency of the ad-
6 ministrative process.

7 (b) FUNCTIONS.—A quality assessment program es-
8 tablished pursuant to subsection (a) shall—

9 (1) assess the performance of the plan or issuer
10 and its participating health professionals and provid-
11 ers and report the results of such assessment to pur-
12 chasers, participating health professionals and pro-
13 viders, and administrative personnel; and

14 (2) analyze quality assessment data to deter-
15 mine specific interactions in the delivery system
16 (both the design and funding of the health insurance
17 coverage and the clinical provision of care) that have
18 an adverse impact on the quality of care.

19 **Subtitle E—Definitions**

20 **SEC. 151. DEFINITIONS.**

21 (a) INCORPORATION OF GENERAL DEFINITIONS.—
22 Except as otherwise provided, the provisions of section
23 2971 of the Public Health Service Act shall apply for pur-
24 poses of this title in the same manner as they apply for
25 purposes of title XXVII of such Act.

1 (b) SECRETARY.—Except as otherwise provided, the
2 term “Secretary” means the Secretary of Health and
3 Human Services, in consultation with the Secretary of
4 Labor and the Secretary of the Treasury and the term
5 “appropriate Secretary” means the Secretary of Health
6 and Human Services in relation to carrying out this title
7 under sections 2706 and 2751 of the Public Health Serv-
8 ice Act and the Secretary of Labor in relation to carrying
9 out this title under section 713 of the Employee Retire-
10 ment Income Security Act of 1974.

11 (c) ADDITIONAL DEFINITIONS.—For purposes of this
12 title:

13 (1) APPLICABLE AUTHORITY.—The term “ap-
14 plicable authority” means—

15 (A) in the case of a group health plan, the
16 Secretary of Health and Human Services and
17 the Secretary of Labor; and

18 (B) in the case of a health insurance issuer
19 with respect to a specific provision of this title,
20 the applicable State authority (as defined in
21 section 2791(d) of the Public Health Service
22 Act), or the Secretary of Health and Human
23 Services, if such Secretary is enforcing such
24 provision under section 2722(a)(2) or
25 2761(a)(2) of the Public Health Service Act.

1 (2) ENROLLEE.—The term “enrollee” means,
2 with respect to health insurance coverage offered by
3 a health insurance issuer, an individual enrolled with
4 the issuer to receive such coverage.

5 (3) FEE-FOR-SERVICE COVERAGE.—The term
6 “fee-for-service coverage” means coverage that—

7 (A) reimburses hospitals, health profes-
8 sionals, or other providers, directly or by pay-
9 ment to enrollees who are required to pay such
10 parties, on the basis of a rate determined by
11 the issuer on a fee-for-service basis without
12 placing the provider at financial risk;

13 (B) does not vary reimbursement for the
14 coverage period for such a provider based on an
15 agreement to contract terms and conditions or
16 the utilization of health care items or services
17 relating to such provider or enrollees; and

18 (C) does not restrict the selection of pro-
19 viders among those who are lawfully authorized
20 to provide the covered services and agree to ac-
21 cept the terms and conditions of payment estab-
22 lished by the issuer; and

23 (D) for which the issuer does not utilize
24 prospective or concurrent review.

1 (4) GROUP HEALTH PLAN.—The term “group
2 health plan” has the meaning given such term in
3 section 733(a) of the Employee Retirement Income
4 Security Act of 1974.

5 (5) HEALTH PROFESSIONAL.—The term
6 “health professional” means an individual who is li-
7 censed, accredited, or certified under State law to
8 provide specified health care services and who is op-
9 erating within the scope of such licensure, accredita-
10 tion, or certification.

11 (6) NETWORK.—The term “network” means,
12 with respect to a group health plan or health insur-
13 ance issuer offering health insurance coverage, the
14 participating health professionals and providers
15 through whom the plan or issuer provides health
16 care items and services to participants, beneficiaries,
17 or enrollees.

18 (7) NETWORK COVERAGE.—The term “network
19 coverage” means, with respect to a group health
20 plan or health insurance coverage offered by a
21 health insurance issuer, health benefits coverage that
22 provides or arranges for the provision of health care
23 items and services to participants, beneficiaries, or
24 enrollees through participating health professionals
25 and providers.

1 (8) NONPARTICIPATING.—The term “non-
2 participating” means, with respect to a health care
3 provider that provides health care items and services
4 to a participant, beneficiary, or enrollee under group
5 health plan or health insurance coverage, a health
6 care provider that is not a participating health care
7 provider with respect to such items and services.

8 (9) PARTICIPATING.—The term “participating”
9 means, with respect to a health care provider that
10 provides health care items and services to a partici-
11 pant, beneficiary, or enrollee under group health
12 plan or health insurance coverage offered by a
13 health insurance issuer, a health care provider that
14 furnishes such items and services under a contract
15 or other arrangement with the plan or issuer.

16 (10) PRIOR AUTHORIZATION.—The term “prior
17 authorization” means the process of obtaining prior
18 approval from a health insurance issuer for the
19 treatment of a medical or clinical condition.

20 (11) PROVIDER.—The term “provider” means a
21 health organization, health facility, or health agency
22 that is licensed, accredited, or certified to provide
23 health care items and services under applicable State
24 law.

1 (12) SERVICE AREA.—The term “service area”
2 means, with respect to a health insurance issuer
3 with respect to health insurance coverage, the geo-
4 graphic area served by the issuer with respect to the
5 coverage.

6 (13) UTILIZATION REVIEW.—The term “utiliza-
7 tion review” means prospective, concurrent, or retro-
8 spective review of health care items and services,
9 and includes prior authorization requirements for
10 coverage of such items and services.

11 (d) ABORTION AND EUTHANASIA SERVICES DE-
12 FINED.—For purposes of this sections 104 and 116:

13 (1) ABORTION SERVICES.—The term “abortion
14 services” means the performance of an abortion, the
15 providing of drugs to induce an abortion, and serv-
16 ices related directly to the performance of an abor-
17 tion (such as the performance of ultrasound and
18 similar preparatory procedures and preparation of
19 post-abortion pathology reports), but does not in-
20 clude the treatment of injuries or illnesses caused by
21 an abortion.

22 (2) EUTHANASIA SERVICES.—The term “eutha-
23 nasia services” means anything for which the use of
24 funds appropriated by the Congress is prohibited
25 under the Assisted Suicide Funding Restriction Act

1 of 1997 (Public Law 105–12; 42 U.S.C. 14401 et
2 seq.), subject to sections 3(b) of such Act (42 U.S.C.
3 14402(b)).

4 (e) APPLICATION TO PARTNERSHIPS.—The provi-
5 sions of paragraphs (1), (2), and (3) of section 732(d)
6 of the Employee Retirement Income Security Act of 1974
7 shall apply with respect to partnerships.

8 **SEC. 152. PREEMPTION; STATE FLEXIBILITY; CONSTRUC-**
9 **TION.**

10 (a) CONTINUED APPLICABILITY OF STATE LAW
11 WITH RESPECT TO HEALTH INSURANCE ISSUERS.—

12 (1) IN GENERAL.—Subject to paragraph (2),
13 this title shall not be construed to supersede any
14 provision of State law which establishes, implements,
15 or continues in effect any standard or requirement
16 solely relating to health insurance issuers (in connec-
17 tion with group health insurance coverage or other-
18 wise) except to the extent that such standard or re-
19 quirement prevents the application of a requirement
20 of this title.

21 (2) CONTINUED PREEMPTION WITH RESPECT
22 TO GROUP HEALTH PLANS.—Nothing in this title
23 shall be construed to affect or modify the provisions
24 of section 514 of the Employee Retirement Income

1 Security Act of 1974 with respect to group health
2 plans.

3 (b) RULES OF CONSTRUCTION.—Nothing in this title
4 shall be construed as requiring a group health plan or
5 health insurance coverage to provide specific benefits
6 under the terms of such plan or coverage.

7 (c) DEFINITIONS.—For purposes of this section:

8 (1) STATE LAW.—The term “State law” in-
9 cludes all laws, decisions, rules, regulations, or other
10 State action having the effect of law, of any State.
11 A law of the United States applicable only to the
12 District of Columbia shall be treated as a State law
13 rather than a law of the United States.

14 (2) STATE.—The term “State” includes a
15 State, the Northern Mariana Islands, any political
16 subdivisions of a State or such Islands, or any agen-
17 cy or instrumentality of either.

18 **SEC. 153. REGULATIONS.**

19 The Secretaries of Health and Human Services,
20 Labor, and the Treasury shall issue such regulations as
21 may be necessary or appropriate to carry out this title.
22 Such regulations shall be issued consistent with section
23 104 of Health Insurance Portability and Accountability
24 Act of 1996. Such Secretaries may promulgate any in-

1 interim final rules as the Secretaries determine are appro-
 2 priate to carry out this title.

3 **TITLE II—APPLICATION OF**
 4 **QUALITY CARE STANDARDS**
 5 **TO GROUP HEALTH PLANS**
 6 **AND HEALTH INSURANCE**
 7 **COVERAGE UNDER PUBLIC**
 8 **HEALTH SERVICE ACT**

9 **SEC. 201. APPLICATION TO GROUP HEALTH PLANS AND**
 10 **GROUP HEALTH INSURANCE COVERAGE.**

11 (a) IN GENERAL.—Subpart 2 of part A of title
 12 XXVII of the Public Health Service Act is amended by
 13 adding at the end the following new section:

14 **“SEC. 2706. PATIENT PROTECTION STANDARDS.**

15 “(a) IN GENERAL.—Each group health plan shall
 16 comply with patient protection requirements under title I
 17 of the Access to Quality Care Act of 1999, and each health
 18 insurance issuer shall comply with patient protection re-
 19 quirements under such title with respect to group health
 20 insurance coverage it offers, and such requirements shall
 21 be deemed to be incorporated into this subsection.

22 “(b) NOTICE.—A group health plan shall comply with
 23 the notice requirement under section 711(d) of the Em-
 24 ployee Retirement Income Security Act of 1974 with re-
 25 spect to the requirements referred to in subsection (a) and

1 a health insurance issuer shall comply with such notice
 2 requirement as if such section applied to such issuer and
 3 such issuer were a group health plan.”.

4 (b) CONFORMING AMENDMENT.—Section
 5 2721(b)(1)(A) of such Act (42 U.S.C. 300gg–21(b)(1)(A))
 6 is amended by inserting “(other than section 2706)” after
 7 “requirements of such subparts”.

8 **SEC. 202. APPLICATION TO INDIVIDUAL HEALTH INSUR-**
 9 **ANCE COVERAGE.**

10 Part B of title XXVII of the Public Health Service
 11 Act is amended by inserting after section 2751 the follow-
 12 ing new section:

13 **“SEC. 2752. PATIENT PROTECTION STANDARDS.**

14 “(a) IN GENERAL.—Each health insurance issuer
 15 shall comply with patient protection requirements under
 16 title I of the Access to Quality Care Act of 1999 with re-
 17 spect to individual health insurance coverage it offers, and
 18 such requirements shall be deemed to be incorporated into
 19 this subsection.

20 “(b) NOTICE.—A health insurance issuer under this
 21 part shall comply with the notice requirement under sec-
 22 tion 711(d) of the Employee Retirement Income Security
 23 Act of 1974 with respect to the requirements of such title
 24 as if such section applied to such issuer and such issuer
 25 were a group health plan.”.

1 **TITLE III—AMENDMENTS TO**
2 **THE EMPLOYEE RETIREMENT**
3 **INCOME SECURITY ACT OF**
4 **1974**

5 **SEC. 301. APPLICATION OF PATIENT PROTECTION STAND-**
6 **ARDS TO GROUP HEALTH PLANS AND GROUP**
7 **HEALTH INSURANCE COVERAGE UNDER THE**
8 **EMPLOYEE RETIREMENT INCOME SECURITY**
9 **ACT OF 1974.**

10 Subpart B of part 7 of subtitle B of title I of the
11 Employee Retirement Income Security Act of 1974 is
12 amended by adding at the end the following new section:

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

14 “A group health plan (and a health insurance issuer
15 offering group health insurance coverage in connection
16 with such a plan) shall comply with the requirements of
17 title I of the Access to Quality Care Act of 1999 (as in
18 effect as of the date of the enactment of such Act), and
19 such requirements shall be deemed to be incorporated into
20 this section.”.

1 **SEC. 302. ERISA PREEMPTION NOT TO APPLY TO CERTAIN**
2 **ACTIONS INVOLVING HEALTH INSURANCE**
3 **POLICYHOLDERS.**

4 (a) IN GENERAL.—Section 514 of the Employee Re-
5 tirement Income Security Act of 1974 (29 U.S.C. 1144)
6 is amended by adding at the end the following subsection:

7 “(e) PREEMPTION NOT TO APPLY TO CERTAIN AC-
8 TIONS ARISING OUT OF PROVISION OF HEALTH BENE-
9 FITS.—

10 “(1) IN GENERAL.—Except as provided in this
11 subsection, nothing in this title shall be construed to
12 invalidate, impair, or supersede any cause of action
13 under State law to recover damages resulting from
14 personal injury or for wrongful death against any
15 person—

16 “(A) in connection with the provision of in-
17 surance, administrative services, or medical
18 services by such person to or for a group health
19 plan (as defined in section 733), or

20 “(B) that arises out of the arrangement by
21 such person for the provision of such insurance,
22 administrative services, or medical services by
23 other persons.

24 “(2) EXCEPTION FOR EMPLOYERS AND OTHER
25 PLAN SPONSORS.—

1 “(A) IN GENERAL.—Subject to subpara-
2 graph (B), paragraph (1) does not authorize—

3 “(i) any cause of action against an
4 employer or other plan sponsor maintain-
5 ing the group health plan, or

6 “(ii) a right of recovery or indemnity
7 by a person against an employer or other
8 plan sponsor for damages assessed against
9 the person pursuant to a cause of action
10 under paragraph (1).

11 “(B) SPECIAL RULE.—Subparagraph (A)
12 shall not preclude any cause of action described
13 in paragraph (1) against an employer or other
14 plan sponsor if—

15 “(i) such action is based on the em-
16 ployer’s or other plan sponsor’s exercise of
17 discretionary authority to make a decision
18 on a claim for benefits covered under the
19 plan or health insurance coverage in the
20 case at issue; and

21 “(ii) the exercise by such employer or
22 other plan sponsor of such authority re-
23 sulted in personal injury or wrongful
24 death.

1 “(C) EXCEPTION.—The exercise of discre-
 2 tionary authority described in subparagraph
 3 (B)(i) shall not be construed to include—

4 “(i) the decision to include or exclude
 5 from the plan any specific benefit;

6 “(ii) any decision affirming the deci-
 7 sion of a treating health care professional;
 8 or

9 “(iii) any decision to provide benefits
 10 beyond those specified in the plan at the
 11 request of a treating health care profes-
 12 sional.”.

13 (b) EFFECTIVE DATE.—The amendment made by
 14 subsection (a) shall apply to acts and omissions occurring
 15 on or after the date of the enactment of this Act from
 16 which a cause of action arises.

17 **SEC. 303. DIRECT ACCESS TO COURTS.**

18 Section 502 of the Employee Retirement Income Se-
 19 curity Act is amended—

20 (1) in subsection (a)(8) by striking “or” at the
 21 end;

22 (2) in subsection (a)(9) by striking the period
 23 at the end and inserting “; or”;

24 (3) by adding at the end of subsection (a) the
 25 following new paragraph:

1 “(10) by a participant or beneficiary for appro-
 2 priate relief under subsection (b)(4).”; and

3 (4) by adding at the end of subsection (b) the
 4 following new paragraph:

5 “(4) In any case in which exhaustion of admin-
 6 istrative remedies otherwise necessary for an action
 7 for relief has not been obtained and it is dem-
 8 onstrated to the court by means of certification by
 9 an appropriate physician that such exhaustion is not
 10 reasonably attainable under the facts and cir-
 11 cumstances without undue risk of irreparable harm
 12 to the health of the participant or beneficiary, a civil
 13 action may be brought by a participant or bene-
 14 ficiary to obtain appropriate equitable relief. Any de-
 15 terminations made while an action under this para-
 16 graph is pending shall be given due consideration by
 17 the court in any such action.”.

18 **TITLE IV—EFFECTIVE DATES;**
 19 **COORDINATION IN IMPLE-**
 20 **MENTATION**

21 **SEC. 401. EFFECTIVE DATES.**

22 (a) GROUP HEALTH COVERAGE.—

23 (1) IN GENERAL.—Subject to paragraph (2),
 24 the amendments made by sections 201(a) and 301
 25 (and title I insofar as it relates to such sections)

1 shall apply with respect to group health plans, and
2 health insurance coverage offered in connection with
3 group health plans, for plan years beginning on or
4 after January 1, 2000 (in this section referred to as
5 the “general effective date”) and also shall apply to
6 portions of plan years occurring on and after such
7 date.

8 (2) TREATMENT OF COLLECTIVE BARGAINING
9 AGREEMENTS.—In the case of a group health plan
10 maintained pursuant to 1 or more collective bargain-
11 ing agreements between employee representatives
12 and 1 or more employers ratified before the date of
13 enactment of this Act, the amendments made by sec-
14 tions 201(a) and 301 (and title I insofar as it re-
15 lates to such sections) shall not apply to plan years
16 beginning before the later of—

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

22 (B) the general effective date.

23 For purposes of subparagraph (A), any plan amend-
24 ment made pursuant to a collective bargaining
25 agreement relating to the plan which amends the

1 plan solely to conform to any requirement added by
2 this Act shall not be treated as a termination of
3 such collective bargaining agreement.

4 (b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—
5 The amendments made by section 202 shall apply with
6 respect to individual health insurance coverage offered,
7 sold, issued, renewed, in effect, or operated in the individ-
8 ual market on or after the general effective date.

9 **SEC. 402. COORDINATION IN IMPLEMENTATION.**

10 Section 104(1) of Health Insurance Portability and
11 Accountability Act of 1996 is amended by striking “this
12 subtitle (and the amendments made by this subtitle and
13 section 401)” and inserting “the provisions of part 7 of
14 subtitle B of title I of the Employee Retirement Income
15 Security Act of 1974, the provisions of parts A and C of
16 title XXVII of the Public Health Service Act, chapter 100
17 of the Internal Revenue Code of 1986, and title I of the
18 Access to Quality Care Act of 1999”.

○