I

106TH CONGRESS
1ST SESSION

H. R. 2758

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

IN THE HOUSE OF REPRESENTATIVES

AUGUST 5, 1999

Mr. HILLEARY (for himself and Mrs. EMERSON) introduced the following bill; which was referred to the Committee on Education and the Workforce

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A BILL

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

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Common Ground Healthcare Security Act of 1999''.

SEC. 2. SPECIAL RULES FOR GROUP HEALTH PLANS.

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

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

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

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

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

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

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

''(B) provide such notice in writing also to any treating medical care provider of such participant or beneficiary, if such provider has claimed reimbursement for any item or service involved in such coverage decision, or if a claim submitted by the provider initiated the proceedings leading to such decision;

''(C) afford a reasonable opportunity to any participant or beneficiary who is in receipt of the notice of such adverse coverage decision, and who files a written request for review of the initial coverage decision within 180 days after receipt of the notice of the initial decision, for a full and fair de novo review of the decision by an appropriate named fiduciary who did not make the initial decision; and

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

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

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

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

reasonable form as may be required under the plan, the plan shall issue in writing an initial coverage decision on the request before the end of the initial decision period under paragraph (10)(I) following the filing completion date.

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

''(B) TIME LIMITS FOR MAKING COVERAGE DECISIONS RELATING TO EMERGENCY MEDICAL

CARE AND FOR COMPLETING INTERNAL APPEALS.—

"(i) INITIAL DECISIONS.—In cases involving emergency medical care, a group health plan shall issue in writing an initial coverage decision on any request for expedited advance determination of coverage or for expedited required determination of medical necessity submitted, in such reasonable form as may be required under the plan, before the end of the emergency decision period under paragraph (10)(K) following the filing completion date.

"(ii) INTERNAL REVIEWS OF INITIAL DENIALS.—In cases involving emergency medical care, upon the written request of a participant or beneficiary for review of an initial adverse coverage decision under clause (i), a review by an appropriate named fiduciary (subject to paragraph (3)) of the initial coverage decision shall be completed, including issuance by the plan of a written decision affirming, reversing, or modifying the initial coverage decision, setting forth the grounds for the decision,

before the end of the emergency decision period under paragraph (10)(K) following the review filing date. Such decision shall be treated as the final decision of the plan, subject to any applicable reconsideration under paragraph (4).

''(C) CONTINUED APPLICABILITY OF SHORTER TIME LIMITS UNDER PLAN.—Nothing in this paragraph shall be construed to exempt any group health plan from the terms of such plan relating to timeliness of decisionmaking thereunder to the extent that such terms require time limits of shorter duration that those provided under this paragraph.

''(3) PHYSICIANS MUST REVIEW INITIAL COVERAGE DECISIONS INVOLVING MEDICAL APPROPRIATENESS OR NECESSITY OR EXPERIMENTAL TREATMENT.—

''(A) IN GENERAL.—If an initial coverage decision under paragraph (2)(A)(i) or (2)(B)(i) is based on a determination that provision of a particular item or service is excluded from coverage under the terms of the plan because the provision of such item or service does not meet the plan's requirements for medical appro-

priateness or necessity or would constitute experimental treatment or technology, the review under paragraph (2)(A)(ii) or (2)(B)(ii), to the extent that it relates to medical appropriateness or necessity or to experimental treatment or technology, shall be conducted by a qualified physician who is selected to serve as an appropriate named fiduciary under the plan and who did not make the initial denial.

''(B) QUALIFIED PHYSICIAN.—For purposes of subparagraph (A), the term 'qualified physician' means a physician who—

''(i) is licensed, accredited, or certified, under the State law of the State in which the review occurs, to provide the particular item or service referred to in subparagraph (A),

''(ii) is professionally accountable for the decision referred to in subparagraph (A) to the applicable licensing authority of such physician, and

''(iii) is, in the course of making such decision, operating within the scope of such licensure, accreditation, or certification.

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

''(A) IN GENERAL.—The requirements of subparagraphs (B), (C) and (D) shall apply—

''(i) in the case of any adverse coverage decision which is not reversed upon a review conducted pursuant to paragraph (1)(C) (including any review pursuant to paragraph (2)(A)(ii) or (2)(B)(ii)), and

''(ii) in the case of any failure to timely issue a coverage decision upon internal review under paragraph (2)(A)(ii) or (2)(B)(ii) which is deemed under paragraph (8) to be a denial of the request for such decision (thereby failing to constitute a coverage decision for which specific reasons have been set forth as required under paragraph (1)(A)).

''(B) LIMITS ON ALLOWABLE ADVANCE PAYMENTS BY PLAN ENROLLEE EXECUTING EXTERNAL APPEAL.—The review under this paragraph in connection with an adverse coverage decision shall be available subject to any requirement of the plan (unless waived by the

plan for financial or other reasons) for payment in advance to the plan by the participant or beneficiary seeking review of an amount not to exceed the greater of—

"(i) the lesser of $100 or 10 percent of the cost of the medical care involved in the decision; or

"(ii) $25,

with each such dollar amount subject to compounded annual adjustments in the same manner and to the same extent as apply under section 215(i) of the Social Security Act, except that, for any calendar year, such amount as so adjusted shall be deemed, solely for such calendar year, to be equal to such amount rounded to the nearest $10. No such payment may be required in the case of any participant or beneficiary whose enrollment under the plan is paid for, in whole or in part, under a State plan under title XIX or XXI of the Social Security Act. Any such advance payment shall be reimbursed to the participant or beneficiary if a recommendation is reported under subparagraph (C)(iv) to reverse or modify the coverage decision.

''(C) RECONSIDERATION OF INITIAL REVIEW DECISION.—In any case in which a participant or beneficiary who has received an adverse decision of the plan upon initial review of the coverage decision and who has not commenced review of the initial coverage decision under section 502 makes a request in writing, within 30 days after the date of the receipt of such review decision, for reconsideration of such review decision, the terms of the plan shall provide for a procedure for such reconsideration under which—

''(i) one or more independent medical experts will be selected in accordance with subparagraph (F) to review the coverage decision described in subparagraph (A) to determine whether benefit determinations in accordance with such decision would meet the requirements for medical appropriateness or necessity or would constitute experimental treatment or technology;

''(ii) one or more independent experts in contract interpretation will be selected in accordance with subparagraph (G) to review the coverage decision described in

subparagraph (A), with respect to matters not described in clause (i), to determine whether such decision was in accordance with the terms of the plan and this title;

"(iii) the record for review—

"(I) will be presented to such experts and maintained in such a manner which will ensure confidentiality of such record,

"(II) will include a specification of the terms of the plan and other criteria serving as the basis for the initial review decision,

"(III) will include all relevant medical records, and

"(IV) will include such other documentary evidence as may be submitted by the participant or beneficiary requesting review; and

"(iv) each expert will report in writing to the plan the expert's decision, based on the determination made under clause (i) or (ii) as to whether such coverage decision should be affirmed, modified, or reversed,

setting forth the grounds (including the clinical basis) for the recommendation.

''(D) TIME LIMITS FOR RECONSIDERATION.—Any review under this paragraph shall be completed before the end of the reconsideration period (as defined in paragraph (10)(M)) following the review filing date in connection with such review.

''(E) FINAL DECISION.—The decision of the experts reported pursuant to subparagraph (C)(iv) in any case on a matter considered under clause (i) or (ii) of subparagraph (C) affirming, reversing, or modifying the initial review decision of the plan regarding such matter shall be the final decision of the plan regarding such matter in such case.

''(F) INDEPENDENT MEDICAL EXPERTS.—

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

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

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

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

''(IV) who is selected in accordance with clause (ii) and meets the requirements of subparagraph (H).

''(ii) SELECTION OF MEDICAL EXPERTS.—An independent medical expert is selected in accordance with this clause if—

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

the aggrieved participant or beneficiary are not disclosed to the expert;

''(II) the expert is selected, by an appropriately credentialed panel of physicians meeting the requirements of subparagraph (H) established by a fully accredited teaching hospital meeting such requirements;

''(III) the expert is selected by an organization described in section 1152(1)(A) of the Social Security Act which meets the requirements of subparagraph (H);

''(IV) the expert is selected by an external review organization which meets the requirements of subparagraph (H) and is accredited by a private standard-setting organization meeting such requirements and recognized as such by the Secretary; or

''(V) the expert is selected, by an intermediary or otherwise, in a manner that is, under regulations issued pursuant to negotiated rulemaking,

sufficient to ensure the expert's independence,

and the method of selection is devised to reasonably ensure that the expert selected meets the independence requirements of subparagraph (H).

''(G) INDEPENDENT EXPERTS ON CONTRACT INTERPRETATION.—

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

''(I) who has demonstrated expertise in making contractual benefit entitlement determinations;

''(II) who is fully credentialed in the relevant area of expertise regarding the matter or matters at issue;

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

''(IV) who is selected in accordance with clause (ii) and meets the requirements of subparagraph (H).

''(ii) SELECTION OF EXPERTS.—An independent expert on contract interpretation is selected in accordance with this clause if—

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

''(II) the expert is selected, by an appropriately credentialed panel of experts in contract interpretation meeting the requirements of subparagraph (H);

''(III) the expert is selected by an organization described in section

1152(1)(A) of the Social Security Act which meets the requirements of subparagraph (H);

''(IV) the expert is selected by an external review organization which meets the requirements of subparagraph (H) and is accredited by a private standard-setting organization meeting such requirements and recognized as such by the Secretary; or

''(V) the expert is selected, by an intermediary or otherwise, in a manner that is, under regulations issued pursuant to negotiated rulemaking, sufficient to ensure the expert's independence,

and the method of selection is devised to reasonably ensure that the expert selected meets the independence requirements of subparagraph (H).

''(H) INDEPENDENCE REQUIREMENTS.—Any independent expert in contract interpretation, any independent medical expert, or any other entity described in subparagraph (F)(ii)

or (G)(ii) meets the independence requirements of this subparagraph if—

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

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

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

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

For purposes of clause (i), the term 'affiliated' means, in connection with any entity, having a familial, financial, or professional relationship with, or interest in, such entity, disregarding any compensation received in connection with

services performed as a reviewing entity under this paragraph.

''(I) RELATED PARTY.—For purposes of subparagraphs (F)(ii)(I) and (G)(ii)(I), the term 'related party' means—

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

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

''(iii) the institution at which the medical care involved in the coverage decision is provided;

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

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

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

''(A) IN GENERAL.—A group health plan shall not be treated as failing to meet the requirements under paragraphs (2)(A)(ii) and (2)(B)(ii) relating to review of initial coverage decisions for benefits, if—

''(i) in lieu of the procedures relating to review under paragraphs (2)(A)(ii) and (2)(B)(ii) and in accordance with such regulations (if any) as may be prescribed by the Secretary—

''(I) the aggrieved participant or beneficiary elects in the request for the review an alternative dispute resolution procedure which is available under the plan with respect to similarly situated participants and beneficiaries; or

''(II) in the case of any such plan or portion thereof which is established and maintained pursuant to a bona fide collective bargaining agreement, the plan provides for a procedure by which such disputes are resolved by

means of any alternative dispute resolution procedure;

''(ii) the time limits not exceeding the time limits otherwise applicable under paragraphs (2)(A)(ii) and (2)(B)(ii) are incorporated in such alternative dispute resolution procedure;

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

''(iv) the plan meets the additional requirements of subparagraph (B).

In any case in which a procedure described in subclause (I) or (II) of clause (i) is utilized and an alternative dispute resolution procedure is voluntarily elected by the aggrieved participant or beneficiary, the plan may require or allow (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures) the aggrieved participant or bene-

ficiary to waive review of the coverage decision under paragraph (3), to waive further review of the coverage decision under paragraph (4) or section 502, and to elect an alternative means of external review (other than review under paragraph (4)).

''(B) ADDITIONAL REQUIREMENTS.—The requirements of this subparagraph are met if the means of resolution of dispute allow for adequate presentation by the aggrieved participant or beneficiary of scientific and medical evidence supporting the position of such participant or beneficiary.

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

''(A) the plan agrees in advance of the recommendations of the experts under paragraph

(4)(C)(iii) to render a final decision in accordance with such recommendations; and

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

''(7) SPECIAL RULE FOR ACCESS TO SPECIALTY CARE.— In the case of a request for advance determination of coverage consisting of a request by a physician for a determination of coverage of the services of a specialist with respect to any condition, if coverage of the services of such specialist for such condition is otherwise provided under the plan, the initial coverage decision referred to in subparagraph (A)(i) or (B)(i) of paragraph (2) shall be issued within the specialty decision period. For purposes of this paragraph, the term 'specialist' means, with respect to a condition, a physician who has a high level of expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise) to treat the condition.

''(8) EFFECT ON PLAN OF FAILURE TO COMPLY WITH TIME LIMITS FOR DECISIONMAKING.— In any case in which a group health plan fails to take reasonable care to ensure that the decision by the plan, on a written request of a participant or beneficiary

made under paragraph (2) or (4), for a reversal or modification of an earlier decision of the plan, is issued to the participant or beneficiary as required under such paragraph before the end of the applicable period specified in such paragraph, for purposes of further review under this subsection or section 502—

"(A) the request shall be deemed to have been denied by the plan, resulting in exhaustion of any review required as a prerequisite for such further review, and

"(B) the position of the participant or beneficiary serving as the basis for the request for review shall be deemed consistent with the terms of the plan, except to the extent that the plan proves in the course of such further review that such position is not consistent with the terms of the plan or this title.

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

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

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

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

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

"(B) REQUIRED DETERMINATION OF MEDICAL APPROPRIATENESS OR NECESSITY.—The term 'required determination of medical appropriateness or necessity' means a determination required under a group health plan solely that proposed medical care meets, under the facts and circumstances at the time of the determination, the requirements for medical appropriateness or necessity (which may be subject to exceptions under the plan for fraud or misrepresentation) as determined, in the case of an initial coverage decision, by the qualified physician (as defined in paragraph (3)(B)) or, in the case

of an elective external review, by the independent medical expert (as defined in paragraph (4)(F)), irrespective of whether the proposed medical care otherwise meets other terms and conditions of coverage, but only if such determination does not constitute an advance determination of coverage (as defined in subparagraph (C)).

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

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

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

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

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

"(H) EMERGENCY MEDICAL CARE.—The term 'emergency medical care' means medical care in any case in which a certification has been made in writing by an appropriate physician (as provided in regulations which shall be prescribed by the Secretary)—

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

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

"(II) serious impairment to bodily functions; or

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

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

"(I) INITIAL DECISION PERIOD.—The term 'initial decision period' means a period of 14 days, or such longer period as may be prescribed in regulations of the Secretary.

"(J) INTERNAL REVIEW PERIOD.—The term 'internal review period' means a period of 14 days, or such longer period as may be prescribed in regulations of the Secretary.

"(K) EMERGENCY DECISION PERIOD.—The term 'emergency decision period' means a period of 72 hours, or such longer period as may be prescribed in regulations of the Secretary.

"(L) SPECIALTY DECISION PERIOD.—The term 'specialty decision period' means a period of 72 hours, or such longer period as may be prescribed in regulations of the Secretary.

"(M) RECONSIDERATION PERIOD.—The term 'reconsideration period' means a period of 14 days, or such longer period as may be prescribed in regulations of the Secretary, except that, in the case of a decision involving emergency medical care, such term means the emergency decision period.

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

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

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

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

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

"(S) WRITTEN OR IN WRITING.—

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

"(ii) MEDICAL APPROPRIATENESS OR EXPERIMENTAL TREATMENT DETERMINATIONS.—For purposes of this subparagraph, in the case of a request for advance determination of coverage, a request for expedited advance determination of coverage, a request for required determination of medical appropriateness or necessity, or a request for expedited required determination of medical appropriateness or necessity, if the decision on such request is conveyed to the provider of medical care or to

the participant or beneficiary by means of telephonic or other electronic communications, such decision shall be treated as a written decision.

''(11) DETERMINATIONS CONSISTENT WITH THE TERMS OF THE PLAN.—Nothing in this subsection shall be construed as permitting, in the case of any group health plan, a determination by any independent expert in contract interpretation, any independent medical expert, or any other person that such plan is required to provide an item or service which is not covered under the terms of such plan. Determinations under this subsection of whether an item or service is covered under the terms of a group health plan shall be made solely by a professional who has demonstrated expertise in making contractual benefit entitlement determinations and who is fully credentialed in the relevant area of expertise regarding the matter or matters at issue.''.

(b) EXPEDITED FEDERAL COURT REVIEW.—

(1) IN GENERAL.—Section 502 of such Act (29 U.S.C. 1132) is amended—

(A) in subsection (a)(8), by striking ''or'' at the end;

(B) in subsection (a)(9), by striking the period and inserting ''; or'';

(C) by adding at the end of subsection (a) the following new paragraph:

''(10) by a participant or beneficiary for appropriate relief under subsection (b)(4).''; and

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

''(4) In any case in which exhaustion of administrative remedies in accordance with paragraph (2)(A)(ii) or (2)(B)(ii) of section 503(b) otherwise necessary for an action for relief under paragraph (1)(B) or (3) of subsection (a) has not been obtained and it is demonstrated to the court by means of certification by an appropriate physician that such exhaustion is not reasonably attainable under the facts and circumstances without undue risk of irreparable harm to the health of the participant or beneficiary, a civil action may be brought by a participant or beneficiary to obtain appropriate equitable relief. Any determinations made under paragraph (2)(A)(ii) or (2)(B)(ii) of section 503(b) made while an action under this paragraph is pending shall be given due consideration by the court in any such action.''.

(2) CONCURRENT JURISDICTION.—Section 502(e)(1) of such Act (29 U.S.C. 1132(e)(1)) is amended—

(A) in the first sentence, by striking ''under subsection (a)(1)(B) of this section'' and inserting ''under subsection (a)(1)(B) or (b)(4)''; and

(B) in the last sentence, by striking ''of actions under paragraphs (1)(B) and (7) of subsection (a) of this section'' and inserting ''of actions under paragraphs (1)(B) and (7) of subsection (a) and paragraph (4) of subsection (b)''.

(3) STANDARD OF REVIEW UNAFFECTED.—The standard of review under section 502 of the Employee Retirement Income Security Act of 1974 (as amended by this subsection) shall continue on and after the date of the enactment of this Act to be the standard of review which was applicable under such section as of immediately before such date.

SEC. 3. AVAILABILITY OF COURT REMEDIES.

(a) IN GENERAL.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) is amended by adding at the end the following new subsection:

"(n) CAUSE OF ACTION RELATING TO PROVISION OF HEALTH BENEFITS.—

"(1) IN GENERAL.—Any fiduciary of a group health plan (as defined in section 733(a)) who fails to exercise ordinary care resulting in personal injury to, or wrongful death of, a participant or beneficiary shall be liable to the participant or beneficiary for actual damages (including compensatory and consequential damages, subject to paragraph (6)) proximately caused by such failure, if such failure consists of—

"(A) failing to exercise ordinary care in making an incorrect determination that an item or service is excluded from coverage under the terms of the plan based on the fact that the item or service—

"(i) does not meet the plan's requirements for medical appropriateness or necessity, or

"(ii) would constitute experimental treatment or technology (as defined under the plan), or

"(B) failing to exercise ordinary care to ensure that—

"(i) any initial coverage decision referred to in subparagraph (A)(i) or (B)(i) of section 503(b)(2) on which the cause of action is based, or

"(ii) any decision by the plan on a request, made in writing by a participant or beneficiary under subparagraph (A)(ii) or (B)(ii) of section 503(b)(2) or under section 503(b)(4), for a reversal or modification of an earlier decision of the plan on which the cause of action is based,

is issued to the participant or beneficiary (in such form and manner as may be prescribed in regulations of the Secretary) before the end of the applicable period specified in the applicable provision cited in clause (i) or (ii).

"(2) ORDINARY CARE.—For purposes of this subsection, the term 'ordinary care' means the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent individual acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

"(3) EXCEPTION FOR EMPLOYERS AND OTHER PLAN SPONSORS.—

"(A) IN GENERAL.—Subject to subparagraph (B), paragraph (1) does not authorize—

"(i) any cause of action against an employer or other plan sponsor maintaining the group health plan (or against an employee of such an employer or sponsor acting within the scope of employment), or

"(ii) a right of recovery or indemnity by a person against an employer or other plan sponsor (or such an employee) for damages assessed against the person pursuant to a cause of action under paragraph (1).

"(B) SPECIAL RULE.—Subparagraph (A) shall not preclude any cause of action described in paragraph (1) commenced during a plan year against an employer or other plan sponsor (or against an employee of such an employer or sponsor acting within the scope of employment) if—

"(i) such action is based on the direct participation of the employer or other plan sponsor (or employee of the employer or plan sponsor) in the final decision of the plan under section 503(b)(2) on a claim

for benefits covered under the plan or health insurance coverage in the case at issue; and

''(ii) the decision on the claim resulted in personal injury or wrongful death.

''(C) DIRECT PARTICIPATION.—For purposes of subparagraph (B)(ii), in determining whether an employer or other plan sponsor (or employee of an employer or other plan sponsor) is engaged in direct participation in the final decision of the plan under section 503(b)(2) on a claim, the employer or plan sponsor (or employee) shall not be construed to be engaged in such direct participation solely because of—

''(i) any participation by the employer or other plan sponsor (or employee) in the selection of the group health plan or health insurance coverage involved,

''(ii) any engagement by the employer or other plan sponsor (or employee) in any cost-benefit analysis undertaken in connection with the selection of, or continued maintenance of, the plan or coverage involved, or

"(iii) any other form of decision-making or other conduct performed by the employer or other plan sponsor (or employee) in connection with the plan or coverage involved which constitutes neither the making of a final decision of the plan consisting of a failure described in paragraph (1)(A) nor a failure described in paragraph (1)(B).

"(4) REQUIREMENT OF EXHAUSTION OF ADMINISTRATIVE REMEDIES.—

"(A) IN GENERAL.—Paragraph (1) applies in the case of any cause of action only if all remedies under section 503 with respect to such cause of action have been exhausted.

"(B) EXTERNAL REVIEW REQUIRED.—

"(i) IN GENERAL.—For purposes of subparagraph (A), administrative remedies under section 503 shall not be deemed exhausted until available remedies under section 503(b)(4) have been elected and are exhausted.

"(ii) EXCEPTION FOR NOT REASONABLY ATTAINABLE EXHAUSTION OF ADMINISTRATIVE REMEDIES.—Clause (i) shall

not apply in the case of any cause of action if it is demonstrated to the court by means of certification by an appropriate physician that such exhaustion is not reasonably attainable under the facts and circumstances without undue risk of irreparable harm to the health of the participant or beneficiary.

''(C) CONSIDERATION OF ADMINISTRATIVE DETERMINATIONS.—Any determinations made under section 503(b) made while an action under this paragraph is pending shall be given due consideration by the court in such action.

''(5) REBUTTABLE PRESUMPTION.—In the case of any action commenced pursuant to paragraph (1), there shall be a rebuttable presumption in favor of the decision of the independent expert rendered upon completion of any review elected under section 503(b)(4).

''(6) STANDARDS FOR AWARD OF PUNITIVE DAMAGES.—

''(A) GENERAL RULE.—Nothing in this subsection shall be construed as authorizing a cause of action for punitive damages, except that punitive damages are authorized in any case in which the plaintiff establishes by clear

and convincing evidence that conduct carried out by the defendant with a conscious, flagrant indifference to the rights or safety of others was the proximate cause of the harm that is the subject of the action.

''(B) LIMITATION ON AMOUNT.—

''(i) IN GENERAL.—The amount of punitive damages that may be awarded in an action described in subparagraph (A) may not exceed the greater of—

''(I) 2 times the sum of the amount awarded to the claimant for economic loss; or

''(II) $250,000.

''(ii) SPECIAL RULE.—Notwithstanding clause (i), in any action described in subparagraph (A) against an individual whose net worth does not exceed $500,000 or against an owner of an unincorporated business, or any partnership, corporation, association, unit of local government, or organization which has fewer that 25 employees, the punitive damages shall not exceed the lesser of—

"(I) 2 times the sum of the amount awarded to the claimant for economic loss and noneconomic loss; or

"(II) $250,000.

"(iii) CONTROLLED GROUPS.—

"(I) IN GENERAL.—For the purpose of determining the applicability of clause (ii) to any employer, in determining the number of employees of an employer who is a member of a controlled group, the employees of any person in such group shall be deemed to be employees of the employer.

"(II) CONTROLLED GROUP.—For purposes of subclause (I), the term 'controlled group' means any group treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986.

"(C) EXCEPTION FOR INSUFFICIENT AWARD IN CASES OF EGREGIOUS CONDUCT.—

"(i) DETERMINATION BY COURT.—If the court makes a determination, after

considering each of the factors in subparagraph (D), that the application of subparagraph (A) would result in an award of punitive damages that is insufficient to punish the egregious conduct of the defendant against whom the punitive damages are to be awarded or to deter such conduct in the future, the court shall determine the additional amount of punitive damages (referred to in this subparagraph as the 'additional amount') in excess of the amount determined in accordance with subparagraph (A) to be awarded against the defendant in a separate proceeding in accordance with this subparagraph.

''(ii) REQUIREMENTS FOR AWARDING ADDITIONAL AMOUNT.—If the court awards an additional amount pursuant to this subparagraph, the court shall state its reasons for setting the amount of the additional amount in findings of fact and conclusions of law.

''(D) FACTORS FOR CONSIDERATION IN CASES OF EGREGIOUS CONDUCT.—In any proceeding under subparagraph (C), the matters to

be considered by the court shall include (but are not limited to)—

''(i) the extent to which the defendant acted with actual malice;

''(ii) the likelihood that serious harm would arise from the conduct of the defendant;

''(iii) the degree of the awareness of the defendant of that likelihood;

''(iv) the profitability of the misconduct to the defendant;

''(v) the duration of the misconduct and any concurrent or subsequent concealment of the conduct by the defendant;

''(vi) the attitude and conduct of the defendant upon the discovery of the misconduct and whether the misconduct has terminated;

''(vii) the financial condition of the defendant; and

''(viii) the cumulative deterrent effect of other losses, damages, and punishment suffered by the defendant as a result of the misconduct, reducing the amount of punitive damages on the basis of the economic

impact and severity of all measures to which the defendant has been or may be subjected, including—

"(I) compensatory and punitive damage awards to similarly situated claimants;

"(II) the adverse economic effect of stigma or loss of reputation;

"(III) civil fines and criminal and administrative penalties; and

"(IV) stop sale, cease and desist, and other remedial or enforcement orders.

"(E) APPLICATION BY COURT.—This paragraph shall be applied by the court and application of this paragraph shall not be disclosed to the jury. Nothing in this paragraph shall authorize the court to enter an award of punitive damages in excess of the jury's initial award of punitive damages.

"(F) BIFURCATION AT REQUEST OF ANY PARTY.—

"(i) IN GENERAL.—At the request of any party the trier of fact in any action that is subject to this paragraph shall con-

sider in a separate proceeding, held subsequent to the determination of the amount of compensatory damages, whether punitive damages are to be awarded for the harm that is the subject of the action and the amount of the award.

''(ii) INADMISSIBILITY OF EVIDENCE RELATIVE ONLY TO A CLAIM OF PUNITIVE DAMAGES IN A PROCEEDING CONCERNING COMPENSATORY DAMAGES.—If any party requests a separate proceeding under clause (i), in a proceeding to determine whether the claimant may be awarded compensatory damages, any evidence, argument, or contention that is relevant only to the claim of punitive damages, as determined by applicable State law, shall be inadmissible.

''(7) SEVERAL LIABILITY.—

''(A) GENERAL RULE.—In an action described in paragraph (1), the liability of each defendant shall be several only and shall not be joint.

''(B) AMOUNT OF LIABILITY.—

"(i) IN GENERAL.—In any such action, each defendant shall be liable only for the amount allocated to the defendant in direct proportion to the percentage of responsibility of the defendant (determined in accordance with clause (ii)) for the harm to the plaintiff with respect to which the defendant is liable. The court shall render a separate judgment against each defendant in an amount determined pursuant to the preceding sentence.

"(ii) PERCENTAGE OF RESPONSIBILITY.—For purposes of determining the amount allocated to a defendant under this paragraph, the trier of fact shall determine the percentage of responsibility of each person responsible for the plaintiff's harm, whether or not such person is a party to the action.

"(8) LIMITATION OF ACTION.—Paragraph (1) shall not apply in connection with any action commenced after the later of—

"(A) 1 year after (i) the date of the last action which constituted a part of the failure, or (ii) in the case of an omission, the latest

date on which the fiduciary could have cured the failure, or

''(B) 1 year after the earliest date on which the plaintiff first knew, or reasonably should have known, of the bodily injury resulting from the failure.

''(9) CONSTRUCTION.—Nothing in this subsection shall be construed as authorizing a cause of action—

''(A) for the failure to provide an item or service which is not covered under the group health plan involved, or

''(B) for any action taken by a fiduciary which consists of full compliance with the reversal or modification by a final decision under section 503(b)(4)(E) of an initial coverage decision under section 503(b)(2).

''(10) PREEMPTION.—This subsection supersedes any action authorized under State law (as defined in section 514(c)(1)) against any person for damages based on any failure described in subparagraph (A) or (B) of paragraph (1) by such person to the extent that an action against such person for damages based on such failure is authorized under this subsection.''.

(b) CONFORMING AMENDMENT.—Section 502(a)(1)(A) of such Act (29 U.S.C. 1132(a)(1)(A)) is amended by inserting ''or (n)'' after ''subsection (c)''.

SEC. 4. EFFECTIVE DATES.

(a) IN GENERAL.—The amendments made by this Act (other than section 3) shall apply with respect to grievances arising in plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary shall first issue all regulations necessary to carry out the amendments made by this Act before such date.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this Act (other than section 3), against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of final regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

(c) COLLECTIVE BARGAINING AGREEMENTS.—Any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this Act

shall not be treated as a termination of such collective bargaining agreement.

(d) EXPANDED SECTION 502 REMEDIES.—The amendments made by section 3 shall apply to acts and omissions (from which a cause of action arises) occurring on or after the date of the enactment of this Act.

(e) SUNSET.—The amendments made by this Act shall not apply with respect to grievances arising (or acts or omissions occurring) in plan years beginning on or after January 1, 2005, and the provisions of the Employee Retirement Income Security Act of 1974 shall read after such date as if such amendments had not been enacted.

SEC. 5. SEVERABILITY.

If any provision of this Act or amendment made by this Act, or the application of a provision or amendment to any person or circumstance, is held to be unconstitutional, the remainder of this Act and amendments made by this Act, and the application of the provisions and amendment to any person or circumstance, shall not be affected by the holding.

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