

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

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.

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Common Ground
5 Healthcare Security Act of 1999”.

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

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

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

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

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

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

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

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

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

“(C) afford a reasonable opportunity to any participant or beneficiary who is in receipt of the notice of such adverse coverage decision, and who files a written request for review of the initial coverage decision within 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

1 reasonable form as may be required under
2 the plan, the plan shall issue in writing an
3 initial coverage decision on the request be-
4 fore the end of the initial decision period
5 under paragraph (10)(I) following the fil-
6 ing completion date.

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

23 “(B) TIME LIMITS FOR MAKING COVERAGE
24 DECISIONS RELATING TO EMERGENCY MEDICAL

CARE AND FOR COMPLETING INTERNAL AP-
PEALS.—

“(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,

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

7 “(C) CONTINUED APPLICABILITY OF
8 SHORTER TIME LIMITS UNDER PLAN.—Nothing
9 in this paragraph shall be construed to exempt
10 any group health plan from the terms of such
11 plan relating to timeliness of decisionmaking
12 thereunder to the extent that such terms re-
13 quire time limits of shorter duration than those
14 provided under this paragraph.

15 “(3) PHYSICIANS MUST REVIEW INITIAL COV-
16 ERAGE DECISIONS INVOLVING MEDICAL APPRO-
17 PRIATENESS OR NECESSITY OR EXPERIMENTAL
18 TREATMENT.—

19 “(A) IN GENERAL.—If an initial coverage
20 decision under paragraph (2)(A)(i) or (2)(B)(i)
21 is based on a determination that provision of a
22 particular item or service is excluded from cov-
23 erage under the terms of the plan because the
24 provision of such item or service does not meet
25 the plan’s requirements for medical appro-

1 priateness or necessity or would constitute ex-
2 perimental treatment or technology, the review
3 under paragraph (2)(A)(ii) or (2)(B)(ii), to the
4 extent that it relates to medical appropriateness
5 or necessity or to experimental treatment or
6 technology, shall be conducted by a qualified
7 physician who is selected to serve as an appro-
8 priate named fiduciary under the plan and who
9 did not make the initial denial.

10 “(B) QUALIFIED PHYSICIAN.—For pur-
11 poses of subparagraph (A), the term ‘qualified
12 physician’ means a physician who—

13 “(i) is licensed, accredited, or cer-
14 tified, under the State law of the State in
15 which the review occurs, to provide the
16 particular item or service referred to in
17 subparagraph (A),

18 “(ii) is professionally accountable for
19 the decision referred to in subparagraph
20 (A) to the applicable licensing authority of
21 such physician, and

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

1 “(4) ELECTIVE EXTERNAL REVIEW BY INDE-
2 PENDENT MEDICAL EXPERT AND RECONSIDERATION
3 OF INITIAL REVIEW DECISION.—

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

6 “(i) in the case of any adverse cov-
7 erage decision which is not reversed upon
8 a review conducted pursuant to paragraph
9 (1)(C) (including any review pursuant to
10 paragraph (2)(A)(ii) or (2)(B)(ii)), and

11 “(ii) in the case of any failure to time-
12 ly issue a coverage decision upon internal
13 review under paragraph (2)(A)(ii) or
14 (2)(B)(ii) which is deemed under para-
15 graph (8) to be a denial of the request for
16 such decision (thereby failing to constitute
17 a coverage decision for which specific rea-
18 sons have been set forth as required under
19 paragraph (1)(A)).

20 “(B) LIMITS ON ALLOWABLE ADVANCE
21 PAYMENTS BY PLAN ENROLLEE EXECUTING EX-
22 TERNAL APPEAL.—The review under this para-
23 graph in connection with an adverse coverage
24 decision shall be available subject to any re-
25 quirement of the plan (unless waived by the

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

5 “(i) the lesser of \$100 or 10 percent
6 of the cost of the medical care involved in
7 the decision; or

8 “(ii) \$25,
9 with each such dollar amount subject to com-
10 pounded annual adjustments in the same man-
11 ner and to the same extent as apply under sec-
12 tion 215(i) of the Social Security Act, except
13 that, for any calendar year, such amount as so
14 adjusted shall be deemed, solely for such cal-
15 endar year, to be equal to such amount rounded
16 to the nearest \$10. No such payment may be
17 required in the case of any participant or bene-
18 ficiary whose enrollment under the plan is paid
19 for, in whole or in part, under a State plan
20 under title XIX or XXI of the Social Security
21 Act. Any such advance payment shall be reim-
22 bursed to the participant or beneficiary if a rec-
23 ommendation is reported under subparagraph
24 (C)(iv) to reverse or modify the coverage deci-
25 sion.

1 “(C) RECONSIDERATION OF INITIAL RE-
2 VIEW DECISION.—In any case in which a partic-
3 ipant or beneficiary who has received an ad-
4 verse decision of the plan upon initial review of
5 the coverage decision and who has not com-
6 menced review of the initial coverage decision
7 under section 502 makes a request in writing,
8 within 30 days after the date of the receipt of
9 such review decision, for reconsideration of such
10 review decision, the terms of the plan shall pro-
11 vide for a procedure for such reconsideration
12 under which—

13 “(i) one or more independent medical
14 experts will be selected in accordance with
15 subparagraph (F) to review the coverage
16 decision described in subparagraph (A) to
17 determine whether benefit determinations
18 in accordance with such decision would
19 meet the requirements for medical appro-
20 priateness or necessity or would constitute
21 experimental treatment or technology;

22 “(ii) one or more independent experts
23 in contract interpretation will be selected
24 in accordance with subparagraph (G) to re-
25 view the coverage decision described in

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

5 “(iii) the record for review—

6 “(I) will be presented to such ex-
7 perts and maintained in such a man-
8 ner which will ensure confidentiality
9 of such record,

10 “(II) will include a specification
11 of the terms of the plan and other cri-
12 teria serving as the basis for the ini-
13 tial review decision,

14 “(III) will include all relevant
15 medical records, and

16 “(IV) will include such other doc-
17 umentary evidence as may be sub-
18 mitted by the participant or bene-
19 ficiary requesting review; and

20 “(iv) each expert will report in writing
21 to the plan the expert’s decision, based on
22 the determination made under clause (i) or
23 (ii) as to whether such coverage decision
24 should be affirmed, modified, or reversed,

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

3 “(D) TIME LIMITS FOR RECONSIDER-
4 ATION.—Any review under this paragraph shall
5 be completed before the end of the reconsider-
6 ation period (as defined in paragraph (10)(M))
7 following the review filing date in connection
8 with such review.

9 “(E) FINAL DECISION.—The decision of
10 the experts reported pursuant to subparagraph
11 (C)(iv) in any case on a matter considered
12 under clause (i) or (ii) of subparagraph (C) af-
13 firming, reversing, or modifying the initial re-
14 view decision of the plan regarding such matter
15 shall be the final decision of the plan regarding
16 such matter in such case.

17 “(F) INDEPENDENT MEDICAL EXPERTS.—

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

23 “(I) who is a physician or, if ap-
24 propriate, another medical profes-
25 sional;

1 “(II) who has appropriate cre-
2 dentials and has attained recognized
3 expertise in the applicable medical
4 field;

5 “(III) who was not involved in
6 the initial decision or any earlier re-
7 view thereof; and

8 “(IV) who is selected in accord-
9 ance with clause (ii) and meets the re-
10 quirements of subparagraph (H).

11 “(ii) SELECTION OF MEDICAL EX-
12 PERTS.—An independent medical expert is
13 selected in accordance with this clause if—

14 “(I) the expert is selected by an
15 intermediary which itself meets the re-
16 quirements of subparagraph (H), by
17 means of a method which ensures that
18 the identity of the expert is not dis-
19 closed to the plan, any health insur-
20 ance issuer offering health insurance
21 coverage to the aggrieved participant
22 or beneficiary in connection with the
23 plan, and the aggrieved participant or
24 beneficiary under the plan, and the
25 identities of the plan, the issuer, and

1 the aggrieved participant or bene-
2 ficiary are not disclosed to the expert;

3 “(II) the expert is selected, by an
4 appropriately credentialed panel of
5 physicians meeting the requirements
6 of subparagraph (H) established by a
7 fully accredited teaching hospital
8 meeting such requirements;

9 “(III) the expert is selected by an
10 organization described in section
11 1152(1)(A) of the Social Security Act
12 which meets the requirements of sub-
13 paragraph (H);

14 “(IV) the expert is selected by an
15 external review organization which
16 meets the requirements of subpara-
17 graph (H) and is accredited by a pri-
18 vate standard-setting organization
19 meeting such requirements and recog-
20 nized as such by the Secretary; or

21 “(V) the expert is selected, by an
22 intermediary or otherwise, in a man-
23 ner that is, under regulations issued
24 pursuant to negotiated rulemaking,

1 sufficient to ensure the expert’s inde-
2 pendence,
3 and the method of selection is devised to
4 reasonably ensure that the expert selected
5 meets the independence requirements of
6 subparagraph (H).

7 “(G) INDEPENDENT EXPERTS ON CON-
8 TRACT INTERPRETATION.—

9 “(i) IN GENERAL.—For purposes of
10 this paragraph, the term ‘independent ex-
11 pert on contract interpretation’ means, in
12 connection with any coverage decision by a
13 group health plan, a professional—

14 “(I) who has demonstrated ex-
15 pertise in making contractual benefit
16 entitlement determinations;

17 “(II) who is fully credentialed in
18 the relevant area of expertise regard-
19 ing the matter or matters at issue;

20 “(III) who was not involved in
21 the initial decision or any earlier re-
22 view thereof; and

23 “(IV) who is selected in accord-
24 ance with clause (ii) and meets the re-
25 quirements of subparagraph (H).

1 “(ii) SELECTION OF EXPERTS.—An
2 independent expert on contract interpreta-
3 tion is selected in accordance with this
4 clause if—

5 “(I) the expert is selected by an
6 intermediary which itself meets the re-
7 quirements of subparagraph (H), by
8 means of a method which ensures that
9 the identity of the expert is not dis-
10 closed to the plan, any health insur-
11 ance issuer offering health insurance
12 coverage to the aggrieved participant
13 or beneficiary in connection with the
14 plan, and the aggrieved participant or
15 beneficiary under the plan, and the
16 identities of the plan, the issuer, and
17 the aggrieved participant or bene-
18 ficiary are not disclosed to the expert;

19 “(II) the expert is selected, by an
20 appropriately credentialed panel of ex-
21 perts in contract interpretation meet-
22 ing the requirements of subparagraph
23 (H);

24 “(III) the expert is selected by an
25 organization described in section

1 1152(1)(A) of the Social Security Act
2 which meets the requirements of sub-
3 paragraph (H);

4 “(IV) the expert is selected by an
5 external review organization which
6 meets the requirements of subpara-
7 graph (H) and is accredited by a pri-
8 vate standard-setting organization
9 meeting such requirements and recog-
10 nized as such by the Secretary; or

11 “(V) the expert is selected, by an
12 intermediary or otherwise, in a man-
13 ner that is, under regulations issued
14 pursuant to negotiated rulemaking,
15 sufficient to ensure the expert’s inde-
16 pendence,

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

21 “(H) INDEPENDENCE REQUIREMENTS.—
22 Any independent expert in contract interpreta-
23 tion, any independent medical expert, or any
24 other entity described in subparagraph (F)(ii)

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

3 “(i) the expert or entity is not affili-
4 ated with any related party;

5 “(ii) any compensation received by
6 such expert or entity in connection with
7 the external review is reasonable and not
8 contingent on any decision rendered by the
9 expert or entity;

10 “(iii) under the terms of the plan and
11 any health insurance coverage offered in
12 connection with the plan, the plan and the
13 issuer (if any) have no recourse against the
14 expert or entity in connection with the ex-
15 ternal review; and

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

20 For purposes of clause (i), the term ‘affiliated’
21 means, in connection with any entity, having a
22 familial, financial, or professional relationship
23 with, or interest in, such entity, disregarding
24 any compensation received in connection with

1 services performed as a reviewing entity under
2 this paragraph.

3 “(I) RELATED PARTY.—For purposes of
4 subparagraphs (F)(ii)(I) and (G)(ii)(I), the
5 term ‘related party’ means—

6 “(i) the plan or any health insurance
7 issuer offering health insurance coverage in
8 connection with the plan (or any officer,
9 director, or management employee of such
10 plan or issuer);

11 “(ii) the physician or other medical
12 care provider that provided the medical
13 care involved in the coverage decision;

14 “(iii) the institution at which the med-
15 ical care involved in the coverage decision
16 is provided;

17 “(iv) the manufacturer of any drug or
18 other item that was included in the med-
19 ical care involved in the coverage decision;
20 or

21 “(v) any other party determined
22 under any regulations which the Secretary
23 may prescribe to have a substantial inter-
24 est in the coverage decision.

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

3 “(A) IN GENERAL.—A group health plan
4 shall not be treated as failing to meet the re-
5 quirements under paragraphs (2)(A)(ii) and
6 (2)(B)(ii) relating to review of initial coverage
7 decisions for benefits, if—

8 “(i) in lieu of the procedures relating
9 to review under paragraphs (2)(A)(ii) and
10 (2)(B)(ii) and in accordance with such reg-
11 ulations (if any) as may be prescribed by
12 the Secretary—

13 “(I) the aggrieved participant or
14 beneficiary elects in the request for
15 the review an alternative dispute reso-
16 lution procedure which is available
17 under the plan with respect to simi-
18 larly situated participants and bene-
19 ficiaries; or

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

1 means of any alternative dispute reso-
2 lution procedure;

3 “(ii) the time limits not exceeding the
4 time limits otherwise applicable under
5 paragraphs (2)(A)(ii) and (2)(B)(ii) are in-
6 corporated in such alternative dispute reso-
7 lution procedure;

8 “(iii) any applicable requirement for
9 review by a physician under paragraph (3),
10 unless waived by the participant or bene-
11 ficiary (in a manner consistent with such
12 regulations as the Secretary may prescribe
13 to ensure equitable procedures), is incor-
14 porated in such alternative dispute resolu-
15 tion procedure; and

16 “(iv) the plan meets the additional re-
17 quirements of subparagraph (B).

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

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

7 “(B) ADDITIONAL REQUIREMENTS.—The
8 requirements of this subparagraph are met if
9 the means of resolution of dispute allow for
10 adequate presentation by the aggrieved partici-
11 pant or beneficiary of scientific and medical evi-
12 dence supporting the position of such partici-
13 pant or beneficiary.

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

24 “(A) the plan agrees in advance of the rec-
25 ommendations of the experts under paragraph

1 (4)(C)(iii) to render a final decision in accord-
2 ance with such recommendations; and

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

6 “(7) SPECIAL RULE FOR ACCESS TO SPECIALTY
7 CARE.— In the case of a request for advance deter-
8 mination of coverage consisting of a request by a
9 physician for a determination of coverage of the
10 services of a specialist with respect to any condition,
11 if coverage of the services of such specialist for such
12 condition is otherwise provided under the plan, the
13 initial coverage decision referred to in subparagraph
14 (A)(i) or (B)(i) of paragraph (2) shall be issued
15 within the specialty decision period. For purposes of
16 this paragraph, the term ‘specialist’ means, with re-
17 spect to a condition, a physician who has a high level
18 of expertise through appropriate training and experi-
19 ence (including, in the case of a child, appropriate
20 pediatric expertise) to treat the condition.

21 “(8) EFFECT ON PLAN OF FAILURE TO COMPLY
22 WITH TIME LIMITS FOR DECISIONMAKING.— In any
23 case in which a group health plan fails to take rea-
24 sonable care to ensure that the decision by the plan,
25 on a written request of a participant or beneficiary

1 made under paragraph (2) or (4), for a reversal or
2 modification of an earlier decision of the plan, is
3 issued to the participant or beneficiary as required
4 under such paragraph before the end of the applica-
5 ble period specified in such paragraph, for purposes
6 of further review under this subsection or section
7 502—

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

12 “(B) the position of the participant or ben-
13 eficiary serving as the basis for the request for
14 review shall be deemed consistent with the
15 terms of the plan, except to the extent that the
16 plan proves in the course of such further review
17 that such position is not consistent with the
18 terms of the plan or this title.

19 “(9) GROUP HEALTH PLAN DEFINED.—For
20 purposes of this section—

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

1 “(B) TREATMENT OF PARTNERSHIPS.—

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

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

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

13 “(B) REQUIRED DETERMINATION OF MED-
14 ICAL APPROPRIATENESS OR NECESSITY.—The
15 term ‘required determination of medical appro-
16 priateness or necessity’ means a determination
17 required under a group health plan solely that
18 proposed medical care meets, under the facts
19 and circumstances at the time of the determina-
20 tion, the requirements for medical appropriate-
21 ness or necessity (which may be subject to ex-
22 ceptions under the plan for fraud or misrepresen-
23 tation) as determined, in the case of an ini-
24 tial coverage decision, by the qualified physician
25 (as defined in paragraph (3)(B)) or, in the case

1 of an elective external review, by the inde-
2 pendent medical expert (as defined in para-
3 graph (4)(F)), irrespective of whether the pro-
4 posed medical care otherwise meets other terms
5 and conditions of coverage, but only if such de-
6 termination does not constitute an advance de-
7 termination of coverage (as defined in subpara-
8 graph (C)).

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

18 “(D) REQUEST FOR ADVANCE DETERMINA-
19 TION OF COVERAGE.—The term ‘request for ad-
20 vance determination of coverage’ means a re-
21 quest for an advance determination of coverage
22 of medical care which is made by or on behalf
23 of a participant or beneficiary before such med-
24 ical care is provided.

1 “(E) REQUEST FOR EXPEDITED ADVANCE
2 DETERMINATION OF COVERAGE.—The term ‘re-
3 quest for expedited advance determination of
4 coverage’ means a request for advance deter-
5 mination of coverage, in any case in which the
6 proposed medical care constitutes emergency
7 medical care.

8 “(F) REQUEST FOR REQUIRED DETER-
9 MINATION OF MEDICAL APPROPRIATENESS OR
10 NECESSITY.—The term ‘request for required
11 determination of medical appropriateness or ne-
12 cessity’ means a request for a required deter-
13 mination of medical appropriateness or neces-
14 sity for medical care which is made by or on be-
15 half of a participant or beneficiary before the
16 medical care is provided.

17 “(G) REQUEST FOR EXPEDITED REQUIRED
18 DETERMINATION OF MEDICAL APPROPRIATE-
19 NESS OR NECESSITY.—The term ‘request for
20 expedited required determination of medical ap-
21 propriateness or necessity’ means a request for
22 required determination of medical appropriate-
23 ness or necessity in any case in which the pro-
24 posed medical care constitutes emergency med-
25 ical care.

1 “(H) EMERGENCY MEDICAL CARE.—The
2 term ‘emergency medical care’ means medical
3 care in any case in which a certification has
4 been made in writing by an appropriate physi-
5 cian (as provided in regulations which shall be
6 prescribed by the Secretary)—

7 “(i) that failure to immediately pro-
8 vide the care to the participant or bene-
9 ficiary could reasonably be expected to re-
10 sult in—

11 “(I) placing the health of such
12 participant or beneficiary (or, with re-
13 spect to such a participant or bene-
14 ficiary who is a pregnant woman, the
15 health of the woman or her unborn
16 child) in serious jeopardy;

17 “(II) serious impairment to bod-
18 ily functions; or

19 “(III) serious dysfunction of any
20 bodily organ or part; or

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

1 “(I) INITIAL DECISION PERIOD.—The term
2 ‘initial decision period’ means a period of 14
3 days, or such longer period as may be pre-
4 scribed in regulations of the Secretary.

5 “(J) INTERNAL REVIEW PERIOD.—The
6 term ‘internal review period’ means a period of
7 14 days, or such longer period as may be pre-
8 scribed in regulations of the Secretary.

9 “(K) EMERGENCY DECISION PERIOD.—
10 The term ‘emergency decision period’ means a
11 period of 72 hours, or such longer period as
12 may be prescribed in regulations of the Sec-
13 retary.

14 “(L) SPECIALTY DECISION PERIOD.—The
15 term ‘specialty decision period’ means a period
16 of 72 hours, or such longer period as may be
17 prescribed in regulations of the Secretary.

18 “(M) RECONSIDERATION PERIOD.—The
19 term ‘reconsideration period’ means a period of
20 14 days, or such longer period as may be pre-
21 scribed in regulations of the Secretary, except
22 that, in the case of a decision involving emer-
23 gency medical care, such term means the emer-
24 gency decision period.

1 “(N) FILING COMPLETION DATE.—The
2 term ‘filing completion date’ means, in connec-
3 tion with a group health plan, the date as of
4 which the plan is in receipt of all information
5 reasonably required (in writing or in such other
6 reasonable form as may be specified by the
7 plan) to make an initial coverage decision.

8 “(O) REVIEW FILING DATE.—The term
9 ‘review filing date’ means, in connection with a
10 group health plan, the date as of which the ap-
11 propriate named fiduciary (or the expert or ex-
12 perts selected in the case of a review under
13 paragraph (4)) is in receipt of all information
14 reasonably required (in writing or in such other
15 reasonable form as may be specified by the
16 plan) to make a decision to affirm, modify, or
17 reverse a coverage decision.

18 “(P) MEDICAL CARE.—The term ‘medical
19 care’ has the meaning provided such term by
20 section 733(a)(2).

21 “(Q) HEALTH INSURANCE COVERAGE.—
22 The term ‘health insurance coverage’ has the
23 meaning provided such term by section
24 733(b)(1).

1 “(R) HEALTH INSURANCE ISSUER.—The
2 term ‘health insurance issuer’ has the meaning
3 provided such term by section 733(b)(2).

4 “(S) WRITTEN OR IN WRITING.—

5 “(i) IN GENERAL.—A request or deci-
6 sion shall be deemed to be ‘written’ or ‘in
7 writing’ if such request or decision is pre-
8 sented in a generally recognized printable
9 or electronic format. The Secretary may by
10 regulation provide for presentation of in-
11 formation otherwise required to be in writ-
12 ten form in such other forms as may be
13 appropriate under the circumstances.

14 “(ii) MEDICAL APPROPRIATENESS OR
15 EXPERIMENTAL TREATMENT DETERMINA-
16 TIONS.—For purposes of this subpara-
17 graph, in the case of a request for advance
18 determination of coverage, a request for
19 expedited advance determination of cov-
20 erage, a request for required determination
21 of medical appropriateness or necessity, or
22 a request for expedited required determina-
23 tion of medical appropriateness or neces-
24 sity, if the decision on such request is con-
25 veyed to the provider of medical care or to

1 the participant or beneficiary by means of
2 telephonic or other electronic communica-
3 tions, such decision shall be treated as a
4 written decision.

5 “(11) DETERMINATIONS CONSISTENT WITH
6 THE TERMS OF THE PLAN.—Nothing in this sub-
7 section shall be construed as permitting, in the case
8 of any group health plan, a determination by any
9 independent expert in contract interpretation, any
10 independent medical expert, or any other person that
11 such plan is required to provide an item or service
12 which is not covered under the terms of such plan.
13 Determinations under this subsection of whether an
14 item or service is covered under the terms of a group
15 health plan shall be made solely by a professional
16 who has demonstrated expertise in making contrac-
17 tual benefit entitlement determinations and who is
18 fully credentialed in the relevant area of expertise
19 regarding the matter or matters at issue.”.

20 (b) EXPEDITED FEDERAL COURT REVIEW.—

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

23 (A) in subsection (a)(8), by striking “or”
24 at the end;

1 (B) in subsection (a)(9), by striking the
2 period and inserting “; or”;

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

5 “(10) by a participant or beneficiary for appropriate
6 relief under subsection (b)(4).”; and

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

9 “(4) In any case in which exhaustion of administra-
10 tive remedies in accordance with paragraph (2)(A)(ii) or
11 (2)(B)(ii) of section 503(b) otherwise necessary for an ac-
12 tion for relief under paragraph (1)(B) or (3) of subsection
13 (a) has not been obtained and it is demonstrated to the
14 court by means of certification by an appropriate physi-
15 cian that such exhaustion is not reasonably attainable
16 under the facts and circumstances without undue risk of
17 irreparable harm to the health of the participant or bene-
18 ficiary, a civil action may be brought by a participant or
19 beneficiary to obtain appropriate equitable relief. Any de-
20 terminations made under paragraph (2)(A)(ii) or
21 (2)(B)(ii) of section 503(b) made while an action under
22 this paragraph is pending shall be given due consideration
23 by the court in any such action.”.

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

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

8 (B) in the last sentence, by striking “of ac-
 9 tions under paragraphs (1)(B) and (7) of sub-
 10 section (a) of this section” and inserting “of ac-
 11 tions under paragraphs (1)(B) and (7) of sub-
 12 section (a) and paragraph (4) of subsection
 13 (b)”.

14 (3) STANDARD OF REVIEW UNAFFECTED.—The
 15 standard of review under section 502 of the Em-
 16 ployee Retirement Income Security Act of 1974 (as
 17 amended by this subsection) shall continue on and
 18 after the date of the enactment of this Act to be the
 19 standard of review which was applicable under such
 20 section as of immediately before such date.

21 **SEC. 3. AVAILABILITY OF COURT REMEDIES.**

22 (a) IN GENERAL.—Section 502 of the Employee Re-
 23 tirement Income Security Act of 1974 (29 U.S.C. 1132)
 24 is amended by adding at the end the following new sub-
 25 section:

1 “(n) CAUSE OF ACTION RELATING TO PROVISION OF
2 HEALTH BENEFITS.—

3 “(1) IN GENERAL.—Any fiduciary of a group
4 health plan (as defined in section 733(a)) who fails
5 to exercise ordinary care resulting in personal injury
6 to, or wrongful death of, a participant or beneficiary
7 shall be liable to the participant or beneficiary for
8 actual damages (including compensatory and con-
9 sequential damages, subject to paragraph (6)) proxi-
10 mately caused by such failure, if such failure con-
11 sists of—

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

17 “(i) does not meet the plan’s require-
18 ments for medical appropriateness or ne-
19 cessity, or

20 “(ii) would constitute experimental
21 treatment or technology (as defined under
22 the plan), or

23 “(B) failing to exercise ordinary care to
24 ensure that—

1 “(i) any initial coverage decision re-
2 ferred to in subparagraph (A)(i) or (B)(i)
3 of section 503(b)(2) on which the cause of
4 action is based, or

5 “(ii) any decision by the plan on a re-
6 quest, made in writing by a participant or
7 beneficiary under subparagraph (A)(ii) or
8 (B)(ii) of section 503(b)(2) or under sec-
9 tion 503(b)(4), for a reversal or modifica-
10 tion of an earlier decision of the plan on
11 which the cause of action is based,

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

17 “(2) ORDINARY CARE.—For purposes of this
18 subsection, the term ‘ordinary care’ means the care,
19 skill, prudence, and diligence under the cir-
20 cumstances then prevailing that a prudent individual
21 acting in a like capacity and familiar with such mat-
22 ters would use in the conduct of an enterprise of a
23 like character and with like aims.

24 “(3) 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 against an
6 employee of such an employer or sponsor
7 acting within the scope of employment), or

8 “(ii) a right of recovery or indemnity
9 by a person against an employer or other
10 plan sponsor (or such an employee) for
11 damages assessed against the person pur-
12 suant to a cause of action under paragraph
13 (1).

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

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

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

4 “(ii) the decision on the claim resulted
5 in personal injury or wrongful death.

6 “(C) DIRECT PARTICIPATION.—For pur-
7 poses of subparagraph (B)(ii), in determining
8 whether an employer or other plan sponsor (or
9 employee of an employer or other plan sponsor)
10 is engaged in direct participation in the final
11 decision of the plan under section 503(b)(2) on
12 a claim, the employer or plan sponsor (or em-
13 ployee) shall not be construed to be engaged in
14 such direct participation solely because of—

15 “(i) any participation by the employer
16 or other plan sponsor (or employee) in the
17 selection of the group health plan or health
18 insurance coverage involved,

19 “(ii) any engagement by the employer
20 or other plan sponsor (or employee) in any
21 cost-benefit analysis undertaken in connec-
22 tion with the selection of, or continued
23 maintenance of, the plan or coverage in-
24 volved, or

1 “(iii) any other form of decision-
2 making or other conduct performed by the
3 employer or other plan sponsor (or em-
4 ployee) in connection with the plan or cov-
5 erage involved which constitutes neither
6 the making of a final decision of the plan
7 consisting of a failure described in para-
8 graph (1)(A) nor a failure described in
9 paragraph (1)(B).

10 “(4) REQUIREMENT OF EXHAUSTION OF AD-
11 MINISTRATIVE REMEDIES.—

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

16 “(B) EXTERNAL REVIEW REQUIRED.—

17 “(i) IN GENERAL.—For purposes of
18 subparagraph (A), administrative remedies
19 under section 503 shall not be deemed ex-
20 hausted until available remedies under sec-
21 tion 503(b)(4) have been elected and are
22 exhausted.

23 “(ii) EXCEPTION FOR NOT REASON-
24 ABLY ATTAINABLE EXHAUSTION OF AD-
25 MINISTRATIVE REMEDIES.—Clause (i) shall

1 not apply in the case of any cause of action
2 if it is demonstrated to the court by means
3 of certification by an appropriate physician
4 that such exhaustion is not reasonably at-
5 tainable under the facts and circumstances
6 without undue risk of irreparable harm to
7 the health of the participant or beneficiary.

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

13 “(5) REBUTTABLE PRESUMPTION.—In the case
14 of any action commenced pursuant to paragraph (1),
15 there shall be a rebuttable presumption in favor of
16 the decision of the independent expert rendered upon
17 completion of any review elected under section
18 503(b)(4).

19 “(6) STANDARDS FOR AWARD OF PUNITIVE
20 DAMAGES.—

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

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

6 “(B) LIMITATION ON AMOUNT.—

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

11 “(I) 2 times the sum of the
12 amount awarded to the claimant for
13 economic loss; or

14 “(II) \$250,000.

15 “(ii) SPECIAL RULE.—Notwith-
16 standing clause (i), in any action described
17 in subparagraph (A) against an individual
18 whose net worth does not exceed \$500,000
19 or against an owner of an unincorporated
20 business, or any partnership, corporation,
21 association, unit of local government, or
22 organization which has fewer than 25 em-
23 ployees, the punitive damages shall not ex-
24 ceed the lesser of—

1 “(I) 2 times the sum of the
2 amount awarded to the claimant for
3 economic loss and noneconomic loss;
4 or

5 “(II) \$250,000.

6 “(iii) CONTROLLED GROUPS.—

7 “(I) IN GENERAL.—For the pur-
8 pose of determining the applicability
9 of clause (ii) to any employer, in de-
10 termining the number of employees of
11 an employer who is a member of a
12 controlled group, the employees of any
13 person in such group shall be deemed
14 to be employees of the employer.

15 “(II) CONTROLLED GROUP.—For
16 purposes of subclause (I), the term
17 ‘controlled group’ means any group
18 treated as a single employer under
19 subsection (b), (c), (m), or (o) of sec-
20 tion 414 of the Internal Revenue Code
21 of 1986.

22 “(C) EXCEPTION FOR INSUFFICIENT
23 AWARD IN CASES OF EGREGIOUS CONDUCT.—

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

1 considering each of the factors in subpara-
2 graph (D), that the application of subpara-
3 graph (A) would result in an award of pu-
4 nitive damages that is insufficient to pun-
5 ish the egregious conduct of the defendant
6 against whom the punitive damages are to
7 be awarded or to deter such conduct in the
8 future, the court shall determine the addi-
9 tional amount of punitive damages (re-
10 ferred to in this subparagraph as the ‘addi-
11 tional amount’) in excess of the amount
12 determined in accordance with subpara-
13 graph (A) to be awarded against the de-
14 fendant in a separate proceeding in accord-
15 ance with this subparagraph.

16 “(ii) REQUIREMENTS FOR AWARDING
17 ADDITIONAL AMOUNT.—If the court
18 awards an additional amount pursuant to
19 this subparagraph, the court shall state its
20 reasons for setting the amount of the addi-
21 tional amount in findings of fact and con-
22 clusions of law.

23 “(D) FACTORS FOR CONSIDERATION IN
24 CASES OF EGREGIOUS CONDUCT.—In any pro-
25 ceeding under subparagraph (C), the matters to

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

3 “(i) the extent to which the defendant
4 acted with actual malice;

5 “(ii) the likelihood that serious harm
6 would arise from the conduct of the de-
7 fendant;

8 “(iii) the degree of the awareness of
9 the defendant of that likelihood;

10 “(iv) the profitability of the mis-
11 conduct to the defendant;

12 “(v) the duration of the misconduct
13 and any concurrent or subsequent conceal-
14 ment of the conduct by the defendant;

15 “(vi) the attitude and conduct of the
16 defendant upon the discovery of the mis-
17 conduct and whether the misconduct has
18 terminated;

19 “(vii) the financial condition of the
20 defendant; and

21 “(viii) the cumulative deterrent effect
22 of other losses, damages, and punishment
23 suffered by the defendant as a result of the
24 misconduct, reducing the amount of puni-
25 tive damages on the basis of the economic

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

4 “(I) compensatory and punitive
5 damage awards to similarly situated
6 claimants;

7 “(II) the adverse economic effect
8 of stigma or loss of reputation;

9 “(III) civil fines and criminal and
10 administrative penalties; and

11 “(IV) stop sale, cease and desist,
12 and other remedial or enforcement or-
13 ders.

14 “(E) APPLICATION BY COURT.—This para-
15 graph shall be applied by the court and applica-
16 tion of this paragraph shall not be disclosed to
17 the jury. Nothing in this paragraph shall au-
18 thorize the court to enter an award of punitive
19 damages in excess of the jury’s initial award of
20 punitive damages.

21 “(F) BIFURCATION AT REQUEST OF ANY
22 PARTY.—

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

1 sider in a separate proceeding, held subse-
2 quent to the determination of the amount
3 of compensatory damages, whether puni-
4 tive damages are to be awarded for the
5 harm that is the subject of the action and
6 the amount of the award.

7 “(ii) INADMISSIBILITY OF EVIDENCE
8 RELATIVE ONLY TO A CLAIM OF PUNITIVE
9 DAMAGES IN A PROCEEDING CONCERNING
10 COMPENSATORY DAMAGES.—If any party
11 requests a separate proceeding under
12 clause (i), in a proceeding to determine
13 whether the claimant may be awarded
14 compensatory damages, any evidence, ar-
15 gument, or contention that is relevant only
16 to the claim of punitive damages, as deter-
17 mined by applicable State law, shall be in-
18 admissible.

19 “(7) SEVERAL LIABILITY.—

20 “(A) GENERAL RULE.—In an action de-
21 scribed in paragraph (1), the liability of each
22 defendant shall be several only and shall not be
23 joint.

24 “(B) AMOUNT OF LIABILITY.—

1 “(i) IN GENERAL.—In any such ac-
 2 tion, each defendant shall be liable only for
 3 the amount allocated to the defendant in
 4 direct proportion to the percentage of re-
 5 sponsibility of the defendant (determined
 6 in accordance with clause (ii)) for the
 7 harm to the plaintiff with respect to which
 8 the defendant is liable. The court shall
 9 render a separate judgment against each
 10 defendant in an amount determined pursu-
 11 ant to the preceding sentence.

12 “(ii) PERCENTAGE OF RESPONSI-
 13 BILITY.—For purposes of determining the
 14 amount allocated to a defendant under this
 15 paragraph, the trier of fact shall determine
 16 the percentage of responsibility of each
 17 person responsible for the plaintiff’s harm,
 18 whether or not such person is a party to
 19 the action.

20 “(8) LIMITATION OF ACTION.—Paragraph (1)
 21 shall not apply in connection with any action com-
 22 menced after the later of—

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

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

3 “(B) 1 year after the earliest date on
4 which the plaintiff first knew, or reasonably
5 should have known, of the bodily injury result-
6 ing from the failure.

7 “(9) CONSTRUCTION.—Nothing in this sub-
8 section shall be construed as authorizing a cause of
9 action—

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

13 “(B) for any action taken by a fiduciary
14 which consists of full compliance with the rever-
15 sal or modification by a final decision under
16 section 503(b)(4)(E) of an initial coverage deci-
17 sion under section 503(b)(2).

18 “(10) PREEMPTION.—This subsection super-
19 sedes any action authorized under State law (as de-
20 fined in section 514(c)(1)) against any person for
21 damages based on any failure described in subpara-
22 graph (A) or (B) of paragraph (1) by such person
23 to the extent that an action against such person for
24 damages based on such failure is authorized under
25 this subsection.”.

1 (b) CONFORMING AMENDMENT.—Section
2 502(a)(1)(A) of such Act (29 U.S.C. 1132(a)(1)(A)) is
3 amended by inserting “or (n)” after “subsection (c)”.

4 **SEC. 4. EFFECTIVE DATES.**

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

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

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

1 shall not be treated as a termination of such collective bar-
2 gaining agreement.

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

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

13 **SEC. 5. SEVERABILITY.**

14 If any provision of this Act or amendment made by
15 this Act, or the application of a provision or amendment
16 to any person or circumstance, is held to be unconstitu-
17 tional, the remainder of this Act and amendments made
18 by this Act, and the application of the provisions and
19 amendment to any person or circumstance, shall not be
20 affected by the holding.

○