II

106TH CONGRESS
1ST SESSION

# H. R. 2990

IN THE SENATE OF THE UNITED STATES

OCTOBER 14, 1999
Recieved

# AN ACT

To amend the Internal Revenue Code of 1986 to allow individuals greater access to health insurance through a health care tax deduction, a long-term care deduction, and other health-related tax incentives, to amend the Employee Retirement Income Security Act of 1974 to provide access to and choice in health care through association health plans, to amend the Public Health Service

Act to create new pooling opportunities for small employers to obtain greater access to health coverage through HealthMarts; to amend title I of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service Act, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage; and for other purposes.

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

**SECTION 1. ORGANIZATION OF ACT INTO DIVISIONS; TABLE OF CONTENTS.**

(a) DIVISIONS.—This Act is organized into 2 divisions as follows:

(1) Division A—Quality Care for the Uninsured Act of 1999.

(2) Division B—Bipartisan Consensus Managed Care Improvement Act of 1999.

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

# DIVISION A—QUALITY CARE FOR THE UNINSURED ACT OF 1999

# TITLE I—GENERAL PROVISIONS

## SEC. 101. SHORT TITLE OF DIVISION; TABLE OF CONTENTS OF DIVISION.

(a) SHORT TITLE OF DIVISION.—This division may be cited as the ''Quality Care for the Uninsured Act of 1999''.

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

**SEC. 102. CONSTITUTIONAL AUTHORITY TO ENACT THIS DIVISION.**

The constitutional authority upon which this division rests is the power of the Congress to regulate commerce with foreign nations and among the several States, set forth in article I, section 8 of the United States Constitution.

**SEC. 103. PURPOSES OF DIVISION.**

The purposes of this division are—

(1) to make it possible for individuals, employees, and the self-employed to purchase and own their own health insurance without suffering any negative tax consequences;

(2) to assist individuals in obtaining and in paying for basic health care services;

(3) to render patients and deliverers sensitive to the cost of health care, giving them both the incentive and the ability to restrain undesired increases in health care costs;

(4) to foster the development of numerous, varied, and innovative systems of providing health care which will compete against each other in terms of price, service, and quality, and thus allow the American people to benefit from competitive forces which will reward efficient and effective deliverers and eliminate those which provide unsatisfactory quality of care or are inefficient; and

(5) to encourage the development of systems of delivering health care which are capable of supplying a broad range of health care services in a comprehensive and systematic manner.

**SEC. 104. FINDINGS RELATING TO HEALTH CARE CHOICE.**

(a) Congress finds that the majority of Americans are receiving health care of a quality unmatched elsewhere in the world but that 43 million Americans remain without private health insurance. Congress further finds that small business faces significant challenges in the purchase of health insurance, including higher costs and lack of choice of coverage. Congress further finds that such challenges lead to fewer Americans who are able to take advantage of private health insurance, leading to higher cost and lower quality care.

(b) Congress finds that reduction of the number of uninsured Americans is an important public policy goal. Congress further finds that the use of alternative pooling mechanisms such as Association Health Plans, HealthMarts and other innovative means could provide significant opportunities for small business and individuals to purchase health insurance. Congress further finds that the use of such mechanisms could provide significant opportunities to expand private health coverage for individuals who are employees of small business, self-employed, or do not work for employers who provide health insurance.

(c) Congress finds that the current Tax Code provides significant incentives for employers to provide health insurance coverage for their employees by providing a de-

duction for the employer for the cost of health insurance coverage and an exclusion from income for the employee for employer-provided health care. Congress further finds that some individuals may prefer to decline coverage under their employer's group health plan and obtain individual health insurance coverage, and some employers may wish to give employees the opportunity to do so. Congress further finds that the Internal Revenue Service has ruled that this tax treatment for the employer and employee for employer-provided health care applies even if the employer pays for individual health insurance polices for its employees. Therefore, the Tax Code makes it possible for employers to provide employees choice among health insurance coverage while retaining favorable tax treatment. Congress further finds that the present-law exclusion for employer-provided health care, together with the tax provisions in the bill, will provide more equitable tax treatment for health insurance expenses, encourage uninsured individuals to purchase insurance, expand health care options, and encourage individuals to better manage their health care needs and expenses.

(d) Congress finds that continually increasing and complex Government regulation of the health care delivery system has proven ineffective in restraining costs and is

itself expensive and counterproductive in fulfilling its purposes and detrimental to the care of patients.

# TITLE II—TAX-RELATED HEALTH CARE PROVISIONS

## SEC. 201. DEDUCTION FOR HEALTH AND LONG-TERM CARE INSURANCE COSTS OF INDIVIDUALS NOT PARTICIPATING IN EMPLOYER-SUBSIDIZED HEALTH PLANS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by redesignating section 222 as section 223 and by inserting after section 221 the following new section:

### "SEC. 222. HEALTH AND LONG-TERM CARE INSURANCE COSTS.

''(a) IN GENERAL.—In the case of an individual, there shall be allowed as a deduction an amount equal to the applicable percentage of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer and the taxpayer's spouse and dependents.

''(b) APPLICABLE PERCENTAGE.—For purposes of subsection (a), the applicable percentage shall be determined in accordance with the following table:

| "For taxable years beginning in calendar year— | The applicable percentage is— |
|---|---|
| 2002, 2003, and 2004 | 25 |
| 2005 | 35 |
| 2006 | 65 |
| 2007 and thereafter | 100. |

''(c) LIMITATION BASED ON OTHER COVERAGE.—

''(1) COVERAGE UNDER CERTAIN SUBSIDIZED EMPLOYER PLANS.—

''(A) IN GENERAL.—Subsection (a) shall not apply to any taxpayer for any calendar month for which the taxpayer participates in any health plan maintained by any employer of the taxpayer or of the spouse of the taxpayer if 50 percent or more of the cost of coverage under such plan (determined under section 4980B and without regard to payments made with respect to any coverage described in subsection (e)) is paid or incurred by the employer.

''(B) EMPLOYER CONTRIBUTIONS TO CAFETERIA PLANS, FLEXIBLE SPENDING ARRANGEMENTS, AND MEDICAL SAVINGS ACCOUNTS.—Employer contributions to a cafeteria plan, a flexible spending or similar arrangement, or a medical savings account which are excluded from gross income under section 106 shall be treated for purposes of subparagraph (A) as paid by the employer.

"(C) AGGREGATION OF PLANS OF EMPLOYER.—A health plan which is not otherwise described in subparagraph (A) shall be treated as described in such subparagraph if such plan would be so described if all health plans of persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 were treated as one health plan.

"(D) SEPARATE APPLICATION TO HEALTH INSURANCE AND LONG-TERM CARE INSURANCE.—Subparagraphs (A) and (C) shall be applied separately with respect to—

"(i) plans which include primarily coverage for qualified long-term care services or are qualified long-term care insurance contracts, and

"(ii) plans which do not include such coverage and are not such contracts.

"(2) COVERAGE UNDER CERTAIN FEDERAL PROGRAMS.—

"(A) IN GENERAL.—Subsection (a) shall not apply to any amount paid for any coverage for an individual for any calendar month if, as of the first day of such month, the individual is

covered under any medical care program described in—

"(i) title XVIII, XIX, or XXI of the Social Security Act,

"(ii) chapter 55 of title 10, United States Code,

"(iii) chapter 17 of title 38, United States Code,

"(iv) chapter 89 of title 5, United States Code, or

"(v) the Indian Health Care Improvement Act.

"(B) EXCEPTIONS.—

"(i) QUALIFIED LONG-TERM CARE.—Subparagraph (A) shall not apply to amounts paid for coverage under a qualified long-term care insurance contract.

"(ii) CONTINUATION COVERAGE OF FEHBP.—Subparagraph (A)(iv) shall not apply to coverage which is comparable to continuation coverage under section 4980B.

"(d) LONG-TERM CARE DEDUCTION LIMITED TO QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.—In the case of a qualified long-term care insur-

ance contract, only eligible long-term care premiums (as defined in section 213(d)(10)) may be taken into account under subsection (a).

''(e) DEDUCTION NOT AVAILABLE FOR PAYMENT OF ANCILLARY COVERAGE PREMIUMS.—Any amount paid as a premium for insurance which provides for—

''(1) coverage for accidents, disability, dental care, vision care, or a specified illness, or

''(2) making payments of a fixed amount per day (or other period) by reason of being hospitalized,

shall not be taken into account under subsection (a).

''(f) SPECIAL RULES.—

''(1) COORDINATION WITH DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.—The amount taken into account by the taxpayer in computing the deduction under section 162(l) shall not be taken into account under this section.

''(2) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—The amount taken into account by the taxpayer in computing the deduction under this section shall not be taken into account under section 213.

''(g) REGULATIONS.—The Secretary shall prescribe such regulations as may be appropriate to carry out this

section, including regulations requiring employers to report to their employees and the Secretary such information as the Secretary determines to be appropriate.''.

(b) DEDUCTION ALLOWED WHETHER OR NOT TAXPAYER ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 of such Code is amended by inserting after paragraph (17) the following new item:

''(18) HEALTH AND LONG-TERM CARE INSURANCE COSTS.—The deduction allowed by section 222.''.

(c) CLERICAL AMENDMENT.—The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following new items:

''Sec. 222. Health and long-term care insurance costs.
''Sec. 223. Cross reference.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2001.

**SEC. 202. DEDUCTION FOR 100 PERCENT OF HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.**

(a) IN GENERAL.—Paragraph (1) of section 162(l) of the Internal Revenue Code of 1986 is amended to read as follows:

''(1) ALLOWANCE OF DEDUCTION.—In the case of an individual who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to 100 percent of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer and the taxpayer's spouse and dependents.''.

(b) CLARIFICATION OF LIMITATIONS ON OTHER COVERAGE.—The first sentence of section 162(l)(2)(B) of such Code is amended to read as follows: ''Paragraph (1) shall not apply to any taxpayer for any calendar month for which the taxpayer participates in any subsidized health plan maintained by any employer (other than an employer described in section 401(c)(4)) of the taxpayer or the spouse of the taxpayer.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2000.

**SEC. 203. EXPANSION OF AVAILABILITY OF MEDICAL SAVINGS ACCOUNTS.**

(a) REPEAL OF LIMITATIONS ON NUMBER OF MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Subsections (i) and (j) of section 220 of the Internal Revenue Code of 1986 are hereby repealed.

(2) CONFORMING AMENDMENTS.—

(A) Paragraph (1) of section 220(c) of such Code is amended by striking subparagraph (D).

(B) Section 138 of such Code is amended by striking subsection (f).

(b) AVAILABILITY NOT LIMITED TO ACCOUNTS FOR EMPLOYEES OF SMALL EMPLOYERS AND SELF-EMPLOYED INDIVIDUALS.—

(1) IN GENERAL.—Section 220(c)(1)(A) of such Code (relating to eligible individual) is amended to read as follows:

"(A) IN GENERAL.—The term 'eligible individual' means, with respect to any month, any individual if—

"(i) such individual is covered under a high deductible health plan as of the 1st day of such month, and

"(ii) such individual is not, while covered under a high deductible health plan, covered under any health plan—

"(I) which is not a high deductible health plan, and

"(II) which provides coverage for any benefit which is covered under the high deductible health plan.".

(2) CONFORMING AMENDMENTS.—

(A) Section 220(c)(1) of such Code is amended by striking subparagraph (C).

(B) Section 220(c) of such Code is amended by striking paragraph (4) (defining small employer) and by redesignating paragraph (5) as paragraph (4).

(C) Section 220(b) of such Code is amended by striking paragraph (4) (relating to deduction limited by compensation) and by redesignating paragraphs (5), (6), and (7) as paragraphs (4), (5), and (6), respectively.

(c) INCREASE IN AMOUNT OF DEDUCTION ALLOWED FOR CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Paragraph (2) of section 220(b) of such Code is amended to read as follows:

"(2) MONTHLY LIMITATION.—The monthly limitation for any month is the amount equal to 1/12 of the annual deductible (as of the first day of such

month) of the individual's coverage under the high deductible health plan.''.

(2) CONFORMING AMENDMENT.—Clause (ii) of section 220(d)(1)(A) of such Code is amended by striking ''75 percent of''.

(d) BOTH EMPLOYERS AND EMPLOYEES MAY CONTRIBUTE TO MEDICAL SAVINGS ACCOUNTS.—Paragraph (4) of section 220(b) of such Code (as redesignated by subsection (b)(2)(C)) is amended to read as follows:

''(4) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS.—The limitation which would (but for this paragraph) apply under this subsection to the taxpayer for any taxable year shall be reduced (but not below zero) by the amount which would (but for section 106(b)) be includible in the taxpayer's gross income for such taxable year.''.

(e) REDUCTION OF PERMITTED DEDUCTIBLES UNDER HIGH DEDUCTIBLE HEALTH PLANS.—

(1) IN GENERAL.—Subparagraph (A) of section 220(c)(2) of such Code (defining high deductible health plan) is amended—

(A) by striking ''$1,500'' in clause (i) and inserting ''$1,000''; and

(B) by striking ''$3,000'' in clause (ii) and inserting ''$2,000''.

(2) CONFORMING AMENDMENT.—Subsection (g) of section 220 of such Code is amended to read as follows:

"(g) COST-OF-LIVING ADJUSTMENT.—

"(1) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1998, each dollar amount in subsection (c)(2) shall be increased by an amount equal to—

"(A) such dollar amount, multiplied by

"(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins by substituting 'calendar year 1997' for 'calendar year 1992' in subparagraph (B) thereof.

"(2) SPECIAL RULES.—In the case of the $1,000 amount in subsection (c)(2)(A)(i) and the $2,000 amount in subsection (c)(2)(A)(ii), paragraph (1)(B) shall be applied by substituting 'calendar year 1999' for 'calendar year 1997'.

"(3) ROUNDING.—If any increase under paragraph (1) or (2) is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.".

(f) MEDICAL SAVINGS ACCOUNTS MAY BE OFFERED UNDER CAFETERIA PLANS.—Subsection (f) of section 125 of such Code is amended by striking ''106(b),''.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2000.

**SEC. 204. LONG-TERM CARE INSURANCE PERMITTED TO BE OFFERED UNDER CAFETERIA PLANS AND FLEXIBLE SPENDING ARRANGEMENTS.**

(a) CAFETERIA PLANS.—

(1) IN GENERAL.—Subsection (f) of section 125 of the Internal Revenue Code of 1986 (defining qualified benefits) is amended by inserting before the period at the end ''; except that such term shall include the payment of premiums for any qualified long-term care insurance contract (as defined in section 7702B) to the extent the amount of such payment does not exceed the eligible long-term care premiums (as defined in section 213(d)(10)) for such contract''.

(b) FLEXIBLE SPENDING ARRANGEMENTS.—Section 106 of such Code (relating to contributions by employer to accident and health plans) is amended by striking subsection (c).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2001.

**SEC. 205. ADDITIONAL PERSONAL EXEMPTION FOR TAXPAYER CARING FOR ELDERLY FAMILY MEMBER IN TAXPAYER'S HOME.**

(a) IN GENERAL.—Section 151 of the Internal Revenue Code of 1986 (relating to allowance of deductions for personal exemptions) is amended by redesignating subsection (e) as subsection (f) and by inserting after subsection (d) the following new subsection:

''(e) ADDITIONAL EXEMPTION FOR CERTAIN ELDERLY FAMILY MEMBERS RESIDING WITH TAXPAYER.—

''(1) IN GENERAL.—An exemption of the exemption amount for each qualified family member of the taxpayer.

''(2) QUALIFIED FAMILY MEMBER.—For purposes of this subsection, the term 'qualified family member' means, with respect to any taxable year, any individual—

''(A) who is an ancestor of the taxpayer or of the taxpayer's spouse or who is the spouse of any such ancestor,

"(B) who is a member for the entire taxable year of a household maintained by the taxpayer, and

"(C) who has been certified, before the due date for filing the return of tax for the taxable year (without extensions), by a physician (as defined in section 1861(r)(1) of the Social Security Act) as being an individual with long-term care needs described in paragraph (3) for a period—

"(i) which is at least 180 consecutive days, and

"(ii) a portion of which occurs within the taxable year.

Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless within the 39½ month period ending on such due date (or such other period as the Secretary prescribes) a physician (as so defined) has certified that such individual meets such requirements.

"(3) INDIVIDUALS WITH LONG-TERM CARE NEEDS.—An individual is described in this paragraph if the individual—

"(A) is unable to perform (without substantial assistance from another individual) at

least two activities of daily living (as defined in section 7702B(c)(2)(B)) due to a loss of functional capacity, or

"(B) requires substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment and is unable to perform, without reminding or cuing assistance, at least one activity of daily living (as so defined) or to the extent provided in regulations prescribed by the Secretary (in consultation with the Secretary of Health and Human Services), is unable to engage in age appropriate activities.

"(4) SPECIAL RULES.—Rules similar to the rules of paragraphs (1), (2), (3), (4), and (5) of section 21(e) shall apply for purposes of this subsection.".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2000.

**SEC. 206. EXPANDED HUMAN CLINICAL TRIALS QUALIFYING FOR ORPHAN DRUG CREDIT.**

(a) IN GENERAL.—Subclause (I) of section 45C(b)(2)(A)(ii) of the Internal Revenue Code of 1986 is amended to read as follows:

''(I) after the date that the application is filed for designation under such section 526, and''.

(b) CONFORMING AMENDMENT.—Clause (i) of section 45C(b)(2)(A) of such Code is amended by inserting ''which is'' before ''being'' and by inserting before the comma at the end ''and which is designated under section 526 of such Act''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to amounts paid or incurred after December 31, 2000.

**SEC. 207. INCLUSION OF CERTAIN VACCINES AGAINST STREPTOCOCCUS PNEUMONIAE TO LIST OF TAXABLE VACCINES; REDUCTION IN PER DOSE TAX RATE.**

(a) INCLUSION OF VACCINES.—

(1) IN GENERAL.—Section 4132(a)(1) of the Internal Revenue Code of 1986 (defining taxable vaccine) is amended by adding at the end the following new subparagraph:

''(L) Any conjugate vaccine against streptococcus pneumoniae.''.

(2) EFFECTIVE DATE.—

(A) SALES.—The amendment made by this subsection shall apply to vaccine sales beginning

on the day after the date on which the Centers for Disease Control makes a final recommendation for routine administration to children of any conjugate vaccine against streptococcus pneumoniae, but shall not take effect if subsection (c) does not take effect.

(B) DELIVERIES.—For purposes of subparagraph (A), in the case of sales on or before the date described in such subparagraph for which delivery is made after such date, the delivery date shall be considered the sale date.

(b) REDUCTION IN PER DOSE TAX RATE.—

(1) IN GENERAL.—Section 4131(b)(1) of such Code (relating to amount of tax) is amended by striking ''75 cents'' and inserting ''50 cents''.

(2) EFFECTIVE DATE.—

(A) SALES.—The amendment made by this subsection shall apply to vaccine sales after December 31, 2004, but shall not take effect if subsection (c) does not take effect.

(B) DELIVERIES.—For purposes of subparagraph (A), in the case of sales on or before the date described in such subparagraph for which delivery is made after such date, the delivery date shall be considered the sale date.

(3) LIMITATION ON CERTAIN CREDITS OR REFUNDS.—For purposes of applying section 4132(b) of the Internal Revenue Code of 1986 with respect to any claim for credit or refund filed after August 31, 2004, the amount of tax taken into account shall not exceed the tax computed under the rate in effect on January 1, 2005.

(c) VACCINE TAX AND TRUST FUND AMENDMENTS.—

(1) Sections 1503 and 1504 of the Vaccine Injury Compensation Program Modification Act (and the amendments made by such sections) are hereby repealed.

(2) Subparagraph (A) of section 9510(c)(1) of such Code is amended by striking ''August 5, 1997'' and inserting ''October 21, 1998''.

(3) The amendments made by this subsection shall take effect as if included in the provisions of the Tax and Trade Relief Extension Act of 1998 to which they relate.

(d) REPORT.—Not later than December 31, 1999, the Comptroller General of the United States shall prepare and submit a report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate on the operation of the Vaccine In-

jury Compensation Trust Fund and on the adequacy of such Fund to meet future claims made under the Vaccine Injury Compensation Program.

**SEC. 208. CREDIT FOR CLINICAL TESTING RESEARCH EXPENSES ATTRIBUTABLE TO CERTAIN QUALIFIED ACADEMIC INSTITUTIONS INCLUDING TEACHING HOSPITALS.**

(a) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business related credits) is amended by inserting after section 41 the following:

**"SEC. 41A. CREDIT FOR MEDICAL INNOVATION EXPENSES.**

''(a) GENERAL RULE.—For purposes of section 38, the medical innovation credit determined under this section for the taxable year shall be an amount equal to 40 percent of the excess (if any) of—

''(1) the qualified medical innovation expenses for the taxable year, over

''(2) the medical innovation base period amount.

''(b) QUALIFIED MEDICAL INNOVATION EXPENSES.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified medical innovation expenses' means the amounts which are paid or incurred by the taxpayer during the taxable

year directly or indirectly to any qualified academic institution for clinical testing research activities.

"(2) CLINICAL TESTING RESEARCH ACTIVITIES.—

"(A) IN GENERAL.—The term 'clinical testing research activities' means human clinical testing conducted at any qualified academic institution in the development of any product, which occurs before—

"(i) the date on which an application with respect to such product is approved under section 505(b), 506, or 507 of the Federal Food, Drug, and Cosmetic Act (as in effect on the date of the enactment of this section),

"(ii) the date on which a license for such product is issued under section 351 of the Public Health Service Act (as so in effect), or

"(iii) the date classification or approval of such product which is a device intended for human use is given under section 513, 514, or 515 of the Federal Food, Drug, and Cosmetic Act (as so in effect).

"(B) PRODUCT.—The term 'product' means any drug, biologic, or medical device.

"(3) QUALIFIED ACADEMIC INSTITUTION.—The term 'qualified academic institution' means any of the following institutions:

"(A) EDUCATIONAL INSTITUTION.—A qualified organization described in section 170(b)(1)(A)(iii) which is owned by, or affiliated with, an institution of higher education (as defined in section 3304(f)).

"(B) TEACHING HOSPITAL.—A teaching hospital which—

"(i) is publicly supported or owned by an organization described in section 501(c)(3), and

"(ii) is affiliated with an organization meeting the requirements of subparagraph (A).

"(C) FOUNDATION.—A medical research organization described in section 501(c)(3) (other than a private foundation) which is affiliated with, or owned by—

"(i) an organization meeting the requirements of subparagraph (A), or

"(ii) a teaching hospital meeting the requirements of subparagraph (B).

"(D) CHARITABLE RESEARCH HOSPITAL.—A hospital that is designated as a cancer center by the National Cancer Institute.

"(4) EXCLUSION FOR AMOUNTS FUNDED BY GRANTS, ETC.—The term 'qualified medical innovation expenses' shall not include any amount to the extent such amount is funded by any grant, contract, or otherwise by another person (or any governmental entity).

"(c) MEDICAL INNOVATION BASE PERIOD AMOUNT.—For purposes of this section, the term 'medical innovation base period amount' means the average annual qualified medical innovation expenses paid by the taxpayer during the 3-taxable year period ending with the taxable year immediately preceding the first taxable year of the taxpayer beginning after December 31, 2000.

"(d) SPECIAL RULES.—

"(1) LIMITATION ON FOREIGN TESTING.—No credit shall be allowed under this section with respect to any clinical testing research activities conducted outside the United States.

''(2) CERTAIN RULES MADE APPLICABLE.—Rules similar to the rules of subsections (f) and (g) of section 41 shall apply for purposes of this section.

''(3) ELECTION.—This section shall apply to any taxpayer for any taxable year only if such taxpayer elects to have this section apply for such taxable year.

''(4) COORDINATION WITH CREDIT FOR INCREASING RESEARCH EXPENDITURES AND WITH CREDIT FOR CLINICAL TESTING EXPENSES FOR CERTAIN DRUGS FOR RARE DISEASES.—Any qualified medical innovation expense for a taxable year to which an election under this section applies shall not be taken into account for purposes of determining the credit allowable under section 41 or 45C for such taxable year.''.

(b) CREDIT TO BE PART OF GENERAL BUSINESS CREDIT.—

(1) IN GENERAL.—Section 38(b) of such Code (relating to current year business credits) is amended by striking ''plus'' at the end of paragraph (11), by striking the period at the end of paragraph (12) and inserting '', plus'', and by adding at the end the following:

''(13) the medical innovation expenses credit determined under section 41A(a).''.

(2) TRANSITION RULE.—Section 39(d) of such Code is amended by adding at the end the following new paragraph:

''(9) NO CARRYBACK OF SECTION 41A CREDIT BEFORE ENACTMENT.—No portion of the unused business credit for any taxable year which is attributable to the medical innovation credit determined under section 41A may be carried back to a taxable year beginning before January 1, 2001.''.

(c) DENIAL OF DOUBLE BENEFIT.—Section 280C of such Code is amended by adding at the end the following new subsection:

''(d) CREDIT FOR INCREASING MEDICAL INNOVATION EXPENSES.—

''(1) IN GENERAL.—No deduction shall be allowed for that portion of the qualified medical innovation expenses (as defined in section 41A(b)) otherwise allowable as a deduction for the taxable year which is equal to the amount of the credit determined for such taxable year under section 41A(a).

''(2) CERTAIN RULES TO APPLY.—Rules similar to the rules of paragraphs (2), (3), and (4) of sub-

section (c) shall apply for purposes of this subsection.''.

(d) DEDUCTION FOR UNUSED PORTION OF CREDIT.—Section 196(c) of such Code (defining qualified business credits) is amended by redesignating paragraphs (5) through (8) as paragraphs (6) through (9), respectively, and by inserting after paragraph (4) the following new paragraph:

''(5) the medical innovation expenses credit determined under section 41A(a) (other than such credit determined under the rules of section 280C(d)(2)),''.

(e) CLERICAL AMENDMENT.—The table of sections for subpart D of part IV of subchapter A of chapter 1 of such Code is amended by adding after the item relating to section 41 the following:

''Sec. 41A. Credit for medical innovation expenses.''.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2000.

# TITLE III—GREATER ACCESS AND CHOICE THROUGH ASSOCIATION HEALTH PLANS

**SEC. 301. RULES.**

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

''PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

**''SEC. 801. ASSOCIATION HEALTH PLANS.**

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

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

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

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

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

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

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

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

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

**"SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH PLANS.**

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

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

''(1) such certification—

''(A) is administratively feasible;

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

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

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

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

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

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

upon appropriate filing under such procedure in connection with plans in such class and payment of the prescribed fee under section 807(a).

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

''(1) a plan which offered such coverage on the date of the enactment of the Quality Care for the Uninsured Act of 1999,

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

''(3) a plan whose eligible participating employers represent one or more trades or businesses, or one or more industries, which have been indicated as having average or above-average health insurance risk or health claims experience by reason of State rate filings, denials of coverage, proposed premium rate levels, and other means demonstrated by such plan in accordance with regulations which the Secretary shall prescribe through negotiated rule-

making, including (but not limited to) the following: agriculture; automobile dealerships; barbering and cosmetology; child care; construction; dance, theatrical, and orchestra productions; disinfecting and pest control; eating and drinking establishments; fishing; hospitals; labor organizations; logging; manufacturing (metals); mining; medical and dental practices; medical laboratories; sanitary services; transportation (local and freight); and warehousing.

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

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

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

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

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

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

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

''(B) LIMITATION.—

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

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

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

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

''(C) CERTAIN PLANS EXCLUDED.—Subparagraph (A) shall not apply to an association health plan which is in existence on the date of the enactment of the Quality Care for the Uninsured Act of 1999.

''(D) SOLE AUTHORITY.—The board has sole authority under the plan to approve applications for participation in the plan and to con-

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

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

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

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

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

''(d) CERTAIN COLLECTIVELY BARGAINED PLANS.—

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

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

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

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

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

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

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

**''SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.**

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

''(1) each participating employer must be—

''(A) a member of the sponsor,

''(B) the sponsor, or

''(C) an affiliated member of the sponsor with respect to which the requirements of subsection (b) are met,

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

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

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

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

''(b) COVERAGE OF PREVIOUSLY UNINSURED EMPLOYEES.—In the case of an association health plan in existence on the date of the enactment of the Quality Care for the Uninsured Act of 1999, an affiliated member of the sponsor of the plan may be offered coverage under the plan as a participating employer only if—

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

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

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

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

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

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

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

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

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

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

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

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

''(C) incorporates the requirements of section 806.

''(2) CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.—

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

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

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

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

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

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

''(4) MARKETING REQUIREMENTS.—

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

ployers coverage which does not consist of health insurance coverage in a manner comparable to the manner in which such agents are used to distribute health insurance coverage.

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

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

''(b) ABILITY OF ASSOCIATION HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Subject to section 514(d), nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from exercising its sole discretion

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

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

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

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

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

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

''(i) a reserve sufficient for unearned contributions;

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

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

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

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

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

specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

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

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

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

ommend, taking into account the specific circumstances of the plan.

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

''(1) $500,000, or

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

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

''(d) ADJUSTMENTS FOR EXCESS/STOP LOSS INSURANCE.—The applicable authority may provide for adjustments to the levels of reserves otherwise required under

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

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

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

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

"(A) IN GENERAL.—In the case of an association health plan described in subsection (a)(2), the requirements of this subsection are met if the plan makes payments into the Association Health Plan Fund under this subparagraph when they are due. Such payments shall consist of annual payments in the amount of $5,000, except that the Secretary shall reduce part or all of such annual payments, or shall provide a rebate of part or all of such a payment, to the extent that the Secretary determines that the balance in such Fund is sufficient (taking into account such a reduction or rebate) to meet all reasonable actuarial requirements. Such determination shall occur not less than once annually. In addition to any such annual payments, such payments may include such supplemental payments as the Secretary may determine to be necessary to meet reasonable actuarial requirements to carry out paragraph (2). Payments under this paragraph are payable to the Fund at the time determined by the Secretary. Initial payments are due in ad-

vance of certification under this part. Payments shall continue to accrue until a plan's assets are distributed pursuant to a termination procedure.

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

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

''(2) PAYMENTS BY SECRETARY TO CONTINUE EXCESS/STOP LOSS INSURANCE COVERAGE AND INDEMNIFICATION INSURANCE COVERAGE FOR CERTAIN PLANS.—In any case in which the applicable authority determines that there is, or that there is reason to believe that there will be: (A) a failure to take necessary corrective actions under section 809(a) with respect to an association health plan described in subsection (a)(2); or (B) a termination of such a plan under section 809(b) or 810(b)(8) (and,

if the applicable authority is not the Secretary, certifies such determination to the Secretary), the Secretary shall determine the amounts necessary to make payments to an insurer (designated by the Secretary) to maintain in force excess/stop loss insurance coverage or indemnification insurance coverage for such plan, if the Secretary determines that there is a reasonable expectation that, without such payments, claims would not be satisfied by reason of termination of such coverage. The Secretary shall, to the extent provided in advance in appropriation Acts, pay such amounts so determined to the insurer designated by the Secretary.

''(3) ASSOCIATION HEALTH PLAN FUND.—

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

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

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

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

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

''(B) which is guaranteed renewable; and

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

''(2) SPECIFIC EXCESS/STOP LOSS INSURANCE.—The term 'specific excess/stop loss insur-

ance' means, in connection with an association health plan, a contract—

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

''(B) which is guaranteed renewable; and

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

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

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

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

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

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

''(j) SOLVENCY STANDARDS WORKING GROUP.—

''(1) IN GENERAL.—Within 90 days after the date of the enactment of the Quality Care for the Uninsured Act of 1999, the applicable authority shall establish a Solvency Standards Working Group. In prescribing the initial regulations under this section, the applicable authority shall take into account the recommendations of such Working Group.

''(2) MEMBERSHIP.—The Working Group shall consist of 18 members appointed by the applicable authority as follows:

''(A) three representatives of the National Association of Insurance Commissioners;

''(B) three representatives of the American Academy of Actuaries;

''(C) three representatives of the State governments, or their interests;

''(D) three representatives of existing self-insured arrangements, or their interests;

''(E) three representatives of associations of the type referred to in section 801(b)(1), or their interests; and

''(F) three representatives of multiemployer plans that are group health plans, or their interests.

**''SEC. 807. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.**

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

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

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

''(A) the sponsor; and

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

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

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

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

be provided to participants and beneficiaries under the plan.

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

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

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

''(B) ADEQUACY OF CONTRIBUTION RATES.—A statement of actuarial opinion, signed by a qualified actuary, which sets forth a description of the extent to which contribution

rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the plan for the 12-month period beginning with such date within such 120-day period, taking into account the expected coverage and experience of the plan. If the contribution rates are not fully adequate, the statement of actuarial opinion shall indicate the extent to which the rates are inadequate and the changes needed to ensure adequacy.

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

''(D) COSTS OF COVERAGE TO BE CHARGED AND OTHER EXPENSES.—A statement of the costs of coverage to be charged, including an itemization of amounts for adminis-

tration, reserves, and other expenses associated with the operation of the plan.

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

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

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

negotiated rulemaking, prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

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

''(f) ENGAGEMENT OF QUALIFIED ACTUARY.—The board of trustees of each association health plan which provides benefits options in addition to health insurance coverage and which is applying for certification under this part or is certified under this part shall engage, on behalf of all participants and beneficiaries, a qualified actuary who shall be responsible for the preparation of the materials comprising information necessary to be submitted by

a qualified actuary under this part. The qualified actuary shall utilize such assumptions and techniques as are necessary to enable such actuary to form an opinion as to whether the contents of the matters reported under this part—

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

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

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

**''SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.**

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

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

''(2) develops a plan for winding up the affairs of the plan in connection with such termination in

a manner which will result in timely payment of all benefits for which the plan is obligated; and

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

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

**''SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.**

''(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—An association health plan which is certified under this part and which provides benefits other than health insurance coverage shall continue to meet the requirements of section 806, irrespective of whether such certification continues in effect. The board of trustees of such plan shall determine quarterly whether the requirements of section 806 are met. In any case in which the board determines that there is reason to believe that there is or will be a failure to meet such requirements, or the applicable authority makes such a determination and so notifies the board, the board shall immediately notify the qualified actuary engaged by the plan, and such actuary shall, not later than the end of the next following month, make such recommendations to the board for corrective action as the actuary determines necessary to ensure com-

pliance with section 806. Not later than 30 days after receiving from the actuary recommendations for corrective actions, the board shall notify the applicable authority (in such form and manner as the applicable authority may prescribe by regulation through negotiated rulemaking) of such recommendations of the actuary for corrective action, together with a description of the actions (if any) that the board has taken or plans to take in response to such recommendations. The board shall thereafter report to the applicable authority, in such form and frequency as the applicable authority may specify to the board, regarding corrective action taken by the board until the requirements of section 806 are met.

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

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

''(2) the applicable authority determines that there is a reasonable expectation that the plan will

continue to fail to meet the requirements of section 806,

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

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

''(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR INSOLVENT PLANS.—Whenever the Secretary determines that an association health plan which is or has been certified under this part and which is described in section 806(a)(2) will be unable to provide benefits when due or is otherwise in a financially hazardous condition, as shall be defined by the Secretary by regulation through negotiated rulemaking, the Secretary shall, upon notice to the plan, apply to the appropriate United States district court

for appointment of the Secretary as trustee to administer the plan for the duration of the insolvency. The plan may appear as a party and other interested persons may intervene in the proceedings at the discretion of the court. The court shall appoint such Secretary trustee if the court determines that the trusteeship is necessary to protect the interests of the participants and beneficiaries or providers of medical care or to avoid any unreasonable deterioration of the financial condition of the plan. The trusteeship of such Secretary shall continue until the conditions described in the first sentence of this subsection are remedied or the plan is terminated.

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

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

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

''(3) to invest any assets of the plan which the Secretary holds in accordance with the provisions of the plan, regulations prescribed by the Secretary

through negotiated rulemaking, and applicable provisions of law;

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

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

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

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

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

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

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

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

''(1) the sponsor and plan administrator;

''(2) each participant;

''(3) each participating employer; and

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

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

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

''(f) JURISDICTION OF COURT.—

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

erty of the plan or sponsor. Pending such adjudication and upon the appointment by it of the Secretary as trustee, the court may stay any proceeding to enforce a lien against property of the plan or the sponsor or any other suit against the plan or the sponsor.

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

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

**''SEC. 811. STATE ASSESSMENT AUTHORITY.**

''(a) IN GENERAL.—Notwithstanding section 514, a State may impose by law a contribution tax on an association health plan described in section 806(a)(2), if the plan commenced operations in such State after the date of the

enactment of the Quality Care for the Uninsured Act of 1999.

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

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

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

''(3) such tax is otherwise nondiscriminatory; and

''(4) the amount of any such tax assessed on the plan is reduced by the amount of any tax or assessment otherwise imposed by the State on premiums, contributions, or both received by insurers or health maintenance organizations for health insur-

ance coverage, aggregate excess/stop loss insurance (as defined in section 806(g)(1)), specific excess/stop loss insurance (as defined in section 806(g)(2)), other insurance related to the provision of medical care under the plan, or any combination thereof provided by such insurers or health maintenance organizations in such State in connection with such plan.

**"SEC. 812. SPECIAL RULES FOR CHURCH PLANS.**

"(a) ELECTION FOR CHURCH PLANS.—Notwithstanding section 4(b)(2), if a church, a convention or association of churches, or an organization described in section 3(33)(C)(i) maintains a church plan which is a group health plan (as defined in section 733(a)(1)), and such church, convention, association, or organization makes an election with respect to such plan under this subsection (in such form and manner as the Secretary may by regulation prescribe), then the provisions of this section shall apply to such plan, with respect to benefits provided under such plan consisting of medical care, as if section 4(b)(2) did not contain an exclusion for church plans. Nothing in this subsection shall be construed to render any other section of this title applicable to church plans, except to the extent that such other section is incorporated by reference in this section.

"(b) EFFECT OF ELECTION.—

''(1) PREEMPTION OF STATE INSURANCE LAWS REGULATING COVERED CHURCH PLANS.—Subject to paragraphs (2) and (3), this section shall supersede any and all State laws which regulate insurance insofar as they may now or hereafter regulate church plans to which this section applies or trusts established under such church plans.

''(2) GENERAL STATE INSURANCE REGULATION UNAFFECTED.—

''(A) IN GENERAL.—Except as provided in subparagraph (B) and paragraph (3), nothing in this section shall be construed to exempt or relieve any person from any provision of State law which regulates insurance.

''(B) CHURCH PLANS NOT TO BE DEEMED INSURANCE COMPANIES OR INSURERS.—Neither a church plan to which this section applies, nor any trust established under such a church plan, shall be deemed to be an insurance company or other insurer or to be engaged in the business of insurance for purposes of any State law purporting to regulate insurance companies or insurance contracts.

''(3) PREEMPTION OF CERTAIN STATE LAWS RELATING TO PREMIUM RATE REGULATION AND

BENEFIT MANDATES.—The provisions of subsections (a)(2)(B) and (b) of section 805 shall apply with respect to a church plan to which this section applies in the same manner and to the same extent as such provisions apply with respect to association health plans.

''(4) DEFINITIONS.—For purposes of this subsection—

''(A) STATE LAW.—The term 'State law' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

''(B) STATE.—The term 'State' includes a State, any political subdivision thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of church plans covered by this section.

''(c) REQUIREMENTS FOR COVERED CHURCH PLANS.—

''(1) FIDUCIARY RULES AND EXCLUSIVE PURPOSE.—A fiduciary shall discharge his duties with

respect to a church plan to which this section applies—

"(A) for the exclusive purpose of:

"(i) providing benefits to participants and their beneficiaries; and

"(ii) defraying reasonable expenses of administering the plan;

"(B) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man 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; and

"(C) in accordance with the documents and instruments governing the plan.

The requirements of this paragraph shall not be treated as not satisfied solely because the plan assets are commingled with other church assets, to the extent that such plan assets are separately accounted for.

"(2) CLAIMS PROCEDURE.—In accordance with regulations of the Secretary, every church plan to which this section applies shall—

"(A) provide adequate notice in writing to any participant or beneficiary whose claim for

benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant;

''(B) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate fiduciary of the decision denying the claim; and

''(C) provide a written statement to each participant describing the procedures established pursuant to this paragraph.

''(3) ANNUAL STATEMENTS.—In accordance with regulations of the Secretary, every church plan to which this section applies shall file with the Secretary an annual statement—

''(A) stating the names and addresses of the plan and of the church, convention, or association maintaining the plan (and its principal place of business);

''(B) certifying that it is a church plan to which this section applies and that it complies with the requirements of paragraphs (1) and (2);

"(C) identifying the States in which participants and beneficiaries under the plan are or likely will be located during the 1-year period covered by the statement; and

"(D) containing a copy of a statement of actuarial opinion signed by a qualified actuary that the plan maintains capital, reserves, insurance, other financial arrangements, or any combination thereof adequate to enable the plan to fully meet all of its financial obligations on a timely basis.

"(4) DISCLOSURE.—At the time that the annual statement is filed by a church plan with the Secretary pursuant to paragraph (3), a copy of such statement shall be made available by the Secretary to the State insurance commissioner (or similar official) of any State. The name of each church plan and sponsoring organization filing an annual statement in compliance with paragraph (3) shall be published annually in the Federal Register.

"(c) ENFORCEMENT.—The Secretary may enforce the provisions of this section in a manner consistent with section 502, to the extent applicable with respect to actions under section 502(a)(5), and with section 3(33)(D), except that, other than for the purpose of seeking a tem-

porary restraining order, a civil action may be brought with respect to the plan's failure to meet any requirement of this section only if the plan fails to correct its failure within the correction period described in section 3(33)(D). The other provisions of part 5 (except sections 501(a), 503, 512, 514, and 515) shall apply with respect to the enforcement and administration of this section.

''(d) DEFINITIONS AND OTHER RULES.—For purposes of this section—

''(1) IN GENERAL.—Except as otherwise provided in this section, any term used in this section which is defined in any provision of this title shall have the definition provided such term by such provision.

''(2) SEMINARY STUDENTS.—Seminary students who are enrolled in an institution of higher learning described in section 3(33)(C)(iv) and who are treated as participants under the terms of a church plan to which this section applies shall be deemed to be employees as defined in section 3(6) if the number of such students constitutes an insignificant portion of the total number of individuals who are treated as participants under the terms of the plan.

**''SEC. 813. DEFINITIONS AND RULES OF CONSTRUCTION.**

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

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

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

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

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

''(5) APPLICABLE AUTHORITY.—

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

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

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

''(B) EXCEPTIONS.—

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

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

with an association health plan, the Secretary.

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

''(7) INDIVIDUAL MARKET.—

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

''(B) TREATMENT OF VERY SMALL GROUPS.—

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

''(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group

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

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

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

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

Secretary may provide by regulation through negotiated rulemaking.

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

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

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

''(C) in the case of an association health plan in existence on the date of the enactment of the Quality Care for the Uninsured Act of 1999, a person eligible to be a member of the sponsor or one of its member associations.

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

''(13) SMALL EMPLOYER.—The term 'small employer' means, in connection with a group health

plan with respect to a plan year, an employer who is not a large employer.

''(b) RULES OF CONSTRUCTION.—

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

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

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

''(2) PLANS, FUNDS, AND PROGRAMS TREATED AS EMPLOYEE WELFARE BENEFIT PLANS.—In the case of any plan, fund, or program which was established or is maintained for the purpose of providing medical care (through the purchase of insurance or

otherwise) for employees (or their dependents) covered thereunder and which demonstrates to the Secretary that all requirements for certification under this part would be met with respect to such plan, fund, or program if such plan, fund, or program were a group health plan, such plan, fund, or program shall be treated for purposes of this title as an employee welfare benefit plan on and after the date of such demonstration.''.

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

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

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

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

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

(B) in subsection (b)(5), by striking ''subsection (a)'' in subparagraph (A) and inserting

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

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

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

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

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

''(A) In any case in which health insurance coverage of any policy type is offered under an association health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may preclude a health insurance issuer from offering health insurance cov-

erage of the same policy type to other employers operating in the State which are eligible for coverage under such association health plan, whether or not such other employers are participating employers in such plan.

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

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

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

the meanings provided such terms in section 811, respectively.''.

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

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

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

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

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

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

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

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

''(2) Nothing in any other provision of law enacted on or after the date of the enactment of the Quality Care for the Uninsured Act of 1999 shall be construed to alter, amend, modify, invalidate, impair, or supersede any provision of this title, except by specific cross-reference to the affected section.''.

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

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

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

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

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

**SEC. 302. CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.**

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

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

(2) in clause (iii)—

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

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

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

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

''(iv) in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only one participating employer

if, after the application of clause (i), the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 75 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement;''.

**SEC. 303. CLARIFICATION OF TREATMENT OF CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.**

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

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

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

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

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

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

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

the contributions made by participating employers or covered individuals to the plan or other arrangement;

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

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

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

''(II) present employees (or former employees who were covered while employed) of the sponsoring employee organization, of an employer who is or was a party to any of the collective bargaining agreements, or of the plan or other arrangement or a related plan or arrange-

ment (nor covered on the basis of such present or former employment);

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

''(iii) The employee organization or other entity sponsoring the plan or other arrangement certifies to the Secretary each year, in a form and manner which shall be prescribed by the Secretary through negotiated rulemaking that the plan or other ar-

rangement meets the requirements of clauses (i) and (ii).

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

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

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

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

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

''(i) the plan or arrangement is in effect as of the date of the enactment of the Quality Care for the Uninsured Act of 1999; or

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

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

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

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

**SEC. 304. ENFORCEMENT PROVISIONS.**

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

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

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

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

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

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

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

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

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

''(n)(1) Subject to paragraph (2), upon application by the Secretary showing the operation, promotion, or marketing of an association health plan (or similar ar-

rangement providing benefits consisting of medical care (as defined in section 733(a)(2))) that—

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

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

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

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

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

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

''(3) The court may grant such additional equitable relief, including any relief available under this title, as it

deems necessary to protect the interests of the public and of persons having claims for benefits against the plan.''.

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

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

**SEC. 305. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.**

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

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

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

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

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

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

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

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

participants and beneficiaries under the plan and the State in which the trust is maintained.''.

**SEC. 306. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.**

(a) EFFECTIVE DATE.—The amendments made by sections 301, 304, and 305 shall take effect on January 1, 2001. The amendments made by sections 302 and 303 shall take effect on the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this title before January 1, 2001. Such regulations shall be issued through negotiated rulemaking.

(b) EXCEPTION.—Section 801(a)(2) of the Employee Retirement Income Security Act of 1974 (added by section 301) does not apply in connection with an association health plan (certified under part 8 of subtitle B of title I of such Act) existing on the date of the enactment of this Act, if no benefits provided thereunder as of the date of the enactment of this Act consist of health insurance coverage (as defined in section 733(b)(1) of such Act).

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

(1) IN GENERAL.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the purpose of

providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make contributions to such arrangement, such arrangement has been in existence for at least 10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 813(a)(5) of the Employee Retirement Income Security Act of 1974 (as amended by this Act)) by the arrangement of an application for certification of the arrangement under part 8 of subtitle B of title I of such Act—

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

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

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

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

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

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

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

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

(2) DEFINITIONS.—For purposes of this subsection, the terms ''group health plan'', ''medical care'', and ''participating employer'' shall have the meanings provided in section 813 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an ''association health plan'' shall be deemed a

reference to an arrangement referred to in this subsection.

(d) PROMOTING USE OF CERTAIN ADDITIONAL ASSOCIATIONS IN PROVIDING INDIVIDUAL HEALTH INSURANCE COVERAGE.—Section 2742(b)(5) of the Public Health Service Act (42 U.S.C. 300gg–42(b)(5)) is amended—

(1) by striking ''paragraph'' and inserting ''subparagraph'';

(2) by inserting ''(A)'' after ''.—''; and

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

''(B)(i) In the case of health insurance coverage that is made available in the individual market only through one or more associations described in clause (ii), the membership of the individual in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this subparagraph uniformly without regard to any health status-related factor of covered individuals and only if the individual is entitled, upon application and without furnishing evidence of insurability, to health insurance conversion coverage that meets and is subject to all the rules and regulations of the State in which application is made.

''(ii) An association described in this clause is an organization that meets the requirements for a bona fide organization described in subparagraphs (A), (B), (C), (E) and (F) of section 2791(d)(3) and, except in the case of an association that enrolls individual members who each pay their own individual membership dues, which provides that all members and dependents of members are eligible for coverage offered through the association regardless of any health status-related factor.''.

# TITLE IV—GREATER ACCESS AND CHOICE THROUGH HEALTHMARTS

**SEC. 401. EXPANSION OF CONSUMER CHOICE THROUGH HEALTHMARTS.**

(a) IN GENERAL.—The Public Health Service Act is amended by adding at the end the following new title:

# "TITLE XXVIII—HEALTHMARTS

**"SEC. 2801. DEFINITION OF HEALTHMART.**

''(a) IN GENERAL.—For purposes of this title, the term 'HealthMart' means a legal entity that meets the following requirements:

''(1) ORGANIZATION.—The HealthMart is a nonprofit organization operated under the direction of a board of directors which is composed of rep-

resentatives of not fewer than two and in equal numbers from each of the following:

"(A) Small employers.

"(B) Employees of small employers.

"(C) Health care providers, which may be physicians, other health care professionals, health care facilities, or any combination thereof.

"(D) Entities, such as insurance companies, health maintenance organizations, and licensed provider-sponsored organizations, that underwrite or administer health benefits coverage.

"(2) OFFERING HEALTH BENEFITS COVERAGE.—

"(A) IN GENERAL.—The HealthMart, in conjunction with those health insurance issuers that offer health benefits coverage through the HealthMart, makes available health benefits coverage in the manner described in subsection (b) to all small employers and eligible employees in the manner described in subsection (c)(2) at rates (including employer's and employee's share) that are established by the health insurance issuer on a policy or product specific basis

and that may vary only as permissible under State law. A HealthMart is deemed to be a group health plan for purposes of applying section 702 of the Employee Retirement Income Security Act of 1974, section 2702 of this Act, and section 9802(b) of the Internal Revenue Code of 1986 (which limit variation among similarly situated individuals of required premiums for health benefits coverage on the basis of health status-related factors).

''(B) NONDISCRIMINATION IN COVERAGE OFFERED.—

''(i) IN GENERAL.—Subject to clause (ii), the HealthMart may not offer health benefits coverage to an eligible employee in a geographic area (as specified under paragraph (3)(A)) unless the same coverage is offered to all such employees in the same geographic area. Section 2711(a)(1)(B) of this Act limits denial of enrollment of certain eligible individuals under health benefits coverage in the small group market.

''(ii) CONSTRUCTION.—Nothing in this title shall be construed as requiring or permitting a health insurance issuer to

provide coverage outside the service area of the issuer, as approved under State law.

''(C) NO FINANCIAL UNDERWRITING.—The HealthMart provides health benefits coverage only through contracts with health insurance issuers and does not assume insurance risk with respect to such coverage.

(D) MINIMUM COVERAGE.—By the end of the first year of its operation and thereafter, the HealthMart maintains not fewer than 10 purchasers and 100 members.

''(3) GEOGRAPHIC AREAS.—

''(A) SPECIFICATION OF GEOGRAPHIC AREAS.—The HealthMart shall specify the geographic area (or areas) in which it makes available health benefits coverage offered by health insurance issuers to small employers. Such an area shall encompass at least one entire county or equivalent area.

''(B) MULTISTATE AREAS.—In the case of a HealthMart that serves more than one State, such geographic areas may be areas that include portions of two or more contiguous States.

"(C) MULTIPLE HEALTHMARTS PERMITTED IN SINGLE GEOGRAPHIC AREA.—Nothing in this title shall be construed as preventing the establishment and operation of more than one HealthMart in a geographic area or as limiting the number of HealthMarts that may operate in any area.

"(4) PROVISION OF ADMINISTRATIVE SERVICES TO PURCHASERS.—

"(A) IN GENERAL.—The HealthMart provides administrative services for purchasers. Such services may include accounting, billing, enrollment information, and employee coverage status reports.

"(B) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a HealthMart from serving as an administrative service organization to any entity.

"(5) DISSEMINATION OF INFORMATION.—The HealthMart collects and disseminates (or arranges for the collection and dissemination of) consumer-oriented information on the scope, cost, and enrollee satisfaction of all coverage options offered through the HealthMart to its members and eligible individuals. Such information shall be defined by the

HealthMart and shall be in a manner appropriate to the type of coverage offered. To the extent practicable, such information shall include information on provider performance, locations and hours of operation of providers, outcomes, and similar matters. Nothing in this section shall be construed as preventing the dissemination of such information or other information by the HealthMart or by health insurance issuers through electronic or other means.

''(6) FILING INFORMATION.—The HealthMart—

''(A) files with the applicable Federal authority information that demonstrates the HealthMart's compliance with the applicable requirements of this title; or

''(B) in accordance with rules established under section 2803(a), files with a State such information as the State may require to demonstrate such compliance.

''(b) HEALTH BENEFITS COVERAGE REQUIREMENTS.—

''(1) COMPLIANCE WITH CONSUMER PROTECTION REQUIREMENTS.—Any health benefits coverage offered through a HealthMart shall—

''(A) be underwritten by a health insurance issuer that—

''(i) is licensed (or otherwise regulated) under State law (or is a community health organization that is offering health insurance coverage pursuant to section 330B(a));

''(ii) meets all applicable State standards relating to consumer protection, subject to section 2802(b); and

''(iii) offers the coverage under a contract with the HealthMart;

''(B) subject to paragraph (2), be approved or otherwise permitted to be offered under State law; and

''(C) provide full portability of creditable coverage for individuals who remain members of the same HealthMart notwithstanding that they change the employer through which they are members in accordance with the provisions of the parts 6 and 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and titles XXII and XXVII of this Act, so long as both employers are purchasers in the HealthMart.

''(2) ALTERNATIVE PROCESS FOR APPROVAL OF HEALTH BENEFITS COVERAGE IN CASE OF DISCRIMINATION OR DELAY.—

''(A) IN GENERAL.—The requirement of paragraph (1)(B) shall not apply to a policy or product of health benefits coverage offered in a State if the health insurance issuer seeking to offer such policy or product files an application to waive such requirement with the applicable Federal authority, and the authority determines, based on the application and other evidence presented to the authority, that—

''(i) either (or both) of the grounds described in subparagraph (B) for approval of the application has been met; and

''(ii) the coverage meets the applicable State standards (other than those that have been preempted under section 2802).

''(B) GROUNDS.—The grounds described in this subparagraph with respect to a policy or product of health benefits coverage are as follows:

''(i) FAILURE TO ACT ON POLICY, PRODUCT, OR RATE APPLICATION ON A TIMELY BASIS.—The State has failed to

complete action on the policy or product (or rates for the policy or product) within 90 days of the date of the State's receipt of a substantially complete application. No period before the date of the enactment of this section shall be included in determining such 90-day period.

''(ii) DENIAL OF APPLICATION BASED ON DISCRIMINATORY TREATMENT.—The State has denied such an application and—

''(I) the standards or review process imposed by the State as a condition of approval of the policy or product imposes either any material requirements, procedures, or standards to such policy or product that are not generally applicable to other policies and products offered or any requirements that are preempted under section 2802; or

''(II) the State requires the issuer, as a condition of approval of the policy or product, to offer any pol-

icy or product other than such policy or product.

"(C) ENFORCEMENT.—In the case of a waiver granted under subparagraph (A) to an issuer with respect to a State, the Secretary may enter into an agreement with the State under which the State agrees to provide for monitoring and enforcement activities with respect to compliance of such an issuer and its health insurance coverage with the applicable State standards described in subparagraph (A)(ii). Such monitoring and enforcement shall be conducted by the State in the same manner as the State enforces such standards with respect to other health insurance issuers and plans, without discrimination based on the type of issuer to which the standards apply. Such an agreement shall specify or establish mechanisms by which compliance activities are undertaken, while not lengthening the time required to review and process applications for waivers under subparagraph (A).

"(3) EXAMPLES OF TYPES OF COVERAGE.—The health benefits coverage made available through a HealthMart may include, but is not limited to, any

of the following if it meets the other applicable requirements of this title:

"(A) Coverage through a health maintenance organization.

"(B) Coverage in connection with a preferred provider organization.

"(C) Coverage in connection with a licensed provider-sponsored organization.

"(D) Indemnity coverage through an insurance company.

"(E) Coverage offered in connection with a contribution into a medical savings account or flexible spending account.

"(F) Coverage that includes a point-of-service option.

"(G) Coverage offered by a community health organization (as defined in section 330B(e)).

"(H) Any combination of such types of coverage.

"(4) WELLNESS BONUSES FOR HEALTH PROMOTION.—Nothing in this title shall be construed as precluding a health insurance issuer offering health benefits coverage through a HealthMart from establishing premium discounts or rebates for members or

from modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention so long as such programs are agreed to in advance by the HealthMart and comply with all other provisions of this title and do not discriminate among similarly situated members.

''(c) PURCHASERS; MEMBERS; HEALTH INSURANCE ISSUERS.—

''(1) PURCHASERS.—

''(A) IN GENERAL.—Subject to the provisions of this title, a HealthMart shall permit any small employer to contract with the HealthMart for the purchase of health benefits coverage for its employees and dependents of those employees and may not vary conditions of eligibility (including premium rates and membership fees) of a small employer to be a purchaser.

''(B) ROLE OF ASSOCIATIONS, BROKERS, AND LICENSED HEALTH INSURANCE AGENTS.—Nothing in this section shall be construed as preventing an association, broker, licensed health insurance agent, or other entity from assisting or representing a HealthMart or small

employers from entering into appropriate arrangements to carry out this title.

''(C) PERIOD OF CONTRACT.—The HealthMart may not require a contract under subparagraph (A) between a HealthMart and a purchaser to be effective for a period of longer than 12 months. The previous sentence shall not be construed as preventing such a contract from being extended for additional 12-month periods or preventing the purchaser from voluntarily electing a contract period of longer than 12 months.

''(D) EXCLUSIVE NATURE OF CONTRACT.—Such a contract shall provide that the purchaser agrees not to obtain or sponsor health benefits coverage, on behalf of any eligible employees (and their dependents), other than through the HealthMart. The previous sentence shall not apply to an eligible individual who resides in an area for which no coverage is offered by any health insurance issuer through the HealthMart.

''(2) MEMBERS.—

''(A) IN GENERAL.—Under rules established to carry out this title, with respect to a

small employer that has a purchaser contract with a HealthMart, individuals who are employees of the employer may enroll for health benefits coverage (including coverage for dependents of such enrolling employees) offered by a health insurance issuer through the HealthMart.

''(B) NONDISCRIMINATION IN ENROLLMENT.—A HealthMart may not deny enrollment as a member to an individual who is an employee (or dependent of such an employee) eligible to be so enrolled based on health status-related factors, except as may be permitted consistent with section 2742(b).

''(C) ANNUAL OPEN ENROLLMENT PERIOD.—In the case of members enrolled in health benefits coverage offered by a health insurance issuer through a HealthMart, subject to subparagraph (D), the HealthMart shall provide for an annual open enrollment period of 30 days during which such members may change the coverage option in which the members are enrolled.

''(D) RULES OF ELIGIBILITY.—Nothing in this paragraph shall preclude a HealthMart from establishing rules of employee eligibility

for enrollment and reenrollment of members during the annual open enrollment period under subparagraph (C). Such rules shall be applied consistently to all purchasers and members within the HealthMart and shall not be based in any manner on health status-related factors and may not conflict with sections 2701 and 2702 of this Act.

''(3) HEALTH INSURANCE ISSUERS.—

''(A) PREMIUM COLLECTION.—The contract between a HealthMart and a health insurance issuer shall provide, with respect to a member enrolled with health benefits coverage offered by the issuer through the HealthMart, for the payment of the premiums collected by the HealthMart (or the issuer) for such coverage (less a pre-determined administrative charge negotiated by the HealthMart and the issuer) to the issuer.

''(B) SCOPE OF SERVICE AREA.—Nothing in this title shall be construed as requiring the service area of a health insurance issuer with respect to health insurance coverage to cover the entire geographic area served by a HealthMart.

''(C) AVAILABILITY OF COVERAGE OPTIONS.—A HealthMart shall enter into contracts with one or more health insurance issuers in a manner that assures that at least two health insurance coverage options are made available in the geographic area specified under subsection (a)(3)(A).

''(d) PREVENTION OF CONFLICTS OF INTEREST.—

''(1) FOR BOARDS OF DIRECTORS.—A member of a board of directors of a HealthMart may not serve as an employee or paid consultant to the HealthMart, but may receive reasonable reimbursement for travel expenses for purposes of attending meetings of the board or committees thereof.

''(2) FOR BOARDS OF DIRECTORS OR EMPLOYEES.—An individual is not eligible to serve in a paid or unpaid capacity on the board of directors of a HealthMart or as an employee of the HealthMart, if the individual is employed by, represents in any capacity, owns, or controls any ownership interest in a organization from whom the HealthMart receives contributions, grants, or other funds not connected with a contract for coverage through the HealthMart.

''(3) EMPLOYMENT AND EMPLOYEE REPRESENTATIVES.—

''(A) IN GENERAL.—An individual who is serving on a board of directors of a HealthMart as a representative described in subparagraph (A) or (B) of section 2801(a)(1) shall not be employed by or affiliated with a health insurance issuer or be licensed as or employed by or affiliated with a health care provider.

''(B) CONSTRUCTION.—For purposes of subparagraph (A), the term ''affiliated'' does not include membership in a health benefits plan or the obtaining of health benefits coverage offered by a health insurance issuer.

''(e) CONSTRUCTION.—

''(1) NETWORK OF AFFILIATED HEALTHMARTS.—Nothing in this section shall be construed as preventing one or more HealthMarts serving different areas (whether or not contiguous) from providing for some or all of the following (through a single administrative organization or otherwise):

''(A) Coordinating the offering of the same or similar health benefits coverage in different areas served by the different HealthMarts.

''(B) Providing for crediting of deductibles and other cost-sharing for individuals who are provided health benefits coverage through the HealthMarts (or affiliated HealthMarts) after—

''(i) a change of employers through which the coverage is provided; or

''(ii) a change in place of employment to an area not served by the previous HealthMart.

''(2) PERMITTING HEALTHMARTS TO ADJUST DISTRIBUTIONS AMONG ISSUERS TO REFLECT RELATIVE RISK OF ENROLLEES.—Nothing in this section shall be construed as precluding a HealthMart from providing for adjustments in amounts distributed among the health insurance issuers offering health benefits coverage through the HealthMart based on factors such as the relative health care risk of members enrolled under the coverage offered by the different issuers.

''(3) APPLICATION OF UNIFORM MINIMUM PARTICIPATION AND CONTRIBUTION RULES.—Nothing in this section shall be construed as precluding a HealthMart from establishing minimum participation and contribution rules (described in section

2711(e)(1)) for small employers that apply to become purchasers in the HealthMart, so long as such rules are applied uniformly for all health insurance issuers.

**"SEC. 2802. APPLICATION OF CERTAIN LAWS AND REQUIREMENTS.**

"(a) AUTHORITY OF STATES.—Nothing in this section shall be construed as preempting State laws relating to the following:

"(1) The regulation of underwriters of health coverage, including licensure and solvency requirements.

"(2) The application of premium taxes and required payments for guaranty funds or for contributions to high-risk pools.

"(3) The application of fair marketing requirements and other consumer protections (other than those specifically relating to an item described in subsection (b)).

"(4) The application of requirements relating to the adjustment of rates for health insurance coverage.

"(b) TREATMENT OF BENEFIT AND GROUPING REQUIREMENTS.—State laws insofar as they relate to any of the following are superseded and shall not apply to

health benefits coverage made available through a HealthMart:

''(1) Benefit requirements for health benefits coverage offered through a HealthMart, including (but not limited to) requirements relating to coverage of specific providers, specific services or conditions, or the amount, duration, or scope of benefits, but not including requirements to the extent required to implement title XXVII or other Federal law and to the extent the requirement prohibits an exclusion of a specific disease from such coverage.

''(2) Requirements (commonly referred to as fictitious group laws) relating to grouping and similar requirements for such coverage to the extent such requirements impede the establishment and operation of HealthMarts pursuant to this title.

''(3) Any other requirements (including limitations on compensation arrangements) that, directly or indirectly, preclude (or have the effect of precluding) the offering of such coverage through a HealthMart, if the HealthMart meets the requirements of this title.

Any State law or regulation relating to the composition or organization of a HealthMart is preempted to the ex-

tent the law or regulation is inconsistent with the provisions of this title.

''(c) APPLICATION OF ERISA FIDUCIARY AND DISCLOSURE REQUIREMENTS.—The board of directors of a HealthMart is deemed to be a plan administrator of an employee welfare benefit plan which is a group health plan for purposes of applying parts 1 and 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and those provisions of part 5 of such subtitle which are applicable to enforcement of such parts 1 and 4, and the HealthMart shall be treated as such a plan and the enrollees shall be treated as participants and beneficiaries for purposes of applying such provisions pursuant to this subsection.

''(d) APPLICATION OF ERISA RENEWABILITY PROTECTION.—A HealthMart is deemed to be a group health plan that is a multiple employer welfare arrangement for purposes of applying section 703 of the Employee Retirement Income Security Act of 1974.

''(e) APPLICATION OF RULES FOR NETWORK PLANS AND FINANCIAL CAPACITY.—The provisions of subsections (c) and (d) of section 2711 apply to health benefits coverage offered by a health insurance issuer through a HealthMart.

''(f) CONSTRUCTION RELATING TO OFFERING REQUIREMENT.—Nothing in section 2711(a) of this Act or 703 of the Employee Retirement Income Security Act of 1974 shall be construed as permitting the offering outside the HealthMart of health benefits coverage that is only made available through a HealthMart under this section because of the application of subsection (b).

''(g) APPLICATION TO GUARANTEED RENEWABILITY REQUIREMENTS IN CASE OF DISCONTINUATION OF AN ISSUER.—For purposes of applying section 2712 in the case of health insurance coverage offered by a health insurance issuer through a HealthMart, if the contract between the HealthMart and the issuer is terminated and the HealthMart continues to make available any health insurance coverage after the date of such termination, the following rules apply:

''(1) RENEWABILITY.—The HealthMart shall fulfill the obligation under such section of the issuer renewing and continuing in force coverage by offering purchasers (and members and their dependents) all available health benefits coverage that would otherwise be available to similarly-situated purchasers and members from the remaining participating health insurance issuers in the same manner as would be required of issuers under section 2712(c).

''(2) APPLICATION OF ASSOCIATION RULES.—The HealthMart shall be considered an association for purposes of applying section 2712(e).

''(h) CONSTRUCTION IN RELATION TO CERTAIN OTHER LAWS.—Nothing in this title shall be construed as modifying or affecting the applicability to HealthMarts or health benefits coverage offered by a health insurance issuer through a HealthMart of parts 6 and 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 or titles XXII and XXVII of this Act.

**''SEC. 2803. ADMINISTRATION.**

''(a) IN GENERAL.—The applicable Federal authority shall administer this title through the division established under subsection (b) and is authorized to issue such regulations as may be required to carry out this title. Such regulations shall be subject to Congressional review under the provisions of chapter 8 of title 5, United States Code. The applicable Federal authority shall incorporate the process of 'deemed file and use' with respect to the information filed under section 2801(a)(6)(A) and shall determine whether information filed by a HealthMart demonstrates compliance with the applicable requirements of this title. Such authority shall exercise its authority under this title in a manner that fosters and promotes the devel-

opment of HealthMarts in order to improve access to health care coverage and services.

''(b) ADMINISTRATION THROUGH HEALTH CARE MARKETPLACE DIVISION.—

''(1) IN GENERAL.—The applicable Federal authority shall carry out its duties under this title through a separate Health Care Marketplace Division, the sole duty of which (including the staff of which) shall be to administer this title.

''(2) ADDITIONAL DUTIES.—In addition to other responsibilities provided under this title, such Division is responsible for—

''(A) oversight of the operations of HealthMarts under this title; and

''(B) the periodic submittal to Congress of reports on the performance of HealthMarts under this title under subsection (c).

''(c) PERIODIC REPORTS.—The applicable Federal authority shall submit to Congress a report every 30 months, during the 10-year period beginning on the effective date of the rules promulgated by the applicable Federal authority to carry out this title, on the effectiveness of this title in promoting coverage of uninsured individuals. Such authority may provide for the production of

such reports through one or more contracts with appropriate private entities.

**"SEC. 2804. DEFINITIONS.**

"For purposes of this title:

"(1) APPLICABLE FEDERAL AUTHORITY.—The term 'applicable Federal authority' means the Secretary of Health and Human Services.

"(2) ELIGIBLE EMPLOYEE OR INDIVIDUAL.—The term 'eligible' means, with respect to an employee or other individual and a HealthMart, an employee or individual who is eligible under section 2801(c)(2) to enroll or be enrolled in health benefits coverage offered through the HealthMart.

"(3) EMPLOYER; EMPLOYEE; DEPENDENT.—Except as the applicable Federal authority may otherwise provide, the terms 'employer', 'employee', and 'dependent', as applied to health insurance coverage offered by a health insurance issuer licensed (or otherwise regulated) in a State, shall have the meanings applied to such terms with respect to such coverage under the laws of the State relating to such coverage and such an issuer.

"(4) HEALTH BENEFITS COVERAGE.—The term 'health benefits coverage' has the meaning given the

term group health insurance coverage in section 2791(b)(4).

''(5) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term in section 2791(b)(2) and includes a community health organization that is offering coverage pursuant to section 330B(a).

''(6) HEALTH STATUS-RELATED FACTOR.—The term 'health status-related factor' has the meaning given such term in section 2791(d)(9).

''(7) HEALTHMART.—The term 'HealthMart' is defined in section 2801(a).

''(8) MEMBER.—The term 'member' means, with respect to a HealthMart, an individual enrolled for health benefits coverage through the HealthMart under section 2801(c)(2).

''(9) PURCHASER.—The term 'purchaser' means, with respect to a HealthMart, a small employer that has contracted under section 2801(c)(1)(A) with the HealthMart for the purchase of health benefits coverage.

''(10) SMALL EMPLOYER.—The term 'small employer' has the meaning given such term for purposes of title XXVII.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2000. The Secretary of Health and Human Services shall first issue all regulations necessary to carry out such amendment before such date.

# TITLE V—COMMUNITY HEALTH ORGANIZATIONS

## SEC. 501. PROMOTION OF PROVISION OF INSURANCE BY COMMUNITY HEALTH ORGANIZATIONS.

(a) WAIVER OF STATE LICENSURE REQUIREMENT FOR COMMUNITY HEALTH ORGANIZATIONS IN CERTAIN CASES.—Subpart I of part D of title III of the Public Health Service Act is amended by adding at the end the following new section:

''WAIVER OF STATE LICENSURE REQUIREMENT FOR COMMUNITY HEALTH ORGANIZATIONS IN CERTAIN CASES

''SEC. 330D. (a) WAIVER AUTHORIZED.—

''(1) IN GENERAL.—A community health organization may offer health insurance coverage in a State notwithstanding that it is not licensed in such a State to offer such coverage if—

''(A) the organization files an application for waiver of the licensure requirement with the Secretary of Health and Human Services (in this section referred to as the 'Secretary') by not later than November 1, 2005; and

"(B) the Secretary determines, based on the application and other evidence presented to the Secretary, that any of the grounds for approval of the application described in subparagraph (A), (B), or (C) of paragraph (2) has been met.

"(2) GROUNDS FOR APPROVAL OF WAIVER.—

"(A) FAILURE TO ACT ON LICENSURE APPLICATION ON A TIMELY BASIS.—The ground for approval of such a waiver application described in this subparagraph is that the State has failed to complete action on a licensing application of the organization within 90 days of the date of the State's receipt of a substantially complete application. No period before the date of the enactment of this section shall be included in determining such 90-day period.

"(B) DENIAL OF APPLICATION BASED ON DISCRIMINATORY TREATMENT.—The ground for approval of such a waiver application described in this subparagraph is that the State has denied such a licensing application and the standards or review process imposed by the State as a condition of approval of the license or as the basis for such denial by the State imposes any

material requirements, procedures, or standards (other than solvency requirements) to such organizations that are not generally applicable to other entities engaged in a substantially similar business.

"(C) DENIAL OF APPLICATION BASED ON APPLICATION OF SOLVENCY REQUIREMENTS.—With respect to waiver applications filed on or after the date of publication of solvency standards established by the Secretary under subsection (d), the ground for approval of such a waiver application described in this subparagraph is that the State has denied such a licensing application based (in whole or in part) on the organization's failure to meet applicable State solvency requirements and such requirements are not the same as the solvency standards established by the Secretary. For purposes of this subparagraph, the term solvency requirements means requirements relating to solvency and other matters covered under the standards established by the Secretary under subsection (d).

''(3) TREATMENT OF WAIVER.—In the case of a waiver granted under this subsection for a community health organization with respect to a State—

''(A) LIMITATION TO STATE.—The waiver shall be effective only with respect to that State and does not apply to any other State.

''(B) LIMITATION TO 36-MONTH PERIOD.—The waiver shall be effective only for a 36-month period but may be renewed for up to 36 additional months if the Secretary determines that such an extension is appropriate.

''(C) CONDITIONED ON COMPLIANCE WITH CONSUMER PROTECTION AND QUALITY STANDARDS.—The continuation of the waiver is conditioned upon the organization's compliance with the requirements described in paragraph (5).

''(D) PREEMPTION OF STATE LAW.—Any provisions of law of that State which relate to the licensing of the organization and which prohibit the organization from providing health insurance coverage shall be superseded.

''(4) PROMPT ACTION ON APPLICATION.—The Secretary shall grant or deny such a waiver application within 60 days after the date the Secretary determines that a substantially complete waiver appli-

cation has been filed. Nothing in this section shall be construed as preventing an organization which has had such a waiver application denied from submitting a subsequent waiver application.

''(5) APPLICATION AND ENFORCEMENT OF STATE CONSUMER PROTECTION AND QUALITY STANDARDS.—A waiver granted under this subsection to an organization with respect to licensing under State law is conditioned upon the organization's compliance with all consumer protection and quality standards insofar as such standards—

''(A) would apply in the State to the community health organization if it were licensed as an entity offering health insurance coverage under State law; and

''(B) are generally applicable to other risk-bearing managed care organizations and plans in the State.

''(6) REPORT.—By not later than December 31, 2004, the Secretary shall submit to the Committee on Commerce of the House of Representatives and the Committee on Labor and Human Resources of the Senate a report regarding whether the waiver process under this subsection should be continued after December 31, 2005.

''(b) ASSUMPTION OF FULL FINANCIAL RISK.—To qualify for a waiver under subsection (a), the community health organization shall assume full financial risk on a prospective basis for the provision of covered health care services, except that the organization—

''(1) may obtain insurance or make other arrangements for the cost of providing to any enrolled member such services the aggregate value of which exceeds such aggregate level as the Secretary specifies from time to time;

''(2) may obtain insurance or make other arrangements for the cost of such services provided to its enrolled members other than through the organization because medical necessity required their provision before they could be secured through the organization;

''(3) may obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 105 percent of its income for such fiscal year; and

''(4) may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial

risk on a prospective basis for the provision of health services by the physicians or other health professionals or through the institutions.

''(c) CERTIFICATION OF PROVISION AGAINST RISK OF INSOLVENCY FOR UNLICENSED CHOS.—

''(1) IN GENERAL.—Each community health organization that is not licensed by a State and for which a waiver application has been approved under subsection (a)(1), shall meet standards established by the Secretary under subsection (d) relating to the financial solvency and capital adequacy of the organization.

''(2) CERTIFICATION PROCESS FOR SOLVENCY STANDARDS FOR CHOS.—The Secretary shall establish a process for the receipt and approval of applications of a community health organization described in paragraph (1) for certification (and periodic recertification) of the organization as meeting such solvency standards. Under such process, the Secretary shall act upon such a certification application not later than 60 days after the date the application has been received.

''(d) ESTABLISHMENT OF SOLVENCY STANDARDS FOR COMMUNITY HEALTH ORGANIZATIONS.—

''(1) IN GENERAL.—The Secretary shall establish, on an expedited basis and by rule pursuant to section 553 of title 5, United States Code and through the Health Resources and Services Administration, standards described in subsection (c)(1) (relating to financial solvency and capital adequacy) that entities must meet to obtain a waiver under subsection (a)(2)(C). In establishing such standards, the Secretary shall consult with interested organizations, including the National Association of Insurance Commissioners, the Academy of Actuaries, and organizations representing Federally qualified health centers.

''(2) FACTORS TO CONSIDER FOR SOLVENCY STANDARDS.—In establishing solvency standards for community health organizations under paragraph (1), the Secretary shall take into account—

''(A) the delivery system assets of such an organization and ability of such an organization to provide services to enrollees;

''(B) alternative means of protecting against insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees, organizational insurance coverage, partnerships with other licensed entities, and valuation at-

tributable to the ability of such an organization to meet its service obligations through direct delivery of care; and

''(C) any standards developed by the National Association of Insurance Commissioners specifically for risk-based health care delivery organizations.

''(3) ENROLLEE PROTECTION AGAINST INSOLVENCY.—Such standards shall include provisions to prevent enrollees from being held liable to any person or entity for the organization's debts in the event of the organization's insolvency.

''(4) DEADLINE.—Such standards shall be promulgated in a manner so they are first effective by not later than April 1, 2000.

''(e) DEFINITIONS.—In this section:

''(1) COMMUNITY HEALTH ORGANIZATION.—The term 'community health organization' means an organization that is a Federally-qualified health center or is controlled by one or more Federally-qualified health centers.

''(2) FEDERALLY-QUALIFIED HEALTH CENTER.—The term 'Federally-qualified health center' has the meaning given such term in section 1905(l)(2)(B) of the Social Security Act.

''(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning given such term in section 2791(b)(1).

''(4) CONTROL.—The term 'control' means the possession, whether direct or indirect, of the power to direct or cause the direction of the management and policies of the organization through membership, board representation, or an ownership interest equal to or greater than 50.1 percent.''.

# DIVISION B—BIPARTISAN CONSENSUS MANAGED CARE IMPROVEMENT ACT OF 1999

## SEC. 1001. SHORT TITLE OF DIVISION; TABLE OF CONTENTS OF DIVISION.

(a) SHORT TITLE OF DIVISION.—This division may be cited as the ''Bipartisan Consensus Managed Care Improvement Act of 1999''.

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

# TITLE XI—IMPROVING MANAGED CARE

## Subtitle A—Grievance and Appeals

**SEC. 1101. UTILIZATION REVIEW ACTIVITIES.**

(a) COMPLIANCE WITH REQUIREMENTS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer that provides health insurance coverage, shall conduct utilization review activities in connection with the provision of benefits under such plan or coverage only in accordance with a utilization review program that meets the requirements of this section.

(2) USE OF OUTSIDE AGENTS.—Nothing in this section shall be construed as preventing a group health plan or health insurance issuer from arranging through a contract or otherwise for persons or entities to conduct utilization review activities on behalf of the plan or issuer, so long as such activities are conducted in accordance with a utilization review program that meets the requirements of this section.

(3) UTILIZATION REVIEW DEFINED.—For purposes of this section, the terms ''utilization review'' and ''utilization review activities'' mean procedures used to monitor or evaluate the use or coverage,

clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings, and includes prospective review, concurrent review, second opinions, case management, discharge planning, or retrospective review.

(b) WRITTEN POLICIES AND CRITERIA.—

(1) WRITTEN POLICIES.—A utilization review program shall be conducted consistent with written policies and procedures that govern all aspects of the program.

(2) USE OF WRITTEN CRITERIA.—

(A) IN GENERAL.—Such a program shall utilize written clinical review criteria developed with input from a range of appropriate actively practicing health care professionals, as determined by the plan, pursuant to the program. Such criteria shall include written clinical review criteria that are based on valid clinical evidence where available and that are directed specifically at meeting the needs of at-risk populations and covered individuals with chronic conditions or severe illnesses, including gender-specific criteria and pediatric-specific criteria where available and appropriate.

(B) CONTINUING USE OF STANDARDS IN RETROSPECTIVE REVIEW.—If a health care service has been specifically pre-authorized or approved for an enrollee under such a program, the program shall not, pursuant to retrospective review, revise or modify the specific standards, criteria, or procedures used for the utilization review for procedures, treatment, and services delivered to the enrollee during the same course of treatment.

(C) REVIEW OF SAMPLE OF CLAIMS DENIALS.—Such a program shall provide for an evaluation of the clinical appropriateness of at least a sample of denials of claims for benefits.

(c) CONDUCT OF PROGRAM ACTIVITIES.—

(1) ADMINISTRATION BY HEALTH CARE PROFESSIONALS.—A utilization review program shall be administered by qualified health care professionals who shall oversee review decisions.

(2) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—

(A) IN GENERAL.—A utilization review program shall provide for the conduct of utilization review activities only through personnel who are qualified and have received appropriate

training in the conduct of such activities under the program.

(B) PROHIBITION OF CONTINGENT COMPENSATION ARRANGEMENTS.—Such a program shall not, with respect to utilization review activities, permit or provide compensation or anything of value to its employees, agents, or contractors in a manner that encourages denials of claims for benefits.

(C) PROHIBITION OF CONFLICTS.—Such a program shall not permit a health care professional who is providing health care services to an individual to perform utilization review activities in connection with the health care services being provided to the individual.

(3) ACCESSIBILITY OF REVIEW.—Such a program shall provide that appropriate personnel performing utilization review activities under the program, including the utilization review administrator, are reasonably accessible by toll-free telephone during normal business hours to discuss patient care and allow response to telephone requests, and that appropriate provision is made to receive and respond promptly to calls received during other hours.

(4) LIMITS ON FREQUENCY.—Such a program shall not provide for the performance of utilization review activities with respect to a class of services furnished to an individual more frequently than is reasonably required to assess whether the services under review are medically necessary or appropriate.

(d) DEADLINE FOR DETERMINATIONS.—

(1) PRIOR AUTHORIZATION SERVICES.—

(A) IN GENERAL.—Except as provided in paragraph (2), in the case of a utilization review activity involving the prior authorization of health care items and services for an individual, the utilization review program shall make a determination concerning such authorization, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed form, as soon as possible in accordance with the medical exigencies of the case, and in no event later than the deadline specified in subparagraph (B).

(B) DEADLINE.—

(i) IN GENERAL.—Subject to clauses (ii) and (iii), the deadline specified in this subparagraph is 14 days after the date of

receipt of the request for prior authorization.

(ii) EXTENSION PERMITTED WHERE NOTICE OF ADDITIONAL INFORMATION REQUIRED.—If a utilization review program—

(I) receives a request for a prior authorization;

(II) determines that additional information is necessary to complete the review and make the determination on the request; and

(III) notifies the requester, not later than five business days after the date of receiving the request, of the need for such specified additional information,

the deadline specified in this subparagraph is 14 days after the date the program receives the specified additional information, but in no case later than 28 days after the date of receipt of the request for the prior authorization. This clause shall not apply if the deadline is specified in clause (iii).

(iii) EXPEDITED CASES.—In the case of a situation described in section 102(c)(1)(A), the deadline specified in this subparagraph is 72 hours after the time of the request for prior authorization.

(2) ONGOING CARE.—

(A) CONCURRENT REVIEW.—

(i) IN GENERAL.—Subject to subparagraph (B), in the case of a concurrent review of ongoing care (including hospitalization), which results in a termination or reduction of such care, the plan must provide by telephone and in printed form notice of the concurrent review determination to the individual or the individual's designee and the individual's health care provider as soon as possible in accordance with the medical exigencies of the case, with sufficient time prior to the termination or reduction to allow for an appeal under section 102(c)(1)(A) to be completed before the termination or reduction takes effect.

(ii) CONTENTS OF NOTICE.—Such notice shall include, with respect to ongoing health care items and services, the number

of ongoing services approved, the new total of approved services, the date of onset of services, and the next review date, if any, as well as a statement of the individual's rights to further appeal.

(B) EXCEPTION.—Subparagraph (A) shall not be interpreted as requiring plans or issuers to provide coverage of care that would exceed the coverage limitations for such care.

(3) PREVIOUSLY PROVIDED SERVICES.—In the case of a utilization review activity involving retrospective review of health care services previously provided for an individual, the utilization review program shall make a determination concerning such services, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed form, within 30 days of the date of receipt of information that is reasonably necessary to make such determination, but in no case later than 60 days after the date of receipt of the claim for benefits.

(4) FAILURE TO MEET DEADLINE.—In a case in which a group health plan or health insurance issuer fails to make a determination on a claim for

benefit under paragraph (1), (2)(A), or (3) by the applicable deadline established under the respective paragraph, the failure shall be treated under this subtitle as a denial of the claim as of the date of the deadline.

(5) REFERENCE TO SPECIAL RULES FOR EMERGENCY SERVICES, MAINTENANCE CARE, AND POST-STABILIZATION CARE.—For waiver of prior authorization requirements in certain cases involving emergency services and maintenance care and post-stabilization care, see subsections (a)(1) and (b) of section 1113, respectively.

(e) NOTICE OF DENIALS OF CLAIMS FOR BENEFITS.—

(1) IN GENERAL.—Notice of a denial of claims for benefits under a utilization review program shall be provided in printed form and written in a manner calculated to be understood by the participant, beneficiary, or enrollee and shall include—

(A) the reasons for the denial (including the clinical rationale);

(B) instructions on how to initiate an appeal under section 1102; and

(C) notice of the availability, upon request of the individual (or the individual's designee)

of the clinical review criteria relied upon to make such denial.

(2) SPECIFICATION OF ANY ADDITIONAL INFORMATION.—Such a notice shall also specify what (if any) additional necessary information must be provided to, or obtained by, the person making the denial in order to make a decision on such an appeal.

(f) CLAIM FOR BENEFITS AND DENIAL OF CLAIM FOR BENEFITS DEFINED.—For purposes of this subtitle:

(1) CLAIM FOR BENEFITS.—The term ''claim for benefits'' means any request for coverage (including authorization of coverage), for eligibility, or for payment in whole or in part, for an item or service under a group health plan or health insurance coverage.

(2) DENIAL OF CLAIM FOR BENEFITS.—The term ''denial'' means, with respect to a claim for benefits, a denial, or a failure to act on a timely basis upon, in whole or in part, the claim for benefits and includes a failure to provide benefits (including items and services) required to be provided under this title.

**SEC. 1102. INTERNAL APPEALS PROCEDURES.**

(a) RIGHT OF REVIEW.—

(1) IN GENERAL.—Each group health plan, and each health insurance issuer offering health insurance coverage—

(A) shall provide adequate notice in writing to any participant or beneficiary under such plan, or enrollee under such coverage, whose claim for benefits under the plan or coverage has been denied (within the meaning of section 1101(f)(2)), setting forth the specific reasons for such denial of claim for benefits and rights to any further review or appeal, written in a manner calculated to be understood by the participant, beneficiary, or enrollee; and

(B) shall afford such a participant, beneficiary, or enrollee (and any provider or other person acting on behalf of such an individual with the individual's consent or without such consent if the individual is medically unable to provide such consent) who is dissatisfied with such a denial of claim for benefits a reasonable opportunity (of not less than 180 days) to request and obtain a full and fair review by a named fiduciary (with respect to such plan) or named appropriate individual (with respect to

such coverage) of the decision denying the claim.

(2) TREATMENT OF ORAL REQUESTS.—The request for review under paragraph (1)(B) may be made orally, but, in the case of an oral request, shall be followed by a request in writing.

(b) INTERNAL REVIEW PROCESS.—

(1) CONDUCT OF REVIEW.—

(A) IN GENERAL.—A review of a denial of claim under this section shall be made by an individual who—

(i) in a case involving medical judgment, shall be a physician or, in the case of limited scope coverage (as defined in subparagraph (B), shall be an appropriate specialist;

(ii) has been selected by the plan or issuer; and

(iii) did not make the initial denial in the internally appealable decision.

(B) LIMITED SCOPE COVERAGE DEFINED.—For purposes of subparagraph (A), the term ''limited scope coverage'' means a group health plan or health insurance coverage the only benefits under which are for benefits de-

scribed in section 2791(c)(2)(A) of the Public Health Service Act (42 U.S.C. 300gg–91(c)(2)).

(2) TIME LIMITS FOR INTERNAL REVIEWS.—

(A) IN GENERAL.—Having received such a request for review of a denial of claim, the plan or issuer shall, in accordance with the medical exigencies of the case but not later than the deadline specified in subparagraph (B), complete the review on the denial and transmit to the participant, beneficiary, enrollee, or other person involved a decision that affirms, reverses, or modifies the denial. If the decision does not reverse the denial, the plan or issuer shall transmit, in printed form, a notice that sets forth the grounds for such decision and that includes a description of rights to any further appeal. Such decision shall be treated as the final decision of the plan. Failure to issue such a decision by such deadline shall be treated as a final decision affirming the denial of claim.

(B) DEADLINE.—

(i) IN GENERAL.—Subject to clauses (ii) and (iii), the deadline specified in this

subparagraph is 14 days after the date of receipt of the request for internal review.

(ii) EXTENSION PERMITTED WHERE NOTICE OF ADDITIONAL INFORMATION REQUIRED.—If a group health plan or health insurance issuer—

(I) receives a request for internal review;

(II) determines that additional information is necessary to complete the review and make the determination on the request; and

(III) notifies the requester, not later than five business days after the date of receiving the request, of the need for such specified additional information,

the deadline specified in this subparagraph is 14 days after the date the plan or issuer receives the specified additional information, but in no case later than 28 days after the date of receipt of the request for the internal review. This clause shall not apply if the deadline is specified in clause (iii).

(iii) EXPEDITED CASES.—In the case of a situation described in subsection (c)(1)(A), the deadline specified in this subparagraph is 72 hours after the time of the request for review.

(c) EXPEDITED REVIEW PROCESS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer, shall establish procedures in writing for the expedited consideration of requests for review under subsection (b) in situations—

(A) in which the application of the normal timeframe for making a determination could seriously jeopardize the life or health of the participant, beneficiary, or enrollee or such an individual's ability to regain maximum function; or

(B) described in section 1101(d)(2) (relating to requests for continuation of ongoing care which would otherwise be reduced or terminated).

(2) PROCESS.—Under such procedures—

(A) the request for expedited review may be submitted orally or in writing by an individual or provider who is otherwise entitled to request the review;

(B) all necessary information, including the plan's or issuer's decision, shall be transmitted between the plan or issuer and the requester by telephone, facsimile, or other similarly expeditious available method; and

(C) the plan or issuer shall expedite the review in the case of any of the situations described in subparagraph (A) or (B) of paragraph (1).

(3) DEADLINE FOR DECISION.—The decision on the expedited review must be made and communicated to the parties as soon as possible in accordance with the medical exigencies of the case, and in no event later than 72 hours after the time of receipt of the request for expedited review, except that in a case described in paragraph (1)(B), the decision must be made before the end of the approved period of care.

(d) WAIVER OF PROCESS.—A plan or issuer may waive its rights for an internal review under subsection (b). In such case the participant, beneficiary, or enrollee involved (and any designee or provider involved) shall be relieved of any obligation to complete the review involved and may, at the option of such participant, beneficiary, enrollee, designee, or provider, proceed directly to seek

further appeal through any applicable external appeals process.

**SEC. 1103. EXTERNAL APPEALS PROCEDURES.**

(a) RIGHT TO EXTERNAL APPEAL.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer offering health insurance coverage, shall provide for an external appeals process that meets the requirements of this section in the case of an externally appealable decision described in paragraph (2), for which a timely appeal is made either by the plan or issuer or by the participant, beneficiary, or enrollee (and any provider or other person acting on behalf of such an individual with the individual's consent or without such consent if such an individual is medically unable to provide such consent). The appropriate Secretary shall establish standards to carry out such requirements.

(2) EXTERNALLY APPEALABLE DECISION DEFINED.—

(A) IN GENERAL.—For purposes of this section, the term ''externally appealable decision'' means a denial of claim for benefits (as defined in section 1101(f)(2))—

(i) that is based in whole or in part on a decision that the item or service is not

medically necessary or appropriate or is investigational or experimental; or

(ii) in which the decision as to whether a benefit is covered involves a medical judgment.

(B) INCLUSION.—Such term also includes a failure to meet an applicable deadline for internal review under section 1102.

(C) EXCLUSIONS.—Such term does not include—

(i) specific exclusions or express limitations on the amount, duration, or scope of coverage that do not involve medical judgment; or

(ii) a decision regarding whether an individual is a participant, beneficiary, or enrollee under the plan or coverage.

(3) EXHAUSTION OF INTERNAL REVIEW PROCESS.—Except as provided under section 1102(d), a plan or issuer may condition the use of an external appeal process in the case of an externally appealable decision upon a final decision in an internal review under section 1102, but only if the decision is made in a timely basis consistent with the deadlines provided under this subtitle.

(4) FILING FEE REQUIREMENT.—

(A) IN GENERAL.—Subject to subparagraph (B), a plan or issuer may condition the use of an external appeal process upon payment to the plan or issuer of a filing fee that does not exceed $25.

(B) EXCEPTION FOR INDIGENCY.—The plan or issuer may not require payment of the filing fee in the case of an individual participant, beneficiary, or enrollee who certifies (in a form and manner specified in guidelines established by the Secretary of Health and Human Services) that the individual is indigent (as defined in such guidelines).

(C) REFUNDING FEE IN CASE OF SUCCESSFUL APPEALS.—The plan or issuer shall refund payment of the filing fee under this paragraph if the recommendation of the external appeal entity is to reverse or modify the denial of a claim for benefits which is the subject of the appeal.

(b) GENERAL ELEMENTS OF EXTERNAL APPEALS PROCESS.—

(1) CONTRACT WITH QUALIFIED EXTERNAL APPEAL ENTITY.—

(A) CONTRACT REQUIREMENT.—Except as provided in subparagraph (D), the external appeal process under this section of a plan or issuer shall be conducted under a contract between the plan or issuer and one or more qualified external appeal entities (as defined in subsection (c)).

(B) LIMITATION ON PLAN OR ISSUER SELECTION.—The applicable authority shall implement procedures—

(i) to assure that the selection process among qualified external appeal entities will not create any incentives for external appeal entities to make a decision in a biased manner; and

(ii) for auditing a sample of decisions by such entities to assure that no such decisions are made in a biased manner.

(C) OTHER TERMS AND CONDITIONS.—The terms and conditions of a contract under this paragraph shall be consistent with the standards the appropriate Secretary shall establish to assure there is no real or apparent conflict of interest in the conduct of external appeal activities. Such contract shall provide that

all costs of the process (except those incurred by the participant, beneficiary, enrollee, or treating professional in support of the appeal) shall be paid by the plan or issuer, and not by the participant, beneficiary, or enrollee. The previous sentence shall not be construed as applying to the imposition of a filing fee under subsection (a)(4).

(D) STATE AUTHORITY WITH RESPECT QUALIFIED EXTERNAL APPEAL ENTITY FOR HEALTH INSURANCE ISSUERS.—With respect to health insurance issuers offering health insurance coverage in a State, the State may provide for external review activities to be conducted by a qualified external appeal entity that is designated by the State or that is selected by the State in a manner determined by the State to assure an unbiased determination.

(2) ELEMENTS OF PROCESS.—An external appeal process shall be conducted consistent with standards established by the appropriate Secretary that include at least the following:

(A) FAIR AND DE NOVO DETERMINATION.—The process shall provide for a fair, de novo determination. However, nothing in this

paragraph shall be construed as providing for coverage of items and services for which benefits are specifically excluded under the plan or coverage.

(B) STANDARD OF REVIEW.—An external appeal entity shall determine whether the plan's or issuer's decision is in accordance with the medical needs of the patient involved (as determined by the entity) taking into account, as of the time of the entity's determination, the patient's medical condition and any relevant and reliable evidence the entity obtains under subparagraph (D). If the entity determines the decision is in accordance with such needs, the entity shall affirm the decision and to the extent that the entity determines the decision is not in accordance with such needs, the entity shall reverse or modify the decision.

(C) CONSIDERATION OF PLAN OR COVERAGE DEFINITIONS.—In making such determination, the external appeal entity shall consider (but not be bound by) any language in the plan or coverage document relating to the definitions of the terms medical necessity, medically

necessary or appropriate, or experimental, investigational, or related terms.

(D) EVIDENCE.—

(i) IN GENERAL.—An external appeal entity shall include, among the evidence taken into consideration—

(I) the decision made by the plan or issuer upon internal review under section 1102 and any guidelines or standards used by the plan or issuer in reaching such decision;

(II) any personal health and medical information supplied with respect to the individual whose denial of claim for benefits has been appealed; and

(III) the opinion of the individual's treating physician or health care professional.

(ii) ADDITIONAL EVIDENCE.—Such entity may also take into consideration but not be limited to the following evidence (to the extent available):

(I) The results of studies that meet professionally recognized stand-

ards of validity and replicability or that have been published in peer-reviewed journals.

(II) The results of professional consensus conferences conducted or financed in whole or in part by one or more Government agencies.

(III) Practice and treatment guidelines prepared or financed in whole or in part by Government agencies.

(IV) Government-issued coverage and treatment policies.

(V) Community standard of care and generally accepted principles of professional medical practice.

(VI) To the extent that the entity determines it to be free of any conflict of interest, the opinions of individuals who are qualified as experts in one or more fields of health care which are directly related to the matters under appeal.

(VII) To the extent that the entity determines it to be free of any con-

flict of interest, the results of peer reviews conducted by the plan or issuer involved.

(E) DETERMINATION CONCERNING EXTERNALLY APPEALABLE DECISIONS.—A qualified external appeal entity shall determine—

(i) whether a denial of claim for benefits is an externally appealable decision (within the meaning of subsection (a)(2));

(ii) whether an externally appealable decision involves an expedited appeal; and

(iii) for purposes of initiating an external review, whether the internal review process has been completed.

(F) OPPORTUNITY TO SUBMIT EVIDENCE.—Each party to an externally appealable decision may submit evidence related to the issues in dispute.

(G) PROVISION OF INFORMATION.—The plan or issuer involved shall provide timely access to the external appeal entity to information and to provisions of the plan or health insurance coverage relating to the matter of the externally appealable decision, as determined by the entity.

(H) TIMELY DECISIONS.—A determination by the external appeal entity on the decision shall—

(i) be made orally or in writing and, if it is made orally, shall be supplied to the parties in writing as soon as possible;

(ii) be made in accordance with the medical exigencies of the case involved, but in no event later than 21 days after the date (or, in the case of an expedited appeal, 72 hours after the time) of requesting an external appeal of the decision;

(iii) state, in layperson's language, the basis for the determination, including, if relevant, any basis in the terms or conditions of the plan or coverage; and

(iv) inform the participant, beneficiary, or enrollee of the individual's rights (including any limitation on such rights) to seek further review by the courts (or other process) of the external appeal determination.

(I) COMPLIANCE WITH DETERMINATION.—If the external appeal entity reverses or modi-

fies the denial of a claim for benefits, the plan or issuer shall—

(i) upon the receipt of the determination, authorize benefits in accordance with such determination;

(ii) take such actions as may be necessary to provide benefits (including items or services) in a timely manner consistent with such determination; and

(iii) submit information to the entity documenting compliance with the entity's determination and this subparagraph.

(c) QUALIFICATIONS OF EXTERNAL APPEAL ENTITIES.—

(1) IN GENERAL.—For purposes of this section, the term ''qualified external appeal entity'' means, in relation to a plan or issuer, an entity that is certified under paragraph (2) as meeting the following requirements:

(A) The entity meets the independence requirements of paragraph (3).

(B) The entity conducts external appeal activities through a panel of not fewer than three clinical peers.

(C) The entity has sufficient medical, legal, and other expertise and sufficient staffing to conduct external appeal activities for the plan or issuer on a timely basis consistent with subsection (b)(2)(G).

(D) The entity meets such other requirements as the appropriate Secretary may impose.

(2) INITIAL CERTIFICATION OF EXTERNAL APPEAL ENTITIES.—

(A) IN GENERAL.—In order to be treated as a qualified external appeal entity with respect to—

(i) a group health plan, the entity must be certified (and, in accordance with subparagraph (B), periodically recertified) as meeting the requirements of paragraph (1)—

(I) by the Secretary of Labor;

(II) under a process recognized or approved by the Secretary of Labor; or

(III) to the extent provided in subparagraph (C)(i), by a qualified private standard-setting organization

(certified under such subparagraph); or

(ii) a health insurance issuer operating in a State, the entity must be certified (and, in accordance with subparagraph (B), periodically recertified) as meeting such requirements—

(I) by the applicable State authority (or under a process recognized or approved by such authority); or

(II) if the State has not established a certification and recertification process for such entities, by the Secretary of Health and Human Services, under a process recognized or approved by such Secretary, or to the extent provided in subparagraph (C)(ii), by a qualified private standard-setting organization (certified under such subparagraph).

(B) RECERTIFICATION PROCESS.—The appropriate Secretary shall develop standards for the recertification of external appeal entities. Such standards shall include a review of—

(i) the number of cases reviewed;

(ii) a summary of the disposition of those cases;

(iii) the length of time in making determinations on those cases;

(iv) updated information of what was required to be submitted as a condition of certification for the entity's performance of external appeal activities; and

(v) such information as may be necessary to assure the independence of the entity from the plans or issuers for which external appeal activities are being conducted.

(C) CERTIFICATION OF QUALIFIED PRIVATE STANDARD-SETTING ORGANIZATIONS.—

(i) FOR EXTERNAL REVIEWS UNDER GROUP HEALTH PLANS.—For purposes of subparagraph (A)(i)(III), the Secretary of Labor may provide for a process for certification (and periodic recertification) of qualified private standard-setting organizations which provide for certification of external review entities. Such an organization shall only be certified if the organization does not certify an external review entity

unless it meets standards required for certification of such an entity by such Secretary under subparagraph (A)(i)(I).

(ii) FOR EXTERNAL REVIEWS OF HEALTH INSURANCE ISSUERS.—For purposes of subparagraph (A)(ii)(II), the Secretary of Health and Human Services may provide for a process for certification (and periodic recertification) of qualified private standard-setting organizations which provide for certification of external review entities. Such an organization shall only be certified if the organization does not certify an external review entity unless it meets standards required for certification of such an entity by such Secretary under subparagraph (A)(ii)(II).

(3) INDEPENDENCE REQUIREMENTS.—

(A) IN GENERAL.—A clinical peer or other entity meets the independence requirements of this paragraph if—

(i) the peer or entity does not have a familial, financial, or professional relationship with any related party;

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

(iii) except as provided in paragraph (4), the plan and the issuer have no recourse against the peer or entity in connection with the external review; and

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

(B) RELATED PARTY.—For purposes of this paragraph, the term ''related party'' means—

(i) with respect to—

(I) a group health plan or health insurance coverage offered in connection with such a plan, the plan or the health insurance issuer offering such coverage; or

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

or any plan sponsor, fiduciary, officer, director, or management employee of such plan or issuer;

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

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

(iv) the manufacturer of any drug or other item that was included in the health 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.

(4) LIMITATION ON LIABILITY OF REVIEWERS.—No qualified external appeal entity having a contract with a plan or issuer under this part and no person who is employed by any such entity or who furnishes professional services to such entity, shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this section, to have violated any criminal law, or to be civilly liable under any law of the

United States or of any State (or political subdivision thereof) if due care was exercised in the performance of such duty, function, or activity and there was no actual malice or gross misconduct in the performance of such duty, function, or activity.

(d) EXTERNAL APPEAL DETERMINATION BINDING ON PLAN.—The determination by an external appeal entity under this section is binding on the plan and issuer involved in the determination.

(e) PENALTIES AGAINST AUTHORIZED OFFICIALS FOR REFUSING TO AUTHORIZE THE DETERMINATION OF AN EXTERNAL REVIEW ENTITY.—

(1) MONETARY PENALTIES.—In any case in which the determination of an external review entity is not followed by a group health plan, or by a health insurance issuer offering health insurance coverage, any person who, acting in the capacity of authorizing the benefit, causes such refusal may, in the discretion in a court of competent jurisdiction, be liable to an aggrieved participant, beneficiary, or enrollee for a civil penalty in an amount of up to $1,000 a day from the date on which the determination was transmitted to the plan or issuer by the external review entity until the date the refusal to provide the benefit is corrected.

(2) CEASE AND DESIST ORDER AND ORDER OF ATTORNEY'S FEES.—In any action described in paragraph (1) brought by a participant, beneficiary, or enrollee with respect to a group health plan, or a health insurance issuer offering health insurance coverage, in which a plaintiff alleges that a person referred to in such paragraph has taken an action resulting in a refusal of a benefit determined by an external appeal entity in violation of such terms of the plan, coverage, or this subtitle, or has failed to take an action for which such person is responsible under the plan, coverage, or this title and which is necessary under the plan or coverage for authorizing a benefit, the court shall cause to be served on the defendant an order requiring the defendant—

(A) to cease and desist from the alleged action or failure to act; and

(B) to pay to the plaintiff a reasonable attorney's fee and other reasonable costs relating to the prosecution of the action on the charges on which the plaintiff prevails.

(3) ADDITIONAL CIVIL PENALTIES.—

(A) IN GENERAL.—In addition to any penalty imposed under paragraph (1) or (2), the appropriate Secretary may assess a civil penalty

against a person acting in the capacity of authorizing a benefit determined by an external review entity for one or more group health plans, or health insurance issuers offering health insurance coverage, for—

(i) any pattern or practice of repeated refusal to authorize a benefit determined by an external appeal entity in violation of the terms of such a plan, coverage, or this title; or

(ii) any pattern or practice of repeated violations of the requirements of this section with respect to such plan or plans or coverage.

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

(i) 25 percent of the aggregate value of benefits shown by the appropriate Secretary to have not been provided, or unlawfully delayed, in violation of this section under such pattern or practice; or

(ii) $500,000.

(4) REMOVAL AND DISQUALIFICATION.—Any person acting in the capacity of authorizing benefits who has engaged in any such pattern or practice described in paragraph (3)(A) with respect to a plan or coverage, upon the petition of the appropriate Secretary, may be removed by the court from such position, and from any other involvement, with respect to such a plan or coverage, and may be precluded from returning to any such position or involvement for a period determined by the court.

(f) PROTECTION OF LEGAL RIGHTS.—Nothing in this subtitle shall be construed as altering or eliminating any cause of action or legal rights or remedies of participants, beneficiaries, enrollees, and others under State or Federal law (including sections 502 and 503 of the Employee Retirement Income Security Act of 1974), including the right to file judicial actions to enforce rights.

**SEC. 1104. ESTABLISHMENT OF A GRIEVANCE PROCESS.**

(a) ESTABLISHMENT OF GRIEVANCE SYSTEM.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall establish and maintain a system to provide for the presentation and resolution of oral and written grievances brought by individuals who are participants, bene-

ficiaries, or enrollees, or health care providers or other individuals acting on behalf of an individual and with the individual's consent or without such consent if the individual is medically unable to provide such consent, regarding any aspect of the plan's or issuer's services.

(2) GRIEVANCE DEFINED.—In this section, the term ''grievance'' means any question, complaint, or concern brought by a participant, beneficiary or enrollee that is not a claim for benefits (as defined in section 1101(f)(1)).

(b) GRIEVANCE SYSTEM.—Such system shall include the following components with respect to individuals who are participants, beneficiaries, or enrollees:

(1) Written notification to all such individuals and providers of the telephone numbers and business addresses of the plan or issuer personnel responsible for resolution of grievances and appeals.

(2) A system to record and document, over a period of at least three previous years, all grievances and appeals made and their status.

(3) A process providing for timely processing and resolution of grievances.

(4) Procedures for follow-up action, including the methods to inform the person making the grievance of the resolution of the grievance.

Grievances are not subject to appeal under the previous provisions of this subtitle.

# Subtitle B—Access to Care

**SEC. 1111. CONSUMER CHOICE OPTION.**

(a) IN GENERAL.—If a health insurance issuer offers to enrollees health insurance coverage in connection with a group health plan which provides for coverage of services only if such services are furnished through health care professionals and providers who are members of a network of health care professionals and providers who have entered into a contract with the issuer to provide such services, the issuer shall also offer or arrange to be offered to such enrollees (at the time of enrollment and during an annual open season as provided under subsection (c)) the option of health insurance coverage which provides for coverage of such services which are not furnished through health care professionals and providers who are members of such a network unless enrollees are offered such non-network coverage through another group health plan or through another health insurance issuer in the group market.

(b) ADDITIONAL COSTS.—The amount of any additional premium charged by the health insurance issuer for the additional cost of the creation and maintenance of the option described in subsection (a) and the amount of any additional cost sharing imposed under such option shall be borne by the enrollee unless it is paid by the health plan sponsor through agreement with the health insurance issuer.

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

**SEC. 1112. CHOICE OF HEALTH CARE PROFESSIONAL.**

(a) PRIMARY CARE.—If a group health plan, or a health insurance issuer that offers health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

(b) SPECIALISTS.—

(1) IN GENERAL.—Subject to paragraph (2), a group health plan and a health insurance issuer that offers health insurance coverage shall permit each

participant, beneficiary, or enrollee to receive medically necessary or appropriate specialty care, pursuant to appropriate referral procedures, from any qualified participating health care professional who is available to accept such individual for such care.

(2) LIMITATION.—Paragraph (1) shall not apply to specialty care if the plan or issuer clearly informs participants, beneficiaries, and enrollees of the limitations on choice of participating health care professionals with respect to such care.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as affecting the application of section 1114 (relating to access to specialty care).

**SEC. 1113. ACCESS TO EMERGENCY CARE.**

(a) COVERAGE OF EMERGENCY SERVICES.—

(1) IN GENERAL.—If a group health plan, or health insurance coverage offered by a health insurance issuer, provides any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

(A) without the need for any prior authorization determination;

(B) whether or not the health care provider furnishing such services is a participating provider with respect to such services;

(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee—

(i) by a nonparticipating health care provider with or without prior authorization; or

(ii) by a participating health care provider without prior authorization,

the participant, beneficiary, or enrollee is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating health care provider with prior authorization; and

(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of the Public Health Service Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

(2) DEFINITIONS.—In this section:

(A) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON STANDARD.—The term ''emergency medical condition'' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(B) EMERGENCY SERVICES.—The term ''emergency services'' means—

(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition (as defined in subparagraph (A)); and

(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient.

(C) STABILIZE.—The term ''to stabilize'' means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

(b) REIMBURSEMENT FOR MAINTENANCE CARE AND POST-STABILIZATION CARE.—In the case of services (other than emergency services) for which benefits are available under a group health plan, or under health insurance coverage offered by a health insurance issuer, the plan or issuer shall provide for reimbursement with respect to such services provided to a participant, beneficiary, or enrollee other than through a participating health care provider in a manner consistent with subsection (a)(1)(C) (and shall otherwise comply with the guidelines established under section 1852(d)(2) of the So-

cial Security Act), if the services are maintenance care or post-stabilization care covered under such guidelines.

**SEC. 1114. ACCESS TO SPECIALTY CARE.**

(a) SPECIALTY CARE FOR COVERED SERVICES.—

(1) IN GENERAL.—If—

(A) an individual is a participant or beneficiary under a group health plan or an enrollee who is covered under health insurance coverage offered by a health insurance issuer;

(B) the individual has a condition or disease of sufficient seriousness and complexity to require treatment by a specialist; and

(C) benefits for such treatment are provided under the plan or coverage,

the plan or issuer shall make or provide for a referral to a specialist who is available and accessible to provide the treatment for such condition or disease.

(2) SPECIALIST DEFINED.—For purposes of this subsection, the term ''specialist'' means, with respect to a condition, a health care practitioner, facility, or center that has adequate expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise) to provide high quality care in treating the condition.

(3) CARE UNDER REFERRAL.—A group health plan or health insurance issuer may require that the care provided to an individual pursuant to such referral under paragraph (1) be—

(A) pursuant to a treatment plan, only if the treatment plan is developed by the specialist and approved by the plan or issuer, in consultation with the designated primary care provider or specialist and the individual (or the individual's designee); and

(B) in accordance with applicable quality assurance and utilization review standards of the plan or issuer.

Nothing in this subsection shall be construed as preventing such a treatment plan for an individual from requiring a specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

(4) REFERRALS TO PARTICIPATING PROVIDERS.—A group health plan or health insurance issuer is not required under paragraph (1) to provide for a referral to a specialist that is not a participating provider, unless the plan or issuer does not have an appropriate specialist that is available

and accessible to treat the individual's condition and that is a participating provider with respect to such treatment.

(5) TREATMENT OF NONPARTICIPATING PROVIDERS.—If a plan or issuer refers an individual to a nonparticipating specialist pursuant to paragraph (1), services provided pursuant to the approved treatment plan (if any) shall be provided at no additional cost to the individual beyond what the individual would otherwise pay for services received by such a specialist that is a participating provider.

(b) SPECIALISTS AS GATEKEEPER FOR TREATMENT OF ONGOING SPECIAL CONDITIONS.—

(1) IN GENERAL.—A group health plan, or a health insurance issuer, in connection with the provision of health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary, or enrollee and who has an ongoing special condition (as defined in paragraph (3)) may request and receive a referral to a specialist for such condition who shall be responsible for and capable of providing and coordinating the individual's care with respect to the condition. Under such procedures if such an individual's care would most appropriately

be coordinated by such a specialist, such plan or issuer shall refer the individual to such specialist.

(2) TREATMENT FOR RELATED REFERRALS.—Such specialists shall be permitted to treat the individual without a referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services as the individual's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment (referred to in subsection (a)(3)(A)) with respect to the ongoing special condition.

(3) ONGOING SPECIAL CONDITION DEFINED.—In this subsection, the term ''ongoing special condition'' means a condition or disease that—

(A) is life-threatening, degenerative, or disabling; and

(B) requires specialized medical care over a prolonged period of time.

(4) TERMS OF REFERRAL.—The provisions of paragraphs (3) through (5) of subsection (a) apply with respect to referrals under paragraph (1) of this subsection in the same manner as they apply to referrals under subsection (a)(1).

(c) STANDING REFERRALS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary, or enrollee and who has a condition that requires ongoing care from a specialist may receive a standing referral to such specialist for treatment of such condition. If the plan or issuer, or if the primary care provider in consultation with the medical director of the plan or issuer and the specialist (if any), determines that such a standing referral is appropriate, the plan or issuer shall make such a referral to such a specialist if the individual so desires.

(2) TERMS OF REFERRAL.—The provisions of paragraphs (3) through (5) of subsection (a) apply with respect to referrals under paragraph (1) of this subsection in the same manner as they apply to referrals under subsection (a)(1).

**SEC. 1115. ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.**

(a) IN GENERAL.—If a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, requires or provides for a participant, beneficiary, or enrollee to designate a participating primary care health care professional, the plan or issuer—

(1) may not require authorization or a referral by the individual's primary care health care professional or otherwise for coverage of gynecological care (including preventive women's health examinations) and pregnancy-related services provided by a participating health care professional, including a physician, who specializes in obstetrics and gynecology to the extent such care is otherwise covered; and

(2) shall treat the ordering of other obstetrical or gynecological care by such a participating professional as the authorization of the primary care health care professional with respect to such care under the plan or coverage.

(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed to—

(1) waive any exclusions of coverage under the terms of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

(2) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.

**SEC. 1116. ACCESS TO PEDIATRIC CARE.**

(a) PEDIATRIC CARE.—If a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, requires or provides for an enrollee to designate a participating primary care provider for a child of such enrollee, the plan or issuer shall permit the enrollee to designate a physician who specializes in pediatrics as the child's primary care provider.

(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed to waive any exclusions of coverage under the terms of the plan or health insurance coverage with respect to coverage of pediatric care.

**SEC. 1117. CONTINUITY OF CARE.**

(a) IN GENERAL.—

(1) TERMINATION OF PROVIDER.—If a contract between a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, and a health care provider is terminated (as defined in paragraph (3)(B)), or benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in a group health plan, and an individual who is a participant, beneficiary, or enrollee in the plan or coverage is undergoing treatment from the provider for an ongoing special condi-

tion (as defined in paragraph (3)(A)) at the time of such termination, the plan or issuer shall—

(A) notify the individual on a timely basis of such termination and of the right to elect continuation of coverage of treatment by the provider under this section; and

(B) subject to subsection (c), permit the individual to elect to continue to be covered with respect to treatment by the provider of such condition during a transitional period (provided under subsection (b)).

(2) TREATMENT OF TERMINATION OF CONTRACT WITH HEALTH INSURANCE ISSUER.—If a contract for the provision of health insurance coverage between a group health plan and a health insurance issuer is terminated and, as a result of such termination, coverage of services of a health care provider is terminated with respect to an individual, the provisions of paragraph (1) (and the succeeding provisions of this section) shall apply under the plan in the same manner as if there had been a contract between the plan and the provider that had been terminated, but only with respect to benefits that are covered under the plan after the contract termination.

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

(A) ONGOING SPECIAL CONDITION.—The term ''ongoing special condition'' has the meaning given such term in section 1114(b)(3), and also includes pregnancy.

(B) TERMINATION.—The term ''terminated'' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by the plan or issuer for failure to meet applicable quality standards or for fraud.

(b) TRANSITIONAL PERIOD.—

(1) IN GENERAL.—Except as provided in paragraphs (2) through (4), the transitional period under this subsection shall extend up to 90 days (as determined by the treating health care professional) after the date of the notice described in subsection (a)(1)(A) of the provider's termination.

(2) SCHEDULED SURGERY AND ORGAN TRANSPLANTATION.—If surgery or organ transplantation was scheduled for an individual before the date of the announcement of the termination of the provider status under subsection (a)(1)(A) or if the individual on such date was on an established waiting list or

otherwise scheduled to have such surgery or transplantation, the transitional period under this subsection with respect to the surgery or transplantation shall extend beyond the period under paragraph (1) and until the date of discharge of the individual after completion of the surgery or transplantation.

(3) PREGNANCY.—If—

(A) a participant, beneficiary, or enrollee was determined to be pregnant at the time of a provider's termination of participation; and

(B) the provider was treating the pregnancy before date of the termination,

the transitional period under this subsection with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

(4) TERMINAL ILLNESS.—If—

(A) a participant, beneficiary, or enrollee was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) at the time of a provider's termination of participation; and

(B) the provider was treating the terminal illness before the date of termination,

the transitional period under this subsection shall extend for the remainder of the individual's life for care directly related to the treatment of the terminal illness or its medical manifestations.

(c) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan or health insurance issuer may condition coverage of continued treatment by a provider under subsection (a)(1)(B) upon the individual notifying the plan of the election of continued coverage and upon the provider agreeing to the following terms and conditions:

(1) The provider agrees to accept reimbursement from the plan or issuer and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or, in the case described in subsection (a)(2), at the rates applicable under the replacement plan or issuer after the date of the termination of the contract with the health insurance issuer) and not to impose cost-sharing with respect to the individual in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in subsection (a)(1) had not been terminated.

(2) The provider agrees to adhere to the quality assurance standards of the plan or issuer responsible

for payment under paragraph (1) and to provide to such plan or issuer necessary medical information related to the care provided.

(3) The provider agrees otherwise to adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

(d) CONSTRUCTION.—Nothing in this section shall be construed to require the coverage of benefits which would not have been covered if the provider involved remained a participating provider.

**SEC. 1118. ACCESS TO NEEDED PRESCRIPTION DRUGS.**

If a group health plan, or health insurance issuer that offers health insurance coverage, provides benefits with respect to prescription drugs but the coverage limits such benefits to drugs included in a formulary, the plan or issuer shall—

(1) ensure participation of participating physicians and pharmacists in the development of the formulary;

(2) disclose to providers and, disclose upon request under section 1121(c)(5) to participants, bene-

ficiaries, and enrollees, the nature of the formulary restrictions; and

(3) consistent with the standards for a utilization review program under section 1101, provide for exceptions from the formulary limitation when a non-formulary alternative is medically indicated.

**SEC. 1119. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.**

(a) COVERAGE.—

(1) IN GENERAL.—If a group health plan, or health insurance issuer that is providing health insurance coverage, provides coverage to a qualified individual (as defined in subsection (b)), the plan or issuer—

(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

(B) subject to subsection (c), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

(C) may not discriminate against the individual on the basis of the enrollee's participation in such trial.

(2) EXCLUSION OF CERTAIN COSTS.—For purposes of paragraph (1)(B), routine patient costs do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

(3) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in paragraph (1) shall be construed as preventing a plan or issuer from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term ''qualified individual'' means an individual who is a participant or beneficiary in a group health plan, or who is an enrollee under health insurance coverage, and who meets the following conditions:

(1)(A) The individual has a life-threatening or serious illness for which no standard treatment is effective.

(B) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of such illness.

(C) The individual's participation in the trial offers meaningful potential for significant clinical benefit for the individual.

(2) Either—

(A) the referring physician is a participating health care professional and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

(B) the participant, beneficiary, or enrollee provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

(c) PAYMENT.—

(1) IN GENERAL.—Under this section a group health plan or health insurance issuer shall provide for payment for routine patient costs described in subsection (a)(2) but is not required to pay for costs of items and services that are reasonably expected (as determined by the Secretary) to be paid for by the sponsors of an approved clinical trial.

(2) PAYMENT RATE.—In the case of covered items and services provided by—

(A) a participating provider, the payment rate shall be at the agreed upon rate; or

(B) a nonparticipating provider, the payment rate shall be at the rate the plan or issuer would normally pay for comparable services under subparagraph (A).

(d) APPROVED CLINICAL TRIAL DEFINED.—

(1) IN GENERAL.—In this section, the term ''approved clinical trial'' means a clinical research study or clinical investigation approved and funded (which may include funding through in-kind contributions) by one or more of the following:

(A) The National Institutes of Health.

(B) A cooperative group or center of the National Institutes of Health.

(C) Either of the following if the conditions described in paragraph (2) are met:

(i) The Department of Veterans Affairs.

(ii) The Department of Defense.

(2) CONDITIONS FOR DEPARTMENTS.—The conditions described in this paragraph, for a study or investigation conducted by a Department, are

that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines—

(A) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and

(B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(e) CONSTRUCTION.—Nothing in this section shall be construed to limit a plan's or issuer's coverage with respect to clinical trials.

# Subtitle C—Access to Information

**SEC. 1121. PATIENT ACCESS TO INFORMATION.**

(a) DISCLOSURE REQUIREMENT.—

(1) GROUP HEALTH PLANS.—A group health plan shall—

(A) provide to participants and beneficiaries at the time of initial coverage under the plan (or the effective date of this section, in the case of individuals who are participants or beneficiaries as of such date), and at least annually thereafter, the information described in subsection (b) in printed form;

(B) provide to participants and beneficiaries, within a reasonable period (as specified by the appropriate Secretary) before or after the date of significant changes in the information described in subsection (b), information in printed form on such significant changes; and

(C) upon request, make available to participants and beneficiaries, the applicable authority, and prospective participants and beneficiaries, the information described in subsection (b) or (c) in printed form.

(2) HEALTH INSURANCE ISSUERS.—A health insurance issuer in connection with the provision of health insurance coverage shall—

(A) provide to individuals enrolled under such coverage at the time of enrollment, and at least annually thereafter, the information described in subsection (b) in printed form;

(B) provide to enrollees, within a reasonable period (as specified by the appropriate Secretary) before or after the date of significant changes in the information described in subsection (b), information in printed form on such significant changes; and

(C) upon request, make available to the applicable authority, to individuals who are prospective enrollees, and to the public the information described in subsection (b) or (c) in printed form.

(b) INFORMATION PROVIDED.—The information described in this subsection with respect to a group health plan or health insurance coverage offered by a health insurance issuer includes the following:

(1) SERVICE AREA.—The service area of the plan or issuer.

(2) BENEFITS.—Benefits offered under the plan or coverage, including—

(A) covered benefits, including benefit limits and coverage exclusions;

(B) cost sharing, such as deductibles, coinsurance, and copayment amounts, including any liability for balance billing, any maximum limitations on out of pocket expenses, and the maximum out of pocket costs for services that are provided by nonparticipating providers or that are furnished without meeting the applicable utilization review requirements;

(C) the extent to which benefits may be obtained from nonparticipating providers;

(D) the extent to which a participant, beneficiary, or enrollee may select from among participating providers and the types of providers participating in the plan or issuer network;

(E) process for determining experimental coverage; and

(F) use of a prescription drug formulary.

(3) ACCESS.—A description of the following:

(A) The number, mix, and distribution of providers under the plan or coverage.

(B) Out-of-network coverage (if any) provided by the plan or coverage.

(C) Any point-of-service option (including any supplemental premium or cost-sharing for such option).

(D) The procedures for participants, beneficiaries, and enrollees to select, access, and change participating primary and specialty providers.

(E) The rights and procedures for obtaining referrals (including standing referrals) to participating and nonparticipating providers.

(F) The name, address, and telephone number of participating health care providers

and an indication of whether each such provider is available to accept new patients.

(G) Any limitations imposed on the selection of qualifying participating health care providers, including any limitations imposed under section 1112(b)(2).

(H) How the plan or issuer addresses the needs of participants, beneficiaries, and enrollees and others who do not speak English or who have other special communications needs in accessing providers under the plan or coverage, including the provision of information described in this subsection and subsection (c) to such individuals.

(4) OUT-OF-AREA COVERAGE.—Out-of-area coverage provided by the plan or issuer.

(5) EMERGENCY COVERAGE.—Coverage of emergency services, including—

(A) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

(B) the process and procedures of the plan or issuer for obtaining emergency services; and

(C) the locations of (i) emergency departments, and (ii) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

(6) PERCENTAGE OF PREMIUMS USED FOR BENEFITS (LOSS-RATIOS).—In the case of health insurance coverage only (and not with respect to group health plans that do not provide coverage through health insurance coverage), a description of the overall loss-ratio for the coverage (as defined in accordance with rules established or recognized by the Secretary of Health and Human Services).

(7) PRIOR AUTHORIZATION RULES.—Rules regarding prior authorization or other review requirements that could result in noncoverage or nonpayment.

(8) GRIEVANCE AND APPEALS PROCEDURES.—All appeal or grievance rights and procedures under the plan or coverage, including the method for filing grievances and the time frames and circumstances for acting on grievances and appeals, who is the applicable authority with respect to the plan or issuer.

(9) QUALITY ASSURANCE.—Any information made public by an accrediting organization in the process of accreditation of the plan or issuer or any

additional quality indicators the plan or issuer makes available.

(10) INFORMATION ON ISSUER.—Notice of appropriate mailing addresses and telephone numbers to be used by participants, beneficiaries, and enrollees in seeking information or authorization for treatment.

(11) NOTICE OF REQUIREMENTS.—Notice of the requirements of this title.

(12) AVAILABILITY OF INFORMATION ON REQUEST.—Notice that the information described in subsection (c) is available upon request.

(c) INFORMATION MADE AVAILABLE UPON REQUEST.—The information described in this subsection is the following:

(1) UTILIZATION REVIEW ACTIVITIES.—A description of procedures used and requirements (including circumstances, time frames, and appeal rights) under any utilization review program under section 1101, including under any drug formulary program under section 1118.

(2) GRIEVANCE AND APPEALS INFORMATION.—Information on the number of grievances and appeals and on the disposition in the aggregate of such matters.

(3) METHOD OF PHYSICIAN COMPENSATION.—A general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which a specified prospective or treating health care professional is (or would be) compensated in connection with the provision of health care under the plan or coverage.

(4) SPECIFIC INFORMATION ON CREDENTIALS OF PARTICIPATING PROVIDERS.—In the case of each participating provider, a description of the credentials of the provider.

(5) FORMULARY RESTRICTIONS.—A description of the nature of any drug formula restrictions.

(6) PARTICIPATING PROVIDER LIST.—A list of current participating health care providers.

(d) CONSTRUCTION.—Nothing in this section shall be construed as requiring public disclosure of individual contracts or financial arrangements between a group health plan or health insurance issuer and any provider.

# Subtitle D—Protecting the Doctor-Patient Relationship

### SEC. 1131. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

(a) GENERAL RULE.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a group health plan or health insurance issuer in relation to health insurance coverage (including any partnership, association, or other organization that enters into or administers such a contract or agreement) and a health care provider (or group of health care providers) shall not prohibit or otherwise restrict a health care professional from advising such a participant, beneficiary, or enrollee who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan or coverage, if the professional is acting within the lawful scope of practice.

(b) NULLIFICATION.—Any contract provision or agreement that restricts or prohibits medical communications in violation of subsection (a) shall be null and void.

**SEC. 1132. PROHIBITION OF DISCRIMINATION AGAINST PROVIDERS BASED ON LICENSURE.**

(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage shall not discriminate with respect to participation or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification.

(b) CONSTRUCTION.—Subsection (a) shall not be construed—

(1) as requiring the coverage under a group health plan or health insurance coverage of particular benefits or services or to prohibit a plan or issuer from including providers only to the extent necessary to meet the needs of the plan's or issuer's participants, beneficiaries, or enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan or issuer;

(2) to override any State licensure or scope-of-practice law; or

(3) as requiring a plan or issuer that offers network coverage to include for participation every willing provider who meets the terms and conditions of the plan or issuer.

**SEC. 1133. PROHIBITION AGAINST IMPROPER INCENTIVE ARRANGEMENTS.**

(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage may not operate any physician incentive plan (as defined in subparagraph (B) of section 1876(i)(8) of the Social Security Act) unless the requirements described in clauses (i), (ii)(I), and (iii) of subparagraph (A) of such section are met with respect to such a plan.

(b) APPLICATION.—For purposes of carrying out paragraph (1), any reference in section 1876(i)(8) of the Social Security Act to the Secretary, an eligible organization, or an individual enrolled with the organization shall be treated as a reference to the applicable authority, a group health plan or health insurance issuer, respectively, and a participant, beneficiary, or enrollee with the plan or organization, respectively.

(c) CONSTRUCTION.—Nothing in this section shall be construed as prohibiting all capitation and similar arrangements or all provider discount arrangements.

**SEC. 1134. PAYMENT OF CLAIMS.**

A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide for prompt payment of claims submitted for health care services or supplies furnished to a participant, beneficiary, or enrollee with respect to benefits covered by the plan or

issuer, in a manner consistent with the provisions of sections 1816(c)(2) and 1842(c)(2) of the Social Security Act (42 U.S.C. 1395h(c)(2) and 42 U.S.C. 1395u(c)(2)), except that for purposes of this section, subparagraph (C) of section 1816(c)(2) of the Social Security Act shall be treated as applying to claims received from a participant, beneficiary, or enrollee as well as claims referred to in such subparagraph.

**SEC. 1135. PROTECTION FOR PATIENT ADVOCACY.**

(a) PROTECTION FOR USE OF UTILIZATION REVIEW AND GRIEVANCE PROCESS.—A group health plan, and a health insurance issuer with respect to the provision of health insurance coverage, may not retaliate against a participant, beneficiary, enrollee, or health care provider based on the participant's, beneficiary's, enrollee's or provider's use of, or participation in, a utilization review process or a grievance process of the plan or issuer (including an internal or external review or appeal process) under this title.

(b) PROTECTION FOR QUALITY ADVOCACY BY HEALTH CARE PROFESSIONALS.—

(1) IN GENERAL.—A group health plan or health insurance issuer may not retaliate or discriminate against a protected health care professional because the professional in good faith—

(A) discloses information relating to the care, services, or conditions affecting one or more participants, beneficiaries, or enrollees of the plan or issuer to an appropriate public regulatory agency, an appropriate private accreditation body, or appropriate management personnel of the plan or issuer; or

(B) initiates, cooperates, or otherwise participates in an investigation or proceeding by such an agency with respect to such care, services, or conditions.

If an institutional health care provider is a participating provider with such a plan or issuer or otherwise receives payments for benefits provided by such a plan or issuer, the provisions of the previous sentence shall apply to the provider in relation to care, services, or conditions affecting one or more patients within an institutional health care provider in the same manner as they apply to the plan or issuer in relation to care, services, or conditions provided to one or more participants, beneficiaries, or enrollees; and for purposes of applying this sentence, any reference to a plan or issuer is deemed a reference to the institutional health care provider.

(2) GOOD FAITH ACTION.—For purposes of paragraph (1), a protected health care professional is considered to be acting in good faith with respect to disclosure of information or participation if, with respect to the information disclosed as part of the action—

(A) the disclosure is made on the basis of personal knowledge and is consistent with that degree of learning and skill ordinarily possessed by health care professionals with the same licensure or certification and the same experience;

(B) the professional reasonably believes the information to be true;

(C) the information evidences either a violation of a law, rule, or regulation, of an applicable accreditation standard, or of a generally recognized professional or clinical standard or that a patient is in imminent hazard of loss of life or serious injury; and

(D) subject to subparagraphs (B) and (C) of paragraph (3), the professional has followed reasonable internal procedures of the plan, issuer, or institutional health care provider es-

tablished for the purpose of addressing quality concerns before making the disclosure.

(3) EXCEPTION AND SPECIAL RULE.—

(A) GENERAL EXCEPTION.—Paragraph (1) does not protect disclosures that would violate Federal or State law or diminish or impair the rights of any person to the continued protection of confidentiality of communications provided by such law.

(B) NOTICE OF INTERNAL PROCEDURES.—Subparagraph (D) of paragraph (2) shall not apply unless the internal procedures involved are reasonably expected to be known to the health care professional involved. For purposes of this subparagraph, a health care professional is reasonably expected to know of internal procedures if those procedures have been made available to the professional through distribution or posting.

(C) INTERNAL PROCEDURE EXCEPTION.—Subparagraph (D) of paragraph (2) also shall not apply if—

(i) the disclosure relates to an imminent hazard of loss of life or serious injury to a patient;

(ii) the disclosure is made to an appropriate private accreditation body pursuant to disclosure procedures established by the body; or

(iii) the disclosure is in response to an inquiry made in an investigation or proceeding of an appropriate public regulatory agency and the information disclosed is limited to the scope of the investigation or proceeding.

(4) ADDITIONAL CONSIDERATIONS.—It shall not be a violation of paragraph (1) to take an adverse action against a protected health care professional if the plan, issuer, or provider taking the adverse action involved demonstrates that it would have taken the same adverse action even in the absence of the activities protected under such paragraph.

(5) NOTICE.—A group health plan, health insurance issuer, and institutional health care provider shall post a notice, to be provided or approved by the Secretary of Labor, setting forth excerpts from, or summaries of, the pertinent provisions of this subsection and information pertaining to enforcement of such provisions.

(6) CONSTRUCTIONS.—

(A) DETERMINATIONS OF COVERAGE.—Nothing in this subsection shall be construed to prohibit a plan or issuer from making a determination not to pay for a particular medical treatment or service or the services of a type of health care professional.

(B) ENFORCEMENT OF PEER REVIEW PROTOCOLS AND INTERNAL PROCEDURES.—Nothing in this subsection shall be construed to prohibit a plan, issuer, or provider from establishing and enforcing reasonable peer review or utilization review protocols or determining whether a protected health care professional has complied with those protocols or from establishing and enforcing internal procedures for the purpose of addressing quality concerns.

(C) RELATION TO OTHER RIGHTS.—Nothing in this subsection shall be construed to abridge rights of participants, beneficiaries, enrollees, and protected health care professionals under other applicable Federal or State laws.

(7) PROTECTED HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, the term ''protected health care professional'' means an

individual who is a licensed or certified health care professional and who—

(A) with respect to a group health plan or health insurance issuer, is an employee of the plan or issuer or has a contract with the plan or issuer for provision of services for which benefits are available under the plan or issuer; or

(B) with respect to an institutional health care provider, is an employee of the provider or has a contract or other arrangement with the provider respecting the provision of health care services.

# Subtitle E—Definitions

**SEC. 1151. DEFINITIONS.**

(a) INCORPORATION OF GENERAL DEFINITIONS.—Except as otherwise provided, the provisions of section 2791 of the Public Health Service Act shall apply for purposes of this title in the same manner as they apply for purposes of title XXVII of such Act.

(b) SECRETARY.—Except as otherwise provided, the term ''Secretary'' means the Secretary of Health and Human Services, in consultation with the Secretary of Labor and the term ''appropriate Secretary'' means the Secretary of Health and Human Services in relation to carrying out this title under sections 2706 and 2751 of

the Public Health Service Act and the Secretary of Labor in relation to carrying out this title under section 713 of the Employee Retirement Income Security Act of 1974.

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

(1) ACTIVELY PRACTICING.—The term ''actively practicing'' means, with respect to a physician or other health care professional, such a physician or professional who provides professional services to individual patients on average at least two full days per week.

(2) APPLICABLE AUTHORITY.—The term ''applicable authority'' means—

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

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

(3) CLINICAL PEER.—The term ''clinical peer'' means, with respect to a review or appeal, an actively practicing physician (allopathic or osteopathic) or other actively practicing health care professional who holds a nonrestricted license, and who is appropriately credentialed in the same or similar specialty or subspecialty (as appropriate) as typically handles the medical condition, procedure, or treatment under review or appeal and includes a pediatric specialist where appropriate; except that only a physician (allopathic or osteopathic) may be a clinical peer with respect to the review or appeal of treatment recommended or rendered by a physician.

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

(5) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given such term in section 733(a) of the Employee Retirement Income Security Act of 1974 and in section 2791(a)(1) of the Public Health Service Act.

(6) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means an individual who is licensed, accredited, or certified under State law

to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

(7) HEALTH CARE PROVIDER.—The term ''health care provider'' includes a physician or other health care professional, as well as an institutional or other facility or agency that provides health care services and that is licensed, accredited, or certified to provide health care items and services under applicable State law.

(8) NETWORK.—The term ''network'' means, with respect to a group health plan or health insurance issuer offering health insurance coverage, the participating health care professionals and providers through whom the plan or issuer provides health care items and services to participants, beneficiaries, or enrollees.

(9) NONPARTICIPATING.—The term ''nonparticipating'' means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage, a health care provider that is not a participating health care provider with respect to such items and services.

(10) PARTICIPATING.—The term ''participating'' means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage offered by a health insurance issuer, a health care provider that furnishes such items and services under a contract or other arrangement with the plan or issuer.

(11) PRIOR AUTHORIZATION.—The term ''prior authorization'' means the process of obtaining prior approval from a health insurance issuer or group health plan for the provision or coverage of medical services.

**SEC. 1152. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.**

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

(1) IN GENERAL.—Subject to paragraph (2), this title shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers (in connection with group health insurance coverage or otherwise) except to the extent that such standard or re-

quirement prevents the application of a requirement of this title.

(2) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.—Nothing in this title shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 with respect to group health plans.

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

(1) STATE LAW.—The term ''State law'' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) STATE.—The term ''State'' includes a State, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, any political subdivisions of such, or any agency or instrumentality of such.

**SEC. 1153. EXCLUSIONS.**

(a) NO BENEFIT REQUIREMENTS.—Nothing in this title shall be construed to require a group health plan or a health insurance issuer offering health insurance cov-

erage to provide items and services (including abortions) that are specifically excluded under the plan or coverage.

(b) EXCLUSION FROM ACCESS TO CARE MANAGED CARE PROVISIONS FOR FEE-FOR-SERVICE COVERAGE.—

(1) IN GENERAL.—The provisions of sections 1111 through 1117 shall not apply to a group health plan or health insurance coverage if the only coverage offered under the plan or coverage is fee-for-service coverage (as defined in paragraph (2)).

(2) FEE-FOR-SERVICE COVERAGE DEFINED.—For purposes of this subsection, the term ''fee-for-service coverage'' means coverage under a group health plan or health insurance coverage that—

(A) reimburses hospitals, health professionals, and other providers on the basis of a rate determined by the plan or issuer on a fee-for-service basis without placing the provider at financial risk;

(B) does not vary reimbursement for such a provider based on an agreement to contract terms and conditions or the utilization of health care items or services relating to such provider;

(C) does not restrict the selection of providers among those who are lawfully authorized to provide the covered services and agree to ac-

cept the terms and conditions of payment established under the plan or by the issuer; and

(D) for which the plan or issuer does not require prior authorization before providing coverage for any services.

**SEC. 1154. COVERAGE OF LIMITED SCOPE PLANS.**

Only for purposes of applying the requirements of this title under sections 2707 and 2753 of the Public Health Service Act and section 714 of the Employee Retirement Income Security Act of 1974, section 2791(c)(2)(A), and section 733(c)(2)(A) of the Employee Retirement Income Security Act of 1974 shall be deemed not to apply.

**SEC. 1155. REGULATIONS.**

The Secretaries of Health and Human Services and Labor shall issue such regulations as may be necessary or appropriate to carry out this title. Such regulations shall be issued consistent with section 104 of Health Insurance Portability and Accountability Act of 1996. Such Secretaries may promulgate any interim final rules as the Secretaries determine are appropriate to carry out this title.

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

**SEC. 1201. APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.**

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

**"SEC. 2707. PATIENT PROTECTION STANDARDS.**

''(a) IN GENERAL.—Each group health plan shall comply with patient protection requirements under title XI of the Bipartisan Consensus Managed Care Improvement Act of 1999, and each health insurance issuer shall comply with patient protection requirements under such title with respect to group health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

''(b) NOTICE.—A group health plan shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements referred to in subsection (a) and a health insurance issuer shall comply with such notice

requirement as if such section applied to such issuer and such issuer were a group health plan.''.

(b) CONFORMING AMENDMENT.—Section 2721(b)(2)(A) of such Act (42 U.S.C. 300gg–21(b)(2)(A)) is amended by inserting ''(other than section 2707)'' after ''requirements of such subparts''.

**SEC. 1202. APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.**

Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2752 the following new section:

**''SEC. 2753. PATIENT PROTECTION STANDARDS.**

''(a) IN GENERAL.—Each health insurance issuer shall comply with patient protection requirements under title XI of the Bipartisan Consensus Managed Care Improvement Act of 1999 with respect to individual health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

''(b) NOTICE.—A health insurance issuer under this part shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of such title as if such section applied to such issuer and such issuer were a group health plan.''.

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

**SEC. 1301. APPLICATION OF PATIENT PROTECTION STANDARDS TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.**

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

**"SEC. 714. PATIENT PROTECTION STANDARDS.**

"(a) IN GENERAL.—Subject to subsection (b), a group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of title XI of the Bipartisan Consensus Managed Care Improvement Act of 1999 (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this subsection.

"(b) PLAN SATISFACTION OF CERTAIN REQUIREMENTS.—

"(1) SATISFACTION OF CERTAIN REQUIREMENTS THROUGH INSURANCE.—For purposes of

subsection (a), insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the following requirements of title XI of the Bipartisan Consensus Managed Care Improvement Act of 1999 with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer:

"(A) Section 1112 (relating to choice of providers).

"(B) Section 1113 (relating to access to emergency care).

"(C) Section 1114 (relating to access to specialty care).

"(D) Section 1115 (relating to access to obstetrical and gynecological care).

"(E) Section 1116 (relating to access to pediatric care).

"(F) Section 1117(a)(1) (relating to continuity in case of termination of provider contract) and section 117(a)(2) (relating to continuity in case of termination of issuer con-

tract), but only insofar as a replacement issuer assumes the obligation for continuity of care.

''(G) Section 1118 (relating to access to needed prescription drugs).

''(H) Section 1119 (relating to coverage for individuals participating in approved clinical trials.)

''(I) Section 1134 (relating to payment of claims).

''(2) INFORMATION.—With respect to information required to be provided or made available under section 1121, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide or make available the information (and is not liable for the issuer's failure to provide or make available the information), if the issuer is obligated to provide and make available (or provides and makes available) such information.

''(3) GRIEVANCE AND INTERNAL APPEALS.—With respect to the internal appeals process and the grievance system required to be established under sections 1102 and 1104, in the case of a group

health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide for such process and system (and is not liable for the issuer's failure to provide for such process and system), if the issuer is obligated to provide for (and provides for) such process and system.

''(4) EXTERNAL APPEALS.—Pursuant to rules of the Secretary, insofar as a group health plan enters into a contract with a qualified external appeal entity for the conduct of external appeal activities in accordance with section 1103, the plan shall be treated as meeting the requirement of such section and is not liable for the entity's failure to meet any requirements under such section.

''(5) APPLICATION TO PROHIBITIONS.—Pursuant to rules of the Secretary, if a health insurance issuer offers health insurance coverage in connection with a group health plan and takes an action in violation of any of the following sections, the group health plan shall not be liable for such violation unless the plan caused such violation:

''(A) Section 1131 (relating to prohibition of interference with certain medical communications).

''(B) Section 1132 (relating to prohibition of discrimination against providers based on licensure).

''(C) Section 1133 (relating to prohibition against improper incentive arrangements).

''(D) Section 1135 (relating to protection for patient advocacy).

''(6) CONSTRUCTION.—Nothing in this subsection shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B.

''(7) APPLICATION TO CERTAIN PROHIBITIONS AGAINST RETALIATION.—With respect to compliance with the requirements of section 1135(b)(1) of the Bipartisan Consensus Managed Care Improvement Act of 1999, for purposes of this subtitle the term 'group health plan' is deemed to include a reference to an institutional health care provider.

''(c) ENFORCEMENT OF CERTAIN REQUIREMENTS.—

''(1) COMPLAINTS.—Any protected health care professional who believes that the professional has been retaliated or discriminated against in violation

of section 1135(b)(1) of the Bipartisan Consensus Managed Care Improvement Act of 1999 may file with the Secretary a complaint within 180 days of the date of the alleged retaliation or discrimination.

''(2) INVESTIGATION.—The Secretary shall investigate such complaints and shall determine if a violation of such section has occurred and, if so, shall issue an order to ensure that the protected health care professional does not suffer any loss of position, pay, or benefits in relation to the plan, issuer, or provider involved, as a result of the violation found by the Secretary.

''(d) CONFORMING REGULATIONS.—The Secretary may issue regulations to coordinate the requirements on group health plans under this section with the requirements imposed under the other provisions of this title.''.

(b) SATISFACTION OF ERISA CLAIMS PROCEDURE REQUIREMENT.—Section 503 of such Act (29 U.S.C. 1133) is amended by inserting ''(a)'' after ''SEC. 503.'' and by adding at the end the following new subsection:

''(b) In the case of a group health plan (as defined in section 733) compliance with the requirements of subtitle A of title XI of the Bipartisan Consensus Managed Care Improvement Act of 1999 in the case of a claims

denial shall be deemed compliance with subsection (a) with respect to such claims denial.''.

(c) CONFORMING AMENDMENTS.—(1) Section 732(a) of such Act (29 U.S.C. 1185(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 714''.

(2) The table of contents in section 1 of such Act is amended by inserting after the item relating to section 713 the following new item:

''Sec. 714. Patient protection standards.''.

(3) Section 502(b)(3) of such Act (29 U.S.C. 1132(b)(3)) is amended by inserting ''(other than section 135(b))'' after ''part 7''.

**SEC. 1302. ERISA PREEMPTION NOT TO APPLY TO CERTAIN ACTIONS INVOLVING HEALTH INSURANCE POLICYHOLDERS.**

(a) IN GENERAL.—Section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) (as amended by section 301(b)) is amended further by adding at the end the following subsections:

''(f) PREEMPTION NOT TO APPLY TO CERTAIN ACTIONS ARISING OUT OF PROVISION OF HEALTH BENEFITS.—

''(1) NON-PREEMPTION OF CERTAIN CAUSES OF ACTION.—

''(A) IN GENERAL.—Except as provided in this subsection, nothing in this title shall be

construed to invalidate, impair, or supersede any cause of action by a participant or beneficiary (or the estate of a participant or beneficiary) under State law to recover damages resulting from personal injury or for wrongful death against any person—

"(i) in connection with the provision of insurance, administrative services, or medical services by such person to or for a group health plan (as defined in section 733), or

"(ii) that arises out of the arrangement by such person for the provision of such insurance, administrative services, or medical services by other persons.

"(B) LIMITATION ON PUNITIVE DAMAGES.—

"(i) IN GENERAL.—No person shall be liable for any punitive, exemplary, or similar damages in the case of a cause of action brought under subparagraph (A) if—

"(I) it relates to an externally appealable decision (as defined in subsection (a)(2) of section 1103 of the

Bipartisan Consensus Managed Care Improvement Act of 1999);

"(II) an external appeal with respect to such decision was completed under such section 1103;

"(III) in the case such external appeal was initiated by the plan or issuer filing the request for the external appeal, the request was filed on a timely basis before the date the action was brought or, if later, within 30 days after the date the externally appealable decision was made; and

"(IV) the plan or issuer complied with the determination of the external appeal entity upon receipt of the determination of the external appeal entity.

The provisions of this clause supersede any State law or common law to the contrary.

"(ii) EXCEPTION.—Clause (i) shall not apply with respect to damages in the case of a cause of action for wrongful death if the applicable State law provides (or has been construed to provide) for

damages in such a cause of action which are only punitive or exemplary in nature.

''(C) PERSONAL INJURY DEFINED.—For purposes of this subsection, the term 'personal injury' means a physical injury and includes an injury arising out of the treatment (or failure to treat) a mental illness or disease.

''(2) EXCEPTION FOR GROUP HEALTH PLANS, EMPLOYERS, AND OTHER PLAN SPONSORS.—

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

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

''(ii) a right of recovery, indemnity, or contribution by a person against a group health plan or 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) against group health plan or an employer or other plan sponsor (or against an employee of such a plan, employer, or sponsor acting within the scope of employment) if—

"(i) such action is based on the exercise by the plan, employer, or sponsor (or employee) of discretionary authority to make a decision on a claim for benefits covered under the plan or health insurance coverage in the case at issue; and

"(ii) the exercise by the plan, employer, or sponsor (or employee) of such authority resulted in personal injury or wrongful death.

"(C) EXCEPTION.—The exercise of discretionary authority described in subparagraph (B)(i) shall not be construed to include—

"(i) the decision to include or exclude from the plan any specific benefit;

"(ii) any decision to provide extra-contractual benefits; or

"(iii) any decision not to consider the provision of a benefit while internal or external review is being conducted.

"(3) FUTILITY OF EXHAUSTION.—An individual bringing an action under this subsection is required to exhaust administrative processes under sections 1102 and 1103 of the Bipartisan Consensus Managed Care Improvement Act of 1999, unless the injury to or death of such individual has occurred before the completion of such processes.

"(4) CONSTRUCTION.—Nothing in this subsection shall be construed as—

"(A) permitting a cause of action under State law for the failure to provide an item or service which is specifically excluded under the group health plan involved;

"(B) as preempting a State law which requires an affidavit or certificate of merit in a civil action; or

"(C) permitting a cause of action or remedy under State law in connection with the provision or arrangement of excepted benefits (as defined in section 733(c)), other than those described in section 733(c)(2)(A).

"(g) RULES OF CONSTRUCTION RELATING TO HEALTH CARE.—Nothing in this title shall be construed as—

''(1) permitting the application of State laws that are otherwise superseded by this title and that mandate the provision of specific benefits by a group health plan (as defined in section 733(a)) or a multiple employer welfare arrangement (as defined in section 3(40)), or

''(2) affecting any State law which regulates the practice of medicine or provision of medical care, or affecting any action based upon such a State law.''.

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

**SEC. 1303. LIMITATIONS ON ACTIONS.**

Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) (as amended by section 304(b)) is amended further by adding at the end the following new subsection:

''(o)(1) Except as provided in this subsection, no action may be brought under subsection (a)(1)(B), (a)(2), or (a)(3) by a participant or beneficiary seeking relief based on the application of any provision in section 1101, subtitle B, or subtitle D of title XI of the Bipartisan Consensus Managed Care Improvement Act of 1999 (as incorporated under section 714).

''(2) An action may be brought under subsection (a)(1)(B), (a)(2), or (a)(3) by a participant or beneficiary seeking relief based on the application of section 1101, 1113, 1114, 1115, 1116, 1117, 1119, or 1118(3) of the Bipartisan Consensus Managed Care Improvement Act of 1999 (as incorporated under section 714) to the individual circumstances of that participant or beneficiary, except that—

''(A) such an action may not be brought or maintained as a class action; and

''(B) in such an action, relief may only provide for the provision of (or payment of) benefits, items, or services denied to the individual participant or beneficiary involved (and for attorney's fees and the costs of the action, at the discretion of the court) and shall not provide for any other relief to the participant or beneficiary or for any relief to any other person.

''(3) Nothing in this subsection shall be construed as affecting any action brought by the Secretary.''.

# TITLE XIV—APPLICATION TO GROUP HEALTH PLANS UNDER THE INTERNAL REVENUE CODE OF 1986

**SEC. 1401. AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.**

Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended—

(1) in the table of sections, by inserting after the item relating to section 9812 the following new item:

"Sec. 9813. Standard relating to patient freedom of choice.";

and

(2) by inserting after section 9812 the following:

**"SEC. 9813. STANDARD RELATING TO PATIENTS' BILL OF RIGHTS.**

"A group health plan shall comply with the requirements of title XI of the Bipartisan Consensus Managed Care Improvement Act of 1999 (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this section.".

# TITLE XV—EFFECTIVE DATES; COORDINATION IN IMPLEMENTATION

**SEC. 1501. EFFECTIVE DATES.**

(a) GROUP HEALTH COVERAGE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by sections 1201(a), 1301, 1303, and 1401 (and title XI insofar as it relates to such sections) shall apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning on or after January 1, 2001 (in this section referred to as the ''general effective date'') and also shall apply to portions of plan years occurring on and after such date.

(2) TREATMENT OF COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by sections 1201(a), 1301, 1303, and 1401 (and title XI insofar as it relates to such sections) shall not apply to plan years beginning before the later of—

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

(B) the general effective date.

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

(b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The amendments made by section 1202 shall apply with respect to individual health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the general effective date.

**SEC. 1502. COORDINATION IN IMPLEMENTATION.**

The Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which such Secretaries have responsibility

under the provisions of this division (and the amendments made thereby) are administered so as to have the same effect at all times; and

(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.

# TITLE XVI—HEALTH CARE PAPERWORK SIMPLIFICATION

**SEC. 1601. HEALTH CARE PAPERWORK SIMPLIFICATION.**

(a) ESTABLISHMENT OF PANEL.—

(1) ESTABLISHMENT.—There is established a panel to be known as the Health Care Panel to Devise a Uniform Explanation of Benefits (in this section referred to as the ''Panel'').

(2) DUTIES OF PANEL.—

(A) IN GENERAL.—The Panel shall devise a single form for use by third-party health care payers for the remittance of claims to providers.

(B) DEFINITION.—For purposes of this section, the term ''third-party health care payer'' means any entity that contractually pays health care bills for an individual.

(3) MEMBERSHIP.—

(A) SIZE AND COMPOSITION.—The Secretary of Health and Human Services shall determine the number of members and the composition of the Panel. Such Panel shall include equal numbers of representatives of private insurance organizations, consumer groups, State insurance commissioners, State medical societies, State hospital associations, and State medical specialty societies.

(B) TERMS OF APPOINTMENT.—The members of the Panel shall serve for the life of the Panel.

(C) VACANCIES.—A vacancy in the Panel shall not affect the power of the remaining members to execute the duties of the Panel, but any such vacancy shall be filled in the same manner in which the original appointment was made.

(4) PROCEDURES.—

(A) MEETINGS.—The Panel shall meet at the call of a majority of its members.

(B) FIRST MEETING.—The Panel shall convene not later than 60 days after the date of the enactment of the Bipartisan Consensus Managed Care Improvement Act of 1999.

(C) QUORUM.—A quorum shall consist of a majority of the members of the Panel.

(D) HEARINGS.—For the purpose of carrying out its duties, the Panel may hold such hearings and undertake such other activities as the Panel determines to be necessary to carry out its duties.

(5) ADMINISTRATION.—

(A) COMPENSATION.—Except as provided in subparagraph (B), members of the Panel shall receive no additional pay, allowances, or benefits by reason of their service on the Panel.

(B) TRAVEL EXPENSES AND PER DIEM.—Each member of the Panel who is not an officer or employee of the Federal Government shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

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

(D) USE OF MAILS.—The Panel may use the United States mails in the same manner

and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

(E) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Panel, the Secretary of Health and Human Services shall provide to the Panel on a reimbursable basis such administrative support services as the Panel may request.

(6) SUBMISSION OF FORM.—Not later than 2 years after the first meeting, the Panel shall submit a form to the Secretary of Health and Human Services for use by third-party health care payers.

(7) TERMINATION.—The Panel shall terminate on the day after submitting the form under paragraph (6).

(b) REQUIREMENT FOR USE OF FORM BY THIRD-PARTY CARE PAYERS.—A third-party health care payer shall be required to use the form devised under subsection

(a) for plan years beginning on or after 5 years following the date of the enactment of this Act.

Passed the House of Representatives October 7, 1999.

Attest: JEFF TRANDAHL,

*Clerk.*