

106TH CONGRESS
1ST SESSION

H. R. 2990

IN THE SENATE OF THE UNITED STATES

OCTOBER 14, 1999

Received

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.

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

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

5 (a) DIVISIONS.—This Act is organized into 2 divi-
 6 sions as follows:

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

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

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

Sec. 1. Organization of Act into divisions; table of contents.

**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.

Sec. 102. Constitutional authority to enact this division.

Sec. 103. Purposes of division.

Sec. 104. Findings relating to health care choice.

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.

Sec. 202. Deduction for 100 percent of health insurance costs of self-employed individuals.

- Sec. 203. Expansion of availability of medical savings accounts.
- Sec. 204. Long-term care insurance permitted to be offered under cafeteria plans and flexible spending arrangements.
- Sec. 205. Additional personal exemption for taxpayer caring for elderly family member in taxpayer's home.
- Sec. 206. Expanded human clinical trials qualifying for orphan drug credit.
- Sec. 207. Inclusion of certain vaccines against streptococcus pneumoniae to list of taxable vaccines; reduction in per dose tax rate.
- Sec. 208. Credit for clinical testing research expenses attributable to certain qualified academic institutions including teaching hospitals.

TITLE III—GREATER ACCESS AND CHOICE THROUGH ASSOCIATION HEALTH PLANS

- Sec. 301. Rules.
- Sec. 302. Clarification of treatment of single employer arrangements.
- Sec. 303. Clarification of treatment of certain collectively bargained arrangements.
- Sec. 304. Enforcement provisions.
- Sec. 305. Cooperation between Federal and State authorities.
- Sec. 306. Effective date and transitional and other rules.

TITLE IV—GREATER ACCESS AND CHOICE THROUGH HEALTHMARTS

- Sec. 401. Expansion of consumer choice through HealthMarts.

TITLE V—COMMUNITY HEALTH ORGANIZATIONS

- Sec. 501. Promotion of provision of insurance by community health organizations.

DIVISION B—BIPARTISAN CONSENSUS MANAGED CARE IMPROVEMENT ACT OF 1999

- Sec. 1001. Short title of division; table of contents of division.

TITLE XI—IMPROVING MANAGED CARE

Subtitle A—Grievances and Appeals

- Sec. 1101. Utilization review activities.
- Sec. 1102. Internal appeals procedures.
- Sec. 1103. External appeals procedures.
- Sec. 1104. Establishment of a grievance process.

Subtitle B—Access to Care

- Sec. 1111. Consumer choice option.
- Sec. 1112. Choice of health care professional.
- Sec. 1113. Access to emergency care.
- Sec. 1114. Access to specialty care.
- Sec. 1115. Access to obstetrical and gynecological care.
- Sec. 1116. Access to pediatric care.
- Sec. 1117. Continuity of care.
- Sec. 1118. Access to needed prescription drugs.
- Sec. 1119. Coverage for individuals participating in approved clinical trials.

Subtitle C—Access to Information

Sec. 1121. Patient access to information.

Subtitle D—Protecting the Doctor-Patient Relationship

- Sec. 1131. Prohibition of interference with certain medical communications.
- Sec. 1132. Prohibition of discrimination against providers based on licensure.
- Sec. 1133. Prohibition against improper incentive arrangements.
- Sec. 1134. Payment of claims.
- Sec. 1135. Protection for patient advocacy.

Subtitle E—Definitions

- Sec. 1151. Definitions.
- Sec. 1152. Preemption; State flexibility; construction.
- Sec. 1153. Exclusions.
- Sec. 1154. Coverage of limited scope plans.
- Sec. 1155. Regulations.

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.
- Sec. 1202. Application to individual health insurance coverage.

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.
- Sec. 1302. ERISA preemption not to apply to certain actions involving health insurance policyholders.
- Sec. 1303. Limitations on actions.

TITLE XIV—APPLICATION TO GROUP HEALTH PLANS UNDER
THE INTERNAL REVENUE CODE OF 1986

- Sec. 1401. Amendments to the Internal Revenue Code of 1986.

TITLE XV—EFFECTIVE DATES; COORDINATION IN
IMPLEMENTATION

- Sec. 1501. Effective dates.
- Sec. 1502. Coordination in implementation.

TITLE XVI—HEALTH CARE PAPERWORK SIMPLIFICATION

- Sec. 1601. Health care paperwork simplification.

1 **DIVISION A—QUALITY CARE FOR**
 2 **THE UNINSURED ACT OF 1999**
 3 **TITLE I—GENERAL PROVISIONS**

4 **SEC. 101. SHORT TITLE OF DIVISION; TABLE OF CONTENTS**
 5 **OF DIVISION.**

6 (a) SHORT TITLE OF DIVISION.—This division may
 7 be cited as the “Quality Care for the Uninsured Act of
 8 1999”.

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

TITLE I—GENERAL PROVISIONS

- Sec. 101. Short title of division; table of contents of division.
- Sec. 102. Constitutional authority to enact this division.
- Sec. 103. Purposes of division.
- Sec. 104. Findings relating to health care choice.

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.
- Sec. 202. Deduction for 100 percent of health insurance costs of self-employed individuals.
- Sec. 203. Expansion of availability of medical savings accounts.
- Sec. 204. Long-term care insurance permitted to be offered under cafeteria plans and flexible spending arrangements.
- Sec. 205. Additional personal exemption for taxpayer caring for elderly family member in taxpayer’s home.
- Sec. 206. Expanded human clinical trials qualifying for orphan drug credit.
- Sec. 207. Inclusion of certain vaccines against streptococcus pneumoniae to list of taxable vaccines; reduction in per dose tax rate.
- Sec. 208. Credit for clinical testing research expenses attributable to certain qualified academic institutions including teaching hospitals.

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

- Sec. 301. Rules.

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

- “Sec. 801. Association health plans.
- “Sec. 802. Certification of association health plans.
- “Sec. 803. Requirements relating to sponsors and boards of trustees.

“Sec. 804. Participation and coverage requirements.

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

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

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

“Sec. 808. Notice requirements for voluntary termination.

“Sec. 809. Corrective actions and mandatory termination.

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

“Sec. 811. State assessment authority.

“Sec. 812. Special rules for church plans.

“Sec. 813. Definitions and rules of construction.

Sec. 302. Clarification of treatment of single employer arrangements.

Sec. 303. Clarification of treatment of certain collectively bargained arrangements.

Sec. 304. Enforcement provisions.

Sec. 305. Cooperation between Federal and State authorities.

Sec. 306. Effective date and transitional and other rules.

TITLE IV—GREATER ACCESS AND CHOICE THROUGH HEALTHMARTS

Sec. 401. Expansion of consumer choice through HealthMarts.

“TITLE XXVIII—HEALTHMARTS

“Sec. 2801. Definition of HealthMart.

“Sec. 2802. Application of certain laws and requirements.

“Sec. 2803. Administration.

“Sec. 2804. Definitions.

TITLE V—COMMUNITY HEALTH ORGANIZATIONS

Sec. 501. Promotion of provision of insurance by community health organizations.

1 **SEC. 102. CONSTITUTIONAL AUTHORITY TO ENACT THIS DI-** 2 **VISION.**

3 The constitutional authority upon which this division
4 rests is the power of the Congress to regulate commerce
5 with foreign nations and among the several States, set
6 forth in article I, section 8 of the United States Constitu-
7 tion.

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

2 The purposes of this division are—

3 (1) to make it possible for individuals, employ-
4 ees, and the self-employed to purchase and own their
5 own health insurance without suffering any negative
6 tax consequences;

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

9 (3) to render patients and deliverers sensitive to
10 the cost of health care, giving them both the incen-
11 tive and the ability to restrain undesired increases in
12 health care costs;

13 (4) to foster the development of numerous, var-
14 ied, and innovative systems of providing health care
15 which will compete against each other in terms of
16 price, service, and quality, and thus allow the Amer-
17 ican people to benefit from competitive forces which
18 will reward efficient and effective deliverers and
19 eliminate those which provide unsatisfactory quality
20 of care or are inefficient; and

21 (5) to encourage the development of systems of
22 delivering health care which are capable of supplying
23 a broad range of health care services in a com-
24 prehensive and systematic manner.

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

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

12 (b) Congress finds that reduction of the number of
13 uninsured Americans is an important public policy goal.
14 Congress further finds that the use of alternative pooling
15 mechanisms such as Association Health Plans,
16 HealthMarts and other innovative means could provide
17 significant opportunities for small business and individuals
18 to purchase health insurance. Congress further finds that
19 the use of such mechanisms could provide significant op-
20 portunities to expand private health coverage for individ-
21 uals who are employees of small business, self-employed,
22 or do not work for employers who provide health insur-
23 ance.

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

1 duction for the employer for the cost of health insurance
2 coverage and an exclusion from income for the employee
3 for employer-provided health care. Congress further finds
4 that some individuals may prefer to decline coverage under
5 their employer's group health plan and obtain individual
6 health insurance coverage, and some employers may wish
7 to give employees the opportunity to do so. Congress fur-
8 ther finds that the Internal Revenue Service has ruled that
9 this tax treatment for the employer and employee for em-
10 ployer-provided health care applies even if the employer
11 pays for individual health insurance policies for its employ-
12 ees. Therefore, the Tax Code makes it possible for employ-
13 ers to provide employees choice among health insurance
14 coverage while retaining favorable tax treatment. Congress
15 further finds that the present-law exclusion for employer-
16 provided health care, together with the tax provisions in
17 the bill, will provide more equitable tax treatment for
18 health insurance expenses, encourage uninsured individ-
19 uals to purchase insurance, expand health care options,
20 and encourage individuals to better manage their health
21 care needs and expenses.

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

1 itself expensive and counterproductive in fulfilling its pur-
 2 poses and detrimental to the care of patients.

3 **TITLE II—TAX-RELATED HEALTH** 4 **CARE PROVISIONS**

5 **SEC. 201. DEDUCTION FOR HEALTH AND LONG-TERM CARE** 6 **INSURANCE COSTS OF INDIVIDUALS NOT** 7 **PARTICIPATING IN EMPLOYER-SUBSIDIZED** 8 **HEALTH PLANS.**

9 (a) IN GENERAL.—Part VII of subchapter B of chap-
 10 ter 1 of the Internal Revenue Code of 1986 is amended
 11 by redesignating section 222 as section 223 and by insert-
 12 ing after section 221 the following new section:

13 **“SEC. 222. HEALTH AND LONG-TERM CARE INSURANCE** 14 **COSTS.**

15 “(a) IN GENERAL.—In the case of an individual,
 16 there shall be allowed as a deduction an amount equal to
 17 the applicable percentage of the amount paid during the
 18 taxable year for insurance which constitutes medical care
 19 for the taxpayer and the taxpayer’s spouse and depend-
 20 ents.

21 “(b) APPLICABLE PERCENTAGE.—For purposes of
 22 subsection (a), the applicable percentage shall be deter-
 23 mined 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.

1 “(c) LIMITATION BASED ON OTHER COVERAGE.—

2 “(1) COVERAGE UNDER CERTAIN SUBSIDIZED
3 EMPLOYER PLANS.—

4 “(A) IN GENERAL.—Subsection (a) shall
5 not apply to any taxpayer for any calendar
6 month for which the taxpayer participates in
7 any health plan maintained by any employer of
8 the taxpayer or of the spouse of the taxpayer if
9 50 percent or more of the cost of coverage
10 under such plan (determined under section
11 4980B and without regard to payments made
12 with respect to any coverage described in sub-
13 section (e)) is paid or incurred by the employer.

14 “(B) EMPLOYER CONTRIBUTIONS TO CAF-
15 ETERIA PLANS, FLEXIBLE SPENDING ARRANGE-
16 MENTS, AND MEDICAL SAVINGS ACCOUNTS.—
17 Employer contributions to a cafeteria plan, a
18 flexible spending or similar arrangement, or a
19 medical savings account which are excluded
20 from gross income under section 106 shall be
21 treated for purposes of subparagraph (A) as
22 paid by the employer.

1 “(C) AGGREGATION OF PLANS OF EM-
2 PLOYER.—A health plan which is not otherwise
3 described in subparagraph (A) shall be treated
4 as described in such subparagraph if such plan
5 would be so described if all health plans of per-
6 sons treated as a single employer under sub-
7 section (b), (c), (m), or (o) of section 414 were
8 treated as one health plan.

9 “(D) SEPARATE APPLICATION TO HEALTH
10 INSURANCE AND LONG-TERM CARE INSUR-
11 ANCE.—Subparagraphs (A) and (C) shall be
12 applied separately with respect to—

13 “(i) plans which include primarily cov-
14 erage for qualified long-term care services
15 or are qualified long-term care insurance
16 contracts, and

17 “(ii) plans which do not include such
18 coverage and are not such contracts.

19 “(2) COVERAGE UNDER CERTAIN FEDERAL
20 PROGRAMS.—

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

1 covered under any medical care program de-
2 scribed in—

3 “(i) title XVIII, XIX, or XXI of the
4 Social Security Act,

5 “(ii) chapter 55 of title 10, United
6 States Code,

7 “(iii) chapter 17 of title 38, United
8 States Code,

9 “(iv) chapter 89 of title 5, United
10 States Code, or

11 “(v) the Indian Health Care Improve-
12 ment Act.

13 “(B) EXCEPTIONS.—

14 “(i) QUALIFIED LONG-TERM CARE.—
15 Subparagraph (A) shall not apply to
16 amounts paid for coverage under a quali-
17 fied long-term care insurance contract.

18 “(ii) CONTINUATION COVERAGE OF
19 FEHBP.—Subparagraph (A)(iv) shall not
20 apply to coverage which is comparable to
21 continuation coverage under section
22 4980B.

23 “(d) LONG-TERM CARE DEDUCTION LIMITED TO
24 QUALIFIED LONG-TERM CARE INSURANCE CON-
25 TRACTS.—In the case of a qualified long-term care insur-

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

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

7 “(1) coverage for accidents, disability, dental
 8 care, vision care, or a specified illness, or

9 “(2) making payments of a fixed amount per
 10 day (or other period) by reason of being hospitalized,
 11 shall not be taken into account under subsection (a).

12 “(f) SPECIAL RULES.—

13 “(1) COORDINATION WITH DEDUCTION FOR
 14 HEALTH INSURANCE COSTS OF SELF-EMPLOYED IN-
 15 DIVIDUALS.—The amount taken into account by the
 16 taxpayer in computing the deduction under section
 17 162(l) shall not be taken into account under this
 18 section.

19 “(2) COORDINATION WITH MEDICAL EXPENSE
 20 DEDUCTION.—The amount taken into account by
 21 the taxpayer in computing the deduction under this
 22 section shall not be taken into account under section
 23 213.

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

1 section, including regulations requiring employers to re-
 2 port to their employees and the Secretary such informa-
 3 tion as the Secretary determines to be appropriate.”.

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

8 “(18) HEALTH AND LONG-TERM CARE INSUR-
 9 ANCE COSTS.—The deduction allowed by section
 10 222.”.

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

“Sec. 222. Health and long-term care insurance costs.

“Sec. 223. Cross reference.”.

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

18 **SEC. 202. DEDUCTION FOR 100 PERCENT OF HEALTH IN-**
 19 **SURANCE COSTS OF SELF-EMPLOYED INDI-**
 20 **VIDUALS.**

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

1 “(1) ALLOWANCE OF DEDUCTION.—In the case
2 of an individual who is an employee within the
3 meaning of section 401(c)(1), there shall be allowed
4 as a deduction under this section an amount equal
5 to 100 percent of the amount paid during the tax-
6 able year for insurance which constitutes medical
7 care for the taxpayer and the taxpayer’s spouse and
8 dependents.”.

9 (b) CLARIFICATION OF LIMITATIONS ON OTHER COV-
10 ERAGE.—The first sentence of section 162(l)(2)(B) of
11 such Code is amended to read as follows: “Paragraph (1)
12 shall not apply to any taxpayer for any calendar month
13 for which the taxpayer participates in any subsidized
14 health plan maintained by any employer (other than an
15 employer described in section 401(c)(4)) of the taxpayer
16 or the spouse of the taxpayer.”.

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

20 **SEC. 203. EXPANSION OF AVAILABILITY OF MEDICAL SAV-**
21 **INGS ACCOUNTS.**

22 (a) REPEAL OF LIMITATIONS ON NUMBER OF MED-
23 ICAL SAVINGS ACCOUNTS.—

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

4 (2) CONFORMING AMENDMENTS.—

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

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

10 (b) AVAILABILITY NOT LIMITED TO ACCOUNTS FOR
11 EMPLOYEES OF SMALL EMPLOYERS AND SELF-EM-
12 PLOYED INDIVIDUALS.—

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

16 “(A) IN GENERAL.—The term ‘eligible in-
17 dividual’ means, with respect to any month, any
18 individual if—

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

22 “(ii) such individual is not, while cov-
23 ered under a high deductible health plan,
24 covered under any health plan—

1 “(I) which is not a high deduct-
 2 ible health plan, and
 3 “(II) which provides coverage for
 4 any benefit which is covered under the
 5 high deductible health plan.”.

6 (2) CONFORMING AMENDMENTS.—

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

9 (B) Section 220(c) of such Code is amend-
 10 ed by striking paragraph (4) (defining small
 11 employer) and by redesignating paragraph (5)
 12 as paragraph (4).

13 (C) Section 220(b) of such Code is amend-
 14 ed by striking paragraph (4) (relating to deduc-
 15 tion limited by compensation) and by redesign-
 16 ating paragraphs (5), (6), and (7) as para-
 17 graphs (4), (5), and (6), respectively.

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

20 (1) IN GENERAL.—Paragraph (2) of section
 21 220(b) of such Code is amended to read as follows:

22 “(2) MONTHLY LIMITATION.—The monthly lim-
 23 itation for any month is the amount equal to $\frac{1}{12}$ of
 24 the annual deductible (as of the first day of such

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

3 (2) CONFORMING AMENDMENT.—Clause (ii) of
4 section 220(d)(1)(A) of such Code is amended by
5 striking “75 percent of”.

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

10 “(4) COORDINATION WITH EXCLUSION FOR EM-
11 PLOYER CONTRIBUTIONS.—The limitation which
12 would (but for this paragraph) apply under this sub-
13 section to the taxpayer for any taxable year shall be
14 reduced (but not below zero) by the amount which
15 would (but for section 106(b)) be includible in the
16 taxpayer's gross income for such taxable year.”.

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

19 (1) IN GENERAL.—Subparagraph (A) of section
20 220(c)(2) of such Code (defining high deductible
21 health plan) is amended—

22 (A) by striking “\$1,500” in clause (i) and
23 inserting “\$1,000”; and

24 (B) by striking “\$3,000” in clause (ii) and
25 inserting “\$2,000”.

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

4 “(g) COST-OF-LIVING ADJUSTMENT.—

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

9 “(A) such dollar amount, multiplied by

10 “(B) the cost-of-living adjustment deter-
11 mined under section 1(f)(3) for the calendar
12 year in which such taxable year begins by sub-
13 stituting ‘calendar year 1997’ for ‘calendar year
14 1992’ in subparagraph (B) thereof.

15 “(2) SPECIAL RULES.—In the case of the
16 \$1,000 amount in subsection (c)(2)(A)(i) and the
17 \$2,000 amount in subsection (c)(2)(A)(ii), para-
18 graph (1)(B) shall be applied by substituting ‘cal-
19 endar year 1999’ for ‘calendar year 1997’.

20 “(3) ROUNDING.—If any increase under para-
21 graph (1) or (2) is not a multiple of \$50, such in-
22 crease shall be rounded to the nearest multiple of
23 \$50.”.

1 (f) MEDICAL SAVINGS ACCOUNTS MAY BE OFFERED
2 UNDER CAFETERIA PLANS.—Subsection (f) of section
3 125 of such Code is amended by striking “106(b),”.

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

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

10 (a) CAFETERIA PLANS.—

11 (1) IN GENERAL.—Subsection (f) of section
12 125 of the Internal Revenue Code of 1986 (defining
13 qualified benefits) is amended by inserting before
14 the period at the end “; except that such term shall
15 include the payment of premiums for any qualified
16 long-term care insurance contract (as defined in sec-
17 tion 7702B) to the extent the amount of such pay-
18 ment does not exceed the eligible long-term care pre-
19 miums (as defined in section 213(d)(10)) for such
20 contract”.

21 (b) FLEXIBLE SPENDING ARRANGEMENTS.—Section
22 106 of such Code (relating to contributions by employer
23 to accident and health plans) is amended by striking sub-
24 section (c).

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

4 **SEC. 205. ADDITIONAL PERSONAL EXEMPTION FOR TAX-**
 5 **PAYER CARING FOR ELDERLY FAMILY MEM-**
 6 **BER IN TAXPAYER’S HOME.**

7 (a) IN GENERAL.—Section 151 of the Internal Rev-
 8 enue Code of 1986 (relating to allowance of deductions
 9 for personal exemptions) is amended by redesignating sub-
 10 section (e) as subsection (f) and by inserting after sub-
 11 section (d) the following new subsection:

12 “(e) ADDITIONAL EXEMPTION FOR CERTAIN ELDER-
 13 LY FAMILY MEMBERS RESIDING WITH TAXPAYER.—

14 “(1) IN GENERAL.—An exemption of the ex-
 15 emption amount for each qualified family member of
 16 the taxpayer.

17 “(2) QUALIFIED FAMILY MEMBER.—For pur-
 18 poses of this subsection, the term ‘qualified family
 19 member’ means, with respect to any taxable year,
 20 any individual—

21 “(A) who is an ancestor of the taxpayer or
 22 of the taxpayer’s spouse or who is the spouse
 23 of any such ancestor,

1 “(B) who is a member for the entire tax-
2 able year of a household maintained by the tax-
3 payer, and

4 “(C) who has been certified, before the due
5 date for filing the return of tax for the taxable
6 year (without extensions), by a physician (as
7 defined in section 1861(r)(1) of the Social Se-
8 curity Act) as being an individual with long-
9 term care needs described in paragraph (3) for
10 a period—

11 “(i) which is at least 180 consecutive
12 days, and

13 “(ii) a portion of which occurs within
14 the taxable year.

15 Such term shall not include any individual otherwise
16 meeting the requirements of the preceding sentence
17 unless within the 39½ month period ending on such
18 due date (or such other period as the Secretary pre-
19 scribes) a physician (as so defined) has certified that
20 such individual meets such requirements.

21 “(3) INDIVIDUALS WITH LONG-TERM CARE
22 NEEDS.—An individual is described in this para-
23 graph if the individual—

24 “(A) is unable to perform (without sub-
25 stantial assistance from another individual) at

1 least two activities of daily living (as defined in
2 section 7702B(c)(2)(B)) due to a loss of func-
3 tional capacity, or

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

14 “(4) SPECIAL RULES.—Rules similar to the
15 rules of paragraphs (1), (2), (3), (4), and (5) of sec-
16 tion 21(e) shall apply for purposes of this sub-
17 section.”.

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

21 **SEC. 206. EXPANDED HUMAN CLINICAL TRIALS QUALI-**
22 **FYING FOR ORPHAN DRUG CREDIT.**

23 (a) IN GENERAL.—Subclause (I) of section
24 45C(b)(2)(A)(ii) of the Internal Revenue Code of 1986 is
25 amended to read as follows:

1 “(I) after the date that the appli-
2 cation is filed for designation under
3 such section 526, and”.

4 (b) CONFORMING AMENDMENT.—Clause (i) of sec-
5 tion 45C(b)(2)(A) of such Code is amended by inserting
6 “which is” before “being” and by inserting before the
7 comma at the end “and which is designated under section
8 526 of such Act”.

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

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

16 (a) INCLUSION OF VACCINES.—

17 (1) IN GENERAL.—Section 4132(a)(1) of the
18 Internal Revenue Code of 1986 (defining taxable
19 vaccine) is amended by adding at the end the fol-
20 lowing new subparagraph:

21 “(L) Any conjugate vaccine against strep-
22 tococcus pneumoniae.”.

23 (2) EFFECTIVE DATE.—

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

1 on the day after the date on which the Centers
2 for Disease Control makes a final recommenda-
3 tion for routine administration to children of
4 any conjugate vaccine against streptococcus
5 pneumoniae, but shall not take effect if sub-
6 section (c) does not take effect.

7 (B) DELIVERIES.—For purposes of sub-
8 paragraph (A), in the case of sales on or before
9 the date described in such subparagraph for
10 which delivery is made after such date, the de-
11 livery date shall be considered the sale date.

12 (b) REDUCTION IN PER DOSE TAX RATE.—

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

16 (2) EFFECTIVE DATE.—

17 (A) SALES.—The amendment made by this
18 subsection shall apply to vaccine sales after De-
19 cember 31, 2004, but shall not take effect if
20 subsection (c) does not take effect.

21 (B) DELIVERIES.—For purposes of sub-
22 paragraph (A), in the case of sales on or before
23 the date described in such subparagraph for
24 which delivery is made after such date, the de-
25 livery date shall be considered the sale date.

1 (3) LIMITATION ON CERTAIN CREDITS OR RE-
2 FUNDS.—For purposes of applying section 4132(b)
3 of the Internal Revenue Code of 1986 with respect
4 to any claim for credit or refund filed after August
5 31, 2004, the amount of tax taken into account shall
6 not exceed the tax computed under the rate in effect
7 on January 1, 2005.

8 (c) VACCINE TAX AND TRUST FUND AMEND-
9 MENTS.—

10 (1) Sections 1503 and 1504 of the Vaccine In-
11 jury Compensation Program Modification Act (and
12 the amendments made by such sections) are hereby
13 repealed.

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

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

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

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

4 **SEC. 208. CREDIT FOR CLINICAL TESTING RESEARCH EX-**
 5 **PENSES ATTRIBUTABLE TO CERTAIN QUALI-**
 6 **FIED ACADEMIC INSTITUTIONS INCLUDING**
 7 **TEACHING HOSPITALS.**

8 (a) IN GENERAL.—Subpart D of part IV of sub-
 9 chapter A of chapter 1 of the Internal Revenue Code of
 10 1986 (relating to business related credits) is amended by
 11 inserting after section 41 the following:

12 **“SEC. 41A. CREDIT FOR MEDICAL INNOVATION EXPENSES.**

13 “(a) GENERAL RULE.—For purposes of section 38,
 14 the medical innovation credit determined under this sec-
 15 tion for the taxable year shall be an amount equal to 40
 16 percent of the excess (if any) of—

17 “(1) the qualified medical innovation expenses
 18 for the taxable year, over

19 “(2) the medical innovation base period
 20 amount.

21 “(b) QUALIFIED MEDICAL INNOVATION EX-
 22 PENSES.—For purposes of this section—

23 “(1) IN GENERAL.—The term ‘qualified medical
 24 innovation expenses’ means the amounts which are
 25 paid or incurred by the taxpayer during the taxable

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

3 “(2) CLINICAL TESTING RESEARCH ACTIVITIES.—
4

5 “(A) IN GENERAL.—The term ‘clinical
6 testing research activities’ means human clinical
7 testing conducted at any qualified academic in-
8 stitution in the development of any product,
9 which occurs before—

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

16 “(ii) the date on which a license for
17 such product is issued under section 351 of
18 the Public Health Service Act (as so in ef-
19 fect), or

20 “(iii) the date classification or ap-
21 proval of such product which is a device in-
22 tended for human use is given under sec-
23 tion 513, 514, or 515 of the Federal Food,
24 Drug, and Cosmetic Act (as so in effect).

1 “(B) PRODUCT.—The term ‘product’
2 means any drug, biologic, or medical device.

3 “(3) QUALIFIED ACADEMIC INSTITUTION.—The
4 term ‘qualified academic institution’ means any of
5 the following institutions:

6 “(A) EDUCATIONAL INSTITUTION.—A
7 qualified organization described in section
8 170(b)(1)(A)(iii) which is owned by, or affili-
9 ated with, an institution of higher education (as
10 defined in section 3304(f)).

11 “(B) TEACHING HOSPITAL.—A teaching
12 hospital which—

13 “(i) is publicly supported or owned by
14 an organization described in section
15 501(c)(3), and

16 “(ii) is affiliated with an organization
17 meeting the requirements of subparagraph
18 (A).

19 “(C) FOUNDATION.—A medical research
20 organization described in section 501(c)(3)
21 (other than a private foundation) which is affli-
22 ated with, or owned by—

23 “(i) an organization meeting the re-
24 quirements of subparagraph (A), or

1 “(ii) a teaching hospital meeting the
2 requirements of subparagraph (B).

3 “(D) CHARITABLE RESEARCH HOS-
4 PITAL.—A hospital that is designated as a can-
5 cer center by the National Cancer Institute.

6 “(4) EXCLUSION FOR AMOUNTS FUNDED BY
7 GRANTS, ETC.—The term ‘qualified medical innova-
8 tion expenses’ shall not include any amount to the
9 extent such amount is funded by any grant, con-
10 tract, or otherwise by another person (or any gov-
11 ernmental entity).

12 “(c) MEDICAL INNOVATION BASE PERIOD
13 AMOUNT.—For purposes of this section, the term ‘medical
14 innovation base period amount’ means the average annual
15 qualified medical innovation expenses paid by the taxpayer
16 during the 3-taxable year period ending with the taxable
17 year immediately preceding the first taxable year of the
18 taxpayer beginning after December 31, 2000.

19 “(d) SPECIAL RULES.—

20 “(1) LIMITATION ON FOREIGN TESTING.—No
21 credit shall be allowed under this section with re-
22 spect to any clinical testing research activities con-
23 ducted outside the United States.

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

4 “(3) ELECTION.—This section shall apply to
5 any taxpayer for any taxable year only if such tax-
6 payer elects to have this section apply for such tax-
7 able year.

8 “(4) COORDINATION WITH CREDIT FOR IN-
9 CREASING RESEARCH EXPENDITURES AND WITH
10 CREDIT FOR CLINICAL TESTING EXPENSES FOR CER-
11 TAIN DRUGS FOR RARE DISEASES.—Any qualified
12 medical innovation expense for a taxable year to
13 which an election under this section applies shall not
14 be taken into account for purposes of determining
15 the credit allowable under section 41 or 45C for
16 such taxable year.”.

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

19 (1) IN GENERAL.—Section 38(b) of such Code
20 (relating to current year business credits) is amend-
21 ed by striking “plus” at the end of paragraph (11),
22 by striking the period at the end of paragraph (12)
23 and inserting “, plus”, and by adding at the end the
24 following:

1 “(13) the medical innovation expenses credit
2 determined under section 41A(a).”.

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

6 “(9) NO CARRYBACK OF SECTION 41A CREDIT
7 BEFORE ENACTMENT.—No portion of the unused
8 business credit for any taxable year which is attrib-
9 utable to the medical innovation credit determined
10 under section 41A may be carried back to a taxable
11 year beginning before January 1, 2001.”.

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

15 “(d) CREDIT FOR INCREASING MEDICAL INNOVA-
16 TION EXPENSES.—

17 “(1) IN GENERAL.—No deduction shall be al-
18 lowed for that portion of the qualified medical inno-
19 vation expenses (as defined in section 41A(b)) other-
20 wise allowable as a deduction for the taxable year
21 which is equal to the amount of the credit deter-
22 mined for such taxable year under section 41A(a).

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

1 section (c) shall apply for purposes of this sub-
2 section.”.

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

9 “(5) the medical innovation expenses credit de-
10 termined under section 41A(a) (other than such
11 credit determined under the rules of section
12 280C(d)(2)),”.

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

 “Sec. 41A. Credit for medical innovation expenses.”.

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

1 **TITLE III—GREATER ACCESS**
2 **AND CHOICE THROUGH ASSO-**
3 **CIATION HEALTH PLANS**

4 **SEC. 301. RULES.**

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

8 “PART 8—RULES GOVERNING ASSOCIATION HEALTH
9 PLANS

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

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

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

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

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

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

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

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

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

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

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

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

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

23 “(1) such certification—

24 “(A) is administratively feasible;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 “(B) LIMITATION.—

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

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

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

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

17 “(C) CERTAIN PLANS EXCLUDED.—Sub-
18 paragraph (A) shall not apply to an association
19 health plan which is in existence on the date of
20 the enactment of the Quality Care for the Unin-
21 sured Act of 1999.

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

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

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

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

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

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

20 “(d) CERTAIN COLLECTIVELY BARGAINED PLANS.—

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

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

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

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

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

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

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

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

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

20 “(1) each participating employer must be—

21 “(A) a member of the sponsor,

22 “(B) the sponsor, or

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

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

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

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

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

19 “(b) COVERAGE OF PREVIOUSLY UNINSURED EM-
20 PLOYEES.—In the case of an association health plan in
21 existence on the date of the enactment of the Quality Care
22 for the Uninsured Act of 1999, an affiliated member of
23 the sponsor of the plan may be offered coverage under
24 the plan as a participating employer only if—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 “(4) MARKETING REQUIREMENTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 “(1) \$500,000, or

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

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

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

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

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

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

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

3 “(A) IN GENERAL.—In the case of an as-
4 sociation health plan described in subsection
5 (a)(2), the requirements of this subsection are
6 met if the plan makes payments into the Asso-
7 ciation Health Plan Fund under this subpara-
8 graph when they are due. Such payments shall
9 consist of annual payments in the amount of
10 \$5,000, except that the Secretary shall reduce
11 part or all of such annual payments, or shall
12 provide a rebate of part or all of such a pay-
13 ment, to the extent that the Secretary deter-
14 mines that the balance in such Fund is suffi-
15 cient (taking into account such a reduction or
16 rebate) to meet all reasonable actuarial require-
17 ments. Such determination shall occur not less
18 than once annually. In addition to any such an-
19 nual payments, such payments may include
20 such supplemental payments as the Secretary
21 may determine to be necessary to meet reason-
22 able actuarial requirements to carry out para-
23 graph (2). Payments under this paragraph are
24 payable to the Fund at the time determined by
25 the Secretary. Initial payments are due in ad-

1 vance of certification under this part. Payments
2 shall continue to accrue until a plan's assets are
3 distributed pursuant to a termination proce-
4 dure.

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

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

16 “(2) PAYMENTS BY SECRETARY TO CONTINUE
17 EXCESS/STOP LOSS INSURANCE COVERAGE AND IN-
18 DEMNIFICATION INSURANCE COVERAGE FOR CER-
19 TAIN PLANS.—In any case in which the applicable
20 authority determines that there is, or that there is
21 reason to believe that there will be: (A) a failure to
22 take necessary corrective actions under section
23 809(a) with respect to an association health plan de-
24 scribed in subsection (a)(2); or (B) a termination of
25 such a plan under section 809(b) or 810(b)(8) (and,

1 if the applicable authority is not the Secretary, cer-
2 tifies such determination to the Secretary), the Sec-
3 retary shall determine the amounts necessary to
4 make payments to an insurer (designated by the
5 Secretary) to maintain in force excess/stop loss in-
6 surance coverage or indemnification insurance cov-
7 erage for such plan, if the Secretary determines that
8 there is a reasonable expectation that, without such
9 payments, claims would not be satisfied by reason of
10 termination of such coverage. The Secretary shall, to
11 the extent provided in advance in appropriation
12 Acts, pay such amounts so determined to the insurer
13 designated by the Secretary.

14 “(3) ASSOCIATION HEALTH PLAN FUND.—

15 “(A) IN GENERAL.—There is established
16 on the books of the Treasury a fund to be
17 known as the ‘Association Health Plan Fund’.
18 The Fund shall be available for making pay-
19 ments pursuant to paragraph (2). The Fund
20 shall be credited with payments received pursu-
21 ant to paragraph (1)(A), penalties received pur-
22 suant to paragraph (1)(B); and earnings on in-
23 vestments of amounts of the Fund under sub-
24 paragraph (B).

1 “(B) INVESTMENT.—Whenever the Sec-
2 retary determines that the moneys of the fund
3 are in excess of current needs, the Secretary
4 may request the investment of such amounts as
5 the Secretary determines advisable by the Sec-
6 retary of the Treasury in obligations issued or
7 guaranteed by the United States.

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

10 “(1) AGGREGATE EXCESS/STOP LOSS INSUR-
11 ANCE.—The term ‘aggregate excess/stop loss insur-
12 ance’ means, in connection with an association
13 health plan, a contract—

14 “(A) under which an insurer (meeting such
15 minimum standards as the applicable authority may
16 prescribe by regulation through negotiated rule-
17 making) provides for payment to the plan with re-
18 spect to aggregate claims under the plan in excess
19 of an amount or amounts specified in such contract;

20 “(B) which is guaranteed renewable; and

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

23 “(2) SPECIFIC EXCESS/STOP LOSS INSUR-
24 ANCE.—The term ‘specific excess/stop loss insur-

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

3 “(A) under which an insurer (meeting such
4 minimum standards as the applicable authority
5 may prescribe by regulation through negotiated
6 rulemaking) provides for payment to the plan
7 with respect to claims under the plan in connec-
8 tion with a covered individual in excess of an
9 amount or amounts specified in such contract
10 in connection with such covered individual;

11 “(B) which is guaranteed renewable; and

12 “(C) which allows for payment of pre-
13 miums by any third party on behalf of the in-
14 sured plan.

15 “(h) INDEMNIFICATION INSURANCE.—For purposes
16 of this section, the term ‘indemnification insurance’
17 means, in connection with an association health plan, a
18 contract—

19 “(1) under which an insurer (meeting such min-
20 imum standards as the applicable authority may pre-
21 scribe through negotiated rulemaking) provides for
22 payment to the plan with respect to claims under the
23 plan which the plan is unable to satisfy by reason
24 of a termination pursuant to section 809(b) (relating
25 to mandatory termination);

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

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

7 “(i) RESERVES.—For purposes of this section, the
8 term ‘reserves’ means, in connection with an association
9 health plan, plan assets which meet the fiduciary stand-
10 ards under part 4 and such additional requirements re-
11 garding liquidity as the applicable authority may prescribe
12 through negotiated rulemaking.

13 “(j) SOLVENCY STANDARDS WORKING GROUP.—

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

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

1 “(A) three representatives of the National
2 Association of Insurance Commissioners;

3 “(B) three representatives of the American
4 Academy of Actuaries;

5 “(C) three representatives of the State
6 governments, or their interests;

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

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

12 “(F) three representatives of multiem-
13 ployer plans that are group health plans, or
14 their interests.

15 **“SEC. 807. REQUIREMENTS FOR APPLICATION AND RE-**
16 **LATED REQUIREMENTS.**

17 “(a) FILING FEE.—Under the procedure prescribed
18 pursuant to section 802(a), an association health plan
19 shall pay to the applicable authority at the time of filing
20 an application for certification under this part a filing fee
21 in the amount of \$5,000, which shall be available in the
22 case of the Secretary, to the extent provided in appropria-
23 tion Acts, for the sole purpose of administering the certifi-
24 cation procedures applicable with respect to association
25 health plans.

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

7 “(1) IDENTIFYING INFORMATION.—The names
8 and addresses of—

9 “(A) the sponsor; and

10 “(B) the members of the board of trustees
11 of the plan.

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

17 “(3) BONDING REQUIREMENTS.—Evidence pro-
18 vided by the board of trustees that the bonding re-
19 quirements of section 412 will be met as of the date
20 of the application or (if later) commencement of op-
21 erations.

22 “(4) PLAN DOCUMENTS.—A copy of the docu-
23 ments governing the plan (including any bylaws and
24 trust agreements), the summary plan description,
25 and other material describing the benefits that will

1 be provided to participants and beneficiaries under
2 the plan.

3 “(5) AGREEMENTS WITH SERVICE PRO-
4 VIDERS.—A copy of any agreements between the
5 plan and contract administrators and other service
6 providers.

7 “(6) FUNDING REPORT.—In the case of asso-
8 ciation health plans providing benefits options in ad-
9 dition to health insurance coverage, a report setting
10 forth information with respect to such additional
11 benefit options determined as of a date within the
12 120-day period ending with the date of the applica-
13 tion, including the following:

14 “(A) RESERVES.—A statement, certified
15 by the board of trustees of the plan, and a
16 statement of actuarial opinion, signed by a
17 qualified actuary, that all applicable require-
18 ments of section 806 are or will be met in ac-
19 cordance with regulations which the applicable
20 authority shall prescribe through negotiated
21 rulemaking.

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

1 rates are adequate to provide for the payment
2 of all obligations and the maintenance of re-
3 quired reserves under the plan for the 12-
4 month period beginning with such date within
5 such 120-day period, taking into account the
6 expected coverage and experience of the plan. If
7 the contribution rates are not fully adequate,
8 the statement of actuarial opinion shall indicate
9 the extent to which the rates are inadequate
10 and the changes needed to ensure adequacy.

11 “(C) CURRENT AND PROJECTED VALUE OF
12 ASSETS AND LIABILITIES.—A statement of ac-
13 tuarial opinion signed by a qualified actuary,
14 which sets forth the current value of the assets
15 and liabilities accumulated under the plan and
16 a projection of the assets, liabilities, income,
17 and expenses of the plan for the 12-month pe-
18 riod referred to in subparagraph (B). The in-
19 come statement shall identify separately the
20 plan’s administrative expenses and claims.

21 “(D) COSTS OF COVERAGE TO BE
22 CHARGED AND OTHER EXPENSES.—A state-
23 ment of the costs of coverage to be charged, in-
24 cluding an itemization of amounts for adminis-

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

3 “(E) OTHER INFORMATION.—Any other
4 information as may be determined by the appli-
5 cable authority, by regulation through nego-
6 tiated rulemaking, as necessary to carry out the
7 purposes of this part.

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

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

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

4 “(e) REPORTING REQUIREMENTS FOR CERTAIN AS-
5 SOCIATION HEALTH PLANS.—An association health plan
6 certified under this part which provides benefit options in
7 addition to health insurance coverage for such plan year
8 shall meet the requirements of section 103 by filing an
9 annual report under such section which shall include infor-
10 mation described in subsection (b)(6) with respect to the
11 plan year and, notwithstanding section 104(a)(1)(A), shall
12 be filed with the applicable authority not later than 90
13 days after the close of the plan year (or on such later date
14 as may be prescribed by the applicable authority). The ap-
15 plicable authority may require by regulation through nego-
16 tiated rulemaking such interim reports as it considers ap-
17 propriate.

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

1 a qualified actuary under this part. The qualified actuary
2 shall utilize such assumptions and techniques as are nec-
3 essary to enable such actuary to form an opinion as to
4 whether the contents of the matters reported under this
5 part—

6 “(1) are in the aggregate reasonably related to
7 the experience of the plan and to reasonable expecta-
8 tions; and

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

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

13 **“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TER-**
14 **MINATION.**

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

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

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

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

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

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

8 **“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMI-**
9 **NATION.**

10 “(a) ACTIONS TO AVOID DEPLETION OF RE-
11 SERVES.—An association health plan which is certified
12 under this part and which provides benefits other than
13 health insurance coverage shall continue to meet the re-
14 quirements of section 806, irrespective of whether such
15 certification continues in effect. The board of trustees of
16 such plan shall determine quarterly whether the require-
17 ments of section 806 are met. In any case in which the
18 board determines that there is reason to believe that there
19 is or will be a failure to meet such requirements, or the
20 applicable authority makes such a determination and so
21 notifies the board, the board shall immediately notify the
22 qualified actuary engaged by the plan, and such actuary
23 shall, not later than the end of the next following month,
24 make such recommendations to the board for corrective
25 action as the actuary determines necessary to ensure com-

1 pliance with section 806. Not later than 30 days after re-
2 ceiving from the actuary recommendations for corrective
3 actions, the board shall notify the applicable authority (in
4 such form and manner as the applicable authority may
5 prescribe by regulation through negotiated rulemaking) of
6 such recommendations of the actuary for corrective action,
7 together with a description of the actions (if any) that the
8 board has taken or plans to take in response to such rec-
9 ommendations. The board shall thereafter report to the
10 applicable authority, in such form and frequency as the
11 applicable authority may specify to the board, regarding
12 corrective action taken by the board until the requirements
13 of section 806 are met.

14 “(b) MANDATORY TERMINATION.—In any case in
15 which—

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

24 “(2) the applicable authority determines that
25 there is a reasonable expectation that the plan will

1 continue to fail to meet the requirements of section
2 806,
3 the board of trustees of the plan shall, at the direction
4 of the applicable authority, terminate the plan and, in the
5 course of the termination, take such actions as the appli-
6 cable authority may require, including satisfying any
7 claims referred to in section 806(a)(2)(B)(iii) and recov-
8 ering for the plan any liability under subsection
9 (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure
10 that the affairs of the plan will be, to the maximum extent
11 possible, wound up in a manner which will result in timely
12 provision of all benefits for which the plan is obligated.

13 **“SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOL-**
14 **VENT ASSOCIATION HEALTH PLANS PRO-**
15 **VIDING HEALTH BENEFITS IN ADDITION TO**
16 **HEALTH INSURANCE COVERAGE.**

17 “(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR
18 INSOLVENT PLANS.—Whenever the Secretary determines
19 that an association health plan which is or has been cer-
20 tified under this part and which is described in section
21 806(a)(2) will be unable to provide benefits when due or
22 is otherwise in a financially hazardous condition, as shall
23 be defined by the Secretary by regulation through nego-
24 tiated rulemaking, the Secretary shall, upon notice to the
25 plan, apply to the appropriate United States district court

1 for appointment of the Secretary as trustee to administer
2 the plan for the duration of the insolvency. The plan may
3 appear as a party and other interested persons may inter-
4 vene in the proceedings at the discretion of the court. The
5 court shall appoint such Secretary trustee if the court de-
6 termines that the trusteeship is necessary to protect the
7 interests of the participants and beneficiaries or providers
8 of medical care or to avoid any unreasonable deterioration
9 of the financial condition of the plan. The trusteeship of
10 such Secretary shall continue until the conditions de-
11 scribed in the first sentence of this subsection are rem-
12 edied or the plan is terminated.

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

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

19 “(2) to require the transfer of all (or any part)
20 of the assets and records of the plan to the Sec-
21 retary as trustee;

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

1 through negotiated rulemaking, and applicable provi-
2 sions of law;

3 “(4) to require the sponsor, the plan adminis-
4 trator, any participating employer, and any employee
5 organization representing plan participants to fur-
6 nish any information with respect to the plan which
7 the Secretary as trustee may reasonably need in
8 order to administer the plan;

9 “(5) to collect for the plan any amounts due the
10 plan and to recover reasonable expenses of the trust-
11 eeship;

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

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

19 “(8) to terminate the plan (or provide for its
20 termination accordance with section 809(b)) and liq-
21 uidate the plan assets, to restore the plan to the re-
22 sponsibility of the sponsor, or to continue the trust-
23 eeship;

1 “(9) to provide for the enrollment of plan par-
2 ticipants and beneficiaries under appropriate cov-
3 erage options; and

4 “(10) to do such other acts as may be nec-
5 essary to comply with this title or any order of the
6 court and to protect the interests of plan partici-
7 pants and beneficiaries and providers of medical
8 care.

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

12 “(1) the sponsor and plan administrator;

13 “(2) each participant;

14 “(3) each participating employer; and

15 “(4) if applicable, each employee organization
16 which, for purposes of collective bargaining, rep-
17 resents plan participants.

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

1 “(e) OTHER PROCEEDINGS.—An application by the
2 Secretary under this subsection may be filed notwith-
3 standing the pendency in the same or any other court of
4 any bankruptcy, mortgage foreclosure, or equity receiver-
5 ship proceeding, or any proceeding to reorganize, conserve,
6 or liquidate such plan or its property, or any proceeding
7 to enforce a lien against property of the plan.

8 “(f) JURISDICTION OF COURT.—

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

1 erty of the plan or sponsor. Pending such adjudica-
2 tion and upon the appointment by it of the Sec-
3 retary as trustee, the court may stay any proceeding
4 to enforce a lien against property of the plan or the
5 sponsor or any other suit against the plan or the
6 sponsor.

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

14 “(g) PERSONNEL.—In accordance with regulations
15 which shall be prescribed by the Secretary through nego-
16 tiated rulemaking, the Secretary shall appoint, retain, and
17 compensate accountants, actuaries, and other professional
18 service personnel as may be necessary in connection with
19 the Secretary’s service as trustee under this section.

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

21 “(a) IN GENERAL.—Notwithstanding section 514, a
22 State may impose by law a contribution tax on an associa-
23 tion health plan described in section 806(a)(2), if the plan
24 commenced operations in such State after the date of the

1 enactment of the Quality Care for the Uninsured Act of
2 1999.

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

7 “(1) such tax is computed by applying a rate to
8 the amount of premiums or contributions, with re-
9 spect to individuals covered under the plan who are
10 residents of such State, which are received by the
11 plan from participating employers located in such
12 State or from such individuals;

13 “(2) the rate of such tax does not exceed the
14 rate of any tax imposed by such State on premiums
15 or contributions received by insurers or health main-
16 tenance organizations for health insurance coverage
17 offered in such State in connection with a group
18 health plan;

19 “(3) such tax is otherwise nondiscriminatory;
20 and

21 “(4) the amount of any such tax assessed on
22 the plan is reduced by the amount of any tax or as-
23 sessment otherwise imposed by the State on pre-
24 miums, contributions, or both received by insurers or
25 health maintenance organizations for health insur-

1 ance coverage, aggregate excess/stop loss insurance
2 (as defined in section 806(g)(1)), specific excess/
3 stop loss insurance (as defined in section 806(g)(2)),
4 other insurance related to the provision of medical
5 care under the plan, or any combination thereof pro-
6 vided by such insurers or health maintenance organi-
7 zations in such State in connection with such plan.

8 **“SEC. 812. SPECIAL RULES FOR CHURCH PLANS.**

9 “(a) ELECTION FOR CHURCH PLANS.—Notwith-
10 standing section 4(b)(2), if a church, a convention or asso-
11 ciation of churches, or an organization described in section
12 3(33)(C)(i) maintains a church plan which is a group
13 health plan (as defined in section 733(a)(1)), and such
14 church, convention, association, or organization makes an
15 election with respect to such plan under this subsection
16 (in such form and manner as the Secretary may by regula-
17 tion prescribe), then the provisions of this section shall
18 apply to such plan, with respect to benefits provided under
19 such plan consisting of medical care, as if section 4(b)(2)
20 did not contain an exclusion for church plans. Nothing in
21 this subsection shall be construed to render any other sec-
22 tion of this title applicable to church plans, except to the
23 extent that such other section is incorporated by reference
24 in this section.

25 “(b) EFFECT OF ELECTION.—

1 “(1) PREEMPTION OF STATE INSURANCE LAWS
2 REGULATING COVERED CHURCH PLANS.—Subject to
3 paragraphs (2) and (3), this section shall supersede
4 any and all State laws which regulate insurance in-
5 sofar as they may now or hereafter regulate church
6 plans to which this section applies or trusts estab-
7 lished under such church plans.

8 “(2) GENERAL STATE INSURANCE REGULATION
9 UNAFFECTED.—

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

15 “(B) CHURCH PLANS NOT TO BE DEEMED
16 INSURANCE COMPANIES OR INSURERS.—Neither
17 a church plan to which this section applies, nor
18 any trust established under such a church plan,
19 shall be deemed to be an insurance company or
20 other insurer or to be engaged in the business
21 of insurance for purposes of any State law pur-
22 porting to regulate insurance companies or in-
23 surance contracts.

24 “(3) PREEMPTION OF CERTAIN STATE LAWS
25 RELATING TO PREMIUM RATE REGULATION AND

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

7 “(4) DEFINITIONS.—For purposes of this
8 subsection—

9 “(A) STATE LAW.—The term ‘State law’
10 includes all laws, decisions, rules, regulations,
11 or other State action having the effect of law,
12 of any State. A law of the United States appli-
13 cable only to the District of Columbia shall be
14 treated as a State law rather than a law of the
15 United States.

16 “(B) STATE.—The term ‘State’ includes a
17 State, any political subdivision thereof, or any
18 agency or instrumentality of either, which pur-
19 ports to regulate, directly or indirectly, the
20 terms and conditions of church plans covered by
21 this section.

22 “(c) REQUIREMENTS FOR COVERED CHURCH
23 PLANS.—

24 “(1) FIDUCIARY RULES AND EXCLUSIVE PUR-
25 POSE.—A fiduciary shall discharge his duties with

1 respect to a church plan to which this section
2 applies—

3 “(A) for the exclusive purpose of:

4 “(i) providing benefits to participants
5 and their beneficiaries; and

6 “(ii) defraying reasonable expenses of
7 administering the plan;

8 “(B) with the care, skill, prudence and dili-
9 gence under the circumstances then prevailing
10 that a prudent man acting in a like capacity
11 and familiar with such matters would use in the
12 conduct of an enterprise of a like character and
13 with like aims; and

14 “(C) in accordance with the documents
15 and instruments governing the plan.

16 The requirements of this paragraph shall not be
17 treated as not satisfied solely because the plan as-
18 sets are commingled with other church assets, to the
19 extent that such plan assets are separately ac-
20 counted for.

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

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

1 benefits under the plan has been denied, setting
2 forth the specific reasons for such denial, writ-
3 ten in a manner calculated to be understood by
4 the participant;

5 “(B) afford a reasonable opportunity to
6 any participant whose claim for benefits has
7 been denied for a full and fair review by the ap-
8 propriate fiduciary of the decision denying the
9 claim; and

10 “(C) provide a written statement to each
11 participant describing the procedures estab-
12 lished pursuant to this paragraph.

13 “(3) ANNUAL STATEMENTS.—In accordance
14 with regulations of the Secretary, every church plan
15 to which this section applies shall file with the Sec-
16 retary an annual statement—

17 “(A) stating the names and addresses of
18 the plan and of the church, convention, or asso-
19 ciation maintaining the plan (and its principal
20 place of business);

21 “(B) certifying that it is a church plan to
22 which this section applies and that it complies
23 with the requirements of paragraphs (1) and
24 (2);

1 “(C) identifying the States in which par-
2 ticipants and beneficiaries under the plan are or
3 likely will be located during the 1-year period
4 covered by the statement; and

5 “(D) containing a copy of a statement of
6 actuarial opinion signed by a qualified actuary
7 that the plan maintains capital, reserves, insur-
8 ance, other financial arrangements, or any com-
9 bination thereof adequate to enable the plan to
10 fully meet all of its financial obligations on a
11 timely basis.

12 “(4) DISCLOSURE.—At the time that the an-
13 nual statement is filed by a church plan with the
14 Secretary pursuant to paragraph (3), a copy of such
15 statement shall be made available by the Secretary
16 to the State insurance commissioner (or similar offi-
17 cial) of any State. The name of each church plan
18 and sponsoring organization filing an annual state-
19 ment in compliance with paragraph (3) shall be pub-
20 lished annually in the Federal Register.

21 “(c) ENFORCEMENT.—The Secretary may enforce
22 the provisions of this section in a manner consistent with
23 section 502, to the extent applicable with respect to ac-
24 tions under section 502(a)(5), and with section 3(33)(D),
25 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 “(1) GROUP HEALTH PLAN.—The term ‘group
2 health plan’ has the meaning provided in section
3 733(a)(1) (after applying subsection (b) of this sec-
4 tion).

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

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

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

13 “(5) APPLICABLE AUTHORITY.—

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

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

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

24 “(B) EXCEPTIONS.—

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

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

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

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

6 “(7) INDIVIDUAL MARKET.—

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

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

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

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

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

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

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

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

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

3 “(11) AFFILIATED MEMBER.—The term ‘affili-
4 ated member’ means, in connection with a sponsor—

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

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

12 “(C) in the case of an association health
13 plan in existence on the date of the enactment
14 of the Quality Care for the Uninsured Act of
15 1999, a person eligible to be a member of the
16 sponsor or one of its member associations.

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

24 “(13) SMALL EMPLOYER.—The term ‘small em-
25 ployer’ means, in connection with a group health

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

3 “(b) RULES OF CONSTRUCTION.—

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

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

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

21 “(2) PLANS, FUNDS, AND PROGRAMS TREATED
22 AS EMPLOYEE WELFARE BENEFIT PLANS.—In the
23 case of any plan, fund, or program which was estab-
24 lished or is maintained for the purpose of providing
25 medical care (through the purchase of insurance or

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

10 (b) CONFORMING AMENDMENTS TO PREEMPTION
11 RULES.—

12 (1) Section 514(b)(6) of such Act (29 U.S.C.
13 1144(b)(6)) is amended by adding at the end the
14 following new subparagraph:

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

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

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

24 (B) in subsection (b)(5), by striking “sub-
25 section (a)” in subparagraph (A) and inserting

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

6 (C) by redesignating subsection (d) as sub-
7 section (e); and

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

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

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

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

1 erage of the same policy type to other employers op-
2 erating in the State which are eligible for coverage
3 under such association health plan, whether or not
4 such other employers are participating employers in
5 such plan.

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

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

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

1 the meanings provided such terms in section 811, respec-
2 tively.”.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

- “Sec. 801. Association health plans.
- “Sec. 802. Certification of association health plans.
- “Sec. 803. Requirements relating to sponsors and boards of trustees.
- “Sec. 804. Participation and coverage requirements.
- “Sec. 805. Other requirements relating to plan documents, contribution rates,
and benefit options.
- “Sec. 806. Maintenance of reserves and provisions for solvency for plans pro-
viding health benefits in addition to health insurance coverage.
- “Sec. 807. Requirements for application and related requirements.
- “Sec. 808. Notice requirements for voluntary termination.
- “Sec. 809. Corrective actions and mandatory termination.
- “Sec. 810. Trusteeship by the Secretary of insolvent association health plans
providing health benefits in addition to health insurance cov-
erage.
- “Sec. 811. State assessment authority.
- “Sec. 812. Special rules for church plans.
- “Sec. 813. Definitions and rules of construction.”.

1 **SEC. 302. CLARIFICATION OF TREATMENT OF SINGLE EM-**
2 **PLOYER ARRANGEMENTS.**

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

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

11 (2) in clause (iii)—

12 (A) by striking “common control shall not
13 be based on an interest of less than 25 percent”
14 and inserting “an interest of greater than 25
15 percent may not be required as the minimum
16 interest necessary for common control”; and

17 (B) by striking “similar to” and inserting
18 “consistent and coextensive with”;

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

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

23 “(iv) in determining, after the application of
24 clause (i), whether benefits are provided to employ-
25 ees of two or more employers, the arrangement shall
26 be treated as having only one participating employer

1 if, after the application of clause (i), the number of
 2 individuals who are employees and former employees
 3 of any one participating employer and who are cov-
 4 ered under the arrangement is greater than 75 per-
 5 cent of the aggregate number of all individuals who
 6 are employees or former employees of participating
 7 employers and who are covered under the arrange-
 8 ment;”.

9 **SEC. 303. CLARIFICATION OF TREATMENT OF CERTAIN**
 10 **COLLECTIVELY BARGAINED ARRANGE-**
 11 **MENTS.**

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

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

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

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

8 “(i) The plan or other arrangement, and the
9 employee organization or any other entity sponsoring
10 the plan or other arrangement, do not—

11 “(I) utilize the services of any licensed in-
12 surance agent or broker for soliciting or enroll-
13 ing employers or individuals as participating
14 employers or covered individuals under the plan
15 or other arrangement; or

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

1 the contributions made by participating employ-
2 ers or covered individuals to the plan or other
3 arrangement;

4 except to the extent that the services used by the
5 plan, arrangement, organization, or other entity con-
6 sist solely of preparation of documents necessary for
7 compliance with the reporting and disclosure re-
8 quirements of part 1 or administrative, investment,
9 or consulting services unrelated to solicitation or en-
10 rollment of covered individuals.

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

14 “(I) employed within a bargaining unit
15 covered by any of the collective bargaining
16 agreements with a participating employer (nor
17 covered on the basis of an individual’s employ-
18 ment in such a bargaining unit); nor

19 “(II) present employees (or former employ-
20 ees who were covered while employed) of the
21 sponsoring employee organization, of an em-
22 ployer who is or was a party to any of the col-
23 lective bargaining agreements, or of the plan or
24 other arrangement or a related plan or arrange-

1 ment (nor covered on the basis of such present
2 or former employment);
3 does not exceed 15 percent of the total number of
4 individuals who are covered under the plan or ar-
5 rangement and who are present or former employees
6 who are or were covered under the plan or arrange-
7 ment pursuant to a collective bargaining agreement
8 with a participating employer. The requirements of
9 the preceding provisions of this clause shall be treat-
10 ed as satisfied if, as of the end of the preceding plan
11 year, such covered individuals are comprised solely
12 of individuals who were covered individuals under
13 the plan or other arrangement as of the date of the
14 enactment of the Quality Care for the Uninsured
15 Act of 1999 and, as of the end of the preceding plan
16 year, the number of such covered individuals does
17 not exceed 25 percent of the total number of present
18 and former employees enrolled under the plan or
19 other arrangement.

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

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

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

6 “(i) all of the benefits provided under the plan
7 or arrangement consist of health insurance coverage;
8 or

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

11 “(II) the requirements of clause (B) of the pro-
12 viso to clause (5) of section 302(c) of the Labor
13 Management Relations Act, 1947 (29 U.S.C.
14 186(c)) are met with respect to such plan or other
15 arrangement.

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

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

22 “(ii) the employee organization or other entity
23 sponsoring the plan or arrangement—

24 “(I) has been in existence for at least 3
25 years; or

1 “(II) demonstrates to the satisfaction of
2 the Secretary that the requirements of subpara-
3 graphs (C) and (D) are met with respect to the
4 plan or other arrangement.”.

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

11 **SEC. 304. ENFORCEMENT PROVISIONS.**

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

16 (1) by inserting “(a)” after “SEC. 501.”; and
17 (2) by adding at the end the following new sub-
18 section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 “(c) RESPONSIBILITY OF STATES WITH RESPECT TO
 19 ASSOCIATION HEALTH PLANS.—

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

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

1 “(B) the Secretary’s authority to certify
2 association health plans under part 8 in accord-
3 ance with regulations of the Secretary applica-
4 ble to certification under part 8; or

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

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

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

1 participants and beneficiaries under the plan and the
2 State in which the trust is maintained.”.

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

5 (a) **EFFECTIVE DATE.**—The amendments made by
6 sections 301, 304, and 305 shall take effect on January
7 1, 2001. The amendments made by sections 302 and 303
8 shall take effect on the date of the enactment of this Act.
9 The Secretary of Labor shall first issue all regulations
10 necessary to carry out the amendments made by this title
11 before January 1, 2001. Such regulations shall be issued
12 through negotiated rulemaking.

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

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

23 (1) **IN GENERAL.**—In any case in which, as of
24 the date of the enactment of this Act, an arrange-
25 ment is maintained in a State for the purpose of

1 providing benefits consisting of medical care for the
2 employees and beneficiaries of its participating em-
3 ployers, at least 200 participating employers make
4 contributions to such arrangement, such arrange-
5 ment has been in existence for at least 10 years, and
6 such arrangement is licensed under the laws of one
7 or more States to provide such benefits to its par-
8 ticipating employers, upon the filing with the appli-
9 cable authority (as defined in section 813(a)(5) of
10 the Employee Retirement Income Security Act of
11 1974 (as amended by this Act)) by the arrangement
12 of an application for certification of the arrangement
13 under part 8 of subtitle B of title I of such Act—

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

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

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

1 (i) is elected by the participating em-
2 ployers, with each employer having one
3 vote; and

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

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

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

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

19 (2) DEFINITIONS.—For purposes of this sub-
20 section, the terms “group health plan”, “medical
21 care”, and “participating employer” shall have the
22 meanings provided in section 813 of the Employee
23 Retirement Income Security Act of 1974, except
24 that the reference in paragraph (7) of such section
25 to an “association health plan” shall be deemed a

1 reference to an arrangement referred to in this sub-
2 section.

3 (d) PROMOTING USE OF CERTAIN ADDITIONAL AS-
4 SOCIATIONS IN PROVIDING INDIVIDUAL HEALTH INSUR-
5 ANCE COVERAGE.—Section 2742(b)(5) of the Public
6 Health Service Act (42 U.S.C. 300gg–42(b)(5)) is
7 amended—

8 (1) by striking “paragraph” and inserting “sub-
9 paragraph”;

10 (2) by inserting “(A)” after “.—”; and

11 (3) by adding at the end the following new sub-
12 paragraph:

13 “(B)(i) In the case of health insurance coverage
14 that is made available in the individual market only
15 through one or more associations described in clause
16 (ii), the membership of the individual in the associa-
17 tion (on the basis of which the coverage is provided)
18 ceases but only if such coverage is terminated under
19 this subparagraph uniformly without regard to any
20 health status-related factor of covered individuals
21 and only if the individual is entitled, upon applica-
22 tion and without furnishing evidence of insurability,
23 to health insurance conversion coverage that meets
24 and is subject to all the rules and regulations of the
25 State in which application is made.

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

11 **TITLE IV—GREATER ACCESS**
 12 **AND CHOICE THROUGH**
 13 **HEALTHMARTS**

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

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

18 **“TITLE XXVIII—HEALTHMARTS**

19 **“SEC. 2801. DEFINITION OF HEALTHMART.**

20 “(a) IN GENERAL.—For purposes of this title, the
 21 term ‘HealthMart’ means a legal entity that meets the fol-
 22 lowing requirements:

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

1 representatives of not fewer than two and in equal
2 numbers from each of the following:

3 “(A) Small employers.

4 “(B) Employees of small employers.

5 “(C) Health care providers, which may be
6 physicians, other health care professionals,
7 health care facilities, or any combination there-
8 of.

9 “(D) Entities, such as insurance compa-
10 nies, health maintenance organizations, and li-
11 censed provider-sponsored organizations, that
12 underwrite or administer health benefits cov-
13 erage.

14 “(2) OFFERING HEALTH BENEFITS COV-
15 ERAGE.—

16 “(A) IN GENERAL.—The HealthMart, in
17 conjunction with those health insurance issuers
18 that offer health benefits coverage through the
19 HealthMart, makes available health benefits
20 coverage in the manner described in subsection
21 (b) to all small employers and eligible employees
22 in the manner described in subsection (c)(2) at
23 rates (including employer’s and employee’s
24 share) that are established by the health insur-
25 ance issuer on a policy or product specific basis

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

11 “(B) NONDISCRIMINATION IN COVERAGE
12 OFFERED.—

13 “(i) IN GENERAL.—Subject to clause
14 (ii), the HealthMart may not offer health
15 benefits coverage to an eligible employee in
16 a geographic area (as specified under para-
17 graph (3)(A)) unless the same coverage is
18 offered to all such employees in the same
19 geographic area. Section 2711(a)(1)(B) of
20 this Act limits denial of enrollment of cer-
21 tain eligible individuals under health bene-
22 fits coverage in the small group market.

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

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

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

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

12 “(3) GEOGRAPHIC AREAS.—

13 “(A) SPECIFICATION OF GEOGRAPHIC
14 AREAS.—The HealthMart shall specify the geo-
15 graphic area (or areas) in which it makes avail-
16 able health benefits coverage offered by health
17 insurance issuers to small employers. Such an
18 area shall encompass at least one entire county
19 or equivalent area.

20 “(B) MULTISTATE AREAS.—In the case of
21 a HealthMart that serves more than one State,
22 such geographic areas may be areas that in-
23 clude portions of two or more contiguous
24 States.

1 “(C) MULTIPLE HEALTHMARTS PER-
2 MITTED IN SINGLE GEOGRAPHIC AREA.—Noth-
3 ing in this title shall be construed as preventing
4 the establishment and operation of more than
5 one HealthMart in a geographic area or as lim-
6 iting the number of HealthMarts that may op-
7 erate in any area.

8 “(4) PROVISION OF ADMINISTRATIVE SERVICES
9 TO PURCHASERS.—

10 “(A) IN GENERAL.—The HealthMart pro-
11 vides administrative services for purchasers.
12 Such services may include accounting, billing,
13 enrollment information, and employee coverage
14 status reports.

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

19 “(5) DISSEMINATION OF INFORMATION.—The
20 HealthMart collects and disseminates (or arranges
21 for the collection and dissemination of) consumer-
22 oriented information on the scope, cost, and enrollee
23 satisfaction of all coverage options offered through
24 the HealthMart to its members and eligible individ-
25 uals. Such information shall be defined by the

1 HealthMart and shall be in a manner appropriate to
2 the type of coverage offered. To the extent prac-
3 ticable, such information shall include information
4 on provider performance, locations and hours of op-
5 eration of providers, outcomes, and similar matters.
6 Nothing in this section shall be construed as pre-
7 venting the dissemination of such information or
8 other information by the HealthMart or by health
9 insurance issuers through electronic or other means.

10 “(6) FILING INFORMATION.—The Health-
11 Mart—

12 “(A) files with the applicable Federal au-
13 thority information that demonstrates the
14 HealthMart’s compliance with the applicable re-
15 quirements of this title; or

16 “(B) in accordance with rules established
17 under section 2803(a), files with a State such
18 information as the State may require to dem-
19 onstrate such compliance.

20 “(b) HEALTH BENEFITS COVERAGE REQUIRE-
21 MENTS.—

22 “(1) COMPLIANCE WITH CONSUMER PROTEC-
23 TION REQUIREMENTS.—Any health benefits coverage
24 offered through a HealthMart shall—

1 “(A) be underwritten by a health insurance
2 issuer that—

3 “(i) is licensed (or otherwise regu-
4 lated) under State law (or is a community
5 health organization that is offering health
6 insurance coverage pursuant to section
7 330B(a));

8 “(ii) meets all applicable State stand-
9 ards relating to consumer protection, sub-
10 ject to section 2802(b); and

11 “(iii) offers the coverage under a con-
12 tract with the HealthMart;

13 “(B) subject to paragraph (2), be approved
14 or otherwise permitted to be offered under
15 State law; and

16 “(C) provide full portability of creditable
17 coverage for individuals who remain members of
18 the same HealthMart notwithstanding that they
19 change the employer through which they are
20 members in accordance with the provisions of
21 the parts 6 and 7 of subtitle B of title I of the
22 Employee Retirement Income Security Act of
23 1974 and titles XXII and XXVII of this Act,
24 so long as both employers are purchasers in the
25 HealthMart.

1 “(2) ALTERNATIVE PROCESS FOR APPROVAL OF
2 HEALTH BENEFITS COVERAGE IN CASE OF DISCRIMI-
3 NATION OR DELAY.—

4 “(A) IN GENERAL.—The requirement of
5 paragraph (1)(B) shall not apply to a policy or
6 product of health benefits coverage offered in a
7 State if the health insurance issuer seeking to
8 offer such policy or product files an application
9 to waive such requirement with the applicable
10 Federal authority, and the authority deter-
11 mines, based on the application and other evi-
12 dence presented to the authority, that—

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

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

19 “(B) GROUNDS.—The grounds described
20 in this subparagraph with respect to a policy or
21 product of health benefits coverage are as fol-
22 lows:

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

1 complete action on the policy or product
2 (or rates for the policy or product) within
3 90 days of the date of the State’s receipt
4 of a substantially complete application. No
5 period before the date of the enactment of
6 this section shall be included in deter-
7 mining such 90-day period.

8 “(ii) DENIAL OF APPLICATION BASED
9 ON DISCRIMINATORY TREATMENT.—The
10 State has denied such an application
11 and—

12 “(I) the standards or review
13 process imposed by the State as a
14 condition of approval of the policy or
15 product imposes either any material
16 requirements, procedures, or stand-
17 ards to such policy or product that
18 are not generally applicable to other
19 policies and products offered or any
20 requirements that are preempted
21 under section 2802; or

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

1 icy or product other than such policy
2 or product.

3 “(C) ENFORCEMENT.—In the case of a
4 waiver granted under subparagraph (A) to an
5 issuer with respect to a State, the Secretary
6 may enter into an agreement with the State
7 under which the State agrees to provide for
8 monitoring and enforcement activities with re-
9 spect to compliance of such an issuer and its
10 health insurance coverage with the applicable
11 State standards described in subparagraph
12 (A)(ii). Such monitoring and enforcement shall
13 be conducted by the State in the same manner
14 as the State enforces such standards with re-
15 spect to other health insurance issuers and
16 plans, without discrimination based on the type
17 of issuer to which the standards apply. Such an
18 agreement shall specify or establish mechanisms
19 by which compliance activities are undertaken,
20 while not lengthening the time required to re-
21 view and process applications for waivers under
22 subparagraph (A).

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

1 of the following if it meets the other applicable re-
2 quirements of this title:

3 “(A) Coverage through a health mainte-
4 nance organization.

5 “(B) Coverage in connection with a pre-
6 ferred provider organization.

7 “(C) Coverage in connection with a li-
8 censed provider-sponsored organization.

9 “(D) Indemnity coverage through an insur-
10 ance company.

11 “(E) Coverage offered in connection with a
12 contribution into a medical savings account or
13 flexible spending account.

14 “(F) Coverage that includes a point-of-
15 service option.

16 “(G) Coverage offered by a community
17 health organization (as defined in section
18 330B(e)).

19 “(H) Any combination of such types of
20 coverage.

21 “(4) WELLNESS BONUSES FOR HEALTH PRO-
22 MOTION.—Nothing in this title shall be construed as
23 precluding a health insurance issuer offering health
24 benefits coverage through a HealthMart from estab-
25 lishing premium discounts or rebates for members or

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

8 “(c) PURCHASERS; MEMBERS; HEALTH INSURANCE
9 ISSUERS.—

10 “(1) PURCHASERS.—

11 “(A) IN GENERAL.—Subject to the provi-
12 sions of this title, a HealthMart shall permit
13 any small employer to contract with the
14 HealthMart for the purchase of health benefits
15 coverage for its employees and dependents of
16 those employees and may not vary conditions of
17 eligibility (including premium rates and mem-
18 bership fees) of a small employer to be a pur-
19 chaser.

20 “(B) ROLE OF ASSOCIATIONS, BROKERS,
21 AND LICENSED HEALTH INSURANCE AGENTS.—

22 Nothing in this section shall be construed as
23 preventing an association, broker, licensed
24 health insurance agent, or other entity from as-
25 sisting or representing a HealthMart or small

1 employers from entering into appropriate ar-
2 rangements to carry out this title.

3 “(C) PERIOD OF CONTRACT.—The
4 HealthMart may not require a contract under
5 subparagraph (A) between a HealthMart and a
6 purchaser to be effective for a period of longer
7 than 12 months. The previous sentence shall
8 not be construed as preventing such a contract
9 from being extended for additional 12-month
10 periods or preventing the purchaser from volun-
11 tarily electing a contract period of longer than
12 12 months.

13 “(D) EXCLUSIVE NATURE OF CON-
14 TRACT.—Such a contract shall provide that the
15 purchaser agrees not to obtain or sponsor
16 health benefits coverage, on behalf of any eligi-
17 ble employees (and their dependents), other
18 than through the HealthMart. The previous
19 sentence shall not apply to an eligible individual
20 who resides in an area for which no coverage is
21 offered by any health insurance issuer through
22 the HealthMart.

23 “(2) MEMBERS.—

24 “(A) IN GENERAL.—Under rules estab-
25 lished to carry out this title, with respect to a

1 small employer that has a purchaser contract
2 with a HealthMart, individuals who are employ-
3 ees of the employer may enroll for health bene-
4 fits coverage (including coverage for dependents
5 of such enrolling employees) offered by a health
6 insurance issuer through the HealthMart.

7 “(B) NONDISCRIMINATION IN ENROLL-
8 MENT.—A HealthMart may not deny enroll-
9 ment as a member to an individual who is an
10 employee (or dependent of such an employee)
11 eligible to be so enrolled based on health status-
12 related factors, except as may be permitted con-
13 sistent with section 2742(b).

14 “(C) ANNUAL OPEN ENROLLMENT PE-
15 RIOD.—In the case of members enrolled in
16 health benefits coverage offered by a health in-
17 surance issuer through a HealthMart, subject
18 to subparagraph (D), the HealthMart shall pro-
19 vide for an annual open enrollment period of 30
20 days during which such members may change
21 the coverage option in which the members are
22 enrolled.

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

1 for enrollment and reenrollment of members
2 during the annual open enrollment period under
3 subparagraph (C). Such rules shall be applied
4 consistently to all purchasers and members
5 within the HealthMart and shall not be based
6 in any manner on health status-related factors
7 and may not conflict with sections 2701 and
8 2702 of this Act.

9 “(3) HEALTH INSURANCE ISSUERS.—

10 “(A) PREMIUM COLLECTION.—The con-
11 tract between a HealthMart and a health insur-
12 ance issuer shall provide, with respect to a
13 member enrolled with health benefits coverage
14 offered by the issuer through the HealthMart,
15 for the payment of the premiums collected by
16 the HealthMart (or the issuer) for such cov-
17 erage (less a pre-determined administrative
18 charge negotiated by the HealthMart and the
19 issuer) to the issuer.

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

1 “(C) AVAILABILITY OF COVERAGE OP-
2 TIONS.—A HealthMart shall enter into con-
3 tracts with one or more health insurance issuers
4 in a manner that assures that at least two
5 health insurance coverage options are made
6 available in the geographic area specified under
7 subsection (a)(3)(A).

8 “(d) PREVENTION OF CONFLICTS OF INTEREST.—

9 “(1) FOR BOARDS OF DIRECTORS.—A member
10 of a board of directors of a HealthMart may not
11 serve as an employee or paid consultant to the
12 HealthMart, but may receive reasonable reimburse-
13 ment for travel expenses for purposes of attending
14 meetings of the board or committees thereof.

15 “(2) FOR BOARDS OF DIRECTORS OR EMPLOY-
16 EES.—An individual is not eligible to serve in a paid
17 or unpaid capacity on the board of directors of a
18 HealthMart or as an employee of the HealthMart, if
19 the individual is employed by, represents in any ca-
20 pacity, owns, or controls any ownership interest in
21 a organization from whom the HealthMart receives
22 contributions, grants, or other funds not connected
23 with a contract for coverage through the
24 HealthMart.

1 “(3) EMPLOYMENT AND EMPLOYEE REP-
2 REPRESENTATIVES.—

3 “(A) IN GENERAL.—An individual who is
4 serving on a board of directors of a HealthMart
5 as a representative described in subparagraph
6 (A) or (B) of section 2801(a)(1) shall not be
7 employed by or affiliated with a health insur-
8 ance issuer or be licensed as or employed by or
9 affiliated with a health care provider.

10 “(B) CONSTRUCTION.—For purposes of
11 subparagraph (A), the term “affiliated” does
12 not include membership in a health benefits
13 plan or the obtaining of health benefits cov-
14 erage offered by a health insurance issuer.

15 “(e) CONSTRUCTION.—

16 “(1) NETWORK OF AFFILIATED
17 HEALTHMARTS.—Nothing in this section shall be
18 construed as preventing one or more HealthMarts
19 serving different areas (whether or not contiguous)
20 from providing for some or all of the following
21 (through a single administrative organization or oth-
22 erwise):

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

1 “(B) Providing for crediting of deductibles
2 and other cost-sharing for individuals who are
3 provided health benefits coverage through the
4 HealthMarts (or affiliated HealthMarts)
5 after—

6 “(i) a change of employers through
7 which the coverage is provided; or

8 “(ii) a change in place of employment
9 to an area not served by the previous
10 HealthMart.

11 “(2) PERMITTING HEALTHMARTS TO ADJUST
12 DISTRIBUTIONS AMONG ISSUERS TO REFLECT REL-
13 ATIVE RISK OF ENROLLEES.—Nothing in this sec-
14 tion shall be construed as precluding a HealthMart
15 from providing for adjustments in amounts distrib-
16 uted among the health insurance issuers offering
17 health benefits coverage through the HealthMart
18 based on factors such as the relative health care risk
19 of members enrolled under the coverage offered by
20 the different issuers.

21 “(3) APPLICATION OF UNIFORM MINIMUM PAR-
22 TICIPATION AND CONTRIBUTION RULES.—Nothing
23 in this section shall be construed as precluding a
24 HealthMart from establishing minimum participa-
25 tion and contribution rules (described in section

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

5 **“SEC. 2802. APPLICATION OF CERTAIN LAWS AND REQUIRE-**
6 **MENTS.**

7 “(a) AUTHORITY OF STATES.—Nothing in this sec-
8 tion shall be construed as preempting State laws relating
9 to the following:

10 “(1) The regulation of underwriters of health
11 coverage, including licensure and solvency require-
12 ments.

13 “(2) The application of premium taxes and re-
14 quired payments for guaranty funds or for contribu-
15 tions to high-risk pools.

16 “(3) The application of fair marketing require-
17 ments and other consumer protections (other than
18 those specifically relating to an item described in
19 subsection (b)).

20 “(4) The application of requirements relating to
21 the adjustment of rates for health insurance cov-
22 erage.

23 “(b) TREATMENT OF BENEFIT AND GROUPING RE-
24 QUIREMENTS.—State laws insofar as they relate to any
25 of the following are superseded and shall not apply to

1 health benefits coverage made available through a
2 HealthMart:

3 “(1) Benefit requirements for health benefits
4 coverage offered through a HealthMart, including
5 (but not limited to) requirements relating to cov-
6 erage of specific providers, specific services or condi-
7 tions, or the amount, duration, or scope of benefits,
8 but not including requirements to the extent re-
9 quired to implement title XXVII or other Federal
10 law and to the extent the requirement prohibits an
11 exclusion of a specific disease from such coverage.

12 “(2) Requirements (commonly referred to as
13 fictitious group laws) relating to grouping and simi-
14 lar requirements for such coverage to the extent
15 such requirements impede the establishment and op-
16 eration of HealthMarts pursuant to this title.

17 “(3) Any other requirements (including limita-
18 tions on compensation arrangements) that, directly
19 or indirectly, preclude (or have the effect of pre-
20 cluding) the offering of such coverage through a
21 HealthMart, if the HealthMart meets the require-
22 ments of this title.

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

1 tent the law or regulation is inconsistent with the provi-
2 sions of this title.

3 “(c) APPLICATION OF ERISA FIDUCIARY AND DIS-
4 CLOSURE REQUIREMENTS.—The board of directors of a
5 HealthMart is deemed to be a plan administrator of an
6 employee welfare benefit plan which is a group health plan
7 for purposes of applying parts 1 and 4 of subtitle B of
8 title I of the Employee Retirement Income Security Act
9 of 1974 and those provisions of part 5 of such subtitle
10 which are applicable to enforcement of such parts 1 and
11 4, and the HealthMart shall be treated as such a plan
12 and the enrollees shall be treated as participants and bene-
13 ficiaries for purposes of applying such provisions pursuant
14 to this subsection.

15 “(d) APPLICATION OF ERISA RENEWABILITY PRO-
16 TECTION.—A HealthMart is deemed to be a group health
17 plan that is a multiple employer welfare arrangement for
18 purposes of applying section 703 of the Employee Retire-
19 ment Income Security Act of 1974.

20 “(e) APPLICATION OF RULES FOR NETWORK PLANS
21 AND FINANCIAL CAPACITY.—The provisions of sub-
22 sections (c) and (d) of section 2711 apply to health bene-
23 fits coverage offered by a health insurance issuer through
24 a HealthMart.

1 “(f) CONSTRUCTION RELATING TO OFFERING RE-
2 QUIREMENT.—Nothing in section 2711(a) of this Act or
3 703 of the Employee Retirement Income Security Act of
4 1974 shall be construed as permitting the offering outside
5 the HealthMart of health benefits coverage that is only
6 made available through a HealthMart under this section
7 because of the application of subsection (b).

8 “(g) APPLICATION TO GUARANTEED RENEWABILITY
9 REQUIREMENTS IN CASE OF DISCONTINUATION OF AN
10 ISSUER.—For purposes of applying section 2712 in the
11 case of health insurance coverage offered by a health in-
12 surance issuer through a HealthMart, if the contract be-
13 tween the HealthMart and the issuer is terminated and
14 the HealthMart continues to make available any health in-
15 surance coverage after the date of such termination, the
16 following rules apply:

17 “(1) RENEWABILITY.—The HealthMart shall
18 fulfill the obligation under such section of the issuer
19 renewing and continuing in force coverage by offer-
20 ing purchasers (and members and their dependents)
21 all available health benefits coverage that would oth-
22 erwise be available to similarly-situated purchasers
23 and members from the remaining participating
24 health insurance issuers in the same manner as
25 would be required of issuers under section 2712(c).

1 “(2) APPLICATION OF ASSOCIATION RULES.—

2 The HealthMart shall be considered an association
3 for purposes of applying section 2712(e).

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

11 **“SEC. 2803. ADMINISTRATION.**

12 “(a) IN GENERAL.—The applicable Federal authority
13 shall administer this title through the division established
14 under subsection (b) and is authorized to issue such regu-
15 lations as may be required to carry out this title. Such
16 regulations shall be subject to Congressional review under
17 the provisions of chapter 8 of title 5, United States Code.
18 The applicable Federal authority shall incorporate the
19 process of ‘deemed file and use’ with respect to the infor-
20 mation filed under section 2801(a)(6)(A) and shall deter-
21 mine whether information filed by a HealthMart dem-
22 onstrates compliance with the applicable requirements of
23 this title. Such authority shall exercise its authority under
24 this title in a manner that fosters and promotes the devel-

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

3 “(b) ADMINISTRATION THROUGH HEALTH CARE
4 MARKETPLACE DIVISION.—

5 “(1) IN GENERAL.—The applicable Federal au-
6 thority shall carry out its duties under this title
7 through a separate Health Care Marketplace Divi-
8 sion, the sole duty of which (including the staff of
9 which) shall be to administer this title.

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

13 “(A) oversight of the operations of
14 HealthMarts under this title; and

15 “(B) the periodic submittal to Congress of
16 reports on the performance of HealthMarts
17 under this title under subsection (c).

18 “(c) PERIODIC REPORTS.—The applicable Federal
19 authority shall submit to Congress a report every 30
20 months, during the 10-year period beginning on the effec-
21 tive date of the rules promulgated by the applicable Fed-
22 eral authority to carry out this title, on the effectiveness
23 of this title in promoting coverage of uninsured individ-
24 uals. Such authority may provide for the production of

1 such reports through one or more contracts with appro-
2 priate private entities.

3 **“SEC. 2804. DEFINITIONS.**

4 “For purposes of this title:

5 “(1) APPLICABLE FEDERAL AUTHORITY.—The
6 term ‘applicable Federal authority’ means the Sec-
7 retary of Health and Human Services.

8 “(2) ELIGIBLE EMPLOYEE OR INDIVIDUAL.—
9 The term ‘eligible’ means, with respect to an em-
10 ployee or other individual and a HealthMart, an em-
11 ployee or individual who is eligible under section
12 2801(c)(2) to enroll or be enrolled in health benefits
13 coverage offered through the HealthMart.

14 “(3) EMPLOYER; EMPLOYEE; DEPENDENT.—
15 Except as the applicable Federal authority may oth-
16 erwise provide, the terms ‘employer’, ‘employee’, and
17 ‘dependent’, as applied to health insurance coverage
18 offered by a health insurance issuer licensed (or oth-
19 erwise regulated) in a State, shall have the meanings
20 applied to such terms with respect to such coverage
21 under the laws of the State relating to such coverage
22 and such an issuer.

23 “(4) HEALTH BENEFITS COVERAGE.—The term
24 ‘health benefits coverage’ has the meaning given the

1 term group health insurance coverage in section
2 2791(b)(4).

3 “(5) HEALTH INSURANCE ISSUER.—The term
4 ‘health insurance issuer’ has the meaning given such
5 term in section 2791(b)(2) and includes a commu-
6 nity health organization that is offering coverage
7 pursuant to section 330B(a).

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

11 “(7) HEALTHMART.—The term ‘HealthMart’ is
12 defined in section 2801(a).

13 “(8) MEMBER.—The term ‘member’ means,
14 with respect to a HealthMart, an individual enrolled
15 for health benefits coverage through the HealthMart
16 under section 2801(c)(2).

17 “(9) PURCHASER.—The term ‘purchaser’
18 means, with respect to a HealthMart, a small em-
19 ployer that has contracted under section
20 2801(c)(1)(A) with the HealthMart for the purchase
21 of health benefits coverage.

22 “(10) SMALL EMPLOYER.—The term ‘small em-
23 ployer’ has the meaning given such term for pur-
24 poses of title XXVII.”.

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

6 **TITLE V—COMMUNITY HEALTH** 7 **ORGANIZATIONS**

8 **SEC. 501. PROMOTION OF PROVISION OF INSURANCE BY** 9 **COMMUNITY HEALTH ORGANIZATIONS.**

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

15 “WAIVER OF STATE LICENSURE REQUIREMENT FOR
 16 COMMUNITY HEALTH ORGANIZATIONS IN CERTAIN CASES

17 “SEC. 330D. (a) WAIVER AUTHORIZED.—

18 “(1) IN GENERAL.—A community health orga-
 19 nization may offer health insurance coverage in a
 20 State notwithstanding that it is not licensed in such
 21 a State to offer such coverage if—

22 “(A) the organization files an application
 23 for waiver of the licensure requirement with the
 24 Secretary of Health and Human Services (in
 25 this section referred to as the ‘Secretary’) by
 26 not later than November 1, 2005; and

1 “(B) the Secretary determines, based on
2 the application and other evidence presented to
3 the Secretary, that any of the grounds for ap-
4 proval of the application described in subpara-
5 graph (A), (B), or (C) of paragraph (2) has
6 been met.

7 “(2) GROUNDS FOR APPROVAL OF WAIVER.—

8 “(A) FAILURE TO ACT ON LICENSURE AP-
9 PPLICATION ON A TIMELY BASIS.—The ground
10 for approval of such a waiver application de-
11 scribed in this subparagraph is that the State
12 has failed to complete action on a licensing ap-
13 plication of the organization within 90 days of
14 the date of the State’s receipt of a substantially
15 complete application. No period before the date
16 of the enactment of this section shall be in-
17 cluded in determining such 90-day period.

18 “(B) DENIAL OF APPLICATION BASED ON
19 DISCRIMINATORY TREATMENT.—The ground for
20 approval of such a waiver application described
21 in this subparagraph is that the State has de-
22 nied such a licensing application and the stand-
23 ards or review process imposed by the State as
24 a condition of approval of the license or as the
25 basis for such denial by the State imposes any

1 material requirements, procedures, or standards
2 (other than solvency requirements) to such or-
3 ganizations that are not generally applicable to
4 other entities engaged in a substantially similar
5 business.

6 “(C) DENIAL OF APPLICATION BASED ON
7 APPLICATION OF SOLVENCY REQUIREMENTS.—

8 With respect to waiver applications filed on or
9 after the date of publication of solvency stand-
10 ards established by the Secretary under sub-
11 section (d), the ground for approval of such a
12 waiver application described in this subpara-
13 graph is that the State has denied such a li-
14 censing application based (in whole or in part)
15 on the organization’s failure to meet applicable
16 State solvency requirements and such require-
17 ments are not the same as the solvency stand-
18 ards established by the Secretary. For purposes
19 of this subparagraph, the term solvency require-
20 ments means requirements relating to solvency
21 and other matters covered under the standards
22 established by the Secretary under subsection
23 (d).

1 “(3) TREATMENT OF WAIVER.—In the case of
2 a waiver granted under this subsection for a commu-
3 nity health organization with respect to a State—

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

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

12 “(C) CONDITIONED ON COMPLIANCE WITH
13 CONSUMER PROTECTION AND QUALITY STAND-
14 ARDS.—The continuation of the waiver is condi-
15 tioned upon the organization’s compliance with
16 the requirements described in paragraph (5).

17 “(D) PREEMPTION OF STATE LAW.—Any
18 provisions of law of that State which relate to
19 the licensing of the organization and which pro-
20 hibit the organization from providing health in-
21 surance coverage shall be superseded.

22 “(4) PROMPT ACTION ON APPLICATION.—The
23 Secretary shall grant or deny such a waiver applica-
24 tion within 60 days after the date the Secretary de-
25 termines that a substantially complete waiver appli-

1 cation has been filed. Nothing in this section shall
2 be construed as preventing an organization which
3 has had such a waiver application denied from sub-
4 mitting a subsequent waiver application.

5 “(5) APPLICATION AND ENFORCEMENT OF
6 STATE CONSUMER PROTECTION AND QUALITY
7 STANDARDS.—A waiver granted under this sub-
8 section to an organization with respect to licensing
9 under State law is conditioned upon the organiza-
10 tion’s compliance with all consumer protection and
11 quality standards insofar as such standards—

12 “(A) would apply in the State to the com-
13 munity health organization if it were licensed as
14 an entity offering health insurance coverage
15 under State law; and

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

19 “(6) REPORT.—By not later than December 31,
20 2004, the Secretary shall submit to the Committee
21 on Commerce of the House of Representatives and
22 the Committee on Labor and Human Resources of
23 the Senate a report regarding whether the waiver
24 process under this subsection should be continued
25 after December 31, 2005.

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

6 “(1) may obtain insurance or make other ar-
7 rangements for the cost of providing to any enrolled
8 member such services the aggregate value of which
9 exceeds such aggregate level as the Secretary speci-
10 fies from time to time;

11 “(2) may obtain insurance or make other ar-
12 rangements for the cost of such services provided to
13 its enrolled members other than through the organi-
14 zation because medical necessity required their pro-
15 vision before they could be secured through the orga-
16 nization;

17 “(3) may obtain insurance or make other ar-
18 rangements for not more than 90 percent of the
19 amount by which its costs for any of its fiscal years
20 exceed 105 percent of its income for such fiscal year;
21 and

22 “(4) may make arrangements with physicians
23 or other health care professionals, health care insti-
24 tutions, or any combination of such individuals or
25 institutions to assume all or part of the financial

1 risk on a prospective basis for the provision of
2 health services by the physicians or other health pro-
3 fessionals or through the institutions.

4 “(c) CERTIFICATION OF PROVISION AGAINST RISK
5 OF INSOLVENCY FOR UNLICENSED CHOS.—

6 “(1) IN GENERAL.—Each community health or-
7 ganization that is not licensed by a State and for
8 which a waiver application has been approved under
9 subsection (a)(1), shall meet standards established
10 by the Secretary under subsection (d) relating to the
11 financial solvency and capital adequacy of the orga-
12 nization.

13 “(2) CERTIFICATION PROCESS FOR SOLVENCY
14 STANDARDS FOR CHOS.—The Secretary shall estab-
15 lish a process for the receipt and approval of appli-
16 cations of a community health organization de-
17 scribed in paragraph (1) for certification (and peri-
18 odic recertification) of the organization as meeting
19 such solvency standards. Under such process, the
20 Secretary shall act upon such a certification applica-
21 tion not later than 60 days after the date the appli-
22 cation has been received.

23 “(d) ESTABLISHMENT OF SOLVENCY STANDARDS
24 FOR COMMUNITY HEALTH ORGANIZATIONS.—

1 “(1) IN GENERAL.—The Secretary shall estab-
2 lish, on an expedited basis and by rule pursuant to
3 section 553 of title 5, United States Code and
4 through the Health Resources and Services Adminis-
5 tration, standards described in subsection (c)(1) (re-
6 lating to financial solvency and capital adequacy)
7 that entities must meet to obtain a waiver under
8 subsection (a)(2)(C). In establishing such standards,
9 the Secretary shall consult with interested organiza-
10 tions, including the National Association of Insur-
11 ance Commissioners, the Academy of Actuaries, and
12 organizations representing Federally qualified health
13 centers.

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

18 “(A) the delivery system assets of such an
19 organization and ability of such an organization
20 to provide services to enrollees;

21 “(B) alternative means of protecting
22 against insolvency, including reinsurance, unre-
23 stricted surplus, letters of credit, guarantees,
24 organizational insurance coverage, partnerships
25 with other licensed entities, and valuation at-

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

4 “(C) any standards developed by the Na-
5 tional Association of Insurance Commissioners
6 specifically for risk-based health care delivery
7 organizations.

8 “(3) ENROLLEE PROTECTION AGAINST INSOL-
9 VENCY.—Such standards shall include provisions to
10 prevent enrollees from being held liable to any per-
11 son or entity for the organization’s debts in the
12 event of the organization’s insolvency.

13 “(4) DEADLINE.—Such standards shall be pro-
14 mulgated in a manner so they are first effective by
15 not later than April 1, 2000.

16 “(e) DEFINITIONS.—In this section:

17 “(1) COMMUNITY HEALTH ORGANIZATION.—
18 The term ‘community health organization’ means an
19 organization that is a Federally-qualified health cen-
20 ter or is controlled by one or more Federally-quali-
21 fied health centers.

22 “(2) FEDERALLY-QUALIFIED HEALTH CEN-
23 TER.—The term ‘Federally-qualified health center’
24 has the meaning given such term in section
25 1905(l)(2)(B) of the Social Security Act.

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

4 “(4) CONTROL.—The term ‘control’ means the
5 possession, whether direct or indirect, of the power
6 to direct or cause the direction of the management
7 and policies of the organization through member-
8 ship, board representation, or an ownership interest
9 equal to or greater than 50.1 percent.”.

10 **DIVISION B—BIPARTISAN CON-**
11 **SENSUS MANAGED CARE IM-**
12 **PROVEMENT ACT OF 1999**

13 **SEC. 1001. SHORT TITLE OF DIVISION; TABLE OF CONTENTS**
14 **OF DIVISION.**

15 (a) SHORT TITLE OF DIVISION.—This division may
16 be cited as the “Bipartisan Consensus Managed Care Im-
17 provement Act of 1999”.

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

Sec. 1001. Short title; table of contents.

TITLE XI—IMPROVING MANAGED CARE

Subtitle A—Grievances and Appeals

Sec. 1101. Utilization review activities.

Sec. 1102. Internal appeals procedures.

Sec. 1103. External appeals procedures.

Sec. 1104. Establishment of a grievance process.

Subtitle B—Access to Care

Sec. 1111. Consumer choice option.

Sec. 1112. Choice of health care professional.

- Sec. 1113. Access to emergency care.
- Sec. 1114. Access to specialty care.
- Sec. 1115. Access to obstetrical and gynecological care.
- Sec. 1116. Access to pediatric care.
- Sec. 1117. Continuity of care.
- Sec. 1118. Access to needed prescription drugs.
- Sec. 1119. Coverage for individuals participating in approved clinical trials.

Subtitle C—Access to Information

- Sec. 1121. Patient access to information.

Subtitle D—Protecting the Doctor-Patient Relationship

- Sec. 1131. Prohibition of interference with certain medical communications.
- Sec. 1132. Prohibition of discrimination against providers based on licensure.
- Sec. 1133. Prohibition against improper incentive arrangements.
- Sec. 1134. Payment of claims.
- Sec. 1135. Protection for patient advocacy.

Subtitle E—Definitions

- Sec. 1151. Definitions.
- Sec. 1152. Preemption; State flexibility; construction.
- Sec. 1153. Exclusions.
- Sec. 1154. Coverage of limited scope plans.
- Sec. 1155. Regulations.

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.
- Sec. 1202. Application to individual health insurance coverage.

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.
- Sec. 1302. ERISA preemption not to apply to certain actions involving health insurance policyholders.
- Sec. 1303. Limitations on actions.

TITLE XIV—APPLICATION TO GROUP HEALTH PLANS UNDER THE INTERNAL REVENUE CODE OF 1986

- Sec. 1401. Amendments to the Internal Revenue Code of 1986.

TITLE XV—EFFECTIVE DATES; COORDINATION IN IMPLEMENTATION

- Sec. 1501. Effective dates.
- Sec. 1502. Coordination in implementation.

TITLE XVI—HEALTH CARE PAPERWORK SIMPLIFICATION

Sec. 1601. Health care paperwork simplification.

1 **TITLE XI—IMPROVING MANAGED**
2 **CARE**

3 **Subtitle A—Grievance and Appeals**

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

5 (a) COMPLIANCE WITH REQUIREMENTS.—

6 (1) IN GENERAL.—A group health plan, and a
7 health insurance issuer that provides health insur-
8 ance coverage, shall conduct utilization review activi-
9 ties in connection with the provision of benefits
10 under such plan or coverage only in accordance with
11 a utilization review program that meets the require-
12 ments of this section.

13 (2) USE OF OUTSIDE AGENTS.—Nothing in this
14 section shall be construed as preventing a group
15 health plan or health insurance issuer from arrang-
16 ing through a contract or otherwise for persons or
17 entities to conduct utilization review activities on be-
18 half of the plan or issuer, so long as such activities
19 are conducted in accordance with a utilization review
20 program that meets the requirements of this section.

21 (3) UTILIZATION REVIEW DEFINED.—For pur-
22 poses of this section, the terms “utilization review”
23 and “utilization review activities” mean procedures
24 used to monitor or evaluate the use or coverage,

1 clinical necessity, appropriateness, efficacy, or effi-
2 ciency of health care services, procedures or settings,
3 and includes prospective review, concurrent review,
4 second opinions, case management, discharge plan-
5 ning, or retrospective review.

6 (b) WRITTEN POLICIES AND CRITERIA.—

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

11 (2) USE OF WRITTEN CRITERIA.—

12 (A) IN GENERAL.—Such a program shall
13 utilize written clinical review criteria developed
14 with input from a range of appropriate actively
15 practicing health care professionals, as deter-
16 mined by the plan, pursuant to the program.
17 Such criteria shall include written clinical re-
18 view criteria that are based on valid clinical evi-
19 dence where available and that are directed spe-
20 cifically at meeting the needs of at-risk popu-
21 lations and covered individuals with chronic
22 conditions or severe illnesses, including gender-
23 specific criteria and pediatric-specific criteria
24 where available and appropriate.

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

11 (C) REVIEW OF SAMPLE OF CLAIMS DENI-
12 ALS.—Such a program shall provide for an
13 evaluation of the clinical appropriateness of at
14 least a sample of denials of claims for benefits.

15 (c) CONDUCT OF PROGRAM ACTIVITIES.—

16 (1) ADMINISTRATION BY HEALTH CARE PRO-
17 FESSIONALS.—A utilization review program shall be
18 administered by qualified health care professionals
19 who shall oversee review decisions.

20 (2) USE OF QUALIFIED, INDEPENDENT PER-
21 SONNEL.—

22 (A) IN GENERAL.—A utilization review
23 program shall provide for the conduct of utiliza-
24 tion review activities only through personnel
25 who are qualified and have received appropriate

1 training in the conduct of such activities under
2 the program.

3 (B) PROHIBITION OF CONTINGENT COM-
4 PENSATION ARRANGEMENTS.—Such a program
5 shall not, with respect to utilization review ac-
6 tivities, permit or provide compensation or any-
7 thing of value to its employees, agents, or con-
8 tractors in a manner that encourages denials of
9 claims for benefits.

10 (C) PROHIBITION OF CONFLICTS.—Such a
11 program shall not permit a health care profes-
12 sional who is providing health care services to
13 an individual to perform utilization review ac-
14 tivities in connection with the health care serv-
15 ices being provided to the individual.

16 (3) ACCESSIBILITY OF REVIEW.—Such a pro-
17 gram shall provide that appropriate personnel per-
18 forming utilization review activities under the pro-
19 gram, including the utilization review administrator,
20 are reasonably accessible by toll-free telephone dur-
21 ing normal business hours to discuss patient care
22 and allow response to telephone requests, and that
23 appropriate provision is made to receive and respond
24 promptly to calls received during other hours.

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

7 (d) DEADLINE FOR DETERMINATIONS.—

8 (1) PRIOR AUTHORIZATION SERVICES.—

9 (A) IN GENERAL.—Except as provided in
10 paragraph (2), in the case of a utilization re-
11 view activity involving the prior authorization of
12 health care items and services for an individual,
13 the utilization review program shall make a de-
14 termination concerning such authorization, and
15 provide notice of the determination to the indi-
16 vidual or the individual's designee and the indi-
17 vidual's health care provider by telephone and
18 in printed form, as soon as possible in accord-
19 ance with the medical exigencies of the case,
20 and in no event later than the deadline specified
21 in subparagraph (B).

22 (B) DEADLINE.—

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

1 receipt of the request for prior authoriza-
2 tion.

3 (ii) EXTENSION PERMITTED WHERE
4 NOTICE OF ADDITIONAL INFORMATION RE-
5 QUIRED.—If a utilization review
6 program—

7 (I) receives a request for a prior
8 authorization;

9 (II) determines that additional
10 information is necessary to complete
11 the review and make the determina-
12 tion on the request; and

13 (III) notifies the requester, not
14 later than five business days after the
15 date of receiving the request, of the
16 need for such specified additional in-
17 formation,

18 the deadline specified in this subparagraph
19 is 14 days after the date the program re-
20 ceives the specified additional information,
21 but in no case later than 28 days after the
22 date of receipt of the request for the prior
23 authorization. This clause shall not apply
24 if the deadline is specified in clause (iii).

1 (iii) EXPEDITED CASES.—In the case
2 of a situation described in section
3 102(c)(1)(A), the deadline specified in this
4 subparagraph is 72 hours after the time of
5 the request for prior authorization.

6 (2) ONGOING CARE.—

7 (A) CONCURRENT REVIEW.—

8 (i) IN GENERAL.—Subject to subpara-
9 graph (B), in the case of a concurrent re-
10 view of ongoing care (including hospitaliza-
11 tion), which results in a termination or re-
12 duction of such care, the plan must provide
13 by telephone and in printed form notice of
14 the concurrent review determination to the
15 individual or the individual's designee and
16 the individual's health care provider as
17 soon as possible in accordance with the
18 medical exigencies of the case, with suffi-
19 cient time prior to the termination or re-
20 duction to allow for an appeal under sec-
21 tion 102(c)(1)(A) to be completed before
22 the termination or reduction takes effect.

23 (ii) CONTENTS OF NOTICE.—Such no-
24 tice shall include, with respect to ongoing
25 health care items and services, the number

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

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

10 (3) PREVIOUSLY PROVIDED SERVICES.—In the
11 case of a utilization review activity involving retro-
12 spective review of health care services previously pro-
13 vided for an individual, the utilization review pro-
14 gram shall make a determination concerning such
15 services, and provide notice of the determination to
16 the individual or the individual's designee and the
17 individual's health care provider by telephone and in
18 printed form, within 30 days of the date of receipt
19 of information that is reasonably necessary to make
20 such determination, but in no case later than 60
21 days after the date of receipt of the claim for bene-
22 fits.

23 (4) FAILURE TO MEET DEADLINE.—In a case
24 in which a group health plan or health insurance
25 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)

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

3 (2) SPECIFICATION OF ANY ADDITIONAL INFOR-
4 MATION.—Such a notice shall also specify what (if
5 any) additional necessary information must be pro-
6 vided to, or obtained by, the person making the de-
7 nial in order to make a decision on such an appeal.

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

10 (1) CLAIM FOR BENEFITS.—The term “claim
11 for benefits” means any request for coverage (in-
12 cluding authorization of coverage), for eligibility, or
13 for payment in whole or in part, for an item or serv-
14 ice under a group health plan or health insurance
15 coverage.

16 (2) DENIAL OF CLAIM FOR BENEFITS.—The
17 term “denial” means, with respect to a claim for
18 benefits, a denial, or a failure to act on a timely
19 basis upon, in whole or in part, the claim for bene-
20 fits and includes a failure to provide benefits (in-
21 cluding items and services) required to be provided
22 under this title.

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

24 (a) RIGHT OF REVIEW.—

1 (1) IN GENERAL.—Each group health plan, and
2 each health insurance issuer offering health insur-
3 ance coverage—

4 (A) shall provide adequate notice in writ-
5 ing to any participant or beneficiary under such
6 plan, or enrollee under such coverage, whose
7 claim for benefits under the plan or coverage
8 has been denied (within the meaning of section
9 1101(f)(2)), setting forth the specific reasons
10 for such denial of claim for benefits and rights
11 to any further review or appeal, written in a
12 manner calculated to be understood by the par-
13 ticipant, beneficiary, or enrollee; and

14 (B) shall afford such a participant, bene-
15 ficiary, or enrollee (and any provider or other
16 person acting on behalf of such an individual
17 with the individual's consent or without such
18 consent if the individual is medically unable to
19 provide such consent) who is dissatisfied with
20 such a denial of claim for benefits a reasonable
21 opportunity (of not less than 180 days) to re-
22 quest and obtain a full and fair review by a
23 named fiduciary (with respect to such plan) or
24 named appropriate individual (with respect to

1 such coverage) of the decision denying the
2 claim.

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

7 (b) INTERNAL REVIEW PROCESS.—

8 (1) CONDUCT OF REVIEW.—

9 (A) IN GENERAL.—A review of a denial of
10 claim under this section shall be made by an in-
11 dividual who—

12 (i) in a case involving medical judg-
13 ment, shall be a physician or, in the case
14 of limited scope coverage (as defined in
15 subparagraph (B), shall be an appropriate
16 specialist;

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

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

21 (B) LIMITED SCOPE COVERAGE DE-
22 FINED.—For purposes of subparagraph (A), the
23 term “limited scope coverage” means a group
24 health plan or health insurance coverage the
25 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

1 subparagraph is 14 days after the date of
2 receipt of the request for internal review.

3 (ii) EXTENSION PERMITTED WHERE
4 NOTICE OF ADDITIONAL INFORMATION RE-
5 QUIRED.—If a group health plan or health
6 insurance issuer—

7 (I) receives a request for internal
8 review;

9 (II) determines that additional
10 information is necessary to complete
11 the review and make the determina-
12 tion on the request; and

13 (III) notifies the requester, not
14 later than five business days after the
15 date of receiving the request, of the
16 need for such specified additional in-
17 formation,

18 the deadline specified in this subparagraph
19 is 14 days after the date the plan or issuer
20 receives the specified additional informa-
21 tion, but in no case later than 28 days
22 after the date of receipt of the request for
23 the internal review. This clause shall not
24 apply if the deadline is specified in clause
25 (iii).

1 (iii) EXPEDITED CASES.—In the case
2 of a situation described in subsection
3 (c)(1)(A), the deadline specified in this
4 subparagraph is 72 hours after the time of
5 the request for review.

6 (c) EXPEDITED REVIEW PROCESS.—

7 (1) IN GENERAL.—A group health plan, and a
8 health insurance issuer, shall establish procedures in
9 writing for the expedited consideration of requests
10 for review under subsection (b) in situations—

11 (A) in which the application of the normal
12 timeframe for making a determination could se-
13 riously jeopardize the life or health of the par-
14 ticipant, beneficiary, or enrollee or such an indi-
15 vidual's ability to regain maximum function; or

16 (B) described in section 1101(d)(2) (relat-
17 ing to requests for continuation of ongoing care
18 which would otherwise be reduced or termi-
19 nated).

20 (2) PROCESS.—Under such procedures—

21 (A) the request for expedited review may
22 be submitted orally or in writing by an indi-
23 vidual or provider who is otherwise entitled to
24 request the review;

1 (B) all necessary information, including
2 the plan's or issuer's decision, shall be trans-
3 mitted between the plan or issuer and the re-
4 quester by telephone, facsimile, or other simi-
5 larly expeditious available method; and

6 (C) the plan or issuer shall expedite the re-
7 view in the case of any of the situations de-
8 scribed in subparagraph (A) or (B) of para-
9 graph (1).

10 (3) DEADLINE FOR DECISION.—The decision on
11 the expedited review must be made and commu-
12 nicated to the parties as soon as possible in accord-
13 ance with the medical exigencies of the case, and in
14 no event later than 72 hours after the time of re-
15 ceipt of the request for expedited review, except that
16 in a case described in paragraph (1)(B), the decision
17 must be made before the end of the approved period
18 of care.

19 (d) WAIVER OF PROCESS.—A plan or issuer may
20 waive its rights for an internal review under subsection
21 (b). In such case the participant, beneficiary, or enrollee
22 involved (and any designee or provider involved) shall be
23 relieved of any obligation to complete the review involved
24 and may, at the option of such participant, beneficiary,
25 enrollee, designee, or provider, proceed directly to seek

1 further appeal through any applicable external appeals
2 process.

3 **SEC. 1103. EXTERNAL APPEALS PROCEDURES.**

4 (a) RIGHT TO EXTERNAL APPEAL.—

5 (1) IN GENERAL.—A group health plan, and a
6 health insurance issuer offering health insurance
7 coverage, shall provide for an external appeals proc-
8 ess that meets the requirements of this section in
9 the case of an externally appealable decision de-
10 scribed in paragraph (2), for which a timely appeal
11 is made either by the plan or issuer or by the partic-
12 ipant, beneficiary, or enrollee (and any provider or
13 other person acting on behalf of such an individual
14 with the individual’s consent or without such consent
15 if such an individual is medically unable to provide
16 such consent). The appropriate Secretary shall es-
17 tablish standards to carry out such requirements.

18 (2) EXTERNALLY APPEALABLE DECISION DE-
19 FINED.—

20 (A) IN GENERAL.—For purposes of this
21 section, the term “externally appealable deci-
22 sion” means a denial of claim for benefits (as
23 defined in section 1101(f)(2))—

24 (i) that is based in whole or in part on
25 a decision that the item or service is not

1 medically necessary or appropriate or is in-
2 vestigational or experimental; or

3 (ii) in which the decision as to wheth-
4 er a benefit is covered involves a medical
5 judgment.

6 (B) INCLUSION.—Such term also includes
7 a failure to meet an applicable deadline for in-
8 ternal review under section 1102.

9 (C) EXCLUSIONS.—Such term does not
10 include—

11 (i) specific exclusions or express limi-
12 tations on the amount, duration, or scope
13 of coverage that do not involve medical
14 judgment; or

15 (ii) a decision regarding whether an
16 individual is a participant, beneficiary, or
17 enrollee under the plan or coverage.

18 (3) EXHAUSTION OF INTERNAL REVIEW PROC-
19 ESS.—Except as provided under section 1102(d), a
20 plan or issuer may condition the use of an external
21 appeal process in the case of an externally appeal-
22 able decision upon a final decision in an internal re-
23 view under section 1102, but only if the decision is
24 made in a timely basis consistent with the deadlines
25 provided under this subtitle.

1 (4) FILING FEE REQUIREMENT.—

2 (A) IN GENERAL.—Subject to subpara-
3 graph (B), a plan or issuer may condition the
4 use of an external appeal process upon payment
5 to the plan or issuer of a filing fee that does
6 not exceed \$25.

7 (B) EXCEPTION FOR INDIGENCY.—The
8 plan or issuer may not require payment of the
9 filing fee in the case of an individual partici-
10 pant, beneficiary, or enrollee who certifies (in a
11 form and manner specified in guidelines estab-
12 lished by the Secretary of Health and Human
13 Services) that the individual is indigent (as de-
14 fined in such guidelines).

15 (C) REFUNDING FEE IN CASE OF SUCCESS-
16 FUL APPEALS.—The plan or issuer shall refund
17 payment of the filing fee under this paragraph
18 if the recommendation of the external appeal
19 entity is to reverse or modify the denial of a
20 claim for benefits which is the subject of the
21 appeal.

22 (b) GENERAL ELEMENTS OF EXTERNAL APPEALS
23 PROCESS.—

24 (1) CONTRACT WITH QUALIFIED EXTERNAL AP-
25 PEAL ENTITY.—

1 (A) CONTRACT REQUIREMENT.—Except as
2 provided in subparagraph (D), the external ap-
3 peal process under this section of a plan or
4 issuer shall be conducted under a contract be-
5 tween the plan or issuer and one or more quali-
6 fied external appeal entities (as defined in sub-
7 section (c)).

8 (B) LIMITATION ON PLAN OR ISSUER SE-
9 LECTION.—The applicable authority shall im-
10 plement procedures—

11 (i) to assure that the selection process
12 among qualified external appeal entities
13 will not create any incentives for external
14 appeal entities to make a decision in a bi-
15 ased manner; and

16 (ii) for auditing a sample of decisions
17 by such entities to assure that no such de-
18 cisions are made in a biased manner.

19 (C) OTHER TERMS AND CONDITIONS.—
20 The terms and conditions of a contract under
21 this paragraph shall be consistent with the
22 standards the appropriate Secretary shall estab-
23 lish to assure there is no real or apparent con-
24 flict of interest in the conduct of external ap-
25 peal activities. Such contract shall provide that

1 all costs of the process (except those incurred
2 by the participant, beneficiary, enrollee, or
3 treating professional in support of the appeal)
4 shall be paid by the plan or issuer, and not by
5 the participant, beneficiary, or enrollee. The
6 previous sentence shall not be construed as ap-
7 plying to the imposition of a filing fee under
8 subsection (a)(4).

9 (D) STATE AUTHORITY WITH RESPECT
10 QUALIFIED EXTERNAL APPEAL ENTITY FOR
11 HEALTH INSURANCE ISSUERS.—With respect to
12 health insurance issuers offering health insur-
13 ance coverage in a State, the State may provide
14 for external review activities to be conducted by
15 a qualified external appeal entity that is des-
16 ignated by the State or that is selected by the
17 State in a manner determined by the State to
18 assure an unbiased determination.

19 (2) ELEMENTS OF PROCESS.—An external ap-
20 peal process shall be conducted consistent with
21 standards established by the appropriate Secretary
22 that include at least the following:

23 (A) FAIR AND DE NOVO DETERMINA-
24 TION.—The process shall provide for a fair, de
25 novo determination. However, nothing in this

1 paragraph shall be construed as providing for
2 coverage of items and services for which bene-
3 fits are specifically excluded under the plan or
4 coverage.

5 (B) STANDARD OF REVIEW.—An external
6 appeal entity shall determine whether the plan’s
7 or issuer’s decision is in accordance with the
8 medical needs of the patient involved (as deter-
9 mined by the entity) taking into account, as of
10 the time of the entity’s determination, the pa-
11 tient’s medical condition and any relevant and
12 reliable evidence the entity obtains under sub-
13 paragraph (D). If the entity determines the de-
14 cision is in accordance with such needs, the en-
15 tity shall affirm the decision and to the extent
16 that the entity determines the decision is not in
17 accordance with such needs, the entity shall re-
18 verse or modify the decision.

19 (C) CONSIDERATION OF PLAN OR COV-
20 ERAGE DEFINITIONS.—In making such deter-
21 mination, the external appeal entity shall con-
22 sider (but not be bound by) any language in the
23 plan or coverage document relating to the defi-
24 nitions of the terms medical necessity, medically

1 necessary or appropriate, or experimental, in-
2 vestigational, or related terms.

3 (D) EVIDENCE.—

4 (i) IN GENERAL.—An external appeal
5 entity shall include, among the evidence
6 taken into consideration—

7 (I) the decision made by the plan
8 or issuer upon internal review under
9 section 1102 and any guidelines or
10 standards used by the plan or issuer
11 in reaching such decision;

12 (II) any personal health and
13 medical information supplied with re-
14 spect to the individual whose denial of
15 claim for benefits has been appealed;
16 and

17 (III) the opinion of the individ-
18 ual's treating physician or health care
19 professional.

20 (ii) ADDITIONAL EVIDENCE.—Such
21 entity may also take into consideration but
22 not be limited to the following evidence (to
23 the extent available):

24 (I) The results of studies that
25 meet professionally recognized stand-

1 ards of validity and replicability or
2 that have been published in peer-re-
3 viewed journals.

4 (II) The results of professional
5 consensus conferences conducted or fi-
6 nanced in whole or in part by one or
7 more Government agencies.

8 (III) Practice and treatment
9 guidelines prepared or financed in
10 whole or in part by Government agen-
11 cies.

12 (IV) Government-issued coverage
13 and treatment policies.

14 (V) Community standard of care
15 and generally accepted principles of
16 professional medical practice.

17 (VI) To the extent that the entity
18 determines it to be free of any conflict
19 of interest, the opinions of individuals
20 who are qualified as experts in one or
21 more fields of health care which are
22 directly related to the matters under
23 appeal.

24 (VII) To the extent that the enti-
25 ty determines it to be free of any con-

1 flict of interest, the results of peer re-
2 views conducted by the plan or issuer
3 involved.

4 (E) DETERMINATION CONCERNING EXTER-
5 NALLY APPEALABLE DECISIONS.—A qualified
6 external appeal entity shall determine—

- 7 (i) whether a denial of claim for bene-
8 fits is an externally appealable decision
9 (within the meaning of subsection (a)(2));
10 (ii) whether an externally appealable
11 decision involves an expedited appeal; and
12 (iii) for purposes of initiating an ex-
13 ternal review, whether the internal review
14 process has been completed.

15 (F) OPPORTUNITY TO SUBMIT EVI-
16 DENCE.—Each party to an externally appeal-
17 able decision may submit evidence related to the
18 issues in dispute.

19 (G) PROVISION OF INFORMATION.—The
20 plan or issuer involved shall provide timely ac-
21 cess to the external appeal entity to information
22 and to provisions of the plan or health insur-
23 ance coverage relating to the matter of the ex-
24 ternally appealable decision, as determined by
25 the entity.

1 (H) TIMELY DECISIONS.—A determination
2 by the external appeal entity on the decision
3 shall—

4 (i) be made orally or in writing and,
5 if it is made orally, shall be supplied to the
6 parties in writing as soon as possible;

7 (ii) be made in accordance with the
8 medical exigencies of the case involved, but
9 in no event later than 21 days after the
10 date (or, in the case of an expedited ap-
11 peal, 72 hours after the time) of requesting
12 an external appeal of the decision;

13 (iii) state, in layperson's language, the
14 basis for the determination, including, if
15 relevant, any basis in the terms or condi-
16 tions of the plan or coverage; and

17 (iv) inform the participant, bene-
18 ficiary, or enrollee of the individual's rights
19 (including any limitation on such rights) to
20 seek further review by the courts (or other
21 process) of the external appeal determina-
22 tion.

23 (I) COMPLIANCE WITH DETERMINATION.—

24 If the external appeal entity reverses or modi-

1 fies the denial of a claim for benefits, the plan
2 or issuer shall—

3 (i) upon the receipt of the determina-
4 tion, authorize benefits in accordance with
5 such determination;

6 (ii) take such actions as may be nec-
7 essary to provide benefits (including items
8 or services) in a timely manner consistent
9 with such determination; and

10 (iii) submit information to the entity
11 documenting compliance with the entity’s
12 determination and this subparagraph.

13 (c) QUALIFICATIONS OF EXTERNAL APPEAL ENTI-
14 TIES.—

15 (1) IN GENERAL.—For purposes of this section,
16 the term “qualified external appeal entity” means,
17 in relation to a plan or issuer, an entity that is cer-
18 tified under paragraph (2) as meeting the following
19 requirements:

20 (A) The entity meets the independence re-
21 quirements of paragraph (3).

22 (B) The entity conducts external appeal
23 activities through a panel of not fewer than
24 three clinical peers.

1 (C) The entity has sufficient medical, legal,
2 and other expertise and sufficient staffing to
3 conduct external appeal activities for the plan
4 or issuer on a timely basis consistent with sub-
5 section (b)(2)(G).

6 (D) The entity meets such other require-
7 ments as the appropriate Secretary may im-
8 pose.

9 (2) INITIAL CERTIFICATION OF EXTERNAL AP-
10 PEAL ENTITIES.—

11 (A) IN GENERAL.—In order to be treated
12 as a qualified external appeal entity with re-
13 spect to—

14 (i) a group health plan, the entity
15 must be certified (and, in accordance with
16 subparagraph (B), periodically recertified)
17 as meeting the requirements of paragraph
18 (1)—

19 (I) by the Secretary of Labor;

20 (II) under a process recognized
21 or approved by the Secretary of
22 Labor; or

23 (III) to the extent provided in
24 subparagraph (C)(i), by a qualified
25 private standard-setting organization

1 (certified under such subparagraph);

2 or

3 (ii) a health insurance issuer oper-
4 ating in a State, the entity must be cer-
5 tified (and, in accordance with subpara-
6 graph (B), periodically recertified) as
7 meeting such requirements—

8 (I) by the applicable State au-
9 thority (or under a process recognized
10 or approved by such authority); or

11 (II) if the State has not estab-
12 lished a certification and recertifi-
13 cation process for such entities, by the
14 Secretary of Health and Human Serv-
15 ices, under a process recognized or ap-
16 proved by such Secretary, or to the
17 extent provided in subparagraph
18 (C)(ii), by a qualified private stand-
19 ard-setting organization (certified
20 under such subparagraph).

21 (B) RECERTIFICATION PROCESS.—The ap-
22 propriate Secretary shall develop standards for
23 the recertification of external appeal entities.
24 Such standards shall include a review of—

25 (i) the number of cases reviewed;

1 (ii) a summary of the disposition of
2 those cases;

3 (iii) the length of time in making de-
4 terminations on those cases;

5 (iv) updated information of what was
6 required to be submitted as a condition of
7 certification for the entity's performance of
8 external appeal activities; and

9 (v) such information as may be nec-
10 essary to assure the independence of the
11 entity from the plans or issuers for which
12 external appeal activities are being con-
13 ducted.

14 (C) CERTIFICATION OF QUALIFIED PRI-
15 VATE STANDARD-SETTING ORGANIZATIONS.—

16 (i) FOR EXTERNAL REVIEWS UNDER
17 GROUP HEALTH PLANS.—For purposes of
18 subparagraph (A)(i)(III), the Secretary of
19 Labor may provide for a process for certifi-
20 cation (and periodic recertification) of
21 qualified private standard-setting organiza-
22 tions which provide for certification of ex-
23 ternal review entities. Such an organization
24 shall only be certified if the organization
25 does not certify an external review entity

1 unless it meets standards required for cer-
2 tification of such an entity by such Sec-
3 retary under subparagraph (A)(i)(I).

4 (ii) FOR EXTERNAL REVIEWS OF
5 HEALTH INSURANCE ISSUERS.—For pur-
6 poses of subparagraph (A)(ii)(II), the Sec-
7 retary of Health and Human Services may
8 provide for a process for certification (and
9 periodic recertification) of qualified private
10 standard-setting organizations which pro-
11 vide for certification of external review en-
12 tities. Such an organization shall only be
13 certified if the organization does not certify
14 an external review entity unless it meets
15 standards required for certification of such
16 an entity by such Secretary under subpara-
17 graph (A)(ii)(II).

18 (3) INDEPENDENCE REQUIREMENTS.—

19 (A) IN GENERAL.—A clinical peer or other
20 entity meets the independence requirements of
21 this paragraph if—

22 (i) the peer or entity does not have a
23 familial, financial, or professional relation-
24 ship with any related party;

1 (ii) any compensation received by such
2 peer or entity in connection with the exter-
3 nal review is reasonable and not contingent
4 on any decision rendered by the peer or en-
5 tity;

6 (iii) except as provided in paragraph
7 (4), the plan and the issuer have no re-
8 course against the peer or entity in connec-
9 tion with the external review; and

10 (iv) the peer or entity does not other-
11 wise have a conflict of interest with a re-
12 lated party as determined under any regu-
13 lations which the Secretary may prescribe.

14 (B) RELATED PARTY.—For purposes of
15 this paragraph, the term “related party”
16 means—

17 (i) with respect to—

18 (I) a group health plan or health
19 insurance coverage offered in connec-
20 tion with such a plan, the plan or the
21 health insurance issuer offering such
22 coverage; or

23 (II) individual health insurance
24 coverage, the health insurance issuer
25 offering such coverage,

1 or any plan sponsor, fiduciary, officer, di-
2 rector, or management employee of such
3 plan or issuer;

4 (ii) the health care professional that
5 provided the health care involved in the
6 coverage decision;

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

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

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

17 (4) LIMITATION ON LIABILITY OF REVIEW-
18 ERS.—No qualified external appeal entity having a
19 contract with a plan or issuer under this part and
20 no person who is employed by any such entity or
21 who furnishes professional services to such entity,
22 shall be held by reason of the performance of any
23 duty, function, or activity required or authorized
24 pursuant to this section, to have violated any crimi-
25 nal law, or to be civilly liable under any law of the

1 United States or of any State (or political subdivi-
2 sion thereof) if due care was exercised in the per-
3 formance of such duty, function, or activity and
4 there was no actual malice or gross misconduct in
5 the performance of such duty, function, or activity.

6 (d) EXTERNAL APPEAL DETERMINATION BINDING
7 ON PLAN.—The determination by an external appeal enti-
8 ty under this section is binding on the plan and issuer
9 involved in the determination.

10 (e) PENALTIES AGAINST AUTHORIZED OFFICIALS
11 FOR REFUSING TO AUTHORIZE THE DETERMINATION OF
12 AN EXTERNAL REVIEW ENTITY.—

13 (1) MONETARY PENALTIES.—In any case in
14 which the determination of an external review entity
15 is not followed by a group health plan, or by a
16 health insurance issuer offering health insurance
17 coverage, any person who, acting in the capacity of
18 authorizing the benefit, causes such refusal may, in
19 the discretion in a court of competent jurisdiction,
20 be liable to an aggrieved participant, beneficiary, or
21 enrollee for a civil penalty in an amount of up to
22 \$1,000 a day from the date on which the determina-
23 tion was transmitted to the plan or issuer by the ex-
24 ternal review entity until the date the refusal to pro-
25 vide the benefit is corrected.

1 (2) CEASE AND DESIST ORDER AND ORDER OF
2 ATTORNEY'S FEES.—In any action described in
3 paragraph (1) brought by a participant, beneficiary,
4 or enrollee with respect to a group health plan, or
5 a health insurance issuer offering health insurance
6 coverage, in which a plaintiff alleges that a person
7 referred to in such paragraph has taken an action
8 resulting in a refusal of a benefit determined by an
9 external appeal entity in violation of such terms of
10 the plan, coverage, or this subtitle, or has failed to
11 take an action for which such person is responsible
12 under the plan, coverage, or this title and which is
13 necessary under the plan or coverage for authorizing
14 a benefit, the court shall cause to be served on the
15 defendant an order requiring the defendant—

16 (A) to cease and desist from the alleged
17 action or failure to act; and

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

22 (3) ADDITIONAL CIVIL PENALTIES.—

23 (A) IN GENERAL.—In addition to any pen-
24 alty imposed under paragraph (1) or (2), the
25 appropriate Secretary may assess a civil penalty

1 against a person acting in the capacity of au-
2 thorizing a benefit determined by an external
3 review entity for one or more group health
4 plans, or health insurance issuers offering
5 health insurance coverage, for—

6 (i) any pattern or practice of repeated
7 refusal to authorize a benefit determined
8 by an external appeal entity in violation of
9 the terms of such a plan, coverage, or this
10 title; or

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

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

20 (i) 25 percent of the aggregate value
21 of benefits shown by the appropriate Sec-
22 retary to have not been provided, or unlaw-
23 fully delayed, in violation of this section
24 under such pattern or practice; or

25 (ii) \$500,000.

1 (4) REMOVAL AND DISQUALIFICATION.—Any
2 person acting in the capacity of authorizing benefits
3 who has engaged in any such pattern or practice de-
4 scribed in paragraph (3)(A) with respect to a plan
5 or coverage, upon the petition of the appropriate
6 Secretary, may be removed by the court from such
7 position, and from any other involvement, with re-
8 spect to such a plan or coverage, and may be pre-
9 cluded from returning to any such position or in-
10 volvement for a period determined by the court.

11 (f) PROTECTION OF LEGAL RIGHTS.—Nothing in
12 this subtitle shall be construed as altering or eliminating
13 any cause of action or legal rights or remedies of partici-
14 pants, beneficiaries, enrollees, and others under State or
15 Federal law (including sections 502 and 503 of the Em-
16 ployee Retirement Income Security Act of 1974), includ-
17 ing the right to file judicial actions to enforce rights.

18 **SEC. 1104. ESTABLISHMENT OF A GRIEVANCE PROCESS.**

19 (a) ESTABLISHMENT OF GRIEVANCE SYSTEM.—

20 (1) IN GENERAL.—A group health plan, and a
21 health insurance issuer in connection with the provi-
22 sion of health insurance coverage, shall establish and
23 maintain a system to provide for the presentation
24 and resolution of oral and written grievances
25 brought by individuals who are participants, bene-

1 ficiaries, or enrollees, or health care providers or
2 other individuals acting on behalf of an individual
3 and with the individual's consent or without such
4 consent if the individual is medically unable to pro-
5 vide such consent, regarding any aspect of the plan's
6 or issuer's services.

7 (2) GRIEVANCE DEFINED.—In this section, the
8 term “grievance” means any question, complaint, or
9 concern brought by a participant, beneficiary or en-
10 rollee that is not a claim for benefits (as defined in
11 section 1101(f)(1)).

12 (b) GRIEVANCE SYSTEM.—Such system shall include
13 the following components with respect to individuals who
14 are participants, beneficiaries, or enrollees:

15 (1) Written notification to all such individuals
16 and providers of the telephone numbers and business
17 addresses of the plan or issuer personnel responsible
18 for resolution of grievances and appeals.

19 (2) A system to record and document, over a
20 period of at least three previous years, all grievances
21 and appeals made and their status.

22 (3) A process providing for timely processing
23 and resolution of grievances.

1 (4) Procedures for follow-up action, including
2 the methods to inform the person making the grievance
3 of the resolution of the grievance.

4 Grievances are not subject to appeal under the previous
5 provisions of this subtitle.

6 **Subtitle B—Access to Care**

7 **SEC. 1111. CONSUMER CHOICE OPTION.**

8 (a) IN GENERAL.—If a health insurance issuer offers
9 to enrollees health insurance coverage in connection with
10 a group health plan which provides for coverage of services
11 only if such services are furnished through health care
12 professionals and providers who are members of a network
13 of health care professionals and providers who have entered
14 into a contract with the issuer to provide such services,
15 the issuer shall also offer or arrange to be offered
16 to such enrollees (at the time of enrollment and during
17 an annual open season as provided under subsection (c))
18 the option of health insurance coverage which provides for
19 coverage of such services which are not furnished through
20 health care professionals and providers who are members
21 of such a network unless enrollees are offered such non-
22 network coverage through another group health plan or
23 through another health insurance issuer in the group market.
24

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

9 (c) OPEN SEASON.—An enrollee may change to the
10 offering provided under this section only during a time pe-
11 riod determined by the health insurance issuer. Such time
12 period shall occur at least annually.

13 **SEC. 1112. CHOICE OF HEALTH CARE PROFESSIONAL.**

14 (a) PRIMARY CARE.—If a group health plan, or a
15 health insurance issuer that offers health insurance cov-
16 erage, requires or provides for designation by a partici-
17 pant, beneficiary, or enrollee of a participating primary
18 care provider, then the plan or issuer shall permit each
19 participant, beneficiary, and enrollee to designate any par-
20 ticipating primary care provider who is available to accept
21 such individual.

22 (b) SPECIALISTS.—

23 (1) IN GENERAL.—Subject to paragraph (2), a
24 group health plan and a health insurance issuer that
25 offers health insurance coverage shall permit each

1 participant, beneficiary, or enrollee to receive medi-
2 cally necessary or appropriate specialty care, pursu-
3 ant to appropriate referral procedures, from any
4 qualified participating health care professional who
5 is available to accept such individual for such care.

6 (2) LIMITATION.—Paragraph (1) shall not
7 apply to specialty care if the plan or issuer clearly
8 informs participants, beneficiaries, and enrollees of
9 the limitations on choice of participating health care
10 professionals with respect to such care.

11 (3) CONSTRUCTION.—Nothing in this sub-
12 section shall be construed as affecting the applica-
13 tion of section 1114 (relating to access to specialty
14 care).

15 **SEC. 1113. ACCESS TO EMERGENCY CARE.**

16 (a) COVERAGE OF EMERGENCY SERVICES.—

17 (1) IN GENERAL.—If a group health plan, or
18 health insurance coverage offered by a health insur-
19 ance issuer, provides any benefits with respect to
20 services in an emergency department of a hospital,
21 the plan or issuer shall cover emergency services (as
22 defined in paragraph (2)(B))—

23 (A) without the need for any prior author-
24 ization determination;

1 (B) whether or not the health care pro-
2 vider furnishing such services is a participating
3 provider with respect to such services;

4 (C) in a manner so that, if such services
5 are provided to a participant, beneficiary, or
6 enrollee—

7 (i) by a nonparticipating health care
8 provider with or without prior authoriza-
9 tion; or

10 (ii) by a participating health care pro-
11 vider without prior authorization,
12 the participant, beneficiary, or enrollee is not
13 liable for amounts that exceed the amounts of
14 liability that would be incurred if the services
15 were provided by a participating health care
16 provider with prior authorization; and

17 (D) without regard to any other term or
18 condition of such coverage (other than exclusion
19 or coordination of benefits, or an affiliation or
20 waiting period, permitted under section 2701 of
21 the Public Health Service Act, section 701 of
22 the Employee Retirement Income Security Act
23 of 1974, or section 9801 of the Internal Rev-
24 enue Code of 1986, and other than applicable
25 cost-sharing).

1 (2) DEFINITIONS.—In this section:

2 (A) EMERGENCY MEDICAL CONDITION
3 BASED ON PRUDENT LAYPERSON STANDARD.—

4 The term “emergency medical condition” means
5 a medical condition manifesting itself by acute
6 symptoms of sufficient severity (including se-
7 vere pain) such that a prudent layperson, who
8 possesses an average knowledge of health and
9 medicine, could reasonably expect the absence
10 of immediate medical attention to result in a
11 condition described in clause (i), (ii), or (iii) of
12 section 1867(e)(1)(A) of the Social Security
13 Act.

14 (B) EMERGENCY SERVICES.—The term
15 “emergency services” means—

16 (i) a medical screening examination
17 (as required under section 1867 of the So-
18 cial Security Act) that is within the capa-
19 bility of the emergency department of a
20 hospital, including ancillary services rou-
21 tinely available to the emergency depart-
22 ment to evaluate an emergency medical
23 condition (as defined in subparagraph
24 (A)); and

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

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

14 (b) REIMBURSEMENT FOR MAINTENANCE CARE AND
15 POST-STABILIZATION CARE.—In the case of services
16 (other than emergency services) for which benefits are
17 available under a group health plan, or under health insur-
18 ance coverage offered by a health insurance issuer, the
19 plan or issuer shall provide for reimbursement with re-
20 spect to such services provided to a participant, bene-
21 ficiary, or enrollee other than through a participating
22 health care provider in a manner consistent with sub-
23 section (a)(1)(C) (and shall otherwise comply with the
24 guidelines established under section 1852(d)(2) of the So-

1 cial Security Act), if the services are maintenance care or
2 post-stabilization care covered under such guidelines.

3 **SEC. 1114. ACCESS TO SPECIALTY CARE.**

4 (a) SPECIALTY CARE FOR COVERED SERVICES.—

5 (1) IN GENERAL.—If—

6 (A) an individual is a participant or bene-
7 ficiary under a group health plan or an enrollee
8 who is covered under health insurance coverage
9 offered by a health insurance issuer;

10 (B) the individual has a condition or dis-
11 ease of sufficient seriousness and complexity to
12 require treatment by a specialist; and

13 (C) benefits for such treatment are pro-
14 vided under the plan or coverage,

15 the plan or issuer shall make or provide for a refer-
16 ral to a specialist who is available and accessible to
17 provide the treatment for such condition or disease.

18 (2) SPECIALIST DEFINED.—For purposes of
19 this subsection, the term “specialist” means, with
20 respect to a condition, a health care practitioner, fa-
21 cility, or center that has adequate expertise through
22 appropriate training and experience (including, in
23 the case of a child, appropriate pediatric expertise)
24 to provide high quality care in treating the condi-
25 tion.

1 (3) CARE UNDER REFERRAL.—A group health
2 plan or health insurance issuer may require that the
3 care provided to an individual pursuant to such re-
4 ferral under paragraph (1) be—

5 (A) pursuant to a treatment plan, only if
6 the treatment plan is developed by the specialist
7 and approved by the plan or issuer, in consulta-
8 tion with the designated primary care provider
9 or specialist and the individual (or the individ-
10 ual's designee); and

11 (B) in accordance with applicable quality
12 assurance and utilization review standards of
13 the plan or issuer.

14 Nothing in this subsection shall be construed as pre-
15 venting such a treatment plan for an individual from
16 requiring a specialist to provide the primary care
17 provider with regular updates on the specialty care
18 provided, as well as all necessary medical informa-
19 tion.

20 (4) REFERRALS TO PARTICIPATING PRO-
21 VIDERS.—A group health plan or health insurance
22 issuer is not required under paragraph (1) to pro-
23 vide for a referral to a specialist that is not a par-
24 ticipating provider, unless the plan or issuer does
25 not have an appropriate specialist that is available

1 and accessible to treat the individual's condition and
2 that is a participating provider with respect to such
3 treatment.

4 (5) TREATMENT OF NONPARTICIPATING PRO-
5 VIDERS.—If a plan or issuer refers an individual to
6 a nonparticipating specialist pursuant to paragraph
7 (1), services provided pursuant to the approved
8 treatment plan (if any) shall be provided at no addi-
9 tional cost to the individual beyond what the indi-
10 vidual would otherwise pay for services received by
11 such a specialist that is a participating provider.

12 (b) SPECIALISTS AS GATEKEEPER FOR TREATMENT
13 OF ONGOING SPECIAL CONDITIONS.—

14 (1) IN GENERAL.—A group health plan, or a
15 health insurance issuer, in connection with the provi-
16 sion of health insurance coverage, shall have a proce-
17 dure by which an individual who is a participant,
18 beneficiary, or enrollee and who has an ongoing spe-
19 cial condition (as defined in paragraph (3)) may re-
20 quest and receive a referral to a specialist for such
21 condition who shall be responsible for and capable of
22 providing and coordinating the individual's care with
23 respect to the condition. Under such procedures if
24 such an individual's care would most appropriately

1 be coordinated by such a specialist, such plan or
2 issuer shall refer the individual to such specialist.

3 (2) TREATMENT FOR RELATED REFERRALS.—

4 Such specialists shall be permitted to treat the indi-
5 vidual without a referral from the individual's pri-
6 mary care provider and may authorize such refer-
7 rals, procedures, tests, and other medical services as
8 the individual's primary care provider would other-
9 wise be permitted to provide or authorize, subject to
10 the terms of the treatment (referred to in subsection
11 (a)(3)(A)) with respect to the ongoing special condi-
12 tion.

13 (3) ONGOING SPECIAL CONDITION DEFINED.—

14 In this subsection, the term “ongoing special condi-
15 tion” means a condition or disease that—

16 (A) is life-threatening, degenerative, or dis-
17 abling; and

18 (B) requires specialized medical care over
19 a prolonged period of time.

20 (4) TERMS OF REFERRAL.—The provisions of
21 paragraphs (3) through (5) of subsection (a) apply
22 with respect to referrals under paragraph (1) of this
23 subsection in the same manner as they apply to re-
24 ferrals under subsection (a)(1).

25 (c) STANDING REFERRALS.—

1 (1) IN GENERAL.—A group health plan, and a
2 health insurance issuer in connection with the provi-
3 sion of health insurance coverage, shall have a proce-
4 dure by which an individual who is a participant,
5 beneficiary, or enrollee and who has a condition that
6 requires ongoing care from a specialist may receive
7 a standing referral to such specialist for treatment
8 of such condition. If the plan or issuer, or if the pri-
9 mary care provider in consultation with the medical
10 director of the plan or issuer and the specialist (if
11 any), determines that such a standing referral is ap-
12 propriate, the plan or issuer shall make such a refer-
13 ral to such a specialist if the individual so desires.

14 (2) TERMS OF REFERRAL.—The provisions of
15 paragraphs (3) through (5) of subsection (a) apply
16 with respect to referrals under paragraph (1) of this
17 subsection in the same manner as they apply to re-
18 ferrals under subsection (a)(1).

19 **SEC. 1115. ACCESS TO OBSTETRICAL AND GYNECOLOGICAL**
20 **CARE.**

21 (a) IN GENERAL.—If a group health plan, or a health
22 insurance issuer in connection with the provision of health
23 insurance coverage, requires or provides for a participant,
24 beneficiary, or enrollee to designate a participating pri-
25 mary care health care professional, the plan or issuer—

1 (1) may not require authorization or a referral
2 by the individual's primary care health care profes-
3 sional or otherwise for coverage of gynecological care
4 (including preventive women's health examinations)
5 and pregnancy-related services provided by a partici-
6 pating health care professional, including a physi-
7 cian, who specializes in obstetrics and gynecology to
8 the extent such care is otherwise covered; and

9 (2) shall treat the ordering of other obstetrical
10 or gynecological care by such a participating profes-
11 sional as the authorization of the primary care
12 health care professional with respect to such care
13 under the plan or coverage.

14 (b) CONSTRUCTION.—Nothing in subsection (a) shall
15 be construed to—

16 (1) waive any exclusions of coverage under the
17 terms of the plan or health insurance coverage with
18 respect to coverage of obstetrical or gynecological
19 care; or

20 (2) preclude the group health plan or health in-
21 surance issuer involved from requiring that the ob-
22 stetrical or gynecological provider notify the primary
23 care health care professional or the plan or issuer of
24 treatment decisions.

1 **SEC. 1116. ACCESS TO PEDIATRIC CARE.**

2 (a) PEDIATRIC CARE.—If a group health plan, or a
3 health insurance issuer in connection with the provision
4 of health insurance coverage, requires or provides for an
5 enrollee to designate a participating primary care provider
6 for a child of such enrollee, the plan or issuer shall permit
7 the enrollee to designate a physician who specializes in pe-
8 diatrics as the child’s primary care provider.

9 (b) CONSTRUCTION.—Nothing in subsection (a) shall
10 be construed to waive any exclusions of coverage under
11 the terms of the plan or health insurance coverage with
12 respect to coverage of pediatric care.

13 **SEC. 1117. CONTINUITY OF CARE.**

14 (a) IN GENERAL.—

15 (1) TERMINATION OF PROVIDER.—If a contract
16 between a group health plan, or a health insurance
17 issuer in connection with the provision of health in-
18 surance coverage, and a health care provider is ter-
19 minated (as defined in paragraph (3)(B)), or bene-
20 fits or coverage provided by a health care provider
21 are terminated because of a change in the terms of
22 provider participation in a group health plan, and an
23 individual who is a participant, beneficiary, or en-
24 rollee in the plan or coverage is undergoing treat-
25 ment 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.

1 (3) DEFINITIONS.—For purposes of this sec-
2 tion:

3 (A) ONGOING SPECIAL CONDITION.—The
4 term “ongoing special condition” has the mean-
5 ing given such term in section 1114(b)(3), and
6 also includes pregnancy.

7 (B) TERMINATION.—The term “termi-
8 nated” includes, with respect to a contract, the
9 expiration or nonrenewal of the contract, but
10 does not include a termination of the contract
11 by the plan or issuer for failure to meet applica-
12 ble quality standards or for fraud.

13 (b) TRANSITIONAL PERIOD.—

14 (1) IN GENERAL.—Except as provided in para-
15 graphs (2) through (4), the transitional period under
16 this subsection shall extend up to 90 days (as deter-
17 mined by the treating health care professional) after
18 the date of the notice described in subsection
19 (a)(1)(A) of the provider’s termination.

20 (2) SCHEDULED SURGERY AND ORGAN TRANS-
21 PLANTATION.—If surgery or organ transplantation
22 was scheduled for an individual before the date of
23 the announcement of the termination of the provider
24 status under subsection (a)(1)(A) or if the individual
25 on such date was on an established waiting list or

1 otherwise scheduled to have such surgery or trans-
2 plantation, the transitional period under this sub-
3 section with respect to the surgery or transplan-
4 tation shall extend beyond the period under para-
5 graph (1) and until the date of discharge of the indi-
6 vidual after completion of the surgery or transplan-
7 tation.

8 (3) PREGNANCY.—If—

9 (A) a participant, beneficiary, or enrollee
10 was determined to be pregnant at the time of
11 a provider's termination of participation; and

12 (B) the provider was treating the preg-
13 nancy before date of the termination,

14 the transitional period under this subsection with re-
15 spect to provider's treatment of the pregnancy shall
16 extend through the provision of post-partum care di-
17 rectly related to the delivery.

18 (4) TERMINAL ILLNESS.—If—

19 (A) a participant, beneficiary, or enrollee
20 was determined to be terminally ill (as deter-
21 mined under section 1861(dd)(3)(A) of the So-
22 cial Security Act) at the time of a provider's
23 termination of participation; and

24 (B) the provider was treating the terminal
25 illness before the date of termination,

1 the transitional period under this subsection shall
2 extend for the remainder of the individual's life for
3 care directly related to the treatment of the terminal
4 illness or its medical manifestations.

5 (c) PERMISSIBLE TERMS AND CONDITIONS.—A
6 group health plan or health insurance issuer may condi-
7 tion coverage of continued treatment by a provider under
8 subsection (a)(1)(B) upon the individual notifying the plan
9 of the election of continued coverage and upon the pro-
10 vider agreeing to the following terms and conditions:

11 (1) The provider agrees to accept reimburse-
12 ment from the plan or issuer and individual involved
13 (with respect to cost-sharing) at the rates applicable
14 prior to the start of the transitional period as pay-
15 ment in full (or, in the case described in subsection
16 (a)(2), at the rates applicable under the replacement
17 plan or issuer after the date of the termination of
18 the contract with the health insurance issuer) and
19 not to impose cost-sharing with respect to the indi-
20 vidual in an amount that would exceed the cost-shar-
21 ing that could have been imposed if the contract re-
22 ferred to in subsection (a)(1) had not been termi-
23 nated.

24 (2) The provider agrees to adhere to the quality
25 assurance standards of the plan or issuer responsible

1 for payment under paragraph (1) and to provide to
2 such plan or issuer necessary medical information
3 related to the care provided.

4 (3) The provider agrees otherwise to adhere to
5 such plan's or issuer's policies and procedures, in-
6 cluding procedures regarding referrals and obtaining
7 prior authorization and providing services pursuant
8 to a treatment plan (if any) approved by the plan or
9 issuer.

10 (d) CONSTRUCTION.—Nothing in this section shall be
11 construed to require the coverage of benefits which would
12 not have been covered if the provider involved remained
13 a participating provider.

14 **SEC. 1118. ACCESS TO NEEDED PRESCRIPTION DRUGS.**

15 If a group health plan, or health insurance issuer that
16 offers health insurance coverage, provides benefits with re-
17 spect to prescription drugs but the coverage limits such
18 benefits to drugs included in a formulary, the plan or
19 issuer shall—

20 (1) ensure participation of participating physi-
21 cians and pharmacists in the development of the for-
22 mulary;

23 (2) disclose to providers and, disclose upon re-
24 quest under section 1121(c)(5) to participants, bene-

1 ficiaries, and enrollees, the nature of the formulary
2 restrictions; and

3 (3) consistent with the standards for a utiliza-
4 tion review program under section 1101, provide for
5 exceptions from the formulary limitation when a
6 non-formulary alternative is medically indicated.

7 **SEC. 1119. COVERAGE FOR INDIVIDUALS PARTICIPATING**
8 **IN APPROVED CLINICAL TRIALS.**

9 (a) COVERAGE.—

10 (1) IN GENERAL.—If a group health plan, or
11 health insurance issuer that is providing health in-
12 surance coverage, provides coverage to a qualified in-
13 dividual (as defined in subsection (b)), the plan or
14 issuer—

15 (A) may not deny the individual participa-
16 tion in the clinical trial referred to in subsection
17 (b)(2);

18 (B) subject to subsection (c), may not deny
19 (or limit or impose additional conditions on) the
20 coverage of routine patient costs for items and
21 services furnished in connection with participa-
22 tion in the trial; and

23 (C) may not discriminate against the indi-
24 vidual on the basis of the enrollee's participa-
25 tion in such trial.

1 (2) EXCLUSION OF CERTAIN COSTS.—For pur-
2 poses of paragraph (1)(B), routine patient costs do
3 not include the cost of the tests or measurements
4 conducted primarily for the purpose of the clinical
5 trial involved.

6 (3) USE OF IN-NETWORK PROVIDERS.—If one
7 or more participating providers is participating in a
8 clinical trial, nothing in paragraph (1) shall be con-
9 strued as preventing a plan or issuer from requiring
10 that a qualified individual participate in the trial
11 through such a participating provider if the provider
12 will accept the individual as a participant in the
13 trial.

14 (b) QUALIFIED INDIVIDUAL DEFINED.—For pur-
15 poses of subsection (a), the term “qualified individual”
16 means an individual who is a participant or beneficiary
17 in a group health plan, or who is an enrollee under health
18 insurance coverage, and who meets the following condi-
19 tions:

20 (1)(A) The individual has a life-threatening or
21 serious illness for which no standard treatment is ef-
22 fective.

23 (B) The individual is eligible to participate in
24 an approved clinical trial according to the trial pro-
25 tocol with respect to treatment of such illness.

1 (C) The individual's participation in the trial
2 offers meaningful potential for significant clinical
3 benefit for the individual.

4 (2) Either—

5 (A) the referring physician is a partici-
6 pating health care professional and has con-
7 cluded that the individual's participation in
8 such trial would be appropriate based upon the
9 individual meeting the conditions described in
10 paragraph (1); or

11 (B) the participant, beneficiary, or enrollee
12 provides medical and scientific information es-
13 tablishing that the individual's participation in
14 such trial would be appropriate based upon the
15 individual meeting the conditions described in
16 paragraph (1).

17 (c) PAYMENT.—

18 (1) IN GENERAL.—Under this section a group
19 health plan or health insurance issuer shall provide
20 for payment for routine patient costs described in
21 subsection (a)(2) but is not required to pay for costs
22 of items and services that are reasonably expected
23 (as determined by the Secretary) to be paid for by
24 the sponsors of an approved clinical trial.

1 (2) PAYMENT RATE.—In the case of covered
2 items and services provided by—

3 (A) a participating provider, the payment
4 rate shall be at the agreed upon rate; or

5 (B) a nonparticipating provider, the pay-
6 ment rate shall be at the rate the plan or issuer
7 would normally pay for comparable services
8 under subparagraph (A).

9 (d) APPROVED CLINICAL TRIAL DEFINED.—

10 (1) IN GENERAL.—In this section, the term
11 “approved clinical trial” means a clinical research
12 study or clinical investigation approved and funded
13 (which may include funding through in-kind con-
14 tributions) by one or more of the following:

15 (A) The National Institutes of Health.

16 (B) A cooperative group or center of the
17 National Institutes of Health.

18 (C) Either of the following if the condi-
19 tions described in paragraph (2) are met:

20 (i) The Department of Veterans Af-
21 fairs.

22 (ii) The Department of Defense.

23 (2) CONDITIONS FOR DEPARTMENTS.—The
24 conditions described in this paragraph, for a study
25 or investigation conducted by a Department, are

1 that the study or investigation has been reviewed
2 and approved through a system of peer review that
3 the Secretary determines—

4 (A) to be comparable to the system of peer
5 review of studies and investigations used by the
6 National Institutes of Health; and

7 (B) assures unbiased review of the highest
8 scientific standards by qualified individuals who
9 have no interest in the outcome of the review.

10 (e) CONSTRUCTION.—Nothing in this section shall be
11 construed to limit a plan’s or issuer’s coverage with re-
12 spect to clinical trials.

13 **Subtitle C—Access to Information**

14 **SEC. 1121. PATIENT ACCESS TO INFORMATION.**

15 (a) DISCLOSURE REQUIREMENT.—

16 (1) GROUP HEALTH PLANS.—A group health
17 plan shall—

18 (A) provide to participants and bene-
19 ficiaries at the time of initial coverage under
20 the plan (or the effective date of this section, in
21 the case of individuals who are participants or
22 beneficiaries as of such date), and at least an-
23 nually thereafter, the information described in
24 subsection (b) in printed form;

1 (B) provide to participants and bene-
2 ficiaries, within a reasonable period (as speci-
3 fied by the appropriate Secretary) before or
4 after the date of significant changes in the in-
5 formation described in subsection (b), informa-
6 tion in printed form on such significant
7 changes; and

8 (C) upon request, make available to par-
9 ticipants and beneficiaries, the applicable au-
10 thority, and prospective participants and bene-
11 ficiaries, the information described in sub-
12 section (b) or (c) in printed form.

13 (2) HEALTH INSURANCE ISSUERS.—A health
14 insurance issuer in connection with the provision of
15 health insurance coverage shall—

16 (A) provide to individuals enrolled under
17 such coverage at the time of enrollment, and at
18 least annually thereafter, the information de-
19 scribed in subsection (b) in printed form;

20 (B) provide to enrollees, within a reason-
21 able period (as specified by the appropriate Sec-
22 retary) before or after the date of significant
23 changes in the information described in sub-
24 section (b), information in printed form on such
25 significant changes; and

1 (C) upon request, make available to the
2 applicable authority, to individuals who are pro-
3 spective enrollees, and to the public the infor-
4 mation described in subsection (b) or (c) in
5 printed form.

6 (b) INFORMATION PROVIDED.—The information de-
7 scribed in this subsection with respect to a group health
8 plan or health insurance coverage offered by a health in-
9 surance issuer includes the following:

10 (1) SERVICE AREA.—The service area of the
11 plan or issuer.

12 (2) BENEFITS.—Benefits offered under the
13 plan or coverage, including—

14 (A) covered benefits, including benefit lim-
15 its and coverage exclusions;

16 (B) cost sharing, such as deductibles, coin-
17 surance, and copayment amounts, including any
18 liability for balance billing, any maximum limi-
19 tations on out of pocket expenses, and the max-
20 imum out of pocket costs for services that are
21 provided by nonparticipating providers or that
22 are furnished without meeting the applicable
23 utilization review requirements;

24 (C) the extent to which benefits may be ob-
25 tained from nonparticipating providers;

1 (D) the extent to which a participant, ben-
2 eficiary, or enrollee may select from among par-
3 ticipating providers and the types of providers
4 participating in the plan or issuer network;

5 (E) process for determining experimental
6 coverage; and

7 (F) use of a prescription drug formulary.

8 (3) ACCESS.—A description of the following:

9 (A) The number, mix, and distribution of
10 providers under the plan or coverage.

11 (B) Out-of-network coverage (if any) pro-
12 vided by the plan or coverage.

13 (C) Any point-of-service option (including
14 any supplemental premium or cost-sharing for
15 such option).

16 (D) The procedures for participants, bene-
17 ficiaries, and enrollees to select, access, and
18 change participating primary and specialty pro-
19 viders.

20 (E) The rights and procedures for obtain-
21 ing referrals (including standing referrals) to
22 participating and nonparticipating providers.

23 (F) The name, address, and telephone
24 number of participating health care providers

1 and an indication of whether each such provider
2 is available to accept new patients.

3 (G) Any limitations imposed on the selec-
4 tion of qualifying participating health care pro-
5 viders, including any limitations imposed under
6 section 1112(b)(2).

7 (H) How the plan or issuer addresses the
8 needs of participants, beneficiaries, and enroll-
9 ees and others who do not speak English or
10 who have other special communications needs in
11 accessing providers under the plan or coverage,
12 including the provision of information described
13 in this subsection and subsection (c) to such in-
14 dividuals.

15 (4) OUT-OF-AREA COVERAGE.—Out-of-area cov-
16 erage provided by the plan or issuer.

17 (5) EMERGENCY COVERAGE.—Coverage of
18 emergency services, including—

19 (A) the appropriate use of emergency serv-
20 ices, including use of the 911 telephone system
21 or its local equivalent in emergency situations
22 and an explanation of what constitutes an
23 emergency situation;

24 (B) the process and procedures of the plan
25 or issuer for obtaining emergency services; and

1 (C) the locations of (i) emergency depart-
2 ments, and (ii) other settings, in which plan
3 physicians and hospitals provide emergency
4 services and post-stabilization care.

5 (6) PERCENTAGE OF PREMIUMS USED FOR
6 BENEFITS (LOSS-RATIOS).—In the case of health in-
7 surance coverage only (and not with respect to group
8 health plans that do not provide coverage through
9 health insurance coverage), a description of the over-
10 all loss-ratio for the coverage (as defined in accord-
11 ance with rules established or recognized by the Sec-
12 retary of Health and Human Services).

13 (7) PRIOR AUTHORIZATION RULES.—Rules re-
14 garding prior authorization or other review require-
15 ments that could result in noncoverage or non-
16 payment.

17 (8) GRIEVANCE AND APPEALS PROCEDURES.—
18 All appeal or grievance rights and procedures under
19 the plan or coverage, including the method for filing
20 grievances and the time frames and circumstances
21 for acting on grievances and appeals, who is the ap-
22 plicable authority with respect to the plan or issuer.

23 (9) QUALITY ASSURANCE.—Any information
24 made public by an accrediting organization in the
25 process of accreditation of the plan or issuer or any

1 additional quality indicators the plan or issuer
2 makes available.

3 (10) INFORMATION ON ISSUER.—Notice of ap-
4 propriate mailing addresses and telephone numbers
5 to be used by participants, beneficiaries, and enroll-
6 ees in seeking information or authorization for treat-
7 ment.

8 (11) NOTICE OF REQUIREMENTS.—Notice of
9 the requirements of this title.

10 (12) AVAILABILITY OF INFORMATION ON RE-
11 QUEST.—Notice that the information described in
12 subsection (c) is available upon request.

13 (c) INFORMATION MADE AVAILABLE UPON RE-
14 QUEST.—The information described in this subsection is
15 the following:

16 (1) UTILIZATION REVIEW ACTIVITIES.—A de-
17 scription of procedures used and requirements (in-
18 cluding circumstances, time frames, and appeal
19 rights) under any utilization review program under
20 section 1101, including under any drug formulary
21 program under section 1118.

22 (2) GRIEVANCE AND APPEALS INFORMATION.—
23 Information on the number of grievances and ap-
24 peals and on the disposition in the aggregate of such
25 matters.

1 (3) METHOD OF PHYSICIAN COMPENSATION.—

2 A general description by category (including salary,
3 fee-for-service, capitation, and such other categories
4 as may be specified in regulations of the Secretary)
5 of the applicable method by which a specified pro-
6 spective or treating health care professional is (or
7 would be) compensated in connection with the provi-
8 sion of health care under the plan or coverage.

9 (4) SPECIFIC INFORMATION ON CREDENTIALS
10 OF PARTICIPATING PROVIDERS.—In the case of each
11 participating provider, a description of the creden-
12 tials of the provider.

13 (5) FORMULARY RESTRICTIONS.—A description
14 of the nature of any drug formula restrictions.

15 (6) PARTICIPATING PROVIDER LIST.—A list of
16 current participating health care providers.

17 (d) CONSTRUCTION.—Nothing in this section shall be
18 construed as requiring public disclosure of individual con-
19 tracts or financial arrangements between a group health
20 plan or health insurance issuer and any provider.

1 **Subtitle D—Protecting the Doctor-**
2 **Patient Relationship**

3 **SEC. 1131. PROHIBITION OF INTERFERENCE WITH CERTAIN**
4 **MEDICAL COMMUNICATIONS.**

5 (a) GENERAL RULE.—The provisions of any contract
6 or agreement, or the operation of any contract or agree-
7 ment, between a group health plan or health insurance
8 issuer in relation to health insurance coverage (including
9 any partnership, association, or other organization that
10 enters into or administers such a contract or agreement)
11 and a health care provider (or group of health care pro-
12 viders) shall not prohibit or otherwise restrict a health
13 care professional from advising such a participant, bene-
14 ficiary, or enrollee who is a patient of the professional
15 about the health status of the individual or medical care
16 or treatment for the individual's condition or disease, re-
17 gardless of whether benefits for such care or treatment
18 are provided under the plan or coverage, if the professional
19 is acting within the lawful scope of practice.

20 (b) NULLIFICATION.—Any contract provision or
21 agreement that restricts or prohibits medical communica-
22 tions in violation of subsection (a) shall be null and void.

1 **SEC. 1132. PROHIBITION OF DISCRIMINATION AGAINST**
2 **PROVIDERS BASED ON LICENSURE.**

3 (a) IN GENERAL.—A group health plan and a health
4 insurance issuer offering health insurance coverage shall
5 not discriminate with respect to participation or indem-
6 nification as to any provider who is acting within the scope
7 of the provider's license or certification under applicable
8 State law, solely on the basis of such license or certifi-
9 cation.

10 (b) CONSTRUCTION.—Subsection (a) shall not be
11 construed—

12 (1) as requiring the coverage under a group
13 health plan or health insurance coverage of par-
14 ticular benefits or services or to prohibit a plan or
15 issuer from including providers only to the extent
16 necessary to meet the needs of the plan's or issuer's
17 participants, beneficiaries, or enrollees or from es-
18 tablishing any measure designed to maintain quality
19 and control costs consistent with the responsibilities
20 of the plan or issuer;

21 (2) to override any State licensure or scope-of-
22 practice law; or

23 (3) as requiring a plan or issuer that offers net-
24 work coverage to include for participation every will-
25 ing provider who meets the terms and conditions of
26 the plan or issuer.

1 **SEC. 1133. PROHIBITION AGAINST IMPROPER INCENTIVE**
2 **ARRANGEMENTS.**

3 (a) IN GENERAL.—A group health plan and a health
4 insurance issuer offering health insurance coverage may
5 not operate any physician incentive plan (as defined in
6 subparagraph (B) of section 1876(i)(8) of the Social Secu-
7 rity Act) unless the requirements described in clauses (i),
8 (ii)(I), and (iii) of subparagraph (A) of such section are
9 met with respect to such a plan.

10 (b) APPLICATION.—For purposes of carrying out
11 paragraph (1), any reference in section 1876(i)(8) of the
12 Social Security Act to the Secretary, an eligible organiza-
13 tion, or an individual enrolled with the organization shall
14 be treated as a reference to the applicable authority, a
15 group health plan or health insurance issuer, respectively,
16 and a participant, beneficiary, or enrollee with the plan
17 or organization, respectively.

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

21 **SEC. 1134. PAYMENT OF CLAIMS.**

22 A group health plan, and a health insurance issuer
23 offering group health insurance coverage, shall provide for
24 prompt payment of claims submitted for health care serv-
25 ices or supplies furnished to a participant, beneficiary, or
26 enrollee with respect to benefits covered by the plan or

1 issuer, in a manner consistent with the provisions of sec-
2 tions 1816(c)(2) and 1842(c)(2) of the Social Security Act
3 (42 U.S.C. 1395h(c)(2) and 42 U.S.C. 1395u(c)(2)), ex-
4 cept that for purposes of this section, subparagraph (C)
5 of section 1816(c)(2) of the Social Security Act shall be
6 treated as applying to claims received from a participant,
7 beneficiary, or enrollee as well as claims referred to in
8 such subparagraph.

9 **SEC. 1135. PROTECTION FOR PATIENT ADVOCACY.**

10 (a) PROTECTION FOR USE OF UTILIZATION REVIEW
11 AND GRIEVANCE PROCESS.—A group health plan, and a
12 health insurance issuer with respect to the provision of
13 health insurance coverage, may not retaliate against a par-
14 ticipant, beneficiary, enrollee, or health care provider
15 based on the participant's, beneficiary's, enrollee's or pro-
16 vider's use of, or participation in, a utilization review proc-
17 ess or a grievance process of the plan or issuer (including
18 an internal or external review or appeal process) under
19 this title.

20 (b) PROTECTION FOR QUALITY ADVOCACY BY
21 HEALTH CARE PROFESSIONALS.—

22 (1) IN GENERAL.—A group health plan or
23 health insurance issuer may not retaliate or dis-
24 criminate against a protected health care profes-
25 sional because the professional in good faith—

1 (A) discloses information relating to the
2 care, services, or conditions affecting one or
3 more participants, beneficiaries, or enrollees of
4 the plan or issuer to an appropriate public reg-
5 ulatory agency, an appropriate private accredi-
6 tation body, or appropriate management per-
7 sonnel of the plan or issuer; or

8 (B) initiates, cooperates, or otherwise par-
9 ticipates in an investigation or proceeding by
10 such an agency with respect to such care, serv-
11 ices, or conditions.

12 If an institutional health care provider is a partici-
13 pating provider with such a plan or issuer or other-
14 wise receives payments for benefits provided by such
15 a plan or issuer, the provisions of the previous sen-
16 tence shall apply to the provider in relation to care,
17 services, or conditions affecting one or more patients
18 within an institutional health care provider in the
19 same manner as they apply to the plan or issuer in
20 relation to care, services, or conditions provided to
21 one or more participants, beneficiaries, or enrollees;
22 and for purposes of applying this sentence, any ref-
23 erence to a plan or issuer is deemed a reference to
24 the institutional health care provider.

1 (2) GOOD FAITH ACTION.—For purposes of
2 paragraph (1), a protected health care professional
3 is considered to be acting in good faith with respect
4 to disclosure of information or participation if, with
5 respect to the information disclosed as part of the
6 action—

7 (A) the disclosure is made on the basis of
8 personal knowledge and is consistent with that
9 degree of learning and skill ordinarily possessed
10 by health care professionals with the same li-
11 censure or certification and the same experi-
12 ence;

13 (B) the professional reasonably believes the
14 information to be true;

15 (C) the information evidences either a vio-
16 lation of a law, rule, or regulation, of an appli-
17 cable accreditation standard, or of a generally
18 recognized professional or clinical standard or
19 that a patient is in imminent hazard of loss of
20 life or serious injury; and

21 (D) subject to subparagraphs (B) and (C)
22 of paragraph (3), the professional has followed
23 reasonable internal procedures of the plan,
24 issuer, or institutional health care provider es-

1 tablished for the purpose of addressing quality
2 concerns before making the disclosure.

3 (3) EXCEPTION AND SPECIAL RULE.—

4 (A) GENERAL EXCEPTION.—Paragraph (1)
5 does not protect disclosures that would violate
6 Federal or State law or diminish or impair the
7 rights of any person to the continued protection
8 of confidentiality of communications provided
9 by such law.

10 (B) NOTICE OF INTERNAL PROCEDURES.—
11 Subparagraph (D) of paragraph (2) shall not
12 apply unless the internal procedures involved
13 are reasonably expected to be known to the
14 health care professional involved. For purposes
15 of this subparagraph, a health care professional
16 is reasonably expected to know of internal pro-
17 cedures if those procedures have been made
18 available to the professional through distribu-
19 tion or posting.

20 (C) INTERNAL PROCEDURE EXCEPTION.—
21 Subparagraph (D) of paragraph (2) also shall
22 not apply if—

- 23 (i) the disclosure relates to an immi-
24 nent hazard of loss of life or serious injury
25 to a patient;

1 (ii) the disclosure is made to an ap-
2 propriate private accreditation body pursu-
3 ant to disclosure procedures established by
4 the body; or

5 (iii) the disclosure is in response to an
6 inquiry made in an investigation or pro-
7 ceeding of an appropriate public regulatory
8 agency and the information disclosed is
9 limited to the scope of the investigation or
10 proceeding.

11 (4) ADDITIONAL CONSIDERATIONS.—It shall
12 not be a violation of paragraph (1) to take an ad-
13 verse action against a protected health care profes-
14 sional if the plan, issuer, or provider taking the ad-
15 verse action involved demonstrates that it would
16 have taken the same adverse action even in the ab-
17 sence of the activities protected under such para-
18 graph.

19 (5) NOTICE.—A group health plan, health in-
20 surance issuer, and institutional health care provider
21 shall post a notice, to be provided or approved by
22 the Secretary of Labor, setting forth excerpts from,
23 or summaries of, the pertinent provisions of this
24 subsection and information pertaining to enforce-
25 ment of such provisions.

1 (6) CONSTRUCTIONS.—

2 (A) DETERMINATIONS OF COVERAGE.—

3 Nothing in this subsection shall be construed to
4 prohibit a plan or issuer from making a deter-
5 mination not to pay for a particular medical
6 treatment or service or the services of a type of
7 health care professional.

8 (B) ENFORCEMENT OF PEER REVIEW PRO-
9 TOCOLS AND INTERNAL PROCEDURES.—Noth-
10 ing in this subsection shall be construed to pro-
11 hibit a plan, issuer, or provider from estab-
12 lishing and enforcing reasonable peer review or
13 utilization review protocols or determining
14 whether a protected health care professional has
15 complied with those protocols or from estab-
16 lishing and enforcing internal procedures for
17 the purpose of addressing quality concerns.

18 (C) RELATION TO OTHER RIGHTS.—Noth-
19 ing in this subsection shall be construed to
20 abridge rights of participants, beneficiaries, en-
21 rollees, and protected health care professionals
22 under other applicable Federal or State laws.

23 (7) PROTECTED HEALTH CARE PROFESSIONAL
24 DEFINED.—For purposes of this subsection, the
25 term “protected health care professional” means an

1 individual who is a licensed or certified health care
2 professional and who—

3 (A) with respect to a group health plan or
4 health insurance issuer, is an employee of the
5 plan or issuer or has a contract with the plan
6 or issuer for provision of services for which ben-
7 efits are available under the plan or issuer; or

8 (B) with respect to an institutional health
9 care provider, is an employee of the provider or
10 has a contract or other arrangement with the
11 provider respecting the provision of health care
12 services.

13 **Subtitle E—Definitions**

14 **SEC. 1151. DEFINITIONS.**

15 (a) INCORPORATION OF GENERAL DEFINITIONS.—
16 Except as otherwise provided, the provisions of section
17 2791 of the Public Health Service Act shall apply for pur-
18 poses of this title in the same manner as they apply for
19 purposes of title XXVII of such Act.

20 (b) SECRETARY.—Except as otherwise provided, the
21 term “Secretary” means the Secretary of Health and
22 Human Services, in consultation with the Secretary of
23 Labor and the term “appropriate Secretary” means the
24 Secretary of Health and Human Services in relation to
25 carrying out this title under sections 2706 and 2751 of

1 the Public Health Service Act and the Secretary of Labor
2 in relation to carrying out this title under section 713 of
3 the Employee Retirement Income Security Act of 1974.

4 (c) ADDITIONAL DEFINITIONS.—For purposes of this
5 title:

6 (1) ACTIVELY PRACTICING.—The term “actively
7 practicing” means, with respect to a physician or
8 other health care professional, such a physician or
9 professional who provides professional services to in-
10 dividual patients on average at least two full days
11 per week.

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

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

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

1 (3) CLINICAL PEER.—The term “clinical peer”
2 means, with respect to a review or appeal, an ac-
3 tively practicing physician (allopathic or osteopathic)
4 or other actively practicing health care professional
5 who holds a nonrestricted license, and who is appro-
6 priately credentialed in the same or similar specialty
7 or subspecialty (as appropriate) as typically handles
8 the medical condition, procedure, or treatment under
9 review or appeal and includes a pediatric specialist
10 where appropriate; except that only a physician
11 (allopathic or osteopathic) may be a clinical peer
12 with respect to the review or appeal of treatment
13 recommended or rendered by a physician.

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

18 (5) GROUP HEALTH PLAN.—The term “group
19 health plan” has the meaning given such term in
20 section 733(a) of the Employee Retirement Income
21 Security Act of 1974 and in section 2791(a)(1) of
22 the Public Health Service Act.

23 (6) HEALTH CARE PROFESSIONAL.—The term
24 “health care professional” means an individual who
25 is licensed, accredited, or certified under State law

1 to provide specified health care services and who is
2 operating within the scope of such licensure, accredi-
3 tation, or certification.

4 (7) HEALTH CARE PROVIDER.—The term
5 “health care provider” includes a physician or other
6 health care professional, as well as an institutional
7 or other facility or agency that provides health care
8 services and that is licensed, accredited, or certified
9 to provide health care items and services under ap-
10 plicable State law.

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

18 (9) NONPARTICIPATING.—The term “non-
19 participating” means, with respect to a health care
20 provider that provides health care items and services
21 to a participant, beneficiary, or enrollee under group
22 health plan or health insurance coverage, a health
23 care provider that is not a participating health care
24 provider with respect to such items and services.

1 (10) PARTICIPATING.—The term “partici-
2 pating” means, with respect to a health care pro-
3 vider that provides health care items and services to
4 a participant, beneficiary, or enrollee under group
5 health plan or health insurance coverage offered by
6 a health insurance issuer, a health care provider that
7 furnishes such items and services under a contract
8 or other arrangement with the plan or issuer.

9 (11) PRIOR AUTHORIZATION.—The term “prior
10 authorization” means the process of obtaining prior
11 approval from a health insurance issuer or group
12 health plan for the provision or coverage of medical
13 services.

14 **SEC. 1152. PREEMPTION; STATE FLEXIBILITY; CONSTRUC-**
15 **TION.**

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

18 (1) IN GENERAL.—Subject to paragraph (2),
19 this title shall not be construed to supersede any
20 provision of State law which establishes, implements,
21 or continues in effect any standard or requirement
22 solely relating to health insurance issuers (in connec-
23 tion with group health insurance coverage or other-
24 wise) except to the extent that such standard or re-

1 requirement prevents the application of a requirement
2 of this title.

3 (2) CONTINUED PREEMPTION WITH RESPECT
4 TO GROUP HEALTH PLANS.—Nothing in this title
5 shall be construed to affect or modify the provisions
6 of section 514 of the Employee Retirement Income
7 Security Act of 1974 with respect to group health
8 plans.

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

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

16 (2) STATE.—The term “State” includes a
17 State, the District of Columbia, Puerto Rico, the
18 Virgin Islands, Guam, American Samoa, the North-
19 ern Mariana Islands, any political subdivisions of
20 such, or any agency or instrumentality of such.

21 **SEC. 1153. EXCLUSIONS.**

22 (a) NO BENEFIT REQUIREMENTS.—Nothing in this
23 title shall be construed to require a group health plan or
24 a health insurance issuer offering health insurance cov-

1 erage to provide items and services (including abortions)
2 that are specifically excluded under the plan or coverage.

3 (b) EXCLUSION FROM ACCESS TO CARE MANAGED
4 CARE PROVISIONS FOR FEE-FOR-SERVICE COVERAGE.—

5 (1) IN GENERAL.—The provisions of sections
6 1111 through 1117 shall not apply to a group health
7 plan or health insurance coverage if the only cov-
8 erage offered under the plan or coverage is fee-for-
9 service coverage (as defined in paragraph (2)).

10 (2) FEE-FOR-SERVICE COVERAGE DEFINED.—
11 For purposes of this subsection, the term “fee-for-
12 service coverage” means coverage under a group
13 health plan or health insurance coverage that—

14 (A) reimburses hospitals, health profes-
15 sionals, and other providers on the basis of a
16 rate determined by the plan or issuer on a fee-
17 for-service basis without placing the provider at
18 financial risk;

19 (B) does not vary reimbursement for such
20 a provider based on an agreement to contract
21 terms and conditions or the utilization of health
22 care items or services relating to such provider;

23 (C) does not restrict the selection of pro-
24 viders among those who are lawfully authorized
25 to provide the covered services and agree to ac-

1 cept the terms and conditions of payment estab-
2 lished under the plan or by the issuer; and

3 (D) for which the plan or issuer does not
4 require prior authorization before providing cov-
5 erage for any services.

6 **SEC. 1154. COVERAGE OF LIMITED SCOPE PLANS.**

7 Only for purposes of applying the requirements of
8 this title under sections 2707 and 2753 of the Public
9 Health Service Act and section 714 of the Employee Re-
10 tirement Income Security Act of 1974, section
11 2791(c)(2)(A), and section 733(c)(2)(A) of the Employee
12 Retirement Income Security Act of 1974 shall be deemed
13 not to apply.

14 **SEC. 1155. REGULATIONS.**

15 The Secretaries of Health and Human Services and
16 Labor shall issue such regulations as may be necessary
17 or appropriate to carry out this title. Such regulations
18 shall be issued consistent with section 104 of Health In-
19 surance Portability and Accountability Act of 1996. Such
20 Secretaries may promulgate any interim final rules as the
21 Secretaries determine are appropriate to carry out this
22 title.

1 **TITLE XII—APPLICATION OF**
2 **QUALITY CARE STANDARDS**
3 **TO GROUP HEALTH PLANS**
4 **AND HEALTH INSURANCE**
5 **COVERAGE UNDER THE PUB-**
6 **LIC HEALTH SERVICE ACT**

7 **SEC. 1201. APPLICATION TO GROUP HEALTH PLANS AND**
8 **GROUP HEALTH INSURANCE COVERAGE.**

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

12 **“SEC. 2707. PATIENT PROTECTION STANDARDS.**

13 “(a) IN GENERAL.—Each group health plan shall
14 comply with patient protection requirements under title XI
15 of the Bipartisan Consensus Managed Care Improvement
16 Act of 1999, and each health insurance issuer shall comply
17 with patient protection requirements under such title with
18 respect to group health insurance coverage it offers, and
19 such requirements shall be deemed to be incorporated into
20 this subsection.

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

1 requirement as if such section applied to such issuer and
2 such issuer were a group health plan.”.

3 (b) CONFORMING AMENDMENT.—Section
4 2721(b)(2)(A) of such Act (42 U.S.C. 300gg–21(b)(2)(A))
5 is amended by inserting “(other than section 2707)” after
6 “requirements of such subparts”.

7 **SEC. 1202. APPLICATION TO INDIVIDUAL HEALTH INSUR-**
8 **ANCE COVERAGE.**

9 Part B of title XXVII of the Public Health Service
10 Act is amended by inserting after section 2752 the fol-
11 lowing new section:

12 **“SEC. 2753. PATIENT PROTECTION STANDARDS.**

13 “(a) IN GENERAL.—Each health insurance issuer
14 shall comply with patient protection requirements under
15 title XI of the Bipartisan Consensus Managed Care Im-
16 provement Act of 1999 with respect to individual health
17 insurance coverage it offers, and such requirements shall
18 be deemed to be incorporated into this subsection.

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

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

5 **SEC. 1301. APPLICATION OF PATIENT PROTECTION STAND-**
6 **ARDS TO GROUP HEALTH PLANS AND GROUP**
7 **HEALTH INSURANCE COVERAGE UNDER THE**
8 **EMPLOYEE RETIREMENT INCOME SECURITY**
9 **ACT OF 1974.**

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

13 **“SEC. 714. PATIENT PROTECTION STANDARDS.**

14 “(a) IN GENERAL.—Subject to subsection (b), a
15 group health plan (and a health insurance issuer offering
16 group health insurance coverage in connection with such
17 a plan) shall comply with the requirements of title XI of
18 the Bipartisan Consensus Managed Care Improvement
19 Act of 1999 (as in effect as of the date of the enactment
20 of such Act), and such requirements shall be deemed to
21 be incorporated into this subsection.

22 “(b) PLAN SATISFACTION OF CERTAIN REQUIRE-
23 MENTS.—

24 “(1) SATISFACTION OF CERTAIN REQUIRE-
25 MENTS THROUGH INSURANCE.—For purposes of

1 subsection (a), insofar as a group health plan pro-
2 vides benefits in the form of health insurance cov-
3 erage through a health insurance issuer, the plan
4 shall be treated as meeting the following require-
5 ments of title XI of the Bipartisan Consensus Man-
6 aged Care Improvement Act of 1999 with respect to
7 such benefits and not be considered as failing to
8 meet such requirements because of a failure of the
9 issuer to meet such requirements so long as the plan
10 sponsor or its representatives did not cause such
11 failure by the issuer:

12 “(A) Section 1112 (relating to choice of
13 providers).

14 “(B) Section 1113 (relating to access to
15 emergency care).

16 “(C) Section 1114 (relating to access to
17 specialty care).

18 “(D) Section 1115 (relating to access to
19 obstetrical and gynecological care).

20 “(E) Section 1116 (relating to access to
21 pediatric care).

22 “(F) Section 1117(a)(1) (relating to con-
23 tinuity in case of termination of provider con-
24 tract) and section 117(a)(2) (relating to con-
25 tinuity in case of termination of issuer con-

1 tract), but only insofar as a replacement issuer
2 assumes the obligation for continuity of care.

3 “(G) Section 1118 (relating to access to
4 needed prescription drugs).

5 “(H) Section 1119 (relating to coverage
6 for individuals participating in approved clinical
7 trials.)

8 “(I) Section 1134 (relating to payment of
9 claims).

10 “(2) INFORMATION.—With respect to informa-
11 tion required to be provided or made available under
12 section 1121, in the case of a group health plan that
13 provides benefits in the form of health insurance
14 coverage through a health insurance issuer, the Sec-
15 retary shall determine the circumstances under
16 which the plan is not required to provide or make
17 available the information (and is not liable for the
18 issuer’s failure to provide or make available the in-
19 formation), if the issuer is obligated to provide and
20 make available (or provides and makes available)
21 such information.

22 “(3) GRIEVANCE AND INTERNAL APPEALS.—
23 With respect to the internal appeals process and the
24 grievance system required to be established under
25 sections 1102 and 1104, in the case of a group

1 health plan that provides benefits in the form of
2 health insurance coverage through a health insur-
3 ance issuer, the Secretary shall determine the cir-
4 cumstances under which the plan is not required to
5 provide for such process and system (and is not lia-
6 ble for the issuer's failure to provide for such proc-
7 ess and system), if the issuer is obligated to provide
8 for (and provides for) such process and system.

9 “(4) EXTERNAL APPEALS.—Pursuant to rules
10 of the Secretary, insofar as a group health plan en-
11 ters into a contract with a qualified external appeal
12 entity for the conduct of external appeal activities in
13 accordance with section 1103, the plan shall be
14 treated as meeting the requirement of such section
15 and is not liable for the entity's failure to meet any
16 requirements under such section.

17 “(5) APPLICATION TO PROHIBITIONS.—Pursu-
18 ant to rules of the Secretary, if a health insurance
19 issuer offers health insurance coverage in connection
20 with a group health plan and takes an action in vio-
21 lation of any of the following sections, the group
22 health plan shall not be liable for such violation un-
23 less the plan caused such violation:

1 “(A) Section 1131 (relating to prohibition
2 of interference with certain medical communica-
3 tions).

4 “(B) Section 1132 (relating to prohibition
5 of discrimination against providers based on li-
6 censure).

7 “(C) Section 1133 (relating to prohibition
8 against improper incentive arrangements).

9 “(D) Section 1135 (relating to protection
10 for patient advocacy).

11 “(6) CONSTRUCTION.—Nothing in this sub-
12 section shall be construed to affect or modify the re-
13 sponsibilities of the fiduciaries of a group health
14 plan under part 4 of subtitle B.

15 “(7) APPLICATION TO CERTAIN PROHIBITIONS
16 AGAINST RETALIATION.—With respect to compliance
17 with the requirements of section 1135(b)(1) of the
18 Bipartisan Consensus Managed Care Improvement
19 Act of 1999, for purposes of this subtitle the term
20 ‘group health plan’ is deemed to include a reference
21 to an institutional health care provider.

22 “(c) ENFORCEMENT OF CERTAIN REQUIREMENTS.—

23 “(1) COMPLAINTS.—Any protected health care
24 professional who believes that the professional has
25 been retaliated or discriminated against in violation

1 of section 1135(b)(1) of the Bipartisan Consensus
2 Managed Care Improvement Act of 1999 may file
3 with the Secretary a complaint within 180 days of
4 the date of the alleged retaliation or discrimination.

5 “(2) INVESTIGATION.—The Secretary shall in-
6 vestigate such complaints and shall determine if a
7 violation of such section has occurred and, if so,
8 shall issue an order to ensure that the protected
9 health care professional does not suffer any loss of
10 position, pay, or benefits in relation to the plan,
11 issuer, or provider involved, as a result of the viola-
12 tion found by the Secretary.

13 “(d) CONFORMING REGULATIONS.—The Secretary
14 may issue regulations to coordinate the requirements on
15 group health plans under this section with the require-
16 ments imposed under the other provisions of this title.”.

17 (b) SATISFACTION OF ERISA CLAIMS PROCEDURE
18 REQUIREMENT.—Section 503 of such Act (29 U.S.C.
19 1133) is amended by inserting “(a)” after “SEC. 503.”
20 and by adding at the end the following new subsection:

21 “(b) In the case of a group health plan (as defined
22 in section 733) compliance with the requirements of sub-
23 title A of title XI of the Bipartisan Consensus Managed
24 Care Improvement Act of 1999 in the case of a claims

1 denial shall be deemed compliance with subsection (a) with
2 respect to such claims denial.”.

3 (c) CONFORMING AMENDMENTS.—(1) Section 732(a)
4 of such Act (29 U.S.C. 1185(a)) is amended by striking
5 “section 711” and inserting “sections 711 and 714”.

6 (2) The table of contents in section 1 of such Act
7 is amended by inserting after the item relating to section
8 713 the following new item:

“Sec. 714. Patient protection standards.”.

9 (3) Section 502(b)(3) of such Act (29 U.S.C.
10 1132(b)(3)) is amended by inserting “(other than section
11 135(b))” after “part 7”.

12 **SEC. 1302. ERISA PREEMPTION NOT TO APPLY TO CERTAIN**
13 **ACTIONS INVOLVING HEALTH INSURANCE**
14 **POLICYHOLDERS.**

15 (a) IN GENERAL.—Section 514 of the Employee Re-
16 tirement Income Security Act of 1974 (29 U.S.C. 1144)
17 (as amended by section 301(b)) is amended further by
18 adding at the end the following subsections:

19 “(f) PREEMPTION NOT TO APPLY TO CERTAIN AC-
20 TIONS ARISING OUT OF PROVISION OF HEALTH BENE-
21 FITS.—

22 “(1) NON-PREEMPTION OF CERTAIN CAUSES OF
23 ACTION.—

24 “(A) IN GENERAL.—Except as provided in
25 this subsection, nothing in this title shall be

1 construed to invalidate, impair, or supersede
2 any cause of action by a participant or bene-
3 ficiary (or the estate of a participant or bene-
4 ficiary) under State law to recover damages re-
5 sulting from personal injury or for wrongful
6 death against any person—

7 “(i) in connection with the provision
8 of insurance, administrative services, or
9 medical services by such person to or for
10 a group health plan (as defined in section
11 733), or

12 “(ii) that arises out of the arrange-
13 ment by such person for the provision of
14 such insurance, administrative services, or
15 medical services by other persons.

16 “(B) LIMITATION ON PUNITIVE DAM-
17 AGES.—

18 “(i) IN GENERAL.—No person shall be
19 liable for any punitive, exemplary, or simi-
20 lar damages in the case of a cause of ac-
21 tion brought under subparagraph (A) if—

22 “(I) it relates to an externally
23 appealable decision (as defined in sub-
24 section (a)(2) of section 1103 of the

1 Bipartisan Consensus Managed Care
2 Improvement Act of 1999);

3 “(II) an external appeal with re-
4 spect to such decision was completed
5 under such section 1103;

6 “(III) in the case such external
7 appeal was initiated by the plan or
8 issuer filing the request for the exter-
9 nal appeal, the request was filed on a
10 timely basis before the date the action
11 was brought or, if later, within 30
12 days after the date the externally ap-
13 pealable decision was made; and

14 “(IV) the plan or issuer complied
15 with the determination of the external
16 appeal entity upon receipt of the de-
17 termination of the external appeal en-
18 tity.

19 The provisions of this clause supersede any
20 State law or common law to the contrary.

21 “(ii) EXCEPTION.—Clause (i) shall
22 not apply with respect to damages in the
23 case of a cause of action for wrongful
24 death if the applicable State law provides
25 (or has been construed to provide) for

1 damages in such a cause of action which
2 are only punitive or exemplary in nature.

3 “(C) PERSONAL INJURY DEFINED.—For
4 purposes of this subsection, the term ‘personal
5 injury’ means a physical injury and includes an
6 injury arising out of the treatment (or failure
7 to treat) a mental illness or disease.

8 “(2) EXCEPTION FOR GROUP HEALTH PLANS,
9 EMPLOYERS, AND OTHER PLAN SPONSORS.—

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

12 “(i) any cause of action against a
13 group health plan or an employer or other
14 plan sponsor maintaining the plan (or
15 against an employee of such a plan, em-
16 ployer, or sponsor acting within the scope
17 of employment), or

18 “(ii) a right of recovery, indemnity, or
19 contribution by a person against a group
20 health plan or an employer or other plan
21 sponsor (or such an employee) for damages
22 assessed against the person pursuant to a
23 cause of action under paragraph (1).

24 “(B) SPECIAL RULE.—Subparagraph (A)
25 shall not preclude any cause of action described

1 in paragraph (1) against group health plan or
2 an employer or other plan sponsor (or against
3 an employee of such a plan, employer, or spon-
4 sor acting within the scope of employment) if—

5 “(i) such action is based on the exer-
6 cise by the plan, employer, or sponsor (or
7 employee) of discretionary authority to
8 make a decision on a claim for benefits
9 covered under the plan or health insurance
10 coverage in the case at issue; and

11 “(ii) the exercise by the plan, em-
12 ployer, or sponsor (or employee) of such
13 authority resulted in personal injury or
14 wrongful death.

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

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

20 “(ii) any decision to provide extra-con-
21 tractual benefits; or

22 “(iii) any decision not to consider the
23 provision of a benefit while internal or ex-
24 ternal review is being conducted.

1 “(3) FUTILITY OF EXHAUSTION.—An individual
2 bringing an action under this subsection is required
3 to exhaust administrative processes under sections
4 1102 and 1103 of the Bipartisan Consensus Man-
5 aged Care Improvement Act of 1999, unless the in-
6 jury to or death of such individual has occurred be-
7 fore the completion of such processes.

8 “(4) CONSTRUCTION.—Nothing in this sub-
9 section shall be construed as—

10 “(A) permitting a cause of action under
11 State law for the failure to provide an item or
12 service which is specifically excluded under the
13 group health plan involved;

14 “(B) as preempting a State law which re-
15 quires an affidavit or certificate of merit in a
16 civil action; or

17 “(C) permitting a cause of action or rem-
18 edy under State law in connection with the pro-
19 vision or arrangement of excepted benefits (as
20 defined in section 733(c)), other than those de-
21 scribed in section 733(c)(2)(A).

22 “(g) RULES OF CONSTRUCTION RELATING TO
23 HEALTH CARE.—Nothing in this title shall be construed
24 as—

1 “(1) permitting the application of State laws
2 that are otherwise superseded by this title and that
3 mandate the provision of specific benefits by a group
4 health plan (as defined in section 733(a)) or a mul-
5 tiple employer welfare arrangement (as defined in
6 section 3(40)), or

7 “(2) affecting any State law which regulates the
8 practice of medicine or provision of medical care, or
9 affecting any action based upon such a State law.”.

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

14 **SEC. 1303. LIMITATIONS ON ACTIONS.**

15 Section 502 of the Employee Retirement Income Se-
16 curity Act of 1974 (29 U.S.C. 1132) (as amended by sec-
17 tion 304(b)) is amended further by adding at the end the
18 following new subsection:

19 “(o)(1) Except as provided in this subsection, no ac-
20 tion may be brought under subsection (a)(1)(B), (a)(2),
21 or (a)(3) by a participant or beneficiary seeking relief
22 based on the application of any provision in section 1101,
23 subtitle B, or subtitle D of title XI of the Bipartisan Con-
24 sensus Managed Care Improvement Act of 1999 (as incor-
25 porated under section 714).

1 “(2) An action may be brought under subsection
2 (a)(1)(B), (a)(2), or (a)(3) by a participant or beneficiary
3 seeking relief based on the application of section 1101,
4 1113, 1114, 1115, 1116, 1117, 1119, or 1118(3) of the
5 Bipartisan Consensus Managed Care Improvement Act of
6 1999 (as incorporated under section 714) to the individual
7 circumstances of that participant or beneficiary, except
8 that—

9 “(A) such an action may not be brought or
10 maintained as a class action; and

11 “(B) in such an action, relief may only provide
12 for the provision of (or payment of) benefits, items,
13 or services denied to the individual participant or
14 beneficiary involved (and for attorney’s fees and the
15 costs of the action, at the discretion of the court)
16 and shall not provide for any other relief to the par-
17 ticipant or beneficiary or for any relief to any other
18 person.

19 “(3) Nothing in this subsection shall be construed as
20 affecting any action brought by the Secretary.”.

1 **TITLE XIV—APPLICATION TO**
2 **GROUP HEALTH PLANS**
3 **UNDER THE INTERNAL REV-**
4 **ENUE CODE OF 1986**

5 **SEC. 1401. AMENDMENTS TO THE INTERNAL REVENUE**
6 **CODE OF 1986.**

7 Subchapter B of chapter 100 of the Internal Revenue
8 Code of 1986 is amended—

9 (1) in the table of sections, by inserting after
10 the item relating to section 9812 the following new
11 item:

“Sec. 9813. Standard relating to patient freedom of choice.”;

12 and

13 (2) by inserting after section 9812 the fol-
14 lowing:

15 **“SEC. 9813. STANDARD RELATING TO PATIENTS’ BILL OF**
16 **RIGHTS.**

17 “A group health plan shall comply with the require-
18 ments of title XI of the Bipartisan Consensus Managed
19 Care Improvement Act of 1999 (as in effect as of the date
20 of the enactment of such Act), and such requirements
21 shall be deemed to be incorporated into this section.”.

1 **TITLE XV—EFFECTIVE DATES;**
2 **COORDINATION IN IMPLE-**
3 **MENTATION**

4 **SEC. 1501. EFFECTIVE DATES.**

5 (a) GROUP HEALTH COVERAGE.—

6 (1) IN GENERAL.—Subject to paragraph (2),
7 the amendments made by sections 1201(a), 1301,
8 1303, and 1401 (and title XI insofar as it relates to
9 such sections) shall apply with respect to group
10 health plans, and health insurance coverage offered
11 in connection with group health plans, for plan years
12 beginning on or after January 1, 2001 (in this sec-
13 tion referred to as the “general effective date”) and
14 also shall apply to portions of plan years occurring
15 on and after such date.

16 (2) TREATMENT OF COLLECTIVE BARGAINING
17 AGREEMENTS.—In the case of a group health plan
18 maintained pursuant to one or more collective bar-
19 gaining agreements between employee representa-
20 tives and one or more employers ratified before the
21 date of the enactment of this Act, the amendments
22 made by sections 1201(a), 1301, 1303, and 1401
23 (and title XI insofar as it relates to such sections)
24 shall not apply to plan years beginning before the
25 later of—

1 (A) the date on which the last collective
2 bargaining agreements relating to the plan ter-
3 minates (determined without regard to any ex-
4 tension thereof agreed to after the date of the
5 enactment of this Act); or

6 (B) the general effective date.

7 For purposes of subparagraph (A), any plan amend-
8 ment made pursuant to a collective bargaining
9 agreement relating to the plan which amends the
10 plan solely to conform to any requirement added by
11 this division shall not be treated as a termination of
12 such collective bargaining agreement.

13 (b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—
14 The amendments made by section 1202 shall apply with
15 respect to individual health insurance coverage offered,
16 sold, issued, renewed, in effect, or operated in the indi-
17 vidual market on or after the general effective date.

18 **SEC. 1502. COORDINATION IN IMPLEMENTATION.**

19 The Secretary of Labor, the Secretary of Health and
20 Human Services, and the Secretary of the Treasury shall
21 ensure, through the execution of an interagency memo-
22 randum of understanding among such Secretaries, that—

23 (1) regulations, rulings, and interpretations
24 issued by such Secretaries relating to the same mat-
25 ter over which such Secretaries have responsibility

1 under the provisions of this division (and the amend-
2 ments made thereby) are administered so as to have
3 the same effect at all times; and

4 (2) coordination of policies relating to enforcing
5 the same requirements through such Secretaries in
6 order to have a coordinated enforcement strategy
7 that avoids duplication of enforcement efforts and
8 assigns priorities in enforcement.

9 **TITLE XVI—HEALTH CARE** 10 **PAPERWORK SIMPLIFICATION**

11 **SEC. 1601. HEALTH CARE PAPERWORK SIMPLIFICATION.**

12 (a) ESTABLISHMENT OF PANEL.—

13 (1) ESTABLISHMENT.—There is established a
14 panel to be known as the Health Care Panel to De-
15 vise a Uniform Explanation of Benefits (in this sec-
16 tion referred to as the “Panel”).

17 (2) DUTIES OF PANEL.—

18 (A) IN GENERAL.—The Panel shall devise
19 a single form for use by third-party health care
20 payers for the remittance of claims to providers.

21 (B) DEFINITION.—For purposes of this
22 section, the term “third-party health care
23 payer” means any entity that contractually
24 pays health care bills for an individual.

25 (3) MEMBERSHIP.—

1 (A) SIZE AND COMPOSITION.—The Sec-
2 retary of Health and Human Services shall de-
3 termine the number of members and the com-
4 position of the Panel. Such Panel shall include
5 equal numbers of representatives of private in-
6 surance organizations, consumer groups, State
7 insurance commissioners, State medical soci-
8 eties, State hospital associations, and State
9 medical specialty societies.

10 (B) TERMS OF APPOINTMENT.—The mem-
11 bers of the Panel shall serve for the life of the
12 Panel.

13 (C) VACANCIES.—A vacancy in the Panel
14 shall not affect the power of the remaining
15 members to execute the duties of the Panel, but
16 any such vacancy shall be filled in the same
17 manner in which the original appointment was
18 made.

19 (4) PROCEDURES.—

20 (A) MEETINGS.—The Panel shall meet at
21 the call of a majority of its members.

22 (B) FIRST MEETING.—The Panel shall
23 convene not later than 60 days after the date
24 of the enactment of the Bipartisan Consensus
25 Managed Care Improvement Act of 1999.

1 (C) QUORUM.—A quorum shall consist of
2 a majority of the members of the Panel.

3 (D) HEARINGS.—For the purpose of car-
4 rying out its duties, the Panel may hold such
5 hearings and undertake such other activities as
6 the Panel determines to be necessary to carry
7 out its duties.

8 (5) ADMINISTRATION.—

9 (A) COMPENSATION.—Except as provided
10 in subparagraph (B), members of the Panel
11 shall receive no additional pay, allowances, or
12 benefits by reason of their service on the Panel.

13 (B) TRAVEL EXPENSES AND PER DIEM.—
14 Each member of the Panel who is not an officer
15 or employee of the Federal Government shall
16 receive travel expenses and per diem in lieu of
17 subsistence in accordance with sections 5702
18 and 5703 of title 5, United States Code.

19 (C) CONTRACT AUTHORITY.—The Panel
20 may contract with and compensate Government
21 and private agencies or persons for items and
22 services, without regard to section 3709 of the
23 Revised Statutes (41 U.S.C. 5).

24 (D) USE OF MAILS.—The Panel may use
25 the United States mails in the same manner

1 and under the same conditions as Federal agen-
2 cies and shall, for purposes of the frank, be
3 considered a commission of Congress as de-
4 scribed in section 3215 of title 39, United
5 States Code.

6 (E) ADMINISTRATIVE SUPPORT SERV-
7 ICES.—Upon the request of the Panel, the Sec-
8 retary of Health and Human Services shall pro-
9 vide to the Panel on a reimbursable basis such
10 administrative support services as the Panel
11 may request.

12 (6) SUBMISSION OF FORM.—Not later than 2
13 years after the first meeting, the Panel shall submit
14 a form to the Secretary of Health and Human Serv-
15 ices for use by third-party health care payers.

16 (7) TERMINATION.—The Panel shall terminate
17 on the day after submitting the form under para-
18 graph (6).

19 (b) REQUIREMENT FOR USE OF FORM BY THIRD-
20 PARTY CARE PAYERS.—A third-party health care payer
21 shall be required to use the form devised under subsection

- 1 (a) for plan years beginning on or after 5 years following
- 2 the date of the enactment of this Act.

Passed the House of Representatives October 7,
1999.

Attest:

JEFF TRANDAHL,
Clerk.