

106TH CONGRESS
1ST SESSION

H. R. 448

To provide new patient protections under group health plans.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 2, 1999

Mr. BILIRAKIS (for himself, Mr. HASTERT, Mr. UPTON, Mr. TALENT, Mr. GOODLING, Mr. GILLMOR, Mr. CUNNINGHAM, Mr. ENGLISH, Mr. GOSS, Ms. PRYCE of Ohio, Mr. HILL of Montana, Mr. ARMEY, and Mr. OXLEY) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Education and the Workforce, Ways and Means, and the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To provide new patient protections under group health plans.

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

3 **SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.**

4 (a) **SHORT TITLE.**—This Act may be cited as the
5 “Patient Protection Act of 1999”.

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

Sec. 1. Short title and table of contents.

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

Subtitle A—Patient Protections

- Sec. 1001. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, and pediatric care.
- Sec. 1002. Effective date and related rules.

Subtitle B—Patient Access to Information

- Sec. 1101. Patient access to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.
- Sec. 1102. Effective date.

Subtitle C—New Procedures and Access to Courts for Grievances Arising
under Group Health Plans

- Sec. 1201. Special rules for group health plans.
- Sec. 1202. Effective date.

Subtitle D—Affordable Health Coverage for Employees of Small Businesses

- Sec. 1301. Short title of subtitle.
- Sec. 1302. Rules governing association health plans.
- Sec. 1303. Clarification of treatment of single employer arrangements.
- Sec. 1304. Clarification of treatment of certain collectively bargained arrangements.
- Sec. 1305. Enforcement provisions relating to association health plans.
- Sec. 1306. Cooperation between Federal and State authorities.
- Sec. 1307. Effective date and transitional and other rules.

TITLE II—AMENDMENTS TO PUBLIC HEALTH SERVICE ACT

Subtitle A—Patient Protections and Point of Service Coverage Requirements

- Sec. 2001. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care.
- Sec. 2002. Requiring health maintenance organizations to offer option of point-of-service coverage.

Subtitle B—Patient Access to Information

- Sec. 2101. Patient access to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.
- Sec. 2102. Effective date.

Subtitle C—HealthMarts

- Sec. 2201. Short title of subtitle.
- Sec. 2202. Expansion of consumer choice through HealthMarts.

Subtitle D—Community Health Organizations

- Sec. 2301. Promotion of provision of insurance by community health organizations.

TITLE III—AMENDMENTS TO THE INTERNAL REVENUE CODE OF
1986

Subtitle A—Patient Protections

- Sec. 3001. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, and pediatric care.
- Sec. 3002. Effective date and related rules.

Subtitle B—Patient Access to Information

- Sec. 3101. Patient access to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.
- Sec. 3102. Effective date.

Subtitle C—Medical Savings Accounts

- Sec. 3201. Expansion of availability of medical savings accounts.
- Sec. 3202. Exception from insurance limitation in case of medical savings accounts.
- Sec. 3203. Sense of the House of Representatives.

TITLE IV—HEALTH CARE LAWSUIT REFORM

Subtitle A—General Provisions

- Sec. 4001. Federal reform of health care liability actions.
- Sec. 4002. Definitions.
- Sec. 4003. Effective date.

Subtitle B—Uniform Standards for Health Care Liability Actions

- Sec. 4011. Statute of limitations.
- Sec. 4012. Calculation and payment of damages.
- Sec. 4013. Alternative dispute resolution.
- Sec. 4014. Reporting on fraud and abuse enforcement activities.

TITLE V—CONFIDENTIALITY OF HEALTH INFORMATION

- Sec. 5001. Confidentiality of protected health information.
- Sec. 5002. Study and report on effect of State law on health-related research.
- Sec. 5003. Study and report on State law on protected health information.
- Sec. 5004. Protection for certain information developed to reduce mortality or morbidity or for improving patient care and safety.

1 **TITLE I—AMENDMENTS TO THE**
 2 **EMPLOYEE RETIREMENT IN-**
 3 **COME SECURITY ACT OF 1974**
 4 **Subtitle A—Patient Protections**

5 **SEC. 1001. PATIENT ACCESS TO UNRESTRICTED MEDICAL**
 6 **ADVICE, EMERGENCY MEDICAL CARE, OB-**
 7 **STETRIC AND GYNECOLOGICAL CARE, AND**
 8 **PEDIATRIC CARE.**

9 (a) IN GENERAL.—Subpart B of part 7 of subtitle
 10 B of title I of the Employee Retirement Income Security
 11 Act of 1974 is amended by adding at the end the following
 12 new section:

13 **“SEC. 714. PATIENT ACCESS TO UNRESTRICTED MEDICAL**
 14 **ADVICE, EMERGENCY MEDICAL CARE, OB-**
 15 **STETRIC AND GYNECOLOGICAL CARE, PEDI-**
 16 **ATRIC CARE.**

17 **“(a) PATIENT ACCESS TO UNRESTRICTED MEDICAL**
 18 **ADVICE.—**

19 **“(1) IN GENERAL.—**In the case of any health
 20 care professional acting within the lawful scope of
 21 practice in the course of carrying out a contractual
 22 employment arrangement or other direct contractual
 23 arrangement between such professional and a group
 24 health plan or a health insurance issuer offering
 25 health insurance coverage in connection with a group

1 health plan, the plan or issuer with which such con-
2 tractual employment arrangement or other direct
3 contractual arrangement is maintained by the pro-
4 fessional may not impose on such professional under
5 such arrangement any prohibition or restriction with
6 respect to advice, provided to a participant or bene-
7 ficiary under the plan who is a patient, about the
8 health status of the participant or beneficiary or the
9 medical care or treatment for the condition or dis-
10 ease of the participant or beneficiary, regardless of
11 whether benefits for such care or treatment are pro-
12 vided under the plan or health insurance coverage
13 offered in connection with the plan.

14 “(2) HEALTH CARE PROFESSIONAL DEFINED.—
15 For purposes of this subsection, the term ‘health
16 care professional’ means a physician (as defined in
17 section 1861(r) of the Social Security Act) or other
18 health care professional if coverage for the profes-
19 sional’s services is provided under the group health
20 plan for the services of the professional. Such term
21 includes a podiatrist, optometrist, chiropractor, psy-
22 chologist, dentist, physician assistant, physical or oc-
23 cupational therapist and therapy assistant, speech-
24 language pathologist, audiologist, registered or li-
25 censed practical nurse (including nurse practitioner,

1 clinical nurse specialist, certified registered nurse
2 anesthetist, and certified nurse-midwife), licensed
3 certified social worker, registered respiratory thera-
4 pist, and certified respiratory therapy technician.

5 “(b) PATIENT ACCESS TO EMERGENCY MEDICAL
6 CARE.—

7 “(1) IN GENERAL.—To the extent that the
8 group health plan (or health insurance issuer offer-
9 ing health insurance coverage in connection with the
10 plan) provides for any benefits consisting of emer-
11 gency medical care (as defined in section
12 503(b)(9)(I)), except for items or services specifi-
13 cally excluded—

14 “(A) the plan or issuer shall provide bene-
15 fits, without requiring preauthorization and
16 without regard to otherwise applicable network
17 limitations, for appropriate emergency medical
18 screening examinations (within the capability of
19 the emergency facility, including ancillary serv-
20 ices routinely available to the emergency facil-
21 ity) to the extent that a prudent layperson, who
22 possesses an average knowledge of health and
23 medicine, would determine such examinations to
24 be necessary in order to determine whether

1 emergency medical care (as so defined) is re-
2 quired; and

3 “(B) the plan or issuer shall provide bene-
4 fits for additional emergency medical services
5 following an emergency medical screening exam-
6 ination (if determined necessary under subpara-
7 graph (A)) to the extent that a prudent emer-
8 gency medical professional would determine
9 such additional emergency services to be nec-
10 essary to avoid the consequences described in
11 section 503(b)(9)(I).

12 “(2) UNIFORM COST-SHARING REQUIRED.—
13 Nothing in this subsection shall be construed as pre-
14 venting a group health plan or issuer from imposing
15 any form of cost-sharing applicable to any partici-
16 pant or beneficiary (including coinsurance, copay-
17 ments, deductibles, and any other charges) in rela-
18 tion to benefits described in paragraph (1), if such
19 form of cost-sharing is uniformly applied under such
20 plan, with respect to similarly situated participants
21 and beneficiaries, to all benefits consisting of emer-
22 gency medical care (as defined in section
23 503(b)(9)(I)) provided to such similarly situated
24 participants and beneficiaries under the plan.

1 “(c) PATIENT ACCESS TO OBSTETRIC AND GYNECO-
2 LOGICAL CARE.—

3 “(1) IN GENERAL.—In any case in which a
4 group health plan (or a health insurance issuer of-
5 fering health insurance coverage in connection with
6 the plan)—

7 “(A) provides benefits under the terms of
8 the plan consisting of—

9 “(i) routine gynecological care (such
10 as preventive women’s health examina-
11 tions); or

12 “(ii) routine obstetric care (such as
13 routine pregnancy-related services),
14 provided by a participating physician who spe-
15 cializes in such care (or provides benefits con-
16 sisting of payment for such care); and

17 “(B) the plan requires or provides for des-
18 ignation by a participant or beneficiary of a
19 participating primary care provider,
20 if the primary care provider designated by such a
21 participant or beneficiary is not such a physician,
22 then the plan (or issuer) shall meet the requirements
23 of paragraph (2).

24 “(2) REQUIREMENTS.—A group health plan (or
25 a health insurance issuer offering health insurance

1 coverage in connection with the plan) meets the re-
2 quirements of this paragraph, in connection with
3 benefits described in paragraph (1) consisting of
4 care described in clause (i) or (ii) of paragraph
5 (1)(A) (or consisting of payment therefor), if the
6 plan (or issuer)—

7 “(A) does not require authorization or a
8 referral by the primary care provider in order
9 to obtain such benefits; and

10 “(B) treats the ordering of other routine
11 care of the same type, by the participating phy-
12 sician providing the care described in clause (i)
13 or (ii) of paragraph (1)(A), as the authorization
14 of the primary care provider with respect to
15 such care.

16 “(3) CONSTRUCTION.—Nothing in paragraph
17 (2)(B) shall waive any requirements of coverage re-
18 lating to medical necessity or appropriateness with
19 respect to coverage of gynecological or obstetric care
20 so ordered.

21 “(d) PATIENT ACCESS TO PEDIATRIC CARE.—

22 “(1) IN GENERAL.—In any case in which a
23 group health plan (or a health insurance issuer of-
24 fering health insurance coverage in connection with
25 the plan) provides benefits consisting of routine pe-

1 diatric care provided by a participating physician
 2 who specializes in pediatrics (or consisting of pay-
 3 ment for such care) and the plan requires or pro-
 4 vides for designation by a participant or beneficiary
 5 of a participating primary care provider, the plan (or
 6 issuer) shall provide that such a participating physi-
 7 cian may be designated, if available, by a parent or
 8 guardian of any beneficiary under the plan who is
 9 under 18 years of age, as the primary care provider
 10 with respect to any such benefits.

11 “(2) CONSTRUCTION.—Nothing in paragraph
 12 (1) shall waive any requirements of coverage relating
 13 to medical necessity or appropriateness with respect
 14 to coverage of pediatric care.

15 “(e) TREATMENT OF MULTIPLE COVERAGE OP-
 16 TIONS.—In the case of a plan providing benefits under two
 17 or more coverage options, the requirements of subsections
 18 (c) and (d) shall apply separately with respect to each cov-
 19 erage option.”.

20 “(b) CONFORMING AMENDMENT.—The table of con-
 21 tents in section 1 of such Act is amended by adding at
 22 the end of the items relating to subpart B of part 7 of
 23 subtitle B of title I of such Act the following new item:

“Sec. 714. Patient access to unrestricted medical advice, emergency medical
 care, obstetric and gynecological care, and pediatric care.”.

1 **SEC. 1002. EFFECTIVE DATE AND RELATED RULES.**

2 (a) IN GENERAL.—The amendments made by this
3 subtitle shall apply with respect to plan years beginning
4 on or after January 1 of the second calendar year follow-
5 ing the date of the enactment of this Act, except that the
6 Secretary of Labor may issue regulations before such date
7 under such amendments. The Secretary shall first issue
8 regulations necessary to carry out the amendments made
9 by this section before the effective date thereof.

10 (b) LIMITATION ON ENFORCEMENT ACTIONS.—No
11 enforcement action shall be taken, pursuant to the amend-
12 ments made by this subtitle, against a group health plan
13 or health insurance issuer with respect to a violation of
14 a requirement imposed by such amendments before the
15 date of issuance of regulations issued in connection with
16 such requirement, if the plan or issuer has sought to com-
17 ply in good faith with such requirement.

18 (c) SPECIAL RULE FOR COLLECTIVE BARGAINING
19 AGREEMENTS.—In the case of a group health plan main-
20 tained pursuant to one or more collective bargaining
21 agreements between employee representatives and one or
22 more employers ratified before the date of the enactment
23 of this Act, the provisions of subsections (b), (c), and (d)
24 of section 714 of the Employee Retirement Income Secu-
25 rity Act of 1974 (as added by this subtitle) shall not apply
26 with respect to plan years beginning before the later of—

1 (1) the date on which the last of the collective
2 bargaining agreements relating to the plan termi-
3 nates (determined without regard to any extension
4 thereof agreed to after the date of the enactment of
5 this Act); or

6 (2) January 1, 2002.

7 For purposes of this subsection, any plan amendment
8 made pursuant to a collective bargaining agreement relat-
9 ing to the plan which amends the plan solely to conform
10 to any requirement added by this subtitle shall not be
11 treated as a termination of such collective bargaining
12 agreement.

13 (d) ASSURING COORDINATION.—The Secretary of
14 Labor, the Secretary of the Treasury, and the Secretary
15 of Health and Human Services shall ensure, through the
16 execution of an interagency memorandum of understand-
17 ing among such Secretaries, that—

18 (1) regulations, rulings, and interpretations
19 issued by such Secretaries relating to the same mat-
20 ter over which two or more such Secretaries have re-
21 sponsibility under the provisions of this subtitle, sec-
22 tion 2101, and subtitle A of title III (and the
23 amendments made thereby) are administered so as
24 to have the same effect at all times; and

1 (2) coordination of policies relating to enforcing
2 the same requirements through such Secretaries in
3 order to have a coordinated enforcement strategy
4 that avoids duplication of enforcement efforts and
5 assigns priorities in enforcement.

6 (e) TREATMENT OF RELIGIOUS NONMEDICAL PRO-
7 VIDERS.—

8 (1) IN GENERAL.—Nothing in this Act (or the
9 amendments made thereby) shall be construed to—

10 (A) restrict or limit the right of group
11 health plans, and of health insurance issuers of-
12 fering health insurance coverage in connection
13 with group health plans, to include as providers
14 religious nonmedical providers;

15 (B) require such plans or issuers to—

16 (i) utilize medically based eligibility
17 standards or criteria in deciding provider
18 status of religious nonmedical providers;

19 (ii) use medical professionals or cri-
20 teria to decide patient access to religious
21 nonmedical providers;

22 (iii) utilize medical professionals or
23 criteria in making decisions in internal or
24 external appeals from decisions denying or

1 limiting coverage for care by religious non-
2 medical providers; or

3 (iv) compel a participant or bene-
4 ficiary to undergo a medical examination
5 or test as a condition of receiving health
6 insurance coverage for treatment by a reli-
7 gious nonmedical provider; or

8 (C) require such plans or issuers to ex-
9 clude religious nonmedical providers because
10 they do not provide medical or other data other-
11 wise required, if such data is inconsistent with
12 the religious nonmedical treatment or nursing
13 care provided by the provider.

14 (2) RELIGIOUS NONMEDICAL PROVIDER.—For
15 purposes of this subsection, the term “religious non-
16 medical provider” means a provider who provides no
17 medical care but who provides only religious non-
18 medical treatment or religious nonmedical nursing
19 care.

**Subtitle B—Patient Access to
Information**

**SEC. 1101. PATIENT ACCESS TO INFORMATION REGARDING
PLAN COVERAGE, MANAGED CARE PROCE-
DURES, HEALTH CARE PROVIDERS, AND
QUALITY OF MEDICAL CARE.**

(a) IN GENERAL.—Part 1 of subtitle B of title I of
the Employee Retirement Income Security Act of 1974 is
amended—

(1) by redesignating section 111 as section 112;

and

(2) by inserting after section 110 the following
new section:

“DISCLOSURE BY GROUP HEALTH PLANS

“SEC. 111. (a) DISCLOSURE REQUIREMENT.—

“(1) GROUP HEALTH PLANS.—The adminis-
trator of each group health plan shall take such ac-
tions as are necessary to ensure that the summary
plan description of the plan required under section
102 (or each summary plan description in any case
in which different summary plan descriptions are ap-
propriate under part 1 for different options of cov-
erage) contains, among any information otherwise
required under this part, the information required
under subsections (b), (c), (d), and (e)(2)(A).

1 “(2) HEALTH INSURANCE ISSUERS.—Each
 2 health insurance issuer offering health insurance
 3 coverage in connection with a group health plan
 4 shall provide the administrator on a timely basis
 5 with the information necessary to enable the admin-
 6 istrator to comply with the requirements of para-
 7 graph (1). To the extent that any such issuer pro-
 8 vides on a timely basis to plan participants and
 9 beneficiaries information otherwise required under
 10 this part to be included in the summary plan de-
 11 scription, the requirements of sections 101(a)(1) and
 12 104(b) shall be deemed satisfied in the case of such
 13 plan with respect to such information.

14 “(b) PLAN BENEFITS.—The information required
 15 under subsection (a) includes the following:

16 “(1) COVERED ITEMS AND SERVICES.—

17 “(A) CATEGORIZATION OF INCLUDED BEN-
 18 EFITS.—A description of covered benefits, cat-
 19 egorized by—

20 “(i) types of items and services (in-
 21 cluding any special disease management
 22 program); and

23 “(ii) types of health care professionals
 24 providing such items and services.

1 “(B) EMERGENCY MEDICAL CARE.—A de-
2 scription of the extent to which the plan covers
3 emergency medical care (including the extent to
4 which the plan provides for access to urgent
5 care centers), and any definitions provided
6 under the plan for the relevant plan terminol-
7 ogy referring to such care.

8 “(C) PREVENTATIVE SERVICES.—A de-
9 scription of the extent to which the plan pro-
10 vides benefits for preventative services.

11 “(D) DRUG FORMULARIES.—A description
12 of the extent to which covered benefits are de-
13 termined by the use or application of a drug
14 formulary and a summary of the process for de-
15 termining what is included in such formulary.

16 “(E) COBRA CONTINUATION COV-
17 ERAGE.—A description of the benefits available
18 under the plan pursuant to part 6.

19 “(2) LIMITATIONS, EXCLUSIONS, AND RESTRIC-
20 TIONS ON COVERED BENEFITS.—

21 “(A) CATEGORIZATION OF EXCLUDED
22 BENEFITS.—A description of benefits specifi-
23 cally excluded from coverage, categorized by
24 types of items and services.

1 “(B) UTILIZATION REVIEW AND
2 PREAUTHORIZATION REQUIREMENTS.—Whether
3 coverage for medical care is limited or excluded
4 on the basis of utilization review or
5 preauthorization requirements.

6 “(C) LIFETIME, ANNUAL, OR OTHER PE-
7 RIOD LIMITATIONS.—A description of the cir-
8 cumstances under which, and the extent to
9 which, coverage is subject to lifetime, annual, or
10 other period limitations, categorized by types of
11 benefits.

12 “(D) CUSTODIAL CARE.—A description of
13 the circumstances under which, and the extent
14 to which, the coverage of benefits for custodial
15 care is limited or excluded, and a statement of
16 the definition used by the plan for custodial
17 care.

18 “(E) EXPERIMENTAL TREATMENTS.—
19 Whether coverage for any medical care is lim-
20 ited or excluded because it constitutes experi-
21 mental treatment or technology, and any defini-
22 tions provided under the plan for the relevant
23 plan terminology referring to such limited or
24 excluded care.

1 “(F) MEDICAL APPROPRIATENESS OR NE-
2 CESSITY.—Whether coverage for medical care
3 may be limited or excluded by reason of a fail-
4 ure to meet the plan’s requirements for medical
5 appropriateness or necessity, and any defini-
6 tions provided under the plan for the relevant
7 plan terminology referring to such limited or
8 excluded care.

9 “(G) SECOND OR SUBSEQUENT OPIN-
10 IONS.—A description of the circumstances
11 under which, and the extent to which, coverage
12 for second or subsequent opinions is limited or
13 excluded.

14 “(H) SPECIALTY CARE.—A description of
15 the circumstances under which, and the extent
16 to which, coverage of benefits for specialty care
17 is conditioned on referral from a primary care
18 provider.

19 “(I) CONTINUITY OF CARE.—A description
20 of the circumstances under which, and the ex-
21 tent to which, coverage of items and services
22 provided by any health care professional is lim-
23 ited or excluded by reason of the departure by
24 the professional from any defined set of provid-
25 ers.

1 “(J) RESTRICTIONS ON COVERAGE OF
2 EMERGENCY SERVICES.—A description of the
3 circumstances under which, and the extent to
4 which, the plan, in covering emergency medical
5 care furnished to a participant or beneficiary of
6 the plan imposes any financial responsibility de-
7 scribed in subsection (c) on participants or
8 beneficiaries or limits or conditions benefits for
9 such care subject to any other term or condition
10 of such plan.

11 “(c) PARTICIPANT’S FINANCIAL RESPONSIBIL-
12 ITIES.—The information required under subsection (a) in-
13 cludes an explanation of—

14 “(1) a participant’s financial responsibility for
15 payment of premiums, coinsurance, copayments,
16 deductibles, and any other charges; and

17 “(2) the circumstances under which, and the
18 extent to which, the participant’s financial respon-
19 sibility described in paragraph (1) may vary, includ-
20 ing any distinctions based on whether a health care
21 provider from whom covered benefits are obtained is
22 included in a defined set of providers.

23 “(d) DISPUTE RESOLUTION PROCEDURES.—The in-
24 formation required under subsection (a) includes a de-

1 scription of the processes adopted by the plan pursuant
2 to section 503(b), including—

3 “(1) descriptions thereof relating specifically
4 to—

5 “(A) coverage decisions;

6 “(B) internal review of coverage decisions;

7 and

8 “(C) any external review of coverage deci-
9 sions; and

10 “(2) the procedures and time frames applicable
11 to each step of the processes referred to in subpara-
12 graphs (A), (B), and (C) of paragraph (1).

13 “(e) INFORMATION AVAILABLE ON REQUEST.—

14 “(1) ACCESS TO PLAN BENEFIT INFORMATION
15 IN ELECTRONIC FORM.—

16 “(A) IN GENERAL.—In addition to the in-
17 formation required to be provided under section
18 104(b)(4), a group health plan (and a health
19 insurance issuer offering health insurance cov-
20 erage in connection with a group health plan)
21 shall, upon written request (made not more fre-
22 quently than annually), make available to par-
23 ticipants and beneficiaries, in a generally recog-
24 nized electronic format, the following informa-
25 tion:

1 “(i) the latest summary plan descrip-
2 tion, including the latest summary of ma-
3 terial modifications; and

4 “(ii) the actual plan provisions setting
5 forth the benefits available under the plan
6 to the extent such information relates to the
7 coverage options under the plan available to the
8 participant or beneficiary. A reasonable charge
9 may be made to cover the cost of providing
10 such information in such generally recognized
11 electronic format. The Secretary may by regula-
12 tion prescribe a maximum amount which will
13 constitute a reasonable charge under the pre-
14 ceding sentence.

15 “(B) ALTERNATIVE ACCESS.—The require-
16 ments of this paragraph may be met by making
17 such information generally available (rather
18 than upon request) on the Internet or on a pro-
19 prietary computer network in a format which is
20 readily accessible to participants and bene-
21 ficiaries.

22 “(2) ADDITIONAL INFORMATION TO BE PRO-
23 VIDED ON REQUEST.—

24 “(A) INCLUSION IN SUMMARY PLAN DE-
25SCRIPTION OF SUMMARY OF ADDITIONAL IN-

1 FORMATION.—The information required under
2 subsection (a) includes a summary description
3 of the types of information required by this
4 subsection to be made available to participants
5 and beneficiaries on request.

6 “(B) INFORMATION REQUIRED FROM
7 PLANS AND ISSUERS ON REQUEST.—In addition
8 to information required to be included in sum-
9 mary plan descriptions under this subsection, a
10 group health plan (and a health insurance
11 issuer offering health insurance coverage in
12 connection with a group health plan) shall pro-
13 vide the following information to a participant
14 or beneficiary on request:

15 “(i) NETWORK CHARACTERISTICS.—If
16 the plan (or issuer) utilizes a defined set of
17 providers under contract with the plan (or
18 issuer), a detailed list of the names of such
19 providers and their geographic location, set
20 forth separately with respect to primary
21 care providers and with respect to special-
22 ists.

23 “(ii) CARE MANAGEMENT INFORMA-
24 TION.—A description of the circumstances
25 under which, and the extent to which, the

1 plan has special disease management pro-
2 grams or programs for persons with dis-
3 abilities, indicating whether these pro-
4 grams are voluntary or mandatory and
5 whether a significant benefit differential
6 results from participation in such pro-
7 grams.

8 “(iii) INCLUSION OF DRUGS AND
9 BIOLOGICALS IN FORMULARIES.—A state-
10 ment of whether a specific drug or biologi-
11 cal is included in a formulary used to de-
12 termine benefits under the plan and a de-
13 scription of the procedures for considering
14 requests for any patient-specific waivers.

15 “(iv) PROCEDURES FOR DETERMINING
16 EXCLUSIONS BASED ON MEDICAL NECES-
17 SITY OR EXPERIMENTAL TREATMENTS.—
18 Upon receipt by the participant or bene-
19 ficiary of any notification of an adverse
20 coverage decision based on a determination
21 relating to medical necessity or an experi-
22 mental treatment or technology, a descrip-
23 tion of the procedures and medically-based
24 criteria used in such decision.

1 “(v) PREAUTHORIZATION AND UTILI-
2 ZATION REVIEW PROCEDURES.—Upon re-
3 ceipt by the participant or beneficiary of
4 any notification of an adverse coverage de-
5 cision, a description of the basis on which
6 any preauthorization requirement or any
7 utilization review requirement has resulted
8 in such decision.

9 “(vi) ACCREDITATION STATUS OF
10 HEALTH INSURANCE ISSUERS AND SERV-
11 ICE PROVIDERS.—A description of the ac-
12 creditation and licensing status (if any) of
13 each health insurance issuer offering
14 health insurance coverage in connection
15 with the plan and of any utilization review
16 organization utilized by the issuer or the
17 plan, together with the name and address
18 of the accrediting or licensing authority.

19 “(vii) MEASURES OF ENROLLEE SAT-
20 ISFACTION.—The latest information (if
21 any) maintained by the plan, or by any
22 health insurance issuer offering health in-
23 surance coverage in connection with the
24 plan, relating to enrollee satisfaction.

1 “(viii) QUALITY PERFORMANCE MEAS-
2 URES.—The latest information (if any)
3 maintained by the plan, or by any health
4 insurance issuer offering health insurance
5 coverage in connection with the plan, relat-
6 ing to quality of performance of the deliv-
7 ery of medical care with respect to cov-
8 erage options offered under the plan and
9 of health care professionals and facilities
10 providing medical care under the plan.

11 “(ix) INFORMATION RELATING TO EX-
12 TERNAL REVIEWS.—The number of exter-
13 nal reviews under section 503(b)(4) that
14 have been completed during the prior plan
15 year and the number of such reviews in
16 which the recommendation reported under
17 section 503(b)(4)(C)(iii) includes a rec-
18 ommendation for modification or reversal
19 of an internal review decision under the
20 plan.

21 “(C) INFORMATION REQUIRED FROM
22 HEALTH CARE PROFESSIONALS ON REQUEST.—
23 Any health care professional treating a partici-
24 pant or beneficiary under a group health plan
25 shall provide to the participant or beneficiary,

1 on request, a description of his or her profes-
2 sional qualifications (including board certifi-
3 cation status, licensing status, and accreditation
4 status, if any), privileges, and experience and a
5 general description by category (including sal-
6 ary, fee-for-service, capitation, and such other
7 categories as may be specified in regulations of
8 the Secretary) of the applicable method by
9 which such professional is compensated in con-
10 nection with the provision of such medical care.

11 “(D) INFORMATION REQUIRED FROM
12 HEALTH CARE FACILITIES ON REQUEST.—Any
13 health care facility from which a participant or
14 beneficiary has sought treatment under a group
15 health plan shall provide to the participant or
16 beneficiary, on request, a description of the fa-
17 cility’s corporate form or other organizational
18 form and all forms of licensing and accredita-
19 tion status (if any) assigned to the facility by
20 standard-setting organizations.

21 “(f) ACCESS TO INFORMATION RELEVANT TO THE
22 COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT
23 OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition
24 to information otherwise required to be made available
25 under this section, a group health plan (and a health in-

1 surance issuer offering health insurance coverage in con-
 2 nection with a group health plan) shall, upon written re-
 3 quest (made not more frequently than annually), make
 4 available to a participant (and an employee who, under
 5 the terms of the plan, is eligible for coverage but not en-
 6 rolled) in connection with a period of enrollment the sum-
 7 mary plan description for any coverage option under the
 8 plan under which the participant is eligible to enroll and
 9 any information described in clauses (i), (ii), (iii), (vi),
 10 (vii), and (viii) of subsection (e)(2)(B).

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

19 “(1) by inclusion of information in publications
 20 broadly distributed by plan sponsors, employers, or
 21 employee organizations;

22 “(2) by electronic means of communication (in-
 23 cluding the Internet or proprietary computer net-
 24 works in a format which is readily accessible to par-
 25 ticipants);

1 “(3) by timely informing participants who,
2 under an ongoing program maintained under the
3 plan, have submitted their names for such notifica-
4 tion; or

5 “(4) by any other reasonable means of timely
6 informing plan participants.

7 “(h) DEFINITIONS.—For purposes of this section—

8 “(1) GROUP HEALTH PLAN.—The term ‘group
9 health plan’ has the meaning provided such term
10 under section 503(b)(8).

11 “(2) MEDICAL CARE.—The term ‘medical care’
12 has the meaning provided such term under section
13 733(a)(2).

14 “(3) HEALTH INSURANCE COVERAGE.—The
15 term ‘health insurance coverage’ has the meaning
16 provided such term under section 733(b)(1).

17 “(4) HEALTH INSURANCE ISSUER.—The term
18 ‘health insurance issuer’ has the meaning provided
19 such term under section 733(b)(2).”.

20 (b) CONFORMING AMENDMENTS.—

21 (1) Section 102(b) of such Act (29 U.S.C.
22 1022(b)) is amended—

23 (A) by striking “section 733(a)(1)” each
24 place it appears and inserting “section
25 503(b)(6)”; and

1 (B) by inserting before the period at the
 2 end the following: “; and, in the case of a group
 3 health plan (as defined in section 111(h)(1)),
 4 the information required to be included under
 5 section 111(a)”.

6 (2) The table of contents in section 1 of such
 7 Act is amended by striking the item relating to sec-
 8 tion 111 and inserting the following new items:

“Sec. 111. Disclosure by group health plans.

“Sec. 112. Repeal and effective date.”.

9 **SEC. 1102. EFFECTIVE DATE AND RELATED RULES.**

10 (a) IN GENERAL.—The amendments made by this
 11 subtitle shall apply with respect to plan years beginning
 12 on or after January 1 of the second calendar year follow-
 13 ing the date of the enactment of this Act. The Secretary
 14 shall first issue all regulations necessary to carry out the
 15 amendments made by this subtitle before such date.

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

1 (c) ASSURING COORDINATION.—The Secretary of
 2 Labor, the Secretary of Health and Human Services, and
 3 the Secretary of the Treasury shall ensure, through the
 4 execution of an interagency memorandum of understand-
 5 ing among such Secretaries, that—

6 (1) regulations, rulings, and interpretations
 7 issued by such Secretaries relating to the same mat-
 8 ter over which two or more such Secretaries have re-
 9 sponsibility under the provisions of this subtitle, sub-
 10 title B of title II, and subtitle B of title III (and the
 11 amendments made thereby) are administered so as
 12 to have the same effect at all times; and

13 (2) coordination of policies relating to enforcing
 14 the same requirements through such Secretaries in
 15 order to have a coordinated enforcement strategy
 16 that avoids duplication of enforcement efforts and
 17 assigns priorities in enforcement.

18 **Subtitle C—New Procedures and**
 19 **Access to Courts for Grievances**
 20 **Arising Under Group Health**
 21 **Plans**

22 **SEC. 1201. SPECIAL RULES FOR GROUP HEALTH PLANS.**

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

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

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

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

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

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

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

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

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

10 “(D) meet the additional requirements of
11 this subsection.

12 “(2) TIME LIMITS FOR MAKING INITIAL COV-
13 ERAGE DECISIONS FOR BENEFITS AND COMPLETING
14 INTERNAL APPEALS.—

15 “(A) TIME LIMITS FOR DECIDING RE-
16 QUESTS FOR BENEFIT PAYMENTS, REQUESTS
17 FOR ADVANCE DETERMINATION OF COVERAGE,
18 AND REQUESTS FOR REQUIRED DETERMINA-
19 TION OF MEDICAL NECESSITY.—Except as pro-
20 vided in subparagraph (B)—

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

1 reasonable form as may be required under
2 the plan, the plan shall issue in writing an
3 initial coverage decision on the request be-
4 fore the end of the initial decision period
5 under paragraph (9)(J) following the filing
6 completion date. Failure to issue a cov-
7 erage decision on such a request before the
8 end of the period required under this
9 clause shall be treated as an adverse cov-
10 erage decision for purposes of internal re-
11 view under clause (ii).

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

1 of the plan, subject to any applicable re-
2 consideration under paragraph (4). Failure
3 to issue before the end of such period such
4 a written decision requested under this
5 clause shall be treated as a final decision
6 affirming the initial coverage decision, sub-
7 ject to any applicable reconsideration
8 under paragraph (4).

9 “(B) TIME LIMITS FOR MAKING COVERAGE
10 DECISIONS RELATING TO URGENT AND EMER-
11 GENCY MEDICAL CARE AND FOR COMPLETING
12 INTERNAL APPEALS.—

13 “(i) INITIAL DECISIONS.—A group
14 health plan shall issue in writing an initial
15 coverage decision on any request for expe-
16 dited advance determination of coverage or
17 for expedited required determination of
18 medical necessity submitted, in such rea-
19 sonable form as may be required under the
20 plan—

21 “(I) before the end of the urgent
22 decision period under paragraph
23 (9)(L), in cases involving urgent med-
24 ical care but not involving emergency
25 medical care; or

1 “(II) before the end of the emer-
2 gency decision period under para-
3 graph (9)(M), in cases involving emer-
4 gency medical care,
5 following the filing completion date. Fail-
6 ure to approve or deny such a request be-
7 fore the end of the applicable decision pe-
8 riod shall be treated as a denial of the re-
9 quest for purposes of internal review under
10 clause (ii).

11 “(ii) INTERNAL REVIEWS OF INITIAL
12 DENIALS.—Upon the written request of a
13 participant or beneficiary for review of an
14 initial adverse coverage decision under
15 clause (i), a review by an appropriate
16 named fiduciary (subject to paragraph (3))
17 of the initial coverage decision shall be
18 completed, including issuance by the plan
19 of a written decision affirming, reversing,
20 or modifying the initial converge decision,
21 setting forth the grounds for the
22 decision—

23 “(I) before the end of the urgent
24 decision period under paragraph
25 (9)(L), in cases involving urgent med-

1 ical care but not involving emergency
2 medical care; or

3 “(II) before the end of the emer-
4 gency decision period under para-
5 graph (9)(M), in cases involving emer-
6 gency medical care,
7 following the review filing date. Such deci-
8 sion shall be treated as the final decision
9 of the plan, subject to any applicable re-
10 consideration under paragraph (4). Failure
11 to issue before the end of the applicable
12 decision period such a written decision re-
13 quested under this clause shall be treated
14 as a final decision affirming the initial cov-
15 erage decision, subject to any applicable re-
16 consideration under paragraph (4).

17 “(3) PHYSICIANS MUST REVIEW INITIAL COV-
18 ERAGE DECISIONS INVOLVING MEDICAL APPRO-
19 PRIATENESS OR NECESSITY OR EXPERIMENTAL
20 TREATMENT.—If an initial coverage decision under
21 paragraph (2)(A)(i) or (2)(B)(i) is based on a deter-
22 mination that provision of a particular item or serv-
23 ice is excluded from coverage under the terms of the
24 plan because the provision of such item or service
25 does not meet the plan’s requirements for medical

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

9 “(4) ELECTIVE EXTERNAL REVIEW BY INDE-
 10 PENDENT MEDICAL EXPERT AND RECONSIDERATION
 11 OF INITIAL REVIEW DECISION.—

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

14 “(i) in the case of any failure to time-
 15 ly issue a coverage decision upon internal
 16 review which is deemed to be an adverse
 17 coverage decision under paragraph
 18 (2)(A)(ii) or (2)(B)(ii) (thereby failing to
 19 constitute a coverage decision for which
 20 specific reasons have been set forth as re-
 21 quired under paragraph (1)(A)); and

22 “(ii) in the case of any adverse cov-
 23 erage decision which is not reversed upon
 24 a review conducted pursuant to paragraph
 25 (1)(C) (including any review pursuant to

1 paragraph (2)(A)(ii) or (2)(B)(ii)), if such
2 coverage decision is based on a determina-
3 tion that provision of a particular item or
4 service is excluded from coverage under the
5 terms of the plan because the provision of
6 such item or service—

7 “(I) does not meet the plan’s re-
8 quirements for medical appropriate-
9 ness or necessity; or

10 “(II) would constitute experi-
11 mental treatment or technology.

12 “(B) LIMITS ON ALLOWABLE ADVANCE
13 PAYMENTS.—The review under this paragraph
14 in connection with an adverse coverage decision
15 shall be available subject to any requirement of
16 the plan (unless waived by the plan for financial
17 or other reasons) for payment in advance to the
18 plan by the participant or beneficiary seeking
19 review of an amount not to exceed the greater
20 of—

21 “(i) the lesser of \$100 or 10 percent
22 of the cost of the medical care involved in
23 the decision; or

24 “(ii) \$25,

1 with each such dollar amount subject to com-
2 pounded annual adjustments in the same man-
3 ner and to the same extent as apply under sec-
4 tion 215(i) of the Social Security Act, except
5 that, for any calendar year, such amount as so
6 adjusted shall be deemed, solely for such cal-
7 endar year, to be equal to such amount rounded
8 to the nearest \$10. No such payment may be
9 required in the case of any participant or bene-
10 ficiary whose enrollment under the plan is paid
11 for, in whole or in part, under a State plan
12 under title XIX or XXI of the Social Security
13 Act. Any such advance payment shall be subject
14 to reimbursement if the recommendation of the
15 independent medical expert or experts under
16 subparagraph (C)(iii) is to reverse or modify
17 the coverage decision.

18 “(C) RECONSIDERATION OF INITIAL RE-
19 VIEW DECISION.—In any case in which a partic-
20 ipant or beneficiary who has received an ad-
21 verse decision of the plan upon initial review of
22 the coverage decision and who has not com-
23 menced review of the initial coverage decision
24 under section 502 makes a request in writing,
25 within 30 days after the date of such review de-

1 cision, for reconsideration of such review deci-
2 sion, the terms of the plan shall provide for a
3 procedure for such reconsideration under
4 which—

5 “(i) one or more independent medical
6 experts will be selected in accordance with
7 subparagraph (E) to review the coverage
8 decision described in subparagraph (A) to
9 determine whether such decision was in ac-
10 cordance with the terms of the plan and
11 this title;

12 “(ii) the record for review (including a
13 specification of the terms of the plan and
14 other criteria serving as the basis for the
15 initial review decision) will be presented to
16 such expert or experts and maintained in
17 a manner which will ensure confidentiality
18 of such record;

19 “(iii) such expert or experts will re-
20 port in writing to the plan their rec-
21 ommendation, based on the determination
22 made under clause (i), as to whether such
23 coverage decision should be affirmed, modi-
24 fied, or reversed, setting forth the grounds

(including the clinical basis) for the recommendation; and

“(iv) a physician who did not make the initial review decision will reconsider the initial review decision to determine whether such decision was in accordance with the terms of the plan and this title and will issue a written decision affirming, modifying, or reversing the initial review decision, taking into account any recommendations reported to the plan pursuant to clause (iii), and setting forth the grounds for the decision.

“(D) TIME LIMITS FOR RECONSIDERATION.—Any review under this paragraph shall be completed before the end of the reconsideration period (as defined in paragraph (9)(O)) following the review filing date in connection with such review. The decision under this paragraph affirming, reversing, or modifying the initial review decision of the plan shall be the final decision of the plan. Failure to issue a written decision before the end of the reconsideration period in any reconsideration requested under this paragraph shall be treated as a final deci-

1 sion affirming the initial review decision of the
2 plan.

3 “(E) INDEPENDENT MEDICAL EXPERTS.—

4 “(i) IN GENERAL.—For purposes of
5 this paragraph, the term ‘independent
6 medical expert’ means, in connection with
7 any coverage decision by a group health
8 plan, a professional—

9 “(I) who is a physician or, if ap-
10 propriate, another medical profes-
11 sional;

12 “(II) who has appropriate cre-
13 dentials and has attained recognized
14 expertise in the applicable medical
15 field;

16 “(III) who was not involved in
17 the initial decision or any earlier re-
18 view thereof; and

19 “(IV) who is selected in accord-
20 ance with clause (ii) and meets the re-
21 quirements of clause (iii).

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

1 “(I) the expert is selected by an
2 intermediary which itself meets the re-
3 quirements of clause (iii), by means of
4 a method which ensures that the iden-
5 tity of the expert is not disclosed to
6 the plan, any health insurance issuer
7 offering health insurance coverage to
8 the aggrieved participant or bene-
9 ficiary in connection with the plan,
10 and the aggrieved participant or bene-
11 ficiary under the plan, and the identi-
12 ties of the plan, the issuer, and the
13 aggrieved participant or beneficiary
14 are not disclosed to the expert;

15 “(II) the expert is selected, by an
16 appropriately credentialed panel of
17 physicians meeting the requirements
18 of clause (iii) established by a fully
19 accredited teaching hospital meeting
20 such requirements;

21 “(III) the expert is selected by an
22 organization described in section
23 1152(1)(A) of the Social Security Act
24 which meets the requirements of
25 clause (iii);

1 “(IV) the expert is selected by an
2 external review organization which
3 meets the requirements of clause (iii)
4 and is accredited by a private stand-
5 ard-setting organization meeting such
6 requirements and recognized as such
7 by the Secretary; or

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

14 and the method of selection is devised to
15 reasonably ensure that the expert selected
16 meets the independence requirements of
17 clause (iii).

18 “(iii) INDEPENDENCE REQUIRE-
19 MENTS.—An independent medical expert
20 or another entity described in clause (ii)
21 meets the independence requirements of
22 this clause if—

23 “(I) the expert or entity is not
24 affiliated with any related party;

1 “(II) any compensation received
2 by such expert or entity in connection
3 with the external review is reasonable
4 and not contingent on any decision
5 rendered by the expert or entity;

6 “(III) under the terms of the
7 plan and any health insurance cov-
8 erage offered in connection with the
9 plan, the plan and the issuer (if any)
10 have no recourse against the expert or
11 entity in connection with the external
12 review; and

13 “(IV) the expert or entity does
14 not otherwise have a conflict of inter-
15 est with a related party as determined
16 under any regulations which the Sec-
17 retary may prescribe.

18 “(iv) RELATED PARTY.—For purposes
19 of clause (ii)(I), the term ‘related party’
20 means—

21 “(I) the plan or any health insur-
22 ance issuer offering health insurance
23 coverage in connection with the plan
24 (or any officer, director, or manage-
25 ment employee of such plan or issuer);

1 “(II) the physician or other medi-
2 cal care provider that provided the
3 medical care involved in the coverage
4 decision;

5 “(III) the institution at which
6 the medical care involved in the cov-
7 erage decision is provided;

8 “(IV) the manufacturer of any
9 drug or other item that was included
10 in the medical care involved in the
11 coverage decision; or

12 “(V) any other party determined
13 under any regulations which the Sec-
14 retary may prescribe to have a sub-
15 stantial interest in the coverage deci-
16 sion.

17 “(v) AFFILIATED.—For purposes of
18 clause (iii)(I), the term ‘affiliated’ means,
19 in connection with any entity, having a fa-
20 milial, financial, or professional relation-
21 ship with, or interest in, such entity.

22 “(F) INAPPLICABILITY WITH RESPECT TO
23 ITEMS AND SERVICES SPECIFICALLY EXCLUDED
24 FROM COVERAGE.—An adverse coverage deci-
25 sion based on a determination that an item or

1 service is excluded from coverage under the
 2 terms of the plan shall not be subject to review
 3 under this paragraph, unless such determina-
 4 tion is found in such decision to be based solely
 5 on the fact that the item or service—

6 “(i) does not meet the plan’s require-
 7 ments for medical appropriateness or ne-
 8 cessity; or

9 “(ii) would constitute experimental
 10 treatment or technology (as defined under
 11 the plan).

12 “(5) PERMITTED ALTERNATIVES TO REQUIRED
 13 INTERNAL REVIEW.—

14 “(A) IN GENERAL.—A group health plan
 15 shall not be treated as failing to meet the re-
 16 quirements under paragraphs (2)(A)(ii) and
 17 (2)(B)(ii) relating to review of initial coverage
 18 decisions for benefits, if—

19 “(i) in lieu of the procedures relating
 20 to review under paragraphs (2)(A)(ii) and
 21 (2)(B)(ii) and in accordance with such reg-
 22 ulations (if any) as may be prescribed by
 23 the Secretary—

24 “(I) the aggrieved participant or
 25 beneficiary elects in the request for

1 the review an alternative dispute reso-
2 lution procedure which is available
3 under the plan with respect to simi-
4 larly situated participants and bene-
5 ficiaries; or

6 “(II) in the case of any such plan
7 or portion thereof which is established
8 and maintained pursuant to a bona
9 fide collective bargaining agreement,
10 the plan provides for a procedure by
11 which such disputes are resolved by
12 means of any alternative dispute reso-
13 lution procedure;

14 “(ii) the time limits not exceeding the
15 time limits otherwise applicable under
16 paragraphs (2)(A)(ii) and (2)(B)(ii) are in-
17 corporated in such alternative dispute reso-
18 lution procedure;

19 “(iii) any applicable requirement for
20 review by a physician under paragraph (3),
21 unless waived by the participant or bene-
22 ficiary (in a manner consistent with such
23 regulations as the Secretary may prescribe
24 to ensure equitable procedures), is incor-

porated in such alternative dispute resolution procedure; and

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

In any case in which a procedure described in subclause (I) or (II) of clause (i) is utilized and an alternative dispute resolution procedure is voluntarily elected by the aggrieved participant or beneficiary, the plan may require or allow (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures) the aggrieved participant or beneficiary to waive review of the coverage decision under paragraph (3), to waive further review of the coverage decision under paragraph (4) or section 502, and to elect an alternative means of external review (other than review under paragraph (4)).

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

1 “(6) PERMITTED ALTERNATIVES TO REQUIRED
2 EXTERNAL REVIEW.—A group health plan shall not
3 be treated as failing to meet the requirements of this
4 subsection in connection with review of coverage de-
5 cisions under paragraph (4) if the aggrieved partici-
6 pant or beneficiary elects to utilize a procedure in
7 connection with such review which is made generally
8 available under the plan (in a manner consistent
9 with such regulations as the Secretary may prescribe
10 to ensure equitable procedures) under which—

11 “(A) the plan agrees in advance of the rec-
12 ommendations of the independent medical ex-
13 pert or experts under paragraph (4)(C)(iii) to
14 render a final decision in accordance with such
15 recommendations; and

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

19 “(7) SPECIAL RULE FOR ACCESS TO SPECIALTY
20 CARE.—In the case of a request for advance deter-
21 mination of coverage consisting of a request by a
22 physician for a determination of coverage of the
23 services of a specialist with respect to any condition,
24 if coverage of the services of such specialist for such
25 condition is otherwise provided under the plan, the

1 initial coverage decision referred to in subparagraph
2 (A)(i) or (B)(i) of paragraph (2) shall be issued
3 within the specialty decision period. For purposes of
4 this paragraph, the term ‘specialist’ means, with re-
5 spect to a condition, a physician who has a high level
6 of expertise through appropriate training and experi-
7 ence (including, in the case of a child, appropriate
8 pediatric expertise) to treat the condition.

9 “(8) GROUP HEALTH PLAN DEFINED.—For
10 purposes of this section—

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

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

17 “(9) OTHER DEFINITIONS.—For purposes of
18 this subsection—

19 “(A) REQUEST FOR BENEFIT PAY-
20 MENTS.—The term ‘request for benefit pay-
21 ments’ means a request, for payment of benefits
22 by a group health plan for medical care, which
23 is made by or on behalf of a participant or ben-
24 eficiary after such medical care has been pro-
25 vided.

1 “(B) REQUIRED DETERMINATION OF MED-
2 ICAL NECESSITY.—The term ‘required deter-
3 mination of medical necessity’ means a deter-
4 mination required under a group health plan
5 solely that proposed medical care meets, under
6 the facts and circumstances at the time of the
7 determination, the plan’s requirements for med-
8 ical appropriateness or necessity (which may be
9 subject to exceptions under the plan for fraud
10 or misrepresentation), irrespective of whether
11 the proposed medical care otherwise meets
12 other terms and conditions of coverage, but
13 only if such determination does not constitute
14 an advance determination of coverage (as de-
15 fined in subparagraph (C)).

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

1 “(D) REQUEST FOR ADVANCE DETERMINA-
2 TION OF COVERAGE.—The term ‘request for ad-
3 vance determination of coverage’ means a re-
4 quest for an advance determination of coverage
5 of medical care which is made by or on behalf
6 of a participant or beneficiary before such medi-
7 cal care is provided.

8 “(E) REQUEST FOR EXPEDITED ADVANCE
9 DETERMINATION OF COVERAGE.—The term ‘re-
10 quest for expedited advance determination of
11 coverage’ means a request for advance deter-
12 mination of coverage, in any case in which the
13 proposed medical care constitutes urgent medi-
14 cal care or emergency medical care.

15 “(F) REQUEST FOR REQUIRED DETER-
16 MINATION OF MEDICAL NECESSITY.—The term
17 ‘request for required determination of medical
18 necessity’ means a request for a required deter-
19 mination of medical necessity for medical care
20 which is made by or on behalf of a participant
21 or beneficiary before the medical care is pro-
22 vided.

23 “(G) REQUEST FOR EXPEDITED REQUIRED
24 DETERMINATION OF MEDICAL NECESSITY.—
25 The term ‘request for expedited required deter-

1 mination of medical necessity’ means a request
2 for required determination of medical necessity
3 in any case in which the proposed medical care
4 constitutes urgent medical care or emergency
5 medical care.

6 “(H) URGENT MEDICAL CARE.—The term
7 ‘urgent medical care’ means medical care in any
8 case in which an appropriate physician has cer-
9 tified in writing (or as otherwise provided in
10 regulations of the Secretary) that failure to pro-
11 vide the participant or beneficiary with such
12 medical care within 45 days can reasonably be
13 expected to result in either—

14 “(i) the imminent death of the partici-
15 pant or beneficiary; or

16 “(ii) the immediate, serious, and irre-
17 versible deterioration of the health of the
18 participant or beneficiary which will sig-
19 nificantly increase the likelihood of death
20 of, or irreparable harm to, the participant
21 or beneficiary.

22 “(I) EMERGENCY MEDICAL CARE.—The
23 term ‘emergency medical care’ means medical
24 care in any case in which an appropriate physi-

1 cian has certified in writing (or as otherwise
2 provided in regulations of the Secretary)—

3 “(i) that failure to immediately pro-
4 vide the care to the participant or bene-
5 ficiary could reasonably be expected to re-
6 sult in—

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

13 “(II) serious impairment to bod-
14 ily functions; or

15 “(III) serious dysfunction of any
16 bodily organ or part; or

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

22 “(J) INITIAL DECISION PERIOD.—The
23 term ‘initial decision period’ means a period of
24 30 days, or such longer period as may be pre-
25 scribed in regulations of the Secretary.

1 “(K) INTERNAL REVIEW PERIOD.—The
2 term ‘internal review period’ means a period of
3 30 days, or such longer period as may be pre-
4 scribed in regulations of the Secretary.

5 “(L) URGENT DECISION PERIOD.—The
6 term ‘urgent decision period’ means a period of
7 10 days, or such longer period as may be pre-
8 scribed in regulations of the Secretary.

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

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

18 “(O) RECONSIDERATION PERIOD.—The
19 term ‘reconsideration period’ means a period of
20 25 days, or such longer period as may be pre-
21 scribed in regulations of the Secretary, except
22 that—

23 “(i) in the case of a decision involving
24 urgent medical care, such term means the
25 urgent decision period; and

1 “(ii) in the case of a decision involving
2 emergency medical care, such term means
3 the emergency decision period.

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

11 “(Q) REVIEW FILING DATE.—The term
12 ‘review filing date’ means, in connection with a
13 group health plan, the date as of which the ap-
14 propriate named fiduciary (or the independent
15 medical expert or experts in the case of a review
16 under paragraph (4)) is in receipt of all infor-
17 mation reasonably required (in writing or in
18 such other reasonable form as may be specified
19 by the plan) to make a decision to affirm, mod-
20 ify, or reverse a coverage decision.

21 “(R) MEDICAL CARE.—The term ‘medical
22 care’ has the meaning provided such term by
23 section 733(a)(2).

24 “(S) HEALTH INSURANCE COVERAGE.—
25 The term ‘health insurance coverage’ has the

1 meaning provided such term by section
2 733(b)(1).

3 “(T) HEALTH INSURANCE ISSUER.—The
4 term ‘health insurance issuer’ has the meaning
5 provided such term by section 733(b)(2).

6 “(U) WRITTEN OR IN WRITING.—

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

16 “(ii) MEDICAL APPROPRIATENESS OR
17 EXPERIMENTAL TREATMENT DETERMINA-
18 TIONS.—For purposes of this subpara-
19 graph, in the case of a request for advance
20 determination of coverage, a request for
21 expedited advance determination of cov-
22 erage, a request for required determination
23 of medical necessity, or a request for expe-
24 dited required determination of medical ne-
25 cessity, if the decision on such request is

1 conveyed to the provider of medical care or
2 to the participant or beneficiary by means
3 of telephonic or other electronic commu-
4 nications, such decision shall be treated as
5 a written decision.”.

6 (b) CIVIL PENALTIES.—

7 (1) IN GENERAL.—Section 502(c) of such Act
8 (29 U.S.C. 1132(c)) is amended by redesignating
9 paragraphs (6) and (7) as paragraphs (7) and (8),
10 respectively, and by inserting after paragraph (5)
11 the following new paragraph:

12 “(6)(A)(i) In any case in which—

13 “(I) a benefit under a group health plan (as de-
14 fined in section 503(b)(8)) is not timely provided to
15 a participant or beneficiary pursuant to a final deci-
16 sion of the plan which was not in accordance with
17 the terms of the plan or this title; and

18 “(II) such final decision of the plan is contrary
19 to a recommendation described in section
20 503(b)(4)(C)(iii),

21 any person acting in the capacity of a fiduciary of such
22 plan so as to cause such failure may, in the court’s discre-
23 tion, be liable to the aggrieved participant or beneficiary
24 for a civil penalty.

1 “(ii) Such civil penalty shall be in the amount of up
2 to \$500 a day (or up to \$1,000 a day in the case of a
3 bad faith failure) from the date on which the recommenda-
4 tion was made to the plan until the date the failure to
5 provide benefits is corrected, up to a total amount not to
6 exceed \$250,000.

7 “(B) In any action commenced under subsection (a)
8 by a participant or beneficiary with respect to a group
9 health plan (as defined in section 503(b)(8)) in which the
10 plaintiff alleges that a person, in the capacity of a fidu-
11 ciary and in violation of the terms of the plan or this title,
12 has taken an action resulting in an adverse coverage deci-
13 sion in violation of the terms of the plan, or has failed
14 to take an action for which such person is responsible
15 under the plan and which is necessary under the plan for
16 a favorable coverage decision, upon finding in favor of the
17 plaintiff, if such action was commenced after a final deci-
18 sion of the plan upon review which included a review under
19 section 503(b)(4) or such action was commenced under
20 subsection (b)(4) of this section, the court shall cause to
21 be served on the defendant an order requiring the
22 defendant—

23 “(i) to cease and desist from the alleged action
24 or failure to act; and

1 “(ii) to pay to the plaintiff a reasonable attor-
2 ney’s fee and other reasonable costs relating to the
3 prosecution of the action on the charges on which
4 the plaintiff prevails.

5 The remedies provided under this subparagraph shall be
6 in addition to remedies otherwise provided under this sec-
7 tion.

8 “(C)(i) The Secretary may assess a civil penalty
9 against a person acting in the capacity of a fiduciary of
10 one or more group health plans (as defined in section
11 503(b)(8)) for—

12 “(I) any pattern or practice of repeated adverse
13 coverage decisions in violation of the terms of the
14 plan or plans or this title; or

15 “(II) any pattern or practice of repeated viola-
16 tions of the requirements of section 503 with respect
17 to such plan or plans.

18 Such penalty shall be payable only upon proof by clear
19 and convincing evidence of such pattern or practice.

20 “(ii) Such penalty shall be in an amount not to exceed
21 the lesser of—

22 “(I) 5 percent of the aggregate value of benefits
23 shown by the Secretary to have not been provided,
24 or unlawfully delayed in violation of section 503,
25 under such pattern or practice; or

1 “(II) \$100,000.

2 “(iii) Any person acting in the capacity of a fiduciary
3 of a group health plan or plans who has engaged in any
4 such pattern or practice with respect to such plans, upon
5 the petition of the Secretary, may be removed by the court
6 from that position, and from any other involvement, with
7 respect to such plan or plans, and may be precluded from
8 returning to any such position or involvement for a period
9 determined by the court.”.

10 (2) CONFORMING AMENDMENT.—Section
11 502(a)(6) of such Act (29 U.S.C. 1132(a)(6)) is
12 amended by striking “, or (6)” and inserting “, (6),
13 or (7)”.

14 (c) EXPEDITED COURT REVIEW.—Section 502 of
15 such Act (29 U.S.C. 1132) is amended—

16 (1) in subsection (a)(8), by striking “or” at the
17 end;

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

20 (3) by adding at the end of subsection (a) the
21 following new paragraph:

22 “(10) by a participant or beneficiary for appropriate
23 relief under subsection (b)(4).”.

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

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

16 (d) STANDARD OF REVIEW UNAFFECTED.—The
17 standard of review under section 502 of the Employee Re-
18 tirement Income Security Act of 1974 (as amended by this
19 section) shall continue on and after the date of the enact-
20 ment of this Act to be the standard of review which was
21 applicable under such section as of immediately before
22 such date.

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

1 (1) in the first sentence, by striking “under
 2 subsection (a)(1)(B) of this section” and inserting
 3 “under subsection (a)(1)(A) for relief under sub-
 4 section (c)(6), under subsection (a)(1)(B), and
 5 under subsection (b)(4)”; and

6 (2) in the last sentence, by striking “of actions
 7 under paragraphs (1)(B) and (7) of subsection (a)
 8 of this section” and inserting “of actions under
 9 paragraph (1)(A) of subsection (a) for relief under
 10 subsection (c)(6) and of actions under paragraphs
 11 (1)(B) and (7) of subsection (a) and paragraph (4)
 12 of subsection (b)”.

13 **SEC. 1202. EFFECTIVE DATE.**

14 (a) IN GENERAL.—The amendments made by this
 15 subtitle shall apply with respect to grievances arising in
 16 plan years beginning on or after January 1 of the second
 17 calendar year following the date of the enactment of this
 18 Act. The Secretary shall first issue all regulations nec-
 19 essary to carry out the amendments made by this subtitle
 20 before such date.

21 (b) LIMITATION ON ENFORCEMENT ACTIONS.—No
 22 enforcement action shall be taken, pursuant to the amend-
 23 ments made by this subtitle, against a group health plan
 24 or health insurance issuer with respect to a violation of
 25 a requirement imposed by such amendments before the

1 date of issuance of final regulations issued in connection
 2 with such requirement, if the plan or issuer has sought
 3 to comply in good faith with such requirement.

4 (c) COLLECTIVE BARGAINING AGREEMENTS.—Any
 5 plan amendment made pursuant to a collective bargaining
 6 agreement relating to the plan which amends the plan
 7 solely to conform to any requirement added by this subtitle
 8 shall not be treated as a termination of such collective bar-
 9 gaining agreement.

10 **Subtitle D—Affordable Health Cov-**
 11 **erage for Employees of Small**
 12 **Businesses**

13 **SEC. 1301. SHORT TITLE OF SUBTITLE.**

14 This subtitle may be cited as the “Small Business
 15 Affordable Health Coverage Act of 1999”.

16 **SEC. 1302. RULES GOVERNING ASSOCIATION HEALTH**
 17 **PLANS.**

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

4 “(a) IN GENERAL.—For purposes of this part, the
5 term ‘association health plan’ means a group health
6 plan—

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

“(1) is organized and maintained in good faith,
with a constitution and bylaws specifically stating its
purpose and providing for periodic meetings on at
least an annual basis, as a trade association, an in-
dustry association (including a rural electric cooper-
ative association or a rural telephone cooperative as-

1 sociation), a professional association, or a chamber
2 of commerce (or similar business association, includ-
3 ing a corporation or similar organization that oper-
4 ates on a cooperative basis (within the meaning of
5 section 1381 of the Internal Revenue Code of
6 1986)), for substantial purposes other than that of
7 obtaining or providing medical care;

8 “(2) is established as a permanent entity which
9 receives the active support of its members and col-
10 lects from its members on a periodic basis dues or
11 payments necessary to maintain eligibility for mem-
12 bership in the sponsor; and

13 “(3) does not condition membership, such dues
14 or payments, or coverage under the plan on the
15 basis of health status-related factors with respect to
16 the employees of its members (or affiliated mem-
17 bers), or the dependents of such employees, and does
18 not condition such dues or payments on the basis of
19 group health plan participation.

20 Any sponsor consisting of an association of entities which
21 meet the requirements of paragraphs (1), (2), and (3)
22 shall be deemed to be a sponsor described in this sub-
23 section.

1 **“SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH**
2 **PLANS.**

3 “(a) IN GENERAL.—The applicable authority shall
4 prescribe by regulation a procedure under which, subject
5 to subsection (b), the applicable authority shall certify as-
6 sociation health plans which apply for certification as
7 meeting the requirements of this part.

8 “(b) STANDARDS.—Under the procedure prescribed
9 pursuant to subsection (a), the applicable authority shall
10 certify an association health plan as meeting the require-
11 ments of this part only if the applicable authority is satis-
12 fied that—

13 “(1) such certification—

14 “(A) is administratively feasible;

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

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

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

23 “(c) REQUIREMENTS APPLICABLE TO CERTIFIED
24 PLANS.—An association health plan with respect to which
25 certification under this part is in effect shall meet the ap-
26 plicable requirements of this part, effective on the date

1 of certification (or, if later, on the date on which the plan
2 is to commence operations).

3 “(d) REQUIREMENTS FOR CONTINUED CERTIFI-
4 CATION.—The applicable authority may provide by regula-
5 tion for continued certification of association health plans
6 under this part, including requirements relating to com-
7 mencement of new benefit options by plans which do not
8 consist of health insurance coverage.

9 “(e) CLASS CERTIFICATION FOR FULLY INSURED
10 PLANS.—The applicable authority shall establish a class
11 certification procedure for association health plans under
12 which all benefits consist of health insurance coverage.
13 Under such procedure, the applicable authority shall pro-
14 vide for the granting of certification under this part to
15 the plans in each class of such association health plans
16 upon appropriate filing under such procedure in connec-
17 tion with plans in such class and payment of the pre-
18 scribed fee under section 807(a).

19 **“SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND**
20 **BOARDS OF TRUSTEES.**

21 “(a) SPONSOR.—The requirements of this subsection
22 are met with respect to an association health plan if—

23 “(1) the sponsor (together with its immediate
24 predecessor, if any) has met (or is deemed under
25 this part to have met) for a continuous period of not

1 less than 3 years ending with the date of the appli-
2 cation for certification under this part, the require-
3 ments of paragraphs (1) and (2) of section 801(b);
4 and

5 “(2) the sponsor meets (or is deemed under this
6 part to meet) the requirements of section 801(b)(3).

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

10 “(1) FISCAL CONTROL.—The plan is operated,
11 pursuant to a trust agreement, by a board of trust-
12 ees which has complete fiscal control over the plan
13 and which is responsible for all operations of the
14 plan.

15 “(2) RULES OF OPERATION AND FINANCIAL
16 CONTROLS.—The board of trustees has in effect
17 rules of operation and financial controls, based on a
18 3-year plan of operation, adequate to carry out the
19 terms of the plan and to meet all requirements of
20 this title applicable to the plan.

21 “(3) RULES GOVERNING RELATIONSHIP TO
22 PARTICIPATING EMPLOYERS AND TO CONTRAC-
23 TORS.—

24 “(A) IN GENERAL.—Except as provided in
25 subparagraph (B), the members of the board of

1 trustees are individuals selected from individ-
2 uals who are the owners, officers, directors, or
3 employees of the participating employers or who
4 are partners in the participating employers and
5 actively participate in the business.

6 “(B) LIMITATION.—

7 “(i) GENERAL RULE.—Except as pro-
8 vided in clauses (ii) and (iii), no such
9 member is an owner, officer, director, or
10 employee of, or partner in, a contract ad-
11 ministrator or other service provider to the
12 plan.

13 “(ii) LIMITED EXCEPTION FOR PRO-
14 VIDERS OF SERVICES SOLELY ON BEHALF
15 OF THE SPONSOR.—Officers or employees
16 of a sponsor which is a service provider
17 (other than a contract administrator) to
18 the plan may be members of the board if
19 they constitute not more than 25 percent
20 of the membership of the board and they
21 do not provide services to the plan other
22 than on behalf of the sponsor.

23 “(iii) TREATMENT OF PROVIDERS OF
24 MEDICAL CARE.—In the case of a sponsor
25 which is an association whose membership

1 consists primarily of providers of medical
2 care, clause (i) shall not apply in the case
3 of any service provider described in sub-
4 paragraph (A) who is a provider of medical
5 care under the plan.

6 “(C) SOLE AUTHORITY.—The board has
7 sole authority to approve applications for par-
8 ticipation in the plan and to contract with a
9 service provider to administer the day-to-day af-
10 fairs of the plan.

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

15 “(1) the requirements of subsection (a) and sec-
16 tion 801(a)(1) shall be deemed met if such require-
17 ments would otherwise be met if the franchiser were
18 deemed to be the sponsor referred to in section
19 801(b), such network were deemed to be an associa-
20 tion described in section 801(b), and each franchisee
21 were deemed to be a member (of the association and
22 the sponsor) referred to in section 801(b); and

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

25 “(d) CERTAIN COLLECTIVELY BARGAINED PLANS.—

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

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

5 “(B) the joint board of trustees shall be
6 deemed a board of trustees with respect to
7 which the requirements of subsection (b) are
8 met; and

9 “(C) the requirements of section 804 shall
10 be deemed met.

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

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

14 “(B) the plan is in existence on April 1,
15 1997, and would be described in section
16 3(40)(A)(i) but solely for the failure to meet
17 the requirements of section 3(40)(C)(ii).

18 **“SEC. 804. PARTICIPATION AND COVERAGE REQUIRE-**
19 **MENTS.**

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

24 “(1) all participating employers must be mem-
25 bers or affiliated members of the sponsor, except

1 that, in the case of a sponsor which is a professional
2 association or other individual-based association, if
3 at least one of the officers, directors, or employees
4 of an employer, or at least one of the individuals
5 who are partners in an employer and who actively
6 participates in the business, is a member or affili-
7 ated member of the sponsor, participating employers
8 may also include such employer; and

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

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

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

18 “(b) COVERAGE OF PREVIOUSLY UNINSURED EM-
19 PLOYEES.—

20 “(1) IN GENERAL.—Subject to paragraph (2),
21 the requirements of this subsection are met with re-
22 spect to an association health plan if, under the
23 terms of the plan, no affiliated member of the spon-
24 sor may be offered coverage under the plan as a par-
25 ticipating employer, unless—

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

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

11 “(2) LIMITATION.—The requirements of this
12 subsection shall apply only in the case of plans
13 which were in existence on the date of the enactment
14 of the Small Business Affordable Health Coverage
15 Act of 1999.

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

1 would, but for such exclusion on such basis, be eligible
 2 for coverage under the plan.

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

7 “(1) under the terms of the plan, no employer
 8 meeting the preceding requirements of this section is
 9 excluded as a participating employer, unless partici-
 10 pation or contribution requirements of the type re-
 11 ferred to in section 2711 of the Public Health Serv-
 12 ice Act are not met with respect to the excluded em-
 13 ployer;

14 “(2) the applicable requirements of sections
 15 701, 702, and 703 are met with respect to the plan;
 16 and

17 “(3) applicable benefit options under the plan
 18 are actively marketed to all eligible participating em-
 19 ployers.

20 **“SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN**
 21 **DOCUMENTS, CONTRIBUTION RATES, AND**
 22 **BENEFIT OPTIONS.**

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

1 “(1) CONTENTS OF GOVERNING INSTRU-
2 MENTS.—The instruments governing the plan in-
3 clude a written instrument, meeting the require-
4 ments of an instrument required under section
5 402(a)(1), which—

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

11 “(B) provides that the sponsor of the plan
12 is to serve as plan sponsor (referred to in sec-
13 tion 3(16)(B)); and

14 “(C) incorporates the requirements of sec-
15 tion 806.

16 “(2) CONTRIBUTION RATES MUST BE NON-
17 DISCRIMINATORY.—

18 “(A) The contribution rates for any par-
19 ticipating small employer do not vary on the
20 basis of the claims experience of such employer
21 and do not vary on the basis of the type of
22 business or industry in which such employer is
23 engaged.

24 “(B) Nothing in this title or any other pro-
25 vision of law shall be construed to preclude an

1 association health plan, or a health insurance
2 issuer offering health insurance coverage in
3 connection with an association health plan,
4 from—

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

7 “(ii) varying contribution rates for
8 small employers in a State to the extent
9 that such rates could vary using the same
10 methodology employed in such State for
11 regulating premium rates in the small
12 group market,

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 may
16 prescribe by regulation as necessary to carry out the
17 purposes of this part.

18 “(b) ABILITY OF ASSOCIATION HEALTH PLANS TO
19 DESIGN BENEFIT OPTIONS.—Nothing in this part or any
20 provision of State law (as defined in section 514(c)(1))
21 shall be construed to preclude an association health plan,
22 or a health insurance issuer offering health insurance cov-
23 erage in connection with an association health plan, from
24 exercising its sole discretion in selecting the specific items
25 and services consisting of medical care to be included as

1 benefits under such plan or coverage, except (subject to
 2 section 514) in the case of any law to the extent that it
 3 (1) prohibits an exclusion of a specific disease from such
 4 coverage, or (2) is not preempted under section 731(a)(1)
 5 with respect to matters governed by section 711 or 712.

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

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

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

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

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

21 “(i) a reserve sufficient for unearned
 22 contributions;

23 “(ii) a reserve sufficient for benefit li-
 24 abilities which have been incurred, which
 25 have not been satisfied, and for which risk

1 of loss has not yet been transferred, and
2 for expected administrative costs with re-
3 spect to such benefit liabilities;

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

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

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

15 “(i) The plan shall secure aggregate
16 excess/stop loss insurance for the plan
17 with an attachment point which is not
18 greater than 125 percent of expected gross
19 annual claims. The applicable authority
20 may by regulation provide for upward ad-
21 justments in the amount of such percent-
22 age in specified circumstances in which the
23 plan specifically provides for and maintains
24 reserves in excess of the amounts required
25 under subparagraph (A).

1 “(ii) The plan shall secure specific ex-
2 cess/stop loss insurance for the plan with
3 an attachment point which is at least equal
4 to an amount recommended by the plan’s
5 qualified actuary (but not more than
6 \$200,000). The applicable authority may
7 by regulation provide for adjustments in
8 the amount of such insurance in specified
9 circumstances in which the plan specifically
10 provides for and maintains reserves in ex-
11 cess of the amounts required under sub-
12 paragraph (A).

13 “(iii) The plan shall secure indem-
14 nification insurance for any claims which
15 the plan is unable to satisfy by reason of
16 a plan termination.

17 Any regulations prescribed by the applicable authority
18 pursuant to clause (i) or (ii) of subparagraph (B) may
19 allow for such adjustments in the required levels of excess/
20 stop loss insurance as the qualified actuary may rec-
21 ommend, taking into account the specific circumstances
22 of the plan.

23 “(b) MINIMUM SURPLUS IN ADDITION TO CLAIMS
24 RESERVES.—The requirements of this subsection are met
25 if the plan establishes and maintains surplus in an amount

1 at least equal to \$2,000,000, reduced in accordance with
2 a scale, prescribed in regulations of the applicable author-
3 ity to an amount not less than \$500,000, based on the
4 level of aggregate and specific excess/stop loss insurance
5 provided with respect to such plan.

6 “(c) ADDITIONAL REQUIREMENTS.—In the case of
7 any association health plan described in subsection (a)(2),
8 the applicable authority may provide such additional re-
9 quirements relating to reserves and excess/stop loss insur-
10 ance as the applicable authority considers appropriate.
11 Such requirements may be provided, by regulation or oth-
12 erwise, with respect to any such plan or any class of such
13 plans.

14 “(d) ADJUSTMENTS FOR EXCESS/STOP LOSS INSUR-
15 ANCE.—The applicable authority may provide for adjust-
16 ments to the levels of reserves otherwise required under
17 subsections (a) and (b) with respect to any plan or class
18 of plans to take into account excess/stop loss insurance
19 provided with respect to such plan or plans.

20 “(e) ALTERNATIVE MEANS OF COMPLIANCE.—The
21 applicable authority may permit an association health plan
22 described in subsection (a)(2) to substitute, for all or part
23 of the requirements of this section (except subsection
24 (a)(2)(B)(iii)), such security, guarantee, hold-harmless ar-
25 rangement, or other financial arrangement as the applica-

1 ble authority determines to be adequate to enable the plan
 2 to fully meet all its financial obligations on a timely basis
 3 and is otherwise no less protective of the interests of par-
 4 ticipants and beneficiaries than the requirements for
 5 which it is substituted. The applicable authority may take
 6 into account, for purposes of this subsection, evidence pro-
 7 vided by the plan or sponsor which demonstrates an as-
 8 sumption of liability with respect to the plan. Such evi-
 9 dence may be in the form of a contract of indemnification,
 10 lien, bonding, insurance, letter of credit, recourse under
 11 applicable terms of the plan in the form of assessments
 12 of participating employers, security, or other financial ar-
 13 rangement.

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

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

18 “(A) IN GENERAL.—In the case of an as-
 19 sociation health plan described in subsection
 20 (a)(2), the requirements of this subsection are
 21 met if the plan makes payments into the Asso-
 22 ciation Health Plan Fund under this subpara-
 23 graph when they are due. Such payments shall
 24 consist of annual payments in the amount of
 25 \$5,000, and, in addition to such annual pay-

1 ments, such supplemental payments as the Sec-
2 retary may determine to be necessary under
3 paragraph (2). Payments under this paragraph
4 are payable to the Fund at the time determined
5 by the Secretary. Initial payments are due in
6 advance of certification under this part. Pay-
7 ments shall continue to accrue until a plan's as-
8 sets are distributed pursuant to a termination
9 procedure.

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

16 “(C) CONTINUED DUTY OF THE SEC-
17 RETARY.—The Secretary shall not cease to
18 carry out the provisions of paragraph (2) on ac-
19 count of the failure of a plan to pay any pay-
20 ment when due.

21 “(2) PAYMENTS BY SECRETARY TO CONTINUE
22 EXCESS/STOP LOSS INSURANCE COVERAGE AND IN-
23 DEMNIFICATION INSURANCE COVERAGE FOR CER-
24 TAIN PLANS.—In any case in which the applicable
25 authority determines that there is, or that there is

1 reason to believe that there will be: (A) a failure to
2 take necessary corrective actions under section
3 809(a) with respect to an association health plan de-
4 scribed in subsection (a)(2); or (B) a termination of
5 such a plan under section 809(b) or 810(b)(8) (and,
6 if the applicable authority is not the Secretary, cer-
7 tifies such determination to the Secretary), the Sec-
8 retary shall determine the amounts necessary to
9 make payments to an insurer (designated by the
10 Secretary) to maintain in force excess/stop loss in-
11 surance coverage or indemnification insurance cov-
12 erage for such plan, if the Secretary determines that
13 there is a reasonable expectation that, without such
14 payments, claims would not be satisfied by reason
15 of termination of such coverage. The Secretary shall,
16 to the extent provided in advance in appropriation
17 Acts, pay such amounts so determined to the insurer
18 designated by the Secretary.

19 “(3) ASSOCIATION HEALTH PLAN FUND.—

20 “(A) IN GENERAL.—There is established
21 on the books of the Treasury a fund to be
22 known as the ‘Association Health Plan Fund’.
23 The Fund shall be available for making pay-
24 ments pursuant to paragraph (2). The Fund
25 shall be credited with payments received pursu-

1 ant to paragraph (1)(A), penalties received pur-
2 suant to paragraph (1)(B); and earnings on in-
3 vestments of amounts of the Fund under sub-
4 paragraph (B).

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

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

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

18 “(A) under which an insurer (meeting such
19 minimum standards as may be prescribed in regula-
20 tions of the applicable authority) provides for pay-
21 ment to the plan with respect to aggregate claims
22 under the plan in excess of an amount or amounts
23 specified in such contract;

24 “(B) which is guaranteed renewable; and

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

3 “(2) SPECIFIC EXCESS/STOP LOSS INSUR-
4 ANCE.—The term ‘specific excess/stop loss insur-
5 ance’ means, in connection with an association
6 health plan, a contract—

7 “(A) under which an insurer (meeting such
8 minimum standards as may be prescribed in
9 regulations of the applicable authority) provides
10 for payment to the plan with respect to claims
11 under the plan in connection with a covered in-
12 dividual in excess of an amount or amounts
13 specified in such contract in connection with
14 such covered individual;

15 “(B) which is guaranteed renewable; and

16 “(C) which allows for payment of pre-
17 miums by any third party on behalf of the in-
18 sured plan.

19 “(h) INDEMNIFICATION INSURANCE.—For purposes
20 of this section, the term ‘indemnification insurance’
21 means, in connection with an association health plan, a
22 contract—

23 “(1) under which an insurer (meeting such min-
24 imum standards as may be prescribed in regulations
25 of the applicable authority) provides for payment to

1 the plan with respect to claims under the plan which
2 the plan is unable to satisfy by reason of a termi-
3 nation pursuant to section 809(b) (relating to man-
4 datory termination);

5 “(2) which is guaranteed renewable and
6 noncancellable for any reason (except as may be pro-
7 vided in regulations of the applicable authority); and

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

10 “(i) RESERVES.—For purposes of this section, the
11 term ‘reserves’ means, in connection with an association
12 health plan, plan assets which meet the fiduciary stand-
13 ards under part 4 and such additional requirements re-
14 garding liquidity as may be prescribed in regulations of
15 the applicable authority.

16 “(j) REGULATIONS PRESCRIBED UNDER NEGO-
17 TIATED RULEMAKING.—The regulations under this sec-
18 tion shall be prescribed under negotiated rulemaking in
19 accordance with subchapter III of chapter 5 of title 5,
20 United States Code, except that, in establishing the nego-
21 tiated rulemaking committee for purposes of such rule-
22 making, the applicable authority shall include among per-
23 sons invited to membership on the committee at least one
24 of each of the following:

1 “(1) a representative of the National Associa-
2 tion of Insurance Commissioners;

3 “(2) a representative of the American Academy
4 of Actuaries;

5 “(3) a representative of the State governments,
6 or their interests;

7 “(4) a representative of existing self-insured ar-
8 rangements, or their interests;

9 “(5) a representative of associations of the type
10 referred to in section 801(b)(1), or their interests;
11 and

12 “(6) a representative of multiemployer plans
13 that are group health plans, or their interests.

14 **“SEC. 807. REQUIREMENTS FOR APPLICATION AND RELAT-**
15 **ED REQUIREMENTS.**

16 “(a) FILING FEE.—Under the procedure prescribed
17 pursuant to section 802(a), an association health plan
18 shall pay to the applicable authority at the time of filing
19 an application for certification under this part a filing fee
20 in the amount of \$5,000, which shall be available in the
21 case of the Secretary, to the extent provided in appropria-
22 tion Acts, for the sole purpose of administering the certifi-
23 cation procedures applicable with respect to association
24 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 prescribed
5 in regulations of the applicable authority, at least the fol-
6 lowing 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 PROVID-
4 ERS.—A copy of any agreements between the plan
5 and contract administrators and other service pro-
6 viders.

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.

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

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

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

20 “(D) COSTS OF COVERAGE TO BE
21 CHARGED AND OTHER EXPENSES.—A state-
22 ment of the costs of coverage to be charged, in-
23 cluding an itemization of amounts for adminis-
24 tration, reserves, and other expenses associated
25 with the operation of the plan.

1 “(E) OTHER INFORMATION.—Any other
2 information which may be prescribed in regula-
3 tions of the applicable authority as necessary to
4 carry out the purposes of this part.

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

15 “(d) NOTICE OF MATERIAL CHANGES.—In the case
16 of any association health plan certified under this part,
17 descriptions of material changes in any information which
18 was required to be submitted with the application for the
19 certification under this part shall be filed in such form
20 and manner as shall be prescribed in regulations of the
21 applicable authority. The applicable authority may require
22 by regulation prior notice of material changes with respect
23 to specified matters which might serve as the basis for
24 suspension or revocation of the certification.

1 “(e) REPORTING REQUIREMENTS FOR CERTAIN AS-
2 SOCIATION HEALTH PLANS.—An association health plan
3 certified under this part which provides benefit options in
4 addition to health insurance coverage for such plan year
5 shall meet the requirements of section 103 by filing an
6 annual report under such section which shall include infor-
7 mation described in subsection (b)(6) with respect to the
8 plan year and, notwithstanding section 104(a)(1)(A), shall
9 be filed with the applicable authority not later than 90
10 days after the close of the plan year (or on such later date
11 as may be prescribed by the applicable authority).

12 “(f) ENGAGEMENT OF QUALIFIED ACTUARY.—The
13 board of trustees of each association health plan which
14 provides benefits options in addition to health insurance
15 coverage and which is applying for certification under this
16 part or is certified under this part shall engage, on behalf
17 of all participants and beneficiaries, a qualified actuary
18 who shall be responsible for the preparation of the mate-
19 rials comprising information necessary to be submitted by
20 a qualified actuary under this part. The qualified actuary
21 shall utilize such assumptions and techniques as are nec-
22 essary to enable such actuary to form an opinion as to
23 whether the contents of the matters reported under this
24 part—

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

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

19 “(2) develops a plan for winding up the affairs
20 of the plan in connection with such termination in
21 a manner which will result in timely payment of all
22 benefits for which the plan is obligated; and

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1 Actions required under this section shall be taken in such
2 form and manner as may be prescribed in regulations of
3 the applicable authority.

4 **“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.**
5 **NATION.**

6 “(a) ACTIONS TO AVOID DEPLETION OF RE-
7 SERVES.—An association health plan which is certified
8 under this part and which provides benefits other than
9 health insurance coverage shall continue to meet the re-
10 quirements of section 806, irrespective of whether such
11 certification continues in effect. The board of trustees of
12 such plan shall determine quarterly whether the require-
13 ments of section 806 are met. In any case in which the
14 board determines that there is reason to believe that there
15 is or will be a failure to meet such requirements, or the
16 applicable authority makes such a determination and so
17 notifies the board, the board shall immediately notify the
18 qualified actuary engaged by the plan, and such actuary
19 shall, not later than the end of the next following month,
20 make such recommendations to the board for corrective
21 action as the actuary determines necessary to ensure com-
22 pliance with section 806. Not later than 30 days after re-
23 ceiving from the actuary recommendations for corrective
24 actions, the board shall notify the applicable authority (in
25 such form and manner as the applicable authority may

1 prescribe by regulation) of such recommendations of the
2 actuary for corrective action, together with a description
3 of the actions (if any) that the board has taken or plans
4 to take in response to such recommendations. The board
5 shall thereafter report to the applicable authority, in such
6 form and frequency as the applicable authority may speci-
7 fy to the board, regarding corrective action taken by the
8 board until the requirements of section 806 are met.

9 “(b) MANDATORY TERMINATION.—In any case in
10 which—

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

19 “(2) the applicable authority determines that
20 there is a reasonable expectation that the plan will
21 continue to fail to meet the requirements of section
22 806,

23 the board of trustees of the plan shall, at the direction
24 of the applicable authority, terminate the plan and, in the
25 course of the termination, take such actions as the appli-

1 cable authority may require, including satisfying any
 2 claims referred to in section 806(a)(2)(B)(iii) and recover-
 3 ing for the plan any liability under subsection
 4 (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure
 5 that the affairs of the plan will be, to the maximum extent
 6 possible, wound up in a manner which will result in timely
 7 provision of all benefits for which the plan is obligated.

8 **“SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOL-**
 9 **VENT ASSOCIATION HEALTH PLANS PROVID-**
 10 **ING HEALTH BENEFITS IN ADDITION TO**
 11 **HEALTH INSURANCE COVERAGE.**

12 “(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR
 13 INSOLVENT PLANS.—Whenever the Secretary determines
 14 that an association health plan which is or has been cer-
 15 tified under this part and which is described in section
 16 806(a)(2) will be unable to provide benefits when due or
 17 is otherwise in a financially hazardous condition as defined
 18 in regulations of such Secretary, the Secretary shall, upon
 19 notice to the plan, apply to the appropriate United States
 20 district court for appointment of the Secretary as trustee
 21 to administer the plan for the duration of the insolvency.
 22 The plan may appear as a party and other interested per-
 23 sons may intervene in the proceedings at the discretion
 24 of the court. The court shall appoint such Secretary trust-
 25 ee if the court determines that the trusteeship is necessary

1 to protect the interests of the participants and bene-
2 ficiaries or providers of medical care or to avoid any un-
3 reasonable deterioration of the financial condition of the
4 plan. The trusteeship of such Secretary shall continue
5 until the conditions described in the first sentence of this
6 subsection are remedied or the plan is terminated.

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

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

13 “(2) to require the transfer of all (or any part)
14 of the assets and records of the plan to the Sec-
15 retary as trustee;

16 “(3) to invest any assets of the plan which the
17 Secretary holds in accordance with the provisions of
18 the plan, regulations of the Secretary, and applicable
19 provisions of law;

20 “(4) to require the sponsor, the plan adminis-
21 trator, any participating employer, and any employee
22 organization representing plan participants to fur-
23 nish any information with respect to the plan which
24 the Secretary as trustee may reasonably need in
25 order to administer the plan;

1 “(5) to collect for the plan any amounts due the
2 plan and to recover reasonable expenses of the trust-
3 eeship;

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

7 “(7) to issue, publish, or file such notices, state-
8 ments, and reports as may be required under regula-
9 tions of the Secretary or by any order of the court;

10 “(8) to terminate the plan (or provide for its
11 termination accordance with section 809(b)) and liq-
12 uidate the plan assets, to restore the plan to the re-
13 sponsibility of the sponsor, or to continue the trust-
14 eeship;

15 “(9) to provide for the enrollment of plan par-
16 ticipants and beneficiaries under appropriate cov-
17 erage options; and

18 “(10) to do such other acts as may be nec-
19 essary to comply with this title or any order of the
20 court and to protect the interests of plan partici-
21 pants and beneficiaries and providers of medical
22 care.

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

1 “(1) the sponsor and plan administrator;

2 “(2) each participant;

3 “(3) each participating employer; and

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

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

14 “(e) OTHER PROCEEDINGS.—An application by the
15 Secretary under this subsection may be filed notwithstand-
16 ing the pendency in the same or any other court of any
17 bankruptcy, mortgage foreclosure, or equity receivership
18 proceeding, or any proceeding to reorganize, conserve, or
19 liquidate such plan or its property, or any proceeding to
20 enforce a lien against property of the plan.

21 “(f) JURISDICTION OF COURT.—

22 “(1) IN GENERAL.—Upon the filing of an appli-
23 cation for the appointment as trustee or the issuance
24 of a decree under this section, the court to which the
25 application is made shall have exclusive jurisdiction

1 of the plan involved and its property wherever lo-
2 cated with the powers, to the extent consistent with
3 the purposes of this section, of a court of the United
4 States having jurisdiction over cases under chapter
5 11 of title 11, United States Code. Pending an adju-
6 dication under this section such court shall stay, and
7 upon appointment by it of the Secretary as trustee,
8 such court shall continue the stay of, any pending
9 mortgage foreclosure, equity receivership, or other
10 proceeding to reorganize, conserve, or liquidate the
11 plan, the sponsor, or property of such plan or spon-
12 sor, and any other suit against any receiver, con-
13 servator, or trustee of the plan, the sponsor, or
14 property of the plan or sponsor. Pending such adju-
15 dication and upon the appointment by it of the Sec-
16 retary as trustee, the court may stay any proceeding
17 to enforce a lien against property of the plan or the
18 sponsor or any other suit against the plan or the
19 sponsor.

20 “(2) VENUE.—An action under this section
21 may be brought in the judicial district where the
22 sponsor or the plan administrator resides or does
23 business or where any asset of the plan is situated.
24 A district court in which such action is brought may

1 issue process with respect to such action in any
2 other judicial district.

3 “(g) PERSONNEL.—In accordance with regulations of
4 the Secretary, the Secretary shall appoint, retain, and
5 compensate accountants, actuaries, and other professional
6 service personnel as may be necessary in connection with
7 the Secretary’s service as trustee under this section.

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

9 “(a) IN GENERAL.—Notwithstanding section 514, a
10 State may impose by law a contribution tax on an associa-
11 tion health plan described in section 806(a)(2), if the plan
12 commenced operations in such State after the date of the
13 enactment of the Small Business Affordable Health Cov-
14 erage Act of 1999.

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

19 “(1) such tax is computed by applying a rate to
20 the amount of premiums or contributions, with re-
21 spect to individuals covered under the plan who are
22 residents of such State, which are received by the
23 plan from participating employers located in such
24 State or from such individuals;

1 “(2) the rate of such tax does not exceed the
 2 rate of any tax imposed by such State on premiums
 3 or contributions received by insurers or health main-
 4 tenance organizations for health insurance coverage
 5 offered in such State in connection with a group
 6 health plan;

7 “(3) such tax is otherwise nondiscriminatory;
 8 and

9 “(4) the amount of any such tax assessed on
 10 the plan is reduced by the amount of any tax or as-
 11 sessment otherwise imposed by the State on pre-
 12 miums, contributions, or both received by insurers or
 13 health maintenance organizations for health insur-
 14 ance coverage, aggregate excess/stop loss insurance
 15 (as defined in section 806(g)(1)), specific excess/
 16 stop loss insurance (as defined in section 806(g)(2)),
 17 other insurance related to the provision of medical
 18 care under the plan, or any combination thereof pro-
 19 vided by such insurers or health maintenance organi-
 20 zations in such State in connection with such plan.

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

22 “(a) ELECTION FOR CHURCH PLANS.—Notwith-
 23 standing section 4(b)(2), if a church, a convention or asso-
 24 ciation of churches, or an organization described in section
 25 3(33)(C)(i) maintains a church plan which is a group

1 health plan (as defined in section 733(a)(1)), and such
 2 church, convention, association, or organization makes an
 3 election with respect to such plan under this subsection
 4 (in such form and manner as the Secretary may by regula-
 5 tion prescribe), then the provisions of this section shall
 6 apply to such plan, with respect to benefits provided under
 7 such plan consisting of medical care, as if section 4(b)(2)
 8 did not contain an exclusion for church plans. Nothing in
 9 this subsection shall be construed to render any other sec-
 10 tion of this title applicable to church plans, except to the
 11 extent that such other section is incorporated by reference
 12 in this section.

13 “(b) EFFECT OF ELECTION.—

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

21 “(2) GENERAL STATE INSURANCE REGULATION
 22 UNAFFECTED.—

23 “(A) IN GENERAL.—Except as provided in
 24 subparagraph (B) and paragraph (3), nothing
 25 in this section shall be construed to exempt or

1 relieve any person from any provision of State
2 law which regulates insurance.

3 “(B) CHURCH PLANS NOT TO BE DEEMED
4 INSURANCE COMPANIES OR INSURERS.—Neither
5 a church plan to which this section applies, nor
6 any trust established under such a church plan,
7 shall be deemed to be an insurance company or
8 other insurer or to be engaged in the business
9 of insurance for purposes of any State law pur-
10 porting to regulate insurance companies or in-
11 surance contracts.

12 “(3) PREEMPTION OF CERTAIN STATE LAWS
13 RELATING TO PREMIUM RATE REGULATION AND
14 BENEFIT MANDATES.—The provisions of subsections
15 (a)(2)(B) and (b) of section 805 shall apply with re-
16 spect to a church plan to which this section applies
17 in the same manner and to the same extent as such
18 provisions apply with respect to association health
19 plans.

20 “(4) DEFINITIONS.—For purposes of this
21 subsection—

22 “(A) STATE LAW.—The term ‘State law’
23 includes all laws, decisions, rules, regulations,
24 or other State action having the effect of law,
25 of any State. A law of the United States appli-

1 cable only to the District of Columbia shall be
2 treated as a State law rather than a law of the
3 United States.

4 “(B) STATE.—The term ‘State’ includes a
5 State, any political subdivision thereof, or any
6 agency or instrumentality of either, which pur-
7 ports to regulate, directly or indirectly, the
8 terms and conditions of church plans covered by
9 this section.

10 “(c) REQUIREMENTS FOR COVERED CHURCH
11 PLANS.—

12 “(1) FIDUCIARY RULES AND EXCLUSIVE PUR-
13 POSE.—A fiduciary shall discharge his duties with
14 respect to a church plan to which this section
15 applies—

16 “(A) for the exclusive purpose of:

17 “(i) providing benefits to participants
18 and their beneficiaries; and

19 “(ii) defraying reasonable expenses of
20 administering the plan;

21 “(B) with the care, skill, prudence and dili-
22 gence under the circumstances then prevailing
23 that a prudent man acting in a like capacity
24 and familiar with such matters would use in the

1 conduct of an enterprise of a like character and
2 with like aims; and

3 “(C) in accordance with the documents
4 and instruments governing the plan.

5 The requirements of this paragraph shall not be
6 treated as not satisfied solely because the plan as-
7 sets are commingled with other church assets, to the
8 extent that such plan assets are separately ac-
9 counted for.

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

13 “(A) provide adequate notice in writing to
14 any participant or beneficiary whose claim for
15 benefits under the plan has been denied, setting
16 forth the specific reasons for such denial, writ-
17 ten in a manner calculated to be understood by
18 the participant;

19 “(B) afford a reasonable opportunity to
20 any participant whose claim for benefits has
21 been denied for a full and fair review by the ap-
22 propriate fiduciary of the decision denying the
23 claim; and

1 “(C) provide a written statement to each
2 participant describing the procedures estab-
3 lished pursuant to this paragraph.

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

8 “(A) stating the names and addresses of
9 the plan and of the church, convention, or asso-
10 ciation maintaining the plan (and its principal
11 place of business);

12 “(B) certifying that it is a church plan to
13 which this section applies and that it complies
14 with the requirements of paragraphs (1) and
15 (2);

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

20 “(D) containing a copy of a statement of
21 actuarial opinion signed by a qualified actuary
22 that the plan maintains capital, reserves, insur-
23 ance, other financial arrangements, or any com-
24 bination thereof adequate to enable the plan to

1 fully meet all of its financial obligations on a
2 timely basis.

3 “(4) DISCLOSURE.—At the time that the an-
4 nual statement is filed by a church plan with the
5 Secretary pursuant to paragraph (3), a copy of such
6 statement shall be made available by the Secretary
7 to the State insurance commissioner (or similar offi-
8 cial) of any State. The name of each church plan
9 and sponsoring organization filing an annual state-
10 ment in compliance with paragraph (3) shall be pub-
11 lished annually in the Federal Register.

12 “(c) ENFORCEMENT.—The Secretary may enforce
13 the provisions of this section in a manner consistent with
14 section 502, to the extent applicable with respect to ac-
15 tions under section 502(a)(5), and with section 3(33)(D),
16 except that, other than for the purpose of seeking a tem-
17 porary restraining order, a civil action may be brought
18 with respect to the plan’s failure to meet any requirement
19 of this section only if the plan fails to correct its failure
20 within the correction period described in section 3(33)(D).
21 The other provisions of part 5 (except sections 501(a),
22 503, 512, 514, and 515) shall apply with respect to the
23 enforcement and administration of this section.

24 “(d) DEFINITIONS AND OTHER RULES.—For pur-
25 poses of this section—

1 “(1) IN GENERAL.—Except as otherwise pro-
 2 vided in this section, any term used in this section
 3 which is defined in any provision of this title shall
 4 have the definition provided such term by such pro-
 5 vision.

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

15 **“SEC. 813. DEFINITIONS AND RULES OF CONSTRUCTION.**

16 “(a) DEFINITIONS.—For purposes of this part—

17 “(1) GROUP HEALTH PLAN.—The term ‘group
 18 health plan’ has the meaning provided in section
 19 733(a)(1) (after applying subsection (b) of this sec-
 20 tion).

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

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

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

4 “(5) APPLICABLE AUTHORITY.—

5 “(A) IN GENERAL.—Except as provided in
6 subparagraph (B), the term ‘applicable author-
7 ity’ means, in connection with an association
8 health plan—

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

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

15 “(B) EXCEPTIONS.—

16 “(i) JOINT AUTHORITIES.—Where
17 such term appears in section 808(3), sec-
18 tion 807(e) (in the first instance), section
19 809(a) (in the second instance), section
20 809(a) (in the fourth instance), and sec-
21 tion 809(b)(1), such term means, in con-
22 nection with an association health plan, the
23 Secretary and the State referred to in sub-
24 paragraph (A)(i) (if any) in connection
25 with such plan.

1 “(ii) REGULATORY AUTHORITIES.—

2 Where such term appears in section 802(a)
 3 (in the first instance), section 802(d), sec-
 4 tion 802(e), section 803(d), section
 5 805(a)(5), section 806(a)(2), section
 6 806(b), section 806(c), section 806(d),
 7 paragraphs (1)(A) and (2)(A) of section
 8 806(g), section 806(h), section 806(i), sec-
 9 tion 807(a) (in the second instance), sec-
 10 tion 807(b), section 807(d), section 807(e)
 11 (in the second instance), section 808 (in
 12 the matter after paragraph (3)), and sec-
 13 tion 809(a) (in the third instance), such
 14 term means, in connection with an associa-
 15 tion health plan, the Secretary.

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

19 “(7) INDIVIDUAL MARKET.—

20 “(A) IN GENERAL.—The term ‘individual
 21 market’ means the market for health insurance
 22 coverage offered to individuals other than in
 23 connection with a group health plan.

24 “(B) TREATMENT OF VERY SMALL
 25 GROUPS.—

1 “(i) IN GENERAL.—Subject to clause
2 (ii), such term includes coverage offered in
3 connection with a group health plan that
4 has fewer than 2 participants as current
5 employees or participants described in sec-
6 tion 732(d)(3) on the first day of the plan
7 year.

8 “(ii) STATE EXCEPTION.—Clause (i)
9 shall not apply in the case of health insur-
10 ance coverage offered in a State if such
11 State regulates the coverage described in
12 such clause in the same manner and to the
13 same extent as coverage in the small group
14 market (as defined in section 2791(e)(5) of
15 the Public Health Service Act) is regulated
16 by such State.

17 “(8) PARTICIPATING EMPLOYER.—The term
18 ‘participating employer’ means, in connection with
19 an association health plan, any employer, if any indi-
20 vidual who is an employee of such employer, a part-
21 ner in such employer, or a self-employed individual
22 who is such employer (or any dependent, as defined
23 under the terms of the plan, of such individual) is
24 or was covered under such plan in connection with
25 the status of such individual as such an employee,

1 partner, or self-employed individual in relation to the
2 plan.

3 “(9) APPLICABLE STATE AUTHORITY.—The
4 term ‘applicable State authority’ means, with respect
5 to a health insurance issuer in a State, the State in-
6 surance commissioner or official or officials des-
7 ignated by the State to enforce the requirements of
8 title XXVII of the Public Health Service Act for the
9 State involved with respect to such issuer.

10 “(10) QUALIFIED ACTUARY.—The term ‘quali-
11 fied actuary’ means an individual who is a member
12 of the American Academy of Actuaries or meets
13 such reasonable standards and qualifications as the
14 Secretary may provide by regulation.

15 “(11) AFFILIATED MEMBER.—The term ‘affili-
16 ated member’ means, in connection with a sponsor,
17 a person eligible to be a member of the sponsor or,
18 in the case of a sponsor with member associations,
19 a person who is a member, or is eligible to be a
20 member, of a member association.

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

1 and who employs at least 2 employees on the first
2 day of the plan year.

3 “(13) SMALL EMPLOYER.—The term ‘small em-
4 ployer’ means, in connection with a group health
5 plan with respect to a plan year, an employer who
6 is not a large employer.

7 “(b) RULES OF CONSTRUCTION.—

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

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

21 “(B) in the case of a self-employed individ-
22 ual, the term ‘employer’ (as defined in section
23 3(5)) and the term ‘employee’ (as defined in
24 section 3(6)) shall include such individual.

1 “(2) PLANS, FUNDS, AND PROGRAMS TREATED
2 AS EMPLOYEE WELFARE BENEFIT PLANS.—In the
3 case of any plan, fund, or program which was estab-
4 lished or is maintained for the purpose of providing
5 medical care (through the purchase of insurance or
6 otherwise) for employees (or their dependents) cov-
7 ered thereunder and which demonstrates to the Sec-
8 retary that all requirements for certification under
9 this part would be met with respect to such plan,
10 fund, or program if such plan, fund, or program
11 were a group health plan, such plan, fund, or pro-
12 gram shall be treated for purposes of this title as an
13 employee welfare benefit plan on and after the date
14 of such demonstration.”.

15 (b) CONFORMING AMENDMENTS TO PREEMPTION
16 RULES.—

17 (1) Section 514(b)(6) of such Act (29 U.S.C.
18 1144(b)(6)) is amended by adding at the end the
19 following new subparagraph:

20 “(E) The preceding subparagraphs of this paragraph
21 do not apply with respect to any State law in the case
22 of an association health plan which is certified under part
23 8.”.

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

1 (A) in subsection (b)(4), by striking “Sub-
2 section (a)” and inserting “Subsections (a) and
3 (d)”;

4 (B) in subsection (b)(5), by striking “sub-
5 section (a)” in subparagraph (A) and inserting
6 “subsection (a) of this section and subsections
7 (a)(2)(B) and (b) of section 805”, and by strik-
8 ing “subsection (a)” in subparagraph (B) and
9 inserting “subsection (a) of this section or sub-
10 section (a)(2)(B) or (b) of section 805”;

11 (C) by redesignating subsection (d) as sub-
12 section (e); and

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

15 “(d)(1) Except as provided in subsection (b)(4), the
16 provisions of this title shall supersede any and all State
17 laws insofar as they may now or hereafter preclude, or
18 have the effect of precluding, a health insurance issuer
19 from offering health insurance coverage in connection with
20 an association health plan which is certified under part
21 8.

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

24 “(A) In any case in which health insurance cov-
25 erage of any policy type is offered under an associa-

1 tion health plan certified under part 8 to a partici-
2 pating employer operating in such State, the provi-
3 sions of this title shall supersede any and all laws
4 of such State insofar as they may preclude a health
5 insurance issuer from offering health insurance cov-
6 erage of the same policy type to other employers op-
7 erating in the State which are eligible for coverage
8 under such association health plan, whether or not
9 such other employers are participating employers in
10 such plan.

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

23 “(3) For additional provisions relating to association
24 health plans, see subsections (a)(2)(B) and (b) of section
25 805.

1 “(4) For purposes of this subsection, the term ‘asso-
 2 ciation health plan’ has the meaning provided in section
 3 801(a), and the terms ‘health insurance coverage’, ‘par-
 4 ticipating employer’, and ‘health insurance issuer’ have
 5 the meanings provided such terms in section 811, respec-
 6 tively.”.

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

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

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

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

18 “(iii) subject to subparagraph (E), in the case
 19 of any other employee welfare benefit plan which is
 20 a multiple employer welfare arrangement and which
 21 provides medical care (within the meaning of section
 22 733(a)(2)), any law of any State which regulates in-
 23 surance may apply.”.

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

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

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

6 “(2) Nothing in any other provision of law enacted
7 on or after the date of the enactment of the Patient Pro-
8 tection Act of 1999 shall be construed to alter, amend,
9 modify, invalidate, impair, or supersede any provision of
10 this title, except by specific cross-reference to the affected
11 section.”.

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

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

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

3 (f) CLERICAL AMENDMENT.—The table of contents
 4 in section 1 of the Employee Retirement Income Security
 5 Act of 1974 is amended by inserting after the item relat-
 6 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.”.

7 **SEC. 1303. CLARIFICATION OF TREATMENT OF SINGLE EM-**
 8 **PLOYER ARRANGEMENTS.**

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

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

1 (2) in clause (iii)—

2 (A) by striking “common control shall not
3 be based on an interest of less than 25 percent”
4 and inserting “an interest of greater than 25
5 percent may not be required as the minimum
6 interest necessary for common control”; and

7 (B) by striking “similar to” and inserting
8 “consistent and coextensive with”;

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

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

13 “(iv) in determining, after the application of
14 clause (i), whether benefits are provided to employ-
15 ees of two or more employers, the arrangement shall
16 be treated as having only one participating employer
17 if, after the application of clause (i), the number of
18 individuals who are employees and former employees
19 of any one participating employer and who are cov-
20 ered under the arrangement is greater than 75 per-
21 cent of the aggregate number of all individuals who
22 are employees or former employees of participating
23 employers and who are covered under the arrange-
24 ment;”.

1 **SEC. 1304. CLARIFICATION OF TREATMENT OF CERTAIN**
2 **COLLECTIVELY BARGAINED ARRANGE-**
3 **MENTS.**

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

7 “(i)(I) under or pursuant to one or more collec-
8 tive bargaining agreements which are reached pursu-
9 ant to collective bargaining described in section 8(d)
10 of the National Labor Relations Act (29 U.S.C.
11 158(d)) or paragraph Fourth of section 2 of the
12 Railway Labor Act (45 U.S.C. 152, paragraph
13 Fourth) or which are reached pursuant to labor-
14 management negotiations under similar provisions of
15 State public employee relations laws, and (II) in ac-
16 cordance with subparagraphs (C), (D), and (E);”.

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

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

24 “(i) The plan or other arrangement, and the
25 employee organization or any other entity sponsoring
26 the plan or other arrangement, do not—

1 “(I) utilize the services of any licensed in-
2 surance agent or broker for soliciting or enroll-
3 ing employers or individuals as participating
4 employers or covered individuals under the plan
5 or other arrangement; or

6 “(II) pay a commission or any other type
7 of compensation to a person, other than a full
8 time employee of the employee organization (or
9 a member of the organization to the extent pro-
10 vided in regulations of the Secretary), that is
11 related either to the volume or number of em-
12 ployers or individuals solicited or enrolled as
13 participating employers or covered individuals
14 under the plan or other arrangement, or to the
15 dollar amount or size of the contributions made
16 by participating employers or covered individ-
17 uals to the plan or other arrangement;

18 except to the extent that the services used by the
19 plan, arrangement, organization, or other entity con-
20 sist solely of preparation of documents necessary for
21 compliance with the reporting and disclosure re-
22 quirements of part 1 or administrative, investment,
23 or consulting services unrelated to solicitation or en-
24 rollment of covered individuals.

1 “(ii) As of the end of the preceding plan year,
2 the number of covered individuals under the plan or
3 other arrangement who are identified to the plan or
4 arrangement and who are neither—

5 “(I) employed within a bargaining unit
6 covered by any of the collective bargaining
7 agreements with a participating employer (nor
8 covered on the basis of an individual’s employ-
9 ment in such a bargaining unit); nor

10 “(II) present employees (or former employ-
11 ees who were covered while employed) of the
12 sponsoring employee organization, of an em-
13 ployer who is or was a party to any of the col-
14 lective bargaining agreements, or of the plan or
15 other arrangement or a related plan or arrange-
16 ment (nor covered on the basis of such present
17 or former employment);

18 does not exceed 15 percent of the total number of
19 individuals who are covered under the plan or ar-
20 rangement and who are present or former employees
21 who are or were covered under the plan or arrange-
22 ment pursuant to a collective bargaining agreement
23 with a participating employer. The requirements of
24 the preceding provisions of this clause shall be treat-
25 ed as satisfied if, as of the end of the preceding plan

1 year, such covered individuals are comprised solely
2 of individuals who were covered individuals under
3 the plan or other arrangement as of the date of the
4 enactment of the Small Business Affordable Health
5 Coverage Act of 1999 and, as of the end of the pre-
6 ceding plan year, the number of such covered indi-
7 viduals does not exceed 25 percent of the total num-
8 ber of present and former employees enrolled under
9 the plan or other arrangement.

10 “(iii) The employee organization or other entity
11 sponsoring the plan or other arrangement certifies
12 to the Secretary each year, in a form and manner
13 which shall be prescribed in regulations of the Sec-
14 retary that the plan or other arrangement meets the
15 requirements of clauses (i) and (ii).

16 “(D) 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) all of the benefits provided under the plan
20 or arrangement consist of health insurance coverage;
21 or

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

24 “(II) the requirements of clause (B) of the pro-
25 viso to clause (5) of section 302(c) of the Labor

1 Management Relations Act, 1947 (29 U.S.C.
2 186(c)) are met with respect to such plan or other
3 arrangement.

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

7 “(i) the plan or arrangement is in effect as of
8 the date of the enactment of the Small Business Af-
9 fordable Health Coverage Act of 1999; or

10 “(ii) the employee organization or other entity
11 sponsoring the plan or arrangement—

12 “(I) has been in existence for at least 3
13 years or is affiliated with another employee or-
14 ganization which has been in existence for at
15 least 3 years; or

16 “(II) demonstrates to the satisfaction of
17 the Secretary that the requirements of subpara-
18 graphs (C) and (D) are met with respect to the
19 plan or other arrangement.”.

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

1 **SEC. 1305. ENFORCEMENT PROVISIONS RELATING TO ASSO-**
2 **CIATION HEALTH PLANS.**

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

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

10 “(b) Any person who, either willfully or with willful
11 blindness, falsely represents, to any employee, any employ-
12 ee’s beneficiary, any employer, the Secretary, or any State,
13 a plan or other arrangement established or maintained for
14 the purpose of offering or providing any benefit described
15 in section 3(1) to employees or their beneficiaries as—

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

18 “(2) having been established or maintained
19 under or pursuant to one or more collective bargain-
20 ing agreements which are reached pursuant to col-
21 lective bargaining described in section 8(d) of the
22 National Labor Relations Act (29 U.S.C. 158(d)) or
23 paragraph Fourth of section 2 of the Railway Labor
24 Act (45 U.S.C. 152, paragraph Fourth) or which are
25 reached pursuant to labor-management negotiations

1 under similar provisions of State public employee re-
2 lations laws; or

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

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

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

12 “(n)(1) Subject to paragraph (2), upon application
13 by the Secretary showing the operation, promotion, or
14 marketing of an association health plan (or similar ar-
15 rangement providing benefits consisting of medical care
16 (as defined in section 733(a)(2))) that—

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

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

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

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

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

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

13 “(3) The court may grant such additional equitable
14 relief, including any relief available under this title, as it
15 deems necessary to protect the interests of the public and
16 of persons having claims for benefits against the plan.”.

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

21 “(c) ASSOCIATION HEALTH PLANS.—The terms of
22 each association health plan which is or has been certified
23 under part 8 shall require the board of trustees or the
24 named fiduciary (as applicable) to ensure that the require-

1 ments of this section are met in connection with claims
 2 filed under the plan.”.

3 **SEC. 1306. COOPERATION BETWEEN FEDERAL AND STATE**
 4 **AUTHORITIES.**

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

8 “(c) RESPONSIBILITY OF STATES WITH RESPECT TO
 9 ASSOCIATION HEALTH PLANS.—

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

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

16 “(B) the Secretary’s authority to certify
 17 association health plans under part 8 in accord-
 18 ance with regulations of the Secretary applica-
 19 ble to certification under part 8; or

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

23 “(2) DELEGATIONS.—Any department, agency,
 24 or instrumentality of a State to which authority is
 25 delegated pursuant to an agreement entered into

1 under this paragraph may, if authorized under State
2 law and to the extent consistent with such agree-
3 ment, exercise the powers of the Secretary under
4 this title which relate to such authority.

5 “(3) RECOGNITION OF PRIMARY DOMICILE
6 STATE.—In entering into any agreement with a
7 State under subparagraph (A), the Secretary shall
8 ensure that, as a result of such agreement and all
9 other agreements entered into under subparagraph
10 (A), only one State will be recognized, with respect
11 to any particular association health plan, as the
12 State to which all authority has been delegated pur-
13 suant to such agreements in connection with such
14 plan. In carrying out this paragraph, the Secretary
15 shall take into account the places of residence of the
16 participants and beneficiaries under the plan and the
17 State in which the trust is maintained.”.

18 **SEC. 1307. EFFECTIVE DATE AND TRANSITIONAL AND**
19 **OTHER RULES.**

20 (a) **EFFECTIVE DATE.**—The amendments made by
21 sections 1302, 1305, and 1306 shall take effect on Janu-
22 ary 1, 2001. The amendments made by sections 1303 and
23 1304 shall take effect on the date of the enactment of
24 this Act. The Secretary of Labor shall first issue all regu-

1 lations necessary to carry out the amendments made by
2 this subtitle before January 1, 2001.

3 (b) EXCEPTION.—Section 801(a)(2) of the Employee
4 Retirement Income Security Act of 1974 (added by section
5 1302) does not apply in connection with an association
6 health plan (certified under part 8 of subtitle B of title
7 I of such Act) existing on April 1, 1997, if no benefits
8 provided thereunder as of the date of the enactment of
9 this Act consist of health insurance coverage (as defined
10 in section 733(b)(1) of such Act).

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

13 (1) IN GENERAL.—In any case in which, as of
14 the date of the enactment of this Act, an arrange-
15 ment is maintained in a State for the purpose of
16 providing benefits consisting of medical care for the
17 employees and beneficiaries of its participating em-
18 ployers, at least 200 participating employers make
19 contributions to such arrangement, such arrange-
20 ment has been in existence for at least 10 years, and
21 such arrangement is licensed under the laws of one
22 or more States to provide such benefits to its par-
23 ticipating employers, upon the filing with the appli-
24 cable authority (as defined in section 813(a)(5) of
25 the Employee Retirement Income Security Act of

1 1974 (as amended by this Act)) by the arrangement
2 of an application for certification of the arrangement
3 under part 8 of subtitle B of title I of such Act—

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

7 (B) the requirements of sections 801(a)(1)
8 and 803(a)(1) of the Employee Retirement In-
9 come Security Act of 1974 shall be deemed met
10 with respect to such arrangement;

11 (C) the requirements of section 803(b) of
12 such Act shall be deemed met, if the arrange-
13 ment is operated by a board of directors
14 which—

15 (i) is elected by the participating em-
16 ployers, with each employer having one
17 vote; and

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

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

24 (E) the arrangement may be certified by
25 any applicable authority with respect to its op-

1 erations in any State only if it operates in such
2 State on the date of certification.

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

8 (2) DEFINITIONS.—For purposes of this sub-
9 section, the terms “group health plan”, “medical
10 care”, and “participating employer” shall have the
11 meanings provided in section 813 of the Employee
12 Retirement Income Security Act of 1974, except
13 that the reference in paragraph (7) of such section
14 to an “association health plan” shall be deemed a
15 reference to an arrangement referred to in this sub-
16 section.

17 (d) PILOT PROGRAM FOR SELF-INSURED ASSOCIA-
18 TION HEALTH PLANS.—

19 (1) IN GENERAL.—During the pilot program
20 period, association health plans which offer benefit
21 options which do not consist of health insurance cov-
22 erage may be certified under part 8 of subtitle B of
23 title I of the Employee Retirement Income Security
24 Act of 1974 only if such plans consist of the follow-
25 ing:

1 (A) plans which offered such coverage on
2 the date of the enactment of this Act;

3 (B) plans under which the sponsor does
4 not restrict membership to one or more trades
5 and businesses or industries and whose eligible
6 participating employers represent a broad cross-
7 section of trades and businesses or industries;
8 or

9 (C) plans whose eligible participating em-
10 ployers represent one or more trades or busi-
11 nesses, or one or more industries, which have
12 been indicated as having average or above-aver-
13 age health insurance risk or health claims expe-
14 rience by reason of State rate filings, denials of
15 coverage, proposed premium rate levels, and
16 other means demonstrated by such plans in ac-
17 cordance with regulations which the Secretary
18 shall prescribe, including (but not limited to)
19 the following: agriculture; automobile dealer-
20 ships; barbering and cosmetology; child care;
21 construction; dance, theatrical, and orchestra
22 productions; disinfecting and pest control; eat-
23 ing and drinking establishments; fishing; hos-
24 pitals; labor organizations; logging; manufactur-
25 ing (metals); mining; medical and dental prac-

1 tices; medical laboratories; sanitary services;
 2 transportation (local and freight); and
 3 warehousing.

4 (2) PILOT PROGRAM PERIOD.—For purposes of
 5 this subsection, the term “pilot program period”
 6 means the 5-year period beginning on January 1,
 7 2000.

8 **TITLE II—AMENDMENTS TO**
 9 **PUBLIC HEALTH SERVICE ACT**
 10 **Subtitle A—Patient Protections**
 11 **and Point of Service Coverage**
 12 **Requirements**

13 **SEC. 2001. PATIENT ACCESS TO UNRESTRICTED MEDICAL**
 14 **ADVICE, EMERGENCY MEDICAL CARE, OB-**
 15 **STETRIC AND GYNECOLOGICAL CARE, PEDI-**
 16 **ATRIC CARE.**

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

20 **“SEC. 2707. PATIENT ACCESS TO UNRESTRICTED MEDICAL**
 21 **ADVICE, EMERGENCY MEDICAL CARE, OB-**
 22 **STETRIC AND GYNECOLOGICAL CARE, PEDI-**
 23 **ATRIC CARE.**

24 “(a) PATIENT ACCESS TO UNRESTRICTED MEDICAL
 25 ADVICE.—

1 “(1) IN GENERAL.—In the case of any health
2 care professional acting within the lawful scope of
3 practice in the course of carrying out a contractual
4 employment arrangement or other direct contractual
5 arrangement between such professional and a group
6 health plan or a health insurance issuer offering
7 health insurance coverage in connection with a group
8 health plan, the plan or issuer with which such con-
9 tractual employment arrangement or other direct
10 contractual arrangement is maintained by the pro-
11 fessional may not impose on such professional under
12 such arrangement any prohibition or restriction with
13 respect to advice, provided to a participant or bene-
14 ficiary under the plan who is a patient, about the
15 health status of the participant or beneficiary or the
16 medical care or treatment for the condition or dis-
17 ease of the participant or beneficiary, regardless of
18 whether benefits for such care or treatment are pro-
19 vided under the plan or health insurance coverage
20 offered in connection with the plan.

21 “(2) HEALTH CARE PROFESSIONAL DEFINED.—
22 For purposes of this subsection, the term ‘health
23 care professional’ means a physician (as defined in
24 section 1861(r) of the Social Security Act) or other
25 health care professional if coverage for the profes-

1 sional's services is provided under the group health
2 plan for the services of the professional. Such term
3 includes a podiatrist, optometrist, chiropractor, psy-
4 chologist, dentist, physician assistant, physical or oc-
5 cupational therapist and therapy assistant, speech-
6 language pathologist, audiologist, registered or li-
7 censed practical nurse (including nurse practitioner,
8 clinical nurse specialist, certified registered nurse
9 anesthetist, and certified nurse-midwife), licensed
10 certified social worker, registered respiratory thera-
11 pist, and certified respiratory therapy technician.

12 “(b) PATIENT ACCESS TO EMERGENCY MEDICAL
13 CARE.—

14 “(1) IN GENERAL.—To the extent that the
15 group health plan (or health insurance issuer offer-
16 ing health insurance coverage in connection with the
17 plan) provides for any benefits consisting of emer-
18 gency medical care (as defined in section
19 503(b)(9)(I) of the Employee Retirement Income Se-
20 curity Act of 1974), except for items or services spe-
21 cifically excluded—

22 “(A) the plan or issuer shall provide bene-
23 fits, without requiring preauthorization and
24 without regard to otherwise applicable network
25 limitations, for appropriate emergency medical

1 screening examinations (within the capability of
2 the emergency facility, including ancillary serv-
3 ices routinely available to the emergency facil-
4 ity) to the extent that a prudent layperson, who
5 possesses an average knowledge of health and
6 medicine, would determine such examinations to
7 be necessary in order to determine whether
8 emergency medical care (as so defined) is re-
9 quired; and

10 “(B) the plan or issuer shall provide bene-
11 fits for additional emergency medical services
12 following an emergency medical screening exam-
13 ination (if determined necessary under subpara-
14 graph (A)) to the extent that a prudent emer-
15 gency medical professional would determine
16 such additional emergency services to be nec-
17 essary to avoid the consequences described in
18 section 503(b)(9)(I) of such Act.

19 “(2) UNIFORM COST-SHARING REQUIRED.—

20 Nothing in this subsection shall be construed as pre-
21 venting a group health plan or issuer from imposing
22 any form of cost-sharing applicable to any partici-
23 pant or beneficiary (including coinsurance, copay-
24 ments, deductibles, and any other charges) in rela-
25 tion to benefits described in paragraph (1), if such

1 form of cost-sharing is uniformly applied under such
 2 plan, with respect to similarly situated participants
 3 and beneficiaries, to all benefits consisting of emer-
 4 gency medical care (as defined in section
 5 503(b)(9)(I) of the Employee Retirement Income Se-
 6 curity Act of 1974) provided to such similarly situ-
 7 ated participants and beneficiaries under the plan.

8 “(c) PATIENT ACCESS TO OBSTETRIC AND GYNECO-
 9 LOGICAL CARE.—

10 “(1) IN GENERAL.—In any case in which a
 11 group health plan (or a health insurance issuer of-
 12 fering health insurance coverage in connection with
 13 the plan)—

14 “(A) provides benefits under the terms of
 15 the plan consisting of—

16 “(i) routine gynecological care (such
 17 as preventive women’s health examina-
 18 tions); or

19 “(ii) routine obstetric care (such as
 20 routine pregnancy-related services),
 21 provided by a participating physician who spe-
 22 cializes in such care (or provides benefits con-
 23 sisting of payment for such care); and

1 “(B) the plan requires or provides for des-
2 ignation by a participant or beneficiary of a
3 participating primary care provider,
4 if the primary care provider designated by such a
5 participant or beneficiary is not such a physician,
6 then the plan (or issuer) shall meet the requirements
7 of paragraph (2).

8 “(2) REQUIREMENTS.—A group health plan (or
9 a health insurance issuer offering health insurance
10 coverage in connection with the plan) meets the re-
11 quirements of this paragraph, in connection with
12 benefits described in paragraph (1) consisting of
13 care described in clause (i) or (ii) of paragraph
14 (1)(A) (or consisting of payment therefor), if the
15 plan (or issuer)—

16 “(A) does not require authorization or a
17 referral by the primary care provider in order
18 to obtain such benefits; and

19 “(B) treats the ordering of other routine
20 care of the same type, by the participating phy-
21 sician providing the care described in clause (i)
22 or (ii) of paragraph (1)(A), as the authorization
23 of the primary care provider with respect to
24 such care.

1 “(3) CONSTRUCTION.—Nothing in paragraph
2 (2)(B) shall waive any requirements of coverage re-
3 lating to medical necessity or appropriateness with
4 respect to coverage of gynecological or obstetric care
5 so ordered.

6 “(d) PATIENT ACCESS TO PEDIATRIC CARE.—

7 “(1) IN GENERAL.—In any case in which a
8 group health plan (or a health insurance issuer of-
9 fering health insurance coverage in connection with
10 the plan) provides benefits consisting of routine pe-
11 diatric care provided by a participating physician
12 who specializes in pediatrics (or consisting of pay-
13 ment for such care) and the plan requires or pro-
14 vides for designation by a participant or beneficiary
15 of a participating primary care provider, the plan (or
16 issuer) shall provide that such a participating physi-
17 cian may be designated, if available, by a parent or
18 guardian of any beneficiary under the plan is who
19 under 18 years of age, as the primary care provider
20 with respect to any such benefits.

21 “(2) CONSTRUCTION.—Nothing in paragraph
22 (1) shall waive any requirements of coverage relating
23 to medical necessity or appropriateness with respect
24 to coverage of pediatric care.

1 “(e) TREATMENT OF MULTIPLE COVERAGE OP-
2 TIONS.—In the case of a plan providing benefits under two
3 or more coverage options, the requirements of subsections
4 (c) and (d) shall apply separately with respect to each cov-
5 erage option.”.

6 (c) EFFECTIVE DATE AND RELATED RULES.—

7 (1) IN GENERAL.—The amendments made by
8 this section shall apply with respect to plan years be-
9 ginning on or after January 1 of the second cal-
10 endar year following the date of the enactment of
11 this Act, except that the Secretary of Health and
12 Human Services may issue regulations before such
13 date under such amendments. The Secretary shall
14 first issue all regulations necessary to carry out the
15 amendments made by this section before the effec-
16 tive date thereof.

17 (2) LIMITATION ON ENFORCEMENT ACTIONS.—

18 No enforcement action shall be taken, pursuant to
19 the amendments made by this section, against a
20 group health plan or health insurance issuer with re-
21 spect to a violation of a requirement imposed by
22 such amendments before the date of issuance of reg-
23 ulations issued in connection with such requirement,
24 if the plan or issuer has sought to comply in good
25 faith with such requirement.

1 (3) SPECIAL RULE FOR COLLECTIVE BARGAIN-
2 ING AGREEMENTS.—In the case of a group health
3 plan maintained pursuant to one or more collective
4 bargaining agreements between employee representa-
5 tives and one or more employers ratified before the
6 date of the enactment of this Act, the amendments
7 made by this section shall not apply with respect to
8 plan years beginning before the later of—

9 (A) the date on which the last of the col-
10 lective bargaining agreements relating to the
11 plan terminates (determined without regard to
12 any extension thereof agreed to after the date
13 of the enactment of this Act); or

14 (B) January 1, 2002.

15 For purposes of this paragraph, any plan amend-
16 ments made pursuant to a collective bargaining
17 agreement relating to the plan which amends the
18 plan solely to conform to any requirement added by
19 this section shall not be treated as a termination of
20 such collective bargaining agreement.

1 **SEC. 2002. REQUIRING HEALTH MAINTENANCE ORGANIZA-**
2 **TIONS TO OFFER OPTION OF POINT-OF-SERV-**
3 **ICE COVERAGE.**

4 (a) IN GENERAL.—Title XXVII of the Public Health
5 Service Act is amended by inserting after section 2713 the
6 following new section:

7 **“SEC. 2714. REQUIRING OFFERING OF OPTION OF POINT-**
8 **OF-SERVICE COVERAGE.**

9 “(a) REQUIREMENT TO OFFER COVERAGE OPTION
10 TO CERTAIN EMPLOYERS.—Except as provided in sub-
11 section (c), any health insurance issuer which—

12 “(1) is a health maintenance organization (as
13 defined in section 2791(b)(3)); and

14 “(2) which provides for coverage of services of
15 one or more classes of health care professionals
16 under health insurance coverage offered in connec-
17 tion with a group health plan only if such services
18 are furnished exclusively through health care profes-
19 sionals within such class or classes who are members
20 of a closed panel of health care professionals,

21 the issuer shall make available to the plan sponsor in con-
22 nection with such a plan a coverage option which provides
23 for coverage of such services which are furnished through
24 such class (or classes) of health care professionals regard-
25 less of whether or not the professionals are members of
26 such panel.

1 “(b) REQUIREMENT TO OFFER SUPPLEMENTAL
2 COVERAGE TO PARTICIPANTS IN CERTAIN CASES.—Ex-
3 cept as provided in subsection (c), if a health insurance
4 issuer makes available a coverage option under and de-
5 scribed in subsection (a) to a plan sponsor of a group
6 health plan and the sponsor declines to contract for such
7 coverage option, then the issuer shall make available in
8 the individual insurance market to each participant in the
9 group health plan optional separate supplemental health
10 insurance coverage in the individual health insurance mar-
11 ket which consists of services identical to those provided
12 under such coverage provided through the closed panel
13 under the group health plan but are furnished exclusively
14 by health care professionals who are not members of such
15 a closed panel.

16 “(c) EXCEPTIONS.—

17 “(1) OFFERING OF NONPANEL OPTION.—Sub-
18 sections (a) and (b) shall not apply with respect to
19 a group health plan if the plan offers a coverage op-
20 tion that provides coverage for services that may be
21 furnished by a class or classes of health care profes-
22 sionals who are not in a closed panel. This para-
23 graph shall be applied separately to distinguishable
24 groups of employees under the plan.

1 “(2) AVAILABILITY OF COVERAGE THROUGH
2 HEALTHMART.—Subsections (a) and (b) shall not
3 apply to a group health plan if the health insurance
4 coverage under the plan is made available through a
5 HealthMart (as defined in section 2801) and if any
6 health insurance coverage made available through
7 the HealthMart provides for coverage of the services
8 of any class of health care professionals other than
9 through a closed panel of professionals.

10 “(3) RELICENSURE EXEMPTION.—Subsections
11 (a) and (b) shall not apply to a health maintenance
12 organization in a State in any case in which—

13 “(A) the organization demonstrates to the
14 applicable authority that the organization has
15 made a good faith effort to obtain (but has
16 failed to obtain) a contract between the organi-
17 zation and any other health insurance issuer
18 providing for the coverage option or supple-
19 mental coverage described in subsection (a) or
20 (b), as the case may be, within the applicable
21 service area of the organization; and

22 “(B) the State requires the organization to
23 receive or qualify for a separate license, as an
24 indemnity insurer or otherwise, in order to offer

1 such coverage option or supplemental coverage,
2 respectively.

3 The applicable authority may require that the orga-
4 nization demonstrate that it meets the requirements
5 of the previous sentence no more frequently than
6 once every 2 years.

7 “(4) INCREASED COSTS.—Subsections (a) and
8 (b) shall not apply to a health maintenance organi-
9 zation if the organization demonstrates to the appli-
10 cable authority, in accordance with generally accept-
11 ed actuarial practice, that, on either a prospective or
12 retroactive basis, the premium for the coverage op-
13 tion or supplemental coverage required to be made
14 available under such respective subsection exceeds by
15 more than 1 percent the premium for the coverage
16 consisting of services which are furnished through a
17 closed panel of health care professionals in the class
18 or classes involved. The applicable authority may re-
19 quire that the organization demonstrate such an in-
20 crease no more frequently than once every 2 years.
21 This paragraph shall be applied on an average per
22 enrollee or similar basis.

23 “(5) COLLECTIVE BARGAINING AGREEMENTS.—
24 Subsections (a) and (b) shall not apply in connection
25 with a group health plan if the plan is established

1 or maintained pursuant to one or more collective
2 bargaining agreements.

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

4 “(1) COVERAGE THROUGH CLOSED PANEL.—
5 Health insurance coverage for a class of health care
6 professionals shall be treated as provided through a
7 closed panel of such professionals only if such cov-
8 erage consists of coverage of items or services con-
9 sisting of professionals services which are reim-
10 bursed for or provided only within a limited network
11 of such professionals.

12 “(2) HEALTH CARE PROFESSIONAL.—The term
13 ‘health care professional’ has the meaning given
14 such term in section 2707(a)(2).”.

15 (b) EFFECTIVE DATE.—The amendment made by
16 subsection (a) shall apply to coverage offered on or after
17 January 1 of the second calendar year following the date
18 of the enactment of this Act.

1 **Subtitle B—Patient Access to**
2 **Information**

3 **SEC. 2101. PATIENT ACCESS TO INFORMATION REGARDING**
4 **PLAN COVERAGE, MANAGED CARE PROCE-**
5 **DURES, HEALTH CARE PROVIDERS, AND**
6 **QUALITY OF MEDICAL CARE.**

7 (a) IN GENERAL.—Subpart 2 of part A of title
8 XXVII of the Public Health Service Act (as amended by
9 subtitle A of this title) is amended further by adding at
10 the end the following new section:

11 **“SEC. 2707. PATIENT ACCESS TO INFORMATION REGARD-**
12 **ING PLAN COVERAGE, MANAGED CARE PRO-**
13 **CEDURES, HEALTH CARE PROVIDERS, AND**
14 **QUALITY OF MEDICAL CARE.**

15 “(a) DISCLOSURE REQUIREMENT.—Each health in-
16 surance issuer offering health insurance coverage in con-
17 nection with a group health plan shall provide the adminis-
18 trator of such plan on a timely basis with the information
19 necessary to enable the administrator to include in the
20 summary plan description of the plan required under sec-
21 tion 102 of the Employee Retirement Income Security Act
22 of 1974 (or each summary plan description in any case
23 in which different summary plan descriptions are appro-
24 priate under part 1 of subtitle B of title I of such Act
25 for different options of coverage) the information required

1 under subsections (b), (c), (d), and (e)(2)(A). To the ex-
 2 tent that any such issuer provides such information on a
 3 timely basis to plan participants and beneficiaries, the re-
 4 quirements of this subsection shall be deemed satisfied in
 5 the case of such plan with respect to such information.

6 “(b) PLAN BENEFITS.—The information required
 7 under subsection (a) includes the following:

8 “(1) COVERED ITEMS AND SERVICES.—

9 “(A) CATEGORIZATION OF INCLUDED BEN-
 10 EFITS.—A description of covered benefits, cat-
 11 egorized by—

12 “(i) types of items and services (in-
 13 cluding any special disease management
 14 program); and

15 “(ii) types of health care professionals
 16 providing such items and services.

17 “(B) EMERGENCY MEDICAL CARE.—A de-
 18 scription of the extent to which the coverage in-
 19 cludes emergency medical care (including the
 20 extent to which the coverage provides for access
 21 to urgent care centers), and any definitions pro-
 22 vided under in connection with such coverage
 23 for the relevant coverage terminology referring
 24 to such care.

1 “(C) PREVENTATIVE SERVICES.—A de-
2 scription of the extent to which the coverage in-
3 cludes benefits for preventative services.

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

9 “(E) COBRA CONTINUATION COV-
10 ERAGE.—A description of the benefits available
11 under the coverage provided pursuant to part 6
12 of subtitle B of title I of the Employee Retire-
13 ment Income Security Act of 1974.

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

16 “(A) CATEGORIZATION OF EXCLUDED
17 BENEFITS.—A description of benefits specifi-
18 cally excluded from coverage, categorized by
19 types of items and services.

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

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

7 “(D) CUSTODIAL CARE.—A description of
8 the circumstances under which, and the extent
9 to which, the coverage of benefits for custodial
10 care is limited or excluded, and a statement of
11 the definition used in connection with such cov-
12 erage for custodial care.

13 “(E) EXPERIMENTAL TREATMENTS.—
14 Whether coverage for any medical care is lim-
15 ited or excluded because it constitutes experi-
16 mental treatment or technology, and any defini-
17 tions provided in connection with such coverage
18 for the relevant plan terminology referring to
19 such limited or excluded care.

20 “(F) MEDICAL APPROPRIATENESS OR NE-
21 CESSITY.—Whether coverage for medical care
22 may be limited or excluded by reason of a fail-
23 ure to meet the plan’s requirements for medical
24 appropriateness or necessity, and any defini-
25 tions provided in connection with such coverage

1 for the relevant coverage terminology referring
2 to such limited or excluded care.

3 “(G) SECOND OR SUBSEQUENT OPIN-
4 IONS.—A description of the circumstances
5 under which, and the extent to which, coverage
6 for second or subsequent opinions is limited or
7 excluded.

8 “(H) SPECIALTY CARE.—A description of
9 the circumstances under which, and the extent
10 to which, coverage of benefits for specialty care
11 is conditioned on referral from a primary care
12 provider.

13 “(I) CONTINUITY OF CARE.—A description
14 of the circumstances under which, and the ex-
15 tent to which, coverage of items and services
16 provided by any health care professional is lim-
17 ited or excluded by reason of the departure by
18 the professional from any defined set of provid-
19 ers.

20 “(J) RESTRICTIONS ON COVERAGE OF
21 EMERGENCY SERVICES.—A description of the
22 circumstances under which, and the extent to
23 which, the coverage, in including emergency
24 medical care furnished to a participant or bene-
25 ficiary of the plan imposes any financial respon-

1 sibility described in subsection (c) on partici-
2 pants or beneficiaries or limits or conditions
3 benefits for such care subject to any other term
4 or condition of such coverage.

5 “(c) PARTICIPANT’S FINANCIAL RESPONSIBIL-
6 ITIES.—The information required under subsection (a) in-
7 cludes an explanation of—

8 “(1) a participant’s financial responsibility for
9 payment of premiums, coinsurance, copayments,
10 deductibles, and any other charges; and

11 “(2) the circumstances under which, and the
12 extent to which, the participant’s financial respon-
13 sibility described in paragraph (1) may vary, includ-
14 ing any distinctions based on whether a health care
15 provider from whom covered benefits are obtained is
16 included in a defined set of providers.

17 “(d) DISPUTE RESOLUTION PROCEDURES.—The in-
18 formation required under subsection (a) includes a de-
19 scription of the processes adopted in connection with such
20 coverage pursuant to section 503(b) of the Employee Re-
21 tirement Income Security Act of 1974, including—

22 “(1) descriptions thereof relating specifically
23 to—

24 “(A) coverage decisions;

1 “(B) internal review of coverage decisions;
2 and

3 “(C) any external review of coverage deci-
4 sions; and

5 “(2) the procedures and time frames applicable
6 to each step of the processes referred to in subpara-
7 graphs (A), (B), and (C) of paragraph (1).

8 “(e) INFORMATION AVAILABLE ON REQUEST.—

9 “(1) ACCESS TO PLAN BENEFIT INFORMATION
10 IN ELECTRONIC FORM.—

11 “(A) IN GENERAL.—A group health plan
12 (and a health insurance issuer offering health
13 insurance coverage in connection with a group
14 health plan) shall, upon written request (made
15 not more frequently than annually), make avail-
16 able to participants and beneficiaries, in a gen-
17 erally recognized electronic format, the follow-
18 ing information:

19 “(i) the latest summary plan descrip-
20 tion, including the latest summary of ma-
21 terial modifications; and

22 “(ii) the actual plan provisions setting
23 forth the benefits available under the plan,
24 to the extent such information relates to the
25 coverage options under the plan available to the

1 participant or beneficiary. A reasonable charge
2 may be made to cover the cost of providing
3 such information in such generally recognized
4 electronic format. The Secretary may by regula-
5 tion prescribe a maximum amount which will
6 constitute a reasonable charge under the pre-
7 ceding sentence.

8 “(B) ALTERNATIVE ACCESS.—The require-
9 ments of this paragraph may be met by making
10 such information generally available (rather
11 than upon request) on the Internet or on a pro-
12 prietary computer network in a format which is
13 readily accessible to participants and bene-
14 ficiaries.

15 “(2) ADDITIONAL INFORMATION TO BE PRO-
16 VIDED ON REQUEST.—

17 “(A) INCLUSION IN SUMMARY PLAN DE-
18SCRIPTION OF SUMMARY OF ADDITIONAL IN-
19FORMATION.—The information required under
20 subsection (a) includes a summary description
21 of the types of information required by this
22 subsection to be made available to participants
23 and beneficiaries on request.

24 “(B) INFORMATION REQUIRED FROM
25 PLANS AND ISSUERS ON REQUEST.—In addition

1 to information required to be included in sum-
2 mary plan descriptions under this subsection, a
3 group health plan (and a health insurance
4 issuer offering health insurance coverage in
5 connection with a group health plan) shall pro-
6 vide the following information to a participant
7 or beneficiary on request:

8 “(i) NETWORK CHARACTERISTICS.—If
9 the plan (or issuer) utilizes a defined set of
10 providers under contract with the plan (or
11 issuer), a detailed list of the names of such
12 providers and their geographic location, set
13 forth separately with respect to primary
14 care providers and with respect to special-
15 ists.

16 “(ii) CARE MANAGEMENT INFORMA-
17 TION.—A description of the circumstances
18 under which, and the extent to which, the
19 plan has special disease management pro-
20 grams or programs for persons with dis-
21 abilities, indicating whether these pro-
22 grams are voluntary or mandatory and
23 whether a significant benefit differential
24 results from participation in such pro-
25 grams.

1 “(iii) INCLUSION OF DRUGS AND
2 BIOLOGICALS IN FORMULARIES.—A state-
3 ment of whether a specific drug or biologi-
4 cal is included in a formulary used to de-
5 termine benefits under the plan and a de-
6 scription of the procedures for considering
7 requests for any patient-specific waivers.

8 “(iv) PROCEDURES FOR DETERMINING
9 EXCLUSIONS BASED ON MEDICAL NECES-
10 SITY OR EXPERIMENTAL TREATMENTS.—
11 Upon receipt by the participant or bene-
12 ficiary of any notification of an adverse
13 coverage decision based on a determination
14 relating to medical necessity or an experi-
15 mental treatment or technology, a descrip-
16 tion of the procedures and medically-based
17 criteria used in such decision.

18 “(v) PREAUTHORIZATION AND UTILI-
19 ZATION REVIEW PROCEDURES.—Upon re-
20 ceipt by the participant or beneficiary of
21 any notification of an adverse coverage de-
22 cision, a description of the basis on which
23 any preauthorization requirement or any
24 utilization review requirement has resulted
25 in such decision.

1 “(vi) ACCREDITATION STATUS OF
2 HEALTH INSURANCE ISSUERS AND SERV-
3 ICE PROVIDERS.—A description of the ac-
4 creditation and licensing status (if any) of
5 each health insurance issuer offering
6 health insurance coverage in connection
7 with the plan and of any utilization review
8 organization utilized by the issuer or the
9 plan, together with the name and address
10 of the accrediting or licensing authority.

11 “(vii) MEASURES OF ENROLLEE SAT-
12 ISFACTION.—The latest information (if
13 any) maintained by the plan, or by any
14 health insurance issuer offering health in-
15 surance coverage in connection with the
16 plan, relating to enrollee satisfaction.

17 “(viii) QUALITY PERFORMANCE MEAS-
18 URES.—The latest information (if any)
19 maintained by the plan, or by any health
20 insurance issuer offering health insurance
21 coverage in connection with the plan, relat-
22 ing to quality of performance of the deliv-
23 ery of medical care with respect to cov-
24 erage options offered under the plan and

1 of health care professionals and facilities
2 providing medical care under the plan.

3 “(ix) INFORMATION RELATING TO EX-
4 TERNAL REVIEWS.—The number of exter-
5 nal reviews under section 503(b)(4) of the
6 Employee Retirement Income Security Act
7 of 1974 that have been completed during
8 the prior plan year and the number of such
9 reviews in which the recommendation re-
10 ported under section 503(b)(4)(C)(iii) of
11 such Act includes a recommendation for
12 modification or reversal of an internal re-
13 view decision under the plan.

14 “(C) INFORMATION REQUIRED FROM
15 HEALTH CARE PROFESSIONALS ON REQUEST.—
16 Any health care professional treating a partici-
17 pant or beneficiary under a group health plan
18 shall provide to the participant or beneficiary,
19 on request, a description of his or her profes-
20 sional qualifications (including board certifi-
21 cation status, licensing status, and accreditation
22 status, if any), privileges, and experience and a
23 general description by category (including sal-
24 ary, fee-for-service, capitation, and such other
25 categories as may be specified in regulations of

1 the Secretary) of the applicable method by
2 which such professional is compensated in con-
3 nection with the provision of such medical care.

4 “(D) INFORMATION REQUIRED FROM
5 HEALTH CARE FACILITIES ON REQUEST.—Any
6 health care facility from which a participant or
7 beneficiary has sought treatment under a group
8 health plan shall provide to the participant or
9 beneficiary, on request, a description of the fa-
10 cility’s corporate form or other organizational
11 form and all forms of licensing and accredita-
12 tion status (if any) assigned to the facility by
13 standard-setting organizations.

14 “(f) ACCESS TO INFORMATION RELEVANT TO THE
15 COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT
16 OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition
17 to information otherwise required to be made available
18 under this section, a group health plan (and a health in-
19 surance issuer offering health insurance coverage in con-
20 nection with a group health plan) shall, upon written re-
21 quest (made not more frequently than annually), make
22 available to a participant (and an employee who, under
23 the terms of the plan, is eligible for coverage but not en-
24 rolled) in connection with a period of enrollment the sum-
25 mary plan description for any coverage option under the

1 plan under which the participant is eligible to enroll and
2 any information described in clauses (i), (ii), (iii), (vi),
3 (vii), and (viii) of subsection (e)(2)(B).

4 “(g) ADVANCE NOTICE OF CHANGES IN DRUG
5 FORMULARIES.—Not later than 30 days before the effec-
6 tive of date of any exclusion of a specific drug or biological
7 from any drug formulary under the plan that is used in
8 the treatment of a chronic illness or disease, the plan shall
9 take such actions as are necessary to reasonably ensure
10 that plan participants are informed of such exclusion. The
11 requirements of this subsection may be satisfied—

12 “(1) by inclusion of information in publications
13 broadly distributed by plan sponsors, employers, or
14 employee organizations;

15 “(2) by electronic means of communication (in-
16 cluding the Internet or proprietary computer net-
17 works in a format which is readily accessible to par-
18 ticipants);

19 “(3) by timely informing participants who,
20 under an ongoing program maintained under the
21 plan, have submitted their names for such notifica-
22 tion; or

23 “(4) by any other reasonable means of timely
24 informing plan participants.”.

1 **SEC. 2102. EFFECTIVE DATE.**

2 (a) IN GENERAL.—The amendments made by this
3 subtitle shall apply with respect to plan years beginning
4 on or after January 1 of the second calendar year follow-
5 ing the date of the enactment of this Act. The Secretary
6 shall first issue all regulations necessary to carry out the
7 amendments made by this subtitle before such date.

8 (b) LIMITATION ON ENFORCEMENT ACTIONS.—No
9 enforcement action shall be taken, pursuant to the amend-
10 ments made by this subtitle, against a group health plan
11 or health insurance issuer with respect to a violation of
12 a requirement imposed by such amendments before the
13 date of issuance of final regulations issued in connection
14 with such requirement, if the plan or issuer has sought
15 to comply in good faith with such requirement.

16 **Subtitle C—HealthMarts**

17 **SEC. 2201. SHORT TITLE OF SUBTITLE.**

18 This subtitle may be cited as the “Health Care Con-
19 sumer Empowerment Act of 1999”.

20 **SEC. 2202. EXPANSION OF CONSUMER CHOICE THROUGH**
21 **HEALTHMARTS.**

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

1 **“TITLE XXVIII—HEALTHMARTS**

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

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

6 “(1) ORGANIZATION.—The HealthMart is a
7 nonprofit organization operated under the direction
8 of a board of directors which is composed of rep-
9 resentatives of not fewer than 2 and in equal num-
10 bers from each of the following:

11 “(A) Small employers.

12 “(B) Employees of small employers.

13 “(C) Health care providers, which may be
14 physicians, other health care professionals,
15 health care facilities, or any combination there-
16 of.

17 “(D) Entities, such as insurance compa-
18 nies, health maintenance organizations, and li-
19 censed provider-sponsored organizations, that
20 underwrite or administer health benefits cov-
21 erage.

22 “(2) OFFERING HEALTH BENEFITS COV-
23 ERAGE.—

24 “(A) IN GENERAL.—The HealthMart, in
25 conjunction with those health insurance issuers

1 that offer health benefits coverage through the
2 HealthMart, makes available health benefits
3 coverage in the manner described in subsection
4 (b) to all small employers and eligible employees
5 in the manner described in subsection (c)(2) at
6 rates (including employer's and employee's
7 share) that are established by the health insur-
8 ance issuer on a policy or product specific basis
9 and that may vary only as permissible under
10 State law. A HealthMart is deemed to be a
11 group health plan for purposes of applying sec-
12 tion 702 of the Employee Retirement Income
13 Security Act of 1974, section 2702 of this Act,
14 and section 9802(b) of the Internal Revenue
15 Code of 1986 (which limit variation among
16 similarly situated individuals of required pre-
17 miums for health benefits coverage on the basis
18 of health status-related factors).

19 “(B) NONDISCRIMINATION IN COVERAGE
20 OFFERED.—

21 “(i) IN GENERAL.—Subject to clause
22 (ii), the HealthMart may not offer health
23 benefits coverage to an eligible employee in
24 a geographic area (as specified under para-
25 graph (3)(A)) unless the same coverage is

1 offered to all such employees in the same
2 geographic area. Section 2711(a)(1)(B) of
3 this Act limits denial of enrollment of cer-
4 tain eligible individuals under health bene-
5 fits coverage in the small group market.

6 “(ii) CONSTRUCTION.—Nothing in
7 this title shall be construed as requiring or
8 permitting a health insurance issuer to
9 provide coverage outside the service area of
10 the issuer, as approved under State law.

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

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

20 “(3) GEOGRAPHIC AREAS.—

21 “(A) SPECIFICATION OF GEOGRAPHIC
22 AREAS.—The HealthMart shall specify the geo-
23 graphic area (or areas) in which it makes avail-
24 able health benefits coverage offered by health
25 insurance issuers to small employers. Such an

1 area shall encompass at least one entire county
2 or equivalent area.

3 “(B) MULTISTATE AREAS.—In the case of
4 a HealthMart that serves more than one State,
5 such geographic areas may be areas that in-
6 clude portions of two or more contiguous
7 States.

8 “(C) MULTIPLE HEALTHMARTS PER-
9 MITTED IN SINGLE GEOGRAPHIC AREA.—Noth-
10 ing in this title shall be construed as preventing
11 the establishment and operation of more than
12 one HealthMart in a geographic area or as lim-
13 iting the number of HealthMarts that may op-
14 erate in any area.

15 “(4) PROVISION OF ADMINISTRATIVE SERVICES
16 TO PURCHASERS.—

17 “(A) IN GENERAL.—The HealthMart pro-
18 vides administrative services for purchasers.
19 Such services may include accounting, billing,
20 enrollment information, and employee coverage
21 status reports.

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

1 “(5) DISSEMINATION OF INFORMATION.—The
2 HealthMart collects and disseminates (or arranges
3 for the collection and dissemination of) consumer-
4 oriented information on the scope, cost, and enrollee
5 satisfaction of all coverage options offered through
6 the HealthMart to its members and eligible individ-
7 uals. Such information shall be defined by the
8 HealthMart and shall be in a manner appropriate to
9 the type of coverage offered. To the extent prac-
10 ticable, such information shall include information
11 on provider performance, locations and hours of op-
12 eration of providers, outcomes, and similar matters.
13 Nothing in this section shall be construed as pre-
14 venting the dissemination of such information or
15 other information by the HealthMart or by health
16 insurance issuers through electronic or other means.

17 “(6) FILING INFORMATION.—The Health-
18 Mart—

19 “(A) files with the applicable Federal au-
20 thority information that demonstrates the
21 HealthMart’s compliance with the applicable re-
22 quirements of this title; or

23 “(B) in accordance with rules established
24 under section 2803(a), files with a State such

1 information as the State may require to dem-
2 onstrate such compliance.

3 “(b) HEALTH BENEFITS COVERAGE REQUIRE-
4 MENTS.—

5 “(1) COMPLIANCE WITH CONSUMER PROTEC-
6 TION REQUIREMENTS.—Any health benefits coverage
7 offered through a HealthMart shall—

8 “(A) be underwritten by a health insurance
9 issuer that—

10 “(i) is licensed (or otherwise regu-
11 lated) under State law (or is a community
12 health organization that is offering health
13 insurance coverage pursuant to section
14 330D(a));

15 “(ii) meets all applicable State stand-
16 ards relating to consumer protection, sub-
17 ject to section 2802(b); and

18 “(iii) offers the coverage under a con-
19 tract with the HealthMart;

20 “(B) subject to paragraph (2), be approved
21 or otherwise permitted to be offered under
22 State law; and

23 “(C) provide full portability of creditable
24 coverage for individuals who remain members of
25 the same HealthMart notwithstanding that they

1 change the employer through which they are
2 members in accordance with the provisions of
3 the parts 6 and 7 of subtitle B of title I of the
4 Employee Retirement Income Security Act of
5 1974 and titles XXII and XXVII of this Act,
6 so long as both employers are purchasers in the
7 HealthMart.

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

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

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

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

1 “(B) GROUNDS.—The grounds described
2 in this subparagraph with respect to a policy or
3 product of health benefits coverage are as fol-
4 lows:

5 “(i) FAILURE TO ACT ON POLICY,
6 PRODUCT, OR RATE APPLICATION ON A
7 TIMELY BASIS.—The State has failed to
8 complete action on the policy or product
9 (or rates for the policy or product) within
10 90 days of the date of the State’s receipt
11 of a substantially complete application. No
12 period before the date of the enactment of
13 this section shall be included in determin-
14 ing such 90-day period.

15 “(ii) DENIAL OF APPLICATION BASED
16 ON DISCRIMINATORY TREATMENT.—The
17 State has denied such an application
18 and—

19 “(I) the standards or review
20 process imposed by the State as a
21 condition of approval of the policy or
22 product imposes either any material
23 requirements, procedures, or stand-
24 ards to such policy or product that
25 are not generally applicable to other

1 policies and products offered or any
2 requirements that are preempted
3 under section 2802; or

4 “(II) the State requires the
5 issuer, as a condition of approval of
6 the policy or product, to offer any pol-
7 icy or product other than such policy
8 or product.

9 “(C) ENFORCEMENT.—In the case of a
10 waiver granted under subparagraph (A) to an
11 issuer with respect to a State, the Secretary
12 may enter into an agreement with the State
13 under which the State agrees to provide for
14 monitoring and enforcement activities with re-
15 spect to compliance of such an issuer and its
16 health insurance coverage with the applicable
17 State standards described in subparagraph
18 (A)(ii). Such monitoring and enforcement shall
19 be conducted by the State in the same manner
20 as the State enforces such standards with re-
21 spect to other health insurance issuers and
22 plans, without discrimination based on the type
23 of issuer to which the standards apply. Such an
24 agreement shall specify or establish mechanisms
25 by which compliance activities are undertaken,

1 while not lengthening the time required to re-
2 view and process applications for waivers under
3 subparagraph (A).

4 “(3) EXAMPLES OF TYPES OF COVERAGE.—The
5 health benefits coverage made available through a
6 HealthMart may include, but is not limited to, any
7 of the following if it meets the other applicable re-
8 quirements of this title:

9 “(A) Coverage through a health mainte-
10 nance organization.

11 “(B) Coverage in connection with a pre-
12 ferred provider organization.

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

15 “(D) Indemnity coverage through an insur-
16 ance company.

17 “(E) Coverage offered in connection with a
18 contribution into a medical savings account or
19 flexible spending account.

20 “(F) Coverage that includes a point-of-
21 service option.

22 “(G) Coverage offered by a community
23 health organization (as defined in section
24 330D(e)).

1 “(H) Any combination of such types of
2 coverage.

3 “(4) WELLNESS BONUSES FOR HEALTH PRO-
4 MOTION.—Nothing in this title shall be construed as
5 precluding a health insurance issuer offering health
6 benefits coverage through a HealthMart from estab-
7 lishing premium discounts or rebates for members or
8 from modifying otherwise applicable copayments or
9 deductibles in return for adherence to programs of
10 health promotion and disease prevention so long as
11 such programs are agreed to in advance by the
12 HealthMart and comply with all other provisions of
13 this title and do not discriminate among similarly
14 situated members.

15 “(c) PURCHASERS; MEMBERS; HEALTH INSURANCE
16 ISSUERS.—

17 “(1) PURCHASERS.—

18 “(A) IN GENERAL.—Subject to the provi-
19 sions of this title, a HealthMart shall permit
20 any small employer to contract with the
21 HealthMart for the purchase of health benefits
22 coverage for its employees and dependents of
23 those employees and may not vary conditions of
24 eligibility (including premium rates and mem-

1 bership fees) of a small employer to be a pur-
2 chaser.

3 “(B) ROLE OF ASSOCIATIONS, BROKERS,
4 AND LICENSED HEALTH INSURANCE AGENTS.—
5 Nothing in this section shall be construed as
6 preventing an association, broker, licensed
7 health insurance agent, or other entity from as-
8 sisting or representing a HealthMart or small
9 employers from entering into appropriate ar-
10 rangements to carry out this title.

11 “(C) PERIOD OF CONTRACT.—The
12 HealthMart may not require a contract under
13 subparagraph (A) between a HealthMart and a
14 purchaser to be effective for a period of longer
15 than 12 months. The previous sentence shall
16 not be construed as preventing such a contract
17 from being extended for additional 12-month
18 periods or preventing the purchaser from volun-
19 tarily electing a contract period of longer than
20 12 months.

21 “(D) EXCLUSIVE NATURE OF CON-
22 TRACT.—Such a contract shall provide that the
23 purchaser agrees not to obtain or sponsor
24 health benefits coverage, on behalf of any eligi-
25 ble employees (and their dependents), other

1 than through the HealthMart. The previous
2 sentence shall not apply to an eligible individual
3 who resides in an area for which no coverage
4 is offered by any health insurance issuer
5 through the HealthMart.

6 “(2) MEMBERS.—

7 “(A) IN GENERAL.—Under rules estab-
8 lished to carry out this title, with respect to a
9 small employer that has a purchaser contract
10 with a HealthMart, individuals who are employ-
11 ees of the employer may enroll for health bene-
12 fits coverage (including coverage for dependents
13 of such enrolling employees) offered by a health
14 insurance issuer through the HealthMart.

15 “(B) NONDISCRIMINATION IN ENROLL-
16 MENT.—A HealthMart may not deny enroll-
17 ment as a member to an individual who is an
18 employee (or dependent of such an employee)
19 eligible to be so enrolled based on health status-
20 related factors, except as may be permitted con-
21 sistent with section 2742(b).

22 “(C) ANNUAL OPEN ENROLLMENT PE-
23 RIOD.—In the case of members enrolled in
24 health benefits coverage offered by a health in-
25 surance issuer through a HealthMart, subject

1 to subparagraph (D), the HealthMart shall pro-
2 vide for an annual open enrollment period of 30
3 days during which such members may change
4 the coverage option in which the members are
5 enrolled.

6 “(D) RULES OF ELIGIBILITY.—Nothing in
7 this paragraph shall preclude a HealthMart
8 from establishing rules of employee eligibility
9 for enrollment and reenrollment of members
10 during the annual open enrollment period under
11 subparagraph (C). Such rules shall be applied
12 consistently to all purchasers and members
13 within the HealthMart and shall not be based
14 in any manner on health status-related factors
15 and may not conflict with sections 2701 and
16 2702 of this Act.

17 “(3) HEALTH INSURANCE ISSUERS.—

18 “(A) PREMIUM COLLECTION.—The con-
19 tract between a HealthMart and a health insur-
20 ance issuer shall provide, with respect to a
21 member enrolled with health benefits coverage
22 offered by the issuer through the HealthMart,
23 for the payment of the premiums collected by
24 the HealthMart (or the issuer) for such cov-
25 erage (less a pre-determined administrative

1 charge negotiated by the HealthMart and the
2 issuer) to the issuer.

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

9 “(C) AVAILABILITY OF COVERAGE OP-
10 TIONS.—A HealthMart shall enter into con-
11 tracts with one or more health insurance issuers
12 in a manner that assures that at least 2 health
13 insurance coverage options are made available
14 in the geographic area specified under sub-
15 section (a)(3)(A).

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

17 “(1) FOR BOARDS OF DIRECTORS.—A member
18 of a board of directors of a HealthMart may not
19 serve as an employee or paid consultant to the
20 HealthMart, but may receive reasonable reimburse-
21 ment for travel expenses for purposes of attending
22 meetings of the board or committees thereof.

23 “(2) FOR BOARDS OF DIRECTORS OR EMPLOY-
24 EES.—An individual is not eligible to serve in a paid
25 or unpaid capacity on the board of directors of a

1 HealthMart or as an employee of the HealthMart, if
2 the individual is employed by, represents in any ca-
3 pacity, owns, or controls any ownership interest in
4 a organization from whom the HealthMart receives
5 contributions, grants, or other funds not connected
6 with a contract for coverage through the
7 HealthMart.

8 “(3) EMPLOYMENT AND EMPLOYEE REP-
9 REPRESENTATIVES.—

10 “(A) IN GENERAL.—An individual who is
11 serving on a board of directors of a HealthMart
12 as a representative described in subparagraph
13 (A) or (B) of section 2801(a)(1) shall not be
14 employed by or affiliated with a health insur-
15 ance issuer or be licensed as or employed by or
16 affiliated with a health care provider.

17 “(B) CONSTRUCTION.—For purposes of
18 subparagraph (A), the term “affiliated” does
19 not include membership in a health benefits
20 plan or the obtaining of health benefits cov-
21 erage offered by a health insurance issuer.

22 “(e) CONSTRUCTION.—

23 “(1) NETWORK OF AFFILIATED HEALTH-
24 MARTS.—Nothing in this section shall be construed
25 as preventing one or more HealthMarts serving dif-

1 ferent areas (whether or not contiguous) from pro-
2 viding for some or all of the following (through a
3 single administrative organization or otherwise):

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

7 “(B) Providing for crediting of deductibles
8 and other cost-sharing for individuals who are
9 provided health benefits coverage through the
10 HealthMarts (or affiliated HealthMarts)
11 after—

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

14 “(ii) a change in place of employment
15 to an area not served by the previous
16 HealthMart.

17 “(2) PERMITTING HEALTHMARTS TO ADJUST
18 DISTRIBUTIONS AMONG ISSUERS TO REFLECT REL-
19 ATIVE RISK OF ENROLLEES.—Nothing in this sec-
20 tion shall be construed as precluding a HealthMart
21 from providing for adjustments in amounts distrib-
22 uted among the health insurance issuers offering
23 health benefits coverage through the HealthMart
24 based on factors such as the relative health care risk

1 of members enrolled under the coverage offered by
2 the different issuers.

3 “(3) APPLICATION OF UNIFORM MINIMUM PAR-
4 TICIPATION AND CONTRIBUTION RULES.—Nothing
5 in this section shall be construed as precluding a
6 HealthMart from establishing minimum participa-
7 tion and contribution rules (described in section
8 2711(e)(1)) for small employers that apply to be-
9 come purchasers in the HealthMart, so long as such
10 rules are applied uniformly for all health insurance
11 issuers.

12 **“SEC. 2802. APPLICATION OF CERTAIN LAWS AND REQUIRE-**
13 **MENTS.**

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

17 “(1) The regulation of underwriters of health
18 coverage, including licensure and solvency require-
19 ments.

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

23 “(3) The application of fair marketing require-
24 ments and other consumer protections (other than

1 those specifically relating to an item described in
2 subsection (b)).

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

6 “(b) TREATMENT OF BENEFIT AND GROUPING RE-
7 QUIREMENTS.—State laws insofar as they relate to any
8 of the following are superseded and shall not apply to
9 health benefits coverage made available through a
10 HealthMart:

11 “(1) Benefit requirements for health benefits
12 coverage offered through a HealthMart, including
13 (but not limited to) requirements relating to cov-
14 erage of specific providers, specific services or condi-
15 tions, or the amount, duration, or scope of benefits,
16 but not including requirements to the extent re-
17 quired to implement title XXVII or other Federal
18 law and to the extent the requirement prohibits an
19 exclusion of a specific disease from such coverage.

20 “(2) Requirements (commonly referred to as
21 fictitious group laws) relating to grouping and simi-
22 lar requirements for such coverage to the extent
23 such requirements impede the establishment and op-
24 eration of HealthMarts pursuant to this title.

1 “(3) Any other requirements (including limita-
2 tions on compensation arrangements) that, directly
3 or indirectly, preclude (or have the effect of preclud-
4 ing) the offering of such coverage through a
5 HealthMart, if the HealthMart meets the require-
6 ments of this title.

7 Any State law or regulation relating to the composition
8 or organization of a HealthMart is preempted to the ex-
9 tent the law or regulation is inconsistent with the provi-
10 sions of this title.

11 “(c) APPLICATION OF ERISA FIDUCIARY AND DIS-
12 CLOSURE REQUIREMENTS.—The board of directors of a
13 HealthMart is deemed to be a plan administrator of an
14 employee welfare benefit plan which is a group health plan
15 for purposes of applying parts 1 and 4 of subtitle B of
16 title I of the Employee Retirement Income Security Act
17 of 1974 and those provisions of part 5 of such subtitle
18 which are applicable to enforcement of such parts 1 and
19 4, and the HealthMart shall be treated as such a plan
20 and the enrollees shall be treated as participants and bene-
21 ficiaries for purposes of applying such provisions pursuant
22 to this subsection.

23 “(d) APPLICATION OF ERISA RENEWABILITY PRO-
24 TECTION.—A HealthMart is deemed to be group health
25 plan that is a multiple employer welfare arrangement for

1 purposes of applying section 703 of the Employee Retirement
2 Income Security Act of 1974.

3 “(e) APPLICATION OF RULES FOR NETWORK PLANS
4 AND FINANCIAL CAPACITY.—The provisions of sub-
5 sections (c) and (d) of section 2711 apply to health bene-
6 fits coverage offered by a health insurance issuer through
7 a HealthMart.

8 “(f) CONSTRUCTION RELATING TO OFFERING RE-
9 QUIREMENT.—Nothing in section 2711(a) of this Act or
10 703 of the Employee Retirement Income Security Act of
11 1974 shall be construed as permitting the offering outside
12 the HealthMart of health benefits coverage that is only
13 made available through a HealthMart under this section
14 because of the application of subsection (b).

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

24 “(1) RENEWABILITY.—The HealthMart shall
25 fulfill the obligation under such section of the issuer

1 renewing and continuing in force coverage by offer-
2 ing purchasers (and members and their dependents)
3 all available health benefits coverage that would oth-
4 erwise be available to similarly-situated purchasers
5 and members from the remaining participating
6 health insurance issuers in the same manner as
7 would be required of issuers under section 2712(c).

8 “(2) APPLICATION OF ASSOCIATION RULES.—

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

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

18 **“SEC. 2803. ADMINISTRATION.**

19 “(a) IN GENERAL.—The applicable Federal authority
20 shall administer this title through the division established
21 under subsection (b) and is authorized to issue such regu-
22 lations as may be required to carry out this title. Such
23 regulations shall be subject to Congressional review under
24 the provisions of chapter 8 of title 5, United States Code.
25 The applicable Federal authority shall incorporate the

1 process of ‘deemed file and use’ with respect to the infor-
 2 mation filed under section 2801(a)(6)(A) and shall deter-
 3 mine whether information filed by a HealthMart dem-
 4 onstrates compliance with the applicable requirements of
 5 this title. Such authority shall exercise its authority under
 6 this title in a manner that fosters and promotes the devel-
 7 opment of HealthMarts in order to improve access to
 8 health care coverage and services.

9 “(b) ADMINISTRATION THROUGH HEALTH CARE
 10 MARKETPLACE DIVISION.—

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

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

19 “(A) oversight of the operations of
 20 HealthMarts under this title; and

21 “(B) the periodic submittal to Congress of
 22 reports on the performance of HealthMarts
 23 under this title under subsection (c).

24 “(c) PERIODIC REPORTS.—The applicable Federal
 25 authority shall submit to Congress a report every 30

1 months, during the 10-year period beginning on the effective date of the rules promulgated by the applicable Federal authority to carry out this title, on the effectiveness of this title in promoting coverage of uninsured individuals. Such authority may provide for the production of such reports through one or more contracts with appropriate private entities.

8 **“SEC. 2804. DEFINITIONS.**

9 “For purposes of this title:

10 “(1) **APPLICABLE FEDERAL AUTHORITY.**—The
11 term ‘applicable Federal authority’ means the Secretary of Health and Human Services.

12
13 “(2) **ELIGIBLE EMPLOYEE OR INDIVIDUAL.**—
14 The term ‘eligible’ means, with respect to an employee or other individual and a HealthMart, an employee or individual who is eligible under section
15
16 2801(c)(2) to enroll or be enrolled in health benefits
17 coverage offered through the HealthMart.

18
19 “(3) **EMPLOYER; EMPLOYEE; DEPENDENT.**—
20 Except as the applicable Federal authority may otherwise provide, the terms ‘employer’, ‘employee’, and
21
22 ‘dependent’, as applied to health insurance coverage
23 offered by a health insurance issuer licensed (or otherwise regulated) in a State, shall have the meanings
24 applied to such terms with respect to such coverage
25

1 under the laws of the State relating to such coverage
2 and such an issuer.

3 “(4) HEALTH BENEFITS COVERAGE.—The term
4 ‘health benefits coverage’ has the meaning given the
5 term group health insurance coverage in section
6 2791(b)(4).

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

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

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

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

21 “(9) PURCHASER.—The term ‘purchaser’
22 means, with respect to a HealthMart, a small em-
23 ployer that has contracted under section
24 2801(c)(1)(A) with the HealthMart for the purchase
25 of health benefits coverage.

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

4 (b) EFFECTIVE DATE.—The amendment made by
 5 subsection (a) shall take effect on January 1, 2001. The
 6 Secretary of Health and Human Services shall first issue
 7 all regulations necessary to carry out such amendment be-
 8 fore such date.

9 **Subtitle D—Community Health** 10 **Organizations**

11 **SEC. 2301. PROMOTION OF PROVISION OF INSURANCE BY** 12 **COMMUNITY HEALTH ORGANIZATIONS.**

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

18 “WAIVER OF STATE LICENSURE REQUIREMENT FOR
 19 COMMUNITY HEALTH ORGANIZATIONS IN CERTAIN CASES

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

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

25 “(A) the organization files an application
 26 for waiver of the licensure requirement with the

1 Secretary of Health and Human Services (in
2 this section referred to as the ‘Secretary’) by
3 not later than November 1, 2004; and

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

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

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

21 “(B) DENIAL OF APPLICATION BASED ON
22 DISCRIMINATORY TREATMENT.—The ground for
23 approval of such a waiver application described
24 in this subparagraph is that the State has de-
25 nied such a licensing application and the stand-

1 ards or review process imposed by the State as
2 a condition of approval of the license or as the
3 basis for such denial by the State imposes any
4 material requirements, procedures, or standards
5 (other than solvency requirements) to such or-
6 ganizations that are not generally applicable to
7 other entities engaged in a substantially similar
8 business.

9 “(C) DENIAL OF APPLICATION BASED ON
10 APPLICATION OF SOLVENCY REQUIREMENTS.—

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

1 established by the Secretary under subsection
2 (d).

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

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

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

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

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

24 “(4) PROMPT ACTION ON APPLICATION.—The
25 Secretary shall grant or deny such a waiver applica-

tion within 60 days after the date the Secretary determines that a substantially complete waiver application has been filed. Nothing in this section shall be construed as preventing an organization which has had such a waiver application denied from submitting a subsequent waiver application.

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

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

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

“(6) REPORT.—By not later than December 31, 2003, the Secretary shall submit to the Committee on Commerce of the House of Representatives and the Committee on Labor and Human Resources of the Senate a report regarding whether the waiver

1 process under this subsection should be continued
2 after December 31, 2004.

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

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

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

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

24 “(4) may make arrangements with physicians
25 or other health care professionals, health care insti-

1 tutions, or any combination of such individuals or
2 institutions to assume all or part of the financial
3 risk on a prospective basis for the provision of
4 health services by the physicians or other health pro-
5 fessionals or through the institutions.

6 “(c) CERTIFICATION OF PROVISION AGAINST RISK
7 OF INSOLVENCY FOR UNLICENSED CHOs.—

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

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

1 “(d) ESTABLISHMENT OF SOLVENCY STANDARDS
2 FOR COMMUNITY HEALTH ORGANIZATIONS.—

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

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

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

23 “(B) alternative means of protecting
24 against insolvency, including reinsurance, unre-
25 stricted surplus, letters of credit, guarantees,

1 organizational insurance coverage, partnerships
2 with other licensed entities, and valuation at-
3 tributable to the ability of such an organization
4 to meet its service obligations through direct
5 delivery of care; and

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

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

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

18 “(e) DEFINITIONS.—In this section:

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

24 “(2) FEDERALLY-QUALIFIED HEALTH CEN-
25 TER.—The term ‘Federally-qualified health center’

1 has the meaning given such term in section
 2 1905(l)(2)(B) of the Social Security Act.

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

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

12 **TITLE III—AMENDMENTS TO**
 13 **THE INTERNAL REVENUE**
 14 **CODE OF 1986**

15 **Subtitle A—Patient Protections**

16 **SEC. 3001. PATIENT ACCESS TO UNRESTRICTED MEDICAL**
 17 **ADVICE, EMERGENCY MEDICAL CARE, OB-**
 18 **STETRIC AND GYNECOLOGICAL CARE, AND**
 19 **PEDIATRIC CARE.**

20 (a) IN GENERAL.—Subchapter B of chapter 100 of
 21 the Internal Revenue Code of 1986 (relating to other re-
 22 quirements) is amended by adding at the end the following
 23 new section:

1 **“SEC. 9813. PATIENT ACCESS TO UNRESTRICTED MEDICAL**
2 **ADVICE, EMERGENCY MEDICAL CARE, OB-**
3 **STETRIC AND GYNECOLOGICAL CARE, AND**
4 **PEDIATRIC CARE.**

5 “(a) PATIENT ACCESS TO UNRESTRICTED MEDICAL
6 ADVICE.—

7 “(1) IN GENERAL.—In the case of any health
8 care professional acting within the lawful scope of
9 practice in the course of carrying out a contractual
10 employment arrangement or other direct contractual
11 arrangement between such professional and a group
12 health plan, the plan with which such contractual
13 employment arrangement or other direct contractual
14 arrangement is maintained by the professional may
15 not impose on such professional under such arrange-
16 ment any prohibition or restriction with respect to
17 advice, provided to a participant or beneficiary
18 under the plan who is a patient, about the health
19 status of the participant or beneficiary or the medi-
20 cal care or treatment for the condition or disease of
21 the participant or beneficiary, regardless of whether
22 benefits for such care or treatment are provided
23 under the plan.

24 “(2) HEALTH CARE PROFESSIONAL DEFINED.—
25 For purposes of this subsection, the term ‘health
26 care professional’ means a physician (as defined in

1 section 1861(r) of the Social Security Act) or other
2 health care professional if coverage for the profes-
3 sional's services is provided under the group health
4 plan for the services of the professional. Such term
5 includes a podiatrist, optometrist, chiropractor, psy-
6 chologist, dentist, physician assistant, physical or oc-
7 cupational therapist and therapy assistant, speech-
8 language pathologist, audiologist, registered or li-
9 censed practical nurse (including nurse practitioner,
10 clinical nurse specialist, certified registered nurse
11 anesthetist, and certified nurse-midwife), licensed
12 certified social worker, registered respiratory thera-
13 pist, and certified respiratory therapy technician.

14 “(b) PATIENT ACCESS TO EMERGENCY MEDICAL
15 CARE.—

16 “(1) IN GENERAL.—To the extent that the
17 group health plan provides for any benefits consist-
18 ing of emergency medical care (as defined in section
19 503(b)(9)(I) of the Employee Retirement Income Se-
20 curity Act of 1974), except for items or services spe-
21 cifically excluded—

22 “(A) the plan shall provide benefits, with-
23 out requiring preauthorization and without re-
24 gard to otherwise applicable network limita-
25 tions, for appropriate emergency medical

1 screening examinations (within the capability of
2 the emergency facility, including ancillary serv-
3 ices routinely available to the emergency facil-
4 ity) to the extent that a prudent layperson, who
5 possesses an average knowledge of health and
6 medicine, would determine such examinations to
7 be necessary in order to determine whether
8 emergency medical care (as so defined) is re-
9 quired; and

10 “(B) the plan shall provide benefits for ad-
11 ditional emergency medical services following an
12 emergency medical screening examination (if
13 determined necessary under subparagraph (A))
14 to the extent that a prudent emergency medical
15 professional would determine such additional
16 emergency services to be necessary to avoid the
17 consequences described in clause (i) of section
18 503(b)(9)(I) of such Act.

19 “(2) UNIFORM COST-SHARING REQUIRED.—

20 Nothing in this subsection shall be construed as pre-
21 venting a group health plan from imposing any form
22 of cost-sharing applicable to any participant or bene-
23 ficiary (including coinsurance, copayments,
24 deductibles, and any other charges) in relation to
25 benefits described in paragraph (1), if such form of

1 cost-sharing is uniformly applied under such plan,
2 with respect to similarly situated participants and
3 beneficiaries, to all benefits consisting of emergency
4 medical care (as defined in section 503(b)(9)(I) of
5 the Employee Retirement Income Security Act of
6 1974) provided to such similarly situated partici-
7 pants and beneficiaries under the plan.

8 “(c) PATIENT ACCESS TO OBSTETRIC AND GYNECO-
9 LOGICAL CARE.—

10 “(1) IN GENERAL.—In any case in which a
11 group health plan—

12 “(A) provides benefits under the terms of
13 the plan consisting of—

14 “(i) routine gynecological care (such
15 as preventive women’s health examina-
16 tions); or

17 “(ii) routine obstetric care (such as
18 routine pregnancy-related services),

19 provided by a participating physician who spe-
20 cializes in such care (or provides benefits con-
21 sisting of payment for such care); and

22 “(B) the plan requires or provides for des-
23 ignation by a participant or beneficiary of a
24 participating primary care provider,

1 if the primary care provider designated by such a
2 participant or beneficiary is not such a physician,
3 then the plan shall meet the requirements of para-
4 graph (2).

5 “(2) REQUIREMENTS.—A group health plan
6 meets the requirements of this paragraph, in connec-
7 tion with benefits described in paragraph (1) con-
8 sisting of care described in clause (i) or (ii) of para-
9 graph (1)(A) (or consisting of payment therefor), if
10 the plan—

11 “(A) does not require authorization or a
12 referral by the primary care provider in order
13 to obtain such benefits; and

14 “(B) treats the ordering of other routine
15 care of the same type, by the participating phy-
16 sician providing the care described in clause (i)
17 or (ii) of paragraph (1)(A), as the authorization
18 of the primary care provider with respect to
19 such care.

20 “(3) CONSTRUCTION.—Nothing in paragraph
21 (2)(B) shall waive any requirements of coverage re-
22 lating to medical necessity or appropriateness with
23 respect to coverage of gynecological or obstetric care
24 so ordered.

25 “(d) PATIENT ACCESS TO PEDIATRIC CARE.—

1 “(1) IN GENERAL.—In any case in which a
2 group health plan (or a health insurance issuer of-
3 fering health insurance coverage in connection with
4 the plan) provides benefits consisting of routine pe-
5 diatric care provided by a participating physician
6 who specializes in pediatrics (or consisting of pay-
7 ment for such care) and the plan requires or pro-
8 vides for designation by a participant or beneficiary
9 of a participating primary care provider, the plan (or
10 issuer) shall provide that such a participating physi-
11 cian may be designated, if available, by a parent or
12 guardian of any beneficiary under the plan who is
13 under 18 years of age, as the primary care provider
14 with respect to any such benefits.

15 “(2) CONSTRUCTION.—Nothing in paragraph
16 (1) shall waive any requirements of coverage relating
17 to medical necessity or appropriateness with respect
18 to coverage of pediatric care.

19 “(e) TREATMENT OF MULTIPLE COVERAGE OP-
20 TIONS.—In the case of a plan providing benefits under two
21 or more coverage options, the requirements of subsections
22 (c) and (d) shall apply separately with respect to each cov-
23 erage option.”.

1 (b) CLERICAL AMENDMENT.—The table of sections
 2 of such subchapter of such chapter is amended by adding
 3 at the end the following new item:

“Sec. 9813. Patient access to unrestricted medical advice, emer-
 gency medical care, obstetric and gynecological
 care, and pediatric care.”.

4 **SEC. 3002. EFFECTIVE DATE AND RELATED RULES.**

5 (a) IN GENERAL.—The amendments made by this
 6 subtitle shall apply with respect to plan years beginning
 7 on or after January 1 of the second calendar year follow-
 8 ing the date of the enactment of this Act, except that the
 9 Secretary of the Treasury may issue regulations before
 10 such date under such amendments. The Secretary shall
 11 first issue regulations necessary to carry out the amend-
 12 ments made by this subtitle before the effective date there-
 13 of.

14 (b) LIMITATION ON PENALTY FOR CERTAIN FAIL-
 15 URES.—No penalty shall be imposed on any failure to
 16 comply with any requirement imposed by the amendments
 17 made by section 3001 to the extent such failure occurs
 18 before the date of issuance of regulations issued in connec-
 19 tion with such requirement if the plan has sought to com-
 20 ply in good faith with such requirement.

21 (c) SPECIAL RULE FOR COLLECTIVE BARGAINING
 22 AGREEMENTS.—In the case of a group health plan main-
 23 tained pursuant to one or more collective bargaining
 24 agreements between employee representatives and one or

1 more employers ratified before the date of the enactment
 2 of this Act, the provisions of subsections (b), (c), and (d)
 3 of section 9813 of the Internal Revenue Code of 1986 (as
 4 added by this subtitle) shall not apply with respect to plan
 5 years beginning before the later of—

6 (1) the date on which the last of the collective
 7 bargaining agreements relating to the plan termi-
 8 nates (determined without regard to any extension
 9 thereof agreed to after the date of the enactment of
 10 this Act); or

11 (2) January 1, 2002.

12 For purposes of this subsection, any plan amendment
 13 made pursuant to a collective bargaining agreement relat-
 14 ing to the plan which amends the plan solely to conform
 15 to any requirement added by this subtitle shall not be
 16 treated as a termination of such collective bargaining
 17 agreement.

18 **Subtitle B—Patient Access to** 19 **Information**

20 **SEC. 3101. PATIENT ACCESS TO INFORMATION REGARDING** 21 **PLAN COVERAGE, MANAGED CARE PROCE-** 22 **DURES, HEALTH CARE PROVIDERS, AND** 23 **QUALITY OF MEDICAL CARE.**

24 (a) IN GENERAL.—Subchapter B of chapter 100 of
 25 the Internal Revenue Code of 1986 (relating to other re-

1 requirements) is amended by adding at the end the following
2 new section:

3 **“SEC. 9814. DISCLOSURE BY GROUP HEALTH PLANS.**

4 “(a) DISCLOSURE REQUIREMENT.—The adminis-
5 trator of each group health plan shall take such actions
6 as are necessary to ensure that the summary plan descrip-
7 tion of the plan required under section 102 of Employee
8 Retirement Income Security Act of 1974 (or each sum-
9 mary plan description in any case in which different sum-
10 mary plan descriptions are appropriate under part 1 of
11 subtitle B of title I of such Act for different options of
12 coverage) contains the information required under sub-
13 sections (b), (c), (d), and (e)(2)(A). To the extent that
14 any health insurance issuer offering health insurance cov-
15 erage in connection with such plan provides such informa-
16 tion on a timely basis to plan participants and bene-
17 ficiaries, the requirements of this subsection shall be
18 deemed satisfied in the case of such plan with respect to
19 such information.

20 “(b) PLAN BENEFITS.—The information required
21 under subsection (a) includes the following:

22 “(1) COVERED ITEMS AND SERVICES.—

23 “(A) CATEGORIZATION OF INCLUDED BEN-
24 EFITS.—A description of covered benefits, cat-
25 egorized by—

1 “(i) types of items and services (in-
2 cluding any special disease management
3 program); and

4 “(ii) types of health care professionals
5 providing such items and services.

6 “(B) EMERGENCY MEDICAL CARE.—A de-
7 scription of the extent to which the plan covers
8 emergency medical care (including the extent to
9 which the plan provides for access to urgent
10 care centers), and any definitions provided
11 under the plan for the relevant plan terminol-
12 ogy referring to such care.

13 “(C) PREVENTATIVE SERVICES.—A de-
14 scription of the extent to which the plan pro-
15 vides benefits for preventative services.

16 “(D) DRUG FORMULARIES.—A description
17 of the extent to which covered benefits are de-
18 termined by the use or application of a drug
19 formulary and a summary of the process for de-
20 termining what is included in such formulary.

21 “(E) COBRA CONTINUATION COV-
22 ERAGE.—A description of the requirements
23 under section 4980B.

24 “(2) LIMITATIONS, EXCLUSIONS, AND RESTRIC-
25 TIONS ON COVERED BENEFITS.—

1 “(A) CATEGORIZATION OF EXCLUDED
2 BENEFITS.—A description of benefits specifi-
3 cally excluded from coverage, categorized by
4 types of items and services.

5 “(B) UTILIZATION REVIEW AND
6 PREAUTHORIZATION REQUIREMENTS.—Whether
7 coverage for medical care is limited or excluded
8 on the basis of utilization review or
9 preauthorization requirements.

10 “(C) LIFETIME, ANNUAL, OR OTHER PE-
11 RIOD LIMITATIONS.—A description of the cir-
12 cumstances under which, and the extent to
13 which, coverage is subject to lifetime, annual, or
14 other period limitations, categorized by types of
15 benefits.

16 “(D) CUSTODIAL CARE.—A description of
17 the circumstances under which, and the extent
18 to which, the coverage of benefits for custodial
19 care is limited or excluded, and a statement of
20 the definition used by the plan for custodial
21 care.

22 “(E) EXPERIMENTAL TREATMENTS.—
23 Whether coverage for any medical care is lim-
24 ited or excluded because it constitutes experi-
25 mental treatment or technology, and any defini-

1 tions provided under the plan for the relevant
2 plan terminology referring to such limited or
3 excluded care.

4 “(F) MEDICAL APPROPRIATENESS OR NE-
5 CESSITY.—Whether coverage for medical care
6 may be limited or excluded by reason of a fail-
7 ure to meet the plan’s requirements for medical
8 appropriateness or necessity, and any defini-
9 tions provided under the plan for the relevant
10 plan terminology referring to such limited or
11 excluded care.

12 “(G) SECOND OR SUBSEQUENT OPIN-
13 IONS.—A description of the circumstances
14 under which, and the extent to which, coverage
15 for second or subsequent opinions is limited or
16 excluded.

17 “(H) SPECIALTY CARE.—A description of
18 the circumstances under which, and the extent
19 to which, coverage of benefits for specialty care
20 is conditioned on referral from a primary care
21 provider.

22 “(I) CONTINUITY OF CARE.—A description
23 of the circumstances under which, and the ex-
24 tent to which, coverage of items and services
25 provided by any health care professional is lim-

1 ited or excluded by reason of the departure by
2 the professional from any defined set of provid-
3 ers.

4 “(J) RESTRICTIONS ON COVERAGE OF
5 EMERGENCY SERVICES.—A description of the
6 circumstances under which, and the extent to
7 which, the plan, in covering emergency medical
8 care furnished to a participant or beneficiary of
9 the plan imposes any financial responsibility de-
10 scribed in subsection (c) on participants or
11 beneficiaries or limits or conditions benefits for
12 such care subject to any other term or condition
13 of such plan.

14 “(c) PARTICIPANT’S FINANCIAL RESPONSIBIL-
15 ITIES.—The information required under subsection (a) in-
16 cludes an explanation of—

17 “(1) a participant’s financial responsibility for
18 payment of premiums, coinsurance, copayments,
19 deductibles, and any other charges; and

20 “(2) the circumstances under which, and the
21 extent to which, the participant’s financial respon-
22 sibility described in paragraph (1) may vary, includ-
23 ing any distinctions based on whether a health care
24 provider from whom covered benefits are obtained is
25 included in a defined set of providers.

1 “(d) DISPUTE RESOLUTION PROCEDURES.—The in-
2 formation required under subsection (a) includes a de-
3 scription of the processes adopted by the plan pursuant
4 to section 503(b) of Employee Retirement Income Secu-
5 rity Act of 1974, including—

6 “(1) descriptions thereof relating specifically
7 to—

8 “(A) coverage decisions;

9 “(B) internal review of coverage decisions;

10 and

11 “(C) any external review of coverage deci-
12 sions; and

13 “(2) the procedures and time frames applicable
14 to each step of the processes referred to in subpara-
15 graphs (A), (B), and (C) of paragraph (1).

16 “(e) INFORMATION AVAILABLE ON REQUEST.—

17 “(1) ACCESS TO PLAN BENEFIT INFORMATION
18 IN ELECTRONIC FORM.—

19 “(A) IN GENERAL.—A group health plan
20 shall, upon written request (made not more fre-
21 quently than annually), make available to par-
22 ticipants and beneficiaries, in a generally recog-
23 nized electronic format, the following informa-
24 tion:

1 “(i) the latest summary plan descrip-
2 tion, including the latest summary of ma-
3 terial modifications; and

4 “(ii) the actual plan provisions setting
5 forth the benefits available under the plan,
6 to the extent such information relates to the
7 coverage options under the plan available to the
8 participant or beneficiary. A reasonable charge
9 may be made to cover the cost of providing
10 such information in such generally recognized
11 electronic format. The Secretary may by regula-
12 tion prescribe a maximum amount which will
13 constitute a reasonable charge under the pre-
14 ceding sentence.

15 “(B) ALTERNATIVE ACCESS.—The require-
16 ments of this paragraph may be met by making
17 such information generally available (rather
18 than upon request) on the Internet or on a pro-
19 prietary computer network in a format which is
20 readily accessible to participants and bene-
21 ficiaries.

22 “(2) ADDITIONAL INFORMATION TO BE PRO-
23 VIDED ON REQUEST.—

24 “(A) INCLUSION IN SUMMARY PLAN DE-
25SCRIPTION OF SUMMARY OF ADDITIONAL IN-

1 FORMATION.—The information required under
2 subsection (a) includes a summary description
3 of the types of information required by this
4 subsection to be made available to participants
5 and beneficiaries on request.

6 “(B) INFORMATION REQUIRED FROM
7 PLANS ON REQUEST.—In addition to informa-
8 tion required to be included in summary plan
9 descriptions under this subsection, a group
10 health plan shall provide the following informa-
11 tion to a participant or beneficiary on request:

12 “(i) NETWORK CHARACTERISTICS.—If
13 the plan (or a health insurance issuer of-
14 fering health insurance coverage in connec-
15 tion with the plan) utilizes a defined set of
16 providers under contract with the plan (or
17 issuer), a detailed list of the names of such
18 providers and their geographic location, set
19 forth separately with respect to primary
20 care providers and with respect to special-
21 ists.

22 “(ii) CARE MANAGEMENT INFORMA-
23 TION.—A description of the circumstances
24 under which, and the extent to which, the
25 plan has special disease management pro-

1 grams or programs for persons with dis-
2 abilities, indicating whether these pro-
3 grams are voluntary or mandatory and
4 whether a significant benefit differential
5 results from participation in such pro-
6 grams.

7 “(iii) INCLUSION OF DRUGS AND
8 BIOLOGICALS IN FORMULARIES.—A state-
9 ment of whether a specific drug or biologi-
10 cal is included in a formulary used to de-
11 termine benefits under the plan and a de-
12 scription of the procedures for considering
13 requests for any patient-specific waivers.

14 “(iv) PROCEDURES FOR DETERMINING
15 EXCLUSIONS BASED ON MEDICAL NECES-
16 SITY OR EXPERIMENTAL TREATMENTS.—
17 Upon receipt by the participant or bene-
18 ficiary of any notification of an adverse
19 coverage decision based on a determination
20 relating to medical necessity or an experi-
21 mental treatment or technology, a descrip-
22 tion of the procedures and medically-based
23 criteria used in such decision.

24 “(v) PREAUTHORIZATION AND UTILI-
25 ZATION REVIEW PROCEDURES.—Upon re-

1 ceipt by the participant or beneficiary of
2 any notification of an adverse coverage de-
3 cision, a description of the basis on which
4 any preauthorization requirement or any
5 utilization review requirement has resulted
6 in such decision.

7 “(vi) ACCREDITATION STATUS OF
8 HEALTH INSURANCE ISSUERS AND SERV-
9 ICE PROVIDERS.—A description of the ac-
10 creditation and licensing status (if any) of
11 each health insurance issuer offering
12 health insurance coverage in connection
13 with the plan and of any utilization review
14 organization utilized by the issuer or the
15 plan, together with the name and address
16 of the accrediting or licensing authority.

17 “(vii) MEASURES OF ENROLLEE SAT-
18 ISFACTION.—The latest information (if
19 any) maintained by the plan, or by any
20 health insurance issuer offering health in-
21 surance coverage in connection with the
22 plan, relating to enrollee satisfaction.

23 “(viii) QUALITY PERFORMANCE MEAS-
24 URES.—The latest information (if any)
25 maintained by the plan, or by any health

1 insurance issuer offering health insurance
2 coverage in connection with the plan, relat-
3 ing to quality of performance of the deliv-
4 ery of medical care with respect to cov-
5 erage options offered under the plan and
6 of health care professionals and facilities
7 providing medical care under the plan.

8 “(ix) INFORMATION RELATING TO EX-
9 TERNAL REVIEWS.—The number of exter-
10 nal reviews under section 503(b)(4) of the
11 Employee Retirement Income Security Act
12 of 1974 that have been completed during
13 the prior plan year and the number of such
14 reviews in which the recommendation re-
15 ported under section 503(b)(4)(C)(iii) of
16 such Act includes a recommendation for
17 modification or reversal of an internal re-
18 view decision under the plan.

19 “(C) INFORMATION REQUIRED FROM
20 HEALTH CARE PROFESSIONALS ON REQUEST.—
21 Any health care professional treating a partici-
22 pant or beneficiary under a group health plan
23 shall provide to the participant or beneficiary,
24 on request, a description of his or her profes-
25 sional qualifications (including board certifi-

1 cation status, licensing status, and accreditation
2 status, if any), privileges, and experience and a
3 general description by category (including sal-
4 ary, fee-for-service, capitation, and such other
5 categories as may be specified in regulations of
6 the Secretary) of the applicable method by
7 which such professional is compensated in con-
8 nection with the provision of such medical care.

9 “(D) INFORMATION REQUIRED FROM
10 HEALTH CARE FACILITIES ON REQUEST.—Any
11 health care facility from which a participant or
12 beneficiary has sought treatment under a group
13 health plan shall provide to the participant or
14 beneficiary, on request, a description of the fa-
15 cility’s corporate form or other organizational
16 form and all forms of licensing and accredita-
17 tion status (if any) assigned to the facility by
18 standard-setting organizations.

19 “(f) ACCESS TO INFORMATION RELEVANT TO THE
20 COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT
21 OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition
22 to information otherwise required to be made available
23 under this section, a group health plan shall, upon written
24 request (made not more frequently than annually), make
25 available to a participant (and an employee who, under

1 the terms of the plan, is eligible for coverage but not en-
2 rolled) in connection with a period of enrollment the sum-
3 mary plan description for any coverage option under the
4 plan under which the participant is eligible to enroll and
5 any information described in clauses (i), (ii), (iii), (vi),
6 (vii), and (viii) of subsection (e)(2)(B).

7 “(g) ADVANCE NOTICE OF CHANGES IN DRUG
8 FORMULARIES.—Not later than 30 days before the effec-
9 tive of date of any exclusion of a specific drug or biological
10 from any drug formulary under the plan that is used in
11 the treatment of a chronic illness or disease, the plan shall
12 take such actions as are necessary to reasonably ensure
13 that plan participants are informed of such exclusion. The
14 requirements of this subsection may be satisfied—

15 “(1) by inclusion of information in publications
16 broadly distributed by plan sponsors, employers, or
17 employee organizations;

18 “(2) by electronic means of communication (in-
19 cluding the Internet or proprietary computer net-
20 works in a format which is readily accessible to par-
21 ticipants);

22 “(3) by timely informing participants who,
23 under an ongoing program maintained under the
24 plan, have submitted their names for such notifica-
25 tion; or

1 “(4) by any other reasonable means of timely
2 informing plan participants.”.

3 (b) CLERICAL AMENDMENT.—The table of sections
4 of such subchapter of such chapter is amended by adding
5 at the end the following new item:

 “Sec. 9814. Disclosure by group health plans.”.

6 **SEC. 3102. EFFECTIVE DATE.**

7 (a) IN GENERAL.—The amendments made by this
8 subtitle shall apply with respect to plan years beginning
9 on or after January 1 of the second calendar year follow-
10 ing the date of the enactment of this Act. The Secretary
11 of the Treasury or the Secretary’s delegate shall first issue
12 all regulations necessary to carry out the amendments
13 made by this subtitle before such date.

14 (b) LIMITATION ON ENFORCEMENT ACTIONS.—No
15 enforcement action shall be taken, pursuant to the amend-
16 ments made by this subtitle, against a group health plan
17 with respect to a violation of a requirement imposed by
18 such amendments before the date of issuance of final regu-
19 lations issued in connection with such requirement, if the
20 plan has sought to comply in good faith with such require-
21 ment.

Subtitle C—Medical Savings Accounts

SEC. 3201. EXPANSION OF AVAILABILITY OF MEDICAL SAV- INGS ACCOUNTS.

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

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

(2) CONFORMING AMENDMENT.—Paragraph (1) of section 220(c) of such Code is amended by striking subparagraph (D).

(b) ALL EMPLOYERS MAY OFFER MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Subclause (I) of section 220(c)(1)(A)(iii) of such Code (defining eligible individual) is amended by striking “and such employer is a small employer”.

(2) CONFORMING AMENDMENTS.—

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

(B) Subsection (c) of section 220 of such Code is amended by striking paragraph (4) and

1 by redesignating paragraph (5) as paragraph
2 (4).

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

5 (1) IN GENERAL.—Paragraph (2) of section
6 220(b) of such Code is amended to read as follows:

7 “(2) MONTHLY LIMITATION.—The monthly lim-
8 itation for any month is the amount equal to $\frac{1}{12}$ of
9 the annual deductible (as of the first day of such
10 month) of the individual’s coverage under the high
11 deductible health plan.”.

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

15 (d) BOTH EMPLOYERS AND EMPLOYEES MAY CON-
16 TRIBUTE TO MEDICAL SAVINGS ACCOUNTS.—Paragraph
17 (5) of section 220(b) of such Code is amended to read
18 as follows:

19 “(5) COORDINATION WITH EXCLUSION FOR EM-
20 PLOYER CONTRIBUTIONS.—The limitation which
21 would (but for this paragraph) apply under this sub-
22 section to the individual for any taxable year shall
23 be reduced (but not below zero) by the amount
24 which would (but for section 106(b)) be includible in
25 the individual’s gross income for such taxable year.”.

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

3 (1) IN GENERAL.—Subparagraph (A) of section
4 220(c)(2) of such Code (defining high deductible
5 health plan) is amended—

6 (A) by striking “\$1,500” and inserting
7 “\$1,000”; and

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

10 (2) CONFORMING AMENDMENT.—Subsection (g)
11 of section 220 of such Code is amended—

12 (A) by striking “1998” and inserting
13 “2000”; and

14 (B) by striking “1997” and inserting
15 “1999”.

16 (f) MEDICAL SAVINGS ACCOUNTS MAY BE OFFERED
17 UNDER CAFETERIA PLANS.—Subsection (f) of section
18 125 of such Code is amended by striking “106(b),”.

19 (g) INDIVIDUALS RECEIVING IMMEDIATE FEDERAL
20 ANNUITIES ELIGIBLE FOR MEDICAL SAVINGS AC-
21 COUNTS.—Paragraph (1) of section 220(c) of such Code
22 (defining eligible individual), as amended by subsections
23 (a) and (b), is amended by adding at the end the following
24 new subparagraph:

1 “(C) SPECIAL RULES FOR INDIVIDUALS
2 RECEIVING IMMEDIATE FEDERAL ANNUITIES.—

3 “(i) IN GENERAL.—Subparagraph
4 (A)(iii) and subsection (b)(4) shall not
5 apply for any month to an individual—

6 “(I) who, as of the first day of
7 such month, is enrolled in a high de-
8 ductible health plan under chapter 89
9 of title 5, United States Code; and

10 “(II) who is entitled to receive
11 for such month any amount by reason
12 of being an annuitant (as defined in
13 section 8901(3) of such title 5).

14 “(ii) SPECIAL RULE FOR SPOUSE OF
15 ANNUITANT.—In the case of the spouse of
16 an individual described in clause (i) who is
17 not also described in clause (i), subsection
18 (b)(4) shall not apply to such spouse if
19 such individual and spouse have family
20 coverage under the same plan described in
21 clause (i)(I).”.

22 (h) EFFECTIVE DATE.—The amendments made by
23 this section shall apply to taxable years ending after the
24 date of the enactment of this Act.

1 **SEC. 3202. EXCEPTION FROM INSURANCE LIMITATION IN**
2 **CASE OF MEDICAL SAVINGS ACCOUNTS.**

3 (a) IN GENERAL.—Section 220(d)(2)(B) of the Inter-
4 nal Revenue Code of 1986 is amended by adding at the
5 end the following new clause:

6 “(iii) INSURANCE OFFERED BY COM-
7 MUNITY HEALTH CENTERS.—

8 “(I) IN GENERAL.—Subject to
9 subclauses (II) and (III), clause (i)
10 shall not apply to any expense for cov-
11 erage under insurance offered by a
12 health center (as defined in section
13 330(a)(1) of the Public Health Serv-
14 ice Act) if the coverage consists solely
15 of coverage for required primary
16 health benefits (as defined in section
17 330(b)(1)(A) of such Act) provided on
18 a capitated basis.

19 “(II) INCOME LIMITATION.—Sub-
20 clause (I) shall only apply to expenses
21 for coverage of an individual who, in
22 the taxable year involved, has income
23 that is less than 200 percent of the
24 income official poverty line (as defined
25 by the Office of Management and
26 Budget, and revised annually in ac-

1 cordance with section 673(2) of the
2 Omnibus Budget Reconciliation Act of
3 1981) applicable to a family of the
4 size involved.

5 “(III) LIMITATION ON NUMBER
6 OF CONTRACTS.—For a taxable year
7 ending in a calendar year, subclause
8 (I) shall apply only to expenses for
9 coverage for the first 15,000 individ-
10 uals enrolled in insurance described in
11 such subclause in the year.”.

12 (b) REPORTS ON ENROLLMENT.—Section 330(j)(3)
13 of the Public Health Service Act (42 U.S.C. 254c(j)(3))
14 is amended—

15 (1) by striking “and” at the end of subpara-
16 graph (K);

17 (2) by striking the period at the end of sub-
18 paragraph (L) and inserting “; and”; and

19 (3) by inserting after subparagraph (L) the fol-
20 lowing new subparagraph:

21 “(M) if the center offers insurance cov-
22 erage to an individual with a medical savings
23 account under subclause (I) of section
24 220(d)(2)(B)(iii), the center shall provide such
25 reports in such time and manner as may be re-

1 quired by the Secretary and the Secretary of
 2 the Treasury in order to carry out subclause
 3 (III) of such section.”.

4 **SEC. 3203. SENSE OF THE HOUSE OF REPRESENTATIVES.**

5 It is the sense of the House of Representatives that
 6 patients are best served when they are empowered to make
 7 informed choices about their own health care. The same
 8 is true regarding an individual’s choice of health insur-
 9 ance. A system that gives people the power to choose the
 10 coverage that best meets their needs, combined with insur-
 11 ance market reforms, offers great promise of increased
 12 choices and greater access to health insurance for Ameri-
 13 cans.

14 **TITLE IV—HEALTH CARE**
 15 **LAWSUIT REFORM**
 16 **Subtitle A—General Provisions**

17 **SEC. 4001. FEDERAL REFORM OF HEALTH CARE LIABILITY**
 18 **ACTIONS.**

19 (a) **APPLICABILITY.**—This title shall apply with re-
 20 spect to any health care liability action brought in any
 21 State or Federal court, except that this title shall not
 22 apply to—

23 (1) an action for damages arising from a vac-
 24 cine-related injury or death to the extent that title

1 XXI of the Public Health Service Act applies to the
2 action; or

3 (2) an action under the Employee Retirement
4 Income Security Act of 1974 (29 U.S.C. 1001 et
5 seq.).

6 (b) PREEMPTION.—This title shall preempt any State
7 law to the extent such law is inconsistent with the limita-
8 tions contained in this title. This title shall not preempt
9 any State law that provides for defenses or places limita-
10 tions on a person’s liability in addition to those contained
11 in this title or otherwise imposes greater restrictions than
12 those provided in this title.

13 (c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE
14 OF LAW OR VENUE.—Nothing in subsection (b) shall be
15 construed to—

16 (1) waive or affect any defense of sovereign im-
17 munity asserted by any State under any provision of
18 law;

19 (2) waive or affect any defense of sovereign im-
20 munity asserted by the United States;

21 (3) affect the applicability of any provision of
22 the Foreign Sovereign Immunities Act of 1976;

23 (4) preempt State choice-of-law rules with re-
24 spect to claims brought by a foreign nation or a citi-
25 zen of a foreign nation; or

1 (5) affect the right of any court to transfer
2 venue or to apply the law of a foreign nation or to
3 dismiss a claim of a foreign nation or of a citizen
4 of a foreign nation on the ground of inconvenient
5 forum.

6 (d) AMOUNT IN CONTROVERSY.—In an action to
7 which this title applies and which is brought under section
8 1332 of title 28, United States Code, the amount of non-
9 economic damages or punitive damages, and attorneys’
10 fees or costs, shall not be included in determining whether
11 the matter in controversy exceeds the sum or value of
12 \$50,000.

13 (e) FEDERAL COURT JURISDICTION NOT ESTAB-
14 LISHED ON FEDERAL QUESTION GROUNDS.—Nothing in
15 this title shall be construed to establish any jurisdiction
16 in the district courts of the United States over health care
17 liability actions on the basis of section 1331 or 1337 of
18 title 28, United States Code.

19 **SEC. 4002. DEFINITIONS.**

20 As used in this title:

21 (1) ACTUAL DAMAGES.—The term “actual dam-
22 ages” means damages awarded to pay for economic
23 loss.

24 (2) ALTERNATIVE DISPUTE RESOLUTION SYS-
25 TEM; ADR.—The term “alternative dispute resolution

1 system” or “ADR” means a system established
2 under Federal or State law that provides for the res-
3 olution of health care liability claims in a manner
4 other than through health care liability actions.

5 (3) CLAIMANT.—The term “claimant” means
6 any person who brings a health care liability action
7 and any person on whose behalf such an action is
8 brought. If such action is brought through or on be-
9 half of an estate, the term includes the claimant’s
10 decedent. If such action is brought through or on be-
11 half of a minor or incompetent, the term includes
12 the claimant’s legal guardian.

13 (4) CLEAR AND CONVINCING EVIDENCE.—The
14 term “clear and convincing evidence” is that meas-
15 ure or degree of proof that will produce in the mind
16 of the trier of fact a firm belief or conviction as to
17 the truth of the allegations sought to be established.
18 Such measure or degree of proof is more than that
19 required under preponderance of the evidence but
20 less than that required for proof beyond a reason-
21 able doubt.

22 (5) COLLATERAL SOURCE PAYMENTS.—The
23 term “collateral source payments” means any
24 amount paid or reasonably likely to be paid in the
25 future to or on behalf of a claimant, or any service,

1 product, or other benefit provided or reasonably like-
2 ly to be provided in the future to or on behalf of a
3 claimant, as a result of an injury or wrongful death,
4 pursuant to—

5 (A) any State or Federal health, sickness,
6 income-disability, accident or workers' com-
7 pensation Act;

8 (B) any health, sickness, income-disability,
9 or accident insurance that provides health bene-
10 fits or income-disability coverage;

11 (C) any contract or agreement of any
12 group, organization, partnership, or corporation
13 to provide, pay for, or reimburse the cost of
14 medical, hospital, dental, or income disability
15 benefits; and

16 (D) any other publicly or privately funded
17 program.

18 (6) DRUG.—The term “drug” has the meaning
19 given such term in section 201(g)(1) of the Federal
20 Food, Drug, and Cosmetic Act (21 U.S.C.
21 321(g)(1)).

22 (7) ECONOMIC LOSS.—The term “economic
23 loss” means any pecuniary loss resulting from injury
24 (including the loss of earnings or other benefits re-
25 lated to employment, medical expense loss, replace-

1 ment services loss, loss due to death, burial costs,
2 and loss of business or employment opportunities),
3 to the extent recovery for such loss is allowed under
4 applicable State law.

5 (8) HARM.—The term “harm” means any le-
6 gally cognizable wrong or injury for which punitive
7 damages may be imposed.

8 (9) HEALTH BENEFIT PLAN.—The term
9 “health benefit plan” means—

10 (A) a hospital or medical expense incurred
11 policy or certificate;

12 (B) a hospital or medical service plan con-
13 tract;

14 (C) a health maintenance subscriber con-
15 tract; or

16 (D) a Medicare+Choice plan (offered
17 under part C of title XVIII of the Social Secu-
18 rity Act),

19 that provides benefits with respect to health care
20 services.

21 (10) HEALTH CARE LIABILITY ACTION.—The
22 term “health care liability action” means a civil ac-
23 tion brought in a State or Federal court against—

24 (A) a health care provider;

1 (B) an entity which is obligated to provide
2 or pay for health benefits under any health ben-
3 efit plan (including any person or entity acting
4 under a contract or arrangement to provide or
5 administer any health benefit); or

6 (C) the manufacturer, distributor, supplier,
7 marketer, promoter, or seller of a medical prod-
8 uct,

9 in which the claimant alleges a claim (including third
10 party claims, cross claims, counter claims, or contribution
11 claims) based upon the provision of (or the failure to pro-
12 vide or pay for) health care services or the use of a medical
13 product, regardless of the theory of liability on which the
14 claim is based or the number of plaintiffs, defendants, or
15 causes of action.

16 (11) HEALTH CARE LIABILITY CLAIM.—The
17 term “health care liability claim” means a claim in
18 which the claimant alleges that injury was caused by
19 the provision of (or the failure to provide) health
20 care services.

21 (12) HEALTH CARE PROVIDER.—The term
22 “health care provider” means any person that is en-
23 gaged in the delivery of health care services in a
24 State and that is required by the laws or regulations
25 of the State to be licensed or certified by the State

1 to engage in the delivery of such services in the
2 State.

3 (13) HEALTH CARE SERVICE.—The term
4 “health care service” means any service eligible for
5 payment under a health benefit plan, including serv-
6 ices related to the delivery or administration of such
7 service.

8 (14) MEDICAL DEVICE.—The term “medical de-
9 vice” has the meaning given such term in section
10 201(h) of the Federal Food, Drug, and Cosmetic
11 Act (21 U.S.C. 321(h)).

12 (15) NONECONOMIC DAMAGES.—The term
13 “noneconomic damages” means damages paid to an
14 individual for pain and suffering, inconvenience,
15 emotional distress, mental anguish, loss of consor-
16 tium, injury to reputation, humiliation, and other
17 nonpecuniary losses.

18 (16) PERSON.—The term “person” means any
19 individual, corporation, company, association, firm,
20 partnership, society, joint stock company, or any
21 other entity, including any governmental entity.

22 (17) PRODUCT SELLER.—

23 (A) IN GENERAL.—Subject to subpara-
24 graph (B), the term “product seller” means a

1 person who, in the course of a business con-
2 ducted for that purpose—

3 (i) sells, distributes, rents, leases, pre-
4 pares, blends, packages, labels, or is other-
5 wise involved in placing, a product in the
6 stream of commerce; or

7 (ii) installs, repairs, or maintains the
8 harm-causing aspect of a product.

9 (B) EXCLUSION.—Such term does not
10 include—

11 (i) a seller or lessor of real property;

12 (ii) a provider of professional services
13 in any case in which the sale or use of a
14 product is incidental to the transaction and
15 the essence of the transaction is the fur-
16 nishing of judgment, skill, or services; or

17 (iii) any person who—

18 (I) acts in only a financial capac-
19 ity with respect to the sale of a prod-
20 uct; or

21 (II) leases a product under a
22 lease arrangement in which the selec-
23 tion, possession, maintenance, and op-
24 eration of the product are controlled
25 by a person other than the lessor.

1 (18) PUNITIVE DAMAGES.—The term “punitive
2 damages” means damages awarded against any per-
3 son not to compensate for actual injury suffered, but
4 to punish or deter such person or others from en-
5 gaging in similar behavior in the future.

6 (19) STATE.—The term “State” means each of
7 the several States, the District of Columbia, Puerto
8 Rico, the Virgin Islands, Guam, American Samoa,
9 the Northern Mariana Islands, and any other terri-
10 tory or possession of the United States.

11 **SEC. 4003. EFFECTIVE DATE.**

12 This title will apply to—

13 (1) any health care liability action brought in a
14 Federal or State court; and

15 (2) any health care liability claim subject to an
16 alternative dispute resolution system,

17 that is initiated on or after the date of enactment of this
18 title, except that any health care liability claim or action
19 arising from an injury occurring before the date of enact-
20 ment of this title shall be governed by the applicable stat-
21 ute of limitations provisions in effect at the time the injury
22 occurred.

1 **Subtitle B—Uniform Standards for**
2 **Health Care Liability Actions**

3 **SEC. 4011. STATUTE OF LIMITATIONS.**

4 A health care liability action may not be brought
5 after the expiration of the 2-year period that begins on
6 the date on which the alleged injury that is the subject
7 of the action was discovered or should reasonably have
8 been discovered, but in no case after the expiration of the
9 5-year period that begins on the date the alleged injury
10 occurred.

11 **SEC. 4012. CALCULATION AND PAYMENT OF DAMAGES.**

12 (a) TREATMENT OF NONECONOMIC DAMAGES.—

13 (1) LIMITATION ON NONECONOMIC DAMAGES.—

14 The total amount of noneconomic damages that may
15 be awarded to a claimant for losses resulting from
16 the injury which is the subject of a health care liabil-
17 ity action may not exceed \$250,000, regardless of
18 the number of parties against whom the action is
19 brought or the number of actions brought with re-
20 spect to the injury. The limitation under this para-
21 graph shall not apply to an action for damages
22 based solely on intentional denial of medical treat-
23 ment necessary to preserve a patient's life that the
24 patient is otherwise qualified to receive, against the
25 wishes of a patient, or if the patient is incompetent,

1 against the wishes of the patient's guardian, on the
2 basis of the patient's present or predicated age, dis-
3 ability, degree of medical dependency, or quality of
4 life.

5 (2) LIMIT.—If, after the date of the enactment
6 of this Act, a State enacts a law which prescribes
7 the amount of noneconomic damages which may be
8 awarded in a health care liability action which is dif-
9 ferent from the amount prescribed by section
10 4012(a)(1), the State amount shall apply in lieu of
11 the amount prescribed by such section. If, after the
12 date of the enactment of this Act, a State enacts a
13 law which limits the amount of recovery in a health
14 care liability action without delineating between eco-
15 nomic and noneconomic damages, the State amount
16 shall apply in lieu of the amount prescribed by such
17 section.

18 (3) JOINT AND SEVERAL LIABILITY.—In any
19 health care liability action brought in State or Fed-
20 eral court, a defendant shall be liable only for the
21 amount of noneconomic damages attributable to
22 such defendant in direct proportion to such defend-
23 ant's share of fault or responsibility for the claim-
24 ant's actual damages, as determined by the trier of
25 fact. In all such cases, the liability of a defendant

1 for noneconomic damages shall be several and not
2 joint and a separate judgment shall be rendered
3 against each defendant for the amount allocated to
4 such defendant.

5 (b) TREATMENT OF PUNITIVE DAMAGES.—

6 (1) GENERAL RULE.—Punitive damages may,
7 to the extent permitted by applicable State law, be
8 awarded in any health care liability action for harm
9 in any Federal or State court against a defendant if
10 the claimant establishes by clear and convincing evi-
11 dence that the harm suffered was the result of
12 conduct—

13 (A) specifically intended to cause harm; or

14 (B) conduct manifesting a conscious, fla-
15 grant indifference to the rights or safety of oth-
16 ers.

17 (2) APPLICABILITY.—This subsection shall
18 apply to any health care liability action brought in
19 any Federal or State court on any theory where pu-
20 nitive damages are sought. This subsection does not
21 create a cause of action for punitive damages. This
22 subsection does not preempt or supersede any State
23 or Federal law to the extent that such law would
24 further limit the award of punitive damages.

1 (3) BIFURCATION.—At the request of any
2 party, the trier of fact shall consider in a separate
3 proceeding whether punitive damages are to be
4 awarded and the amount of such award. If a separate
5 proceeding is requested, evidence relevant only
6 to the claim of punitive damages, as determined by
7 applicable State law, shall be inadmissible in any
8 proceeding to determine whether actual damages are
9 to be awarded.

10 (4) DRUGS AND DEVICES.—

11 (A) IN GENERAL.—

12 (i) PUNITIVE DAMAGES.—Punitive
13 damages shall not be awarded against a
14 manufacturer or product seller of a drug
15 or medical device which caused the claimant's
16 harm where—

17 (I) such drug or device was subject
18 to premarket approval by the
19 Food and Drug Administration with
20 respect to the safety of the formulation
21 or performance of the aspect of
22 such drug or device which caused the
23 claimant's harm, or the adequacy of
24 the packaging or labeling of such drug
25 or device which caused the harm, and

1 such drug, device, packaging, or label-
2 ing was approved by the Food and
3 Drug Administration; or

4 (II) the drug is generally recog-
5 nized as safe and effective pursuant to
6 conditions established by the Food
7 and Drug Administration and applica-
8 ble regulations, including packaging
9 and labeling regulations.

10 (ii) APPLICATION.—Clause (i) shall
11 not apply in any case in which the defend-
12 ant, before or after premarket approval of
13 a drug or device—

14 (I) intentionally and wrongfully
15 withheld from or misrepresented to
16 the Food and Drug Administration in-
17 formation concerning such drug or de-
18 vice required to be submitted under
19 the Federal Food, Drug, and Cos-
20 metic Act (21 U.S.C. 301 et seq.) or
21 section 351 of the Public Health Serv-
22 ice Act (42 U.S.C. 262) that is mate-
23 rial and relevant to the harm suffered
24 by the claimant; or

1 (II) made an illegal payment to
2 an official or employee of the Food
3 and Drug Administration for the pur-
4 pose of securing or maintaining ap-
5 proval of such drug or device.

6 (B) PACKAGING.—In a health care liability
7 action for harm which is alleged to relate to the
8 adequacy of the packaging or labeling of a drug
9 which is required to have tamper-resistant
10 packaging under regulations of the Secretary of
11 Health and Human Services (including labeling
12 regulations related to such packaging), the
13 manufacturer or product seller of the drug shall
14 not be held liable for punitive damages unless
15 such packaging or labeling is found by the court
16 by clear and convincing evidence to be substan-
17 tially out of compliance with such regulations.

18 (c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

19 (1) GENERAL RULE.—In any health care liabil-
20 ity action in which the damages awarded for future
21 economic and noneconomic loss exceeds \$50,000, a
22 person shall not be required to pay such damages in
23 a single, lump-sum payment, but shall be permitted
24 to make such payments periodically based on when

1 the damages are likely to occur, as such payments
2 are determined by the court.

3 (2) FINALITY OF JUDGMENT.—The judgment
4 of the court awarding periodic payments under this
5 subsection may not, in the absence of fraud, be re-
6 opened at any time to contest, amend, or modify the
7 schedule or amount of the payments.

8 (3) LUMP-SUM SETTLEMENTS.—This sub-
9 section shall not be construed to preclude a settle-
10 ment providing for a single, lump-sum payment.

11 (d) TREATMENT OF COLLATERAL SOURCE PAY-
12 MENTS.—

13 (1) INTRODUCTION INTO EVIDENCE.—In any
14 health care liability action, any defendant may intro-
15 duce evidence of collateral source payments. If any
16 defendant elects to introduce such evidence, the
17 claimant may introduce evidence of any amount paid
18 or contributed or reasonably likely to be paid or con-
19 tributed in the future by or on behalf of the claim-
20 ant to secure the right to such collateral source pay-
21 ments.

22 (2) NO SUBROGATION.—No provider of collat-
23 eral source payments shall recover any amount
24 against the claimant or receive any lien or credit
25 against the claimant's recovery or be equitably or le-

1 gally subrogated to the right of the claimant in a
2 health care liability action.

3 (3) APPLICATION TO SETTLEMENTS.—This sub-
4 section shall apply to an action that is settled as well
5 as an action that is resolved by a fact finder.

6 **SEC. 4013. ALTERNATIVE DISPUTE RESOLUTION.**

7 Any ADR used to resolve a health care liability action
8 or claim shall contain provisions relating to statute of limi-
9 tations, noneconomic damages, joint and several liability,
10 punitive damages, collateral source rule, and periodic pay-
11 ments which are consistent with the provisions relating to
12 such matters in this title.

13 **SEC. 4014. REPORTING ON FRAUD AND ABUSE ENFORCE-**
14 **MENT ACTIVITIES.**

15 The General Accounting Office shall—

16 (1) monitor—

17 (A) the compliance of the Department of
18 Justice and all United States Attorneys-with
19 the guideline entitled “Guidance on the Use of
20 the False Claims Act in Civil Health Care Mat-
21 ters” issued by the Department on June 3,
22 1998, including any revisions to that guideline;
23 and

24 (B) the compliance of the Office of the In-
25 spector General of the Department of Health

1 and Human Services with the protocols and
2 guidelines entitled “National Project Proto-
3 cols—Best Practice Guidelines” issued by the
4 Inspector General on June 3, 1998, including
5 any revisions to such protocols and guidelines;
6 and

7 (2) submit a report on such compliance to the
8 Committee on Commerce, the Committee on the Ju-
9 diciary, and the Committee on Ways and Means of
10 the House of Representatives and the Committee on
11 the Judiciary and the Committee on Finance of the
12 Senate not later than February 1, 2000, and every
13 year thereafter for a period of 4 years ending Feb-
14 ruary 1, 2003.

15 **TITLE V—CONFIDENTIALITY OF**
16 **HEALTH INFORMATION**

17 **SEC. 5001. CONFIDENTIALITY OF PROTECTED HEALTH IN-**
18 **FORMATION.**

19 (a) IN GENERAL.—Title XI of the Social Security Act
20 (42 U.S.C. 1301 et seq.) is amended by adding at the end
21 the following:

3 “INSPECTION AND COPYING OF PROTECTED HEALTH
4 INFORMATION

15 “(b) ACCESS THROUGH ORIGINATING PROVIDER.—
16 Protected health information that is created by an origi-
17 nating provider, and subsequently received by another
18 health care provider or a health plan as part of treatment
19 or payment activities, shall be made available for inspec-
20 tion and copying as provided in this section through the
21 originating provider, rather than the receiving health care
22 provider or health plan, unless the originating provider
23 does not maintain the information.

24 “(c) INVESTIGATIONAL INFORMATION.—With respect
25 to protected health information that was created as part

1 of the requesting individual's participation in a clinical
2 trial monitored by an institutional review board estab-
3 lished to review health research with respect to potential
4 risks to human subjects pursuant to Federal regulations
5 adopted under section 1802(b) of the Public Health Serv-
6 ice Act (42 U.S.C. 300v-1(b)) and the notice (informally
7 referred to as the 'Common Rule') promulgated in the
8 Federal Register at 56 Fed. Reg. 28003), a request under
9 subsection (a) shall be granted only to the extent and in
10 a manner consistent with such regulations.

11 “(d) OTHER EXCEPTIONS.—Unless ordered by a
12 court of competent jurisdiction, a person to whom a re-
13 quest under subsection (a) is made is not required to grant
14 the request, if—

15 “(1) the person determines that the disclosure
16 of the information could reasonably be expected to
17 endanger the life or physical safety of, or cause sub-
18 stantial harm to, any individual; or

19 “(2) the information is compiled principally—

20 “(A) in anticipation of a civil, criminal, or
21 administrative action or proceeding; or

22 “(B) for use in such action or proceeding.

23 “(e) DENIAL OF REQUEST FOR INSPECTION OR
24 COPYING.—If a person to whom a request under sub-
25 section (a) is made denies a request for inspection or copy-

1 ing pursuant to this section, the person shall inform the
2 individual making the request, in writing, of—

3 “(1) the reasons for the denial of the request;

4 “(2) the availability of procedures for further
5 review of the denial; and

6 “(3) the individual’s right to file with the per-
7 son a concise statement setting forth the request.

8 “(f) STATEMENT REGARDING REQUEST.—If an indi-
9 vidual has filed with a person a statement under sub-
10 section (e)(3) with respect to protected health information,
11 the person, in any subsequent disclosure of the
12 information—

13 “(1) shall include a notation concerning the in-
14 dividual’s statement; and

15 “(2) may include a concise statement of the
16 reasons for denying the request for inspection or
17 copying.

18 “(g) PROCEDURES.—A person providing access to
19 protected health information for inspection or copying
20 under this section may set forth appropriate procedures
21 to be followed for such inspection or copying and may re-
22 quire an individual to pay reasonable costs associated with
23 such inspection or copying.

24 “(h) INSPECTION AND COPYING OF SEGREGABLE
25 PORTION.—A person to whom a request under subsection

1 (a) is made shall permit the inspection and copying of any
2 reasonably segregable portion of a record after deletion of
3 any portion that the person is not required to disclose
4 under this section.

5 “(i) DEADLINE.—A person described in subsection
6 (a) shall comply with or deny, in accordance with this sec-
7 tion, a request for inspection or copying of protected
8 health information under this section not later than 30
9 days after the date on which the person receives the re-
10 quest.

11 “(j) RULES GOVERNING AGENTS.—An agent of a
12 person described in subsection (a) shall not be required
13 to provide for the inspection and copying of protected
14 health information, except where—

15 “(1) the protected health information is re-
16 tained by the agent; and

17 “(2) the agent has been asked by the person to
18 fulfill the requirements of this section.

19 “SUPPLEMENTATION OF PROTECTED HEALTH
20 INFORMATION

21 “SEC. 1182. (a) IN GENERAL.—Subject to subsection
22 (b), not later than 45 days after the date on which a per-
23 son who is a health care provider, health plan, employer,
24 health or life insurer, or educational institution receives,
25 from an individual who is a subject of protected health
26 information that is maintained by the person, a request

1 in writing to amend the information by adding a concise
2 written supplement to it, the person—

3 “(1) shall make the amendment requested;

4 “(2) shall inform the individual of the amend-
5 ment that has been made; and

6 “(3) shall make reasonable efforts to inform
7 any person who is identified by the individual, who
8 is not an officer, employer, or agent of the person
9 receiving the request, and to whom the unamended
10 portion of the information was disclosed during the
11 preceding year, by sending a notice to the person’s
12 last known address that an amendment, consisting
13 of the addition of a supplement, has been made to
14 the protected health information of the individual.

15 “(b) REFUSAL TO AMEND.—If a person described in
16 subsection (a) refuses to make an amendment requested
17 by an individual under such subsection, the person shall
18 inform the individual, in writing, of—

19 “(1) the reasons for the refusal to make the
20 amendment;

21 “(2) any procedures for further review of the
22 refusal; and

23 “(3) the individual’s right to file with the per-
24 son a concise statement setting forth the requested

1 amendment and the individual's reasons for dis-
2 agreeing with the refusal.

3 “(c) STATEMENT OF DISAGREEMENT.—If an individ-
4 ual has filed a statement of disagreement with a person
5 under subsection (b)(3), the person, in any subsequent dis-
6 closure of the disputed portion of the information—

7 “(1) shall include a notation that such individ-
8 ual has filed a statement of disagreement; and

9 “(2) may include a concise statement of the
10 reasons for not making the requested amendment.

11 “(d) RULES GOVERNING AGENTS.—The agent of a
12 person described in subsection (a) shall not be required
13 to make amendments to individually identifiable health in-
14 formation, except where—

15 “(1) the information is retained by the agent;
16 and

17 “(2) the agent has been asked by such person
18 to fulfill the requirements of this section.

19 “(e) DUPLICATIVE REQUESTS FOR AMENDMENTS.—
20 If a person described in subsection (a) receives a duplica-
21 tive request for an amendment of information as provided
22 for in such subsection and a statement of disagreement
23 with respect to the request has been filed pursuant to sub-
24 section (c), the person shall inform the individual of such

1 filing and shall not be required to carry out the procedures
2 under this section.

3 “(f) RULE OF CONSTRUCTION.—This section shall
4 not be construed—

5 “(1) to permit an individual to modify state-
6 ments in his or her record that document the factual
7 observations of another individual or state the re-
8 sults of diagnostic tests; or

9 “(2) to permit an individual to amend his or
10 her record as to the type, duration, or quality of
11 treatment the individual believes he or she should
12 have been provided.

13 “NOTICE OF CONFIDENTIALITY PRACTICES

14 “SEC. 1183. (a) PREPARATION OF WRITTEN NO-
15 TICE.—A person who is a health care provider, health
16 plan, health oversight agency, public health authority, em-
17 ployer, health or life insurer, health researcher, or edu-
18 cational institution shall post or provide, in writing and
19 in a clear and conspicuous manner, notice of the person’s
20 protected health information confidentiality practices. The
21 notice shall include—

22 “(1) a description of an individual’s rights with
23 respect to protected health information;

24 “(2) the intended uses and disclosures of pro-
25 tected health information;

1 “(3) the procedures established by the person
2 for the exercise of an individual’s rights with respect
3 to protected health information; and

4 “(4) the procedures established by the person
5 for obtaining copies of the notice.

6 “(b) MODEL NOTICE.—The Secretary, after notice
7 and opportunity for public comment, and based on the ad-
8 vice of the National Committee on Vital and Health Sta-
9 tistics established under section 306(k) of the Public
10 Health Service Act (42 U.S.C. 242k(k)), shall develop and
11 disseminate, not later than 6 months after the date of the
12 enactment of the Patient Protection Act of 1999, model
13 notices of confidentiality practices, for use under this sec-
14 tion. Use of a model notice developed by the Secretary
15 shall serve as a complete defense in any civil action to an
16 allegation that a violation of this section has occurred.

17 “ESTABLISHMENT OF SAFEGUARDS

18 “SEC. 1184. (a) IN GENERAL.—A person who is a
19 health care provider, health plan, health oversight agency,
20 public health authority, employer, health or life insurer,
21 health researcher, or educational institution shall estab-
22 lish, maintain, and enforce reasonable and appropriate ad-
23 ministrative, technical, and physical safeguards to protect
24 the confidentiality, security, accuracy, and integrity of
25 protected health information created, received, obtained,

1 maintained, used, transmitted, or disposed of by the per-
2 son.

3 “(b) FACTORS TO BE CONSIDERED.—A person sub-
4 ject to subsection (a) shall consider the following factors
5 in establishing safeguards under such subsection:

6 “(1) The need for protected health information.

7 “(2) The categories of personnel who will have
8 access to protected health information.

9 “(3) The feasibility of limiting access to individ-
10 ual identifiers.

11 “(4) The appropriateness of the policy or proce-
12 dure to the person, and to the medium in which pro-
13 tected health information is stored and transmitted.

14 “(5) The value of audit trails in computerized
15 records.

16 “(c) RELATIONSHIP TO PART C REQUIREMENT.—
17 Any safeguard established under this section shall be con-
18 sistent with the requirement in section 1173(d)(2).

19 “(d) CONVERSION TO NONIDENTIFIABLE HEALTH
20 INFORMATION.—A person subject to subsection (a) shall,
21 to the extent practicable and consistent with the purpose
22 for which protected health information is maintained, con-
23 vert such information into nonidentifiable health informa-
24 tion.

1 “AVAILABILITY OF PROTECTED HEALTH INFORMATION
2 FOR PURPOSES OF HEALTH CARE OPERATIONS

3 “SEC. 1185. (a) DISCLOSURE.—Any person who
4 maintains protected health information may disclose the
5 information to a health care provider or a health plan for
6 the purpose of permitting the provider or plan to conduct
7 health care operations.

8 “(b) USE.—A health care provider or a health plan
9 that maintains protected health information may use it for
10 the purpose described in subsection (a).

11 “(c) LIMITATION ON SALE OR BARTER.—Notwith-
12 standing subsection (b), no health care provider or health
13 plan may, as part of conducting health care operations,
14 sell or barter protected health information.

15 “RELATIONSHIP TO OTHER LAWS

16 “SEC. 1186. (a) STATE LAW.—

17 “(1) IN GENERAL.—Except as provided in para-
18 graphs (2) and (3), the provisions of this part shall
19 preempt a provision of State law to the extent that
20 such provision—

21 “(A) otherwise would be preempted as in-
22 consistent with this part under article VI of the
23 Constitution of the United States;

24 “(B) relates to authorization for the use or
25 disclosure of—

1 “(i) protected health information for
2 health care operations; or

3 “(ii) nonidentifiable health informa-
4 tion; or

5 “(C) relates to any of the following:

6 “(i) Inspection or copying of protected
7 health information by a person who is a
8 subject of the information.

9 “(ii) Amendment of protected health
10 information by a person who is a subject
11 of the information.

12 “(iii) Notice of confidentiality prac-
13 tices with respect to protected health infor-
14 mation.

15 “(iv) Establishment of safeguards for
16 protected health information.

17 “(2) EXCEPTIONS.—Nothing in this part shall
18 be construed to preempt or modify a provision of
19 State law to the extent that such provision relates
20 to protected health information and—

21 “(A) the confidentiality of the records
22 maintained by a licensed mental health profes-
23 sional;

1 “(B) the provision of health care to a
2 minor, or the disclosure of information about a
3 minor to a parent or guardian of the minor;

4 “(C) condition-specific limitations on dis-
5 closure;

6 “(D) the use or disclosure of information
7 for use in legally authorized—

8 “(i) disease or injury reporting;

9 “(ii) public health surveillance, inves-
10 tigation, or intervention;

11 “(iii) vital statistics reporting, such as
12 reporting of birth or death information;

13 “(iv) reporting of abuse or neglect in-
14 formation;

15 “(v) reporting of information concern-
16 ing a communicable disease status; or

17 “(vi) reporting concerning the safety
18 or effectiveness of a biological product reg-
19 ulated under section 351 of the Public
20 Health Service Act (42 U.S.C. 262) or a
21 drug or device regulated under the Federal
22 Food, Drug, and Cosmetic Act (21 U.S.C.
23 301 et seq.);

24 “(E) the disclosure to a person by a health
25 care provider of information about an individ-

1 ual, in any case in which the provider has
2 determined—

3 “(i) in the provider’s reasonable medi-
4 cal judgment, that the individual is uncon-
5 scious, incompetent, or otherwise incapable
6 of deciding whether to authorize disclosure
7 of the protected health information; and

8 “(ii) in the provider’s reasonable judg-
9 ment, that the person is a spouse, relative,
10 guardian, or close friend of the individ-
11 ual’s; or

12 “(F) the use of information by, or the dis-
13 closure of information to, a person holding a
14 valid and applicable power of attorney that in-
15 cludes the authority to make health care deci-
16 sions on behalf of an individual who is a subject
17 of the information.

18 “(3) PRIVILEGES.—Nothing in this part shall
19 be construed to preempt or modify a provision of
20 State law to the extent that such provision relates
21 to a privilege of a witness or other person in a court
22 of that State.

23 “(b) FEDERAL LAW.—Nothing in this part shall be
24 construed to preempt, modify, or repeal a provision of any
25 other Federal law relating to protected health information

1 or relating to an individual's access to protected health
2 information or health care services. Nothing in this part
3 shall be construed to preempt, modify, or repeal a provi-
4 sion of Federal law to the extent that such provision re-
5 lates to a privilege of a witness or other person in a court
6 of the United States.

7 "CIVIL PENALTIES

8 "SEC. 1187. (a) VIOLATION.—A person who the Sec-
9 retary determines has substantially and materially failed
10 to comply with this part shall be subject, in addition to
11 any other penalties that may be prescribed by law—

12 "(1) in a case in which the violation relates to
13 section 1181 or 1182, to a civil penalty of not more
14 than \$500 for each such violation but not to exceed
15 \$5,000 in the aggregate for all violations of an iden-
16 tical requirement or prohibition during a calendar
17 year;

18 "(2) in the case in which the violation relates
19 to section 1183, 1184, or 1185(c), to a civil penalty
20 of not more than \$10,000 for each such violation,
21 but not to exceed \$50,000 in the aggregate for all
22 violations of an identical requirement or prohibition
23 during a calendar year; or

24 "(3) in a case in which the Secretary finds that
25 such violations have occurred with such frequency as

1 to constitute a general business practice, to a civil
2 penalty of not more than \$100,000.

3 “(b) PROCEDURES FOR IMPOSITION OF PEN-
4 ALTIES.—Section 1128A, other than subsections (a) and
5 (b) and the second sentence of subsection (f) of that sec-
6 tion, shall apply to the imposition of a civil or monetary
7 penalty under this section in the same manner as such
8 provisions apply with respect to the imposition of a penalty
9 under section 1128A.

10 “DEFINITIONS

11 “SEC. 1188. As used in this part:

12 “(1) AGENT.—The term ‘agent’ means a per-
13 son, including a contractor, who represents and acts
14 for another under the contract or relation of agency,
15 or whose function is to bring about, modify, affect,
16 accept performance of, or terminate contractual obli-
17 gations between the principal and a third person.

18 “(2) CONDITION-SPECIFIC LIMITATIONS ON DIS-
19 CLOSURE.—The term ‘condition-specific limitations
20 on disclosure’ means State laws that prohibit the
21 disclosure of protected health information relating to
22 a health condition or disease that has been identified
23 by the Secretary as posing a public health threat.

24 “(3) DISCLOSE.—The term ‘disclose’ means to
25 release, transfer, provide access to, or otherwise di-
26 vulge protected health information to any person

1 other than an individual who is the subject of such
2 information.

3 “(4) EDUCATIONAL INSTITUTION.—The term
4 ‘educational institution’ means an institution or
5 place accredited or licensed for purposes of providing
6 for instruction or education, including an elementary
7 school, secondary school, or institution of higher
8 learning, a college, or an assemblage of colleges
9 united under one corporate organization or govern-
10 ment.

11 “(5) EMPLOYER.—The term ‘employer’ has the
12 meaning given such term under section 3(5) of the
13 Employee Retirement Income Security Act of 1974
14 (29 U.S.C. 1002(5)), except that such term shall in-
15 clude only employers of two or more employees.

16 “(6) HEALTH CARE.—The term ‘health care’
17 means—

18 “(A) preventive, diagnostic, therapeutic,
19 rehabilitative, maintenance, or palliative care,
20 including appropriate assistance with disease or
21 symptom management and maintenance, coun-
22 seling, service, or procedure—

23 “(i) with respect to the physical or
24 mental condition of an individual; or

1 “(ii) affecting the structure or func-
2 tion of the human body or any part of the
3 human body, including the banking of
4 blood, sperm, organs, or any other tissue;
5 or

6 “(B) any sale or dispensing, pursuant to a
7 prescription or medical order, of a drug, device,
8 equipment, or other health care-related item to
9 an individual, or for the use of an individual.

10 “(7) HEALTH CARE OPERATIONS.—The term
11 ‘health care operations’ means services, provided di-
12 rectly by or on behalf of a health plan or health care
13 provider or by its agent, for any of the following
14 purposes:

15 “(A) Coordinating health care, including
16 health care management of the individual
17 through risk assessment, case management, and
18 disease management.

19 “(B) Conducting quality assessment and
20 improvement activities, including outcomes eval-
21 uation, clinical guideline development and im-
22 provement, and health promotion.

23 “(C) Carrying out utilization review activi-
24 ties, including precertification and
25 preauthorization of services, and health plan

1 rating activities, including underwriting and ex-
2 perience rating.

3 “(D) Conducting or arranging for auditing
4 services.

5 “(8) HEALTH CARE PROVIDER.—The term
6 ‘health care provider’ means a person, who with re-
7 spect to a specific item of protected health informa-
8 tion, receives, creates, uses, maintains, or discloses
9 the information while acting in whole or in part in
10 the capacity of—

11 “(A) a person who is licensed, certified,
12 registered, or otherwise authorized by Federal
13 or State law to provide an item or service that
14 constitutes health care in the ordinary course of
15 business, or practice of a profession;

16 “(B) a Federal, State, or employer-spon-
17 sored or any other privately-sponsored program
18 that directly provides items or services that con-
19 stitute health care to beneficiaries; or

20 “(C) an officer or employee of a person de-
21 scribed in subparagraph (A) or (B).

22 “(9) HEALTH OR LIFE INSURER.—The term
23 ‘health or life insurer’ means a health insurance
24 issuer, as defined in section 9832(b)(2) of the Inter-

1 nal Revenue Code of 1986, or a life insurance com-
2 pany, as defined in section 816 of such Code.

3 “(10) HEALTH PLAN.—The term ‘health plan’
4 means any health insurance plan, including any hos-
5 pital or medical service plan, dental or other health
6 service plan, health maintenance organization plan,
7 plan offered by a provider-sponsored organization
8 (as defined in section 1855(d)), or other program
9 providing or arranging for the provision of health
10 benefits.

11 “(11) HEALTH RESEARCHER.—The term
12 ‘health researcher’ means a person (or an officer,
13 employee, or agent of a person) who is engaged in
14 systematic investigation, including research develop-
15 ment, testing, data analysis, and evaluation, de-
16 signed to develop or contribute to generalizable
17 knowledge relating to basic biomedical processes,
18 health, health care, health care delivery, or health
19 care cost.

20 “(12) NONIDENTIFIABLE HEALTH INFORMA-
21 TION.—The term ‘nonidentifiable health information’
22 means protected health information from which per-
23 sonal identifiers that reveal the identity of the indi-
24 vidual who is the subject of such information or pro-
25 vide a direct means of identifying the individual

1 (such as name, address, and social security number)
2 have been removed, encrypted, or replaced with a
3 code, such that the identity of the individual is not
4 evident without (in the case of encrypted or coded
5 information) use of a key.

6 “(13) ORIGINATING PROVIDER.—The term
7 ‘originating provider’, when used with respect to
8 protected health information, means the health care
9 provider who takes an action that initiates the treat-
10 ment episode to which that information relates, such
11 as prescribing a drug, ordering a diagnostic test, or
12 admitting an individual to a health care facility. A
13 hospital or nursing facility is the originating pro-
14 vider with respect to protected health information
15 created or received as part of inpatient or outpatient
16 treatment provided in the hospital or facility.

17 “(14) PAYMENT ACTIVITIES.—The term ‘pay-
18 ment activities’ means—

19 “(A) activities undertaken—

20 “(i) by, or on behalf of, a health plan
21 to determine its responsibility for coverage
22 under the plan; or

23 “(ii) by a health care provider to ob-
24 tain payment for items or services provided
25 to an individual, provided under a health

1 plan, or provided based on a determination
2 by the health plan of responsibility for cov-
3 erage under the plan; and

4 “(B) includes the following activities, when
5 performed in a manner consistent with subpara-
6 graph (A):

7 “(i) Billing, claims management, med-
8 ical data processing, other administrative
9 services, and actual payment.

10 “(ii) Determinations of coverage or
11 adjudication of health benefit or subroga-
12 tion claims.

13 “(iii) Review of health care services
14 with respect to coverage under a health
15 plan or justification of charges.

16 “(15) PERSON.—The term ‘person’ means—

17 “(A) a natural person;

18 “(B) a government or governmental sub-
19 division, agency, or authority;

20 “(C) a company, corporation, estate, firm,
21 trust, partnership, association, joint venture,
22 society, or joint stock company; or

23 “(D) any other legal entity.

24 “(16) PROTECTED HEALTH INFORMATION.—

25 The term ‘protected health information’, when used

1 with respect to an individual who is a subject of in-
2 formation means any information (including genetic
3 information) that identifies the individual, whether
4 oral or recorded in any form or medium, and that—

5 “(A) is created or received by a health care
6 provider, health plan, health oversight agency,
7 public health authority, employer, health or life
8 insurer, or educational institution;

9 “(B) relates to the past, present, or future
10 physical or mental health or condition of an in-
11 dividual (including individual cells and their
12 components);

13 “(C) is derived from—

14 “(i) the provision of health care to an
15 individual; or

16 “(ii) payment for the provision of
17 health care to an individual; and

18 “(D) is not nonidentifiable health informa-
19 tion.

20 “(17) STATE.—The term ‘State’ includes the
21 District of Columbia, Puerto Rico, the Virgin Is-
22 lands, Guam, American Samoa, and the Northern
23 Mariana Islands.

1 “(18) TREATMENT.—The term ‘treatment’
2 means the provision of health care by a health care
3 provider.

4 “(19) WRITING.—The term ‘writing’ means
5 writing either in a paper-based, computer-based, or
6 electronic form, including electronic signatures.”.

7 (b) ENFORCEMENT OF PROVISIONS THROUGH CON-
8 DITIONS ON PARTICIPATION.—

9 (1) PARTICIPATING PHYSICIANS AND SUPPLI-
10 ERS.—Section 1842(h) of the Social Security Act
11 (42 U.S.C. 1395u(h)) is amended by adding at the
12 end the following:

13 “(9) The Secretary may refuse to enter into an agree-
14 ment with a physician or supplier under this subsection,
15 or may terminate or refuse to renew such agreement, in
16 the event that such physician or supplier has been found
17 to have violated a provision of part D of title XI.”.

18 (2) MEDICARE+CHOICE ORGANIZATIONS.—Sec-
19 tion 1852(h) of the Social Security Act (42 U.S.C.
20 1395w–22(h)) is amended—

21 (A) in the matter preceding paragraph (1),
22 by striking “procedures—” and inserting “pro-
23 cedures, consistent with sections 1181 through
24 1185—”; and

1 (B) in paragraph (1), by striking “privacy
2 of any individually identifiable enrollee informa-
3 tion;” and inserting “confidentiality of pro-
4 tected health information concerning enroll-
5 ees;”.

6 (3) MEDICARE PROVIDERS.—Section
7 1866(a)(1) of the Social Security Act (42 U.S.C.
8 1395cc(a)(1)) is amended—

9 (A) by inserting a semicolon at the end of
10 subparagraph (R);

11 (B) by striking the period at the end of
12 subparagraph (S) and inserting “; and”; and

13 (C) by inserting immediately after sub-
14 paragraph (S) the following new subparagraph:

15 “(T) to comply with sections 1181 through
16 1184.”.

17 (4) HEALTH MAINTENANCE ORGANIZATIONS
18 WITH RISK-SHARING CONTRACTS.—Section
19 1876(k)(4) of the Social Security Act (42 U.S.C.
20 1395mm(k)(4)) is amended by adding at the end the
21 following:

22 “(E) The confidentiality and accuracy proce-
23 dure requirements under section 1852(h).”.

24 (c) CONFORMING AMENDMENTS.—

1 (1) TITLE HEADING.—Title XI of the Social
2 Security Act (42 U.S.C. 1301 et seq.) is amended by
3 striking the title heading and inserting the following:
4 “TITLE XI—GENERAL PROVISIONS, PEER RE-
5 VIEW, ADMINISTRATIVE SIMPLIFICATION,
6 AND CONFIDENTIALITY OF PROTECTED
7 HEALTH INFORMATION”.

8 (2) NATIONAL COMMITTEE ON VITAL AND
9 HEALTH STATISTICS.—Section 306(k)(5) of the
10 Public Health Service Act (42 U.S.C. 242(k)(5)) is
11 amended—

12 (A) in subparagraphs (A)(viii) and (D), by
13 striking “part C” and inserting “parts C and
14 D”;

15 (B) in subparagraph (C), by striking
16 “and” at the end;

17 (C) in subparagraph (D), by striking the
18 period at the end and inserting “; and”; and

19 (D) by adding at the end the following:

20 “(E) shall study the issues relating to section
21 1184 of the Social Security Act (as added by the Pa-
22 tient Protection Act of 1998), and, not later than 1
23 year after the date of the enactment of the Patient
24 Protection Act of 1999, shall report to the Congress
25 on such section.”.

9 Not later than 1 year after the date of the enactment
10 of this Act, the Comptroller General of the United States
11 shall prepare and submit to the Congress a report contain-
12 ing the results of a study on the effect of State laws on
13 health-related research subject to review by an institu-
14 tional review board or institutional review committee with
15 respect to the protection of human subjects.

(a) IN GENERAL.—Not later than 9 months after the date of the enactment of this Act, the Comptroller General of the United States shall prepare and submit to the Congress a report containing the results of a study—

(1) compiling State laws on the confidentiality of protected health information (as defined in section 1188 of the Social Security Act, as added by section 5001 of this Act); and

1 (2) analyzing the effect of such laws on the pro-
2 vision of health care and securing payment for such
3 care.

4 (b) MODIFICATION OF DEADLINE.—Section
5 264(c)(1) of the Health Insurance Portability and Ac-
6 countability Act of 1996 (Public Law 104–191; 110 Stat.
7 2033) is amended by striking “36 months after the date
8 of the enactment of this Act,” and inserting “6 months
9 after the date on which the Comptroller General of the
10 United States submits to the Congress a report under sec-
11 tion 5003(a) of the Patient Protection Act of 1999,”.

12 **SEC. 5004. PROTECTION FOR CERTAIN INFORMATION DE-**
13 **VELOPED TO REDUCE MORTALITY OR MOR-**
14 **BIDITY OR FOR IMPROVING PATIENT CARE**
15 **AND SAFETY.**

16 (a) PROTECTION OF CERTAIN INFORMATION.—Not-
17 withstanding any other provision of Federal or State law,
18 health care response information shall be exempt from any
19 disclosure requirement (regardless of whether the require-
20 ment relates to subpoenas, discovery, introduction of evi-
21 dence, testimony, or any other form of disclosure), in con-
22 nection with a civil or administrative proceeding under
23 Federal or State law, to the same extent as information
24 developed by a health care provider with respect to any
25 of the following:

1 (1) Peer review.

2 (2) Utilization review.

3 (3) Quality management or improvement.

4 (4) Quality control.

5 (5) Risk management.

6 (6) Internal review for purposes of reducing
7 mortality, morbidity, or for improving patient care
8 or safety.

9 (b) NO WAIVER OF PROTECTION THROUGH INTER-
10 ACTION WITH ACCREDITING BODY.—Notwithstanding
11 any other provision of Federal or State law, the protection
12 of health care response information from disclosure pro-
13 vided under subsection (a) shall not be deemed to be modi-
14 fied or in any way waived by—

15 (1) the development of such information in con-
16 nection with a request or requirement of an accredi-
17 ting body; or

18 (2) the transfer of such information to an ac-
19 crediting body.

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

21 (1) The term “accrediting body” means a na-
22 tional, not-for-profit organization that—

23 (A) accredits health care providers; and

1 (B) is recognized as an accrediting body by
2 statute or by a Federal or State agency that
3 regulates health care providers.

4 (2) The term “health care provider” has the
5 meaning given such term in section 1188 of the So-
6 cial Security Act (as added by section 5001 of this
7 Act).

8 (3) The term “health care response informa-
9 tion” means information (including any data, report,
10 record, memorandum, analysis, statement, or other
11 communication) developed by, or on behalf of, a
12 health care provider in response to a serious, ad-
13 verse, patient-related event—

14 (A) during the course of analyzing or
15 studying the event and its causes; and

16 (B) for purposes of—

17 (i) reducing mortality or morbidity; or

18 (ii) improving patient care or safety

19 (including the provider’s notification to an
20 accrediting body and the provider’s plans
21 of action in response to such event).

22 (5) The term “State” has the meaning given
23 such term in section 1188 of the Social Security Act
24 (as added by section 5001 of this Act).

○