

106TH CONGRESS  
1ST SESSION

# H. R. 448

To provide new patient protections under group health plans.

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## 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

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## 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.

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

3   **SEC. 1101. 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.—Part 1 of subtitle B of title I of  
8 the Employee Retirement Income Security Act of 1974 is  
9 amended—

10                   (1) by redesignating section 111 as section 112;

11           and

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

14                   “DISCLOSURE BY GROUP HEALTH PLANS

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

16                   “(1) GROUP HEALTH PLANS.—The adminis-  
17 trator of each group health plan shall take such ac-  
18 tions as are necessary to ensure that the summary  
19 plan description of the plan required under section  
20 102 (or each summary plan description in any case  
21 in which different summary plan descriptions are ap-  
22 propriate under part 1 for different options of cov-  
23 erage) contains, among any information otherwise  
24 required under this part, the information required  
25 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 description 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-  
25                 SCRIPTION 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

1 (including the clinical basis) for the rec-  
2 ommendation; and

3 “(iv) a physician who did not make  
4 the initial review decision will reconsider  
5 the initial review decision to determine  
6 whether such decision was in accordance  
7 with the terms of the plan and this title  
8 and will issue a written decision affirming,  
9 modifying, or reversing the initial review  
10 decision, taking into account any rec-  
11 ommendations reported to the plan pursu-  
12 ant to clause (iii), and setting forth the  
13 grounds for the decision.

14 “(D) TIME LIMITS FOR RECONSIDER-  
15 ATION.—Any review under this paragraph shall  
16 be completed before the end of the reconsider-  
17 ation period (as defined in paragraph (9)(O))  
18 following the review filing date in connection  
19 with such review. The decision under this para-  
20 graph affirming, reversing, or modifying the ini-  
21 tial review decision of the plan shall be the final  
22 decision of the plan. Failure to issue a written  
23 decision before the end of the reconsideration  
24 period in any reconsideration requested under  
25 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-

1           porated in such alternative dispute resolu-  
2           tion procedure; and

3                   “(iv) the plan meets the additional re-  
4                   quirements of subparagraph (B).

5           In any case in which a procedure described in  
6           subclause (I) or (II) of clause (i) is utilized and  
7           an alternative dispute resolution procedure is  
8           voluntarily elected by the aggrieved participant  
9           or beneficiary, the plan may require or allow (in  
10          a manner consistent with such regulations as  
11          the Secretary may prescribe to ensure equitable  
12          procedures) the aggrieved participant or bene-  
13          ficiary to waive review of the coverage decision  
14          under paragraph (3), to waive further review of  
15          the coverage decision under paragraph (4) or  
16          section 502, and to elect an alternative means  
17          of external review (other than review under  
18          paragraph (4)).

19                   “(B) ADDITIONAL REQUIREMENTS.—The  
20                   requirements of this subparagraph are met if  
21                   the means of resolution of dispute allow for  
22                   adequate presentation by the aggrieved partici-  
23                   pant or beneficiary of scientific and medical evi-  
24                   dence supporting the position of such partici-  
25                   pant 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 efiary 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(e) 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:

1 “PART 8—RULES GOVERNING ASSOCIATION HEALTH  
2 PLANS

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

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

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

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

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

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

1       society), 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 affli-  
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           employers 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       “(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—



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 TERMI-**  
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 Retirement  
13          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-  
18 SCRPTION OF SUMMARY OF ADDITIONAL IN-  
19 FORMATION.—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 RESENTATIVES.—

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(e)(2) to enroll or be enrolled in health benefits  
17  
18 coverage offered through the HealthMart.

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  
24 offered by a health insurance issuer licensed (or otherwise regulated) in a State, shall have the meanings  
25 applied to such terms with respect to such coverage

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-

1 tion within 60 days after the date the Secretary de-  
2 termines that a substantially complete waiver appli-  
3 cation has been filed. Nothing in this section shall  
4 be construed as preventing an organization which  
5 has had such a waiver application denied from sub-  
6 mitting a subsequent waiver application.

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

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

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

21 “(6) REPORT.—By not later than December 31,  
22 2003, the Secretary shall submit to the Committee  
23 on Commerce of the House of Representatives and  
24 the Committee on Labor and Human Resources of  
25 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       organization 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-  
25                 SCRIPTION 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.

1           **Subtitle C—Medical Savings**  
2                           **Accounts**

3   **SEC. 3201. EXPANSION OF AVAILABILITY OF MEDICAL SAV-**  
4                           **INGS ACCOUNTS.**

5           (a) REPEAL OF LIMITATIONS ON NUMBER OF MEDI-  
6   CAL SAVINGS ACCOUNTS.—

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

10                   (2) CONFORMING AMENDMENT.—Paragraph (1)  
11           of section 220(c) of such Code is amended by strik-  
12           ing subparagraph (D).

13           (b) ALL EMPLOYERS MAY OFFER MEDICAL SAVINGS  
14   ACCOUNTS.—

15                   (1) IN GENERAL.—Subclause (I) of section  
16           220(c)(1)(A)(iii) of such Code (defining eligible indi-  
17           vidual) is amended by striking “and such employer  
18           is a small employer”.

19                   (2) CONFORMING AMENDMENTS.—

20                           (A) Paragraph (1) of section 220(c) of  
21           such Code is amended by striking subparagraph  
22           (C).

23                           (B) Subsection (c) of section 220 of such  
24           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 sepa-  
5 rate 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 claim-  
16 ant's harm where—

17           (I) such drug or device was sub-  
18 ject to premarket approval by the  
19 Food and Drug Administration with  
20 respect to the safety of the formula-  
21 tion 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:

1 “PART D—CONFIDENTIALITY OF PROTECTED HEALTH  
2 INFORMATION

3 “INSPECTION AND COPYING OF PROTECTED HEALTH  
4 INFORMATION

5 “SEC. 1181. (a) IN GENERAL.—Subject to the suc-  
6 ceeding provisions of this section, upon the request of an  
7 individual who is the subject of protected health informa-  
8 tion, a person who is a health care provider, health plan,  
9 employer, health or life insurer, or educational institution  
10 shall make available to the individual (or, in the discretion  
11 of the person, to a health care provider designated by the  
12 individual), for inspection and copying, protected health  
13 information concerning the individual that the person  
14 maintains, including records created under section 1182.

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.”.

1 (d) EFFECTIVE DATE.—The amendments made by  
2 this section shall take effect on the date that is 1 year  
3 after the date of the enactment of this Act, except that  
4 subsection (c)(2), and section 1183(b) of the Social Secu-  
5 rity Act (as added by subsection (a)), shall take effect on  
6 the date of the enactment of this Act.

7 **SEC. 5002. STUDY AND REPORT ON EFFECT OF STATE LAW**  
8 **ON HEALTH-RELATED RESEARCH.**

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.

16 **SEC. 5003. STUDY AND REPORT ON STATE LAW ON PRO-**  
17 **TECTED HEALTH INFORMATION.**

18 (a) IN GENERAL.—Not later than 9 months after the  
19 date of the enactment of this Act, the Comptroller General  
20 of the United States shall prepare and submit to the Con-  
21 gress a report containing the results of a study—

22 (1) compiling State laws on the confidentiality  
23 of protected health information (as defined in sec-  
24 tion 1188 of the Social Security Act, as added by  
25 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).

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