

106TH CONGRESS  
1ST SESSION

# H. R. 719

To amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage.

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## IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 11, 1999

Mr. GANSKE (for himself, Mrs. ROUKEMA, Mr. LEACH, Mr. WAMP, Mr. FORBES, Mr. PETRI, Mr. SHAYS, Mr. HORN, Mr. FRELINGHUYSEN, Mr. FOLEY, and Mr. COOKSEY) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committee on Education and the Workforce, 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 amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage.

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; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the  
5 “Managed Care Reform Act of 1999”.

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

Sec. 1. Short title; table of contents.

## TITLE I—MANAGED CARE CONSUMER PROTECTIONS

### Subtitle A—Access to Care

- Sec. 101. Access to emergency care.
- Sec. 102. Offering of choice of coverage options under group health plans.
- Sec. 103. Choice of providers.
- Sec. 104. Access to specialty care.
- Sec. 105. Continuity of care.
- Sec. 106. Coverage for individuals participating in approved clinical trials.
- Sec. 107. Access to needed prescription drugs.
- Sec. 108. Adequacy of provider network.

### Subtitle B—Quality Assurance

- Sec. 111. Standards for utilization review activities.

### Subtitle C—Patient Information

- Sec. 121. Patient information.
- Sec. 122. Protection of patient confidentiality.
- Sec. 123. Health insurance ombudsmen.

### Subtitle D—Grievance and Appeals Procedures

- Sec. 131. Establishment of grievance process.
- Sec. 132. Internal appeals of adverse determinations.
- Sec. 133. External appeals of adverse determinations.

### Subtitle E—Protecting the Doctor-Patient Relationship

- Sec. 141. Prohibition of interference with certain medical communications.
- Sec. 142. Prohibition against transfer of indemnification or improper incentive arrangements.
- Sec. 143. Additional rules regarding participation of health care professionals.
- Sec. 144. Protection for patient advocacy.

### Subtitle F—Promoting Good Medical Practice

- Sec. 151. Promoting good medical practice.
- Sec. 152. Standards relating to benefits for certain breast cancer treatment.

### Subtitle G—Definitions

- Sec. 191. Definitions.
- Sec. 192. Preemption; State flexibility; construction.
- Sec. 193. Regulations.

## TITLE II—APPLICATION OF PATIENT PROTECTION STANDARDS TO GROUP HEALTH PLANS AND HEALTH INSURANCE COVERAGE UNDER PUBLIC HEALTH SERVICE ACT

- Sec. 201. Application to group health plans and group health insurance coverage.
- Sec. 202. Application to individual health insurance coverage.

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

Sec. 301. Application of patient protection standards to group health plans and group health insurance coverage under the Employee Retirement Income Security Act of 1974.

Sec. 302. ERISA preemption not to apply to certain actions involving health insurance policyholders.

TITLE IV—EFFECTIVE DATES; COORDINATION IN  
IMPLEMENTATION

Sec. 401. Effective dates.

Sec. 402. Coordination in implementation.

1           **TITLE I—MANAGED CARE**  
2           **CONSUMER PROTECTIONS**  
3           **Subtitle A—Access to Care**

4   **SEC. 101. ACCESS TO EMERGENCY CARE.**

5           (a) COVERAGE OF EMERGENCY SERVICES.—

6                   (1) IN GENERAL.—If a group health plan, or  
7           health insurance coverage offered by a health insur-  
8           ance issuer, provides any benefits with respect to  
9           emergency services (as defined in paragraph (2)(B)),  
10          the plan or issuer shall cover emergency services fur-  
11          nished under the plan or coverage—

12                   (A) without the need for any prior author-  
13                  ization determination;

14                   (B) whether or not the health care pro-  
15                  vider furnishing such services is a participating  
16                  provider with respect to such services;

17                   (C) in a manner so that, if such services  
18                  are provided to a participant, beneficiary, or en-  
19                  rollee by a nonparticipating health care provider

1 the participant, beneficiary, or enrollee is not  
2 liable for amounts that exceed the amounts of  
3 liability that would be incurred if the services  
4 were provided by a participating health care  
5 provider; and

6 (D) without regard to any other term or  
7 condition of such coverage (other than exclusion  
8 or coordination of benefits, or an affiliation or  
9 waiting period, permitted under section 2701 of  
10 the Public Health Service Act, section 701 of  
11 the Employee Retirement Income Security Act  
12 of 1974, or section 9801 of the Internal Reve-  
13 nue Code of 1986, and other than applicable  
14 cost-sharing).

15 (2) DEFINITIONS.—In this section:

16 (A) EMERGENCY MEDICAL CONDITION  
17 BASED ON PRUDENT LAYPERSON STANDARD.—

18 The term “emergency medical condition” means  
19 a medical condition manifesting itself by acute  
20 symptoms of sufficient severity (including se-  
21 vere pain) such that a prudent layperson, who  
22 possesses an average knowledge of health and  
23 medicine, could reasonably expect the absence  
24 of immediate medical attention to result in a  
25 condition described in clause (i), (ii), or (iii) of

1 section 1867(e)(1)(A) of the Social Security  
2 Act.

3 (B) EMERGENCY SERVICES.—The term  
4 “emergency services” means—

5 (i) a medical screening examination  
6 (as required under section 1867 of the So-  
7 cial Security Act) that is within the capa-  
8 bility of the emergency department of a  
9 hospital, including ancillary services rou-  
10 tinely available to the emergency depart-  
11 ment to evaluate an emergency medical  
12 condition (as defined in subparagraph  
13 (A)), and

14 (ii) within the capabilities of the staff  
15 and facilities available at the hospital, such  
16 further medical examination and treatment  
17 as are required under section 1867 of such  
18 Act to stabilize the patient.

19 (b) REIMBURSEMENT FOR MAINTENANCE CARE AND  
20 POST-STABILIZATION CARE.—In the case of services  
21 (other than emergency services) for which benefits are  
22 available under a group health plan, or under health insur-  
23 ance coverage offered by a health insurance issuer, the  
24 plan or issuer shall provide for reimbursement with re-  
25 spect to such services provided to a participant, bene-

1 ficiary, or enrollee other than through a participating  
 2 health care provider in a manner consistent with sub-  
 3 section (a)(1)(C) (and shall otherwise comply with the  
 4 guidelines established under section 1852(d)(2) of the So-  
 5 cial Security Act (relating to promoting efficient and time-  
 6 ly coordination of appropriate maintenance and post-sta-  
 7 bilization care of an enrollee after an enrollee has been  
 8 determined to be stable), or, in the absence of guidelines  
 9 under such section, such guidelines as the Secretary shall  
 10 establish to carry out this subsection), if the services are  
 11 maintenance care or post-stabilization care covered under  
 12 such guidelines.

13 **SEC. 102. OFFERING OF CHOICE OF COVERAGE OPTIONS**  
 14 **UNDER GROUP HEALTH PLANS.**

15 (a) REQUIREMENT.—

16 (1) OFFERING OF POINT-OF-SERVICE COV-  
 17 ERAGE OPTION.—Except as provided in paragraph  
 18 (2), if a group health plan (or health insurance cov-  
 19 erage offered by a health insurance issuer in connec-  
 20 tion with a group health plan) provides benefits only  
 21 through participating health care providers, the plan  
 22 or issuer shall offer the participant the option to  
 23 purchase point-of-service coverage (as defined in  
 24 subsection (b)) for all such benefits for which cov-  
 25 erage is otherwise so limited. Such option shall be

1       made available to the participant at the time of en-  
2       rollment under the plan or coverage and at such  
3       other times as the plan or issuer offers the partici-  
4       pant a choice of coverage options.

5               (2) EXCEPTION.—Paragraph (1) shall not  
6       apply with respect to a participant in a group health  
7       plan if the plan offers the participant—

8                       (A) a choice of health insurance coverage;  
9       and

10                      (B) one or more coverage options which do  
11       not provide benefits only through participating  
12       health care providers and which provide for  
13       payment for nonparticipating providers in an  
14       amount that is not less than the amount paid  
15       to a participating provider for the same serv-  
16       ices.

17       (b) POINT-OF-SERVICE COVERAGE DEFINED.—In  
18       this section, the term “point-of-service coverage” means,  
19       with respect to benefits covered under a group health plan  
20       or health insurance issuer, coverage of such benefits when  
21       provided by a nonparticipating health care provider  
22       through payment of an amount that is not less than the  
23       amount paid to a participating health care provider for  
24       the same services. Such coverage need not include cov-

1 erage of providers that the plan or issuer excludes because  
2 of fraud, quality, or similar reasons.

3 (c) CONSTRUCTION.—Nothing in this section shall be  
4 construed—

5 (1) as requiring coverage for benefits for a par-  
6 ticular type of health care provider;

7 (2) as requiring an employer to pay any costs  
8 as a result of this section or to make equal contribu-  
9 tions with respect to different health coverage op-  
10 tions; or

11 (3) as preventing a group health plan or health  
12 insurance issuer from imposing higher premiums or  
13 cost-sharing on a participant for the exercise of a  
14 point-of-service coverage option.

15 (d) NO REQUIREMENT FOR GUARANTEED AVAIL-  
16 ABILITY.—If a health insurance issuer offers health insur-  
17 ance coverage that includes point-of-service coverage with  
18 respect to an employer solely in order to meet the require-  
19 ment of subsection (a), nothing in section 2711(a)(1)(A)  
20 of the Public Health Service Act shall be construed as re-  
21 quiring the offering of such coverage with respect to an-  
22 other employer.

23 **SEC. 103. CHOICE OF PROVIDERS.**

24 (a) PRIMARY CARE.—A group health plan, and a  
25 health insurance issuer that offers health insurance cov-



1 erage, shall permit each participant, beneficiary, and en-  
 2 rollee to receive primary care from any participating pri-  
 3 mary care provider who is available to accept such individ-  
 4 ual.

5 (b) SPECIALISTS.—

6 (1) IN GENERAL.—Subject to paragraph (2), a  
 7 group health plan and a health insurance issuer that  
 8 offers health insurance coverage shall permit each  
 9 participant, beneficiary, or enrollee to receive medi-  
 10 cally necessary or appropriate specialty care, pursu-  
 11 ant to appropriate referral procedures, from any  
 12 qualified participating health care provider who is  
 13 available to accept such individual for such care.

14 (2) LIMITATION.—Paragraph (1) shall not  
 15 apply to specialty care if the plan or issuer clearly  
 16 informs participants, beneficiaries, and enrollees of  
 17 the limitations on choice of participating providers  
 18 with respect to such care.

19 **SEC. 104. ACCESS TO SPECIALTY CARE.**

20 (a) OBSTETRICAL AND GYNECOLOGICAL CARE.—

21 (1) IN GENERAL.—If a group health plan, or a  
 22 health insurance issuer in connection with the provi-  
 23 sion of health insurance coverage, requires or pro-  
 24 vides for a participant, beneficiary, or enrollee to

1 designate a participating primary care provider, the  
2 plan or issuer—

3 (A) may not require authorization or a re-  
4 ferral by the individual's primary care provider  
5 or otherwise for coverage of routine gynecological  
6 care (such as preventive women's health  
7 examinations) and pregnancy-related services  
8 provided by a participating health care profes-  
9 sional who specializes in obstetrics and gynecology  
10 to the extent such care is otherwise covered,  
11 and

12 (B) may treat the ordering of other gynecological  
13 care by such a participating physician  
14 as the authorization of the primary care provider  
15 with respect to such care under the plan  
16 or coverage.

17 (2) CONSTRUCTION.—Nothing in paragraph  
18 (1)(B) shall waive any requirements of coverage relating  
19 to medical necessity or appropriateness with  
20 respect to coverage of gynecological care so ordered.

21 (b) PEDIATRIC CARE.—If a group health plan, or a  
22 health insurance issuer in connection with the provision  
23 of health insurance coverage, requires or provides for an  
24 enrollee to designate a participating primary care provider  
25 for a child of such enrollee, the plan or issuer shall permit

1 the enrollee to designate a physician who specializes in pe-  
2 diatrics as the child's primary care provider.

3 (c) SPECIALTY CARE.—

4 (1) SPECIALTY CARE FOR COVERED SERV-  
5 ICES.—

6 (A) IN GENERAL.—If—

7 (i) an individual is a participant or  
8 beneficiary under a group health plan or  
9 an enrollee who is covered under health in-  
10 surance coverage offered by a health insur-  
11 ance issuer,

12 (ii) the individual has a condition or  
13 disease of sufficient seriousness and com-  
14 plexity to require treatment by a specialist,  
15 and

16 (iii) benefits for such treatment are  
17 provided under the plan or coverage,

18 the plan or issuer shall make or provide for a  
19 referral to a specialist who is available and ac-  
20 cessible to provide the treatment for such condi-  
21 tion or disease.

22 (B) SPECIALIST DEFINED.—For purposes  
23 of this subsection, the term “specialist” means,  
24 with respect to a condition, a health care practi-  
25 tioner, facility, or center (such as a center of

1 excellence) that has adequate expertise through  
2 appropriate training and experience (including,  
3 in the case of a child, appropriate pediatric ex-  
4 pertise) to provide high quality care in treating  
5 the condition.

6 (C) CARE UNDER REFERRAL.—A group  
7 health plan or health insurance issuer may re-  
8 quire that the care provided to an individual  
9 pursuant to such referral under subparagraph  
10 (A) be—

11 (i) pursuant to a treatment plan, only  
12 if the treatment plan is developed by the  
13 specialist and approved by the plan or  
14 issuer, in consultation with the designated  
15 primary care provider or specialist and the  
16 individual (or the individual's designee),  
17 and

18 (ii) in accordance with applicable  
19 quality assurance and utilization review  
20 standards of the plan or issuer.

21 Nothing in this subsection shall be construed as  
22 preventing such a treatment plan for an individ-  
23 ual from requiring a specialist to provide the  
24 primary care provider with regular updates on

1 the specialty care provided, as well as all nec-  
2 essary medical information.

3 (D) REFERRALS TO PARTICIPATING PRO-  
4 VIDERS.—A group health plan or health insur-  
5 ance issuer is not required under subparagraph  
6 (A) to provide for a referral to a specialist that  
7 is not a participating provider, unless the plan  
8 or issuer does not have an appropriate specialist  
9 that is available and accessible to treat the indi-  
10 vidual's condition and that is a participating  
11 provider with respect to such treatment.

12 (E) TREATMENT OF NONPARTICIPATING  
13 PROVIDERS.—If a plan or issuer refers an indi-  
14 vidual to a nonparticipating specialist pursuant  
15 to subparagraph (A), services provided pursu-  
16 ant to the approved treatment plan (if any)  
17 shall be provided at no additional cost to the in-  
18 dividual beyond what the individual would oth-  
19 erwise pay for services received by such a spe-  
20 cialist that is a participating provider.

21 (2) SPECIALISTS AS GATEKEEPER FOR TREAT-  
22 MENT OF ONGOING SPECIAL CONDITIONS.—

23 (A) IN GENERAL.—A group health plan, or  
24 a health insurance issuer, in connection with  
25 the provision of health insurance coverage, shall

1 have a procedure by which an individual who is  
2 a participant, beneficiary, or enrollee and who  
3 has an ongoing special condition (as defined in  
4 subparagraph (C)) may receive a referral to a  
5 specialist for such condition who shall be re-  
6 sponsible for and capable of providing and co-  
7 ordinating the individual's care with respect to  
8 the condition. If such an individual's care would  
9 most appropriately be coordinated by such a  
10 specialist, such plan or issuer shall refer the in-  
11 dividual to such specialist.

12 (B) TREATMENT AS PRIMARY CARE PRO-  
13 VIDER FOR RELATED REFERRALS.—Such spe-  
14 cialist shall be permitted to treat the individual  
15 without a referral from the individual's primary  
16 care provider and may authorize such referrals,  
17 procedures, tests, and other medical services as  
18 the individual's primary care provider would  
19 otherwise be permitted to provide or authorize,  
20 subject to the terms of the treatment plan (re-  
21 ferred to in paragraph (1)(C)(i)) with respect to  
22 the ongoing special condition.

23 (C) ONGOING SPECIAL CONDITION DE-  
24 FINED.—In this paragraph, the term “ongoing

special condition” means a condition or disease  
that—

(i) is life-threatening, degenerative, or  
disabling, and

(ii) requires specialized medical care  
over a prolonged period of time.

(D) TERMS OF REFERRAL.—The provisions of subparagraphs (C) through (E) of paragraph (1) apply with respect to referrals under subparagraph (A) of this paragraph in the same manner as they apply to referrals under paragraph (1)(A).

(3) STANDING REFERRALS.—

(A) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary, or enrollee and who has a condition that requires ongoing care from a specialist may receive a standing referral to such specialist for treatment of such condition. If the plan or issuer, or if the primary care provider in consultation with the medical director of the plan or issuer and the specialist (if any), determines that such a

1 standing referral is appropriate, the plan or  
2 issuer shall make such a referral to such a spe-  
3 cialist.

4 (B) TERMS OF REFERRAL.—The provi-  
5 sions of subparagraphs (C) through (E) of  
6 paragraph (1) apply with respect to referrals  
7 under subparagraph (A) of this paragraph in  
8 the same manner as they apply to referrals  
9 under paragraph (1)(A).

10 **SEC. 105. CONTINUITY OF CARE.**

11 (a) IN GENERAL.—

12 (1) TERMINATION OF PROVIDER.—If a contract  
13 between a group health plan, or a health insurance  
14 issuer in connection with the provision of health in-  
15 surance coverage, and a health care provider is ter-  
16 minated (as defined in paragraph (3)), or benefits or  
17 coverage provided by a health care provider are ter-  
18 minated because of a change in the terms of pro-  
19 vider participation in a group health plan, and an in-  
20 dividual who is a participant, beneficiary, or enrollee  
21 in the plan or coverage is undergoing a course of  
22 treatment from the provider at the time of such ter-  
23 mination, the plan or issuer shall—

24 (A) notify the individual on a timely basis  
25 of such termination, and



1 (B) subject to subsection (c), permit the  
2 individual to continue or be covered with re-  
3 spect to the course of treatment with the pro-  
4 vider during a transitional period (provided  
5 under subsection (b)).

6 (2) TREATMENT OF TERMINATION OF CON-  
7 TRACT WITH HEALTH INSURANCE ISSUER.—If a  
8 contract for the provision of health insurance cov-  
9 erage between a group health plan and a health in-  
10 surance issuer is terminated and, as a result of such  
11 termination, coverage of services of a health care  
12 provider is terminated with respect to an individual,  
13 the provisions of paragraph (1) (and the succeeding  
14 provisions of this section) shall apply under the plan  
15 in the same manner as if there had been a contract  
16 between the plan and the provider that had been ter-  
17 minated, but only with respect to benefits that are  
18 covered under the plan after the contract termi-  
19 nation.

20 (3) TERMINATION.—In this section, the term  
21 “terminated” includes, with respect to a contract,  
22 the expiration or nonrenewal of the contract, but  
23 does not include a termination of the contract by the  
24 plan or issuer for failure to meet applicable quality  
25 standards or for fraud.

1 (b) TRANSITIONAL PERIOD.—

2 (1) IN GENERAL.—Except as provided in para-  
3 graphs (2) through (4), the transitional period under  
4 this subsection shall extend for at least 90 days from  
5 the date of the notice described in subsection  
6 (a)(1)(A) of the provider’s termination.

7 (2) INSTITUTIONAL CARE.—The transitional pe-  
8 riod under this subsection for institutional or inpa-  
9 tient care from a provider shall extend until the dis-  
10 charge or termination of the period of institutional-  
11 ization and also shall include institutional care pro-  
12 vided within a reasonable time of the date of termi-  
13 nation of the provider status if the care was sched-  
14 uled before the date of the announcement of the ter-  
15 mination of the provider status under subsection  
16 (a)(1)(A) or if the individual on such date was on  
17 an established waiting list or otherwise scheduled to  
18 have such care.

19 (3) PREGNANCY.—If—

20 (A) a participant, beneficiary, or enrollee  
21 has entered the second trimester of pregnancy  
22 at the time of a provider’s termination of par-  
23 ticipation, and

24 (B) the provider was treating the preg-  
25 nancy before date of the termination,

1 the transitional period under this subsection with re-  
2 spect to provider's treatment of the pregnancy shall  
3 extend through the provision of post-partum care di-  
4 rectly related to the delivery.

5 (4) TERMINAL ILLNESS.—If—

6 (A) a participant, beneficiary, or enrollee  
7 was determined to be terminally ill (as deter-  
8 mined under section 1861(dd)(3)(A) of the So-  
9 cial Security Act) at the time of a provider's  
10 termination of participation, and

11 (B) the provider was treating the terminal  
12 illness before the date of termination,

13 the transitional period under this subsection shall  
14 extend for the remainder of the individual's life for  
15 care directly related to the treatment of the terminal  
16 illness or its medical manifestations.

17 (c) PERMISSIBLE TERMS AND CONDITIONS.—A  
18 group health plan or health insurance issuer may condi-  
19 tion coverage of continued treatment by a provider under  
20 subsection (a)(1)(B) upon the provider agreeing to the fol-  
21 lowing terms and conditions:

22 (1) The provider agrees to accept reimburse-  
23 ment from the plan or issuer and individual involved  
24 (with respect to cost-sharing) at the rates applicable  
25 prior to the start of the transitional period as pay-

1       ment in full (or, in the case described in subsection  
2       (a)(2), at the rates applicable under the replacement  
3       plan or issuer after the date of the termination of  
4       the contract with the health insurance issuer) and  
5       not to impose cost-sharing with respect to the indi-  
6       vidual in an amount that would exceed the cost-shar-  
7       ing that could have been imposed if the contract re-  
8       ferred to in subsection (a)(1) had not been termi-  
9       nated.

10           (2) The provider agrees to adhere to the quality  
11       assurance standards of the plan or issuer responsible  
12       for payment under paragraph (1) and to provide to  
13       such plan or issuer necessary medical information  
14       related to the care provided.

15           (3) The provider agrees otherwise to adhere to  
16       such plan's or issuer's policies and procedures, in-  
17       cluding procedures regarding referrals and obtaining  
18       prior authorization and providing services pursuant  
19       to a treatment plan (if any) approved by the plan or  
20       issuer.

21       (d) CONSTRUCTION.—Nothing in this section shall be  
22       construed to require the coverage of benefits which would  
23       not have been covered if the provider involved remained  
24       a participating provider.

1 **SEC. 106. COVERAGE FOR INDIVIDUALS PARTICIPATING IN**  
2 **APPROVED CLINICAL TRIALS.**

3 (a) COVERAGE.—

4 (1) IN GENERAL.—If a group health plan, or  
5 health insurance issuer that is providing health in-  
6 surance coverage, provides coverage to a qualified in-  
7 dividual (as defined in subsection (b)), the plan or  
8 issuer—

9 (A) may not deny the individual participa-  
10 tion in the clinical trial referred to in subsection  
11 (b)(2);

12 (B) subject to subsection (c), may not deny  
13 (or limit or impose additional conditions on) the  
14 coverage of routine patient costs for items and  
15 services furnished in connection with participa-  
16 tion in the trial; and

17 (C) may not discriminate against the indi-  
18 vidual on the basis of the enrollee's participa-  
19 tion in such trial.

20 (2) EXCLUSION OF CERTAIN COSTS.—For pur-  
21 poses of paragraph (1)(B), routine patient costs do  
22 not include the cost of the tests or measurements  
23 conducted primarily for the purpose of the clinical  
24 trial involved.

25 (3) USE OF IN-NETWORK PROVIDERS.—If one  
26 or more participating providers is participating in a

1 clinical trial, nothing in paragraph (1) shall be con-  
2 strued as preventing a plan or issuer from requiring  
3 that a qualified individual participate in the trial  
4 through such a participating provider if the provider  
5 will accept the individual as a participant in the  
6 trial.

7 (b) QUALIFIED INDIVIDUAL DEFINED.—For pur-  
8 poses of subsection (a), the term “qualified individual”  
9 means an individual who is a participant or beneficiary  
10 in a group health plan, or who is an enrollee under health  
11 insurance coverage, and who meets the following condi-  
12 tions:

13 (1)(A) The individual has a life-threatening or  
14 serious illness for which no standard treatment is ef-  
15 fective.

16 (B) The individual is eligible to participate in  
17 an approved clinical trial according to the trial pro-  
18 tocol with respect to treatment of such illness.

19 (C) The individual’s participation in the trial  
20 offers meaningful potential for significant clinical  
21 benefit for the individual.

22 (2) Either—

23 (A) the referring physician is a participat-  
24 ing health care professional and has concluded  
25 that the individual’s participation in such trial

1 would be appropriate based upon the individual  
2 meeting the conditions described in paragraph  
3 (1); or

4 (B) the participant, beneficiary, or enrollee  
5 provides medical and scientific information es-  
6 tablishing that the individual's participation in  
7 such trial would be appropriate based upon the  
8 individual meeting the conditions described in  
9 paragraph (1).

10 (c) PAYMENT.—

11 (1) IN GENERAL.—Under this section a group  
12 health plan or health insurance issuer shall provide  
13 for payment for routine patient costs described in  
14 subsection (a)(2) but is not required to pay for costs  
15 of items and services that are reasonably expected  
16 (as determined by the Secretary) to be paid for by  
17 the sponsors of an approved clinical trial.

18 (2) PAYMENT RATE.—In the case of covered  
19 items and services provided by—

20 (A) a participating provider, the payment  
21 rate shall be at the agreed upon rate, or

22 (B) a nonparticipating provider, the pay-  
23 ment rate shall be at the rate the plan or issuer  
24 would normally pay for comparable services  
25 under subparagraph (A).

1 (d) APPROVED CLINICAL TRIAL DEFINED.—

2 (1) IN GENERAL.—In this section, the term  
3 “approved clinical trial” means a clinical research  
4 study or clinical investigation approved and funded  
5 (which may include funding through in-kind con-  
6 tributions) by one or more of the following:

7 (A) The National Institutes of Health.

8 (B) A cooperative group or center of the  
9 National Institutes of Health.

10 (C) Either of the following if the condi-  
11 tions described in paragraph (2) are met:

12 (i) The Department of Veterans Af-  
13 fairs.

14 (ii) The Department of Defense.

15 (2) CONDITIONS FOR DEPARTMENTS.—The  
16 conditions described in this paragraph, for a study  
17 or investigation conducted by a Department, are  
18 that the study or investigation has been reviewed  
19 and approved through a system of peer review that  
20 the Secretary determines—

21 (A) to be comparable to the system of peer  
22 review of studies and investigations used by the  
23 National Institutes of Health, and



1 (B) assures unbiased review of the highest  
2 scientific standards by qualified individuals who  
3 have no interest in the outcome of the review.

4 (e) CONSTRUCTION.—Nothing in this section shall be  
5 construed to limit a plan’s or issuer’s coverage with re-  
6 spect to clinical trials.

7 **SEC. 107. ACCESS TO NEEDED PRESCRIPTION DRUGS.**

8 (a) IN GENERAL.—If a group health plan, or health  
9 insurance issuer that offers health insurance coverage,  
10 provides benefits with respect to prescription drugs but  
11 the coverage limits such benefits to drugs included in a  
12 formulary, the plan or issuer shall—

13 (1) ensure participation of participating physi-  
14 cians and pharmacists in the development of the for-  
15 mulary;

16 (2) disclose to providers and, disclose upon re-  
17 quest under section 121(c)(6) to participants, bene-  
18 ficiaries, and enrollees, the nature of the formulary  
19 restrictions; and

20 (3) consistent with the standards for a utiliza-  
21 tion review program under section 111, provide for  
22 exceptions from the formulary limitation when a  
23 non-formulary alternative is medically indicated.

24 (b) COVERAGE OF APPROVED DRUGS AND MEDICAL  
25 DEVICES.—

1           (1) IN GENERAL.—A group health plan (or  
2           health insurance coverage offered in connection with  
3           such a plan) that provides any coverage of prescrip-  
4           tion drugs or medical devices shall not deny coverage  
5           of such a drug or device on the basis that the use  
6           is investigational, if the use—

7                   (A) in the case of a prescription drug—

8                           (i) is included in the labeling author-  
9                           ized by the application in effect for the  
10                          drug pursuant to subsection (b) or (j) of  
11                          section 505 of the Federal Food, Drug,  
12                          and Cosmetic Act, without regard to any  
13                          postmarketing requirements that may  
14                          apply under such Act; or

15                          (ii) is included in the labeling author-  
16                          ized by the application in effect for the  
17                          drug under section 351 of the Public  
18                          Health Service Act, without regard to any  
19                          postmarketing requirements that may  
20                          apply pursuant to such section; or

21                   (B) in the case of a medical device, is in-  
22                   cluded in the labeling authorized by a regula-  
23                   tion under subsection (d) or (3) of section 513  
24                   of the Federal Food, Drug, and Cosmetic Act,  
25                   an order under subsection (f) of such section, or

1 an application approved under section 515 of  
2 such Act, without regard to any postmarketing  
3 requirements that may apply under such Act.

4 (2) CONSTRUCTION.—Nothing in this sub-  
5 section shall be construed as requiring a group  
6 health plan (or health insurance coverage offered in  
7 connection with such a plan) to provide any coverage  
8 of prescription drugs or medical devices.

9 **SEC. 108. ADEQUACY OF PROVIDER NETWORK.**

10 (a) IN GENERAL.—Each group health plan, and each  
11 health insurance issuer offering health insurance coverage,  
12 that provides benefits, in whole or in part, through partici-  
13 pating health care providers shall have (in relation to the  
14 coverage) a sufficient number, distribution, and variety of  
15 qualified participating health care providers to ensure that  
16 all covered health care services, including specialty serv-  
17 ices, will be available and accessible in a timely manner  
18 to all participants, beneficiaries, and enrollees under the  
19 plan or coverage. This subsection shall only apply to a  
20 plan's or issuer's application of restrictions on the partici-  
21 pation of health care providers in a network and shall not  
22 be construed as requiring a plan or issuer to create or  
23 establish new health care providers in an area.

24 (b) TREATMENT OF CERTAIN PROVIDERS.—The  
25 qualified health care providers under subsection (a) may

1 include Federally qualified health centers, rural health  
 2 clinics, migrant health centers, and other essential com-  
 3 munity providers located in the service area of the plan  
 4 or issuer and shall include such providers if necessary to  
 5 meet the standards established to carry out such sub-  
 6 section.

## 7 **Subtitle B—Quality Assurance**

### 8 **SEC. 111. STANDARDS FOR UTILIZATION REVIEW ACTIVI-** 9 **TIES.**

#### 10 (a) COMPLIANCE WITH REQUIREMENTS.—

11 (1) IN GENERAL.—A group health plan, and a  
 12 health insurance issuer that provides health insur-  
 13 ance coverage, shall conduct utilization review activi-  
 14 ties in connection with the provision of benefits  
 15 under such plan or coverage only in accordance with  
 16 a utilization review program that meets the require-  
 17 ments of this section.

18 (2) USE OF OUTSIDE AGENTS.—Nothing in this  
 19 section shall be construed as preventing a group  
 20 health plan or health insurance issuer from arrang-  
 21 ing through a contract or otherwise for persons or  
 22 entities to conduct utilization review activities on be-  
 23 half of the plan or issuer, so long as such activities  
 24 are conducted in accordance with a utilization review  
 25 program that meets the requirements of this section.

1           (3) UTILIZATION REVIEW DEFINED.—For pur-  
2       poses of this section, the terms “utilization review”  
3       and “utilization review activities” mean procedures  
4       used to monitor or evaluate the clinical necessity,  
5       appropriateness, efficacy, or efficiency of health care  
6       services, procedures or settings, and includes pro-  
7       spective review, concurrent review, second opinions,  
8       case management, discharge planning, or retrospec-  
9       tive review.

10       (b) WRITTEN POLICIES AND CRITERIA.—

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

15           (2) USE OF WRITTEN CRITERIA.—

16           (A) IN GENERAL.—Such a program shall  
17       utilize written clinical review criteria developed  
18       pursuant to the program with the input of ap-  
19       propriate physicians.

20           (B) CONTINUING USE OF STANDARDS IN  
21       RETROSPECTIVE REVIEW.—If a health care  
22       service has been specifically pre-authorized or  
23       approved for an enrollee under such a program,  
24       the program shall not, pursuant to retrospective  
25       review, revise or modify the specific standards,

1 criteria, or procedures used for the utilization  
2 review for procedures, treatment, and services  
3 delivered to the enrollee during the same course  
4 of treatment.

5 (c) CONDUCT OF PROGRAM ACTIVITIES.—

6 (1) ADMINISTRATION BY HEALTH CARE PRO-  
7 FESSIONALS.—A utilization review program shall be  
8 administered by qualified health care professionals  
9 who shall oversee review decisions. In this sub-  
10 section, the term “health care professional” means a  
11 physician or other health care practitioner licensed,  
12 accredited, or certified to perform specified health  
13 services consistent with State law.

14 (2) USE OF QUALIFIED, INDEPENDENT PER-  
15 SONNEL.—

16 (A) IN GENERAL.—A utilization review  
17 program shall provide for the conduct of utiliza-  
18 tion review activities only through personnel  
19 who are qualified and, to the extent required,  
20 who have received appropriate training in the  
21 conduct of such activities under the program.

22 (B) PEER REVIEW OF SAMPLE OF AD-  
23 VERSE CLINICAL DETERMINATIONS.—Such a  
24 program shall provide that clinical peers (as de-  
25 fined in section 191(c)(2)) shall evaluate the

1 clinical appropriateness of at least a sample of  
2 adverse clinical determinations.

3 (C) PROHIBITION OF CONTINGENT COM-  
4 PENSATION ARRANGEMENTS.—Such a program  
5 shall not, with respect to utilization review ac-  
6 tivities, permit or provide compensation or any-  
7 thing of value to its employees, agents, or con-  
8 tractors in a manner that—

9 (i) provides incentives, direct or indi-  
10 rect, for such persons to make inappropri-  
11 ate review decisions, or

12 (ii) is based, directly or indirectly, on  
13 the quantity or type of adverse determina-  
14 tions rendered.

15 (D) PROHIBITION OF CONFLICTS.—Such a  
16 program shall not permit a health care profes-  
17 sional who provides health care services to an  
18 individual to perform utilization review activi-  
19 ties in connection with the health care services  
20 being provided to the individual.

21 (3) ACCESSIBILITY OF REVIEW.—Such a pro-  
22 gram shall provide that appropriate personnel per-  
23 forming utilization review activities under the pro-  
24 gram are reasonably accessible by toll-free telephone  
25 during normal business hours to discuss patient care

1 and allow response to telephone requests, and that  
2 appropriate provision is made to receive and respond  
3 promptly to calls received during other hours.

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

10 (5) LIMITATION ON INFORMATION REQUESTS.—  
11 Under such a program, information shall be required  
12 to be provided by health care providers only to the  
13 extent it is necessary to perform the utilization re-  
14 view activity involved.

15 (d) DEADLINE FOR DETERMINATIONS.—

16 (1) PRIOR AUTHORIZATION SERVICES.—Except  
17 as provided in paragraph (2), in the case of a utili-  
18 zation review activity involving the prior authoriza-  
19 tion of health care items and services for an individ-  
20 ual, the utilization review program shall make a de-  
21 termination concerning such authorization, and pro-  
22 vide notice of the determination to the individual or  
23 the individual's designee and the individual's health  
24 care provider by telephone and in printed form, as  
25 soon as possible in accordance with the medical ex-



1 agencies of the cases, and in no event later than 3  
2 business days after the date of receipt of information  
3 that is reasonably necessary to make such deter-  
4 mination.

5 (2) CONTINUED CARE.—In the case of a utiliza-  
6 tion review activity involving authorization for con-  
7 tinued or extended health care services for an indi-  
8 vidual, or additional services for an individual under-  
9 going a course of continued treatment prescribed by  
10 a health care provider, the utilization review pro-  
11 gram shall make a determination concerning such  
12 authorization, and provide notice of the determina-  
13 tion to the individual or the individual's designee  
14 and the individual's health care provider by tele-  
15 phone and in printed form, as soon as possible in ac-  
16 cordance with the medical exigencies of the cases,  
17 and in no event later than 1 business day after the  
18 date of receipt of information that is reasonably nec-  
19 essary to make such determination. Such notice shall  
20 include, with respect to continued or extended health  
21 care services, the number of extended services ap-  
22 proved, the new total of approved services, the date  
23 of onset of services, and the next review date, if any.

24 (3) PREVIOUSLY PROVIDED SERVICES.—In the  
25 case of a utilization review activity involving retro-

spective review of health care services previously provided for an individual, the utilization review program shall make a determination concerning such services, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed form, within 30 days of the date of receipt of information that is reasonably necessary to make such determination.

(4) REFERENCE TO SPECIAL RULES FOR EMERGENCY SERVICES, MAINTENANCE CARE, AND POST-STABILIZATION CARE.—For waiver of prior authorization requirements in certain cases involving emergency services and maintenance care and post-stabilization care, see subsections (a)(1) and (b) of section 101, respectively.

(e) NOTICE OF ADVERSE DETERMINATIONS.—

(1) IN GENERAL.—Notice of an adverse determination under a utilization review program shall be provided in printed form and shall include—

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

(B) instructions on how to initiate an appeal under section 132; and

1 (C) notice of the availability, upon request  
 2 of the individual (or the individual's designee)  
 3 of the clinical review criteria relied upon to  
 4 make such determination.

5 (2) SPECIFICATION OF ANY ADDITIONAL INFOR-  
 6 MATION.—Such a notice shall also specify what (if  
 7 any) additional necessary information must be pro-  
 8 vided to, or obtained by, the person making the de-  
 9 termination in order to make a decision on such an  
 10 appeal.

## 11 **Subtitle C—Patient Information**

### 12 **SEC. 121. PATIENT INFORMATION.**

13 (a) DISCLOSURE REQUIREMENT.—

14 (1) GROUP HEALTH PLANS.—A group health  
 15 plan shall—

16 (A) provide to participants and bene-  
 17 ficiaries at the time of initial coverage under  
 18 the plan (or the effective date of this section, in  
 19 the case of individuals who are participants or  
 20 beneficiaries as of such date), and at least an-  
 21 nually thereafter, the information described in  
 22 subsection (b) in printed form;

23 (B) provide to participants and bene-  
 24 ficiaries, within a reasonable period (as speci-  
 25 fied by the appropriate Secretary) before or

1 after the date of significant changes in the in-  
2 formation described in subsection (b), informa-  
3 tion in printed form on such significant  
4 changes; and

5 (C) upon request, make available to par-  
6 ticipants and beneficiaries, the applicable au-  
7 thority, and prospective participants and bene-  
8 ficiaries, the information described in sub-  
9 section (b) or (c) in printed form.

10 (2) HEALTH INSURANCE ISSUERS.—A health  
11 insurance issuer in connection with the provision of  
12 health insurance coverage shall—

13 (A) provide to individuals enrolled under  
14 such coverage at the time of enrollment, and at  
15 least annually thereafter, the information de-  
16 scribed in subsection (b) in printed form;

17 (B) provide to enrollees, within a reason-  
18 able period (as specified by the appropriate Sec-  
19 retary) before or after the date of significant  
20 changes in the information described in sub-  
21 section (b), information in printed form on such  
22 significant changes; and

23 (C) upon request, make available to the  
24 applicable authority, to individuals who are pro-  
25 spective enrollees, and to the public the infor-

1           mation described in subsection (b) or (c) in  
2           printed form.

3           (b) INFORMATION PROVIDED.—The information de-  
4           scribed in this subsection with respect to a group health  
5           plan or health insurance coverage offered by a health in-  
6           surance issuer includes the following:

7           (1) SERVICE AREA.—The service area of the  
8           plan or issuer.

9           (2) BENEFITS.—Benefits offered under the  
10          plan or coverage, including—

11           (A) covered benefits, including benefit lim-  
12           its and coverage exclusions;

13           (B) cost sharing, such as deductibles, coin-  
14           surance, and copayment amounts, including any  
15           liability for balance billing, any maximum limi-  
16           tations on out of pocket expenses, and the max-  
17           imum out of pocket costs for services that are  
18           provided by nonparticipating providers or that  
19           are furnished without meeting the applicable  
20           utilization review requirements;

21           (C) the extent to which benefits may be ob-  
22           tained from nonparticipating providers;

23           (D) the extent to which a participant, ben-  
24           eficiary, or enrollee may select from among par-

1           ticipating providers and the types of providers  
2           participating in the plan or issuer network;

3           (E) process for determining experimental  
4           coverage; and

5           (F) use of a prescription drug formulary.

6       (3) ACCESS.—A description of the following:

7           (A) The number, mix, and distribution of  
8           providers under the plan or coverage.

9           (B) Out-of-network coverage (if any) pro-  
10          vided by the plan or coverage.

11          (C) Any point-of-service option (including  
12          any supplemental premium or cost-sharing for  
13          such option).

14          (D) The procedures for participants, bene-  
15          ficiaries, and enrollees to select, access, and  
16          change participating primary and specialty pro-  
17          viders.

18          (E) The rights and procedures for obtain-  
19          ing referrals (including standing referrals) to  
20          participating and nonparticipating providers.

21          (F) The name, address, and telephone  
22          number of participating health care providers  
23          and an indication of whether each such provider  
24          is available to accept new patients.

1 (G) Any limitations imposed on the selec-  
2 tion of qualifying participating health care pro-  
3 viders, including any limitations imposed under  
4 section 103(b)(2).

5 (H) How the plan or issuer addresses the  
6 needs of participants, beneficiaries, and enroll-  
7 ees and others who do not speak English or  
8 who have other special communications needs in  
9 accessing providers under the plan or coverage,  
10 including the provision of information described  
11 in this subsection and subsection (c) to such in-  
12 dividuals and including the provision of infor-  
13 mation in a language other than English if 5  
14 percent of the number of participants, bene-  
15 ficiaries, and enrollees communicate in that lan-  
16 guage instead of English.

17 (4) OUT-OF-AREA COVERAGE.—Out-of-area cov-  
18 erage provided by the plan or issuer.

19 (5) EMERGENCY COVERAGE.—Coverage of  
20 emergency services, including—

21 (A) the appropriate use of emergency serv-  
22 ices, including use of the 911 telephone system  
23 or its local equivalent in emergency situations  
24 and an explanation of what constitutes an  
25 emergency situation;

1 (B) the process and procedures of the plan  
2 or issuer for obtaining emergency services; and

3 (C) the locations of (i) emergency depart-  
4 ments, and (ii) other settings, in which plan  
5 physicians and hospitals provide emergency  
6 services and post-stabilization care.

7 (6) PERCENTAGE OF PREMIUMS USED FOR  
8 BENEFITS (LOSS-RATIOS).—In the case of health in-  
9 surance coverage only (and not with respect to group  
10 health plans that do not provide coverage through  
11 health insurance coverage), a description of the over-  
12 all loss-ratio for the coverage (as defined in accord-  
13 ance with rules established or recognized by the Sec-  
14 retary of Health and Human Services).

15 (7) PRIOR AUTHORIZATION RULES.—Rules re-  
16 garding prior authorization or other review require-  
17 ments that could result in noncoverage or non-  
18 payment.

19 (8) GRIEVANCE AND APPEALS PROCEDURES.—  
20 All appeal or grievance rights and procedures under  
21 the plan or coverage, including the method for filing  
22 grievances and the time frames and circumstances  
23 for acting on grievances and appeals, who is the ap-  
24 plicable authority with respect to the plan or issuer,  
25 and the availability of assistance through an om-



1       budsman to individuals in relation to group health  
2       plans and health insurance coverage.

3               (9) SUMMARY OF PROVIDER FINANCIAL INCEN-  
4       TIVES.—A summary description of the information  
5       on the types of financial payment incentives (de-  
6       scribed in section 1852(j)(4) of the Social Security  
7       Act) provided by the plan or issuer under the cov-  
8       erage.

9               (10) INFORMATION ON ISSUER.—Notice of ap-  
10      propriate mailing addresses and telephone numbers  
11      to be used by participants, beneficiaries, and enroll-  
12      ees in seeking information or authorization for treat-  
13      ment.

14              (11) AVAILABILITY OF INFORMATION ON RE-  
15      QUEST.—Notice that the information described in  
16      subsection (c) is available upon request.

17      (c) INFORMATION MADE AVAILABLE UPON RE-  
18      QUEST.—The information described in this subsection is  
19      the following:

20              (1) UTILIZATION REVIEW ACTIVITIES.—A de-  
21      scription of procedures used and requirements (in-  
22      cluding circumstances, time frames, and appeal  
23      rights) under any utilization review program under  
24      section 111, including under any drug formulary  
25      program under section 107.

1           (2) GRIEVANCE AND APPEALS INFORMATION.—

2           Information on the number of grievances and ap-  
3           peals and on the disposition in the aggregate of such  
4           matters.

5           (3) METHOD OF PHYSICIAN COMPENSATION.—

6           An overall summary description as to the method of  
7           compensation of participating physicians, including  
8           information on the types of financial payment incen-  
9           tives (described in section 1852(j)(4) of the Social  
10          Security Act) provided by the plan or issuer under  
11          the coverage.

12          (4) SPECIFIC INFORMATION ON CREDENTIALS  
13          OF PARTICIPATING PROVIDERS.—In the case of each  
14          participating provider, a description of the creden-  
15          tials of the provider as they relate to education,  
16          training, specialty qualifications, and national ac-  
17          creditation.

18          (5) CONFIDENTIALITY POLICIES AND PROCE-  
19          DURES.—A description of the policies and proce-  
20          dures established to carry out section 122.

21          (6) FORMULARY RESTRICTIONS.—A description  
22          of the nature of any drug formula restrictions.

23          (7) PARTICIPATING PROVIDER LIST.—A list of  
24          current participating health care providers.

25          (d) FORM OF DISCLOSURE.—

1           (1) UNIFORMITY.—Information required to be  
2       disclosed under this section shall be provided in ac-  
3       cordance with uniform, national reporting standards  
4       specified by the Secretary, after consultation with  
5       applicable State authorities, so that prospective en-  
6       rollees may compare the attributes of different  
7       issuers and coverage offered within an area.

8           (2) INFORMATION INTO HANDBOOK.—Nothing  
9       in this section shall be construed as preventing a  
10      group health plan or health insurance issuer from  
11      making the information under subsections (b) and  
12      (c) available to participants, beneficiaries, and en-  
13      rollees through an enrollee handbook or similar pub-  
14      lication.

15          (3) UPDATING PARTICIPATING PROVIDER IN-  
16      FORMATION.—The information on participating  
17      health care providers described in subsection  
18      (b)(3)(C) shall be updated within such reasonable  
19      period as determined appropriate by the Secretary.  
20      Nothing in this section shall prevent an issuer from  
21      changing or updating other information made avail-  
22      able under this section.

23          (e) CONSTRUCTION.—Nothing in this section shall be  
24      construed as requiring public disclosure of individual con-

1 tracts or financial arrangements between a group health  
2 plan or health insurance issuer and any provider.

3 **SEC. 122. PROTECTION OF PATIENT CONFIDENTIALITY.**

4 Insofar as a group health plan, or a health insurance  
5 issuer that offers health insurance coverage, maintains  
6 medical records or other health information regarding par-  
7 ticipants, beneficiaries, and enrollees, the plan or issuer  
8 shall establish procedures—

9 (1) to safeguard the privacy of any individually  
10 identifiable enrollee information;

11 (2) to maintain such records and information in  
12 a manner that is accurate and timely, and

13 (3) to assure timely access of such individuals  
14 to such records and information.

15 **SEC. 123. HEALTH INSURANCE OMBUDSMEN.**

16 (a) IN GENERAL.—Each State that obtains a grant  
17 under subsection (c) shall provide for creation and oper-  
18 ation of a Health Insurance Ombudsman through a con-  
19 tract with a not-for-profit organization that operates inde-  
20 pendent of group health plans and health insurance  
21 issuers. Such Ombudsman shall be responsible for at least  
22 the following:

23 (1) To assist consumers in the State in choos-  
24 ing among health insurance coverage or among cov-  
25 erage options offered within group health plans.

1           (2) To provide counseling and assistance to en-  
2       rollees dissatisfied with their treatment by health in-  
3       surance issuers and group health plans in regard to  
4       such coverage or plans and with respect to griev-  
5       ances and appeals regarding determinations under  
6       such coverage or plans.

7       (b) FEDERAL ROLE.—In the case of any State that  
8       does not provide for such an Ombudsman under sub-  
9       section (a), the Secretary shall provide for the creation  
10      and operation of a Health Insurance Ombudsman through  
11      a contract with a not-for-profit organization that operates  
12      independent of group health plans and health insurance  
13      issuers and that is responsible for carrying out with re-  
14      spect to that State the functions otherwise provided under  
15      subsection (a) by a Health Insurance Ombudsman.

16      (c) AUTHORIZATION OF APPROPRIATIONS.—There  
17      are authorized to be appropriated to the Secretary of  
18      Health and Human Services such amounts as may be nec-  
19      essary to provide for grants to States for contracts for  
20      Health Insurance Ombudsmen under subsection (a) or  
21      contracts for such Ombudsmen under subsection (b).

22      (d) CONSTRUCTION.—Nothing in this section shall be  
23      construed to prevent the use of other forms of enrollee  
24      assistance.

1 **Subtitle D—Grievance and Appeals**  
2 **Procedures**

3 **SEC. 131. ESTABLISHMENT OF GRIEVANCE PROCESS.**

4 (a) ESTABLISHMENT OF GRIEVANCE SYSTEM.—

5 (1) IN GENERAL.—A group health plan, and a  
6 health insurance issuer in connection with the provi-  
7 sion of health insurance coverage, shall establish and  
8 maintain a system to provide for the presentation  
9 and resolution of oral and written grievances  
10 brought by individuals who are participants, bene-  
11 ficiaries, or enrollees, or health care providers or  
12 other individuals acting on behalf of an individual  
13 and with the individual's consent, regarding any as-  
14 pect of the plan's or issuer's services.

15 (2) SCOPE.—The system shall include griev-  
16 ances regarding access to and availability of services,  
17 quality of care, choice and accessibility of providers,  
18 network adequacy, and compliance with the require-  
19 ments of this title.

20 (b) GRIEVANCE SYSTEM.—Such system shall include  
21 the following components with respect to individuals who  
22 are participants, beneficiaries, or enrollees:

23 (1) Written notification to all such individuals  
24 and providers of the telephone numbers and business

1 addresses of the plan or issuer personnel responsible  
2 for resolution of grievances and appeals.

3 (2) A system to record and document, over a  
4 period of at least 3 previous years, all grievances  
5 and appeals made and their status.

6 (3) A process providing for timely processing  
7 and resolution of grievances.

8 (4) Procedures for follow-up action, including  
9 the methods to inform the person making the grievance  
10 of the resolution of the grievance.

11 **SEC. 132. INTERNAL APPEALS OF ADVERSE DETERMINA-**  
12 **TIONS.**

13 (a) RIGHT OF APPEAL.—

14 (1) IN GENERAL.—A participant or beneficiary  
15 in a group health plan, and an enrollee in health in-  
16 surance coverage offered by a health insurance  
17 issuer, and any provider or other person acting on  
18 behalf of such an individual with the individual's  
19 consent, may appeal any appealable decision (as de-  
20 fined in paragraph (2)) under the procedures de-  
21 scribed in this section and (to the extent applicable)  
22 section 133. Such individuals and providers shall be  
23 provided with a written explanation of the appeal  
24 process and the determination upon the conclusion

1 of the appeals process and as provided in section  
2 121(b)(8).

3 (2) APPEALABLE DECISION DEFINED.—In this  
4 section, the term “appealable decision” means any of  
5 the following:

6 (A) Denial, reduction, or termination of, or  
7 failure to provide or make payment (in whole or  
8 in part) for, a benefit, including a failure to  
9 cover an item or service for which benefits are  
10 otherwise provided because it is determined to  
11 be experimental or investigational or not medi-  
12 cally necessary or appropriate.

13 (B) Failure to provide coverage of emer-  
14 gency services or reimbursement of mainte-  
15 nance care or post-stabilization care under sec-  
16 tion 101.

17 (C) Failure to provide a choice of provider  
18 under section 103.

19 (D) Failure to provide qualified health care  
20 providers under section 103.

21 (E) Failure to provide access to specialty  
22 and other care under section 104.

23 (F) Failure to provide continuation of care  
24 under section 105.



1 (G) Failure to provide coverage of routine  
2 patient costs in connection with an approval  
3 clinical trial under section 106.

4 (H) Failure to provide access to needed  
5 drugs under section 107(a)(3) or 107(b).

6 (I) An adverse determination under a utili-  
7 zation review program under section 111.

8 (J) The imposition of a limitation that is  
9 prohibited under section 151.

10 (b) INTERNAL APPEAL PROCESS.—

11 (1) IN GENERAL.—Each group health plan and  
12 health insurance issuer shall establish and maintain  
13 an internal appeal process under which any partici-  
14 pant, beneficiary, enrollee, or provider acting on be-  
15 half of such an individual with the individual's con-  
16 sent, who is dissatisfied with any appealable decision  
17 has the opportunity to appeal the decision through  
18 an internal appeal process. The appeal may be com-  
19 municated orally.

20 (2) CONDUCT OF REVIEW.—

21 (A) IN GENERAL.—The process shall in-  
22 clude a review of the decision by a physician or  
23 other health care professional (or professionals)  
24 who has been selected by the plan or issuer and

1 who has not been involved in the appealable de-  
2 cision at issue in the appeal.

3 (B) AVAILABILITY AND PARTICIPATION OF  
4 CLINICAL PEERS.—The individuals conducting  
5 such review shall include one or more clinical  
6 peers (as defined in section 191(c)(2)) who have  
7 not been involved in the appealable decision at  
8 issue in the appeal.

9 (3) DEADLINE.—

10 (A) IN GENERAL.—Subject to subsection  
11 (c), the plan or issuer shall conclude each ap-  
12 peal as soon as possible after the time of the re-  
13 ceipt of the appeal in accordance with medical  
14 exigencies of the case involved, but in no event  
15 later than—

16 (i) 72 hours after the time of receipt  
17 of an expedited appeal, and

18 (ii) except as provided in subpara-  
19 graph (B), 30 days after such time (or, if  
20 the participant, beneficiary, or enrollee  
21 supplies additional information that was  
22 not available to the plan or issuer at the  
23 time of the receipt of the appeal, after the  
24 date of supplying such additional informa-  
25 tion) in the case of all other appeals.

1           (B) EXTENSION.—In the case of an appeal  
2           that does not relate to a decision regarding an  
3           expedited appeal and that does not involve med-  
4           ical exigencies, if a group health plan or health  
5           insurance issuer is unable to conclude the ap-  
6           peal within the time period provided under sub-  
7           paragraph (A)(ii) due to circumstances beyond  
8           the control of the plan or issuer, the deadline  
9           shall be extended for up to an additional 3 busi-  
10          ness days if the plan or issuer provides, on or  
11          before 10 days before the deadline otherwise ap-  
12          plicable, written notice to the participant, bene-  
13          ficiary, or enrollee and the provider involved of  
14          the extension and the reasons for the extension.

15          (4) NOTICE.—If a plan or issuer denies an ap-  
16          peal, the plan or issuer shall provide the participant,  
17          beneficiary, or enrollee and provider involved with  
18          notice in printed form of the denial and the reasons  
19          therefore, together with a notice in printed form of  
20          rights to any further appeal.

21          (c) EXPEDITED REVIEW PROCESS.—

22               (1) IN GENERAL.—A group health plan, and a  
23               health insurance issuer, shall establish procedures in  
24               writing for the expedited consideration of appeals  
25               under subsection (b) in situations in which the appli-

1 cation of the normal timeframe for making a deter-  
2 mination could seriously jeopardize the life or health  
3 of the participant, beneficiary, or enrollee or such an  
4 individual's ability to regain maximum function.

5 (2) PROCESS.—Under such procedures—

6 (A) the request for expedited appeal may  
7 be submitted orally or in writing by an individ-  
8 ual or provider who is otherwise entitled to re-  
9 quest the appeal;

10 (B) all necessary information, including  
11 the plan's or issuer's decision, shall be trans-  
12 mitted between the plan or issuer and the re-  
13 quester by telephone, facsimile, or other simi-  
14 larly expeditious available method; and

15 (C) the plan or issuer shall expedite the  
16 appeal if the request for an expedited appeal is  
17 submitted under subparagraph (A) by a physi-  
18 cian and the request indicates that the situation  
19 described in paragraph (1) exists.

20 (d) DIRECT USE OF FURTHER APPEALS.—In the  
21 event that the plan or issuer fails to comply with any of  
22 the deadlines for completion of appeals under this section  
23 or in the event that the plan or issuer for any reason ex-  
24 pressly waives its rights to an internal review of an appeal  
25 under subsection (b), the participant, beneficiary, or en-

1 rollee involved and the provider involved shall be relieved  
 2 of any obligation to complete the appeal involved and may,  
 3 at such an individual's or provider's option, proceed di-  
 4 rectly to seek further appeal through any applicable exter-  
 5 nal appeals process.

6 **SEC. 133. EXTERNAL APPEALS OF ADVERSE DETERMINA-**  
 7 **TIONS.**

8 (a) RIGHT TO EXTERNAL APPEAL.—

9 (1) IN GENERAL.—A group health plan, and a  
 10 health insurance issuer offering group health insur-  
 11 ance coverage, shall provide for an external appeals  
 12 process that meets the requirements of this section  
 13 in the case of an externally appealable decision de-  
 14 scribed in paragraph (2), for which a timely appeal  
 15 is made either by the plan or issuer or by the partic-  
 16 ipant, beneficiary, or enrollee, or a representative of  
 17 any of them. The appropriate Secretary shall estab-  
 18 lish standards to carry out such requirements.

19 (2) EXTERNALLY APPEALABLE DECISION DE-  
 20 FINED.—For purposes of this section, the term “ex-  
 21 ternally appealable decision” means an appealable  
 22 decision (as defined in section 132(a)(2)) if—

- 23 (A) the amount involved exceeds \$100; or
- 24 (B) the patient's life or health is jeopard-
- 25 ized as a consequence of the decision.

1 Such term does not include a denial of coverage for  
2 services that are specifically listed in plan or cov-  
3 erage documents as excluded from coverage.

4 (3) EXHAUSTION OF INTERNAL APPEALS PROC-  
5 ESS.—A plan or issuer may condition the use of an  
6 external appeal process in the case of an externally  
7 appealable decision upon completion of the internal  
8 review process provided under section 132, but only  
9 if the decision is made in a timely basis consistent  
10 with the deadlines provided under this subtitle.

11 (b) GENERAL ELEMENTS OF EXTERNAL APPEALS  
12 PROCESS.—

13 (1) CONTRACT WITH QUALIFIED EXTERNAL AP-  
14 PEAL ENTITY.—

15 (A) CONTRACT REQUIREMENT.—Subject to  
16 subparagraph (B), the external appeal process  
17 under this section of a plan or issuer shall be  
18 conducted under a contract between the plan or  
19 issuer and one or more qualified external appeal  
20 entities (as defined in subsection (c)).

21 (B) RESTRICTIONS ON QUALIFIED EXTER-  
22 NAL APPEAL ENTITY.—

23 (i) BY STATE FOR HEALTH INSUR-  
24 ANCE ISSUERS.—With respect to health in-  
25 surance issuers in a State, the State may

1 provide for external review activities to be  
2 conducted by a qualified external appeal  
3 entity that is designated by the State or  
4 that is selected by the State in such a  
5 manner as to assure an unbiased deter-  
6 mination.

7 (ii) BY FEDERAL GOVERNMENT FOR  
8 GROUP HEALTH PLANS.—With respect to  
9 group health plans, the appropriate Sec-  
10 retary may exercise the same authority as  
11 a State may exercise with respect to health  
12 insurance issuers under clause (i). Such  
13 authority may include requiring the use of  
14 the qualified external appeal entity des-  
15 ignated or selected under such clause.

16 (iii) LIMITATION ON PLAN OR ISSUER  
17 SELECTION.—If an applicable authority  
18 permits more than one entity to qualify as  
19 a qualified external appeal entity with re-  
20 spect to a group health plan or health in-  
21 surance issuer and the plan or issuer may  
22 select among such qualified entities, the  
23 applicable authority—

24 (I) shall assure that the selection  
25 process will not create any incentives

1 for external appeal entities to make a  
2 decision in a biased manner, and

3 (II) shall implement procedures  
4 for auditing a sample of decisions by  
5 such entities to assure that no such  
6 decisions are made in a biased man-  
7 ner.

8 (C) OTHER TERMS AND CONDITIONS.—

9 The terms and conditions of a contract under  
10 this paragraph shall be consistent with the  
11 standards the appropriate Secretary shall estab-  
12 lish to assure there is no real or apparent con-  
13 flict of interest in the conduct of external ap-  
14 peal activities. Such contract shall provide that  
15 the direct costs of the process (not including  
16 costs of representation of a participant, bene-  
17 ficiary, or enrollee) shall be paid by the plan or  
18 issuer, and not by the participant, beneficiary,  
19 or enrollee.

20 (2) ELEMENTS OF PROCESS.—An external ap-  
21 peal process shall be conducted consistent with  
22 standards established by the appropriate Secretary  
23 that include at least the following:

24 (A) FAIR PROCESS; DE NOVO DETERMINA-  
25 TION.—The process shall provide for a fair, de



1            novo determination. In carrying out this sub-  
2            paragraph, the determination of medical neces-  
3            sity shall be made under the process without re-  
4            gard to the definition used by the plan or  
5            issuer. However, nothing in this sentence shall  
6            be construed as providing for coverage of items  
7            and services for which benefits are specifically  
8            excluded under the plan or coverage.

9            (B) DETERMINATION CONCERNING EXTER-  
10          NALLY APPEALABLE DECISIONS.—A qualified  
11          external appeal entity shall determine whether a  
12          decision is an externally appealable decision and  
13          related decisions, including—

14                (i) whether such a decision involves an  
15                expedited appeal;

16                (ii) the appropriate deadlines for in-  
17                ternal review process required due to medi-  
18                cal exigencies in a case; and

19                (iii) whether such a process has been  
20                completed.

21          (C) OPPORTUNITY TO SUBMIT EVIDENCE,  
22          HAVE REPRESENTATION, AND MAKE ORAL  
23          PRESENTATION.—Each party to an externally  
24          appealable decision (directly or through an au-

1           thorized representative or representatives, any  
2           of whom may be an attorney)—

3                   (i) may submit and review evidence  
4                   related to the issues in dispute,

5                   (ii) may use the assistance or rep-  
6                   resentation of one or more individuals (any  
7                   of whom may be an attorney), and

8                   (iii) may make an oral presentation.

9           (D) PROVISION OF INFORMATION.—The  
10          plan or issuer involved shall provide timely ac-  
11          cess to all its records relating to the matter of  
12          the externally appealable decision and to all  
13          provisions of the plan or health insurance cov-  
14          erage (including any coverage manual) relating  
15          to the matter.

16          (E) TIMELY DECISIONS.—A determination  
17          by the external appeal entity on the decision  
18          shall—

19                   (i) be made orally or in writing and,  
20                   if it is made orally, shall be supplied to the  
21                   parties in writing as soon as possible;

22                   (ii) be binding on the plan or issuer;

23                   (iii) be made in accordance with the  
24                   medical exigencies of the case involved, but  
25                   in no event later than 60 days (or 72

1 hours in the case of an expedited appeal  
 2 or, in the case of an appeal involving emer-  
 3 gency circumstances, as soon as possible in  
 4 accordance with the medical exigencies of  
 5 the case, and in no event later than 24  
 6 hours) from the date of completion of the  
 7 filing of notice requesting an external ap-  
 8 peal of the decision;

9 (iv) state, in layperson’s language, the  
 10 basis for the determination, including, if  
 11 relevant, any basis in the terms or condi-  
 12 tions of the plan or coverage; and

13 (v) inform the participant, beneficiary,  
 14 or enrollee of the individual’s rights (in-  
 15 cluding any limitation on such rights) to  
 16 seek further review by the courts (or other  
 17 process) of the external appeal determina-  
 18 tion.

19 (c) QUALIFICATIONS OF EXTERNAL APPEAL ENTI-  
 20 TIES.—

21 (1) IN GENERAL.—For purposes of this section,  
 22 the term “qualified external appeal entity” means,  
 23 in relation to a plan or issuer, an entity (which may  
 24 be a governmental entity) that is certified under

1 paragraph (2) as meeting the following require-  
2 ments:

3 (A) There is no real or apparent conflict of  
4 interest that would impede the entity conduct-  
5 ing external appeal activities independent of the  
6 plan or issuer.

7 (B) The entity conducts external appeal  
8 activities through clinical peers.

9 (C) The entity has sufficient medical, legal,  
10 and other expertise and sufficient staffing to  
11 conduct external appeal activities for the plan  
12 or issuer on a timely basis consistent with sub-  
13 section (b)(3)(E).

14 (D) The entity meets such other require-  
15 ments as the appropriate Secretary may im-  
16 pose.

17 (2) CERTIFICATION OF EXTERNAL APPEAL EN-  
18 TITIES.—

19 (A) IN GENERAL.—In order to be treated  
20 as a qualified external appeal entity with re-  
21 spect to—

22 (i) a group health plan, the entity  
23 must be certified (and, in accordance with  
24 subparagraph (B), periodically recertified)  
25 as meeting the requirements of paragraph

1 (1) by the Secretary of Labor (or under a  
2 process recognized or approved by the Sec-  
3 retary of Labor); or

4 (ii) a health insurance issuer operat-  
5 ing in a State, the entity must be certified  
6 (and, in accordance with subparagraph  
7 (B), periodically recertified) as meeting  
8 such requirements by the applicable State  
9 authority (or, if the State has not estab-  
10 lished an adequate certification and recer-  
11 tification process, by the Secretary of  
12 Health and Human Services, or under a  
13 process recognized or approved by such  
14 Secretary).

15 (B) RECERTIFICATION PROCESS.—The ap-  
16 propriate Secretary shall develop standards for  
17 the recertification of external appeal entities.  
18 Such standards shall include a specification  
19 of—

20 (i) the information required to be sub-  
21 mitted as a condition of recertification on  
22 the entity's performance of external appeal  
23 activities, which information shall include  
24 the number of cases reviewed, a summary  
25 of the disposition of those cases, the length

1 of time in making determinations on those  
2 cases, and such information as may be nec-  
3 essary to assure the independence of the  
4 entity from the plans or issuers for which  
5 external appeal activities are being con-  
6 ducted; and

7 (ii) the periodicity which recertifi-  
8 cation will be required.

9 (3) LIMITATION ON LIABILITY OF REVIEW-  
10 ERS.—No qualified external appeal entity having a  
11 contract with a plan or issuer under this part and  
12 no person who is employed by, or who has a fidu-  
13 ciary relationship with, any such entity or who fur-  
14 nishes professional services to such entity, shall be  
15 held by reason of the performance of any duty, func-  
16 tion, or activity required or authorized pursuant to  
17 this section, to have violated any criminal law, or to  
18 be civilly liable under any law of the United States  
19 or of any State (or political subdivision thereof) if  
20 due care was exercised in the performance of such  
21 duty, function, or activity and there was no actual  
22 malice or gross misconduct in the performance of  
23 such duty, function, or activity.

24 (d) EXTERNAL APPEAL DETERMINATION BINDING  
25 ON PLAN.—

1           (1) IN GENERAL.—Subject to paragraph (2),  
 2           the determination by an external appeals entity  
 3           under this section is binding on the plan (and issuer,  
 4           if any) involved in the determination.

5           (2) VACATION OR MODIFICATION OF DECISION.—The determination by an external appeals  
 6           entity under this section may be vacated or modified  
 7           by a court under the same circumstances as the de-  
 8           cision of an arbitrator may be vacated or modified  
 9           under sections 10 and 11 of title 9, United States  
 10          Code.  
 11

## 12       **Subtitle E—Protecting the Doctor-** 13       **Patient Relationship**

### 14       **SEC. 141. PROHIBITION OF INTERFERENCE WITH CERTAIN** 15       **MEDICAL COMMUNICATIONS.**

16       (a) PROHIBITION.—

17           (1) GENERAL RULE.—The provisions of any  
 18           contract or agreement, or the operation of any con-  
 19           tract or agreement, between a group health plan or  
 20           health insurance issuer in relation to health insur-  
 21           ance coverage (including any partnership, associa-  
 22           tion, or other organization that enters into or ad-  
 23           ministers such a contract or agreement) and a  
 24           health care provider (or group of health care provid-  
 25           ers) shall not prohibit or otherwise restrict a covered

1 health care professional (as defined in subsection  
2 (b)) from advising such a participant, beneficiary, or  
3 enrollee who is a patient of the professional about  
4 the health status of the individual or medical care or  
5 treatment for the individual's condition or disease,  
6 regardless of whether benefits for such care or treat-  
7 ment are provided under the plan or coverage, if the  
8 professional is acting within the lawful scope of  
9 practice.

10 (2) NULLIFICATION.—Any contract provision or  
11 agreement that restricts or prohibits medical com-  
12 munications in violation of paragraph (1) shall be  
13 null and void.

14 (b) HEALTH CARE PROFESSIONAL DEFINED.—For  
15 purposes of this section, the term “health care profes-  
16 sional” means a physician (as defined in section 1861(r)  
17 of the Social Security Act) or other health care profes-  
18 sional if coverage for the professional's services of the pro-  
19 fessional is provided under the group health plan or health  
20 insurance coverage. Such term includes a podiatrist, op-  
21 tometrist, chiropractor, psychologist, dentist, physician as-  
22 sistant, physical or occupational therapist and therapy as-  
23 sistant, speech-language pathologist, audiologist, reg-  
24 istered or licensed practical nurse (including nurse practi-  
25 tioner, clinical nurse specialist, certified registered nurse



1 anesthetist, and certified nurse-midwife), licensed clinical  
2 social worker, registered respiratory therapist, and cer-  
3 tified respiratory therapy technician.

4 **SEC. 142. PROHIBITION AGAINST TRANSFER OF INDEM-**  
5 **NIFICATION OR IMPROPER INCENTIVE AR-**  
6 **RANGEMENTS.**

7 (a) PROHIBITION OF TRANSFER OF INDEMNIFICA-  
8 TION.—

9 (1) IN GENERAL.—No contract or agreement  
10 between a group health plan or health insurance  
11 issuer (or any agent acting on behalf of such a plan  
12 or issuer) and a health care provider shall contain  
13 any provision purporting to transfer to the health  
14 care provider by indemnification or otherwise any li-  
15 ability relating to activities, actions, or omissions of  
16 the plan, issuer, or agent (as opposed to the pro-  
17 vider).

18 (2) NULLIFICATION.—Any contract or agree-  
19 ment provision described in paragraph (1) shall be  
20 null and void.

21 (b) PROHIBITION OF IMPROPER PHYSICIAN INCEN-  
22 TIVE PLANS.—

23 (1) IN GENERAL.—A group health plan and a  
24 health insurance issuer offering health insurance  
25 coverage may not operate any physician incentive

1 plan (as defined in subparagraph (B) of section  
2 1876(i)(8) of the Social Security Act) unless the re-  
3 quirements described in subparagraph (A) of such  
4 section are met with respect to such a plan.

5 (2) APPLICATION.—For purposes of carrying  
6 out paragraph (1), any reference in section  
7 1876(i)(8) of the Social Security Act to the Sec-  
8 retary, an eligible organization, or an individual en-  
9 rolled with the organization shall be treated as a ref-  
10 erence to the applicable authority, a group health  
11 plan or health insurance issuer, respectively, and a  
12 participant, beneficiary, or enrollee with the plan or  
13 organization, respectively.

14 **SEC. 143. ADDITIONAL RULES REGARDING PARTICIPATION**  
15 **OF HEALTH CARE PROFESSIONALS.**

16 (a) PROCEDURES.—Insofar as a group health plan,  
17 or health insurance issuer that offers health insurance cov-  
18 erage, provides benefits through participating health care  
19 professionals, the plan or issuer shall establish reasonable  
20 procedures relating to the participation (under an agree-  
21 ment between a professional and the plan or issuer) of  
22 such professionals under the plan or coverage. Such proce-  
23 dures shall include—

24 (1) providing notice of the rules regarding par-  
25 ticipation;

1           (2) providing written notice of participation de-  
2           cisions that are adverse to professionals; and

3           (3) providing a process within the plan or issuer  
4           for appealing such adverse decisions, including the  
5           presentation of information and views of the profes-  
6           sional regarding such decision.

7           (b) CONSULTATION IN MEDICAL POLICIES.—A group  
8           health plan, and health insurance issuer that offers health  
9           insurance coverage, shall consult with participating physi-  
10          cians (if any) regarding the plan’s or issuer’s medical pol-  
11          icy, quality, and medical management procedures.

12   **SEC. 144. PROTECTION FOR PATIENT ADVOCACY.**

13          (a) PROTECTION FOR USE OF UTILIZATION REVIEW  
14          AND GRIEVANCE PROCESS.—A group health plan, and a  
15          health insurance issuer with respect to the provision of  
16          health insurance coverage, may not retaliate against a par-  
17          ticipant, beneficiary, enrollee, or health care provider  
18          based on the participant’s, beneficiary’s, enrollee’s or pro-  
19          vider’s use of, or participation in, a utilization review proc-  
20          ess or a grievance process of the plan or issuer (including  
21          an internal or external review or appeal process) under  
22          this title.

23          (b) PROTECTION FOR QUALITY ADVOCACY BY  
24          HEALTH CARE PROFESSIONALS.—

1           (1) IN GENERAL.—A group health plan or  
2 health insurance issuer may not retaliate or dis-  
3 criminate against a protected health care profes-  
4 sional because the professional in good faith—

5           (A) discloses information relating to the  
6 care, services, or conditions affecting one or  
7 more participants, beneficiaries, or enrollees of  
8 the plan or issuer to an appropriate public reg-  
9 ulatory agency, an appropriate private accredi-  
10 tation body, or appropriate management per-  
11 sonnel of the plan or issuer;

12           (B) initiates, cooperates, or otherwise par-  
13 ticipates in an investigation or proceeding by  
14 such an agency with respect to such care, serv-  
15 ices, or conditions; or

16           (C) participates in an external appeals  
17 process under section 133.

18 If an institutional health care provider is a partici-  
19 pating provider with such a plan or issuer or other-  
20 wise receives payments for benefits provided by such  
21 a plan or issuer, the provisions of the previous sen-  
22 tence shall apply to the provider in relation to care,  
23 services, or conditions affecting one or more patients  
24 within an institutional health care provider in the  
25 same manner as they apply to the plan or issuer in

1 relation to care, services, or conditions provided to  
2 one or more participants, beneficiaries, or enrollees;  
3 and for purposes of applying this sentence, any ref-  
4 erence to a plan or issuer is deemed a reference to  
5 the institutional health care provider.

6 (2) GOOD FAITH ACTION.—For purposes of  
7 paragraph (1), a protected health care professional  
8 is considered to be acting in good faith with respect  
9 to disclosure of information or participation if, with  
10 respect to the information disclosed as part of the  
11 action—

12 (A) the disclosure is made on the basis of  
13 personal knowledge and is consistent with that  
14 degree of learning and skill ordinarily possessed  
15 by health care professionals with the same li-  
16 censure or certification and the same experi-  
17 ence;

18 (B) the professional reasonably believes the  
19 information to be true;

20 (C) the information evidences either a vio-  
21 lation of a law, rule, or regulation, of an appli-  
22 cable accreditation standard, or of a generally  
23 recognized professional or clinical standard or  
24 that a patient is in imminent hazard of loss of  
25 life or serious injury; and

1 (D) subject to subparagraphs (B) and (C)  
2 of paragraph (3), the professional has followed  
3 reasonable internal procedures of the plan,  
4 issuer, or institutional health care provider es-  
5 tablished or the purpose of addressing quality  
6 concerns before making the disclosure.

7 (3) EXCEPTION AND SPECIAL RULE.—

8 (A) GENERAL EXCEPTION.—Paragraph (1)  
9 does not protect disclosures that would violate  
10 Federal or State law or diminish or impair the  
11 rights of any person to the continued protection  
12 of confidentiality of communications provided  
13 by such law.

14 (B) NOTICE OF INTERNAL PROCEDURES.—  
15 Subparagraph (D) of paragraph (2) shall not  
16 apply unless the internal procedures involved  
17 are reasonably expected to be known to the  
18 health care professional involved. For purposes  
19 of this subparagraph, a health care professional  
20 is reasonably expected to know of internal pro-  
21 cedures if those procedures have been made  
22 available to the professional through distribu-  
23 tion or posting.

1 (C) INTERNAL PROCEDURE EXCEPTION.—

2 Subparagraph (D) of paragraph (2) also shall  
3 not apply if—

4 (i) the disclosure relates to an immi-  
5 nent hazard of loss of life or serious injury  
6 to a patient;

7 (ii) the disclosure is made to an ap-  
8 propriate private accreditation body pursu-  
9 ant to disclosure procedures established by  
10 the body; or

11 (iii) the disclosure is in response to an  
12 inquiry made in an investigation or pro-  
13 ceeding of an appropriate public regulatory  
14 agency and the information disclosed is  
15 limited to the scope of the investigation or  
16 proceeding.

17 (4) ADDITIONAL CONSIDERATIONS.—It shall  
18 not be a violation of paragraph (1) to take an ad-  
19 verse action against a protected health care profes-  
20 sional if the plan, issuer, or provider taking the ad-  
21 verse action involved demonstrates that it would  
22 have taken the same adverse action even in the ab-  
23 sence of the activities protected under such para-  
24 graph.

1           (5) NOTICE.—A group health plan, health in-  
2           surance issuer, and institutional health care provider  
3           shall post a notice, to be provided or approved by  
4           the Secretary of Labor, setting forth excerpts from,  
5           or summaries of, the pertinent provisions of this  
6           subsection and information pertaining to enforce-  
7           ment of such provisions.

8           (6) CONSTRUCTIONS.—

9                   (A) DETERMINATIONS OF COVERAGE.—  
10           Nothing in this subsection shall be construed to  
11           prohibit a plan or issuer from making a deter-  
12           mination not to pay for a particular medical  
13           treatment or service or the services of a type of  
14           health care professional.

15                   (B) ENFORCEMENT OF PEER REVIEW PRO-  
16           TOCOLS AND INTERNAL PROCEDURES.—Noth-  
17           ing in this subsection shall be construed to pro-  
18           hibit a plan, issuer, or provider from establish-  
19           ing and enforcing reasonable peer review or uti-  
20           lization review protocols or determining whether  
21           a protected health care professional has com-  
22           plied with those protocols or from establishing  
23           and enforcing internal procedures for the pur-  
24           pose of addressing quality concerns.



1 (C) RELATION TO OTHER RIGHTS.—Noth-  
 2 ing in this subsection shall be construed to  
 3 abridge rights of participants, beneficiaries, en-  
 4 rollees, and protected health care professionals  
 5 under other applicable Federal or State laws.

6 (7) PROTECTED HEALTH CARE PROFESSIONAL  
 7 DEFINED.—For purposes of this subsection, the  
 8 term “protected health care professional” means an  
 9 individual who is a licensed or certified health care  
 10 professional and who—

11 (A) with respect to a group health plan or  
 12 health insurance issuer, is an employee of the  
 13 plan or issuer or has a contract with the plan  
 14 or issuer for provision of services for which ben-  
 15 efits are available under the plan or issuer; or

16 (B) with respect to an institutional health  
 17 care provider, is an employee of the provider or  
 18 has a contract or other arrangement with the  
 19 provider respecting the provision of health care  
 20 services.

## 21 **Subtitle F—Promoting Good** 22 **Medical Practice**

### 23 **SEC. 151. PROMOTING GOOD MEDICAL PRACTICE.**

24 (a) PROHIBITING ARBITRARY LIMITATIONS OR CON-  
 25 DITIONS FOR THE PROVISION OF SERVICES.—

1           (1) IN GENERAL.—A group health plan, and a  
2           health insurance issuer in connection with the provi-  
3           sion of health insurance coverage, may not arbitrar-  
4           ily interfere with or alter the decision of the treating  
5           physician regarding the manner or setting in which  
6           particular services are delivered if the services are  
7           medically necessary or appropriate for treatment or  
8           diagnosis to the extent that such treatment or diag-  
9           nosis is otherwise a covered benefit.

10          (2) CONSTRUCTION.—Paragraph (1) shall not  
11          be construed as prohibiting a plan or issuer from  
12          limiting the delivery of services to one or more  
13          health care providers within a network of such pro-  
14          viders.

15          (3) MANNER OR SETTING DEFINED.—In para-  
16          graph (1), the term “manner or setting” means the  
17          location of treatment, such as whether treatment is  
18          provided on an inpatient or outpatient basis, and the  
19          duration of treatment, such as the number of days  
20          in a hospital. Such term does not include the cov-  
21          erage of a particular service or treatment.

22          (b) NO CHANGE IN COVERAGE.—Subsection (a) shall  
23          not be construed as requiring coverage of particular serv-  
24          ices the coverage of which is otherwise not covered under

1 the terms of the plan or coverage or from conducting utili-  
 2 zation review activities consistent with this subsection.

3 (c) MEDICAL NECESSITY OR APPROPRIATENESS DE-  
 4 FINED.—In subsection (a), the term “medically necessary  
 5 or appropriate” means, with respect to a service or benefit,  
 6 a service or benefit which is consistent with generally ac-  
 7 cepted principles of professional medical practice.

8 **SEC. 152. STANDARDS RELATING TO BENEFITS FOR CER-**  
 9 **TAIN BREAST CANCER TREATMENT.**

10 (a) INPATIENT CARE.—

11 (1) IN GENERAL.—A group health plan, and a  
 12 health insurance issuer offering group health insur-  
 13 ance coverage, that provides medical and surgical  
 14 benefits shall ensure that inpatient coverage with re-  
 15 spect to the treatment of breast cancer is provided  
 16 for a period of time as is determined by the attend-  
 17 ing physician, in the physician’s professional judg-  
 18 ment consistent with generally accepted medical  
 19 standards, in consultation with the patient, to be  
 20 medically appropriate following—

21 (A) a mastectomy;

22 (B) a lumpectomy; or

23 (C) a lymph node dissection for the treat-  
 24 ment of breast cancer.

1           (2) EXCEPTION.—Nothing in this section shall  
2       be construed as requiring the provision of inpatient  
3       coverage if the attending physician and patient de-  
4       termine that a shorter period of hospital stay is  
5       medically appropriate.

6       (b) PROHIBITIONS.—A group health plan, and a  
7       health insurance issuer offering group health insurance  
8       coverage in connection with a group health plan, may  
9       not—

10           (1) deny to a woman eligibility, or continued  
11       eligibility, to enroll or to renew coverage under the  
12       terms of the plan, solely for the purpose of avoiding  
13       the requirements of this section;

14           (2) provide monetary payments or rebates to  
15       women to encourage such women to accept less than  
16       the minimum protections available under this sec-  
17       tion;

18           (3) penalize or otherwise reduce or limit the re-  
19       imbursement of an attending provider because such  
20       provider provided care to an individual participant  
21       or beneficiary in accordance with this section;

22           (4) provide incentives (monetary or otherwise)  
23       to an attending provider to induce such provider to  
24       provide care to an individual participant or bene-  
25       ficiary in a manner inconsistent with this section; or

1           (5) subject to subsection (c)(3), restrict benefits  
2           for any portion of a period within a hospital length  
3           of stay required under subsection (a) in a manner  
4           which is less favorable than the benefits provided for  
5           any preceding portion of such stay.

6           (c) RULES OF CONSTRUCTION.—

7           (1) Nothing in this section shall be construed to  
8           require a woman who is a participant or  
9           beneficiary—

10                 (A) to undergo a mastectomy, lumpectomy,  
11                 or lymph node dissection in a hospital; or

12                 (B) to stay in the hospital for a fixed pe-  
13                 riod of time following a mastectomy,  
14                 lumpectomy, or lymph node dissection.

15           (2) This section shall not apply with respect to  
16           any group health plan, or any group health insur-  
17           ance coverage offered by a health insurance issuer,  
18           which does not provide benefits for hospital lengths  
19           of stay in connection with a mastectomy,  
20           lumpectomy, or lymph node dissection for the treat-  
21           ment of breast cancer.

22           (3) Nothing in this section shall be construed as  
23           preventing a group health plan or issuer from impos-  
24           ing deductibles, coinsurance, or other cost-sharing in  
25           relation to benefits for hospital lengths of stay in

1 connection with a mastectomy or lymph node dissec-  
2 tion for the treatment of breast cancer under the  
3 plan (or under health insurance coverage offered in  
4 connection with a group health plan), except that  
5 such coinsurance or other cost-sharing for any por-  
6 tion of a period within a hospital length of stay re-  
7 quired under subsection (a) may not be greater than  
8 such coinsurance or cost-sharing for any preceding  
9 portion of such stay.

10 (d) LEVEL AND TYPE OF REIMBURSEMENTS.—Noth-  
11 ing in this section shall be construed to prevent a group  
12 health plan or a health insurance issuer offering group  
13 health insurance coverage from negotiating the level and  
14 type of reimbursement with a provider for care provided  
15 in accordance with this section.

16 (e) EXCEPTION FOR HEALTH INSURANCE COVERAGE  
17 IN CERTAIN STATES.—

18 (1) IN GENERAL.—The requirements of this  
19 section shall not apply with respect to health insur-  
20 ance coverage if there is a State law (as defined in  
21 section 2723(d)(1) of the Public Health Service Act)  
22 for a State that regulates such coverage that is de-  
23 scribed in any of the following subparagraphs:

24 (A) Such State law requires such coverage  
25 to provide for at least a 48-hour hospital length

1 of stay following a mastectomy performed for  
2 treatment of breast cancer and at least a 24-  
3 hour hospital length of stay following a lymph  
4 node dissection for treatment of breast cancer.

5 (B) Such State law requires, in connection  
6 with such coverage for surgical treatment of  
7 breast cancer, that the hospital length of stay  
8 for such care is left to the decision of (or re-  
9 quired to be made by) the attending provider in  
10 consultation with the woman involved.

11 (2) CONSTRUCTION.—Section 2723(a)(1) of the  
12 Public Health Service Act and section 731(a)(1) of  
13 the Employee Retirement Income Security Act of  
14 1974 shall not be construed as superseding a State  
15 law described in paragraph (1).

## 16 **Subtitle G—Definitions**

### 17 **SEC. 191. DEFINITIONS.**

18 (a) INCORPORATION OF GENERAL DEFINITIONS.—  
19 The provisions of section 2971 of the Public Health Serv-  
20 ice Act shall apply for purposes of this title in the same  
21 manner as they apply for purposes of title XXVII of such  
22 Act.

23 (b) SECRETARY.—Except as otherwise provided, the  
24 term “Secretary” means the Secretary of Health and  
25 Human Services, in consultation with the Secretary of

1 Labor and the Secretary of the Treasury and the term  
2 “appropriate Secretary” means the Secretary of Health  
3 and Human Services in relation to carrying out this title  
4 under sections 2706 and 2751 of the Public Health Serv-  
5 ice Act, the Secretary of Labor in relation to carrying out  
6 this title under section 714 of the Employee Retirement  
7 Income Security Act of 1974, and the Secretary of the  
8 Treasury in relation to carrying out this title under chap-  
9 ter 100 and section 4980D of the Internal Revenue Code  
10 of 1986.

11 (c) ADDITIONAL DEFINITIONS.—For purposes of this  
12 title:

13 (1) APPLICABLE AUTHORITY.—The term “ap-  
14 plicable authority” means—

15 (A) in the case of a group health plan, the  
16 Secretary of Health and Human Services and  
17 the Secretary of Labor; and

18 (B) in the case of a health insurance issuer  
19 with respect to a specific provision of this title,  
20 the applicable State authority (as defined in  
21 section 2791(d) of the Public Health Service  
22 Act), or the Secretary of Health and Human  
23 Services, if such Secretary is enforcing such  
24 provision under section 2722(a)(2) or  
25 2761(a)(2) of the Public Health Service Act.



1           (2) CLINICAL PEER.—The term “clinical peer”  
2       means, with respect to a review or appeal, a physi-  
3       cian (allopathic or osteopathic) or other health care  
4       professional who holds a license, and who, in the  
5       case of a physician, is appropriately certified by a  
6       nationally recognized, peer reviewed accrediting body  
7       in the same or similar specialty as typically manages  
8       the medical condition, procedure, or treatment under  
9       review or appeal and includes a pediatric specialist  
10      where appropriate; except that only a physician may  
11      be a clinical peer with respect to the review or ap-  
12      peal of treatment recommended or rendered by a  
13      physician.

14          (3) HEALTH CARE PROVIDER.—The term  
15      “health care provider” includes a physician or other  
16      health care professional, as well as an institutional  
17      provider of health care services.

18          (4) NONPARTICIPATING.—The term “non-  
19      participating” means, with respect to a health care  
20      provider that provides health care items and services  
21      to a participant, beneficiary, or enrollee under group  
22      health plan or health insurance coverage, a health  
23      care provider that is not a participating health care  
24      provider with respect to such items and services.

1           (5) PARTICIPATING.—The term “participating”  
2       mean, with respect to a health care provider that  
3       provides health care items and services to a partici-  
4       pant, beneficiary, or enrollee under group health  
5       plan or health insurance coverage offered by a  
6       health insurance issuer, a health care provider that  
7       furnishes such items and services under a contract  
8       or other arrangement with the plan or issuer.

9   **SEC. 192. PREEMPTION; STATE FLEXIBILITY; CONSTRUC-**  
10                           **TION.**

11       (a) CONTINUED APPLICABILITY OF STATE LAW  
12 WITH RESPECT TO HEALTH INSURANCE ISSUERS.—

13           (1) IN GENERAL.—Subject to paragraph (2),  
14       this title shall not be construed to supersede any  
15       provision of State law which establishes, implements,  
16       or continues in effect any standard or requirement  
17       solely relating to health insurance issuers in connec-  
18       tion with group health insurance coverage, except to  
19       the extent that such standard or requirement pre-  
20       vents the application of a requirement of this title,  
21       or which requires (in connection with any litigation  
22       against a health insurance issuer) that the dispute  
23       be first, or simultaneously, considered through an al-  
24       ternative dispute resolution system.

1           (2) CONTINUED PREEMPTION WITH RESPECT  
2           TO GROUP HEALTH PLANS.—Nothing in this title  
3           shall be construed to affect or modify the provisions  
4           of section 514 of the Employee Retirement Income  
5           Security Act of 1974 with respect to group health  
6           plans.

7           (b) RULES OF CONSTRUCTION.—Except as provided  
8           in section 152, nothing in this title shall be construed as  
9           requiring a group health plan or health insurance coverage  
10          to provide specific benefits under the terms of such plan  
11          or coverage.

12          (c) DEFINITIONS.—For purposes of this section:

13           (1) STATE LAW.—The term “State law” in-  
14           cludes all laws, decisions, rules, regulations, or other  
15           State action having the effect of law, of any State.  
16           A law of the United States applicable only to the  
17           District of Columbia shall be treated as a State law  
18           rather than a law of the United States.

19           (2) STATE.—The term “State” includes a  
20           State, the Northern Mariana Islands, any political  
21           subdivisions of a State or such Islands, or any agen-  
22           cy or instrumentality of either.

23   **SEC. 193. REGULATIONS.**

24           The Secretaries of Health and Human Services and  
25   Labor shall issue such regulations as may be necessary

1 or appropriate to carry out this title, other than section  
 2 151. Such regulations shall be issued consistent with sec-  
 3 tion 104 of Health Insurance Portability and Accountabil-  
 4 ity Act of 1996. Such Secretaries may promulgate any in-  
 5 terim final rules as the Secretaries determine are appro-  
 6 priate to carry out this title.

7 **TITLE II—APPLICATION OF PA-**  
 8 **TIENT PROTECTION STAND-**  
 9 **ARDS TO GROUP HEALTH**  
 10 **PLANS AND HEALTH INSUR-**  
 11 **ANCE COVERAGE UNDER**  
 12 **PUBLIC HEALTH SERVICE**  
 13 **ACT**

14 **SEC. 201. APPLICATION TO GROUP HEALTH PLANS AND**  
 15 **GROUP HEALTH INSURANCE COVERAGE.**

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

19 **“SEC. 2706. PATIENT PROTECTION STANDARDS.**

20 “(a) IN GENERAL.—Each group health plan shall  
 21 comply with patient protection requirements under title I  
 22 of the Managed Care Reform Act of 1999, and each health  
 23 insurance issuer shall comply with patient protection re-  
 24 quirements under such title with respect to group health

1 insurance coverage it offers, and such requirements shall  
 2 be deemed to be incorporated into this subsection.

3 “(b) NOTICE.—A group health plan shall comply with  
 4 the notice requirement under section 711(d) of the Em-  
 5 ployee Retirement Income Security Act of 1974 with re-  
 6 spect to the requirements referred to in subsection (a) and  
 7 a health insurance issuer shall comply with such notice  
 8 requirement as if such section applied to such issuer and  
 9 such issuer were a group health plan.”.

10 (b) CONFORMING AMENDMENT.—Section  
 11 2721(b)(2)(A) of such Act (42 U.S.C. 300gg–21(b)(2)(A))  
 12 is amended by inserting “(other than section 2706)” after  
 13 “requirements of such subparts”.

14 **SEC. 202. APPLICATION TO INDIVIDUAL HEALTH INSUR-**  
 15 **ANCE COVERAGE.**

16 Part B of title XXVII of the Public Health Service  
 17 Act is amended by inserting after section 2751 the follow-  
 18 ing new section:

19 **“SEC. 2752. PATIENT PROTECTION STANDARDS.**

20 “(a) IN GENERAL.—Each health insurance issuer  
 21 shall comply with patient protection requirements under  
 22 title I of the Managed Care Reform Act of 1999 with re-  
 23 spect to individual health insurance coverage it offers, and  
 24 such requirements shall be deemed to be incorporated into  
 25 this subsection.

1       “(b) NOTICE.—A health insurance issuer under this  
 2 part shall comply with the notice requirement under sec-  
 3 tion 711(d) of the Employee Retirement Income Security  
 4 Act of 1974 with respect to the requirements of such title  
 5 as if such section applied to such issuer and such issuer  
 6 were a group health plan.”.

7       **TITLE     III—AMENDMENTS     TO**  
 8       **THE EMPLOYEE RETIREMENT**  
 9       **INCOME SECURITY ACT OF**  
 10       **1974**

11       **SEC. 301. APPLICATION OF PATIENT PROTECTION STAND-**  
 12                       **ARDS TO GROUP HEALTH PLANS AND GROUP**  
 13                       **HEALTH INSURANCE COVERAGE UNDER THE**  
 14                       **EMPLOYEE RETIREMENT INCOME SECURITY**  
 15                       **ACT OF 1974.**

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

20       **“SEC. 714. PATIENT PROTECTION STANDARDS.**

21       “(a) IN GENERAL.—Subject to subsection (b), a  
 22 group health plan (and a health insurance issuer offering  
 23 group health insurance coverage in connection with such  
 24 a plan) shall comply with the requirements of title I of  
 25 the Managed Care Reform Act of 1999 (as in effect as

1 of the date of the enactment of such Act), and such re-  
 2 quirements shall be deemed to be incorporated into this  
 3 subsection.

4 “(b) PLAN SATISFACTION OF CERTAIN REQUIRE-  
 5 MENTS.—

6 “(1) SATISFACTION OF CERTAIN REQUIRE-  
 7 MENTS THROUGH INSURANCE.—For purposes of  
 8 subsection (a), insofar as a group health plan pro-  
 9 vides benefits in the form of health insurance cov-  
 10 erage through a health insurance issuer, the plan  
 11 shall be treated as meeting the following require-  
 12 ments of title I of the Managed Care Reform Act of  
 13 1999 with respect to such benefits and not be con-  
 14 sidered as failing to meet such requirements because  
 15 of a failure of the issuer to meet such requirements  
 16 so long as the plan sponsor or its representatives did  
 17 not cause such failure by the issuer:

18 “(A) Section 101 (relating to access to  
 19 emergency care).

20 “(B) Section 102(a)(1) (relating to offer-  
 21 ing option to purchase point-of-service cov-  
 22 erage), but only insofar as the plan is meeting  
 23 such requirement through an agreement with  
 24 the issuer to offer the option to purchase point-  
 25 of-service coverage under such section.

1           “(C) Section 103 (relating to choice of pro-  
2           viders).

3           “(D) Section 104 (relating to access to  
4           specialty care).

5           “(E) Section 105(a)(1) (relating to con-  
6           tinuity in case of termination of provider con-  
7           tract) and section 105(a)(2) (relating to con-  
8           tinuity in case of termination of issuer con-  
9           tract), but only insofar as a replacement issuer  
10          assumes the obligation for continuity of care.

11          “(F) Section 106 (relating to coverage for  
12          individuals participating in approved clinical  
13          trials.)

14          “(G) Section 107 (relating to access to  
15          needed prescription drugs).

16          “(H) Section 108 (relating to adequacy of  
17          provider network).

18          “(I) Subtitle B (relating to quality assur-  
19          ance).

20          “(J) Section 143 (relating to additional  
21          rules regarding participation of health care pro-  
22          fessionals).

23          “(K) Section 152 (relating to standards re-  
24          lating to benefits for certain breast cancer  
25          treatment).



1           “(2) INFORMATION.—With respect to informa-  
2           tion required to be provided or made available under  
3           section 121, in the case of a group health plan that  
4           provides benefits in the form of health insurance  
5           coverage through a health insurance issuer, the Sec-  
6           retary shall determine the circumstances under  
7           which the plan is not required to provide or make  
8           available the information (and is not liable for the  
9           issuer’s failure to provide or make available the in-  
10          formation), if the issuer is obligated to provide and  
11          make available (or provides and makes available)  
12          such information.

13           “(3) GRIEVANCE AND INTERNAL APPEALS.—  
14          With respect to the grievance system and internal  
15          appeals process required to be established under sec-  
16          tions 131 and 132, in the case of a group health  
17          plan that provides benefits in the form of health in-  
18          surance coverage through a health insurance issuer,  
19          the Secretary shall determine the circumstances  
20          under which the plan is not required to provide for  
21          such system and process (and is not liable for the  
22          issuer’s failure to provide for such system and proc-  
23          ess), if the issuer is obligated to provide for (and  
24          provides for) such system and process.

1           “(4) EXTERNAL APPEALS.—Pursuant to rules  
2           of the Secretary, insofar as a group health plan en-  
3           ters into a contract with a qualified external appeal  
4           entity for the conduct of external appeal activities in  
5           accordance with section 133, the plan shall be treat-  
6           ed as meeting the requirement of such section and  
7           is not liable for the entity’s failure to meet any re-  
8           quirements under such section.

9           “(5) APPLICATION TO PROHIBITIONS.—Pursu-  
10          ant to rules of the Secretary, if a health insurance  
11          issuer offers health insurance coverage in connection  
12          with a group health plan and takes an action in vio-  
13          lation of any of the following sections, the group  
14          health plan shall not be liable for such violation un-  
15          less the plan caused such violation:

16               “(A) Section 141 (relating to prohibition of  
17               interference with certain medical communica-  
18               tions).

19               “(B) Section 142 (relating to prohibition  
20               against transfer of indemnification or improper  
21               incentive arrangements).

22               “(C) Section 144 (relating to prohibition  
23               on retaliation).

24               “(D) Section 151 (relating to promoting  
25               good medical practice).

1           “(6) CONSTRUCTION.—Nothing in this sub-  
2           section shall be construed to affect or modify the re-  
3           sponsibilities of the fiduciaries of a group health  
4           plan under part 4 of subtitle B.

5           “(7) APPLICATION TO CERTAIN PROHIBITIONS  
6           AGAINST RETALIATION.—With respect to compliance  
7           with the requirements of section 144(b)(1) of the  
8           Managed Care Reform Act of 1999, for purposes of  
9           this subtitle the term ‘group health plan’ is deemed  
10          to include a reference to an institutional health care  
11          provider.

12          “(c) ENFORCEMENT OF CERTAIN REQUIREMENTS.—

13               “(1) COMPLAINTS.—Any protected health care  
14              professional who believes that the professional has  
15              been retaliated or discriminated against in violation  
16              of section 144(b)(1) of the Managed Care Reform  
17              Act of 1999 may file with the Secretary a complaint  
18              within 180 days of the date of the alleged retaliation  
19              or discrimination.

20               “(2) INVESTIGATION.—The Secretary shall in-  
21              vestigate such complaints and shall determine if a  
22              violation of such section has occurred and, if so,  
23              shall issue an order to ensure that the protected  
24              health care professional does not suffer any loss of  
25              position, pay, or benefits in relation to the plan,

1 issuer, or provider involved, as a result of the viola-  
 2 tion found by the Secretary.

3 “(d) CONFORMING REGULATIONS.—The Secretary  
 4 may issue regulations to coordinate the requirements on  
 5 group health plans under this section with the require-  
 6 ments imposed under the other provisions of this title.”.

7 (b) SATISFACTION OF ERISA CLAIMS PROCEDURE  
 8 REQUIREMENT.—Section 503 of such Act (29 U.S.C.  
 9 1133) is amended by inserting “(a)” after “SEC. 503.”  
 10 and by adding at the end the following new subsection:

11 “(b) In the case of a group health plan (as defined  
 12 in section 733) compliance with the requirements of sub-  
 13 title D (and section 111) of title I of the Managed Care  
 14 Reform Act of 1999 in the case of a claims denial shall  
 15 be deemed compliance with subsection (a) with respect to  
 16 such claims denial.”.

17 (c) CONFORMING AMENDMENTS.—(1) Section 732(a)  
 18 of such Act (29 U.S.C. 1185(a)) is amended by striking  
 19 “section 711” and inserting “sections 711 and 714”.

20 (2) The table of contents in section 1 of such Act  
 21 is amended by inserting after the item relating to section  
 22 712 the following new item:

“Sec. 714. Patient protection standards.”.

23 (3) Section 502(b)(3) of such Act (29 U.S.C.  
 24 1132(b)(3)) is amended by inserting “(other than section  
 25 144(b))” after “part 7”.

1 **SEC. 302. ERISA PREEMPTION NOT TO APPLY TO CERTAIN**  
2 **ACTIONS INVOLVING HEALTH INSURANCE**  
3 **POLICYHOLDERS.**

4 (a) IN GENERAL.—Section 514 of the Employee Re-  
5 tirement Income Security Act of 1974 (29 U.S.C. 1144)  
6 is amended by adding at the end the following subsection:

7 “(e) PREEMPTION NOT TO APPLY TO CERTAIN AC-  
8 TIONS ARISING OUT OF PROVISION OF HEALTH BENE-  
9 FITS.—

10 “(1) NON-PREEMPTION OF CERTAIN CAUSES OF  
11 ACTION.—

12 “(A) IN GENERAL.—Except as provided in  
13 this subsection, nothing in this title shall be  
14 construed to invalidate, impair, or supersede  
15 any cause of action brought by a plan partici-  
16 pant or beneficiary (or the estate of a plan par-  
17 ticipant or beneficiary) under State law to re-  
18 cover damages resulting from personal injury or  
19 for wrongful death against any person—

20 “(i) in connection with the provision  
21 of insurance, administrative services, or  
22 medical services by such person to or for  
23 a group health plan (as defined in section  
24 733), or

25 “(ii) that arises out of the arrange-  
26 ment by such person for the provision of

1           such insurance, administrative services, or  
2           medical services by other persons.

3           “(B) LIMITATION ON PUNITIVE DAM-  
4           AGES.—The plan or issuer is not liable for any  
5           punitive, exemplary, or similar damages in the  
6           case of a cause of action brought under sub-  
7           paragraph (A) if—

8                   “(i) it relates to an externally appeal-  
9                   able decision (as defined in subsection  
10                  (a)(2) of section 133 of the Managed Care  
11                  Reform Act of 1999);

12                  “(ii) an external appeal with respect  
13                  to such decision was completed under such  
14                  section 133;

15                  “(iii) in the case such external appeal  
16                  was initiated by the plan or issuer filing  
17                  the request for the external appeal, the re-  
18                  quest was filed on a timely basis before the  
19                  date the action was brought or, if later,  
20                  within 30 days after the date the exter-  
21                  nally appealable decision was made;

22                  “(iv) the plan or issuer promptly fol-  
23                  lowed the recommendation of the qualified  
24                  external appeal entity involved; and

1                   “(v) such recommendation is not va-  
2                   cated under subsection (d)(3) of such sec-  
3                   tion based upon an action of the plan or  
4                   issuer.

5                   The provisions of this subparagraph supersede  
6                   any State law or common law to the contrary.

7                   “(C) PERSONAL INJURY DEFINED.—For  
8                   purposes of this subsection, the term ‘personal  
9                   injury’ means a physical injury and includes an  
10                  injury arising out of the treatment (or failure  
11                  to treat) a mental illness or disease.

12                  “(2) EXCEPTION FOR EMPLOYERS AND OTHER  
13                  PLAN SPONSORS.—

14                  “(A) IN GENERAL.—Subject to subpara-  
15                  graph (B), paragraph (1) does not authorize—

16                         “(i) any cause of action against an  
17                         employer or other plan sponsor maintain-  
18                         ing the group health plan (or against an  
19                         employee of such an employer or sponsor  
20                         acting within the scope of employment), or

21                         “(ii) a right of recovery or indemnity  
22                         by a person against an employer or other  
23                         plan sponsor (or such an employee) for  
24                         damages assessed against the person pur-

1           suant to a cause of action under paragraph  
2           (1).

3           “(B) SPECIAL RULE.—Subparagraph (A)  
4           shall not preclude any cause of action described  
5           in paragraph (1) against an employer or other  
6           plan sponsor (or against an employee of such  
7           an employer or sponsor acting within the scope  
8           of employment) if—

9                   “(i) such action is based on the em-  
10                  ployer’s or other plan sponsor’s (or em-  
11                  ployee’s) exercise of discretionary authority  
12                  to make a decision on a claim for benefits  
13                  covered under the plan or health insurance  
14                  coverage in the case at issue; and

15                  “(ii) the exercise by such employer or  
16                  other plan sponsor (or employee) of such  
17                  authority resulted in personal injury or  
18                  wrongful death.

19           “(3) CONSTRUCTION.—Nothing in this sub-  
20           section shall be construed as permitting a cause of  
21           action under State law for the failure to provide an  
22           item or service which is specifically excluded under  
23           the group health plan involved.”.

24           (b) EFFECTIVE DATE.—The amendment made by  
25           subsection (a) shall apply to acts and omissions occurring



1 on or after the date of the enactment of this Act from  
2 which a cause of action arises.

3 **TITLE IV—EFFECTIVE DATES;**  
4 **COORDINATION IN IMPLE-**  
5 **MENTATION**

6 **SEC. 401. EFFECTIVE DATES.**

7 (a) GROUP HEALTH COVERAGE.—

8 (1) IN GENERAL.—Subject to paragraph (2),  
9 the amendments made by sections 201(a) and 301  
10 (and title I insofar as it relates to such sections)  
11 shall apply with respect to group health plans, and  
12 health insurance coverage offered in connection with  
13 group health plans, for plan years beginning on or  
14 after October 1, 2000 (in this section referred to as  
15 the “general effective date”).

16 (2) TREATMENT OF COLLECTIVE BARGAINING  
17 AGREEMENTS.—In the case of a group health plan  
18 maintained pursuant to 1 or more collective bargain-  
19 ing agreements between employee representatives  
20 and 1 or more employers ratified before the date of  
21 enactment of this Act, the amendments made by sec-  
22 tions 201(a) and 301 (and title I insofar as it re-  
23 lates to such sections) shall not apply to plan years  
24 beginning before the later of—

1           (A) the date on which the last collective  
 2           bargaining agreements relating to the plan ter-  
 3           minates (determined without regard to any ex-  
 4           tension thereof agreed to after the date of en-  
 5           actment of this Act), or

6           (B) the general effective date.

7       For purposes of subparagraph (A), any plan amend-  
 8       ment made pursuant to a collective bargaining  
 9       agreement relating to the plan which amends the  
 10      plan solely to conform to any requirement added by  
 11      this Act shall not be treated as a termination of  
 12      such collective bargaining agreement.

13      (b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—  
 14      The amendments made by section 202 shall apply with  
 15      respect to individual health insurance coverage offered,  
 16      sold, issued, renewed, in effect, or operated in the individ-  
 17      ual market on or after the general effective date.

18      **SEC. 402. COORDINATION IN IMPLEMENTATION.**

19      The Secretary of Health and Human Services and the  
 20      Secretary of Labor shall ensure, through the execution of  
 21      an interagency memorandum of understanding among  
 22      such Secretaries, that—

23           (1) regulations, rulings, and interpretations  
 24      issued by such Secretaries relating to the same mat-  
 25      ter over which two or more such Secretaries have re-

1       sponsibility under title I (and the amendments made  
2       by titles II and III) are administered so as to have  
3       the same effect at all times; and

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

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