

July 30, 1999

Ordered to be printed as passed

106TH CONGRESS
1ST SESSION

S. 1344

AN ACT

To amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 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 “Patients’ Bill of Rights Plus Act”.

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

Sec. 1. Short title; table of contents.

TITLE I—PATIENTS’ BILL OF RIGHTS

Subtitle A—Right to Advice and Care

Sec. 101. Patient right to medical advice and care.

“SUBPART C—PATIENT RIGHT TO MEDICAL ADVICE AND CARE

“Sec. 721. Patient access to emergency medical care.

“Sec. 722. Offering of choice of coverage options.

“Sec. 723. Patient access to obstetric and gynecological care.

“Sec. 724. Patient access to pediatric care.

“Sec. 725. Timely access to specialists.

“Sec. 726. Continuity of care.

“Sec. 727. Protection of patient-provider communications.

“Sec. 728. Patient’s right to prescription drugs.

“Sec. 729. Self-payment for behavioral health care services.

“Sec. 730. Coverage for individuals participating in approved cancer clinical trials.

“Sec. 730A. Prohibiting discrimination against providers.

“Sec. 730B. Generally applicable provision.”.

Sec. 102. Conforming amendment to the Internal Revenue Code of 1986.

“SUBCHAPTER C—PATIENT RIGHT TO MEDICAL ADVICE AND CARE

“Sec. 9821. Patient access to emergency medical care.

“Sec. 9822. Offering of choice of coverage options.

“Sec. 9823. Patient access to obstetric and gynecological care.

“Sec. 9824. Patient access to pediatric care.

“Sec. 9825. Timely access to specialists.

“Sec. 9826. Continuity of care.

“Sec. 9827. Protection of patient-provider communications.

“Sec. 9828. Patient’s right to prescription drugs.

“Sec. 9829. Self-payment for behavioral health care services.

“Sec. 9830. Coverage for individuals participating in approved cancer clinical trials.

“Sec. 9830A. Prohibiting discrimination against providers.

“Sec. 9830B. Generally applicable provision.”.

Sec. 103. Effective date and related rules.

Subtitle B—Right to Information About Plans and Providers

Sec. 111. Information about plans.

Sec. 112. Information about providers.

Subtitle C—Right to Hold Health Plans Accountable

Sec. 121. Amendment to Employee Retirement Income Security Act of 1974.

TITLE II—WOMEN’S HEALTH AND CANCER RIGHTS

Sec. 201. Women’s health and cancer rights.

TITLE III—GENETIC INFORMATION AND SERVICES

- Sec. 301. Short title.
- Sec. 302. Amendments to Employee Retirement Income Security Act of 1974.
- Sec. 303. Amendments to the Public Health Service Act.
- Sec. 304. Amendments to the Internal Revenue Code of 1986.

TITLE IV—HEALTHCARE RESEARCH AND QUALITY

- Sec. 401. Short title.
- Sec. 402. Amendment to the Public Health Service Act.

“TITLE IX—AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

“PART A—ESTABLISHMENT AND GENERAL DUTIES

- “Sec. 901. Mission and duties.
- “Sec. 902. General authorities.

“PART B—HEALTHCARE IMPROVEMENT RESEARCH

- “Sec. 911. Healthcare outcome improvement research.
- “Sec. 912. Private-public partnerships to improve organization and delivery.
- “Sec. 913. Information on quality and cost of care.
- “Sec. 914. Information systems for healthcare improvement.
- “Sec. 915. Research supporting primary care and access in underserved areas.
- “Sec. 916. Clinical practice and technology innovation.
- “Sec. 917. Coordination of Federal government quality improvement efforts.

“PART C—GENERAL PROVISIONS

- “Sec. 921. Advisory Council for Healthcare Research and Quality.
- “Sec. 922. Peer review with respect to grants and contracts.
- “Sec. 923. Certain provisions with respect to development, collection, and dissemination of data.
- “Sec. 924. Dissemination of information.
- “Sec. 925. Additional provisions with respect to grants and contracts.
- “Sec. 926. Certain administrative authorities.
- “Sec. 927. Funding.
- “Sec. 928. Definitions.”.
- Sec. 403. References.

TITLE V—ENHANCED ACCESS TO HEALTH INSURANCE
COVERAGE

- Sec. 501. Full deduction of health insurance costs for self-employed individuals.
- Sec. 502. Full availability of medical savings accounts.
- Sec. 503. Permitting contribution towards medical savings account through Federal employees health benefits program (FEHBP).
- Sec. 504. Carryover of unused benefits from cafeteria plans, flexible spending arrangements, and health flexible spending accounts.

TITLE VI—PROVISIONS RELATING TO LONG-TERM CARE
INSURANCE

- Sec. 601. Inclusion of qualified long-term care insurance contracts in cafeteria plans, flexible spending arrangements, and health flexible spending accounts.
- Sec. 602. Deduction for premiums for long-term care insurance.
- Sec. 603. Study of long-term care needs in the 21st century.

TITLE VII—INDIVIDUAL RETIREMENT PLANS

- Sec. 701. Modification of income limits on contributions and rollovers to Roth IRAs.

TITLE VIII—REVENUE PROVISIONS

- Sec. 801. Modification to foreign tax credit carryback and carryover periods.
- Sec. 802. Limitation on use of non-accrual experience method of accounting.
- Sec. 803. Returns relating to cancellations of indebtedness by organizations lending money.
- Sec. 804. Extension of Internal Revenue Service user fees.
- Sec. 805. Property subject to a liability treated in same manner as assumption of liability.
- Sec. 806. Charitable split-dollar life insurance, annuity, and endowment contracts.
- Sec. 807. Transfer of excess defined benefit plan assets for retiree health benefits.
- Sec. 808. Limitations on welfare benefit funds of 10 or more employer plans.
- Sec. 809. Modification of installment method and repeal of installment method for accrual method taxpayers.
- Sec. 810. Inclusion of certain vaccines against streptococcus pneumoniae to list of taxable vaccines.

TITLE IX—MISCELLANEOUS PROVISIONS

- Sec. 901. Medicare competitive pricing demonstration project.

TITLE I—PATIENTS’ BILL OF RIGHTS

Subtitle A—Right to Advice and Care

SEC. 101. PATIENT RIGHT TO MEDICAL ADVICE AND CARE.

(a) IN GENERAL.—Part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181 et seq.) is amended—

(1) by redesignating subpart C as subpart D;

and

(2) by inserting after subpart B the following:

1 **“Subpart C—Patient Right to Medical Advice and**
2 **Care**

3 **“SEC. 721. PATIENT ACCESS TO EMERGENCY MEDICAL**
4 **CARE.**

5 “(a) COVERAGE OF EMERGENCY CARE.—

6 “(1) IN GENERAL.—To the extent that the
7 group health plan (other than a fully insured group
8 health plan) provides coverage for benefits consisting
9 of emergency medical care (as defined in subsection
10 (c)) or emergency ambulance services, except for
11 items or services specifically excluded—

12 “(A) the plan shall provide coverage for
13 benefits, without requiring preauthorization, for
14 emergency medical screening examinations or
15 emergency ambulance services, to the extent
16 that a prudent layperson, who possesses an av-
17 erage knowledge of health and medicine, would
18 determine such examinations or emergency am-
19 bulance services to be necessary to determine
20 whether emergency medical care (as so defined)
21 is necessary; and

22 “(B) the plan shall provide coverage for
23 benefits, without requiring preauthorization, for
24 additional emergency medical care to stabilize
25 an emergency medical condition following an
26 emergency medical screening examination (if

determined necessary under subparagraph (A)), pursuant to the definition of stabilize under section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

“(2) REIMBURSEMENT FOR CARE TO MAINTAIN MEDICAL STABILITY.—

“(A) IN GENERAL.—In the case of services provided to a participant or beneficiary by a nonparticipating provider in order to maintain the medical stability of the participant or beneficiary, the group health plan involved shall provide for reimbursement with respect to such services if—

“(i) coverage for services of the type furnished is available under the group health plan;

“(ii) the services were provided for care related to an emergency medical condition and in an emergency department in order to maintain the medical stability of the participant or beneficiary; and

“(iii) the nonparticipating provider contacted the plan regarding approval for such services.

1 “(B) FAILURE TO RESPOND.—If a group
 2 health plan fails to respond within 1 hours of
 3 being contacted in accordance with subpara-
 4 graph (A)(iii), then the plan shall be liable for
 5 the cost of services provided by the nonpartici-
 6 pating provider in order to maintain the sta-
 7 bility of the participant or beneficiary.

8 “(C) LIMITATION.—The liability of a
 9 group health plan to provide reimbursement
 10 under subparagraph (A) shall terminate when
 11 the plan has contacted the nonparticipating
 12 provider to arrange for discharge or transfer.

13 “(D) LIABILITY OF PARTICIPANT.—A par-
 14 ticipant or beneficiary shall not be liable for the
 15 costs of services to which subparagraph (A) in
 16 an amount that exceeds the amount of liability
 17 that would be incurred if the services were pro-
 18 vided by a participating health care provider
 19 with prior authorization by the plan.

20 “(b) IN-NETWORK UNIFORM COSTS-SHARING AND
 21 OUT-OF-NETWORK CARE.—

22 “(1) IN-NETWORK UNIFORM COST-SHARING.—
 23 Nothing in this section shall be construed as pre-
 24 venting a group health plan (other than a fully in-
 25 sured group health plan) from imposing any form of

1 cost-sharing applicable to any participant or bene-
2 ficiary (including coinsurance, copayments,
3 deductibles, and any other charges) in relation to
4 coverage for benefits described in subsection (a), if
5 such form of cost-sharing is uniformly applied under
6 such plan, with respect to similarly situated partici-
7 pants and beneficiaries, to all benefits consisting of
8 emergency medical care (as defined in subsection
9 (c)) provided to such similarly situated participants
10 and beneficiaries under the plan, and such cost-shar-
11 ing is disclosed in accordance with section 714.

12 “(2) OUT-OF-NETWORK CARE.—If a group
13 health plan (other than a fully insured group health
14 plan) provides any benefits with respect to emer-
15 gency medical care (as defined in subsection (c)), the
16 plan shall cover emergency medical care under the
17 plan in a manner so that, if such care is provided
18 to a participant or beneficiary by a nonparticipating
19 health care provider, the participant or beneficiary is
20 not liable for amounts that exceed any form of cost-
21 sharing (including co-insurance, co-payments,
22 deductibles, and any other charges) that would be
23 incurred if the services were provided by a partici-
24 pating provider.

1 “(c) DEFINITION OF EMERGENCY MEDICAL CARE.—

2 In this section:

3 “(1) IN GENERAL.—The term ‘emergency med-
4 ical care’ means, with respect to a participant or
5 beneficiary under a group health plan (other than a
6 fully insured group health plan), covered inpatient
7 and outpatient services that—

8 “(A) are furnished by any provider, includ-
9 ing a nonparticipating provider, that is qualified
10 to furnish such services; and

11 “(B) are needed to evaluate or stabilize (as
12 such term is defined in section 1867(e)(3) of
13 the Social Security Act (42 U.S.C.
14 1395dd)(e)(3)) an emergency medical condition
15 (as defined in paragraph (2)).

16 “(2) EMERGENCY MEDICAL CONDITION.—The
17 term ‘emergency medical condition’ means a medical
18 condition manifesting itself by acute symptoms of
19 sufficient severity (including severe pain) such that
20 a prudent layperson, who possesses an average
21 knowledge of health and medicine, could reasonably
22 expect the absence of immediate medical attention to
23 result in—

24 “(A) placing the health of the participant
25 or beneficiary (or, with respect to a pregnant

1 woman, the health of the woman or her unborn
2 child) in serious jeopardy,

3 “(B) serious impairment to bodily func-
4 tions, or

5 “(C) serious dysfunction of any bodily
6 organ or part.

7 **“SEC. 722. OFFERING OF CHOICE OF COVERAGE OPTIONS.**

8 “(a) REQUIREMENT.—

9 “(1) OFFERING OF POINT-OF-SERVICE COV-
10 ERAGE OPTION.—Except as provided in paragraph
11 (2), if a group health plan (other than a fully in-
12 sured group health plan) provides coverage for bene-
13 fits only through a defined set of participating
14 health care professionals, the plan shall offer the
15 participant the option to purchase point-of-service
16 coverage (as defined in subsection (b)) for all such
17 benefits for which coverage is otherwise so limited.
18 Such option shall be made available to the partici-
19 pant at the time of enrollment under the plan and
20 at such other times as the plan offers the participant
21 a choice of coverage options.

22 “(2) EXCEPTION IN CASE OF LACK OF AVAIL-
23 ABILITY.—Paragraph (1) shall not apply with re-
24 spect to a group health plan (other than a fully in-
25 sured group health plan) if care relating to the

1 point-of-service coverage would not be available and
2 accessible to the participant with reasonable prompt-
3 ness (consistent with section 1301(b)(4) of the Pub-
4 lic Health Service Act (42 U.S.C. 300e(b)(4))).

5 “(b) POINT-OF-SERVICE COVERAGE DEFINED.—In
6 this section, the term ‘point-of-service coverage’ means,
7 with respect to benefits covered under a group health plan
8 (other than a fully insured group health plan), coverage
9 of such benefits when provided by a nonparticipating
10 health care professional.

11 “(c) SMALL EMPLOYER EXEMPTION.—

12 “(1) IN GENERAL.—This section shall not apply
13 to any group health plan (other than a fully insured
14 group health plan) of a small employer.

15 “(2) SMALL EMPLOYER.—For purposes of
16 paragraph (1), the term ‘small employer’ means, in
17 connection with a group health plan (other than a
18 fully insured group health plan) with respect to a
19 calendar year and a plan year, an employer who em-
20 ployed an average of at least 2 but not more than
21 50 employees on business days during the preceding
22 calendar year and who employs at least 2 employees
23 on the first day of the plan year. For purposes of
24 this paragraph, the provisions of subparagraph (C)

1 of section 712(c)(1) shall apply in determining em-
 2 ployer size.

3 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
 4 tion shall be construed—

5 “(1) as requiring coverage for benefits for a
 6 particular type of health care professional;

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;

11 “(3) as preventing a group health plan (other
 12 than a fully insured group health plan) from impos-
 13 ing higher premiums or cost-sharing on a partici-
 14 pant for the exercise of a point-of-service coverage
 15 option; or

16 “(4) to require that a group health plan (other
 17 than a fully insured group health plan) include cov-
 18 erage of health care professionals that the plan ex-
 19 cludes because of fraud, quality of care, or other
 20 similar reasons with respect to such professionals.

21 **“SEC. 723. PATIENT ACCESS TO OBSTETRIC AND GYNECO-**
 22 **LOGICAL CARE.**

23 “(a) GENERAL RIGHTS.—

24 “(1) WAIVER OF PLAN REFERRAL REQUIRE-
 25 MENT.—If a group health plan described in sub-

1 section (b) requires a referral to obtain coverage for
2 specialty care, the plan shall waive the referral re-
3 quirement in the case of a female participant or ben-
4 eficiary who seeks coverage for obstetrical care and
5 related follow-up obstetrical care or routine gynecological care (such as preventive gynecological care).

7 “(2) RELATED ROUTINE CARE.—With respect
8 to a participant or beneficiary described in para-
9 graph (1), a group health plan described in sub-
10 section (b) shall treat the ordering of other routine
11 care that is related to routine gynecologic care, by
12 a physician who specializes in obstetrics and gynecology as the authorization of the primary care pro-
13 vider for such other care.

15 “(b) APPLICATION OF SECTION.—A group health
16 plan described in this subsection is a group health plan
17 (other than a fully insured group health plan), that—

18 “(1) provides coverage for obstetric care (such
19 as pregnancy-related services) or routine gynecologic
20 care (such as preventive women’s health examina-
21 tions); and

22 “(2) requires the designation by a participant
23 or beneficiary of a participating primary care pro-
24 vider who is not a physician who specializes in ob-
25 stetrics or gynecology.

1 “(c) RULES OF CONSTRUCTION.—Nothing in this
2 section shall be construed—

3 “(1) as waiving any coverage requirement relat-
4 ing to medical necessity or appropriateness with re-
5 spect to the coverage of obstetric or gynecologic care
6 described in subsection (a);

7 “(2) to preclude the plan from requiring that
8 the physician who specializes in obstetrics or gyne-
9 cology notify the designated primary care provider or
10 the plan of treatment decisions;

11 “(3) to preclude a group health plan from al-
12 lowing health care professionals other than physi-
13 cians to provide routine obstetric or routine
14 gynecologic care; or

15 “(4) to preclude a group health plan from per-
16 mitting a physician who specializes in obstetrics and
17 gynecology from being a primary care provider
18 under the plan.

19 **“SEC. 724. PATIENT ACCESS TO PEDIATRIC CARE.**

20 “(a) IN GENERAL.—In the case of a group health
21 plan (other than a fully insured group health plan) that
22 provides coverage for routine pediatric care and that re-
23 quires the designation by a participant or beneficiary of
24 a participating primary care provider, if the designated

1 primary care provider is not a physician who specializes
 2 in pediatrics—

3 “(1) the plan may not require authorization or
 4 referral by the primary care provider in order for a
 5 participant or beneficiary to obtain coverage for rou-
 6 tine pediatric care; and

7 “(2) the plan shall treat the ordering of other
 8 routine care related to routine pediatric care by such
 9 a specialist as having been authorized by the des-
 10 ignated primary care provider.

11 “(b) RULES OF CONSTRUCTION.—Nothing in sub-
 12 section (a) shall be construed—

13 “(1) as waiving any coverage requirement relat-
 14 ing to medical necessity or appropriateness with re-
 15 spect to the coverage of any pediatric care provided
 16 to, or ordered for, a participant or beneficiary;

17 “(2) to preclude a group health plan from re-
 18 quiring that a specialist described in subsection (a)
 19 notify the designated primary care provider or the
 20 plan of treatment decisions; or

21 “(3) to preclude a group health plan from al-
 22 lowing health care professionals other than physi-
 23 cians to provide routine pediatric care.

24 **“SEC. 725. TIMELY ACCESS TO SPECIALISTS.**

25 “(a) TIMELY ACCESS.—

1 “(1) IN GENERAL.—A group health plan (other
 2 than a fully insured group health plan) shall ensure
 3 that participants and beneficiaries have timely, in
 4 accordance with the medical exigencies of the case,
 5 access to primary and specialty health care profes-
 6 sionals who are appropriate to the condition of the
 7 participant or beneficiary, when such care is covered
 8 under the plan. Such access may be provided
 9 through contractual arrangements with specialized
 10 providers outside of the network of the plan.

11 “(2) RULE OF CONSTRUCTION.—Nothing in
 12 paragraph (1) shall be construed—

13 “(A) to require the coverage under a group
 14 health plan of particular benefits or services or
 15 to prohibit a plan from including providers only
 16 to the extent necessary to meet the needs of the
 17 plan’s participants or beneficiaries or from es-
 18 tablishing any measure designed to maintain
 19 quality and control costs consistent with the re-
 20 sponsibilities of the plan; or

21 “(B) to override any State licensure or
 22 scope-of-practice law.

23 “(b) TREATMENT PLANS.—

24 “(1) IN GENERAL.—Nothing in this section
 25 shall be construed to prohibit a group health plan

1 (other than a fully insured group health plan) from
2 requiring that specialty care be provided pursuant to
3 a treatment plan so long as the treatment plan is—

4 “(A) developed by the specialist, in con-
5 sultation with the case manager or primary
6 care provider, and the participant or bene-
7 ficiary;

8 “(B) approved by the plan in a timely
9 manner in accordance with the medical exigen-
10 cies of the case; and

11 “(C) in accordance with the applicable
12 quality assurance and utilization review stand-
13 ards of the plan.

14 “(2) NOTIFICATION.—Nothing in paragraph (1)
15 shall be construed as prohibiting a plan from requir-
16 ing the specialist to provide the case manager or pri-
17 mary care provider with regular updates on the spe-
18 cialty care provided, as well as all other necessary
19 medical information.

20 “(c) REFERRALS.—Nothing in this section shall be
21 construed to prohibit a plan from requiring an authoriza-
22 tion by the case manager or primary care provider of the
23 participant or beneficiary in order to obtain coverage for
24 specialty services so long as such authorization is for an
25 adequate number of referrals.

1 “(d) SPECIALTY CARE DEFINED.—For purposes of
 2 this subsection, the term ‘specialty care’ means, with re-
 3 spect to a condition, care and treatment provided by a
 4 health care practitioner, facility, or center (such as a cen-
 5 ter of excellence) that has adequate expertise (including
 6 age-appropriate expertise) through appropriate training
 7 and experience.

8 **“SEC. 726. CONTINUITY OF CARE.**

9 “(a) IN GENERAL.—

10 “(1) TERMINATION OF PROVIDER.—If a con-
 11 tract between a group health plan (other than a fully
 12 insured group health plan) and a health care pro-
 13 vider is terminated (as defined in paragraph (2)), or
 14 benefits or coverage provided by a health care pro-
 15 vider are terminated because of a change in the
 16 terms of provider participation in such group health
 17 plan, and an individual who is a participant or bene-
 18 ficiary in the plan is undergoing a course of treat-
 19 ment from the provider at the time of such termi-
 20 nation, the plan shall—

21 “(A) notify the individual on a timely basis
 22 of such termination;

23 “(B) provide the individual with an oppor-
 24 tunity to notify the plan of a need for transi-
 25 tional care; and

1 “(C) in the case of termination described
 2 in paragraph (2), (3), or (4) of subsection (b),
 3 and subject to subsection (c), permit the indi-
 4 vidual to continue or be covered with respect to
 5 the course of treatment with the provider’s con-
 6 sent during a transitional period (as provided
 7 under subsection (b)).

8 “(2) TERMINATED.—In this section, the term
 9 ‘terminated’ includes, with respect to a contract, the
 10 expiration or nonrenewal of the contract by the
 11 group health plan, but does not include a termi-
 12 nation of the contract by the plan for failure to meet
 13 applicable quality standards or for fraud.

14 “(3) CONTRACTS.—For purposes of this sec-
 15 tion, the term ‘contract between a group health plan
 16 (other than a fully insured group health plan) and
 17 a health care provider’ shall include a contract be-
 18 tween such a plan and an organized network of pro-
 19 viders.

20 “(b) TRANSITIONAL PERIOD.—

21 “(1) GENERAL RULE.—Except as provided in
 22 paragraph (3), the transitional period under this
 23 subsection shall permit the participant or beneficiary
 24 to extend the coverage involved for up to 90 days

1 from the date of the notice described in subsection
 2 (a)(1)(A) of the provider's termination.

3 “(2) INSTITUTIONAL CARE.—Subject to para-
 4 graph (1), the transitional period under this sub-
 5 section for institutional or inpatient care from a pro-
 6 vider shall extend until the discharge or termination
 7 of the period of institutionalization and also shall in-
 8 clude institutional care provided within a reasonable
 9 time of the date of termination of the provider sta-
 10 tus if the care was scheduled before the date of the
 11 announcement of the termination of the provider
 12 status under subsection (a)(1)(A) or if the individual
 13 on such date was on an established waiting list or
 14 otherwise scheduled to have such care.

15 “(3) PREGNANCY.—Notwithstanding paragraph
 16 (1), if—

17 “(A) a participant or beneficiary has en-
 18 tered the second trimester of pregnancy at the
 19 time of a provider's termination of participa-
 20 tion; and

21 “(B) the provider was treating the preg-
 22 nancy before the date of the termination;
 23 the transitional period under this subsection with re-
 24 spect to provider's treatment of the pregnancy shall

1 extend through the provision of post-partum care di-
2 rectly related to the delivery.

3 “(4) TERMINAL ILLNESS.—Notwithstanding
4 paragraph (1), if—

5 “(A) a participant or beneficiary was de-
6 termined to be terminally ill (as determined
7 under section 1861(dd)(3)(A) of the Social Se-
8 curity Act) prior to a provider’s termination of
9 participation; and

10 “(B) the provider was treating the ter-
11 minal illness before the date of termination;
12 the transitional period under this subsection shall be
13 for care directly related to the treatment of the ter-
14 minal illness and shall extend for the remainder of
15 the individual’s life for such care.

16 “(c) PERMISSIBLE TERMS AND CONDITIONS.—A
17 group health plan (other than a fully insured group health
18 plan) may condition coverage of continued treatment by
19 a provider under subsection (a)(1)(C) upon the provider
20 agreeing to the following terms and conditions:

21 “(1) The provider agrees to accept reimburse-
22 ment from the plan and individual involved (with re-
23 spect to cost-sharing) at the rates applicable prior to
24 the start of the transitional period as payment in
25 full (or at the rates applicable under the replacement

1 plan after the date of the termination of the contract
2 with the group health plan) and not to impose cost-
3 sharing with respect to the individual in an amount
4 that would exceed the cost-sharing that could have
5 been imposed if the contract referred to in sub-
6 section (a)(1) had not been terminated.

7 “(2) The provider agrees to adhere to the qual-
8 ity assurance standards of the plan responsible for
9 payment under paragraph (1) and to provide to such
10 plan necessary medical information related to the
11 care provided.

12 “(3) The provider agrees otherwise to adhere to
13 such plan’s policies and procedures, including proce-
14 dures regarding referrals and obtaining prior au-
15 thorization and providing services pursuant to a
16 treatment plan (if any) approved by the plan.

17 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
18 tion shall be construed to require the coverage of benefits
19 which would not have been covered if the provider involved
20 remained a participating provider.

21 “(e) DEFINITION.—In this section, the term ‘health
22 care provider’ or ‘provider’ means—

23 “(1) any individual who is engaged in the deliv-
24 ery of health care services in a State and who is re-
25 quired by State law or regulation to be licensed or

1 certified by the State to engage in the delivery of
 2 such services in the State; and

3 “(2) any entity that is engaged in the delivery
 4 of health care services in a State and that, if it is
 5 required by State law or regulation to be licensed or
 6 certified by the State to engage in the delivery of
 7 such services in the State, is so licensed.

8 “(f) COMPREHENSIVE STUDY OF COST, QUALITY
 9 AND COORDINATION OF COVERAGE FOR PATIENTS AT
 10 THE END OF LIFE.—

11 “(1) STUDY BY THE MEDICARE PAYMENT ADVI-
 12 SORY COMMISSION.—The Medicare Payment Advi-
 13 sory Commission shall conduct a study of the costs
 14 and patterns of care for persons with serious and
 15 complex conditions and the possibilities of improving
 16 upon that care to the degree it is triggered by the
 17 current category of terminally ill as such term is
 18 used for purposes of section 1861(dd) of the Social
 19 Security Act (relating to hospice benefits) or of uti-
 20 lizing care in other payment settings in Medicare.

21 “(2) AGENCY FOR HEALTH CARE POLICY AND
 22 RESEARCH.—The Agency for Health Care Policy
 23 and Research shall conduct studies of the possible
 24 thresholds for major conditions causing serious and

1 complex illness, their administrative parameters and
2 feasibility, and their impact upon costs and quality.

3 “(3) HEALTH CARE FINANCING ADMINISTRA-
4 TION.—The Health Care Financing Administration
5 shall conduct studies of the merits of applying simi-
6 lar thresholds in Medicare+Choice programs, includ-
7 ing adapting risk adjustment methods to account for
8 this category.

9 “(4) INITIAL REPORT.—

10 “(A) IN GENERAL.—Not later than 12
11 months after the date of enactment of this sec-
12 tion, the Medicare Payment Advisory Commis-
13 sion and the Agency for Health Care Policy and
14 Research shall each prepare and submit to the
15 Committee on Health, Education, Labor and
16 Pensions of the Senate a report concerning the
17 results of the studies conducted under para-
18 graphs (1) and (2), respectively.

19 “(B) COPY TO SECRETARY.—Concurrent
20 with the submission of the reports under sub-
21 paragraph (A), the Medicare Payment Advisory
22 Commission and the Agency for health Care
23 Policy and Research shall transmit a copy of
24 the reports under such subparagraph to the
25 Secretary.

1 “(5) FINAL REPORT.—

2 “(A) CONTRACT WITH INSTITUTE OF MED-
3 ICINE.—Not later than 1 year after the submis-
4 sion of the reports under paragraph (4), the
5 Secretary of Health and Human Services shall
6 contract with the Institute of Medicine to con-
7 duct a study of the practices and their effects
8 arising from the utilization of the category “se-
9 rious and complex” illness.

10 “(B) REPORT.—Not later than 1 year
11 after the date of the execution of the contract
12 referred to in subparagraph (A), the Institute
13 of Medicine shall prepare and submit to the
14 Committee on Health, Education, Labor and
15 Pensions of the Senate a report concerning the
16 study conducted pursuant to such contract.

17 “(6) FUNDING.—From funds appropriated to
18 the Department of Health and Human Services, the
19 Secretary of Health and Human Services shall make
20 available such funds as the Secretary determines is
21 necessary to carry out this subsection.

22 **“SEC. 727. PROTECTION OF PATIENT-PROVIDER COMMU-**
23 **NICATIONS.**

24 “(a) IN GENERAL.—Subject to subsection (b), a
25 group health plan (other than a fully insured group health

1 plan and in relation to a participant or beneficiary) shall
 2 not prohibit or otherwise restrict a health care professional
 3 from advising such a participant or beneficiary who is a
 4 patient of the professional about the health status of the
 5 participant or beneficiary or medical care or treatment for
 6 the condition or disease of the participant or beneficiary,
 7 regardless of whether coverage for such care or treatment
 8 are provided under the contract, if the professional is act-
 9 ing within the lawful scope of practice.

10 “(b) RULE OF CONSTRUCTION.—Nothing in this sec-
 11 tion shall be construed as requiring a group health plan
 12 (other than a fully insured group health plan) to provide
 13 specific benefits under the terms of such plan.

14 **“SEC. 728. PATIENT’S RIGHT TO PRESCRIPTION DRUGS.**

15 “To the extent that a group health plan (other than
 16 a fully insured group health plan) provides coverage for
 17 benefits with respect to prescription drugs, and limits such
 18 coverage to drugs included in a formulary, the plan shall—

19 “(1) ensure the participation of physicians and
 20 pharmacists in developing and reviewing such for-
 21 mulary; and

22 “(2) in accordance with the applicable quality
 23 assurance and utilization review standards of the
 24 plan, provide for exceptions from the formulary limi-

1 tation when a non-formulary alternative is medically
2 necessary and appropriate.

3 **“SEC. 729. SELF-PAYMENT FOR BEHAVIORAL HEALTH CARE**
4 **SERVICES.**

5 “(a) IN GENERAL.—A group health plan (other than
6 a fully insured group health plan) may not—

7 “(1) prohibit or otherwise discourage a partici-
8 pant or beneficiary from self-paying for behavioral
9 health care services once the plan has denied cov-
10 erage for such services; or

11 “(2) terminate a health care provider because
12 such provider permits participants or beneficiaries to
13 self-pay for behavioral health care services—

14 “(A) that are not otherwise covered under
15 the plan; or

16 “(B) for which the group health plan pro-
17 vides limited coverage, to the extent that the
18 group health plan denies coverage of the serv-
19 ices.

20 “(b) RULE OF CONSTRUCTION.—Nothing in sub-
21 section (a)(2)(B) shall be construed as prohibiting a group
22 health plan from terminating a contract with a health care
23 provider for failure to meet applicable quality standards
24 or for fraud.

1 **“SEC. 730. COVERAGE FOR INDIVIDUALS PARTICIPATING IN**
2 **APPROVED CANCER CLINICAL TRIALS.**

3 “(a) COVERAGE.—

4 “(1) IN GENERAL.—If a group health plan
5 (other than a fully insured group health plan) pro-
6 vides coverage to a qualified individual (as defined in
7 subsection (b)), the plan—

8 “(A) may not deny the individual partici-
9 pation in the clinical trial referred to in sub-
10 section (b)(2);

11 “(B) subject to subsections (b), (c), and
12 (d) may not deny (or limit or impose additional
13 conditions on) the coverage of routine patient
14 costs for items and services furnished in con-
15 nection with participation in the trial; and

16 “(C) may not discriminate against the in-
17 dividual on the basis of the participant’s or
18 beneficiaries participation in such trial.

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

24 “(3) USE OF IN-NETWORK PROVIDERS.—If one
25 or more participating providers is participating in a
26 clinical trial, nothing in paragraph (1) shall be con-

1 strued as preventing a plan from requiring that a
 2 qualified individual participate in the trial through
 3 such a participating provider if the provider will ac-
 4 cept the individual as a participant in the trial.

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

10 “(1)(A) The individual has been diagnosed with
 11 cancer for which no standard treatment is effective.

12 “(B) The individual is eligible to participate in
 13 an approved clinical trial according to the trial pro-
 14 tocol with respect to treatment of such illness.

15 “(C) The individual’s participation in the trial
 16 offers meaningful potential for significant clinical
 17 benefit for the individual.

18 “(2) Either—

19 “(A) the referring physician is a partici-
 20 pating health care professional and has con-
 21 cluded that the individual’s participation in
 22 such trial would be appropriate based upon the
 23 individual meeting the conditions described in
 24 paragraph (1); or

1 “(B) the participant or beneficiary pro-
2 vides medical and scientific information estab-
3 lishing that the individual’s participation in
4 such trial would be appropriate based upon the
5 individual meeting the conditions described in
6 paragraph (1).

7 “(c) PAYMENT.—

8 “(1) IN GENERAL.—Under this section a group
9 health plan (other than a fully insured group health
10 plan) shall provide for payment for routine patient
11 costs described in subsection (a)(2) but is not re-
12 quired to pay for costs of items and services that are
13 reasonably expected to be paid for by the sponsors
14 of an approved clinical trial.

15 “(2) STANDARDS FOR DETERMINING ROUTINE
16 PATIENT COSTS ASSOCIATED WITH CLINICAL TRIAL
17 PARTICIPATION.—

18 “(A) IN GENERAL.—The Secretary shall
19 establish, on an expedited basis and using a ne-
20 gotiated rulemaking process under subchapter
21 III of chapter 5 of title 5, United States Code,
22 standards relating to the coverage of routine
23 patient costs for individuals participating in
24 clinical trials that group health plans must
25 meet under this section.

1 “(B) FACTORS.—In establishing routine
2 patient cost standards under subparagraph (A),
3 the Secretary shall consult with interested par-
4 ties and take into account —

5 “(i) quality of patient care;

6 “(ii) routine patient care costs versus
7 costs associated with the conduct of clinical
8 trials, including unanticipated patient care
9 costs as a result of participation in clinical
10 trials; and

11 “(iii) previous and on-going studies
12 relating to patient care costs associated
13 with participation in clinical trials.

14 “(C) PUBLICATION OF NOTICE.—In car-
15 rying out the rulemaking process under this
16 paragraph, the Secretary, after consultation
17 with organizations representing cancer patients,
18 health care practitioners, medical researchers,
19 employers, group health plans, manufacturers
20 of drugs, biologics and medical devices, medical
21 economists, hospitals, and other interested par-
22 ties, shall publish notice provided for under sec-
23 tion 564(a) of title 5, United States Code, by
24 not later than 45 days after the date of the en-
25 actment of this section.

1 “(D) TARGET DATE FOR PUBLICATION OF
 2 RULE.—As part of the notice under subpara-
 3 graph (C), and for purposes of this paragraph,
 4 the ‘target date for publication’ (referred to in
 5 section 564(a)(5) of such title 5) shall be June
 6 30, 2000.

7 “(E) ABBREVIATED PERIOD FOR SUBMIS-
 8 SION OF COMMENTS.—In applying section
 9 564(c) of such title 5 under this paragraph, ‘15
 10 days’ shall be substituted for ‘30 days’.

11 “(F) APPOINTMENT OF NEGOTIATED
 12 RULEMAKING COMMITTEE AND FACILITATOR.—
 13 The Secretary shall provide for—

14 “(i) the appointment of a negotiated
 15 rulemaking committee under section
 16 565(a) of such title 5 by not later than 30
 17 days after the end of the comment period
 18 provided for under section 564(c) of such
 19 title 5 (as shortened under subparagraph
 20 (E)), and

21 “(ii) the nomination of a facilitator
 22 under section 566(c) of such title 5 by not
 23 later than 10 days after the date of ap-
 24 pointment of the committee.

1 “(G) PRELIMINARY COMMITTEE RE-
2 PORT.—The negotiated rulemaking committee
3 appointed under subparagraph (F) shall report
4 to the Secretary, by not later than March 29,
5 2000, regarding the committee’s progress on
6 achieving a consensus with regard to the rule-
7 making proceeding and whether such consensus
8 is likely to occur before 1 month before the tar-
9 get date for publication of the rule. If the com-
10 mittee reports that the committee has failed to
11 make significant progress towards such con-
12 sensus or is unlikely to reach such consensus by
13 the target date, the Secretary may terminate
14 such process and provide for the publication of
15 a rule under this paragraph through such other
16 methods as the Secretary may provide.

17 “(H) FINAL COMMITTEE REPORT.—If the
18 committee is not terminated under subpara-
19 graph (G), the rulemaking committee shall sub-
20 mit a report containing a proposed rule by not
21 later than 1 month before the target date of
22 publication.

23 “(I) FINAL EFFECT.—The Secretary shall
24 publish a rule under this paragraph in the Fed-

1 eral Register by not later than the target date
2 of publication.

3 “(J) PUBLICATION OF RULE AFTER PUB-
4 LIC COMMENT.—The Secretary shall provide for
5 consideration of such comments and republica-
6 tion of such rule by not later than 1 year after
7 the target date of publication.

8 “(K) EFFECTIVE DATE.—The provisions of
9 this paragraph shall apply to group health
10 plans (other than a fully insured group health
11 plan) for plan years beginning on or after Jan-
12 uary 1, 2001.

13 “(3) PAYMENT RATE.—In the case of covered
14 items and services provided by—

15 “(A) a participating provider, the payment
16 rate shall be at the agreed upon rate, or

17 “(B) a nonparticipating provider, the pay-
18 ment rate shall be at the rate the plan would
19 normally pay for comparable services under
20 subparagraph (A).

21 “(d) APPROVED CLINICAL TRIAL DEFINED.—

22 “(1) IN GENERAL.—In this section, the term
23 ‘approved clinical trial’ means a cancer clinical re-
24 search study or cancer clinical investigation ap-
25 proved and funded (which may include funding

1 through in-kind contributions) by one or more of the
 2 following:

3 “(A) The National Institutes of Health.

4 “(B) A cooperative group or center of the
 5 National Institutes of Health.

6 “(C) Either of the following if the condi-
 7 tions described in paragraph (2) are met:

8 “(i) The Department of Veterans Af-
 9 fairs.

10 “(ii) The Department of Defense.

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

17 “(A) to be comparable to the system of
 18 peer review of studies and investigations used
 19 by the National Institutes of Health, and

20 “(B) assures unbiased review of the high-
 21 est scientific standards by qualified individuals
 22 who have no interest in the outcome of the re-
 23 view.

1 “(e) CONSTRUCTION.—Nothing in this section shall
 2 be construed to limit a plan’s coverage with respect to clin-
 3 ical trials.

4 “(f) PLAN SATISFACTION OF CERTAIN REQUIRE-
 5 MENTS; RESPONSIBILITIES OF FIDUCIARIES.—

6 “(1) IN GENERAL.—For purposes of this sec-
 7 tion, insofar as a group health plan provides benefits
 8 in the form of health insurance coverage through a
 9 health insurance issuer, the plan shall be treated as
 10 meeting the requirements of this section with respect
 11 to such benefits and not be considered as failing to
 12 meet such requirements because of a failure of the
 13 issuer to meet such requirements so long as the plan
 14 sponsor or its representatives did not cause such
 15 failure by the issuer.

16 “(2) CONSTRUCTION.—Nothing in this section
 17 shall be construed to affect or modify the respon-
 18 sibilities of the fiduciaries of a group health plan
 19 under part 4 of subtitle B.

20 “(g) STUDY AND REPORT.—

21 “(1) STUDY.—The Secretary shall study the
 22 impact on group health plans for covering routine
 23 patient care costs for individuals who are entitled to
 24 benefits under this section and who are enrolled in
 25 an approved cancer clinical trial program.

1 “(2) REPORT TO CONGRESS.—Not later than
 2 January 1, 2005, the Secretary shall submit a re-
 3 port to Congress that contains an assessment of—

4 “(A) any incremental cost to group health
 5 plans resulting from the provisions of this sec-
 6 tion;

7 “(B) a projection of expenditures to such
 8 plans resulting from this section; and

9 “(C) any impact on premiums resulting
 10 from this section.

11 **“SEC. 730A. PROHIBITING DISCRIMINATION AGAINST PRO-**
 12 **VIDERS.**

13 “(a) IN GENERAL.—A group health plan (other than
 14 a fully insured group health plan) shall not discriminate
 15 with respect to participation or indemnification as to any
 16 provider who is acting within the scope of the provider’s
 17 license or certification under applicable State law, solely
 18 on the basis of such license or certification. This sub-
 19 section shall not be construed as requiring the coverage
 20 under a plan of particular benefits or services or to pro-
 21 hibit a plan from including providers only to the extent
 22 necessary to meet the needs of the plan’s participants and
 23 beneficiaries or from establishing any measure designed
 24 to maintain quality and control costs consistent with the
 25 responsibilities of the plan.

1 “(b) NO REQUIREMENT FOR ANY WILLING PRO-
 2 VIDER.—Nothing in this section shall be construed as re-
 3 quiring a group health plan that offers network coverage
 4 to include for participation every willing provider or health
 5 professional who meets the terms and conditions of the
 6 plan.

7 **“SEC. 730B. GENERALLY APPLICABLE PROVISION.**

8 “‘In the case of a group health plan that provides ben-
 9 efits under 2 or more coverage options, the requirements
 10 of this subpart shall apply separately with respect to each
 11 coverage option.’”.

12 (b) RULE WITH RESPECT TO CERTAIN PLANS.—

13 (1) IN GENERAL.—Notwithstanding any other
 14 provision of law, health insurance issuers may offer,
 15 and eligible individuals may purchase, high deduct-
 16 ible health plans described in section 220(c)(2)(A) of
 17 the Internal Revenue Code of 1986. Effective for the
 18 4-year period beginning on the date of the enact-
 19 ment of this Act, such health plans shall not be re-
 20 quired to provide payment for any health care items
 21 or services that are exempt from the plan’s deduct-
 22 ible.

23 (2) EXISTING STATE LAWS.—A State law relat-
 24 ing to payment for health care items and services in
 25 effect on the date of enactment of this Act that is

1 preempted under paragraph (1), shall not apply to
 2 high deductible health plans after the expiration of
 3 the 4-year period described in such paragraph unless
 4 the State reenacts such law after such period.

5 (c) DEFINITION.—Section 733(a) of the Employee
 6 Retirement Income Security Act of 1974 (42 U.S.C.
 7 1191(a)) is amended by adding at the end the following:

8 “(3) FULLY INSURED GROUP HEALTH PLAN.—
 9 The term ‘fully insured group health plan’ means a
 10 group health plan where benefits under the plan are
 11 provided pursuant to the terms of an arrangement
 12 between a group health plan and a health insurance
 13 issuer and are guaranteed by the health insurance
 14 issuer under a contract or policy of insurance.”.

15 (d) CONFORMING AMENDMENT.—The table of con-
 16 tents in section 1 of such Act is amended—

17 (1) in the item relating to subpart C, by strik-
 18 ing “Subpart C” and inserting “Subpart D”; and

19 (2) by adding at the end of the items relating
 20 to subpart B of part 7 of subtitle B of title I of such
 21 Act the following new items:

“SUBPART C—PATIENT RIGHT TO MEDICAL ADVICE AND CARE

“Sec. 721. Patient access to emergency medical care.

“Sec. 722. Offering of choice of coverage options.

“Sec. 723. Patient access to obstetric and gynecological care.

“Sec. 724. Patient access to pediatric care.

“Sec. 725. Timely access to specialists.

“Sec. 726. Continuity of care.

“Sec. 727. Protection of patient-provider communications.

“Sec. 728. Patient’s right to prescription drugs.

“Sec. 729. Self-payment for behavioral health care services.

“Sec. 730. Coverage for individuals participating in approved cancer clinical trials.

“Sec. 730A. Prohibiting discrimination against providers.

“Sec. 730B. Generally applicable provision.”.

1 **SEC. 102. CONFORMING AMENDMENT TO THE INTERNAL**
 2 **REVENUE CODE OF 1986.**

3 (a) IN GENERAL.—Chapter 100 of the Internal Rev-
 4 enue Code of 1986 is amended—

5 (1) by redesignating subchapter C as sub-
 6 chapter D; and

7 (2) by inserting after subchapter B the fol-
 8 lowing:

9 **“Subchapter C—Patient Right to Medical**
 10 **Advice and Care**

“Sec. 9821. Patient access to emergency medical care.

“Sec. 9822. Offering of choice of coverage options.

“Sec. 9823. Patient access to obstetric and gynecological care.

“Sec. 9824. Patient access to pediatric care.

“Sec. 9825. Timely access to specialists.

“Sec. 9826. Continuity of care.

“Sec. 9827. Protection of patient-provider communications.

“Sec. 9828. Patient’s right to prescription drugs.

“Sec. 9829. Self-payment for behavioral health care services.

“Sec. 9830. Coverage for individuals participating in approved cancer clinical trials.

“Sec. 9830A. Prohibiting discrimination against providers.

“Sec. 9830B. Generally applicable provision.

11 **“SEC. 9821. PATIENT ACCESS TO EMERGENCY MEDICAL**
 12 **CARE.**

13 **“(a) COVERAGE OF EMERGENCY CARE.—**

14 **“(1) IN GENERAL.—**To the extent that the
 15 group health plan (other than a fully insured group
 16 health plan) provides coverage for benefits consisting

1 of emergency medical care (as defined in subsection
2 (c)) or emergency ambulance services, except for
3 items or services specifically excluded—

4 “(A) the plan shall provide coverage for
5 benefits, without requiring preauthorization, for
6 emergency medical screening examinations or
7 emergency ambulance services, to the extent
8 that a prudent layperson, who possesses an av-
9 erage knowledge of health and medicine, would
10 determine such examinations or emergency am-
11 bulance services to be necessary to determine
12 whether emergency medical care (as so defined)
13 is necessary; and

14 “(B) the plan shall provide coverage for
15 benefits, without requiring preauthorization, for
16 additional emergency medical care to stabilize
17 an emergency medical condition following an
18 emergency medical screening examination (if
19 determined necessary under subparagraph (A)),
20 pursuant to the definition of stabilize under sec-
21 tion 1867(e)(3) of the Social Security Act (42
22 U.S.C. 1395dd(e)(3)).

23 “(2) REIMBURSEMENT FOR CARE TO MAINTAIN
24 MEDICAL STABILITY.—

1 “(A) IN GENERAL.—In the case of services
2 provided to a participant or beneficiary by a
3 nonparticipating provider in order to maintain
4 the medical stability of the participant or bene-
5 ficiary, the group health plan involved shall pro-
6 vide for reimbursement with respect to such
7 services if—

8 “(i) coverage for services of the type
9 furnished is available under the group
10 health plan;

11 “(ii) the services were provided for
12 care related to an emergency medical con-
13 dition and in an emergency department in
14 order to maintain the medical stability of
15 the participant or beneficiary; and

16 “(iii) the nonparticipating provider
17 contacted the plan regarding approval for
18 such services.

19 “(B) FAILURE TO RESPOND.—If a group
20 health plan fails to respond within 1 hours of
21 being contacted in accordance with subpara-
22 graph (A)(iii), then the plan shall be liable for
23 the cost of services provided by the nonparti-
24 cipating provider in order to maintain the sta-
25 bility of the participant or beneficiary.

1 “(C) LIMITATION.—The liability of a
 2 group health plan to provide reimbursement
 3 under subparagraph (A) shall terminate when
 4 the plan has contacted the nonparticipating
 5 provider to arrange for discharge or transfer.

6 “(D) LIABILITY OF PARTICIPANT.—A par-
 7 ticipant or beneficiary shall not be liable for the
 8 costs of services to which subparagraph (A) in
 9 an amount that exceeds the amount of liability
 10 that would be incurred if the services were pro-
 11 vided by a participating health care provider
 12 with prior authorization by the plan.

13 “(b) IN-NETWORK UNIFORM COSTS-SHARING AND
 14 OUT-OF-NETWORK CARE.—

15 “(1) IN-NETWORK UNIFORM COST-SHARING.—
 16 Nothing in this section shall be construed as pre-
 17 venting a group health plan (other than a fully in-
 18 sured group health plan) from imposing any form of
 19 cost-sharing applicable to any participant or bene-
 20 ficiary (including coinsurance, copayments,
 21 deductibles, and any other charges) in relation to
 22 coverage for benefits described in subsection (a), if
 23 such form of cost-sharing is uniformly applied under
 24 such plan, with respect to similarly situated partici-
 25 pants and beneficiaries, to all benefits consisting of

1 emergency medical care (as defined in subsection
 2 (c)) provided to such similarly situated participants
 3 and beneficiaries under the plan, and such cost-shar-
 4 ing is disclosed in accordance with section 9814.

5 “(2) OUT-OF-NETWORK CARE.—If a group
 6 health plan (other than a fully insured group health
 7 plan) provides any benefits with respect to emer-
 8 gency medical care (as defined in subsection (c)), the
 9 plan shall cover emergency medical care under the
 10 plan in a manner so that, if such care is provided
 11 to a participant or beneficiary by a nonparticipating
 12 health care provider, the participant or beneficiary is
 13 not liable for amounts that exceed any form of cost-
 14 sharing (including coinsurance, copayments,
 15 deductibles, and any other charges) that would be
 16 incurred if the services were provided by a partici-
 17 pating provider.

18 “(c) DEFINITION OF EMERGENCY MEDICAL CARE.—

19 In this section:

20 “(1) IN GENERAL.—The term ‘emergency med-
 21 ical care’ means, with respect to a participant or
 22 beneficiary under a group health plan (other than a
 23 fully insured group health plan), covered inpatient
 24 and outpatient services that—

1 “(A) are furnished by any provider, includ-
2 ing a nonparticipating provider, that is qualified
3 to furnish such services; and

4 “(B) are needed to evaluate or stabilize (as
5 such term is defined in section 1867(e)(3) of
6 the Social Security Act (42 U.S.C.
7 1395dd)(e)(3)) an emergency medical condition
8 (as defined in paragraph (2)).

9 “(2) EMERGENCY MEDICAL CONDITION.—The
10 term ‘emergency medical condition’ means a medical
11 condition manifesting itself by acute symptoms of
12 sufficient severity (including severe pain) such that
13 a prudent layperson, who possesses an average
14 knowledge of health and medicine, could reasonably
15 expect the absence of immediate medical attention to
16 result in—

17 “(A) placing the health of the participant
18 or beneficiary (or, with respect to a pregnant
19 woman, the health of the woman or her unborn
20 child) in serious jeopardy,

21 “(B) serious impairment to bodily func-
22 tions, or

23 “(C) serious dysfunction of any bodily
24 organ or part.

1 **“SEC. 9822. OFFERING OF CHOICE OF COVERAGE OPTIONS.**

2 “(a) REQUIREMENT.—

3 “(1) OFFERING OF POINT-OF-SERVICE COV-
4 ERAGE OPTION.—Except as provided in paragraph
5 (2), if a group health plan (other than a fully in-
6 sured group health plan) provides coverage for bene-
7 fits only through a defined set of participating
8 health care professionals, the plan shall offer the
9 participant the option to purchase point-of-service
10 coverage (as defined in subsection (b)) for all such
11 benefits for which coverage is otherwise so limited.
12 Such option shall be made available to the partici-
13 pant at the time of enrollment under the plan and
14 at such other times as the plan offers the participant
15 a choice of coverage options.

16 “(2) EXCEPTION IN CASE OF LACK OF AVAIL-
17 ABILITY.—Paragraph (1) shall not apply with re-
18 spect to a group health plan (other than a fully in-
19 sured group health plan) if care relating to the
20 point-of-service coverage would not be available and
21 accessible to the participant with reasonable prompt-
22 ness (consistent with section 1301(b)(4) of the Pub-
23 lic Health Service Act (42 U.S.C. 300e(b)(4))).

24 “(b) POINT-OF-SERVICE COVERAGE DEFINED.—In
25 this section, the term ‘point-of-service coverage’ means,
26 with respect to benefits covered under a group health plan

1 (other than a fully insured group health plan), coverage
 2 of such benefits when provided by a nonparticipating
 3 health care professional.

4 “(c) SMALL EMPLOYER EXEMPTION.—

5 “(1) IN GENERAL.—This section shall not apply
 6 to any group health plan (other than a fully insured
 7 group health plan) of a small employer.

8 “(2) SMALL EMPLOYER.—For purposes of
 9 paragraph (1), the term ‘small employer’ means, in
 10 connection with a group health plan (other than a
 11 fully insured group health plan) with respect to a
 12 calendar year and a plan year, an employer who em-
 13 ployed an average of at least 2 but not more than
 14 50 employees on business days during the preceding
 15 calendar year and who employs at least 2 employees
 16 on the first day of the plan year. For purposes of
 17 this paragraph, the provisions of subparagraph (C)
 18 of section 4980D(d)(2) shall apply in determining
 19 employer size.

20 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
 21 tion shall be construed—

22 “(1) as requiring coverage for benefits for a
 23 particular type of health care professional;

24 “(2) as requiring an employer to pay any costs
 25 as a result of this section or to make equal contribu-

1 tions with respect to different health coverage op-
2 tions;

3 “(3) as preventing a group health plan (other
4 than a fully insured group health plan) from impos-
5 ing higher premiums or cost-sharing on a partici-
6 pant for the exercise of a point-of-service coverage
7 option; or

8 “(4) to require that a group health plan (other
9 than a fully insured group health plan) include cov-
10 erage of health care professionals that the plan ex-
11 cludes because of fraud, quality of care, or other
12 similar reasons with respect to such professionals.

13 **“SEC. 9823. PATIENT ACCESS TO OBSTETRIC AND GYNECO-**
14 **LOGICAL CARE.**

15 “(a) GENERAL RIGHTS.—

16 “(1) WAIVER OF PLAN REFERRAL REQUIRE-
17 MENT.—If a group health plan described in sub-
18 section (b) requires a referral to obtain coverage for
19 specialty care, the plan shall waive the referral re-
20 quirement in the case of a female participant or ben-
21 eficiary who seeks coverage for obstetrical care and
22 related follow-up obstetrical care or routine gynecolo-
23 gical care (such as preventive gynecological care).

24 “(2) RELATED ROUTINE CARE.—With respect
25 to a participant or beneficiary described in para-

1 graph (1), a group health plan described in sub-
2 section (b) shall treat the ordering of other routine
3 care that is related to routine gynecologic care, by
4 a physician who specializes in obstetrics and gyne-
5 cology as the authorization of the primary care pro-
6 vider for such other care.

7 “(b) APPLICATION OF SECTION.—A group health
8 plan described in this subsection is a group health plan
9 (other than a fully insured group health plan), that—

10 “(1) provides coverage for obstetric care (such
11 as pregnancy-related services) or routine gynecologic
12 care (such as preventive women’s health examina-
13 tions); and

14 “(2) requires the designation by a participant
15 or beneficiary of a participating primary care pro-
16 vider who is not a physician who specializes in ob-
17 stetrics or gynecology.

18 “(c) RULES OF CONSTRUCTION.—Nothing in this
19 section shall be construed—

20 “(1) as waiving any coverage requirement relat-
21 ing to medical necessity or appropriateness with re-
22 spect to the coverage of obstetric or gynecologic care
23 described in subsection (a);

24 “(2) to preclude the plan from requiring that
25 the physician who specializes in obstetrics or gyne-

1 cology notify the designated primary care provider or
2 the plan of treatment decisions;

3 “(3) to preclude a group health plan from al-
4 lowing health care professionals other than physi-
5 cians to provide routine obstetric or routine
6 gynecologic care; or

7 “(4) to preclude a group health plan from per-
8 mitting a physician who specializes in obstetrics and
9 gynecology from being a primary care provider
10 under the plan.

11 **“SEC. 9824. PATIENT ACCESS TO PEDIATRIC CARE.**

12 “(a) IN GENERAL.—In the case of a group health
13 plan (other than a fully insured group health plan) that
14 provides coverage for routine pediatric care and that re-
15 quires the designation by a participant or beneficiary of
16 a participating primary care provider, if the designated
17 primary care provider is not a physician who specializes
18 in pediatrics—

19 “(1) the plan may not require authorization or
20 referral by the primary care provider in order for a
21 participant or beneficiary to obtain coverage for rou-
22 tine pediatric care; and

23 “(2) the plan shall treat the ordering of other
24 routine care related to routine pediatric care by such

1 a specialist as having been authorized by the des-
2 ignated primary care provider.

3 “(b) RULES OF CONSTRUCTION.—Nothing in sub-
4 section (a) shall be construed—

5 “(1) as waiving any coverage requirement relat-
6 ing to medical necessity or appropriateness with re-
7 spect to the coverage of any pediatric care provided
8 to, or ordered for, a participant or beneficiary;

9 “(2) to preclude a group health plan from re-
10 quiring that a specialist described in subsection (a)
11 notify the designated primary care provider or the
12 plan of treatment decisions; or

13 “(3) to preclude a group health plan from al-
14 lowing health care professionals other than physi-
15 cians to provide routine pediatric care.

16 **“SEC. 9825. TIMELY ACCESS TO SPECIALISTS.**

17 “(a) TIMELY ACCESS.—

18 “(1) IN GENERAL.—A group health plan (other
19 than a fully insured group health plan) shall ensure
20 that participants and beneficiaries have timely, in
21 accordance with the medical exigencies of the case,
22 access to primary and specialty health care profes-
23 sionals who are appropriate to the condition of the
24 participant or beneficiary, when such care is covered
25 under the plan. Such access may be provided

1 through contractual arrangements with specialized
 2 providers outside of the network of the plan.

3 “(2) RULE OF CONSTRUCTION.—Nothing in
 4 paragraph (1) shall be construed—

5 “(A) to require the coverage under a group
 6 health plan of particular benefits or services or
 7 to prohibit a plan from including providers only
 8 to the extent necessary to meet the needs of the
 9 plan’s participants or beneficiaries or from es-
 10 tablishing any measure designed to maintain
 11 quality and control costs consistent with the re-
 12 sponsibilities of the plan; or

13 “(B) to override any State licensure or
 14 scope-of-practice law.

15 “(b) TREATMENT PLANS.—

16 “(1) IN GENERAL.—Nothing in this section
 17 shall be construed to prohibit a group health plan
 18 (other than a fully insured group health plan) from
 19 requiring that specialty care be provided pursuant to
 20 a treatment plan so long as the treatment plan is—

21 “(A) developed by the specialist, in con-
 22 sultation with the case manager or primary
 23 care provider, and the participant or bene-
 24 ficiary;

1 “(B) approved by the plan in a timely
2 manner in accordance with the medical exigen-
3 cies of the case; and

4 “(C) in accordance with the applicable
5 quality assurance and utilization review stand-
6 ards of the plan.

7 “(2) NOTIFICATION.—Nothing in paragraph (1)
8 shall be construed as prohibiting a plan from requir-
9 ing the specialist to provide the case manager or pri-
10 mary care provider with regular updates on the spe-
11 cialty care provided, as well as all other necessary
12 medical information.

13 “(c) REFERRALS.—Nothing in this section shall be
14 construed to prohibit a plan from requiring an authoriza-
15 tion by the case manager or primary care provider of the
16 participant or beneficiary in order to obtain coverage for
17 specialty services so long as such authorization is for an
18 adequate number of referrals.

19 “(d) SPECIALTY CARE DEFINED.—For purposes of
20 this subsection, the term ‘specialty care’ means, with re-
21 spect to a condition, care and treatment provided by a
22 health care practitioner, facility, or center (such as a cen-
23 ter of excellence) that has adequate expertise (including
24 age-appropriate expertise) through appropriate training
25 and experience.

1 **“SEC. 9826. CONTINUITY OF CARE.**

2 “(a) IN GENERAL.—

3 “(1) TERMINATION OF PROVIDER.—If a con-
4 tract between a group health plan (other than a fully
5 insured group health plan) and a health care pro-
6 vider is terminated (as defined in paragraph (2)), or
7 benefits or coverage provided by a health care pro-
8 vider are terminated because of a change in the
9 terms of provider participation in such group health
10 plan, and an individual who is a participant or bene-
11 ficiary in the plan is undergoing a course of treat-
12 ment from the provider at the time of such termi-
13 nation, the plan shall—

14 “(A) notify the individual on a timely basis
15 of such termination;

16 “(B) provide the individual with an oppor-
17 tunity to notify the plan of a need for transi-
18 tional care; and

19 “(C) in the case of termination described
20 in paragraph (2), (3), or (4) of subsection (b),
21 and subject to subsection (c), permit the indi-
22 vidual to continue or be covered with respect to
23 the course of treatment with the provider’s con-
24 sent during a transitional period (as provided
25 under subsection (b)).

1 “(2) TERMINATED.—In this section, the term
2 ‘terminated’ includes, with respect to a contract, the
3 expiration or nonrenewal of the contract by the
4 group health plan, but does not include a termi-
5 nation of the contract by the plan for failure to meet
6 applicable quality standards or for fraud.

7 “(3) CONTRACTS.—For purposes of this sec-
8 tion, the term ‘contract between a group health plan
9 (other than a fully insured group health plan) and
10 a health care provider’ shall include a contract be-
11 tween such a plan and an organized network of pro-
12 viders.

13 “(b) TRANSITIONAL PERIOD.—

14 “(1) GENERAL RULE.—Except as provided in
15 paragraph (3), the transitional period under this
16 subsection shall permit the participant or beneficiary
17 to extend the coverage involved for up to 90 days
18 from the date of the notice described in subsection
19 (a)(1)(A) of the provider’s termination.

20 “(2) INSTITUTIONAL CARE.—Subject to para-
21 graph (1), the transitional period under this sub-
22 section for institutional or inpatient care from a pro-
23 vider shall extend until the discharge or termination
24 of the period of institutionalization and also shall in-
25 clude institutional care provided within a reasonable

1 time of the date of termination of the provider sta-
 2 tus if the care was scheduled before the date of the
 3 announcement of the termination of the provider
 4 status under subsection (a)(1)(A) or if the individual
 5 on such date was on an established waiting list or
 6 otherwise scheduled to have such care.

7 “(3) PREGNANCY.—Notwithstanding paragraph
 8 (1), if—

9 “(A) a participant or beneficiary has en-
 10 tered the second trimester of pregnancy at the
 11 time of a provider’s termination of participa-
 12 tion; and

13 “(B) the provider was treating the preg-
 14 nancy before the date of the termination;
 15 the transitional period under this subsection with re-
 16 spect to provider’s treatment of the pregnancy shall
 17 extend through the provision of post-partum care di-
 18 rectly related to the delivery.

19 “(4) TERMINAL ILLNESS.—Notwithstanding
 20 paragraph (1), if—

21 “(A) a participant or beneficiary was de-
 22 termined to be terminally ill (as determined
 23 under section 1861(dd)(3)(A) of the Social Se-
 24 curity Act) prior to a provider’s termination of
 25 participation; and

1 “(B) the provider was treating the ter-
2 minal illness before the date of termination;
3 the transitional period under this subsection shall be
4 for care directly related to the treatment of the ter-
5 minal illness and shall extend for the remainder of
6 the individual’s life for such care.

7 “(c) PERMISSIBLE TERMS AND CONDITIONS.—A
8 group health plan (other than a fully insured group health
9 plan) may condition coverage of continued treatment by
10 a provider under subsection (a)(1)(C) upon the provider
11 agreeing to the following terms and conditions:

12 “(1) The provider agrees to accept reimburse-
13 ment from the plan and individual involved (with re-
14 spect to cost-sharing) at the rates applicable prior to
15 the start of the transitional period as payment in
16 full (or at the rates applicable under the replacement
17 plan after the date of the termination of the contract
18 with the group health plan) and not to impose cost-
19 sharing with respect to the individual in an amount
20 that would exceed the cost-sharing that could have
21 been imposed if the contract referred to in sub-
22 section (a)(1) had not been terminated.

23 “(2) The provider agrees to adhere to the qual-
24 ity assurance standards of the plan responsible for
25 payment under paragraph (1) and to provide to such

1 plan necessary medical information related to the
2 care provided.

3 “(3) The provider agrees otherwise to adhere to
4 such plan’s policies and procedures, including proce-
5 dures regarding referrals and obtaining prior au-
6 thorization and providing services pursuant to a
7 treatment plan (if any) approved by the plan.

8 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
9 tion shall be construed to require the coverage of benefits
10 which would not have been covered if the provider involved
11 remained a participating provider.

12 “(e) DEFINITION.—In this section, the term ‘health
13 care provider’ or ‘provider’ means—

14 “(1) any individual who is engaged in the deliv-
15 ery of health care services in a State and who is re-
16 quired by State law or regulation to be licensed or
17 certified by the State to engage in the delivery of
18 such services in the State; and

19 “(2) any entity that is engaged in the delivery
20 of health care services in a State and that, if it is
21 required by State law or regulation to be licensed or
22 certified by the State to engage in the delivery of
23 such services in the State, is so licensed.

1 “(f) COMPREHENSIVE STUDY OF COST, QUALITY
2 AND COORDINATION OF COVERAGE FOR PATIENTS AT
3 THE END OF LIFE.—

4 “(1) STUDY BY THE MEDICARE PAYMENT ADVI-
5 SORY COMMISSION.—The Medicare Payment Advi-
6 sory Commission shall conduct a study of the costs
7 and patterns of care for persons with serious and
8 complex conditions and the possibilities of improving
9 upon that care to the degree it is triggered by the
10 current category of terminally ill as such term is
11 used for purposes of section 1861(dd) of the Social
12 Security Act (relating to hospice benefits) or of uti-
13 lizing care in other payment settings in Medicare.

14 “(2) AGENCY FOR HEALTH CARE POLICY AND
15 RESEARCH.—The Agency for Health Care Policy
16 and Research shall conduct studies of the possible
17 thresholds for major conditions causing serious and
18 complex illness, their administrative parameters and
19 feasibility, and their impact upon costs and quality.

20 “(3) HEALTH CARE FINANCING ADMINISTRA-
21 TION.—The Health Care Financing Administration
22 shall conduct studies of the merits of applying simi-
23 lar thresholds in Medicare+Choice programs, includ-
24 ing adapting risk adjustment methods to account for
25 this category.

1 “(4) INITIAL REPORT.—

2 “(A) IN GENERAL.—Not later than 12
3 months after the date of enactment of this sec-
4 tion, the Medicare Payment Advisory Commis-
5 sion and the Agency for Health Care Policy and
6 Research shall each prepare and submit to the
7 Committee on Health, Education, Labor and
8 Pensions of the Senate a report concerning the
9 results of the studies conducted under para-
10 graphs (1) and (2), respectively.

11 “(B) COPY TO SECRETARY.—Concurrent
12 with the submission of the reports under sub-
13 paragraph (A), the Medicare Payment Advisory
14 Commission and the Agency for health Care
15 Policy and Research shall transmit a copy of
16 the reports under such subparagraph to the
17 Secretary.

18 “(5) FINAL REPORT.—

19 “(A) CONTRACT WITH INSTITUTE OF MED-
20 ICINE.—Not later than 1 year after the submis-
21 sion of the reports under paragraph (4), the
22 Secretary of Health and Human Services shall
23 contract with the Institute of Medicine to con-
24 duct a study of the practices and their effects

1 arising from the utilization of the category “se-
2 rious and complex” illness.

3 “(B) REPORT.—Not later than 1 year
4 after the date of the execution of the contract
5 referred to in subparagraph (A), the Institute
6 of Medicine shall prepare and submit to the
7 Committee on Health, Education, Labor and
8 Pensions of the Senate a report concerning the
9 study conducted pursuant to such contract.

10 “(6) FUNDING.—From funds appropriated to
11 the Department of Health and Human Services, the
12 Secretary of Health and Human Services shall make
13 available such funds as the Secretary determines is
14 necessary to carry out this subsection.

15 **“SEC. 9827. PROTECTION OF PATIENT-PROVIDER COMMU-**
16 **NICATIONS.**

17 “(a) IN GENERAL.—Subject to subsection (b), a
18 group health plan (other than a fully insured group health
19 plan and in relation to a participant or beneficiary) shall
20 not prohibit or otherwise restrict a health care professional
21 from advising such a participant or beneficiary who is a
22 patient of the professional about the health status of the
23 participant or beneficiary or medical care or treatment for
24 the condition or disease of the participant or beneficiary,
25 regardless of whether coverage for such care or treatment

1 are provided under the contract, if the professional is act-
 2 ing within the lawful scope of practice.

3 “(b) **RULE OF CONSTRUCTION.**—Nothing in this sec-
 4 tion shall be construed as requiring a group health plan
 5 (other than a fully insured group health plan) to provide
 6 specific benefits under the terms of such plan.

7 **“SEC. 9828. PATIENT’S RIGHT TO PRESCRIPTION DRUGS.**

8 “To the extent that a group health plan (other than
 9 a fully insured group health plan) provides coverage for
 10 benefits with respect to prescription drugs, and limits such
 11 coverage to drugs included in a formulary, the plan shall—

12 “(1) ensure the participation of physicians and
 13 pharmacists in developing and reviewing such for-
 14 mulary; and

15 “(2) in accordance with the applicable quality
 16 assurance and utilization review standards of the
 17 plan, provide for exceptions from the formulary limi-
 18 tation when a non-formulary alternative is medically
 19 necessary and appropriate.

20 **“SEC. 9829. SELF-PAYMENT FOR BEHAVIORAL HEALTH**
 21 **CARE SERVICES.**

22 “(a) **IN GENERAL.**—A group health plan (other than
 23 a fully insured group health plan) may not—

24 “(1) prohibit or otherwise discourage a partici-
 25 pant or beneficiary from self-paying for behavioral

1 health care services once the plan has denied cov-
 2 erage for such services; or

3 “(2) terminate a health care provider because
 4 such provider permits participants or beneficiaries to
 5 self-pay for behavioral health care services—

6 “(A) that are not otherwise covered under
 7 the plan; or

8 “(B) for which the group health plan pro-
 9 vides limited coverage, to the extent that the
 10 group health plan denies coverage of the serv-
 11 ices.

12 “(b) RULE OF CONSTRUCTION.—Nothing in sub-
 13 section (a)(2)(B) shall be construed as prohibiting a group
 14 health plan from terminating a contract with a health care
 15 provider for failure to meet applicable quality standards
 16 or for fraud.

17 **“SEC. 9830. COVERAGE FOR INDIVIDUALS PARTICIPATING**
 18 **IN APPROVED CANCER CLINICAL TRIALS.**

19 “(a) COVERAGE.—

20 “(1) IN GENERAL.—If a group health plan
 21 (other than a fully insured group health plan) pro-
 22 vides coverage to a qualified individual (as defined in
 23 subsection (b)), the plan—

1 “(A) may not deny the individual partici-
2 pation in the clinical trial referred to in sub-
3 section (b)(2);

4 “(B) subject to subsections (b), (c), and
5 (d) may not deny (or limit or impose additional
6 conditions on) the coverage of routine patient
7 costs for items and services furnished in con-
8 nection with participation in the trial; and

9 “(C) may not discriminate against the in-
10 dividual on the basis of the participant’s or
11 beneficiaries participation in such trial.

12 “(2) EXCLUSION OF CERTAIN COSTS.—For pur-
13 poses of paragraph (1)(B), routine patient costs do
14 not include the cost of the tests or measurements
15 conducted primarily for the purpose of the clinical
16 trial involved.

17 “(3) USE OF IN-NETWORK PROVIDERS.—If one
18 or more participating providers is participating in a
19 clinical trial, nothing in paragraph (1) shall be con-
20 strued as preventing a plan from requiring that a
21 qualified individual participate in the trial through
22 such a participating provider if the provider will ac-
23 cept the individual as a participant in the trial.

24 “(b) QUALIFIED INDIVIDUAL DEFINED.—For pur-
25 poses of subsection (a), the term “qualified individual”

1 means an individual who is a participant or beneficiary
2 in a group health plan and who meets the following condi-
3 tions:

4 “(1)(A) The individual has been diagnosed with
5 cancer for which no standard treatment is effective.

6 “(B) The individual is eligible to participate in
7 an approved clinical trial according to the trial pro-
8 tocol with respect to treatment of such illness.

9 “(C) The individual’s participation in the trial
10 offers meaningful potential for significant clinical
11 benefit for the individual.

12 “(2) Either—

13 “(A) the referring physician is a partici-
14 pating health care professional and has con-
15 cluded that the individual’s participation in
16 such trial would be appropriate based upon the
17 individual meeting the conditions described in
18 paragraph (1); or

19 “(B) the participant or beneficiary pro-
20 vides medical and scientific information estab-
21 lishing that the individual’s participation in
22 such trial would be appropriate based upon the
23 individual meeting the conditions described in
24 paragraph (1).

25 “(c) PAYMENT.—

1 “(1) IN GENERAL.—Under this section a group
 2 health plan (other than a fully insured group health
 3 plan) shall provide for payment for routine patient
 4 costs described in subsection (a)(2) but is not re-
 5 quired to pay for costs of items and services that are
 6 reasonably expected to be paid for by the sponsors
 7 of an approved clinical trial.

8 “(2) STANDARDS FOR DETERMINING ROUTINE
 9 PATIENT COSTS ASSOCIATED WITH CLINICAL TRIAL
 10 PARTICIPATION.—

11 “(A) IN GENERAL.—The Secretary shall
 12 establish, on an expedited basis and using a ne-
 13 gotiated rulemaking process under subchapter
 14 III of chapter 5 of title 5, United States Code,
 15 standards relating to the coverage of routine
 16 patient costs for individuals participating in
 17 clinical trials that group health plans must
 18 meet under this section.

19 “(B) FACTORS.—In establishing routine
 20 patient cost standards under subparagraph (A),
 21 the Secretary shall consult with interested par-
 22 ties and take into account —

23 “(i) quality of patient care;

24 “(ii) routine patient care costs versus
 25 costs associated with the conduct of clinical

1 trials, including unanticipated patient care
2 costs as a result of participation in clinical
3 trials; and

4 “(iii) previous and on-going studies
5 relating to patient care costs associated
6 with participation in clinical trials.

7 “(C) PUBLICATION OF NOTICE.—In car-
8 rying out the rulemaking process under this
9 paragraph, the Secretary, after consultation
10 with organizations representing cancer patients,
11 health care practitioners, medical researchers,
12 employers, group health plans, manufacturers
13 of drugs, biologics and medical devices, medical
14 economists, hospitals, and other interested par-
15 ties, shall publish notice provided for under sec-
16 tion 564(a) of title 5, United States Code, by
17 not later than 45 days after the date of the en-
18 actment of this section.

19 “(D) TARGET DATE FOR PUBLICATION OF
20 RULE.—As part of the notice under subpara-
21 graph (C), and for purposes of this paragraph,
22 the ‘target date for publication’ (referred to in
23 section 564(a)(5) of such title 5) shall be June
24 30, 2000.

1 “(E) ABBREVIATED PERIOD FOR SUBMIS-
 2 SION OF COMMENTS.—In applying section
 3 564(c) of such title 5 under this paragraph, ‘15
 4 days’ shall be substituted for ‘30 days’.

5 “(F) APPOINTMENT OF NEGOTIATED
 6 RULEMAKING COMMITTEE AND FACILITATOR.—
 7 The Secretary shall provide for—

8 “(i) the appointment of a negotiated
 9 rulemaking committee under section
 10 565(a) of such title 5 by not later than 30
 11 days after the end of the comment period
 12 provided for under section 564(c) of such
 13 title 5 (as shortened under subparagraph
 14 (E)), and

15 “(ii) the nomination of a facilitator
 16 under section 566(c) of such title 5 by not
 17 later than 10 days after the date of ap-
 18 pointment of the committee.

19 “(G) PRELIMINARY COMMITTEE RE-
 20 PORT.—The negotiated rulemaking committee
 21 appointed under subparagraph (F) shall report
 22 to the Secretary, by not later than March 29,
 23 2000, regarding the committee’s progress on
 24 achieving a consensus with regard to the rule-
 25 making proceeding and whether such consensus

1 is likely to occur before 1 month before the tar-
2 get date for publication of the rule. If the com-
3 mittee reports that the committee has failed to
4 make significant progress towards such con-
5 sensus or is unlikely to reach such consensus by
6 the target date, the Secretary may terminate
7 such process and provide for the publication of
8 a rule under this paragraph through such other
9 methods as the Secretary may provide.

10 “(H) FINAL COMMITTEE REPORT.—If the
11 committee is not terminated under subpara-
12 graph (G), the rulemaking committee shall sub-
13 mit a report containing a proposed rule by not
14 later than 1 month before the target date of
15 publication.

16 “(I) FINAL EFFECT.—The Secretary shall
17 publish a rule under this paragraph in the Fed-
18 eral Register by not later than the target date
19 of publication.

20 “(J) PUBLICATION OF RULE AFTER PUB-
21 LIC COMMENT.—The Secretary shall provide for
22 consideration of such comments and republica-
23 tion of such rule by not later than 1 year after
24 the target date of publication.

1 “(K) EFFECTIVE DATE.—The provisions of
 2 this paragraph shall apply to group health
 3 plans (other than a fully insured group health
 4 plan) for plan years beginning on or after Jan-
 5 uary 1, 2001.

6 “(3) PAYMENT RATE.—In the case of covered
 7 items and services provided by—

8 “(A) a participating provider, the payment
 9 rate shall be at the agreed upon rate, or

10 “(B) a nonparticipating provider, the pay-
 11 ment rate shall be at the rate the plan would
 12 normally pay for comparable services under
 13 subparagraph (A).

14 “(d) APPROVED CLINICAL TRIAL DEFINED.—

15 “(1) IN GENERAL.—In this section, the term
 16 ‘approved clinical trial’ means a cancer clinical re-
 17 search study or cancer clinical investigation ap-
 18 proved and funded (which may include funding
 19 through in-kind contributions) by one or more of the
 20 following:

21 “(A) The National Institutes of Health.

22 “(B) A cooperative group or center of the
 23 National Institutes of Health.

24 “(C) Either of the following if the condi-
 25 tions described in paragraph (2) are met:

1 “(i) The Department of Veterans Af-
2 fairs.

3 “(ii) The Department of Defense.

4 “(2) CONDITIONS FOR DEPARTMENTS.—The
5 conditions described in this paragraph, for a study
6 or investigation conducted by a Department, are
7 that the study or investigation has been reviewed
8 and approved through a system of peer review that
9 the Secretary determines—

10 “(A) to be comparable to the system of
11 peer review of studies and investigations used
12 by the National Institutes of Health, and

13 “(B) assures unbiased review of the high-
14 est scientific standards by qualified individuals
15 who have no interest in the outcome of the re-
16 view.

17 “(e) CONSTRUCTION.—Nothing in this section shall
18 be construed to limit a plan’s coverage with respect to clin-
19 ical trials.

20 “(f) PLAN SATISFACTION OF CERTAIN REQUIRE-
21 MENTS; RESPONSIBILITIES OF FIDUCIARIES.—

22 “(1) IN GENERAL.—For purposes of this sec-
23 tion, insofar as a group health plan provides benefits
24 in the form of health insurance coverage through a
25 health insurance issuer, the plan shall be treated as

1 meeting the requirements of this section with respect
2 to such benefits and not be considered as failing to
3 meet such requirements because of a failure of the
4 issuer to meet such requirements so long as the plan
5 sponsor or its representatives did not cause such
6 failure by the issuer.

7 “(2) CONSTRUCTION.—Nothing in this section
8 shall be construed to affect or modify the respon-
9 sibilities of the fiduciaries of a group health plan
10 under part 4 of subtitle B of title I of the Employee
11 Retirement Income Security Act of 1974.

12 “(g) STUDY AND REPORT.—

13 “(1) STUDY.—The Secretary shall study the
14 impact on group health plans for covering routine
15 patient care costs for individuals who are entitled to
16 benefits under this section and who are enrolled in
17 an approved cancer clinical trial program.

18 “(2) REPORT TO CONGRESS.—Not later than
19 January 1, 2005, the Secretary shall submit a re-
20 port to Congress that contains an assessment of—

21 “(A) any incremental cost to group health
22 plans resulting from the provisions of this sec-
23 tion;

24 “(B) a projection of expenditures to such
25 plans resulting from this section; and

1 “(C) any impact on premiums resulting
2 from this section.

3 **“SEC. 9830A. PROHIBITING DISCRIMINATION AGAINST PRO-**
4 **VIDERS.**

5 “(a) IN GENERAL.—A group health plan (other than
6 a fully insured group health plan) shall not discriminate
7 with respect to participation or indemnification as to any
8 provider who is acting within the scope of the provider’s
9 license or certification under applicable State law, solely
10 on the basis of such license or certification. This sub-
11 section shall not be construed as requiring the coverage
12 under a plan of particular benefits or services or to pro-
13 hibit a plan from including providers only to the extent
14 necessary to meet the needs of the plan’s participants and
15 beneficiaries or from establishing any measure designed
16 to maintain quality and control costs consistent with the
17 responsibilities of the plan.

18 “(b) NO REQUIREMENT FOR ANY WILLING PRO-
19 VIDER.—Nothing in this section shall be construed as re-
20 quiring a group health plan that offers network coverage
21 to include for participation every willing provider or health
22 professional who meets the terms and conditions of the
23 plan.

1 **“SEC. 9830B. GENERALLY APPLICABLE PROVISION.**

2 “In the case of a group health plan that provides ben-
3 efits under 2 or more coverage options, the requirements
4 of this subchapter shall apply separately with respect to
5 each coverage option.”.

6 (b) DEFINITION.—Section 9832(b) of the Internal
7 Revenue Code of 1986 is amended by adding at the end
8 the following:

9 “(4) FULLY INSURED GROUP HEALTH PLAN.—
10 The term ‘fully insured group health plan’ means a
11 group health plan where benefits under the plan are
12 provided pursuant to the terms of an arrangement
13 between a group health plan and a health insurance
14 issuer and are guaranteed by the health insurance
15 issuer under a contract or policy of insurance.”.

16 (c) CONFORMING AMENDMENT.—Chapter 98 of the
17 Internal Revenue Code of 1986 is amended in the table
18 of subchapters in the item relating to subchapter C, by
19 striking “Subchapter C” and inserting “Subchapter D”.

20 **SEC. 103. EFFECTIVE DATE AND RELATED RULES.**

21 (a) IN GENERAL.—The amendments made by this
22 subtitle shall apply with respect to plan years beginning
23 on or after January 1 of the second calendar year fol-
24 lowing the date of the enactment of this Act. The Sec-
25 retary shall issue all regulations necessary to carry out

1 the amendments made by this section before the effective
2 date thereof.

3 (b) LIMITATION ON ENFORCEMENT ACTIONS.—No
4 enforcement action shall be taken, pursuant to the amend-
5 ments made by this subtitle, against a group health plan
6 with respect to a violation of a requirement imposed by
7 such amendments before the date of issuance of regula-
8 tions issued in connection with such requirement, if the
9 plan has sought to comply in good faith with such require-
10 ment.

11 **Subtitle B—Right to Information** 12 **About Plans and Providers**

13 **SEC. 111. INFORMATION ABOUT PLANS.**

14 (a) EMPLOYEE RETIREMENT INCOME SECURITY ACT
15 OF 1974.—

16 (1) IN GENERAL.—Subpart B of part 7 of sub-
17 title B of title I of the Employee Retirement Income
18 Security Act of 1974 (29 U.S.C. 1185 et seq.) is
19 amended by adding at the end the following:

20 **“SEC. 714. HEALTH PLAN COMPARATIVE INFORMATION.**

21 **“(a) REQUIREMENT.—**

22 **“(1) IN GENERAL.—**A group health plan, and a
23 health insurance issuer that provides coverage in
24 connection with group health insurance coverage,
25 shall, not later than 12 months after the date of en-

1 actment of this section, and at least annually there-
2 after, provide for the disclosure, in a clear and accu-
3 rate form to each participant and each beneficiary
4 who does not reside at the same address as the par-
5 ticipant, or upon request to an individual eligible for
6 coverage under the plan, of the information de-
7 scribed in subsection (b).

8 “(2) RULE OF CONSTRUCTION.—Nothing in
9 this section shall be construed to prevent a plan or
10 issuer from entering into any agreement under
11 which the issuer agrees to assume responsibility for
12 compliance with the requirements of this section and
13 the plan is released from liability for such compli-
14 ance.

15 “(3) PROVISION OF INFORMATION.—Informa-
16 tion shall be provided to participants and bene-
17 ficiaries under this section at the address maintained
18 by the plan or issuer with respect to such partici-
19 pants or beneficiaries.

20 “(b) REQUIRED INFORMATION.—The informational
21 materials to be distributed under this section shall include
22 for each package option available under a group health
23 plan the following:

24 “(1) A description of the covered items and
25 services under each such plan and any in- and out-

1 of-network features of each such plan, including a
2 summary description of the specific exclusions from
3 coverage under the plan.

4 “(2) A description of any cost-sharing, includ-
5 ing premiums, deductibles, coinsurance, and copay-
6 ment amounts, for which the participant or bene-
7 ficiary will be responsible, including any annual or
8 lifetime limits on benefits, for each such plan.

9 “(3) A description of any optional supplemental
10 benefits offered by each such plan and the terms
11 and conditions (including premiums or cost-sharing)
12 for such supplemental coverage.

13 “(4) A description of any restrictions on pay-
14 ments for services furnished to a participant or ben-
15 eficiary by a health care professional that is not a
16 participating professional and the liability of the
17 participant or beneficiary for additional payments
18 for these services.

19 “(5) A description of the service area of each
20 such plan, including the provision of any out-of-area
21 coverage.

22 “(6) A description of the extent to which par-
23 ticipants and beneficiaries may select the primary
24 care provider of their choice, including providers
25 both within the network and outside the network of

1 each such plan (if the plan permits out-of-network
2 services).

3 “(7) A description of the procedures for ad-
4 vance directives and organ donation decisions if the
5 plan maintains such procedures.

6 “(8) A description of the requirements and pro-
7 cedures to be used to obtain preauthorization for
8 health services (including telephone numbers and
9 mailing addresses), including referrals for specialty
10 care.

11 “(9) A description of the definition of medical
12 necessity used in making coverage determinations by
13 each such plan.

14 “(10) A summary of the rules and methods for
15 appealing coverage decisions and filing grievances
16 (including telephone numbers and mailing address-
17 es), as well as other available remedies.

18 “(11) A summary description of any provisions
19 for obtaining off-formulary medications if the plan
20 utilizes a defined formulary for providing specific
21 prescription medications.

22 “(12) A summary of the rules for access to
23 emergency room care. Also, any available edu-
24 cational material regarding proper use of emergency
25 services.

1 “(13) A description of whether or not coverage
2 is provided for experimental treatments, investiga-
3 tional treatments, or clinical trials and the cir-
4 cumstances under which access to such treatments
5 or trials is made available.

6 “(14) A description of the specific preventative
7 services covered under the plan if such services are
8 covered.

9 “(15) A statement regarding—

10 “(A) the manner in which a participant or
11 beneficiary may access an obstetrician, gyne-
12 cologist, or pediatrician in accordance with sec-
13 tion 723 or 724; and

14 “(B) the manner in which a participant or
15 beneficiary obtains continuity of care as pro-
16 vided for in section 726.

17 “(16) A statement that the following informa-
18 tion, and instructions on obtaining such information
19 (including telephone numbers and, if available,
20 Internet websites), shall be made available upon re-
21 quest:

22 “(A) The names, addresses, telephone
23 numbers, and State licensure status of the
24 plan’s participating health care professionals
25 and participating health care facilities, and, if

1 available, the education, training, specialty
2 qualifications or certifications of such profes-
3 sionals.

4 “(B) A summary description of the meth-
5 ods used for compensating participating health
6 care professionals, such as capitation, fee-for-
7 service, salary, or a combination thereof. The
8 requirement of this subparagraph shall not be
9 construed as requiring plans to provide infor-
10 mation concerning proprietary payment meth-
11 odology.

12 “(C) A summary description of the meth-
13 ods used for compensating health care facilities,
14 including per diem, fee-for-service, capitation,
15 bundled payments, or a combination thereof.
16 The requirement of this subparagraph shall not
17 be construed as requiring plans to provide in-
18 formation concerning proprietary payment
19 methodology.

20 “(D) A summary description of the proce-
21 dures used for utilization review.

22 “(E) The list of the specific prescription
23 medications included in the formulary of the
24 plan, if the plan uses a defined formulary.

1 “(F) A description of the specific exclu-
2 sions from coverage under the plan.

3 “(G) Any available information related to
4 the availability of translation or interpretation
5 services for non-English speakers and people
6 with communication disabilities, including the
7 availability of audio tapes or information in
8 Braille.

9 “(H) Any information that is made public
10 by accrediting organizations in the process of
11 accreditation if the plan is accredited, or any
12 additional quality indicators that the plan
13 makes available.

14 “(c) MANNER OF DISTRIBUTION.—The information
15 described in this section shall be distributed in an acces-
16 sible format that is understandable to an average plan
17 participant or beneficiary.

18 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
19 tion may be construed to prohibit a group health plan,
20 or health insurance issuer in connection with group health
21 insurance coverage, from distributing any other additional
22 information determined by the plan or issuer to be impor-
23 tant or necessary in assisting participants and bene-
24 ficiaries or upon request potential participants and bene-
25 ficiaries in the selection of a health plan or from providing

1 information under subsection (b)(15) as part of the re-
 2 quired information.

3 “(e) CONFORMING REGULATIONS.—The Secretary
 4 shall issue regulations to coordinate the requirements on
 5 group health plans and health insurance issuers under this
 6 section with the requirements imposed under part 1, to
 7 reduce duplication with respect to any information that
 8 is required to be provided under any such requirements.

9 “(f) HEALTH CARE PROFESSIONAL.—In this section,
 10 the term ‘health care professional’ means a physician (as
 11 defined in section 1861(r) of the Social Security Act) or
 12 other health care professional if coverage for the profes-
 13 sional’s services is provided under the health plan involved
 14 for the services of the professional. Such term includes a
 15 podiatrist, optometrist, chiropractor, psychologist, dentist,
 16 physician assistant, physical or occupational therapist and
 17 therapy assistant, speech-language pathologist, audiol-
 18 ogist, registered or licensed practical nurse (including
 19 nurse practitioner, clinical nurse specialist, certified reg-
 20 istered nurse anesthetist, and certified nurse-midwife), li-
 21 censed certified social worker, registered respiratory thera-
 22 pist, and certified respiratory therapy technician.”.

23 (2) CONFORMING AMENDMENTS.—

24 (A) Section 732(a) of the Employee Retirement
 25 ment Income Security Act of 1974 (29 U.S.C.

1 1191a(a)) is amended by striking “section 711,
2 and inserting “sections 711 and 714”.

3 (B) The table of contents in section 1 of
4 the Employee Retirement Income Security Act
5 of 1974 (29 U.S.C. 1001) is amended by insert-
6 ing after the item relating to section 713, the
7 following:

“Sec. 714. Health plan comparative information.”.

8 (b) INTERNAL REVENUE CODE OF 1986.—Sub-
9 chapter B of chapter 100 of the Internal Revenue Code
10 of 1986 is amended—

11 (1) in the table of sections, by inserting after
12 the item relating to section 9812 the following new
13 item:

“Sec. 9813. Health plan comparative information.”;

14 and

15 (2) by inserting after section 9812 the fol-
16 lowing:

17 **“SEC. 9813. HEALTH PLAN COMPARATIVE INFORMATION.**

18 **“(a) REQUIREMENT.—**

19 **“(1) IN GENERAL.—**A group health plan shall,
20 not later than 12 months after the date of enact-
21 ment of this section, and at least annually there-
22 after, provide for the disclosure, in a clear and accu-
23 rate form to each participant and each beneficiary
24 who does not reside at the same address as the par-

1 ticipant, or upon request to an individual eligible for
2 coverage under the plan, of the information de-
3 scribed in subsection (b).

4 “(2) RULES OF CONSTRUCTION.—Nothing in
5 this section shall be construed to prevent a plan
6 from entering into any agreement under which a
7 health insurance issuer agrees to assume responsi-
8 bility for compliance with the requirements of this
9 section and the plan is released from liability for
10 such compliance.

11 “(3) PROVISION OF INFORMATION.—Informa-
12 tion shall be provided to participants and bene-
13 ficiaries under this section at the address maintained
14 by the plan with respect to such participants or
15 beneficiaries.

16 “(b) REQUIRED INFORMATION.—The informational
17 materials to be distributed under this section shall include
18 for each package option available under a group health
19 plan the following:

20 “(1) A description of the covered items and
21 services under each such plan and any in- and out-
22 of-network features of each such plan, including a
23 summary description of the specific exclusions from
24 coverage under the plan.

1 “(2) A description of any cost-sharing, includ-
2 ing premiums, deductibles, coinsurance, and copay-
3 ment amounts, for which the participant or bene-
4 ficiary will be responsible, including any annual or
5 lifetime limits on benefits, for each such plan.

6 “(3) A description of any optional supplemental
7 benefits offered by each such plan and the terms
8 and conditions (including premiums or cost-sharing)
9 for such supplemental coverage.

10 “(4) A description of any restrictions on pay-
11 ments for services furnished to a participant or ben-
12 eficiary by a health care professional that is not a
13 participating professional and the liability of the
14 participant or beneficiary for additional payments
15 for these services.

16 “(5) A description of the service area of each
17 such plan, including the provision of any out-of-area
18 coverage.

19 “(6) A description of the extent to which par-
20 ticipants and beneficiaries may select the primary
21 care provider of their choice, including providers
22 both within the network and outside the network of
23 each such plan (if the plan permits out-of-network
24 services).

1 “(7) A description of the procedures for ad-
2 vance directives and organ donation decisions if the
3 plan maintains such procedures.

4 “(8) A description of the requirements and pro-
5 cedures to be used to obtain preauthorization for
6 health services (including telephone numbers and
7 mailing addresses), including referrals for specialty
8 care.

9 “(9) A description of the definition of medical
10 necessity used in making coverage determinations by
11 each such plan.

12 “(10) A summary of the rules and methods for
13 appealing coverage decisions and filing grievances
14 (including telephone numbers and mailing address-
15 es), as well as other available remedies.

16 “(11) A summary description of any provisions
17 for obtaining off-formulary medications if the plan
18 utilizes a defined formulary for providing specific
19 prescription medications.

20 “(12) A summary of the rules for access to
21 emergency room care. Also, any available edu-
22 cational material regarding proper use of emergency
23 services.

24 “(13) A description of whether or not coverage
25 is provided for experimental treatments, investiga-

1 tional treatments, or clinical trials and the cir-
2 cumstances under which access to such treatments
3 or trials is made available.

4 “(14) A description of the specific preventative
5 services covered under the plan if such services are
6 covered.

7 “(15) A statement regarding—

8 “(A) the manner in which a participant or
9 beneficiary may access an obstetrician, gyne-
10 cologist, or pediatrician in accordance with sec-
11 tion 723 or 724; and

12 “(B) the manner in which a participant or
13 beneficiary obtains continuity of care as pro-
14 vided for in section 726.

15 “(16) A statement that the following informa-
16 tion, and instructions on obtaining such information
17 (including telephone numbers and, if available,
18 Internet websites), shall be made available upon re-
19 quest:

20 “(A) The names, addresses, telephone
21 numbers, and State licensure status of the
22 plan’s participating health care professionals
23 and participating health care facilities, and, if
24 available, the education, training, specialty

1 qualifications or certifications of such profes-
2 sionals.

3 “(B) A summary description of the meth-
4 ods used for compensating participating health
5 care professionals, such as capitation, fee-for-
6 service, salary, or a combination thereof. The
7 requirement of this subparagraph shall not be
8 construed as requiring plans to provide infor-
9 mation concerning proprietary payment meth-
10 odology.

11 “(C) A summary description of the meth-
12 ods used for compensating health care facilities,
13 including per diem, fee-for-service, capitation,
14 bundled payments, or a combination thereof.
15 The requirement of this subparagraph shall not
16 be construed as requiring plans to provide in-
17 formation concerning proprietary payment
18 methodology.

19 “(D) A summary description of the proce-
20 dures used for utilization review.

21 “(E) The list of the specific prescription
22 medications included in the formulary of the
23 plan, if the plan uses a defined formulary.

24 “(F) A description of the specific exclu-
25 sions from coverage under the plan.

1 “(G) Any available information related to
2 the availability of translation or interpretation
3 services for non-English speakers and people
4 with communication disabilities, including the
5 availability of audio tapes or information in
6 Braille.

7 “(H) Any information that is made public
8 by accrediting organizations in the process of
9 accreditation if the plan is accredited, or any
10 additional quality indicators that the plan
11 makes available.

12 “(c) MANNER OF DISTRIBUTION.—The information
13 described in this section shall be distributed in an acces-
14 sible format that is understandable to an average plan
15 participant or beneficiary.

16 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
17 tion may be construed to prohibit a group health plan
18 from distributing any other additional information deter-
19 mined by the plan to be important or necessary in assist-
20 ing participants and beneficiaries or upon request poten-
21 tial participants and beneficiaries in the selection of a
22 health plan or from providing information under sub-
23 section (b)(15) as part of the required information.

24 “(e) HEALTH CARE PROFESSIONAL.—In this section,
25 the term ‘health care professional’ means a physician (as

1 defined in section 1861(r) of the Social Security Act) or
 2 other health care professional if coverage for the profes-
 3 sional's services is provided under the health plan involved
 4 for the services of the professional. Such term includes a
 5 podiatrist, optometrist, chiropractor, psychologist, dentist,
 6 physician assistant, physical or occupational therapist and
 7 therapy assistant, speech-language pathologist, audiol-
 8 ogist, registered or licensed practical nurse (including
 9 nurse practitioner, clinical nurse specialist, certified reg-
 10 istered nurse anesthetist, and certified nurse-midwife), li-
 11 censed certified social worker, registered respiratory thera-
 12 pist, and certified respiratory therapy technician.”.

13 **SEC. 112. INFORMATION ABOUT PROVIDERS.**

14 (a) STUDY.—The Secretary of Health and Human
 15 Services shall enter into a contract with the Institute of
 16 Medicine for the conduct of a study, and the submission
 17 to the Secretary of a report, that includes—

18 (1) an analysis of information concerning health
 19 care professionals that is currently available to pa-
 20 tients, consumers, States, and professional societies,
 21 nationally and on a State-by-State basis, including
 22 patient preferences with respect to information
 23 about such professionals and their competencies;

1 (2) an evaluation of the legal and other barriers
 2 to the sharing of information concerning health care
 3 professionals; and

4 (3) recommendations for the disclosure of infor-
 5 mation on health care professionals, including the
 6 competencies and professional qualifications of such
 7 practitioners, to better facilitate patient choice, qual-
 8 ity improvement, and market competition.

9 (b) REPORT.—Not later than 18 months after the
 10 date of enactment of this Act, the Secretary of Health and
 11 Human Services shall forward to the appropriate commit-
 12 tees of Congress a copy of the report and study conducted
 13 under subsection (a).

14 **Subtitle C—Right to Hold Health** 15 **Plans Accountable**

16 **SEC. 121. AMENDMENT TO EMPLOYEE RETIREMENT IN-** 17 **COME SECURITY ACT OF 1974.**

18 (a) IN GENERAL.—Section 503 of the Employee Re-
 19 tirement Income Security Act of 1974 (29 U.S.C. 1133)
 20 is amended to read as follows:

21 **“SEC. 503. CLAIMS PROCEDURE, COVERAGE DETERMINA-** 22 **TION, GRIEVANCES AND APPEALS.**

23 “(a) CLAIMS PROCEDURE.—In accordance with regu-
 24 lations of the Secretary, every employee benefit plan
 25 shall—

1 “(1) provide adequate notice in writing to any
 2 participant or beneficiary whose claim for benefits
 3 under the plan has been denied, setting forth the
 4 specific reasons for such denial, written in a manner
 5 calculated to be understood by the participant; and

6 “(2) afford a reasonable opportunity to any
 7 participant whose claim for benefits has been denied
 8 for a full and fair review by the appropriate named
 9 fiduciary of the decision denying the claim.

10 “(b) COVERAGE DETERMINATIONS UNDER GROUP
 11 HEALTH PLANS.—

12 “(1) PROCEDURES.—

13 “(A) IN GENERAL.—A group health plan
 14 or health insurance issuer conducting utilization
 15 review shall ensure that procedures are in place
 16 for—

17 “(i) making determinations regarding
 18 whether a participant or beneficiary is eli-
 19 gible to receive a payment or coverage for
 20 health services under the plan or coverage
 21 involved and any cost-sharing amount that
 22 the participant or beneficiary is required to
 23 pay with respect to such service;

24 “(ii) notifying a covered participant or
 25 beneficiary (or the authorized representa-

1 tive of such participant or beneficiary) and
2 the treating health care professionals in-
3 volved regarding determinations made
4 under the plan or issuer and any addi-
5 tional payments that the participant or
6 beneficiary may be required to make with
7 respect to such service; and

8 “(iii) responding to requests, either
9 written or oral, for coverage determina-
10 tions or for internal appeals from a partici-
11 pant or beneficiary (or the authorized rep-
12 resentative of such participant or bene-
13 ficiary) or the treating health care profes-
14 sional with the consent of the participant
15 or beneficiary.

16 “(B) ORAL REQUESTS.—With respect to
17 an oral request described in subparagraph
18 (A)(iii), a group health plan or health insurance
19 issuer may require that the requesting indi-
20 vidual provide written evidence of such request.

21 “(2) TIMELINE FOR MAKING DETERMINA-
22 TIONS.—

23 “(A) ROUTINE DETERMINATION.—A group
24 health plan or a health insurance issuer shall
25 maintain procedures to ensure that prior au-

1 thorization determinations concerning the provi-
2 sion of non-emergency items or services are
3 made within 30 days from the date on which
4 the request for a determination is submitted,
5 except that such period may be extended where
6 certain circumstances exist that are determined
7 by the Secretary to be beyond control of the
8 plan or issuer.

9 “(B) EXPEDITED DETERMINATION.—

10 “(i) IN GENERAL.—A prior authoriza-
11 tion determination under this subsection
12 shall be made within 72 hours, in accord-
13 ance with the medical exigencies of the
14 case, after a request is received by the plan
15 or issuer under clause (ii) or (iii).

16 “(ii) REQUEST BY PARTICIPANT OR
17 BENEFICIARY.—A plan or issuer shall
18 maintain procedures for expediting a prior
19 authorization determination under this
20 subsection upon the request of a partici-
21 pant or beneficiary if, based on such a re-
22 quest, the plan or issuer determines that
23 the normal time for making such a deter-
24 mination could seriously jeopardize the life
25 or health of the participant or beneficiary.

1 “(iii) DOCUMENTATION BY HEALTH
2 CARE PROFESSIONAL.—A plan or issuer
3 shall maintain procedures for expediting a
4 prior authorization determination under
5 this subsection if the request involved indi-
6 cates that the treating health care profes-
7 sional has reasonably documented, based
8 on the medical exigencies, that a deter-
9 mination under the procedures described in
10 subparagraph (A) could seriously jeop-
11 ardize the life or health of the participant
12 or beneficiary.

13 “(C) CONCURRENT DETERMINATIONS.—A
14 plan or issuer shall maintain procedures to cer-
15 tify or deny coverage of an extended stay or ad-
16 ditional services.

17 “(D) RETROSPECTIVE DETERMINATION.—
18 A plan or issuer shall maintain procedures to
19 ensure that, with respect to the retrospective re-
20 view of a determination made under paragraph
21 (1), the determination shall be made within 30
22 working days of the date on which the plan or
23 issuer receives necessary information.

24 “(3) NOTICE OF DETERMINATIONS.—

1 “(A) ROUTINE DETERMINATION.—With re-
2 spect to a coverage determination of a plan or
3 issuer under paragraph (2)(A), the plan or
4 issuer shall issue notice of such determination
5 to the participant or beneficiary (or the author-
6 ized representative of the participant or bene-
7 ficiary) and, consistent with the medical exigen-
8 cies of the case, to the treating health care pro-
9 fessional involved not later than 2 working days
10 after the date on which the determination is
11 made.

12 “(B) EXPEDITED DETERMINATION.—With
13 respect to a coverage determination of a plan or
14 issuer under paragraph (2)(B), the plan or
15 issuer shall issue notice of such determination
16 to the participant or beneficiary (or the author-
17 ized representative of the participant or bene-
18 ficiary), and consistent with the medical exigen-
19 cies of the case, to the treating health care pro-
20 fessional involved within the 72 hour period de-
21 scribed in paragraph (2)(B).

22 “(C) CONCURRENT REVIEWS.—With re-
23 spect to the determination under a plan or
24 issuer under paragraph (2)(C) to certify or
25 deny coverage of an extended stay or additional

1 services, the plan or issuer shall issue notice of
2 such determination to the treating health care
3 professional and to the participant or bene-
4 ficiary involved (or the authorized representa-
5 tive of the participant or beneficiary) within 1
6 working day of the determination.

7 “(D) RETROSPECTIVE REVIEWS.—With re-
8 spect to the retrospective review under a plan
9 or issuer of a determination made under para-
10 graph (2)(D), the plan or issuer shall issue
11 written notice of an approval or disapproval of
12 a determination under this subparagraph to the
13 participant or beneficiary (or the authorized
14 representative of the participant or beneficiary)
15 and health care provider involved within 5
16 working days of the date on which such deter-
17 mination is made.

18 “(E) REQUIREMENTS OF NOTICE OF AD-
19 VERSE COVERAGE DETERMINATIONS.—A writ-
20 ten notice of an adverse coverage determination
21 under this subsection, or of an expedited ad-
22 verse coverage determination under paragraph
23 (2)(B), shall be provided to the participant or
24 beneficiary (or the authorized representative of
25 the participant or beneficiary) and treating

1 health care professional (if any) involved and
2 shall include—

3 “(i) the reasons for the determination
4 (including the clinical or scientific-evidence
5 based rationale used in making the deter-
6 mination) written in a manner to be under-
7 standable to the average participant or
8 beneficiary;

9 “(ii) the procedures for obtaining ad-
10 ditional information concerning the deter-
11 mination; and

12 “(iii) notification of the right to ap-
13 peal the determination and instructions on
14 how to initiate an appeal in accordance
15 with subsection (d).

16 “(c) GRIEVANCES.—A group health plan or a health
17 insurance issuer shall have written procedures for address-
18 ing grievances between the plan or issuer offering health
19 insurance coverage in connection with a group health plan
20 and a participant or beneficiary. Determinations under
21 such procedures shall be non-appealable.

22 “(d) INTERNAL APPEAL OF COVERAGE DETERMINA-
23 TIONS.—

24 “(1) RIGHT TO APPEAL.—

1 “(A) IN GENERAL.—A participant or bene-
2 ficiary (or the authorized representative of the
3 participant or beneficiary) or the treating
4 health care professional with the consent of the
5 participant or beneficiary (or the authorized
6 representative of the participant or beneficiary),
7 may appeal any adverse coverage determination
8 under subsection (b) under the procedures de-
9 scribed in this subsection.

10 “(B) TIME FOR APPEAL.—A plan or issuer
11 shall ensure that a participant or beneficiary
12 has a period of not less than 180 days begin-
13 ning on the date of an adverse coverage deter-
14 mination under subsection (b) in which to ap-
15 peal such determination under this subsection.

16 “(C) FAILURE TO ACT.—The failure of a
17 plan or issuer to issue a determination under
18 subsection (b) within the applicable timeline es-
19 tablished for such a determination under such
20 subsection shall be treated as an adverse cov-
21 erage determination for purposes of proceeding
22 to internal review under this subsection.

23 “(2) RECORDS.—A group health plan and a
24 health insurance issuer shall maintain written
25 records, for at least 6 years, with respect to any ap-

1 peal under this subsection for purposes of internal
2 quality assurance and improvement. Nothing in the
3 preceding sentence shall be construed as preventing
4 a plan and issuer from entering into an agreement
5 under which the issuer agrees to assume responsi-
6 bility for compliance with the requirements of this
7 section and the plan is released from liability for
8 such compliance.

9 “(3) ROUTINE DETERMINATIONS.—A group
10 health plan or a health insurance issuer shall com-
11 plete the consideration of an appeal of an adverse
12 routine determination under this subsection not later
13 than 30 working days after the date on which a re-
14 quest for such appeal is received.

15 “(4) EXPEDITED DETERMINATION.—

16 “(A) IN GENERAL.—An expedited deter-
17 mination with respect to an appeal under this
18 subsection shall be made in accordance with the
19 medical exigencies of the case, but in no case
20 more than 72 hours after the request for such
21 appeal is received by the plan or issuer under
22 subparagraph (B) or (C).

23 “(B) REQUEST BY PARTICIPANT OR BENE-
24 FICIARY.—A plan or issuer shall maintain pro-
25 cedures for expediting a prior authorization de-

1 termination under this subsection upon the re-
2 quest of a participant or beneficiary if, based on
3 such a request, the plan or issuer determines
4 that the normal time for making such a deter-
5 mination could seriously jeopardize the life or
6 health of the participant or beneficiary.

7 “(C) DOCUMENTATION BY HEALTH CARE
8 PROFESSIONAL.—A plan or issuer shall main-
9 tain procedures for expediting a prior author-
10 ization determination under this subsection if
11 the request involved indicates that the treating
12 health care professional has reasonably docu-
13 mented, based on the medical exigencies of the
14 case that a determination under the procedures
15 described in paragraph (2) could seriously jeop-
16 ardize the life or health of the participant or
17 beneficiary.

18 “(5) CONDUCT OF REVIEW.—A review of an ad-
19 verse coverage determination under this subsection
20 shall be conducted by an individual with appropriate
21 expertise who was not directly involved in the initial
22 determination.

23 “(6) LACK OF MEDICAL NECESSITY.—A review
24 of an appeal under this subsection relating to a de-
25 termination to deny coverage based on a lack of

1 medical necessity and appropriateness, or based on
2 an experimental or investigational treatment, shall
3 be made only by a physician with appropriate exper-
4 tise, including age-appropriate expertise, who was
5 not involved in the initial determination.

6 “(7) NOTICE.—

7 “(A) IN GENERAL.—Written notice of a
8 determination made under an internal review
9 process shall be issued to the participant or
10 beneficiary (or the authorized representative of
11 the participant or beneficiary) and the treating
12 health care professional not later than 2 work-
13 ing days after the completion of the review (or
14 within the 72-hour period referred to in para-
15 graph (4) if applicable).

16 “(B) ADVERSE COVERAGE DETERMINA-
17 TIONS.—With respect to an adverse coverage
18 determination made under this subsection, the
19 notice described in subparagraph (A) shall
20 include—

21 “(i) the reasons for the determination
22 (including the clinical or scientific-evidence
23 based rationale used in making the deter-
24 mination) written in a manner to be under-

1 standable to the average participant or
2 beneficiary;

3 “(ii) the procedures for obtaining ad-
4 ditional information concerning the deter-
5 mination; and

6 “(iii) notification of the right to an
7 independent external review under sub-
8 section (e) and instructions on how to ini-
9 tiate such a review.

10 “(e) INDEPENDENT EXTERNAL REVIEW.—

11 “(1) ACCESS TO REVIEW.—

12 “(A) IN GENERAL.—A group health plan
13 or a health insurance issuer offering health in-
14 surance coverage in connection with a group
15 health plan shall have written procedures to
16 permit a participant or beneficiary (or the au-
17 thorized representative of the participant or
18 beneficiary) access to an independent external
19 review with respect to an adverse coverage de-
20 termination concerning a particular item or
21 service (including a circumstance treated as an
22 adverse coverage determination under subpara-
23 graph (B)) where—

24 “(i) the particular item or service
25 involved—

1 “(I)(aa) would be a covered ben-
2 efit, when medically necessary and ap-
3 propriate under the terms and condi-
4 tions of the plan, and the item or
5 service has been determined not to be
6 medically necessary and appropriate
7 under the internal appeals process re-
8 quired under subsection (d) or there
9 has been a failure to issue a coverage
10 determination as described in sub-
11 paragraph (B); and

12 “(bb)(AA) the amount of such
13 item or service involved exceeds a sig-
14 nificant financial threshold; or

15 “(BB) there is a significant risk
16 of placing the life or health of the
17 participant or beneficiary in jeopardy;
18 or

19 “(II) would be a covered benefit,
20 when not considered experimental or
21 investigational under the terms and
22 conditions of the plan, and the item or
23 service has been determined to be ex-
24 perimental or investigational under
25 the internal appeals process required

1 under subsection (d) or there has been
2 a failure to issue a coverage deter-
3 mination as described in subpara-
4 graph (B); and

5 “(ii) the participant or beneficiary has
6 completed the internal appeals process
7 under subsection (d) with respect to such
8 determination.

9 “(B) FAILURE TO ACT.—The failure of a
10 plan or issuer to issue a coverage determination
11 under subsection (d)(6) within the applicable
12 timeline established for such a determination
13 under such subsection shall be treated as an ad-
14 verse coverage determination for purposes of
15 proceeding to independent external review
16 under this subsection.

17 “(2) INITIATION OF THE INDEPENDENT EXTER-
18 NAL REVIEW PROCESS.—

19 “(A) FILING OF REQUEST.—A participant
20 or beneficiary (or the authorized representative
21 of the participant or beneficiary) who desires to
22 have an independent external review conducted
23 under this subsection shall file a written request
24 for such a review with the plan or issuer in-
25 volved not later than 30 working days after the

1 receipt of a final denial of a claim under sub-
2 section (d). Any such request shall include the
3 consent of the participant or beneficiary (or the
4 authorized representative of the participant or
5 beneficiary) for the release of medical informa-
6 tion and records to independent external review-
7 ers regarding the participant or beneficiary.

8 “(B) TIMEFRAME FOR SELECTION OF AP-
9 PEALS ENTITY.—Not later than 5 working days
10 after the receipt of a request under subpara-
11 graph (A), or earlier in accordance with the
12 medical exigencies of the case, the plan or
13 issuer involved shall—

14 “(i) select an external appeals entity
15 under paragraph (3)(A) that shall be re-
16 sponsible for designating an independent
17 external reviewer under paragraph (3)(B);
18 and

19 “(ii) provide notice of such selection
20 to the participant or beneficiary (which
21 shall include the name and address of the
22 entity).

23 “(C) PROVISION OF INFORMATION.—Not
24 later than 5 working days after the plan or
25 issuer provides the notice required under sub-

1 paragraph (B)(ii), or earlier in accordance with
2 the medical exigencies of the case, the plan,
3 issuer, participant, beneficiary or physician (of
4 the participant or beneficiary) involved shall
5 forward necessary information (including, only
6 in the case of a plan or issuer, medical records,
7 any relevant review criteria, the clinical ration-
8 ale consistent with the terms and conditions of
9 the contract between the plan or issuer and the
10 participant or beneficiary for the coverage de-
11 nial, and evidence of the coverage of the partici-
12 pant or beneficiary) to the qualified external
13 appeals entity designated under paragraph
14 (3)(A).

15 “(D) FOLLOW-UP WRITTEN NOTIFICA-
16 TION.—The plan or issuer involved shall send a
17 follow-up written notification, in a timely man-
18 ner, to the participant or beneficiary (or the au-
19 thorized representative of the participant or
20 beneficiary) and the plan administrator, indi-
21 cating that an independent external review has
22 been initiated.

23 “(3) CONDUCT OF INDEPENDENT EXTERNAL
24 REVIEW.—

1 “(A) DESIGNATION OF EXTERNAL AP-
2 PEALS ENTITY BY PLAN OR ISSUER.—

3 “(i) IN GENERAL.—A plan or issuer
4 that receives a request for an independent
5 external review under paragraph (2)(A)
6 shall designate a qualified entity described
7 in clause (ii), in a manner designed to en-
8 sure that the entity so designated will
9 make a decision in an unbiased manner, to
10 serve as the external appeals entity.

11 “(ii) QUALIFIED ENTITIES.—A quali-
12 fied entity shall be—

13 “(I) an independent external re-
14 view entity licensed or credentialed by
15 a State;

16 “(II) a State agency established
17 for the purpose of conducting inde-
18 pendent external reviews;

19 “(III) any entity under contract
20 with the Federal Government to pro-
21 vide independent external review serv-
22 ices;

23 “(IV) any entity accredited as an
24 independent external review entity by

1 an accrediting body recognized by the
2 Secretary for such purpose; or

3 “(V) any other entity meeting
4 criteria established by the Secretary
5 for purposes of this subparagraph.

6 “(B) DESIGNATION OF INDEPENDENT EX-
7 TERNAL REVIEWER BY EXTERNAL APPEALS EN-
8 TITY.—The external appeals entity designated
9 under subparagraph (A) shall, not later than 30
10 days after the date on which such entity is des-
11 ignated under subparagraph (A), or earlier in
12 accordance with the medical exigencies of the
13 case, designate one or more individuals to serve
14 as independent external reviewers with respect
15 to a request received under paragraph (2)(A).
16 Such reviewers shall be independent medical ex-
17 perts who shall—

18 “(i) be appropriately credentialed or
19 licensed in any State to deliver health care
20 services;

21 “(ii) not have any material, profes-
22 sional, familial, or financial affiliation with
23 the case under review, the participant or
24 beneficiary involved, the treating health
25 care professional, the institution where the

1 treatment would take place, or the manu-
2 facturer of any drug, device, procedure, or
3 other therapy proposed for the participant
4 or beneficiary whose treatment is under re-
5 view;

6 “(iii) have expertise (including age-ap-
7 propriate expertise) in the diagnosis or
8 treatment under review and be a physician
9 of the same specialty, when reasonably
10 available, as the physician treating the par-
11 ticipant or beneficiary or recommending or
12 prescribing the treatment in question;

13 “(iv) receive only reasonable and cus-
14 tomary compensation from the group
15 health plan or health insurance issuer in
16 connection with the independent external
17 review that is not contingent on the deci-
18 sion rendered by the reviewer; and

19 “(v) not be held liable for decisions re-
20 garding medical determinations (but may
21 be held liable for actions that are arbitrary
22 and capricious).

23 “(4) STANDARD OF REVIEW.—

24 “(A) IN GENERAL.—An independent exter-
25 nal reviewer shall—

1 “(i) make an independent determina-
2 tion based on the valid, relevant, scientific
3 and clinical evidence to determine the med-
4 ical necessity, appropriateness, experi-
5 mental or investigational nature of the pro-
6 posed treatment; and

7 “(ii) take into consideration appro-
8 priate and available information, including
9 any evidence-based decision making or clin-
10 ical practice guidelines used by the group
11 health plan or health insurance issuer;
12 timely evidence or information submitted
13 by the plan, issuer, patient or patient’s
14 physician; the patient’s medical record; ex-
15 pert consensus including both generally ac-
16 cepted medical practice and recognized
17 best practice; medical literature as defined
18 in section 556(5) of the Federal Food,
19 Drug, and Cosmetic Act; the following
20 standard reference compendia: The Amer-
21 ican Hospital Formulary Service-Drug In-
22 formation, the American Dental Associa-
23 tion Accepted Dental Therapeutics, and
24 the United States Pharmacopoeia-Drug In-
25 formation; and findings, studies, or re-

1 search conducted by or under the auspices
2 of Federal Government agencies and na-
3 tionally recognized Federal research insti-
4 tutes including the Agency for Healthcare
5 Research and Quality, National Institutes
6 of Health, National Academy of Sciences,
7 Health Care Financing Administration,
8 and any national board recognized by the
9 National Institutes of Health for the pur-
10 poses of evaluating the medical value of
11 health services.

12 “(B) NOTICE.—The plan or issuer involved
13 shall ensure that the participant or beneficiary
14 receives notice, within 30 days after the deter-
15 mination of the independent medical expert, re-
16 garding the actions of the plan or issuer with
17 respect to the determination of such expert
18 under the independent external review.

19 “(5) TIMEFRAME FOR REVIEW.—

20 “(A) IN GENERAL.—The independent ex-
21 ternal reviewer shall complete a review of an
22 adverse coverage determination in accordance
23 with the medical exigencies of the case.

24 “(B) EXPEDITED REVIEW.—Notwith-
25 standing subparagraph (A), a review described

1 in such subparagraph shall be completed not
 2 later than 72 hours after the later of—

3 “(i) the date on which such reviewer
 4 is designated; or

5 “(ii) the date on which all information
 6 necessary to completing such review is re-
 7 ceived;

8 if the completion of such review in a period of
 9 time in excess of 72 hours would seriously jeop-
 10 ardize the life or health of the participant or
 11 beneficiary.

12 “(C) LIMITATION.—Notwithstanding sub-
 13 paragraph (A), and except as provided in sub-
 14 paragraph (B), a review described in subpara-
 15 graph (A) shall be completed not later than 30
 16 working days after the later of—

17 “(i) the date on which such reviewer
 18 is designated; or

19 “(ii) the date on which all information
 20 necessary to completing such review is re-
 21 ceived.

22 “(6) BINDING DETERMINATION AND ACCESS TO
 23 CARE.—

24 “(A) IN GENERAL.—The determination of
 25 an independent external reviewer under this

1 subsection shall be binding upon the plan or
2 issuer if the provisions of this subsection or the
3 procedures implemented under such provisions
4 were complied with by the independent external
5 reviewer.

6 “(B) TIMETABLE FOR COMMENCEMENT OF
7 CARE.—Where an independent external reviewer
8 determines that the participant or beneficiary is
9 entitled to coverage of the items or services that
10 were the subject of the review, the reviewer
11 shall establish a timeframe, in accordance with
12 the medical exigencies of the case, during which
13 the plan or issuer shall comply with the decision
14 of the reviewer with respect to the coverage of
15 such items or services under the terms and con-
16 ditions of the plan.

17 “(C) FAILURE TO COMPLY.—If a plan or
18 issuer fails to comply with the timeframe estab-
19 lished under subparagraph (B) with respect to
20 a participant or beneficiary, where such failure
21 to comply is caused by the plan or issuer, the
22 participant or beneficiary may obtain the items
23 or services involved (in a manner consistent
24 with the determination of the independent ex-
25 ternal reviewer) from any provider regardless of

1 whether such provider is a participating pro-
2 vider under the plan or coverage.

3 “(D) REIMBURSEMENT.—

4 “(i) IN GENERAL.—Where a partici-
5 pant or beneficiary obtains items or serv-
6 ices in accordance with subparagraph (C),
7 the plan or issuer involved shall provide for
8 reimbursement of the costs of such items
9 of services. Such reimbursement shall be
10 made to the treating provider or to the
11 participant or beneficiary (in the case of a
12 participant or beneficiary who pays for the
13 costs of such items or services).

14 “(ii) AMOUNT.—The plan or issuer
15 shall fully reimburse a provider, partici-
16 pant or beneficiary under clause (i) for the
17 total costs of the items or services provided
18 (regardless of any plan limitations that
19 may apply to the coverage of such items of
20 services) so long as—

21 “(I) the items or services would
22 have been covered under the terms of
23 the plan or coverage if provided by the
24 plan or issuer; and

1 “(II) the items or services were
2 provided in a manner consistent with
3 the determination of the independent
4 external reviewer.

5 “(E) FAILURE TO REIMBURSE.—Where a
6 plan or issuer fails to provide reimbursement to
7 a provider, participant or beneficiary in accord-
8 ance with this paragraph, the provider, partici-
9 pant or beneficiary may commence a civil action
10 (or utilize other remedies available under law)
11 to recover only the amount of any such reim-
12 bursement that is unpaid and any necessary
13 legal costs or expenses (including attorneys’
14 fees) incurred in recovering such reimburse-
15 ment.

16 “(7) STUDY.—Not later than 2 years after the
17 date of enactment of this section, the General Ac-
18 counting Office shall conduct a study of a statis-
19 tically appropriate sample of completed independent
20 external reviews. Such study shall include an assess-
21 ment of the process involved during an independent
22 external review and the basis of decisionmaking by
23 the independent external reviewer. The results of
24 such study shall be submitted to the appropriate
25 committees of Congress.

1 “(8) EFFECT ON CERTAIN PROVISIONS.—Noth-
 2 ing in this section shall be construed as affecting or
 3 modifying section 514 of this Act with respect to a
 4 group health plan.

5 “(f) RULE OF CONSTRUCTION.—Nothing in this sec-
 6 tion shall be construed to prohibit a plan administrator
 7 or plan fiduciary or health plan medical director from re-
 8 questing an independent external review by an inde-
 9 pendent external reviewer without first completing the in-
 10 ternal review process.

11 “(g) DEFINITIONS.—In this section:

12 “(1) ADVERSE COVERAGE DETERMINATION.—
 13 The term ‘adverse coverage determination’ means a
 14 coverage determination under the plan which results
 15 in a denial of coverage or reimbursement.

16 “(2) COVERAGE DETERMINATION.—The term
 17 ‘coverage determination’ means with respect to items
 18 and services for which coverage may be provided
 19 under a health plan, a determination of whether or
 20 not such items and services are covered or reimburs-
 21 able under the coverage and terms of the contract.

22 “(3) GRIEVANCE.—The term ‘grievance’ means
 23 any complaint made by a participant or beneficiary
 24 that does not involve a coverage determination.

1 “(4) GROUP HEALTH PLAN.—The term ‘group
2 health plan’ shall have the meaning given such term
3 in section 733(a). In applying this paragraph, ex-
4 cepted benefits described in section 733(c) shall not
5 be treated as benefits consisting of medical care.

6 “(5) HEALTH INSURANCE COVERAGE.—The
7 term ‘health insurance coverage’ has the meaning
8 given such term in section 733(b)(1). In applying
9 this paragraph, excepted benefits described in sec-
10 tion 733(c) shall not be treated as benefits con-
11 sisting of medical care.

12 “(6) HEALTH INSURANCE ISSUER.—The term
13 ‘health insurance issuer’ has the meaning given such
14 term in section 733(b)(2).

15 “(7) PRIOR AUTHORIZATION DETERMINA-
16 TION.—The term ‘prior authorization determination’
17 means a coverage determination prior to the provi-
18 sion of the items and services as a condition of cov-
19 erage of the items and services under the coverage.

20 “(8) TREATING HEALTH CARE PROFES-
21 SIONAL.—The term ‘treating health care profes-
22 sional’ with respect to a group health plan, health
23 insurance issuer or provider sponsored organization
24 means a physician (medical doctor or doctor of oste-
25 opathy) or other health care practitioner who is act-

1 ing within the scope of his or her State licensure or
2 certification for the delivery of health care services
3 and who is primarily responsible for delivering those
4 services to the participant or beneficiary.

5 “(9) UTILIZATION REVIEW.—The term ‘utiliza-
6 tion review’ with respect to a group health plan or
7 health insurance coverage means a set of formal
8 techniques designed to monitor the use of, or evalu-
9 ate the clinical necessity, appropriateness, efficacy,
10 or efficiency of, health care services, procedures, or
11 settings. Techniques may include ambulatory review,
12 prospective review, second opinion, certification, con-
13 current review, case management, discharge plan-
14 ning or retrospective review.”.

15 (b) ENFORCEMENT.—Section 502(c) of the Employee
16 Retirement Income Security Act of 1974 (29 U.S.C.
17 1132(c)) is amended by adding at the end the following:

18 “(8) The Secretary may assess a civil penalty against
19 any plan of up to \$10,000 for the plan’s failure or refusal
20 to comply with any timeline applicable under section
21 503(e) or any determination under such section, except
22 that in any case in which treatment was not commenced
23 by the plan in accordance with the determination of an
24 independent external reviewer, the Secretary shall assess
25 a civil penalty of \$10,000 against the plan and the plan

1 shall pay such penalty to the participant or beneficiary
2 involved.”.

3 (c) CONFORMING AMENDMENT.—The table of con-
4 tents in section 1 of the Employee Retirement Income Se-
5 curity Act of 1974 is amended by striking the item relat-
6 ing to section 503 and inserting the following new item:

“Sec. 503. Claims procedures, coverage determination, grievances and appeals.”.

7 (d) EFFECTIVE DATE.—The amendments made by
8 this section shall apply with respect to plan years begin-
9 ning on or after 1 year after the date of enactment of
10 this Act. The Secretary shall issue all regulations nec-
11 essary to carry out the amendments made by this section
12 before the effective date thereof.

13 **TITLE II—WOMEN’S HEALTH AND** 14 **CANCER RIGHTS**

15 **SEC. 201. WOMEN’S HEALTH AND CANCER RIGHTS.**

16 (a) SHORT TITLE.—This section may be cited as the
17 “Women’s Health and Cancer Rights Act of 1999”.

18 (b) FINDINGS.—Congress finds that—

19 (1) the offering and operation of health plans
20 affect commerce among the States;

21 (2) health care providers located in a State
22 serve patients who reside in the State and patients
23 who reside in other States; and

24 (3) in order to provide for uniform treatment of
25 health care providers and patients among the States,

1 it is necessary to cover health plans operating in 1
 2 State as well as health plans operating among the
 3 several States.

4 (c) AMENDMENTS TO ERISA.—

5 (1) IN GENERAL.—Subpart B of part 7 of sub-
 6 title B of title I of the Employee Retirement Income
 7 Security Act of 1974, as amended by section 111(a),
 8 is further amended by adding at the end the fol-
 9 lowing:

10 **“SEC. 715. REQUIRED COVERAGE FOR MINIMUM HOSPITAL**
 11 **STAY FOR MASTECTOMIES AND LYMPH NODE**
 12 **DISSECTIONS FOR THE TREATMENT OF**
 13 **BREAST CANCER AND COVERAGE FOR SEC-**
 14 **ONDARY CONSULTATIONS.**

15 “(a) INPATIENT CARE.—

16 “(1) IN GENERAL.—A group health plan, and a
 17 health insurance issuer providing health insurance
 18 coverage in connection with a group health plan,
 19 that provides medical and surgical benefits shall en-
 20 sure that inpatient coverage with respect to the
 21 treatment of breast cancer is provided for a period
 22 of time as is determined by the attending physician,
 23 in consultation with the patient, to be medically nec-
 24 essary and appropriate following—

25 “(A) a mastectomy;

1 “(B) a lumpectomy; or

2 “(C) a lymph node dissection for the treat-
3 ment of breast cancer.

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

9 “(b) PROHIBITION ON CERTAIN MODIFICATIONS.—
10 In implementing the requirements of this section, a group
11 health plan, and a health insurance issuer providing health
12 insurance coverage in connection with a group health plan,
13 may not modify the terms and conditions of coverage
14 based on the determination by a participant or beneficiary
15 to request less than the minimum coverage required under
16 subsection (a).

17 “(c) NOTICE.—A group health plan, and a health in-
18 surance issuer providing health insurance coverage in con-
19 nection with a group health plan shall provide notice to
20 each participant and beneficiary under such plan regard-
21 ing the coverage required by this section in accordance
22 with regulations promulgated by the Secretary. Such no-
23 tice shall be in writing and prominently positioned in any
24 literature or correspondence made available or distributed
25 by the plan or issuer and shall be transmitted—

1 “(1) in the next mailing made by the plan or
2 issuer to the participant or beneficiary;

3 “(2) as part of any yearly informational packet
4 sent to the participant or beneficiary; or

5 “(3) not later than January 1, 2000;

6 whichever is earlier.

7 “(d) SECONDARY CONSULTATIONS.—

8 “(1) IN GENERAL.—A group health plan, and a
9 health insurance issuer providing health insurance
10 coverage in connection with a group health plan,
11 that provides coverage with respect to medical and
12 surgical services provided in relation to the diagnosis
13 and treatment of cancer shall ensure that full cov-
14 erage is provided for secondary consultations by spe-
15 cialists in the appropriate medical fields (including
16 pathology, radiology, and oncology) to confirm or re-
17 fute such diagnosis. Such plan or issuer shall ensure
18 that full coverage is provided for such secondary
19 consultation whether such consultation is based on a
20 positive or negative initial diagnosis. In any case in
21 which the attending physician certifies in writing
22 that services necessary for such a secondary con-
23 sultation are not sufficiently available from special-
24 ists operating under the plan with respect to whose
25 services coverage is otherwise provided under such

1 plan or by such issuer, such plan or issuer shall en-
 2 sure that coverage is provided with respect to the
 3 services necessary for the secondary consultation
 4 with any other specialist selected by the attending
 5 physician for such purpose at no additional cost to
 6 the individual beyond that which the individual
 7 would have paid if the specialist was participating in
 8 the network of the plan.

9 “(2) EXCEPTION.—Nothing in paragraph (1)
 10 shall be construed as requiring the provision of sec-
 11 ondary consultations where the patient determines
 12 not to seek such a consultation.

13 “(e) PROHIBITION ON PENALTIES OR INCENTIVES.—
 14 A group health plan, and a health insurance issuer pro-
 15 viding health insurance coverage in connection with a
 16 group health plan, may not—

17 “(1) penalize or otherwise reduce or limit the
 18 reimbursement of a provider or specialist because
 19 the provider or specialist provided care to a partici-
 20 pant or beneficiary in accordance with this section;

21 “(2) provide financial or other incentives to a
 22 physician or specialist to induce the physician or
 23 specialist to keep the length of inpatient stays of pa-
 24 tients following a mastectomy, lumpectomy, or a
 25 lymph node dissection for the treatment of breast

1 cancer below certain limits or to limit referrals for
 2 secondary consultations; or

3 “(3) provide financial or other incentives to a
 4 physician or specialist to induce the physician or
 5 specialist to refrain from referring a participant or
 6 beneficiary for a secondary consultation that would
 7 otherwise be covered by the plan or coverage in-
 8 volved under subsection (d).”.

9 (2) CLERICAL AMENDMENT.—The table of con-
 10 tents in section 1 of the Employee Retirement In-
 11 come Security Act of 1974 is amended by inserting
 12 after the item relating to section 714 the following
 13 new item:

“Sec. 715. Required coverage for minimum hospital stay for mastectomies and
 lymph node dissections for the treatment of breast cancer and
 coverage for secondary consultations.”.

14 (d) AMENDMENTS TO PHSA RELATING TO THE
 15 GROUP MARKET.—Subpart 2 of part A of title XXVII of
 16 the Public Health Service Act (42 U.S.C. 300gg-4 et seq.)
 17 is amended by adding at the end the following new section:

18 **“SEC. 2707. REQUIRED COVERAGE FOR MINIMUM HOSPITAL**
 19 **STAY FOR MASTECTOMIES AND LYMPH NODE**
 20 **DISSECTIONS FOR THE TREATMENT OF**
 21 **BREAST CANCER AND COVERAGE FOR SEC-**
 22 **ONDARY CONSULTATIONS.**

23 “(a) INPATIENT CARE.—

1 “(1) IN GENERAL.—A group health plan, and a
2 health insurance issuer providing health insurance
3 coverage in connection with a group health plan,
4 that provides medical and surgical benefits shall en-
5 sure that inpatient coverage with respect to the
6 treatment of breast cancer is provided for a period
7 of time as is determined by the attending physician,
8 in consultation with the patient, to be medically nec-
9 essary and appropriate following—

10 “(A) a mastectomy;

11 “(B) a lumpectomy; or

12 “(C) a lymph node dissection for the treat-
13 ment of breast cancer.

14 “(2) EXCEPTION.—Nothing in this section shall
15 be construed as requiring the provision of inpatient
16 coverage if the attending physician and patient de-
17 termine that a shorter period of hospital stay is
18 medically appropriate.

19 “(b) PROHIBITION ON CERTAIN MODIFICATIONS.—
20 In implementing the requirements of this section, a group
21 health plan, and a health insurance issuer providing health
22 insurance coverage in connection with a group health plan,
23 may not modify the terms and conditions of coverage
24 based on the determination by a participant or beneficiary

1 to request less than the minimum coverage required under
 2 subsection (a).

3 “(c) NOTICE.—A group health plan, and a health in-
 4 surance issuer providing health insurance coverage in con-
 5 nection with a group health plan shall provide notice to
 6 each participant and beneficiary under such plan regard-
 7 ing the coverage required by this section in accordance
 8 with regulations promulgated by the Secretary. Such no-
 9 tice shall be in writing and prominently positioned in any
 10 literature or correspondence made available or distributed
 11 by the plan or issuer and shall be transmitted—

12 “(1) in the next mailing made by the plan or
 13 issuer to the participant or beneficiary;

14 “(2) as part of any yearly informational packet
 15 sent to the participant or beneficiary; or

16 “(3) not later than January 1, 2000;
 17 whichever is earlier.

18 “(d) SECONDARY CONSULTATIONS.—

19 “(1) IN GENERAL.—A group health plan, and a
 20 health insurance issuer providing health insurance
 21 coverage in connection with a group health plan that
 22 provides coverage with respect to medical and sur-
 23 gical services provided in relation to the diagnosis
 24 and treatment of cancer shall ensure that full cov-
 25 erage is provided for secondary consultations by spe-

1 cialists in the appropriate medical fields (including
2 pathology, radiology, and oncology) to confirm or re-
3 fute such diagnosis. Such plan or issuer shall ensure
4 that full coverage is provided for such secondary
5 consultation whether such consultation is based on a
6 positive or negative initial diagnosis. In any case in
7 which the attending physician certifies in writing
8 that services necessary for such a secondary con-
9 sultation are not sufficiently available from special-
10 ists operating under the plan with respect to whose
11 services coverage is otherwise provided under such
12 plan or by such issuer, such plan or issuer shall en-
13 sure that coverage is provided with respect to the
14 services necessary for the secondary consultation
15 with any other specialist selected by the attending
16 physician for such purpose at no additional cost to
17 the individual beyond that which the individual
18 would have paid if the specialist was participating in
19 the network of the plan.

20 “(2) EXCEPTION.—Nothing in paragraph (1)
21 shall be construed as requiring the provision of sec-
22 ondary consultations where the patient determines
23 not to seek such a consultation.

24 “(e) PROHIBITION ON PENALTIES OR INCENTIVES.—
25 A group health plan, and a health insurance issuer pro-

1 viding health insurance coverage in connection with a
 2 group health plan, may not—

3 “(1) penalize or otherwise reduce or limit the
 4 reimbursement of a provider or specialist because
 5 the provider or specialist provided care to a partici-
 6 pant or beneficiary in accordance with this section;

7 “(2) provide financial or other incentives to a
 8 physician or specialist to induce the physician or
 9 specialist to keep the length of inpatient stays of pa-
 10 tients following a mastectomy, lumpectomy, or a
 11 lymph node dissection for the treatment of breast
 12 cancer below certain limits or to limit referrals for
 13 secondary consultations; or

14 “(3) provide financial or other incentives to a
 15 physician or specialist to induce the physician or
 16 specialist to refrain from referring a participant or
 17 beneficiary for a secondary consultation that would
 18 otherwise be covered by the plan or coverage in-
 19 volved under subsection (d).”.

20 (e) AMENDMENTS TO PHSA RELATING TO THE IN-
 21 DIVIDUAL MARKET.—The first subpart 3 of part B of title
 22 XXVII of the Public Health Service Act (42 U.S.C.
 23 300gg-51 et seq.) (relating to other requirements) (42
 24 U.S.C. 300gg-51 et seq.) is amended—

1 (1) by redesignating such subpart as subpart 2;
 2 and

3 (2) by adding at the end the following:

4 **“SEC. 2753. REQUIRED COVERAGE FOR MINIMUM HOSPITAL**
 5 **STAY FOR MASTECTOMIES AND LYMPH NODE**
 6 **DISSECTIONS FOR THE TREATMENT OF**
 7 **BREAST CANCER AND SECONDARY CON-**
 8 **SULTATIONS.**

9 “The provisions of section 2707 shall apply to health
 10 insurance coverage offered by a health insurance issuer
 11 in the individual market in the same manner as they apply
 12 to health insurance coverage offered by a health insurance
 13 issuer in connection with a group health plan in the small
 14 or large group market.”.

15 (f) AMENDMENTS TO THE IRC.—

16 (1) IN GENERAL.—Subchapter B of chapter
 17 100 of the Internal Revenue Code of 1986, as
 18 amended by section 111(b), is further amended by
 19 inserting after section 9813 the following:

20 **“SEC. 9814. REQUIRED COVERAGE FOR MINIMUM HOSPITAL**
 21 **STAY FOR MASTECTOMIES AND LYMPH NODE**
 22 **DISSECTIONS FOR THE TREATMENT OF**
 23 **BREAST CANCER AND COVERAGE FOR SEC-**
 24 **ONDARY CONSULTATIONS.**

25 “(a) INPATIENT CARE.—

1 “(1) IN GENERAL.—A group health plan that
2 provides medical and surgical benefits shall ensure
3 that inpatient coverage with respect to the treatment
4 of breast cancer is provided for a period of time as
5 is determined by the attending physician, in con-
6 sultation with the patient, to be medically necessary
7 and appropriate following—

8 “(A) a mastectomy;

9 “(B) a lumpectomy; or

10 “(C) a lymph node dissection for the treat-
11 ment of breast cancer.

12 “(2) EXCEPTION.—Nothing in this section shall
13 be construed as requiring the provision of inpatient
14 coverage if the attending physician and patient de-
15 termine that a shorter period of hospital stay is
16 medically appropriate.

17 “(b) PROHIBITION ON CERTAIN MODIFICATIONS.—
18 In implementing the requirements of this section, a group
19 health plan may not modify the terms and conditions of
20 coverage based on the determination by a participant or
21 beneficiary to request less than the minimum coverage re-
22 quired under subsection (a).

23 “(c) NOTICE.—A group health plan shall provide no-
24 tice to each participant and beneficiary under such plan
25 regarding the coverage required by this section in accord-

1 ance with regulations promulgated by the Secretary. Such
 2 notice shall be in writing and prominently positioned in
 3 any literature or correspondence made available or distrib-
 4 uted by the plan and shall be transmitted—

5 “(1) in the next mailing made by the plan to
 6 the participant or beneficiary;

7 “(2) as part of any yearly informational packet
 8 sent to the participant or beneficiary; or

9 “(3) not later than January 1, 2000;

10 whichever is earlier.

11 “(d) SECONDARY CONSULTATIONS.—

12 “(1) IN GENERAL.—A group health plan that
 13 provides coverage with respect to medical and sur-
 14 gical services provided in relation to the diagnosis
 15 and treatment of cancer shall ensure that full cov-
 16 erage is provided for secondary consultations by spe-
 17 cialists in the appropriate medical fields (including
 18 pathology, radiology, and oncology) to confirm or re-
 19 fute such diagnosis. Such plan or issuer shall ensure
 20 that full coverage is provided for such secondary
 21 consultation whether such consultation is based on a
 22 positive or negative initial diagnosis. In any case in
 23 which the attending physician certifies in writing
 24 that services necessary for such a secondary con-
 25 sultation are not sufficiently available from special-

1 ists operating under the plan with respect to whose
2 services coverage is otherwise provided under such
3 plan or by such issuer, such plan or issuer shall en-
4 sure that coverage is provided with respect to the
5 services necessary for the secondary consultation
6 with any other specialist selected by the attending
7 physician for such purpose at no additional cost to
8 the individual beyond that which the individual
9 would have paid if the specialist was participating in
10 the network of the plan.

11 “(2) EXCEPTION.—Nothing in paragraph (1)
12 shall be construed as requiring the provision of sec-
13 ondary consultations where the patient determines
14 not to seek such a consultation.

15 “(e) PROHIBITION ON PENALTIES.—A group health
16 plan may not—

17 “(1) penalize or otherwise reduce or limit the
18 reimbursement of a provider or specialist because
19 the provider or specialist provided care to a partici-
20 pant or beneficiary in accordance with this section;

21 “(2) provide financial or other incentives to a
22 physician or specialist to induce the physician or
23 specialist to keep the length of inpatient stays of pa-
24 tients following a mastectomy, lumpectomy, or a
25 lymph node dissection for the treatment of breast

1 cancer below certain limits or to limit referrals for
 2 secondary consultations; or

3 “(3) provide financial or other incentives to a
 4 physician or specialist to induce the physician or
 5 specialist to refrain from referring a participant or
 6 beneficiary for a secondary consultation that would
 7 otherwise be covered by the plan involved under sub-
 8 section (d).”.

9 (2) CLERICAL AMENDMENT.—The table of con-
 10 tents for chapter 100 of such Code is amended by
 11 inserting after the item relating to section 9813 the
 12 following new item:

“Sec. 9814. Required coverage for minimum hospital stay for mastectomies and
 lymph node dissections for the treatment of breast cancer and
 coverage for secondary consultations.”.

13 **TITLE III—GENETIC** 14 **INFORMATION AND SERVICES**

15 **SEC. 301. SHORT TITLE.**

16 This title may be cited as the “Genetic Information
 17 Nondiscrimination in Health Insurance Act of 1999”.

18 **SEC. 302. AMENDMENTS TO EMPLOYEE RETIREMENT IN-** 19 **COME SECURITY ACT OF 1974.**

20 (a) PROHIBITION OF HEALTH DISCRIMINATION ON
 21 THE BASIS OF GENETIC INFORMATION OR GENETIC
 22 SERVICES.—

23 (1) NO ENROLLMENT RESTRICTION FOR GE-
 24 NETIC SERVICES.—Section 702(a)(1)(F) of the Em-

1 ployee Retirement Income Security Act of 1974 (29
 2 U.S.C. 1182(a)(1)(F)) is amended by inserting be-
 3 fore the period the following: “(including informa-
 4 tion about a request for or receipt of genetic serv-
 5 ices)”.

6 (2) NO DISCRIMINATION IN GROUP PREMIUMS
 7 BASED ON PREDICTIVE GENETIC INFORMATION.—
 8 Subpart B of part 7 of subtitle B of title I of the
 9 Employee Retirement Income Security Act of 1974,
 10 as amended by sections 111(a) and 201, is further
 11 amended by adding at the end the following:

12 **“SEC. 716. PROHIBITING PREMIUM DISCRIMINATION**
 13 **AGAINST GROUPS ON THE BASIS OF PRE-**
 14 **DICTIVE GENETIC INFORMATION.**

15 “A group health plan, or a health insurance issuer
 16 offering group health insurance coverage in connection
 17 with a group health plan, shall not adjust premium or con-
 18 tribution amounts for a group on the basis of predictive
 19 genetic information concerning any individual (including
 20 a dependent) or family member of the individual (includ-
 21 ing information about a request for or receipt of genetic
 22 services).”.

23 (3) CONFORMING AMENDMENTS.—

24 (A) IN GENERAL.—Section 702(b) of the
 25 Employee Retirement Income Security Act of

1 1974 (29 U.S.C. 1182(b)) is amended by add-
2 ing at the end the following:

3 “(3) REFERENCE TO RELATED PROVISION.—
4 For a provision prohibiting the adjustment of pre-
5 mium or contribution amounts for a group under a
6 group health plan on the basis of predictive genetic
7 information (including information about a request
8 for or receipt of genetic services), see section 716.”.

9 (B) TABLE OF CONTENTS.—The table of
10 contents in section 1 of the Employee Retirement
11 Income Security Act of 1974, as amended
12 by sections 111(a) and 201, is further amended
13 by inserting after the item relating to section
14 715 the following new item:

“Sec. 716. Prohibiting premium discrimination against groups on the basis of
predictive genetic information.”.

15 (b) LIMITATION ON COLLECTION OF PREDICTIVE
16 GENETIC INFORMATION.—Section 702 of the Employee
17 Retirement Income Security Act of 1974 (29 U.S.C. 1182)
18 is amended by adding at the end the following:

19 “(c) COLLECTION OF PREDICTIVE GENETIC INFOR-
20 MATION.—

21 “(1) LIMITATION ON REQUESTING OR REQUIR-
22 ING PREDICTIVE GENETIC INFORMATION.—Except
23 as provided in paragraph (2), a group health plan,
24 or a health insurance issuer offering health insur-

1 ance coverage in connection with a group health
2 plan, shall not request or require predictive genetic
3 information concerning any individual (including a
4 dependent) or family member of the individual (in-
5 cluding information about a request for or receipt of
6 genetic services).

7 “(2) INFORMATION NEEDED FOR DIAGNOSIS,
8 TREATMENT, OR PAYMENT.—

9 “(A) IN GENERAL.—Notwithstanding para-
10 graph (1), a group health plan, or a health in-
11 surance issuer offering health insurance cov-
12 erage in connection with a group health plan,
13 that provides health care items and services to
14 an individual or dependent may request (but
15 may not require) that such individual or de-
16 pendent disclose, or authorize the collection or
17 disclosure of, predictive genetic information for
18 purposes of diagnosis, treatment, or payment
19 relating to the provision of health care items
20 and services to such individual or dependent.

21 “(B) NOTICE OF CONFIDENTIALITY PRAC-
22 TICES AND DESCRIPTION OF SAFEGUARDS.—As
23 a part of a request under subparagraph (A),
24 the group health plan, or a health insurance
25 issuer offering health insurance coverage in

1 connection with a group health plan, shall pro-
 2 vide to the individual or dependent a descrip-
 3 tion of the procedures in place to safeguard the
 4 confidentiality, as described in subsection (d),
 5 of such predictive genetic information.

6 “(d) CONFIDENTIALITY WITH RESPECT TO PRE-
 7 DICTIVE GENETIC INFORMATION.—

8 “(1) NOTICE OF CONFIDENTIALITY PRAC-
 9 TICES.—

10 “(A) PREPARATION OF WRITTEN NO-
 11 TICE.—A group health plan, or a health insur-
 12 ance issuer offering health insurance coverage
 13 in connection with a group health plan, shall
 14 post or provide, in writing and in a clear and
 15 conspicuous manner, notice of the plan or
 16 issuer’s confidentiality practices, that shall
 17 include—

18 “(i) a description of an individual’s
 19 rights with respect to predictive genetic in-
 20 formation;

21 “(ii) the procedures established by the
 22 plan or issuer for the exercise of the indi-
 23 vidual’s rights; and

1 “(iii) the right to obtain a copy of the
2 notice of the confidentiality practices re-
3 quired under this subsection.

4 “(B) MODEL NOTICE.—The Secretary, in
5 consultation with the National Committee on
6 Vital and Health Statistics and the National
7 Association of Insurance Commissioners, and
8 after notice and opportunity for public com-
9 ment, shall develop and disseminate model no-
10 tices of confidentiality practices. Use of the
11 model notice shall serve as a defense against
12 claims of receiving inappropriate notice.

13 “(2) ESTABLISHMENT OF SAFEGUARDS.—A
14 group health plan, or a health insurance issuer offer-
15 ing health insurance coverage in connection with a
16 group health plan, shall establish and maintain ap-
17 propriate administrative, technical, and physical
18 safeguards to protect the confidentiality, security,
19 accuracy, and integrity of predictive genetic informa-
20 tion created, received, obtained, maintained, used,
21 transmitted, or disposed of by such plan or issuer.”.

22 (c) DEFINITIONS.—Section 733(d) of the Employee
23 Retirement Income Security Act of 1974 (29 U.S.C.
24 1191b(d)) is amended by adding at the end the following:

1 “(5) FAMILY MEMBER.—The term ‘family
2 member’ means with respect to an individual—

3 “(A) the spouse of the individual;

4 “(B) a dependent child of the individual,
5 including a child who is born to or placed for
6 adoption with the individual; and

7 “(C) all other individuals related by blood
8 to the individual or the spouse or child de-
9 scribed in subparagraph (A) or (B).

10 “(6) GENETIC INFORMATION.—The term ‘ge-
11 netic information’ means information about genes,
12 gene products, or inherited characteristics that may
13 derive from an individual or a family member (in-
14 cluding information about a request for or receipt of
15 genetic services).

16 “(7) GENETIC SERVICES.—The term ‘genetic
17 services’ means health services provided to obtain,
18 assess, or interpret genetic information for diag-
19 nostic and therapeutic purposes, and for genetic
20 education and counseling.

21 “(8) PREDICTIVE GENETIC INFORMATION.—

22 “(A) IN GENERAL.—The term ‘predictive
23 genetic information’ means, in the absence of
24 symptoms, clinical signs, or a diagnosis of the
25 condition related to such information—

1 “(i) information about an individual’s
2 genetic tests;

3 “(ii) information about genetic tests
4 of family members of the individual; or

5 “(iii) information about the occur-
6 rence of a disease or disorder in family
7 members.

8 “(B) EXCEPTIONS.—The term ‘predictive
9 genetic information’ shall not include—

10 “(i) information about the sex or age
11 of the individual;

12 “(ii) information derived from phys-
13 ical tests, such as the chemical, blood, or
14 urine analyses of the individual including
15 cholesterol tests; and

16 “(iii) information about physical
17 exams of the individual.

18 “(9) GENETIC TEST.—The term ‘genetic test’
19 means the analysis of human DNA, RNA, chro-
20 mosomes, proteins, and certain metabolites, includ-
21 ing analysis of genotypes, mutations, phenotypes, or
22 karyotypes, for the purpose of predicting risk of dis-
23 ease in asymptomatic or undiagnosed individuals.
24 Such term does not include physical tests, such as
25 the chemical, blood, or urine analyses of the indi-

vidual including cholesterol tests, and physical exams of the individual, in order to detect symptoms, clinical signs, or a diagnosis of disease.”.

(d) EFFECTIVE DATE.—Except as provided in this section, this section and the amendments made by this section shall apply with respect to group health plans for plan years beginning 1 year after the date of the enactment of this Act.

SEC. 303. AMENDMENTS TO THE PUBLIC HEALTH SERVICE

ACT.

(a) AMENDMENTS RELATING TO THE GROUP MARKET.—

(1) PROHIBITION OF HEALTH DISCRIMINATION ON THE BASIS OF GENETIC INFORMATION IN THE GROUP MARKET.—

(A) NO ENROLLMENT RESTRICTION FOR GENETIC SERVICES.—Section 2702(a)(1)(F) of the Public Health Service Act (42 U.S.C. 300gg–1(a)(1)(F)) is amended by inserting before the period the following: “(including information about a request for or receipt of genetic services)”.

(B) NO DISCRIMINATION IN PREMIUMS BASED ON PREDICTIVE GENETIC INFORMATION.—Subpart 2 of part A of title XXVII of

1 the Public Health Service Act, as amended by
 2 section 201, is further amended by adding at
 3 the end the following new section:

4 **“SEC. 2708. PROHIBITING PREMIUM DISCRIMINATION**
 5 **AGAINST GROUPS ON THE BASIS OF PRE-**
 6 **DICTIVE GENETIC INFORMATION IN THE**
 7 **GROUP MARKET.**

8 “A group health plan, or a health insurance issuer
 9 offering group health insurance coverage in connection
 10 with a group health plan shall not adjust premium or con-
 11 tribution amounts for a group on the basis of predictive
 12 genetic information concerning any individual (including
 13 a dependent) or family member of the individual (includ-
 14 ing information about a request for or receipt of genetic
 15 services).”.

16 (C) CONFORMING AMENDMENT.—Section
 17 2702(b) of the Public Health Service Act (42
 18 U.S.C. 300gg–1(b)) is amended by adding at
 19 the end the following:

20 “(3) REFERENCE TO RELATED PROVISION.—
 21 For a provision prohibiting the adjustment of pre-
 22 mium or contribution amounts for a group under a
 23 group health plan on the basis of predictive genetic
 24 information (including information about a request
 25 for or receipt of genetic services), see section 2708.”.

1 (D) LIMITATION ON COLLECTION AND DIS-
2 CLOSURE OF PREDICTIVE GENETIC INFORMA-
3 TION.—Section 2702 of the Public Health Serv-
4 ice Act (42 U.S.C. 300gg-1) is amended by
5 adding at the end the following:

6 “(c) COLLECTION OF PREDICTIVE GENETIC INFOR-
7 MATION.—

8 “(1) LIMITATION ON REQUESTING OR REQUIR-
9 ING PREDICTIVE GENETIC INFORMATION.—Except
10 as provided in paragraph (2), a group health plan,
11 or a health insurance issuer offering health insur-
12 ance coverage in connection with a group health
13 plan, shall not request or require predictive genetic
14 information concerning any individual (including a
15 dependent) or a family member of the individual (in-
16 cluding information about a request for or receipt of
17 genetic services).

18 “(2) INFORMATION NEEDED FOR DIAGNOSIS,
19 TREATMENT, OR PAYMENT.—

20 “(A) IN GENERAL.—Notwithstanding para-
21 graph (1), a group health plan, or a health in-
22 surance issuer offering health insurance cov-
23 erage in connection with a group health plan,
24 that provides health care items and services to
25 an individual or dependent may request (but

1 may not require) that such individual or de-
2 pendent disclose, or authorize the collection or
3 disclosure of, predictive genetic information for
4 purposes of diagnosis, treatment, or payment
5 relating to the provision of health care items
6 and services to such individual or dependent.

7 “(B) NOTICE OF CONFIDENTIALITY PRAC-
8 TICES AND DESCRIPTION OF SAFEGUARDS.—As
9 a part of a request under subparagraph (A),
10 the group health plan, or a health insurance
11 issuer offering health insurance coverage in
12 connection with a group health plan, shall pro-
13 vide to the individual or dependent a descrip-
14 tion of the procedures in place to safeguard the
15 confidentiality, as described in subsection (d),
16 of such predictive genetic information.

17 “(d) CONFIDENTIALITY WITH RESPECT TO PRE-
18 DICTIVE GENETIC INFORMATION.—

19 “(1) NOTICE OF CONFIDENTIALITY PRAC-
20 TICES.—

21 “(A) PREPARATION OF WRITTEN NO-
22 TICE.—A group health plan, or a health insur-
23 ance issuer offering health insurance coverage
24 in connection with a group health plan, shall
25 post or provide, in writing and in a clear and

1 conspicuous manner, notice of the plan or
2 issuer's confidentiality practices, that shall
3 include—

4 “(i) a description of an individual's
5 rights with respect to predictive genetic in-
6 formation;

7 “(ii) the procedures established by the
8 plan or issuer for the exercise of the indi-
9 vidual's rights; and

10 “(iii) the right to obtain a copy of the
11 notice of the confidentiality practices re-
12 quired under this subsection.

13 “(B) MODEL NOTICE.—The Secretary, in
14 consultation with the National Committee on
15 Vital and Health Statistics and the National
16 Association of Insurance Commissioners, and
17 after notice and opportunity for public com-
18 ment, shall develop and disseminate model no-
19 tices of confidentiality practices. Use of the
20 model notice shall serve as a defense against
21 claims of receiving inappropriate notice.

22 “(2) ESTABLISHMENT OF SAFEGUARDS.—A
23 group health plan, or a health insurance issuer offer-
24 ing health insurance coverage in connection with a
25 group health plan, shall establish and maintain ap-

1 appropriate administrative, technical, and physical
2 safeguards to protect the confidentiality, security,
3 accuracy, and integrity of predictive genetic informa-
4 tion created, received, obtained, maintained, used,
5 transmitted, or disposed of by such plan or issuer.”.

6 (2) DEFINITIONS.—Section 2791(d) of the Pub-
7 lic Health Service Act (42 U.S.C. 300gg–91(d)) is
8 amended by adding at the end the following:

9 “(15) FAMILY MEMBER.—The term ‘family
10 member’ means, with respect to an individual—

11 “(A) the spouse of the individual;

12 “(B) a dependent child of the individual,
13 including a child who is born to or placed for
14 adoption with the individual; and

15 “(C) all other individuals related by blood
16 to the individual or the spouse or child de-
17 scribed in subparagraph (A) or (B).

18 “(16) GENETIC INFORMATION.—The term ‘ge-
19 netic information’ means information about genes,
20 gene products, or inherited characteristics that may
21 derive from an individual or a family member (in-
22 cluding information about a request for or receipt of
23 genetic services).

24 “(17) GENETIC SERVICES.—The term ‘genetic
25 services’ means health services provided to obtain,

1 assess, or interpret genetic information for diag-
2 nostic and therapeutic purposes, and for genetic
3 education and counseling.

4 “(18) PREDICTIVE GENETIC INFORMATION.—

5 “(A) IN GENERAL.—The term ‘predictive
6 genetic information’ means, in the absence of
7 symptoms, clinical signs, or a diagnosis of the
8 condition related to such information—

9 “(i) information about an individual’s
10 genetic tests;

11 “(ii) information about genetic tests
12 of family members of the individual; or

13 “(iii) information about the occur-
14 rence of a disease or disorder in family
15 members.

16 “(B) EXCEPTIONS.—The term ‘predictive
17 genetic information’ shall not include—

18 “(i) information about the sex or age
19 of the individual;

20 “(ii) information derived from phys-
21 ical tests, such as the chemical, blood, or
22 urine analyses of the individual including
23 cholesterol tests; and

24 “(iii) information about physical
25 exams of the individual.

1 “(19) GENETIC TEST.—The term ‘genetic test’
 2 means the analysis of human DNA, RNA, chro-
 3 mosomes, proteins, and certain metabolites, includ-
 4 ing analysis of genotypes, mutations, phenotypes, or
 5 karyotypes, for the purpose of predicting risk of dis-
 6 ease in asymptomatic or undiagnosed individuals.
 7 Such term does not include physical tests, such as
 8 the chemical, blood, or urine analyses of the indi-
 9 vidual including cholesterol tests, and physical exams
 10 of the individual, in order to detect symptoms, clin-
 11 ical signs, or a diagnosis of disease.”.

12 (b) AMENDMENT RELATING TO THE INDIVIDUAL
 13 MARKET.—Subpart 2 of part B of title XXVII of the Pub-
 14 lic Health Service Act, as amended by section 201, is fur-
 15 ther amended by adding at the end the following new sec-
 16 tion:

17 **“SEC. 2754. PROHIBITION OF HEALTH DISCRIMINATION ON**
 18 **THE BASIS OF PREDICTIVE GENETIC INFOR-**
 19 **MATION.**

20 “(a) PROHIBITION ON PREDICTIVE GENETIC INFOR-
 21 MATION AS A CONDITION OF ELIGIBILITY.—A health in-
 22 surance issuer offering health insurance coverage in the
 23 individual market may not use predictive genetic informa-
 24 tion as a condition of eligibility of an individual to enroll

1 in individual health insurance coverage (including infor-
2 mation about a request for or receipt of genetic services).

3 “(b) PROHIBITION ON PREDICTIVE GENETIC INFOR-
4 MATION IN SETTING PREMIUM RATES.—A health insur-
5 ance issuer offering health insurance coverage in the indi-
6 vidual market shall not adjust premium rates for individ-
7 uals on the basis of predictive genetic information con-
8 cerning such an individual (including a dependent) or a
9 family member of the individual (including information
10 about a request for or receipt of genetic services).

11 “(c) COLLECTION OF PREDICTIVE GENETIC INFOR-
12 MATION.—

13 “(1) LIMITATION ON REQUESTING OR REQUIR-
14 ING PREDICTIVE GENETIC INFORMATION.—Except
15 as provided in paragraph (2), a health insurance
16 issuer offering health insurance coverage in the indi-
17 vidual market shall not request or require predictive
18 genetic information concerning any individual (in-
19 cluding a dependent) or a family member of the in-
20 dividual (including information about a request for
21 or receipt of genetic services).

22 “(2) INFORMATION NEEDED FOR DIAGNOSIS,
23 TREATMENT, OR PAYMENT.—

24 “(A) IN GENERAL.—Notwithstanding para-
25 graph (1), a health insurance issuer offering

1 health insurance coverage in the individual mar-
 2 ket that provides health care items and services
 3 to an individual or dependent may request (but
 4 may not require) that such individual or de-
 5 pendent disclose, or authorize the collection or
 6 disclosure of, predictive genetic information for
 7 purposes of diagnosis, treatment, or payment
 8 relating to the provision of health care items
 9 and services to such individual or dependent.

10 “(B) NOTICE OF CONFIDENTIALITY PRAC-
 11 TICES AND DESCRIPTION OF SAFEGUARDS.—As
 12 a part of a request under subparagraph (A),
 13 the health insurance issuer offering health in-
 14 surance coverage in the individual market shall
 15 provide to the individual or dependent a de-
 16 scription of the procedures in place to safe-
 17 guard the confidentiality, as described in sub-
 18 section (d), of such predictive genetic informa-
 19 tion.

20 “(d) CONFIDENTIALITY WITH RESPECT TO PRE-
 21 DICTIVE GENETIC INFORMATION.—

22 “(1) NOTICE OF CONFIDENTIALITY PRAC-
 23 TICES.—

24 “(A) PREPARATION OF WRITTEN NO-
 25 TICE.—A health insurance issuer offering

1 health insurance coverage in the individual mar-
2 ket shall post or provide, in writing and in a
3 clear and conspicuous manner, notice of the
4 issuer's confidentiality practices, that shall
5 include—

6 “(i) a description of an individual's
7 rights with respect to predictive genetic in-
8 formation;

9 “(ii) the procedures established by the
10 issuer for the exercise of the individual's
11 rights; and

12 “(iii) the right to obtain a copy of the
13 notice of the confidentiality practices re-
14 quired under this subsection.

15 “(B) MODEL NOTICE.—The Secretary, in
16 consultation with the National Committee on
17 Vital and Health Statistics and the National
18 Association of Insurance Commissioners, and
19 after notice and opportunity for public com-
20 ment, shall develop and disseminate model no-
21 tices of confidentiality practices. Use of the
22 model notice shall serve as a defense against
23 claims of receiving inappropriate notice.

24 “(2) ESTABLISHMENT OF SAFEGUARDS.—A
25 health insurance issuer offering health insurance

1 coverage in the individual market shall establish and
 2 maintain appropriate administrative, technical, and
 3 physical safeguards to protect the confidentiality, se-
 4 curity, accuracy, and integrity of predictive genetic
 5 information created, received, obtained, maintained,
 6 used, transmitted, or disposed of by such issuer.”.

7 (c) EFFECTIVE DATE.—The amendments made by
 8 this section shall apply with respect to—

9 (1) group health plans, and health insurance
 10 coverage offered in connection with group health
 11 plans, for plan years beginning after 1 year after the
 12 date of enactment of this Act; and

13 (2) health insurance coverage offered, sold,
 14 issued, renewed, in effect, or operated in the indi-
 15 vidual market after 1 year after the date of enact-
 16 ment of this Act.

17 **SEC. 304. AMENDMENTS TO THE INTERNAL REVENUE CODE**
 18 **OF 1986.**

19 (a) PROHIBITION OF HEALTH DISCRIMINATION ON
 20 THE BASIS OF GENETIC INFORMATION OR GENETIC
 21 SERVICES.—

22 (1) NO ENROLLMENT RESTRICTION FOR GE-
 23 NETIC SERVICES.—Section 9802(a)(1)(F) of the In-
 24 ternal Revenue Code of 1986 is amended by insert-
 25 ing before the period the following: “(including in-

1 formation about a request for or receipt of genetic
2 services)”.
3

4 (2) NO DISCRIMINATION IN GROUP PREMIUMS
5 BASED ON PREDICTIVE GENETIC INFORMATION.—

6 (A) IN GENERAL.—Subchapter B of chap-
7 ter 100 of the Internal Revenue Code of 1986,
8 as amended by sections 111(b) and 201, is fur-
9 ther amended by adding at the end the fol-
10 lowing:

11 **“SEC. 9815. PROHIBITING PREMIUM DISCRIMINATION**
12 **AGAINST GROUPS ON THE BASIS OF PRE-**
13 **DICTIVE GENETIC INFORMATION.**

14 “A group health plan shall not adjust premium or
15 contribution amounts for a group on the basis of predictive
16 genetic information concerning any individual (including
17 a dependent) or a family member of the individual (includ-
18 ing information about a request for or receipt of genetic
19 services).”.

20 (B) CONFORMING AMENDMENT.—Section
21 9802(b) of the Internal Revenue Code of 1986
22 is amended by adding at the end the following:

23 “(3) REFERENCE TO RELATED PROVISION.—
24 For a provision prohibiting the adjustment of pre-
25 mium or contribution amounts for a group under a
26 group health plan on the basis of predictive genetic

1 information (including information about a request
 2 for or the receipt of genetic services), see section
 3 9815.”.

4 (C) AMENDMENT TO TABLE OF SEC-
 5 TIONS.—The table of sections for subchapter B
 6 of chapter 100 of the Internal Revenue Code of
 7 1986, as amended by sections 111(b) and 201,
 8 is further amended by adding at the end the
 9 following:

“Sec. 9816. Prohibiting premium discrimination against groups on the basis of
 predictive genetic information.”.

10 (b) LIMITATION ON COLLECTION OF PREDICTIVE
 11 GENETIC INFORMATION.—Section 9802 of the Internal
 12 Revenue Code of 1986 is amended by adding at the end
 13 the following:

14 “(d) COLLECTION OF PREDICTIVE GENETIC INFOR-
 15 MATION.—

16 “(1) LIMITATION ON REQUESTING OR REQUIR-
 17 ING PREDICTIVE GENETIC INFORMATION.—Except
 18 as provided in paragraph (2), a group health plan
 19 shall not request or require predictive genetic infor-
 20 mation concerning any individual (including a de-
 21 pendent) or a family member of the individual (in-
 22 cluding information about a request for or receipt of
 23 genetic services).

1 “(2) INFORMATION NEEDED FOR DIAGNOSIS,
2 TREATMENT, OR PAYMENT.—

3 “(A) IN GENERAL.—Notwithstanding para-
4 graph (1), a group health plan that provides
5 health care items and services to an individual
6 or dependent may request (but may not re-
7 quire) that such individual or dependent dis-
8 close, or authorize the collection or disclosure
9 of, predictive genetic information for purposes
10 of diagnosis, treatment, or payment relating to
11 the provision of health care items and services
12 to such individual or dependent.

13 “(B) NOTICE OF CONFIDENTIALITY PRAC-
14 TICES; DESCRIPTION OF SAFEGUARDS.—As a
15 part of a request under subparagraph (A), the
16 group health plan shall provide to the individual
17 or dependent a description of the procedures in
18 place to safeguard the confidentiality, as de-
19 scribed in subsection (e), of such predictive ge-
20 netic information.

21 “(e) CONFIDENTIALITY WITH RESPECT TO PRE-
22 DICTIVE GENETIC INFORMATION.—

23 “(1) NOTICE OF CONFIDENTIALITY PRAC-
24 TICES.—

1 “(A) PREPARATION OF WRITTEN NO-
 2 TICE.—A group health plan shall post or pro-
 3 vide, in writing and in a clear and conspicuous
 4 manner, notice of the plan’s confidentiality
 5 practices, that shall include—

6 “(i) a description of an individual’s
 7 rights with respect to predictive genetic in-
 8 formation;

9 “(ii) the procedures established by the
 10 plan for the exercise of the individual’s
 11 rights; and

12 “(iii) the right to obtain a copy of the
 13 notice of the confidentiality practices re-
 14 quired under this subsection.

15 “(B) MODEL NOTICE.—The Secretary, in
 16 consultation with the National Committee on
 17 Vital and Health Statistics and the National
 18 Association of Insurance Commissioners, and
 19 after notice and opportunity for public com-
 20 ment, shall develop and disseminate model no-
 21 tices of confidentiality practices. Use of the
 22 model notice shall serve as a defense against
 23 claims of receiving inappropriate notice.

24 “(2) ESTABLISHMENT OF SAFEGUARDS.—A
 25 group health plan shall establish and maintain ap-

1 appropriate administrative, technical, and physical
2 safeguards to protect the confidentiality, security,
3 accuracy, and integrity of predictive genetic informa-
4 tion created, received, obtained, maintained, used,
5 transmitted, or disposed of by such plan.”.

6 (c) DEFINITIONS.—Section 9832(d) of the Internal
7 Revenue Code of 1986 is amended by adding at the end
8 the following:

9 “(6) FAMILY MEMBER.—The term ‘family
10 member’ means, with respect to an individual—

11 “(A) the spouse of the individual;

12 “(B) a dependent child of the individual,
13 including a child who is born to or placed for
14 adoption with the individual; and

15 “(C) all other individuals related by blood
16 to the individual or the spouse or child de-
17 scribed in subparagraph (A) or (B).

18 “(7) GENETIC INFORMATION.—The term ‘ge-
19 netic information’ means information about genes,
20 gene products, or inherited characteristics that may
21 derive from an individual or a family member (in-
22 cluding information about a request for or receipt of
23 genetic services).

24 “(8) GENETIC SERVICES.—The term ‘genetic
25 services’ means health services provided to obtain,

1 assess, or interpret genetic information for diag-
2 nostic and therapeutic purposes, and for genetic
3 education and counseling.

4 “(9) PREDICTIVE GENETIC INFORMATION.—

5 “(A) IN GENERAL.—The term ‘predictive
6 genetic information’ means, in the absence of
7 symptoms, clinical signs, or a diagnosis of the
8 condition related to such information—

9 “(i) information about an individual’s
10 genetic tests;

11 “(ii) information about genetic tests
12 of family members of the individual; or

13 “(iii) information about the occur-
14 rence of a disease or disorder in family
15 members.

16 “(B) EXCEPTIONS.—The term ‘predictive
17 genetic information’ shall not include—

18 “(i) information about the sex or age
19 of the individual;

20 “(ii) information derived from phys-
21 ical tests, such as the chemical, blood, or
22 urine analyses of the individual including
23 cholesterol tests; and

24 “(iii) information about physical
25 exams of the individual.

1 “(10) GENETIC TEST.—The term ‘genetic test’
 2 means the analysis of human DNA, RNA, chro-
 3 mosomes, proteins, and certain metabolites, includ-
 4 ing analysis of genotypes, mutations, phenotypes, or
 5 karyotypes, for the purpose of predicting risk of dis-
 6 ease in asymptomatic or undiagnosed individuals.
 7 Such term does not include physical tests, such as
 8 the chemical, blood, or urine analyses of the indi-
 9 vidual including cholesterol tests, and physical exams
 10 of the individual, in order to detect symptoms, clin-
 11 ical signs, or a diagnosis of disease.”.

12 (d) EFFECTIVE DATE.—Except as provided in this
 13 section, this section and the amendments made by this
 14 section shall apply with respect to group health plans for
 15 plan years beginning after 1 year after the date of the
 16 enactment of this Act.

17 **TITLE IV—HEALTHCARE** 18 **RESEARCH AND QUALITY**

19 **SEC. 401. SHORT TITLE.**

20 This title may be cited as the “Healthcare Research
 21 and Quality Act of 1999”.

22 **SEC. 402. AMENDMENT TO THE PUBLIC HEALTH SERVICE** 23 **ACT.**

24 Title IX of the Public Health Service Act (42 U.S.C.
 25 299 et seq.) is amended to read as follows:

1 **“TITLE IX—AGENCY FOR**
 2 **HEALTHCARE RESEARCH**
 3 **AND QUALITY**

4 **“PART A—ESTABLISHMENT AND GENERAL**
 5 **DUTIES**

6 **“SEC. 901. MISSION AND DUTIES.**

7 “(a) IN GENERAL.—There is established within the
 8 Public Health Service an agency to be known as the Agen-
 9 cy for Healthcare Research and Quality. In carrying out
 10 this subsection, the Secretary shall redesignate the Agency
 11 for Health Care Policy and Research as the Agency for
 12 Healthcare Research and Quality.

13 “(b) MISSION.—The purpose of the Agency is to en-
 14 hance the quality, appropriateness, and effectiveness of
 15 healthcare services, and access to such services, through
 16 the establishment of a broad base of scientific research
 17 and through the promotion of improvements in clinical
 18 and health system practices, including the prevention of
 19 diseases and other health conditions. The Agency shall
 20 promote healthcare quality improvement by—

21 “(1) conducting and supporting research that
 22 develops and presents scientific evidence regarding
 23 all aspects of healthcare, including—

24 “(A) the development and assessment of
 25 methods for enhancing patient participation in

1 their own care and for facilitating shared pa-
 2 tient-physician decision-making;

3 “(B) the outcomes, effectiveness, and cost-
 4 effectiveness of healthcare practices, including
 5 preventive measures and long-term care;

6 “(C) existing and innovative technologies;

7 “(D) the costs and utilization of, and ac-
 8 cess to healthcare;

9 “(E) the ways in which healthcare services
 10 are organized, delivered, and financed and the
 11 interaction and impact of these factors on the
 12 quality of patient care;

13 “(F) methods for measuring quality and
 14 strategies for improving quality; and

15 “(G) ways in which patients, consumers,
 16 purchasers, and practitioners acquire new infor-
 17 mation about best practices and health benefits,
 18 the determinants and impact of their use of this
 19 information;

20 “(2) synthesizing and disseminating available
 21 scientific evidence for use by patients, consumers,
 22 practitioners, providers, purchasers, policy makers,
 23 and educators; and

24 “(3) advancing private and public efforts to im-
 25 prove healthcare quality.

1 “(c) REQUIREMENTS WITH RESPECT TO RURAL
 2 AREAS AND PRIORITY POPULATIONS.—In carrying out
 3 subsection (b), the Director shall undertake and support
 4 research, demonstration projects, and evaluations with re-
 5 spect to the delivery of health services—

6 “(1) in rural areas (including frontier areas);

7 “(2) for low-income groups, and minority
 8 groups;

9 “(3) for children;

10 “(4) for elderly; and

11 “(5) for people with special healthcare needs,
 12 including disabilities, chronic care and end-of-life
 13 healthcare.

14 “(d) APPOINTMENT OF DIRECTOR.—There shall be
 15 at the head of the Agency an official to be known as the
 16 Director for Healthcare Research and Quality. The Direc-
 17 tor shall be appointed by the Secretary. The Secretary,
 18 acting through the Director, shall carry out the authorities
 19 and duties established in this title.

20 **“SEC. 902. GENERAL AUTHORITIES.**

21 “(a) IN GENERAL.—In carrying out section 901(b),
 22 the Director shall support demonstration projects, conduct
 23 and support research, evaluations, training, research net-
 24 works, multi-disciplinary centers, technical assistance, and
 25 the dissemination of information, on healthcare, and on

1 systems for the delivery of such care, including activities
 2 with respect to—

3 “(1) the quality, effectiveness, efficiency, appro-
 4 priateness and value of healthcare services;

5 “(2) quality measurement and improvement;

6 “(3) the outcomes, cost, cost-effectiveness, and
 7 use of healthcare services and access to such serv-
 8 ices;

9 “(4) clinical practice, including primary care
 10 and practice-oriented research;

11 “(5) healthcare technologies, facilities, and
 12 equipment;

13 “(6) healthcare costs, productivity, organiza-
 14 tion, and market forces;

15 “(7) health promotion and disease prevention,
 16 including clinical preventive services;

17 “(8) health statistics, surveys, database devel-
 18 opment, and epidemiology; and

19 “(9) medical liability.

20 “(b) HEALTH SERVICES TRAINING GRANTS.—

21 “(1) IN GENERAL.—The Director may provide
 22 training grants in the field of health services re-
 23 search related to activities authorized under sub-
 24 section (a), to include pre- and post-doctoral fellow-
 25 ships and training programs, young investigator

1 awards, and other programs and activities as appro-
2 priate. In carrying out this subsection, the Director
3 shall make use of funds made available under sec-
4 tion 487 as well as other appropriated funds.

5 “(2) REQUIREMENTS.—In developing priorities
6 for the allocation of training funds under this sub-
7 section, the Director shall take into consideration
8 shortages in the number of trained researchers ad-
9 dressing the priority populations.

10 “(c) MULTIDISCIPLINARY CENTERS.—The Director
11 may provide financial assistance to assist in meeting the
12 costs of planning and establishing new centers, and oper-
13 ating existing and new centers, for multidisciplinary
14 health services research, demonstration projects, evalua-
15 tions, training, and policy analysis with respect to the mat-
16 ters referred to in subsection (a).

17 “(d) RELATION TO CERTAIN AUTHORITIES REGARD-
18 ING SOCIAL SECURITY.—Activities authorized in this sec-
19 tion shall be appropriately coordinated with experiments,
20 demonstration projects, and other related activities au-
21 thorized by the Social Security Act and the Social Security
22 Amendments of 1967. Activities under subsection (a)(2)
23 of this section that affect the programs under titles XVIII,
24 XIX and XXI of the Social Security Act shall be carried
25 out consistent with section 1142 of such Act.

1 “(e) DISCLAIMER.—The Agency shall not mandate
 2 national standards of clinical practice or quality
 3 healthcare standards. Recommendations resulting from
 4 projects funded and published by the Agency shall include
 5 a corresponding disclaimer.

6 “(f) RULE OF CONSTRUCTION.—Nothing in this sec-
 7 tion shall be construed to imply that the Agency’s role is
 8 to mandate a national standard or specific approach to
 9 quality measurement and reporting. In research and qual-
 10 ity improvement activities, the Agency shall consider a
 11 wide range of choices, providers, healthcare delivery sys-
 12 tems, and individual preferences.

13 **“PART B—HEALTHCARE IMPROVEMENT**

14 **RESEARCH**

15 **“SEC. 911. HEALTHCARE OUTCOME IMPROVEMENT RE-** 16 **SEARCH.**

17 “(a) EVIDENCE RATING SYSTEMS.—In collaboration
 18 with experts from the public and private sector, the Agen-
 19 cy shall identify and disseminate methods or systems that
 20 it uses to assess healthcare research results, particularly
 21 methods or systems that it uses to rate the strength of
 22 the scientific evidence behind healthcare practice, rec-
 23 ommendations in the research literature, and technology
 24 assessments. The Agency shall make methods and systems
 25 for evidence rating widely available. Agency publications

1 containing healthcare recommendations shall indicate the
2 level of substantiating evidence using such methods or sys-
3 tems.

4 “(b) HEALTHCARE IMPROVEMENT RESEARCH CEN-
5 TERS AND PROVIDER-BASED RESEARCH NETWORKS.—In
6 order to address the full continuum of care and outcomes
7 research, to link research to practice improvement, and
8 to speed the dissemination of research findings to commu-
9 nity practice settings, the Agency shall employ research
10 strategies and mechanisms that will link research directly
11 with clinical practice in geographically diverse locations
12 throughout the United States, including—

13 “(1) Healthcare Improvement Research Centers
14 that combine demonstrated multidisciplinary exper-
15 tise in outcomes or quality improvement research
16 with linkages to relevant sites of care;

17 “(2) Provider-based Research Networks, includ-
18 ing plan, facility, or delivery system sites of care (es-
19 pecially primary care), that can evaluate and pro-
20 mote quality improvement; and

21 “(3) other innovative mechanisms or strategies
22 to link research with clinical practice.

1 **“SEC. 912. PRIVATE-PUBLIC PARTNERSHIPS TO IMPROVE**
2 **ORGANIZATION AND DELIVERY.**

3 “(a) SUPPORT FOR EFFORTS TO DEVELOP INFOR-
4 MATION ON QUALITY.—

5 “(1) SCIENTIFIC AND TECHNICAL SUPPORT.—

6 In its role as the principal agency for healthcare re-
7 search and quality, the Agency may provide sci-
8 entific and technical support for private and public
9 efforts to improve healthcare quality, including the
10 activities of accrediting organizations.

11 “(2) ROLE OF THE AGENCY.—With respect to
12 paragraph (1), the role of the Agency shall include—

13 “(A) the identification and assessment of
14 methods for the evaluation of the health of—

15 “(i) enrollees in health plans by type
16 of plan, provider, and provider arrange-
17 ments; and

18 “(ii) other populations, including
19 those receiving long-term care services;

20 “(B) the ongoing development, testing, and
21 dissemination of quality measures, including
22 measures of health and functional outcomes;

23 “(C) the compilation and dissemination of
24 healthcare quality measures developed in the
25 private and public sector;

1 “(D) assistance in the development of im-
2 proved healthcare information systems;

3 “(E) the development of survey tools for
4 the purpose of measuring participant and bene-
5 ficiary assessments of their healthcare; and

6 “(F) identifying and disseminating infor-
7 mation on mechanisms for the integration of in-
8 formation on quality into purchaser and con-
9 sumer decision-making processes.

10 “(b) CENTERS FOR EDUCATION AND RESEARCH ON
11 THERAPEUTICS.—

12 “(1) IN GENERAL.—The Secretary, acting
13 through the Director and in consultation with the
14 Commissioner of Food and Drugs, shall establish a
15 program for the purpose of making one or more
16 grants for the establishment and operation of one or
17 more centers to carry out the activities specified in
18 paragraph (2).

19 “(2) REQUIRED ACTIVITIES.—The activities re-
20 ferred to in this paragraph are the following:

21 “(A) The conduct of state-of-the-art clin-
22 ical, laboratory, or health services research for
23 the following purposes:

24 “(i) To increase awareness of—

1 “(I) new uses of drugs, biological
2 products, and devices;

3 “(II) ways to improve the effec-
4 tive use of drugs, biological products,
5 and devices; and

6 “(III) risks of new uses and risks
7 of combinations of drugs and biologi-
8 cal products.

9 “(ii) To provide objective clinical in-
10 formation to the following individuals and
11 entities:

12 “(I) Healthcare practitioners and
13 other providers of healthcare goods or
14 services.

15 “(II) Pharmacists, pharmacy
16 benefit managers and purchasers.

17 “(III) Health maintenance orga-
18 nizations and other managed
19 healthcare organizations.

20 “(IV) Healthcare insurers and
21 governmental agencies.

22 “(V) Patients and consumers.

23 “(iii) To improve the quality of
24 healthcare while reducing the cost of
25 Healthcare through—

1 “(I) an increase in the appro-
2 priate use of drugs, biological prod-
3 ucts, or devices; and

4 “(II) the prevention of adverse
5 effects of drugs, biological products,
6 and devices and the consequences of
7 such effects, such as unnecessary hos-
8 pitalizations.

9 “(B) The conduct of research on the com-
10 parative effectiveness, cost-effectiveness, and
11 safety of drugs, biological products, and devices.

12 “(C) Such other activities as the Secretary
13 determines to be appropriate, except that grant
14 funds may not be used by the Secretary in con-
15 ducting regulatory review of new drugs.

16 “(c) REDUCING ERRORS IN MEDICINE.—The Direc-
17 tor shall conduct and support research and build private-
18 public partnerships to—

19 “(1) identify the causes of preventable
20 healthcare errors and patient injury in healthcare
21 delivery;

22 “(2) develop, demonstrate, and evaluate strate-
23 gies for reducing errors and improving patient safe-
24 ty; and

1 “(3) promote the implementation of effective
2 strategies throughout the healthcare industry.

3 **“SEC. 913. INFORMATION ON QUALITY AND COST OF CARE.**

4 “(a) IN GENERAL.—In carrying out 902(a), the Di-
5 rector shall—

6 “(1) conduct a survey to collect data on a na-
7 tionally representative sample of the population on
8 the cost, use and, for fiscal year 2001 and subse-
9 quent fiscal years, quality of healthcare, including
10 the types of healthcare services Americans use, their
11 access to healthcare services, frequency of use, how
12 much is paid for the services used, the source of
13 those payments, the types and costs of private
14 health insurance, access, satisfaction, and quality of
15 care for the general population including rural resi-
16 dents and for the populations identified in section
17 901(c); and

18 “(2) develop databases and tools that provide
19 information to States on the quality, access, and use
20 of healthcare services provided to their residents.

21 “(b) QUALITY AND OUTCOMES INFORMATION.—

22 “(1) IN GENERAL.—Beginning in fiscal year
23 2001, the Director shall ensure that the survey con-
24 ducted under subsection (a)(1) will—

1 “(A) identify determinants of health out-
2 comes and functional status, and their relation-
3 ships to healthcare access and use, determine
4 the ways and extent to which the priority popu-
5 lations enumerated in section 901(c) differ from
6 the general population with respect to such
7 variables, measure changes over time with re-
8 spect to such variable, and monitor the overall
9 national impact of changes in Federal and
10 State policy on healthcare;

11 “(B) provide information on the quality of
12 care and patient outcomes for frequently occur-
13 ring clinical conditions for a nationally rep-
14 resentative sample of the population including
15 rural residents; and

16 “(C) provide reliable national estimates for
17 children and persons with special healthcare
18 needs through the use of supplements or peri-
19 odic expansions of the survey.

20 In expanding the Medical Expenditure Panel Survey,
21 as in existence on the date of enactment of this title,
22 in fiscal year 2001 to collect information on the
23 quality of care, the Director shall take into account
24 any outcomes measurements generally collected by
25 private sector accreditation organizations.

1 “(2) ANNUAL REPORT.—Beginning in fiscal
2 year 2003, the Secretary, acting through the Direc-
3 tor, shall submit to Congress an annual report on
4 national trends in the quality of healthcare provided
5 to the American people.

6 **“SEC. 914. INFORMATION SYSTEMS FOR HEALTHCARE IM-**
7 **PROVEMENT.**

8 “(a) IN GENERAL.—In order to foster a range of in-
9 novative approaches to the management and communica-
10 tion of health information, the Agency shall support re-
11 search, evaluations and initiatives to advance—

12 “(1) the use of information systems for the
13 study of healthcare quality, including the generation
14 of both individual provider and plan-level compara-
15 tive performance data;

16 “(2) training for healthcare practitioners and
17 researchers in the use of information systems;

18 “(3) the creation of effective linkages between
19 various sources of health information, including the
20 development of information networks;

21 “(4) the delivery and coordination of evidence-
22 based healthcare services, including the use of real-
23 time healthcare decision-support programs;

24 “(5) the utility and comparability of health in-
25 formation data and medical vocabularies by address-

1 ing issues related to the content, structure, defini-
2 tions and coding of such information and data in
3 consultation with appropriate Federal, State and
4 private entities;

5 “(6) the use of computer-based health records
6 in all settings for the development of personal health
7 records for individual health assessment and mainte-
8 nance, and for monitoring public health and out-
9 comes of care within populations; and

10 “(7) the protection of individually identifiable
11 information in health services research and
12 healthcare quality improvement.

13 “(b) DEMONSTRATION.—The Agency shall support
14 demonstrations into the use of new information tools
15 aimed at improving shared decision-making between pa-
16 tients and their care-givers.

17 **“SEC. 915. RESEARCH SUPPORTING PRIMARY CARE AND**
18 **ACCESS IN UNDERSERVED AREAS.**

19 “(a) PREVENTIVE SERVICES TASK FORCE.—

20 “(1) ESTABLISHMENT AND PURPOSE.—The Di-
21 rector may periodically convene a Preventive Serv-
22 ices Task Force to be composed of individuals with
23 appropriate expertise. Such a task force shall review
24 the scientific evidence related to the effectiveness,
25 appropriateness, and cost-effectiveness of clinical

1 preventive services for the purpose of developing rec-
2 ommendations for the healthcare community, and
3 updating previous clinical preventive recommenda-
4 tions.

5 “(2) ROLE OF AGENCY.—The Agency shall pro-
6 vide ongoing administrative, research, and technical
7 support for the operations of the Preventive Services
8 Task Force, including coordinating and supporting
9 the dissemination of the recommendations of the
10 Task Force.

11 “(3) OPERATION.—In carrying out its respon-
12 sibilities under paragraph (1), the Task Force is not
13 subject to the provisions of Appendix 2 of title 5,
14 United States Code.

15 “(b) PRIMARY CARE RESEARCH.—

16 “(1) IN GENERAL.—There is established within
17 the Agency a Center for Primary Care Research (re-
18 ferred to in this subsection as the ‘Center’) that
19 shall serve as the principal source of funding for pri-
20 mary care practice research in the Department of
21 Health and Human Services. For purposes of this
22 paragraph, primary care research focuses on the
23 first contact when illness or health concerns arise,
24 the diagnosis, treatment or referral to specialty care,
25 preventive care, and the relationship between the cli-

1 nician and the patient in the context of the family
2 and community.

3 “(2) RESEARCH.—In carrying out this section,
4 the Center shall conduct and support research
5 concerning—

6 “(A) the nature and characteristics of pri-
7 mary care practice;

8 “(B) the management of commonly occur-
9 ring clinical problems;

10 “(C) the management of undifferentiated
11 clinical problems; and

12 “(D) the continuity and coordination of
13 health services.

14 **“SEC. 916. CLINICAL PRACTICE AND TECHNOLOGY INNOVA-**
15 **TION.**

16 “(a) IN GENERAL.—The Director shall promote inno-
17 vation in evidence-based clinical practice and healthcare
18 technologies by—

19 “(1) conducting and supporting research on the
20 development, diffusion, and use of healthcare tech-
21 nology;

22 “(2) developing, evaluating, and disseminating
23 methodologies for assessments of healthcare prac-
24 tices and healthcare technologies;

1 “(3) conducting intramural and supporting ex-
2 tramural assessments of existing and new healthcare
3 practices and technologies;

4 “(4) promoting education, training, and pro-
5 viding technical assistance in the use of healthcare
6 practice and healthcare technology assessment meth-
7 odologies and results; and

8 “(5) working with the National Library of Med-
9 icine and the public and private sector to develop an
10 electronic clearinghouse of currently available assess-
11 ments and those in progress.

12 “(b) SPECIFICATION OF PROCESS.—

13 “(1) IN GENERAL.—Not later than December
14 31, 2000, the Director shall develop and publish a
15 description of the methodology used by the Agency
16 and its contractors in conducting practice and tech-
17 nology assessment.

18 “(2) CONSULTATIONS.—In carrying out this
19 subsection, the Director shall cooperate and consult
20 with the Assistant Secretary for Health, the Admin-
21 istrator of the Health Care Financing Administra-
22 tion, the Director of the National Institutes of
23 Health, the Commissioner of Food and Drugs, and
24 the heads of any other interested Federal depart-
25 ment or agency, and shall seek input, where appro-

1 piate, from professional societies and other private
2 and public entities.

3 “(3) METHODOLOGY.—The Director, in devel-
4 oping assessment methodology, shall consider—

5 “(A) safety, efficacy, and effectiveness;

6 “(B) legal, social, and ethical implications;

7 “(C) costs, benefits, and cost-effectiveness;

8 “(D) comparisons to alternate technologies
9 and practices; and

10 “(E) requirements of Food and Drug Ad-
11 ministration approval to avoid duplication.

12 “(c) SPECIFIC ASSESSMENTS.—

13 “(1) IN GENERAL.—The Director shall conduct
14 or support specific assessments of healthcare tech-
15 nologies and practices.

16 “(2) REQUESTS FOR ASSESSMENTS.—The Di-
17 rector is authorized to conduct or support assess-
18 ments, on a reimbursable basis, for the Health Care
19 Financing Administration, the Department of De-
20 fense, the Department of Veterans Affairs, the Of-
21 fice of Personnel Management, and other public or
22 private entities.

23 “(3) GRANTS AND CONTRACTS.—In addition to
24 conducting assessments, the Director may make
25 grants to, or enter into cooperative agreements or

1 contracts with, entities described in paragraph (4)
2 for the purpose of conducting assessments of experi-
3 mental, emerging, existing, or potentially outmoded
4 healthcare technologies, and for related activities.

5 “(4) ELIGIBLE ENTITIES.—An entity described
6 in this paragraph is an entity that is determined to
7 be appropriate by the Director, including academic
8 medical centers, research institutions and organiza-
9 tions, professional organizations, third party payers,
10 governmental agencies, and consortia of appropriate
11 research entities established for the purpose of con-
12 ducting technology assessments.

13 **“SEC. 917. COORDINATION OF FEDERAL GOVERNMENT**
14 **QUALITY IMPROVEMENT EFFORTS.**

15 “(a) REQUIREMENT.—

16 “(1) IN GENERAL.—To avoid duplication and
17 ensure that Federal resources are used efficiently
18 and effectively, the Secretary, acting through the Di-
19 rector, shall coordinate all research, evaluations, and
20 demonstrations related to health services research,
21 quality measurement and quality improvement ac-
22 tivities undertaken and supported by the Federal
23 Government.

24 “(2) SPECIFIC ACTIVITIES.—The Director, in
25 collaboration with the appropriate Federal officials

1 representing all concerned executive agencies and de-
2 partments, shall develop and manage a process to—

3 “(A) improve interagency coordination, pri-
4 ority setting, and the use and sharing of re-
5 search findings and data pertaining to Federal
6 quality improvement programs, technology as-
7 sessment, and health services research;

8 “(B) strengthen the research information
9 infrastructure, including databases, pertaining
10 to Federal health services research and
11 healthcare quality improvement initiatives;

12 “(C) set specific goals for participating
13 agencies and departments to further health
14 services research and healthcare quality im-
15 provement; and

16 “(D) strengthen the management of Fed-
17 eral healthcare quality improvement programs.

18 “(b) STUDY BY THE INSTITUTE OF MEDICINE.—

19 “(1) IN GENERAL.—To provide Congress, the
20 Department of Health and Human Services, and
21 other relevant departments with an independent, ex-
22 ternal review of their quality oversight, quality im-
23 provement and quality research programs, the Sec-
24 retary shall enter into a contract with the Institute
25 of Medicine—

1 “(A) to describe and evaluate current qual-
2 ity improvement, quality research and quality
3 monitoring processes through—

4 “(i) an overview of pertinent health
5 services research activities and quality im-
6 provement efforts conducted by all Federal
7 programs, with particular attention paid to
8 those under titles XVIII, XIX, and XXI of
9 the Social Security Act; and

10 “(ii) a summary of the partnerships
11 that the Department of Health and
12 Human Services has pursued with private
13 accreditation, quality measurement and
14 improvement organizations; and

15 “(B) to identify options and make rec-
16 ommendations to improve the efficiency and ef-
17 fectiveness of quality improvement programs
18 through—

19 “(i) the improved coordination of ac-
20 tivities across the medicare, medicaid and
21 child health insurance programs under ti-
22 tles XVIII, XIX and XXI of the Social Se-
23 curity Act and health services research
24 programs;

1 “(ii) the strengthening of patient
2 choice and participation by incorporating
3 state-of-the-art quality monitoring tools
4 and making information on quality avail-
5 able; and

6 “(iii) the enhancement of the most ef-
7 fective programs, consolidation as appro-
8 priate, and elimination of duplicative ac-
9 tivities within various federal agencies.

10 “(2) REQUIREMENTS.—

11 “(A) IN GENERAL.—The Secretary shall
12 enter into a contract with the Institute of Medi-
13 cine for the preparation—

14 “(i) not later than 12 months after
15 the date of enactment of this title, of a re-
16 port providing an overview of the quality
17 improvement programs of the Department
18 of Health and Human Services for the
19 medicare, medicaid, and CHIP programs
20 under titles XVIII, XIX, and XXI of the
21 Social Security Act; and

22 “(ii) not later than 24 months after
23 the date of enactment of this title, of a
24 final report containing recommendations.

1 “(B) REPORTS.—The Secretary shall sub-
 2 mit the reports described in subparagraph (A)
 3 to the Committee on Finance and the Com-
 4 mittee on Health, Education, Labor, and Pen-
 5 sions of the Senate and the Committee on Ways
 6 and Means and the Committee on Commerce of
 7 the House of Representatives.

8 **“PART C—GENERAL PROVISIONS**

9 **“SEC. 921. ADVISORY COUNCIL FOR HEALTHCARE RE-**
 10 **SEARCH AND QUALITY.**

11 “(a) ESTABLISHMENT.—There is established an advi-
 12 sory council to be known as the Advisory Council for
 13 Healthcare Research and Quality.

14 “(b) DUTIES.—

15 “(1) IN GENERAL.—The Advisory Council shall
 16 advise the Secretary and the Director with respect
 17 to activities proposed or undertaken to carry out the
 18 purpose of the Agency under section 901(b).

19 “(2) CERTAIN RECOMMENDATIONS.—Activities
 20 of the Advisory Council under paragraph (1) shall
 21 include making recommendations to the Director
 22 regarding—

23 “(A) priorities regarding healthcare re-
 24 search, especially studies related to quality, out-

1 comes, cost and the utilization of, and access
2 to, healthcare services;

3 “(B) the field of healthcare research and
4 related disciplines, especially issues related to
5 training needs, and dissemination of informa-
6 tion pertaining to healthcare quality; and

7 “(C) the appropriate role of the Agency in
8 each of these areas in light of private sector ac-
9 tivity and identification of opportunities for
10 public-private sector partnerships.

11 “(c) MEMBERSHIP.—

12 “(1) IN GENERAL.—The Advisory Council shall,
13 in accordance with this subsection, be composed of
14 appointed members and ex officio members. All
15 members of the Advisory Council shall be voting
16 members other than the individuals designated
17 under paragraph (3)(B) as ex officio members.

18 “(2) APPOINTED MEMBERS.—The Secretary
19 shall appoint to the Advisory Council 21 appro-
20 priately qualified individuals. At least 17 members of
21 the Advisory Council shall be representatives of the
22 public who are not officers or employees of the
23 United States. The Secretary shall ensure that the
24 appointed members of the Council, as a group, are
25 representative of professions and entities concerned

1 with, or affected by, activities under this title and
2 under section 1142 of the Social Security Act. Of
3 such members—

4 “(A) 4 shall be individuals distinguished in
5 the conduct of research, demonstration projects,
6 and evaluations with respect to healthcare;

7 “(B) 4 shall be individuals distinguished in
8 the practice of medicine of which at least 1
9 shall be a primary care practitioner;

10 “(C) 3 shall be individuals distinguished in
11 the other health professions;

12 “(D) 4 shall be individuals either rep-
13 resenting the private healthcare sector, includ-
14 ing health plans, providers, and purchasers or
15 individuals distinguished as administrators of
16 healthcare delivery systems;

17 “(E) 4 shall be individuals distinguished in
18 the fields of healthcare quality improvement, ec-
19 onomics, information systems, law, ethics, busi-
20 ness, or public policy, including at least 1 indi-
21 vidual specializing in rural aspects in 1 or more
22 of these fields; and

23 “(F) 2 shall be individuals representing the
24 interests of patients and consumers of
25 healthcare.

1 “(3) EX OFFICIO MEMBERS.—The Secretary
2 shall designate as ex officio members of the Advisory
3 Council—

4 “(A) the Assistant Secretary for Health,
5 the Director of the National Institutes of
6 Health, the Director of the Centers for Disease
7 Control and Prevention, the Administrator of
8 the Health Care Financing Administration, the
9 Assistant Secretary of Defense (Health Af-
10 fairs), and the Under Secretary for Health of
11 the Department of Veterans Affairs; and

12 “(B) such other Federal officials as the
13 Secretary may consider appropriate.

14 “(d) TERMS.—Members of the Advisory Council ap-
15 pointed under subsection (c)(2) shall serve for a term of
16 3 years. A member of the Council appointed under such
17 subsection may continue to serve after the expiration of
18 the term of the members until a successor is appointed.

19 “(e) VACANCIES.—If a member of the Advisory
20 Council appointed under subsection (c)(2) does not serve
21 the full term applicable under subsection (d), the indi-
22 vidual appointed to fill the resulting vacancy shall be ap-
23 pointed for the remainder of the term of the predecessor
24 of the individual.

1 “(f) CHAIR.—The Director shall, from among the
2 members of the Advisory Council appointed under sub-
3 section (c)(2), designate an individual to serve as the chair
4 of the Advisory Council.

5 “(g) MEETINGS.—The Advisory Council shall meet
6 not less than once during each discrete 4-month period
7 and shall otherwise meet at the call of the Director or the
8 chair.

9 “(h) COMPENSATION AND REIMBURSEMENT OF EX-
10 PENSES.—

11 “(1) APPOINTED MEMBERS.—Members of the
12 Advisory Council appointed under subsection (c)(2)
13 shall receive compensation for each day (including
14 travel time) engaged in carrying out the duties of
15 the Advisory Council unless declined by the member.
16 Such compensation may not be in an amount in ex-
17 cess of the daily equivalent of the annual rate of
18 basic pay prescribed for level IV of the Executive
19 Schedule under section 5315 of title 5, United
20 States Code, for each day during which such mem-
21 ber is engaged in the performance of the duties of
22 the Advisory Council.

23 “(2) EX OFFICIO MEMBERS.—Officials des-
24 ignated under subsection (c)(3) as ex officio mem-
25 bers of the Advisory Council may not receive com-

1 pensation for service on the Advisory Council in ad-
 2 dition to the compensation otherwise received for du-
 3 ties carried out as officers of the United States.

4 “(i) STAFF.—The Director shall provide to the Advi-
 5 sory Council such staff, information, and other assistance
 6 as may be necessary to carry out the duties of the Council.

7 **“SEC. 922. PEER REVIEW WITH RESPECT TO GRANTS AND**
 8 **CONTRACTS.**

9 “(a) REQUIREMENT OF REVIEW.—

10 “(1) IN GENERAL.—Appropriate technical and
 11 scientific peer review shall be conducted with respect
 12 to each application for a grant, cooperative agree-
 13 ment, or contract under this title.

14 “(2) REPORTS TO DIRECTOR.—Each peer re-
 15 view group to which an application is submitted pur-
 16 suant to paragraph (1) shall report its finding and
 17 recommendations respecting the application to the
 18 Director in such form and in such manner as the
 19 Director shall require.

20 “(b) APPROVAL AS PRECONDITION OF AWARDS.—
 21 The Director may not approve an application described in
 22 subsection (a)(1) unless the application is recommended
 23 for approval by a peer review group established under sub-
 24 section (c).

25 “(c) ESTABLISHMENT OF PEER REVIEW GROUPS.—

1 “(1) IN GENERAL.—The Director shall establish
2 such technical and scientific peer review groups as
3 may be necessary to carry out this section. Such
4 groups shall be established without regard to the
5 provisions of title 5, United States Code, that govern
6 appointments in the competitive service, and without
7 regard to the provisions of chapter 51, and sub-
8 chapter III of chapter 53, of such title that relate
9 to classification and pay rates under the General
10 Schedule.

11 “(2) MEMBERSHIP.—The members of any peer
12 review group established under this section shall be
13 appointed from among individuals who by virtue of
14 their training or experience are eminently qualified
15 to carry out the duties of such peer review group.
16 Officers and employees of the United States may not
17 constitute more than 25 percent of the membership
18 of any such group. Such officers and employees may
19 not receive compensation for service on such groups
20 in addition to the compensation otherwise received
21 for these duties carried out as such officers and em-
22 ployees.

23 “(3) DURATION.—Notwithstanding section
24 14(a) of the Federal Advisory Committee Act, peer
25 review groups established under this section may

1 continue in existence until otherwise provided by
2 law.

3 “(4) QUALIFICATIONS.—Members of any peer-
4 review group shall, at a minimum, meet the fol-
5 lowing requirements:

6 “(A) Such members shall agree in writing
7 to treat information received, pursuant to their
8 work for the group, as confidential information,
9 except that this subparagraph shall not apply to
10 public records and public information.

11 “(B) Such members shall agree in writing
12 to recuse themselves from participation in the
13 peer-review of specific applications which
14 present a potential personal conflict of interest
15 or appearance of such conflict, including em-
16 ployment in a directly affected organization,
17 stock ownership, or any financial or other ar-
18 rangement that might introduce bias in the
19 process of peer-review.

20 “(d) AUTHORITY FOR PROCEDURAL ADJUSTMENTS
21 IN CERTAIN CASES.—In the case of applications for finan-
22 cial assistance whose direct costs will not exceed \$100,000,
23 the Director may make appropriate adjustments in the
24 procedures otherwise established by the Director for the
25 conduct of peer review under this section. Such adjust-

1 ments may be made for the purpose of encouraging the
 2 entry of individuals into the field of research, for the pur-
 3 pose of encouraging clinical practice-oriented or provider-
 4 based research, and for such other purposes as the Direc-
 5 tor may determine to be appropriate.

6 “(e) REGULATIONS.—The Director shall issue regula-
 7 tions for the conduct of peer review under this section.

8 **“SEC. 923. CERTAIN PROVISIONS WITH RESPECT TO DEVEL-**
 9 **OPMENT, COLLECTION, AND DISSEMINATION**
 10 **OF DATA.**

11 “(a) STANDARDS WITH RESPECT TO UTILITY OF
 12 DATA.—

13 “(1) IN GENERAL.—To ensure the utility, accu-
 14 racy, and sufficiency of data collected by or for the
 15 Agency for the purpose described in section 901(b),
 16 the Director shall establish standard methods for de-
 17 veloping and collecting such data, taking into
 18 consideration—

19 “(A) other Federal health data collection
 20 standards; and

21 “(B) the differences between types of
 22 healthcare plans, delivery systems, healthcare
 23 providers, and provider arrangements.

24 “(2) RELATIONSHIP WITH OTHER DEPARTMENT
 25 PROGRAMS.—In any case where standards under

1 paragraph (1) may affect the administration of other
2 programs carried out by the Department of Health
3 and Human Services, including the programs under
4 title XVIII, XIX or XXI of the Social Security Act,
5 or may affect health information that is subject to
6 a standard developed under part C of title XI of the
7 Social Security Act, they shall be in the form of rec-
8 ommendations to the Secretary for such program.

9 “(b) STATISTICS AND ANALYSES.—The Director
10 shall—

11 “(1) take appropriate action to ensure that sta-
12 tistics and analyses developed under this title are of
13 high quality, timely, and duly comprehensive, and
14 that the statistics are specific, standardized, and
15 adequately analyzed and indexed; and

16 “(2) publish, make available, and disseminate
17 such statistics and analyses on as wide a basis as is
18 practicable.

19 “(c) AUTHORITY REGARDING CERTAIN REQUESTS.—
20 Upon request of a public or private entity, the Director
21 may conduct or support research or analyses otherwise au-
22 thorized by this title pursuant to arrangements under
23 which such entity will pay the cost of the services provided.
24 Amounts received by the Director under such arrange-

1 ments shall be available to the Director for obligation until
2 expended.

3 **“SEC. 924. DISSEMINATION OF INFORMATION.**

4 “(a) IN GENERAL.—The Director shall—

5 “(1) without regard to section 501 of title 44,
6 United States Code, promptly publish, make avail-
7 able, and otherwise disseminate, in a form under-
8 standable and on as broad a basis as practicable so
9 as to maximize its use, the results of research, dem-
10 onstration projects, and evaluations conducted or
11 supported under this title;

12 “(2) ensure that information disseminated by
13 the Agency is science-based and objective and under-
14 takes consultation as necessary to assess the appro-
15 priateness and usefulness of the presentation of in-
16 formation that is targeted to specific audiences;

17 “(3) promptly make available to the public data
18 developed in such research, demonstration projects,
19 and evaluations;

20 “(4) provide, in collaboration with the National
21 Library of Medicine where appropriate, indexing, ab-
22 stracting, translating, publishing, and other services
23 leading to a more effective and timely dissemination
24 of information on research, demonstration projects,
25 and evaluations with respect to healthcare to public

1 and private entities and individuals engaged in the
2 improvement of healthcare delivery and the general
3 public, and undertake programs to develop new or
4 improved methods for making such information
5 available; and

6 “(5) as appropriate, provide technical assistance
7 to State and local government and health agencies
8 and conduct liaison activities to such agencies to fos-
9 ter dissemination.

10 “(b) PROHIBITION AGAINST RESTRICTIONS.—Except
11 as provided in subsection (c), the Director may not restrict
12 the publication or dissemination of data from, or the re-
13 sults of, projects conducted or supported under this title.

14 “(c) LIMITATION ON USE OF CERTAIN INFORMA-
15 TION.—No information, if an establishment or person sup-
16 plying the information or described in it is identifiable,
17 obtained in the course of activities undertaken or sup-
18 ported under this title may be used for any purpose other
19 than the purpose for which it was supplied unless such
20 establishment or person has consented (as determined
21 under regulations of the Director) to its use for such other
22 purpose. Such information may not be published or re-
23 leased in other form if the person who supplied the infor-
24 mation or who is described in it is identifiable unless such

1 person has consented (as determined under regulations of
2 the Director) to its publication or release in other form.

3 “(d) PENALTY.—Any person who violates subsection
4 (c) shall be subject to a civil monetary penalty of not more
5 than \$10,000 for each such violation involved. Such pen-
6 alty shall be imposed and collected in the same manner
7 as civil money penalties under subsection (a) of section
8 1128A of the Social Security Act are imposed and col-
9 lected.

10 **“SEC. 925. ADDITIONAL PROVISIONS WITH RESPECT TO**
11 **GRANTS AND CONTRACTS.**

12 “(a) FINANCIAL CONFLICTS OF INTEREST.—With
13 respect to projects for which awards of grants, cooperative
14 agreements, or contracts are authorized to be made under
15 this title, the Director shall by regulation define—

16 “(1) the specific circumstances that constitute
17 financial interests in such projects that will, or may
18 be reasonably expected to, create a bias in favor of
19 obtaining results in the projects that are consistent
20 with such interests; and

21 “(2) the actions that will be taken by the Direc-
22 tor in response to any such interests identified by
23 the Director.

24 “(b) REQUIREMENT OF APPLICATION.—The Director
25 may not, with respect to any program under this title au-

1 thorizing the provision of grants, cooperative agreements,
 2 or contracts, provide any such financial assistance unless
 3 an application for the assistance is submitted to the Sec-
 4 retary and the application is in such form, is made in such
 5 manner, and contains such agreements, assurances, and
 6 information as the Director determines to be necessary to
 7 carry out the program in involved.

8 “(c) PROVISION OF SUPPLIES AND SERVICES IN
 9 LIEU OF FUNDS.—

10 “(1) IN GENERAL.—Upon the request of an en-
 11 tity receiving a grant, cooperative agreement, or con-
 12 tract under this title, the Secretary may, subject to
 13 paragraph (2), provide supplies, equipment, and
 14 services for the purpose of aiding the entity in car-
 15 rying out the project involved and, for such purpose,
 16 may detail to the entity any officer or employee of
 17 the Department of Health and Human Services.

18 “(2) CORRESPONDING REDUCTION IN FUNDS.—
 19 With respect to a request described in paragraph
 20 (1), the Secretary shall reduce the amount of the fi-
 21 nancial assistance involved by an amount equal to
 22 the costs of detailing personnel and the fair market
 23 value of any supplies, equipment, or services pro-
 24 vided by the Director. The Secretary shall, for the

1 payment of expenses incurred in complying with
2 such request, expend the amounts withheld.

3 “(d) APPLICABILITY OF CERTAIN PROVISIONS WITH
4 RESPECT TO CONTRACTS.—Contracts may be entered into
5 under this part without regard to sections 3648 and 3709
6 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

7 **“SEC. 926. CERTAIN ADMINISTRATIVE AUTHORITIES.**

8 “(a) DEPUTY DIRECTOR AND OTHER OFFICERS AND
9 EMPLOYEES.—

10 “(1) DEPUTY DIRECTOR.—The Director may
11 appoint a deputy director for the Agency.

12 “(2) OTHER OFFICERS AND EMPLOYEES.—The
13 Director may appoint and fix the compensation of
14 such officers and employees as may be necessary to
15 carry out this title. Except as otherwise provided by
16 law, such officers and employees shall be appointed
17 in accordance with the civil service laws and their
18 compensation fixed in accordance with title 5,
19 United States Code.

20 “(b) FACILITIES.—The Secretary, in carrying out
21 this title—

22 “(1) may acquire, without regard to the Act of
23 March 3, 1877 (40 U.S.C. 34), by lease or otherwise
24 through the Director of General Services, buildings
25 or portions of buildings in the District of Columbia

1 or communities located adjacent to the District of
2 Columbia for use for a period not to exceed 10
3 years; and

4 “(2) may acquire, construct, improve, repair,
5 operate, and maintain laboratory, research, and
6 other necessary facilities and equipment, and such
7 other real or personal property (including patents)
8 as the Secretary deems necessary.

9 “(c) PROVISION OF FINANCIAL ASSISTANCE.—The
10 Director, in carrying out this title, may make grants to
11 public and nonprofit entities and individuals, and may
12 enter into cooperative agreements or contracts with public
13 and private entities and individuals.

14 “(d) UTILIZATION OF CERTAIN PERSONNEL AND RE-
15 SOURCES.—

16 “(1) DEPARTMENT OF HEALTH AND HUMAN
17 SERVICES.—The Director, in carrying out this title,
18 may utilize personnel and equipment, facilities, and
19 other physical resources of the Department of
20 Health and Human Services, permit appropriate (as
21 determined by the Secretary) entities and individuals
22 to utilize the physical resources of such Department,
23 and provide technical assistance and advice.

24 “(2) OTHER AGENCIES.—The Director, in car-
25 rying out this title, may use, with their consent, the

1 services, equipment, personnel, information, and fa-
2 cilities of other Federal, State, or local public agen-
3 cies, or of any foreign government, with or without
4 reimbursement of such agencies.

5 “(e) CONSULTANTS.—The Secretary, in carrying out
6 this title, may secure, from time to time and for such peri-
7 ods as the Director deems advisable but in accordance
8 with section 3109 of title 5, United States Code, the as-
9 sistance and advice of consultants from the United States
10 or abroad.

11 “(f) EXPERTS.—

12 “(1) IN GENERAL.—The Secretary may, in car-
13 rying out this title, obtain the services of not more
14 than 50 experts or consultants who have appropriate
15 scientific or professional qualifications. Such experts
16 or consultants shall be obtained in accordance with
17 section 3109 of title 5, United States Code, except
18 that the limitation in such section on the duration
19 of service shall not apply.

20 “(2) TRAVEL EXPENSES.—

21 “(A) IN GENERAL.—Experts and consult-
22 ants whose services are obtained under para-
23 graph (1) shall be paid or reimbursed for their
24 expenses associated with traveling to and from
25 their assignment location in accordance with

1 sections 5724, 5724a(a), 5724a(c), and
2 5726(C) of title 5, United States Code.

3 “(B) LIMITATION.—Expenses specified in
4 subparagraph (A) may not be allowed in con-
5 nection with the assignment of an expert or
6 consultant whose services are obtained under
7 paragraph (1) unless and until the expert
8 agrees in writing to complete the entire period
9 of assignment, or 1 year, whichever is shorter,
10 unless separated or reassigned for reasons that
11 are beyond the control of the expert or consult-
12 ant and that are acceptable to the Secretary. If
13 the expert or consultant violates the agreement,
14 the money spent by the United States for the
15 expenses specified in subparagraph (A) is recov-
16 erable from the expert or consultant as a statu-
17 tory obligation owed to the United States. The
18 Secretary may waive in whole or in part a right
19 of recovery under this subparagraph.

20 “(g) VOLUNTARY AND UNCOMPENSATED SERV-
21 ICES.—The Director, in carrying out this title, may accept
22 voluntary and uncompensated services.

23 **“SEC. 927. FUNDING.**

24 “(a) INTENT.—To ensure that the United States’s in-
25 vestment in biomedical research is rapidly translated into

1 improvements in the quality of patient care, there must
2 be a corresponding investment in research on the most ef-
3 fective clinical and organizational strategies for use of
4 these findings in daily practice. The authorization levels
5 in subsection (b) provide for a proportionate increase in
6 healthcare research as the United States investment in
7 biomedical research increases.

8 “(b) AUTHORIZATION OF APPROPRIATIONS.—For the
9 purpose of carrying out this title, there are authorized to
10 be appropriated \$250,000,000 for fiscal year 2000, and
11 such sums as may be necessary for each of the fiscal years
12 2001 through 2006.

13 “(c) EVALUATIONS.—In addition to amounts avail-
14 able pursuant to subsection (b) for carrying out this title,
15 there shall be made available for such purpose, from the
16 amounts made available pursuant to section 241 (relating
17 to evaluations), an amount equal to 40 percent of the max-
18 imum amount authorized in such section 241 to be made
19 available for a fiscal year.

20 **“SEC. 928. DEFINITIONS.**

21 “In this title:

22 “(1) ADVISORY COUNCIL.—The term ‘Advisory
23 Council’ means the Advisory Council on Healthcare
24 Research and Quality established under section 921.

1 “(2) AGENCY.—The term ‘Agency’ means the
2 Agency for Healthcare Research and Quality.

3 “(3) DIRECTOR.—The term ‘Director’ means
4 the Director for the Agency for Healthcare Research
5 and Quality.”.

6 **SEC. 403. REFERENCES.**

7 Effective upon the date of enactment of this Act, any
8 reference in law to the “Agency for Health Care Policy
9 and Research” shall be deemed to be a reference to the
10 “Agency for Healthcare Research and Quality”.

11 **TITLE V—ENHANCED ACCESS TO**
12 **HEALTH INSURANCE COVERAGE**

13 **SEC. 501. FULL DEDUCTION OF HEALTH INSURANCE COSTS**
14 **FOR SELF-EMPLOYED INDIVIDUALS.**

15 (a) IN GENERAL.—Section 162(l)(1) of the Internal
16 Revenue Code of 1986 (relating to allowance of deduc-
17 tions) is amended to read as follows:

18 “(1) ALLOWANCE OF DEDUCTION.—In the case
19 of an individual who is an employee within the
20 meaning of section 401(c)(1), there shall be allowed
21 as a deduction under this section an amount equal
22 to the amount paid during the taxable year for in-
23 surance which constitutes medical care for the tax-
24 payer, his spouse, and his dependents.”.

1 (b) EFFECTIVE DATE.—The amendments made by
 2 this section shall apply to taxable years beginning after
 3 December 31, 1999.

4 **SEC. 502. FULL AVAILABILITY OF MEDICAL SAVINGS AC-**
 5 **COUNTS.**

6 (a) AVAILABILITY NOT LIMITED TO ACCOUNTS FOR
 7 EMPLOYEES OF SMALL EMPLOYERS AND SELF-EM-
 8 PLOYED INDIVIDUALS.—

9 (1) IN GENERAL.—Section 220(c)(1)(A) of the
 10 Internal Revenue Code of 1986 (relating to eligible
 11 individual) is amended to read as follows:

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

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

18 “(ii) such individual is not, while cov-
 19 ered under a high deductible health plan,
 20 covered under any health plan—

21 “(I) which is not a high deduct-
 22 ible health plan, and

23 “(II) which provides coverage for
 24 any benefit which is covered under the
 25 high deductible health plan.”.

1 (2) CONFORMING AMENDMENTS.—

2 (A) Section 220(c)(1) of such Code is
3 amended by striking subparagraphs (C) and
4 (D).

5 (B) Section 220(c) of such Code is amend-
6 ed by striking paragraph (4) (defining small
7 employer) and by redesignating paragraph (5)
8 as paragraph (4).

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

14 (b) REMOVAL OF LIMITATION ON NUMBER OF TAX-
15 PAYERS HAVING MEDICAL SAVINGS ACCOUNTS.—

16 (1) IN GENERAL.—Section 220 of the Internal
17 Revenue Code of 1986 (relating to medical savings
18 accounts) is amended by striking subsections (i) and
19 (j).

20 (2) MEDICARE+CHOICE.—Section 138 of such
21 Code (relating to Medicare+Choice MSA) is amend-
22 ed by striking subsection (f).

23 (c) REDUCTION IN HIGH DEDUCTIBLE PLAN MIN-
24 IMUM ANNUAL DEDUCTIBLE.—

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

4 (A) by striking “\$1,500” and inserting
 5 “\$1,000”, and

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

8 (2) CONFORMING AMENDMENT.—Subsection (g)
 9 of section 220 of such Code is amended—

10 (A) by striking “1998” and inserting
 11 “1999”; and

12 (B) by striking “1997” and inserting
 13 “1998”.

14 (d) INCREASE IN CONTRIBUTION LIMIT TO 100 PER-
 15 CENT OF ANNUAL DEDUCTIBLE.—

16 (1) IN GENERAL.—Section 220(b)(2) of the In-
 17 ternal Revenue Code of 1986 (relating to monthly
 18 limitation) is amended to read as follows:

19 “(2) MONTHLY LIMITATION.—The monthly lim-
 20 itation for any month is the amount equal to $\frac{1}{12}$ of
 21 the annual deductible of the high deductible health
 22 plan of the individual.”.

23 (2) CONFORMING AMENDMENT.—Section
 24 220(d)(1)(A) of such Code is amended by striking
 25 “75 percent of”.

1 (e) LIMITATION ON ADDITIONAL TAX ON DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—Section 220(f)(4) of the Internal Revenue Code of 1986 (relating to additional tax on distributions not used for qualified medical expenses) is amended by adding at the end the following:

2 “(D) EXCEPTION IN CASE OF SUFFICIENT ACCOUNT BALANCE.—Subparagraph (A) shall not apply to any payment or distribution in any taxable year, but only to the extent such payment or distribution does not reduce the fair market value of the assets of the medical savings account to an amount less than the annual deductible for the high deductible health plan of the account holder (determined as of January 1 of the calendar year in which the taxable year begins).”.

3 (f) TREATMENT OF NETWORK-BASED MANAGED CARE PLANS.—Section 220(c)(2)(B) of the Internal Revenue Code of 1986 (relating to special rules for high deductible health plans) is amended by adding at the end the following:

4 “(iii) TREATMENT OF NETWORK-BASED MANAGED CARE PLANS.—A plan that provides health care services through

1 a network of contracted or affiliated health
2 care providers, if the benefits provided
3 when services are obtained through net-
4 work providers meet the requirements of
5 subparagraph (A), shall not fail to be
6 treated as a high deductible health plan by
7 reason of providing benefits for services
8 rendered by providers who are not mem-
9 bers of the network, so long as the annual
10 deductible and annual limit on out-of-pock-
11 et expenses applicable to services received
12 from non-network providers are not lower
13 than those applicable to services received
14 from the network providers.”.

15 (g) EFFECTIVE DATE.—The amendments made by
16 this section shall apply to taxable years beginning after
17 December 31, 1999.

18 **SEC. 503. PERMITTING CONTRIBUTION TOWARDS MEDICAL**
19 **SAVINGS ACCOUNT THROUGH FEDERAL EM-**
20 **PLOYEES HEALTH BENEFITS PROGRAM**
21 **(FEHBP).**

22 (a) AUTHORITY TO CONTRACT FOR CATASTROPHIC
23 PLANS.—Section 8902 of title 5, United States Code, is
24 amended by adding at the end the following:

1 “(p)(1) The Office shall contract under this chapter
2 for a catastrophic plan with any qualified carrier that—

3 “(A) offers such a plan; and

4 “(B) as of the date of enactment of the Pa-
5 tients’ Bill of Rights Plus Act, offers a health bene-
6 fits plan under this chapter.

7 “(2) The Office may contract under this chapter for
8 a catastrophic plan with any qualified carrier that—

9 “(A) offers such a plan; but

10 “(B) does not satisfy the requirement under
11 paragraph (1)(B).”.

12 (b) GOVERNMENT CONTRIBUTION TO MEDICAL SAV-
13 INGS ACCOUNT.—

14 (1) IN GENERAL.—Section 8906 of title 5,
15 United States Code, is amended by adding at the
16 end the following:

17 “(j)(1) In the case of an employee or annuitant who
18 is enrolled in a catastrophic plan described by section
19 8903(5), there shall be a Government contribution under
20 this subsection to a medical savings account established
21 or maintained for the benefit of the individual. The con-
22 tribution under this subsection shall be in addition to the
23 Government contribution under subsection (b).

1 “(2) The amount of the Government contribution
 2 under this subsection with respect to an individual is equal
 3 to the amount by which—

4 “(A) the maximum contribution allowed under
 5 subsection (b)(1) with respect to any employee or
 6 annuitant, exceeds

7 “(B) the amount of the Government contribu-
 8 tion actually made with respect to the individual
 9 under subsection (b) for coverage under the cata-
 10 strophic plan.

11 “(3) The Government contributions under this sub-
 12 section shall be paid into a medical savings account (des-
 13 ignated by the individual involved) in a manner that is
 14 specified by the Office and consistent with the timing of
 15 contributions under subsection (b).

16 “(4) Subsections (f) and (g) shall apply to contribu-
 17 tions under this section in the same manner as they apply
 18 to contributions under subsection (b).

19 “(5) For the purpose of this subsection, the term
 20 ‘medical savings account’ has the meaning given such term
 21 by section 220(d) of the Internal Revenue Code of 1986.”.

22 (2) ALLOWING PAYMENT OF FULL AMOUNT OF
 23 CHARGE FOR CATASTROPHIC PLAN.—Section
 24 8906(b)(2) of such title is amended by inserting “(or
 25 100 percent of the subscription charge in the case

1 of a catastrophic plan)” after “75 percent of the
2 subscription charge”.

3 (c) OFFERING OF CATASTROPHIC PLANS.—

4 (1) IN GENERAL.—Section 8903 of title 5,
5 United States Code, is amended by adding at the
6 end the following:

7 “(5) CATASTROPHIC PLANS.—(A) One or more
8 plans described in paragraph (1), (2), or (3), but
9 which provide benefits of the types referred to by
10 paragraph (5) of section 8904(a), instead of the
11 types referred to in paragraphs (1), (2), and (3) of
12 such section.

13 “(B) Nothing in this section shall be
14 considered—

15 “(i) to prevent a carrier from simulta-
16 neously offering a plan described by subpara-
17 graph (A) and a plan described by paragraph
18 (1) or (2);

19 “(ii) to require that a catastrophic plan
20 offer two levels of benefits; or

21 “(iii) to allow, in any contract year, for—

22 “(I) more than one plan to be offered
23 which satisfies both subparagraph (A) and
24 paragraph (1) (subject to clause (ii)); and

1 “(II) more than one plan which satis-
 2 fies both subparagraph (A) and paragraph
 3 (2) (subject to clause (ii)).”.

4 (2) TYPES OF BENEFITS.—Section 8904(a) of
 5 such title is amended by inserting after paragraph
 6 (4) the following new paragraph:

7 “(5) CATASTROPHIC PLANS.—Benefits of the
 8 types named under paragraph (1) or (2) of this sub-
 9 section or both, except that the plan shall meet the
 10 annual deductible and annual out-of-pocket expenses
 11 requirements under section 220(c)(2) of the Internal
 12 Revenue Code of 1986.”.

13 (3) DETERMINING LEVEL OF GOVERNMENT
 14 CONTRIBUTIONS.—Section 8906(b) of such title is
 15 amended by adding at the end the following: “Sub-
 16 scription charges for medical savings accounts shall
 17 be deemed to be the amount of Government con-
 18 tributions made under subsection (j)(2).”.

19 (d) CONFORMING AMENDMENTS.—

20 (1) ADDITIONAL HEALTH BENEFITS PLANS.—
 21 Section 8903a of title 5, United States Code, is
 22 amended by redesignating subsection (d) as sub-
 23 section (e) and by inserting after subsection (c) the
 24 following:

1 “(d) The plans under this section may include one
2 or more plans, otherwise allowable under this section, that
3 satisfy the requirements of clauses (i) and (ii) of section
4 8903(5)(A).”.

5 (2) REFERENCE.—Section 8909(d) of title 5,
6 United States Code, is amended by striking
7 “8903a(d)” and inserting “8903a(e)”.

8 (e) REFERENCES.—Section 8903 of title 5, United
9 States Code, is amended by adding at the end (as a flush
10 left sentence) the following:

11 “The Office shall prescribe regulations under which the
12 requirements of section 8902(c), 8902(n), 8909(e), and
13 any other provision of this chapter that applies with re-
14 spect to a plan described by paragraph (1), (2), (3), or
15 (4) of this section shall apply with respect to the cor-
16 responding plan under paragraph (5) of this section. Simi-
17 lar regulations shall be prescribed with respect to any plan
18 under section 8903a(d).”.

19 (f) EFFECTIVE DATE.—The amendments made by
20 this section shall apply to contract terms beginning on or
21 after January 1, 2000.

1 **SEC. 504. CARRYOVER OF UNUSED BENEFITS FROM CAFETERIA PLANS, FLEXIBLE SPENDING ARRANGEMENTS, AND HEALTH FLEXIBLE SPENDING ACCOUNTS.**

5 (a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 (relating to cafeteria plans) is amended
6
7 by redesignating subsections (h) and (i) as subsections (i) and (j) and by inserting after subsection (g) the following
8
9 new subsection:

10 “(h) ALLOWANCE OF CARRYOVERS OF UNUSED BENEFITS TO LATER TAXABLE YEARS.—

12 “(1) IN GENERAL.—For purposes of this title—

13 “(A) notwithstanding subsection (d)(2), a
14 plan or other arrangement shall not fail to be
15 treated as a cafeteria plan or flexible spending
16 or similar arrangement, and

17 “(B) no amount shall be required to be included in gross income by reason of this section
18
19 or any other provision of this chapter,

20 solely because under such plan or other arrangement
21 any nontaxable benefit which is unused as of the
22 close of a taxable year may be carried forward to 1
23 or more succeeding taxable years.

24 “(2) LIMITATION.—Paragraph (1) shall not
25 apply to amounts carried from a plan to the extent
26 such amounts exceed \$500 (applied on an annual

1 basis). For purposes of this paragraph, all plans and
2 arrangements maintained by an employer or any re-
3 lated person shall be treated as 1 plan.

4 “(3) ALLOWANCE OF ROLLOVER.—

5 “(A) IN GENERAL.—In the case of any un-
6 used benefit described in paragraph (1) which
7 consists of amounts in a health flexible spend-
8 ing account or dependent care flexible spending
9 account, the plan or arrangement shall provide
10 that a participant may elect, in lieu of such car-
11 ryover, to have such amounts distributed to the
12 participant.

13 “(B) AMOUNTS NOT INCLUDED IN IN-
14 COME.—Any distribution under subparagraph
15 (A) shall not be included in gross income to the
16 extent that such amount is transferred in a
17 trustee-to-trustee transfer, or is contributed
18 within 60 days of the date of the distribution,
19 to—

20 “(i) a qualified cash or deferred ar-
21 rangement described in section 401(k),

22 “(ii) a plan under which amounts are
23 contributed by an individual’s employer for
24 an annuity contract described in section
25 403(b),

1 “(iii) an eligible deferred compensa-
2 tion plan described in section 457, or

3 “(iv) a medical savings account (with-
4 in the meaning of section 220).

5 Any amount rolled over under this subpara-
6 graph shall be treated as a rollover contribution
7 for the taxable year from which the unused
8 amount would otherwise be carried.

9 “(C) TREATMENT OF ROLLOVER.—Any
10 amount rolled over under subparagraph (B)
11 shall be treated as an eligible rollover under
12 section 220, 401(k), 403(b), or 457, whichever
13 is applicable, and shall be taken into account in
14 applying any limitation (or participation re-
15 quirement) on employer or employee contribu-
16 tions under such section or any other provision
17 of this chapter for the taxable year of the roll-
18 over.

19 “(4) COST-OF-LIVING ADJUSTMENT.—In the
20 case of any taxable year beginning in a calendar
21 year after 1999, the \$500 amount under paragraph
22 (2) shall be adjusted at the same time and in the
23 same manner as under section 415(d)(2), except
24 that the base period taken into account shall be the
25 calendar quarter beginning October 1, 1998, and

1 any increase which is not a multiple of \$50 shall be
 2 rounded to the next lowest multiple of \$50.

3 “(5) APPLICABILITY.—This subsection shall
 4 apply to taxable years beginning after December 31,
 5 1999.”.

6 (b) EFFECTIVE DATE.—The amendments made by
 7 this section shall apply to taxable years beginning after
 8 December 31, 1999.

9 **TITLE VI—PROVISIONS RELAT-**
 10 **ING TO LONG-TERM CARE IN-**
 11 **SURANCE**

12 **SEC. 601. INCLUSION OF QUALIFIED LONG-TERM CARE IN-**
 13 **SURANCE CONTRACTS IN CAFETERIA PLANS,**
 14 **FLEXIBLE SPENDING ARRANGEMENTS, AND**
 15 **HEALTH FLEXIBLE SPENDING ACCOUNTS.**

16 (a) IN GENERAL.—Section 125(f) of the Internal
 17 Revenue Code of 1986 (defining qualified benefits) is
 18 amended by striking the last sentence and inserting the
 19 following: “Such term includes any qualified long-term
 20 care insurance contract.”.

21 (b) EFFECTIVE DATE.—The amendment made by
 22 this section shall apply to taxable years beginning after
 23 December 31, 1999.

1 **SEC. 602. DEDUCTION FOR PREMIUMS FOR LONG-TERM**
 2 **CARE INSURANCE.**

3 (a) IN GENERAL.—Part VII of subchapter B of chap-
 4 ter 1 of the Internal Revenue Code of 1986 (relating to
 5 additional itemized deductions) is amended by redesign-
 6 nating section 222 as section 223 and by inserting after
 7 section 221 the following:

8 **“SEC. 222. PREMIUMS FOR LONG-TERM CARE INSURANCE.**

9 “(a) IN GENERAL.—In the case of an eligible indi-
 10 vidual, there shall be allowed as a deduction an amount
 11 equal to 100 percent of the amount paid during the tax-
 12 able year for any coverage for qualified long-term care
 13 services (as defined in section 7702B(c)) or any qualified
 14 long-term care insurance contract (as defined in section
 15 7702B(b)) which constitutes medical care for the tax-
 16 payer, his spouse, and dependents.

17 “(b) LIMITATIONS.—

18 “(1) DEDUCTION NOT AVAILABLE TO INDIVID-
 19 UALS ELIGIBLE FOR EMPLOYER-SUBSIDIZED COV-
 20 ERAGE.—

21 “(A) IN GENERAL.—Except as provided in
 22 subparagraph (B), subsection (a) shall not
 23 apply to any taxpayer for any calendar month
 24 for which the taxpayer is eligible to participate
 25 in any plan which includes coverage for quali-
 26 fied long-term care services (as so defined) or

1 is a qualified long-term care insurance contract
2 (as so defined) maintained by any employer (or
3 former employer) of the taxpayer or of the
4 spouse of the taxpayer.

5 “(B) CONTINUATION COVERAGE.—Cov-
6 erage shall not be treated as subsidized for pur-
7 poses of this paragraph if—

8 “(i) such coverage is continuation cov-
9 erage (within the meaning of section
10 4980B(f)) required to be provided by the
11 employer, and

12 “(ii) the taxpayer or the taxpayer’s
13 spouse is required to pay a premium for
14 such coverage in an amount not less than
15 100 percent of the applicable premium
16 (within the meaning of section
17 4980B(f)(4)) for the period of such cov-
18 erage.

19 “(2) LIMITATION ON LONG-TERM CARE PRE-
20 MIUMS.—In the case of a qualified long-term care
21 insurance contract (as so defined), only eligible long-
22 term care premiums (as defined in section
23 213(d)(10)) shall be taken into account under sub-
24 section (a)(2).

1 “(c) SPECIAL RULES.—For purposes of this
2 section—

3 “(1) COORDINATION WITH MEDICAL DEDUC-
4 TION, ETC.—Any amount paid by a taxpayer for in-
5 surance to which subsection (a) applies shall not be
6 taken into account in computing the amount allow-
7 able to the taxpayer as a deduction under section
8 213(a).

9 “(2) DEDUCTION NOT ALLOWED FOR SELF-EM-
10 PLOYMENT TAX PURPOSES.—The deduction allow-
11 able by reason of this section shall not be taken into
12 account in determining an individual’s net earnings
13 from self-employment (within the meaning of section
14 1402(a)) for purposes of chapter 2.”.

15 (b) CONFORMING AMENDMENTS.—

16 (1) Subsection (a) of section 62 of the Internal
17 Revenue Code of 1986 is amended by inserting after
18 paragraph (17) the following:

19 “(18) LONG-TERM CARE INSURANCE COSTS OF
20 CERTAIN INDIVIDUALS.—The deduction allowed by
21 section 222.”.

22 (2) The table of sections for part VII of sub-
23 chapter B of chapter 1 of such Code is amended by
24 striking the last item and inserting the following:

“Sec. 222. Premiums for long-term care insurance.

“Sec. 223. Cross reference.”.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to taxable years beginning after
3 December 31, 1999.

4 **SEC. 603. STUDY OF LONG-TERM CARE NEEDS IN THE 21ST**
5 **CENTURY.**

6 (a) IN GENERAL.—The Secretary of Health and
7 Human Services (referred to in this section as the “Sec-
8 retary”) shall provide, in accordance with this section, for
9 a study in order to determine—

10 (1) future demand for long-term health care
11 services (including institutional and home and com-
12 munity-based services) in the United States in order
13 to meet the needs in the 21st century; and

14 (2) long-term options to finance the provision of
15 such services.

16 (b) DETAILS.—The study conducted under sub-
17 section (a) shall include the following:

18 (1) An identification of the relevant demo-
19 graphic characteristics affecting demand for long-
20 term health care services, at least through the year
21 2030.

22 (2) The viability and capacity of community-
23 based and other long-term health care services under
24 different federal programs, including through the

1 medicare and medicaid programs, grants to States,
2 housing services, and changes in tax policy.

3 (3) How to improve the quality of long-term
4 health care services.

5 (4) The integration of long-term health care
6 services for individuals between different classes of
7 health care providers (such as hospitals, nursing fa-
8 cilities, and home care agencies) and different Fed-
9 eral programs (such as the medicare and medicaid
10 programs).

11 (5) The possibility of expanding private sector
12 initiatives, including long-term care insurance, to
13 meet the need to finance such services.

14 (6) An examination of the effect of enactment
15 of the Health Insurance Portability and Account-
16 ability Act of 1996 on the provision and financing
17 of long-term health care services, including on port-
18 ability and affordability of private long-term care in-
19 surance, the impact of insurance options on low-in-
20 come older Americans, and the options for eligibility
21 to improve access to such insurance.

22 (7) The financial impact of the provision of
23 long-term health care services on caregivers and
24 other family members.

25 (c) REPORT AND RECOMMENDATIONS.—

1 (1) IN GENERAL.—Not later than 1 year after
2 the date of the enactment of this Act, the Secretary
3 shall provide for a report on the study under this
4 section.

5 (2) RECOMMENDATIONS.—The report under
6 paragraph (1) shall include findings and rec-
7 ommendations regarding each of the following:

8 (A) The most effective and efficient man-
9 ner that the Federal government may use its
10 resources to educate the public on planning for
11 needs for long-term health care services.

12 (B) The public, private, and joint public-
13 private strategies for meeting identified needs
14 for long-term health care services.

15 (C) The role of States and local commu-
16 nities in the financing of long-term health care
17 services.

18 (3) INCLUSION OF COST ESTIMATES.—The re-
19 port under paragraph (1) shall include cost esti-
20 mates of the various options for which recommenda-
21 tions are made.

22 (d) CONDUCT OF STUDY.—

23 (1) USE OF INSTITUTE OF MEDICINE.—The
24 Secretary of Health and Human Services shall seek
25 to enter into an appropriate arrangement with the

1 Institute of Medicine of the National Academy of
 2 Sciences to conduct the study under this section. If
 3 such an arrangement cannot be made, the Secretary
 4 may provide for the conduct of the study by any
 5 other qualified non-governmental entity.

6 (2) CONSULTATION.—The study should be con-
 7 ducted under this section in consultation with ex-
 8 perts from a wide-range of groups from the public
 9 and private sectors.

10 **TITLE VII—INDIVIDUAL** 11 **RETIREMENT PLANS**

12 **SEC. 701. MODIFICATION OF INCOME LIMITS ON CON-** 13 **TRIBUTIONS AND ROLLOVERS TO ROTH IRAS.**

14 (a) INCREASE IN AGI LIMIT FOR ROLLOVER CON-
 15 TRIBUTIONS.—Clause (i) of section 408A(c)(3)(A) of the
 16 Internal Revenue Code of 1986 (relating to rollover from
 17 IRA), as redesignated by subsection (a), is amended by
 18 striking “\$100,000” and inserting “\$1,000,000”.

19 (b) CONFORMING AMENDMENTS.—

20 (1)(A) Subparagraph (B) of section 408A(c)(3)
 21 of the Internal Revenue Code of 1986, as redesign-
 22 nated by subsection (a), is amended to read as fol-
 23 lows:

1 “(B) DEFINITION OF ADJUSTED GROSS IN-
 2 COME.—For purposes of subparagraph (A), ad-
 3 justed gross income shall be determined—

4 “(i) after application of sections 86
 5 and 469, and

6 “(ii) without regard to sections 135,
 7 137, 221, and 911, the deduction allowable
 8 under section 219, or any amount included
 9 in gross income under subsection (d)(3).”.

10 (B) EFFECTIVE DATE.—The amendment made
 11 by this paragraph shall apply to taxable years begin-
 12 ning after December 31, 1999.

13 (2)(A) Subparagraph (B) of section 408A(c)(3)
 14 of such Code, as amended by paragraph (1), is
 15 amended to read as follows:

16 “(B) DEFINITION OF ADJUSTED GROSS IN-
 17 COME.—For purposes of subparagraph (A), ad-
 18 justed gross income shall be determined—

19 “(i) after application of sections 86
 20 and 469, and

21 “(ii) without regard to sections 135,
 22 137, 221, and 911, the deduction allowable
 23 under section 219, or any amount included
 24 in gross income under subsection (d)(3) or

1 by reason of a required distribution under
2 a provision described in paragraph (5).”.

3 (B) EFFECTIVE DATE.—The amendment made
4 by this paragraph shall apply to taxable years begin-
5 ning after December 31, 2004.

6 (c) EFFECTIVE DATE.—Except as otherwise provided
7 in this section, the amendments made by this section shall
8 apply to taxable years beginning after December 31, 1999.

9 **TITLE VIII—REVENUE**
10 **PROVISIONS**

11 **SEC. 801. MODIFICATION TO FOREIGN TAX CREDIT**

12 **CARRYBACK AND CARRYOVER PERIODS.**

13 (a) IN GENERAL.—Section 904(c) of the Internal
14 Revenue Code of 1986 (relating to limitation on credit)
15 is amended—

16 (1) by striking “in the second preceding taxable
17 year,” and

18 (2) by striking “or fifth” and inserting “fifth,
19 sixth, or seventh”.

20 (b) EFFECTIVE DATE.—The amendment made by
21 subsection (a) shall apply to credits arising in taxable
22 years beginning after December 31, 2001.

1 **SEC. 802. LIMITATION ON USE OF NON-ACCRUAL EXPERI-**
2 **ENCE METHOD OF ACCOUNTING.**

3 (a) IN GENERAL.—Section 448(d)(5) of the Internal
4 Revenue Code of 1986 (relating to special rule for serv-
5 ices) is amended—

6 (1) by inserting “in fields described in para-
7 graph (2)(A)” after “services by such person”, and

8 (2) by inserting “CERTAIN PERSONAL” before
9 “SERVICES” in the heading.

10 (b) EFFECTIVE DATE.—

11 (1) IN GENERAL.—The amendments made by
12 this section shall apply to taxable years ending after
13 the date of the enactment of this Act.

14 (2) CHANGE IN METHOD OF ACCOUNTING.—In
15 the case of any taxpayer required by the amend-
16 ments made by this section to change its method of
17 accounting for its first taxable year ending after the
18 date of the enactment of this Act—

19 (A) such change shall be treated as initi-
20 ated by the taxpayer,

21 (B) such change shall be treated as made
22 with the consent of the Secretary of the Treas-
23 ury, and

24 (C) the net amount of the adjustments re-
25 quired to be taken into account by the taxpayer
26 under section 481 of the Internal Revenue Code

1 of 1986 shall be taken into account over a pe-
2 riod (not greater than 4 taxable years) begin-
3 ning with such first taxable year.

4 **SEC. 803. RETURNS RELATING TO CANCELLATIONS OF IN-**
5 **DEBTEDNESS BY ORGANIZATIONS LENDING**
6 **MONEY.**

7 (a) IN GENERAL.—Paragraph (2) of section
8 6050P(c) of the Internal Revenue Code of 1986 (relating
9 to definitions and special rules) is amended by striking
10 “and” at the end of subparagraph (B), by striking the
11 period at the end of subparagraph (C) and inserting “,
12 and”, and by inserting after subparagraph (C) the fol-
13 lowing new subparagraph:

14 “(D) any organization a significant trade
15 or business of which is the lending of money.”.

16 (b) EFFECTIVE DATE.—The amendment made by
17 subsection (a) shall apply to discharges of indebtedness
18 after December 31, 1999.

19 **SEC. 804. EXTENSION OF INTERNAL REVENUE SERVICE**
20 **USER FEES.**

21 (a) IN GENERAL.—Chapter 77 of the Internal Rev-
22 enue Code of 1986 (relating to miscellaneous provisions)
23 is amended by adding at the end the following new section:

1 **“SEC. 7527. INTERNAL REVENUE SERVICE USER FEES.**

2 “(a) GENERAL RULE.—The Secretary shall establish
3 a program requiring the payment of user fees for—

4 “(1) requests to the Internal Revenue Service
5 for ruling letters, opinion letters, and determination
6 letters, and

7 “(2) other similar requests.

8 “(b) PROGRAM CRITERIA.—

9 “(1) IN GENERAL.—The fees charged under the
10 program required by subsection (a)—

11 “(A) shall vary according to categories (or
12 subcategories) established by the Secretary,

13 “(B) shall be determined after taking into
14 account the average time for (and difficulty of)
15 complying with requests in each category (and
16 subcategory), and

17 “(C) shall be payable in advance.

18 “(2) EXEMPTIONS, ETC.—The Secretary shall
19 provide for such exemptions (and reduced fees)
20 under such program as the Secretary determines to
21 be appropriate.

22 “(3) AVERAGE FEE REQUIREMENT.—The aver-
23 age fee charged under the program required by sub-
24 section (a) shall not be less than the amount deter-
25 mined under the following table:

“Category	Average Fee
Employee plan ruling and opinion	\$250
Exempt organization ruling	\$350
Employee plan determination	\$300
Exempt organization determination	\$275
Chief counsel ruling	\$200.

1 “(c) TERMINATION.—No fee shall be imposed under
2 this section with respect to requests made after September
3 30, 2009.”.

4 (b) CONFORMING AMENDMENTS.—

5 (1) The table of sections for chapter 77 of the
6 Internal Revenue Code of 1986 is amended by add-
7 ing at the end the following new item:

“Sec. 7527. Internal Revenue Service user fees.”.

8 (2) Section 10511 of the Revenue Act of 1987
9 is repealed.

10 (c) EFFECTIVE DATE.—The amendments made by
11 this section shall apply to requests made after the date
12 of the enactment of this Act.

13 **SEC. 805. PROPERTY SUBJECT TO A LIABILITY TREATED IN**
14 **SAME MANNER AS ASSUMPTION OF LIABIL-**
15 **ITY.**

16 (a) REPEAL OF PROPERTY SUBJECT TO A LIABILITY
17 TEST.—

18 (1) SECTION 357.—Section 357(a)(2) of the In-
19 ternal Revenue Code of 1986 (relating to assump-
20 tion of liability) is amended by striking “, or ac-

1 quires from the taxpayer property subject to a liabil-
2 ity”.

3 (2) SECTION 358.—Section 358(d)(1) of such
4 Code (relating to assumption of liability) is amended
5 by striking “or acquired from the taxpayer property
6 subject to a liability”.

7 (3) SECTION 368.—

8 (A) Section 368(a)(1)(C) of such Code is
9 amended by striking “, or the fact that prop-
10 erty acquired is subject to a liability,”.

11 (B) The last sentence of section
12 368(a)(2)(B) of such Code is amended by strik-
13 ing “, and the amount of any liability to which
14 any property acquired from the acquiring cor-
15 poration is subject,”.

16 (b) CLARIFICATION OF ASSUMPTION OF LIABIL-
17 ITY.—

18 (1) IN GENERAL.—Section 357 of the Internal
19 Revenue Code of 1986 is amended by adding at the
20 end the following new subsection:

21 “(d) DETERMINATION OF AMOUNT OF LIABILITY AS-
22 SUMED.—

23 “(1) IN GENERAL.—For purposes of this sec-
24 tion, section 358(d), section 362(d), section

1 368(a)(1)(C), and section 368(a)(2)(B), except as
2 provided in regulations—

3 “(A) a recourse liability (or portion there-
4 of) shall be treated as having been assumed if,
5 as determined on the basis of all facts and cir-
6 cumstances, the transferee has agreed to, and is
7 expected to, satisfy such liability (or portion),
8 whether or not the transferor has been relieved
9 of such liability, and

10 “(B) except to the extent provided in para-
11 graph (2), a nonrecourse liability shall be treat-
12 ed as having been assumed by the transferee of
13 any asset subject to such liability.

14 “(2) EXCEPTION FOR NONRECOURSE LIABIL-
15 ITY.—The amount of the nonrecourse liability treat-
16 ed as described in paragraph (1)(B) shall be reduced
17 by the lesser of—

18 “(A) the amount of such liability which an
19 owner of other assets not transferred to the
20 transferee and also subject to such liability has
21 agreed with the transferee to, and is expected
22 to, satisfy, or

23 “(B) the fair market value of such other
24 assets (determined without regard to section
25 7701(g)).

1 “(3) REGULATIONS.—The Secretary shall pre-
 2 scribe such regulations as may be necessary to carry
 3 out the purposes of this subsection and section
 4 362(d). The Secretary may also prescribe regula-
 5 tions which provide that the manner in which a li-
 6 ability is treated as assumed under this subsection
 7 is applied, where appropriate, elsewhere in this
 8 title.”.

9 (2) LIMITATION ON BASIS INCREASE ATTRIB-
 10 UTABLE TO ASSUMPTION OF LIABILITY.—Section
 11 362 of such Code is amended by adding at the end
 12 the following new subsection:

13 “(d) LIMITATION ON BASIS INCREASE ATTRIB-
 14 UTABLE TO ASSUMPTION OF LIABILITY.—

15 “(1) IN GENERAL.—In no event shall the basis
 16 of any property be increased under subsection (a) or
 17 (b) above the fair market value of such property (de-
 18 termined without regard to section 7701(g)) by rea-
 19 son of any gain recognized to the transferor as a re-
 20 sult of the assumption of a liability.

21 “(2) TREATMENT OF GAIN NOT SUBJECT TO
 22 TAX.—Except as provided in regulations, if—

23 “(A) gain is recognized to the transferor as
 24 a result of an assumption of a nonrecourse li-

1 ability by a transferee which is also secured by
 2 assets not transferred to such transferee, and

3 “(B) no person is subject to tax under this
 4 title on such gain,

5 then, for purposes of determining basis under sub-
 6 sections (a) and (b), the amount of gain recognized
 7 by the transferor as a result of the assumption of
 8 the liability shall be determined as if the liability as-
 9 sumed by the transferee equaled such transferee’s
 10 ratable portion of such liability determined on the
 11 basis of the relative fair market values (determined
 12 without regard to section 7701(g)) of all of the as-
 13 sets subject to such liability.”.

14 (c) APPLICATION TO PROVISIONS OTHER THAN SUB-
 15 CHAPTER C.—

16 (1) SECTION 584.—Section 584(h)(3) of the In-
 17 ternal Revenue Code of 1986 is amended—

18 (A) by striking “, and the fact that any
 19 property transferred by the common trust fund
 20 is subject to a liability,” in subparagraph (A),
 21 and

22 (B) by striking clause (ii) of subparagraph
 23 (B) and inserting:

24 “(ii) ASSUMED LIABILITIES.—For
 25 purposes of clause (i), the term ‘assumed

1 liabilities' means any liability of the com-
2 mon trust fund assumed by any regulated
3 investment company in connection with the
4 transfer referred to in paragraph (1)(A).

5 “(C) ASSUMPTION.—For purposes of this
6 paragraph, in determining the amount of any li-
7 ability assumed, the rules of section 357(d)
8 shall apply.”.

9 (2) SECTION 1031.—The last sentence of section
10 1031(d) of such Code is amended—

11 (A) by striking “assumed a liability of the
12 taxpayer or acquired from the taxpayer prop-
13 erty subject to a liability” and inserting “as-
14 sumed (as determined under section 357(d)) a
15 liability of the taxpayer”, and

16 (B) by striking “or acquisition (in the
17 amount of the liability)”.

18 (d) CONFORMING AMENDMENTS.—

19 (1) Section 351(h)(1) of the Internal Revenue
20 Code of 1986 is amended by striking “, or acquires
21 property subject to a liability,”.

22 (2) Section 357 of such Code is amended by
23 striking “or acquisition” each place it appears in
24 subsection (a) or (b).

1 (3) Section 357(b)(1) of such Code is amended
2 by striking “or acquired”.

3 (4) Section 357(c)(1) of such Code is amended
4 by striking “, plus the amount of the liabilities to
5 which the property is subject,”.

6 (5) Section 357(c)(3) of such Code is amended
7 by striking “or to which the property transferred is
8 subject”.

9 (6) Section 358(d)(1) of such Code is amended
10 by striking “or acquisition (in the amount of the li-
11 ability)”.

12 (e) EFFECTIVE DATE.—The amendments made by
13 this section shall apply to transfers after October 19,
14 1998.

15 **SEC. 806. CHARITABLE SPLIT-DOLLAR LIFE INSURANCE,**
16 **ANNUITY, AND ENDOWMENT CONTRACTS.**

17 (a) IN GENERAL.—Subsection (f) of section 170 of
18 the Internal Revenue Code of 1986 (relating to disallow-
19 ance of deduction in certain cases and special rules) is
20 amended by adding at the end the following new para-
21 graph:

22 “(10) SPLIT-DOLLAR LIFE INSURANCE, ANNU-
23 ITY, AND ENDOWMENT CONTRACTS.—

24 “(A) IN GENERAL.—Nothing in this sec-
25 tion or in section 545(b)(2), 556(b)(2), 642(c),

1 2055, 2106(a)(2), or 2522 shall be construed to
2 allow a deduction, and no deduction shall be al-
3 lowed, for any transfer to or for the use of an
4 organization described in subsection (c) if in
5 connection with such transfer—

6 “(i) the organization directly or indi-
7 rectly pays, or has previously paid, any
8 premium on any personal benefit contract
9 with respect to the transferor, or

10 “(ii) there is an understanding or ex-
11 pectation that any person will directly or
12 indirectly pay any premium on any per-
13 sonal benefit contract with respect to the
14 transferor.

15 “(B) PERSONAL BENEFIT CONTRACT.—

16 For purposes of subparagraph (A), the term
17 ‘personal benefit contract’ means, with respect
18 to the transferor, any life insurance, annuity, or
19 endowment contract if any direct or indirect
20 beneficiary under such contract is the trans-
21 feror, any member of the transferor’s family, or
22 any other person (other than an organization
23 described in subsection (c)) designated by the
24 transferor.

“(C) APPLICATION TO CHARITABLE RE-
 MAINDER TRUSTS.—In the case of a transfer to
 a trust referred to in subparagraph (E), ref-
 erences in subparagraphs (A) and (F) to an or-
 ganization described in subsection (c) shall be
 treated as a reference to such trust.

“(D) EXCEPTION FOR CERTAIN ANNUITY
 CONTRACTS.—If, in connection with a transfer
 to or for the use of an organization described
 in subsection (c), such organization incurs an
 obligation to pay a charitable gift annuity (as
 defined in section 501(m)) and such organiza-
 tion purchases any annuity contract to fund
 such obligation, persons receiving payments
 under the charitable gift annuity shall not be
 treated for purposes of subparagraph (B) as in-
 direct beneficiaries under such contract if—

“(i) such organization possesses all of
 the incidents of ownership under such con-
 tract,

“(ii) such organization is entitled to
 all the payments under such contract, and

“(iii) the timing and amount of pay-
 ments under such contract are substan-
 tially the same as the timing and amount

1 of payments to each such person under
 2 such obligation (as such obligation is in ef-
 3 fect at the time of such transfer).

4 “(E) EXCEPTION FOR CERTAIN CON-
 5 TRACTS HELD BY CHARITABLE REMAINDER
 6 TRUSTS.—A person shall not be treated for pur-
 7 poses of subparagraph (B) as an indirect bene-
 8 ficiary under any life insurance, annuity, or en-
 9 dowment contract held by a charitable remain-
 10 der annuity trust or a charitable remainder
 11 unitrust (as defined in section 664(d)) solely by
 12 reason of being entitled to any payment re-
 13 ferred to in paragraph (1)(A) or (2)(A) of sec-
 14 tion 664(d) if—

15 “(i) such trust possesses all of the in-
 16 cidents of ownership under such contract,
 17 and

18 “(ii) such trust is entitled to all the
 19 payments under such contract.

20 “(F) EXCISE TAX ON PREMIUMS PAID.—

21 “(i) IN GENERAL.—There is hereby
 22 imposed on any organization described in
 23 subsection (c) an excise tax equal to the
 24 premiums paid by such organization on
 25 any life insurance, annuity, or endowment

1 contract if the payment of premiums on
2 such contract is in connection with a trans-
3 fer for which a deduction is not allowable
4 under subparagraph (A), determined with-
5 out regard to when such transfer is made.

6 “(ii) PAYMENTS BY OTHER PER-
7 SONS.—For purposes of clause (i), pay-
8 ments made by any other person pursuant
9 to an understanding or expectation re-
10 ferred to in subparagraph (A) shall be
11 treated as made by the organization.

12 “(iii) REPORTING.—Any organization
13 on which tax is imposed by clause (i) with
14 respect to any premium shall file an an-
15 nual return which includes—

16 “(I) the amount of such pre-
17 miums paid during the year and the
18 name and TIN of each beneficiary
19 under the contract to which the pre-
20 mium relates, and

21 “(II) such other information as
22 the Secretary may require.

23 The penalties applicable to returns re-
24 quired under section 6033 shall apply to
25 returns required under this clause. Returns

1 required under this clause shall be fur-
2 nished at such time and in such manner as
3 the Secretary shall by forms or regulations
4 require.

5 “(iv) CERTAIN RULES TO APPLY.—

6 The tax imposed by this subparagraph
7 shall be treated as imposed by chapter 42
8 for purposes of this title other than sub-
9 chapter B of chapter 42.

10 “(G) SPECIAL RULE WHERE STATE RE-
11 QUIRES SPECIFICATION OF CHARITABLE GIFT
12 ANNUITANT IN CONTRACT.—In the case of an
13 obligation to pay a charitable gift annuity re-
14 ferred to in subparagraph (D) which is entered
15 into under the laws of a State which requires,
16 in order for the charitable gift annuity to be ex-
17 empt from insurance regulation by such State,
18 that each beneficiary under the charitable gift
19 annuity be named as a beneficiary under an an-
20 nuity contract issued by an insurance company
21 authorized to transact business in such State,
22 the requirements of clauses (i) and (ii) of sub-
23 paragraph (D) shall be treated as met if—

24 “(i) such State law requirement was
25 in effect on February 8, 1999,

1 “(ii) each such beneficiary under the
 2 charitable gift annuity is a bona fide resi-
 3 dent of such State at the time the obliga-
 4 tion to pay a charitable gift annuity is en-
 5 tered into, and

6 “(iii) the only persons entitled to pay-
 7 ments under such contract are persons en-
 8 titled to payments as beneficiaries under
 9 such obligation on the date such obligation
 10 is entered into.

11 “(H) REGULATIONS.—The Secretary shall
 12 prescribe such regulations as may be necessary
 13 or appropriate to carry out the purposes of this
 14 paragraph, including regulations to prevent the
 15 avoidance of such purposes.”.

16 (b) EFFECTIVE DATE.—

17 (1) IN GENERAL.—Except as otherwise pro-
 18 vided in this section, the amendment made by this
 19 section shall apply to transfers made after February
 20 8, 1999.

21 (2) EXCISE TAX.—Except as provided in para-
 22 graph (3) of this subsection, section 170(f)(10)(F)
 23 of the Internal Revenue Code of 1986 (as added by
 24 this section) shall apply to premiums paid after the
 25 date of the enactment of this Act.

1 (3) REPORTING.—Clause (iii) of such section
 2 170(f)(10)(F) shall apply to premiums paid after
 3 February 8, 1999 (determined as if the tax imposed
 4 by such section applies to premiums paid after such
 5 date).

6 **SEC. 807. TRANSFER OF EXCESS DEFINED BENEFIT PLAN**
 7 **ASSETS FOR RETIREE HEALTH BENEFITS.**

8 (a) EXTENSION.—

9 (1) IN GENERAL.—Section 420(b)(5) of the In-
 10 ternal Revenue Code of 1986 (relating to expiration)
 11 is amended by striking “in any taxable year begin-
 12 ning after December 31, 2000” and inserting “made
 13 after September 30, 2009”.

14 (2) CONFORMING AMENDMENTS.—

15 (A) Section 101(e)(3) of the Employee Re-
 16 tirement Income Security Act of 1974 (29
 17 U.S.C. 1021(e)(3)) is amended by striking
 18 “1995” and inserting “2001”.

19 (B) Section 403(c)(1) of such Act (29 U.S.C.
 20 1103(c)(1)) is amended by striking “1995” and in-
 21 serting “2001”.

22 (C) Paragraph (13) of section 408(b) of such
 23 Act (29 U.S.C. 1108(b)(13)) is amended—

1 (i) by striking “in a taxable year beginning
 2 before January 1, 2001” and inserting “made
 3 before October 1, 2009”, and

4 (ii) by striking “1995” and inserting
 5 “2001”.

6 (b) APPLICATION OF MINIMUM COST REQUIRE-
 7 MENTS.—

8 (1) IN GENERAL.—Section 420(c)(3) of the In-
 9 ternal Revenue Code of 1986 is amended to read as
 10 follows:

11 “(3) MINIMUM COST REQUIREMENTS.—

12 “(A) IN GENERAL.—The requirements of
 13 this paragraph are met if each group health
 14 plan or arrangement under which applicable
 15 health benefits are provided provides that the
 16 applicable employer cost for each taxable year
 17 during the cost maintenance period shall not be
 18 less than the higher of the applicable employer
 19 costs for each of the 2 taxable years imme-
 20 diately preceding the taxable year of the quali-
 21 fied transfer.

22 “(B) APPLICABLE EMPLOYER COST.—For
 23 purposes of this paragraph, the term ‘applicable
 24 employer cost’ means, with respect to any tax-
 25 able year, the amount determined by dividing—

1 “(i) the qualified current retiree
2 health liabilities of the employer for such
3 taxable year determined—

4 “(I) without regard to any reduc-
5 tion under subsection (e)(1)(B), and

6 “(II) in the case of a taxable
7 year in which there was no qualified
8 transfer, in the same manner as if
9 there had been such a transfer at the
10 end of the taxable year, by

11 “(ii) the number of individuals to
12 whom coverage for applicable health bene-
13 fits was provided during such taxable year.

14 “(C) ELECTION TO COMPUTE COST SEPA-
15 RATELY.—An employer may elect to have this
16 paragraph applied separately with respect to in-
17 dividuals eligible for benefits under title XVIII
18 of the Social Security Act at any time during
19 the taxable year and with respect to individuals
20 not so eligible.

21 “(D) COST MAINTENANCE PERIOD.—For
22 purposes of this paragraph, the term ‘cost
23 maintenance period’ means the period of 5 tax-
24 able years beginning with the taxable year in
25 which the qualified transfer occurs. If a taxable

1 year is in 2 or more overlapping cost mainte-
 2 nance periods, this paragraph shall be applied
 3 by taking into account the highest applicable
 4 employer cost required to be provided under
 5 subparagraph (A) for such taxable year.”.

6 (2) CONFORMING AMENDMENTS.—

7 (A) Section 420(b)(1)(C)(iii) of such Code
 8 is amended by striking “benefits” and inserting
 9 “cost”.

10 (B) Section 420(e)(1)(D) of such Code is
 11 amended by striking “and shall not be subject
 12 to the minimum benefit requirements of sub-
 13 section (c)(3)” and inserting “or in calculating
 14 applicable employer cost under subsection
 15 (c)(3)(B)”.

16 (c) EFFECTIVE DATE.—The amendments made by
 17 this section shall apply to qualified transfers occurring
 18 after December 31, 2000, and before October 1, 2009.

19 **SEC. 808. LIMITATIONS ON WELFARE BENEFIT FUNDS OF 10**
 20 **OR MORE EMPLOYER PLANS.**

21 (a) BENEFITS TO WHICH EXCEPTION APPLIES.—
 22 Section 419A(f)(6)(A) of the Internal Revenue Code of
 23 1986 (relating to exception for 10 or more employer plans)
 24 is amended to read as follows:

1 “(A) IN GENERAL.—This subpart shall not
 2 apply to a welfare benefit fund which is part of
 3 a 10 or more employer plan if the only benefits
 4 provided through the fund are 1 or more of the
 5 following:

6 “(i) Medical benefits.

7 “(ii) Disability benefits.

8 “(iii) Group term life insurance bene-
 9 fits which do not provide for any cash sur-
 10 render value or other money that can be
 11 paid, assigned, borrowed, or pledged for
 12 collateral for a loan.

13 The preceding sentence shall not apply to any
 14 plan which maintains experience-rating arrange-
 15 ments with respect to individual employers.”.

16 (b) LIMITATION ON USE OF AMOUNTS FOR OTHER
 17 PURPOSES.—Section 4976(b) of the Internal Revenue
 18 Code of 1986 (defining disqualified benefit) is amended
 19 by adding at the end the following new paragraph:

20 “(5) SPECIAL RULE FOR 10 OR MORE EM-
 21 PLOYER PLANS EXEMPTED FROM PREFUNDING LIM-
 22 ITS.—For purposes of paragraph (1)(C), if—

23 “(A) subpart D of part I of subchapter D
 24 of chapter 1 does not apply by reason of section
 25 419A(f)(6) to contributions to provide 1 or

1 more welfare benefits through a welfare benefit
 2 fund under a 10 or more employer plan, and

3 “(B) any portion of the welfare benefit
 4 fund attributable to such contributions is used
 5 for a purpose other than that for which the con-
 6 tributions were made,

7 then such portion shall be treated as reverting to the
 8 benefit of the employers maintaining the fund.”.

9 (c) EFFECTIVE DATE.—The amendments made by
 10 this section shall apply to contributions paid or accrued
 11 after the date of the enactment of this Act, in taxable
 12 years ending after such date.

13 **SEC. 809. MODIFICATION OF INSTALLMENT METHOD AND**
 14 **REPEAL OF INSTALLMENT METHOD FOR AC-**
 15 **CRUAL METHOD TAXPAYERS.**

16 (a) REPEAL OF INSTALLMENT METHOD FOR AC-
 17 CRUAL BASIS TAXPAYERS.—

18 (1) IN GENERAL.—Subsection (a) of section
 19 453 of the Internal Revenue Code of 1986 (relating
 20 to installment method) is amended to read as fol-
 21 lows:

22 “(a) USE OF INSTALLMENT METHOD.—

23 “(1) IN GENERAL.—Except as otherwise pro-
 24 vided in this section, income from an installment

1 sale shall be taken into account for purposes of this
2 title under the installment method.

3 “(2) ACCRUAL METHOD TAXPAYER.—The in-
4 stallment method shall not apply to income from an
5 installment sale if such income would be reported
6 under an accrual method of accounting without re-
7 gard to this section. The preceding sentence shall
8 not apply to a disposition described in subparagraph
9 (A) or (B) of subsection (l)(2).”.

10 (2) CONFORMING AMENDMENTS.—Sections
11 453(d)(1), 453(i)(1), and 453(k) of such Code are
12 each amended by striking “(a)” each place it ap-
13 pears and inserting “(a)(1)”.

14 (b) MODIFICATION OF PLEDGE RULES.—Paragraph
15 (4) of section 453A(d) of the Internal Revenue Code of
16 1986 (relating to pledges, etc., of installment obligations)
17 is amended by adding at the end the following: “A pay-
18 ment shall be treated as directly secured by an interest
19 in an installment obligation to the extent an arrangement
20 allows the taxpayer to satisfy all or a portion of the indebt-
21 edness with the installment obligation.”.

22 (c) EFFECTIVE DATE.—The amendments made by
23 this section shall apply to sales or other dispositions occur-
24 ring on or after the date of the enactment of this Act.

1 **SEC. 810. INCLUSION OF CERTAIN VACCINES AGAINST**
2 **STREPTOCOCCUS PNEUMONIAE TO LIST OF**
3 **TAXABLE VACCINES.**

4 (a) IN GENERAL.—Section 4132(a)(1) of the Internal
5 Revenue Code of 1986 (defining taxable vaccine) is
6 amended by adding at the end the following new subpara-
7 graph:

8 “(L) Any conjugate vaccine against strep-
9 tococcus pneumoniae.”.

10 (b) EFFECTIVE DATE.—

11 (1) SALES.—The amendment made by this sec-
12 tion shall apply to vaccine sales beginning on the
13 day after the date on which the Centers for Disease
14 Control makes a final recommendation for routine
15 administration to children of any conjugate vaccine
16 against streptococcus pneumoniae.

17 (2) DELIVERIES.—For purposes of paragraph
18 (1), in the case of sales on or before the date de-
19 scribed in such paragraph for which delivery is made
20 after such date, the delivery date shall be considered
21 the sale date.

1 **TITLE IX—MISCELLANEOUS**
2 **PROVISIONS**

3 **SEC. 901. MEDICARE COMPETITIVE PRICING DEMONSTRA-**
4 **TION PROJECT.**

5 (a) FINDING.—The Senate finds that implementing
6 competitive pricing in the medicare program under title
7 XVIII of the Social Security Act is an important goal.

8 (b) PROHIBITION ON IMPLEMENTATION OF PROJECT
9 IN CERTAIN AREAS.—Notwithstanding subsection (b) of
10 section 4011 of the Balanced Budget Act of 1997 (Public
11 Law 105–33)), the Secretary of Health and Human Serv-
12 ices may not implement the Medicare Competitive Pricing
13 Demonstration Project (operated by the Secretary of
14 Health and Human Services pursuant to such section) in
15 Kansas City, Missouri or Kansas City, Kansas, or in any
16 area in Arizona.

17 (c) MORATORIUM ON IMPLEMENTATION OF PROJECT
18 IN ANY AREA UNTIL JANUARY, 1, 2001.—Notwith-
19 standing any provision of section 4011 of the Balanced
20 Budget Act of 1997 (Public Law 105–33)), the Secretary
21 of Health and Human Services may not implement the
22 Medicare Competitive Pricing Demonstration Project in
23 any area before January 1, 2001.

24 (d) STUDY AND REPORT TO CONGRESS.—

1 (1) STUDY.—The Secretary of Health and
2 Human Services, in conjunction with the Competi-
3 tive Pricing Advisory Committee, shall conduct a
4 study on the different approaches of implementing
5 the Medicare Competitive Pricing Demonstration
6 Project on a voluntary basis.

7 (2) REPORT.—Not later than June 30, 2000,
8 the Secretary of Health and Human Services shall
9 submit a report to Congress which shall contain a
10 detailed description of the study conducted under
11 paragraph (1), together with the recommendations
12 of the Secretary and the Competitive Pricing Advi-
13 sory Committee regarding the implementation of the
14 Medicare Competitive Pricing Demonstration
15 Project.

Passed the Senate July 15, 1999.

Attest:

Secretary.

106TH CONGRESS
1ST Session

S. 1344

AN ACT

To amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage.

July 30, 1999

Ordered to be printed as passed